THE SELF-CONCEPT IN
PSYCHIATRIC REHABILITATION

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ABSTRACT

The aim of the study is to describe and explain changes in the self-concept at various stages during psychiatric rehabilitation. Viewing rehabilitation as a process of resocialisation and using self theories developed from the symbolic interactionist tradition, two groups of hypotheses are developed. The first concerns rehabilitees' expected rejection of the patient-role and acquisition of normal social roles. Concomitant changes in attitudes to self, self-esteem and identification with (other) psychiatric patients are hypothesised, with social milieu as an important variable. The second group of hypotheses concerns the effect on rehabilitees' self-concepts of the attitudes towards them held by close relatives. It is suggested that close relatives will find it hard to change their attitudes to rehabilitees (away from the negative stereotype of the psychiatric patient) and that rehabilitees will deal with the consequent discrepancy by reappraising either the feedback from close relatives or the significance of their close relatives.

An associated study provided an 'opportunist' sample of relatively long-stay and often chronically disabled rehabilitees whose current stage in rehabilitation could be defined by their place of residence. A secondary sample of close relatives was obtained from amongst the close relatives of these rehabilitees. During interview rehabilitees completed various self-report measures of the self-concept: semantic differential scales, 'Who-Am-I?' schedule and attitude scales; close relatives completed semantic differential scales.

The above measures provide a comprehensive body of data on the self-concept in psychiatric rehabilitation which largely supports the hypotheses. In particular the results confirm the importance for rehabilitees' self-concepts of the specific social milieu in which they live (i.e. the type of ward for those in hospital; whether or not they live with parents for those in the community). This contrasts with the attitudes of close relatives towards rehabilitees, which appear to be largely determined by whether or not rehabilitees are still in hospital. The findings enable a range of recommendations to be made regarding rehabilitation practice, especially in the area of individual treatment plans.
ACKNOWLEDGMENTS

As I explain in the Introduction, the opportunity to undertake this doctoral study came whilst I was working as a researcher in the Rehabilitation Unit at Netherne Hospital. I am greatly indebted to Dr. Ekdawi and other staff on the rehabilitation team for their co-operation and support in my research endeavours. Further, I am in no doubt that it was essentially my position as a member of the rehabilitation team that ensured such a positive response from both rehabilitees and their close relatives.

Most importantly my thanks are due to all the rehabilitees and close relatives who gave their time to be interviewed; talked openly about their lives; and so patiently completed the not inconsiderable number of self-report questionnaires on which the doctoral study is based.

Lastly, I would like to thank Dr. Margaret Norris for her energetic, supportive and constructive supervision; her encouragement and friendship over the past six years are greatly valued.
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1 INTRODUCTION

1.1 The Research Problem – Genesis and Development

The opportunity to undertake a doctoral research project occurred whilst the writer was employed as a researcher in the Rehabilitation Unit at Netherne Hospital. Since it became fully operational in 1958, the Rehabilitation Unit has concentrated on the resettlement of chronic, long-stay psychiatric patients in community based accommodation and/or employment. This is achieved through intensive programmes of re-socialisation and training in self-care and work skills in a series of graded living environments.

The genesis of the research problem was during the writer's first weeks at Netherne while she was familiarising herself with the various rehabilitation services, both within the hospital and out in the community. One such service was the Relatives' Meeting, held within the hospital for relatives of rehabilitees in the Rehabilitation Unit and at the Wingfield Day Hospital for relatives of rehabilitees who had been discharged from the Rehabilitation Unit to live in the community. Relatives' Meetings were intended to function as self-help groups, with relatives using their own experiences to help others. During the meetings it became apparent to the writer that relatives of hospital based rehabilitees were often very sceptical (and sometimes outrightly rejecting) of the rehabilitation team's plans for rehabilitees' resettlement in the community. These relatives talked of past experiences where discharge had all too often been followed by 'breakdown' and re-hospitalisation. Many of them voiced the opinion that 'people like this' were more appropriately cared for in hospital, as they were unable to take responsibility for themselves or to cope with life outside the hospital.

1. The hospital is situated in its own catchment area of North East Surrey, just outside the GLC boundary near Coulsdon.

2. To differentiate them from patients and ex-patients from other hospital units, current and former residents of the Rehabilitation Unit are referred to throughout the study as rehabilitees.
Some relatives of rehabilitees in the community had similar attitudes, especially if their rehabilitees were currently experiencing difficulties. They tended to see failure in one area of living (such as losing a job or being unable to obtain work) or an isolated episode of irresponsible behaviour (such as acting aggressively towards another resident in a Group Home or forgetting to do something important) as evidence that rehabilitees should really be in hospital where they were 'looked after' and 'safe'. In other cases, especially where rehabilitees lived in the parental home, relatives tended to make allowances for them, for example, by suggesting that they should 'take it easy around the house' or 'not worry about going to work if they did not feel like it'.

Thus, while programmes on the Rehabilitation Unit provided training in self-care and rehabilitees learned to take responsibility for themselves, in anticipation of taking up normal adult roles after discharge, some relatives seemed happier with the idea of their rehabilitees as occupants of the patient or sick role. What interested the writer was the effect of these attitudes on rehabilitees. In other words: how did rehabilitees cope with being seen as psychiatric patients by their close relatives when they were being encouraged by staff and other rehabilitees to see themselves as responsible adults capable of taking up normal social roles?

With the writer's initial observations now formulated in this way, several things became clear. Firstly, interest was centred on the relationship between rehabilitees' conceptions of themselves and the conceptions of them held by 'others' such as close relatives, other patients and hospital staff. Secondly, there were implications of changes in the self-concept during rehabilitation which were related to changes in social roles. Thirdly, before it was possible to address the above question, it would be necessary to obtain a more general understanding of the changes in self-concept which occur during rehabilitation: what changes take place; when does change take
place (at what stage of the rehabilitation process); where does change take place (what is the effect of different social environments on self-concepts)?

Thus, from a specific concern with the observed discrepancy between the attitudes prevalent on the Rehabilitation Unit and the attitudes of close relatives towards rehabilitees, the research problem broadened out into a more general study of self-concept and psychiatric rehabilitation in a population of relatively long-stay and sometimes chronic patients. The aim of the study is to describe and explain changes in the self-concept during psychiatric rehabilitation.

1.2 The Research in Context.

Since the doctoral research on the self-concept and the research completed for the Netherne Hospital Rehabilitation Unit are separate but over-lapping studies, it is necessary to clarify the writer's responsibilities for the latter and to put the two in context. The appointment at Netherne Hospital was for a period of eighteen months from June 1980, with the specific task of assessing the psychiatric rehabilitation needs of the East Surrey Health District. The design and implementation of that study, including all the stages of the research process and the written presentation of the findings were the writer's sole responsibility. Dr. M.Y. Ekdawi, Consultant Psychiatrist with special responsibility for rehabilitation, provided the necessary clinical input to the project and contributed to the 'Recommendations' chapter of the final report: Psychiatric Rehabilitation - Needs of a Health District (Collis & Ekdawi, 1982). The Appendices to the report presented a discussion on 'Social Adjustment in Rehabilitation' based on a number of behavioural and attitudinal measures, including two which are also included in the doctoral study (attitude scale measures of self-esteem and acceptance/rejection of the patient-role). A paper entitled 'Social Adjustment in Rehabilitation' has also been published (Collis & Ekdawi, 1984(a)).

This then was the background and starting point for the doctoral study.
of changes in the self-concept during psychiatric rehabilitation. The sample of rehabilitees was 'given' by the 'Needs of a Health District' study, and the use of structured interviews placed certain limitations on the number and type of self-concept measures which could be employed (3.3). Unlike the rehabilitee interviews in which data was collected for both projects, interviews with close relatives were completed specifically for the doctoral study. The more descriptive information obtained in those interviews has been presented as a Netherne Monograph entitled 'The Relatives' Story' (Collis & Ekdawi, 1984(b)).

It is recognised that the conducting of 'in house' research is likely to lead to some loss of objectivity on the part of a researcher, due to the internalisation of the attitudes of the milieu in which he/she works. In the present study, this is most likely to occur when comparing the attitudes of the rehabilitation team with those of the relatives. However, it is hoped that the recognition of this possibility, together with the fact that the writer has been away from Netherne Hospital during the period of analysis and interpretation, may guard against more serious bias of this nature.
2.1 A Symbolic Interactionist Theory of Self

2.1.1 The Self in History

Although recognised since the Homeric writings, the distinction between the physical human body and a non-physical 'self', 'soul' or 'mind' was essentially a philosophical and theological concern until late last century. However, few questions were raised about the nature of this distinction until Descartes (Diggory, 1966). In his 'Principles of Philosophy' Descartes (1644) introduced his now famous dictum 'I think, therefore I am', which he used as evidence of the distinction between the 'mind' and the body. On the basis that one can doubt the existence of the body but not of the mind which thinks, he considered that the two must be separate. He also distinguished between this 'I' the thinker, a 'thinking, knowing, cognizing entity' (Meltzer et al, 1975:6), the subject of knowledge, and the thoughts or objects of knowledge. It is this latter distinction which became central to later discussions on the 'self', although most of the 18th and 19th century philosophers were more interested in the self as subject, that is the process of experience and knowing the self, rather than the self as object, that is the content of experience and knowledge. Thus Berkeley (1710) concluded: 'We need only the knowing, thinking, willing subject, which Descartes had said we could not doubt the existence of' (Diggory, 1966:6).

However, introspection led Hume (1888) to doubt the existence of such a self since he was unable to find any consciousness of continuity between his perceptions: 'all our distinct perceptions are distinct existences and the mind never perceives any real connection among distinct existences' (Appendix to Book 1). Thus rather than a consciousness of unity, which Locke had considered to be the overriding characteristic of the self, Hume found that consciousness of diversity characterised the self. The Mills also directed their attention to the problem of the continuity of consciousness. James Mill (1869) found the continuity
which Hume had sought in memory: 'after defining Memory as a train of associated ideas beginning with that of my past self and ending with that of my present self, (James Mill) defines my Self as a train of ideas of which Memory declares the first to be continuously connected with the last' (James, 1891: 355). John Stuart Mill (1865) seemed to retreat from such an explicit statement of the link between perceptions and wrote only of 'the inexplicable tie ... which connects the present consciousness with the past one of which it reminds' (p.263).

It was left to the psychologist William James not only to present the first coherent account of the 'inexplicable tie', but also to reunite the self as subject and the self as object. While James (1891) agreed with the idea of self as 'a train of feelings or thoughts', he criticised the philosophers for their concentration on a consciousness of diversity and found them to be 'very shy about openly tackling the problem of how it comes to be aware of itself' (p.354). James found both unity and diversity in the train of feelings and thoughts, and did not need to resort to a metaphysical entity such as the 'soul', as some philosophers such as Locke and Kant had done, to explain the 'I which knows'. He presented a purely phenomenal solution of the present or 'judging Thought': 'at each moment different from that of the last moment, but appropriative of the latter, together with all the latter called its own' (p.401). Referring to the unity-diversity dichotomy, he says: 'both connection and separation are ways in which the past thoughts appear to the present Thought; - unlike each other in respect of date and certain qualities - this is the separation; alike in other qualities, and continuous in time - this is the connection' (p.353).

2.1.2 The Self of the Early Interactionists

Early Self Theorists

Mead (1863-1931) is generally considered to be both the father of the Symbolic Interactionist tradition, and the leading exponent of one of its central concepts, the self. Several of his (near) contemporaries also made important contributions to the interactionist perspective: Dewey (1859-1952), a philosopher and psychologist, a friend of Mead's
and a member of the Chicago school; Cooley (1864-1929), a sociologist at the University of Michigan who studied under Dewey and was considered a member of the Chicago school; Thomas (1863-1947), a sociologist and early interactionist. Among them Mead and Cooley were the main self theorists and it is their ideas which will form the core of this section.

However, prior to the theorising of the interactionists, James (1842-1910) had expounded a psychological view of self which had considerable influence on their thinking, and which in fact incorporated many of the essential characteristics of the Symbolic Interactionist framework (the self as a reflexive process, social in nature and multiple in structure). This was not surprising since James and the interactionists shared similar conceptions about the nature of man (both determined and determiner) and about the relationship of the individual and society (society being prior to the individual). Hence it seems appropriate to include the ideas of James along with those of Mead and Cooley in this analysis of the self of the early interactionists.

The Self is Reflexive

To Mead, the essential and distinguishing characteristic of the self was its reflexiveness; it was simultaneously both subject and object. While this idea was not new, his analysis of the basis of this reflexiveness differed from other theorists like James who also recognised this important characteristic of the self. James identified two 'discriminated aspects' of the self, which he referred to as 'the self as knower' and the 'self as known', or alternatively the 'I' and the 'me'. As the subject and object of consciousness the two could not be separated 'because the identity of I with me, even in the very act of their discrimination, is perhaps the most ineradicable dictum of common-sense' (1968:41). The self as knower or 'I', James held to be 'that which at any given moment is conscious ..... it is the Thinker'(1968:46) or 'judging Thought', able to remember, experience and have feelings about that which is objectively known or the 'me'. 'A Man's Me' he defined as 'the sum total of all that he CAN call his' (1891:291) and to which the 'I' experiences certain kinds of feelings or emotions: 'self-complacency' ('pride, conceit, vanity, self-
esteem, arrogance, vainglory') and 'self-dissatisfaction' ('modesty, humility, confusion, diffidence, shame', etc.) (1891:306).

Unlike James and Mead, Cooley (1902) was essentially concerned with the self as object, 'the empirical self, the self that can be apprehended or verified by ordinary observation' (1964 [1902]:168). He defined the self as 'simply that which is designated in common speech by the pronouns of the first person singular, 'I', 'me', 'my', 'mine', and 'myself' since these imply 'a characteristic kind of feeling which may be called the my-feeling' (p.168/9). Thus as for James, the self as object appropriates those things which are identified with or possessed by the individual and which call out certain kinds of self-feeling. Mead was critical of these attempts by James and Cooley 'to find the basis of the self in reflexive affective experiences, that is, experiences involving 'self-feeling'; (since) the theory that the nature of the self is to be found in such experience does not account for the origin of the self or of the self-feeling which is supposed to characterize such experiences' (1934:173). For Mead, the individual can only become an object to himself by taking the attitudes of others towards him; he 'experiences himself as such, not directly, but only indirectly' from the standpoint of others (p.138). This process of self-consciousness is made possible by language and the internalised 'conversation of gestures'. Mead uses the example of an individual who starts to say something unpleasant, but by taking the attitude of the other and becoming an object to himself realises that it is a cruel thing to say, and in consequence checks himself. It is this 'self-consciousness rather than affective experience ...... (which) provides the core and primary structure of the self, which is thus essentially a cognitive rather than an emotional phenomenon' (p.173) as suggested by James and Cooley. Once the self is developed an individual 'is able to think and to converse with himself as he had communicated with others' (p.140).

The Self is Social

According to Mead, the individual is not born with a self, but it arises during social experience. Society is prior to the individual, and the
social group into which the individual is born provides the immediate or
significant others necessary for the first stage of the development of the
self. Mead termed this the 'play stage' in which the child takes the
attitudes of significant others towards him, and towards one another.
In the second, or 'game stage' he learns to generalise all the attitudes
of individual others into a pattern of attitudes held by the social group(s)
to which he belongs and to take these generalised attitudes for his own.
By this means the community is able to exercise control over the conduct
of its members.

Mead's self then is a social structure in both origin and form: it has its
genesis in social experience and its reflexiveness depends on the
individual taking the attitude of the other, whether individual others or
the generalised other of a social group or the general community. By
comparison James' social self was only one constituent of the self as
object or 'me', defined as 'the recognition which (the individual) gets
from his mates' (1891:293). The other parts of the self consisted of the
material me and the spiritual me. However, at the time his ideas
represented a 'significant advance' in 'the removal of the concept of self
from the purely metaphysical realm and the view of at least some aspects
of it as derived from interaction in the social environment' (Meltzer
et al, 1975:6). Cooley went one step further and saw the total objective
self as a social self. He considered the objects appropriated to self
were social in two ways. Firstly, their meaning was derived from a
common language and culture: Cooley saw the individual and society as
'twinborn' and stressed the importance of the social group in mediating
the expectations and norms of the wider community to the individual.
Secondly, the individual's conception of self and his evaluation of it
depended on how he thought others saw and evaluated him. For this process
Cooley coined the phrase 'looking-glass self', which idea he considered
'to have three principal elements: 'the imagination of our appearance to
the other person; :the':imagination of his judgment of that appearance, and
some sort of self-feeling' (1964 /1902/: 184). Thus others are intimately
bound up in the individual's conception of self and he will come to see
himself as others see him.
The Self has Two Phases

The social origins and structure of the self as outlined above, could appear to give a very deterministic view of man, with his actions entirely defined by the attitudes of others. However, this would be quite erroneous since the early interactionists specifically rejected the deterministic views of Spencer and his followers, and were much drawn towards the pragmatic view of man as 'active, creative beings who could play a conscious role in their own destinies' (Meltzer et al., 1975:7). In fact the interactionists took a stance intermediate between the two; Mead saw the individual as able to choose how to satisfy his blocked impulses, within the constraints imposed by his position in society. Thus the individual was both determined and determiner. Mead internalised this dual system into the self by identifying two phases to the process, the 'I' and the 'Me'. 'The 'I' reacts to the self which arises through the taking of the attitudes of others. Through taking those attitudes we have introduced the 'me', and we react to it as an 'I' (1934:174). In other words, the 'me' represents the generalised other or the determinate phase of the self and the 'I' is the response which is uncertain and represents the non-determinate phase of the self. It is the 'I' which 'gives the sense of freedom, of initiative' (p.177). Mead puts the role of the two phases of the self quite clearly when he says: 'the self is essentially a social process going on with these two distinguishable phases. If it did not have these two phases there could not be conscious responsibility, and there would be nothing novel in experience' (p.178).

The Self is Multiple

Both James and Mead viewed the self as being multiple rather than unitary; an individual has many selves, and each is related to either individual others with whom the individual interacts, or to the social groups of which he is a member. According to Mead 'we divide ourselves up in all sorts of different selves with reference to our acquaintances' (p.142); he called these 'elementary selves' and saw a multiple personality as
normal. To James, 'a man has as many selves as there are individuals who recognize him and carry an image of him in their mind' (1891:294). Since these individuals could be grouped into classes this definition could refer to 'distinct groups of persons about whose opinions he cares' (p.294) rather than to individuals. Mead also saw his 'elementary selves' as answering to the different social groups to which the individual belonged.

Self-Evaluation and Self-Esteem

James, Cooley and Mead all made some reference both to the individual's need for a positive self-evaluation and to the motivational bases of self-esteem. Their emphasis on the role of others and the social group in motivation developed parallel with the changing view of the relationship between the individual and society. The individualistic orientation of early American sociologists (notably Ward) had led to the idea of behaviour being motivated from within the individual, through instincts. However, from the interactionist viewpoint society preceded the individual, and this led to the recognition of the importance of the social group in human motivation on account of the shared meanings by which behaviour was interpreted. Cooley, as noted above, was quite explicit as to the importance of the judgment of others in determining both the individual's conception of self and the self-feeling attached to that conception. He considered the self-feeling to be instinctive with the 'important function (of) stimulating and unifying the special activities of individuals' (1964 A902:171) and to be based on how others judged the individual. Thus Cooley combined both biological and social bases of motivation. He also considered that the 'character and weight' of the others is important in affecting the individual's self-feeling, incorporating the idea of social comparison. 'We are ashamed to seem evasive in the presence of a straightforward man, cowardly in the presence of a brave one, gross in the eyes of a refined one, and so on' (p.184). Cooley suggests that a positive self-feeling seems to be attached to those things
which the individual can excel at and do better than others with whom he compares himself. However, the others who judge the individual may not always be 'distinct and particular', they may be 'vague and general', in which case the individual is 'expressing his sense of social responsibility' (p.182). These 'vague and general' others would appear to be equivalent to Mead's generalised other.

James also uses the term self-feeling (or self-appreciation) to apply to the emotions the 'I' or self as knower experiences with respect to the contents of the self as known or 'me'. Self-esteem he notes is just one of the synonyms for a positive self-feeling. To James, an individual's self-feeling is determined by his 'actual success or failure, and the good or bad actual position one holds in the world' (1891:306). While the latter would appear to be socially determined, James does not elaborate further, but concentrates on the part played by 'actual success or failure' in the determination of self-esteem. Cooley stresses the importance to the self-feeling of those things on which an individual compares favourably with others; James makes quite explicit the fact that some parts of the self are more important to the individual than others in determining his self-feeling or self-esteem. The individual has to choose a self (or selves) on which to stake his self-feeling: it seems likely to be a self in which he can excel. However, his self-feeling is not only determined by his actual level of achievement, but also by what he has backed himself to achieve. To James then, self-esteem is 'the ratio of our actualities to our supposed potentialities: a fraction of which our pretensions are the denominator and the numerator our success: thus,

\[
\text{Success} = \frac{\text{Self-Esteem}}{\text{Pretensions}}
\]  

(1891:310)
Thus an individual who has set himself the goal of being the number one oarsman in the world is shamed to find he is only the number two. 'He is to his own regard as if he were not, indeed, he is not' (p.310). The mathematical analogy shows clearly that self-esteem may be increased either by greater effort and increased 'success' or by lowering one's goals and diminishing 'pretensions'.

Mead himself does not use the terms self-feeling or self-esteem, but his 'self-realization' appears to be a comparable concept. The individual is continually seeking realisation of his self and 'since it is a social self, it is a self that is realized in its relationship to others' (1934:204) and particularly through its 'superiority' to others. While superiority may come from one's membership in a prestigious social group, Mead, like Cooley, stresses the need to distinguish ourselves from others through 'things which on the whole we do better than other people do' (p.205). This success or positive self-evaluation in comparison with others leads to feelings of self-satisfaction. Like Cooley, Mead also acknowledges 'that any adequate explanation of motivation had to account for the biological, as well as the social, heritage of humans' (Meltzer et al, 1975:33); Mead uses the term impulse instead of instinct, to refer to the innate tendencies in the individual. The defining character of impulses is 'undifferentiated activity' which has its ends socially defined, with membership of a social group 'a prerequisite for the realization of the biological potential' (Meltzer et al, 1975:49).

The Self of the Early Interactionists - A Summary

1. The self is a reflexive process whereby the individual becomes an object to himself by taking the attitude of others towards himself. 'It is a structure of attitudes then, which goes to make up a self' (Mead, 1934:163).

2. The self is social in origin and structure; it arises out of
social experience and reflects the attitudes of the social group to which the individual belongs. The attitudes may be those of significant others or of the generalised other.

3. The self is multiple: the individual has as many selves as there are individual others with whom he interacts or as there are social groups to which he belongs.

4. The reference points for self-evaluation include (i) the attitudes of significant others (ii) the attitude of the generalised other (iii) social comparison with others (iv) self-chosen goals.

5. The self plays an important role in directing and explaining human behaviour: 'the behavior of men and women is 'caused' not so much by forces within themselves (instincts, drives, needs, etc.) but what lies in between, a reflective and socially derived interpretation of the internal and external stimuli that are present' (Meltzer, et al., 1975:2).

6. The self has two phases the 'I' and the 'me' which represent the indeterminate and determinate, individualist and social, sides of human behaviour. While the 'me' represents the attitudes of the generalised other the 'I' represents the impulsive tendencies of the individual, and allows for novelty and innovation in human behaviour.

2.1.3 Development of the Interactionist Theory of Self

Criticisms of the Traditional View of Self

In their review of the 'in-house' criticisms of symbolic interactionism, Meltzer, et al (1975) note that the key concept of self 'is the source and object of much confusion and disagreement' (p.94). While this has led to the self of the early interactionists, especially Mead, being interpreted and developed
in (at least) two quite different ways by later interactionists, the source of the 'confusion and disagreement' is often held to be the founding father of symbolic interactionism himself. Mead has been criticised both for his imprecise and varying definitions of key concepts, and for his failure adequately to define conceptual relationships. With particular reference to his analysis of the self, the concepts so criticised include impulse, the 'I', self, self-consciousness, generalised other and attitudes (Meltzer, 1959), and the interrelationships between the 'I' and the 'me' and between self and other (Kuhn, 1964). A second group of criticisms relates to the problems of armchair theorising: Meltzer (1959) suggests that there is a lack, not only of empirical support for many of Mead's ideas, but also of any suggestions as to how such research should (or could) be carried out.

Kuhn versus Blumer, Structure versus Process

According to Meltzer, et al (1975) these methodological issues are at the core of Kuhn's criticisms of Mead, and are central to the development of the view of self generally ascribed to the Iowa school of symbolic interactionism, of which Kuhn has been the foremost proponent. Kuhn's self theory contrasts with the view of self developed by Blumer and his colleagues at the University of Chicago, which is considered to follow closely the 'classical, Meadian tradition' (Meltzer, et al, 1975:55). These two perspectives on the self make quite different assumptions regarding the nature of human behaviour (whether it is free or determined) and appropriate methods of researching the self. However, since these differences are reflected in the fundamental debate between structure and process, it is from this dichotomy that an analysis of the two views of self is presented: 'is the self the content or products of reflexive behavior or the relation which defines reflexive behavior as unique from other sorts of social behavior?' (Wells & Marwell, 1976:46).
While Blumer views the self as a process, emphasising the interaction between the 'I' and the 'me' and the self as emergent in the social act, much as Mead himself did, Kuhn defines the self as an organised structure of self-attitudes, which is relatively stable and situationally non-specific. For Blumer (1969) 'such schemes ........ make no sense since they miss the reflexive process which alone can yield and constitute a self' (p.63). Further, the ongoing interactions between the 'I' and the 'me', whereby the individual rehearses plans of action, assesses their outcome, changes them and formulates new ones, brings about 'the possibility of novelty in behavior' (Meltzer et al, 1975:63) and shows the individual as actively constructing his behaviour.

On the other hand, in Kuhn's theory, behaviour is released rather than constructed, since it is determined by the individual's self-attitudes. These self-attitudes are themselves determined by the individual's location in society (his/her significant social groups) not by interaction in specific social situations. Thus Kuhn's theory 'takes no explicit cognizance of either impulses or the I-me components of the self' (Meltzer & Petras, 1970:10) and behaviour is determined by the 'me'. While theoretically Kuhn rejects this totally deterministic view: 'the individual is not merely a passive agent automatically responding to group-assigned meanings of objects' (Hickman & Kuhn, 1956:26) it is methodologically simpler since it 'conveniently disposes of such 'non-empirical' concepts as the I and impulses' (Meltzer et al, 1975:62). Critical of Mead's empirically unproven analysis of the self, Kuhn attempted to apply the scientific method to analysis of the self, with the result that he tended to reconceptualise or abandon those ideas he considered non-empirical. In consequence his self-theory views the self as a structure (of self-attitudes) rather than a (reflexive) process: he operationalised the self by defining it as the responses given to the question 'Who am I?'

Although Meltzer et al (1975) suggest that Kuhn used the term
self-theory 'in recognition of the magnitude of (the) modifications
of symbolic interactionism' (p.67), Kuhn himself (1964) states
quite clearly that his intention was not to 'differentiate an
emerging point of view from the more or less orthodox ideas of
symbolic interaction' (p.71). However, it seems likely that his
quest to develop a 'derivative ... set of generalizations, tested
by empirical research' from within 'a body of conjectural and
deductive orientation' (p.71), 'led him to a particular image of
man' (Meltzer & Petras, 1970:9) whereas 'Blumer's image of man led
him to a particular methodology' (p.9).

Blumer's criticism of Kuhn's method (as of all forms of
'questionnaires, schedules, tests, laboratory procedures, and
detached observation') is that it fails 'to catch the meanings that
crucially mediate and determine how individuals respond to objects
is no substitute for 'firsthand knowledge' (p.39): 'to catch the
process of interpretation through which (individuals) construct
their actions ....... the student must take the role of the
(individual) whose behavior he is studying' (Blumer, 1962:188).
Therefore, he argues for 'naturalistic inquiry, embracing the dual
procedures of exploration and inspection' (Blumer, 1969:47), using
participant observation (plus interviewing, listening, life histories,
letters and diaries, public records, group discussions, etc.).
However, from a purely practical point of view, it is hardly feasible
for a student or researcher to 'form a close and comprehensive
acquaintance with (every) sphere of social life that is unfamiliar
and hence unknown to him' (p.40). By comparison the content of the
structural self, that is an individual's self-attitudes or self-
conceptions is relatively easy to obtain via specially constructed
questionnaires and attitude scales or asking individuals to respond
to the question 'Who am I?'.
2.1.4. Self and Others

Feedback from Others

The importance of others in determining an individual's self-attitudes and self-evaluation has been central to symbolic interactionist views of self since Cooley's theory of the 'looking-glass' self and Mead's description of how the individual experiences him/her-self only indirectly by taking the attitude of others towards him/her. This section makes a more systematic analysis of the ways in which feedback from others occurs during interaction. The discussion then moves on to a consideration of which others are likely to have the most effect on the individual's self-attitudes. The final section considers the effect of a discrepancy between self-attitudes and others' attitudes to self.

Direct feedback from others is obtained through the process of 'reflected appraisal', whereby the individual's self-attitudes reflect the way others see him/her, through his/her interpretation of their behaviour towards him/her. Cooley, in his discussion of the 'looking-glass' self, stressed that what is important is the individual's 'imagination' of how he/she appears to others and how they judge him/her; that is their perceived response rather than their actual response. Since 'no one can ever enter the mind of another with unerring accuracy; he can only make a judgment of the other's view' (Rosenberg, 1973:830), there is likely to be greater congruence between the individual's perception of how others see him/her and his/her own self-attitudes than between how others actually see him/her and his/her own self-attitudes.

However, the individual is not a passive reflection of the opinions of others and social interaction is likely to influence self-attitudes in several indirect ways, the most important of which is social comparison. Again, Cooley was one of the first to draw attention to this process, for he noted that an individual is 'ashamed to seem evasive in the presence of a straightforward man' (1964:[1902]:184). Festinger (1954) in his theory of social comparison also suggests that individuals rely
on comparison with others in their social group to evaluate their own 'opinions and attitudes' (including opinions and attitudes about themselves). Further, 'when a discrepancy exists with respect to opinions or abilities' he suggests that 'there will be tendencies to change one's own position so as to move closer to others in the group' (1968:132).

Several other forms of indirect feedback have been identified by Shrauger and Schoeneman (1979). They note that the deliberate performance of socially desirable actions when interacting with specific others is likely to lead to a change in self-attitudes through reflection by the individual of his own behaviour. An individual also receives indirect feedback when observing the interaction in which one person is appraised by another, since he gauges how others would be likely to appraise him. Finally, Shrauger and Schoeneman note that others influence an individual's self-attitudes simply by how they interact with him, that is by the implications of their actions and responses although there is no explicit appraisal. For example, a boss may not actually tell an individual whether he considers her to be a competent or incompetent worker, but he will imply as much by giving her or not giving her a specially important piece of work.

Which Others?

'Individuals are continually interacting with a set of potentially significant others whose opinions, cognitions, expectations, and evaluations they perceive and evaluate and incorporate into the self' (Kemper, 1966:325). While Kemper notes simply that the number of actually significant others is limited by time, the social structure and cultural prescriptions, Rosenberg (1973) makes a detailed analysis of interpersonal factors determining just which potentially significant others become significant. He sees the key factor as the individual's attitude towards the other and gives it an important role in the development of self-attitudes: since 'significance is in the eye of the beholder; ultimately, he alone can determine whether a particular other is significant to him' (p.831). Significance in this context has
two aspects, valuation and credibility. Valued others according to Rosenberg 'are people whose opinions we care about, whose opinions make a difference to us' (1973:831), while credible others are those whose opinions we respect; 'respect ...... involves confidence in the good judgment of the other' (p.831).

Since the individual decides whose opinions he/she cares about, valued others are likely to be those who confirm the individual's self-attitudes and who think well of him/her. Backman, Secord and Pierce (1963) suggest that individuals will selectively interact with others who treat them in a manner congruent with their self-attitudes and that they will evaluate them positively, that is to say 'like them'. On the other hand, they will avoid contact with others whose view of them is discordant with their own, and will come to dislike them. Thus individuals are likely to decide that they 'don't care' what others with discordant or derogatory views of them think. Likewise, individuals are more likely to respect the views of others if they are consistent with their own and complimentary, but to doubt the credibility of those who are critical, since they have 'little understanding of what (the individual) is really like' (Rosenberg, 1973:848).

Thus, Rosenberg suggests that the influence of others on self-attitudes is greatest where the other is a valued and credible source of feedback. In consequence he amends Mead's (1934) statement 'we are more or less unconsciously seeing ourselves as others see us' (p.68) to read 'we are more or less unconsciously seeing ourselves as we think others who are important to us and whose opinions we trust see us' (Rosenberg, 1973:857). From this it follows that congruency between self-attitudes and the individual's perception of other's attitudes towards him/her is likely to be greatest where the other is a valued and/or credible other.

The Effect of Discrepancies between Self-Attitudes and Other's Attitudes to Self

If there is congruence between self-attitudes and other's attitudes to
self, then the outcome will be to 'fortify' the individual's self-attitudes. However, if there is a discrepancy this will lead to 'dissonance or tension that requires cognitive reappraisal' (Shrauger & Schoeneman, 1979:567). The above discussion suggests that the individual will either reappraise his/her own self-attitudes in the direction of the perceived attitudes of other, or reappraise the other so that he/she is no longer valued and/or credible. A third possibility is that the individual will distort the feedback from a significant other to make it more congruent with self-attitudes, but at the same time widen the gap between the perceived attitudes of other and the actual attitudes he/she accords the individual.

Which of the above processes dominates is likely to depend on the relative influence of several competing and inter-related factors: (1) the characteristics of the other; (2) whether other's attitudes are more positive or negative than the individual's self-attitudes; (3) the availability of contradictory feedback; (4) the characteristics of the self-attitudes under threat. While the first two factors have already been discussed, it is necessary to briefly describe the influence of (3) and (4) on a discrepancy between self-attitudes and other's attitudes to self. Factor (3) suggests that if feedback from other sources contradicts other's discrepant view of self and is of greater frequency, then the discrepant feedback or its source is likely to be reappraised rather than the individual's self-attitudes (Gergen, 1971).

Regarding factor (4), Shrauger and Schoeneman (1979) note that the certainty of the self-attitudes under consideration is particularly important: certainty is affected by salience, clarity and the degree to which social comparison is possible. Thus, they suggest that a self-attitude that is highly salient, has clearly defined criteria against which it is judged (clarity) and for which there are many opportunities for social comparison, should have a high degree of certainty for the individual and be unlikely to be affected by the discrepant view of a significant other.
2.1.5 **Self and Social Roles**

**Social Roles and Self-Conception**

The previous section showed how interaction with others plays a key part in the formation of, and change in, self-attitudes/conceptions. This section follows on from that discussion by examining the framework within which self-other interactions take place, namely social roles.

In interaction, individuals approach each other in terms of self and other roles, which carry with them certain behavioural expectations. According to Turner (1968), a role is not 'a set of prescriptions inherent in a position .... (but) refers to a pattern which can be regarded as the consistent behavior of a single type of actor' (p.25). Through his 'performance' the individual puts across the idea of himself/herself as a particular type of 'actor', such that the other's interpretation of his/her behaviour will be consistent with his/her own view. At the same time he/she interprets the response behaviour of the other through the Meadian process of 'taking the role of the other', and formulates his/her own response accordingly. Thus, interaction 'is always a tentative process' (Turner, 1968:23) based on the principle of 'role reciprocity': for every role there is a corresponding other-role.

The self-role relationship is particularly important in explaining how changes in self-conception take place. Performance of a role (role-playing) tends 'to move the person's underlying view in the direction favored by the role' (Gergen, 1971:56) and he/she 'comes to see himself (herself) as actually having those attributes characterizing the role' (p.55). This is the process of identification, whereby the individual takes over the role as his/her own; further, seeing himself/herself as a certain type of person, he/she then tends to generalise this behaviour to other situations. These effects of role-playing are obviously strengthened if the others with whom the individual interacts accept his/her role performance and give it legitimacy through their responses.
Their praise or positive evaluation of the individual's role-playing is also likely to encourage changes in self-conception, since 'if a person is rewarded for behaving in a particular role, he should come to prefer it and should receive gratification for thinking of himself in terms of the role (Gergen, 1971:57).

Thus social roles (and their associated behavioural expectations) form the organising structure for social interaction; they also form the core of self-conceptions, since for every role the individual plays there is a corresponding conception of self.

Theoretical Views of the Self-Role Relationship

The idea of the self 'as a structure of attitudes derived from the individual's internalized statuses and roles' (Meltzer et al, 1975:64) was implicit in the work of both James and Mead. They developed the notion of multiple selves, each relating to different others with whom the individual interacted or to social groups to which he/she belonged (2.1.2). The Iowa school of symbolic interactionism made the relationship more explicit: 'Central to an individual's conception of himself is his identity; that is, his generalized position in society deriving from his statuses in the groups of which he is a member, the roles which stem from these statuses, and the social categories which his group memberships lead him to assign himself' (Kuhn, 1964:630/1).

The link between self and role has been developed further in the more recent writings of the identity theorists (McCall & Simmons, 1966; Stryker, 1968; Burke, 1980) who see the self in terms of 'some sort of dynamic, hierarchically organised system of social identities as the core structure of a person' (McCall, 1977:278). According to Stone (1962) 'identity establishes what and where the person is in social terms ...... One's identity is established when others place him as a social object by assigning him the same words of identity that he appropriates for himself or announces' (p.93). Stone stresses that 'identity' is not equivalent to 'self', although it is 'close to Mead's conception of the 'me', the self as object related to and differentiated
from others' (p.94). Hewitt (1984) defines identity in a similar way (the location of the self in relation to other selves) and sees it as one of the three analytical divisions of the self as object, of which the other two are its qualities and attributes, and its evaluation.

According to Stryker (1977) identity theory is concerned with the behavioural consequences (role performance) of changes in parts of the self (identities). The link between role and self is to be found in interaction, where 'the meanings of the self are learned by the person because others respond as if he had an identity appropriate to that role performance' (Burke & Tully, 1977:883). Thus Burke and his colleagues use the term role/identities after McCall and Simmons (1966) in order to 'keep this link between self and role explicit' (Burke & Tully, 1977:883). They define role as the external component and identity as the internal component. Although particularly interested in the influences of identity on role performance, Burke and his colleagues acknowledge that there is also some influence in the other direction; ultimately their concern is with the nature of the link rather than its direction. That link is 'common meaning': 'the meanings of the self (as object) are established and assessed in terms of the meanings of the performance generated by the self (as subject) within the culture of the interactional situation' (Burke & Reitzes, 1981:85).

Thus identities as defined by Burke (1980) are self-in-role meanings: they are relational (defined in terms of counter identities, just as roles are defined in terms of other or counter roles); they are reflexive ('identities influence performance and these performances are assessed by the self for the kinds of feedback they imply' (p.20)); and they motivate social behaviour (by classifying and naming performance according to shared meanings).

2.1.6 Proposals for a Working Synthesis of the Self-Concept

Structure versus Process - A Compromise

Whilst the Chicago (Blumer) and Iowa (Kuhn) schools of symbolic
interactionism have described the self as either a process or a structure (2.1.3), some theorists have attempted to combine the processual and structural features of the self. Thus Gordon (1968) has proposed 'a relatively rigorous definition' (p.116) which he sees as the first requirement for an adequate program of self-conception:

'The self is not a thing; it is a complex process of continuing interpretive activity - simultaneously the person's located subjective stream of consciousness (both reflexive and non reflexive, including perceiving, thinking, planning, evaluating, choosing, etc.) and the resultant accruing structure of self-conceptions (the special system of self-referential meanings available to this active consciousness)' (1968:116).

Thus while acknowledging the essentially processual characteristics of the self as expounded by Mead and the Chicago school interactionists, this definition recognises that 'it must be empirically studied primarily in terms of its content and structure' (Wells & Marwell, 1976:48), that is in terms of self-conceptions/perceptions/attitudes and their evaluation, self-esteem/regard/acceptance.

The Self-Concept Defined

The self-concept is the self as object, and as such consists of the reflexive perceptions of the individual about himself/herself, that is his/her self-conceptions or self-attitudes. These self-conceptions incorporate social identities (location of self in relation to others), individualising attributes (personal qualities), and an evaluative component (evaluation of self with reference to significant others, generalised others or the individual's own performance).

Self-Concept and Behaviour

Formation of, and change in, self-conception takes place during social interaction either by direct feedback from others (the individual's self-conception reflects the way others see him/her, through his/her interpretation of their behaviour towards him/her) or by indirect feedback (especially social comparison processes whereby the individual
compares himself/herself with others in his/her reference group(s) in order to evaluate his/her own attributes or performance). (2.1.4).

The organising framework for interaction is provided by social roles (individuals approach each other in terms of self and other roles which carry with them certain behavioural expectations), the internal component of which is the individual's social identity - an integral part of his/her self-concept as defined above. The role/identity link mirrors the behaviour/self-concept link which works in both directions. Thus, while the self-concept serves to direct behaviour, behaviour (role performance) which receives appropriate feedback from others leads to the internalisation of the concomitant identity and other personal attributes which characterise the role into the self-concept. (2.1.5).

Components of the Self-Concept

While in the strict sense (as defined above) the self-concept refers only to the individual's self-attitudes, previous sections (2.1.2, 2.1.4) have described a number of other categories of self-related attitudes which influence the individual's self-attitudes. Thus, it is proposed to broaden the scope of the term self-concept to include the following components:

(1) **Real-Self** - the individual's self-conception/self-attitudes, or how the individual defines 'himself to himself/herself to herself'.
(2) **Perceived Self** - the perceived attitudes of others to self, or how the individual thinks others see him/her.
(3) **Accorded-Self** - the attitudes which others accord to self, or how others actually see the individual.
(4) **Ideal-Self** - the individual's 'ideal' self-conception, or how the individual would like to be (based on the expectations of his/her reference groups).

Relationships between Components of the Self-Concept

(a) **Real-Self/Perceived-Self**: the individual's self-attitudes are based

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1 The 'working synthesis' here outlined follows closely the work of Kinch (1963) in developing 'a formalised theory of (interactionist notions of) the self-concept'.
on his/her perception of others' attitudes towards him/her. There is likely to be greater congruency between self-attitudes and other's perceived attitudes if the other is seen to be significant (valued and/or credible) and has more frequent contact with the individual than others whose perceived attitudes are contradictory.

(b) Perceived-Self/Accorded-Self: the individual's perception of the attitudes of others reflects the actual attitudes of others towards him/her. There is likely to be greater congruence between other's perceived and actual attitudes to the individual where the other's actual attitudes are complimentary. The corollary is that derogatory attitudes may require reappraisal (distortion) unless the other is no longer to be seen as significant.

(c) Real-Self/Accorded-Self: it follows that the individual's self-attitudes reflect the actual attitudes of others towards him/her. Congruency depends on the interplay of a number of factors: the characteristics of the other; whether other's actual attitudes are more positive or more negative than the individual's self-attitudes; the availability of contradictory feedback (direct and indirect).

(d) Real-Self/Ideal-Self; the discrepancy between attitudes to self and the ideal-self can be used as a measure of self-esteem; the smaller the discrepancy then the higher the individual's self-esteem, that is the closer he/she comes to 'living up to' his/her expectations of himself/herself. Since the individual's personal ideal reflects the ideal of his/her current reference group(s), changes in self-esteem can occur through changes in attitudes to self or to the ideal-self.

This definition of self-esteem relies on indirect evaluation (by comparison of the Real-Self and the Ideal-Self), but there is an alternative definition based on direct evaluation which will also be used in this study. This is the 'evaluative component' of the self-concept which Coopersmith (1967) describes as 'the evaluation which the individual customarily maintains with regard to himself: it expresses an attitude of approval or disapproval' (p.4/5). It is both specific and global, with the evaluation of each self-conception being summed to produce an overall evaluation.
2.2 A Theory of Psychiatric Rehabilitation

2.2.1 Rehabilitation and Social Roles

The aim of rehabilitation is resettlement, the success of which is judged by the extent to which the disabled individual is able to work independently, to sustain ordinary domestic and family responsibilities, and to make enjoyable and creative use of his leisure time.

(Bennett, 1978:211)

Rehabilitation should be concerned with optimal restoration of social roles and social functioning within the social systems significant for the patient, such as family, job, various associations, and participation in the general life of the community.

(Freeman & Simmons, 1963:ix)

Rehabilitation for psychiatric patients is essentially concerned with preparation and training to take up normal social roles; they must leave behind the institutionalised patterns of behaviour and attitudes appropriate to the role of psychiatric patient and learn new ways of acting and thinking concomitant with family, work and recreational roles. An interactionist perspective on social roles has already been introduced (2.1.5) but the concept may be viewed from an alternative perspective. The functionalists view social roles as given and external to the individual, representing clear prescriptions for action: the individual puts into action patterns of behavioural expectations dependent on his/her status or social position. Thus role is viewed as the dynamic aspect of status, since 'when he (the individual) puts the rights and duties which constitute the status into effect, he is performing a role' (Linton, 1936:113).

This deterministic view of social role is criticised by symbolic interactionists who stress the importance of situational aspects and the interactive relationship. Individuals negotiate the actual patterns of behaviour within broadly defined limits established by the behavioural expectations they bring to the encounter. They interpret the other's behaviour by taking the role of the other and responding in terms of the 'continuing dialectic between 'I' and 'me'' (Turner, 1962:23). Thus 'the actor is not the occupant of a position for which there is a
neat set of rules - a culture or set of norms - but a person who must act in the perspective supplied in part by his relationship to others whose actions reflect roles that he must identify' (p.23).

Biddle and Thomas (1966) provide one of the most comprehensive definitions of social role, incorporating elements from both the above theoretical stances:

Individuals in society occupy positions, and their role performance in these positions is determined by social norms, demands, and rules; by the role performances of others in their respective positions; by those who observe and react to the performance; and by the individual's particular capabilities and personality. (p.4).

Whilst recognising the importance of individual characteristics and situational factors in determining the precise nature of the actual role performance, this definition clearly implies that this occurs within the framework set by the social prescriptions of the role. It is these prescriptions which the process of rehabilitation aims to teach the individual; Mechanic's (1968) view of roles as 'functional-adaptive' units seems particularly apt in this context. Roles are functional because they represent a patterning of specific skills and associated attitudes and values which aids the teaching of 'new occupants of the position' (p.83); adaptive, because 'role-stereotypes' facilitate participation in social life by allowing individuals 'to anticipate what to expect from others who have particular social identities' (p.83).

Thus rehabilitation can be thought of as a process of socialisation, specifically adult socialisation, of which 'role acquisition is probably the most important aspect' (Brim, 1966:5).

2.2.2. Rehabilitation as Socialisation

Satisfactory role performance requires that the individual 'must know what is expected of him (both in behaviour and in values), must be able to meet the role requirements, and must desire to practice the behaviour, and pursue the appropriate ends' (Brim, 1966:25). Brim argues that the
emphasis in adult socialisation is on the first two of these, knowledge and ability, rather than the third, motivation. Likewise the learning of behaviours is more important than the internalisation of values. The assumption is that 'the adult knows the values to be pursued in different roles, that he wants to pursue them with the socially appropriate means, and that all that remains to be done is to teach him what to do' (p.26). However, these assumptions are likely to be invalid for psychiatric patients who have spent many years of their lives in hospital, acting out behaviours and internalising values and attitudes appropriate to their patient status, that is the patient or sick-role. According to Parsons (1951) the 'sick-role' exempts an individual from both his/her normal social roles and from responsibility for his/her illness. Further, it requires that he/she should want to get well; should seek professional help to do so; accept the authority of those helping him/her; and co-operate with them in the treatment. Thus, the 'sick-role' engenders attitudes of passivity, dependence and helplessness, so that rehabilitation is more likely to approximate a process of re-socialisation, with equal emphasis on the internalisation of new values and the acquisition of motivation to perform new roles, as on the learning of new skills. Thus, the rehabilitation setting must provide the necessary environmental conditions to satisfy the individual's need for knowledge, ability and motivation in role performance, remembering that any or all of these may be affected by a rehabilitee's impairments and disabilities. Wheeler (1966) describes these conditions as the provision of (1) 'clear and unambiguous norms'; (2) 'opportunities for learning and practicing' and (3) 'rewards' for appropriate behaviour (p.110). This is usually done through the provision of sheltered environments, which can provide opportunities for the learning and practice of specific self-care and work skills, and also help rehabilitees to understand the more general norms which operate in different social settings. Further, motivation to learn new roles is engendered by a variety of reward systems, which may include the setting of attainable goals, various types of incentive pay schemes in occupational settings and positive feedback from staff. As an example of a sheltered environment an industrial
training unit should concentrate not only on training in work skills (how to use tools and machinery, etc.) but also on the general demands of the work situation and appropriate social behaviours. These will include regular attendance, time keeping, concentration on the task in hand, and getting on with workmates and supervisors. Incentive pay schemes may take some or all of these aspects into account as well as task difficulty and speed of completion. Bennett (1978) notes that 'it is not easy to introduce normal roles into the mental hospital' (p.218), but it is important to ensure that the sheltered environments for both living and working are as much like those of the real world as possible, so that learning is easily transferable to community venues.

2.2.3 Psychiatric Handicaps and Rehabilitation

It was noted above that the ultimate aim of rehabilitation is resettlement in the community. However, complete independence is not possible for all rehabilitees due to primary, secondary or premorbid handicaps. Primary handicaps are those which are a direct result of the illness itself, while secondary handicaps are due to the reactions to their illness of individuals themselves or others with whom they interact. Often it is quite difficult to distinguish between the two. For example, the primary handicaps of chronic schizophrenia are withdrawal, apathy and lack of initiative, but these may also be intensified by secondary causes such as institutionalisation and the reaction of others to the labels 'mentally ill' or 'psychiatric patient'. Premorbid handicaps are those which are extrinsic to the illness; the individual is disadvantaged in some way quite apart from his illness. For example, rehabilitees may lack basic educational (literacy and numeracy) or interpersonal skills as the result of impoverished family, social or educational environments during childhood.

The more realistic aim of rehabilitation then, is for individuals to achieve their optimum level of role or task functioning and to maintain at that level. For this to be possible, protected environments may be required in one or more areas of living. While some rehabilitees may
be able to live quite independently in their own homes and yet require sheltered work or attendance at a day centre, others may be able to cope with the demands of open employment yet require a protected living environment such as a group home or hostel. Even rehabilitees who are able to cope relatively independently in the community may need the support of resources such as a Community Psychiatric Nursing Service or an Out-Patient Clinic, not only for regular medication but also for the interpersonal support and help.

One very important handicap of many psychiatric patients is their low stress threshold, where stress is defined as 'the discrepancy between the demands presented to the individual and his capacity to deal with them' (Bennett, 1978: 213/4). Mechanic (1967) notes that an individual's ability to deal with stress depends not only on his abilities in task and role performance but also on whether his emotional response to the situation is one of confidence rather than anxiety. Bennett suggests that a third requirement is the motivation to cope. The lack of one or all of these attributes means that too much pressure or too high expectations placed on a rehabilitee will lead to breakdown and regression, and the manifestation of florid symptoms (incoherence of speech, delusions or hallucinations) in the case of chronic schizophrenia. Hence rehabilitation should take place in a series of small graded steps, with the rehabilitee mastering each one before moving on. In this way, he/she will gradually build up confidence in his/her own abilities, which in turn leads to the motivation to cope. Ideally, then, both living and working should be arranged in a series of graded sheltered environments, with each providing preparation and training for the move to the next step up the ladder to independence.

