ORIGINAL ARTICLE

The Coping Process of Patients with Schizophrenia — Searching for a Place of Acceptance

Yu-Chun Ma, Shu-Jung Lin[1], Wei-Herng Hu[2], Ping-Chuan Hsiung[3]

Department of Nursing, Mackay Medicine, Nursing and Management College, Taipei, Taiwan; Institute of Anthropology[1], National Tsing Hua University, Hsinchu, Taiwan; Department of Adult Psychiatry[2], Taipei City Psychiatric Center, Taipei, Taiwan; School of Nursing[3], National Taiwan University, Taipei, Taiwan

ABSTRACT

Objective: The purposes of this study were to understand the positive and negative impacts of illness on patients with schizophrenia and to attempt to formulate a theoretical framework of the coping process of patients. **Materials and Methods:** Face-to-face interviews were done using a semi-structured questionnaire. The data was analyzed using grounded theory. The study was conducted using purpose sampling. Data were collected from 10 patients with schizophrenia. **Results:** This study showed that " Searching for a place of acceptance" was the essential theme of the coping process. Three subcategories of the theme included: (1) changes in the place of acceptance: patients experienced changes in their living environment, social recognition, and emotion interactions; (2) my place of acceptance: Where to go? reconstructing the meaning of "place of acceptance," and the transitional home. **Conclusion:** The emphasis on professionalism and quality nursing care has changed the focus of nurses beyond psychiatric diagnoses to caring for persons with psychiatric diagnoses. This study is an attempt to echo this research trend. Future studies can focus on understanding how patients with schizophrenia reconstruct the meanings of home or family and their psychological process in transition from institutions to community. It is hoped that the results of this and future studies will enhance' the sensitivity of nurses toward the subjective symptom experiences of patients and increase nurses' capacity to provide individualized care. (***Tzu Chi Med J*** 2005; **17**:247-256)

Key words: schizophrenia, coping process, a place of acceptance

INTRODUCTION

In clinical practice psychiatric patients who have been stabilized often return to the hospital following a relapse at home. When asked, the patients often say, "They don't care about me returning home...", " My family says I'm worthless.." or " I'm so bored so I wanted to come to the hospital...". A patient, has the psychological tortures of both longing for and fearing home. He also has the desire to return to productivity in society, but at the same time fears discrimination. These hidden factors are potentially dangerous for relapse in stabilized patients.

Home, has always been regarded as a place that represents safety and belonging [1], and the concept of home represents a defining relationship which is based on emotions between people and their places of residence. Thus the importance of returning home during holidays reflects the important role of the home in maintaining interpersonal relations. The home allows us to define ourselves in this world and it provides a place of recognition so that one can interact meaningfully with this world [2]. Social psychologists regard the home as playing an important role in self-recognition as it replaces the role of dialogue between a person and the varied

Received: December 16, 2004, Revised: January 6, 2005, Accepted: February 15, 2004
Address reprint requests and correspondence to: Assistant Professor Ping-Chuan Hsiung, School of Nursing, National Taiwan University, 1, Section 1, Jen Ai Road, Taipei, Taiwan

groups in society [3]. A study that targeted homeless women to explore the meaning of home and experiences in city-life clearly showed the existence of asymmetrical relationships between different family members in a home. Under the power of mainstream society, the form of family awareness has been driven to limit women to develop in certain directions. For women, the home is unlike that posed by books, lyrics and commercials but more of a source of oppression and psychological strain. Homeless women that were forced to leave the home had broken the myth of the patriarchal family ideology [1]. The concept of a place of acceptance and the concept of home are actually similar but the meaningful content included in the place of acceptance is more comprehensive than that of the home. Taiwanese social psychology often focuses on studying the family system, designation of family chores ? and marital and parent-child relationships. Anthropologists mainly study kinship systems and housing, while constitutional law defines a home as: “A related group of individuals with the aim to cohabit for an indefinite period of time”. However, for patients, it is not enough to pursue a physical living environment such as a house. More importantly this place must provide emotional support and self-recognition.

