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Assessing Suicide Ideation: Comparing Self-Report Versus Clinician Report

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BACKGROUND: The accurate identification of suicidal individuals is an important but complex process. Common approaches to suicide assessment include self-report tools and clinician interview. PURPOSE: The purpose of this study was to examine and compare two assessment methods for determining suicidal ideation of patients admitted for treatment of a mood or anxiety disorder. DESIGN: A secondary analysis of an existing dataset was conducted. Sixty-eight inpatients treated for mood or anxiety disorders completed the Beck Depression Inventory (BDI) and were assessed by a clinician using an investigator-developed interview schedule. One item from BDI and one question from the interview schedule were used to compare two methods for assessing suicidal ideation. RESULTS: In 80% of cases, responses were in agreement between the two assessment methods. However, disagreement between assessment methods was found for 13 (19.4%) cases. The rate of disagreement was beyond chance (p = .00). CONCLUSION: The findings support inclusion of both a self-report method and a face-to-face interview to assess suicide ideations. Further research is warranted to examine if both methods for assessing suicide ideations are indicated during the first 24 hours after admission to an inpatient unit. J Am Psychiatr Nurses Assoc, 2004; 10(1), 9-15.

Keywords: suicide assessment; depression; comparing methods; psychiatric hospitalization

Each year about 30,000 people die by suicide in the United States (Kaplan & Sadock, 1998). The loss of even one person’s life by suicide is especially tragic and affects many others, particularly the victim’s family, friends, and health care providers. However, the accurate identification of suicidal individuals is a complex and difficult process. Patients are not always willing to talk openly about their suicidal ideas, and, in turn, clinicians may not always thoroughly or accurately assess this sensitive topic.

Self-rating instruments that include one or more items on suicidal thoughts, such as the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and clinical face-to-face interviews have been the most widely used methods to determine if a person is suicidal or not. Several authors suggest that some patients feel more comfortable disclosing their suicidal thoughts using a self-rating questionnaire than in discussing such information in a face-to-face interview (Erdman, Greist, Gustafson, Taves, & Erbaugh, 1961), and clinical face-to-face interviews have been the most widely used methods to determine if a person is suicidal or not. Several authors suggest that some patients feel more comfortable disclosing their suicidal thoughts using a self-rating questionnaire than in discussing such information in a face-to-face interview (Erdman, Greist, Gustafson, Taves, & Klein, 1987; Greist et al., 1973; Levine, Ancill, & Roberts, 1989). According to the findings from these studies, self-rating instruments for assessing suicidal behaviors have the advantage of being standardized. Whereas clinicians may either rely on their intuitions and/or omit or fail to inquire about specific data relevant to suicide risk, standardized self-rating instruments encourage a more complete and objective assessment of suicidal behaviors (Asnis et al., 1994).
Little research has been conducted on the agreement between clinician assessment of suicide and self-report methods, yet clinician assessment remains the primary standard for determining suicidal risk and treatment recommendation. By investigating and comparing these two methods of suicidal assessment, a better understanding of the consistency and agreement of each in assessing suicidal patients can be discovered.

Thus, the purpose of this study was to examine and compare two assessment methods for determining suicidal ideation. A secondary analysis of an existing dataset was performed to determine whether patients admitted for treatment of a mood or anxiety disorder disclosed the same suicide-related information on a self-administered questionnaire that clinicians subsequently reported based on a face-to-face structured interview with the patient. One item from a self-report questionnaire and one question from an interview schedule were used to compare two methods for assessing suicidal ideation.

The following research questions were addressed: (a) What is the observed agreement between two methods of assessing suicide ideation among patients admitted for inpatient treatment for a mood or anxiety disorder? (b) What is the observed agreement between two methods of assessing suicidal ideation among patients admitted for inpatient treatment for a mood or anxiety disorder based on gender, treatment, education, and age?

METHODOLOGY

The primary study consisted of a convenience sample of 68 participants admitted to a Midwestern adult inpatient psychiatric unit that treated primarily mood, anxiety, eating, and adjustment disorders. The purpose of the primary study was to examine the relationship between brief inpatient treatment intensity and treatment outcomes (Tucker, Moore, & Luedtke, 2000). At the time of admission and dismissal to the inpatient treatment unit, all participants completed the BDI (Beck et al., 1961) and a clinician/researcher interviewed (assessed) all patients using an interview schedule designed by the researchers. Data from the primary study were used in the current study to explore whether patients disclosed the same suicide-related information in the BDI that clinicians subsequently reported based on a face-to-face interview with the patient in the initial 24 hours following admission.

The two methods of assessment of suicide ideation compared in this study were one item from the BDI (Beck et al., 1961) and one item from the interview schedule designed for the primary study. The BDI is a 21-item scale that assesses the presence and severity of affective, cognitive, motivational, vegetative, and psychomotor components of depression. Each of the 21 items consists of three or four self-evaluative statements of increasing severity (ranging from 0 to 3 points). Patients choose the statement that best describes how they have been feeling over the past week. Scores range from 0 to 63, with higher scores indicating greater severity of depression. The BDI was standardized on two samples of mixed inpatients and outpatients and has been used on a wide range of groups including both clinical and nonclinical populations. Clinical cutoff scores have been identified for different degrees of depression. Validity and reliability have been demonstrated (Corcoran & Fischer, 1987, p. 107; Thompson, 1989). In this study, only one item from the BDI was used for analysis. This question directly addresses suicidal ideation by instructing the patient to circle the statement that best describes the way he or she has been feeling the past week, including the day of admission. The response statements include

I don’t have any thoughts of killing myself.
I have thoughts of killing myself, but I would not carry them out.
I would like to kill myself.
I would kill myself if I had the chance.

An interview schedule was developed in the primary study for purposes of guiding and standardizing a clinical interview with patients. The interview schedule was developed and tested on nonstudy patients to provide training so that a consistent interview process was established for the clinicians and patients. It consisted of 35 questions and was used for all interviews with study participants at time of admission and dismissal to the inpatient psychiatric unit. Examples of questions include

Describe what symptoms brought you to the hospital.
What previous psychiatric/emotional problems have you experienced?
What do you want most to change as a result of your hospital stay?
Have there been times when you have felt unusually depressed, sad, hopeless for several days at a time? Describe.
Describe your energy level.
Do you ever experience hopelessness or suicidal thinking? Describe.

Only this last question among the examples from the interview schedule was used for the purpose of this secondary analysis. For this question, participants were asked to elaborate on any answer that was not a definite no. The interviewer used prompting questions
such as “Tell me what you mean by sometimes” or “Are you having suicidal thoughts now?” or “How would you carry out a suicidal thought?”

Secondary data analysis was conducted. Demographic data (age, gender, marital status, employment status, and education) are reported in frequencies and percentages, as well as central tendencies where appropriate. The responses on both the BDI and interview schedule were dichotomized into two categories for each instrument: negative for or denies suicide ideations and positive for or expresses suicide ideations (regardless of degree or seriousness). Any ambivalence was counted as a positive. The responses for both the item on the BDI and the item from the interview schedule are summarized with frequencies and percentages. Agreements and disagreements between methods are also reported with frequencies and percentages. The data are then compared by subsets based on gender, education, and age. A Kappa statistic was calculated to determine if observed disagreement between methods of suicide ideation assessment is statistically significant.

## RESULTS

The sample was a convenience sample that consisted initially of 68 patients admitted to a Midwestern adult inpatient psychiatric unit that treated primarily mood, anxiety, eating, and adjustment disorders. Of the 68 patients, 18 (26.5%) were male and 50 (73.5%) were female. The sample ranged in age from 19 to 80 years, with a mean age of 38.4 years. Marital status, education level, employment status, and primary diagnoses of the 68 patients are described in Table 1.

### Observed Agreement Between Two Methods

Among the 68 participants in this study who completed the BDI, 50 (73.53%) responded positive to the suicide item, 17 (25%) responded negative, and 1 (1.47%) left the item blank. This latter participant’s data were deleted from further analysis. For the face-to-face interview, clinicians recorded a positive response for suicide ideations for 45 (67.16%) participants and a negative response for 22 (32.84%) participants. The two sets of data were compared for each subject. Figure 1 displays the agreement between the two assessment methods. Of the 50 participants who responded positive for suicide ideations on the BDI, 41 (82%) were also rated as positive by clinicians following the face-to-face interviews. Nine (18%) of the 50 participants who responded positive on the BDI were rated by clinicians as negative for suicide ideations following the face-to-face interviews. Of the 17 (25.4%) participants who responded negative for suicide ideations on the BDI, clinicians rated 13 (76%) as negative for suicide ideations and 4 (24%) as positive following the face-to-face interviews. Overall, the responses between assessment methods were in agreement for 80% of the 67 cases. However, for 13 cases (19.4%) there was disagreement between the two assessment methods. The Kappa statistic suggests this disagreement is statistically significant (.53, p = .00).

### Observed Agreement Based on Gender, Education, and Age

The responses between assessment methods were further compared by subsets based on gender, education, and age. Figure 2 displays frequencies of agreements and disagreements between suicide ideation assessment methods by gender. Agreement between assessment methods was found for 80% of the 49 female participants, and for 83% of the 18 male participants. Figure 3 presents frequencies of agreements and disagreements between suicide ideation assessment

| TABLE 1. Sample Demographic Frequencies and Percentages (N = 68) |
|------------------|------------------|
| **Frequency (%)** | **Frequency (%)** |
| **Marital status** | **Marital status** |
| Single | 18 (26.9) |
| Married | 36 (53.7) |
| Divorced | 9 (13.4) |
| Widowed | 4 (6.0) |
| **Education** | **Education** |
| Below high school | 6 (8.8) |
| High school | 39 (57.4) |
| College | 19 (27.9) |
| Beyond college | 4 (5.9) |
| **Employment** | **Employment** |
| Employed | 39 (57.4) |
| Unemployed | 29 (42.6) |
| **Primary diagnoses** | **Primary diagnoses** |
| Major depression disorder | 40 (59.7) |
| Adjustment disorder | 19 (28.4) |
| General anxiety disorder | 8 (11.9) |
| Dysthymia | 6 (9.0) |
| Panic disorder | 4 (6.0) |
| Bipolar disorder | 3 (4.5) |
| Agoraphobia | 1 (1.5) |
| Obsessive compulsive disorder | 1 (1.5) |
| Posttraumatic stress disorder | 1 (1.5) |

*Note: Patients often had more than one diagnosis.*
Methods by education. Agreement between assessment methods was found for 66% of the participants who had less than a high school education ($n = 6$), 79% of participants who had a high school education ($n = 38$), 84% of participants who had a college education ($n = 19$), and 100% of participants who had an education beyond college ($n = 4$). Overall, agreement rates increased as education levels increased.

Figure 4 presents frequencies of agreements and disagreements between suicide ideation assessment methods by age groups. Agreement between methods was found for 70% of participants who were 19 to 29 years old ($n = 20$), 83% of participants who were 33 to 39 years old ($n = 18$), 82% of participants who were 40 to 49 years old ($n = 17$), 88% of participants who were 50 to 58 years old ($n = 8$), and 100% of participants who were 63 to 78 years old ($n = 4$). As with education, agreement between methods increased as education levels increased.

In summary, the data indicate a fairly high observed agreement between assessment methods for suicide ideation. However, disagreement between methods was found for about 20% of the sample, which is statistically significant. Analyzing demographic subsets indicated that agreement between assessment methods increased as age and education levels increased.