Related to the need for the rehabilitation process to take place a step at a time, is the need for adequate assessment procedures and the development of individual goals and associated training programmes. Goals should be realistic and kept clearly in view, with the rehabilitee receiving feedback from staff as to his/her progress and being rewarded for success, however small.
2.2.4 Summary

(1) Rehabilitation is concerned with the learning of normal social roles and the rejection of the patient or sick role.
(2) Rehabilitation can be considered as a process of re-socialisation, requiring the learning of both values and behaviours. Not only do rehabilitees lack knowledge of new roles and tasks but often the necessary basic abilities (due to primary, secondary and premorbid handicaps) and the motivation to perform them (due to the internalisation of the values and attitudes of the sick role).
(3) To prevent regression and the re-occurrence of acute symptoms it is necessary for rehabilitees not to be subjected to too many new demands or expectations all at once.

Good rehabilitation practice should therefore incorporate the following:
(a) Rehabilitation should take place in small graded steps, which place steadily increasing demands on rehabilitees. Each step should provide preparation for the next step up the ladder to independence.
(b) Individual goals should be set after suitable assessment, with rehabilitees receiving appropriate rewards.
(c) Rehabilitation environments should be as much like those normally found in the community as possible, especially during the latter stage of rehabilitation.
(d) Protected environments are needed for those rehabilitees who are unable to achieve full independence in one or more areas of living.

2.3 The Self in Psychiatric Rehabilitation

Viewed as a process of re-socialisation, psychiatric rehabilitation involves the rejection of the patient-role/identity and the (re)-learning of normal social roles. Repeated role-taking leads not only to the internalisation of new social identities but to the rehabilitee seeing himself/herself as a different type of person, that is in terms of the personal attributes which characterise the new roles. Since,
in turn, an individual's self-conception guides or influences his/her behaviour, changes in self-conception lead to changes in the way rehabilitees respond to situations, interact with others etc.

The process of rehabilitation is facilitated by the provision of graded living environments (wards) with differential expectations for behaviour. These expectations are mediated to the rehabilitee not only through interaction with specific staff or patients (significant others) but also by his/her internalisation of the shared perspective of the group (generalised other). 'The individual accepts as guides for his own behaviour the standards and norms characteristic of his reference group' (Hartley, 1968:239). While Shibutani (1955) has noted that membership groups (e.g. being a patient on a particular ward) are especially important, reference groups may include groups of which the individual is not yet a member (e.g. people in the community may form a reference group for rehabilitees still in hospital) 'using them to establish patterns of behavior appropriate to the kind of person they hope to become' (Hewitt, 1984:85).

Similarly, a rehabilitee's attitudes to his/her Ideal-Self (the way he/she would like to be) and to other psychiatric patients are largely determined by the perceived attitudes of the social group to which he/she belongs or aspires to belong. In respect of the Ideal-Self, Mannheim (1966) notes that an individual 'sets himself goals for future development, in terms of the standards set by his social surroundings' (p.266). Turning to consider attitudes to psychiatric patients, it is important to note that the labelling of an individual as a psychiatric patient has important consequences for an individual's self-conception and others' conceptions of him/her. Firstly, because of the normal

2 It has been argued (Friedman, 1955; Hillson & Worchel, 1957) that some groups of psychiatric patients (particularly those diagnosed as schizophrenic) are unable to give a 'realistic' appraisal of their self-concept. However, whether it is objectively accurate is not important; if it is how the individual experiences himself/herself, then it is true for him/her and will direct his/her behaviour.
typification of 'patients' as passive, dependent and helpless, and secondly, because the 'psychiatric patient' identity is a deviant identity and leads to 'the attribution of negative being to individuals' (Hewitt, 1984:239). Thus the negative stereotype of the 'psychiatric patient' sees him/her as 'strange, bizarre, unpleasant and even dangerous' (p.253). Further, Hewitt suggests that a deviant identity 'tends to control all social interaction in which others are aware of the deviant label' (p.241) so that there are strong pressures on the individual to accept the deviant label. Having done so, then all behaviour is interpreted by self and others in terms of the deviant role/identity. For psychiatric patients this means that there is the loss of normal social roles/identities in favour of the role/identity of 'psychiatric patient', and that over time patients can be expected to have internalised the negative attributes which characterise the role and have developed a negative self-conception. This suggests that the individual's conception of 'most psychiatric patients' could usefully be included as a fifth component of their self-concept (2.1.6). The relationship between self-conception and the rehabilitee's conception of 'most psychiatric patients' is likely to change during rehabilitation as the patient-role/identity is rejected and normal social roles/identities re-acquired.

It would be expected not only that psychiatric patients would see themselves in terms of the negative stereotype of the 'psychiatric patient' but that their close relatives would also see them in this way. Experience at Netherne Hospital (1.1) suggested that even after their transfer to the Rehabilitation Unit and the acquisition of 'rehabilitee' status, rehabilitees in hospital were still seen in this way, or at least that the attitudes of close relatives to rehabilitees were considerably more negative than those prevailing amongst the rehabilitees' reference group of other rehabilitees and Rehabilitation Unit staff. How then will rehabilitees deal with the negative feedback from close relatives and what effects will it have on their rehabilitation (acquisition of new self-conceptions based on new social identities and more positive personal attributes)? The discussion in 2.1.4 suggests that rehabilitees may
reappraise their self-conceptions, their close relatives or the discrepant/negative feedback. Reappraisal of their self-conceptions would lead to retardation or regression of the process of rehabilitation, that is towards rather than away from identification with the patient-role.

However, relatively infrequent contact with close relatives when compared with their reference group of other rehabilitees and staff on their ward may prevent this happening to any marked degree. In this situation rehabilitees may be more likely to reappraise either their close relatives or the negative feedback. While rehabilitees may decide that their close relatives are no longer valued and/or credible others, there may be strong reasons for not making this decision, not least of which are the emotional ties with members of one's family and the fact that they may represent an important (or indeed the only) link with the world outside the hospital. Alternatively, rehabilitees may reappraise or distort the negative feedback from close relatives to make it more congruent with their own self-conception; relatively infrequent and superficial contact with close relatives would aid this process.

After discharge to the community, rehabilitees are technically no longer 'patients', but the above discussion on deviant identities and some of the observations described in 1.1 suggest that it may be difficult for close relatives to change their attitudes to rehabilitees. This would be particularly damaging to rehabilitees' self-conceptions where they are discharged to live with their close relatives. On the other hand, it may be that more frequent and less superficial interaction with rehabilitees can lead to close relatives changing their attitudes as they experience rehabilitees behaving in new and relatively 'normal' ways.
2.4 Research Hypotheses

Hypothesis One

Rehabilitees at progressive stages of the rehabilitation process will show increasing rejection of the patient-role in favour of community-based social roles. There will be concomitant changes in self-conception, away from an identification with (other) psychiatric patients. However, whether rehabilitees in the later stages of rehabilitation have more positive self-conceptions and higher self-esteem will depend on their social milieu.

Hypothesis Two

Close relatives will also show changes in their conception of rehabilitees who are at different stages of the rehabilitation process. At the later stages close relatives will see rehabilitees more positively and as less like psychiatric patients. However, their view of the ideal for their rehabilitees is also likely to change as expectations rise, so that their more positive attitudes towards rehabilitees may not be closer to the ideal. Further, changes in their attitudes to rehabilitees are likely to occur more slowly than changes in rehabilitees attitudes to themselves; this is likely to lead to significant discrepancies between rehabilitees' self-conceptions and the conceptions of them held by close relatives. Such discrepancies will require cognitive reappraisal by rehabilitees of either their close relatives or their perception of the discrepant, negative feedback.
3 METHODOLOGY

3.1 The Samples

3.1.1 The Primary Sample of Rehabilitees

The sample of rehabilitees was essentially an 'opportunist' sample, made up of respondents to the 'Needs of a Health District' study conducted by the writer in 1980 (1.2). For the purposes of that study 'rehabilitees' were defined as in-patients at Netherne Hospital who were resident in the Rehabilitation Unit wards or day-patients attending the Wingfield Day Hospital (an industrial and clerical training unit at Redhill). The criteria for inclusion in the 1980 study was that an individual had been a 'rehabilitee' in July 1977, and by mid-1980 was still living within the Netherne catchment area. Some 111 rehabilitees were eligible for inclusion and interviews were completed with 100 (90%) of them between October 1980 and January 1981. Of the 11 rehabilitees who were not interviewed, two lived in the community and refused to participate, and the remaining nine were hospital patients who were unable to take part for a variety of reasons, mainly due to their current mental state.

The rehabilitee sample¹ was made up of 61 men and 39 women, whose average age was 50, and of whom 81 were single (never married). Rehabilitees were divided into four roughly equal groups by age; those under 40, between 40 and 49, between 50 and 59, and 60 and over. At the extreme ends of the age range, three rehabilitees were under 30 and eight over 70. Classified by their highest status job prior to hospitalisation, some 35 rehabilitees had been in a non-manual occupation, usually of clerical status, that is social class IIIN. Of the 47 classified as manual workers, 40% (19) had been in semi-skilled occupations (social class IV) and the rest were divided fairly equally between skilled manual occupations (social class IIIM).

¹ See 3.7.1 and Table 3.7 for a more detailed description of the rehabilitee sample.
and unskilled manual jobs (social class V). Meanwhile six rehabilitees had been in the Armed Forces and 12 had had no known occupation.

Summarising their psychiatric histories: two-thirds (66) of the rehabilitees had had more than one admission to Netherne, including one-third with four or more admissions. Overall, 59 had a cumulative stay in Netherne of over five years at the time of interview, including one-third of the total (32) who had been in hospital for over 15 years. Only 11 rehabilitees had a hospital stay of under one year.

Medically, over two-thirds (70) of the rehabilitees were classified as having a schizophrenic illness, with the rest being more or less equally divided between those considered to have an affective disorder, a neurosis/personality disorder or an organic disorder. Of those classified as schizophrenic, one quarter (18) were considered to exhibit severe florid symptoms and were diagnostically categorised in Wing's (1961) clinical subgroups 2 (coherent delusions) or 3 (severe incoherence of speech). A further one-third (23) were found to have moderate verbal disorder and severe flatness of affect, and were classified in subgroup Ic. The remaining 41 showed only minimal or moderate symptoms of speech disturbance and flatness of affect, and were classified in subgroups la and lb.

At the time of interview 65 of the rehabilitees were still in the hospital and 35 were living in the community (Figure 3.1). Of those in hospital some three-fifths (39) were resident in the Rehabilitation Unit and the remainder had been transferred to other types of ward. Some 14 of the 35 rehabilitees in the community lived with their parents, ten lived in a Group Home and five in a Hostel, while the remaining six lived independently, either on their own or with a spouse. One-half of the rehabilitees in the community had been

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2 These categories were shown by Wing (1961) to have a high degree of concordance with the Paranoid end of the P-Np continuum (Venables and O'Connor, 1959).
Figure 3.1  Place of Residence of Respondents in the Rehabilitee Sample
discharged from hospital for less than three years (since July 1977), one-quarter for between three and five years and the remaining one-quarter for over five years (including three rehabilitees who had never actually been admitted to hospital, but had used the rehabilitation services at the Wingfield Day Hospital). One-fifth (7) of the community based rehabilitees had had one or more short readmissions to Netherne since July 1977.

Thus, the 'given' sample was essentially a population of middle-aged to elderly, generally single rehabilitees, with limited achievements in the occupational sphere prior to hospitalisation. Many had past histories of repeated spells of hospitalisation, totalling five, ten and sometimes fifteen years or more. With or without more actively psychotic symptoms, many showed severely flattened affect and moderate levels of verbal disorder characteristic of chronic schizophrenia. Overall then many of the rehabilitees could be classified as chronically disabled long stay patients. By contrast there did seem to be a minority who were younger, showed only minimal or moderate symptoms of impairment, and who had had only a relatively short period of hospitalisation.

3.1.2 The Primary Sample and the Rehabilitation Process

While the 'one-off' interview of the 'Needs of a Health District' study (1.2) did not permit analysis of individual changes in the self-concept during rehabilitation, Figure 3.1 shows that it did provide a sample of rehabilitees who could be grouped according to their current place of residence. Knowledge of the organisation of the hospital and rehabilitation services suggested to the writer that a rehabilitee's current place of residence could be used to provide an operational definition of his/her current stage in the rehabilitation process.

Administratively the hospital is divided into a number of units providing a range of ward environments catering for the needs of admission, long-stay, geriatric, disturbed and rehabilitation patients.
Within this structure, the Rehabilitation Unit forms an intermediate step between other hospital units – henceforth referred to as 'other wards' – and the community. Its aim is to prepare patients for discharge and successful resettlement in the community. Patients from 'other wards' who show certain abilities (including a good work record in the industrial therapy workshops or hospital departments; some skills at mixing with other patients; the ability to travel on a bus; some skills in cooking and preparing meals) and motivation are referred to the Rehabilitation Unit and generally taken on a month's trial. If accepted a rehabilitation plan and detailed training programme is prepared for them. Patients who find themselves unable to cope with the requirements of a rehabilitation ward or who experience a relapse in their mental state are likely to be transferred back to 'other wards' either temporarily or permanently.

The villa wards in the Rehabilitation Unit have developed as a series of graded living environments. As they move through the Unit rehabilitees are expected to take increasing responsibility for all areas of their lives (personal, social, domestic and occupational). Initially emphasis is placed on resocialisation; rehabilitees are helped to lose their institutional patterns of personal and social behaviour and to replace them with ones which are more acceptable to the outside world. Training is provided over a wide range of self-care activities: personal hygiene, clothes care, domestic chores, cooking and meal preparation, and rehabilitees have to take their turn on the ward rotas for cooking and cleaning. Later the emphasis moves to developing skills in work and leisure activities, and generally interacting with the outside world. Training is provided in the use of public services such as shops, transport, the Post Office, banks, hairdressers, launderettes, cinemas, pubs, restaurants etc.

One of the rehabilitation villa wards has gradually developed a different and rather specialised function over recent years. The more dependent patients have gradually been transferred to 'other wards' and this villa now caters for fairly independent but long stay elderly rehabilitees who are no longer aiming for resettlement in the community. There is
comparatively little supervision and residents are expected to have a reasonable level of personal care, organise their laundry and look after their own medication. The villa is their 'home' and its role is that of a 'hospital hostel'.

Up until the early 1980s, discharge from the Rehabilitation Unit meant a choice between returning to live with parents, a group home or a hostel; only a few rehabilitees went straight into more independent accommodation. Over the past thirty years there has been an accumulation of research evidence to suggest that discharge to the parental home may not be in the best interests of either patients or their relatives. Compared with discharged patients living elsewhere in the community, those living with parents have been found to have lower levels of social adjustment (Brown, Carstairs and Topping, 1958) and of participation in work and social activities outside the home (Freeman and Simmons, 1968). Further, they have been shown to have higher rates of readmission (Brown, 1959) particularly if they are at home all day in face to face contact with parents who show high levels of 'expressed emotion' (as measured by the expression of critical or emotionally over-involved attitudes towards the discharged patient) (Brown et al, 1962 and 1972; Vaughn and Leff, 1976; Leff and Vaughn, 1981; Vaughn et al, 1982). Listening to parents talking in the Relatives' Meetings (1.1) the writer heard little to suggest that the situation of Netherne rehabilitees who had been discharged to live with parents was in any way markedly different. The parental home seemed to offer a relatively undemanding but sometimes isolated and over-emotional social environment, in which rehabilitees often found it hard to break away from the patient-role; at best they exchanged it for the child-role.

In order to be eligible for a place in a Group Home rehabilitees have to be reasonably independent in coping with everyday life. Each resident has his or her own room, whilst other facilities and responsibilities for housekeeping and household chores are
shared with other residents. Supervision is provided by one or more members of the Rehabilitation Unit staff, who may, for example, attend the weekly residents' meeting. Rehabilitees may stay in their Group Home for as long as they like; when a vacancy does occur the selection of the new resident is generally a joint decision.

Hostel accommodation, rather than a Group Home, is preferred by those rehabilitees who are unable or unwilling to undertake their own cooking and housekeeping, or who need supervision on a day to day basis. Most of the hostels are run by voluntary organisations, and although all expect a reasonable level of personal hygiene and appearance, they vary in respect of other expectations of residents. However, many do expect residents to make their beds, keep their rooms clean and tidy, do their own washing and help lay the tables for meals or wash up afterwards.

The above descriptions of the various types of accommodation in the hospital and community in which rehabilitees may be resident at different stages in their rehabilitation suggest considerable variations in social milieu. However, it is also important that the number of rehabilitees in each subgroup of the sample to be used in the data analysis should not be too small. Taking hospital based rehabilitees, the two obvious stages of rehabilitation as defined by place of residence are 'other wards' and the rehabilitation villa wards (Rehabilitation Unit).

There are 26 rehabilitees in the former and 39 in the latter categories. However, the theoretical importance of social milieu (2.3) suggests that it would be appropriate to keep residents of the hospital hostel separate from other rehabilitees in the Rehabilitation Unit who are aiming for resettlement in the community. Numerically this gives 27 rehabilitees in the rehabilitation villas.
and 12 in the hospital hostel. Turning to consider community based rehabilitees, the 14 rehabilitees living with parents form an interesting group from the perspective of their social milieu. Although the expectations of rehabilitees in other types of community accommodation are quite varied, numerically it does not seem possible to separate them, since this would give subgroups with less than ten rehabilitees. Consequently, for the purposes of this study the 21 community based rehabilitees who do not live with parents will be grouped together for analysis under the heading of 'rehabilitees living elsewhere in the community'.

3.1.3 The Secondary Sample of Close Relatives

The secondary sample of close relatives (CRs) was drawn from amongst the relatives of the 100 rehabilitees in the primary sample. During the interviews with rehabilitees, they were asked to name their 'closest relative', defined as the family member or close relative whose contact was the most important to them. Some 25 rehabilitees had no CR by this definition, either because they had no living relative (6 rehabilitees) or because they had either no contact (12 rehabilitees) or only very infrequent contact (6 rehabilitees) with any one relative. In addition one rehabilitee had quite regular contact with several relatives, but denied that they were of any importance to him. Thus there were 75 potential respondents in the secondary sample of close relatives.
3.2 Self-Concept Measurement - An Introduction.

3.2.1 Self-Concept and Self-Report

Since one cannot literally climb into the skin of another person, measurement of the self-concept relies essentially on inferences made from either an individual's behaviour, his/her responses to projective tests, or from what he/she has to say about himself/herself, that is his/her self-report. Since the present research was carried out in conjunction with another project using structured interviews, self-report techniques presented as the most appropriate method for investigating the self-concept. There are basically two types of self-report techniques: in the first, respondents measure their self-conceptions in terms of given adjectives or statements; in the second, respondents generate their own descriptive adjectives or statements against which to measure their self-conceptions.

The first type of technique includes Check Lists (respondents answer 'yes' or 'no' to indicate whether an adjective or statement describes them well), Rating Scales (rather than a simple 'yes' or 'no' answer, respondents indicate the degree to which a description applies to them, usually on a five or seven point scale), Q-Sorts (respondents sort cards into piles according to how well the descriptive statements printed on them describe them) and the Semantic Differential (respondents rate self-conceptions on a series of bi-polar adjectives, usually on a five or seven point scale). The second type of technique where respondents generate their own statements includes the Repertory Grid technique (respondents generate their own descriptive statements or 'constructs' against which they sort various dimensions of the self-concept or 'elements') and the 'Who-Am-I?' schedule (respondents are asked to give up to twenty statements in answer to the question who-am-I?). A more detailed description of each of these techniques is given in Appendix 1 (A1.1).

The aim of all self-report techniques is 'to tap individuals' conceptions of themselves through the self-representations they are
willing and able to give' (Gordon, 1969). Herein, however, lies a methodological problem basic to self-report techniques: the equivalence of verbal or written self-reports and the individual's actual self-concept or inner experiences.

One view is that what an individual believes about himself/herself and what he/she reports are so different that self-reports are not valid representations of the self-concept; two studies by Combs et al (1963) and Parker (1966) which compared children's self-reports and inferred-self ratings made by trained observers were considered to support this position. However, as Wells and Harwell (1976) point out, these conclusions assume firstly, that self-reports and inferred-self ratings are equivalent (since it was hypothesised that there would be a high correlation between them if both methods gave valid accounts of the self-concept) and secondly that inferred-self ratings are preferable and more valid (when the correlation is low).

Neither of these points were proven by Combs and his associates and are refuted by Wells and Marwell (1976) on the basis of available evidence. They consider self-reports to be more valid because although they 'do not constitute direct observation of the self-concept, because they are filtered through the individual's abilities and motives .... (they) do constitute a more directly phenomenological measure ... than ratings-by-others' (p.141). They stress the time and situational limitations of the content of behavioural observations which form the basis for inferred-self ratings, plus the necessary use of 'broad stylistic interpretations of behaviour ... rather than individual meanings' (p.141).

Burns (1979) takes a more pragmatic stand by asserting that 'self-report techniques are literally the only method available for measuring the self-concept, and if they are to be rejected then psychology would be seriously limited. Psychology must concern itself with covert feelings in order to explain behaviour more adequately' (p.77). However, it is obviously important to ensure that invalidating
influences on responses are minimised and that the self-report approximates the self-concept as closely as possible. The next section looks in more detail at the main invalidating influences: (1) motivation, (2) social desirability, (3) acquiescence, (4) differential meanings, and (5) rating styles.

3.2.2 Invalidating Influences on Self-Concept Responses

(1) Motivation. An individual who is unwilling to co-operate may consciously or unconsciously hide his/her true feelings of self; it is thus vitally important that the individual is well motivated to participate. This is most likely if the purpose and structure of the interview is fully explained; if the respondent is able to feel competent, unthreatened and at ease; and if the interviewer is able to establish a good rapport.

(2) Social Desirability. The most widely studied and probably the most contentious invalidating influence within self-concept research is the social desirability variable. Firstly, it is necessary to distinguish between two approaches to social desirability, which can be broadly differentiated by the concern with item content (Edwards, 1953 and 1957) or response style (Crowne and Marlowe, 1960 and 1964). The former approach states that the probability of an item being endorsed is related to its social desirability value, which can be determined objectively. This value is a constant property of the item and does not vary significantly between individuals. On the other hand, the latter approach is very much concerned with variation between individuals, seeing social desirability as a personality trait, and the individual 'as motivated by a need for approval from others in order to protect a vulnerable self-esteem' (McCarthy and Rafferty, 1971:576).

Early studies to assess the effect of item social desirability compared the probability of endorsement of items on various self-report measures with their social desirability scale values (as objectively rated by a group of judges): questionnaire items (Kenny, 1956), rating scales (Kenny, 1956; Cowen and Tongas, 1959) and Q-Sorts (Kenny, 1956; Cowen and Tongas, 1959) and Q-Sorts (Kenny, 1956; Cowen and Tongas, 1959).
Edwards, 1957). They all found high correlations (mostly over .80) between social desirability scale values and self-concept ratings. In a review of these and other studies Crowne and Stephens concluded that 'failure to control for the effects of this variable ... means, in effect, that the test in question may better be interpreted as a measure of social desirability' (1961:116).

However, the assumptions underlying these arguments have been questioned on two counts. Firstly, Wells and Marwell (1976) have disputed the direction of the causal relationship between desirability scale value and frequency of endorsement. It seems likely that an item 'may be socially desirable because it is 'true' for most people' (p.161) rather than being endorsed by most people because it is socially desirable. Secondly, both they and Wylie (1974) question an approach which does not take into account individual variations as to what is socially desirable. Wylie cites studies by Messick and Jackson (1961) and Scott (1963) to show that 'there are great individual differences in social desirability scale values for any given item' (p.54).

Turning to examine studies which have sought to measure the effect of social desirability on individual responses, one method has been to use 'faking good' instructions. McCarthy and Brodsky (1970) asked students to complete a Self-Concept Scale (derived from Butler-Haigh Q sort items) under three experimental conditions: anonymously, honestly (including putting their name to it), and faking good (to appear well adjusted). The students were also divided into two groups on the basis of their scores on the Marlowe-Crowne Social Desirability Scale. On the basis that high scorers are already 'faking good' due to their defensiveness and need for approval, it could be hypothesised that the high scorers on the Marlowe-Crowne SDS would show higher self-concept scores under the 'honest' instructions than the low scorers, but that there would be no difference under the

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3 The Marlowe-Crowne Social Desirability Scale, developed to measure social desirability response tendencies, consists of 33 culturally approved behaviours (to which neither a socially desirable or socially undesirable response is indicative of maladjustment) which are relatively unlikely to occur (Crowne and Marlowe, 1960).
'faking good' instructions. While the results supported this hypothesis, interpretation of the results was not straightforward. McCarthy and Brodsky (1970) questioned whether the high self-concept scores of the high Marlowe-Crowne SDS group under the 'honest' instructions were due to the social desirability bias, or whether this group was in fact better adjusted and this was also reflected in their higher Marlowe-Crowne SD scores? Further study is needed before the relationship between self-concept responses under 'honest' and 'faking good' instructions is clearly understood.

A second method of assessing the effect of social desirability on individual responses has been to compare the correlations between self-concept measures and measures of social desirability. Wells and Marwell (1976) compared the results of several such studies using social desirability scales developed by Edwards (1957), Crowne and Marlowe (1960) and Ford (1964). While the Edwards scale was shown to generally correlate quite highly (0.33 to 0.75), the Marlowe-Crowne and Ford scales showed more moderate correlations (-0.01 to 0.44). However, the Edwards scale has been criticised for confounding psychological content with the measurement of social desirability, since it uses items from the MMPI with substantive content, which may well be both socially desirable and true for most people. The other two scales have attempted to overcome this problem by using items which are generally socially desirable but untrue for most people or socially undesirable and true for most people.

Thus the correlations between self-concept measures and measures of social desirability as a response tendency are considerably lower than those between self-concept measures and measures of social desirability as a characteristic of scale items.

However, just as the basic assumptions of item social desirability have been challenged by Wylie (1961, 1974) and Wells and Marwell (1976) the same is true for social desirability response tendencies. In analysing responses, Wylie (1974) commented that most self-report studies assume that if an individual possesses a trait that is socially
desirable then his/her self-report will be favourable and accurate. The possibility of it being unfavourable and inaccurate, that is 'faking bad' rather than 'faking good', is not generally considered. However, if an individual possesses a trait that is less than desirable or even undesirable, then his/her self-report may either be unfavourable and accurate or favourable but inaccurate, in which case he/she is making a socially desirable response. The inaccuracy may be unconscious or deliberate, and Wylie points out that only in the latter case does the self-report become invalid as a measure of the self-concept from a phenomenological viewpoint. If an individual sees himself/herself as having certain socially desirable traits, whether or not his/her assessment is objectively true, it is true for him/her and will organise his/her behaviour. Thus whether or not his/her responses contain a high degree of social desirability they are still valid self-reports.

Thus self-concept research is really only concerned with conscious or deliberate attempts by individuals at 'faking good' or giving socially desirable responses.

To Wylie then the problem became a practical one: 'How can we minimise the invalidating influences upon our measures?' (1974:58). She suggested two possibilities: the manipulation of either the self-concept measure or the interview situation. Procedures to correct for social desirability in self-concept measures include: matching pairs of forced choice items according to their Social Desirability Scale Value (SDSV); including only items which have relatively 'neutral' SDSVs; including a separate social desirability scale and correcting a respondent's self-report scores accordingly. All these procedures make assumptions concerning the relationships between group, individual and personal desirability values which have already been questioned. It seems then that the minimisation of social desirability influences on response is a situational task. It involves establishing rapport between interviewer and respondent in a non-threatening and accepting atmosphere, where confidentiality is
assured. This will give every encouragement to the respondent to report his/her self-concept honestly.

(3) **Acquiescence.** Acquiescence refers to the tendency of individuals to agree with adjectives or descriptive statements regardless of their content. In order to minimise the effects of acquiescence Wylie (1974) proposed that attention should be paid to the following procedures in the design of self-concept measurement techniques:

1. Items should be chosen for their conceptual relevance.
2. If a total score is to be calculated by summing across item scores, then their inter-correlations should be high, so that trait variance will accumulate faster than response-set variance' (p.75).
3. Items should be written in everyday language so that they are easily understood. (This point applies equally to the instructions for completing the instrument).
4. There should be an equal number of positively and negatively phrased items.

There is one further method of minimising the acquiescence response tendency: using only items of very high salience to respondents. Wylie (1974) does not recommend this procedure since it 'narrows the range of self-concept aspects one can explore with one's instrument, and ....... tends to increase the possibility that social-desirability tendencies will distort self-concept reports on one's instrument, since salience and desirability quite probably co-vary' (p.75).

(4) **Differential Meanings.** This refers simply to individual differences in the meaning of words; both the terms used to describe the points on a rating scale (strongly agree, slightly disagree, often, sometimes, etc.) and the self-referent adjectives or descriptive statements which form the items to be rated. Wells and Marwell (1976) referred to these as 'modifier variance' and 'descriptive variance' respectively. Descriptive variance is the easier of the
two to counteract; the suggested procedure is to provide supplementary information in order to reduce ambiguity and anchor meaning. This is obviously most important for check lists, since other techniques do make some attempt towards anchoring meanings. In this context the semantic differential provides bi-polar pairs of adjectives and most rating scales utilise descriptive statements rather than single adjectives. Modifier variance poses a particularly difficult problem; Wells and Marwell (1976) propose several alternative solutions, but do not find them satisfactory. While the aim is to use only those modifiers 'which have low ambiguity and high inter-subject agreement in meaning' this is not easy in practice and 'may exclude all but the most extreme modifiers ..... since virtually all midscale quantifier terms have substantial variation in meaning' (p.174).

(5) Rating Styles. Rating styles are also concerned with rating scale points, but with individual response patterns rather than interpretation of the modifier terms. Two main rating styles can be identified: the tendency to use extremes and the tendency to respond in a neutral way. While items 1. and 3. from the procedures to minimise the acquiescence response set are also relevant here, other possibilities include:

(a) Reducing the number of points on the rating scale, since the effect of an extreme response tendency is likely to increase with the number of scale points.
(b) Having an even number of scale points with no neutral point.
(c) Headed the scale points with descriptive modifiers rather than leaving them blank.

While the above invalidating influences seem to represent important limitations on the use of self-report techniques the present study sought to minimise their effects by following the suggested procedures: careful choice of the techniques to be used (3.3); attention to the order, wording and content of questions, scales, etc. (3.4 & 3.5); the establishment of rapport between interviewer and respondent in a non-threatening atmosphere and the assurance of confidentiality.
3.3 Selection of the Research Instruments

Ideally the selection of the most appropriate research instrument(s) is determined by the type of data required to test the research hypotheses together with an appraisal of the validity and reliability of competing techniques. However, since much of the information regarding the validity and reliability of self-concept measures is inconclusive and itself subject to theoretical and/or methodological criticisms (Al.2), selection of appropriate techniques for the present research was essentially based on practical considerations within the boundaries set by the operational needs of the research hypotheses (2.4).

To test the first part of Hypothesis One required data on respondents' social identity in terms of identification with/or acceptance of the patient-role and/or normal social roles. Meanwhile the second part required data on various dimensions of the self-concept (attitudes to self, ideal-self and other psychiatric patients) and the measurement of differences between them. Hypothesis Two also required various dimensions of the self-concept to be measured and compared, including the way in which rehabilitees perceive their close relatives to see them, and the way in which relatives themselves actually see rehabilitees; plus the relatives' views of how they would like their rehabilitees to be and psychiatric patients in general.

Thus the hypotheses required basically two types of self-concept measurement: firstly a technique that allowed rehabilitees to define themselves in terms of social roles, and secondly a technique where measures of individual attributes could be completed for a range of self-concept dimensions and statistical comparisons made between them. While the 'Who-am-I?' schedule was considered to be the obvious choice of technique to satisfy the criteria of the first type of self-concept measurement (Al.l.6), a range of techniques could have satisfied the criteria of the second type of measurement, including check-lists, rating scales, Q-sorts, the semantic differential and repertory grid (Al.l.1 to Al.l.5).
Turning to more practical considerations, the main limitations on the choice of self-concept techniques was time. Interviews with rehabilitees were carried out during the 'Needs of a Health District' study (1.2) and it was imperative that the additional measures for the doctoral study should be as short as possible if they were to be completed willingly, conscientiously and honestly by respondents. The 'Who-am-I?' schedule could be given a limit of ten to twelve minutes, so that time considerations impinged most on the choice of a technique to produce the mass of comparative data on individual attributes. From the discussion in Al.1.3, Q- Sorts were easily removed from the list of alternatives, being much more time consuming (40 minutes per sort) than comparable pen-and-paper techniques. The ACL and ICL checklists (Al.1.1) with 300 items and 128 items respectively, and the IAV rating scale (Al.1.2) with 49 items, were also considered too time consuming since four different dimensions of the self-concept had to be checked or rated (rehabilitees' attitudes to themselves, their ideal, (other) psychiatric patients and how they perceived their close relatives to see them). With experience a 10 by 10 repertory grid was considered to take about forty minutes to complete, but rating four concepts on a 20 scale semantic differential would take most respondents only between twelve and twenty minutes. Thus, on time consideration alone the semantic differential appeared the most promising technique. Its suitability was confirmed by well validated techniques of discrepancy measurement (Al.1.4).

Attitude rating scales (Al.1.2) were also considered fairly quick to complete and two short scales were already included in the interview schedule for the 'Needs of a Health District' study: one measured acceptance/rejection of the patient-role (16 items) and the other self-esteem (10 items). It was considered that these would provide useful comparison measures to the semantic differential discrepancy measures of identification with (other) psychiatric patients and self-esteem.

55.
3.4 Description and Justification of Chosen Instruments

3.4.1 'Who-Am-I?'

The 'Who-Am-I?' schedule (also known as the Twenty Statements Test or TST) owes its origins to the symbolic interactionists of the Iowa school and was derived from Kuhn’s attempts to test Mead’s theoretical ideas empirically, using the scientific method (2.1.3). Kuhn gave respondents a page consisting of 20 numbered blanks and the instructions requested them to give 20 answers to the question 'who am I?': 'Answer as if you were giving the answers to yourself, not to somebody else. Write the answers in the order that they occur to you. Don’t worry about the logic or 'importance'. Go along fairly fast, for time is limited' (Kuhn & McPartland, 1954:69).

Respondents were allowed 12 minutes to write their answers. The format has remained much the same over the considerable volume of research that has been generated using this method.

Tucker (1966) and Gordon (1968,1969) have presented fairly rigorous formulations of the underlying theoretical framework which is found to be generally consistent with the symbolic interactionist view of self described in 2.1. According to Tucker (1966) the question 'who am I?' implies firstly, the self as object and secondly, knowledge of that self which the individual is able to express linguistically. Further, the knowledge comes from the interactional responses of significant others. One particular advantage of this technique is that by 'volunteering' rather than responding to 'given' statements, respondents are able to express the significance of the statements for them and thereby enable predictions of their behaviour over a wide range of situations. On the other hand, responses obtained from fixed format techniques 'have no predictive utility for they do not indicate the plans by which the individual organizes and directs his behavior' (Hickman & Kuhn, 1956:243). Gordon (1969) details a theoretical framework within which various levels of self-conception are located in terms of a concrete-abstract continuum. For him the 'who-am-I?' technique is employed in the elicitation of respondents' most
'important, pervasive and enduring self-conceptions at the most specific and concrete level' (p.333).

Gordon sees as the most important advantage of the 'who-am-I?' its capacity to elicit not only attributive descriptions (in common with most fixed-response techniques) but also categories of social identity including roles and memberships. These latter descriptions act to anchor the individual in the social system and to relate him/her to others, while personal attributes act to differentiate him/her from others. Kuhn also identified two basic kinds of responses which he termed Consensual and Subconsensual. According to Hickman and Kuhn (1956) a Consensual statement is 'one which requires no further explanation in order to be understood' (p.244), while a Subconsensual statement is more ambiguous and one would need to question the respondent to find out its exact meaning to him/her. They use the examples of husband, engineer, Londoner and patient to represent the former and 'quite intelligent', 'a good wife' and 'rather unlucky' to represent the latter type of statement. Examination of Consensual and Subconsensual responses led Kuhn and McPartland (1954) to suggest that respondents tended to exhaust all Consensual statements before making Subconsensual ones. This regularity led to the application of Guttman scaling techniques, whereby the total number of Consensual statements represented a respondent's 'locus' score. The locus score was seen to indicate his/her degree of social anchorage, that is the importance of social roles and statuses in the self-concept. Gordon (1968) agrees with the idea of the locus score as an indication of social anchorage, but suggests that such a concept 'may be better indicated by the use of categorical versus attributive responses' (p.133), since the former tend to give information concerning social identity and the latter individualising characteristics. Analysis of the protocols of 'elite-college' students supported his hypothesis that 'use of categorical references will tend to precede use of attributive references' (p.133).

However, it is in the area of more detailed content analysis that much
of Gordon's 1968 paper is directed and which probably encompasses his greatest contribution to the interpretation of 'who-am-I?' responses and hence to the continued use of the technique in self-concept research. Building on the work of Kuhn (1960), who proposed five broad categories of statements (social groups, ideological beliefs, interests, ambitions and self-evaluations), Gordon proposes a 30 category content analysis scheme. The categories are grouped into four major 'rubrics' covering social identity, abstract allegiances and connections, particular interests, activities and objects, and personal characteristics of self and psyche (p.124). Each category is named (with further explanations where necessary) and examples given from the schedules of high school students. Thus, Gordon (1968) provides a very comprehensive account of the scheme which other researchers can follow or adapt as required. In a subsequent paper Gordon (1969) details a further expansion of the 1968 content analysis to form the Person Conception Analytic System which facilitates computer aided analysis of 'who-am-I?' responses.

Thus the appeal of the 'who-am-I?' technique lies in its free response, phenomenological approach which is consistent with the symbolic interactionist perspective; the wealth and variety of self-referent information it can obtain for which well developed schemes of content analysis are available; its flexibility. However, such characteristics are not without some disadvantages for the researcher: flexibility makes comparisons between studies difficult; the wealth of information tends to make coding difficult and time-consuming; some writers consider that the phenomenological approach is violated by the necessity to code.

Taking the latter point first; Tucker (1966) and Wylie (1974) suggest that content analysis procedures contradict the essentially phenomenological stance of the 'who-am-I?' technique. Thus while the aim is to elicit self-representations from the perspective of the respondent, content analysis by the researcher/coder means that the latter inevitably imposes meanings from his/her own perspective. On the other hand, Schutz (1954) suggests that the use of such 'second level
constructs' by the social scientist is both valid and necessary in the process of explaining the social world. However there would seem to be some contradictions when first and second level constructs are compared. In a comparison of respondents' and researchers' classifications of Consensual and Subconsensual statements McPhail and Tucker (1972) found an overall agreement of only 68%, with just 56% of responses classified as Consensual by respondents being considered Consensual by researchers.

Further, McPhail and Tucker (1972) found that neither respondents' nor researchers' classifications produced a reliable Guttman scale, thus bringing into question the credibility of the locus score as an index of social anchorage. They criticised Kuhn and McPartland's (1954) methodology on three counts: (1) they had used their own rather than respondents' classifications of Consensual and Subconsensual; (2) in classifying statements in the order in which respondents had made them, they failed to guard against 'experimenter bias'; (3) where respondents had made fewer than twenty statements they classified the 'blanks' as Subconsensual. However, there does appear to be a general pattern of Consensual/categorical statements followed by Subconsensual/attributive statements. When Bugental and Zelen (1950) asked for just three responses to the question 'who are you?', the statements were found to overemphasize social identity at the expense of individual characteristics. Further, Schwirian (1964) found that when he asked for thirty statements instead of twenty, some 80% of all Consensual statements on the thirty statement schedule were made within the first twenty statements, and the locus remained relatively unchanged between the two lengths of schedule. It was concluded that respondents in general hold only a limited number of Consensual identifications (which are adequately explored in twenty statements) which tend to be presented early in the schedule and to be followed by Subconsensual statements.

A further problem in analysing 'who-am-I?' schedules concerns the difficulty of comparing the response distributions of individuals (groups of individuals) who give different numbers of statements
This occurs because the probability of an individual making at least one response in any one category of statement increases directly with the total number of statements made.

Finally, and in spite of the content-analysis work by Gordon, 'who-am-I?' schedules are more time consuming and difficult to code than fixed-response techniques and the use of different coding schemes hinders comparisons between studies. Further, there is a comparative lack of inter-coder reliability statistics, although Spitzer et al (1971) conclude from their extensive study of all forms of reliability (inter-coder, test-retest and parallel-form) that where such issues have been addressed the results are encouraging compared with other self-concept instruments.

While it is obviously important to be aware of these criticisms of the 'who-am-I?' technique (especially as they concern possible limitations on the analysis and interpretation of responses), they are themselves the subject of disagreement amongst writers. Certainly, as far as the present doctoral study is concerned any disadvantages of the technique would seem to be outweighed by its advantages.

In summary, use of the 'who-am-I?' technique in this study is justified by its theoretical framework; its ability to elicit self identifications in terms of social roles and group memberships; the availability of a system of content analysis which can be readily adapted to include categories of particular relevance to the hypotheses under investigation.

3.4.2 The Semantic Differential

The semantic differential requires respondents to rate given concepts on a range of scales, usually adjectives, presented as bi-polar pairs and hence assumed to be linearly related through a neutral centre point from which they are equidistant. Respondents are presented with a set of scales for each concept and the adjective pairs are listed down the page with an odd number (usually 5 or 7) of divisions marked out between
them. They are asked to place one tick on the continuum between each pair of adjectives, within the marked divisions. This is done according to which of the adjective pair best describes the concept and to what degree the description is appropriate. To clarify this the divisions may be assigned headings or descriptive modifiers, for example: (1) very (2) slightly (3) in between (4) slightly (5) very. Alternatively, where a large number of divisions are used and it is not possible to linguistically express the numerous small variations in intensity, respondents may simply be told that 'more extreme responses should be used to indicate greater applicability of a polar term' (Warr & Knapper, 1968:58). The use of an odd number of divisions allows respondents to indicate ambivalence (equal association of each adjective with the concept), irrelevance (neither adjective is related to the concept), or neutrality. However, conceptually only the neutral response is permissible since by definition all scales should be relevant and 'averaged-out' scores due to equal association contradict the assumed linearity of scale pairs (Mann, Phillips & Thompson, 1979).

Development of the semantic differential as an attitude scale was essentially a by-product of the original work by Osgood and his colleagues aimed at identifying the dimensions of connotative meaning. Early research led to the identification through factor analysis of three primary dimensions of meaning: Evaluation, Potency and Activity (Osgood, Suci & Tannenbaum, 1957). They suggested that the Evaluation dimension represented the attitudinal component of meaning, but a detailed examination of the research evidence led Heise (1970) to conclude that was 'erroneous' and he recommended that 'studies employing the SD (semantic differential) for attitude measurements should make use of all three dimensions to get measurements paralleling those on traditional attitude scales' (p.24).

One of the main advantages of the semantic differential is that it is quick to complete (20 scales take three to five minutes on average) and easy to code (being merely a case of identifying which division has been 'ticked' for each pair of adjectives). Further, it is flexible
in that scales can be chosen to suit the concepts being rated or to comply with the underlying theoretical orientation of the study in hand. Heise (1970) recommends the selection of scales on the basis of relevance and factorial composition. Taking relevance first, he suggests that it is important to use scales which are meaningful in terms of the concepts to be rated and which make familiar distinctions for respondents. However, 'selection on the basis of published factor analyses' (p.239) is not as simple as he suggests due to the problem of concept-scale interaction, which refers to changes in both meaning and degree of relevance of adjectival scales when applied to different classes of concepts. This will lead to differences in factorial composition so that it is necessary to carry out factor analyses for each new class of concepts. Mayerberg and Bean (1978) summarise quite succinctly the main guidelines for constructing a semantic differential for attitudinal research: (1) 'the concepts must be carefully selected to represent the special area of interest ..... (2) the scales selected should meaningfully relate to the particular set of concepts included ..... (3) dimensionality of this particular combination of scales and concepts must be empirically determined' (p.479).

Although the semantic differential technique is subject to most of the 'invalidating influences' described in 3.2.2, many of these can be overcome or at least minimised by relatively simple and well tested methods. Motivation of respondents can generally be best assured by the use of meaningful adjective pairs and attention to the interviewer/respondent relationship. The latter factor is also important in minimising conscious attempts by respondents to give socially desirable responses, while in the case of self-concept research unconsciously socially desirable responses are considered to be valid (3.2.2) since they are 'true' for the individual (Wylie, 1974). Acquiescence (the tendency to agree with adjectives along one pole or the other regardless of content) can be minimised by reversing the positive and negative poles of half the scales; choosing items that are relevant and meaningful; making sure that the instructions for completion are clear. Turning to consider differential meanings,
the semantic differential helps counteract 'descriptive variance' by using bi-polar adjectives which help to anchor meaning, but 'modifier variance' is more difficult to overcome. Possibly the best method is to use only a small number of divisions 'since virtually all midscale quantifier terms have substantial variation in meaning' (Wells & Marwell, 1976:174).

The question of rating styles, in particular the tendency of some respondents to mark the extreme ends of scales, is an important one in the context of this research since some of the findings in this area relate to individuals with psychiatric diagnoses. While Luria (1959) compared three groups of neurotics undergoing therapy with three groups of normals and found no difference in their rating styles, later studies (Zax, Gardiner & Lowry, 1964; Arthur, 1963, 1966) did find significant differences between psychiatric and control groups. Zax, Gardiner and Lowry (1964) noted the number of times two pairs of matched 'adjusted' and 'maladjusted' groups made extreme (1,7), intermediate (2,3,5 or 6), and neutral (4) responses when rating Rorschach inkblots. For both pairs of groups (including one pair made up of 30 chronic schizophrenic long stay patients and 30 attendants from the same hospital) the 'maladjusted' group made significantly more extreme and significantly less intermediate responses but there was no difference on the number of neutral responses made by each. Similarly Arthur (1963) found that paranoid schizophrenics made significantly more extreme ratings than either a neurotic group or a normal control group, and then (Arthur, 1966) that a group of psychotics gave extreme responses significantly more frequently than a group of neurotics (although the differences for intermediate and neutral responses were not significant). He concluded that an extreme response tendency was related to the severity of psychiatric illness and found it to be independent of test content and hence a reliable person characteristic for this sample. On the basis of these results it would seem particularly important to minimise the effects of an extreme response tendency; this can best be done by using a small number of divisions with descriptive modifiers and making the adjectives meaningful to the respondents and relevant to the concepts.
Thus in the present study attention was given to minimising invalidating response biases both within the interview situation (the establishment of rapport in a non-threatening situation where confidentiality was assured) and by following certain basic rules in the presentation of the semantic differential schedules. Adjective pairs were chosen which were considered highly relevant to the concepts being rated and which would be meaningful to respondents; the positive and negative poles were reversed for half the scales; the number of divisions was kept to five; descriptive modifiers were used to indicate the degree to which the adjectives described the concept; the instructions for completion were written in plain, straightforward language (3.5.1 and A3.4).

One further advantage of the semantic differential, especially when compared with the 'who-am-I' technique, is that there are well validated and relatively simple methods of analysis, that allow comparisons between different groups of respondents on their rating of the same concept or their discrepancies between two concepts, or alternatively the comparison between a group of respondents of their ratings on two or more different concepts. Further, the analyses may be made for individual scales, groups of scales or the total scale profile. The latter is the traditional method of analysis which enables a comparison of profiles for different groups of respondents through the distance or 'D' score. Developed by Osgood et al (1957) to measure the 'semantic distance' between two profiles, D is mathematically defined as: 

$$D = \sqrt{n \sum (x-y)^2}$$

that is the square root of the sum of the squared differences between scores on each scale. The x and y may either represent individual scores or averaged scores for groups of individuals. D may also be calculated by summing across factor scores rather than individual scale scores. However, there are two main disadvantages to the use of D scores: firstly, any information regarding constituent parts of the total profile is lost, and secondly, the same D score can be derived from quite different combinations of profile pairs. Thus there may be small differences...
on many scales or large differences on only one or two, but the resulting D is the same. It should also be noted that as for summing across scales to obtain total scale scores, this technique makes the unproven assumption that all scales are equally important to all respondents since they all contribute equally to the overall D score. Consequently many researchers prefer to compare either factor scores or individual scale scores, since although it is 'more laborious .... it is a more rigorous procedure and one which is likely to lead to a more meaningful interpretation of a set of results' (Warr & Knapper, 1968:60). However, Judd and Smith (1974) point out that even the comparison of factor scores is not straightforward. Using ratings of 445 students for the concepts 'self' and 'ideal-self' they showed that the factor structure of the 'ideal-self' was quite different to that of the 'self', and that any discrepancy measure based on the assumption of equivalent factor structures (using just the 'self' factor structure) would be meaningless. Consequently it is necessary to check the equivalence of factor structures before comparing factor scores on different concepts.

To sum up its advantages, the semantic differential provides a relatively efficient technique for attitude measurement. It is quick to complete and easy to administer and code, with the bi-polar adjectives offering some 'anchoring' of meaning. Extensive use and development of the technique has led to the identification of three main dimensions of meaning which are relevant across a range of concept classes and respondents; a range of studies detail its general reliability and validity characteristics. Beyond this, the technique is flexible: the selection of scales can be tailored to suit the class of concept under study and the format can be tailored to suit the abilities of respondent groups. Further, a variety of analytic procedures have been developed for data analysis which can be efficiently handled by computer.

However, its disadvantages must not be overlooked. The use of different scales and concepts has made comparability between studies difficult, and it shares many of the problems general to fixed-response
techniques, both in terms of 'invalidating influences' and assumptions concerning the equal importance of scales.

Justification for its use in the present study centres around its ability to statistically compare ratings by different groups of respondents on the same concept and ratings by the same group of respondents on different concepts. Further, it is relatively quick and easy to complete and its format can take account of possible intellectual limitations and response tendencies of a population of psychiatric patients/rehabilitees. Lastly, a suitable set of scales for the measurement of the self-concept was available which had already been tested in studies covering a range of age groups (Gordon, 1969). These scales seemed particularly appropriate since they were drawn firstly from 'the general symbolic interactionist tradition' and secondly from 'suggestions by those experienced in working with mental patients' (p.343).

3.4.3 Rosenberg's Self-Esteem Scale

Designed to measure global self-esteem (2.1.6) the Rosenberg Self Esteem Scale consists of ten statements using very general items implying positive or negative attitudes to self (Table 3.1). Respondents are asked to rate the ten statements on a four or five point scale from 'strongly agree' to 'strongly disagree'.