The place of acceptance was demonstrated according to the results of this study. It is similar to the concept of a home but entails a physical living place that functions to share emotions and recognition. Regardless of sociologists’ definition of the “ home” or that believed by the researcher to represent family, the concept often centers around a normal family core. However, for patients suffering from psychiatric illness, the family structure may have changed or even lost its meaning. With regards to the “ family” described by literature, it seems that this part of the patient’s experience has been neglected. Attempts were made in this study to understand the patients’ reconstruction of a new “ family” as a place of acceptance, Since the effect and changes brought about by the disease are a part of the disease progression, there must be adequate countermeasures.

MATERIALS AND METHODS

Research Method

Grounded theory expands on a researcher’s interest or wish to conduct research on a phenomenon or field. In this study the topic of interest was to utilize the personal disease experiences of schizophrenia patients to understand the positive and negative impacts of the symptoms on their lives and their needs in the face of changes brought on by their disease. It is hoped that this journey may contain mechanisms or processes as yet unknown. The collection of data via personal symptomatic experiences of patients thus requires the utilization of qualitative research methods. Thus grounded theory was chosen and the data collection steps of grounded theory were revised to code and collect data. These data were categorized and conceptualized to further explore the concepts and concept-groups related to the phenomenon, to discover and develop a theoretical structure based on the data and thereby achieve the aim of this research.

Research Procedure

Course of Research

The subjects of this study were schizophrenic patients in a state psychiatric teaching hospital rehabilitation ward. The researcher selected samples by purposive sampling and patient files were screened to select those that met the selection criteria listed below. After signing consent forms, these patients were included in the study. The study period ran from November 2001 to April 2002 with a total of 10 patients interviewed. Before the interview the study’s content and procedure and the need for voice-recording were explained to the patients. Two to three interviews were conducted after the consent forms were signed. Interviews took place in the meeting room in the hospital ward. To avoid interference and insure interviewee privacy, the content of the interviews was not discussed with other healthcare staff.

Study sampling

The criteria for inclusion in the study were as follows: (1) A diagnosis of schizophrenia made by psychiatric specialists. (2) Disease onset after 18 years of age, with medical or inpatient treatment for at least a year. (3) Ability to communicate in Mandarin or Taiwanese, and willingness to be interviewed and tape recorded during the interviews. (4) No current positive symptoms, such as delusions, auditory hallucinations or visual hallucinations. (5) Emotional stability with no aggressive or violent behaviors. A total of ten patients were included in the study.

Data analysis

The data were analyzed with continuous comparisons of grounded theory, and were labeled respectively in order to find meaningful units for encoding. After the core data were selected, they were categorized through further analysis and extractions. During the process, comparisons between the original data, encoding, and the concepts were continued in order to form core concepts. Throughout the process of analysis, written notes were used to distinguish the concept relatedness and the thinking procedure followed, to gradually form a theoretical structure.

Evaluation of Research Rigor

Measurement of reliability and validity for this study was done according to the four principles proposed by Lincoln and Guba for qualitative studies: Credibility, Transferability, Dependability and Confirmability [4].

1. Credibility: This is the internal validity, referring to the degree of accuracy of the qualitative study data, i. e. the researcher really observed that which he/she wanted to observe. In this study one on one interviews were used to obtain personal accounts of disease experiences. The researcher also employed participatory observation to gather data, and the voice recordings and results of data analysis were discussed with the supervising professor in order to obtain accurate data on what was observed and ? what was predicted.

2. Transferability: This is the external reliability, referring to the efficacy that the interviewees' feelings and experiences were transferred through descriptions and words; the technique to improve transferability was via? broad description. This study, through a broad viewpoint, explores the patients' feelings and changes as well as the journey of longing for a home after being affected by symptoms. Analysis of the basic data by grounded theory revealed the processing of experiences broughtabout by disease. In the future, it may be provided to healthcare professionals as a clinical reference and to patients affected by similar diseases.

3. Dependability: This is the internal reliability, referring to the importance and congruency of personal experiences. The data collection was done by one researcher and the structure of all the interviews was identical. Data were collected via voice-recordings and participatory observation. The original voice-recordings were transcribed whole and analysis was done word-by-word and sentence-by-sentence. Results were conveyed to the patients to ensure that the original meanings were maintained. Thus the dependability of the research outcome was raised.

