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Attitudes of the family toward the mentally ill patient

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Introduction. In this article the attitudes towards mental illness in those families who have mentally ill members is presented in order to compare them with those found 25 years before in a similar research.

Methodology. In order to carry out the survey we used Struening and Cohen's Opinion about Mental Illness (OMI) questionnaire. adapted for use in Spain by Yllá and Guimón (1979). The population studied were the families associations of the mentally ill persons suffering from psychotic and affective disturbance. alcoholism and Alzheimer's dementia; the control group was made up of a number of Civil Servants and another section of health care workers. The samples were collected at random among the associated members. For the study we undertook a factorial analysis of the answers.

Results. The first five factors contain the greater part of the accumulated variation. that is to say 34.2%. 19 factors explain the whole 100% of the variation. The five principle factors are: (i) Mental hygiene (14% of the variation). (ii) therapeutic negativism (7% of the variation). (iii) Social reinsertion (4.87% of the variation). which was also similar to the following factor. (iv) social rehabilitation. and (v) authoritarism (3.62% of the variation).

Conclusion. The extensive knowledge of these illnesses and a close relationship with those who are ill could be the cause of the large and diverse opinions and that some attitudes are more complex nowadays. According to these five principle factors we can see that the controls are appreciably less authoritarian and restrictive than that of the families of these ill people and that the attitudes vary depending on the age. profession and diagnosis of the illness.

Key words:
Attitudes. Mental illness. Association of families. Struening and Cohen's OMI Questionnaire.

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Actitud de la familia hacia el enfermo mental

Introducción. En este artículo se presenta el estudio de investigación de las actitudes hacia la enfermedad mental en familiares de enfermos mentales. con objeto de comparar estas actitudes con las encontradas 25 años atrás en un estudio similar.

Metodología. Para la encuesta utilizamos el cuestionario de Opinión sobre Enfermedad Mental (OMI) de Struening y Cohen. adaptado en España por Yllá y Guimón (1979). La población estudiada ha sido las asociaciones de familiares de enfermos con trastornos psicóticos. afectivos. alcoholismo y demencia de Alzheimer; el grupo control está compuesto de un grupo de funcionarios y otro de sanitarios. Las muestras se han cogido al azar. entre los miembros asociados. Para el estudio realizamos el análisis factorial de las respuestas.

Resultados. Los cinco primeros factores agrupan la mayor parte de la varianza acumulable que es un 34.2 %; 19 factores explican el 100% de la varianza. Los cinco factores principales son: 1.º higiene mental (14% de la varianza); 2.º negativismo terapéutico (7%); 3.º reinserción social; 4.º restrictividad social (3.º y 4.º suponen menos del 5% de la varianza cada uno). y 5.º autoritarismo (3.62%).

Conclusión. El mayor conocimiento de estas enfermedades y una relación más próxima con estos enfermos podría ser la causa de la mayor diversidad en las opiniones y unas actitudes más complejas al día de hoy. Según estos factores principales. podemos ver que los controles son sensiblemente menos autoritarios y restrictivos que los familiares de estos enfermos y que las actitudes varían en dependencia de la edad. profesión y diagnóstico de la enfermedad.

Palabras clave:
Actitudes. Enfermedad mental. Asociación de familiares. Cuestionario OMI de Struening y Cohen.

INTRODUCTION

The family is understood to be a system of persons united and related by affect and closeness. which may entail kinship or not and that is the first reference and socialization framework of the individual. It is the basic core where care is carried out. since in spite of the public network services and resources available. the families are the principal persons involved in providing care[1].

In a study on abnormal or inadequate attitudes that may be adapted by families in relationship with the disease and with the patient.[2] it was observed that the most common attitude in reference to mental disease is negation. In the attitudes in relationship to the mental patient. abandonment by part of the family is not rare. On the other extreme. there are those family members who are excessively solicitous. persons who cannot detach themselves from the patient or who besiege them with questions. precautions and explanations.

Katz and Stotland[3] Krech Crutchfield and Ballachey4 emphasize three components that give it coherence within the structure of attitude: cognitive component formed by beliefs and knowledge of the object. This component is generally accompanied by strong emotion that is the affective component of the attitude.[5] and is the most difficult to change. This would be the case of the families who besides. because they belong to family associations. would also be assumed to be well informed regarding the disease. The behavior component is the tendency or disposition to act. This action would be a consequence of the two previous components.

