# The Impact of Organizational Factors on Mental Health Professionals' Involvement With Families

**Eric R. Wright, Ph.D.**

*Objective:* **Drawing on an organizational behavior framework, this study explored the impact of attitudinal, occupational, and organizational factors on mental health professionals' involvement with clients' families.** *Methods:* **Data came from a survey conducted with psychiatric staff at the largest public hospital and the largest private hospital in Indianapolis between 1991 and 1993 as part of the Indianapolis network mental health study. Responses of 184 clinicians who provided direct care were analyzed using multiple regression to assess the impact of their attitudes toward families, job characteristics, and organizational work environment on the amount of contact they had with clients' families.** *Results:* **Providers' attitudes toward families had no significant effect on the frequency of their contact with families. Job and organizational factors were the strongest predictors. Specifically, being a social worker or therapist and working on day and evening shifts were associated with increased involvement with families. Staff members' perceptions of how well their unit functioned were also positively correlated with frequency of contact with families.** *Conclusions:* **The organizational environment in mental health agencies has a significant influence on the extent to which professionals become involved with clients' families. Administrators and policy makers should give careful consideration to how the work environment encourages or limits mental health professionals' abilities and willingness to get more involved with clients' families. (*Psychiatric Services* 48:921–927, 1997)**

Over the past decade, public and professional concern about the quality of the relationship between family members and mental health professionals has grown significantly. An expanding body of research has documented that many families feel unconnected with the treatment process and are frequently dissatisfied with the quality or the amount of contact they have with providers (1–10). Studies have also found that family involvement in treatment can have a positive influence on both family members and clients in care (3,11–14). Yet mental health professionals typically do not integrate family members into the treatment process, nor do they provide very much direct support or psychoeducational services to families (6,8,10).

Explanations for families' dissatisfaction and for the low rates of family involvement in services are relatively limited. However, a broad consensus exists that much of the tension between families and professionals arises from basic conflicts between what families want and what families receive from mental health professionals (2,8,15,16). For example, family members most often want emotional support, useful information about mental illness, information about treatment plans, and practical suggestions for dealing with their ill relative (6,7,12,15). Mental health professionals, on the other hand, tend to treat families primarily as sources of intake information, sometimes blaming families for their loved one's illness and frequently disregarding family members' own needs for support and services (10). Recent efforts to improve the family-provider relationship have targeted the need to change providers' attitudes about families and to educate professionals that families can be an important resource in clients' treatment and rehabilitation (4,17).

Less well understood is how the work environment in mental health agencies may encourage or limit providers' abilities and willingness to get more involved with families. The central focus in clinical services is on clients, which has meant that working with family members is something providers must do in addition to their work with clients. Such work often goes unrecognized and uncompensated. Professionals who work with families may even be stigmatized by colleagues for engaging in such work both because of conflicting professional views over the value of family involvement and because of increased pressure from supervisors, insurance companies,

*Dr. Wright is the associate director of the Indiana Consortium for Mental Health Services Research. He is also assistant professor in the department of sociology at Indiana University–Purdue University Indianapolis, Cavanaugh Hall 303, 425 University Boulevard, Indianapolis, Indiana 46202.*

***Table 1***

Survey responses of 184 mental health professionals on items describing their involvement with clients' families in the past six months, by occupational category

