Published in final edited form as:

Int J Soc Psychiatry. 2009 May ; 55(3): 257–271. doi:10.1177/0020764008093687.

Satisfied Carers of Persons With Enduring Mental Illness: Who and Why?

Yulia Kartalova-O'Doherty and Donna Tedstone Doherty

Mental Health Research Unit, Health Research Board, Dublin, Ireland

Abstract

Background—This secondary mixed-methods analysis is based on the interview data collected for an exploratory study of the experiences and needs of carers of persons with enduring mental illness. The aims were to identify and describe socio-demographic and contextual factors associated with the satisfaction of carers with family support.

Method—Content analysis and non-parametric tests were used for the exploration of qualitative and quantitative data collected from 38 carers.

Results—The majority of the satisfied carers were male, and from a higher socio-economic group than other carers. The ill relatives of all satisfied participants resided outside of their family homes. Carer satisfaction was associated with such categories as: a caring service; supportive and unintrusive family relationships; being accepted as partners; supportive community; and suitable family services. All the identified categories were interrelated.

Conclusions—The identified categories and socio-demographic factors should be considered for inclusion in the planning and evaluation of family support services.

Keywords

mental illness; family carers; mixed methods; family support; satisfaction with services; socio-demographic factors

As shown by numerous studies, carers and relatives of persons with serious mental illness, such as schizophrenia or bipolar disorder, are at greater risk of stress-related illness than the general population (Stengard, 2000). There is evidence that educational programmes for carers not only enhance the coping strategies of family carers and improve their psychological well-being, but also reduce relapse rates, and help the rehabilitation and recovery of persons with mental illness (Cassidy, 2001) (Dixon, 2001). The National Institute for Clinical Excellence (NICE) highlights the positive role of carers in promoting the recovery of their ill relatives, and recommends the provision of treatment in partnership with service users and carers (National, 2002).

In this article we use Lefley's (Lefley, 2001) broad definition of carers as 'individuals whose own happiness is entwined with the well-being of people who are dear to them' (p. 141). The terms carers and *participants* are used interchangeably in this article and refer to parents, step-parents, spouses and siblings of persons with enduring mental illness (Rothausen, 1999). The term *persons with enduring mental illness* refers to the ill relatives of the participants. To facilitate analysis of needs of carers, *enduring mental illness* was broadly defined in this study as being of approximately two or more years' duration and requiring

contacts with mental health professionals at least twice within one year. Our exclusion criteria were persons with primary diagnoses of organic disorders or substance abuse.

Several studies (Ruggeri, 1994; Leavey *et al.*, 1997) used satisfaction of service users and their carers as an indirect measure of quality of care and support provided for the family. Dyck *et al.* (1999) found that a higher degree of severity of symptoms of ill relatives and a lower level of carer satisfaction with social support predicted presence of episodes of infectious illness among carers of persons with schizophrenia. More research on carers who are satisfied with services and support may identify service requirements and contextual factors helping families to positively adapt to enduring mental illness.

Previous studies have shown gender differences in satisfaction of carers of persons with serious mental illness with mental health services (Grella, 1989), whereby women were more often dissatisfied with services than men. A qualitative analysis of experiences of caring for persons with anorexia nervosa found that mothers tended to express greater anxiety, whereas fathers used more cognitive reappraisals of caring experience (Whitney J, 2005).

The residential status of the ill relative may have an impact on both carers' and service users' satisfaction with services. Carers were more likely to be dissatisfied with their situation if they lived with their ill relatives (Stengard, 2000). An Irish study found that service users with serious mental illness living in mental health community residential services would have preferred to live in independent accommodation (Tedstone Doherty, 2007).

Carers of persons with schizophrenia were found to be more dissatisfied with psychiatric services if the level of functioning of their ill relative was poor, and if their relative used fewer rehabilitation services (Stengard *et al.*, 2000).

The levels of carers' satisfaction may also vary depending on the type of mental health professionals with whom they are in contact. Carers who had contact with psychologists were found to be the most satisfied, followed by those who were in contact with nurses, case managers, social workers, and, finally, psychiatrists (Tessler, 1991). This suggests that different mental health professionals may meet the needs of the carers differently.

Perceived quality of relationships with mental health professionals may also influence family satisfaction. Qualitative studies showed that the satisfaction of carers had at least two dimensions: acceptance of carers as partners in treatment, and the perceived availability of long-term rehabilitation facilities (Stengard, 2000). A grounded theory study of the alliance of family carers with the community mental health services found the establishment of trust between family members and service providers to be one of the main emerging themes (Kirsh, 2006).