4. Confirmability: The data were accessible for confirmation. The collected notes and voice recordings were all marked by date and time, and the original data showed the process of coding, categorizing and forming of theory. Thus it was confirmable.

RESULTS

Patient Data

A total of 10 patients participated in this study: 4 men and 6 women. Most had junior-high level education. They were between 17 to 42 years old and the time since onset of disease ranged from 2 to 15 years, with an average of 7.9 years. One patient was interviewed 3 times while the rest were interviewed twice. Each interview lasted between 40 to 70 minutes, with an average of 49.7 minutes (Table 1).

Structural Concept of this Study

Through out the study, a central core concept of " finding a place of acceptance" was clearly felt and always surfaced from the patient data. From the time of diagnosis with schizophrenia and when symptoms appeared unexpectedly, patients began to withstand changes in their worlds. These included physical changes in the living environment, and perhaps having no one willing to talk with them. They felt alienation, rejection, lack of sharing, and denial and were scolded or even labeled to refute their roles. These changes also affected patients in their choices to fight or to give up. Therefore, through experiencing changes in awareness and through

Table 1. Basic Attributes of Participating Patients

Patient Code	Gender	Educational Level	Age	Years Affected	Religion	No. of Interviews	Interview Time
A	M	5-year Vocational college	28	8	Tibetan Buddhism	3	160
B	M	University	37	8	None	2	90
C	F	2-year Vocational college	27	8	Taoism	2	105
D	F	Junior-High	35	6	Taoism	2	110
E	M	Junior-High	37	4	Taoism	2	95
F	M	Junior-High	25	3	None	2	105
G	F	2-year Vocational college	31	11	Taoism	2	100
H	F	Junior-High	17	2	Tibetan Buddhism	2	90
I	F	Masters Candidate	42	14	None	2	85
J	F	Junior-High	29	15	Catholic	2	105

attempts to prove, question, discern, explain, deny and accept, they discovered their inner feelings towards change or began to accept their symptoms. Then though active strategies and choices they tried to actively fight against the symptoms or to actively change society, where they may also have sought third-parties for emotional or physical alliances to increase their power to fight change. Finally patients began to remind themselves and encourage themselves to regard the symptoms in a different light and see themselves differently. At this point, through utilizing various strategies, the patients' lives continued towards another obstacle involving what to do about the future. This represented an important direction for stabilized patients. After having fought for long periods with the symptoms, at least when stable they could return to a place of acceptance, where living space, emotional support, and recognition is awarded. When this place materializes from the patients' hearts into a physical destination, they begin to have expectations and hopes about that place. Therefore, I have called this the reconstruction of the content of the " place of acceptance" that suits each patient individually, so that patients can truly live with their disease.

Changes in the place of acceptance

Referring to the outcomes of this? study as well as the literature, the place of acceptance refers to the self-awareness of an environment where patients can feel accepted after being affected by disease. It represents a physical living environment, and also has symbolic meanings such as psychological feelings and acceptance of society. If the patient was not satisfied with one aspect of this place of acceptance, then the patient felt that this place of acceptance did not exist. The researcher has named this " changes in the place of acceptance" (Table 2). Through analysis of data, the changes in the place of acceptance can mainly be grouped into changes in the living environment, changes in recognition by society and changes in emotional interaction.

Living Environment

This refers to the situation where a patient is forced to leave the family and live in an unfamiliar environment; this may be the medical institution, rehabilitation facility or long-term shelter.

" It's been a while. I think it was 1993, when I began to live here and there in institutions and lived with many psychiatric patients. I finally returned to XX (hospital name)" (PA-12-431).

" Before I came to XX (hospital name), my sister lived close by on Sungshan Rd. and I used to visit every Saturday. But after I came to XX (hospital name) they moved to Shijr. At my last visit, I discovered that even my sister's house was no place for me, so I ran to the Friends of XX Association" (PA-12-435).

The first problem faced by patients after their illness was the change of living environment. Some patients had problems similar to Patient A as they rotated through various places as if they had no roots. Patients may possibly have developed their own ways to adapt or sought a temporary place to stay during these changes.