The stigma of mental disease. according to Sarturius6 hinders the development of the mental health programs and of the rights of these patients.[7] Steps to combat the stigma would be to redefine insanity. dangerousness. psychic abnormality and to reevaluate the implications in the civil and criminal code.[8] Angermeyer and Matschinger[9] verified how selective disclosure in the media reinforces the stereotype of mental disease.

In studies on the changes of attitude Yllá. Gonzalez-Pinto. Guimón.[10] Madianos. M. Economou. M. et al..[11] Madianos. MG. Priami. M. Alivisupaulus. G.[12] and Schulze. B. Richiter-Werling. M. Matschiner. Angermeyer. MC. Crazy H.[13] verified how the specific information improved the attitudes towards mental illness and the usual treatment of these patients.

In 1979. Yllá[14] studied the attitudes towards mental disease in the general population of Vizcaya. The results of the factorial analysis in this study were 5 negative factors towards mental disease. Simultaneously. there was a psychiatric reform in Spain and a change toward democracy in politics. In subsequent studies. Aparicio.[15] and Sánchez Blanqué.[16] using the same questionnaire. obtained very similar factors in the general population.

Our hypothesis is to suppose that the attitudes of these family members would be more positive than in the rest of the population.

Our objectives were to discover the attitudes of the families of mental patients towards mental illness. We aimed to find the most significant factors representing these attitudes by means of the factorial analysis of the results of the survey. With these factors. we have tried to discover the significant differences regarding the variables of age. gender. occupation. studies. religious beliefs. grade of kinship. if the person was the principal caretaker or not. grade of dependence or diagnosis of the family member of the person surveyed. and we compared then with a control group and with previous studies.

Population and sample

The population was made up of family members of mental patients belonging to three different associations: association of family members of mental patients (ASAPME) in which family members of patients with affective disorders and those of patients with psychotic disorders could be interviewed. association of family members of patients with Alzheimer's disease and association of ex-alcoholics. all of them in the city of Huesca. The controls used were employees of the telephone company and health care employees from a health care center in Huesca.

Extraction of the sample

The person who was the principal caretaker or who had the most contact with the patient was preferentially interviewed. The sample was collected in the different associations randomly according to the number of members and the involvement in the association in the last year.

Instrument

The questionnaire on the opinion on mental disease. OMI of Struening and Cohen adapted in Spain by Yllá and Guimón was used as the instrument.

These 60 items were answered by responding between: *a)* Strongly agree; *b)* Agree; *c)* I am not sure. but I agree; *d)* I am not sure. but I disagree; *e)* Disagree; *f)* Strongly disagree.

All the participants answered a series of sociodemographic questions that included gender. age. profession. religious beliefs. studies. kinship. diagnosis of the family member and if they were the principal caretakers or not.

Table 1	Factors rotated with Varimax		
Components	Initial self-values		
	Total	% of the variance	% accumulated
1	8.441	14.068	
2	4.577	7.629	
3	2.925	4.875	
4	2.401	4.001	
5	2.175	3.626	34.199

RESULTS

Prior to making the factorial analysis. we searched for the correlation between the variables. using the sampling adequacy measurement of Kaiser-Meyer-Olkin (KMO). The KMO in this study was 0.690. Thus. since they were less than 0.800. this indicated that the correlations. although valid. were not totally sufficient. In the Bartlett sphericity. as the null hypothesis was rejected (sig. 0.000) it was assumed that the correlation matrix was different from that of the identity matrix. Thus. there was correlation between the variables.

We obtained 5 factors in the factorial analysis. which explained 34.20% of the variance (table). A total of 86% of the variance would be represented by 19 factors. although only the first 5 accumulated sufficient variance in order to have significance and provide information.

PRINCIPAL FACTORS

Factor 1: Mental hygiene. Extracted from component 1 (table 2). The factor was the most important one in this study. It explained 14.06% of the variance. Items that refer to the etiology and its relationship with mental hygiene. style of life. coping forms and management of thoughts are included in it.

Factor 2: Therapeutic negativism. Extracted from component 2 (table 3). It explained 7.62% of the variance. half of the first factor. It groups items that discuss the effectiveness of the treatments and expectations for cure. Struening and Cohen called this factor benevolence. considering this a charitable. simplistic. paternal and authoritative attitude. The items that appeared in this factor did not have any significant differences between the case-control responses.