| Item[1] | Full sample (N=184) | | Psychiatrists (N=11) | | Nurses (N=82) | | Therapists and social workers (N=23) | | Attendants, occupational and recreational therapists (N=68) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD | F | p< |
| Helping families understand the client's illness | 1.53 | 1.17 | 2.45 | .93 | 1.45 | 1.20 | 2.22 | 1.00 | 1.24 | 1.08 | 7.11 | .001 |
| Encouraging families to support the client emotionally | 1.64 | 1.25 | 2.45 | .93 | 1.56 | 1.29 | 2.35 | .88 | 1.37 | 1.23 | 5.58 | .01 |
| Helping families set appropriate limits for the client | 1.39 | 1.14 | 2.36 | .92 | 1.23 | 1.05 | 2.30 | .93 | 1.12 | 1.23 | 10.97 | .001 |
| Informing families of the client's progress | 1.47 | 1.20 | 2.36 | .92 | 1.52 | 1.25 | 1.74 | 1.05 | 1.16 | 1.13 | 4.21 | .01 |
| Encouraging families to accept the client's independence | 1.44 | 1.15 | 2.36 | .92 | 1.35 | 1.13 | 2.09 | .90 | 1.18 | 1.16 | 6.67 | .001 |
| Doing family therapy with the family and the client | .54 | .84 | 1.36 | .92 | .34 | .71 | 1.13 | 1.01 | .44 | .74 | 10.73 | .001 |
| Advocating to help families get needed services | .98 | 1.08 | 1.91 | .94 | .72 | .99 | 1.87 | .87 | .84 | 1.04 | 11.59 | .001 |
| Mediating conflicts between families and the client | 1.06 | .98 | 1.91 | 1.04 | .80 | .85 | 1.96 | .93 | .93 | .90 | 13.80 | .001 |
| Providing families with crisis intervention services | 1.02 | 1.06 | 1.91 | .83 | .72 | .89 | 1.91 | .90 | .93 | 1.11 | 12.23 | .001 |
| Total family involvement score[2] | 1.44 | 1.09 | 2.12 | .79 | 1.08 | .87 | 1.95 | .74 | 1.02 | .91 | 11.39 | .001 |

[1] Items were rated on a 4-point scale: 0=never, 1=not very often, 2=sometimes, and 3=very often.

[2] The total family involvement score is the average of the nine items.

and other funding sources to engage in strictly billable work (18).

Work with families, then, is usually done above and beyond the strict definition of an employee's job description, a concept that organizational behavior researchers refer to as extra-role behavior or good organizational citizenship (19,20). Studies indicate that such extra-role behavior is essential for organizations to function effectively and efficiently (21) and that the extent to which workers are good organizational citizens is heavily shaped by the work environment (19,20,22).

This paper explores the impact of attitudinal, job, and organizational factors on mental health professionals' involvement with families. Three hypotheses guided this research. The first is that mental health professionals' attitudes about families strongly affect the frequency with which professionals interact with family members. As already noted, numerous experts on families have long maintained that mental health professionals who hold more positive attitudes about family involvement are more likely to interact with and respond to the informational and psychosocial needs of their clients' family members (10,23,24). Thus a hypothesis examined in this study is that the more providers view families as a resource for their clients, the more likely they are to involve and communicate with families.

The second hypothesis is that characteristics of staff members' jobs affect their level of involvement with families. Tessler and colleagues (6) found a professional division of labor when it comes to dealing with families. Specifically, they reported that the type of professional who works with family members depends on where the client is in the continuum of care. For example, psychiatrists are most involved during acute episodes, and case managers and social workers are active during aftercare. Others suggest that these patterns reflect broader differences in professional training and clinical beliefs about families held by different professional groups (10,23,24). Although there is some indication that many providers are becoming more sensitive to family concerns (24), a tendency still exists for social workers and case managers to be both more involved and more supportive of family concerns than other mental health professionals (7).

Other aspects of mental health professionals' jobs are also likely to shape their opportunities to interact with families. For example, providers who work more hours, such as full-time employees, and those who work on day and evening shifts are more likely to come in contact with family members because they are on duty when family members are more likely to be available. Consequently, an aspect of the second hypothesis in this study is that professionals who are most likely to have contact with families are social workers and other front-line staff who work day and evening shifts.