The scale was originally developed by Rosenberg (1965) in a study of adolescent self-image. By collapsing the ten item scale into six items, using a number of contrived items (Rosenberg, 1965: Appendix D; Cohen, 1976), he found that the scale approximated a Guttman scale\(^4\), with satisfactory reproducibility (0.93) and scalability (0.73). It was thus concluded that the scale was

\(^4\) In a Guttman scale the items can be ordered from least to most extreme, so that each respondent will endorse an item if it is less extreme than the most extreme one he agrees with. The number of items endorsed thus represents his scale score.
Table 3.1  *  Factor Analysis of Self Esteem Items

Showing Factor Loadings for the Varimax Rotated Solution

<table>
<thead>
<tr>
<th>Self Esteem Items#</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At times I think I am no good at all.</td>
<td>0.70</td>
<td></td>
</tr>
<tr>
<td>2. On the whole I am satisfied with myself.</td>
<td>-0.30</td>
<td>0.60</td>
</tr>
<tr>
<td>3. I am able to do things as well as most people.</td>
<td>0.59</td>
<td></td>
</tr>
<tr>
<td>4. I feel that I do not have much to be proud of.</td>
<td>0.57</td>
<td></td>
</tr>
<tr>
<td>5. I feel that I have a number of good qualities.</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>6. I take a positive attitude toward myself.</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>7. I certainly feel useless at times.</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>8. All in all, I am inclined to feel that I am a failure.</td>
<td>0.77</td>
<td>-0.33</td>
</tr>
<tr>
<td>9. I feel that I am a person of worth, at least on an equal plane with others.</td>
<td>0.62</td>
<td></td>
</tr>
<tr>
<td>10. I wish I could have more respect for myself.</td>
<td>0.72</td>
<td></td>
</tr>
</tbody>
</table>

*(Taken from Table A4.5, Collis & Ekdawi, 1982:217)*

# Rosenberg, 1965

* 67.  

unidimensional. Most studies using the Rosenberg Self Esteem Scale have assumed its unidimensionality, regardless of the population under study. However, with a sample of 500 adults Kaplan and Pokorny (1969) found a two-dimensional structure; the two factors accounted for 45% of the total variance and were identified as 'self-derogation' and 'defense of individual worth'. To compare this result with the factor structure for an adolescent population for whom the scale was originally developed, Hensley and Roberts (1976) administered the scale to 479 university students and asked them to rate themselves on a 1 to 5 scale from 'strongly agree' to 'strongly disagree'. Factor analysis produced two factors, one containing items indicating positive self evaluation and the other items indicating negative self evaluation. They concluded that 'the factors identify an underlying response set and ... the scale probably measures a single variable' (p.583).

In the light of the above findings it is obviously necessary to check the dimensionality of the scale for each study population. This was done for the sample of psychiatric rehabilitees in the doctoral study under the auspices of the 'Needs of a Health District' study.

A factor analysis of the responses of the 92 rehabilitees who were able to complete the ratings (on a 1 to 5 scale) on the ten item scale found a very similar result to Hensley and Roberts (1976). Table 3.1 shows the factor loadings of 0.30 and above for the varimax rotated solution. 'Factor 1 can be seen to contain all the items indicating a negative evaluation of self, and factor 2 all the items indicating a positive evaluation of self. In each case one item loads negatively, although at a much lower level than the positively loaded items. Thus there appears to be no identifiable dimensions to the scale' (Collis & Ekdawi, 1982:215). Hensley and Roberts (1976) suggested that Kaplan and Pokorny (1969) had not found unidimensionality 'because factors of self-esteem change with increasing age and new expectations and responsibilities' (p.584). Collis and Ekdawi (1982) noted that many of their rehabilitees (being long-stay patients) would not have 'experienced this normal developmental pattern due to their illness and related handicaps, (and that) this could account for the similarity
in the structure of their responses to those of adolescents as measured by factor analysis' (p.218). More importantly the result gives validity to the calculation of a global self-esteem score in the doctoral study by summing across the ten items.

Apart from its obvious advantages in being short and easy to complete for respondents and requiring little manipulation from researchers to calculate the self-esteem score, Rosenberg's scale has quite impressive reliability and validity. Taking reliability first, Silber and Tippett (1965) found a test-retest reliability of 0.85 for 28 college students over two weeks. Turning to consider validity, Wylie (1974) suggests that content validity is assured by the very general evaluative statements which allow a respondent 'to select and weight as he sees fit whatever specific behavioural referents seem appropriate to him as bases for responding to the .... items' (p.181). Thus the problem of selecting representative items which are relevant to respondents is avoided. Further, Rosenberg (1965) took good care to establish criterion-related validity during pretesting, showing significant relationships between low self-esteem and measures of depression, neuroticism and peer group reputation. In his study of 5024 New York high school students he presented a vast array of data relating level of self-esteem to anxiety; interpersonal attitudes and behaviour; participation and leadership; concern with public affairs; occupational orientation etc. He concluded that 'to the extent that the relationships reported .... appear to be theoretically meaningful and consistent with expectations, they would suggest that the scale actually is measuring self-esteem' (p.29). In addition, Silber and Tippett (1965) found good convergent validity with scores from other self-esteem measures including the Kelly repertory grid (r=0.67), a self-image questionnaire (r=0.83) and interviewer judged self-esteem on the basis of a personal interview (r=0.56).

Use of the Rosenberg Self Esteem Scale in the present study is justified on the basis of its length; the impressive data on its reliability and validity; its provision of very general statements which allow
respondents to choose their own behavioural content on which to base their evaluations; its unidimensionality for the population under study which validates the use of a summed total scale score; its provision of a comparison measure of self-esteem to the discrepancy measure of the semantic differential (self-esteem as attitudes compared with self-esteem as the relationship between attitudes) (2.1.6).

3.4.4 Rating Scale: Attitudes to the Patient Role

One of the research hypotheses (2.4) is specifically concerned with respondents' level of acceptance/rejection of the patient-role, and since no suitable published scale could be found a scale was constructed by the researcher. There were originally 16 items in the scale with an equal number of positively and negatively phrased items covering general coping abilities, conversational topics, friendship patterns, types of problems experienced, future expectations and dependence on the hospital (A3.2). As for the Self Esteem Scale (3.4.3) respondents were asked to rate themselves on a 1 to 5 scale from 'strongly agree' to 'strongly disagree', and development and testing of the scale took place during the 'Needs of a Health District' study (Collis & Ekdawi, 1982).

"There were 14 items on the attitude scale which were relevant to all respondents"5. Using the five point rating scale item scores were correlated with the total scale score, and it was found that the correlation coefficient for 'Sometimes I feel I don't want to associate with other (ex) patients' was not significant at the 5% level. This was not surprising: its ability to differentiate between respondents accepting and rejecting the patient-role had already been questioned by experience during interviewing. Such an attitude was characteristic not only of respondents rejecting the patient-role as had been expected, but also of some of those who embraced it, being a common

5 Two items concerning 'workers' meetings' were found not to be relevant to all rehabilitees and were discarded from the analysis.
symptom shown by many in-patients on other (long stay) wards.

"The correlation process was repeated excluding this item from the total scale score. The result was that a further item 'I find it very boring hearing other (ex) patients go on about their problems' which had previously reached the 5% level of significance was now not significant and was consequently also removed from the scale. The same reasoning was valid here as for the first item excluded.

"The correlation process was repeated yet again for the 12 item scale and the results shown in the first column of table (3.2). All the items were found to correlate with the total scale score at the 1% level of significance. It will be noted that there were 92 respondents who completed the attitude scale, but the understanding of some 12 respondents was seriously questioned by the interviewer with consequent doubt as to the reliability of their responses. (See 3.6.4). Excluding these 12, the correlation coefficient for the 80 so called 'reliable' responses are included in the table for comparison. A number of respondents giving both 'reliable' and 'unreliable' responses seemed unable to cope with a 5 point scale, and so Table (3.2) also shows the results of the correlation of each item with the total scale score using a 3 point scale. This was formed by combining the 'strongly agree' and 'agree' responses and similarly the 'strongly disagree' and 'disagree' responses. Overall, the 4 results shown in the Table are not dissimilar, although the relationship of item 5 to the overall scale has a decreased significance for both 'reliable' responses and for those measured on a 3 point scale.

"In order to explore the underlying dimensions of the scale, a factor analysis was carried out on the 92 rehabilitee responses to the 12 items that made up the scale. Factor loadings of 0.30 and above for the varimax rotated solution,
### Table 3.2#

Identification with the Patient Role: The Structure of the Attitude Scale

<table>
<thead>
<tr>
<th>Attitude Scale Items</th>
<th>Spearman Correlation Coefficients between item scores and the total scale score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Responses</td>
</tr>
<tr>
<td></td>
<td>1-5 rating scale</td>
</tr>
<tr>
<td>N</td>
<td>92</td>
</tr>
<tr>
<td>1. I can now cope for myself with most problems that arise in day to day living.</td>
<td>0.58 ***</td>
</tr>
<tr>
<td>2. I often feel that other people can tell from my behaviour that I've been in hospital/I'm a hospital patient.</td>
<td>0.62 ***</td>
</tr>
<tr>
<td>3. Most of my friends have also been patients.</td>
<td>0.27 **</td>
</tr>
<tr>
<td>4. I feel and act much like anyone else/anyone in the community.</td>
<td>0.48 ***</td>
</tr>
<tr>
<td>5. Most of the problems I experience now are shared by most people in the community.</td>
<td>0.24 **</td>
</tr>
<tr>
<td>6. I feel happy with my life now and think it will go on getting better.</td>
<td>0.53 ***</td>
</tr>
<tr>
<td>7. My illness is still a very great burden which I cannot share with many others.</td>
<td>0.57 ***</td>
</tr>
<tr>
<td>8. Sometimes when I'm feeling good I forget I was ever in hospital/I am in hospital.</td>
<td>0.33 ***</td>
</tr>
<tr>
<td>9. When things get hard I wish I was back in hospital/to stay in hospital for ever.</td>
<td>0.45 ***</td>
</tr>
<tr>
<td>10. I often worry that I may get sick and have to go back in hospital/never get well enough to leave hospital.</td>
<td>0.50 ***</td>
</tr>
<tr>
<td>11. I often find myself talking about things that happened/happen in hospital.</td>
<td>0.45 ***</td>
</tr>
<tr>
<td>12. I would enjoy visiting (the hospital) and talking to patients on the/other wards.</td>
<td>0.30 **</td>
</tr>
</tbody>
</table>

* P<0.05  ** P<0.01  *** P<0.001

#Taken from Table A4.1, Collis & Ekdawi, 1982:209

72.
for all responses coded on a 1-5 rating scale, are shown in Table (3.3). There is little difference in the composition of the 4 factors if only 'reliable' responses are considered, although the factor coefficient for items 7 and 6 do not quite reach the 0.30 level on Factors 3 and 4 respectively. No extra items load significantly.

"Factor 1 has high positive loadings on those items concerned with coping with day to day problems, acting like other people in the community, and feeling happy with the present and optimistic about the future. It is best summed up as identifying a feeling of well-being and normality. Factor 2 is concerned with whether (friendships) and conversation are hospital orientated, having positive loadings on items relating to often talking about what happens in hospital and most of one's friends being (ex) patients. Factor 3 loads positively on items relating to illness as a burden and hospital as a refuge or solution. Factor 4 is concerned with forgetting the past (being ill in hospital), being happy (in the present) and optimistic (about the future)."
(pp 210-214)

Justification for the use of a new and unvalidated scale relies basically on the fact that no published scale was considered to measure acceptance/rejection of the patient-role as required by research hypothesis one. Further, it was hoped to compare this measure of identification with the patient-role with the discrepancy measure obtained from the semantic differential (just as the Rosenberg Self Esteem Scale provided an alternative measure to the discrepancy measure of self-esteem).

Attempts were made to include items covering attitudes to a range of behaviours and feelings that could be expected on the basis of experience to differ between individuals identifying themselves as 'patient' or 'non-patient'. Testing of the scale led to the
Table 3.3  Factor Analysis of Attitudes
(Showing Factor Loadings for the Varimax Rotated Solution)

<table>
<thead>
<tr>
<th>Attitude Scale Items</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can now cope for myself with most problems that arise in day to day living.</td>
<td>0.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I often feel that other people can tell from my behaviour that I've been in hospital/I'm a hospital patient.</td>
<td>-0.49</td>
<td>0.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Most of my friends have also been patients.</td>
<td></td>
<td>0.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel and act much like anyone else/anyone in the community.</td>
<td>0.72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Most of the problems I experience now are shared by most people in the community.</td>
<td>0.37</td>
<td>0.42</td>
<td></td>
<td>0.30</td>
</tr>
<tr>
<td>6. I feel happy with my life now and think it will go on getting better.</td>
<td>0.61</td>
<td></td>
<td></td>
<td>0.30</td>
</tr>
<tr>
<td>7. My illness is still a very great burden which I cannot share with many others.</td>
<td>-0.46</td>
<td>0.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Sometimes when I'm feeling good I forget I was ever in hospital/I am in hospital.</td>
<td></td>
<td></td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>9. When things get hard I wish I was back in hospital/to stay in hospital for ever.</td>
<td></td>
<td></td>
<td></td>
<td>0.52</td>
</tr>
<tr>
<td>10. I often worry that I may get sick and have to go back in hospital/never get well enough to leave hospital.</td>
<td></td>
<td></td>
<td></td>
<td>0.69</td>
</tr>
<tr>
<td>11. I often find myself talking about things that happened/happen in hospital.</td>
<td></td>
<td>0.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I would enjoy visiting (the hospital) and talking to patients on the/other wards.</td>
<td></td>
<td>0.42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Taken from Table A4.3, Collis & Ekdawi, 1982:213
removal of those items which were not relevant to all respondents and those which were not statistically correlated with the total scale score, thus increasing the internal consistency of the scale. Dividing the scale randomly into two halves, and using the Spearman-Brown formula 6, the remaining 12 items have a split half reliability of 0.64. Since the scale has been shown to be multi-dimensional, use of the total scale score as a measure of acceptance/rejection of the patient-role will be supplemented by the use of factor scores. These will allow the identification of those aspects of the patient-role which are most important to respondents in their overall acceptance/rejection.

Considering the invalidating influences (3.2.2) on scale responses, attention was paid to the wording of both the items and instructions for completion; half the statements were positively phrased and half negatively phrased; only five divisions were used on the ratings with modifiers to describe the division.

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6 $r = \frac{nr_1}{1 + (n-r)r_1}$ where $r_1$ is the correlation between any two parts of the scale and $n$ is the number of equivalent parts into which the scale is divided.
3.5 Format of the Interview Schedules and Self-Concept Instruments

3.5.1 The Rehabilitee Interview Schedule

Together with background information on rehabilitees (demographic, socio-economic and medical variables) the interview focussed on their past and present use of a range of rehabilitation services and their future needs. The results of the study are fully documented in 'Psychiatric Rehabilitation: Needs of a Health District' (Collis & Ekdawi, 1982). Those sections of the interview specifically included to provide data for the doctoral research are reproduced in Appendix 3, and include a series of questions concerning the CR-rehabilitee relationship plus a range of techniques designed to measure self-concept.

Discussion of the CR-rehabilitee relationship (A3.1) followed a series of questions on the rehabilitee's contact with family members and close relatives, and was introduced by the request: 'Can we now talk a little more about the person whose contact means the most to you'. The main aim of the series of questions which followed was to operationalise the concepts 'valued-other' and 'credible-other' as defined in 2.1.4. In each case one key question was supplemented by a further one or two questions so that 'valued-others' and 'credible-others' could be distinguished from 'not-so-valued-others' and 'not-so-credible-others' either by the response to a single question or by summing the responses to two or more questions. All responses were rated on a 1 to 5 scale from seeing the CR as 'very' valued or credible to seeing them as 'not at all' valued or credible. The key question on 'valued-others' was 'Do you try to live up to his/her (CR) expectations of you?' supplemented by the questions: 'Do you usually do what he/she (CR) suggests?' and 'Do you ever do things which he/she (CR) disagrees with?'. The key question on 'credible-others' was 'Do you think he/she (CR) knows what is best for you?' and this was supplemented by 'Do you feel he/she (CR) understands you?'.

The first section of the interview schedule designed to elicit details
of rehabilitees' self-conceptions consisted of a 26 item Likert-type attitude scale (A3.2). Rehabilitees were given the following instructions:

Considering your own experiences and feelings at the present time can you tell me whether you agree or disagree (and to what extent) with each of the following statements. Please read each statement carefully and then tick (✓) one box for each, according to whether you (1) strongly agree (2) agree (3) cannot decide (4) disagree or (5) strongly disagree.

The scale included the 10 item self-esteem scale and 16 items concerned with attitudes to the patient-role (3.4.3 and 3.4.4); the items were placed in a randomly selected order.

The second technique of self-conception measurement was the 'Who-Am-I?' schedule (A3.3). Rehabilitees were simply handed a sheet of paper headed with the question 'WHO AM I?' and with the numbers 1 to 20 spaced down the left hand side of the page. The instructions read:

Now I would like you to ask yourself the simple question 'Who am I?' and to write up to 20 answers in the numbered spaces below. Just write down the answers as they come into your head: don't worry about the order or how important each one is. Try to work quickly as time is limited.

Finally rehabilitees were asked to complete four 20 item semantic differential scales (A3.4). The instructions on the first page read:

Please rate 'THE WAY I AM NOW' using the scales set out below. Place one tick (✓) along each scale, in between the colons, according to which of the pair of opposites seems to you to best describe 'THE WAY I AM NOW'. The scale allows you to indicate whether the word describes 'THE WAY I AM NOW' very well or only slightly. Work quickly, ticking according to first impressions.

Rehabilitees were asked to complete a further three semantic differential scales for 'THE WAY I WOULD MOST LIKE TO BE', 'THE WAY MY (CR) SEES ME', and 'THE WAY MOST PSYCHIATRIC PATIENTS ARE'.

Each of Osgood et al's (1957) three dimensions of semantic space was represented by a 'marker' scale: Evaluation by Good-Bad, Potency by Strong-Weak and Activity by Active-Passive. All but four of the remaining scales seemed to be concerned with either Psychic Style (how the individual typically feels and acts) or Interpersonal Style.
(how the individual typically interacts with others). Some seven scales were concerned with how the individual typically feels and acts: Calm-Emotional, Happy-Unhappy, High in Confidence-Low in Confidence, Creative-Uncreative, Optimistic-Pessimistic, Important-Unimportant and Lucky-Unlucky. A further six scales were concerned with how the individual typically interacts with others: Friendly-Unfriendly, Outgoing-Shy, Dominant-Submissive, Interested in Getting Things Done-Interested in Enjoying Myself, Well Liked-Not Well Liked and Independent-Dependent. All the above scales were included in the set of 20 scales suggested by Gordon (1969) as appropriate to measuring the self-conception of psychiatric patients (3.4.2). The final four scales were Responsible-Irresponsible, Young-Old, Masculine-Feminine and Beautiful-Ugly. The scale Beautiful-Ugly was intended to replace Gordon's 'body image' subset (three scales) by one scale, so that the scales Responsible-Irresponsible and Masculine-Feminine could be included without lengthening the scale. The former seemed to incorporate one of the basic aims of rehabilitation, to enable rehabilitees to take responsibility for themselves in their everyday lives; the latter is one of the most basic categories which individuals apply to themselves (how they match up to the stereotype view of being masculine or feminine), as is the final scale Young-Old (which was included in Gordon's 20 scales).

3.5.2 The Close Relative Interview Schedule

The interview with close relatives (CRs) was mainly concerned with the joys and problems of living with or visiting/being visited by rehabilitees, also including sections on CRs' attitudes to rehabilitees' present and possible future living accommodation and the CR-rehabilitee relationship.

A descriptive account of the interviews with close relatives is given in 'The Relatives' Story' (Collis & Ekdawi, 1984(b)). CRs were also asked to complete three semantic differential scales for 'THE WAY (REHABILITEE) IS NOW', 'THE WAY I WOULD MOST LIKE (REHABILITEE) TO BE', and 'THE WAY MOST PSYCHIATRIC PATIENTS ARE'.
3.6 Response Rates and Limitations on Data Analysis

3.6.1 Response of the Secondary Sample of Close Relatives

There were 75 potential respondents in the sample of close relatives (3.1.3). Nine had to be excluded from the interviews: in two cases the rehabilitee or close relative was deceased by mid-1981 when the CR interviews were completed; in a further seven cases the close relatives lived too far away to make interviewing feasible. Thus permission to contact their close relatives was requested of 66 rehabilitees in the primary sample (Letter 1). Rehabilitees were asked to sign and return the reply slip at the bottom of the letter in the enclosed stamped, addressed envelope. If they had not replied within two weeks, rehabilitees were sent a brief reminder. A second, longer reminder (Letter 2) with a written option of 'I do not wish my (CR) to be contacted', was finally sent to the few rehabilitees who still had not replied after a further two weeks. Nursing staff were asked to help patients complete the reply slips where necessary, but it was stressed that each rehabilitee should make his/her own decision regarding permission for the writer to contact the CR. Overall, 56 (85%) rehabilitees gave their permission; five gave a definite refusal and five failed to reply at all or were unable to make the decision regarding permission to contact due to their current mental state.

The CRs of these 56 rehabilitees were then contacted requesting an interview (Letter 3); they were asked to complete the reply slip indicating their agreement to be interviewed and suggest suitable dates/times. A stamped, addressed envelope was again enclosed. If a reply had not been received within three weeks CRs were sent a reminder (Letter 4) which gave a written option of 'I do not wish to participate in the study'. Some 48 (86%) agreed to be interviewed; five refused by returning the reply slip or telephoning the writer;

---

7 See Appendix 2 for copies of all letters sent to rehabilitees and close relatives. Different groups of rehabilitees and CRs received slightly different versions of letters dependent on rehabilitees' place of residence. The letters in A2 incorporate the various alternative formats.
three failed to respond at all. Unfortunately, a further three CRs were unable to be interviewed due to their personal ill-health, overseas business travel, and a family death. Thus a total of 45 interviews were completed with CRs between mid-July and November 1981.

In all 60% of potential respondents were interviewed; this represents 80% of those who were contacted by the writer. Only eight (14%) of those contacted refused to be interviewed or failed to reply, while three (6%) were not available for interview.

Table 3.4 shows that compared with potential respondents those CRs interviewed were more likely to be a parent (44% compared with 35%) and less likely to be a spouse or 'other relative' (cousin, uncle, grandmother). Parents tended to live locally (the Hospital being situated within its own catchment area) and only one couple refused, although several rehabilitees refused the writer permission to contact their parent CRs on the grounds of age and ill-health. Spouses (all female) also lived locally, and here refusals were by default: two rehabilitees were unable to give permission for their wives to be contacted, and two wives failed to respond to the letters requesting an interview. 'Other relatives' were more scattered geographically, although personal ill-health and a death in the family also decreased the proportion who were interviewed.

3.6.2 Response to the Semantic Differential Scales

Table 3.5 shows the number of rehabilitees and CRs who completed two or more of the 20 item semantic differential scales by rehabilitees' place of residence in 1980. Rehabilitee numbers are given both for the total sample of rehabilitees and for those in the CR Sample, that is those rehabilitees whose CRs completed complementary interviews. Since there were 100 rehabilitees in the primary sample, the table indicates that almost one-quarter of them failed to complete at least two semantic differential scales. This was usually because they lacked the necessary intellectual or literacy skills. The proportion of
### Table 3.4

<table>
<thead>
<tr>
<th>Relationship of Close Relative to Rehabsitees</th>
<th>Rehabsitees</th>
<th>Total Potential Close Relative Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Spouse</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Sibling</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Child</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Other</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for the Non-Completion of Close Relative Interviews</th>
<th>Completed Close Relative Interviews</th>
<th>Non-Completed Close Relative Interviews</th>
<th>Refused</th>
<th>Other Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>3 (20)</td>
<td>2 (23)</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Spouse</td>
<td>2 (13)</td>
<td>4 (57)</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Sibling</td>
<td>1 (13)</td>
<td>5 (40)</td>
<td>2</td>
<td>85</td>
</tr>
<tr>
<td>Child</td>
<td>2 (17)</td>
<td>5 (50)</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>Other</td>
<td>2 (17)</td>
<td>2 (29)</td>
<td>2</td>
<td>45</td>
</tr>
</tbody>
</table>

81.
Table 3.5 Numbers of Rehabilitees and CRs Completing Two or More 20 Item Semantic Differential Scales by Rehabilitees' Place of Residence

<table>
<thead>
<tr>
<th>Rehabilitees' Place of Residence</th>
<th>Rehabilitees</th>
<th></th>
<th>CRs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Sample</td>
<td>CR Sample</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Villa</td>
<td>20</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Hospital Hostel</td>
<td>9</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>'Other Ward'</td>
<td>16</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Hospital</td>
<td>45</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>With Parents</td>
<td>14</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Elsewhere in Community</td>
<td>17</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Community</td>
<td>31</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td><strong>76</strong></td>
<td><strong>34</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>
rehabilitees in the CR Sample who did not complete two or more semantic differential scales was the same as for the total sample of rehabilitees. Only three (7%) of the 45 close relatives in the CR Sample were unable to complete the semantic differential scales: this was due to their age. The numbers in the table are correct for the concepts 'the way I am now' (Real-Self) and 'the way (my rehabilitee) is now' (Accorded-Self). The numbers of respondents completing scales on the other dimensions of the self-concept varied slightly since one or two rehabilitees became restless and tired before completing all four scales, and one rehabilitee and one close relative refused to complete the scale for 'the way most psychiatric patients are'.

The main limitation on the analysis is imposed by the comparatively small number of rehabilitees and close relatives in the CR Sample. This effectively means that only hospital - community comparisons can be made and not comparisons between the three groups of hospital and two groups of community residents, as for the total sample (3.1.2). In addition, the time difference between rehabilitee and close relative interviews makes the comparison of semantic differential responses problematic for three rehabilitee/close relative pairs. Due to work commitments on the 'Needs of a Health District' study, the writer was unable to begin interviewing close relatives until some six months after the completion of interviews with rehabilitees (3.1.1 and 3.6.1). During the intervening time between interviews with individual rehabilitee/close relative pairs, two rehabilitees had been discharged from the hospital to the community and one had been readmitted from the community to the hospital. This resulted in their 1980 place of residence classifications (hospital/community) being incorrect at the time of interviews with their close relatives. While the methodologically correct procedure would have been to remove these three rehabilitee/close relative pairs from the CR Sample, this would have reduced the already small numbers in the sample. In particular it would have further reduced the number of paired responses on the semantic differential scales from 33 to 30. Since all three moves had occurred within two months of the date of interviews with close relatives.
it seems probable that any expected changes in the attitudes of close relatives (2.4) had not yet taken place. To test this hypothesis, a discriminant analysis was carried out on close relatives' semantic differential ratings for Accorde-Self ('the way my rehabilitee is now'), with rehabilitees' 1980 place of residence as the dependent variable. The resulting discriminant function correctly classified all three rehabilitees. This suggests that at the time of their interviews, the close relatives of these three rehabilitees (who had recently moved between the hospital and community) had not yet incorporated their rehabilitees' new statuses into their conceptions of them. This result lends support for including these three rehabilitee/close relative pairs in the CR sample.

During the interview it became apparent that two of the semantic differential scales (in particular) were not truly bi-polar for this sample. The first was Interested in Getting Things Done - Interested in Enjoying Myself; many respondents considered that the two ends of the continuum were not bi-polar and wanted to tick both ends. In ticking the mid-point most commented that both adjectives were equally relevant; this contravened the meaning of the mid-point as a neutral point (3.4.2). The second scale that caused problems was Masculine-Feminine; most respondents took it to mean male-female and hence the mean rating for any group of respondents would be dependent on the proportion of men and women in the group. In consequence these two scales have been excluded from the analysis. In addition a few close relatives considered the scales Beautiful-Ugly and/or Lucky-UnLucky irrelevant; in respect of the latter they generally commented that they did not believe in luck. A mid-point rating was given in these cases and in other instances where respondents inadvertently missed scales or did not respond for some

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8 In Discriminant Analysis cases (respondents) are divided into two groups according to the dependent variable (place of residence). The independent variables (scales rated for Accorde-Self) which best distinguish between the two groups are then taken out in turn and formed into a linear equation or discriminant function. Each of the independent variables is weighted so that there is maximum differential of the discriminant score between the two groups, and maximum similarity for cases within groups. The discriminant function is then used to reclassify cases into the two groups, and the resulting predicted group membership compared with actual group membership.
other reason. While there were problems with the comprehension of one or two other scales (Optimistic-Pessimistic and Dominant-Submissive) these were dealt with by giving standard definitions.

3.6.3 Response to the 'Who-Am-I?' Schedule

Table 3.6 shows that a slightly higher number of 'rehabilitees were able to complete the 'who-am-I?' schedule than had completed the semantic differential scales, 84 compared with 76. The 'who-am-I?' schedule demands not only some degree of literacy, but also the ability to think about one's self in a certain way and to express this linguistically. Some 14 rehabilitees lacked one or both of these skills and a further two refused to complete the schedule.

The provision for up to 20 statements appeared to amply cover most rehabilitees' salient self-conceptions; only four of them actually completed 20 statements, three community residents and one hospital resident. In total the 84 rehabilitees gave some 605 self-referent statements, giving a mean of 7.2; however, Table 3.6 shows that there was considerable variation by place of residence, with community groups averaging more than hospital residents. While 41% of community residents gave more than 10 statements this was so for only 15% of hospital residents, with rehabilitees on 'other wards' in particular giving small numbers of responses. Some 60% of them gave three statements or less, compared with only 22% of other hospital residents and 16% of community residents.

The general methodological problems caused by the variation in the number of responses given by individuals and groups of individuals were noted above (3.4.1). Since much of the analysis of the present data relies on comparisons of the proportion of respondents giving statements in specific content categories, it is important to restate the problem and assess the limitations it may impose on the interpretation of the results. Taking the comparison between hospital and community residents as an example; since the latter group have a higher average number of responses than the former (9.4 and 5.9.
Table 3.6  Numbers of Rehabilitees Completing 'Who-Am-I?' Schedules and Attitude Scales by Rehabilitees' Place of Residence

<table>
<thead>
<tr>
<th>Rehabilitees' Place of Residence</th>
<th>Rehabilitees Completing 'Who-Am-I?' Schedule</th>
<th>Rehabilitees Completing Attitude Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean no. of statements</td>
</tr>
<tr>
<td>Rehabilitation Villa</td>
<td>23</td>
<td>7.3</td>
</tr>
<tr>
<td>Hospital Hostel</td>
<td>9</td>
<td>5.8</td>
</tr>
<tr>
<td>'Other Ward'</td>
<td>20</td>
<td>4.3</td>
</tr>
<tr>
<td>Hospital</td>
<td>52</td>
<td>5.9</td>
</tr>
<tr>
<td>With Parents</td>
<td>14</td>
<td>10.5</td>
</tr>
<tr>
<td>Elsewhere in Community</td>
<td>18</td>
<td>8.5</td>
</tr>
<tr>
<td>Community</td>
<td>32</td>
<td>9.4</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>84</td>
<td>7.2</td>
</tr>
</tbody>
</table>
respectively), there is a general expectation that the proportion of community residents giving at least one statement in each category of response will be higher than for hospital residents. Further, if the ordering of responses was entirely random if would be possible to correct for this difference; however, on the basis of the discussion in 3.4.1, this is not so. Most of the 'extra' responses of community residents are likely to be in the personal characteristics categories rather than the social and abstract identifications categories. Since the 'who-am-I?' schedule was specifically included to provide information of identification with the patient-role and normal social roles, that is on social identifications, interpretations of the differences between groups of rehabilitees is unlikely to be affected to any significant degree by variations in the number of responses.

3.6.4 Response to the Attitude Scales

Table 3.6 shows that a higher proportion of rehabilitees were able to complete the attitude scales than either of the other two self-concept instruments: 92% compared with 84% for the 'who-am-I?' schedule and 76% for the semantic differentials. In fact all community residents completed the scales and just 88% of hospital residents. Considering either rehabilitees' poor general level of interaction during the interview or their verbalised difficulties in understanding and responding to the attitudinal statements, the writer questioned the reliability of the responses given by some 12 respondents. However, various measures adopted to test this assumption proved fairly inconclusive and it was decided to use all 92 responses in the analysis and keep to the 1 to 5 rating (3.4.4): the latter was also used on the semantic differential scales.

3.7 Characteristics of the Rehabilitee and Close Relative Samples

3.7.1 Characteristics of Rehabilitees

Table 3.7 summarises the main demographic characteristics of rehabilitees in the study by their stage in the rehabilitation process.
Table 3.7 Characteristics of Rehabilitee Sample by Place of Residence (Stage in the Rehabilitation Process) in 1980

<table>
<thead>
<tr>
<th>Characteristics of Rehabilitees</th>
<th>Rehabilitees in Hospital 'Other Ward'</th>
<th>Hostel Rehabilitation Villa</th>
<th>Rehabilitees in Community With Parents</th>
<th>Elsewhere in community</th>
<th>All Rehabilitees</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>26</td>
<td>12</td>
<td>27</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Demographic Variables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>9</td>
<td>12</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>3</td>
<td>15</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Age (mean)</td>
<td>(57)</td>
<td>(63)</td>
<td>(48)</td>
<td>(40)</td>
<td>(43)</td>
</tr>
<tr>
<td>Under 40</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>40-49</td>
<td>5</td>
<td>-</td>
<td>12</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>50-59</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>60-69</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70 and over</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single (never married)</td>
<td>18</td>
<td>10</td>
<td>26</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Married at some time</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

88.
Table 3.7 cont'd

<table>
<thead>
<tr>
<th>Characteristics of Rehabilitees</th>
<th>Rehabilitees in Hospital 'Other Ward'</th>
<th>Rehabilitees in Hospital Hostel</th>
<th>Rehabilitees in Rehabilitation Villa</th>
<th>Rehabilitees in Community With Parents</th>
<th>Rehabilitees in Community Elsewhere</th>
<th>All Rehabilitees</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>26</td>
<td>12</td>
<td>27</td>
<td>14</td>
<td>21</td>
<td>100</td>
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Psychiatric History

<table>
<thead>
<tr>
<th>Number of Admissions to Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>One</td>
<td>9</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Two or Three</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>Four or more</td>
<td>9</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>34</td>
</tr>
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</table>

Cumulative stay in Netherne Hospital

<table>
<thead>
<tr>
<th>Cumulative stay in Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under One Year</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>One to Five Years</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>Five to Ten Years</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>-</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Ten to Fifteen Years</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Fifteen Years or more</td>
<td>15</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>33</td>
</tr>
</tbody>
</table>

Time Since Discharge

<table>
<thead>
<tr>
<th>Time Since Discharge</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
<th>Netherne Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than Three Years</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Three to Five Years</td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over Five Years</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Admitted</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One or more Readmissions during the previous three years

89.
Table 3.7 cont'd.

<table>
<thead>
<tr>
<th>Characteristics of Rehabilitees</th>
<th>Rehabilitees in Hospital Hostel</th>
<th>Rehabilitees in Rehabilitation Villa</th>
<th>Rehabilitees Elsewhere in Community</th>
<th>All Rehabilitees</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>26</td>
<td>12</td>
<td>27</td>
<td>14</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>18</td>
<td>11</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Affective Disorder</td>
<td>5</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Neuroses/Personality Disorder</td>
<td>3</td>
<td>-</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Organic Disorder</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

Clinical Subgroups of Schizophrenia (Wing, 1961)

<table>
<thead>
<tr>
<th>Schizophrenia without severe florid symptoms:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>l(a) minimal symptoms</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>l(b) moderate symptoms</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>l(c) moderate verbal disorder/severe flatness of affect</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schizophrenia with severe florid symptoms:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2 coherent delusions</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>3 incoherence of speech</td>
<td>3</td>
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Table 3.7 cont'd....

<table>
<thead>
<tr>
<th>Characteristics of Rehabilitees</th>
<th>Rehabilitees in Hospital 'Other Ward'</th>
<th>Hospital Hostel</th>
<th>Rehabilitation Villa</th>
<th>Rehabilitees in Community With Parents</th>
<th>Elsewhere in Community</th>
<th>All Rehabil­itees</th>
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<tr>
<td><strong>Behavioural Scales</strong></td>
<td></td>
<td></td>
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<tr>
<td>(mean ratings by staff)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Symptomatic Behaviour*</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>(total score on 6 items rated 1 to 6)</td>
<td></td>
<td></td>
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<tr>
<td>Social Withdrawal</td>
<td>21.6</td>
<td>25.6</td>
<td>24.8</td>
<td>27.2</td>
<td>26.0</td>
<td>24.7</td>
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<tr>
<td>Socially Embarrassing Behaviour</td>
<td>24.8</td>
<td>27.8</td>
<td>26.8</td>
<td>29.1</td>
<td>28.1</td>
<td>27.0</td>
</tr>
<tr>
<td>Social Behaviour *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(total score on n items rated 1 to 4)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Relationship with Living Companions (n=6)</td>
<td>17.9</td>
<td>21.0</td>
<td>19.4</td>
<td>20.4</td>
<td>18.9</td>
<td>19.2</td>
</tr>
<tr>
<td>Responsibility for Personal Care (n=8)</td>
<td>24.1</td>
<td>26.2</td>
<td>25.0</td>
<td>26.2</td>
<td>25.4</td>
<td>25.4</td>
</tr>
<tr>
<td>Acts Responsibly and Independently (n=4)</td>
<td>11.7</td>
<td>14.2</td>
<td>12.6</td>
<td>13.5</td>
<td>13.0</td>
<td>12.8</td>
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<tr>
<td>Sociability (n=4)</td>
<td>9.1</td>
<td>9.9</td>
<td>10.0</td>
<td>10.0</td>
<td>10.5</td>
<td>9.9</td>
</tr>
<tr>
<td>Use of Leisure Time (n=6)</td>
<td>8.1</td>
<td>7.9</td>
<td>9.4</td>
<td>9.4</td>
<td>9.3</td>
<td>8.9</td>
</tr>
<tr>
<td>Performance in Work Role (n=6)</td>
<td>17.4</td>
<td>21.7</td>
<td>20.9</td>
<td>16.7</td>
<td>18.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Average overall rating giving equal weighting to above six scores</td>
<td>16.1</td>
<td>18.5</td>
<td>17.8</td>
<td>18.0</td>
<td>17.8</td>
<td>17.5</td>
</tr>
<tr>
<td>Self Care Involvement# (Rated 1 to 5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td>4.3</td>
<td>4.4</td>
<td>2.8</td>
<td>3.5</td>
<td>3.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Clothes Care</td>
<td>3.9</td>
<td>4.0</td>
<td>1.7</td>
<td>3.1</td>
<td>2.5</td>
<td>2.9</td>
</tr>
<tr>
<td>Household Chores</td>
<td>3.0</td>
<td>3.8</td>
<td>1.4</td>
<td>2.9</td>
<td>2.3</td>
<td>2.5</td>
</tr>
<tr>
<td>No. of Public Services used</td>
<td>4.1</td>
<td>3.7</td>
<td>8.5</td>
<td>10.5</td>
<td>10.0</td>
<td>7.4</td>
</tr>
</tbody>
</table>

* See Appendix 4.1 for a complete description of methods, scales, etc.
# See Appendix 4.2 for a complete description of methods, scales, etc.

91.
as defined by place of residence (3.1.2); it also gives details of their psychiatric history. Since place of residence is to represent the key independent variable in the study, it is important to ascertain its level of association with other variables which themselves may be important determinants of the self-concept. Where there are significant associations between place of residence and variables measuring demographic or psychiatric characteristics, it will be necessary to check during the analysis in Chapters 4 and 5 whether any differences in rehabilitees' attitudes to self and others are due primarily to place of residence or to the influence of other variables.

Taking the total sample of 100 rehabilitees, place of residence as a dichotomy (hospital or community), and demographic (sex, age, marital status) and psychiatric (number of admissions to Netherne Hospital, cumulative stay in Netherne Hospital, diagnosis) variables as defined in Table 3.7, there are significant (p<0.05) associations between place of residence and age ($X^2 = 25.629$, df4, p<0.001), cumulative stay ($X^2 = 32.96$, df5, p<0.001) and diagnosis ($X^2 = 23.185$, df4, p<0.001). Measured by Cramer's V, the strength of the associations are 0.51, 0.57 and 0.48 respectively.

Further these three variables are themselves closely inter-related, with significant associations between age and cumulative stay ($X^2 = 52.619$, df20, p<0.001), age and diagnosis ($X^2 = 28.368$, df16, p<0.05) and cumulative stay and diagnosis ($X^2 = 32.635$, df20, p<0.05).

If only rehabilitees in hospital are considered, the three-fold division of place of residence as shown in Table 3.7 gives a significant association with only one of the listed variables, age ($X^2 = 26.213$, df8, p<0.01); the value for Cramer's V is 0.45. Age is also associated with cumulative stay ($X^2 = 42.049$, df16, p<0.001) but not with diagnosis. If only rehabilitees in the community are considered there are no significant associations between place of residence (with parents, elsewhere in community) and demographic or
psychiatric variables.

Table 3.7 also gives details of rehabilitees' levels of clinical impairment (2.2.3) which are reflected not only in the degree to which symptoms of the illness are present but also in more general social behaviour and abilities/disabilities in performing the normal tasks of everyday life - that is self-care. Wing (1978) has suggested that the social disabilities of schizophrenia are due to two kinds of intrinsic impairments, a 'syndrome of negative traits' (p.110) related to social withdrawal and verbal disorders due to 'impairment of inner language' (p.110). Further, he contends that 'the intensity of the negative syndrome is highly correlated with measures of social performance at virtually any task, creative or routine, personal or social' (p.110). However, the discussion in 2.3 also suggests that social performance varies according to social milieu. Further, one of the main aims of rehabilitation is to help individuals overcome some of the limitations of their intrinsic (and extrinsic) impairments (2.2).

In Table 3.7 symptomatic behaviour is measured by Wing's (1960) 'behavioural rating scale' which is designed to measure changes in the behaviour of chronic schizophrenic patients during rehabilitation. A high score represents low levels of symptomatic behaviour. For the present sample, the scores on the two major dimensions of behaviour, 'social withdrawal' and 'socially embarrassing behaviour' were found to show considerable variation between subgroups of the diagnostic classification (Collis & Ekdawi, 1982: Appendix 1)^9. Since there is also a significant association between rehabilitees' place of residence (using the five subgroups identified in Table 3.7) and the five clinical subgroups of schizophrenia ($X^2 = 36.432$, df16, $p<0.01$), it would be expected that symptomatic behaviour will also vary according to place of residence. While Table 3.7 shows this to be so, there does seem to be an anomalous situation for residents of the hospital hostel. Thus, while two-thirds of these residents

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9 See Appendix 4.1
are classified in the diagnostic subgroups lc, 2 and 3 (moderate or severe verbal disorder) overall they show markedly less symptomatic behaviour on both dimensions than 'other ward' residents, of whom 58% were classified in subgroups lc, 2 and 3. In fact hospital hostel residents have a level of symptomatic behaviour similar to rehabilitees living 'elsewhere in the community'. While the difference between 'other wards' and the hospital hostel may to some extent be due to the comparatively high proportion of non-schizophrenic patients on 'other wards', it may also indicate important differences in expectations between the two milieux. These differences become more apparent when levels of social behaviour are considered.

Social behaviour was measured by a specially constructed scale covering positive and negative behaviours in six areas of daily life (Collis & Ekdawi, 1982: Appendix I)\(^\text{10}\). Staff were asked to rate rehabilitees on 32 items of behaviour according to how often each described their behaviour over the past two months; a high score represented a positive rating. The overall score for 'social behaviour' gave equal weighting to the six dimensions listed in Table 3.7. Once again residents in the hospital hostel are seen to rate well against other groups on most dimensions and 'other ward' residents to do badly compared with other groups. The association of positive ratings for use of leisure time and performance in the work role with an active rehabilitation milieu is also clearly seen.

The final dimension of behaviour to be considered is self-care, that is rehabilitees' skills and involvement in clothes' care, cooking, household chores and use of public services (Collis & Ekdawi, 1982: Appendix II)\(^\text{11}\). Table 3.7 shows how the different groups of rehabilitees compared on their involvement in these four areas of daily living, as judged by staff members. On this scale (except for use of public services) a low score represents a positive rating. It is here that those residents on the rehabilitation villas tend to stand out, with their involvement being much greater than for other hospital residents and rehabilitees living with parents.

\(^{10}\) See Appendix 4.1

\(^{11}\) See Appendix 4.2
Having introduced some of the variables in Table 3.7 and looked at their inter-relationships, it is now possible to build up a picture of the different groups of rehabilitees, their similarities and differences. Taking rehabilitees already discharged to the community, they are noticeably younger on average than those still in hospital, with half of them being under 40. They also tend to have had a shorter stay in hospital than other groups, with only 11% having a cumulative stay of over ten years compared with between 48% and 83% of rehabilitees in the hospital based groups. Very few of the rehabilitees living in the community are classified as having a schizophrenic illness in subgroups 1c, 2 or 3; half of all rehabilitees in the community show only minimum or moderate symptoms of schizophrenia (flatness of affect and verbal disorder) and a further 30% have a non-schizophrenic illness. In general there is little difference in the psychiatric histories of rehabilitees living with parents and those living elsewhere in the community, but the two groups do differ quite markedly in the length of time rehabilitees have been discharged from the Rehabilitation Unit. Thus, while only one-fifth of those discharged to live with parents have been discharged within the past three years, this is so for two-thirds of those discharged to live elsewhere in the community. However, the proportion of rehabilitees who have been readmitted over the past three years is very similar for both groups, roughly one-fifth.

Rehabilitees living in the community show the least amount of symptomatic behaviour of any rehabilitee group, and except for their performance in the work role are rated equal to, or marginally better than, rehabilitation villa residents on the dimensions of social behaviour. However, on their involvement in the daily activities of self-care they do not seem to match up so well when compared with rehabilitees currently undertaking active training in these areas. This is particularly so for rehabilitees living with parents. Amongst those living elsewhere in the community, Collis and Ekdawi (1982) show that Group Home residents do particularly well on their involvement in self-care activities and on the more 'outward looking'
aspects of social behaviour such as sociability, use of leisure time and performance in the work role (A4.1 and A4.2).

Rehabilitees still undergoing active rehabilitation within the hospital tend to be slightly older than those already discharged to the community, with most being between 40 and 60. All but one are single. They also tend to have had a longer period of hospitalisation, with half of them having a cumulative stay of over ten years, and two-thirds multiple admissions. Two-thirds of rehabilitation villa residents have a diagnosis of schizophrenia, with over half of this group being classified in subgroup 1c (moderate verbal disorder and severe flatness of affect). Their greater impairments when compared with rehabilitees in the community are reflected in their poorer scores for symptomatic behaviour but not on their ratings for social behaviour and self-care involvement. Thus the social behaviour ratings are very similar for the two groups, with rehabilitees in the rehabilitation villas being rated markedly higher for their performance in the work role than rehabilitees living with parents. As also might be expected of rehabilitees still engaged in active programmes of rehabilitation, rehabilitation villa residents do extremely well on the staff ratings of their involvement in self-care activities. The exception is for use of public services, this is not as extensive as for rehabilitees actually living in the community. The 'Needs of a Health District' study also found that lack of basic literacy and numeracy skills (extrinsic impairments) could be hindering use of community resources and delaying the discharge of some of this group (Collis and Ekdawi, 1982).

Turning to consider those rehabilitees who have taken a backward step in the rehabilitation process during the previous three years or so, and have been transferred to 'other wards'; they tend to be older on average than rehabilitees in the community or rehabilitation villas. Further, almost one-third of them have been married at some time. Considering their psychiatric histories, two-thirds of them have spent over ten years in hospital. Diagnostically nearly one-third of them
are classified as showing severe florid symptoms of schizophrenia (subgroups 2 and 3), and a similar proportion as having a non-schizophrenic illness. Only 12% have a schizophrenic illness with only moderate symptoms (subgroup 1b), and none with minimum symptoms. Not surprisingly this group show the most marked symptoms of social withdrawal and socially embarrassing behaviour. Further, they generally have the poorest ratings on the dimensions of social behaviour. They also have markedly lower ratings on their involvement in self-care activities than any of the groups so far considered, but they are not as low as those for residents of the hospital hostel.

The lack of involvement in self-care for the latter group is possibly related to the age and sex of hospital hostel residents; all of them are over 60 and three-quarters of them are single men. Further, 83% of rehabilitees in the hospital hostel have been in hospital for over ten years. All but one resident has a diagnosis of schizophrenia, half of whom show severe florid symptoms. However, on average this group show slightly less evidence of symptomatic behaviour than rehabilitation villa residents and markedly less evidence than 'other ward' residents. It was suggested above that this could be related to the different ward environments and expectations. This would seem to be confirmed by their good ratings for social behaviour, except on the dimension concerning use of leisure time. Their age and length of hospitalisation may account for their lesser performance on the latter dimension, but residence in the hospital hostel does demand a certain level of skill in getting on with living companions and in acting responsibly. Inability to perform to the expected level or the exhibition of too much symptomatic behaviour would lead to transfer to 'other wards'.

Thus a brief description of the main characteristics of rehabilitees at different stages in the rehabilitation process shows that the social milieu is very important in determining the inter-relationship between
diagnosis, symptomatic behaviour, social behaviour and self-care involvement. While the intrinsic impairments of a psychiatric illness appear to be fairly critical in determining the placement of rehabilitees (and presumably hospital patients in general), the effect of these impairments on behaviour is clearly dependent on the characteristics and expectations of the different social milieux. Further, the latter would seem to be particularly important in redressing the effects of secondary impairments such as institutionalisation and extrinsic impairments such as lack of basic literacy and numeracy skills (2.2.3). The resulting effect of social milieu on self-conception is one of the main concerns of this study.

3.7.2 Characteristics of Close Relatives

Just over four-fifths of the close relatives (CRs) are women; the majority of them are mothers or sisters of rehabilitees (Table 3.8). Overall, mothers are the most popular choice for a CR, being chosen by three-quarters of the rehabilitees whose mothers are still alive. Where rehabilitees have no mother, the choice tends to depend on whether they have grown-up children; if yes, then a daughter tends to be the usual choice; if no, then a sister is most likely to be chosen (Collis & Ekdawi, 1984(b)). The older average age of rehabilitees in hospital is thus reflected in the fact that only one-quarter of their CRs are mothers compared with just over half the CRs of rehabilitees in the community. Further, while nearly half the CRs of hospital residents are sisters, only one CR of community residents is a sister.

The large number of mothers amongst the CR population means that on average CRs are older than rehabilitees; over three-quarters of them are 50 or over compared with half the rehabilitees. Further, more of the elderly CRs (that is those over 60) of rehabilitees in the hospital are very elderly (over 70) compared with the elderly CRs of rehabilitees in the community; three-quarters and one-fifth respectively. Over half the CRs are currently not in paid employment.
Table 3.8 Characteristics of Close Relative Sample

<table>
<thead>
<tr>
<th>Characteristics of Close Relatives</th>
<th>Close Relative of Rehabilitee in Hospital</th>
<th>Close Relative of Rehabilitee in Community</th>
<th>All Close Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>24</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N %</td>
</tr>
<tr>
<td>Relationship to Rehabilitee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>6</td>
<td>11</td>
<td>17 38</td>
</tr>
<tr>
<td>Father</td>
<td>2</td>
<td>1</td>
<td>3 7</td>
</tr>
<tr>
<td>Spouse</td>
<td>-</td>
<td>3</td>
<td>3 7</td>
</tr>
<tr>
<td>Sister</td>
<td>11</td>
<td>1</td>
<td>12 27</td>
</tr>
<tr>
<td>Brother</td>
<td>2</td>
<td>1</td>
<td>3 6</td>
</tr>
<tr>
<td>Daughter</td>
<td>3</td>
<td>1</td>
<td>4 9</td>
</tr>
<tr>
<td>Son</td>
<td>-</td>
<td>1</td>
<td>1 2</td>
</tr>
<tr>
<td>Cousin</td>
<td>-</td>
<td>2</td>
<td>2 4</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>4</td>
<td>8 18</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>17</td>
<td>37 82</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 40</td>
<td>3</td>
<td>2</td>
<td>5 11</td>
</tr>
<tr>
<td>40 - 49</td>
<td>3</td>
<td>2</td>
<td>5 11</td>
</tr>
<tr>
<td>50 - 59</td>
<td>6</td>
<td>7</td>
<td>13 29</td>
</tr>
<tr>
<td>60 - 69</td>
<td>3</td>
<td>8</td>
<td>11 24</td>
</tr>
<tr>
<td>70 and over</td>
<td>9</td>
<td>2</td>
<td>11 25</td>
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99.
Table 3.8 cont'd.....