DISCUSSION

The purpose of this study was to examine and compare two assessment methods for assessing suicidal ideation. A secondary analysis of an existing dataset was conducted to explore whether participants admitted for treatment of a mood or anxiety disorder disclosed the same suicide-related information on a self-administered questionnaire that clinicians subsequently reported based on a face-to-face interview with the patient.

Few studies have been conducted on suicidal assessment to determine whether self-report or the face-to-face interview is more or equally reliable in assessing a
suicidal ideations creating a very unstable thought process for depressed persons. Additionally, some persons have ambivalence about admitting to suicidal thoughts, whereas others experience fluctuating thoughts with even slight changes in mood or environmental events. Thus, with more time and stabilization of patients in an inpatient setting, greater agreement between assessment methods may be observed.

Also related to time of data collection is the comfort level of the patients at the time that the BDI and the interview schedule were administered. In general, most people are not comfortable revealing their innermost thoughts to strangers that they have known for a very short time. This is a matter of not only their level of comfort but also that of trust. So although they might answer with a positive response about suicidal thoughts in a self-report assessment tool such as the BDI, they might feel initially uncomfortable in revealing a similar response during the face-to-face interview.

Indeed, the data in this study indicated that although three fourths of participants reported suicide ideations on the self-report tool (BDI), clinicians rated only two thirds of the participants as positive for suicide ideation. Conceivably, a later comparison of assessment methods might reveal greater agreement in methods of assessing participants’ responses because their comfort and trust level would be higher at a later time. It would also be important to look at reasons these participants came to the hospital initially. If the decision was voluntary, then it would make sense that these participants would reveal as much as possible in order to get treatment and feel better. On the other hand, those who were forced or encouraged against their choice, either by family members or friends, to go to the hospital may not feel like they need help or treatment. Consequently, they might not reveal as much to avoid an extended stay at the hospital.

Another possible explanation could be participant misunderstanding or misinterpretation of the questions posed either during the face-to-face interview or on the BDI. This explanation may be associated with education level because for those with the least amount of education, who might have the most difficulty understanding a question, the rate of agreement between methods was lowest (66%). Establishing clear and concise questions during the interview may eliminate misunderstandings that might possibly influence what patients reveal about suicidal thoughts and behaviors. Being sensitive to education level when performing the assessment would be important.

Like education, age also appeared to influence rate of agreement. The youngest group had the lowest observed agreement (70%) between assessment methods, whereas the agreement increased with each older age bracket. Hence, trust issues or ambivalence could be greater among younger patients.

In sum, the findings of this secondary analysis indicated that for the majority (approximately 80%) of participants, ratings of suicide ideations were similar between methods. However, the data also suggested suicide ideation assessments in the first 24 hours of admission to an inpatient setting might vary depending on assessment method, particularly with younger and less-educated participants. The factors outlined above should be considered in the suicide assessment process. Being aware of these factors and using different methods may result in more accurate assessments of suicidal tendencies, more appropriate and effective treatments, and optimally, prevention of suicide.
SCOPE AND LIMITATIONS

This study included several limitations. There are many complex issues related to the assessment of suicidal ideation. Many variables and issues could not be addressed or controlled in this particular study.

Because the study was analyzed in the form of secondary analysis, no direct contact with the participants was made to clarify aspects of responses made on the self-reports. There was also the limitation of uncontrolled/unknown clinical bias imposed on the secondary analysis due to the subjectivity of clinicians’ reports. The researchers were not present for the face-to-face interviews; therefore, the original study research clinicians may have relied on their own intuition and/or omitted or failed to inquire about specific data relevant to suicide risk. Any biases or omissions of the original study research clinician may have been incorporated in the documents reviewed for this study. Another limitation concerns comprehension of the questions for the participants. Questions posed in the self-rating instrument or administered by the clinician may have been stated unclearly to participants, thereby leading to ambiguities that would be impossible to glean from a secondary analysis of the original study.

The small sample size and involvement of only one institution limit generalizability of the findings. Moreover, the small sample size limited the analyses of subsets of data based on demographics. For example, 70% of the participants were female, resulting in a disproportionate gender distribution. On the other hand, the high rate of females is consistent with previous demographic reports of gender distribution for depression. Nonetheless, future investigation of the effects of age, gender, and education on suicide ideations and tendencies is warranted. Despite the limitations of this study, the findings are clinically important and need to be considered when implementing and improving assessment of suicidal ideation.

IMPLICATIONS AND RECOMMENDATIONS

Practice and Treatment

The findings support inclusion of both a self-report method such as the BDI and a face-to-face interview to assess suicide ideations with each patient admitted to an inpatient setting for treatment of a depression-related disorder. Patients have different needs, and although some may not feel comfortable enough to reveal thoughts of suicide to a clinician in a face-to-face interview, they may be able to do so on a self-report question-naire. Collecting both self-report method and interview data may serve as a best practice and verify a patient’s mental status and thoughts on suicide. Administering both methods rather than only one may reduce some doubt or failure to identify a suicidal patient. Because the overall goal is to accurately identify those with suicidal ideations and provide them with the best possible treatment, minimizing doubts and questions should be of utmost importance.

To increase the efficacy of suicide assessment methods, a follow-up assessment plan should also be implemented so that patients who might feel overwhelmed and disoriented upon admission might have a chance to reveal accurate and/or changing information about their suicidal tendencies. Regular suicide assessments through different methods are advised throughout hospitalization. The results of this study show that the utilization of self-report and interview methods rather than just one method may help to improve identification of a suicidal patient and minimize the risk of suicide.

Research

Although suicide has been the focus of much research, unanswered questions remain in regard to assessment and factors that influence how, when, and what a patient decides to reveal about his or her suicidal thoughts. Studies examining suicidal assessment to determine whether a self-report or the face-to-face interview is more or equally reliable in assessing a suicidal patient are needed. Also, subsets of patients based on gender, age, education level, and other such factors need to be explored in the context of suicide assessment in order to investigate their weight in accurately assessing suicidal ideation. Future research to explore the role of these subsets would be of importance to the study and practice of suicidal assessment.

Another idea for future research is to replicate this study using the same assessment methods and tools but with a larger sample size. A wide variety of participants of a wide range of ages, from different race, ethnic, educational backgrounds, and settings would improve generalizability. Future studies could also focus on patient preferences in regard to type of assessment tools to determine what, if any, differences exist regarding patient preferences for revealing suicide ideations. Finally, it would be interesting to rigorously compare those patients who were admitted to a psychiatric facility and immediately administered the BDI and interview schedule with those who had a delay between admission and assessment.
SUMMARY

This study compared two methods of assessing suicide ideations among participants receiving inpatient treatment for depression and anxiety disorders. For the majority of the participants, agreement between methods was observed. However, for a subset of the sample, a statistically significant rate of disagreement between methods was found. Although the study design imposed several limitations, the findings support using both self-report and interview methods to obtain the best suicide ideation assessment data on each patient. Future investigations are needed on comparing suicide ideation assessment methods and tools and their efficacy in identifying suicide ideations.

REFERENCES


Anger Management: A Holistic Approach

Berthenya Dunbar

Anger is often a difficult emotion to express and understand. However, the consequences of unmanaged anger are manifested in the physical, emotional, and interpersonal arenas of many lives everyday. The program presented in this article uses cognitive behavioral therapy in a holistic approach to anger management treatment. Twelve anger management treatment concepts, participant assessment, group design, and facilitator characteristics are addressed. This article provides a guide for advanced-practice registered nurses to use in the development of a program that respects the complexity of patients who present for anger management treatment. J Am Psychiatr Nurses Assoc, 2004; 10(1), 16-23.

Keywords: anger management; groups; cognitive behavioral therapy

Anger is an uncomfortable emotional feeling that varies from mild irritation to rage. Thomas (1998) reported that anger is a normal response to an assault to one’s self-esteem or sense of integrity. Many people find anger to be an emotion that is difficult to use in a productive manner. Primary goals of anger management treatment are to assist participants in recognizing that anger is a normal emotion and to develop skills that will enable them to express emotions, needs, and desires in a manner that displays respect for themselves and others. It is not merely assertiveness training or stress management.

Evidence of the negative effect of anger can be seen in the lives of those who present for individual, group or couples’ therapy. Dyer (2000) commented on the difficulty associated with calculating the cost of dysfunctional anger. Ineffective management of anger can have devastating consequences manifested as physical, emotional, and/or interpersonal costs. These include damaged relationships, unmet needs, loss of self-esteem, lost jobs, and feelings of powerlessness.

This article presents a comprehensive, literature-based anger management treatment program. Cognitive behavioral therapy is the basis of the program, which promotes a holistic approach to treating persons who manage anger unhealthily. The treatment program is intended to treat those persons who exhibit anger management problems in relationships at home, work, and in social situations. The program is not designed to address domestic violence issues. Because the dynamics of domestic violence treatment differs significantly from the treatment of anger management, patients with domestic violence issues will benefit from treatment that specifically addresses domestic violence issues.

BACKGROUND

Ellis (1993), a pioneer in the field of anger management, suggested that anger occurs as a result of one’s perceptions and thus can be managed by thinking one’s way out of unhealthy anger expression. His approach is designed to help clients become aware of how thoughts and feelings are related. Individuals’ emotions are influenced by their perception of an event in their lives; this is an assumption of cognitive behavioral therapy (Beck, 1995). For example, it is not the event that causes the anger, it is what the person thinks about the event that causes the anger. The perception of the event is embedded in the person’s core beliefs about himself or herself. Another important concept of cognitive behavior therapy is that one can change one’s response to an occurrence by changing one’s thoughts about the occurrence. Cognitive behavioral therapy includes rapport building, patient education, instillation of hope, data gathering, and goal development (Beck, 1995). Cognitive behavioral therapy is a process that is designed to help patients understand how and why they act the way they do. With this insight, patients will have better success at maintaining any changes that occur in treatment.
Anger is a major issue in the treatment of post-traumatic stress disorder (PTSD). Gerlock (1994) used a pre/posttest design to determine the efficacy of a group therapy anger management treatment intervention with male veterans (N = 51). In the study, veterans who had combat trauma had higher mean anger scores than those who did not have exposure to combat. The participants were in groups of 6 to 12 for an 8-week class; 38 of the veterans completed the program. Participants were evaluated preintervention and post-intervention. The investigator found a 4.80 mean score drop in state anger and a 5.26 mean score drop in trait anger; lower scores indicate less anger. Twenty of the 38 participants improved their immediate and general levels of anger when compared to their preintervention levels.

Cognitive behavioral therapy has been used to help patients lower the intensity of their anger episodes. Tang (2001), in a retrospective study of 64 clients, evaluated the effectiveness of anger management treatment that focused on a cognitive behavioral approach. The posttreatment scores indicated a significant reduction of the participant’s overall experience of intense anger and significant improvement in cognitive behavioral coping and anger control.

Deffenbacher and colleagues (2002) used cognitive behavioral therapy and relaxation training in a study of 55 high-anger drivers. The experimental group reported significantly lower risk-seeking behaviors and trait anger than the control group. Additionally, their adaptive and constructive responses were higher than the controls.

The health benefits gained from learning to effectively manage one’s anger are documented. Larkin and Zayfert (1996) studied 13 patients with hypertension in a 6-week anger management treatment program that incorporated role-play, relaxation training, self-statement modification, and assertiveness. At the end of treatment, patients significantly increased their assertiveness skills and significantly lowered their blood pressure rates.