Factor 3: Social reinsertion or dependence. Extracted from component 3 (table 4). The items of this factor refer to the capacity of these patients to cope alone in the society and it accounted for 4.87% of the variance.

Factor 4. Social restrictiveness. Extracted from component 4 (table 5). It was 4% of the variance and the items grouped in it refer to the possible social limitations imposed on these patients. It is a stigmatizing factor.

Table 2	Factors rotated with Varimax			
Item	Potency	Characteristics	Means	
			Case	Control
07	0.686	They get carried away by their emotions	3.10	3.87
05	- 0.679 INV	Reaction to demands of society	2.46	3.02
20	0.678	Homes with little interest	4.20	4.66
10	- 0.676 INV	Become ill to avoid problems	3.31	3.90
30	0.622	Separation or divorce of parents	3.58	4.48
06	- 0.615 INV	Illness due to life style	3.33	3.90
16	0.556	Flee from bad thoughts	4.07	4.30
44	- 0.552 INV	More ill outside than inside	2.16	2.85
48	0.514	Lack of will	4.04	4.60
17	0.483	They pay no attention to feelings	2.81	3.52
15	- 0.473 INV	Fond of work	3.33	4.29
39	0.442	SNC disorder	2.32	3.12
01	- 0.429 INV	Depression due to too much work	3.75	4.11
19	0.409	Different than heart patients	2.22	3.37
53	- 0.388 INV	Measures morality of the society	2.49	3.03
28	- 0.388 INV	They prefer to live in community	2.17	2.51
29	0.359	Not authorized to vote	3.98	4.59
43	0.329	There are more prone professions	4.39	4.61

Factor 5: Stigmatization. Extracted from component 5 (table 6). It was 3.62% of the variance and is a very authoritative factor. With these items. the patients are labeled as persons who are different from the others and judge their lives.

FACTOR AND RELATIONSHIP WITH OTHER VARIABLES

Factors and age. (Fig. 1) In factors 2. therapeutic negativism. and 3. reinsertion. significant differences were observed regarding age in cases. However. no difference was found regarding the factors in controls.

Factors and gender. No significant differences regarding the factors were found in either cases or controls.

Factors and studies (Fig. 2). In cases. differences were found regarding the level of studies in factors 1. etiology. and 2. therapeutic negativism: In controls. the level of studies represented differences in factor 4. social restrictiveness. and did not show any in the rest of the factors.

Table 3 Factor 2

Item	Potency	Characteristics	Means	
			Case	Control
38	-.596 INV	They need support and understanding from the family	1.33	1.76
40	.568	They are not really human	5.34	4.97
22	-.553 INV	They deserve the respect of the others	1.16	1.27
36	.537	Enclosed hospitals with guards	5.14	4.47
34	.491	Punish them for attaching someone	4.60	4.31
47	-.472	Feeling at home in the hospital	1.82	1.81
52	-.452	Refuse to go to a children's hospital	5.35	5.03
49	-.426 INV	The patient can only hope to be well cared for	4.60	4.73
31	-.423 INV	It is best to treat them in an enclosed site	5.14	4.95
46	.408	Disease as punishment for bad actions	5.45	5.05
37	.385	The woman gets a divorce because of husband's illness	3.78	3.85
18	-.324 INV	More money from taxes for the disease	1.25	1.67
12	-.225 INV	It is bad to laugh at them. even if they behave oddly	1.30	1.43

Table 4 Factor 3

Item	Potency	Characteristics	Means	
			Case	Control
24	.537	A woman would be crazy to get married.	3.84	4.45
27	-.531 INV	Capable of qualified work	2.07	1.95
41	-.516 INV	Once cured. he/she could be a good person to take care of babies	3.38	3.93
35	-.494 INV	Get ill due to the environment	4.07	4.13
50	-.482 INV	They would not leave with open doors	3.83	3.44
02	.456	Mental disease as any other	1.92	2.46
57	.455	Right to live where they choose	2.00	1.76
03	.427	Most are not dangerous	2.99	2.65
45	-.425 INV	Dangerous to forget they are ill	3.42	3.24
08	-.395 INV.	No more dangerous than the average citizen	2.60	3.32
54	-.318 INV	Important to speak clearly	2.08	2.42
56	-.286 INV	Those who don't want they close by is because they are afraid	2.39	2.48
13	-.262 INV	Most would like to work	2.82	2.92