<table>
<thead>
<tr>
<th>Characteristics of Close Relatives</th>
<th>Close Relative of Rehabilitee in Hospital</th>
<th>Close Relative of Rehabilitee in Community</th>
<th>All Close Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>24</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>%</td>
<td>N</td>
<td>N</td>
<td>N %</td>
</tr>
<tr>
<td>Household Composition</td>
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</tr>
<tr>
<td>Single Person</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Married Couple</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Married Couple + Child(ren)</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Single Parent + Child(ren)</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Household includes Rehabilitee</td>
<td>-</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Employment Status</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Working Full-time</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Working Part-time</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Retired/Home Duties</td>
<td>15</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>Social Class</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Professional</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>II Intermediate</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>IIIIN Clerical</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>IIIIN Skilled Manual</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>IV Partly Skilled Manual &amp; V and Unskilled Manual</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>(Student, Unemployed or Army personnel)</td>
<td>(2)</td>
<td>(3)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

100.
with one-third of this group being classified as retired and two-thirds as on 'home duties' and never in paid employment. The slightly younger age of CRs of community based rehabilitees is reflected in the higher proportion of them who are in full or part time employment, 57%, compared with only 37% of CRs of hospital based rehabilitees. Where rehabilitees live with their CR, only four of the 13 CRs are currently employed, all but one in part-time employment (Collis & Ekdawi, 1984(b)).

Just as it was noted above (3.7.1) that checks may need to be made on the relationship between self-concept responses and variables measuring key characteristics of rehabilitees, so the same applies to close relatives' responses and characteristics. The first step is to check for statistical associations between the characteristics of close relatives (as defined in Table 3.8) and place of residence (defined as a dichotomy, hospital or community). There are significant (p<0.05) associations between place of residence and just two of the variables listed in Table 3.8: relationship to rehabilitee ($X^2 = 20.164$, df7, $p<0.01$) and household composition ($X^2 = 16.305$, df4, $p<0.01$). Using Cramer's V, the strength of the association is considerably higher for the former (0.67) than the latter (0.40).

Turning to look in more detail at the household units in which CRs live, Table 3.8 shows that some 20 (45%) of them contain one or more dependent children. Eleven of these households include a rehabilitee, and in all but one he/she is the only child still living at home (Collis & Ekdawi, 1984(b)). Other rehabilitees who live with their CRs are two married men living with their wives. In total, one-quarter of the households where CRs live consist of a married couple and just over one-fifth of a CR living alone. Classified according to the head of household's present or previous occupation, Table 3.8 shows that 40% of the households who could be classified (40) are in Social Class I or II and almost half in Social Class III. Thus the CRs in the present study are essentially a middle to upper-middle class population, with only 18% of the heads of household having a manual classification, mostly skilled workers. If just those households where a rehabilitee lives with his/

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12 Since analysis of close relatives' responses will be limited to the hospital/community comparison (3.6.1), there is no need to test for associations using the more detailed subgroups of place of residence.
her parent are considered, only one of the 11 household heads does not have a non-manual classification, and over half (6) are in Social Class I or II.

Thus the typical close relative (CR) is a late middle-aged or elderly, middle-class woman, not currently in paid employment, who is either the rehabilitee's mother or sister.

Relatives' experiences of rehabilitees obviously depend not only on rehabilitees' behaviour, particularly in everyday interaction and task functioning but also on the frequency and venue of face to face contact. Hence for this population of relatives 'The Relatives' Story' (Collis & Ekdawi, 1984(b)) was told for those relatives whose rehabilitees lived with them, those who mainly visited rehabilitees, and those whose rehabilitees visited them on a regular basis.

Many of the rehabilitees who lived 'at home' were able to provide a considerable degree of companionship for their close relatives, and this was particularly important where the relative was an elderly widowed mother. However, where rehabilitees lived with both parents, the latter tended to find having rehabilitees living with them more restricting, especially since rehabilitees tended to lack social contacts outside the family. At the same time few relatives saw any true alternatives, often grateful that their rehabilitees were relatively stable and happy, and not wishing to risk the re-occurrence of a 'breakdown' by putting too many demands on rehabilitees. On the whole their expectations for rehabilitees were limited, though most thought their rehabilitees would be able to cope somehow, often with support from other family members, when they themselves were no longer around to care for them.

For relatives whose rehabilitees were not living with them, visiting tended to be one-way, with rehabilitees visiting relatives being the most usual pattern; mutual visiting was comparatively rare. Where relatives visited rehabilitees, this often entailed a difficult journey to the hospital (especially for those who were old and/or did
not have a car) where much of the visit was spent 'talking', walking in the grounds, having tea in the canteen or watching TV. Enjoyment of these visits often depended on rehabilitees' current mental state and in general the visits were short and rather 'difficult'.

The more popular pattern of visiting, where rehabilitees visited their close relatives was also the more satisfactory; many visited weekly or fortnightly and some stayed one, two, or even three nights over the weekend. While there were considerable behavioural problems mentioned by relatives, the most frequent 'complaint' was that rehabilitees just sat around, smoked and 'did nothing'. In many cases it was very difficult to interest them in normal family activities or to persuade them to help with household chores such as washing-up or making their beds. While for widowed mothers they often provided company if not actual companionship (and certainly not emotional support), for many sisters and their husbands visits from rehabilitees meant a 'lost' weekend, since rehabilitees often refused to participate in any social events or outside activities.

Most relatives of hospital-based rehabilitees were very pessimistic about the future, with few seeing any alternative to a life in hospital. Even relatives of rehabilitees in the Rehabilitation Unit seemed to reject the idea of resettlement in the community; they spoke of past hopes and ensuing disappointments. The comment of one relative summed up the general feeling of many: 'We can't see him altering from what he is. We expected in the past; now we accept' (Collis & Edkawi, 1984(b): 28).
RESULTS 1: PRESENTATION AND INTERPRETATION OF DATA RELATING TO
HYPOTHESIS ONE

4.1 Introduction

4.1.1 Hypothesis One

Rehabilitees at progressive stages of the rehabilitation process
will show increasing rejection of the patient-role in favour of
community-based social roles. There will be concomitant changes
in self-conception, away from an identification with (other)
psychiatric patients. However, whether rehabilitees in the later
stages of rehabilitation have more positive self-conceptions and
higher self-esteem will depend on their social milieu.

4.1.2 Order and Format of Data Presentation

The following sections will present data on changes in attitudes
to self at various stages in the rehabilitation process (4.2),
changes in identification with (other) psychiatric patients (4.3),
and changes in self-esteem (4.4). At the end of each section
the main findings will be summarised and some basic interpretations
presented. To conclude the chapter, section 4.5 will present an
overview of the findings related to Hypothesis One, and an
assessment of the extent to which the hypothesis has been
substantiated. The theoretical, methodological and practical
implications of the results will be considered in Chapter 6.

Since data from the semantic differential scales is central to the
analysis of each of the three topics outlined above, it will be
presented first in each section. Data from the other measures
of the self-concept will then be introduced and the findings
compared.

Where other variables differentiating the sample of rehabilitees

104.
have been found to be statistically associated with place of residence (stage in the rehabilitation process) (3.7.1), checks have been made throughout the analysis in this chapter to ascertain whether or not significant differences in responses on semantic differential scales by place of residence are independent of these variables. To simplify the presentation of data related to Hypothesis One, only those cases where other variables are found to be important in explaining the differences in responses by place of residence will be noted. Hence, unless otherwise stated significant differences in the self-concept by place of residence are independent of the demographic and psychiatric characteristics of rehabilitees described in Table 3.7.

4.2 Changes in Attitudes to Self during Rehabilitation

4.2.1 Differences in Rehabilitees' Attitudes to Real-Self by Place of Residence

Figure 4.1(b) shows that all rehabilitees tend to see their Real-Self ('the way I am now') in a basically positive way, regardless of whether they are still hospital patients or have been discharged to the community. In particular they see themselves as Good, Optimistic, Happy, Friendly and Responsible. Both groups rate themselves towards the negative end of the continuum on only four scales, seeing themselves as slightly Low in Confidence, Submissive and Shy. In addition, rehabilitees in the hospital see themselves as slightly Ugly, and those in the community as slightly Unimportant.

While hospital residents rate themselves more positively on half the

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1 Throughout the analysis scale ratings of under 3.0 represent the positive end of the bi-polar continuum, and scale ratings of over 3.0 the negative end.
Figure 6.1 Differences in Rehabilitates' Attitudes to Real-Self ('the way I am now') by Place of Residence.

(a) Rehabilitates Resident in the Hospital

(b) All Rehabilitates

(c) Rehabilitates Resident in the Community

Scale

Good
Strong
Active
Optimistic
Gain
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

Scale

Bed
Weak
Passive
Pessimistic
Parents
Emotional
Community

Scale

Low in Confidence
Uncreative
Unimportant
Unlucky
Dependent
Submissive
Shy
Unfriendly
Not Well Liked
Irresponsible
Old

Scale

Mean rating
individual scales and the total scale score\textsuperscript{2}, the differences between the self-attitudes of the two groups are generally small and none is statistically significant (p<0.05)\textsuperscript{3,4}.

Turning to consider differences amongst hospital residents, Figure 4.1(a) shows the Real-Self ratings for rehabilitees in the rehabilitation villas, hospital hostel and 'other wards'\textsuperscript{5}. Both rehabilitation villa and hospital hostel residents rate themselves negatively on only four scales, while 'other ward' residents rate themselves negatively on seven. All three groups see themselves as Submissive rather than Dominant and Shy rather than Outgoing, with rehabilitation villa residents also tending to see themselves as Emotional and Low in Confidence, and hospital hostel residents

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\textsuperscript{2} The total scale score measures the concept profile; it is obtained by summing an individual's scores on each of the individual scales – in this case there are 18 individual scores. The difference between the total scale score of two concepts is a measure of the linear distance between the two concept profiles. However, it is important to note that the total scale score gives equal weight to each individual scale (3.4.2).

\textsuperscript{3} Analysis of variance is used to test whether the means of subsamples are significantly different from one another. The computed F ratio (between-groups mean square/within-groups mean square) is compared to the known sampling distribution of the F ratio.

The computation of F is a parametric statistical procedure which assumes an interval level of measurement and a normal distribution of data. Warr and Knapper (1968) give confidence to the assumption of 'equal intervals' for semantic differential scales when they conclude that available evidence suggests 'that the deviations from equal intervals are small, and well within the error limits of the instrument' (p.61). While the assumption of normally distributed responses is more problematic for the population and concepts (particularly Ideal-Self and 'most psychiatric patients') under study, the use of parametric techniques is justified by their power and sensitivity – they make better use of the data. Further, as Warr and Knapper (1968) note 'the dichotomy between parametric and non-parametric tests appears in fact to be breaking down' (p.63).

Labovitz (1972) has gone so far as to suggest that in general interval level statistics can be applied to any ordinal level data.

\textsuperscript{4} Throughout the analysis the term 'significant' is used to indicate that the results are statistically significant at the 5% level (p<0.05). It is recognised that use of .05 is largely a matter of convention in the social sciences. Its strict application may mask results which are of substantive importance or highlight those which are not. In consequence it is intended to use it as a comparative tool or guide rather than a technique with absolute power.

\textsuperscript{5} See 3.1.2 for a justification of this division, and for a description of the different ward environments.
themselves as Old and Ugly. However, the latter group also see themselves as more Creative, Calm and Active than other hospital residents, while 'other ward' residents rate themselves as more Good and more Independent. Meanwhile, rehabilitation villa residents consider themselves to be more Optimistic, Friendly, Responsible and Young (F=5.544, df2, 42, p<0.01) than other hospital groups. A comparison of the total scale scores for the three groups suggests that, overall, rehabilitees in the rehabilitation villas have the most positive self-attitudes and those on 'other wards' the most negative, with hospital hostel residents being closer to the former group. However, neither the differences between the three groups nor that between rehabilitation villa residents and the other two groups taken together is significant.

Compared with the three groups of hospital residents, the two groups of rehabilitees living in the community show more marked differences between them in their self-attitudes (Figure 4.1(c)), especially on the scales Creative-Uncreative (F=7.865, df1, 29 p<0.01) and Strong-Weak (F=5.200, df1, 29, p<0.05). Rehabilitees living with parents see themselves more negatively on these and 13 other scales; in particular they see themselves as less Independent, Unimportant rather than Important, Unlucky rather than Lucky and Low in Confidence rather than High in Confidence.

Overall, rehabilitees living with parents see themselves in a negative way on eight scales, but those living elsewhere in the community see themselves in a negative way on only two (Outgoing - Shy and Dominant - Submissive). Thus, it is not surprising that the total scale scores for the two groups are markedly different, though the difference is not quite significant at the 5% level (F=4.112, df1, 29, p<0.06).

In fact, when total scale scores are compared, rehabilitees living with parents have the least positive self-attitudes of any group of rehabilitees in the hospital or community. Meanwhile, rehabilitees living elsewhere in the community have the most positive self-attitudes of any group, closely followed by rehabilitees in the rehabilitation villas and the hospital hostel.
Comparing rehabilitees in the rehabilitation villas with the two groups in the community, the former see themselves as more Good, Active, Optimistic, Important, Outgoing, Friendly, Responsible and Young than either of the community groups. On the other hand they are Emotional rather than Calm and more Submissive.

Looking at Figure 4.1 as a whole, one of the most striking features is that the differences on (a) and (c) are greater than those on (b); that is, that within hospital and within community differences are greater than those between hospital and community residents as a whole. Of all rehabilitees in the hospital, those in 'other wards' tend to have the least positive self-attitudes. Meanwhile, hospital hostel residents are particularly positive on scales concerning how they typically feel, and rehabilitation villa residents see themselves as more Friendly, Responsible and Optimistic than any other group of rehabilitees in the hospital or community.

That rehabilitees in the hospital hostel see themselves as older and those in the rehabilitation villas see themselves as younger than rehabilitees in other groups is objectively true for both groups if just hospital residents are considered. Thus the average age of hospital hostel residents who completed the ratings for Real-Self was 64 years (at interview), compared with 56 years for 'other ward' residents, and 46 years for rehabilitation residents. However, the average age of community residents was 42, so that they were younger than rehabilitation villa residents.

Overall, there are significant differences in rehabilitees' ratings on the scales Young-Old and Active-Passive by age, with younger respondents seeing themselves as Younger but Passive rather than Active when compared with older respondents. Controlling for age, the differences on the scale Young-Old by place of residence are no longer significant, although rehabilitation villa residents still see themselves as markedly Younger than the other two groups of hospital residents. On the other hand, the differences on the scale Active-Passive disappear and would seem to be almost entirely related to age.
and not place of residence.

There are marked differences between the self-attitudes of the two groups of rehabilitees in the community; those living with parents tend to have markedly less positive self-attitudes than those living elsewhere in the community, who are the most positive of any rehabilitee group in the hospital or community. However, all groups of rehabilitees see themselves as Submissive and Shy.

4.2.2 Summary and Interpretation of Differences in Attitudes to Real-Self by Place of Residence

Apart from being Submissive and Shy, most rehabilitees see themselves in a basically positive way, with those in hospital not seeing themselves in a markedly different way from those in the community. However, there are some marked differences in rehabilitees' attitudes to themselves depending on the type of ward they are resident in, if they are hospital patients, or whether or not they live with parents, if they are resident in the community. Thus, it would seem to be the specific social milieu in which they live that determines rehabilitees' self-attitudes rather than simply whether they are in the hospital or have been discharged to the community.

Taking rehabilitees on 'other wards' first, their self-attitudes are not nearly so negative as might be expected of psychiatric patients (2.3). Although seeing themselves less positively than other hospital groups, reflecting the fact that they have taken a backward step in the rehabilitation process, it seems that any marked changes in their own evaluation of themselves is mediated by social comparison with other patients on the ward, who may be more chronically disabled. Turning to consider rehabilitees still on the rehabilitation villas, they tend to see themselves more positively. They have been undergoing extensive training programmes in basic skills (numeracy

6 By definition (3.1.1) all rehabilitees in the sample were resident on the Rehabilitation Unit or had been discharged to the community in mid-1977.
and literacy) and self-care activities, with the emphasis being on learning to take responsibility for themselves in their everyday lives (3.1.2). Thus, it is not surprising that they see themselves as more Responsible, and also as more Optimistic than other groups of rehabilitees; after all they are looking forward to resettlement in the community, often after many years in hospital.

However, it seems that this level of optimism is not necessarily maintained after discharge, especially if rehabilitees go to live with parents. As previous research and the experiences of the writer testify (3.1.2), rehabilitees who are discharged to live with parents may find themselves in the 'child' role, which is not unlike the patient-role (2.2.2). Parents, especially mothers, may tend to take over many of the self-care activities which rehabilitees have learned to do for themselves on the rehabilitation villas; they may even manage their interactions with the wider community. Thus, it is not surprising that in comparison with rehabilitees living elsewhere in the community those living with parents evaluate themselves markedly less positively. In particular they see themselves as Weak, Low in Confidence, Uncreative, Unimportant and Unlucky. Furthermore, in many ways they also see themselves less positively than rehabilitees in hospital.

There is one more group of rehabilitees to be considered, those in the hospital hostel. Having chosen not to aim for resettlement in the community, this group of rehabilitees do not fit into the normal process of rehabilitation (3.1.2). The hospital hostel is a mixed villa ward, on the periphery of the hospital grounds, and residents think of it as their home. The social milieu is comparatively relaxed compared with the rehabilitation villas and less hospitalised than 'other wards'; it seems likely that this is reflected in rehabilitees' positive ratings on scales concerning how they typically feel (Calm, Creative, Happy, Optimistic and High in Confidence).
4.3 Changes in the Identification of Self as a Psychiatric Patient and Acceptance of the Patient-Role during Rehabilitation

4.3.1 Differences in Rehabilitees' Attitudes to 'Most Psychiatric Patients' by Place of Residence

While the mean ratings for Real-Self were shown (4.2.1) to be basically very similar for both hospital and community residents, Figure 4.2(b) shows that those relating to 'the way most psychiatric patients are' are markedly different. While community residents see 'most psychiatric patients' in generally negative terms: Emotional, Unhappy, Low in Confidence, Dependent, Unlucky, Shy and Pessimistic, hospital residents see them in fairly neutral terms, with only the scale Independent-Dependent having a mean score of over 3.5 and none a mean score of under 2.5. Overall, there are significant differences between the mean scores for hospital and community residents on five individual scales and the total scale score (F = 5.387, df1,74, p<0.05). Compared with those in hospital, community residents see psychiatric patients as Unlucky rather than Lucky (F = 11.085, df1, 70, p<0.01), Pessimistic rather than Optimistic (F = 7.857, df1,70, p<0.05), more Low in Confidence (F = 5.944, df1,70, p<0.05), more Unhappy (F = 4.916, df1,70, p<0.05) and Shy rather than Outgoing (F = 5.543, df1,70, p<0.05).

Dividing rehabilitees into two groups by age (under 50/50 and over), the trend for community residents to have the more negative attitudes to 'most psychiatric patients' is still evident, although any marked differences in the attitudes of hospital and community residents are restricted to the older group (50 and over). Thus, while most younger rehabilitees (under 50) and older rehabilitees in the community tend to see psychiatric patients in a negative way, older rehabilitees in the hospital tend to see them more positively. The significant association between age and length of stay (3.7) suggests that this finding may be associated with differences in the length of time in hospital. Controlling for length of time in hospital (under 10 years/10 years and over), the hospital/community split no longer tends to differentiate rehabilitees to such a marked degree on
the basis of their attitudes to (other) psychiatric patients (except on the scales Calm-Emotional and Lucky-Unlucky). This suggests that the length of time in hospital is also an important determinant of rehabilitees' attitudes to 'most psychiatric patients'.

Considering rehabilitees in the hospital, Figure 4.2(a) shows that rehabilitees in the hospital hostel tend to have the most positive view of 'most psychiatric patients' and rehabilitation villa residents the most negative, or at best neutral view. Thus, the latter group give psychiatric patients a mean rating of over 3.0 on 11 scales, compared for those on 'other wards' and only two for hospital hostel residents. While the former two groups of rehabilitees see them as Emotional, Unhappy, Dependent and Low in Confidence, hospital hostel residents see psychiatric patients as Calm, Happy and High in Confidence, as well as Outgoing and Optimistic, but also as Dependent. However, the only significant difference between the three groups is on the scale Calm-Emotional ($F = 6.320$, df2,29, $p < 0.01$) and this is due to the very positive mean rating of hospital hostel residents. Even if only those hospital residents aged 50 or over are considered (there are no rehabilitees under 50 in the hospital hostel), the difference in ratings is still marked, although no longer significant ($F = 2.840$, df2,22, $p<0.09$). Overall, rehabilitees in the rehabilitation villas are the most negative of the three groups on 14 of the 18 scales, and the total scale score; the latter difference between the three groups is marked but not significant ($F = 2.719$, df2,29, $p<0.11$). Further when younger (under 50) and older (50 and over) rehabilitees are considered separately, the mean ratings for rehabilitation villa residents are found to be consistently (but not significantly) more negative than those for other hospital residents. This suggests that although attitudes towards 'most psychiatric patients' do tend to become less negative/more positive with increasing age, the association between attitudes and place of residence within the hospital is not totally spurious.

Both groups of rehabilitees in the community tend to see 'most psychiatric patients' even more negatively than those in the rehabilitation villas,

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7 This hypothesis will be examined in more detail for hospital residents in Section 4.3.7.
with negative mean ratings on two-thirds of the scales. The most negative ratings tend to be on scales concerning how psychiatric patients typically feel; they are seen as very Pessimistic, Emotional, Unhappy, Uncreative and Unlucky. Overall, rehabilitees living with parents and those elsewhere in the community share very similar attitudes to psychiatric patients; their total scale scores show the latter group to be marginally more negative, and both groups to be slightly more negative than rehabilitees on the rehabilitation villas. None of the differences is significant.

In general, hospital and community residents show quite different attitudes to 'most psychiatric patients', in contrast to their very similar attitudes to Real-Self. Both the community groups are in close agreement and see psychiatric patients in a basically negative way. There is more variation amongst hospital residents, with rehabilitees in the rehabilitation villas tending to share the negative attitudes of community residents. This is in contrast to the attitude of other hospital residents. Both hospital hostel and 'other ward' residents have a basically positive view of other psychiatric patients, with the former group being the most positive.

However, it is important to note that rehabilitees' age and/or length of time in hospital were found to be important intervening variables in the association between attitudes to 'most psychiatric patients' and place of residence. In consequence, the effect of the present distribution of rehabilitees by age and length of hospital stay (with comparatively few of the older and/or 'long-stay' rehabilitees in the rehabilitation villas or community) is to exaggerate the true differences between the attitudes of hospital and community residents, and between rehabilitation villa and other hospital residents.

4.3.2. Differences in the Discrepancy between Rehabilitees' Attitudes to Real-Self and 'Most Psychiatric Patients' by Place of Residence

Figure 4.3 compares the mean ratings for Real-Self and 'most psychiatric patients' for hospital and community residents, and shows that the
discrepancy is generally greater for community residents. This is
born out to some extent statistically, since there are six scales
on which the difference is significant\textsuperscript{8} for hospital residents,
compared with nine for community residents. The total scale scores
are significantly different for both groups ($t = 2.31, \text{df}41, p<0.05$
and $t = 4.58, \text{df}29, p<0.001$, for hospital and community residents
respectively). Looking at the individual scales, while both groups
of rehabilitees see themselves as Calm, Happy, Independent and
Responsible, they see psychiatric patients as Emotional, Unhappy,
Dependent and Irresponsible ($p<0.05$ on all scales for hospital
residents, and $p<0.001$ on all scales for community residents). Other
significant differences for the latter group are found on the scales
Optimistic-Pessimistic, Well Liked-Not Well Liked, Lucky-Unlucky,
Strong-Weak and High in Confidence-Low in Confidence, while for
hospital residents they are found on the scales Friendly-Unfriendly
and Good-Bad. However, attitudes to psychiatric patients are not
consistently more negative than attitudes to self, especially for
hospital residents. Thus, on five scales Real-Self is more negative
than attitudes to psychiatric patients, although the differences are
mostly small and not significant.

In contrast to the above analysis of individual scales and concept

\textsuperscript{8} Student's t is used to test whether the difference between the
means of paired ratings (e.g. between the mean rating for Real-
Self and 'most psychiatric patients' for the same group of
respondents) is significant. The computed t is compared with
the Student's t distribution to assess the level of probability.
Since no assumptions are made regarding the direction of the
differences, a two-tailed test is used throughout the analysis.
As for F values, Student's t is a parametric statistic: see
footnote 3 (this chapter) for a justification of the use of
such measures in the analysis of semantic differential scales
in this study.
Figure 4.3 A Comparison of Rehabilitees' Attitudes to Real-Self and 'Most Psychiatric Patients' for Hospital and Community Residents.

(a) Rehabilitees Resident in the Hospital

Scale: Good, Strong, Active, Optimistic, Calm, Happy, High in Confidence, Creative, Important, Lucky, Independent, Dominant, Outgoing, Friendly, Well Liked, Responsible, Young, Beautiful

(b) Rehabilitees Resident in the Community

Scale: Bad, Weak, Passive, Pessimistic, Emotional, Unhappy, Low in Confidence, Uncreative, Unimportant, Unlucky, Dependent, Submissive, Shy, Unfriendly, Not Well Liked, Irresponsible, Old, Ugly

mean rating 1 2 3 4 5
profiles (total scale scores), when the mean 'D' scores for the two concepts are compared for hospital and community residents, the latter group are shown to see themselves as marginally closer to their view of psychiatric patients than the former. A detailed analysis of the discrepancies for rehabilitee subgroups is obviously required in order to understand this apparently unlikely finding. Looking firstly at rehabilitees in the hospital, Figure 4.4 shows that in many ways both 'other ward' and hospital hostel residents see themselves as very similar to psychiatric patients. Thus, Real-Self ratings are equal to or slightly more negative than those for 'most psychiatric patients' on half the scales, and slightly more positive on the other half; the total scale scores are not significantly different. Overall, hospital hostel residents seem to identify most closely with their view of psychiatric patients, since there are no significant differences between their ratings for Real-Self and 'most psychiatric patients', compared with three significant differences for 'other ward' residents. The latter see themselves as more Good (t = 2.55, df13, p < 0.05), Calm rather than Emotional (t = 2.52, df13, p < 0.05) and Independent rather than Dependent (t = 3.03, df13, p < 0.05). In contrast to the other two groups of hospital residents, rehabilitees in the rehabilitation villas see themselves in a very different way from how they see psychiatric patients. Thus, on all except one scale (Dominant-Submissive) Real-Self is seen markedly more positively than 'most psychiatric patients', and the discrepancy is significant on five scales and the total scale score (t = 2.12, df19, p < 0.05). Rehabilitation villa residents see themselves as more Good

9 The 'D' score measures the geometric distance between two concept profiles, and as such 'takes into account both the absolute discrepancy between sets of measurements as well as their profile similarities' (Osgood & Suci, 1952:254). An individual's 'D' score is obtained by summing the squares of the differences between the pairs of individual scale scores - in this case there are 18 pairs of scores. However, as for the total scale score the 'D' score gives equal weight to each individual scale (3.4.2).
Figure 4.4 A Comparison of Rehabilitees' Attitudes to Real-Self and 'Most Psychiatric Patients' for Three Groups of Hospital Residents.

(a) Rehabilitees Resident in 'Other Wards'
(b) Rehabilitees Resident in the Hospital Hostel
(c) Rehabilitees Resident in the Rehabilitation Villas

Scale:
- Good
- Strong
- Active
- Optimistic
- Calm
- Happy
- High in Confidence
- Creative
- Important
- Lucky
- Independent
- Dominant
- Outgoing
- Friendly
- Well Liked
- Responsible
- Young
- Beautiful

Real-Self
Most Psychiatric Patients

Mean rating

Sad
Weak
Passive
Pessimistic
Emotional
Unhappy
Low in Confidence
Uncreative
Unimportant
Unlucky
Dependent
Submissive
Shy
Unfriendly
Not Well Liked
Irresponsible
Old
Ugly
(t = 2.24, df19, p< 0.05), more Friendly (t = 2.46, df19, p< 0.05),
more Optimistic (t = 2.44, df19, p< 0.05) and Happy rather than
Unhappy (t = 3.75, df19, p< 0.01) when compared with psychiatric
patients. A comparison of the mean 'D' scores for the three groups
of rehabilitees in the hospital confirms the analysis of individual
scale differences, with that for rehabilitation villas residents
being the largest and that for hospital hostel residents the smallest,
although the differences are not significant.

Turning to consider rehabilitees in the community, Figure 4.5 shows
that on most scales those living elsewhere in the community see
themselves as farther away from their view of psychiatric patients
than do those living with parents. In addition, the Real-Self of
the former group is only more negative than 'most psychiatric
patients' on one scale (Important-Unimportant), while the Real-Self of
the latter is more negative on five scales (Creative-Uncreative,
Important-Unimportant, Dominant-Submissive, Outgoing-Shy and Friendly-
Unfriendly). While none of these positive discrepancies between
Real-Self and 'most psychiatric patients' is significant, there are
five significant differences in the opposite direction for rehabilitees
living with parents (the same number as for rehabilitation villa
residents) and eight for those living elsewhere in the community. In
particular, both groups see themselves as significantly different on the
scales Calm-Emotional, Happy-Unhappy and Responsible-Irrponsible.
The first two relate to how rehabilitees and psychiatric patients
typically feel, as do a further three of the scales on which
rehabilitees living elsewhere in the community see a significant
difference: Optimistic-Pessimistic (t = 3.16, df15, p<0.01), High in
Confidence-Low in Confidence (t = 3.10, df15, p<0.01) and Lucky-
Unlucky (t = 3.30, df15, p<0.01). The total scale scores for Real-
Self and 'most psychiatric patients' are significantly different for
both groups (t = 2.32, df13, p<0.05 and t = 4.18, df16, p<0.01
for rehabilitees living with parents and elsewhere in the community
respectively).

The mean 'D' scores for the two groups confirm the above analysis,
Figure 4.5: A Comparison of Rehabiliites' Attitudes to Real-Self and 'Most Psychiatric Patients' for Two groups of Community Residents.

(a) Rehabiliites Living with Parents

(b) Rehabiliites Living Elsewhere in the Community

Scale

Good
Strong
Active
Optimistic
Calm
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

Real-Self
Most Psychiatric Patients

Mean rating
with that for rehabilitees living with parents being markedly, though not significantly, smaller than that for rehabilitees living elsewhere in the community ($F = 2.490, df1,28, p<0.13$). Perhaps more surprisingly, the mean 'D' score for the former group is the lowest for any group of rehabilitees in the hospital or community, with that for the latter group (which from a comparison of Figures 4.4 and 4.5 might have been assumed to be the largest) being slightly smaller than the 'D' score for rehabilitation villa residents. However, the extremity of the 'D' scores of these two groups does explain the direction of the discrepancy between hospital and community residents noted above.

Thus, analysis of the 'D' scores shows rehabilitees living with parents to identify most closely with their view of psychiatric patients, followed by rehabilitees in the hospital hostel and 'other wards'. Meanwhile, rehabilitees in the rehabilitation villas show the least identification with their view of psychiatric patients, followed by those living elsewhere in the community.

Whilst the various statistical measures give results which are different in detail, it is possible to extrapolate certain trends shown by the analysis. Thus, rehabilitees in the community share a basically negative attitude towards psychiatric patients. However, whilst those living elsewhere in the community see themselves very positively and in a markedly different way from psychiatric patients, particularly on scales concerning the way they typically feel, those living with parents identify much more closely with psychiatric patients, particularly on some of the scales concerning the way they typically interact with others. Compared with community residents, rehabilitees in the hospital hostel and 'other wards' tend to see other psychiatric patients in a basically positive way, very similar to the way they see themselves. In contrast, the third group of hospital residents, rehabilitees in the rehabilitation villas, not only have a view of other psychiatric patients which is more like that of community residents, but also fail to identify with it, seeing themselves in a much more positive way, very similar to the way rehabilitees living
elsewhere in the community see themselves.

4.3.3 Differences in Rehabilitees' Responses to the Attitudinal Measure of Acceptance/Rejection of the Patient-Role by Place of Residence

Factor analysis of responses to the 12 item attitude scale identified four underlying dimensions (3.4.4). The positive poles representing rejection of the patient-role are described as follows: Factor 1, a general feeling of well-being (which includes being like other people, having the confidence to cope with everyday problems, and being happy in the present and optimistic about the future); Factor 2, friendships and conversations not being hospital orientated; Factor 3, illness not being a burden and the hospital not seen as a refuge or solution to problems/illness; Factor 4, forgetting the past/being in hospital and being happy and optimistic. Total scale and factor scores are used to compare attitudes of respondents according to their place of residence, and throughout the analysis a low score represents comparative rejection of the patient-role.

Looking firstly at the basic division between hospital and community residents, Table 4.1 shows that there is a significant difference between the mean total scale scores for the two groups ($F = 11.414$, df1,90, $p < 0.01$), with community residents being less accepting or more rejecting of the patient-role than hospital residents. The mean factor scores are also significantly different for Factor 2 ($F = 9.578$, df1,90, $p < 0.01$) and Factor 3 ($F = 7.560$, df1,90, $p < 0.01$), both of which the above descriptions show to be specifically concerned with a positive or negative orientation towards the hospital. Thus, hospital residents see the hospital as a refuge and/or worry that they may never get well enough to leave it; they have met most of their friends there and often talk about what happens there. This is not so for community residents. However, the other two factors (Factor 1 and Factor 4) identifying more general attitudes to how rehabilitees typically feel (confident, happy, optimistic, normal) and act (like others, independently) do not have mean scores which are significantly
Table 4.1 Differences in Rehabilitees' Attitudes to the Patient-Role by Place of Residence

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Total Scale (N)</th>
<th>Factor 1 (12 items)</th>
<th>Factor 2 (6 items)</th>
<th>Factor 3 (5 items)</th>
<th>Factor 4 (3 items)</th>
<th>Factor 5 (2 items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (57)</td>
<td>33.51</td>
<td>15.11</td>
<td>15.14</td>
<td>8.72</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>Community (35)</td>
<td>29.29</td>
<td>14.17</td>
<td>13.11</td>
<td>7.23</td>
<td>4.66</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>11.414*</td>
<td>1.049</td>
<td>9.578</td>
<td>7.560</td>
<td>0.826</td>
<td></td>
</tr>
<tr>
<td>Within Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Villa (25)</td>
<td>33.08</td>
<td>14.48</td>
<td>15.64</td>
<td>8.84</td>
<td>4.28</td>
<td></td>
</tr>
<tr>
<td>Hospital (11)</td>
<td>30.82</td>
<td>14.18</td>
<td>13.73</td>
<td>7.27</td>
<td>5.36</td>
<td></td>
</tr>
<tr>
<td>'Other Ward'(21)</td>
<td>35.43</td>
<td>16.33</td>
<td>15.29</td>
<td>9.33</td>
<td>5.87</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>2.479</td>
<td>1.580</td>
<td>1.528</td>
<td>2.359</td>
<td>4.157</td>
<td></td>
</tr>
<tr>
<td>Within Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Parents (14)</td>
<td>29.29</td>
<td>14.29</td>
<td>12.57</td>
<td>7.64</td>
<td>4.71</td>
<td></td>
</tr>
<tr>
<td>Elsewhere in Community (21)</td>
<td>29.19</td>
<td>14.10</td>
<td>13.48</td>
<td>6.95</td>
<td>4.62</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.002</td>
<td>0.014</td>
<td>0.770</td>
<td>0.734</td>
<td>0.025</td>
<td></td>
</tr>
</tbody>
</table>

** p < 0.01;  *p < 0.05
different for hospital and community residents.

Turning to consider the three groups of hospital residents; although there are marked differences in their mean total scale scores, with 'other ward' residents showing the most acceptance of the patient-role and hospital hostel residents the least, the differences are not significant. Hospital hostel residents also show least acceptance (lowest mean score) on three of the four factors, with the exception of Factor 4 (forgetting the past/hospital, being happy and optimistic) on which rehabilitation villa residents are the least accepting/most rejecting of the patient-role. Further, Factor 4 is the only factor on which the mean scores are significantly different for the within hospital groups ($F = 4.157$, df2,54, $p<0.05$), with 'other ward' residents being the least likely to forget they are in hospital or to feel happy and optimistic. 'Other ward' residents are also the most accepting of the patient-role on Factor 1 (in that they often feel they do not want to leave the hospital or that they will never get well enough to do so). Rehabilitation villa residents are slightly more likely than 'other ward' residents to feel that their friendships and conversations are hospital orientated, this is the hospital group most accepting of the patient-role on Factor 2.

By comparison there is little difference between the mean total scale scores of the two groups of community residents, although rehabilitees living elsewhere in the community tend to show slightly greater rejection of the patient-role than those living with parents. In fact the latter group show marginally less rejection on Factors 1 and 3 than hospital hostel residents, and both groups show markedly less rejection on Factor 4 than rehabilitation villa residents.

In summary, community residents show themselves to be markedly less accepting/more rejecting of the patient-role on the 12 item attitude scale than hospital residents. Factor analysis shows that this difference is mainly due to differing orientations towards the hospital, either concerning friendships and conversations (Factor 2), or seeing the hospital as a place of refuge/treatment (Factor 3). On the other
hand, the mean scores of both community and hospital residents on the factors related to whether or not rehabilitees are able to feel and act in a normal way (like others), or forget the past, be happy about the present and optimistic for the future, are not significantly different. Looking at the three groups of residents within the hospital, 'other ward' residents are the most accepting of the patient-role while hospital hostel residents are the most rejecting. Rehabilitation villa residents vary; while they are able to forget the past, be happy in the present and optimistic for the future to a greater extent than any other group of rehabilitees, they are more likely to consider their friendships and conversations to be hospital orientated than other hospital residents.

4.3.4 Comparison of the Discrepancy Measure of Identification with 'Most Psychiatric Patients' and the Attitudinal Measure of Acceptance/Rejection of the Patient-Role

A comparison of the two measures may be approached in two ways, either by looking at the correlation between comparable scores, or by comparing the results of the two measures. Taking the correlational method first; there is a significant correlation between the 'D' scores (on the discrepancy measure) and the total scale scores (on the attitudinal measure) for community residents ($r = -0.336$, $p<0.05$), but not for hospital residents. This would suggest that there are important differences in the response patterns of the two groups on one or other of the measures. A comparison of the results of the two measures may help to clarify the situation.

While there is agreement over the direction of the results of the two measures, with hospital residents showing both a closer identification with 'most psychiatric patients' (4.3.2), and more acceptance of the patient-role (4.3.3) than community residents, there is disagreement over the magnitude of the differential between the two groups and in the results for the three groups of residents within the hospital. Taking the differential between hospital and community residents; while there is a significant difference between them on their mean
total scale scores on the attitude scale (4.3.3), their 'D' scores are not significantly different (4.3.2). Since the significant difference on the attitude scale was shown to be due to the hospital orientation of some of the scale items and not to the more general scale items (concerning such characteristics as being happy, optimistic, confident and independent) which mirror those used on the semantic differential scale, it seems likely that scale composition may account for the variation in results.

Turning to consider results on the two measures for the three groups of hospital residents, both hospital hostel and 'other ward' residents are found to have attitudes to 'most psychiatric patients' which are similar to those relating to their Real-Self; that is they identify closely with other psychiatric patients (4.3.2). However, while 'other ward' residents also accept the patient-role as measured by the attitude scale, this is not so for hospital hostel residents, who are the least accepting/most rejecting of any of the three hospital groups; in particular they reject the factors related to hospital orientation (4.3.3).

By comparison, rehabilitation villa residents do not identify with 'most psychiatric patients' to nearly the same degree as other hospital residents, with marked differences between their ratings on this concept and their Real-Self on most scales. However, their overall level of acceptance/rejection of the patient-role places them in between 'other ward' and hospital hostel residents. While they show rejection of the patient-role in that they can forget the past, be happy in the present and optimistic about the future, they show acceptance by being hospital orientated as regards friendships and conversations.

Thus there are considerable differences in the response patterns of some groups of hospital residents, which both help to explain the variation in the results of the two measures of identification with other patients/the patient-role and the lack of association between scores on the two measures for hospital residents as a whole.
4.3.5 Differences in Rehabilitees' Identification with Patient and Community Roles on the 'Who-Am-I?' Schedule, by Place of Residence

Statements made by rehabilitees in response to the question 'Who-am-I?' were each coded into one or more content categories, with statements related to aspects of the patient-role forming a separate category alongside family-role, work-role, etc. Together with ascribed characteristics such as name, sex and nationality, these role related categories formed one of the four main subgroups of categories, social identity (3.4.1). Rehabilitees made several types of statement defining themselves in social roles; these included: (a) self-in-role statements (I am a patient, engineer, mother); (b) self related to other-in-role statements (I have one brother; I am loved by my daughter); (c) statements of role enactment (I play cards with my sister's children; I like my work in the occupational therapy department); (d) statements identifying self as being in a place which implied participation in a role (I live in this hospital).

Looking firstly at the comparative distribution of patient-role and family-role identifications; while 37% of hospital residents made one or more patient-role statements and 22% made one or more family-role statements, the comparative proportions for community residents were 6% and 50% respectively. The association between place of residence (hospital or community) and role identification (whether rehabilitees made one or more role statements or none) was significant for both the patient-role ($X^2 = 8.143$, df1, $p < 0.01$) and the family-role ($X^2 = 7.545$, df1, $p < 0.05$). Thus, hospital residents were significantly more likely to make patient-role statements and significantly less likely to make family-role statements than community residents.

Considering the three groups of hospital residents, there were considerable differences between them in the proportion of rehabilitees making patient-role statements but not in the proportion making family-
role statements. The latter proportions were very similar for all three groups, but 'other ward' residents were twice as likely as rehabilitation villa residents to make one or more patient-role statements, 50% compared with 25%. Hospital hostel residents formed an intermediate group, with one-third making one or more patient-role statements. Meanwhile, more of the community residents living with parents made family-role statements (57%) than those living elsewhere in the community (44%), and only two community residents made a patient-role statement, both in the latter group.

Just under three-quarters of the rehabilitees who made patient-role and/or family-role statements made only one such statement, with the maximum number of statements made in either category being six. Table 4.2 shows the categories of patient-role and family-role statements by rehabilitees' place of residence. It shows that nearly half the 28 patient-role statements made by hospital residents concerned role enactment, often related to their work in the occupational therapy department. 'Other ward' residents were particularly likely to make statements about their work, ward or leisure activities in the hospital (I am very fond of my work in O.T.; I like doing the table rota on the ward; I go to entertainments in the Recreation Hall); overall, some 65% of their patient-role statements were of the role enactment type. By comparison, more of the patient-role statements made by rehabilitation villa and hospital hostel residents were of the self-in-role type (I am a patient) or identified them as being in a place which implied participation in the patient-role (I am in Netherne Hospital; I like to live in Hedgefield Villa). The two statements made by community residents also referred to place of role (I feel very much better since leaving hospital; I am fortunate my G.P. sent me to Netherne).

Turning to consider the categories of family-role statements, Table 4.2 shows that while just over half the statements made by community residents were of the self-in-role type (I am my mother's daughter;
Table 4.2 Categorization of Patient-Role and Family-Role Statements on the 'Who-Am-I?' Schedule by Place of Residence

(a) Patient-Role Statements

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Category of Patient-Role Statement</th>
<th>All Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-in-Role</td>
<td>Role Enactment</td>
</tr>
<tr>
<td>Rehabilitation Villa</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Hostel</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>'Other Ward'</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Within Hospital</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>With Parents</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Elsewhere in Community</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Within Community</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(b) Family-Role Statements

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Category of Family-Role Statement</th>
<th>All Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-in-Role</td>
<td>Role Enactment</td>
</tr>
<tr>
<td>Rehabilitation Villa</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Hospital Hostel</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>'Other Ward'</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Within Hospital</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>With Parents</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Elsewhere in Community</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Within Community</td>
<td>14</td>
<td>7</td>
</tr>
</tbody>
</table>
a sister; a married man; one of the family - son - brother), this was so for only 15% of the statements made by hospital residents. Statements made by the latter group tended to be concentrated in the role enactment category (60%). Looking at within group differences, rehabilitees living with parents had the highest proportion of self-in-role type statements (64%) while rehabilitation villa residents had the highest proportion of role-enactment statements (70%). This latter result was in sharp contrast to the findings for hospital hostel residents; they made no statements concerning role-enactment.

In the hospital most activities (including work and leisure) are undertaken with other patients and staff within the confines of the hospital; thus an individual's social world and his/her role as a patient are virtually synonymous. However, in the wider community an individual's life is generally divided into quite distinct parts: work, leisure, family and friends; different roles tend to be enacted with different people, in different places. Thus an individual's family-role is likely to be just one part of his/her social world. Consequently it may be more correct to compare hospital-world and community-world orientation rather than the more restrictive patient-role and family-role. Community-world orientation includes all community based roles, activities, and interests.

While some 84% of community residents made one or more community-world statements, the proportion of hospital residents making such statements was just 31% (χ² = 22.787, df1, p<0.001); this compared with 50% and 22% for family-role statements. Thus the difference between hospital and community residents is widened by including non-family roles and activities. Table 4.3 also shows that comparatively few rehabilitees made both hospital-world and community-world statements; 12% of hospital residents and 6% of community residents. Meanwhile, one-quarter of hospital residents made hospital-world statements only and one-fifth community-world statements only, with hospital hostel residents being the most likely to make both types of statement. None of the community residents...
<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Hospital-World Orientation only</th>
<th>Community-World Orientation only</th>
<th>Hospital and Community-World Orientation</th>
<th>No Social World Orientation</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Villa</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Hospital Hostel</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>'Other Ward'</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Within Hospital N</td>
<td>13</td>
<td>10</td>
<td>6</td>
<td>23</td>
<td>52</td>
</tr>
<tr>
<td>%</td>
<td>25.0</td>
<td>19.2</td>
<td>11.5</td>
<td>44.2</td>
<td>100.0</td>
</tr>
<tr>
<td>With Parents</td>
<td>-</td>
<td>11</td>
<td>-</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Elsewhere in Community</td>
<td>-</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Within Community N</td>
<td>-</td>
<td>25</td>
<td>2</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>%</td>
<td>-</td>
<td>78.1</td>
<td>6.2</td>
<td>15.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Hospital/Community N</td>
<td>13</td>
<td>35</td>
<td>8</td>
<td>28</td>
<td>84</td>
</tr>
<tr>
<td>%</td>
<td>15.5</td>
<td>41.7</td>
<td>9.5</td>
<td>33.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>
made hospital-world statements only, but 78% made community-world statements only.

Looking at the three hospital groups, the comparative proportions of residents who made hospital-world and community-world statements follows closely the pattern for patient-role and family-role statements. Thus, the lower proportion of rehabilitation villa residents making hospital-world statements was not counterbalanced by an increase in community-world statements relative to other groups of hospital residents. The result was that just over half the rehabilitation villa residents made no social world statements. This was similar to the proportion for hospital hostel residents, who were more likely than other groups to make both types of statement. Meanwhile 'other ward' residents more often made only hospital-world statements (40%) with only 30% making no social-world statements.

Turning to consider the two community groups; while those living with parents made more family-role statements than those living elsewhere, this was not so for community-world statements. Some 89% of residents living elsewhere in the community made such statements compared with 79% of those living with parents.

In summary, the main findings are that hospital residents showed significantly greater identification with the patient-role and more hospital-world orientation, and significantly less identification with the family-role and less community-world orientation than community residents. Amongst hospital residents, 'other ward' residents showed the greatest identification with the patient-role and rehabilitation villa residents the least; however, identification with the family-role was similar for all three groups of hospital residents. Hence, while they all showed greater identification with the patient-role than the family-role, the difference was minimal for rehabilitation villa residents. Identification with the family-role was higher for community residents living with parents than for those living elsewhere, yet even for this latter group the proportion making
family-role statements was twice that for hospital residents. There was a complete lack of any identification with the patient-role by those living with parents, but one in ten of those living elsewhere in the community showed some identification with their former role.

The vast majority of community residents showed community-world orientation, and although fewer of those living elsewhere showed family-role identification, more showed community-world orientation. Rehabilitation villa residents differed from other hospital residents in that more of them showed community-world orientation than hospital-world orientation. However, this was not due to an increased orientation to the community compared with other hospital residents, but to a comparative lack of hospital-world orientation. The result was that one-half of rehabilitation villa residents showed no social world orientation.

4.3.6 Comparison of the 'Who-Am-I?' measure of Identification with the Patient-Role with the Discrepancy and Attitudinal Measures

Comparing the proportions of hospital and community residents who made one or more patient-role type statements on the 'who-am-I?' schedule, there was a significant difference between them (4.3.5), and this measure of identification with the patient-role confirmed the results of the discrepancy and attitudinal measures (4.3.4). Hospital residents identify to a far greater extent with the patient-role than do community residents.

Looking at the three groups of hospital residents, those on 'other wards' showed the highest level of identification with the patient-role, with some 50% of them making patient-role statements compared with 33% of hospital hostel residents and 25% of rehabilitation villa residents. The result for 'other ward' residents concurred with results from both the other measures; the result for rehabilitation villa residents with that from the discrepancy measure but not the attitudinal measure; the result for hospital hostel residents with the results from neither of the other measures. Thus, while rehabilitation villa residents
considered their Real-Self to be more discrepant from their view of 'most psychiatric patients' than rehabilitees in the other two groups, and were less likely to make patient-role type statements on the 'who-am-I?' schedule, they identified more strongly than hospital hostel residents on the attitudinal measure, especially on the factors concerning hospital orientation. Meanwhile, hospital hostel residents, while rejecting the patient-role on the attitude scale, showed more identification than rehabilitation villa residents on the 'who-am-I?' schedule and an even greater identification on the discrepancy measure (on which their Real-Self was very similar to 'most psychiatric patients').

Considering community residents, none of those living with parents identified with the patient-role on the 'who-am-I?' schedule while a minority of those living elsewhere made a patient-role statement. On the other hand, while both groups were equally rejecting on the attitude scale, those with parents considered themselves to be more like 'most psychiatric patients' on the discrepancy measure. The latter statement is not necessarily contradictory, since those living with parents were particularly rejecting of the attitudinal items concerning hospital orientation, but more accepting than those living elsewhere on the more general items which were similar to the semantic differential scale items.

4.3.7 Differences in Hospital Residents' Identification with the Patient-Role by Length of Time in Hospital

The main hypothesis being explored in this section is concerned with changes in attitudes to self and (other) psychiatric patients during rehabilitation (as defined by place of residence). However, it was felt that important insights might be gained into understanding the effects of hospitalisation on the self-concept (and the subsequent changes that accompany rehabilitation) by looking at the relationship between self-concept responses and the length of time in hospital (cumulative hospital stay).
Taking hospital residents only, roughly one-fifth had a cumulative hospital stay of under five years and a further one-fifth a cumulative stay of twenty years or more. The remainder were more or less equally divided between the three intervening five year time-spans. Thus, divided into two groups at the ten year mark, some 40% of hospital residents had been in hospital for less than ten years (short stay) and some 60% for ten years or more (long stay). Although the hospital hostel contained a higher proportion of residents in the long stay group (83%) compared with both 'other wards' (65%) and the rehabilitation villas (48%), the statistical association between type of ward and cumulative hospital stay (under ten years, ten years or over) was not significant ($X^2 = 4.6162$, df2, $p < 0.10$) (3.7.1).