Although there are many treatment models for anger management, programs that include a holistic approach to the physical, emotional, and social issues related to anger expression are lacking. In addition to the use of cognitive behavioral therapy, psychosocial and medical assessment, a psycho-educational focus, individual support, patient goal setting, and patient self-assessment need to be integrated into the treatment program. The rationale for such an approach is to acknowledge that anger management treatment is complex and requires a multidimensional perspective.

**PROGRAM CONCEPTS**

Twelve concepts are addressed in the program. When used together, the concepts provide participants with an opportunity to learn how their thinking, feelings, and behavioral choices contribute to healthy anger management.

The concepts are open-mindedness, anger does not equal bad, responsibility for management of one’s own anger, physical cues, relaxation, identification of underlying emotion, negative thoughts, reasoned assertive responses, physical exercise, self-esteem, the should system, and resentment. The 12 concepts selected for inclusion in the program relate to healthy anger management and appear regularly in the anger management treatment literature.

**Open Mind**

Open-mindedness is necessary to learn tolerance (Williams & Williams, 1993). It is a willingness to listen to different viewpoints even when one thinks he or she is “right.” An open mind allows one to determine if the situation is important enough to pursue, compromise, or ignore. Many who have difficulty managing their anger healthily are intolerant of the opinions of others. The group discussion in this session explores the definition of open-mindedness. Members are invited to define the concept and give examples to support the definition.

In the treatment program, participants are given a therapeutic exercise that will help them develop an open mind. For instance, when participants are given homework on the concept open-mindedness, participants are asked to have someone give him or her directions to a place already known to the participant. The assignment is a building block for learning tolerance and listening to others. Participants discuss their successes or difficulties in the next session.

Participants, who are trying to grasp this concept, may benefit from asking themselves, “Would I rather be right or happy?” This question may help lessen argumentative behavior and help open lines of communication. It certainly offers the opportunity for participants to assess a personal need to control the outcome of a given situation.

**Anger Does Not Equal Bad**

“Anger does not equal bad” is a difficult concept to grasp. Many people have been socialized to believe that
even a healthy expression of anger is “bad.” Individuals often avoid expressing their anger because they fear the anger will emerge in an uncontrolled state (Egelko & Galanter, 1993). Therefore, they vacillate between outbursts of anger and passivity.

During the group discussion, participants are encouraged to refrain from describing their responses to anger-provoking situations as bad or good. Instead, they are encouraged to assess their behavior as effective or ineffective; thus, there is less chance of self-labeling in punitive terms if the attempt at assertiveness was not successful.

As homework, participants are asked to explore one anger-provoking situation that occurs prior to the next session as an opportunity to view the resulting anger as simply an emotion that is neither bad nor good. Participants are invited to discuss the situation, in detail, in the next session, to determine their level of success or lack of success in thinking about their anger without labeling the anger.

**Responsibility for Management of Anger**

Anger is often accompanied by emotional pain. It is important for those who decide to do something about their anger to refrain from blaming others for their pain and dissatisfaction. Healthy anger management involves one’s taking responsibility for one’s own anger (Grogan, 1991). The tendency to blame others for one’s pain can be quite compelling. However, blaming does not allow for a healthy development of self-awareness and the development of emotional empowerment.

In this session, participants are introduced to several coping statements to be used when a tendency to blame occurs in an anger-provoking situation during the next week. The coping statements may include, “Blame is not helpful. It will not change the situation.” “Is it possible for me to compromise?” Or, “How can I help myself in this situation?” Participants are encouraged to use one or more coping statements and discuss at the next session their success or lack of success and thoughts and feelings during the situation.

**Physical Cues**

Anger gives the body early physical symptoms called cues. Gottlieb (1999) reported that one of the first steps to managing one’s anger is to recognize these cues. Anger is not sudden or unpredictable. These cues can be manifested as clenched jaw, sweaty palms, queasy stomach, warm face or ears, tics, pain in the neck, and shallow breathing. Program participants gain a sense of personal empowerment as they learn to use cues to help them make early decisions to use deep breathing, take timeouts, and make affirmations (Powell, 1992). The group discussion focuses on participants beginning to view themselves as bigger than their anger, instead of feeling consumed by their anger. Localizing the physical feelings of anger to specific areas helps to decrease feelings of being consumed by one’s anger.

Participants are asked to begin to identify where they feel their anger in their bodies during anger-provoking situations. This is discussed in the next session.

**Relaxation**

As participants become more aware of their physical cues, they are better able to conceptualize the value of relaxation. Relaxation has long been thought to be useful in the management of anger. Deep breathing and progressive relaxation have been found to be effective (Moore, Adams, Elsworth, & Lewis, 1997). Deep breathing is a method of relaxation that is easy and simple and can be used in conjunction with other components in the program. Participants are taught deep breathing as well as progressive relaxation in combination with imagery in this session.

Relaxation alone is not a viable treatment approach to anger management. However, because anger-provoking situations are thought to be stressful, the role of relaxation in anger management treatment cannot be minimized. As homework, participants are asked to practice (2 to 3 times) deep breathing and progressive relaxation during the week. Participants’ experiences with this exercise are discussed in the next week’s group.

**Underlying Emotion**

Anger masks other primary emotions (Reilly, Clark, Shopshire, Lewis, & Sorensen, 1994). The underlying emotion can be shame, fear, powerlessness, hurt, humiliation, guilt, abandonment, loss of respect, or any other feeling or combination of feelings. Once the underlying feeling is identified, one can deal honestly with the primary emotion. For example, a father’s 15-year-old son says something disrespectful to him. The father gets angry, yells, and curses. The father will probably have more success at handling his anger in a healthy manner if he is able to talk to the son about how bothered he is about being disrespected. If he acts only on his anger, the primary feeling gets lost in the yelling and the cursing. An understanding of this con-
cept helps participants determine how their perceptions contribute to the anger process. When participants understand the process, they are better able to manage the underlying primary emotion instead of relenting to acting on the anger or rage. The understanding provides participants with a sense that they are in charge of their emotions instead of thinking and feeling their emotions are in charge of them. Group participants are asked to practice underlying feeling identification in anger-provoking situations over the next week, record them, and discuss them in the next session.

**Negative Thoughts**

Beck (1995) stressed the importance of the relationship between thinking and anger management. Negative thoughts can sometimes result from misinterpretation of data. The message or the motive is simply misunderstood. Negative thoughts can include statements such as “Who do you think you are?” “I’ll show you!” “I am not going to let her get the best of me.” These thoughts add fuel to the situation. In the program, participants involve themselves in identifying how their thoughts influence their responses to anger-provoking situations. Understanding how one’s perception of an anger-provoking situation can affect the outcome of a situation is a major key to effective management of anger. Often participants in anger management treatment do not recognize how the thinking process influences the intensity of one’s anger and behavioral choices. Group process is helpful when working with this concept. In the group, participants are asked to relate their experiences in terms of identification of the anger-provoking situation, their thoughts and feelings about the situation, their chosen action, and the resulting consequence of their action.

For the next session, participants are asked to identify how they may use negative thought in anger-provoking situations. Participants are asked to choose one anger-provoking situation during the next week, list any negative thoughts that may have occurred, and discuss how the thoughts affected the anger-provoking situation.

**Assertive Responses**

One goal of healthy management of anger is to learn to make reasoned assertive responses to anger-provoking situations. Such responses reflect rational thinking and respectful verbal and nonverbal expressions. Schmidt (1993) reported that one can learn to tolerate uncomfortable feelings until they pass in an effort to begin to express anger in a manner that is not harmful to one’s self or others. Role-play is an excellent way to practice this concept. Participants in the program use real-life scenarios or events. Using their own experiences allows participants to relate better to one another and to feel more accomplished at the end of the session.

**Physical Activity**

Stored anger or anger that is not expressed has long been recognized as a contributor to stress. In the 1960s and early 1970s, therapists recommended punching bags, pillow beating, and yelling as a healthy means of avoiding the storage of anger. It is now understood that this kind of physical activity is at best a temporary release. Physical activity lowers the adrenaline that causes the feelings of anger. The thoughts that produced the adrenaline are still present, and the anger and the feelings of aggression return (Bilodeau, 1992). However, physical exercise continues to be a recommendation to help relieve stress and replenish the endorphin stores of the body. Regular exercise works to reduce stress over time and not just for the moment. The benefits of such a program need to be stressed in relationship to healthy anger management. Program participants are instructed to clear any physical activity with their primary health care giver. Any progress, or lack of progress, related to starting an exercise program is discussed during the next session.

**Self-Esteem**

The inability to ask for what one wants is a classic symptom of low self-esteem (McKay & Fanning, 1992) and is often seen in passive and indirect expressions of anger. In the passive approach, one does not express how he or she thinks or feels. In the indirect expression of anger, one does not express anger directly to the person or persons involved in the anger-provoking situation. Neither approach to the expression of anger provides resolution of angry feelings. The consistent use of either approach is an ineffectual behavior pattern that perpetuates decreased feelings of self-worth. One has to feel good about oneself in order to manage anger healthily. Additionally, Ellis (1993) suggested that when people devalue themselves instead of their behavior, it interferes with their ability to think through their anger.

Participants are asked to list their character strengths and begin to develop a self-esteem affirma-
tion list. The list is to be discussed in the next session and evaluated and modified throughout the treatment process.

**Should System**

Persons who have difficulty managing their anger in a healthy manner often have a well-defined *should* system. A *should* system is a person's values and expectations that he or she imposes upon others. Most people respond in ways that meet their own needs rather than the needs of others. Ellis (1993) reported that imposing one's values on others causes disastrous results when others do not live up to one's values and/or expectations. These expectations of others lead to angry, unproductive feelings.

People usually do what they think they should do, rather than what others think they should do and hence the potential for unmet expectations and a conflict of values. During the group, participants are asked to identify their top three values and discuss how they may impose their value system onto others. Participants are asked to list their top three values. These are compared with those of others in the group. Participants can identify how the differences can cause conflict if compromise cannot be reached. A scenario of conflicting values is used to have patients identify how thoughts of defining what others should do can affect the outcome of anger-provoking situations. Patients are asked to use the affirmation, “I will not should on others or myself today” when confronted with conflicting situations. The outcomes are to be discussed in the next group sessions.

**Resentment**

Resentment is based on stored anger. Powell (1992) referred to resentment as old baggage. This old anger prevents one from enjoying the present. Many times the person who has difficulty with anger management feels justified in holding onto his or her anger. Participants are encouraged to ask themselves, “Would I rather be right or happy?” Participants can begin to resolve some feelings of resentment by writing letters or poems or arranging face-to-face encounters, when possible. Role-play can be a useful tool. Participants also benefit from the use of imagery to do resentment work. During the group session, the concept of resentment is discussed. Additionally, participants are asked to identify a resentment and answer the following: (a) If I hold on to this resentment, who will this hurt the most? (b) Who still cares that I am holding on to this resentment? and (c) What would happen if I gave up the resentment?

Participants are encouraged to use journaling, tapes, imagery, and affirmation to begin the long process of dealing with resentments. Because this is an extended process, members are invited to discuss their thoughts and feelings about their early work related to this concept in the next session.

**ASSESSMENT**

Each prospective program participant is seen for intake and assessment prior to the first group session. Information is obtained about how the participant expresses his or her anger; alcohol and drug usage; domestic violence history; medical history; previous anger management intervention; history of any trauma such as sexual, physical, and combat involvement; level of education; spirituality; and mental status. The data collection is the basis for the holistic approach to treatment, and the background information is used to help the facilitator address problems that may be contributing to the participant’s anger management issues. Assessment and planning increase the chances of a successful outcome. For example, if a participant cannot read or has chronic pain or nightmares secondary to posttraumatic stress issues, anger management skill-building interventions alone will not produce a successful outcome. During the assessment phase of treatment, referrals are made for prerequisite or concurrent intervention for identified outstanding contributing issues that may interfere with treatment success.