The third hypothesis focuses attention on the organizational environment of treatment settings. Stress and ambiguous work expectations have been found to negatively affect workers' job satisfaction, their commitment to work organizations, and their willingness to engage in extra-role behavior (18,21,25). In mental health settings, pressure from fund-

*Table 2*

Survey responses of 184 mental health professionals on items describing their attitudes toward clients' families, by occupational category

| Item[1] | Full sample (N=184) | | Psychiatrists (N=11) | | Nurses (N=82) | | Therapists and social workers (N=23) | | Attendants, occupational and recreational therapists (N=68) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | Mean | SD | F | p< |
| The client has family support | 1.92 | .54 | 1.90 | .54 | 1.96 | .55 | 1.83 | .58 | 1.90 | .51 | .374 | .772 |
| Family members also have mental health problems[2] | 2.32 | .52 | 2.48 | .50 | 2.31 | .53 | 2.29 | .44 | 2.32 | .55 | .392 | .759 |
| Families have a great deal of experience with the welfare and social service systems[2] | 1.88 | .67 | 1.63 | .50 | 1.74 | .61 | 1.99 | .74 | 2.05 | .70 | 3.477 | .017 |
| Families are optimistic about the client's chances for recovery | 1.71 | .55 | 1.95 | .46 | 1.76 | .57 | 1.54 | .58 | 1.66 | .52 | 1.853 | .139 |
| Families have little education[2] | 2.16 | .61 | 1.76 | .66 | 2.03 | .63 | 2.14 | .46 | 2.40 | .56 | 6.725 | .001 |
| Families are cooperative | 2.23 | .47 | 2.20 | .40 | 2.26 | .51 | 2.28 | .44 | 2.20 | .44 | .274 | .844 |
| Families have an average or a high income | 1.46 | .56 | 1.68 | .46 | 1.56 | .59 | 1.37 | .64 | 1.34 | .48 | 2.681 | .048 |
| Total family attitude score[3] | 12.98 | 2.30 | 13.89 | 1.79 | 13.47 | 2.26 | 12.60 | 2.54 | 12.37 | 2.18 | 3.800 | .011 |

[1] Items were rated on a 3-point scale: 1=not typical, 2=somewhat typical, and 3=very typical.
[2] The response was recoded so that a higher score would indicate more positive feelings about families.
[3] The total family attitude score is the sum of the seven items.

ing agencies, the overall illness severity of clients in the caseload, heavy workloads, and feelings that staff do not work well together increase staff stress, which can lead to lower job satisfaction and burnout (18,26,27). According to Glisson and others (18,19,22,25–27), these organizational effects are especially important because they can influence both the quality of care and client outcomes. The study reported here extends this logic, and it was hypothesized that as staff perceptions of the organizational environment or unit functioning improve, professionals' involvement with families will increase.

## Methods

### *Data and sample*

The data for this study came from a survey of all psychiatric staff members at the two largest general hospitals, one public and one private, in Indianapolis. The survey was conducted between 1991 and 1993 as part of the Indianapolis network mental health study (28,29). The two facilities provide inpatient, outpatient, and community outreach and support services for people with a wide variety of mental health problems.

The total sample included 231 staff members—114 from the private hospital and 117 from the public hospital. The response rates for the survey were very high, 94.4 percent and 96.6 percent, respectively (30). Because the focus of this study is on clinical staff involvement with families, survey data from only the 184 staff who indicated that they provided direct clinical care were included.

At the private hospital, 98 clinical staff worked in four program areas, and in the public hospital, 86 staff were employed in three treatment units. The mean±SD age of the clinicians was 39.23±9.45 years. A total of 142 of the 184 staff members (77.2 percent) were white, and 136 (73.9 percent) were women. Most had a college education or better (85.2 percent). The median personal income for the sample was between $25,000 and $30,000. The mean±SD number of years spent working in the mental health field was 10.88±10.01. The clinicians had spent a mean of 7.62±7.84 years employed in their current position.

The sample was composed of 11 psychiatrists (6 percent), 82 nurses (44.6 percent), 23 therapists and social workers (12.5 percent), and 68 psychiatric technicians or occupational and recreational therapists (37 percent). Of the 184 staff members, 145 (78.8 percent) worked full time, and 114 (62 percent) worked on a day or evening shift.