Availability of family therapy or peer support groups may also influence carer satisfaction with family support services. For example, parents of persons diagnosed with schizophrenia who participated in group psychotherapy found it beneficial as it helped them to overcome stigma and re-establish of the psychological balance in the family (Gruber *et al.*, 2006).

Method

Aims

The aim of this secondary analysis is to identify socio-demographic and contextual factors associated with the satisfaction of carers with family services. The research questions are as follows:

1. Who was satisfied? What socio-demographic characteristics of participants, satisfied with family services and support, distinguished them from the rest of the participants?
2. Why and with what were they satisfied? What positive categories emerging from the satisfied participants distinguished their narratives from the rest of the participants?

Overview of the original study

An exploratory qualitative *Family Support Study* (Kartalova-O'Doherty, 2006) investigated the experiences and needs of 38 Irish carers of persons with enduring mental illness. The aims, methods and results of the original study have been described in the study report.

The original study received ethical approval from the Research Ethics Committee of the Irish Health Research Board (HRB), and the ethics committee of a participating mental health services area. Representatives of Schizophrenia Ireland (SI), a voluntary Irish organisation supporting families with enduring mental illness, and public mental health services (MHS) of an area of county Dublin distributed the HRB letter to potential participants. The letter contained information about the study, an invitation to participate, and the contact details of the lead researcher.

Volunteers filled out a consent form and two questionnaires related to socio-demographic and other characteristics of carers and their ill relatives. The Psychosocial Resistance to Activities of Daily Living Inventory (PRADLI) was used to evaluate the level of impairment and independent functioning of persons with mental illness in the last 30 days (Clifford, 2003). Carers were asked to rate their satisfaction with the services and support provided to them and their families and to their ill relatives on two five-point Likert scales ranging from *very dissatisfied* to *very satisfied*.

Participants responded to open-ended questions about their experiences, needs and support requirements at different stages of mental illness in the family. The interviews lasted for between 45 minutes and two hours. All interviews were audio-taped and transcribed verbatim.

Participants

In total, 38 carers of persons with mental illness took part in the study: twenty-three mothers, nine fathers, one step-father, three sisters, one brother, and one wife.

The reported current or previous occupation of interviewees was coded into two broad socio-economic groups (SEG): professionals (managers and higher/lower professionals, $n=17$, 44.7%), and other (non-manual, manual skilled, and home makers, $n=21$, 55.3%) (Central Statistics Office, 2003). More than one-third of participants reported that their relative lived in their homes ($n=14$, 36.8%). The ill relatives of nine participants were living in community accommodation supported by the mental health services. In eight cases persons with mental illness lived independently, and the ill relatives of seven participants were in in-patient units at the time of the study.

The majority of participants ($n=31$, 81.6%) reported that their relative had been diagnosed with schizophrenia, and four ($n=10.5\%$) with bi-polar disorder. Three participants were unsure about the diagnosis of their relative. The average PRADLI scores of ill relatives, reported by 36 participants ($M=50.7$, $SD=4.6$, range 42–46), indicated a relatively independent level of functioning (Clifford, 2003). Two participants were unable to rate the level of functioning of their relative in the last 30 days.

Design

Currently, health researchers have started to combine qualitative and quantitative methods (Hansen, 2006) due to the complexity of issues involved in the multidisciplinary area of public health (Baum, 1995).

We were driven by pragmatism rather than epistemological principle and selected a mixed-methods approach to address our research questions, and to maximise comprehensiveness of the findings (O'Cathain, 2007). Quantitative findings were triangulated with qualitative findings. Integration of content analysis and non-parametric statistics helped to identify and interpret socio-demographic and contextual factors influencing the satisfaction of carers with family support services.

We used bespoke criteria of quality for this mixed-methods study (Sale, 2004). Such criteria are based on similarities of concepts used for appraisal of quantitative and qualitative research, and include truth value that combines internal validity (quantitative) and credibility (qualitative), consistency (reliability and dependability), applicability (external validity and transferability), and neutrality (objectivity and confirmability).

Data Analysis

Quantitative analysis

Due to the small size of the sample, quantitative analysis was based on a comparison of the socio-demographic characteristics of two groups: participants who were *satisfied* with family services and support ($n=11/38$), and those *less than satisfied* ($n=27/38$), including 23 *dissatisfied* or *very dissatisfied*, and four *neither satisfied nor dissatisfied*. Non-parametric Mann-Whitney tests were used to explore the differences between the two satisfaction groups across continuous variables. Cross-tabulations were used for the exploration of the effects of categorical variables. For two-way cross-tabulations where more than 20% of expected cell counts were less than five, Fisher's exact test was calculated (Norusis, 2006) (Dubois, 2007). Two-tailed Fisher's exact test results significant at 0.05 level are reported in this article (McKinney, 1989).