Table 5	Factor 4			
Item	Potency	Characteristics	Means	
			Case	Control
21	682	Do not treat them in the same hospital	3.66	3.98
04	.555	Should not marry, even if they seem to be cured	3.45	4.62
25	.437	Disease by inheritance	4.35	4.70
51	.415	They would remain with open doors	4.00	4.92
58	-.359 INV	Help from religious organizations	2.50	2.43
60	.335	Suicide caused by disease	3.77	4.03
14	.312	Children cannot visit them	3.83	4.55
55	.263	Most of us feel uncomfortable around them	2.46	2.42

Table 6	Factor 5			
Item	Potency	Characteristics	Means	
			Case	Control
24	.537	The patient is not the same as before	3.84	4.45
27	-.531 INV.	They are different from others	2.07	1.95
41	-.516 INV.	Most do not care about their appearance	3.38	3.93
35	-.494 INV.	More privacy in the hospitals	4.07	4.13
50	-.482 INV.	More doctors and nurses	3.83	3.44
02	.456	Being ill is a failure	1.92	2.46
57	.455	Do not discharge until they act normal	2.00	1.76
03	.427	Better not to think about problems	2.99	2.65
45	-.425 INV.	Peligroso olvidarse que son enfermos	3.42	3.24
08	-.395 INV.	No más peligrosos que el ciudadano medio	2.60	3.32
54	-.318 INV.	Importante hablar claro	2.08	2.42
56	-.286 INV.	Los que no les quieren cerca es por miedo	2.39	2.48
13	-.262 INV.	La mayoría está deseando trabajar	2.82	2.92

Factors and occupation (Fig. 3). In cases. the different professions showed significant differences in etiology. therapeutic negativism and social restrictiveness factors. In controls. there were differences regarding the reinsertion factor.

Factor and religious beliefs (Fig. 4). In cases. there were differences in factor 1 or etiology. the same occurring with the controls.

Factors and diagnosis of the family members (Fig. 5). According to the diagnoses of the family members of those surveyed. there were significant differences in factors 1. etiology. and 2. therapeutic negativism.

Kinship factors and grade (Fig. 6). According to the grade of kinship of those surveyed. there were differences in factor 4 or social restrictiveness.

Factors and time of evolution of the disease. There were no differences regarding any factor.

Factors and grade of caretaker (Fig. 7). According to whether the person was the principal caretaker or a secon-

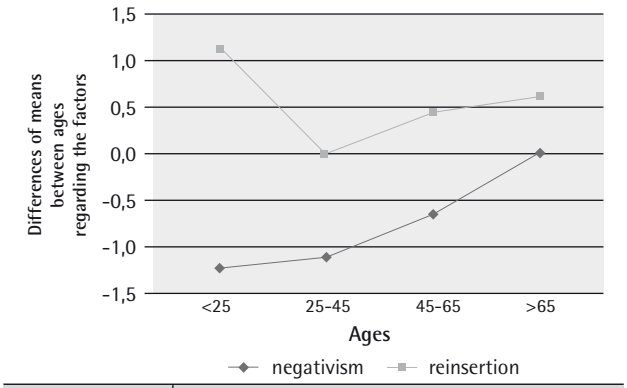

Figure 1 *Influence of age in the therapeutic negativism and social reinsertion factors.*

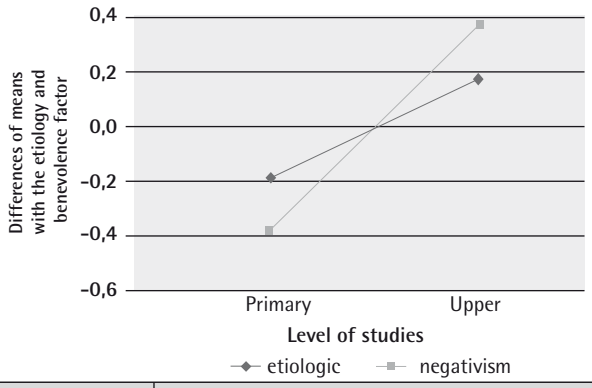

Figure 2 *Influence of studies on the etiology and therapeutic negativism factors.*

dary one. differences were found regarding factor 1 or etiology.

Factors and background of disease in the family (Fig. 8). According to whether there was any background in the family. there were differences in the etiology and reinsertion factors.