Additionally, prospective participants are required to identify a treatment goal. A goal is a necessary agreement for successful treatment (Beck, 1995). The participant’s goal is listed as a quoted statement in the intake note and on the Anger Management Self-Assessment Scale (AMSAS). This tool (Figure 1) incorporates the program concepts and was developed by the author so program participants could monitor their progress while in treatment. An item on the AMSAS represents each of the 12 group concepts. The items have a Likert-type scale of 1 to 10, with 1 = never and 10 = always. Participants can track any changes in their ratings. Participants are asked to rate themselves prior to the first group session, 4 weeks into the program, and again within 2 weeks of completing the program. This self-rating process becomes the participant’s skill-building marker. Participants must be able to conceptualize and have the potential to gain insight from program participation. Thus, prospective program participants who are acutely psychotic, manic, actively abusing alcohol or other substances, severely de-
pressed, or who have moderate to severe traumatic brain injuries will not benefit from treatment. Also, those who have medical conditions that prevent them from participating in a 1-hour weekly group are not admitted to the program. Appropriate referrals should be made for any prospective participant who is not accepted into treatment. Additionally, domestic violence perpetrators should be referred to domestic violence treatment.

THE GROUP

The group is most manageable with 9 to 15 participants. Participants who are both voluntary and court ordered can benefit from program involvement. The anger management program is designed to present the 12 concepts over a 16-week period.

Some participants enter an anger management treatment program in an attempt to validate their be-
lie that the program will not work for them. Therefore, participants benefit if the facilitator ensures inclusion during each session. It is helpful to ask each participant to express his or her thoughts about the session material and to avoid the appearance of one-way communication from instructor to participant. Participant questions and comments are strongly encouraged.

The first session of the program begins with a discussion of open-mindedness and a definition of anger that is a composite of the facilitators’ and participants’ input. One concept is discussed each week, with the exception of assertiveness and self-esteem. Assertiveness is discussed in a 3-week format that explores passive, indirect, and aggressive anger styles and basic assertive rights, and uses role-play. Self-esteem is discussed over a 2-week period. The concepts are presented each week in the order discussed in this article. Each concept is linked to the next.

Each group meets for 1 hour weekly and integrates components of psycho-education and cognitive behavioral therapy. The first half of the group is dedicated to a review of the previous week’s concept and a discussion of the homework assignment. During the first part of the group session, participants are encouraged to share real-life experiences as part of their homework. Others in the group offer their thoughts and feelings about the shared experience. The second half of the group is used to discuss the next concept. This may be accomplished with exercises written and/or in active participation format. Again, participants are encouraged to share personal experiences during this phase of the group. At the end of the second half of the group, homework is explained and questions about the assignment are encouraged. Participants’ questions are invited and addressed throughout the entire fast-paced session.

The seating is arranged so that all participants can see each other. The group has an open-ended format. An open-ended format affords participants an opportunity to enter the program at any point. A major advantage of an open-ended format is that participants already in the program offer newer attendees valuable feedback, model healthy anger management, and demonstrate the progress they can expect to make. Another advantage is that there is no waiting list for prospective participants. Although one concept leads into another, most participants say they feel on target in about 3 weeks, even when they may not get the first concepts in the 16-week cycle for several weeks. The group process is limited to helping the participant gain insight into how his or her behavior related to anger management is ineffective or interferes with the learning process. Participants are referred to individual therapy for more deep-seated issues.

Some participants exhibit a need for individual therapy to address complex issues such as trauma, resentment, or depression. If this was not manifested in the assessment phase of treatment, it is addressed as the need becomes evident to the facilitator. Only a small number of participants will need to end anger management treatment until individual issues can be addressed.

Each participant is seen for a 20-minute session every 4 weeks to review progress and follow-up on any referrals. This is not to be considered an individual therapy session.

Group exercises are used to enhance the participant’s understanding of a particular concept. For example, a writing exercise is used when discussing “shoulds.” Participants list their top three personal values, and one participant may list family, attending church, and being on time. A discussion may include how one’s values can become a list of destructive shoulds that can be the source of anger when others choose to respond to their own should list. At the end of the group, the facilitator leads the group in a discussion that recaps the high points. The group ends when the facilitator gives homework, which is based on the concept discussed. Homework is always a practical experience.

THE FACILITATOR

The facilitator must be aware of his or her own anger (Levin & Spauster, 1994) and avoid treating anger as positive or negative. It is not helpful for patients to be treated as naughty school children who need to learn to be good. Modeling of healthy anger management is a necessary facilitator characteristic. If the facilitator has a tendency to deny, misdirect, or spew anger, this may encourage participants to continue with such ineffective approaches. Participants must sense the facilitator is not frightened of his or her anger and will lead a therapeutic session that is safe. A psychiatric advanced-practice registered nurse certainly has the skill set to serve as a facilitator for an anger management group.

Because those who have anger management difficulties often take themselves and others too seriously, it is helpful for the facilitator to model the use of humor in the healthy management of anger-provoking situations, when appropriate. A nonjudgmental approach, wherein the facilitator periodically assesses his or her own personal attitude, motives, and limitations will lend itself to the most therapeutic interven-
tion. Each participant brings a set of talents and tools to treatment. It is the facilitator’s role to help participants learn to enhance the skills they bring to treatment in order to achieve what they want from treatment.

The facilitator is challenged to keep monopolization and disruption of sessions at a minimum. He or she needs to be able to address disruptive occurrences with firmness and respect and solicit the help of the group when appropriate. Participants usually respond with respect when treated with respect. The facilitator’s respectful approach will nurture and support patients’ efforts to become participants in their treatment.

OUTCOMES/EVALUATION

The program described in this article has evolved over a 12-year period. It began as an assertiveness skill-building group. When the program started, no assessment was done. Participants had no formal means of self-monitoring. As participant needs were identified, the program evolved.

Most participants (98%) have been male. Participant completion rates improved from a less-than-15% completion rate (2000) to a greater than 50% completion rate (2001). Approximately 30% of the participants voluntarily repeated the 16-week program at least once in 2001. As participants progress in the program, they begin to report an increased ability to recognize anger cues and an increased ability to identify and act on their primary emotions, increased assertive responses, and increased feelings of self-worth as a healthy anger management style begins to replace ineffective anger management. Additionally, and probably most important, the participants begin to acknowledge the role they played in many anger-provoking situations. Subsequently, participants begin to report progress in meeting personal treatment goals identified in the initial intake session.

CONCLUSION

The program can be used by the psychiatric advanced-practice nurse as a holistic approach to anger management treatment. It is important to remember that comprehensive assessment and planning are integral parts of this treatment approach. Additionally, the program provides the facilitator and the patient with a tool to measure treatment progress. The cognitive behavioral approach encourages participants to develop their own specific treatment goal, think through anger-provoking situations, and monitor their own success. Each success improves the participant’s self-esteem level.

REFERENCES


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The Lived Experience of Loss:  
A Phenomenological Study

Dianna H. Douglas

BACKGROUND: Few studies of bereaved individuals have considered the bereaved individual’s perspective of loss. Also, there are no exhaustive descriptions of the lived experience of loss found in nursing literature. OBJECTIVES: This study explored the lived experience of bereaved individuals and the effects that loss had on their physical and mental health. A description of the bereaved individual’s lived experience of loss is presented. DESIGN: Interviews were conducted with bereaved individuals, and the phenomenological method was used to formulate a description of the lived experience of loss. RESULTS: Participants experienced profound emotional and physical pain, reported a deeper sense of spiritual awareness and a more complete understanding of life and death, and were faced with irreversible changes that caused depression and suicidal ideation. CONCLUSIONS: Care provided to bereaved individuals can be improved when the bereaved individual’s lived experience of loss is more completely understood and used to identify maladaptive psychological and physiological responses in the bereaved. Bereaved clients can benefit greatly from individual, family, and especially group therapy. Grief resolution support groups give the bereaved an opportunity to learn more about themselves, their behavior, and their relationships with others and can potentially modify perceptions of self and others. J Am Psychiatr Nurses Assoc, 2004; 10(1), 24-32.

Keywords: loss; bereavement; phenomenology; unresolved grief; grief resolution

The events surrounding the destruction of the World Trade Centers in New York on September 11, 2001, and the deaths that occurred as a result of that tragedy, have brought to the forefront the impact that loss can have on bereaved survivors. How might mental health professionals more adequately serve the bereaved population? Loss of loved ones through death causes suffering and intense mental anguish in survivors. Bereavement resulting from death of a loved one includes a wide range of psychological and physiological responses that are frequently categorized as part of the grief process. Bereavement increases stress and anxiety and can inhibit health-producing behavior, thereby increasing negative health outcomes. Decreased cognitive function, decreased problem-solving ability, inability to relax, and assumption of a hostile attitude typify the anxiety and stress response seen in the bereaved (Caplan, 1990; Freud, 1957; Joffroin & Douglas, 1994; Lindemann, 1944; Miles, 1985). Some of the negative mental health outcomes experienced by the bereaved may develop into full-blown psychiatric diagnosis such as dysthymia, major depression, and anxiety disorders (American Psychiatric Association, 2000). The bereaved experience various physical problems that can result in illnesses. They have an increase in number of physician/clinic visits and hospital admissions, and there is an increased use of medication (Stroebe, Stroebe, & Domittner, 1998). For example, Zimmerman (2001) presented a case study of a patient who blamed herself for the death of her son and experienced severe symptoms of heartburn, epigastric pain, and regurgitation that persisted for more than 2 years before hypnosis resulted in a complete resolution of her symptoms.

BACKGROUND

Historical Perspective

Early archeological records as far back as Neanderthal man living during the late Pleistocene age have recorded various rituals associated with death, such as rites and ceremonies performed during burial and symbolic articles buried with the decedent (Shanley, 1982). These rituals were a means of supporting the society’s bereaved, a reflection of attitudes toward death, and beliefs about life after death. In some cultures, death rituals facilitate or symbolize the
passage of the deceased to another state (e.g., Egyptian, Native American, and Indian).

Attitudes toward death have changed throughout history. Before the 12th century, people seemed to accept death as a familiar and inevitable phenomenon. During the 12th century, the attitude of cavalier acceptance changed, and death and loss came to be experienced as a time of personal crisis (Shanley, 1982). In the 15th century, death was no longer regarded as a transition into the next world but was believed to be a finality of the self. The concept of death as “the enemy” emerged and persisted until the 18th century. The physician was perceived to have little or no influence over death, and persons viewed themselves as passive victims of that enemy (Joffrin, & Douglas, 1994).

Rapid medical advances were achieved mostly after World War II. These transformed hospitals from being poor houses and repositories for infectious disease to institutions in which medical practice and patient care were guided by modern science. Improvements in surgery and infection control, along with the increasingly advanced technology and medications, moved the delivery of health care and management of the dying person out of the home and into the hospital (Joffrin & Douglas, 1994). Societal attitudes toward death and loss also changed. It was no longer accepted that certain diseases followed a predictable course. The illusion was created that death and the accompanying experience of loss might be deferred indefinitely (Amenta, 1985). Today the Western belief system encourages seriously ill persons to attempt to overcome death, rather than to accept death and to resolve the sense of loss experienced among survivors.