Qualitative analysis

To facilitate constant comparison (Strauss & Corbin, 1998), the sample was divided into three groups: participants who were *satisfied* ($n=11$), *dissatisfied* ($n=23$), and *neither satisfied nor dissatisfied* ($n=4$) with family support.

Conventional (inductive) content analysis was used for the exploration of themes and concepts in the narratives of 11 satisfied participants (Hsieh, 2005). The first author read the full interview transcripts of 11 satisfied participants several times and identified and highlighted 42 *in vivo* themes and concepts. The identified themes were entered on an Excel spreadsheet with the interview numbers and transcript pages for further reference.

The Excel spreadsheet was separately coded by the two authors. Both authors identified five broad categories which formed the coding scheme for further analysis. These pertained to quality of care, co-operation or partnership, community support, family support services, and internal family factors. The subcategories used to form the coding scheme were discussed and agreed between the two authors. The authors tried to define the categories so that they were as internally homogenous and externally heterogeneous as possible (Lincoln, 1985).

In order to compare and validate the identified categories, directed (deductive) content analysis of the narratives of participants who were dissatisfied ($n=23$), and those who were

neither satisfied nor dissatisfied ($n=4$) with family support was performed (Hsieh, 2005). The first author separately coded the narratives of dissatisfied participants and found that most of the identified positive categories were negative. In the narratives of those who were neither satisfied nor dissatisfied some of the categories occurred as positive, and some as negative. These findings added to the truth value and consistency of the agreed coding scheme.

The second author explored the narratives of participants who were neither satisfied nor dissatisfied and found an additional negative category of the 'system' of service provision. The subcategories of 'system' were discussed and agreed. The first author explored the occurrences of the new category in the narratives of both *satisfied* and *dissatisfied* participants for its further definition and validation. The final labels, definitions and constituents of all categories were further discussed and agreed upon by the authors.

The positive and negative occurrences of the identified categories were added to the original SPSS 14.0 dataset for further triangulation of qualitative and quantitative findings. SPSS Text Analysis for Surveys 1.5 was used to explore the interaction of the identified codes across all three satisfaction groups of participants.

The article was drafted by the first author and revised by the second author. In order to check the truth value, consistency and neutrality of the analysis and reporting, the revised article has undergone further revision after two peer reviews: one internal and one external. Interview transcripts and the SPSS dataset are available on request.

Results

Quantitative findings

More than half of male participants ($n=6/11$, 54.5%) were satisfied with the services and support provided to them and their family. The majority of female carers ($n=22/27$, 81.5%) were less than satisfied with family services and support ($p=0.047$, Fisher's exact test).

A significantly higher proportion of 14 participants who were caring for their ill relative at home were female ($n=13/14$, 92.9%) whereas only one was male ($n=1/14$, 7.1%) ($p=0.030$, Fisher's exact test).

The reported occupation of most of the satisfied participants fell into the category of managers/professionals ($n=8/11$, 72.7%). The majority of less than satisfied carers (18/27, 66.7%) reported an occupation coded in the *other* category ($p=0.037$, Fisher's exact test).

All 11 satisfied participants reported that their relative resided outside of their homes at the time of the study, namely, in a community residential facility ($n=4$), in an in-patient unit ($n=4$), or in independent accommodation ($n=3$). All 14 participants whose relative resided in their home were less than satisfied ($p=0.003$, Fisher's exact test).

The average PRADLI scores of impairment and functioning of the ill relatives, reported by participants whose relative lived in their home, were significantly lower ($M=48.79$, $SD=4.64$, range 42–56) than the average scores reported by participants whose relative lived outside of their home ($M=51.95$, $SD=3.90$, range 45–56) [$U(14,22)=91.00$, $p=0.041$].

A significantly lower proportion of satisfied participants reported that their relative was using the services of psychiatrists at least once a year ($n=7$, 63.6%), compared to that of the less than satisfied group of participants ($n=25/27$, 92.6%) ($p=0.047$, Fisher's exact test).

Qualitative findings

Table 1 shows numbers and percentages of satisfied (n=11), dissatisfied (n=23) and neither satisfied nor dissatisfied (n=4) participants by the identified categories and types of comments.