### *Measures*

The central dependent variable, family involvement, was measured with nine items developed by Grusky (31), which ask respondents how often they have had nine types of contact with families in the past six months (see Table 1). Responses are coded as 0, never; 1, not very often; 2, sometimes; and 3, very often. A respondent's total score was computed as the mean of the nine items. The internal consistency of the family involvement scale was excellent (Cronbach's alpha=.961).

The clinician's attitude toward families was measured as the simple sum of an additional seven items from the instrument developed by Grusky (31). These items assess the extent to which the respondent perceives families in general to be a resource for clients (see Table 2). Response categories are 1, not typical; 2, somewhat typical; and 3, very typical. Possible scores on this measure range from 7 to 21, with higher

*Table 3*

Survey responses of 184 mental health professionals on items describing the functioning of their unit[1]

| Item | Mean | SD |
|---|---|---|
| New and different intervention ideas are being tried out here[2] | 2.49 | 1.03 |
| New ideas about clinical methods are not viewed with enthusiasm here | 2.96 | 1.00 |
| The same clinical methods have been used here for a long time | 2.71 | .93 |
| Staff find the work here interesting and challenging[2] | 2.75 | .86 |
| The work atmosphere around here is impersonal | 3.49 | .94 |
| Staff seem to be just putting in time in this program | 3.32 | .97 |
| The program approach is well planned[2] | 2.65 | .90 |
| Clinical policies and procedures are vague and ambiguous here | 3.38 | 1.00 |
| Things are pretty disorganized around here | 3.36 | 1.00 |
| The details of assigned responsibilities are well explained to staff | 2.56 | .88 |
| Staff feel comfortable working through work-related concerns[2] | 2.97 | .91 |
| Group spirit is poor around here | 3.18 | .96 |
| Staff don't look to each other for support in this program | 3.59 | .86 |
| Supervisors compliment staff on a job well done[2] | 2.83 | 1.06 |
| Supervisors tend to criticize staff | 3.11 | .96 |
| Supervisors expect far too much from staff | 3.56 | .78 |
| Supervisors really stand up for staff[2] | 2.81 | .98 |
| Total unit functioning scale | 55.61 | 9.19 |

[1] Items are modified from original questions developed by Jerrell and Hargreaves (32). Responses were coded so that 1 indicates strongly agree and 5 indicates strongly disagree.

[2] The response was recoded before summing so that a higher score would indicate more positive perceptions of unit functioning.

scores indicating more positive views of the family. The internal consistency for this measure was good (Cronbach's alpha=.676).

The respondent's job-related characteristics were modeled with variables indicating occupation (psychiatrist, nurse, counselor–social worker, and psychiatric attendant–occupational or recreational therapist), primary shift (day or evening=1, night=0), work status (full time=1, part time=0), and the number of years employed in the organization.

In addition, four organizational measures were used in the analyses. A single-item ordinal measure assessed the respondent's perception of his or her overall workload. Response categories on this item range from 1, never too heavy, to 5, always too heavy. The respondent's perception of clients' severity of illness was measured using nine items that rate the global difficulty of clients in his or her caseload (31). For example, different items describe clients as being cooperative, well educated, socially isolated, having stable employment, and acting out. As above, response categories range from 1, not typical, to 3, very typical. Possible scores range from 9 to 27, with higher values indicating more severely disabled clients (Cronbach's alpha=.606).

A categorical variable was used to indicate the type of hospital (private=1, public=0). The organizational environment (unit functioning) was measured with 17 items from Jerrell and Hargreaves' Community Program Philosophy Scale (32). The items describe the respondent's general perceptions of workgroup process, cohesiveness, and supervisor support (see Table 3).

The 17 items are rated on a 5-point scale, with 1 indicating strong agreement and 5 strong disagreement. The total score is computed as the sum of the items and has a possible range of 17 to 85, with higher scores indicating more positive perceptions of unit functioning. The internal consistency of this scale was high (Cronbach's alpha=.875). Finally, a series of controls were included in the multivariate model. These variables were age, race, sex, education, and income.