**Theoretical Perspective**

There is no universally accepted theoretical perspective on the phenomena of bereavement and loss. However, three major perspectives from Freud (1957), Lindemann (1944), and Kubler-Ross (1975, 1985) appear in the literature. Table 1 provides a comparison of these three theorist perspectives on grief resolution.

**Freud**. The psychoanalytic model of grief may be traced to Freud’s (1957) “Mourning and Melancholia.” Freud explored the normal emotion of grief and its expression in mourning. He observed that mourning had a typical, general appearance and described grief and its accompanying sense of loss as a nonpathological condition involving the transfer of libidinal energy. Furthermore, he asserted that nonpathological grief eventually reached a state of completion through the survivor’s mourning.

**Lindemann**. The normal response to a death is a sequence of stages that can progress from an initial shock to acceptance of the situation. These stages are denial, shock, preoccupation with the deceased, undoing or negativism, ambivalence, and acceptance. Each stage may last for a variable amount of time, and individuals may experience these stages in a different order.

**Kubler-Ross**. The stages of grief are denial, anger, bargaining, depression, and acceptance. The bereaved person may经历 these stages in any order and may experience more than one stage at a time.

<table>
<thead>
<tr>
<th>Freud</th>
<th>Lindemann</th>
<th>Kubler-Ross</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of loss</td>
<td>Acceptance of pain</td>
<td>Denial</td>
</tr>
<tr>
<td>Decline of self-esteem</td>
<td>Loss of pattern of conduct</td>
<td>Shock</td>
</tr>
<tr>
<td>Self-reproach</td>
<td>Alteration in emotions</td>
<td></td>
</tr>
<tr>
<td>Hatred toward self and lost object</td>
<td>Acknowledgment of guilt and hostility</td>
<td>Anger</td>
</tr>
<tr>
<td>Sadistic tendencies</td>
<td>Development of somatic symptoms</td>
<td></td>
</tr>
<tr>
<td>Loss of interest in outside world</td>
<td>Preoccupation with lost loved one</td>
<td>Depression</td>
</tr>
<tr>
<td>Remembering events linked to deceased</td>
<td>Expression of sorrow and feelings of loss</td>
<td></td>
</tr>
<tr>
<td>Reliving hopes and dreams connected with the deceased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altered self-image</td>
<td>Review of relationship with deceased</td>
<td>Bargaining</td>
</tr>
<tr>
<td>Detachment of each hope and dream connected with the deceased</td>
<td>Overidentification with lost loved one</td>
<td></td>
</tr>
<tr>
<td>Reaching a state of completion</td>
<td>Re-identification of self</td>
<td>Acceptance</td>
</tr>
<tr>
<td>Transfer of libidinal energy to another loved object</td>
<td>Acquisition of new patterns of conduct</td>
<td>Reaching out</td>
</tr>
</tbody>
</table>

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overmagnified (hypercathected) and subsequently detached in the consciousness reality of the survivor’s mind. Then, and only then, would the surviving bereaved be able to detach from that memory, dream, and hope. He admitted that this process was time consuming and extraordinarily painful and one not easily or quickly completed. Yet eventually, a transfer of libidinal energy could take place and the bereaved can regain a feeling of completeness.

Lindemann. Lindemann (1944) studied 101 bereaved persons whose loved ones had died in the Coconut Grove nightclub fire and observed the characteristics of their grief. He defined the resolution of grief as the bereaved’s efforts to extract from bondage with the deceased. Breaking bonds with the deceased is a painful and dynamic process that Lindemann asserted is necessary for the resolution and eventual acceptance of the death of a loved one. The bereaved person used the whole process of breaking bonds to establish new relationships. Lindemann described the grief resolution process as (a) acknowledgement (an embracing) of the pain of the bereavement, (b) a review of one’s relationship with the deceased, (c) acknowledgment of the alterations in one’s own emotions (e.g., fear, hostility, anger), (d) expression of sorrow and sense of loss, (e) verbalization of feelings of loss and guilt, (f) discovery of an acceptable sublimation for future relationships, and (g) acquisition of new patterns of conduct.

Kubler-Ross. Kubler-Ross (1975, 1985) in her work with the dying and bereaved individuals identified six stages of grief: (a) shock and denial, (b) anger, (c) depression, (d) bargaining, (e) acceptance, and (f) reaching out. According to Kubler-Ross, each person does not necessarily experience all six stages, nor do they progress smoothly in a sequence from one to another stage. Kubler-Ross (1975, 1985) believed that resolution of grief occurred during the stage of acceptance, when loss was fully comprehended and the bereaved became able to feel a measure of peace and hopefulness again. She identified the sixth stage of grief resolution, termed as “reaching out,” in her later works (Kubler-Ross, 1985). Some bereaved persons progressed beyond grief resolution and developed a desire to share with and care for others who had experienced similar losses (Kubler-Ross, 1985).

Loss From the Bereaved’s Perspective

Despite considerable studies of the phenomenon of loss and its effect upon the survivor, no single, general, and universally accepted objective definition of loss exists in the nursing literature. Only limited research has been conducted with consideration of the bereaved’s perspective. Consequently, no accurate exhaustive description (Colaizzi, 1978) of loss, as experienced by the bereaved, is found in nursing literature. Thus, the purposes of this study were to address the gaps in the literature by identifying and describing the meanings and qualities of the lived experience of loss in the bereaved and formulating an exhaustive description of loss using the bereaved’s words derived from interviews in which they described their lived experience of loss (Sandelowski, 2000).

METHODS

Phenomenology is both a philosophical movement and a research method in which the main objective is to examine and describe phenomena as they are consciously experienced by persons in defined circumstances (Sandelowski, 2000; Spiegelberg, 1984). The task of the phenomenologist is to discover the process of perception by describing as comprehensively as possible an experience from the participant’s perspective (Munhall, 2000; Oiler, 1986).

The inductive, descriptive approach of the phenomenological method was used for this study. A basic philosophical assumption of phenomenology is that one can know only by attending to perceptions and meanings that awaken conscious awareness (Husserl, 1962; Sandelowski, 2000). To achieve the goal of phenomenological research, researchers must reawaken their own presuppositions and abstain from them. The process of bracketing involves peeling away the layers of interpretation so that the phenomena can be seen, as they actually exist, not as reflected through preconceptions. Bracketing does not eliminate perspective, yet it is an attempt to bring the experience into clear focus. Layers of meaning that interpret an experience are laid aside, the remainder is the perceived world before interpretation and explanation (Munhall, 2000; Oiler, 1986).

Sample

A convenience sample of 12 individuals participated in the study. The participants were selected from individuals who responded to a newspaper advertisement to join a grief support group at a health care agency in the Greater New Orleans area. The inclusion criteria stipulated that participants must be (a) 18 years old or older, (b) at least 3 months past the death of a loved one, and (c) receiving no psychotropic drugs. The final sample included eight women and four men, all Caucasians ranging in age from 32 to 65 years. The fiancée and fiancé, respectively, of one man and one woman had
died; there were three widowers and three widows; and the children of four participants died. The elapsed time since the death of the participants’ loved ones ranged from 3 to 19 months.

The participants were homogeneous in their education (all completed high school or above) and socioeconomic status (ranged from middle to upper socioeconomic level). Job positions of the participants included secretary, sales person, a professional nurse, an educator, and entrepreneurs in the agricultural, mechanical, and engineering industries. The participants were heterogeneous in that their ages ranged from 32 to 65 years and the relationship to lost loved one were either spouse, child, or fiancée/fiancé. All participants were either Roman Catholic or Baptist. Two of the participants held master’s degrees and four had baccalaureate degrees; the remainder were high school graduates. See Table 2 for demographic characteristics of the bereaved participants.

### Procedure

After approval from the university’s Human Subjects Review Board, the individuals who volunteered to participate in the study were asked to sign informed consent forms. Confidentiality of participants was protected by not revealing their identity in any manner, and a number was assigned for identification. Anonymity of each participant was assured by excluding names during audiotaping, transcription, and analysis. Participants were informed that they had a right to refuse and/or withdraw from participation at any time during the process.

The participants were interviewed in the privacy and comfort of the interviewer’s office, with freedom from distractions and interruptions. The same interviewer conducted all interviews. Audiotaped interviews were conducted for approximately 1 hour. The participants were asked to respond verbally to open-ended questions, such as “Tell me about the death of your loved one,” “Tell me your feelings and experiences associated with the loss of your loved one,” “Tell me some of the ways the experience of loss of a loved one has affected your general attitude toward life,” and “Tell me some of the ways the experience of loss of a loved one has affected how you feel about yourself... others.” The interview schedule included only open-ended questions and probing techniques such as silence, reflective listening, nonverbal attending skills (show of interest), and urging phrases (e.g., “go on” and “tell me more”). Babbie (1992) stated that appropriate probing elicited more information from participants’ responses to open-ended questions than would otherwise be the case, and such probing further clarified ambiguous and/or incomplete responses.

When participants had fully described their feelings of loss and no other further clarification was necessary, the recording was considered complete. Audiotaped interviews were transcribed verbatim and erased after the researcher listened to each tape at least three times.

### Data Analysis

The phenomenological method of research is inductive and descriptive. To facilitate a systematic form of data analysis, the operational stages for data organization and reduction, as recommended by Colaizzi (1978), were used. Data analysis was an ongoing process, with clusters of themes of each transcript considered concur-
Participants were contacted and asked to review the ex-

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themes. To help ensure the credibility of data, the par-

clarified the conversion of formulated meanings into

time was incorporated into the fundamental structure

relevant data obtained from the participants at that

validation, the researcher returned to the participants

preparation. Each of the participants confirmed that he or she

had an intimate identification with the exhaustive de-

categorical analysis and a master's prepared nurse

working toward a doctorate in a qualitative research

course) was achieved at each phase of data analysis.

hubristic description of loss. They were asked to vali-
date the accuracy of the exhaustive description yielded

from the data reduction (Colaizzi, 1978; Sandelowski,

2000). Each of the participants confirmed that he or she

had an intimate identification with the exhaustive de-

scription and none suggested the addition or deletion of

any data.

RESULTS

Analysis of data provided sample characteristics and significant statements. By means of Colaizzi's (1978) procedural steps, Miles and Huberman's (1984) data organization matrix, and Sandelowski's (2002) discovering the findings in qualitative studies, 116 significant statements regarding loss were extracted from the bereaved participants' audiotaped interviews. The 116 statements were combined and condensed to a total of 64 significant statements (Table 3) regarding loss, such as (a) "I felt devastated and alone"; (b) "It hurts all the time, this ache is always here"; (c) "I am empty and angry"; and (d) "I really do not want to go on living."

Fourteen formulated meanings were drawn from the significant statements. For example, the formulated meanings drawn from the significant statements a, b, c, and d above were "The bereaved experience extreme emotional pain, agonizing physical pain, and many experience anger and suicidal ideation."

After identification of the 14 formulated meanings, they were organized into 12 categories of feelings of loss. These included emotional pain ("I am devastated, lost, vulnerable, and alone"); physical pain ("I am physically sick... pain in my chest... stomach"); anger ("I'm actually infuriated, really!"); suicidal ideation ("When I get up in the morning, I have to literally make the decision not to kill myself"); loss of control ("It is the most 'out of control' feeling I've ever felt"); sense of being lost and purposeless ("I've lost direction"); "I have no purpose in life"); irreversible change ("Everything just changed... I will never be the same"); loss of identity ("I'm not the same person"); ("It's like part of me died too"); enlightenment about life and death ("I've learned a lot"); ("I'm more understanding... more sympathetic"); insightfulness and deeper understanding of others who have experienced loss; increased compassion ("I know that I can feel other people's pain now"); "Now I know how to help others"); and broadened spirituality ("I've come to understand life better"); ("I know I've grown spiritually") (Table 3).