Looking first at the discrepancy measure of identification with other psychiatric patients; the short stay group (in hospital for less than ten years) tended to see themselves more positively and 'most psychiatric patients' more negatively than the long stay group (in hospital for ten years or over), although the differences were not generally significant. Thus, while the short stay group rated their Real-Self more positively on 11 scales, especially Young-Old ($F = 4.209$, df1,43, $p < 0.05$) and Responsible-Irresponsible, they rated 'most psychiatric patients' more negatively on 16 scales, especially Beautiful-Ugly ($F = 4.9776$, df1,40, $p < 0.05$), Strong-Weak ($F = 4.238$, df1,40, $p < 0.05$), Outgoing-Shy, Optimistic-Pessimistic and High in Confidence-Low in Confidence. Taking the total scale scores; while the discrepancy between Real-Self ratings was small, that between ratings for 'most psychiatric patients' was quite marked, but not significant ($F = 3.380$, df1,40, $p < 0.08$).

Comparing each group's ratings on individual scales for Real-Self and 'most psychiatric patients', Figure 4.6 shows that the short stay group rated themselves more positively than other psychiatric patients on all but one scale (Dominant-Submissive); in particular they saw themselves as Happy rather than Unhappy ($t = 3.17$, df16, $p < 0.01$), Independent rather than Dependent ($t = 3.36$, df16, $p < 0.01$), Optimistic rather than Pessimistic ($t = 3.44$, df16, $p < 0.01$) and

136.
Figure 4.6 A Comparison of Rehabiliates' Attitudes to Real-Self and 'Most Psychiatric Patients' by Length of Time in Hospital, for Hospital Residents.

(a) Rehabiliates with a Hospital Stay of under 10 Years
(b) Rehabiliates with a Hospital Stay of 10 Years or Over

Scale

Good
Strong
Active
Optimistic
Calm
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

Mean rating

Mean rating
Responsible rather than Irresponsible ($t = 4.53$, df16, $p < 0.001$).
On the other hand, the long stay group saw themselves as very similar
to other psychiatric patients, rating themselves slightly more
negatively on ten scales. However, while none of these differences
was significant, there were two significant differences in the
opposite direction, with long stay rehabilitees seeing themselves as
Independent rather than Dependent ($t = 2.23$, df24, $p < 0.05$) and more
Good ($t = 2.13$, df24, $p < 0.05$) when compared with other psychiatric
patients. Overall, while the total scale scores for Real-Self and
'most psychiatric patients' were significantly different for the
short stay group ($t = 3.73$, df16, $p < 0.01$), they were very similar
for the long stay group ($t = 0.46$, df24, n.s.). Thus the short stay
group do not identify with their view of other psychiatric patients,
but the long stay group do, mainly due to their more positive
attitude to psychiatric patients.

Turning to consider identification with the patient-role as measured
by the attitude scale, Table 4.4(A) shows that the differences between
the short and long stay groups were minimal. While short stay
rehabilitees tended to be marginally more rejecting of the patient-
role on Factors 1, 2 and 4, they were less rejecting on Factor 3 and
the total scale score. Thus there seems to be no association
between length of time in hospital and identification with the
patient-role as defined by the attitude scale.

Turning to consider the third measure of identification with the
patient-role, the pattern of patient-role responses on the 'who-am-I?'
schedule, the findings present yet a different account of the
relationship between identification with the patient-role and
length of time in hospital. The proportion of rehabilitees making
one or more patient-role statements was 43% for the short stay group
but only 31% for the long stay group, so that identification with the
patient-role actually declined over time. However, the association
between patient-role identification and length of stay in hospital

138.
Table 4.4  Differences in Rehabilitees' Attitudes to the Patient-Role by Length of Time in Hospital, Time Since Discharge and Readmission during the Previous Three Years

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Total Scale (N)</th>
<th>Factor 1 mean score (12 items)</th>
<th>Factor 2 mean score (6 items)</th>
<th>Factor 3 mean score (5 items)</th>
<th>Factor 4 mean score (3 items)</th>
<th>Factor 4 mean score (2 items)</th>
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<tbody>
<tr>
<td>A. Within Hospital</td>
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<td></td>
</tr>
<tr>
<td>Length of Time in Hospital</td>
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<td></td>
<td></td>
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<tr>
<td>(a) Less than Ten Years</td>
<td>24</td>
<td>28.20</td>
<td>14.83</td>
<td>14.96</td>
<td>8.96</td>
<td>4.79</td>
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<tr>
<td>(b) Ten Years or Over</td>
<td>33</td>
<td>27.24</td>
<td>15.30</td>
<td>15.27</td>
<td>8.55</td>
<td>5.15</td>
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<td>F</td>
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<td>0.337</td>
<td>0.562</td>
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<tr>
<td>B. Within Community</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Time Since Discharge</td>
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<td></td>
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<tr>
<td>(a) Less than Three Years</td>
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<td>13.53</td>
<td>13.35</td>
<td>6.88</td>
<td>4.53</td>
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<tr>
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<td>14.78</td>
<td>12.89</td>
<td>7.56</td>
<td>4.78</td>
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<td>F</td>
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<td>0.652</td>
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<td>0.726</td>
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<td>14.57</td>
<td>13.86</td>
<td>9.29</td>
<td>4.86</td>
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<tr>
<td>(b) None</td>
<td>28</td>
<td>28.39</td>
<td>14.07</td>
<td>12.93</td>
<td>6.71</td>
<td>4.61</td>
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<td>2.901</td>
<td>0.066</td>
<td>0.537</td>
<td>8.304</td>
<td>0.116</td>
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</tbody>
</table>

** p < 0.01
was not significant ($X^2 = 0.407$, df1, n.s.). Further, while this pattern was repeated for rehabilitees in all three types of hospital ward (rehabilitation villas, the hospital hostel and 'other wards'), the proportion making patient-role statements was higher for the long stay groups on 'other wards' than for short stay groups elsewhere in the hospital, 45% compared with 36%.

In the face of three different accounts of the relationship between identification with the patient-role and the length of stay in hospital, it seems important to return to the relationship hypothesised on the basis of the discussions in section 2.3. There it was suggested that 'over time patients can be expected to have internalised the negative attributes which characterise the role (of psychiatric patient) and have developed a negative self-conception'. The discrepancy measure confirms this hypothesis to a limited extent, in that the long stay group were seen to have more negative attitudes to self than the short stay group. However, their increased identification with the patient-role ('most psychiatric patients') was shown to be mostly due to changes in their attitudes to other psychiatric patients, since they tended to reject the negative stereotype and see them in a markedly more positive way than the short stay group. Meanwhile, the 'who-am-I?' measure suggested a trend in the opposite direction to that hypothesised, with identification with the patient-role actually declining as the length of hospital stay increased. However, a comparison between rehabilitees in different types of hospital ward showed that social environment (which includes the degree to which the patient-status and hospitalisation impinge on the everyday lives of rehabilitees) is probably more important in determining the level of spontaneous identification with the patient-role than length of time in hospital per se.

10 The proportion of identifications with community-based roles also declined over time, but to a much greater extent. Thus 48% of the short stay group made one or more statements showing identification with community roles but only 17% of the long stay group. There was a significant association between length of stay and identification in terms of community roles ($X^2 = 4.283$, df1, $p < 0.05$).
4.3.8 Differences in Community Residents' Identification with the Patient-Role by Length of Time Since Discharge and whether or not Rehabilitees had been Readmitted during the Previous Three Years

Just as the previous sub-section has shown that length of time in hospital is an important variable in understanding the identification of hospital residents with other psychiatric patients/the patient-role, so it can be hypothesised that changes in the level of identification after discharge are to some extent related to both the length of time since discharge and whether or not rehabilitees have experienced a recent readmission. Rehabilitees living in the community at the time of interview were almost equally divided between those who had been discharged from the Rehabilitation Unit for three years or more, and those who had been discharged for less than three years. However, while most of the former group lived with parents (67%), most of the latter did not (88%): \( \chi^2 = 5.1899, \text{df} = 1, p < 0.05 \).

Looking first at the discrepancy measure of identification with the patient-role, both groups have very similar attitudes to Real-Self and 'most psychiatric patients', with those discharged for three years or more tending to have slightly more positive attitudes to psychiatric patients on most of the 18 scales. Thus the pattern of differences between the two concepts is very similar for both groups of rehabilitees, with each having significant differences on one-third of the scales and the total scale score \( t = 3.36, \text{df} = 12, p < 0.01 \) and \( t = 3.12, \text{df} = 16, p < 0.01 \) for rehabilitees discharged for less than three years and three years or over respectively). However, a comparison of the 'D' scores for the two groups suggests that rehabilitees discharged for less than three years tend to identify more closely with psychiatric patients than those discharged for three years or more.

Table 4.4(B) shows that this lack of association between time since discharge and the level of identification with the patient-role is
repeated on the attitude scale measure: there are no significant differences between the two groups of rehabilitees on the total scale score or the factor scores. Turning to consider identification with the patient-role and family-role as measured on the 'who-am-I?' schedule, the results are much the same. Only two community residents made any patient-role statements, one of whom had been discharged for less than three years and the other for over three years. Meanwhile, half the rehabilitees in each group made one or more family-role statements. The only slight difference between the two groups is in their level of orientation towards the community-world, with those discharged for less than three years being slightly more likely to make one or more such statements (94%) than those discharged for over three years (75%). However, this trend towards a lower level of community-world orientation as the time since discharge increases was found to be related to the high proportion of those living elsewhere in the community in the more recently discharged group (4.3.5).

Turning to consider the effects of one or more readmissions during the preceding three years, it is important to note that there is no association between whether or not rehabilitees had experienced a readmission and their place of residence in the community, with roughly one-fifth of both groups, that is those living with parents and those living elsewhere in the community, having experienced a readmission. Further, there is similarly no association between the length of time since discharge and whether or not rehabilitees had experienced a readmission during the preceding three years.

Figure 4.7 shows that the Real-Self of rehabilitees who had been readmitted was in some respects more negative; in particular they rated themselves as Emotional rather than Calm (F = 12.342, df1,29, p<0.01), less Happy, less Responsible and more Shy. However, while they were not so positive about how they typically felt, they were more positive about how they typically interacted with others, seeing themselves as more Well-Liked and more Friendly. The pattern was much the same for the rating of 'most psychiatric patients', with rehabilitees who had been readmitted seeing them more positively on two-thirds of the scales, but also as more Submissive, more Emotional,
Figure 4.7 A Comparison of Rehabilitees' Attitudes to Real-Self and 'Most Psychiatric Patients' by whether they had been Readmitted in the past Three Years.

(a) Rehabilitees with No Readmissions in the Past 3 Years

Scale

Good
Strong
Active
Optimistic
Calm
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

mean rating

(b) Rehabilitees with one or more Readmissions in the past 3 Years

Scale

Bad
Weak
Passive
Pessimistic
Emotional
Unhappy
Low in Confidence
Uncreative
Unimportant
Unlucky
Dependent
Submissive
Shy
Unfriendly
Not Well Liked
Irresponsible
Old
Ugly

mean rating
more Shy, more Weak and Unimportant rather than Important. Overall, rehabilitees who had experienced one or more readmissions over the preceding three years identified far more closely with 'most psychiatric patients' than those who had remained in the community the whole time. Thus, while those with readmissions saw themselves as significantly different from psychiatric patients on only one scale (Well Liked–Not Well Liked), those without readmissions saw themselves as significantly different on half the scales and the total scale score ($t = 4.30$, $df_{23}, p < 0.001$). In particular the latter group saw themselves as Happy rather than Unhappy ($t = 7.56$, $df_{23}, p < 0.001$), Calm rather than Emotional ($t = 5.90$, $df_{23}, p < 0.001$) and Responsible rather than Irresponsible ($t = 5.03$, $df_{23}, p < 0.001$). However, the overall 'D' scores for the two groups were not significantly different but confirmed the trend for rehabilitees with one or more readmissions over the preceding three years to identify more closely with psychiatric patients.

Table 4.4(B) shows that on the attitudinal measure of identification with the patient-role, the one significant difference between the two groups of rehabilitees is on Factor 3 (seeing their illness as a burden and the hospital as a refuge) ($F = 8.304$, $df_{1,33}, p < 0.01$). However, there is a general trend for rehabilitees who have experienced a recent readmission to identify more closely with the patient-role. In fact, their level of acceptance/rejection as defined by the attitude scale is very similar to that for rehabilitees in the rehabilitation villas for the total scale score and Factor 1 (a general feeling of well-being and normality) (Table 4.1).

Only two rehabilitees in the community made patient-role statements on the 'who-am-I?' schedule, and neither of them had been readmitted to hospital during the three years prior to interview. However, the proportion of rehabilitees making family-role statements was markedly, though not significantly, greater for those with a readmission, 71% compared with 40%. This difference is greater than would have been expected on the basis of place of residence alone, since only a slightly higher proportion of rehabilitees with a readmission lived
with parents (43%) than those without a readmission (39%). However, when the broader concept of community-world orientation is considered, rehabilitees with a readmission were only marginally more likely to make such statements than those without a readmission, 86% compared with 82%.

In summary, it seems that time since discharge from the rehabilitation villas (less than three years or three years and over) is not associated with marked changes in rehabilitees' attitudes to themselves or psychiatric patients and does not basically change their level of identification with the patient-role. However, rehabilitees who have experienced a relatively recent (within the preceding three years) readmission to hospital tend to show a stronger identification with psychiatric patients/the patient-role than those who have not been readmitted. The discrepancy measured shows that this is mainly due to their more positive attitudes towards psychiatric patients. The 'who-am-I?' measure shows that, while identification with family roles tends to increase for rehabilitees with a recent admission, orientation towards a more extensive range of community roles does not. Further, there is a negative association between the level of orientation towards community roles and the length of time since discharge.

4.3.9 Summary and Interpretation of Changes in Identification with Psychiatric Patients and Acceptance of the Patient-Role during Rehabilitation

Rehabilitees on 'other wards' show a neutral to positive view of other psychiatric patients with which they strongly identify, seeing themselves more positively in some ways and more negatively in others. They are also far more orientated towards the hospital social-world than the community social-world. By comparison, rehabilitees in the hospital hostel have an even more positive view of psychiatric patients, with which they also strongly identify. The difference between the two groups of rehabilitees is that while the former accept the patient-role as defined in the attitude scale, the latter do not, and this difference is particularly marked on dimensions concerning the degree
of orientation towards the hospital. Similarly, rehabilitees in the hospital hostel are less likely to make statements concerning the patient-role/hospital social-world on the 'who-am-I?' schedule. Thus, while rehabilitees on 'other wards' show themselves to be highly orientated towards the hospital, those in the hospital hostel are not, showing quite clearly the effects of different ward environments and patient reference groups. However, what both groups have in common is that by rejecting the negative stereotype of the psychiatric patient (2.3) they are able to internalise the role/identity of the psychiatric patient without developing a negative self-conception. This process is also related to rehabilitees' age and length of time in hospital, with older/long-stay patients tending to identify more strongly due to their markedly more positive attitudes to other psychiatric patients.

Rehabilitees in the rehabilitation villas have a markedly different view of other psychiatric patients from that described for 'other ward' and hospital hostel residents. Possibly in anticipation of their discharge to the community (but also because a higher proportion of them are younger with a shorter hospital stay) they tend to accept the negative stereotype of the psychiatric patient to a marked degree. Further, the discrepancy measure shows that they do not identify with this view, seeing themselves in a far more positive way. Similarly, on the 'who-am-I?' schedule, they do not identify with the patient-role to nearly the same degree as other hospital patients. However, the attitude scale shows their friendships and conversations to be still orientated towards the hospital, and the 'who-am-I?' schedule that they have not yet acquired the family and other community based roles to give them a basic orientation towards the community social-world. In consequence one half of the rehabilitees in the rehabilitation villas lack any orientation to a social-world.

Turning to consider rehabilitees in the community; they all share a negative attitude towards psychiatric patients, although those who have experienced a recent readmission to hospital do seem to be a little more charitable. Rehabilitees living with parents identify with their negative view of psychiatric patients to a more marked degree than do
rehabilitees in the rehabilitation villas. The main difference when they are compared with the latter group is that rehabilitees living with parents are not at all hospital orientated, showing a high level of rejection on such items on the attitude scale and making no patient-role/hospital-world orientation statements on the 'who-am-I?' schedule. Rehabilitees living elsewhere in the community show the most extreme lack of identification with psychiatric patients of any group since they have a very positive view of themselves; they also show a higher level of orientation towards the community-world than those living with parents. However, not being in immediate contact with family members, their level of identification with family roles is lower than for rehabilitees living with parents. The length of time since discharge seems to have little effect on levels of identification with either psychiatric patients or the patient-role. Neither is there an increase in the level of identification with family or community roles as the time since discharge increases. Thus, it would seem that it is in the early stages of the move from hospital to community that rehabilitees acquire family and other community-based roles to replace the patient-role, and also lose their orientation towards the hospital. Readmission tends to have a greater effect on roles/identities than the length of time since rehabilitees' original discharge from the Rehabilitation Unit. The discrepancy measure shows that rehabilitees with a relatively recent readmission (within the last three years) tend to identify more closely with psychiatric patients, mainly since they see the latter in a more positive way. The attitude scale also shows them to be more accepting of the patient-role than rehabilitees who have not been readmitted.

4.4 Changes in Self-Esteem during Rehabilitation

4.4.1 Differences in Rehabilitees' Attitudes to their Ideal-Self by Place of Residence

The majority of Ideal-Self ('the way I would most like to be') ratings for both hospital and community residents are between 1.0 and 2.0
(Figure 4.8(b)); the exceptions are on the scales Dominant-Submissive for both groups of rehabilitees, and Important-Unimportant and Young-Old for community residents. The ratings for both groups are generally very similar, with just two significant differences: hospital residents see the Ideal as more Calm \((F = 6.534, \text{ df}\;1, \;73, \;p < 0.05)\) and more Important \((F = 6.859, \text{ df}\;1, \;73, \;p < 0.05)\).

Figure 4.8(a) considers the three groups of hospital residents and shows that 'other ward' residents have the most extreme (that is positive) ratings on half the scales and the least positive on only three; in contrast hospital hostel residents have the most positive on just three and the least positive on eight. Meanwhile, rehabilitation villa residents take an intermediate position on over half the scales, although their Ideal-Self is significantly more Optimistic than that of the other two groups \((F = 3.257, \text{ df}\;2, \;41, \;p < 0.05)\). There are no other significant differences between the three groups of hospital residents on either the individual scales or the total scale score. The latter shows that rehabilitation villa and 'other ward' residents share similar scale profiles, while that for hospital hostel residents is markedly less positive.

The mean ratings for the two groups of community residents are also very close on most of the individual scales (Figure 4.8(c)) and their total scale scores are virtually equal. While the latter are more positive than the total scale score for hospital hostel residents, they are not so extreme as those for rehabilitation villa and 'other ward' residents.

Thus Ideal-Self ratings tend to vary only slightly between groups, with 'other ward' and rehabilitation villa residents having the most extreme view and hospital hostel residents the least extreme view.
Figure 4.6 Differences in Rehabilitees' Attitudes to Ideal-Self ('the way I would most like to be') by Place of Residence.

(a) Rehabilitees Resident in the Hospital
(b) All Rehabilitees
(c) Rehabilitees Resident in the Community

Scale
- Good
- Strong
- Active
- Optimistic
- Calm
- Happy
- High in Confidence
- Creative
- Important
- Lucky
- Independent
- Dominant
- Outgoing
- Friendly
- Well Liked
- Responsible
- Young
- Beautiful
- 'Other Words'
- Hospital Hostel
- Rehabilitation
- 'Villas'
- Hospital
- Community
- With Parents
- Elsewhere
- In the Community
- Weak
- Passive
- Pessimistic
- Emotional
- Unhappy
- Low in Confidence
- Uncreative
- Unimportant
- Unlucky
- Independent
- Submissive
- Shy
- Unfriendly
- Not Well Liked
- Irresponsible
- Old
- Ugly
4.4.2 Differences in the Discrepancy between Rehabilitees' Attitudes to Real-Self and Ideal-Self by Place of Residence

Figure 4.9 shows that there are marked differences between the mean ratings for Real-Self and Ideal-Self on all scales for both hospital and community residents; the differences are all significant, except on the scale Dominant-Submissive for community residents, as are the differences between the total scale scores ($t = 8.96, df=43, p<0.001$; $t = 8.67, df=30, p<0.001$ for hospital and community residents respectively). Figure 4.10 shows that this pattern tends to be repeated for two of the three groups of hospital residents, 'other ward' and rehabilitation villa residents, but not for hospital hostel residents. The Real-Self of the latter group was noted to be more positive than that of other hospital residents on those concerning how they typically feel (4.2), which combined with the less extreme view of the Ideal-Self results in there being significant differences between Real-Self and Ideal-Self on only six (one-third) of the scales, compared with 14 for rehabilitation villa residents and 16 for 'other ward' residents.

Turning to consider community residents, those living with parents tend to see their Real-Self as further away from their Ideal than do those living elsewhere in the community (Figure 4.11). Thus, while there are significant differences between the ratings on the two concepts on all but one scale (Dominant-Submissive) for those living with parents, this is so for only eleven of the 18 scales for those living elsewhere in the community. However, even this number of significant differences is greater than for hospital hostel residents.

Thus the Real-Self/Ideal-Self discrepancy differs little for hospital and community residents, but there are some marked differences between groups of rehabilitees within the hospital and within the community. Hospital hostel residents have relatively similar views of their Real-Self and Ideal-Self, in contrast to the other groups of hospital residents who see themselves as farther from the way they would most like to be. This is particularly true of 'other ward' residents who have a less positive view of themselves and a more extreme view of how
Figure 4.9 A Comparison of Rehabiliites' Attitudes to Real-Self and Ideal-Self for Hospital and Community Residents.

(a) Rehabiliites Resident in the Hospital

- Good
- Strong
- Active
- Optimistic
- Calm
- Happy
- High in Confidence
- Creative
- Important
- Lucky
- Independent
- Dominant
- Outgoing
- Friendly
- Well Liked
- Responsible
- Young
- Beautiful

(b) Rehabiliites Resident in the Community

- Sad
- Weak
- Passive
- Pessimistic
- Emotional
- Unhappy
- Low in Confidence
- Uncreative
- Unimportant
- Unlucky
- Dependent
- Submissive
- Shy
- Unfriendly
- Not Well Liked
- Irresponsible
- Old
- Ugly

Scale: 1 to 5

mean rating
Figure 4.10 A Comparison of Rehabилитees' Attitudes to Real-Self and Ideal-Self for Three Groups of Hospital Residents.

(a) Rehabилитees Resident in 'Other Wards'

(b) Rehabилитees Resident in the Hospital Hostel

(c) Rehabилитees Resident in the Rehabilitation Villas

<table>
<thead>
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mean rating 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
Figure 4.11 A Comparison of Rehabilitates' Attitudes to Real-Self and Ideal-Self for Two Groups of Community Residents.

(a) Rehabilitates Living with Parents

(b) Rehabilitates Living Elsewhere in the Community

Scale Good Strong Active Optimistic Calm Happy High in Confidence Creative Important Lucky Independent Dominant Outgoing Friendly Well Liked Responsible Young Beautiful

Real-Self Ideal-Self

mean rating

mean rating

1 2 3 4 5

1 2 3 4 5

Bad Weak Passive Pessimistic Emotional Unhappy Low in Confidence Uncreative Unimportant Unlucky Dependent Submissive Shy Unfriendly Not Well Liked Irresponsible Old Ugly
they would like to be than other rehabilitee groups. While the Ideal-Self of both community based groups is very similar, those living with parents have a less positive view of themselves; consequently the discrepancy between Real-Self and Ideal-Self is greater than for rehabilitees living elsewhere in the community.

While a comparison of total scale scores simply shows that all groups of rehabilitees see themselves as significantly different from the way they would most like to be, a comparison of 'D' scores supports the above analysis. They show that 'other ward' residents have the largest distance between the scale profiles of Real-Self and Ideal-Self, and hospital hostel residents the smallest. The group of rehabilitees with the second closest identification with their Ideal-Self is those living elsewhere in the community. Meanwhile the 'D' scores for those living with parents or in the rehabilitation villas are very similar, and intermediate between the scores for those living elsewhere in the community and those in 'other wards'.

Thus, if the Real-Self/Ideal-Self discrepancy is used as a measure of self-esteem (2.1.6), rehabilitees in the hospital hostel have the highest self-esteem followed by those living elsewhere in the community. Next comes those living with parents and in the rehabilitation villas, with rehabilitees in 'other wards' having the lowest self-esteem of all.

4.4.3 Differences in Rehabilitees' Self-Esteem as Measured by Rosenberg's Attitude Scale, by Place of Residence

The total scale score (obtained by summing the scores on each of the ten items in the scale) is used as a measure of global self-esteem (3.4.3). A low score represents the positive end of the continuum, that is a high level of self-esteem.

The mean scale scores given in Table 4.5 show that community residents have a higher level of self-esteem than hospital residents, although the difference is not significant. Similarly, neither of the 'within group' differences is significant. However, the 'within community' difference
Table 4.5 Differences in Rehabilitees' Self-Esteem by Place of Residence, Length of Time in Hospital, Time Since Discharge and Readmission during the Previous Three Years

<table>
<thead>
<tr>
<th>Place of Residence (N)</th>
<th>Self-Esteem Scale - Mean Total Score (10 Items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/Community</td>
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<tr>
<td>Hospital (57)</td>
<td>27.65</td>
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<tr>
<td>Community (35)</td>
<td>25.69</td>
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<tr>
<td>F</td>
<td>1.610</td>
</tr>
</tbody>
</table>

A. Within Hospital

(a) Place of Residence

| Rehabilitation Villa (25) | (b) Length of Time in Hospital
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<tbody>
<tr>
<td></td>
<td>Less than Ten Years (24)</td>
</tr>
<tr>
<td>Hospital Hostel (11)</td>
<td>Ten Years of Over (33)</td>
</tr>
<tr>
<td>'Other Ward' (21)</td>
<td>F</td>
</tr>
</tbody>
</table>

F 0.830 F 0.295

B. Within Community

(a) Place of Residence

| With parents (14) | (b) Time Since Discharge
<table>
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</thead>
<tbody>
<tr>
<td></td>
<td>Less than Three Years (17)</td>
</tr>
<tr>
<td>Elsewhere in Community (21)</td>
<td>Three Years or Over (18)</td>
</tr>
</tbody>
</table>

F 3.132 F 1.242

(c) Readmission in the Previous Three Years

| One or more (7) | 29.86 |
| None (28)       | 24.64 |

F 2.405

155.
is quite marked, with rehabilitees living with parents having a lower level of self-esteem than those living elsewhere; further, the level of self-esteem for those living with parents is very similar to that for two of the 'within hospital' groups: rehabilitation villa and 'other ward' residents. Meanwhile hospital hostel residents show a level of self-esteem intermediate between these three groups and rehabilitees living elsewhere in the community.

Thus the ten item self-esteem scale shows rehabilitees living in the community, but not living with parents, to have the highest self-esteem. They are followed by those resident in the hospital hostel, who have markedly higher self-esteem than other hospital groups. Rehabilitees living with parents share the lower self-esteem of rehabilitation villa and 'other ward' residents.

4.4.4 Comparison of the Discrepancy and Attitudinal Measures of Self-Esteem

The correlational method of comparison (4.3.4) shows that there is a significant correlation between the 'D' scores (discrepancy measure) and the total scale scores (attitudinal measure) for both hospital and community residents \((r = 0.76, p < 0.01 \text{ and } r = 0.79, p < 0.01)\) respectively.

Turning to consider the comparison of the results of the two methods, while neither the discrepancy scores on the semantic differential scales (between Real-Self and Ideal-Self) nor the total scale scores on the ten item attitude scale show any significant differences between hospital and community residents, both attribute a generally higher level of self-esteem to community residents. Similarly, both show a marked but not significant difference between hospital hostel residents and other hospital residents, and between community residents living with parents and those living elsewhere in the community. Thus hospital hostel residents have an Ideal-Self that is more similar in many respects to their Real-Self (the former being less positive and the latter more positive than for other hospital residents) and a lower score on the
attitude scale than rehabilitation villa and 'other ward' residents. Meanwhile, rehabilitees living elsewhere in the community have an Ideal-Self that is more like their Real-Self and a lower score on the attitude scale than those living with parents. However, the difference in this case is due to a more positive Real-Self, with the Ideal-Self of both community groups being very similar.

4.4.5 Differences in Hospital Residents' Self-Esteem by Length of Time in Hospital

Just as subsections 4.3.7 and 4.3.8 looked at other variables concerning length of hospital stay and the time since discharge which might influence identification with psychiatric patients and the patient-role, so subsections 4.4.5 and 4.4.6 will do the same as regards self-esteem. Taking hospital residents first, and dividing them into two groups on the basis of length of stay in hospital (under ten years or ten years and over), there are no significant differences in the mean ratings for Ideal-Self on any of the individual scales or the total scale score, with the individual scale ratings being slightly more positive for each group on half the 18 scales. However, the tendency for the Real-Self of the long-stay group (ten years or over) to be more negative than that of the short-stay (under ten years) (4.3.7) means that there is a significant difference between Real-Self and Ideal-Self on all 18 scales for the long-stay group but only 13 for the short-stay group. The five scales on which the short-stay group see their Real-Self as not significantly different from their Ideal-Self are Good-Bad, Independent-Dependent, Optimistic-Pessimistic, Young-Old and Responsible-Irresponsible.

However, this tendency for the self-esteem of the short-stay group to be higher than that for the long-stay group is not confirmed by the attitudinal measure of self-esteem. Table 4.5 shows that the long-stay group have a lower mean rating and hence higher self-esteem than the short-stay group, although the difference is small.

The discrepancy measure of self-esteem suggests that the self-esteem
of rehabilitees resident in the hospital for over ten years is lower than that of the shorter stay group due to their more negative Real-Self. However, neither the total scale scores nor the 'D' scores are significantly different and the result is not confirmed by the attitudinal measure of self-esteem, which suggests a trend in the opposite direction.

4.4.6 Differences in Community Residents' Self-Esteem by Length of Time Since Discharge and whether or not Rehabilitees had been Readmitted during the Previous Three Years

Taking length of time since discharge from the Rehabilitation Unit, Figure 4.12 shows that there is more variation in the ratings for Ideal-Self than Real-Self; the latter ratings are very similar for both groups of rehabilitees with no significant differences (4.3.8). On the other hand, there are three significant differences between the mean ratings for Ideal-Self, with rehabilitees discharged for three years or more seeing the Ideal as more Lucky (F = 7.329, df1,29, p<0.05), more Outgoing (F = 6.222, df1,29, p<0.05) and more Responsible (F = 5.224, df1,29, p<0.05) than those discharged for less than three years. Overall, those discharged for three years or more have the more extreme Ideal-Self on 14 scales and the total scale score (F = 3.608, df1,29, p<0.07) with the result that there are significant differences between their Real-Self and Ideal-Self on 16 of the 18 scales, compared with significant differences on nine scales for those discharged for less than three years. However, the 'D' scores are not significantly different.

The attitudinal measure of self-esteem confirms this finding, with rehabilitees discharged for less than three years at interview having a lower mean total scale score and hence higher self-esteem than those discharged for three years or more (Table 4.5): this difference is not significant.

Turning to consider the effect of one or more readmissions (during the three years prior to interview) on self-esteem, Figure 4.13 confirms
Figure 4.12 A Comparison of Rehabilitees' Attitudes to Real-Self and Ideal-Self by Length of Time since Discharge, for Community Residents.

(a) Rehabilitees Discharged for under Three Years
(b) Rehabilitees Discharged for Three Years or Over

Scale
Good
Strong
Active
Optimistic
Calm
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

Real-Self
Ideal-Self

Mean rating

1 2 3 4 5

Bad
Weak
Passive
Pessimistic
Emotional
Unhappy
Low in Confidence
Uncreative
Unimportant
Unlucky
Dependent
Submissive
Shy
Unfriendly
Not Well Liked
Irresponsible
Old
Ugly
the analysis of Real-Self differences described in 4.3.8.

Rehabilitees with a recent readmission tend to be more negative on scales describing how they typically feel, in particular being Emotional rather than Calm ($F = 12.342$, df1,29, $p<0.01$), but more positive on scales describing how they typically interact with others. By comparison their Ideal-Self is more positive on two-thirds of the scales, especially Young-Old, High in Confidence-Low in Confidence, Active-Passive and Creative-Uncreative. Overall, there are slightly more significant differences between Real-Self and Ideal-Self, and hence lower self-esteem, for rehabilitees who have not experienced readmission (15) than for those who have (12). Both the above analysis and Figure 4.13 would perhaps suggest the opposite result; it is suggested that the small number of respondents in the 'readmission' group may account for the lower number of 'significant' differences between scales.

Table 4.5 shows that the mean scale rating on the attitudinal measure of self-esteem for rehabilitees who have experienced one or more recent readmissions is markedly higher than for rehabilitees who have not (29.86 compared with 24.64). Thus, readmission tends to lead to a lowering of self-esteem, although the change is not significant.

Thus, both measures of self-esteem show that rehabilitees discharged for three years or more tend to have lower self-esteem than those more recently discharged, with the discrepancy measure showing this to be due to their more extreme/positive view of the Ideal rather than any marked change in how they see themselves. The attitudinal measure of self-esteem also suggests that readmission to hospital results in a lowering of self-esteem, although the discrepancy measure does not confirm this result, despite the fact that the Ideal-Self is more extreme on two-thirds of the scales for rehabilitees with a readmission during the three years prior to interview.
Figure 4.13 A Comparison of Rehabilitees' Attitudes to Real-Self and Ideal-Self by whether they had been Readmitted in the Past Three Years, for Community Residents.

(a) Rehabilitees with No Readmissions in the Past 3 Years

(b) Rehabilitees with One or more Readmissions in the Past 3 Years
Rehabilitees in 'other wards' tend to have relatively low self-esteem; the discrepancy measure shows that this is not only because they have a less positive view of themselves but also because they have a more extreme view of the Ideal or 'how they would like to be' than other groups. In comparison residents of the hospital hostel have high self-esteem due to their more positive view of themselves and their less extreme view of the Ideal. This latter group are generally happy and contented with life; they are no longer striving for resettlement in the community or comparing themselves with people in the community. Instead, their Ideal seems to be based on a generalised other derived from the attitudes of other residents of the hospital hostel. In contrast, 'other ward' residents are apparently far from happy with their present selves; they are now further from their goal of resettlement in the community than they had been in the Rehabilitation Unit (in 1977). Perhaps, rather than seeing themselves in too negative a way, they have chosen to keep their original Ideal or even to exaggerate it, thus lowering their self-esteem. The discrepancy measure suggests that rehabilitation villa residents have a level of self-esteem in between that of 'other ward' and hospital hostel residents. They have a more positive view of themselves than rehabilitees in 'other wards', so that their similar view of the Ideal is more realistic and attainable. Compared with rehabilitees in the hospital hostel, they still have high expectations of themselves in that they are aiming towards resettlement in the community, and striving to be like 'normal' community residents. The results of the attitudinal measure of self-esteem do not support the view that rehabilitees in the rehabilitation villas have higher self-esteem than those in 'other wards'; they suggest no change.

Considering rehabilitees living in the community, both groups have very similar views of how they would like to be which tend to be less extreme than the views of 'other ward' and rehabilitation villa residents. However, those living with parents have lower self-esteem due to their less positive attitudes to themselves. This was interpreted as being
due to being treated like a 'child' and trying to live up to the
standards set by their parents and others with whom they interact in their
daily lives (4.2.2). Thus while rehabilitees who are discharged to live
elsewhere in the community seem to gain self-esteem, those who go to live
with parents do not; their self-esteem remains at a similar level to
that of rehabilitation villa residents. This is agreed by both measures.

There is contradictory evidence as to whether length of hospital stay
is related to higher or lower self-esteem although the discrepancy
measure suggests that any changes are due to changes in rehabilitees' attitudes to themselves rather than the Ideal. Once discharged to the community rehabilitees' expectations of themselves tend to rise over time leading to a slight decline in self-esteem. Readmission to hospital even for a short time takes them further away from their Ideal on some aspects of self-conception (mainly those related to how they typically feel) but closer on others (mainly those related to how they typically interact with others), although it seems likely on balance that there is an overall lowering of self-esteem on readmission.

4.5 Summary and Interpretation of Findings Related to Hypothesis One

The first part of the hypothesis starts from the perspective of rehabilitation as a process of re-socialisation, which requires the (re)-learning of normal social roles: 'rehabilitees at progressive stages of the rehabilitation process will show increasing rejection of the patient-role in favour of community-based social roles.'

Operationally defining the course of rehabilitation as the move from 'other wards' to the 'rehabilitation villas' and thence to resettlement in the community, this part of the hypothesis is largely supported by the findings. In comparison with patients in 'other wards', those in the rehabilitation villas are found to be far less accepting/more rejecting of the patient-role as measured by the attitude scale, and a much smaller proportion of them give one or more statements concerning the patient-role on the 'who-am-I?' schedule. However, the attitude scale shows that they are still orientated towards the hospital as regards their friendships and conversations. Further, their lower
level of identification with the patient-role is not counterbalanced by an increase in identification with normal social roles, that is, family roles and community-based work and leisure-time roles. Thus it is not until rehabilitees are discharged to the community that they can be said to have completely rejected the patient-role and to have taken up normal social roles. In contrast to those still in the hospital, rehabilitees in the community are highly rejecting of all aspects of the patient-role, show no orientation towards the hospital, and the majority of them identify themselves in terms of one or more community-based roles.

The second part of the hypothesis looks at the effects on self-conception of the internalisation of new social identities: 'there will be concomitant changes in self-conception away from an identification with (other) psychiatric patients'. The discrepancy measure shows that patients in 'other wards' identify closely with their view of other psychiatric patients, whom they evaluate in a neutral/positive way. In this way, patients in the more traditional type of long stay ward are able to see themselves as 'psychiatric patients' without the negative consequences to their self-attitudes that would come from acceptance of the negative stereotypical view of psychiatric patients. By comparison, the move to the rehabilitation villas and gaining of 'rehabilitee' status leads to considerable changes in both attitudes to self and psychiatric patients. While rehabilitees tend to see themselves more positively than do patients on 'other wards', they see 'psychiatric patients' in a markedly more negative way. Thus, rehabilitation villa residents no longer identify with other psychiatric patients, and it would seem that they have already taken over the negative stereotypical view held by their community-based reference groups (membership groups to which they aspire to belong).

While all rehabilitees living in the community share the negative stereotypical view of the psychiatric patient, attitudes to self vary markedly between those who live with parents and those who live elsewhere in the community. Thus, while the latter group have very positive attitudes to themselves which are far removed from how they see
psychiatric patients, rehabilitees living with parents see themselves less positively than other rehabilitees and hence identify more closely with the negative stereotype of the psychiatric patient.

Thus, although the findings basically support the hypothesised changes in self-attitudes during rehabilitation, away from identifying with the 'psychiatric patient', there is one group of rehabilitees who form an important exception. This section of the hypothesis needs to be slightly amended to include one further important variable – social milieu.

The third part of the hypothesis concerns the relationship between attitudes to self and ideal-self, that is self-esteem: it is suggested that 'whether rehabilitees in the later stages of rehabilitation have more positive self-conceptions and higher self-esteem will depend on their social milieu'. This is generally confirmed.

The above discussion suggests that while the move from 'other wards' to the rehabilitation villas has a positive effect on rehabilitees' self-conceptions, this is only repeated for the move from hospital to community if they are discharged to live elsewhere in the community. Meanwhile, discharge to the parental home appears to have a negative effect on rehabilitees' self-conceptions.

The attitudinal measure of self-esteem suggests that there is little change in self-esteem between 'other wards', the rehabilitation villas and living with parents. However, rehabilitees discharged to live elsewhere in the community do show considerable gains in self-esteem. While the findings from the discrepancy measure of self-esteem confirm most of these results, they also suggest that there is an increase in self-esteem between 'other wards' and the rehabilitation villas.

Thus, although rehabilitation does generally lead to more positive self-conceptions and self-esteem, this certainly does not appear to be so for rehabilitees who are discharged to live with parents. While
they share the Ideal of other rehabilitees in the community, their poor self-conceptions mean that they have low self-esteem. The hypothesis suggests that this difference between the groups of rehabilitees in the community can be explained in terms of their social milieu. To briefly recap on the argument presented in 4.2.2: it is suggested that rehabilitees who go to live with parents may be treated like 'children' and that they will not be expected (or perhaps allowed) to put into practice the various self-care skills they have learned in the Rehabilitation Unit. Further, allowances may be made for them and normal adult activities, like getting and keeping a job, may not be encouraged. Thus, rehabilitees tend to have a low evaluation of themselves, especially when they see others around them coping with life in a more independent, confident and responsible way. By comparison, rehabilitees who go to live elsewhere in the community, especially if it is to a Group Home or to independent accommodation, have far more opportunities not only to put into practice what they have learned but to become competent at coping with everyday life. Thus, in comparison with others around them they may see themselves as doing well and evaluate themselves accordingly.

Post-Script

There is one group of rehabilitees who have not been mentioned in this section - residents of the hospital hostel. They present something of an anomaly in the 'rehabilitation process' and this tends to be reflected in their self-conceptions and role identifications. While their move from the rehabilitation villas has taken them out of active preparation for resettlement in the community, this is more because of their age and length of time in hospital than any relapse in their mental state. The hostel ward gives them more freedom and independence than a more traditional type of ward; perhaps this is why they tend to reject the patient-role as measured on the attitude scale. In particular they reject those items concerning orientation towards the hospital. However, they have both a close identification with

166.
their own view of other psychiatric patients and a high level of self-esteem on the discrepancy measure. This apparent anomaly is due to their comparatively positive view of 'most psychiatric patients' (not dissimilar to that of 'other ward' residents), and their less extreme view of the ideal as compared with all other groups. Thus, not only are they able to identify with other psychiatric patients and keep their very positive self-attitudes, but having lowered their expectations they are also able to see themselves as very similar to how they would most like to be. They are no longer expecting to be discharged to live in the community and the demands of their social milieu, as mediated to them by other patients in the hostel, are relatively limited and easy to live up to.
5 RESULTS 2: PRESENTATION AND INTERPRETATION OF DATA RELATING TO HYPOTHESIS TWO

5.1 Introduction

5.1.1 Hypothesis Two

Close relatives will also show changes in their conception of rehabilitees who are at different stages of the rehabilitation process. At the later stages close relatives will see rehabilitees more positively and as less like psychiatric patients. However, their view of the ideal for their rehabilitees is also likely to change as expectations rise, so that their more positive attitudes towards rehabilitees may not be closer to the ideal. Further, changes in their attitudes to rehabilitees are likely to occur more slowly than changes in rehabilitees' attitudes to themselves; this is likely to lead to significant discrepancies between rehabilitees' self-conceptions and the conceptions of them held by close relatives. Such discrepancies will require cognitive reappraisal by rehabilitees of either their close relatives or their perception of the discrepant, negative feedback.

5.1.2 Order and Format of Data Presentation

The next three sections will present data on changes in CRs' attitudes to rehabilitees at different stages during rehabilitation (5.2); changes in the discrepancies between how rehabilitees see themselves, how they perceive their CRs to see them and how CRs actually do see them (5.3); and differences in discrepancies by the degree to which CRs are seen by rehabilitees as being 'valued' or 'credible' others (5.4). As for Chapter 4, the main findings will be summarised and some basic interpretations presented at the end of each section. Finally, Section 5.5 will present an overview of the findings related to Hypothesis Two, and an assessment of the extent to which the hypothesis has been substantiated. Chapter 6 will look at the theoretical, methodological and practical implications of the results.
All data in Chapter 5 come from semantic differential scales completed by rehabilitees and CRs in the CR Sample only. As noted above (3.6.2) the relatively small numbers in the CR Sample means that the stage of rehabilitation will generally only be represented by the basic division between hospital and community residents. Similarly, when the division is based on the degree to which CRs are seen as 'valued' or 'credible' others, no further subdivisions will be made.

On the basis of the discussion in 3.7.1 and 3.7.2, checks have been made throughout the analysis in this chapter to ascertain whether or not significant differences in CRs' responses on semantic differential scales by rehabilitees' place of residence (hospital/community) are independent of CRs' relationship to rehabilitees and rehabilitees' age and length of time in hospital. As in Chapter 4 only those cases where the relationship is found to be important in explaining the differences in responses by place of residence will be noted.

5.2 Changes in CRs' Attitudes to Rehabilitees during Rehabilitation

5.2.1. Differences in CRs' Attitudes to their Rehabilitees by Rehabilitees' Place of Residence

Figure 5.1(a) shows that there are considerable differences in CRs' attitudes to rehabilitees ('the way my rehabilitee is now') depending on whether they are resident in the hospital or community. Thus, while rehabilitees living in the community are seen in basically positive terms: as Good, Friendly, Important, Happy and Well-Liked, those who are hospital patients (while also Good and Well-Liked) are for the most part seen in negative terms: as Low in Confidence, Uncreative, Shy, Unlucky, Passive, Pessimistic and Dependent. Overall, hospital residents are given negative mean ratings (over 3.0) on eleven of the scales, but community residents negative mean ratings on only four, with both groups being seen as Submissive, Shy, Unlucky and Low in Confidence.

Looking at the differences in the mean ratings between hospital and
Figure 5. Differences in Chi's Attitudes to their Rehabilitates, their Ideal-Other* and 'Most Psychiatric Patients' by Rehabilitates' Place of Residence

(a) Attitudes to Rehabilitates
(b) Attitudes to Ideal-Other
(c) Attitudes to 'Most Psychiatric Patients'

Scale
1 2 3 4 5

Good
Strong
Active
Optimistic
Calm
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

Mean Rating

*Ideal-Other = Ideal for Rehabilitates
community residents, these are significant ($p<0.05$) on ten individual scales and the total scale score ($F = 19.693$, df1,40, $P<0.001$). In particular rehabilitees in the hospital are seen as more Low in Confidence ($F = 22.304$, df1,40, $p<0.001$), Uncreative rather than Creative ($F = 19.679$, df1,40, $p<0.001$), less Friendly ($F = 15.084$, df1,40, $p<0.001$) and less Good ($F = 14.862$, df1,40, $p<0.001$).

To find out at what stage in the rehabilitation process these important changes in CRs' attitudes to rehabilitees take place, it is necessary to take this analysis a step further, although results should be treated with caution due to the small number of respondents in some subgroups. Firstly, comparing ratings for rehabilitation villa residents and the other two groups of hospital residents, there are only two significant differences. CRs of rehabilitation villa residents see them as less Shy ($F = 4.606$, df2,19, $p<0.05$) and less Pessimistic ($F = 4.282$, df2,19, $p<0.05$) than do the CRs of hospital hostel and 'other ward' residents; otherwise, the rehabilitee status appears to have little effect on CRs' attitudes to their rehabilitees, and the total scale scores are very similar. Secondly, comparing ratings for rehabilitation villa residents and those already discharged to the community, CRs of community residents are more positive in their attitudes on 16 of the 18 scales and half of these differences are significant ($p<0.05$). The difference between the total scale scores is also significant ($F = 11.913$, df1,30, $p<0.01$) suggesting a marked change in attitudes to rehabilitees when they move from the hospital to the community.

Considering community residents, CRs of rehabilitees living with parents give rehabilitees more positive mean ratings on all but one scale (Calm-Emotional) than do those of rehabilitees living elsewhere in the community. However, the differences are significant on only three scales, with rehabilitees living with parents being seen as more Strong, more Friendly and Young rather than Old (all $p<0.05$), the difference on the total scale score is marked but not significant.
Overall then, there are marked differences in CRs' attitudes to rehabilitees in the hospital and community, with CRs of those in the hospital seeing them negatively on two-thirds of the scales and CRs of those in the community seeing them positively on three-quarters of the scales. Further, the difference between the total scale scores is also significant. While there is little difference in the attitudes to the three groups of hospital residents, the difference in attitudes to rehabilitees in the rehabilitation villas and the community is seen to mirror those for the hospital/community division, showing that changes in CRs' attitudes to rehabilitees tend to take place after discharge. However, CRs' attitudes do not appear to be greatly affected by either the length of time since discharge or rehabilitees' brief readmission to hospital.

Next it is necessary to consider whether these marked differences in CRs' attitudes to rehabilitees in the hospital and community are independent of rehabilitees' age and length of time in hospital, and CRs' relationship to rehabilitees (5.1.2). While the differences are found to be independent of rehabilitees' age and to hold where they have a cumulative hospital stay of under ten years, there is some evidence to suggest that the CRs of rehabilitees with a hospital stay of ten years or more may find it more difficult to change their attitudes to rehabilitees after discharge. However, the result may simply be due to the small number (4) of rehabilitees in this group who have so far been discharged to the community.

When the relationship of CRs to their rehabilitees is considered, the interaction with place of residence is even more complicated. Overall, parents tend to have more positive attitudes towards their rehabilitees than other relatives. The difference between the mean ratings of the two groups is significant on half the scales, including six of the
scales on which were significant differences between the CR ratings for hospital and community based rehabilitees. Controlling for the relationship of CRs to their rehabilitees (parent/other relative), although there is still the general tendency for CRs of community-based rehabilitees to be more positive than CRs of hospital-based rehabilitees, the differences are only significant on two of the six scales. Thus, it would seem that for some scales the association between rehabilitees' place of residence (hospital/community) and CRs' attitudes towards rehabilitees is strengthened by the fact that a higher proportion of community-based rehabilitees have parent CRs, roughly three-fifths, compared with one-third of hospital-based rehabilitees.

Comparing CRs' attitudes towards rehabilitees with rehabilitees' attitudes towards themselves (4.2) using the mean total scale scores, there seems to be a general agreement between rehabilitees in the community and their CRs (t = 1.05, df17, n.s.) but not between rehabilitees in the hospital and their CRs (t = 2.53, df15, p < 0.05). Thus, while hospital residents see themselves in a basically positive way, not dissimilar to how community residents see themselves, their CRs see them negatively and very different from how the CRs of community residents see their rehabilitees. However, there does appear to be a general agreement between most groups of rehabilitees and CRs that rehabilitees are Submissive rather than Dominant, Shy rather than Outgoing and Low in Confidence rather than High in Confidence; this is independent of rehabilitees' place of residence.

5.2.2 Differences in CRs' Attitudes to 'Most Psychiatric Patients' and their Ideal for Rehabilitees, by Rehabilitees' Place of Residence

Compared with the marked differences in their attitude to rehabilitees, CRs of hospital and community residents show fairly close agreement concerning 'the way most psychiatric patients are'. The only significant difference between them is on the scale Beautiful-Ugly.
(F = 4.670, df1,39, p<0.05), and controlling for the relationship of CRs to rehabilitees (parent/other relative) this difference disappears. Figure 5.1(c) shows that the two groups of CRs see 'most psychiatric patients' as Emotional, Unhappy, Dependent, Unlucky, Shy, Low in Confidence and Pessimistic. CRs of hospital residents tend to be the most negative, with a mean rating of over 3.5 on seven scales, particularly those concerned with how psychiatric patients typically feel, compared with a mean rating of over 3.5 on four scales for CRs of community residents.

Thus both groups of CRs tend to be in agreement with rehabilitees in the community (4.3.1) in their attitudes to 'most psychiatric patients', seeing them in a basically negative way. This is in sharp contrast to the neutral/positive attitudes of rehabilitees in hospital (4.3.1). The latter group give 'most psychiatric patients' a positive mean rating (less than 3.0) on ten scales compared with five scales for rehabilitees in the community, six for CRs of community residents and only one for CRs of hospital residents. Comparing the total scale scores for rehabilitees and CRs, there is a significant difference for hospital residents (t = 2.45, df14, p<0.05) but not for community residents (t = 0.05, df16, n.s.)