Categories identified in the narratives of satisfied participants—As can be seen from Table 1, the two most frequent categories identified in the narratives of the 11 satisfied participants (n=10, 90.9%) were those of a caring service, and a supportive and unintrusive relationship with the ill relative. The majority (n=9, 81.8%) felt that they were accepted as partners by the mental health services; eight (72.7%) also mentioned that they had access to suitable family support groups or programmes. More than half (n=6, 54.5%) spoke about suitable formal and informal supports for their family in the community. However, five satisfied participants provided negative comments about the system of service provision in general (45.5%).

Caring service: The category of a caring service included subcategories of being interested in a person's well-being and recovery, good relationships between service providers and ill relatives, and continuity of care on discharge:

Her psychiatrist said to me that she wouldn't stop looking for some form of medication that would give her some quality of life. It was fantastic to hear that, because it gave me hope, and I knew her psychiatrist and her team were interested in giving her some quality of life (father 2).

Satisfied participants valued mental health professionals who had worked with their relatives for a while and established trusting relationships with the ill relatives. Help with finding alternative accommodation for relatives on discharge was highly valued by the participants and perceived as going over and above the normal call of duty of the services.

Supportive and unintrusive relationship with the relative: The category of establishing supportive and unintrusive relationship with the ill relative was identified in the narratives of most (n=10/11, 90.9%) satisfied participants (Table 1). This category included such subcategories and processes as accepting that the relative had mental health problems, respecting the right of relatives to live independently and be responsible for their own recovery, providing social and financial support to the ill relative when necessary, and the perceived satisfaction of ill relatives with their life situation:

At the moment he has rejected us ... We will never reject him; he's our son. We'd like to see a situation where he has his own accommodation, has on-going support, where he is able to come visit us but not live with us, but where we are able to support him (mother 13).

Adaptation of participants to mental illness in the family was associated with a gradual realisation that ill relatives needed to take control of their lives: 'No matter what you do, it's dependant on the person who has the problem to get on with things' (father 11).

Participants felt that it was easier for them to establish supportive and unintrusive relationships with their relative when they lived independently from their family home. A father commented that it was more difficult for his wife than for him to accept their daughter's mental illness because his wife had been at home with her most of the time, whereas he had been working (father 2).

Being accepted as partners in rehabilitation and recovery: The category of partnership, or 'being together', with mental health services in rehabilitation and recovery was identified in the narratives of nine satisfied participants (81.8%) (Table 1).

Being accepted as partners by mental health services was associated with availability and approachability of service providers for queries; open and trusting communication with carers; sharing information about illness and treatment; and feeling involved in the rehabilitation or recovery of their relative.

Open and trusting communication with service providers, such as psychiatrists or nurses, was highly valued by satisfied participants:

We actually met the doctor, who is a man I have a lot of confidence in, and respect for, a good straight talker. If someone says 'I don't know', that's fine, but I hate somebody ... throwing medical jargon at me (father 22).

Participants felt that families played an important role in their relatives' community care by seeking help during relapse, and supporting rehabilitation or recovery after discharge.

Having access to suitable family support services: Most satisfied participants (n=6, 54.5%) spoke about the benefits of family counselling and peer support groups they were either attending or had access to when needed.

Satisfied participants considered counselling very helpful for establishing unintrusive relationships with their relative, in terms of handing over control and responsibility to their relatives for their own rehabilitation.

Family support groups provided carers with social support and information about mental illness and treatment, and were viewed as complementary to family counselling.

Living in a supportive community: The category of a supportive community included the availability of formal and informal support resources in a residential area.

Satisfied participants spoke highly about formal supports, such as the community integration programmes provided by the mental health services, day centres, and the out-patient services of psychologists, social workers and occupational therapists. Also mentioned were informal community resources provided by relatives, peer support groups, priests, general practitioners, police, and neighbours: 'Where we live, people are OK, they understand' (mother 27).

System of service provision: In addition to the positive categories described above, a negative category of the drawbacks in the system of service provision was identified in the narratives of five (45.5%) satisfied participants. The perceived drawbacks were lack of recovery-oriented services; lack of staff, time and resources; and lack of continuity and uniformity of services across different areas and between the private and public sectors. Satisfied participants felt that staff were doing their best, but their efforts were hindered by the drawbacks of the system.

Four of the satisfied participants had experience with both private and public services, and commented that the public sector, despite its limited resources, was providing more caring and continuous services to their relative than the private sector.