The categories of feelings of loss were further re-
duced to five themes of loss (Table 3):
<table>
<thead>
<tr>
<th>Significant Statements</th>
<th>Formulated Meanings of Loss</th>
<th>Categories of Feelings of Loss</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am still shattered, in a state of confusion</td>
<td>Extreme emotional pain, feeling of being alone</td>
<td>Emotional pain</td>
<td></td>
</tr>
<tr>
<td>I feel my whole world just collapsed then and there</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m devastated, lost, vulnerable, and alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It’s just the most empty, lonely feeling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m empty, alone, and isolated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am totally saturated with fear, emptiness, and pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel helpless, so helpless, and I can’t do anything about it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It hurts all the time this ache, flu-like feeling</td>
<td>Excruciating physical pain, aches, spasms, tired, drained, and exhausted</td>
<td>Physical pain</td>
<td></td>
</tr>
<tr>
<td>I just feel drained and tired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The pain hits me like a contraction in my uterus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It’s like someone knocked the breath out of me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The pain just tears me apart, severe muscle spasms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My legs are weak and I get all knotted up in my stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am physically sick, pain in my chest and stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel cheated, very cheated</td>
<td>Feeling cheated and angry with God, self, and everyone</td>
<td>Anger</td>
<td></td>
</tr>
<tr>
<td>I’m angry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m actually infuriated, really!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m angry with God, with myself, and with the world</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I really do not want to live; I want to die</td>
<td>Prevalence of suicidal ideation</td>
<td>Suicidal ideation</td>
<td></td>
</tr>
<tr>
<td>It’s difficult to go on knowing that I could be with him</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I get up in the morning, I have to literally make the decision not to kill myself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am just stunned, sort of mechanical, like a robot</td>
<td>A sense that their life is out of control</td>
<td>Loss of control</td>
<td>Life is out of control and without purpose</td>
</tr>
<tr>
<td>I feel out of control; It is the most out-of-control feeling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’ve ever felt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’ve lost direction and purpose</td>
<td>A sense of loss of direction and purpose in life</td>
<td>No direction or purpose</td>
<td></td>
</tr>
<tr>
<td>I’ve lost all purpose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have no purpose in life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There’s something empty inside; I know it will be that way for the rest of my life</td>
<td>Irreversible and eternal change</td>
<td>Irreversible change</td>
<td>Irreversible and eternal change requiring one to undergo a process of re-identification</td>
</tr>
<tr>
<td>It’s like everything switched off, changed, shifted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My whole perception, everything just changed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This has shortened my life; It took part of my life with it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everything’s changed and I’m beginning to realize that things will never be the same for me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My life isn’t ever going to be the same again</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part of me is gone and will never come back</td>
<td>Part of the “self” is missing</td>
<td>Loss of identity</td>
<td></td>
</tr>
<tr>
<td>It’s like part of me died too</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m not the same person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’ll never be the same as I was</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I realize now that life is just a loan
I have a much deeper respect for life
I've found out that life is very precious, short, uncertain
Life is very, very fragile
Death is quick, life is delicate, and gone so fast
Death is such a final thing, the finality is such a difficult thing to grasp
I know now that I have no assurances of tomorrow
I have this new realization now that life is so fragile

I have learned a lot about myself; I like myself better
My patience is better; I don't judge people the way I used to
I'm more understanding and more sympathetic now
I'm more open; I think I like myself better
Things that used to be important are not important anymore
I see things differently now, notice things I never saw before

I have compassion for people that I never had before
I know how to "just be there" now
I know better how to give now, extend myself
I know that what I do for others I am really doing for myself; I know that I can feel other people's pain now
I'm more in tune with other people's pain
Now I know how to help others

I've come to understand life better, death has made me wise
I know I've grown spiritually
I've gotten stronger in some ways
I'm more religious [spiritual] now
I feel closer to God

---

**TABLE 3 (continued)**

<table>
<thead>
<tr>
<th>Significant Statements</th>
<th>Formulated Meanings of Loss</th>
<th>Categories of Feelings of Loss</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I realize now that life is just a loan</td>
<td>Death has been a teacher</td>
<td>Enlightenment about life and death</td>
<td>Enlightenment about the definition of life and death, new insights into the self, and a deeper understanding of others</td>
</tr>
<tr>
<td>I have a much deeper respect for life</td>
<td>A new revised definition of life and death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I've found out that life is very precious, short, uncertain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life is very, very fragile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death is quick, life is delicate, and gone so fast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death is such a final thing, the finality is such a difficult thing to grasp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know now that I have no assurances of tomorrow</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have this new realization now that life is so fragile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have learned a lot about myself; I like myself better</td>
<td>New insights into self, the world, others; revalued revised self-image, re-evaluation of priorities</td>
<td>Improved insight and deeper understanding</td>
<td>Improved insight and deeper understanding</td>
</tr>
<tr>
<td>My patience is better; I don't judge people the way I used to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I'm more understanding and more sympathetic now</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I'm more open; I think I like myself better</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Things that used to be important are not important anymore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I see things differently now, notice things I never saw before</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have compassion for people that I never had before</td>
<td>Identity with others suffering loss, increased knowledge and a desire to ease the suffering of the grieving other</td>
<td>Gained compassion and knowledge</td>
<td>Gained compassion and knowledge</td>
</tr>
<tr>
<td>I know how to &quot;just be there&quot; now</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know better how to give now, extend myself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know that what I do for others I am really doing for myself; I know that I can feel other people's pain now</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I'm more in tune with other people's pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Now I know how to help others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I've come to understand life better, death has made me wise</td>
<td>Spiritual growth, gained a depth of understanding and a measure of wisdom</td>
<td>Spiritual growth and greater wisdom</td>
<td>Spiritual growth and greater wisdom</td>
</tr>
<tr>
<td>I know I've grown spiritually</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I've gotten stronger in some ways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I'm more religious [spiritual] now</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel closer to God</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The experience of loss of a loved one permeates through the body and emotional being of the bereaved individual causing profound emotional and physical pain. A loss of direction, purpose, and identity is experienced, often accompanied by anger and thoughts of suicide. The bereaved individuals are faced with irreversible changes in themselves that are in some cases seen as positive. Loss brings with it a deeper sense of spirituality and understanding of life and death. Many bereaved individuals seek to help others who are experiencing pain following the death of a loved one.

These themes were then organized into an exhaustive description of the phenomenon of interest (Colaizzi, 1978). Based on the findings of the study, the following description of the lived experience of loss is proposed: The loss of a loved one permeates through the body and emotional being of the bereaved individual causing profound emotional and physical pain. A loss of direction, purpose, and identity is experienced, often accompanied by anger and thoughts of suicide. The bereaved individuals are faced with irreversible changes in themselves that are in some cases seen as positive. Loss brings with it a deeper sense of spirituality and understanding of life and death. Many bereaved individuals seek to help others who are experiencing pain following the death of a loved one.

DISCUSSION AND IMPLICATIONS

Findings of this phenomenological study contribute to the body of nursing knowledge by describing the experience of loss of a loved one and its effect on the daily life of the bereaved person. Bereaved individuals, though devastated by the loss of a loved one and grieving in a unique manner, were able to describe the meanings and qualities of their lived experience of loss. The lived experience of loss altered the lives and relationships of the bereaved persons who participated in this study, which correlates with other studies (Freud, 1957; Lindemann, 1944; Stroebe et al., 1998; Zimmerman, 2001), indicating that the bereaved revert to an earlier stage of psychosocial development, similar to the stage Erikson (1985) called “identity versus role confusion.” The separation from their loved one forced bereaved individuals to renegotiate previously resolved stages of psychosocial development. Their ego integrity, the sum of their identification, was seriously devastated by the loss of their loved one. Both situational and developmental crises were precipitated by the death of a loved one (Freud, 1957; Lindemann, 1944). The death of a loved one pierced the individual’s core of fear and previous coping skills failed. They no longer experienced the feelings of love and belonging they had shared with their dead loved ones, and their identity and self-esteem were seriously wounded.

Another important finding was that those who had begun the healing process were eager to share some of the newfound knowledge, understanding, and insights gained from experiencing the death of their loved one. These individuals are a vast and untapped source of support for the more recentlybereaved. The former bring to any grief resolution support group, when invited and given an opportunity to share, an example and role model for other grieving persons. They are able to assist the newly bereaved as they continue their own journey through grief resolution and move toward healing. Some of the participants said that when they communicated with others who had lost loved ones, their own grief was greatly alleviated.

Equipped with the knowledge gained from this study, health care professionals, counselors, clergy, and therapists can assist the bereaved to accomplish positive grief resolution and avoid the complications of unresolved grief. Individual, family, and group therapy are possible modes of intervention.

As members of the health care team, the psychiatric nurses must realize that the emotional pain, anger, and loss of control that a bereaved individual feels may persist for an extended period of time. Unresolved grief often leads to extreme feelings of hopelessness and thoughts of suicide. Assessment of suicide potential with clinical screening tools to determine level of depression, such as with the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and lethality of suicide risk with the SAD PERSONS Scale (Patterson, Dohn, Bird, & Patterson, 1983), is highly recommended for the bereaved individual. The key element in determining suicide potential is the establishment of a therapeutic interpersonal connection. Once a therapeutic alliance is established, conducting an interview with the client that will elicit reliable information is essential. Shea’s (1999) Chronological Assessment of Suicide Event is useful for structuring a productive interview.

Advanced practice nurses can facilitate a heightened sense of identity, self-understanding, self-esteem, and control through individual therapy and the use of techniques such as role play, assertiveness training, and guided imagery. Group therapy allows the bereaved individual to express his or her feelings of lone-
liness and isolation within a supportive context thereby decreasing feelings of hopelessness, helplessness, and powerlessness.

Joint educational workshops and seminars for health care professionals using the findings of this study can increase the understanding of grief, the effects of grief, and the dynamics of grief resolution. Fortified with enhanced knowledge, health care professionals will be more appropriately prepared in assisting the bereaved to avoid the negative physical and emotional effects of unresolved grief.

REFERENCES


Mental Health Care Experiences: Listening to Families

Linda E. Jensen

BACKGROUND: Family experiences and satisfaction can affect recovery of the person with mental illness. OBJECTIVE: The purpose was to listen to what families perceived as positive and negative experiences related to the mental health care services received by their family members diagnosed with severe mental illnesses. STUDY DESIGN: As part of a larger study, qualitative data were collected from a purposive sample of 30 family members describing and rating their experiences with mental health services. RESULTS: Themes included caring through communication, competence, financial concerns, accessibility, and recovery-oriented care. CONCLUSION: Family members should be included in treatment planning and in quality-improvement programs. Mental health professionals may need additional training to learn to effectively engage families in the treatment and evaluation process. J Am Psychiatr Nurses Assoc, 2004; 10(1) 33-41.

Keywords: evaluation; families; mental health care; MHSIP survey; rural; satisfaction

Although the U.S. Surgeon General's Report (U.S. Department of Health and Human Services, 1999) proclaims advances in evidence-based mental health treatment, many family members become frustrated attempting to find quality care for their loved ones diagnosed with severe mental illnesses (Kasper, Steinwachs, & Skinner, 1992; Mohr & Regan-Kubinski, 2001). Many families feel disconnected from the treatment process and dissatisfied with the quality or the amount of contact they have with providers (Czuchta & McCay, 2001; Dixon, Lyles, et al., 1999; Levine & Ligenza, 2002; Lukens, Thorming, & Lohrer, 2002; Rose, 1998). Given needed support and knowledge, families can be strong allies to help their members affected by mental illness work toward recovery (Buchanan, 1995; Froland, Brodsky, Olson, & Stewart, 2000). However, few mental health professionals have been trained to be accessible and helpful to families or to effectively involve families in the care process (Mohr, 2000; Wright, 1997).