Turning to consider CRs' attitudes to the Ideal for their rehabilitees ('the way I would most like my rehabilitee to be'), Figure 5.1(b) shows that both groups of CRs have very similar and very positive attitudes. They give a mean rating of less than 2.0 on all but three scales, Dominant-Submissive, Young-Old and Beautiful-Ugly, with CRs of rehabilitees in the community being slightly more positive on most of the scales, with the noticeable exception of Dominant-Submissive.

Thus CRs’ view of how they would like their rehabilitees to be is

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1 Parents are consistently more positive in their attitudes to 'most psychiatric patients' than other relatives. The differences are marked on half the scales and significant on six. The pattern for attitudes to the Ideal for rehabilitees is similar, although the differences tend to be smaller and are only significant on two scales.
very similar to how rehabilitees themselves would like to be, that is their Ideal-Self (4.4.1), with community residents giving mean ratings of less than 2.0 on all scales except Dominant-Submissive, Young-Old and Important-Unimportant. Meanwhile hospital residents give a mean rating of less than 2.0 on all scales except Dominant-Submissive. Comparing the total scale scores, these are not significantly different as between rehabilitees and CRs for either hospital or community residents.

Compared with their markedly different attitudes to rehabilitees, both groups of CRs see the Ideal for their rehabilitees and 'most psychiatric patients' in similar ways, with CRs of community residents being slightly more positive in both cases. Overall, psychiatric patients are seen in generally negative terms (as they are also seen by rehabilitees in the community) and the Ideal for rehabilitees in highly positive terms (as both groups of rehabilitees wish for themselves).

5.2.3 Differences in the Discrepancy between CRs' Attitudes to Rehabilitees and 'Most Psychiatric Patients', by Rehabilitees' Place of Residence

A comparison between Figure 5.2(a) and 5.2(b) shows the discrepancies between how CRs see their rehabilitees and how they see 'most psychiatric patients' to be generally greater for CRs of community residents than for CRs of hospital residents. Overall, this is confirmed by a comparison of the discrepancies between the total scale scores for the two groups: while those for CRs of hospital residents are not significantly different \( (t = 1.75, df21, p < 0.09) \) those for CRs of community residents are \( (t = 5.42, df18, p < 0.001) \). Further, there is a marked, though not significant, difference between the 'D' scores for the two groups of CRs \( (F = 3.566, df1,39, p < 0.07) \). However, the discrepancies between the attitudes of the two groups of CRs are not as great as might have been expected from the analysis of CRs' attitudes to rehabilitees alone (5.2.1). This is because, although CRs of hospital residents rated their rehabilitees
Figure 5.2 A Comparison of GHA's Attitudes to their Rehabsilites, their Ideal-Other and 'Most Psychiatric Patients' for Hospital and Community Residents.

(a) Rehabsilites Resident in the Hospital

(b) Rehabsilites Resident in the Community
far more negatively than did CRs of community residents (with significant differences on just over half the scales and the total scale score), they also rated 'most psychiatric patients' slightly more negatively. The result is that the number of significant differences between individual scale scores is only slightly higher for CRs of rehabilitees in the community than for CRs of rehabilitees in the hospital, nine compared with seven. The two groups have five significant differences in common (p<0.05): Calm-Emotional, Beautiful-Ugly, Happy-Unhappy, Good-Bad and Independent-Dependent. In all cases rehabilitees are seen more positively than 'most psychiatric patients', and there is just one significant difference in the opposite direction: rehabilitees in the hospital are seen as more Shy than psychiatric patients in general. Overall, CRs rate rehabilitees more negatively than 'most psychiatric patients' on five scales for hospital residents but only one for community residents; this latter, Dominant-Submissive is common to both groups.

5.2.4 Differences in the Discrepancy between CRs' Attitudes to Rehabilitees and their Ideal for Rehabilitees, by Rehabilitees' Place of Residence

While Figure 5.2 shows the individual scale discrepancies between how CRs see their rehabilitees and how they would like them to be, to be greater for hospital residents, once again the number of statistically significant differences is similar, 13 for community residents and 14 for hospital residents. Further, the total scale scores are significantly different for both groups (t = 10.55, df21, p<0.001 and t = 5.36, df19, p<0.001 for CRs of hospital and community residents respectively). The scales on which both groups of CRs do not see their rehabilitees as significantly different from how they would like them to be are Beautiful-Ugly, Good-Bad and Young-Old, plus Calm-Emotional and Friendly-Unfriendly for community residents and Dominant-Submissive for hospital residents. However, overall on the 18 scales the discrepancy ('D' score) between how CRs see their rehabilitees and how they would like them to be is significantly greater for hospital
than community residents ($F = 6.876, dfl,39, p<0.05$).

Thus, the discrepancy between CRs' attitudes to rehabilitees and their Ideal for rehabilitees is greater for rehabilitees in hospital than those in the community, since although the Ideal of CRs of community residents is slightly more extreme than that of CRs of hospital residents, they also see their rehabilitees in a significantly more positive way.

5.2.5 Summary and Interpretation of Changes in CRs' Attitudes to Rehabilitees during Rehabilitation

Looking firstly at CRs' attitudes to psychiatric patients in general and their expectations of rehabilitees, the analysis shows that all CRs share the basically negative stereotype of the 'psychiatric patient' identified for rehabilitees living in the community (4.3.1), which is far removed from their Ideal for their rehabilitees, or how they would most like them to be. However, while the differences are not generally significant, CRs of rehabilitees in the community do tend to have more positive attitudes to both concepts than CRs of rehabilitees in the hospital. This association is only partly explained by the higher proportion of parent CRs amongst the former group (5.2.1). It also seems that while being out of direct contact with 'psychiatric patients' may lead to CRs moderating their negative attitudes towards them, their expectations of their own rehabilitees actually rise slightly after discharge.

However, the above changes are not nearly so marked as the changes in CRs' attitudes to their rehabilitees after discharge. Unlike rehabilitees themselves, for whom there is comparatively little change in self-attitudes between the rehabilitation villas and community, but a more marked change between other hospital wards and the rehabilitation villas (4.2), CRs do not seem to change their attitudes to rehabilitees until after discharge from hospital. It is only at this stage in the rehabilitation process that CRs seem able to leave behind their negative attitudes to rehabilitees and see them in a markedly more positive way. However, as for CRs' attitudes to 'most psychiatric patients' and the
ideal for rehabilitees, it must be remembered that some of the identified change in their attitudes to rehabilitees was shown to be due to the higher proportion of parent CRs amongst rehabilitees living in the community. Nevertheless, it is still true that CRs in general seem to experience a marked change in their attitudes to rehabilitees after discharge, which (bearing in mind the caution in 5.2.1) does not appear to be affected by brief readmissions to hospital or the length of time since discharge.

Thus, while the CRs of rehabilitees in the hospital see their rehabilitees in a negative way and one that is very similar to their view of psychiatric patients in general but very different from how they would like them to be, CRs of rehabilitees in the community tend to see their rehabilitees as less like psychiatric patients and as closer to how they would like them to be. However, because of their more positive attitudes to psychiatric patients and rising expectations of their own rehabilitees, CRs of rehabilitees in the community still see them as not significantly different from psychiatric patients in many ways and with significant gaps to bridge if they are to meet their expectations.

5.3 Changes in the Discrepancies between Real-Self, Perceived-Self and Accorded-Self during Rehabilitation

5.3.1 Differences in the Discrepancies between Real-Self, Perceived-Self and Accorded-Self by Rehabilitees' Place of Residence

The previous section showed the relationship between rehabilitees' self-attitudes ('the way I am now') and their CRs' attitudes to them ('the way my rehabilitee is now') to be closely associated with rehabilitees' place of residence. This section looks at these discrepancies from the point of view of rehabilitees in the

2 The differences between the 'D' scores (for the 18 scales taken together), for the discrepancies between CRs' attitudes to their rehabilitees and their Ideal for rehabilitees on the one hand and their attitude to psychiatric patients on the other, is significant for CRs of hospital residents (t = 6.12, df21, p < 0.001) but not for CRs of community residents (t = 0.56, df17, n.s.)
CR Sample, and in particular seeks to understand how rehabilitees cope with marked discrepancies between the two sets of attitudes. Thus, Figure 5.3 shows the mean ratings for rehabilitees in the CR Sample on the concepts Real-Self ('the way I am now') and Perceived-Self ('the way my CR sees me'), and the mean ratings for CRs on the concept Accorded-Self ('the way my rehabilitee is now'). In other words, the comparison is between how rehabilitees see themselves, how they think their CRs see them and how CRs actually see them (2.1.6).

Taking hospital residents first, Figure 5.3(a) shows that there is a negative difference between Real-Self and Accorded-Self on 14 of the 18 scales; this difference is significant on five, with the Accorded-Self being less Happy (t = 3.66, df15, p<0.01), Pessimistic rather than Optimistic (t = 4.99, df15, p<0.001), more Low in Confidence (t = 4.04, df15, p<0.01), Uncreative rather than Creative (t = 5.44, df15, p<0.001) and more Unlucky (t = 2.14, df15, p<0.05). There is also one significant difference in the opposite direction, with CRs seeing rehabilitees as more Well-Liked than they see.

In order to test for any differences between the self-conceptions of rehabilitees in the CR Sample and those not in the CR Sample which might limit the implications of the findings, t tests were carried out on each of the 72 pairs of mean ratings (four dimensions of the self-concept rated on 18 scales) for both hospital and community residents. There was only one significant difference (p<0.05) for community residents and four for hospital residents. Three of the latter were on ratings of 'how my CR sees me' (Perceived-Self), with rehabilitees not in the CR Sample perceiving their CRs to see them more positively, that is as more Good (t = 2.42, df29, p<0.05), less Submissive (t = 2.09, df29, p<0.05), and Responsible rather than Irresponsible (t = 2.23, df29, p<0.05). In view of these findings, the difference between the mean total scale scores for Perceived-Self was also calculated, but was not significant. It was concluded that the attitudes of rehabilitees in the CR Sample did not differ significantly from those of other rehabilitees.

In Section 5.2 'the way my rehabilitee is now' was referred to as 'CRs' attitudes to their rehabilitees', since the ratings were to be compared with CRs' ratings on other concepts. In this and subsequent sections, ratings for 'the way my rehabilitee is now' are to be compared with rehabilitees' ratings on other concepts, so that Accorded-Self is both a more logical term and one that is theoretically meaningful (2.1.6).
Figure 5.3 A Comparison of Attitudes to Real-Self, Perceived-Self (Rehabilitees) and Accorted-Self (CRs) for Hospital and Community Residents.

(a) Rehabilitees Resident in the Hospital

- Good
- Strong
- Active
- Optimistic
- Calm
- Happy
- High in Confidence
- Creative
- Important
- Lucky
- Independent
- Dominant
- Outgoing
- Friendly
- Well Liked
- Responsible
- Young
- Beautiful

(b) Rehabilitees Resident in the Community

- Bed
- Weak
- Passive
- Pessimistic
- Emotional
- Unhappy
- Low in Confidence
- Uncreative
- Unimportant
- Unlucky
- Dependent
- Submissive
- Shy
- Unfriendly
- Not Well Liked
- Irresponsible
- Old
- Ugly
themselves \( t = 2.82, df15, p < 0.05 \).

Looking at the two component discrepancies which together make up the Real-Self/Accorded-Self discrepancy, that between Real-Self and Perceived-Self (rehabilitates' self-attitudes compared with the perceived attitudes of CRs) is generally small (with significant differences on only two scales) but may be positive (nine scales) or negative (eight scales). In comparison, that between Perceived-Self and Accorded-Self (CRs' perceived attitudes compared with their actual attitudes) tends to be larger (11 scales), more often significant (five scales) and negative (13 scales). The five significant differences are all negative, and on the four scales where they follow small (positive or negative) discrepancies between Real-Self and Perceived-Self (Optimistic-Pessimistic, High in Confidence-Low in Confidence, Creative-Uncreative and Lucky-Unlucky) result in the overall significant differences between Real-Self and Accorded-Self noted above. The fifth overall, negative, significant difference on the scale Happy-Unhappy results from a combination of two small negative differences on the component discrepancies. Meanwhile, the significant negative difference between Perceived-Self and Accorded-Self on the scale Beautiful-Ugly is more than cancelled out by the significant, positive difference between Real-Self and Perceived-Self, so that overall there is little difference between Real-Self and Accorded-Self.

Thus, the pattern of individual scale discrepancies for hospital residents is varied, but does seem to be characterised by small, positive or negative differences between rehabilitates' self-attitudes and the perceived attitudes of CRs, and larger, negative differences between CRs' perceived and actual attitudes. This is confirmed by comparing the differences between the total scale scores for each of the component discrepancies: that between Real-Self and Perceived-Self is small and positive \( t = 0.38, df14, n.s. \) while that between Perceived-Self and Accorded-Self is larger, significant and negative \( t = 3.22, df14, p < 0.01 \). Further, when the 'D' scores of the two component discrepancies are compared, that
between Perceived-Self and Accorded-Self is significantly larger than that between Real-Self and Perceived-Self \( (t = 5.91, \text{ df}14, \ p < 0.001) \).

Although not specifically encompassed in the research hypotheses, the discussion in 2.3 suggested that the more infrequent the contact between rehabilitees and CRs then the greater would be the distortion of the negative feedback from CRs. In order to test this out, hospital residents were divided into two groups on the basis of those who were in face to face contact with their CRs at least once every two weeks (frequent contact) and those for whom contact was less than once every two weeks (infrequent contact). Using the total scale scores to illustrate the general pattern of scale discrepancies, the discrepancy between Real-Self and Accorded-Self is found to be small and negative for the frequent contact group \( (t = 1.19, \text{ df}8, \text{n.a.}) \) but large and negative for the infrequent contact group \( (t = 3.75, \text{ df}6, \ p < 0.01) \). For the frequent contact group this negative discrepancy is made up of two small negative discrepancies between Real-Self and Perceived-Self, and Perceived-Self and Accorded-Self. By contrast, for the infrequent contact group the negative discrepancy is made up of a small, positive discrepancy between Real-Self and Perceived-Self, and a large, negative discrepancy between Perceived-Self and Accorded-Self \( (t = 5.58, \text{ df}6, \ p < 0.01) \).

It is also important to note that for both Real-Self and Accorded-Self, the ratings tend to be more negative for the frequent contact groups; the differences are not generally significant.

Turning to consider community residents, Figure 5.3(b) shows that in contrast to hospital residents, there is a general picture of small positive differences between Real-Self and Accorded-Self. Only two of the 12 positive differences are significant, Good-Bad \( (t = 4.27, \text{ df}17, \ p < 0.001) \) and Important-Unimportant \( (t = 2.77, \text{ df}17, \ p < 0.05) \), and none of those in the opposite direction. Considering the component discrepancies, there are positive differences between Real-Self and Perceived-Self on 13 scales, and as for the overall Real-Self/
Accorded-Self discrepancy these are generally small, with just two significant differences on the scales Beautiful-Ugly (t = 2.70, df17, p < 0.05) and Important-Unimportant (t = 2.46, df17, p < 0.05). However, while the latter discrepancy is added to by the Perceived-Self/Accorded-Self component to give the significant overall discrepancy between Real-Self and Accorded-Self noted above, the former is decreased and becomes no longer significant, though still positive. Compared with the Real-Self/Perceived-Self discrepancy, that between Perceived-Self and Accorded-Self tends to be smaller (12 scales), but is equally as likely to be positive or negative. There is only one significant difference, with CRs seeing rehabilitees as more Good than rehabilitees perceive them to be (t = 4.51, df17, p < 0.001). This discrepancy, combined with a small positive difference between Real-Self and Perceived-Self results in the significant overall discrepancy between the attitudes of rehabilitees and CRs.

The most common pattern of scale discrepancies for community residents is a relatively small positive difference between rehabilitees' self-attitudes and CRs' perceived attitudes and an even smaller positive difference between CRs' perceived and actual attitudes. The total scale score discrepancies confirm this, with neither being significant and both being positive. However, a comparison of the 'D' scores for the two component discrepancies suggests that while the discrepancies are not significantly different, that between Perceived-Self and Accorded-Self is the greater (t = 2.09, df17, p < 0.06).

Summarising the discrepancy between Real-Self and Accorded-Self, most rehabilitees tend to think that their CRs see them only slightly more positively or negatively than they see themselves, and this is true for both hospital and community residents. However, it is when the discrepancy between CRs' perceived and actual attitudes are considered that the difference between hospital and community residents becomes clear. While hospital residents' perception of their CRs' attitudes towards them tends to be very inaccurate, community residents' perception is comparatively accurate. This is confirmed by the marked,
though not significant, difference between the 'D' scores for the Perceived-Self/Accorded-Self discrepancy between hospital and community residents ($F = 2.974$, df1,31, $p<0.10$). Thus, although hospital residents think that their CRs see them only slightly more positively or negatively than they see themselves, CRs actually tend to see rehabilitees in hospital not only far more negatively than rehabilitees think they do, but also more negatively than rehabilitees see themselves. By comparison the perceptions of community residents and their CRs are very similar with CRs seeing rehabilitees only slightly more positively than either they are perceived to do or than rehabilitees see themselves.

Although any findings which relate to subdivisions of the CR sample beyond the hospital/community dichotomy must be treated with caution (3.6.2), it does seem that the negative Real-Self/Accorded-Self discrepancy for hospital residents is smaller where there is more frequent contact between rehabilitees and CRs. Where contact is infrequent (less than once every two weeks) there tends to be a large discrepancy between how rehabilitees see themselves and how their CRs see them. It seems that rehabilitees cope with this by distorting the negative feedback from CRs, not only to the extent that their self-attitudes and their perception of their CRs' attitudes become closer, but to the extent that they perceive CRs' attitudes to be more positive than their own self-attitudes.

By contrast, where there is more frequent contact between rehabilitees and CRs, the discrepancy between how rehabilitees see themselves and how their CRs see them is much smaller. Further, this group of rehabilitees seem to accept that their CRs see them more negatively than they see themselves, so that there is a small negative discrepancy between self-attitudes and the perceived-attitudes of CRs. However, this is still an underestimate of just how negatively their CRs actually do see them, so that there is still a small negative discrepancy between the perceived and actual attitudes of CRs. It is perhaps important to note that the lesser amount of distortion in the perception of CRs' attitudes by the frequent contact group appears to
result in their own self-attitudes becoming more negative.

5.3.2 Summary and Interpretation of Changes in the Discrepancies between Real-Self, Perceived-Self and Accorded-Self during Rehabilitation

While important changes in self-conception were found to be associated with changes in ward environment/social milieu during rehabilitation, rehabilitees in general tend to evaluate themselves fairly positively regardless of whether they have been discharged to the community or are still hospital patients (4.2). However, due to the negative evaluation of them by their CRs, it seems that many rehabilitees in the hospital have to cope with a large negative discrepancy between Real-Self and Accorded-Self, that is between how they see themselves and how their CRs see them. The above discussion shows that this discrepancy tends to be made up of a small positive or negative discrepancy between self-attitudes and CRs' perceived attitudes, and a large negative discrepancy between CRs' perceived and actual attitudes to rehabilitees. This suggests that rehabilitees in hospital minimise the discrepancy between how they see themselves and how they perceive that their CRs see them by distorting the negative feedback from their CRs (2.3). The distortion tends to be greater for rehabilitees who have less frequent contact with their CRs. Meanwhile, those hospital residents in more frequent contact with CRs seem to find it more difficult to maintain such a high level of distortion. However, since frequent contact appears to be associated with CRs having more negative attitudes to rehabilitees, the result is that rehabilitees in frequent contact with CRs also have more negative self-attitudes than those in less frequent contact.

On the other hand, there is much greater congruence between Real-Self and Accorded-Self for rehabilitees in the community, with CRs tending to see rehabilitees slightly more positively than they see themselves. In this situation there appears little need for any distortion of feedback from CRs; in fact it seems likely from some of the larger discrepancies between Real-Self and Perceived-Self that CRs'
attitudes may be seen as less than fully credible and that rehabilitees may also take into account their own assessment of their behaviour/performance in comparison with others around them. This seems particularly likely for rehabilitees living with parents, since while their own self-attitudes are less positive than those of rehabilitees living elsewhere in the community, they are evaluated more positively by their CRs (4.2 and 5.2).

5.4 Changes in the Discrepancies between Real-Self, Perceived-Self and Accorded-Self by Rehabilitees' Attitudes to their CRs

5.4.1 Introduction

In the previous section it was shown that where there are large negative discrepancies between self-attitudes and CRs' attitudes to them, rehabilitees tend to reappraise the negative feedback to make the two sets of attitudes more congruent. On the other hand, where there are (albeit smaller) positive discrepancies, rehabilitees seem more able to cope with some level of dissonance. It was also suggested that the availability of alternative feedback and opportunities for social comparison is important in explaining rehabilitees' responses to the discrepancy between Real-Self and Accorded-Self. One other factor which has been hypothesised to be important is the attitude of rehabilitees towards their CRs, that is the degree to which CRs are seen as 'valued' or 'credible' by rehabilitees (2.1.4). Thus, this section seeks to compare the discrepancies between Real-Self, Perceived-Self and Accorded-Self for 'valued' CRs and 'not-so-valued' CRs (5.4.2) and 'credible' CRs and 'not-so-credible' CRs (5.4.3). In the discussion which follows in 5.4.4 some attempt will also be made to integrate the findings of the previous section (5.3).

The degree to which rehabilitees consider CRs to be 'valued' or 'credible' was operationally defined for the purposes of this research in terms of rehabilitees' scaled responses to specific questions on the interview schedule (3.5.1). In both cases there was the option of
using the responses to just one key question or devising a composite measure by summing the responses to the key question and one or two supplementary questions.

5.4.2 Differences in the Discrepancies between Real-Self, Perceived-Self and Accorded-Self by the degree to which Rehabilitees consider their CRs to be 'Valued Others'

Figure 5.4 shows the ratings for Real-Self, Perceived-Self and Accorded-Self for rehabilitees whose CRs are (a) 'Valued Others' and (b) 'Not-so-Valued Others', as defined by the composite measure of the degree to which CRs are 'valued'. The composite measure was calculated by summing across the responses to the key question 'Do you try to live up to your CR's expectations of you?' and two others: 'Do you usually do what your CR suggests?' and 'Do you ever do things your CR disagrees with?'. Using the mean of the summed responses and dividing between positive and neutral/negative ratings, the composite measure divided rehabilitees into two roughly equal groups. On this basis, some 15 rehabilitees were identified as considering their CRs to be 'valued' and 17 identified as considering their CRs to be 'not-so-valued'.

From a comparison of Figures 5.4(a) and 5.4(b), some striking differences in the patterns of discrepancies for the two groups of rehabilitees can be identified. Most obvious is the large negative discrepancy on some scales between Real-Self and Accorded-Self where CRs are 'valued', which is in sharp contrast to the relatively congruent attitudes where CRs are 'not-so-valued'. Thus, while there is a negative discrepancy between the attitudes of rehabilitees and CRs on nine and seven scales respectively, six of those where CRs are

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5 Some 32 of the 34 rehabilitees in the CR Sample who completed two or more semantic differential scales answered the key question 'Do you try to live up to your CRs' expectations of you?'. However, since 27 of them responded positively (rather than in a neutral or negative way) this question alone did not seem to provide a suitable basis for the division of the sample.
Figure 5.4 A Comparison of Attitudes to Real-Self, Perceived-Self, and Accorded-Self by whether CRs are 'Valued Others' or 'Not so Valued Others'.

(a) Rehabilitates whose CRs are 'Valued Others'

Scale

Good
Strong
Active
Optimistic
Calm
Happy
High in Confidence
Creative
Important
Lucky
Independent
Dominant
Outgoing
Friendly
Well Liked
Responsible
Young
Beautiful

Real-Self
Perceived-Self
Accorded-Self

(b) Rehabilitates whose CRs are 'Not so Valued Others'

Bad
Weak
Passive
Pessimistic
Emotional
Unhappy
Low in Confidence
Uncreative
Unimportant
Unlucky
Dependent
Submissive
Shy
Unfriendly
Not Well Liked
Irresponsible
Old
Ugly

mean rating
'valued' are significant but none where they are 'not-so-valued'.
The significant differences are on the scales Happy-Unhappy
(t = 2.78, df14, p<0.05), Active-Passive (t = 2.24, df14, p<0.05),
Optimistic-Pessimistic (t = 3.41, df14, p<0.05), High in Confidence-
Low in Confidence (t = 2.25, df14, p<0.05), Creative-Uncreative
(t = 2.60, df14, p<0.05) and Lucky-Unlucky (t = 2.66, df14,
p<0.05). Further, the total scale score for the attitudes of
'vealed' CRs is significantly more negative than for rehabilitees'
self-attitudes (t = 2.53, df14, p<0.05), while the total scale score
for the attitudes of 'not-so-valued' CRs is marginally more positive.

Figure 5.4(a) shows that the significant discrepancies on individual
scales between Real-Self and Accorded-Self tend to be made up of
small positive or negative discrepancies between Real-Self and
Perceived-Self and larger, significant, negative discrepancies between
Perceived-Self and Accorded-Self (except for the scale Happy-Unhappy).
Overall, the Perceived-Self of rehabilitees with 'valued' CRs is more
positive than Real-Self on 13 scales and the total scale score,
although the differences are only significant on three of the
individual scales (Beautiful-Ugly (t = 4.86, df14, p<0.001), Strong-
Weak (t = 2.57, df14, p<0.05) and Well Liked-Not Well Liked
(t = 2.45, df14, p<0.05)), and not on the total scale score. By
comparison the Accorded-Self is more negative than the Perceived-Self
on 15 scales and the total scale score, with six significant
differences on individual scales (already noted) and the total scale
score (t = 3.35, df14, p<0.01).

Meanwhile, the Perceived-Self of rehabilitees with 'not-so-valued' CRs
is almost equally as likely to be slightly more positive or negative
than rehabilitees' self-attitudes, with the overall total scale scores
being almost identical. The difference between the total scale scores
for Perceived-Self and Accorded-Self is only slightly greater and also
positive, as are the discrepancies on 13 of the individual scales,
with no significant differences.

Thus CRs who are 'valued' tend to see their rehabilitees far more
negatively than rehabilitees see themselves, with this overall discrepancy being made up of a small positive discrepancy between rehabilitees' self-attitudes and the perceived attitudes of CRs and a large negative discrepancy between the perceived and actual attitudes of CRs. On the other hand, CRs who are 'not-so-valued' tend to see their rehabilitees marginally more positively than rehabilitees see themselves, with this overall discrepancy being made up of a marginally positive or negative discrepancy between rehabilitees' self-attitudes and the perceived attitudes of CRs and a similarly small, but positive discrepancy between the perceived and actual attitudes of CRs.

5.4.3 Differences in the Discrepancies between Real-Self, Perceived-Self and Accorded-Self by the degree to which Rehabilitees consider their CRs to be 'Credible Others'

Figure 5.5 shows the ratings for Real-Self, Perceived-Self and Accorded-Self for rehabilitees whose CRs are (a) 'Credible Others' and (b) 'Not-so-Credible Others', as defined by the response to the question 'Do you think your CR knows what is best for you?'. Since the single question response divided rehabilitees into two equal groups according to positive or neutral/negative responses it was decided to identify rehabilitees with 'credible' and 'not-so-credible' CRs on this basis, with 17 rehabilitees in each group.

The immediate impression on turning to consider Figure 5.5(a) and (b) is the apparent similarity with Figure 4.5 (a) and (b). This is in fact confirmed by a more detailed analysis of the patterns of discrepancies. Taking rehabilitees with 'credible' CRs (Figure 5.5(a)), the Real-Self/Accorded-Self discrepancy is significant and negative on the total scale score ($t = 2.82$, df16, $p < 0.05$) and the same six individual scales as for rehabilitees with 'valued' CRs (Figure 5.4(a)). Further, these significant differences are made up

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6 By comparison, the two question composite measure which included 'Do you feel your CR understands you?' divided rehabilitees into two rather unequal groups of 24 and 10.
in the same way from the two component discrepancies as for rehabilitees with 'valued' CRs. That is, there are small positive or negative discrepancies between Real-Self and Perceived-Self, and large, significant (with the exception of the scale Happy-Unhappy) discrepancies between Perceived-Self and Accorded-Self. The pattern of discrepancies for rehabilitees whose CRs are 'not-so-credible' is also similar to that for rehabilitees whose CRs are 'not-so-valued', although the overall positive discrepancies between Real-Self and Accorded-Self are significant on four scales: Beautiful-Ugly ($t = 3.43$, df16, $p < 0.01$), Strong-Weak ($t = 2.22$, df16, $p < 0.05$), Friendly-Unfriendly ($t = 2.55$, df16, $p < 0.05$) and Well liked-Not Well Liked ($t = 2.91$, df16, $p < 0.05$).

These similarities in the pattern of discrepancies for rehabilitees whose CRs are 'valued' and 'credible' or 'not-so-valued' and 'not-so-credible' suggests that there may be a close association between the degree to which CRs are seen as 'valued' and 'credible'. Overall, roughly one-third of rehabilitees see their CRs as 'valued' and 'credible' and one-third see them as 'not-so-valued' and 'not-so-credible'. The remaining one-third are more or less equally divided between those who see their CRs as 'valued' and 'not-so-credible' and those who see them as 'not-so-valued' and 'credible'. However, the association between the degree to which CRs are 'valued' and 'credible' is not significant ($X^2 = 2.008$, df1, $p > 0.05$).

Thus, as for CRs who are 'valued', those who are 'credible' tend to see their rehabilitees far more negatively than rehabilitees see themselves. This discrepancy is made up of small positive (10 scales) or negative (7 scales) discrepancies between rehabilitees' self-attitudes and the perceived attitudes of CRs (total scale score: $t = 1.13$, df16, n.s.), and large negative (14 scales) discrepancies between the perceived and actual attitudes of CRs (total scale score: $t = 3.75$, df16, $p < 0.01$). On the other hand, CRs who are 'not-so-credible' tend to see their rehabilitees more positively (10 scales, with four significant differences) than rehabilitees see themselves, with the overall discrepancy for the total scale score being positive.
but not significant \( t = 0.78, \text{df}15, \text{n.s.} \) as for the 'not-so-valued' group. This positive discrepancy is most often made up of two small, positive component discrepancies of which that between self-attitudes and CRs' perceived attitudes is usually the larger. Overall neither of the positive component discrepancies between the total scale scores are significant \( (t = 0.45, \text{df}15, \text{n.s.} \) and \( t = 0.78, \text{df}15, \text{n.s.} \) respectively).

5.4.4 Summary and Interpretation of the Discrepancies between Real-Self, Perceived-Self and Accorded-Self by Rehabilitees' Attitudes to CRs

Rehabilitees' attitudes to their CRs were defined along two dimensions of significance. The first was the degree to which CRs were seen as 'valued' others (people whose opinions they cared about and took notice of), and the second was the degree to which CRs were seen as 'credible' others (people whose opinions they respected and had confidence in) (2.1.4). Rehabilitees were divided into two roughly equal groups along each dimension by means of their scaled responses to specific questions on the interview schedule. In each case the analysis found there to be marked differences in the pattern of discrepancies between rehabilitees' self-attitudes and the perceived and actual attitudes of CRs for the two groups of rehabilitees. Further, the pattern of discrepancies was seen to be very similar for the 'valued' and 'credible' groups on the one hand, and the 'not-so-valued' and 'not-so-credible' groups on the other hand.

In general it was shown that CRs who are considered to be 'valued' or 'credible' tend to have attitudes towards their rehabilitees which are far more negative than rehabilitees' own self-attitudes. The analysis suggests that rather than changing their attitudes towards their CRs rehabilitees choose to cope with the negative discrepancy by distorting the feedback from CRs. The result is that the discrepancy between rehabilitees' self-attitudes and their perception of how their CRs see them is minimised, but that between CRs' perceived and actual attitudes is made even wider.
This pattern of discrepancies between rehabilitees' and CRs' attitudes was also found where rehabilitees were hospital patients\(^7\), particularly where there was relatively infrequent contact (less than once every two weeks) between rehabilitees and CRs (5.3). It seems that in this situation the social milieu of the hospital ward (with almost constant opportunities for feedback from, or social comparison with, other patients) minimises the effect of CRs' negative attitudes on rehabilitees' own self-attitudes. Findings in this section suggest that the frequency of contact between hospital-based rehabilitees and CRs may also be important in determining rehabilitees' attitudes to their CRs. Thus it seems likely that infrequent contact may enable patient rehabilitees to continue to regard their CRs as 'valued' and/or 'credible' others without prejudicing their own self-conceptions and any positive changes that may occur during rehabilitation (Chapter 4).

Turning to consider the pattern of discrepancies between the attitudes of rehabilitees and CRs where CRs are seen as 'not-so-valued' or 'not-so-credible', the analysis shows that the attitudes of CRs tend to be slightly more positive than rehabilitees' own self-attitudes. In general, rehabilitees are seen to perceive the direction of this discrepancy but not its full extent, with two small, usually positive and at times minimal discrepancies between self-attitudes and the perceived attitudes of CRs, and again between the perceived and actual attitudes of CRs. While the latter discrepancies are significantly smaller than those identified for rehabilitees whose CRs are 'valued' or 'credible', those between rehabilitees' self-attitudes and CRs' perceived attitudes do not differ greatly in size between the two groups of rehabilitees on either dimension.

\(^7\) Although a higher proportion of rehabilitees in the hospital identified their CRs as 'valued' and 'credible', 60% and 56%, compared to those in the community, 35% and 44% respectively, statistically there was no association between the degree to which CRs were seen as 'valued' or 'credible' and rehabilitees' place of residence, hospital or community ($\chi^2 = 1.09$, df1, n.s. and $\chi^2 = 0.118$, df1, n.s.).
So the question remains as to why rehabilitees whose CRs see them in such a positive way should consider them to be 'not-so-valued' and/or 'not-so-credible' as rehabilitees whose CRs see them in a very negative way. The analysis of the pattern of discrepancies between rehabilitees' and CRs' attitudes by place of residence of rehabilitees (5.3) may well go some way towards an explanation. Just as the pattern of discrepancies where CRs are considered to be 'valued' or 'credible' was found to be very similar to that for rehabilitees who were hospital patients, so the pattern of discrepancies where CRs are 'not-so-valued' or 'not-so-credible' is found to be similar to that for rehabilitees living in the community. Thus it would seem that rehabilitees whose CRs see them in a very positive way, and this is particularly so for rehabilitees living with parents, may consider their CRs to be somewhat biased and indulgent and, therefore, not entirely credible in their evaluation of them. As a result, they may decide not to take too much notice of the feedback from CRs, weighting it against the feedback from more credible others in the different spheres of their everyday lives. Social comparison too, is likely to be important in determining self-conception as rehabilitees in the community evaluate their own performance in comparison with that of others in their various reference groups.

5.5. Summary and Interpretation of Findings Related to Hypothesis Two

Hypothesis Two is concerned with the conceptions of rehabilitees held by close relatives (CRs) and the effect of these conceptions on rehabilitees' own self-conceptions. The first part of the hypothesis suggests that close relatives will also show changes in their conception of rehabilitees who are at different stages of the rehabilitation process. At the later stages close relatives will see rehabilitees more positively and as less like psychiatric patients; this is supported with some reservations.

There is a very marked change in CRs' attitudes to rehabilitees which takes place after the move from hospital to community. While rehabilitees in the hospital, including those in the rehabilitation villas.
are seen in basically negative terms, those in the community are seen positively; this difference is often significant. However, all rehabilitees are seen as Submissive, Shy, Low in Confidence and Unlucky regardless of their stage in the rehabilitation process.

Meanwhile, all CRs tend to concur with the negative stereotype of the psychiatric patient, although CRs of rehabilitees in the community have a slightly less negative view than CRs of rehabilitees in the hospital. Consequently, although CRs do see rehabilitees in the community as further from their typification of psychiatric patients than those with rehabilitees in the hospital, the difference is not so marked as the difference in their attitudes to rehabilitees themselves would suggest.

The second part of the hypothesis concerns the relationship between CRs' present attitudes to rehabilitees and how they would ideally like them to be: 'their (close relatives') view of the ideal for their rehabilitees is also likely to change as expectations rise, so that their more positive attitudes towards rehabilitees may not be closer to the ideal'.

The analysis shows that CRs' view of the ideal for their rehabilitees does change during rehabilitation, being generally more positive for rehabilitees in the community than those in the hospital. However, the changes are generally not as great as those concerning their attitudes to rehabilitees themselves. Consequently, CRs' more positive view of rehabilitees, although generally closer to their ideal, is still significantly different from it in many ways.

The third part of the hypothesis concerns the stage at which CRs' attitudes to rehabilitees change: 'changes in their (CRs') attitudes to rehabilitees are likely to occur more slowly than changes in rehabilitees' attitudes to themselves; this is likely to lead to significant discrepancies between rehabilitees' self-conceptions and the conceptions of them held by close relatives'.

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The analysis supports the hypothesis to some extent by showing that CRs' attitudes to rehabilitees do not change until after discharge, with all rehabilitees in hospital being seen in a basically negative way, and one that is similar to the stereotype of the psychiatric patient. Meanwhile Chapter 4 showed that important changes in rehabilitees' self-attitudes are associated with the move to the Rehabilitation Unit, with rehabilitees coming to see themselves more positively, particularly on scales concerning their interactions with others, and more like rehabilitees already discharged to the community see themselves.

While it is correct to say that these changes are likely to exaggerate differences in the discrepancies between rehabilitees' self-attitudes and the attitudes of their CRs towards them, marked negative discrepancies do exist for hospital patients in general, not just those in the rehabilitation villas. In fact it seems that the frequency of contact between rehabilitees and CRs may be a more important determinant of the size of the negative discrepancy than rehabilitees' type of ward.

The fourth part of the hypothesis suggests ways in which rehabilitees cope with the negative discrepancies between their self-attitudes and the attitudes of CRs towards them: 'such discrepancies will require cognitive reappraisal by rehabilitees of either their close relatives or their perception of the discrepant, negative feedback'.

Where there is a large, negative discrepancy between the attitudes of rehabilitees and CRs, the analysis suggests that rehabilitees are more likely to deal with the cognitive dissonance by reappraising or distorting the negative feedback from their CRs rather than reappraising their CRs themselves. In fact this pattern of discrepancies is particularly characteristic of rehabilitees whose CRs are highly significant to them, in that they are considered to have opinions about rehabilitees which are credible (they know what is best for rehabilitees) and/or valued (rehabilitees try to live up to their expectations and do what they suggest). It seems that
rehabilitees are able to maintain their positive attitudes towards themselves and their CRs, and the discrepancy between CRs' perceived and actual attitudes towards them because of relatively infrequent (and often superficial contact) with CRs. Important too, is the availability of alternative feedback from their own reference group of other patients on the ward.
6 DISCUSSION

6.1 Overview of Research Achievements

The objectives outlined in Chapter 1 have been largely achieved. As a result of the study, both a detailed description and a clearer understanding of changes in the self-concept at various stages during rehabilitation have been obtained. This has enabled important suggestions to be made regarding rehabilitation practice, which it is hoped will be of use to practitioners in other hospitals with different populations of psychiatric patients; these implications for rehabilitation practice are considered in 6.4.

Similarly, in general, the theoretical perspective (with its origins in the symbolic interactionist tradition) outlined in Chapter 2 and embodied in the two broad hypotheses (2.4) appeared very adequate in explaining and interpreting the findings. In particular, the effects of different ward environments within the hospital were clearly identified, along with the more general importance of reference groups in determining rehabilitees' conceptions of self, ideal-self and (other) psychiatric patients. The theoretical implications of the study are considered in 6.3.

Within the limitations of a 'one-off' interview (3.1.2) and the size of the samples (3.6), the chosen research instruments (3.4) provided a very comprehensive description of changes in the self-concept at various stages during rehabilitation, for a population of chronic, long-stay psychiatric patients. Each of the self-concept instruments was useful in adding a further piece of the jigsaw to complete the picture. This was especially true where alternative measures were used, enabling validation of scales and a better understanding of changes in the self-concept through a comparison of the findings of different measures. These points are taken up in some detail in the next section (6.2).
Thus from a methodological, theoretical, and probably most importantly a practical viewpoint, the study can be said to have achieved its objectives. However, this chapter also seeks to look to the future and to make suggestions as to how further research into rehabilitation can build on the foundations of knowledge here presented (6.5).

6.2 Methodological Implications

Before considering the usefulness for the present study of the chosen measures of the self-concept it might be helpful to make two more general points relating, firstly, to the method of sampling and sample size, and secondly, to the number and reliability of completed self-report schedules. Experience in this study suggests that the method of obtaining a secondary sample of respondents from amongst people who are in some way connected with the primary sample of respondents is likely to lead to comparatively small numbers in the secondary sample, even though the actual response rate for the latter is quite high. Thus, in the present study the primary sample of 100 Netherne rehabilitees (3.1.1) produced a secondary sample of only 45 close relatives, although the response rate for close relatives was 86% (3.6.1). The reasons for this difference in size between the samples were discussed in detail in 3.1.3 and 3.1.6. The problem for the researcher is that this may impose limitations on the analysis of the data as well as the generalisation of the results to those not included in the secondary sample. For example, in the present study most of the data analysis was limited to a comparison of hospital and community based rehabilitees for the secondary sample; this was not ideal as the considerable differences in attitudes between the three groups of hospital-based rehabilitees in the primary sample were found to be concealed when the data was aggregated (Chapter 4). However, it was shown that in the present study analysis of data for only those rehabilitees in the secondary sample did not affect generalisation of the findings to those not included in this sample (5.3.1).

A further loss in the number of respondents completing self-concept measures relates to the nature of self-report techniques: they can
only tap the conceptions of self and others that respondents are willing and able to give (3.2.1). Whilst a willingness to co-operate can best be assured by the establishment of a good rapport between interviewer and respondent in a non-threatening environment, some respondents lack the necessary intellectual and/or literacy skills to complete self-report schedules. Thus, in spite of attention to the interviewer/respondent relationship, in the present study only three-quarters of the rehabilitee sample were able to complete the semantic differential scales, with slightly higher proportions able to complete the 'Who-am-I?' schedule (84%) and attitude scales (92%) (3.6). In addition the interviewer/writer had some doubts about the understanding of the attitude scales by a further 12 respondents, and steps were taken to check that their responses did not affect the reliability of the scales (3.4.4). Since previous studies had suggested that psychiatric groups, especially chronic or paranoid schizophrenics, would be more likely than was normal to use the end points of scales on the semantic differential, a five point rating scale with modifiers was used rather than the more conventional seven point rating scale (3.4.2). The format of the attitude scales was similar. While previous studies of the self-concept using semantic differential scales (Arthur, 1966; Marks, 1965; Kennard, 1974) have sought to show that the percentage of extreme responses was not significantly different for either various groups of patients or patients and close relatives, it seems to the writer that this is not entirely valid due to concept-scale interaction. Thus, some groups may give extreme ratings on dimensions of the self-concept because that is truly how they see themselves, their ideal-self or psychiatric patients not because they have an 'extreme response tendency'. A more valid test would be to analyse their response patterns on concepts which would not involve concept-scale interaction.

Turning to consider the individual measures of self-concept in more detail, the 'Who-am-I?' schedule proved easy to administer, and most of the respondents who could write attempted one or more statements. The schedule was included specifically to obtain information on rehabilitees' social identities and to make a comparison of the importance of patient-
roles and family roles, and community orientated roles and hospital orientated roles for different groups of rehabilitees. It proved relatively easy to identify and code statements referring to social roles, since they were generally 'categorical' or 'consensual' (requiring no further explanation in order to be understood). However, an attempt to code 'attributive' or 'subconsensual' items (requiring further explanation from the respondent in order to understand the exact meaning of the statement for him/her) proved a tortuous experience and demonstrated the near impossibility of 'climb(ing) into the skin of another person' (3.2.1). Further, in the process of quantification into predefined categories, attributive statements tended to lose not only their true phenomenological stance but much of their emotional richness too.

In spite of these comments (which are probably related to the writer's dilemma of whether to simply analyse the small amount of relevant data required by the study or to try and come to grips with the vast amount of very interesting and essentially qualitative data which the schedules produced), the technique did provide some important pieces of the jigsaw without which the picture of changes in the self-concept would have been incomplete (4.3).

Considering next the semantic differential technique; this proved easy to administer and code, while the statistical measures used to analyse between respondent and between scale discrepancies enabled the vast amount of data to be handled systematically and efficiently. One additional advantage of this method which did not appear to have been considered in the literature (3.4.2) was that the data could be presented visually. This was found to be both an aid to analysis for the writer, and a more effective way of presenting the mass of data on individual scale discrepancies to the reader. Grouping the scales for visual presentation into whether they were 'marker' scales for the major dimensions of semantic space; scales referring to how the individual typically feels; scales referring to how the individual typically interacts with others; scales concerning the individual's...
physical image (3.5.1), enabled various types of 'changes' in different social environments to be more easily identified, whilst keeping the detailed information on individual scales. One interesting outcome of the latter procedure, which is that most groups of rehabilitees and all close relatives rated rehabilitees as shy, submissive and lacking in confidence, may have important implications for rehabilitation practice (6.4.5). Discrepancies between total scale scores were used only to back up analysis of individual scale discrepancies due to the methodological problems in summing across scales (3.4.2), and likewise distance or 'D' scores (between the scale profiles of two dimensions of the self-concept) due to the possibility of obtaining similar scores from quite different profiles (3.4.2). Unfortunately the factor structures of the various dimensions of the self-concept were found to be quite different, so that one could not 'sensibly arrive at a value of the discrepancy between them' (Judd & Smith, 1974) (Appendix 5). By showing whether differences in the discrepancy measures of self-esteem and identification with psychiatric patients were due to differences in self-attitudes or self-expectations/attitudes to psychiatric patients, the semantic differential technique enables important theoretical statements to be made concerning the applicability of cultural stereotypes to the Ideal-Self and 'most psychiatric patients' (6.3), as well as helping to validate attitude scale measurements (see below).

As for the other instruments measuring the self-concept, the attitude scales proved relatively quick and easy to complete, although some respondents found the abstract nature of the items on Rosenberg's (1965) self-esteem scale rather difficult to understand. When tested the scale was found to be unidimensional for the population under study, thus justifying use of the total scale score (3.4.3). On the other hand, the scale measuring acceptance/rejection of the patient-role was found to have a clearly defined factor structure, so that factor scores and the total scale score were used (3.4.4).

When initial analysis of the self-esteem scale was completed under the auspices of the Netherne Hospital study 'Needs of a Health District',
the variation in self-esteem levels between rehabilitees on different types of ward was explained in terms of differential 'pretensions' (James, 1891) or self-expectations, due to different environmental demands/expectations (Collis & Ekdawi, 1982). In the present study, the chosen theoretical perspective together with the use of the discrepancy measure of self-esteem has enabled these explanations to be confirmed and expanded in terms of the importance of reference groups in determining attitudes to self and the standards against which these are evaluated (4.5). In spite of their differing theoretical antecedents (2.1.6), the two measures of self-esteem showed markedly similar results for the hospital/community comparison and the more detailed analysis of discrepancies between groups of rehabilitees within the hospital and within the community (4.4.4). Further there were significant correlations between the total scale scores of the self-esteem scale and the 'D' scores (measuring the distance between the scale profiles of attitudes to self and ideal-self) on the semantic differential for both rehabilitees resident in the hospital and the community (4.4.4). This confirms findings in a previous study which sought to establish the construct validity of Rosenberg's self-esteem scale (Sliper & Tippett, 1965) (3.4.3).

Unlike the self-esteem scale, the scale measuring attitudes to the patient-role was not a published scale with well established validity and reliability. It was developed and tested by the writer during the 'Needs of a Health District' study in order to provide a measure of the comparative levels of acceptance/rejection of the patient-role by rehabilitees at different stages of the rehabilitation process (3.4.4). In general the results of the hospital/community comparison when compared with the semantic differential discrepancy scores supported the construct validity of the attitude scale (4.3.4). However, the comparisons of the more detailed analysis for groups of rehabilitees within the hospital and within the community did not. This was shown to be due to the underlying dimensions of hospital orientation explicit in some of the items on the attitude scale (4.3.4). These points were confirmed by the correlations between the total scale scores on the attitude scale and the 'D' scores (between the scale profiles...
of attitudes to self and attitudes to 'most psychiatric patients')
on the semantic differential (4.3.4).

A comparison of the results of the 'Who-am-I?' measure of identification
with the patient-role with those of the attitudinal and discrepancy
measures, also showed that while the results of the hospital/community
comparison were similar, the more detailed analysis by type of ward
showed marked variations between measures (4.3.6). However, it was
also clear that each of the three measures added something unique to
the understanding of changes in the self-concept and role identities
during rehabilitation, which fully justified their inclusion in the
study.

6.3 Theoretical Implications

6.3.1 Self-Conception and the Stereotype of the Psychiatric Patient

The theoretical perspective outlined in 2.3 suggested that there will
be strong pressures on individuals identified as 'psychiatric patients'
to accept the deviant role/identity in place of their normal social
roles/identities. Furthermore, over time it would be expected that
they will have internalised the negative attributes typically
ascribed to 'psychiatric patients' and have developed a negative self-
conception. The findings in the present study did not fully support
this hypothesis, and highlighted the importance of social milieu.

There was a marked decrease in self-identification on the 'Who-am-I?'
schedule in terms of normal (community-based) social roles between
patients in hospital for under ten years and those in hospital for
ten years or more (4.3.7). However, not only was there no reciprocal
increase in self-identification in terms of the hospital-based patient-
role, but the proportion of patients giving such statements actually
declined over time, (although the decline was not so marked as for
identification in terms of community-based roles). The pattern of
change over time was repeated in each of the three types of ward
environment. More importantly, analysis of patient-role
identification by type of ward found that the level of identification for the long stay group (with ten years or more in hospital) on the more traditional type of ward (where it was considered that the patient status and hospitalisation would impinge more directly) was greater than for the shorter stay group (with less than ten years in hospital) on other types of ward. The results were considered to support the theoretical position concerning the importance of ward environment/social milieu in determining identification with the patient role/identity (4.3.9).

One previous study which looked at the identification of 'institutionalised chronic mental patients' with the 'mentally ill' in terms of social roles is of particular relevance in view of the somewhat unexpected findings. Karmel (1970) used responses on the 'Who-am-I?' schedule to categorise patients according to whether they had a 'home world' (community-based) identity or a 'hospital world' identity; identities were based on statements of self-in-role or role enactment. He found a marked decrease in 'home-world' identification for patients in hospital for over two years, but no reciprocal increase in terms of 'hospital world' identification. This was true even for patients who had been in hospital for up to 20 years. Results of the present study lend support to Karmel's (1970) findings.

Turning to consider conceptions of self and (other) patients as measured by semantic differential scales, studies of newly admitted psychiatric patients (Kennard, 1974; O'Mahony, 1982) have found that while they share the negative stereotypical view of the 'mentally ill', they do not accept this identity for themselves. The present study showed that long stay psychiatric patients were also able to avoid self-identification in terms of the negative stereotype (4.3.7). However, this was accomplished not by maintaining a large discrepancy between conceptions of self and conceptions of 'most psychiatric
patients', but by rejecting the negative stereotype of the psychiatric patient. In this way patients who had been in the hospital for ten years or more were able to internalise the role/identity of psychiatric patient without developing unduly negative self-conceptions.