Figure 1 presents a SPSS Text Analysis for Surveys visualisation diagram of the interaction of the codes shared by at least six out of 11 participants who were satisfied with family services and support.

As can be seen from Figure 1, in most cases a caring service was viewed as accepting carers as partners in treatment and rehabilitation of their relatives. Having access to good family services was also connected with the perception of a caring service, and establishing supportive but unintrusive relationships with ill relatives. Living in a supportive community was often associated with caring services, being accepted as partners, and establishing satisfactory relationships with the ill relative.

Exploration of the identified categories in the narratives of less than satisfied participants—Figure 2 presents a visualisation diagram of the interaction of categories shared by at least ten out of 23 dissatisfied participants.

As can be seen from Figure 2, the two main interrelated factors of dissatisfaction of 23 participants were the absence of services and support in the community ($n=19/23$), and the perception that services did not care about their relatives and their future. In addition, 10 out of 23 dissatisfied participants reported that there was no partnership between mental health services, themselves and the ill relative. They often complained about the social isolation of their families due to the stigma associated with mental illness.

The majority felt that services did not care about the ill relative's well-being and recovery ($n=19$, 82.6%), and that there was no partnership between carers and service providers ($n=10$, 43.5%). In addition, nearly half of dissatisfied participants ($n=10$, 43.5%) complained that their relationship with the ill relative was lacking either trust or independence: 'I'm the one she leans on, and I worry what is going to happen when I die, because she doesn't talk to anybody else' (mother 18).

Dissatisfied participants often reported a lack of open and trusting communication with psychiatrists: 'There was no such thing as co-operation between the family and him [the psychiatrist], he was the boss and no discussion about anything' (mother 1).

Figure 3 presents a visualisation diagram of the interaction of categories shared by at least three out of four participants who were neither satisfied nor dissatisfied with family services and support.

All four participants who were neither satisfied nor dissatisfied felt that mental health services did not care about the well-being and recovery of their ill relatives (Figure 3, Table 1). Most ($n=3$) also commented that there was no community support for their relative, and that there was no partnership between mental health services and families. However, all four of them had access to suitable family support resources, and the majority ($n=3$) commented that they had accepting and unintrusive relationships with the ill relative. Most ($n=3$) also spoke about the drawbacks of the system, including the lack of staff and resources, lack of recovery-oriented services, and the perceived difference in the quality of services provided by the public and the private sector.

Triangulation of quantitative and qualitative findings

Gender, SEG, residential status, use of psychiatrists' services by ill relatives, and the reported PRADLI scores were explored among participants who provided positive and negative comments regarding the identified categories. Only significant group differences are reported in this section.

Accepting and unintrusive relationships with the ill relative and gender—Male carers viewed their relationship with their ill relative as more positive than females ($p=0.024$, Fisher's exact test). More than half of the 18 female participants who spoke about relationships with their relative ($n=10$, 55.6%) considered them mutually intrusive. All of

the comments by the six male participants about relationships with their ill relative were positive.

Supportive community and SEG—The majority of the seven participants who viewed the community as supportive ($n=6$, 85.7%) were professionals. Conversely, the majority of the 24 participants who provided comments about lack of community support ($n=16$, 66.7%) were in a lower SEG category (non-manual, manual skilled, and home makers) ($p=0.028$, Fisher's exact test).

Caring services, being accepted as partners, accepting and unintrusive relationships, and place of residence of ill relative—The perceptions of the quality of service provision differed depending on the residential status of the ill relative ($p=0.011$, Fisher's exact test). Most of the 14 participants who felt that mental health services were not caring about their ill relative ($n=13$, 92.9%) lived with their relative, while half of the 22 participants ($n=11$) who viewed services as caring did not share their accommodation with the relative.

Likewise, the perception of partnership differed across the residential status of the ill relative ($p=0.007$, Fisher's exact test). None of the nine participants who felt that they were accepted as partners by the mental health services lived with their ill relative. The majority of 15 participants ($n=9$, 60%) who commented that there was no partnership between the mental health services and carers shared their accommodation with the ill relative.

Most of the 14 participants who spoke about supportive and unintrusive relationships with the ill relative ($n=13$, 92.9%) did not live with their relative, while most of 10 participants who complained about mutually intrusive relationships with ill relatives ($n=7$, 70%) shared the same accommodation with them ($p=0.002$, Fisher's exact test).