### *Analysis*

Ordinary least-squares multiple regression analysis (33) was used to examine the effects of professionals' attitudes toward families, job characteristics, and perceptions of unit functioning on their involvement with families. While simultaneously controlling for staff members' individual demographic characteristics, this method focused the analysis on the relative independent effects of the three hypothesized predictors of family involvement.

## Results

Table 1 lists the nine items measuring the frequency of family contact and presents means for the entire sample and for the four occupational categories. On most of the items, psychiatrists reported having the most frequent contact with families. The response pattern of therapists and social workers closely paralleled that of the psychiatrists. Psychiatric attendants and occupational and recreational therapists had the least amount of family contact. As the table shows, simple analyses of variance indicated significant differences between the four groups on each of the nine types of family contact and on the overall measure of family involvement.

Unexpectedly, and in contrast to previous findings (10), the responses indicated that family therapy was seldom a major focus in these providers' interaction with families. As Table 1 shows, the sample mean on the item about family therapy was .54±.84. This mean is significantly lower ($p<.001$) than the means on the eight other types of family interaction. The most common types of interaction were helping families provide emotional support to clients (1.64±1.25) and helping them understand clients' illness (1.53±1.17).

Table 2 lists the seven items measuring clinicians' attitudes toward families and presents means for the entire sample and for the four occupational groups. In general, the staff described the "typical" families of their clients as being cooperative and as having mental health problems of their own. Staff attitudes about families varied slightly by occupation. Compared with psychiatrists and nurses, therapists and social workers and psychiatric attendants and recreational and occupational therapists were more likely to view clients' families as being heavi-

ly involved with the welfare and social service systems and as having little education. In general, as the statistical data in Table 2 show, psychiatrists and nurses tended to hold the most strongly positive views toward families; their total attitudinal scores were significantly different from those of professionals in the other occupational categories.

Table 3 presents the individual means and mean total score for the providers' responses on the perception of unit functioning scale. The providers indicated that they felt they could rely on their colleagues for support at work and that the work environment was fairly well organized. In addition, they reported that supervisors' expectations of them were reasonable and that the work atmosphere was comfortable. However, the respondents were less positive when asked if they found the work interesting and challenging and whether or not new and different intervention ideas were being tried on the unit. The overall score suggests that these professionals were modestly positive about their work situation.

*Table 4*

Ordinary least-squares regression model of the effects of attitudinal, job-related, and organizational factors on 184 mental health professionals' reported involvement with families, controlled for demographic factors[1]

| Factor | beta[2] | t[3] |
|---|---|---|
| Attitude toward families | .004 | .04 |
| Job-related factors | | |
| Organizational tenure (in years) | −.141 | −1.49 |
| Shift (day or evening) | .187* | 2.25 |
| Works part time | .020 | .24 |
| Nurse[4] | .078 | .75 |
| Psychiatrist[4] | .071 | .85 |
| Therapist or social worker[4] | .242** | 2.79 |
| Organizational factors | | |
| Unit functioning | .224* | 2.48 |
| Workload | .098 | 1.20 |
| Caseload severity | .205* | 1.97 |
| Private hospital | .024 | .23 |
| Demographic controls | | |
| Age (in years) | −.037 | −.41 |
| Race (nonwhite) | .137 | 1.53 |
| Sex (female) | −.010 | −.12 |
| Education (in years) | .001 | .01 |
| Income | .028 | .25 |

[1] $F=2.75$, df=16,142, $p<.001$; SE=.82; $R^2=.237$
[2] Standardized regression coefficients
[3] df=156
[4] The omitted comparison category was psychiatric attendants and occupational and recreational therapists.
*$p<.05$
**$p<.01$

The ordinary least squares multiple regression model of family involvement is presented in Table 4. The model specifies the direct effect of clinicians' attitudes toward families, their job characteristics, and the organizational factors on their reported involvement with families while controlling for their demographic characteristics. In sharp contrast with expectations, clinicians' attitudes toward families had no statistically significant effect on the amount of family contact (beta=.004).