However, the results also showed that a patient's social milieu was an important variable in determining the level of identification with the psychiatric patient role/identity (4.3.2, 4.3.3, and 4.3.5). Thus, it was basically patients who were currently not in the rehabilitation villas (and hence not undertaking active programmes of rehabilitation preparing them for resettlement in the community), who identified closely with their own neutral/positive view of psychiatric patients (4.3.2). Meanwhile, patients currently resident in the rehabilitation villas tended to reject the psychiatric patient role/identity. While they saw the latter very much in terms of the negative stereotype, their own self-conceptions were markedly more positive. It was suggested that in anticipation of their resettlement in the community, rehabilitees had taken over the stereotypical view of psychiatric patients of their community based reference group(s) (membership groups to which they aspired to belong) (4.3.9). Rehabilitees who had been discharged from the rehabilitation villas to live in the community also shared the negative stereotypical view of psychiatric patients, as did all close relatives, regardless of whether their rehabilitees were in the hospital or community.

In a follow up study to Kennard (1974), Kennard and Clements (1976) suggested that 'desensitisation' ('the opportunity to learn that people designated as mentally ill are less alien or threatening than .... previously supposed' p.37) would lead to both patients and close relatives describing the 'mentally ill' in more positive terms on discharge than they had done on admission. They explained the rejection of the hypothesis for their study in terms of the therapeutic community approach employed on the ward. They felt that this type of ward environment would mitigate against the use of the
'mental patient' label. This suggests that attitudes might be expected to differ for patients and relatives in other kinds of social milieu.

However, the results of the present study do not lend much support to the desensitisation hypothesis, except in the case of long-stay patients not actively engaged in rehabilitation (see above) whose reference group(s) consisted entirely of other patients. Once patients achieved rehabilitee status it seemed that they adopted the negative stereotypical view towards other psychiatric patients prevalent amongst members of the community. These attitudes tended to become even more entrenched after discharge, although data collected from rehabilitees with experience of one or more short readmissions within the previous three years did lend some support to the desensitisation hypothesis, since the attitudes of these respondents became slightly more charitable than those of other rehabilitees in the community (4.3.8). All close relatives had extremely negative attitudes towards psychiatric patients even after years of contact with patients in the wards; only a break in contact with hospitalised patients, after their own rehabilitees had been discharged to the community, made the views of close relatives slightly less extreme. This trend is in fact the very opposite of that hypothesised by desensitisation, and may have more to do with close relatives seeing their own rehabilitees in a more positive way after discharge.

In summary, the findings of the present study suggest that an individual's social milieu and his/her length of time in hospital (and by association, age) are important variables in determining both the degree to which he/she internalises the patient role/identity, and his/her acceptance of the negative stereotypical view of psychiatric patients.

6.3.2 Ideal-Self and Changes in Self-Esteem

The theoretical perspective adopted in the study suggests that the individual sets him/her-self goals for the future in terms of the expectations of his/her specific social milieu. These expectations
are mediated to the individual through individuals (significant others) or the shared perspective (generalised other) of his/her reference group. This perspective outlined in 2.3 sees the Ideal-Self as dependent on the individual's reference group, not as a cultural norm. Thus, it follows that changes in self-esteem may occur as a result of changes in self-conception or changes in the individual's conception of the ideal.

Many studies of changes in self-esteem during treatment have considered the Ideal-Self as a cultural constant which changes little over time (see for example: Butler & Haigh, 1954; Turner & Vanderlippe, 1958; Kennard & Clemmey, 1976). However, such findings have generally concerned out-patients or short stay hospital patients. Where changes have been compared for hospitalised and non-hospitalised groups, an increase in self-esteem was found to be due to changes in Ideal-Self for the hospitalised group and changes in self-conception for the outpatient group (Truax, Schuldt & Wargo, 1968). This concurred with Rudikoff's (1954) findings that some individuals lowered their Ideal during treatment to a more achievable goal; Rudikoff related this to Horney's (1945) view that lack of acceptance of self could lead to the glorification of the Ideal-Self.

This would seem to be what had happened to those patients in the present study who had experienced a move from the rehabilitation villas to a more traditional type of hospital ward, catering for long stay or disturbed patients. Thus, at interview they found themselves even further from their original goal of resettlement in the community than they had been three years previously (3.1.2). The findings showed that this group of patients had the lowest self-esteem of all hospital respondents. While their self-conceptions were slightly less positive than those of patients who were still in the rehabilitation villas, their backward step in the rehabilitation process had not lowered their expectations of how they would like to be. In some ways their Ideal-Self had become even more idealistic (4.4.1). This was interpreted as a measure to safeguard their self-conception, but at the expense of lowered self-esteem due to an exaggerated Ideal-Self
(4.4.7), or in Horney's terms, to the 'glorification' of the Ideal-Self.

By comparison, the other group of hospital patients who had relinquished their rehabilitee status had the highest self-esteem of any group of respondents in the hospital. These were the residents of the hospital hostel. While their self-conceptions were more positive than those of 'other ward' residents, their Ideal-Self was the least extreme of any group of respondents and in many ways very similar to their self-conceptions (4.4.2). Rehabilitees in this group were described as no longer striving for resettlement in the community; due to their age and length of hospitalisation they had chosen to live in the hospital hostel, where the patient status and hospitalisation were less obvious than on the more traditional type of long stay ward (3.1.2). Thus, their high level of self-esteem was interpreted as evidence that they were happy and contented with themselves and that the expectations of their social milieu were comparatively modest, especially when compared with those of the rehabilitation villas (4.4.7).

Rehabilitees resident in the rehabilitation villas tended to have a level of self-esteem in between that of the other two groups of hospital patients. Although their participation in a range of rehabilitation programmes had given them comparatively positive self-conceptions, their Ideal-Self was also comparatively high since they were still aiming for resettlement in the community and the standards necessary to achieve this goal (4.4.7).

In a previous study which sought to compare the self-regard/esteem of chronic schizophrenics in the hospital and community, Manasse (1965) found that the self-esteem of the hospitalised group was higher than that of the group living in the community and attending a day centre. This was interpreted in terms of the differing demands and expectations of the two environments. A similar argument was presented in the present study to suggest that rehabilitation would not necessarily lead to higher self-esteem (Hypothesis One, 2.4).
This was in fact found to be true for rehabilitees who had been discharged to live with parents. Their self-esteem was markedly lower than that of rehabilitees living elsewhere in the community (4.4.2). However, this was not due to a more extreme Ideal-Self, but to much less positive self-conceptions. This was interpreted as being the result of rehabilitees living with parents taking on the child role, which was considered to be very similar to the patient-role (4.4.7).

Overall, the present study found that the average level of self-esteem was not very different for hospital and community based respondents. However, there were some marked differences between groups of respondents dependent on their specific social milieu. While for those in hospital the differences appeared to be due to a combination of differences in rehabilitees' conceptions of self and how they would like to be, for those in the community differences in self-esteem were found to be due to differences in conceptions of self alone. However, it did also seem that while rehabilitees' expectations of themselves declined slightly on discharge, they then rose again as their stay in the community lengthened. Meanwhile, close relatives' expectations of rehabilitees tended to rise on discharge and to be very similar to community-based rehabilitees' own expectations of themselves.

In summary, the findings of the present study support the perspective which sees changes in self-esteem as being the result of changes in conceptions of Self (the way the individual is now) or Ideal-Self (how the individual would most like to be). Both were found to be related to the individual's specific social milieu within the hospital, although the results did suggest the idea of a community norm for the Ideal-Self shared by rehabilitees and close relatives.
6.3.3 Resolution of Discrepancies between Self-Conceptions and Significant Others' Conceptions of Self

On the basis of observation (1.1) it was hypothesised that changes in self-conception while patients were actively engaged in programmes of rehabilitation, would lead to negative discrepancies between their self-conceptions and the conceptions of them held by significant close relatives (2.3). The theoretical perspective adopted in 2.1.4 suggested that rehabilitees would deal with the resulting cognitive dissonance by reappraising their self-conceptions, or the discrepant feedback from close relatives, or the significance of close relatives.

It was further hypothesised that hospital based rehabilitees' relatively infrequent contact with close relatives, compared with their almost constant opportunities for feedback from, and social comparison with, other rehabilitees, would lead to rehabilitees in hospital choosing to reappraise the negative feedback (2.3).

The study found that a marked negative discrepancy between self-conceptions and the conceptions of them held by close relatives was characteristic not only of rehabilitees resident in the Rehabilitation Unit, but of hospital patients in general (5.3.1). Patient rehabilitees tended to cope with the discrepancy by distorting the negative feedback from close relatives so that it was no longer perceived as markedly different from their own self-conceptions. This pattern of discrepancies was also found to be characteristic of respondents who considered their close relatives to be significant others (5.4.1). Further, the amount of distortion to the negative feedback from close relatives tended to be greater when there was less frequent contact between patients and close relatives (5.3.1). This showed support for the interpretation of the findings in terms of the relative availability of more frequent and more complimentary feedback from the reference group of other patients. In this way infrequent contact with close relatives had the effect of safeguarding rehabilitees' more positive self-conceptions and the changes which occurred during rehabilitation (4.2.1). However, where contact was more frequent (fortnightly or more) it appeared that rehabilitees were less able to
distort the (even more) negative feedback from close relatives, resulting in their self-conceptions becoming less positive.

Regarding rehabilitees discharged to live in the community, it was considered that if close relatives maintained their negative conceptions of rehabilitees this would be particularly damaging for the self-conceptions of those living with their close relatives. In fact, however, the study showed that rehabilitees' move from hospital to community was accompanied by considerable changes in the attitudes of close relatives. In sharp contrast to the negative conceptions close relatives held of patients (including rehabilitees) in the hospital, the conceptions close relatives held of rehabilitees in the community were very positive (5.2.1). This was particularly so where the close relative was a parent, and hence for rehabilitees discharged to live in the parental home.

Thus, for rehabilitees in the community there was a pattern of small positive discrepancies between their own self-conceptions and the conceptions of them held by their close relatives (5.2.1). While rehabilitees correctly perceived the direction of this discrepancy they still underestimated how positively their close relatives evaluated them. This pattern of discrepancies was also found to be characteristic of respondents who considered their close relatives to be less significant (5.3.1). These two findings taken together suggested that rehabilitees in the community, especially those living with their close relatives (most of whom were parents), probably considered their close relatives to be over-indulgent, and less credible in judging them than others with whom they interacted. Social comparison was also thought to provide an important form of feedback to rehabilitees' own self-conceptions (5.4.4).

In summary, the availability of alternative sources of feedback was found to be important for both hospital patients and rehabilitees in the community. As long as contact between rehabilitees and close relatives remained infrequent hospital-based rehabilitees dealt with the negative feedback from close relatives by reappraising the feedback (so that neither self-conceptions nor attitudes to close relatives were affected). On the other hand, it seemed that community-based
rehabilitees dealt with positive feedback by reappraising their attitudes to close relatives (so that neither self-conception nor the feedback from close relatives were affected).

6.4 Implications for Rehabilitation Practice

6.4.1 Moving Rehabilitation out into the Community

The findings of the study suggest that there comes a time during rehabilitation when rehabilitees are held back simply by the fact of living in the hospital. In general, rehabilitees still in the rehabilitation villas rejected the patient-role/identity (4.3.2, 4.3.3, 4.3.5) and their expectations of themselves were more like those of rehabilitees already discharged to the community (4.4.1). However, they still considered their friendships and conversations to be hospital orientated (4.3.3) and they had not yet acquired community based social roles to replace their lost hospital based roles (4.3.5). These changes only occurred after rehabilitees had been discharged to live in the community. Further, it seemed that an identification in terms of community based roles was acquired fairly soon after discharge, since there was no increase for rehabilitees who had been living in the community for three years or more when compared with those more recently discharged (4.3.8).

It would seem on the basis of this evidence that patients should perhaps be accommodated in the community during the final stages of rehabilitation. There it might be easier for them to take up community roles and complete their separation from the hospital, whilst still having the support of staff from the Rehabilitation Unit. This idea also fits in with the perspective which supports the view that 'good' rehabilitation should take place in a series of small graded steps, where each provides the necessary training and preparation for the move to the next step (2.2.3). By not placing quite so many demands on rehabilitees all at once, it would also be hoped that the addition of a further step in the

1 Following a similar recommendation in the 'Needs of a Health District' study, the Netherne Rehabilitation Unit has opened a 'training' group home in the community to replace the 'resettlement villa' in the hospital grounds which previously formed the final stage of the formal rehabilitation process. It is too early to be able to evaluate its success.
rehabilitation process would lessen the likelihood of readmission during the first weeks in the community.

6.4.2 The Involvement of Close Relatives in Rehabilitation

Family roles formed an important part of rehabilitees' total orientation towards the community social-world after discharge, especially where they were actually living with parents (4.3.5). However, if rehabilitees are to be able to take up these family roles successfully, family members need to adopt complementary roles. Whilst recognising that there are practical difficulties in achieving this while rehabilitees are still in hospital, there is evidence from this study that a more insurmountable difficulty at this stage is the negative view of rehabilitees held by close relatives. Thus, while hospital patients in general, and those in the rehabilitation villas in particular, were found to have positive attitudes towards themselves (4.2.1), close relatives saw them very much in terms of the negative stereotype of the 'psychiatric patient' (5.2.3). There was evidence that in order to retain close relatives as significant others, rehabilitees distorted the negative feedback from close relatives so that it was no longer perceived as discrepant from rehabilitees' own attitudes to themselves (5.3.2). It was further shown that this strategy was made possibly by relatively infrequent (and probably superficial) contact between rehabilitees and close relatives. More frequent contact, while lessening the discrepancy between the attitudes to self and other held by rehabilitees and close relatives respectively, also led to both sets of attitudes becoming more negative.

The results suggest that simply encouraging close relatives to have more contact with rehabilitees is not enough. It may in fact be detrimental to rehabilitees' own progress. Close relatives need to be actively included and involved in their rehabilitees' rehabilitation, so that they understand and agree with both the long term aims of rehabilitation and the short term strategies of individual training programmes set up in the Rehabilitation Unit. Perhaps they even need to be taught how to recognise 'progress' in terms of positive changes in behaviour, attitudes and abilities. However, hospital staff involved in rehabilitation also need to recognise that it is not easy for close relatives of chronic, long stay patients (who may have had numerous previous failed attempts at living in the community) to put aside their feelings of hopelessness.
and resignation. The original observations that led to this study are evidence of a gulf between the expectations of Rehabilitation Unit staff and close relatives (1.1) which a few Relatives' Meetings are not going to bridge, but which intense support by hospital staff might narrow. Serban (1980) suggests that 'the lack of concordance between the attitudes and expectations of patients and their close relatives regarding post-hospitalisation life becomes crucial in many cases when the patient is returned to the community in the care of his relatives' (p.227). In the present study most of the rehabilitees who had already been discharged in the care of their relatives had gone home to live with parents.

6.4.3. Alternatives to Living with Parents

The research findings lend strong support to the accumulated evidence of previous studies (cited in 3.1.2), which suggests that returning to live with parents on discharge from hospital may not be in the best interests of rehabilitees. In particular, the present study showed that the self-attitudes and self-esteem of rehabilitees who had been discharged to live with parents were markedly less positive than those of rehabilitees discharged to live elsewhere in the community (group homes, hostels, independent accommodation) (4.2.1; 4.4.3). In fact, rehabilitees living with parents had the least positive self-attitudes of any group of respondents in the hospital or community (4.2.1). Further, while they showed a high level of identification with family roles, rehabilitees living with parents were less likely to identify themselves in terms of other types of community roles (such as work and leisure-time roles) than those living elsewhere in the community (4.3.5). Meanwhile, their close relatives were shown to have extremely positive attitudes towards them, which was in marked contrast to the attitudes of close relatives to rehabilitees still in the hospital (5.2.1). However, it seems likely that rehabilitees considered their close relatives (usually mothers) to be somewhat indulgent and not entirely credible as 'evaluators'; rehabilitees tended to be more critical of themselves, probably comparing their abilities with those of others around them (5.4.4). It was certainly true that compared with
rehabilitees living either elsewhere in the community or in the rehabilitation villas, those living with parents were less involved in self-care activities (3.7.1).

These findings would seem to support the suggestions made above (6.4.2) concerning the involvement of close relatives in the rehabilitation plans for their rehabilitees from an early stage. This would include both rehabilitees and close relatives being made aware of the various types of alternative accommodation in the community, some of which may be more appropriate for individual rehabilitees than returning to the parental home. However, if the final choice is for rehabilitees to live with their parents, then parent cooperation needs to be encouraged in helping rehabilitees to continue their progress towards independence in the normal activities of daily living that they began in the Rehabilitation Unit, rather than providing a relatively undemanding and possibly over-protective environment which was seen to have such dire consequences for rehabilitees' self-conceptions and self-esteem. Rehabilitees would not be the only ones to benefit from the extension of rehabilitation into the family home; continued liaison with the rehabilitation team staff who knew the rehabilitee well would also provide support for parents and other family members. 2 A follow-up study of 'schizophrenic patients discharged from hospital' (Johnstone et al, 1984) found such support to be extremely valued; they reported that 'the greatest distress for patients and relatives was found among those receiving no medical or social attention' (p.588).

Since in the present study it was generally the older, more disabled (by intrinsic and extrinsic impairments) rehabilitees who had yet to be discharged from the Rehabilitation Unit (3.7.1), it would seem all the more important that continuity of care should extend into the

2 For close relatives of Netherne rehabilitees such support is currently provided on an informal basis via community nurses and staff at out patient-clinics (Collis & Ekdawi, 1984(b)).
community. In this context it may be important to note the results of a recent study of the 'community management of schizophrenia' (Falloon and Pederson, 1985; Doane et al, 1986). The authors found that a family orientated (rather than a patient orientated) approach, with its emphasis on educating relatives about the nature of the 'disorder' and enhancing the effectiveness of family coping behaviour, was most effective. They reported that the family orientated approach not only resulted in fewer crises and readmissions for the ex-patient, but also in less stress for other family members (as measured by disruption of activities, physical and mental health problems and subjective burden).

6.4.4 Reducing the Negative Effects of Readmission

A rehabilitee's life in the community is obviously severely disrupted by even brief readmissions to hospital and a return to the patient status. The present study found that while the overall effects on self-conception were not marked, rehabilitees who had experienced one or more readmissions during the preceding three years had more negative attitudes to themselves than other community-based rehabilitees concerning the way they felt; in particular they saw themselves as more emotional (4.3.8). However, the main effects of readmission were a more negative self-esteem and a greater identification with the patient-role (4.3.8).

In order to reduce the trauma of readmission and ease the return to the community, it would seem appropriate to suggest that rehabilitees should not be readmitted to an ordinary hospital ward in the Admission Unit or Rehabilitation Unit. Instead, an alternative type of ward environment might be provided; one which is not unduly 'hospitalised', where admission procedures can be kept to a minimum, and which is orientated towards a speedy return to life in the community.
6.4.5 Training Programmes to Combat Residual Handicaps

The research suggests that there are certain residual handicaps of psychiatric illness and/or hospitalisation which rehabilitees find very difficult to overcome and which put them at a distinct disadvantage in their attempts to reintegrate themselves into life in the community. It was discovered that all groups of rehabilitees both within the hospital and community saw themselves as shy and submissive, and many groups rated themselves as low in confidence, irrespective of how positively (or negatively) they rated themselves on the other aspects of self-conception (4.2.1). Further, close relatives concurred with this assessment, including the close relatives of community residents who saw their rehabilitees very positively in other respects (5.2.1).

Thus it would seem that current training programmes on the rehabilitation villas may not be proving adequate in helping rehabilitees to have confidence in their abilities to cope with the demands of normal life in the community, particularly in their interaction with other people, in comparison with whom they see themselves as shy and submissive. It is suggested that confidence can only be built up through the practical experience of actually 'doing' and 'succeeding', whether it is in simple everyday tasks such as travelling on public transport or shopping in the supermarket, or in more complex social situations such as going to a party and talking to strangers (especially those of the opposite sex) or going for a job interview. Thus social skills training needs to move out into the community during the later stages of rehabilitation into realistic community situations. The movement of rehabilitees into accommodation within the community in the final stages of their rehabilitation (6.4.1) would greatly facilitate this and may in itself help rehabilitees to become more outgoing, less submissive and more self-confident.
6.5 Future Research

Looking to the future, there would seem to be two main directions for research on the self-concept in psychiatric rehabilitation: firstly, a more structured examination of the relationship between social setting and the individual's self-attitudes and expectations; secondly, exploration of the relationship between self-attitudes and behaviour.

6.5.1 The Relationship between Social Setting and Self-Attitudes and Expectations

The theoretical perspective developed in Chapter 2 was able to provide a very adequate explanation of the differences in self-concept shown by rehabilitees differentiated by their place of residence. The argument was presented that the individual's attitudes to self, ideal-self and 'most psychiatric patients' are determined by the attitudes and standards prevailing in their significant social groups. Future research needs to test these theoretical assumptions by expanding the dimensions of the self-concept which rehabilitees are asked to rate. For rehabilitees in hospital their immediate reference group is composed of other patients on the same ward; thus the new dimensions of the self-concept would include: (1) 'the way other patients on this ward see me', and (2) 'the way I see other patients on this ward'. Since it would be impractical to ask each rehabilitee how he/she sees other patients on the ward individually, it is suggested that the mean ratings of all ward patients on dimension (2) should be used to represent the generalised attitude of ward patients to each other. In this way dimension (1) and the group mean of dimension (2) would represent respectively the individual's perceived view of how members of his/her reference group see him/her and how they as a group actually see him/her. From the results of the present study it would be hypothesised that the individual's self-attitudes would closely reflect (1) and the group mean of (2). (This was found not to be the case when self-attitudes were compared with the perceived and actual attitudes of close relatives; although self-attitudes were similar to perceived
attitudes, they were markedly different from actual attitudes.)

The results of the present study would also suggest that for rehabilitees in some ward settings (e.g. those where there were no active programmes of rehabilitation nor expectations of resettlement in the community) attitudes to 'other patients on this ward' (2) would be very similar to attitudes to 'most psychiatric patients', whilst for those in other ward environments (e.g. those with an active rehabilitation 'milieu' and the expectation of resettlement in the community) they would be quite different. Expectations of the different ward environments could be explored by asking rehabilitees to rate (3) 'the way other patients on this ward expect me to be'. It would be expected that personal expectations or attitudes to the ideal-self would closely reflect the individual's perception of the expectations of other members of his reference group (3).

For rehabilitees in the community it would be necessary to substitute alternative significant social groups for 'other patients on this ward'; these could be determined during interview. Since it is likely that they would be quite different for each individual in the community, it would not be possible to gain a measure of the generalised attitudes of group members, that is the way they actually see the individual. However it would still be possible to test hypotheses concerning the relationship between self-attitudes and the perceived attitudes of the individual's reference group, and the relationship between personal expectations and perceived group expectations.

Further, it was argued that rehabilitees in the community tended to see their close relatives as somewhat indulgent in their attitudes towards them, and hence showed more negative self-attitudes than either the actual or perceived attitudes of close relatives would have suggested. It was suggested that rehabilitees in the community relied more on social comparison of themselves with significant others (including close relatives) rather than on the reflected appraisal of other's attitudes. It might be possible to go some way towards examining this by asking rehabilitees to rate 'the way I see my close
relative' (4). It would be hypothesised that where rehabilitees had self-attitudes that were markedly more negative than their close relatives' attitudes to them, there would also be a marked discrepancy between how rehabilitees saw their close relative (4) and their own self-attitudes, with the close relatives being seen far more positively. Social comparison with members of their reference group could also be explored by comparing the ratings on (2) with attitudes to self.

6.5.2 The Relationship between Self-Attitudes and Behaviour

One important reason for studying changes in self-conception during rehabilitation is that social behaviour and attitudes to self are closely inter-related. Rehabilitation takes place through the learning of new social roles; during role-taking the individual comes to take on the attitudes appropriate to that role and by internalising the role and its concomitant attitudes (including attitudes to self) the individual comes to see himself as a particular type of person and directs his behaviour accordingly. Further, this behaviour is generalised to other social situations.

The results of the present study would seem to raise some important questions which a study of the relationship between behaviour and self-attitudes could clarify: what is the effect on behaviour of rehabilitees in the rehabilitation villas rejecting the patient-role but not yet having acquired community-based roles? What are the differences in behaviour between patients on other types of ward who very much identify with the patient-role and those who do not?

One study which set out to examine the relationship between self-attitudes and 'behaviour in realistic social settings' for newly admitted psychiatric patients used the 'Who-am-I?' measure of self-conception and categorised behaviour on the ward from comprehensive ward notes or interviews with ward staff (McPartland, Cumming and Garretson, 1961). It is suggested that this methodology could be replicated for a study of rehabilitees. It would involve
categorising 'Who-am-I?' statements into just four modal types according to their level of abstraction from social experience: (1) self as a physical entity 'not involved in social relations or socially consequential action' (p. 114); (2) self in institutionalised statuses or roles, mostly self-in-role statements; (3) characteristic ways in which the individual acts, feels or responds in a social situation showing 'experience of self as a person interacting more or less directly with other persons' (p. 115); (4) abstract identifications which transcend social interaction. The study found that patients with most statements in category (1) were withdrawn, whereas those in category (4) exhibited restless or extravagant behaviour; in between those in category (2) were found to be pleasantly 'cooperative but not initiating in social interaction' and category (3) socialised well and took an active part in ward activities.

These findings suggest that there could be marked differences in the social behaviour of rehabilitees in the hospital and those who live in the community. The latter have more opportunities to take up community orientated roles, to internalise the attitudes, values and behaviours appropriate to those roles and to generalise them to everyday social situations, so that they are able to 'socialise well' or at least be 'cooperative' in social interaction. The implications of this for rehabilitation practice emphasises the importance of the recommendations in 6.4.1.

On the basis of comments on the 'Who-am-I?' technique in 6.2 it is considered important that two or three independent coders should be used to categorise the statements and decide on which mode characterises each respondent; the categories need to be clearly defined. With these guidelines fulfilled, the study quoted above found that three independent coders agreed on 97% of the responses and all the modal categories of the 60 respondents (McPartland, Cumming & Garretson, 1961).
Finally, a general point can be made concerning the design of any future research attempting to study changes in the self-concept during rehabilitation. As suggested in 3.1.2, ideally such projects should be designed as longitudinal studies in which the same sample of individuals complete the same measures of the self-concept at successive points during the rehabilitation process. The latter could be identified by time (e.g. on referral to the Rehabilitation Unit and every year thereafter until they have been discharged for (say) one year without readmission) or place of residence (e.g. on referral and then at every change of social environment, whether it be a change of ward, discharge or readmission, etc.). Although it is recognised that there are practical considerations, namely time and funding, which make the one-off approach the more usual and pragmatic option, a longitudinal design would control for the possible effects of extraneous variables inherent in the 'one-off' design of the present study (e.g. differences in age, cumulative hospital stay, diagnosis, etc. amongst the different subgroups of respondents).
APPENDICES
A1    SELF-CONCEPT MEASUREMENT

A1.1    Self-Report Techniques

A1.1.1    Check Lists

The simplest form of self-report technique used to measure the self-concept is the check list; respondents answer a simple 'yes' or 'no' to a series of adjectives or descriptive statements according to whether they are true of them or not. This is usually done by checking those items which are true of them. Instruments of this type include the Adjective Check List (Gough, 1960) and the Interpersonal Check List (La Forge and Suczek, 1955).

A later version of the Adjective Check List (Gough and Heilbrun, 1965) consists of 300 adjectives presented in alphabetical order to the respondent. Some of the items are taken from Cattell's factor analysis of Allport and Odbert's (1936) list of traits with other aspects of personality considered to be important by the authors added to them. A variety of scoring procedures are used to achieve measures of defensiveness, self-favourability, self-unfavourability, self-confidence, self-control, personal adjustment and counselling readiness.

The ICL consists of 128 descriptive words and phrases, 8 for each of 16 variables defined in Leary's Interpersonal Personal Personality System (1957). While the respondent is simply asked to complete the checklist for his self and ideal-self, the scoring procedure is fairly complicated.

Both these checklists can also provide measures of self-acceptance: the ICL from a discrepancy measure between self and ideal-self checks and the ACL from the ratio of the number of favourable items checked to the total number of items checked.

However, it should be noted that in her detailed review of self-concept measurement techniques Wylie (1974) found both the ACL and ICL checklists
to be less than satisfactory instruments as regards self-concept and self-acceptance measurement. Information on their reliability and validity was either absent or discouraging, and the ICL in particular suffered from 'an unusually high incidence of serious methodological flaws' (p.223). Checklists in general do allow respondents to respond to a large number of items in a fairly short time, however, the check or no check format does not allow them to indicate to what degree an item is or is not characteristic of them. Other problems relating to summing across items are shared by those instruments using rating scales and are discussed below.

Al.1.2 Attitude Rating Scales

Rather than simply giving a yes or no response, rating scales require respondents to indicate the extent or degree to which various characteristics describe them or others. Thus they provide a more sensitive measure of self and other conceptions than checklists. Most instruments use a 5 point rating scale, although a larger or smaller number of points is possible.

It is usual to obtain a total score by summing the scale scores for each item, although this method leads to considerable loss of information regarding individual items or groups of items. It also makes the unproven assumption that all items are of equal importance in contributing to the total score. This implies two further assumptions: there are no inter-respondent variations in the salience of each item and the scale is unidimensional. The latter assumption can be investigated through the use of factor analysis. If all the items are found to load significantly on one factor which accounts for a high proportion of the variance in total scores, then unidimensionality is indicated and summing across items is an acceptable procedure. However, findings from the few factor analytic studies performed on self-concept rating scales do not offer much support for the assumption of unidimensionality (Wylie, 1974).

Although it is probably the most popular format for self-concept measurement techniques, many rating scale instruments have been used only
once, often with very small samples, and they have been inadequately described (Wylie, 1961). This severely limits the choice of published scales which would be worth considering for use in the present study. On the basis of Wylie's (1974) detailed review of specific self-concept measurements, the following rating scale instruments were selected for further exploration: Bill's Index of Adjustment and Values (IAV) (Bills, Vance and McLean, 1951) and Rosenberg's Self Esteem Scale (1965).

In its final form the IAV consists of 49 trait adjectives (e.g. acceptable, accurate, alert, ambitious, annoying), 40 of which are categorised as desirable and 9 as undesirable. Three different ratings are obtained from a respondent designed to measure (1) his self-concept, (2) his level of self-acceptance, and (3) his ideal-self. For (1) he is asked: 'How often are you this sort of person?', to be rated on a five point rating scale from 'seldom' to 'most of the time'; for (2) he is asked: 'How do you feel about being this way?', to be rated from 'very much dislike' to 'very much like'; for (3) he is asked: 'How much of the time would you like this trait to be characteristic of you?', to be rated as for (1) from 'seldom' to 'most of the time'. A further measure of self-acceptance is also obtained from the discrepancy between self and ideal-self scores.

One of the aims of the IAV was to assess changes in adjustment over therapy, and the original selection of 124 items from Allport and Odbert's (1936) list of traits was made with this in mind. Items were selected on the basis of their frequent occurrence in counselling interviews and whether they represented clear examples of self-concept characteristics (Bills, Vance and McLean, 1951). Item analysis was later employed to remove unreliable items, leaving a short and easy to administer 49 item instrument.

Designed to measure global self-esteem, the Rosenberg Self Esteem Scale consists of 10 statements covering very general evaluations of the self-concept. There are an equal number of positively phrased and negatively phrased items, for example: 'On the whole I am satisfied
with myself', 'I certainly feel useless at times'. Respondents are asked to rate the 10 items on a four or five point rating scale from 'strongly agree' to 'strongly disagree'.

The scale was developed by Rosenberg to investigate the relationships between self-esteem and a range of social and psychological variables in a study of Society and the Adolescent Self Image (1965). He provided a mass of criterion-related evidence for the scale's validity, while other researchers have confirmed its construct validity and test-retest reliability (Silber & Tippett, 1965), which Wylie (1974) considers 'impressive' especially considering its length. Further, the very general evaluative statements allow respondents 'to select and weight ... whatever specific behavioural referents seem appropriate ... as bases for responding to the ... items' (Wylie, 1974:181). Thus the Self Esteem Scale avoids the usual problem with rating scales of selecting representative items which are relevant to all respondents.

The scale is generally considered to be unidimensional (Rosenberg, 1965; Hensley & Roberts, 1976) at least for the adolescent population for whom it was designed, so that ratings on the 10 items can be summed to produce an overall measure of self-esteem. Thus, again the scale avoids a common problem with many rating scales for which such a procedure is inappropriate due to their multi-dimensional structure.

Al.1.3 Q-Sorts

Developed by Stevenson (1953) this technique also uses self-referent statements, but this time they are presented on cards and the respondent is asked to sort the cards into a number of piles according to how well the statements describe him/her. Butler and Haigh (1954) developed a universe of 100 items (selected from statements made by clients during therapy) and for the self-sort the respondent sorts the 100 cards into 9 piles from 'least like me' to 'most like me'. The number of cards to be sorted into each pile is specified in order to give a normal distribution. Respondents may be asked for a range of sorts as well as
their self-sort, for example idealsorts or ordinary person sorts. Correlations may then be made either (i) across sorts for different individuals or (ii) across individuals for different sorts. If correlations are high and positive between individuals on their selfsorts then they will have similar self-concepts. If correlations are high and positive between an individual's self and ideal sorts this is indicative of self-acceptance or a high self-esteem.

Much of the research using Qsorts has taken place in clinical settings and the aim has been to study changes in an individual's self and ideal sorts and the self-ideal correlation during therapy (Rogers and Dymond, 1954). This approach has close ties with Roger's client-centred therapy and its emphasis on the relationship between self-acceptance and adjustment.

Due to the forced distribution of sorts the Qsort technique cannot be used to compare mean or total scores for individuals or groups; its concern is with 'detailed analysis of intra-individual processes within a larger population' (Wells and Marwell, 1976:88). Thus this technique is not ideally suited to the needs of survey-type studies. More practical considerations lend further support to this conclusion, for Qsorts are considerably more time consuming to administer, and probably require more effort on the behalf of respondents than other pen-and-paper instruments using self-referent items to measure the self-concept.

1.4 The Semantic Differential

The semantic differential requires the respondent to rate given concepts (in the context of the present research, real-self, ideal-self, others' conceptions of self, etc.) on a range of scales (usually adjectives) presented as bi-polar pairs. Respondents are presented with a set of scales for each concept; the adjective pairs are listed down the page with an odd number of divisions (usually 5 or 7) marked out between them. Respondents are asked to place one tick on the continuum between each pair of adjectives, within the marked divisions. This is to be done according to which of the adjective pairs best describe the concept.
and to what degree the description is appropriate. To clarify this the divisions may be assigned headings or descriptive modifiers such as 'very', 'slightly', 'in-between'.

The conceptual framework for the technique was developed by Osgood et al. (1957) as a means to quantify the connotative meanings which individuals attach to various concepts. Using factor analysis they identified three underlying dimensions, Evaluation, Potency and Activity, which have been found to be relatively reliable across concepts. However, even Osgood (1962) admitted that there was 'no such entity as "The Semantic Differential", with a rigidly defined set of factors' and realised that 'for significant concept classes we will therefore want to develop specific instruments' (p.24/25). In doing so, the most important methodological consideration is to select scales which are appropriate to the class of concepts being measured and which are thereby meaningful to respondents in this context.

Once respondents have understood what is required of them this technique is a relatively quick and easy way of exploring attitudes to a range of self and other conceptions. The use of bi-polar scales, rather than a single 'stimulus' as for rating scales or checklists, helps to clarify the intended meaning more clearly, and there are well validated statistical techniques for analysing the data. Thus it is possible to compare the ratings of individuals or groups of individuals on individual scales, groups of scales (such as those identified by factor analysis) and the total scale score. Further, Distance or 'D' scores can be calculated to measure differences in profiles between different concepts for one individual/group or different individuals/groups for one concept. However, as for techniques of analysis using total scale scores there are the problems of equal salience of items and the variety of profile patterns represented by any one D score.

Al.1.5 Repertory Grid

All the above techniques require respondents to describe the concepts
under study in terms of 'given' adjectives or statements, regardless of
their relevance or salience to the individual. By contrast, the
repertory grid allows respondents to generate their own adjectives
(constructs). Based on the Personal Construct Theory of Kelly (1955)
repertory grids are used to sort 'elements' (concepts) according to
elicited personal 'constructs' (the means by which individuals
structure their world in the light of past and present experiences).
A grid is formed by listing elements along the horizontal axis, and
constructs down the vertical axis; the size of the matrix, often being
10 by 10, but it may be up to 40 by 40. The most usual procedure is
for the respondent to be presented with three elements and asked to
suggest in what way any two of them are alike but the third is different.
This process is then repeated until the required number of constructs
have been elicited. Supplied constructs, such as those required to
test hypotheses, may also be used; in this case statistical measures
can be employed to test whether they are as relevant to the respondent
as elicited constructs. The respondent then sorts all the elements in
terms of all the constructs. This may be done by (1) ranking all the
elements from 'most like' to 'most unlike', (2) grading the elements
into several groups from 'very like' to 'very unlike', or (3)
dichotomising the elements into 'like' and 'not like'.

Data analysis is essentially concerned with individuals; the grids are
so designed that statistical tests of significance can be applied at
the individual level. Comparisons may be made between the structures
of two elements at one point in time or the changes in one of these
elements over time (where the same grid has been completed on 2 or more
occasions). Factor analysis can also be used to explore the underlying
structure of the individual's construct system. The repertory grid was
not originally designed to elicit quantitative information concerning
groups of respondents, but it has been used for this purpose in many
studies.

In the context of self and other conceptions the 'elements' of the
repertory grid would be made up of concepts such as real-self, ideal-self,
mother's conception of self; analysis would examine differences between
them for individuals, and individuals could be grouped according to the nature of these differences. Alternatively, one 'element' could be examined for changes over a period of time, and individuals grouped according to the direction of change.

The main problem with the repertory grid technique is that it is very time-consuming; at its first presentation respondents take at least 40 minutes to complete a 10 by 10 matrix. However, subsequent completions are much quicker since respondents have only to sort (according to previously elicited constructs). Thus this technique is perhaps more economic to use over a longitudinal study than in the context of a one-off interview.

Al.1.6  'Who-Am-I?' or Twenty Statements Test

Also a free-response technique, the 'who-am-I?' schedule was developed directly from the symbolic interactionist framework of Kuhn and his associates at the University of Iowa. The respondent is simply asked to give up to 20 statements in answer to the question: Who am I? He/she is generally given about 12 minutes and told to write down whatever comes into his/her head, and not to worry about the order, spelling or logic of the responses. As well as responding in terms of individualising characteristics (I am intelligent, I am easy going, I am quite good) the individual may also respond in terms of roles and memberships (I am a good mother, I play in the local football team, I am a teacher). These roles and memberships provide details of a respondent's social anchorage and the significant and/or generalised others with whom he/she interacts and who therefore play an important part in determining his/her self-concept.

Each statement may be coded in four ways according to (1) content, (2) saliency, (3) evaluation, and (4) tense. Kuhn (1960) proposed five categories of content (social groups, ideological beliefs, interests, ambitions and self-evaluation) and Gordon (1968) has developed a 30 category scheme which forms the basis for a computer-aided content analysis system (Gordon, 1969). There has been conflicting evidence as
to whether saliency is represented by the ordering of statements (Gordon, 1968; McPhail and Tucker, 1972), while measuring evaluation by coding statements as self-favourable or self-unfavourable has not led to statistically significant correlations with other self-esteem measures (Spitzer et al, 1966).

While the unstructured nature of the technique allows respondents to make a wide range of self-referent statements in a relatively short time, it raises considerable problems for the researcher. Even given a suitable system of content analysis the actual coding process is considerably more time consuming than for other self-concept instruments using a simple scoring system.

A1.2 Instrument Selection: Validity and Reliability in Self-Concept Measurement

A1.2.1 Validity

Validity of a measurement technique is concerned with whether it actually measures what it sets out to measure; three types of validity need to be considered: content validity, predictive or criterion validity, and construct validity.

Content Validity

Most self-concept measurement techniques consist of a number of self-referent statements or adjectives, or else seek to elicit them from respondents. All too often content validity is assumed to be equivalent to face validity; a measure is taken as a valid self-concept test if, in the opinions of experts (usually the researcher), it looks like a self-concept test, that is it contains self-referent items. Strong and Feder take this view when they declare that 'every evaluative statement that a person makes concerning himself can be considered a sample of his self concept' (1961:170). However, the question arises as to the representativeness of the chosen or elicited items from the total population of possible items. Wells and Marwell
define content validity as 'the exhaustiveness or representativeness with which the measure indicates the construct' (1976: 157) and clearly emphasise its relationship to the underlying theoretical view of the self-concept. It was on theoretical inadequacies that Crowne and Stephens (1961) clearly placed some of the problems in ensuring content validity, and they stressed the need to provide 'a definition at the construct level, in which the behavioral referents ... are specified' (p.113).

An examination of the bases of item selection on several well known measurement techniques (Butler and Haigh's Q sort, Bills' Index of Adjustment and Values, and Gough's Adjective Check List), by Crowne and Stephens (1961) found them lacking in representativeness, regarding either the total population of items (as determined by construct definition) or their occurrence in the population of respondents under study. Their value was thus considered to be severely limited since it was not possible to generalise to other self-referent items or to other populations of respondents.

Spitzer et al. (1966) were also concerned with the content of self-concept measures, but this time from the point of view of the respondents: 'To what degree do subjects feel that various self-concept instruments allow for the accurate expression of self attitudes?'(p.267). They chose four measures of the self-concept, three fixed-response instruments: Bills' Index of Adjustment and Values (IAV), Gough's Adjective Check List (ACL) and Fiedler's Semantic Differential Technique (FSD), and one free-response instrument: Kuhn's Twenty Statements Test (TST). Having completed the four instruments respondents (Sociology students) were asked which of the 4 measures allowed them to give both the most accurate and the least accurate description of themselves. While there was no majority opinion the ACL was seen to be the most accurate and the TST the least accurate (35% of respondents rated the ACL as the most accurate and only 16% the TST, while 40% rated the TST as the least accurate and only 19% the ACL.) This result was considered particularly interesting as it contradicted the usual assumptions made by advocates of free-response techniques.
Criterion Validity

In criterion validity the measure is validated against an external criterion, but in self-concept research there are no operationally defined behavioural manifestations against which to validate self-concept measures. Instead validity has been approached by establishing causal relationships (via correlations) with other variables, which can be hypothesised from the theoretical framework of the research. Wells and Marwell (1976) suggest that this type of validation is more correctly termed 'criterion-related evidence', adding somewhat cynically that 'any variable which can be postulated to have a relationship to some aspect of self-esteem, self-evaluation, or self-acceptance may be (and probably has been) correlated with a self-esteem measure for validation' (p.191/2). There is no reason to suppose that this statement cannot be extended to self-concept measurement in general.

Since many of the instruments for measuring the self-concept were developed for use in a clinical setting, it is not surprising that the majority of 'criterion-related evidence' has sought to establish a causal relationship between self-concept measures and measures of psychological adjustment. The latter have included: objective personality tests (MMPI scales: Calvin & Holtzman, 1953; Block & Thomas, 1955; Truax, Schuldt & Wargo, 1968. Edwards PPS and Cattell factors: Smith, 1958), projected personality tests (Rorschach: Bills, 1953, 1954; Bills, Vance & McLean, 1951. TAT: Friedman, 1955. Rorschach and TAT: Chodorkoff, 1954. Rotter Incomplete Sentences Blank: McCarthy & Rafferty, 1971), and improvement over therapy (Butler & Haigh, 1954; Rudikoff, 1954; Truax, Schuldt & Wargo, 1968).

Another method has been to examine group differences using subsamples of normals and groups with known psychological difficulties: adolescents with behaviour problems and normals (Cole, Getting & Hinkle, 1967), a group of psychotics, neurotics and those with personality disorders and a group with no psychological disorders (Chase, 1957) and patients with anxiety states and a matched control group (Bond & Lader, 1976).
Many, though by no means all, of these studies have found a significant relationship between measures of the self-concept (using a range of instruments, most often Q sorts or the IAV, but also semantic differentials and rating scales) and psychological adjustment. However, Lowe's (1961) conclusions regarding the use of objective personality tests is probably still true of most validation studies whatever the measure of adjustment: 'Validating self-concept measures against objective personality tests has generally been successful, but the true significance of these studies is still not clear' (p.328/9).

Contradictory results abound, especially concerning the relationship between self-acceptance (as measured by the discrepancy between self and ideal-self) and psychological adjustment. While some studies have found a positive linear relationship (Calvin & Holtzman, 1953; Bills, 1954; Chase, 1957; Turner & Vanderlippe, 1958; Truax, Schuldt & Wargo, 1968; Wilcox & Fretz, 1971) and others a negative or zero relationship (Borislow, 1962), still others have found a curvilinear relationship. However, even they disagree as to the shape of the curve, with some considering both very high and very low discrepancies to be indicative of maladjustment (Block & Thomas, 1955; Cole, Getting & Hinkle, 1967) and others finding the greatest level of maladjustment to be in the middle ranges of discrepancy scores (Chodorkoff, 1954).

Construct Validity

Construct validity is concerned with the relationship between responses or measurements and the conceptual framework, that is, whether the findings can be explained by the theory. Attempts to prove construct validity for self-concept measures have generally taken a more indirect route involving the intercorrelation of results from different instruments. The assumption behind this procedure is that the various instruments are all measuring the same underlying theoretical construct: the self-concept.

Spitzer et al. (1966) found that intercorrelations of scores on three fixed response instruments, the IAV, ACL and Fiedler's semantic differential, ranged from 0.39 to 0.67 over eleven correlations, but
that scores from the free response TST had 'little in common with scores from the other instruments' (p.272). They also warned that even moderate correlations between the fixed response instruments did not necessarily indicate probable equivalence of operations. A range of irrelevant response determiners could have contributed towards the intercorrelations between instruments. These were seen to include: overlapping instrument content, similarities in assessment operations, and a range of invalidating influences as discussed in 3.2.2. The most important of the latter was considered by Crowne and Stephens (1961) to be a social desirability response set, and this was confirmed by them in a study comparing measures of self-acceptance from six different instruments (Crowne, Stephens & Kelly, 1961). The intercorrelations ranged from 0.13 to 0.90, with a mean of 0.52, but the correlations with Edwards’ Social Desirability Scale (1957) were either greater than or equal to the correlations between self-acceptance measures. However, as discussed in 3.2.2, both the concept of a social desirability response set and its measurement by Edwards SDS have been the subject of considerable debate and criticism.

Even if it is not accepted that social desirability is a 'common denominator' (Crowne & Stephens, 1961: 109) in self-acceptance research, the intercorrelations between the six measures showed that a considerable proportion of the variance was accounted for by other factors, and the measures were by no means equivalent. Nor is this very surprising considering the range of theoretical viewpoints from which the various measures have been operationalised, especially considering the lack of adequate definitions at the construct level.

Thus attempts to provide construct validity for various measures of the self-concept through cross-instrument correlations have generally been disappointing.

Al.2.2: Reliability

Reliability is concerned with the consistency and stability of scores; it involves computing correlations between scores on comparable parts
of the same scale (split-half reliability) or between scores for the same scale at two points in time (test-retest reliability).

Internal consistency may also be measured by Cronbach's alpha which tests the degree of homogeneity among scale items. With regard to self-concept scores, even though it is possible (and relatively easy) to compute measures of internal consistency, few studies have in fact done so. Even fewer have investigated the stability of self-concept measures over time, although this is often an important assumption in the evaluation of self-concept data.
Dear

Thank you for taking part in the recent follow-up study of rehabilitees, and for your help and co-operation during our interview.

Realising how important family members or close relatives are in helping many patients/rehabilitees adjust to community life, I would now like to interview your ............... 

Please could you confirm the name and address/write in the name and address for me, and return the bottom section of this letter in the enclosed envelope/stamped, addressed envelope as soon as possible.

Thank you very much.

Yours sincerely,

MARION COLLIS
Research Social Scientist

Dear Mrs. Collis

My ............... Mr/Mrs/Miss ................................

may be contacted at the following address:

..................................................

..................................................

..................................................

Signed ......................... Date .................
Letter 2: Reminder to Rehabilitees

Netherne Hospital
June 1981

Dear

Sorry to keep bothering you with my letters, but I am very keen to interview as many family members as possible of my follow-up population of Netherne rehabilitees, so as to get the widest possible range of experiences and attitudes. Consequently I am repeating my request for permission to contact your ...............

Please would you complete the bottom section of this letter - even if you do not wish me to contact your family - and return it to me in the enclosed envelope/stamped, addressed envelope.

Thank you for your co-operation.

Yours sincerely,

MARION COLLIS
Research Social Scientist

Dear Mrs. Collis

* (1) I do not wish my ............... to be contacted.
* (2) I am happy for you to contact my ............
   His/her address is .................
   ........................................
   ........................................

*please delete as appropriate

Signed ................................. Date .....................
Dear

Working closely with Dr. Ekdawi, I have just completed a follow-up study of some 100 Netherne rehabilitees (that is all patients resident on the rehabilitation villas in mid-1977), including your ............. I asked them about their life over the past three years or so and about their adjustment in various areas of living/community living such as work, leisure and social activities.

Looking at what many rehabilitees (patients) told me, it became clear that family members and close relatives were often very important in helping them in their rehabilitation/adjustment to life in the community. (At the same time it is realised that visiting and being visited by a patient may well cause problems for the family members concerned, especially if his/her symptoms and behaviour deteriorate.) Consequently, in order to gain an overall view of the situation, I have expanded my research to include, where possible, a family member of each rehabilitee (patient) interviewed.

Agreement to my contacting you has been obtained from ............., and all information will be treated as strictly confidential. I would be very grateful for your help and would like to arrange a convenient time to come and talk with you. Please could you complete and sign the reply slip at the bottom of this letter and return it to me in the enclosed stamped, addressed envelope.

Thank you for your help, I look forward to hearing from you.

Yours sincerely,

MARION COLLIS
Research Social Scientist

Dear Mrs. Collis

I am happy for you to come and see me.

*(1) I will be home on ..........day(s) .................date(s)
and suggest you call at ......................... am/pm  time(s)
(a) please confirm by phone; my number is .................
(b) please write to confirm date and time as I do not have a phone.

*(2) Please phone to arrange a convenient date and time; my number is

 .........................

(*please complete (1) or (2) and option (a) or (b) if (1) completed.)

Signed ................. Date .................
A2.4 Letter 4: Reminder to Close Relatives

Netherne Hospital
August 1981

Dear

This is just to remind you that I have not yet received a reply to my recent letter requesting your participation in the second phase of my follow-up study of a population of Netherne rehabilitees, in which I am hoping to talk to a family member or close relative of as many rehabilitees interviewed in the study as possible.

It seems to me to be very important that we look at adjustment and rehabilitation from all sides, and this is an attempt to understand the problems (if any) that family members experience either in having a rehabilitee living at home with them or in visiting and being visited by a rehabilitee, and to see how they think the rehabilitee is progressing.

Agreement to my contacting you has been obtained from your .............., and all information will be treated as strictly confidential. I would be most grateful for your help and would like to arrange a convenient time to come and talk with you. Therefore, could you please complete the bottom section of this letter and return it to me in the enclosed stamped, addressed envelope.

Thank you.

Yours sincerely,

MARION COLLIS
Research Social Scientist

Dear Mrs. Collis

(i) I do not wish to participate in the study.

(ii) I am happy for you to come and see me:

(a) Please phone to arrange a convenient date and time; my number is ......................

(b) I suggest you call on .............day(s) .............date(s) at .................am/pm time(s). Please phone/write to confirm.

(Please delete options as applicable)

Signed ......................... Date .....................

245.
A3.1 Questions on Family Contacts and Relationships

NOW I would like to know something about your family and close relatives. Can you tell me who they are starting with the person you see or hear from most often.