The purpose of this study was to determine what family caregivers perceived as positive and negative experiences with the mental health care services of affected members. Based on the findings, implications were identified to assist professionals to improve care by engaging families in the treatment process. These implications could be integrated into current and continuing education for all types of mental health professionals to improve communication with consumers and families, thus improving future outcomes of care.

BACKGROUND

In many situations, family caregivers are essential to helping their loved ones with severe mental illness find their way through a maze of bureaucracies and health care personnel to access mental health care. If no family member becomes an advocate, these affected persons may end up homeless or in the criminal justice system (Lamb & Weinberger, 1998). There has been limited examination of the mental health care system care experiences of family caregivers. Kasper and colleagues (1992) conducted a survey of 1,401 family members of the National Alliance for the Mentally Ill to examine their perspective regarding whether needs for assistance of their family member with mental illness were being met. They found the following unmet needs: crisis management (2%), community living skills (11%), managing relationships (38%), productive activities (57%), illness management (8%), and personal care (4%). The unmet needs varied according to living arrangements, financial resources, outpatient sources of care, and use of social/rehabilitation ser-
vices. In two focus groups totaling nine people, Rose (1998) explored families’ perceptions of professional interventions related to the care of affected members with schizophrenia or bipolar disorder. Content analysis of the focus group data identified critical elements of supportive and nonsupportive behaviors from professionals. Supportive behaviors included having a primary contact person to be called at any time about any concern, having the opportunity to meet with other patients living with the illness, and having a professional interpret the meaning of bizarre behaviors their relative may be exhibiting. Families criticized care when they felt communication was inadequate, or when they felt judged by a professional.

Lukens et al. (2002) studied the effects of having a brother or sister with a severe and persistent mental illness on the lives of adult siblings. Using a focus group approach, participants identified the challenges associated with the mental health care of an affected sibling, such as gaps in services and communication with mental health providers about timing of interventions and identifying readiness for treatment. Levine and Ligenza (2002) also used a focus group method to learn about needs of family caregivers of persons with severe and persistent mental illness during crisis. They found the mental health system often failed to listen to families or to provide them with the information they need to carry out their roles as caregivers and de facto case managers. The investigators developed two sets of recommendations, one for families and one for mental health policymakers.

The family caregivers’ experiences with mental health care services will greatly influence the actions of family members and the resources sought during times of a loved one’s relapse. Some family members have learned to be advocates from courses such as Journey of Hope (Pickett-Shenk, Cook, & Laris, 2000) and the Family-to-Family Program (Burland, 2001). These courses, taught by trained family members, are specifically designed to help families learn about mental illnesses, the affected person’s experiences, and evidence-based practices to work toward recovery. Recovery, in this context, does not mean being cured but is the process of an individual finding new meaning in life despite the presence of psychiatric symptoms and their consequences (Anthony, 1993). In these courses, information such as “questions to ask the psychiatrist,” “guides to comprehensive care,” and the latest “expert consensus guidelines” for various psychiatric disorders are distributed and discussed. The courses help family caregivers understand their own feelings so they can be more objective in evaluation of the care their family member is receiving and search for more effective care when needed (Dixon, Goldman, & Hirad, 1999). Family caregivers learn to partner with professionals and to seek out community resources for the most comprehensive and satisfactory recovery possible.

Health care satisfaction surveys have traditionally not included perceptions of families about the care of one of their members. Mental health departments in most states use portions of the Mental Health Statistics Improvement Program (MHSIP) survey to determine consumers’ satisfaction with their care. Only a few states use surveys, either an adapted version of the MHSIP or others, for family members to report their experiences with the mental health care system (MHSIP Report Card Phase II Task Force, 1996; Riesser & Schorske, 2001). Hall, Edgar, and Flynn (1997) rated managed care companies on various aspects of access to care and found most failed on the aspect of consumer and family involvement in care planning. Accreditation agencies require quality improvement programs, but these frequently do not include evaluations of care by family members. There are federal requirements for family members to be included on public behavioral health advisory boards; however, this may be a token inclusion, with little attempt to really understand the experiences of the families.

Most expert guidelines have recommended family involvement in the treatment process (Psychguides, 2002). Because they know and understand the affected person, the entire family, including parents, siblings, and spouse, can make a tremendous difference in the recovery for a person with severe mental illness (Hall & Purdy, 2000). Listening to families’ experiences with the mental health care systems can help bring about vital improvements in both care and outcomes.

**METHODS**

**Design**

The data reported in this article were part of a larger descriptive retrospective exploratory study collecting both qualitative and quantitative data longitudinally from family members about their experiences of finding care for their loved ones with serious mental illness. The data were collected cross-sectionally at the beginning of the larger study and focused on the satisfaction of family members with various services the affected member had received and also the inaccessibility of some needed services.
Sample

Criteria for study participation included being more than 21 years of age and having a family member with severe mental illness. Participants were recruited at meetings of mental health support and advocacy groups, with additional participants obtained by the snowball method as respondents told other families to contact the researcher. Participants resided in a rural Midwestern state that lacked comprehensive community mental health services and was rated toward the bottom in expenditures per capita for community mental health services (National Association of State Mental Health Program Directors, 2000). Data were collected over a 2-year period; however, some of the experiences the families described may have occurred several years previously.

Data Collection

A report grid (Figure 1) was designed for the respondents to describe and rate mental health services their family member had received with the following headings: Type of Services, How Long Used, Satisfaction Scale, Positive Aspects of Services, and Negative Aspects of Services. Types of services listed included psychiatrists, hospitals, therapists, psychologists, social workers, case management, vocational rehabilitation, day treatment, and drug or alcohol treatment, with several blank lines for other categories. The satisfac-

### FIGURE 1. Report card of services used by son, daughter, or parent.

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th>Name of Firm or Professional</th>
<th>Used Now?</th>
<th>Length of Use</th>
<th>Level of Satisfaction</th>
<th>Positive Aspects of Care</th>
<th>Problems With Care (Include why no longer used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist, Psychologist</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational Training</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Treatment</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or Alcohol Treatment</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services used previously</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Or if used more than above please fill in other ratings blanks. Another page enclosed.)</td>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Directions:** Please fill in the following information according to your perception. Use the back of this sheet for additional information you wish to contribute to this study. (No information identifying you or your relative will be reported to any providers.)

Levels of Satisfaction: 1 = Very Dissatisfied 2 = Somewhat Dissatisfied 3 = Somewhat Satisfied 4 = Very Satisfied.
tion measure, which was investigator developed, included a scale ranging from 1 to 4, with 1 = very dissatisfied, 2 = somewhat dissatisfied, 3 = somewhat satisfied, and 4 = very satisfied. Respondents filled out the report grid and mailed it to the researcher in a stamped addressed envelope. Using the most positive and the most negative information on the grid, a purposive sample of 10 respondents were chosen to be interviewed either on the telephone or face-to-face. The purposes of the interviews were to enhance and explain the written responses. Field notes were taken on the interview process.

Analysis

Open, axial, and selective coding were used to examine the responses. Open coding involves breaking down, examining, comparing, conceptualizing, and categorizing data. Axial coding is a process of making connections between categories by involving conditions, context, action/interactional strategies, and consequences. Selective coding is a process of selecting the core category, systematically relating it to other categories, validating those relationships, and finding categories that need further refinement and development (Strauss & Corbin, 1990).

Thirty respondents described experiences with 204 mental health services as represented in Table 1. Some respondents described only one or two professional services, whereas others described up to 20. A few respondents rated the services without any comments. During open coding, all experiences were categorized by type of service. Most experiences were with psychiatrists (37%). Hospitals ranked second in number of evaluations (22%). As data were examined and compared, the roles of counselor, social worker, and psychologist were collapsed into a counselor category, due to the overlap in the roles of these professionals. Case management, respite services, and vocational rehabilitation services were collapsed into community services. Experiences with support/advocacy groups were also reported. Positive and negative experiences were separated under each service category. Axial coding resulted in similar patterns of positive and negative experiences across services. Selective coding resulted in the overarching themes described below. The description of themes and the selected data quotes were reviewed with several participants and other mental health professionals to achieve creditability and confirmability (Leininger, 1991).

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Number of Services Rated</th>
<th>Average Rating**</th>
<th>Positive Comments</th>
<th>Negative Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>75 (37%)</td>
<td>2.3</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Hospital</td>
<td>45 (22%)</td>
<td>2.1</td>
<td>22</td>
<td>34</td>
</tr>
<tr>
<td>Counselors</td>
<td>31 (15%)</td>
<td>2.3</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Community services</td>
<td>39 (19%)</td>
<td>2.4</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Support groups</td>
<td>14 (7%)</td>
<td>3.5</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>204 (100%)</td>
<td>2.4</td>
<td>120*</td>
<td>133*</td>
</tr>
</tbody>
</table>

*Some respondents gave both positive and negative comments about the same provider.
**1 = Very dissatisfied, 2 = Somewhat dissatisfied, 3 = Somewhat satisfied, 4 = Very satisfied.

RESULTS

A majority (n = 16) of the 30 respondents were parents of sons diagnosed with schizophrenia or bipolar disorders. Thirteen respondents were mothers with daughters affected by severe mental illnesses, again either schizophrenia or bipolar disorders. Five respondents were parents of children younger than 18, 24 were parents of adults with mental illness, and 1 respondent cared for a parent. Five respondents had other experiences with the mental health care system, such as mental diagnosis themselves or parents with mental illnesses. All respondents were Caucasian and English-speaking, with education levels varying from high school to completion of a doctorate.

WHAT’S IMPORTANT: LISTENING TO THE FAMILIES

Most of the families’ concerns could be categorized under five themes: caring through communication, competence, financial concerns, accessibility, and recovery-oriented care. Respondents provided both positive and negative experiences that further explained the patterns that emerged from the data.

Perceptions of Caring Through Communication

Respondents emphasized the importance of taking time to listen to the family with an honest, caring, understanding, pleasant, and kind attitude. Other words used to describe this attitude were “seems concerned,
positive attitude, honest, helpful, available.” One mother told of a psychiatrist who always spent 10 to 15 minutes with the parents during each appointment and sometimes included the entire family, along with the affected person in a joint session.

Dr. W. says we are with our son 24/7, and he only sees him monthly. He needs our input so we can work together to help our son. It’s nice to be seen as experts in knowing our son rather than blamed for problems in his illness.

Other parents told of frustrating experiences in communicating with the psychiatrists caring for their children. Parents reported that when they tried to ask questions about the medications or other services their children were or were not receiving, they were told they were too overprotective. There were psychiatrists who refused their calls or to discuss any aspects of the care. Respondents did acknowledge that patient privacy and respect for confidentiality may have been reasons for the lack of response. Several parents complained about a lack of empathy and concern for the parents’ feelings. A parent said the psychiatrist told her, “Your son was always this way, you just didn’t notice it.” Another parent commented, “I got tired of people asking if we had relatives with mental illness, like it was our fault that we got married and then our child came down with this illness 20 years later.”