However, Lefley (10) and others (7) have suggested that mental health professionals' views of the family often vary by occupation. To explore this possibility, the attitudes of the four occupational groups were also examined by introducing interaction terms to the basic model of family involvement. (These data are not reported here but are available from the author.) In the interactive models, the only significant interaction was for nurses (beta=.925, $p<.029$), indicating that positive attitudes toward families influenced only nurses' involvement with families.

As shown in Table 4, only two job characteristics appeared to be important in predicting family involvement. As hypothesized, staff members who worked on day or evening shifts were significantly more likely to interact with families than those who worked at night. Therapists and social workers were also more involved with families. Surprisingly, the multivariate model indicated that psychiatrists, who reported relatively frequent family contact (see Table 1), were not significantly involved with families. This finding suggests that psychiatrists' involvement with families is not as consistent as social workers' involvement and is heavily affected by the other personal, job, and organizational factors in the model.

Finally, the organizational environment of treatment programs also had a significant impact on staff involvement with families. Specifically, clinicians with caseloads of more clinically challenging clients had significantly more contact with families. In addition, as hypothesized, staff who perceived that the unit was functioning more smoothly tended to interact with families more often.

This finding echoes results of previous research indicating that the organizational environment affects the quality of care clients receive (18,25, 26). Additional analyses of this pattern indicated that the organizational environment affects family involvement primarily because of the effect it has on staff members' satisfaction with their jobs. (These data are not reported here but are available from the author.)

## Discussion and conclusions

The central findings of this research are threefold. First, little evidence was found that providers' attitudes about families influence the amount of contact they have with families. Generally, the professionals in this study held relatively positive views of families. Only nurses' attitudes toward families were significantly and positively correlated with the fre-

quency of their involvement with clients' families.

Second, job characteristics, in particular occupation and shift, influenced providers' opportunities to interact with families. The finding that social workers and other front-line staff were most consistently involved with families affirms both Tessler and associates' proposition (6) about the professional division of work with families and claims by Solomon (7) and others that social workers and case managers are usually families' primary resource in the mental health system. Third, the quality of the organizational environment in the treatment setting was also a critical factor in encouraging professionals' involvement with families.

However, it is important to keep in mind that this study used self-reported measures of the frequency of mental health professionals' contact with families. The results should thus be viewed as preliminary and must be replicated using more objective indicators of the nature and frequency of family-provider involvement, such as counts of observed contacts or of contacts documented in clients' charts. Further, measures of the amount of contact a professional has with families do not necessarily provide any detail about the quality of the interaction. Having a great deal of contact with a hostile staff member may be less beneficial than having limited contact with a relatively helpful therapist. Future studies should focus on specific family-professional interactions and assess both what happened and how both the family and the professional felt about it.

The results of this study have important theoretical implications for research on families' experience of mental illness. To date, most research efforts have focused on families' perceptions of mental health professionals' attitudes about families with little regard for how the organizational aspects of the setting in which families are seeking help might influence their experiences (5,7). This study has provided further evidence of a broad division of work with families among mental health professionals.

In addition, the results also clearly suggest that other less tangible factors, such as worker morale and perceptions of how well staff work together, have an impact on clinicians' involvement with families. In this regard, research on families' experiences in the mental health system could be strengthened significantly by giving more careful consideration to the service-related circumstances that shape the frequency and quality of provider-family interaction.

At a policy level, the results underline the need to rethink current efforts to develop more family-inclusive or family-centered service systems (34,35). There is some evidence that the family movement has had an impact on professionals and has raised their sensitivity to the needs of families and the complexity of the ethical and legal issues involved in including families in the treatment process (10,35). However, the results of this study highlight that educating professionals about the special needs of families and changing their attitudes about families may not be enough. Encouraging family involvement demands that policy makers and administrators take a closer look at how mental health services are actually provided and how specific organizational, cultural, and ideological factors inform actual practice.