Where do they live?

How often do you see them?

Where do you most often see them, at your home/the hospital, at their home or elsewhere?

(If there is no face-to-face contact)
Do you keep in contact by telephone or letter, or is there no contact at all?

How important is this contact with your (family member) to you?

(Repeat the above set of questions for each family member/close relative mentioned by rehabilitee)

Can we now talk a little more about the person whose contact means the most to you. This would be your?

Do you get on well together?

What do you usually talk about when you are together?

Do you feel he/she understands you?

Do you think he/she knows what is best for you?

Do you usually do what he/she suggests?

Do you ever do things which he/she disagrees with?
Questions on Family Contacts and Relationships (cont'd.)

Do you try to live up to his/her expectation of you?

What are these expectations?

Do they ever conflict with your own expectations of yourself?

How do you go about resolving any conflicts?

How do you think he/she sees you?
A3.2  Attitude Scale

Considering your own experiences and feelings at the present time can you tell me whether you agree or disagree (and to what extent) with each of the following statements. Please read each statement carefully and then tick (✓) one box for each, according to whether you:


<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Cannot Decide</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel very much at home at Workers' Meetings.</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>2. At times I think I am no good at all.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. On the whole I am satisfied with myself.</td>
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<tr>
<td>4. I can now cope for myself with most problems that arise in day to day living.</td>
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<tr>
<td>5. I often feel that other people can tell from my behaviour that I've been in hospital/I'm a hospital patient.</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. Most of my friends have also been patients.</td>
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<tr>
<td>7. I feel and act much like anyone in the community.</td>
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<tr>
<td>8. I am able to do things as well as most people.</td>
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<td></td>
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<tr>
<td>9. Most of the problems I experience now are shared by most people in the community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Going to Workers' Meetings often makes me depressed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I feel happy with my life now and think it will go on getting better.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My illness is still a very great burden which I cannot share with many others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

248.
<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Cannot Decide</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>I feel that I do not have much to be proud of.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I feel that I have a number of good qualities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I take a positive attitude towards myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I find it very boring hearing patients/other patients go on about their problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I certainly feel useless at times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Sometimes when I'm feeling good I forget I was ever in hospital/I am in hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Sometimes I feel I don't want to associate with patients/other patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>When things get hard I wish I was back in hospital/to stay in hospital for ever.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I often worry that I may have to go back into hospital/never get well enough to leave hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I feel that I am a person worth, at least on an equal plane with others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I often find myself talking about things that happened/ happen in hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I would enjoy visiting (the hospital) and talking to patients on the/other wards.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I wish I could have more respect for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A.3.3 'Who-Am-I' Schedule

Now I would like you to ask yourself the simple question 'WHO AM I?' and to write up to 20 answers in the numbered spaces below.

Just write down the answers as they come into your head: don't worry about the order or how important each one is. Try to work quickly as time is limited.

'WHO AM I?'

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.
A3.4 Semantic Differential Scales

Please rate 'THE WAY I AM NOW' using the scales set out below.

Place one (✓) along each scale, in between the colons, according to which of the pair of opposites seems to you to best describe 'THE WAY I AM NOW'. The scale allows you to indicate whether the word describes 'THE WAY I AM NOW' very well or only slightly.

Work quickly, ticking according to your first impressions.

<table>
<thead>
<tr>
<th>'THE WAY I AM NOW'</th>
<th>Very 1</th>
<th>Slightly 2</th>
<th>In Between 3</th>
<th>Slightly 4</th>
<th>Very 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ugly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unhappy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimistic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submissive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interested</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in enjoying myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High in self-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>confidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not well liked</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlucky</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irresponsible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masculine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

251.
BEHAVIOURAL CHARACTERISTICS OF REHABILITEES -

EXTRACTS FROM 'PSYCHIATRIC REHABILITATION: NEEDS OF A HEALTH DISTRICT' (Collis and Ekdawi, 1982)
A4.1  Symptomatic and Social Behaviour

Extract from Chapter A1, 'Psychiatric Rehabilitation: Needs of a Health District'
(Collis & Ekdawi, 1982: 175-190)
Al. SYMPTOMATIC AND SOCIAL BEHAVIOUR

Al.1 Introduction, Methodology and Hypotheses

Adjustment in rehabilitation is usually measured in terms of how well a person matches up to 'normal' behavioural expectations in the social environment in which they are (or will be) living. It is also usual to distinguish between symptomatic and social behaviours, since although the former may have important consequences for the latter, the two are not necessarily inter-related. Thus two rating scales were included on the Nursing Questionnaire and both referred to behaviour 'over the past two months' (to give a sufficient number of interactions for assessment between community nurses and rehabilitees living in the community).

Symptomatic behaviour was measured using Wing's (1960) Behaviour Rating Scale, which had been shown to have satisfactory reliability and validity. The 27 item scale was presented on the Nursing Questionnaire in the original order and the nursing staff asked to indicate whether each of the behaviours had occurred 'frequently', 'occasionally' or 'not at all'. The scale covered varying grades of negative, and some positive, behaviours. Following Wing's methodology these were then grouped for scoring purposes into 12 main subgroups of behaviour common in chronic schizophrenia (table Al.1). The item to which nursing staff gave the most severe rating was used to determine the score for each subgroup, with the scores in the present study varying from zero to 6; the lower the score the greater the severity. * Using factor analysis Wing (1960) had identified 2 main dimensions of behaviour, 'social withdrawal' and 'socially embarrassing behaviour'.

The requirements for the Social Behaviour Scale were that it should be relatively short and concerned with easily observable general

* The original scoring system ranged from -4 to +2; whilst not altering the magnitude of any differences the range 0 to 6 was easier to cope with on the computer package.
behaviours. The aim was to include a wide range of social behaviours relevant to all respondents including those on hospital wards. While a number of published scales were considered, none seemed ideal and it was decided to develop a scale which would better suit the present study. The result was a 32 item scale covering both positive and negative behaviours in 6 areas of daily life. As listed in Table A1.4, the scale covered: responsibility for personal care and hygiene (8 items), ability to act responsibly and without supervision (4 items), performance in the work role (6 items), relationship with living companions (6 items), use of leisure time (4 items), and sociability (4 items). On the Nursing Questionnaire the items were listed in random order as indicated by the numbers alongside each item in Table A1.4, and nursing staff were asked to indicate how often each item had described the rehabilitee's social behaviour over the past two months, 'never', 'occasionally', 'often', or 'constantly'.

It was hypothesised (considering chapters 3 and 9) that respondents resident in the hospital would be less well adjusted on both their symptomatic and social behaviours, with rehabilitation villa residents being more like community residents than those on the hospital hostel or other wards. Within the community it seemed likely that social adjustment would generally be highest for respondents living in group homes.

A1.2 Development and Testing of Scales
A1.2.1. Symptomatic Behaviour Scale. As noted above, Wing (1960) had identified two major dimensions to the symptomatic behaviour scale, social withdrawal and socially embarrassing behaviour. For comparison a factor analysis was carried out using present study data, and the factor loadings of the 12 behaviour subgroups for the varimax rotated solution are given in Table A1.1. Two main factors can be identified and the labels Social Withdrawal and Socially Embarrassing Behaviour are again appropriate. Of the 12 behaviour subgroups, 7 load significantly on each factor, with 5 loading on only one factor in each case. The behaviour subgroups careless of
Table A1.1

FACTOR ANALYSIS OF SYMPTOMATIC BEHAVIOUR SUBGROUPS

Showing Factor loadings for the Varimax Rotated Solution

<table>
<thead>
<tr>
<th>Symptomatic Behaviour Subgroups</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Social Withdrawal</td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II Lack of Conversation</td>
<td>0.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III Indifference</td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Careless of Appearance</td>
<td>0.55</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>V Slow</td>
<td>0.34</td>
<td></td>
<td>0.77</td>
</tr>
<tr>
<td>VI Underactive</td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII Overactive</td>
<td></td>
<td>0.55</td>
<td></td>
</tr>
<tr>
<td>VIII Irritable</td>
<td>0.39</td>
<td>0.34</td>
<td></td>
</tr>
<tr>
<td>IX Mannerisms</td>
<td></td>
<td></td>
<td>0.74</td>
</tr>
<tr>
<td>X Talks to Self</td>
<td></td>
<td>0.68</td>
<td></td>
</tr>
<tr>
<td>XI Laughs to Self</td>
<td></td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>XII Abnormal Speech</td>
<td></td>
<td>0.47</td>
<td></td>
</tr>
</tbody>
</table>
appearance and irritable load on both factors and are thus characteristic of social withdrawal and, to a lesser extent in each case, socially embarrassing behaviour.

If the Social Withdrawal and Socially Embarrassing Behaviour scores are calculated by summing only the scores for behaviour subgroups I to VI for Social Withdrawal and subgroups VII to XII for Socially Embarrassing Behaviour (in order to allow comparisons to be made with previous studies), table A1.2 shows that each behaviour subgroup score correlates significantly \( (P<0.001) \) with its respective total score. As might be expected from the significant loadings of careless of appearance and irritable on both the Social Withdrawal and Socially Embarrassing Behaviour factors, the factor scores correlate at a higher level \( (r=0.55, P<0.001) \) than in either the original study of chronic schizophrenic males \( (\text{Hospital A}, r=0.29, \text{Hospital B}, r=0.19) \) \( (\text{Wing, 1960}) \) or a later study of 273 chronic schizophrenic women \( (r=0.31) \) \( (\text{Wing, 1961}) \).

In his second study Wing \( (1961) \) used the Behaviour Rating Scale to validate the diagnostic classification of chronic schizophrenia, and found that analysis of variance disclosed 'a significant degree of variation between the five subgroups (of classification) on both the SW (Social Withdrawal) and the SE (Socially Embarrassing Behaviour) scores.' \( (\text{p.871}) \) Table A1.3 shows the mean scores by diagnostic subgroup for Social Withdrawal and Socially Embarrassing Behaviour for the 70 respondents in the present study who had a diagnosis of schizophrenia. It should be noted that due to the use of interviews there were no respondents in the Wing subgroups 4 or 5 which covered poverty of speech and muteness. This in fact led to a loss of only 1 or 2 possible respondents from the total eligible for interview since the follow-up was for a rehabilitation population. Wing found that the Social Withdrawal and Socially Embarrassing Behaviour scores did not differentiate between patients in subgroups 1, 4 or 5 (without severe florid symptoms) and subgroups 2 and 3 (with severe florid symptoms) but that there were significant differences in the scores within the two sets of subgroups.
Table A1.2

**CORRELATION OF SCORES FOR BEHAVIOUR SUBGROUPS WITH SOCIAL WITHDRAWAL OR Socially Embarrassing Behaviour Factor Scores**

<table>
<thead>
<tr>
<th>Symptomatic Behaviour Subgroups</th>
<th>Spearman Correlation Coefficients* with Social Withdrawal Score</th>
<th>with Socially Embarrassing Behaviour Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Social Withdrawal</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>II Lack of Conversation</td>
<td>0.77</td>
<td></td>
</tr>
<tr>
<td>III Indifference</td>
<td>0.77</td>
<td></td>
</tr>
<tr>
<td>IV Careless of Appearance</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>V Slow</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>VI Underactive</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>VII Overactive</td>
<td></td>
<td>0.71</td>
</tr>
<tr>
<td>VIII Irritable</td>
<td></td>
<td>0.77</td>
</tr>
<tr>
<td>IX Mannerisms</td>
<td></td>
<td>0.60</td>
</tr>
<tr>
<td>X Talks to Self</td>
<td></td>
<td>0.55</td>
</tr>
<tr>
<td>XI Laughs to Self</td>
<td></td>
<td>0.41</td>
</tr>
<tr>
<td>XII Abnormal Speech</td>
<td></td>
<td>0.51</td>
</tr>
</tbody>
</table>

*"P < 0.001 in all cases*
## Table A1.3

**Comparison of Differences in Symptomatic Behaviour Scores by Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis (Schizophrenia Subclassifications)</th>
<th>Social Withdrawal mean score</th>
<th>Socially Embarrassing Behaviour mean score</th>
<th>Total Respondents N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without severe florid symptoms*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a Minimal Symptoms</td>
<td>28.89</td>
<td>29.22</td>
<td>9</td>
<td>12.9</td>
</tr>
<tr>
<td>1b Moderate Symptoms</td>
<td>25.00</td>
<td>28.05</td>
<td>20</td>
<td>28.6</td>
</tr>
<tr>
<td>1c Moderate verbal disorder but severe flatness of affect</td>
<td>23.17</td>
<td>26.70</td>
<td>23</td>
<td>32.8</td>
</tr>
<tr>
<td>With severe florid symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Coherent delusions</td>
<td>22.60</td>
<td>24.60</td>
<td>15</td>
<td>21.4</td>
</tr>
<tr>
<td>3 Incoherence of speech</td>
<td>16.00</td>
<td>21.00</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>All Respondents with a diagnosis of Schizophrenia</td>
<td>24.29</td>
<td>26.71</td>
<td>70</td>
<td>100.0</td>
</tr>
</tbody>
</table>

| F | 4.906* | 3.453* |

*F < 0.05

**F < 0.01**

*There were no respondents in subgroups 4 (Poverty of speech) or 5 (mute) due to the use of 'interviews' which obviously demand certain verbal abilities and co-operation.
Due to the fact that the present study had no respondents in subgroups 4 or 5 it is not possible to follow up this finding. However, for respondents in the subgroups listed in table A1.3 there were significance differences between the scores for Social Withdrawal and Socially Embarrassing Behaviour, with easily identifiable gradations in mean scores from respondents in subgroup 1a (minimal symptoms) through those in subgroup 1c (moderate verbal disorder but severe flatness of affect) to those in subgroups 2 and 3 (with severe florid symptoms).

A1.2.2. Social Behaviour Scale. As for the Symptomatic Behaviour scale, a factor analysis was carried out on the scores of the 32 items in the Social Behaviour Scale. This was done in order: (i) to test whether the 32 items did in fact group in the way the researcher had hypothesised; (ii) to identify underlying relationships which may have been present and (iii) to identify 'key' items of behaviour which were shared by several factors. The principal 4 factors (with eigenvalues $\geq 1.0$), and the factor loadings ($\geq 0.30$) for the varimax rotated solution, are shown in table A1.4. Together these 4 factors accounted for 86% of the explained variance.

The only item which did not load significantly on any of the 4 factors was 'takes his medication regularly', item 10. This was probably because in the context of hospital life most patients did not have to take ultimate responsibility for remembering to take their medication, making the item inappropriate. Similarly, it will be noticed that 'forgets to take his medication' only just loads on Factor 1 at 0.30 (due to rounding up). Otherwise the factors produced are similar in composition to the subgroups of social behaviour listed in A1.1, except that what the researcher had suggested were 6 different subgroups are now seen to be regrouped into 4 main underlying factors. The items under responsibility for personal care and hygiene are amalgamated with ability to act responsibly and without supervision and items under sociability with use of leisure time.
### Table A1.4

**Factor Analysis of Social Behaviour Items**

showing factor loadings for the varimax rotated solution

<table>
<thead>
<tr>
<th>Social Behaviour</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Has good personal hygiene.</td>
<td>0.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Takes care over his clothes and appearance.</td>
<td></td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Keeps his room/things tidy and clean.</td>
<td></td>
<td>0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Tends to spend money on useless things.</td>
<td>-0.44</td>
<td></td>
<td>0.31</td>
<td></td>
</tr>
<tr>
<td>31 Budgets sensibly for rent (or equivalent), food etc.</td>
<td></td>
<td>0.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Forgets to take his medication.</td>
<td>-0.30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Does his expected share of household chores.</td>
<td></td>
<td></td>
<td></td>
<td>0.32</td>
</tr>
<tr>
<td>10 Takes his medication regularly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Forgets to do important things.</td>
<td>-0.66</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Needs considerable supervision and guidance from others.</td>
<td>-0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Has difficulty in making everyday decisions.</td>
<td>-0.56</td>
<td>0.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Seems more like a 10 year old child than a responsible adult.</td>
<td>-0.40</td>
<td>0.33</td>
<td>0.37</td>
<td></td>
</tr>
<tr>
<td>2 Spends most of his time out of work.</td>
<td></td>
<td></td>
<td></td>
<td>0.80</td>
</tr>
<tr>
<td>16 Attends work regularly.</td>
<td></td>
<td>-0.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Is often in and out of work.</td>
<td></td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Doesn't manage to keep a job for long.</td>
<td></td>
<td></td>
<td>0.65</td>
<td></td>
</tr>
<tr>
<td>27 Has a good attitude towards work.</td>
<td>0.33</td>
<td>-0.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Gets on well with his workmates.</td>
<td></td>
<td>-0.34</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
Table A1.4 (cont)

<table>
<thead>
<tr>
<th>Social Behaviour</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Upsets others he lives with.</td>
<td></td>
<td>0.41</td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td>24 Complains a lot about those he lives with.</td>
<td></td>
<td></td>
<td>0.79</td>
<td></td>
</tr>
<tr>
<td>30 Argues with those he lives with.</td>
<td></td>
<td></td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>29 Gets along well with those he lives with.</td>
<td></td>
<td></td>
<td>-0.70</td>
<td></td>
</tr>
<tr>
<td>13 Behaves considerately towards those he lives with.</td>
<td>0.39</td>
<td></td>
<td>-0.60</td>
<td></td>
</tr>
<tr>
<td>1 Is friendly and sociable towards those he lives with.</td>
<td></td>
<td>-0.45</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>21 Has several interests/hobbies which he spends time doing.</td>
<td></td>
<td></td>
<td></td>
<td>0.68</td>
</tr>
<tr>
<td>19 Organises his spare time constructively.</td>
<td>0.44</td>
<td></td>
<td></td>
<td>0.59</td>
</tr>
<tr>
<td>17 Participates in the activities of one or more community organisations.</td>
<td></td>
<td></td>
<td></td>
<td>0.55</td>
</tr>
<tr>
<td>9 Tends to sit around and do nothing.</td>
<td>-0.31</td>
<td>0.39</td>
<td></td>
<td>-0.34</td>
</tr>
<tr>
<td>4 Entertains his friends in the house/flat/ward.</td>
<td></td>
<td></td>
<td></td>
<td>0.60</td>
</tr>
<tr>
<td>5 Goes out and visits his friends.</td>
<td></td>
<td></td>
<td></td>
<td>0.52</td>
</tr>
<tr>
<td>32 Spends a great deal of time alone.</td>
<td></td>
<td></td>
<td></td>
<td>-0.51</td>
</tr>
<tr>
<td>22 Refuses to be sociable with people who visit the house/flat/ward.</td>
<td></td>
<td>0.41</td>
<td></td>
<td>-0.37</td>
</tr>
</tbody>
</table>
Thus if the factors are examined one at a time, Factor 1 loads positively on items of behaviour concerned with being responsible, independent, reliable and presentable. Perhaps 'Responsibility for Self' is the most apt heading for this factor. Doing one's share of household chores was found not to be related to this major orientation of Factor 1, but has to do more with use of time, covered in Factor 4. Other items which load on Factor 1 such as behaves considerately towards those he lives with, organises his spare time constructively, while not loading as high as they do on one or more of the other factors, are quite compatible with taking 'Responsibility for Self'.

Factor 2 is very much concerned with aspects of the work role, but also loads to a lesser degree on related items which cover more general attitudes and abilities which are of relevance in the working environment, e.g. tends to sit around and do nothing, has difficulty in making everyday decisions, upsets others he lives with. Factor 2 can thus be entitled 'Performance in the Work Role'. Factor 3 loads highly on all the items related to how one gets on with the other people one lives with, and can be called simply 'Relationship with living companions'. Factor 4 loads on those items concerned with how one uses one's free time, including whether it is spent with others in a sociable way or alone. Perhaps this factor can best be termed 'Use of Leisure Time and Sociability'.

There are 2 items which load significantly on 3 factors: seems more like a 10 year old child than a responsible adult and tends to sit around and do nothing. These can thus be seen as very general behavioural characteristics which affect all areas of life.

A1.3 Analysis and Discussion: Differences in Behaviour by Place of Residence.

Tables A1.5 and A1.6 show the mean scores on various dimensions of behaviour for respondents in different types of accommodation. Analysis of variance was used to examine the differences, and the tables also show the F values and levels of significance (p<0.05).
Taking symptomatic behaviour first, table A1.5 shows that there were significant differences between hospital and community residents on their Social Withdrawal and Socially Embarrassing Behaviour scores. As expected, hospital residents had lower average scale scores and thus showed more social withdrawal and socially embarrassing behaviour. Both hospital and community residents were more likely to show symptoms of social withdrawal than socially embarrassing behaviour.

Considering within community and within hospital differences, these were not significant, although it is interesting to examine the ordering of mean scores. Within the community, group home respondents and those living with parents showed the least amount of symptomatic behaviour, hostel residents the most, on both scales. Within the hospital it is not the rehabilitation villa residents who come out best, but the hospital hostel residents, although the differences are very small. Hospital hostel residents even show less symptomatic behaviour than respondents in community hostels. Not surprisingly, respondents on other wards have the lowest scores on each scale, indicating the greatest amount of symptomatic behaviour.

Turning to consider social behaviour, table A1.6 shows the mean scores for the 6 dimensions identified by the researcher and the total scale score. In order to give each of the 6 dimensions equal weighting in the total score, each dimension score was divided by the number of items in that dimension. Thus if D represents a dimension, Total Score = \( \frac{D_1}{6} + \frac{D_2}{8} + \frac{D_3}{4} + \frac{D_4}{4} + \frac{D_5}{4} + \frac{D_6}{6} \). With one exception the mean scores are higher for community respondents than those still resident in the hospital in October 1980, but the differences are not significant. It will be noted that hospital patients scored better on their performance in the work role than rehabilitees living in the community, due one would expect to greater supervision and the provision of a wide range of day-time
### Table A1.5

**COMPARISON OF DIFFERENCES IN SYMPTOMATIC BEHAVIOUR SCORES BY ACCOMMODATION 1980**

<table>
<thead>
<tr>
<th>Accommodation 1980</th>
<th>Social Withdrawal mean score</th>
<th>Socially Embarrassing Behaviour mean score</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(a) Differences between Community and Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>26.51</td>
<td>28.51</td>
<td>35</td>
</tr>
<tr>
<td>Hospital</td>
<td>23.66</td>
<td>26.22</td>
<td>65</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>24.66</td>
<td>27.02</td>
<td>100</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>5.493</td>
<td>7.057**</td>
<td></td>
</tr>
<tr>
<td><strong>(b) Differences within Community</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Parent(s)</td>
<td>27.21</td>
<td>29.07</td>
<td>14</td>
</tr>
<tr>
<td>With Spouse/Independent</td>
<td>25.17</td>
<td>27.83</td>
<td>6</td>
</tr>
<tr>
<td>Group Home</td>
<td>27.30</td>
<td>29.00</td>
<td>10</td>
</tr>
<tr>
<td>Hostel</td>
<td>24.60</td>
<td>26.80</td>
<td>5</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>26.51</td>
<td>28.51</td>
<td>35</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>0.399</td>
<td>1.103</td>
<td></td>
</tr>
<tr>
<td><strong>(c) Differences within Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Villa</td>
<td>24.78</td>
<td>26.81</td>
<td>27</td>
</tr>
<tr>
<td>Hospital Hostel</td>
<td>25.58</td>
<td>27.83</td>
<td>12</td>
</tr>
<tr>
<td>Other Ward</td>
<td>21.62</td>
<td>24.85</td>
<td>26</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>23.66</td>
<td>26.22</td>
<td>65</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>2.925</td>
<td>2.096</td>
<td></td>
</tr>
</tbody>
</table>

* P<0.05  **P<0.01

265.
## Table A1.6

**COMPARISON OF DIFFERENCES IN SOCIAL BEHAVIOUR SCORES BY ACCOMMODATION 1980**

<table>
<thead>
<tr>
<th>Accommodation 1980</th>
<th>Relationship with living companions (6 items) mean score</th>
<th>Responsibility for personal care (8 items) mean score</th>
<th>Ability to act responsibly and independently (4 items) mean score</th>
<th>Sociability (4 items) mean score</th>
<th>Use of Leisure time (4 items) mean score</th>
<th>Performance in the Work Role (6 items) mean score</th>
<th>Total Social Behaviour mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Differences between Community and Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community (35)</td>
<td>19.49</td>
<td>26.51</td>
<td>13.20</td>
<td>10.31</td>
<td>9.34</td>
<td>17.61</td>
<td>17.89</td>
</tr>
<tr>
<td>Hospital (65)</td>
<td>19.08</td>
<td>24.86</td>
<td>12.52</td>
<td>9.66</td>
<td>8.62</td>
<td>17.91</td>
<td>17.25</td>
</tr>
<tr>
<td>Total Respondents (100)</td>
<td>19.22</td>
<td>25.44</td>
<td>12.76</td>
<td>9.89</td>
<td>8.87</td>
<td>19.03</td>
<td>17.47</td>
</tr>
<tr>
<td>F</td>
<td>0.276</td>
<td>2.660</td>
<td>1.419</td>
<td>1.987</td>
<td>1.518</td>
<td>2.925</td>
<td>0.979</td>
</tr>
<tr>
<td>(b) Differences within Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Parent(s) (14)</td>
<td>20.36</td>
<td>28.21</td>
<td>13.50</td>
<td>10.00</td>
<td>9.36</td>
<td>16.67</td>
<td>18.00</td>
</tr>
<tr>
<td>With Spouse/Independent (6)</td>
<td>17.33</td>
<td>25.83</td>
<td>13.67</td>
<td>9.63</td>
<td>9.00</td>
<td>18.33</td>
<td>17.50</td>
</tr>
<tr>
<td>Group Home (10)</td>
<td>19.00</td>
<td>26.00</td>
<td>13.30</td>
<td>10.80</td>
<td>10.00</td>
<td>17.90</td>
<td>18.10</td>
</tr>
<tr>
<td>Hostel (5)</td>
<td>20.50</td>
<td>23.60</td>
<td>11.60</td>
<td>10.80</td>
<td>8.40</td>
<td>20.80</td>
<td>17.60</td>
</tr>
<tr>
<td>Total Respondents (35)</td>
<td>19.49</td>
<td>26.51</td>
<td>13.20</td>
<td>10.31</td>
<td>9.34</td>
<td>17.91</td>
<td>17.89</td>
</tr>
<tr>
<td>F</td>
<td>1.025</td>
<td>1.775</td>
<td>0.632</td>
<td>0.431</td>
<td>0.275</td>
<td>0.768</td>
<td>0.054</td>
</tr>
<tr>
<td>(c) Differences within Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Villa (27)</td>
<td>19.37</td>
<td>24.96</td>
<td>12.59</td>
<td>10.04</td>
<td>9.37</td>
<td>20.69</td>
<td>17.81</td>
</tr>
<tr>
<td>Hospital Hostel (12)</td>
<td>21.00</td>
<td>26.25</td>
<td>14.17</td>
<td>9.92</td>
<td>7.92</td>
<td>21.75</td>
<td>18.50</td>
</tr>
<tr>
<td>Other Ward (26)</td>
<td>17.88</td>
<td>24.12</td>
<td>11.69</td>
<td>9.15</td>
<td>8.15</td>
<td>17.35</td>
<td>16.08</td>
</tr>
<tr>
<td>Total Respondents (65)</td>
<td>19.08</td>
<td>24.86</td>
<td>12.52</td>
<td>9.66</td>
<td>8.62</td>
<td>19.63</td>
<td>17.25</td>
</tr>
<tr>
<td>F</td>
<td>3.482*</td>
<td>0.720</td>
<td>3.390*</td>
<td>1.132</td>
<td>2.159</td>
<td>6.519**</td>
<td>3.971*</td>
</tr>
</tbody>
</table>

*P<0.05  **P<0.01
occupations. The table goes on to examine the differences in social behaviour scores within the hospital and community. Whilst there are few significant differences, the ordering of the scores is again worth examining in some detail.

Looking firstly at respondents resident in the community: those living with parents were below average on their performance in the work role and marginally on sociability, but otherwise scored well especially on responsibility for personal care and hygiene; group home residents scored only marginally higher overall, but were above average on use of leisure time and sociability. On the other hand hostel residents scored relatively well on performance in the work role, getting on with living companions and sociability, but were noticeably poor on responsibility for personal care and hygiene, ability to act responsibly and without supervision, and use of leisure time.

Only when differences between various groups of respondents within the hospital are considered do they become significant, for performance in the work role, getting on with living companions, and ability to act responsibly and without supervision. Patients in other wards scored badly on all three, as well as on most of the other dimensions. In general those in the hospital hostel had the highest scores; the main exception being for use of leisure time. It was on this dimension that patients on the rehabilitation villas came out on top; on all other dimensions (except sociability) they took up the intermediate position between hospital hostel and other ward residents.

Differences were also analysed using scores on the four dimensions of social behaviour identified through factor analysis. The results were very similar to those already discussed, with the only significant difference being for Factor 2 scores, performance in the Work Role, for within hospital groups.

Interpretation of the above analysis must be made cautiously, since the differences are numerically small and few are
statistically significant. However, this in itself is interesting if rather unexpected. Thus while the symptomatic behaviour of community respondents is significantly better than for hospital respondents this is not reflected to such a marked degree by better social behaviour. Is it then true that freedom from symptomatic behaviours is more important in determining discharge than a rehabilitee's level of social adjustment?

While keeping the above comments in mind, certain differences in social adjustment between respondents in different types of community accommodation do illustrate the differing requirements made of rehabilitees, and are worth summarising. Both parental and group homes demand rehabilitees to take a high level of responsibility for personal care and to act responsibly and without supervision. However, the parental home makes fewer demands than other types of community accommodation as regards performance in the work role. While it is important that rehabilitees should get on well with those they live with, sociability with others outside the family group tends to be low. By contrast group home residents score high on sociability and also tend to make more constructive use of their leisure time than others in the community.

Hostels provide more supervision than other types of community accommodation, with residents also taking less responsibility for their personal care. However, they tend to get on well with their living companions and have a good level of sociability (? only with other residents), although they make poor use of the leisure time. Hostel residents in the present study also tend to be very competent in the work role. This may simply reflect the tie up between sheltered work and hostel accommodation at the Ex-Services Hostel Welfare Society set up at Leatherhead, and may not be true for other hostel residents.

Turning to hospital residents, the results were not as hypothesised. Except on their use of leisure time and sociability, residents in the hospital hostel and not those on the rehabilitation villa had
the highest levels of social adjustment. However, perhaps this is not so difficult to explain as the hospital hostel does cater for relatively independent elderly rehabilitees, who require little supervision. Most of the residents are regularly occupied during the day and many respondents on the villa volunteered during interview how much they like the other residents and the fact that they all got on well together.
A4.2 Self-Care Skills and Involvement

Extract from Chapter A2, 'Psychiatric Rehabilitation: Needs of a Health District' (Collis & Ekdawi, 1982: 191-199)
A2. SELF-CARE SKILLS AND INVOLVEMENT

A2.1 Introduction, Methodology and Hypotheses

During rehabilitation a major emphasis is placed on (re)training in the activities of daily living, with rehabilitees taking increasing responsibility for their self-care in the personal, domestic and social sphere. The assessment schedule used on the rehabilitation villas to measure rehabilitees' skills and involvement in 5 main areas of self-care (plus educational skills) has also been described in 5.1. During the follow-up study both rehabilitees and nursing staff were asked to complete the self-care schedule. The ratings covered a number of specific activities in each of the main topic areas: cooking (11 items), clothes care (5 items), household chores (5 items), use of public services (12 items) and handling money (4 items). The ratings were on a 5-point scale: (0) very satisfactory (1) probably satisfactory (2) definitely not satisfactory; thus the lower the cumulative score in each topic area the more satisfactory the rehabilitee.

To simplify the analysis only staff assessments will be used in the following discussion. In general these were lower than respondents' self assessments, the exceptions being for involvement in clothes care and use of public services. However, respondents resident on other wards consistently rated themselves less satisfactory than did the nursing staff on both skills and involvement.

The varying self-care requirements made of rehabilitees in different types of accommodation means that on discharge satisfactory adjustment is likely to be achieved with different levels of ability. Thus it can be hypothesised, for example, that rehabilitees being discharged to a group home will require a higher level of ability in domestic activities (cooking and household chores) than those going to the type of hostel where meals are supplied and domestic staff employed to do much of the cleaning etc. Rehabilitees returning to the parental home may find that 'mother' not only takes care of most of the domestic activities but also assumes an important role in clothes-care (since this includes washing, ironing...
and mending of clothes) and possibly in dealing with public services. The problems this is likely to cause in the future were described in 9.1 and it was recommended that parents should be informed and involved in the self-care rehabilitation programmes so that they understand the importance of allowing rehabilitees to do as much as they are able (12.2.2).

It has already been noted (4.1) that for 1977 rehabilitation villa residents female respondents rated consistently above male respondents on their self-care abilities. (However, this did not mean they were more likely to have been discharged; in fact the opposite was true). Whether this difference is consistent for all types of accommodation needs to be examined further. Thus the following analysis will seek to compare respondents' 1980 self-care ratings both between those resident in different types of accommodation and between males and females.

A2.2 Analysis and Discussion

A2.2.1. Differences in Self-Care Abilities by Place of Residence.

Table A2.1 shows the mean skills ratings on the 6 areas of self-care for respondents in different types of accommodation. The differences between means were tested for significance by analysis of variance and the F values and significance levels are given in the table. Table A2.2 shows the corresponding data for ratings on self-care involvement; as noted earlier (7.2) involvement ratings were analysed on only 4 areas of self-care: cooking, clothes care, household chores and public service use. Comparing firstly the ratings for respondents in the community and the hospital; those for community residents showed them to be consistently more satisfactory on both skills and involvement than hospital residents. The differences were significant for skills and involvement in cooking and use of public services and for skills in handling money.

Looking next at differences within the hospital, the tables show that these were significant for both skills and involvement in cooking, clothes care, household chores and public service use. Respondents on the rehabilitation villas were by far the most
Table A2.1

DIFFERENCES IN SELF-CARE SKILLS BY ACCOMMODATION 1980

<table>
<thead>
<tr>
<th>Accommodation 1980</th>
<th>Mean Scores for Staff Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Education</td>
</tr>
<tr>
<td>(a) Differences between Community and Hospital</td>
<td></td>
</tr>
<tr>
<td>Community (35)</td>
<td>1.86</td>
</tr>
<tr>
<td>Hospital (65)</td>
<td>2.79</td>
</tr>
<tr>
<td>Total Respondents (100)</td>
<td>2.46</td>
</tr>
<tr>
<td>F</td>
<td>3.169</td>
</tr>
<tr>
<td>(b) Differences within Community</td>
<td></td>
</tr>
<tr>
<td>With Parent(s) (14)</td>
<td>0.86</td>
</tr>
<tr>
<td>With Spouse/Independent (6)</td>
<td>2.50</td>
</tr>
<tr>
<td>Group Home (10)</td>
<td>1.60</td>
</tr>
<tr>
<td>Hostel (5)</td>
<td>4.40</td>
</tr>
<tr>
<td>Total Respondents (35)</td>
<td>1.86</td>
</tr>
<tr>
<td>F</td>
<td>3.435*</td>
</tr>
<tr>
<td>(c) Differences within Hospital</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Villa (27)</td>
<td>3.22</td>
</tr>
<tr>
<td>Hospital Hostel (12)</td>
<td>2.17</td>
</tr>
<tr>
<td>Other Ward (26)</td>
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<tr>
<td>Total Respondents (65)</td>
<td>2.78</td>
</tr>
<tr>
<td>F</td>
<td>0.821</td>
</tr>
</tbody>
</table>

* P < 0.05  ** P < 0.01  *** P < 0.001
Table A2.2

DIFFERENCES IN SELF-CARE INVOLVEMENT BY ACCOMMODATION 1980

<table>
<thead>
<tr>
<th>Accommodation 1980</th>
<th>Mean Scores for Staff Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cooking</td>
</tr>
<tr>
<td>(a) Differences between Community and Hospital</td>
<td></td>
</tr>
<tr>
<td>Community (55)</td>
<td>3.20</td>
</tr>
<tr>
<td>Hospital (65)</td>
<td>3.74</td>
</tr>
<tr>
<td>Total Respondents (100)</td>
<td>3.55</td>
</tr>
<tr>
<td>F</td>
<td>4.087</td>
</tr>
<tr>
<td>(b) Differences within Community</td>
<td></td>
</tr>
<tr>
<td>With Parent(s) (14)</td>
<td>3.50</td>
</tr>
<tr>
<td>Spouse/Independent (6)</td>
<td>3.83</td>
</tr>
<tr>
<td>Group Home (10)</td>
<td>1.70</td>
</tr>
<tr>
<td>Hostel (5)</td>
<td>4.60</td>
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<tr>
<td>Total Respondents (55)</td>
<td>3.20</td>
</tr>
<tr>
<td>F</td>
<td>6.449</td>
</tr>
<tr>
<td>(c) Differences within Hospital</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Villa (27)</td>
<td>2.85</td>
</tr>
<tr>
<td>Hospital Hostel (12)</td>
<td>4.42</td>
</tr>
<tr>
<td>Other Ward (26)</td>
<td>4.35</td>
</tr>
<tr>
<td>Total Respondents (65)</td>
<td>3.74</td>
</tr>
</tbody>
</table>

*P < 0.05  **P < 0.01  ***P < 0.001
satisfactory and those in the hospital hostel the least satisfactory in all cases. Other ward residents were rated between these two, with their mean ratings being generally closer to those for hospital hostel residents than rehabilitation villa residents. Respondents in the latter group were particularly noticeable for their much greater involvement in self-care activities than the other two groups.

Turning to compare ratings for respondents in different types of within community accommodation, those in a group home were the most satisfactory on both skills and involvement in cooking, clothes care, household chores and public service use. Meanwhile hostel residents rated the least satisfactory on skills in these 4 areas but only on involvement in cooking and public service use. Respondents living with parents were lowest on clothes care involvement and those either living with a spouse or independently were lowest on involvement in household chores. However, only a few of the differences were significant. Compared with other groups hostel residents were particularly unsatisfactory on skills in education and public service use; group home respondents were particularly satisfactory on their involvement in cooking and household chores.

Since most rehabilitation villa residents are being prepared for eventual resettlement in the community, it is important to see to what extent they match up to those already living in the community. Comparing firstly rehabilitation villa residents and all community respondents, villa residents are more skilled and involved in clothes care and household chores although the differences are only significant for involvement, \( (P < 0.05 \) and \( P < 0.01 \) respectively) and they are slightly more involved, although less skilled, in cooking. Compared with the 4 groups of within community residents rehabilitation villa residents come out third on skills in clothes care and cooking (to group home residents and those living with parents) but top on involvement in clothes care (marginally above group
home residents) and second on involvement in cooking (to group home residents). They come out top on both skills and involvement in household chores, with group home residents and those living with parents coming next on skills and group home and hostel residents next on involvement.

However, on skills and involvement in public service use rehabilitation villa respondents do not do so well, being significantly less satisfactory than community respondents generally ($P < 0.001$ and $P < 0.05$ respectively). Compared to the 4 groups of community residents they are only slightly more satisfactory than hostel residents who are noticeably less satisfactory than other community residents. On skills in handling money rehabilitation villa residents do not reach the level of any group of community residents and in education they are the least satisfactory of any group except hostel residents in the community. The former rehabilitation villa/all community difference is significant ($P < 0.05$) the latter just not significant ($P > 0.05$).

In general then the training programmes on the rehabilitation villas seem to ensure an adequate level of skills in cooking, clothes care and household chores compared with the requirements of community living. Involvement in these activities tends to be very high whilst respondents are on the rehabilitation villas, but once they are discharged may decline especially if there are others around to take over. This was particularly so for respondents living with parents; their involvement tended to be below that expected by the level of their skills.

In contrast, rehabilitation villa residents' skills in education, handling money and both skills and involvement in public service use were generally unsatisfactory compared with respondents already resident in the community. These results are discussed in some detail in chapter 7, and it is recommended (12.1.1) that the relevant rehabilitation programmes should be revised to take account
of the needs of this more handicapped group of rehabilitees. Particular attention needs to be paid to the teaching of basic educational skills (literacy and numeracy) since these are necessary pre-requisites both for handling money and for use of public services. Satisfactory involvement in the latter area requires knowledge, competence and confidence, which for rehabilitees who have spent some years in the hospital may take a long time to acquire. It will also require considerable input of time and energy by nursing staff, especially in the initial stages. However, if rehabilitees discharged to the community are to be of the community and not just in the community; if they are to be able to take advantage of the services the community has to offer and to participate in community activities then it is essential that they should be adequately trained in both basic skills and use of public services.

A2.2.2. Differences in Self-Care Skills and Involvement between Males and Females. The second area of differences in self-care skills and involvement to be analysed in this appendix is between male and female respondents. The analysis is for 3 groups of respondents, all hospital residents, rehabilitation villa residents and community residents. Taking all respondents resident in the hospital in October 1980, table A2.3 shows that females were more satisfactory on both their skills and involvement in all areas of self-care; the differences being highly significant for cooking, clothes care and household chores.

Looking next at a subgroup of the above, respondents resident on the rehabilitation villas, the most striking comparison is that the differences are not so great as for all hospital residents. Females are still more satisfactory than males in the areas of domestic care but the differences are only significant (and at a lower level than for all hospital residents) for clothes care and household chores. On cooking the males have caught up considerably so that the difference is not significant on either skills or involvement.
For respondents still resident on the rehabilitation villas in October 1980 the males were slightly more satisfactory on their education skills, and there was little difference on skills in handling money. There was also little difference on skills and involvement in use of public services with males doing marginally better on involvement. Thus the training programmes on the rehabilitation villas seem most effective in diminishing the gap between male and female skills and involvement in the areas of cooking and public service use, while the gap seems harder to close for clothes care and household chores.

To see how discharge to the community affects the differences between males and females, table A2.3 also gives data for community residents. Females are still significantly more satisfactory on their skills and involvement in clothes care and household chores, and on their cooking skills, though not involvement. If the mean ratings are compared with those for rehabilitation villa residents, the males in the community are in fact very similar to those on the rehabilitation villas, whilst the females in the community have improved their cooking skills considerably over females on the rehabilitation villas. Thus it appears that the traditional ideas of domestic care activities as a 'female' role remains. Males can get by with lower skills in all areas, and lower involvement in clothes care and household chores. Once they are discharged it seems that females tend to improve their cooking skills, whilst the males are content with what they learnt on the rehabilitation villas. However, for both males and females discharge means more use of public services, with the males becoming marginally better skilled in this area.
### Differences in Self-Care Abilities for Males and Females

<table>
<thead>
<tr>
<th>Sex</th>
<th>Mean Ratings on Staff Assessments</th>
<th>Self-Care Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Education</td>
<td>Cooking</td>
</tr>
<tr>
<td>(a) Differences between Hospital residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (36)</td>
<td>2.86</td>
<td>13.50</td>
</tr>
<tr>
<td>Females (29)</td>
<td>2.69</td>
<td>7.28</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>2.78</td>
<td>10.72</td>
</tr>
<tr>
<td>F</td>
<td>0.073</td>
<td>16.274</td>
</tr>
<tr>
<td>(b) Differences between Rehabilitation Villa residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (12)</td>
<td>2.92</td>
<td>8.25</td>
</tr>
<tr>
<td>Females (15)</td>
<td>3.47</td>
<td>6.20</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>3.22</td>
<td>7.11</td>
</tr>
<tr>
<td>F</td>
<td>0.213</td>
<td>0.953</td>
</tr>
<tr>
<td>(c) Differences between Community residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (25)</td>
<td>2.28</td>
<td>8.04</td>
</tr>
<tr>
<td>Females (10)</td>
<td>0.80</td>
<td>3.40</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>1.86</td>
<td>6.71</td>
</tr>
<tr>
<td>F</td>
<td>2.827</td>
<td>6.317</td>
</tr>
</tbody>
</table>

*P < 0.05  **P < 0.01  ***P < 0.001
The comparison of factor scores between the same population on different concepts or different populations on the same concept was shown to have considerable methodological advantages over the comparison of individual scale scores or total scale scores (3.4.2). However, there would seem to be two important conditions to be met to ensure that the comparison of factor scores produces theoretically and methodologically valid results. The first condition is that the underlying dimensions identified through factor analysis are meaningful in terms of the concept being considered. The second condition is that the factor structures of two concepts which are to be compared on their factor scores should be similar. Judd and Smith (1974) suggested that this was not necessarily the case for Real-Self and Ideal-Self (3.4.2).

In order to decide whether it is appropriate to use factor scores in addition to individual and total scale scores in the analysis undertaken in Chapters 4 and 5, this Appendix sets out to see whether the two conditions outlined are met for the concepts and population under study.

In order to see whether the first condition is fulfilled for the factor analysis of rehabilitees' ratings of Real-Self, the first part of Table A5.1 shows the factor loadings (greater than or equal to 0.30) for the varimax rotated solution. Eight scales (out of 18) load on the first factor, which seems to be a general factor concerning whether or not rehabilitees are getting on with life in a normal way. Thus the positive pole suggests that rehabilitees feel Confident, Calm, Lucky and Optimistic, and that in interactions with others they are Outgoing, Well-Liked and Friendly. The second factor is essentially an evaluative dimension, loading highest on the scale Good-Bad, which was included in the chosen set of scales as the marker scale for Osgood et al's (1957) evaluative dimension of connotative meaning (3.5.1). Being Good is associated with being Responsible and Happy, as well as with several of the adjectives also loading on factor 1, Lucky, Friendly and Well-Liked. The highest loading scale on the third factor is Optimistic-Pessimistic, with rehabilitees who see themselves as Optimistic also seeing themselves
<table>
<thead>
<tr>
<th>Semantic Differential Scales</th>
<th>REAL-SELF</th>
<th>IDEAL-SELF</th>
<th>MOST PSYCHIATRIC PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good-Bad</td>
<td>0.56</td>
<td>0.45</td>
<td>0.55</td>
</tr>
<tr>
<td>Strong-Weak</td>
<td>0.30</td>
<td>0.33</td>
<td>0.37</td>
</tr>
<tr>
<td>Active-Passive</td>
<td>0.31</td>
<td>0.46</td>
<td>0.70</td>
</tr>
<tr>
<td>Optimistic-Pessimistic</td>
<td>0.38</td>
<td>0.77</td>
<td>0.59</td>
</tr>
<tr>
<td>Calm-Emotional</td>
<td>0.59</td>
<td>0.78</td>
<td>0.36</td>
</tr>
<tr>
<td>Happy-Unhappy</td>
<td>0.55</td>
<td></td>
<td>0.32</td>
</tr>
<tr>
<td>High in Confidence-Low in Confidence</td>
<td>0.67</td>
<td>0.57</td>
<td>0.77</td>
</tr>
<tr>
<td>Creative-Uncreative</td>
<td>0.50</td>
<td>0.70</td>
<td>0.52</td>
</tr>
<tr>
<td>Important-Unimportant</td>
<td>0.56</td>
<td>0.68</td>
<td>0.49</td>
</tr>
<tr>
<td>Lucky-Unlucky</td>
<td>0.40</td>
<td>0.49</td>
<td>0.59</td>
</tr>
<tr>
<td>Independent-Dependent</td>
<td></td>
<td>0.53</td>
<td>0.52</td>
</tr>
<tr>
<td>Outgoing-Shy</td>
<td>0.61</td>
<td>0.47</td>
<td>0.35</td>
</tr>
<tr>
<td>Friendly-Unfriendly</td>
<td>0.40</td>
<td>0.40</td>
<td>0.75</td>
</tr>
<tr>
<td>Well Liked - Not Well Liked</td>
<td>0.45</td>
<td>0.57</td>
<td>0.73</td>
</tr>
<tr>
<td>Responsible-Irresponsible</td>
<td>0.60</td>
<td>0.62</td>
<td>0.36</td>
</tr>
<tr>
<td>Young-Old</td>
<td></td>
<td>0.40</td>
<td>0.57</td>
</tr>
<tr>
<td>Beautiful-Ugly</td>
<td>0.82</td>
<td>0.56</td>
<td>0.68</td>
</tr>
</tbody>
</table>
as Creative and Important, and also as Responsible, High in Confidence and Good. The latter three scales all load at only 0.30 or just over, and had primary loadings on factors 1 or 2. The fourth factor combines Osgood et al's (1957) Potency and Activity marker scales, Strong-Weak and Active-Passive, with secondary loadings on High in Confidence-Low in Confidence, Creative-Uncreative and Responsible-Irresponsible. Only two scales load on each of the last two factors, with factor 5 being concerned with being Young and Beautiful (or Old and Ugly) and factor 6 with being Happy and Independent (or Unhappy and Dependent).

Overall the six factors are able to explain 63% of the variance in rehabilitees' responses, and would seem to be fairly meaningful and easy to 'label'. While the scale Dominant-Submissive does not load on any factor, the two scales High in Confidence-Low in Confidence and Responsible-Irresponsible load on three, and a further eight scales on two factors.

However, it is over the fulfillment of the second condition that the use of factor scores in the present study becomes problematic. Even a quick glance at the factor structures for Real-Self, Ideal-Self and 'Most Psychiatric Patients' in Table A5.1 shows considerable variations between them. While factor 1 does appear to have certain similarities between Real-Self and Ideal-Self (with five out of eight scales in common), when all three concepts are compared there are only two scales in common: Active-Passive and High in Confidence-Low in Confidence. Further, while the scale Active-Passive is of only secondary importance for Real-Self and Ideal-Self, it loads 0.70 on factor 1 for 'Most Psychiatric Patients'.

There are some similarities between the three concepts, with the scales Strong-Weak and Active-Passive on the one hand and the scales Young-Old and Beautiful-Ugly on the other, having their highest loadings on the same factors of each concept. Further, the second factor seems to be an evaluative one in each case, with a high loading on the scale Good-Bad. However, on further inspection the relevant factors do not appear quite so equivalent. Thus, while for Real-Self the scales Strong-Weak and Active-Passive characterise a separate factor (factor 4), for Ideal-Self...
and 'Most Psychiatric Patients' they form part of factor 1, relating to a general sense of how the individual, his/her Ideal or 'Most Psychiatric Patients' feel about life and interact with others. This suggests that it might be possible to combine factors 1 and 4 for Real-Self and make a factor equivalent to factor 1 on the other concepts. However, while this leads to Real-Self having seven scales in common with factor 1 on the other two concepts, there are still only four scales which are common to factor 1 for Ideal-Self and 'Most Psychiatric Patients'.

Looking more carefully at the second factors, those for Real-Self and 'Most Psychiatric Patients' are seen to be fairly similar, with four scales in common out of six and seven, respectively. However, Ideal-Self has only two scales in common with each of the other concepts for factor 2. Thus, while for Real-Self and 'Most Psychiatric Patients' being Good is associated with being Happy, Friendly and Well-Liked (plus Lucky and Responsible for Real-Self, and Strong, Important and Beautiful for 'Most Psychiatric Patients'), for Ideal-Self it is associated with being Lucky, Outgoing, Young and Beautiful. The latter two scales form a separate factor, not associated with being Good or Bad, for Real-Self and 'Most Psychiatric Patients' (factors 5 and 4 respectively). This might suggest combining these factors with factor 2 to make them equivalent to factor 2 for Ideal-Self; however, the evaluative factor for Ideal-Self is still quite unlike the evaluative factors for Real-Self and 'Most Psychiatric Patients'.

The above discussion would seem to suggest that the factor structures of the three concepts are not equivalent and that 'juggling' with various combinations of factors is both arbitrary and not very productive. Consequently the decision was made to limit the analysis of semantic differential data to the use of individual scale scores, total scale scores (summing across the 18 scales) and 'D' scores (for the 18 scales taken together).
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