Social Recognition

This refers to changes brought on by the symptoms and includes society grouping patients as abnormal. Moreover, labeling is done to discriminate, deeming the patients worthless, terrifying and contagious. Also, role-expectations are placed upon patients by their families or society. It is hoped that they may suit the role and be capable of certain functions by social standards. Yet this is filled with irony as the patients are both discriminated against as aliens outside of social values, but also have expectations placed upon them to function normally. Thus, one of the great changes brought on by the symptoms is changes and conflicts in social recognition. These changes can even directly affect whether the patients can return to the physical " home" or obtain a spiritual " place of acceptance", thereby further becoming an accepted part of society.

1. Social Grouping

This refers to the use of social views and certain criteria, such as employment, to distinguish between normal and psychiatric patients. According to these norms, patients are asked to withdraw from participating in normal social events.

" But it scares me during the day to think about these things, the issue of the future, such as should a normal person have a job, will he/she come here (hospital name)?

Table 2. Changes to Place of Acceptance

Changes	Definition
Living Environment	From home to medical institution
Society's Recognition	Society grouping, labeling, role completion or giving up, abilities
Emotional Interaction	Neglect, unable to share, distrust, lack of feeling belonged

Most people are troubled by the same issues.” (PB-3-101)

“ So, if you are economically weak, you will become a patient. If you were strong then these problems would not happen to you.” (PB-2-50)

The use of social views and standards to evaluate patients is not only limited to society, as patients themselves often regard their self worth with the same value systems. For example. during the interview Patient B said that his trouble stemmed being unemployed and he felt that he was a worthless person., Therefore he emphasizd that work ability proves one’s self worth. Thus, it can be seen that the strategy to actively counter changes by working is in part also affected by social grouping.

2.Social Labeling

They (friends & family) already thought that I had enough problems. After I became ill, they said that I am already beyond help and still have all these problems which give them even more headaches. I will not tell them about my illness? because they can’t help me. It only increases my suffering.” (PJ-8-271)

“ In my family everyone is sick, but only I am labeled. So many things are blamed on me and is not fair.” (PI-4-122)

“ I feel that the doctors here rarely talk to the patients. He (doctor) is quick to label you with auditory hallucinations or delusions of reference.” (PI-6-171)

Usually labeling is believed to be negative views or rejections formed due to lack of understanding of this group. But the emotional experiences expressed by Patient I shows that even professionals are viewed as labelers and lack understanding. This has brought about certain reflections.

“ I actually regret that I did not tell my husband that I had a psychiatric illness since we would not have gotten married. Then at least I would not have to carry the label of divorcee while living at the rehab institute.” (PG-6-200)

“ My mother-in-law had requested that I get a divorce. So I thought, okay, let’s get a divorce. At least it will help them rip off this label. If I don’t divorce then this label will stay with them, so why not do it? All their relatives know (psychiatric illness) and if we don’t divorce, then when I relapse and come here again, what will happen?” (PG-5-175)

“ Other illnesses do not have the symptoms of hallucinations as psychiatric illnesses do. When my mother-in-law sees me, first, she feels I am infertile and second, she says she is afraid of me especially when I relapse. My mother-in-law wishes to come and see me, but I tell her not to.” (PG-6-189)

Labeling is also called stigmatization by sociology. Because some patients have behavioral symptoms such as talking to themselves, laughing and hallucinations, society can easily distinguish and label them. Under this stigmatization the patients must endure many stressful issues, such as not being allowed to release emotions, which are rooted in family problems. The family of the patient above was given a label because of the patient’s symptoms, so the patient sacrificed her marriage to rid her spouse’s family of this label.

3. Completing and Giving up Roles

A role refers to the power that one exerts in society such as a working role, or the role of an older family member who guides the family. It also refers to family expectations of patients. However, as the disease progresses, patients gradually realize that these roles, such as becoming a wife, uncle or mother, must be given up.