Suitable family support programmes and PRADLI scores—The average PRADLI score of independent functioning of ill relatives ($M=52.56$, $SD=3.96$, range 44–56), reported by 18 participants who had access to family support services, was significantly higher than the average PRADLI score ($M=48.00$, $SD=4.52$, range 44–56) reported by six participants who complained about the lack of family support services [$U(18,6)=23.5$, $p=0.040$].

Discussion

The findings of this study replicate findings from previous research. In addition, the study identifies more dimensions of carer satisfaction with services. The results of this study suggest that satisfaction with services and support constitutes a family-specific interplay of interrelated socio-demographic and contextual factors, which warrant further exploration and validation with larger samples.

Family satisfaction, gender and residential status of ill relative

In line with previous studies (Grella, 1989), a higher proportion of male than female carers in this study were satisfied with family services and support. Female carers may experience a higher emotional burden, display a higher intensity of emotional response, and resort to fewer cognitive strategies, as compared to male carers (Whitney J, 2005). The finding that the female participants of this study more often reported difficulty in establishing supportive and unintrusive relationships with their ill relatives than male participants is in agreement with gender differences highlighted by the previous studies (Grella & Grusky, 1989; Whitney *et al.*, 2005).

However, one cannot underestimate the role of contextual factors that may underlie these gender differences. A higher proportion of ill relatives of male carers were living outside of their homes, than that of female carers. The reported level of independent functioning of persons with mental illness who lived outside their family homes was higher than the scores of those who resided with their carer. Carers who did not share accommodation with ill relatives also reported less frequent use by their ill relatives of the services of psychiatrists, which may indicate that their relatives were experiencing fewer or less severe symptoms. Female carers in this study could have been in more stressful situations than male carers, which could partially explain their anxiety and inability to positively reassess their relationships with ill relatives. In support of previous findings (Tedstone Doherty, 2007), participants in this study expressed the view that it was not beneficial for persons with mental illness to reside at home, as it was impeding their rehabilitation.

The finding that the majority of carers whose ill relatives resided in their homes reported that the services were not caring about the well-being of their ill relative, and that there was no partnership between carers and mental health service, is worrying and requires further investigation. This finding suggests that home carers may need more support than currently provided by mental health services.

Family satisfaction, SEG and community support

Satisfied carers were more likely to be of a higher SEG than less than satisfied carers, and provided a significantly higher number of positive comments about a supportive community, than those from a lower SEG. Their residential area could have been more affluent in terms of community resources, and their neighbourhood could have been more informed and accepting of mental health problems.

Family satisfaction and the use of psychiatrists' services

In support of previous research (Tessler, 1991), a lower proportion of satisfied as compared to less than satisfied participants reported that their relative was using the services of psychiatrists. Whereas most of the participants provided positive comments about their contacts with nurses, only satisfied participants provided comments regarding open and trusting communication with the psychiatrists of their ill relatives. The reasons behind these differences require further exploration. In addition, the degree of symptoms of ill relatives may have influenced the number and range of family contacts with various mental health professionals, and warrants further investigation in this context.

Family support programmes, accepting and unintrusive relationships, and PRADLI scores

In agreement with previous research (Cassidy, 2001), this study suggests that suitable family support programmes can help carers to establish accepting and unintrusive relationships with their ill relatives, which may assist the rehabilitation of persons with mental illness. Indeed, the study participants who spoke about helpful family support programmes reported higher PRADLI scores of ill relatives than other participants. Further research needs to address the impact of satisfaction of carers on the functioning of those with serious mental illness, such as their clinical, social or occupational functioning.

Factors related to family satisfaction

The two identified categories related to carers' satisfaction with services, such as caring services and being accepted as partners, were similar to the dimensions found by some previous research (Stengard, 2000). However, this study identified more interrelated factors, or multiple dimensions of family satisfaction, such as supportive and unintrusive

relationships between carers and their ill relatives, suitable family support programmes, and supportive community.

Most of the satisfied participants saw their role as an additional source of social support for their relative, aimed at their rehabilitation or recovery, and felt that this role had been accepted by the mental health services. This important and beneficial role of carers is supported by NICE guidelines (National Institute for Clinical Excellence, 2002), and needs to be welcomed by the mental health services.

Limitations

The narratives may have been influenced by the questions in the interview schedule. Grounded theory method involving theoretical sampling and modification of the interview schedule on the basis of emerging findings could have helped to build up a tighter explanatory framework of family satisfaction.

Data on the extent of the emotional burden, psychological distress of carers, and the degree of symptoms of ill relatives could have provided more insights into the levels of satisfaction of carers, and could also have accounted for the use of services of various mental health professionals by their ill relatives.