Finally, as this study suggests, special attention should be given to the quality of the environment in which mental health work is performed as a condition for fostering family-provider collaboration. The extra-role nature of working with families means that during periods of organizational dissatisfaction and stress, clinicians will be less able and less likely to involve family members because working with families is not a central or rewarded component of standard clinical work. Planners interested in building family-centered services should consider ways to enhance mental health organizations' capacity to involve families in the ongoing work process. ♦


### *Acknowledgments*

This research was supported by grants MH44780 and MH51669 from the National Institute of Mental Health, Bernice A. Pescosolido, Ph.D., principal investigator. The author gratefully acknowledges the helpful comments of Bernice Pescosolido, Ph.D., Barbara Burns, Ph.D., John McGrew, Ph.D., William P. Gronfein, Ph.D., Debra J. Mesch, Ph.D., Joan E. Lafuze, Ph.D., Gayle Howard, B.A., and Terry White, M.B.A.


### *References*


1. Holden DF, Lewine RR: How families evaluate mental health professionals, resources, and effects of illness. Schizophrenia Bulletin 8:626–633, 1982
2. McElroy EM: The beat of a different drummer, in Families of the Mentally Ill: Coping and Adaptation. Edited by Hatfield A, Lefley HP. New York, Guilford, 1987
3. Spaniol L, Jung H, Zipple AM, et al: Families as a resource in the rehabilitation of the severely psychiatrically disabled. Ibid
4. Bernheim KF: Family-provider relationships: charting a new course, in Families as Allies in Treatment of the Mentally Ill: New Directions for Mental Health Professionals. Edited by Lefley HP, Johnson DL. Washington, DC, American Psychiatric Press, 1990
5. Grella CE, Grusky O: Families of the seriously mentally ill and their satisfaction with services. Hospital and Community Psychiatry 40:831–835, 1989
6. Tessler RC, Gamache GM, Fisher GA: Patterns of contact of patients' families with mental health professionals and attitudes toward professionals. Hospital and Community Psychiatry 42:929–935, 1991
7. Solomon P: Families' views of service delivery: an empirical assessment, in Helping Families Cope With Mental Illness. Edited by Lefley HP, Wasow M. Langhorne, Pa, Harwood Academic Publishers, 1994
8. Greenberg JS, Greenley JR, Kim HW: The provision of mental health services to families of persons with serious mental illness. Research in Community Mental Health 8:181–204, 1995
9. Biegel DE, Song L, Milligan SE: A comparative analysis of family caregivers' perceived relationships with mental health professionals. Psychiatric Services 46:477–482, 1995
10. Lefley HP: Family Caregiving in Mental Illness. Newbury Park, Calif, Sage, 1996
11. Hatfield AB: Help-seeking behavior in families of schizophrenics. American Journal of Community Psychology 7:563–569, 1979
12. Hatfield A: The family's role in caregiving and service delivery, in Helping Families Cope With Mental Illness. Edited by Lefley HP, Wasow M. Langhorne, Pa, Harwood Academic Publishers, 1994
13. McFarlane WR: Families, patients, and clinicians as partners: clinical strategies and research outcomes in single- and multiple-family psychoeducation. Ibid
14. Dixon LB, Lehman AF: Family interven-

tions for schizophrenia. Schizophrenia Bulletin 21:631–643, 1995

15. Hatfield AB, Fierstein R, Johnson DL: Meeting the needs of families of the psychiatrically disabled. Psychosocial Rehabilitation Journal 6:27–40, 1982

16. Thompson R, Weisberg S: Families as educational consumers: what do they want? What do they receive? Health and Social Work 15:221–227, 1990

17. Lefley HP: Research directions for new conceptualization of families, in Families as Allies in Treatment of the Mentally Ill: New Directions for Mental Health Professionals. Edited by Lefley HP, Johnson DL. Washington, DC, American Psychiatric Press, 1990