“ She (mother-in-law) hopes that I can find a stable job. It would reassure her if I could have an income.” (PF-4-19)

“ Right now I care more about a job after being discharged. Of course I hope to have a job after getting out, no matter what the salary is. I dare not think about the future. I can only take it step-by-step as thinking too much is unproductive.” (PE-6-203)

“ I am dissappointed with my nephew, who has special privileges in the house, and does many things that displease me. I have seen him grow up. He does things I do not like, but I cannot control him. I’m not his father. Besides, his only memory of me is that I have always been sick.” (PA-13-453)

4. Ability

This refers to deterioration in the ability to work. study, and think as well as a lessened capacity for self-reflection, after the onset of symptoms.

“Umn! Just like this, I cannot study. At the first onset of disease I found many jobs but I only worked a few days before quitting.” (PI-3-100)

“ My mind wonders on certain things and I cannot function at work, because I make many mistakes and everything is difficult. I have a friend who was in security but that job also did not last.” (PB-6-125)

Changes in Emotional Interaction

Due to the appearance of disease symptoms, every patient directly faced emotional reactions from family. Some were called certain negative names such as “ garbage” and “ worthless” . Attitudes and vocal tones led to negative family interactions and lack of family emotional communication. According to research data, changes in emotional interaction include being regarded lightly, lack of sharing, distrust from family, lack of feeling accepted and neglect.

" He (patient's brother) said, " Isn't that like XX (hospital name), being back at the beginning? What good does that do?" He said it like I was garbage." (PJ-9-303)

" Before it was tolerable when I had a job. I could make some money for the family. But now that I'm unemployed, my mom doesn't say anything but my brother says that I am useless and crazy too." (PF-4-122)

Being with the family is similar to the situation that Patient E described. Being ill makes one feel that he/she has a no place to speak, even when the patient is an older brother. To the family the patient represents a useless person and naturally will be taken lightly.

" He (patient's brother) never speaks as if I am older... I often forget to switch off the gas after trying to boil some water. My brother ordered me to use only electric stoves, but I forgot. ... My brother's tone was very bad when he said, " I've told you this already and yet..." (PE-6-196)

Patient J could not discuss anything or chat with a family member regarding living problems after falling ill.

" I rarely speak of my problems since they (patient's brother and sister-in-law) would feel that I was sick. If it was my mother I would be more willing, but not with my brother and sister-in-law. They would think I was sick and send me to the hospital" . (PJ-8-268)

" I felt like I was a tramp... Afterwards I went home and the same night the overdose occurred (took excessive medication)." (PF-3-83)

" In America I was still alone. I really don't want to live with them (patient's mother and brother)... Actually I went to America to escape this family... My mom also favors my brother more." (PI-4-48)

In this study the descriptions of emotional interactions were mostly negative experiences in dealing with family members. This is probably natural as the basic arena of activity for people is in the family and thus it is where changes are most clearly seen by patients. Thus when the researcher categorized changes in the place of acceptance, emphasis was placed on the emotional interaction between patients and their families. The reactions of families can help in the understanding of emotional changes in the place of acceptance with the hope to further empathize with the desire of the patients for family.

My place of acceptance

In a serious psychiatric disease the fight against changes centers on being able to rest a bit. Where would this resting place be? What place provides emotional satisfaction as well as recognizes that patients are entitled to human rights? Similar to that described by one patient, the final place of acceptance may not be a home, and the home may also not be able to accommodate the patient. In this study, the conditions of the patients had gradually stabilized after treatment, and now they wished to return to a socially recognized place and be supported emotionally, i.e. the place of acceptance. With this premise, the changes brought about by the symptoms and the final place of acceptance are both closely entwined with the disease as it progresses. " My place of acceptance", refers to the following three aspects: (1) Where to go? (2) Reconstructing the meaning of " place of acceptance" and (3) The transitional home (Table 3).

Where to go?

This refers to where the patients choos to return after their condition stabilizes, such as home, a rehab shelter or a rehab ward in an institution.

