

The Ten Phases of Families' Reactions to Serious Mental Illness

Adapted from: a chapter by Kenneth G. Terkelsen, "The Evolution of Family Responses to Mental Illness through Time", in Agnes Hatfield's *Families of the Mentally Ill: Coping and Adaptation*, 1987.

The way families respond to mental illness varies over time. Some of the variation is due to changes in the manifestations of the illness and the degree of social and occupational disability attached to the illness, whether or not the ill person has needed hospitalization, contact with professionals, medication effects and side-effects, and to events and developments in the family unrelated to the illness.

Terkelsen describes 10 phases that families experience in developing competence to cope and adapt to serious mental illness in a family member.

No family proceeds in lockstep fashion from one phase to the next and there is great variation in the pace at which individual members move on this path. Recognizing and coming to terms with mental illness in a loved one can be profoundly disruptive of the well-being of all of the members of the family.

1. Phase ONE - Ignoring what is coming (and what is going on). Denial/Disbelief Stage.

This is not happening. There is really nothing wrong with this person. The person can control it and snap out of it – "He'll out grow it soon." The symptoms and behaviors at this stage are mild, and the families' reactions are intermittent anxiety and vague feelings that something "might" be seriously wrong. Disagreement among family members about the seriousness of what is going on is common.

2. Phase TWO - The First Shock of Recognition

Something happens that cannot be ignored, minimized or normalized. The family begins to seek help from professionals and redouble their efforts to "reach" the affected person. They encourage the person to "pull themselves together" and "get their life back on track."

For the family at this stage, there is persistent and increasingly urgent help-seeking behavior, intensified feelings of anxiety, and dread of the now more compelling possibility of further worsening of the affected person's social and occupational disabilities and the appearance of life-threatening behaviors.

3. Phase THREE - Stalemate

The picture gets more confusing because someone - the person with the illness, a family member, or maybe even the professional believes the situation is "not so serious." The professionals may even view the now distraught, confused family as part of the PROBLEM.

For the family, other pressing family issues are usually not being dealt with and this postponing of other problem-solving activities will eventually catch up with them. The family is no longer able to ignore the person's problematic behavior, yet they are unable to act effectively, for whatever reason.

4. Phase FOUR - Containment of the Implications of the Illness

At this stage, the family believes the problem is not insoluble, not necessarily enduring, and not arising from an infirmity or vulnerability in the affected person, or if he does have a disease, it is one that can be easily cured or will resolve itself the way a cold does.

The family is still optimistic and hopeful, and they do not yet know about the rage and despair, the shame and guilt that will fill their experience as the problem continues or gets worse.

5. Phase FIVE - Transformation to Official Patienthood

Eventually something very compelling or disastrous occurs - a suicide attempt, an assault, an arrest. The affected person's social status is changed to that of "patient".

6. Phase SIX - The Search for Causes

As soon as the family accepts the presence of mental illness, the search for causes emerges in full force. They blame themselves, each other, the professionals. Almost regardless of which direction the search takes, the family is ultimately confounded by the absence of definitive answers.

7. Phase SEVEN: The Search for Treatment

Far from simply providing a solution to the problem of the affected person's illness, the search for treatment often poses a major challenge to the family's capacity to cope with ambiguity, controversy, and unanticipated outcomes of treatment. The family is confronted with a panoply of attitudes on the part of the professionals that they encounter and from friends and other extended family members.

Unfortunately, very few families come in contact with a professional who will take the time to help the family learn to understand the illness.

8. Phase EIGHT: The Collapse of Optimism

In all but the mildest of cases, as treatment progresses, it becomes increasingly apparent to the family that the affected person is not returning to his or her previous level of functioning. Reactions of overconcern, resentment, and avoidance are common as the family begins to realize that a cure is out of reach.

9. Phase NINE: The Surrendering of the Dream

The collapse of optimism eventually sets in motion yet another process: mourning the loss of the idealized internal images of the affected member. The dreams of what this person could have done with their life are no longer believable. The natural reaction to this recognition is grief. It often takes years for the family to realize that the illness is prolonged in nature.

As the patient begins to improve and stabilize, the clinicians (who have not known the person prior to the illness) are celebrating what looks to them like recovery - while the family is being hit hard by the realization that their loved one is still very far off from his or her former self. This is a stage at which professionals can misinterpret the family's grieving behaviors as not wanting the patient to get better and having an investment in the patient being ill.

10. Phase TEN: Picking Up the Pieces - OR - Getting the Illness in Perspective

As families mourn the unattainable future, the path is open to the restoration of balance in the family's life. As the family learns to "get the illness in perspective" they learn to compartmentalize the illness so that it is seen as one of an array of challenges in the life of the family, rather than as the only problem or the central problem. Secondly, the family discovers or rediscovers activities unrelated to the illness, and learns to regard these activities as legitimate activities for them to engage in.

In truth, many families are finding that there is no really good way to bring about meaningful compartmentalization that permits a restoration of balanced family priorities, while at the same time providing for the affected person's need to the satisfaction of all concerned. This is why NAMI provides the **Family to Family Education Program** and advocates for improvements in hospital and community services for mental illness.