The small size of the sample limited statistical analysis of the study. The findings of this study require further validation via larger samples. Due to the small number of participants, it was not possible to establish whether other socio-demographic factors such as level of education or type of residential area (urban or rural) influenced satisfaction with family services.

Implications for further research and service provision

- Exploration of the availability of community services, and public perceptions about mental illness across various geographical areas can highlight priorities for service development and health promotion activities.
- The style and quality of communication between carers and psychiatrists need to be further explored and considered by the mental health services.
- Carers need positive reassurance from service providers that all efforts are aimed at the well-being and recovery of persons with mental illness.
- Home-based carers need to receive an appropriate level of support and advice from the mental health services. Information about available counselling and peer support groups should be provided to all family carers by mental health services or professionals.
- The perceived differences in the quality of public and private service provision require further research, especially in the context of the rapid development of the private health sector.
- The identified categories and subcategories, combined with selected socio-demographic characteristics of carers and their relatives, can be used to develop a multidimensional measure of carer satisfaction with family support services. Such a measure can be tested among larger groups of participants and considered for inclusion in the planning and evaluation of family-tailored mental health services.
- The impact of carer satisfaction with family services on the rehabilitation of persons with enduring mental illness requires further investigation.

Acknowledgments

We would like to thank all family carers for sharing their experiences with the researchers. Special thanks are due to representatives of SI and the MHS for their help with the recruitment of interviewees. We would also like to thank Professor Chris Stevenson and Mr Derek Beattie for their comments on this article.

References

- Baum F. Researching public health: Behind the qualitative-quantitative methodological debate. *Social Science and Medicine*. 1995; 40:459–468. [PubMed: 7725120]
- Cassidy E, Hill S, O'Callaghan E. Efficacy of psychoeducational intervention in improving relatives' knowledge about schizophrenia and reducing hospitalisation. *European Psychiatry*. 2001; 16(8): 446–450. [PubMed: 11777734]
- Central Statistics Office. Census 2002. Volume 4. Principal Socio-economic Results. The Stationery Office; Dublin: 2003.
- Clifford P, Cipher DJ, Roper KD. Assessing resistance to activities of daily living in long-term care. *Journal of the American Medical Directors Association*. Nov-Dec;2003 :313–319. [PubMed: 14613598]
- Dixon L, McFarlane WR, Lefley H, Lucksted A, Cohen M, Falloon I, Mueser K, Milkowitz D, Solomon P, Sondheim D. Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services*. 2001; 59:903–910. [PubMed: 11433107]
- Dubois J, Rypens F, Garel L, David M, Lacroix J, Gauvin F. Incidence of deep vein thrombosis related to peripherally inserted central catheters in children and adolescents. *Canadian Medical Association journal*. 2007; 177(10):1185–1190. [PubMed: 17978273]
- Grella C, Grusky O. Families of the seriously mentally ill and their satisfaction with services. *Hospital & community psychiatry*. 1989; 40:831–835. [PubMed: 2759574]
- Gruber E, Kajevi M, Agius M, Marti -Bio ina S. Group psychotherapy for parents of patients with schizophrenia. *International Journal of Social Psychiatry*. 2006; 52(6):487–500. [PubMed: 17294595]
- Hansen, E. *Successful Qualitative Health Research: A practical introduction*. Open University Press; New York: 2006.
- Hsieh H, Shannon SE. Three Approaches to Qualitative Content Analysis [Electronic Version]. *Qualitative Health Research*. 2005; 15:1277. from <http://qhr.sagepub.com/cgi/content/abstract/15/9/1277>. [PubMed: 16204405]
- Kartalova-O'Doherty, Y.; Doherty, D Tedstone; Walsh, D. *Family Support Study: A study of experiences, needs, and support requirements of families with enduring mental illness in Ireland*. Health Research Board; Dublin: 2006.
- Kirsh B, Tate E. Developing a Comprehensive Understanding of the Working Alliance in Community Mental Health. *Qualitative Health Research*. 2006; 16(8):1054–1074. [PubMed: 16954525]
- Lefley, H. The impact of mental disorders on families and carers. In: S., G.; Thornicroft, G., editors. *Textbook of Community Psychiatry*. University Press; Oxford: 2001. p. 141-154.
- Lincoln, Y.; Guba, EG. *Naturalistic inquiry*. Sage; Beverly Hills, CA: 1985.
- McKinney W, Yong MJ, Hartz A, Lee MB. The inexact use of Fisher's Exact Test in six major medical journals. *JAMA : the journal of the American Medical Association*. 1989; 261(23):3430–3433. [PubMed: 2724487]
- National, I. f. C. E.. *Clinical Guideline 1. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care*. NICE; London: 2002.
- Norusis, M. *SPSS 15.0 Statistical Procedures Companion*. Prentice Hall Inc.; Upper Saddle River, NJ: 2006.
- O'Cathain A, Murphy E, Nicoll J. Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study [Electronic Version]. *BMC Health Services Research*. 2007; 7:85. from <http://www.biomedcentral.com/1472-6963/7/85>. [PubMed: 17570838]
- Rothausen T. 'Family' in organisational research. *Journal of Organisational Behaviour*. 1999; 20:817–836.