**Competence and Quality of Care**

Correct diagnosis and prescribing medications that worked were the most frequent descriptions of competence. One participant, who was receiving treatment for a mental health issue, responded that she personally had a positive experience with a psychiatric nurse practitioner. The nurse practitioner looked at her as a whole person (“not just the disease”), encouraged her strengths, and displayed a positive attitude, while trying to find the medication that worked. A few parents reported that counselors had helped the consumer and their family members develop de-escalating techniques to deal with extreme anxiety and find ways to release feelings in an acceptable manner. Encouraging exploration of healthier lifestyles was noted to be very helpful in promoting recovery. A parent told of her relief in finding a competent psychiatrist:

It was so wonderful when the new doctor found the right med, and my son was not shaking all the time . . . The first doctor told me the shaking was not side effects, that it was the illness, but I knew better, and decided to change doctors.

The majority of the negative responses doubted competence in either the diagnosis or the medications prescribed. Some respondents described psychiatrists who diagnosed all clients as bipolar or who continued to prescribe medications that were outdated, ineffective, and caused miserable side effects. Families complained about only receiving 10-minute outpatient medication checks and not being referred to counselors by their psychiatrist, whereas other psychiatrists regularly included counseling through associates in their office. Other parents complained that psychiatrists were reluctant to order diagnostic tests to rule out medical problems or injuries that could be causing the psychotic symptoms.

Several respondents said that they had encountered professionals who blamed parents for causing the illness. They expressed frustration that these professionals had not accepted newer evidence that severe mental illnesses are caused by chemical imbalances in the brain. Some respondents complained that many counselors were not trained to work with severe mental illnesses and only knew interaction theories. One parent, who was also a counselor, told of associates asking how her son could have schizophrenia when she was a mental health counselor. She stated,

Over 10 psychiatrists and counselors did not recognize our son was psychotic . . . because he had negative symptoms. They said he was just a depressed teenager and . . . expected him to be responsible to keep his appointments . . . One got mad and yelled at him when he acted bizarre.

Some respondents told of the fears their family member experienced when hospitalized and of concerns of assault from other patients. Excessive use of restraints and seclusion were noted to have caused extreme trauma emotionally and, in some situations, physically. One parent told of the hospital keeping her son in seclusion and restraints for almost 2 weeks when he was disoriented during his first episode of schizophrenia.

The next time the doctor wrote down to call his mother immediately if you have to put him in restraints. One nurse told me she figured out she could talk to him and calm him down . . . I thought that should be standard practice in a mental hospital, to talk to the patients.

Another common complaint was that staff did not seem to communicate or work together. Lack of individualized programs and aftercare programs were also noted, along with a lack of programming for persons with co-occurring disorders of substance abuse and
other mental disorders. Some respondents complained their adult child was treated like he was mentally retarded rather than mentally ill. Several families told of their terrible experiences with psychiatrists and hospitals as they listed “none” on the positive side and “too many to tell” on the negative side.

**Financial Concerns**

Many negative comments were expressed about the lack of insurance coverage for mental illnesses and the problems of depleting low mental health care limits or paying large copays.

Families reported that even though Medicaid or other public funds should have covered the medical bills, they continued to receive bills from hospitals and even began payment rather than risk a poor credit report. One parent reported,

> It bothers my daughter when she receives all these bills. She gets so upset, she ends up back in the hospital and that costs more. I just started paying about $10 each month, even though the bill is supposed to be paid by Medicaid. She owes over $20,000 and it will never get paid that way, but it’s all we can afford.

One respondent stated the problem of receiving repetitious bills was solved when she wrote a letter stating she was going to report the hospital for fraud because they kept billing her when other sources were supposed to pay. Another parent told of her husband changing jobs so that they were able to have another insurance company and a new lifetime deductible.

A mother was told she had to give up custody of her child so the hospital could receive Medicaid payments for her child’s care. She found out about a Medicaid waiver from another mother and asked the social services worker about it.

> The social services worker said we would never get that waiver. We shouldn’t even apply for it. But I said, “give me the papers.” We applied for it, and we got it. Only a few waivers were granted in the state at that time because nobody was told about them.

Several parents told about not being able to afford medications unless their child received Medicaid assistance. One mother was shocked about having to pay more than $400 for the medications when she took the prescription to the pharmacy. She had not been informed about available patient assistance programs provided by the pharmaceutical companies or a special state program to furnish medications to people who had been placed in emergency protective custody or treatment.

> “Is it any wonder that people quit taking their meds?” she said.

**Accessibility: Distance to Quality Care**

Many family members told of continuing their search for better care and listed positive information about services they found later in their quest for recovery. They told of driving hundreds of miles weekly in this rural state for expert treatment. Some respondents in very rural areas related their feelings of being stuck with poor psychiatric care because they could not take time away from their jobs to drive to the urban areas. In some frontier areas of this state, services were only available 1 day per week and an assigned therapist may only be there once a month. As one mother commented, “It’s a relief when my son is in the hospital, as there’s nothing out here for him.”

**Lack of Recovery-Oriented Community Care**

Most respondents told of a lack of recovery-oriented community care available in the rural areas. A few family members described the new interdisciplinary assertive community treatment teams positively; however, because there were only two teams in the state, the covered areas were limited. Many areas in this rural state were without day rehabilitation services, and consumers often were not referred to community support services after hospitalization.

Community caseworkers were described as inexperienced, poorly trained, with large case loads, and only able to do crisis care. It was noted that a recovery philosophy was needed that recognized each individual’s strengths and allowed the consumers to make choices, instead of a patronizing, control type of care. Several parents said they wanted someone to help their adult child find a job and housing, rather than just talk about staying out of the hospital.

Vocational rehabilitation workers were noted by some respondents to be very helpful in finding jobs and providing job coaches, whereas others said their worker did not communicate with the family or expected people to find their own jobs. They complained that the workers seemed more concerned about bureaucratic details. One mother said,

> The rehabilitation counselor asked me how long it would be before my son could work 40 hours per week. Wasn’t that her job to evaluate that? She said he wasn’t ready for services, but I had to find volunteer work for him. I think she was just too lazy to help us, or maybe she didn’t know how.
Some respondents complained that some rehabilitation counselors seemed to concentrate on finding jobs in the 3 fs—filing, filth (cleaning), and food service—for clients who were college graduates and able to perform higher level jobs. Rehabilitation counselors were reported to lack knowledge about social security benefits, work incentives, and the Americans With Disabilities Act accommodations for their clients. Parents complained that some vocational testing services did not understand psychiatric disabilities. In one instance, a young man had to stay at the home of a stranger for 2 weeks and was given humiliating and menial work at the testing center, such as pounding nails and sorting rags. This young man had been a college student and kept telling the evaluators he wanted to work on computers. He left the program and then was refused vocational rehabilitation services. A few years later, after successfully completing 2 years of college, he was re-tested. Again he had to be away from home, which was anxiety producing. At the conclusion of the testing, his parents were asked to come immediately and receive the results. The testing service advised the young man to enter their training program to become a motel manager. The entry-level position would be a night desk clerk. The testing results did not acknowledge that he was now a junior in college and making good progress or that the night job might be inappropriate because of a sleeping disorder. Through the persistence of his parents, the state-funded vocational rehabilitation services finally began to pay for college tuition and books to finish his degree. The mother reported “I wrote a PASS [plan for self sufficiency] that was accepted on the first attempt even though I was discouraged by the rehabilitation worker. I found out later that this plan was one of the few submitted from our rural state.”

A few respondents told of in-home support or respite services accessed through the developmental disabilities services. Workers hired by an agency came to their home to assist with childcare and allowed the parents some respite from the constant stressors. Parents described problems of rapid turnover of workers, lack of training, and worker supervision that resulted in damage to the child’s fragile personality from bumbling workers. A parent said,

I learned to watch these workers, and I let them know right away if there’s a problem. Now they let me choose my agency, but I really have to train the workers myself so they can help my child. If the workers stay with us long enough, it does let me get out to do more advocacy.

Respondents in the more rural areas of this state did not have these respite services available. Some parents of adult children expressed a need for respite care also, especially as the parents aged and had more health problems.

Most support groups discussed were affiliates of the National Alliance for the Mentally Ill, the most developed statewide support/advocacy organization at that time. The most common reason given for attending a support group was to talk to caring friends; however, in this rural state, several people did not live close to a group that met regularly. The respondents noted that some groups consisted mostly of elderly people who did not seem as helpful to parents with younger children. Respondents stated that more Journey of Hope classes, more affiliates, more training in outreach, and more funding were needed. State and national conferences were seen as valuable, but many families had exhausted their resources to find care for their loved ones and found attending the conferences too expensive. Several respondents had become involved in advisory committees advocating for improved services but were frustrated that high-ranking government officials did not seem to listen to them.

LIMITATIONS

The goal of qualitative research is to understand people’s experiences from their own perspective rather than to generalize to a large population; therefore, data from this small purposive sample cannot be generalized to a majority of professionals, services, or consumers. However, the data offer rationale for actively involving families in the evaluation and improvement of mental health services and some guidance for engaging the families along with the consumer in plans for recovery.

These data were part of a larger study with several questionnaires on the various aspects of caring for family members with severe mental illnesses. The number of questionnaires may have discouraged some people from participating in the study. More telephone follow-up may have enhanced the data. Recruiting participants from care settings, rather than advocacy groups, may add more variety of experiences and diversity of families.

DISCUSSION AND IMPLICATIONS

Communicating a caring attitude and treating the family and the consumer with respect and dignity are of utmost importance. Portraying to the family a potential for recovery and hope for a return to a productive life were also mentioned as being important. These practices would not add greatly to the care costs and could significantly contribute to better outcomes.
Competence with diagnosis, medications, and knowledge of the latest treatments were listed most frequently as positive aspects of services. Generally, there were low levels of satisfaction with psychiatrists, hospitals, counseling services, and vocational rehabilitation services. Most respondents complained about the lack of a comprehensive system and the lack of communication between their psychiatrists and the other services they used. Efficient patterns of communication need to be developed between different professionals caring for a consumer so that the synergy of an interdisciplinary team can be maximized.

It would be useful for health care providers to assess financial resources of patients so that the families could be assisted with Medicaid and other funding applications, if necessary. Of course, advocacy for laws that would force insurance and Medicare to provide parity for mental illness would lessen the burden to families.

Services appeared to be drastically lacking in the rural areas. Telemedicine has been touted as a solution but is not satisfactory in many ways. Helping families who live in the same area of the state to connect through support and advocacy groups may facilitate carpooling for appointments. Information about support/advocacy groups should be available in each waiting room, and professionals should include referral to these groups as part of their routine care. Self-help support and advocacy groups can be instrumental in giving hope for recovery to consumers and family members (Ralph, Kidder, & Phillips, 2000).

Education and training of health care professionals should actively involve consumers and families. This approach will allow professionals to understand the families’ perspectives on their experiences with the mental illness, treatments, hospitalization, rehabilitation, and recovery of their affected members. A National Alliance for the Mentally Ill provider education program, developed in Vermont, is now being implemented in several other states (Burland, 2001). A recent training program in the United Kingdom was found to enable nurses to improve the support provided to family carers of people diagnosed with schizophrenia (Gall, Atkinson, Elliott, & Johansen, 2003).

Consumer satisfaction teams, including family members, have been established in several states to visit mental health services to identify problems and solutions and to encourage more recovery-driven care (Ross, 2000). Research with these consumer/family quality improvement teams could assist in designing and evaluating more effective models of care. Listening to the experiences of both families and consumers could vitally improve mental health care satisfaction and outcomes.

REFERENCES