18. Arches J: Social structure, burnout, and job satisfaction. Social Work 36:202–206, 1991

19. Konovsky MA, Pugh SD: Citizenship behavior and social exchange. Academy of Management Journal 37:565–569, 1994

20. Organ DW, Ryan K: A meta-analytic review of attitudinal and dispositional predictors of organizational citizenship behavior. Personnel Psychology 48:775–802, 1995

21. Organ DW: Organizational Citizenship Behavior: The Good Soldier Syndrome. Lexington, Mass, Lexington Books, 1988

22. Barr SH, Pawar BS: Organizational citizenship behavior: domain specifications for three middle range theories. Academy of Management Journal 38(Best Paper Proceedings):302–306, 1995

23. Hatfield A: Culture and mental illness: the family role, in Families of the Mentally Ill: Coping and Adaptation. Edited by Hatfield A, Lefley HP. New York, Guilford, 1987

24. Riesser GG, Schorske BJ: Relationships between family caregivers and mental health professionals: the American experience, in Helping Families Cope With Mental Illness. Edited by Lefley HP, Wasow M. Langhorne, Pa, Harwood Academic Publishers, 1994

25. Glisson C, Durick M: Predictors of job satisfaction and organizational commitment in human service organizations. Administrative Science Quarterly 33:61–81, 1988

26. Pines A, Maslach C: Characteristics of staff burnout in mental health settings. Hospital and Community Psychiatry 29:233–237, 1978

27. Farley JE: Transitions in psychiatric inpatient clinical social work. Social Work 39:207–212, 1994

28. Pescosolido BA: A Network-Episode Model for Mental Health Services. Proposal to the National Institute of Mental Health. Bloomington, Ind, Institute of Social Research, 1989

29. Pescosolido BA: A Multi-Level Model for Mental Health Services Research. Proposal to the National Institute of Mental Health. Bloomington, Ind, Institute of Social Research, 1989

30. Pescosolido BA, Figert AE, Lubell KM: Professional work in public and private settings: the use and evaluation of the DSM in psychiatric units. Current Research on Occupations and Professions 9: 31–51, 1996

31. Grusky O: Mental Health Services Project Interview Guide 2: Case Manager (Interview Schedule). Los Angeles, University of California, Department of Sociology, 1986

32. Jerrell JM, Hargreaves WP: Community Program Philosophy Scale (CPPS): Preliminary Report. Berkeley, Calif, Institute for Mental Health Services Research, 1989

33. Hanushek EA, Jackson JE: Statistical Methods for Social Scientists. New York, Academic Press, 1977

34. Friesen BJ, Koroloff NM: Family-centered services: implications for mental health administration and research. Journal of Mental Health Administration 17:13–25, 1990

35. Matori S: The changing role of the family in treatment: a review and some strategies. Discharge Planning Update 14(4):14–21, 1994

## Guidelines for Authors of Research Reports

Research reports published in *Psychiatric Services* may be either regular articles (a maximum of 3,000 words excluding references and tables) or brief reports (a maximum of 1,200 words, plus no more than ten references and one table or figure).

For research reports presented as regular articles, include a structured abstract (maximum, 250 words) with headings of *Objective*, *Methods*, *Results*, and *Conclusions*. For brief reports, include an unstructured abstract (maximum, 100 words).

In the text, use the standard format of introduction, methods, results, discussion, and conclusions. In the last paragraph of the introduction, briefly state the purpose of the research or the research question and indicate the type of study design.

Include data on the sex, age, and race of the study subjects. Preferably in the methods section, describe the data analysis procedure concisely and in a manner understandable by nonstatisticians.

In the results section, including tables, report only the findings directly related to the research purpose or question; omit other data. Report numbers for all percents. For statistically significant results, report the observed test statistic value, degrees of freedom, and probability level.

Send manuscripts (six copies) to the editor, John A. Talbott, M.D., *Psychiatric Services*, APA, 1400 K Street, N.W., Washington, D.C. 20005. For further information, see Information for Contributors in the February and May 1997 issues or contact the editorial office (phone, 202-682-6070; fax, -6189).