Factors and age of appearance of the disease (Fig. 9). According to the age in which the disease appears in the family member. there were differences in the therapeutic negativism factor.

DISCUSSION

The factor having the highest percentage of variants accumulated is one that includes etiology and mental hygiene. Therefore. this is not a negative factor but rather it would be a reflection of the concern. involvement or information of the family members of these patients.

The second factor. therapeutic negativism. would express the lack of confidence of the family members of these patients in the treatment and in the cure. and the benevolent behavior they have towards them.

The third. fourth and fifth factors with very similar variances were more clearly negative factors. They included judgments on the capacity of these patients to manage alone. in society. and the self-image of these patients.

In studies performed recently. Yllá.[16] in the general population in Vizcaya. five factors also appeared that would explain a similar percentage of variance. although the factors were very different for this population. The factors that accumulated the most variance were more negative ones.

The etiology or mental hygiene factor varied according to studies. occupation. religious beliefs. diagnoses of the family member. if the person was the principal caretaker or not and if there was a history of disease in the family. Therefore. we observe that the disease. its causes and the way

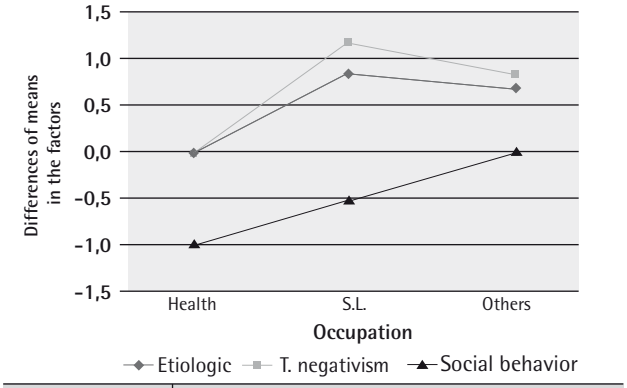

Figure 3 *Influence of the profession in the etiology, therapeutic negativism and social behavior factor.*

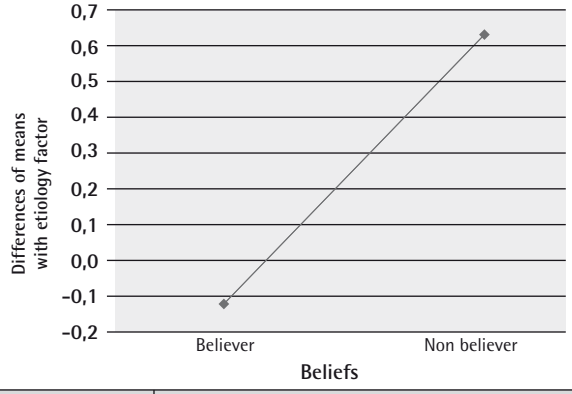

Figure 4 *Influence of religious beliefs in the etiology factor.*

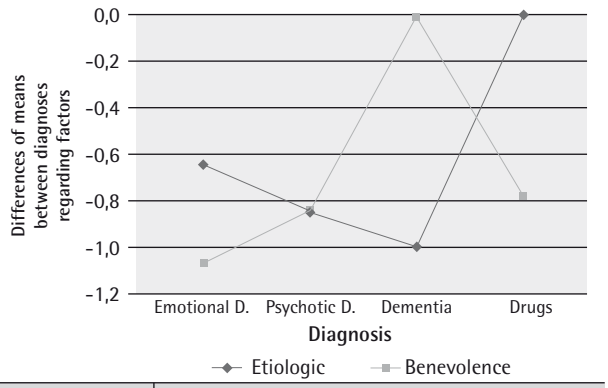

Figure 5 *IInfluence of the diagnosis of the family member in the etiology and therapeutic negativism or benevolence factors.*

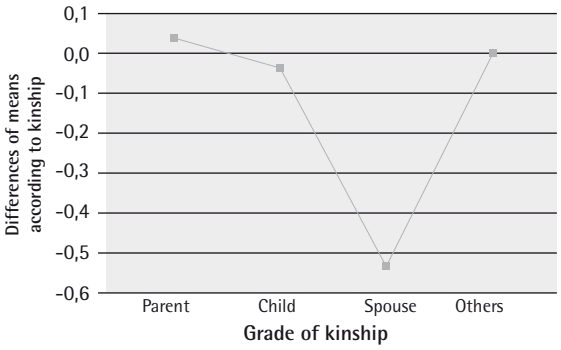

Figure 6 *Influence of kinship in the social behavior factor.*

one becomes ill are interpreted in different ways and change with each variant.