- Sale J, Brazil K. A strategy to identify critical appraisal criteria for primary mixed-methods studies. *Quality and Quantity*. 2004; 38:351–365.
- Stengard E, Honkonen T, Koivisto A, Salokangas RK. Satisfaction of Caregivers of Patients with Schizophrenia in Finland. *Psychiatric Services*. 2000; 51(8):1034–1039. [PubMed: 10913458]
- Strauss, A.; Corbin, J. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. 2 ed. SAGE; Thousand Oaks, London, New Delhi: 1998.
- Tedstone Doherty, D.; Walsh, D.; Moran, R. *Happy Living Here... A Survey and Evaluation of Community Residential Mental Health Services in Ireland*. Mental Health Commission; Dublin: 2007.
- Tessler R, Gamacho G, Fisher G. Patterns of contact of patients' families with mental health professionals. *Hospital & Community Psychiatry*. 1991; 42:929–935. [PubMed: 1743664]
- Whitney J, M. J, Gavan K, Todd G, Whitaker W, Treasure J. Experience of caring for someone with anorexia nervosa: qualitative study. *The British journal of psychiatry*. 2005; 187:444–449. [PubMed: 16260820]

Figure 1. Interaction of categories shared by at least six out of 11 *satisfied* participants, by numbers and percentages of *satisfied participants*¹

¹The figure was manually reproduced from a SPSS Text Analysis for Surveys 1.5 visualisation diagram

Figure 2. Interaction of categories shared by at least 10 out of 23 *dissatisfied* participants, by numbers and percentages of *dissatisfied participants*¹

Figure 3. Interaction of categories shared by at least three out of four *neither satisfied nor dissatisfied* participants, by numbers and percentages of participants¹

Table 1

Numbers and percentages of participants by categories and types of comments, by the level of satisfaction of participants

Categories by type of comments	Satisfied participants (n=11, 100%)					Dissatisfied participants (n=23, 100%)					Neither satisfied nor dissatisfied participants (n=4, 100%)				
	Positive comments n (%)	Negative comments n (%)	Total coded n (%)	Not found n (%)		Positive comments n (%)	Negative comments n (%)	Total coded n (%)	Not found n (%)		Positive comments n (%)	Negative comments n (%)	Total coded n (%)	Not found n (%)	
Caring service	10 (90.9%)	1 (9.1%)	11 (100%)	0		2 (8.7%)	19 (82.6%)	21 (91.3%)	2 (8.7%)		0	4 (100%)	4 (100%)	0	
Supportive and unintrusive relationships with ill relative	10 (90.9%)	1 (9.1%)	11 (100%)	0		1 (4.3%)	10 (43.5%)	11 (47.8%)	12 (52.2%)		3 (75%)	1 (25%)	4 (100%)	0	
Being accepted as partners by services	9 (81.8%)	2 (18.2%)	11 (100%)	0		0	10 (43.5%)	10 (43.5%)	13 (56.5%)		0	3 (75%)	3 (75%)	1 (25%)	
Suitable family programmes	8 (72.7%)	0	8 (72.7%)	3 (27.3%)		6 (26.1%)	6 (26.1%)	12 (52.2%)	11 (47.8%)		4 (100%)	0	4 (100%)	0	
Supportive community	6 (54.5%)	0	6 (54.5%)	5 (45.5%)		0	23 (100%)	23 (100%)	0		1 (25%)	3 (75%)	4 (100%)	0	
System of service provision	0	5 (45.5%)	5 (45.5%)	6 (64.5%)		0	5 (21.7%)	5 (21.7%)	18 (78.3%)		0	3 (75%)	3 (75%)	1 (25%)	
Total coded comments	43 (82.7%)	9 (17.3%)	52 (100%)			9 (11.0%)	73 (89.0%)	82 (100%)			8 (36.4%)	14 (63.6%)	22 (100%)		