The therapeutic negativism factor has variations according to age. occupation. the diagnoses of the family member or age in which the disease appeared. Those over 65 years and health-care professionals are those who had the least therapeutic negativism. On the contrary. the family members of patients with dementia and those who became ill at older ages. had the greatest therapeutic negativism.

The reinsertion factor changed with age and if the patient had a history of this disease in the family. Those surveyed with ages between 25 and 45 years and those who had no history had less belief in the reinsertion of these patients.

The restriction factor depended on the occupation and kinship. Spouses and health-care professionals were those who were the least restrictive with the patients.

The stigma factor did not change with any of the variables studied.

The controls only presented changes in the reinsertion factor. depending on occupation. Health-care professionals were those who believed the most in reinsertion of these patients.

The control group with few studies was the one that presented more social restrictiveness.

CONCLUSIONS

The events of recent years have given rise to a change in attitudes towards the disease. In general. there is a more human. less restrictive and less authoritarian view than before. However. it is significantly greater in the controls. A very paternalistic attitude continues with these patients.

In regards to the variants. there were no differences according to gender.

Persons with a higher level of education were more restrictive and less authoritarian in both cases and controls.

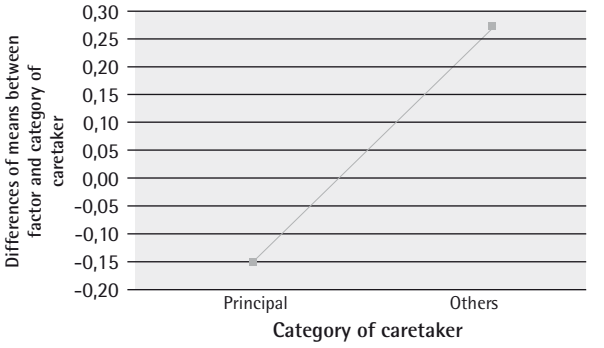

Figure 7 *Influence of being a caretaker or not in the etiology factor.*

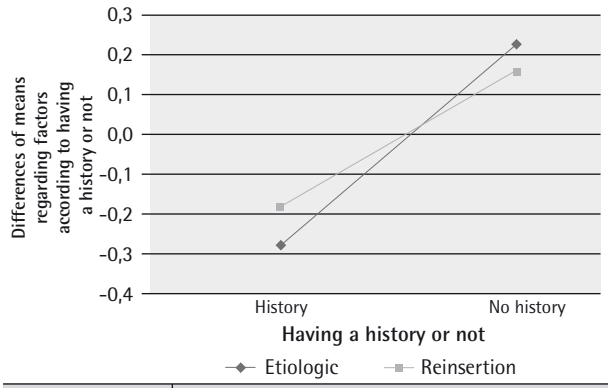

Figure 8 *Influence of having a history in the etiology and reinsertion factors.*

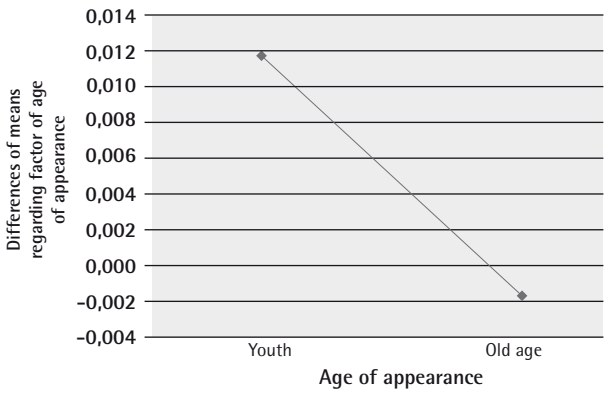

Figure 9 | *Influence of age of appearance of mental disease to the family member and therapeutic negativity or benevolence.*

Those with less education were more benevolent. the same as the controls.

Those over 65 years were more authoritarian than the rest of the age groups.

In regards to profession. health care professionals are less authoritarian and restrictive than the rest.

Comparing the groups of the different diagnoses of the disease and the control group. the family members of alcoholics and the control group were the least authoritarians. The control group was also less restrictive and benevolent. although they had little faith in the treatments.

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