" They (association staff) said that there are many treatment routes for psychiatric patients with different approaches. He (association staff) also said that there are many places to stay where they respect human rights, unlike before when I was admitted to hospital when I was bad. y... I thought I would go to Friends of XX association, to a place with more humane management. " (PA-4-133)

" I still hope to return home to live, and to keep a

Table 3. My Place of Acceptance

Place of Acceptance	Definition
Where to go?	Home, Rehab shelter
Reconstructing the meaning of "place of acceptance"	1. Physical environment — family, rehab shelter, rehab ward in an institution 2. Feeling important emotionally, concern, return of love, sharing, freedom, living, respect, feeling of comfort, being at ease with one another and independent
Transitional home	Unsure for how long?

stable job. Although I am in the hospital now, I hope to return to society. It's like playing baseball. I need to break through obstacles, make a home run and reach the destination." (PJ-9)

" I will be discharged on Thursday. Since I have been in XX (rehab ward) a long time, the doctor thought that I should try to live with my family at home, but I don't really want to go home. I want to live at XX (rehab home in hospital), but the doctor and nurse have decided I should go home so I will. ... Actually I worry that my mom will nag me at home." (PG-8)

After learning to respect the choices of patients on their future place of acceptance, which may not always be their home or chronic disease institutions, and through flexible arrangements for patients, this researcher believes that perhaps individualized case management can be achieved. This differs from placement by healthcare professionals.

" No matter what, the home is a shelter from storm. So I wish to go home. If I had a job it would be even better. Thus after leaving here I will first go home." (PE-6)

Reconstructing the meaning of " place of acceptance"

This refers to the criteria for the place of acceptance. Patients have expectations that it is filled with love, concern, feelings of importance, sharing, independence, freedom, faith, feelings of comfort and feelings of being at ease with one another.

" Actually in environments like XX (rehab ward), I feel I can speak to the nurses if I have a problem, which I can't do at home. I think living at XX (rehab shelter in hospital) is best as I avoid fights with family and I can also be free, as long as I do my cleaning chores. But in reality, I must go home first before I can come to the hospital again." (PG-8)

" I feel that as long as love is given and received, then I would want to go to that place. I wish to be respected at home and not be a useless person. Lately, every time I go home I help my sister-in-law with cleaning and cooking. My brother has seen this change in me, unlike before when I lived pitifully. Now I'm not lazy. I help out as soon as I get up in the morning. One day, when my brother and sister-in-law asked me if I wanted to go to movies with them, I felt so happy. At least they considered me now and showed concern." (PJ-10)

" I hope to live happily without stress. Don't force me to do things I don't like. Let me choose by myself." (PF-6)

"As long as it is habitable and there are trust and respect in living, then the place feels comfortable... When I was admitted this time my younger brother said, " If you do this again, I will move out (meaning disease relapse)". If he doesn't live with me, how will I live ? So I think family must trust me and not treat me like someone who doesn't know anything. It's like I'm a degenerate when they speak to me disrespectfully, which sounds odd. I think the family should ask the nurses how to live with patients. Otherwise that kind of tone is intolerable." (PE-6)

When the patients spoke about their places of acceptance after the onset of disease, the majority chose their family, but patients also knew that certain emotional interactions had changed within the family. Thus there were emotional expectations. For example. Patient E expressed a wish to be trusted and respected. Therefore understanding how to live with patients and understanding the reconstructed content of the place of acceptance will also help healthcare professionals, families and community workers properly plan for the needs of patients leaving the hospital.

Transitional Home

This refers to the physical environment patients elect to return to in the future - their original homes. Yet there is still uncertainty, similar to the home that Patient J wanted to return to. But it did not seem to be a place for a long stay. Once the main support in the home is gone, the problem of having no where to go will probably be faced.

" Although my brothers are better to me now and have not mentioned sending me back to XX (hospital name), my sister-in-law calls me a burden when she fights with my brother. Once my brother is gone she will send me to a shelter. So my home no longer feels like a place I can stay for long. I think perhaps I should continue to look for my home. Maybe I should find someone to marry, but marriage seems difficult and I am so lazy... Maybe in the future, I can seek religious groups like nuns to stay with... everyone has the same faith and direction. One time, I asked about living with them, but I did not tell them I had this illness. I was so tired that day and I laid there waiting. When the nuns asked me if I was tired, I nodded. They said if I wanted to live there I needed to serve the public. If I have poor health then I can't stay. I thought maybe I could adjust and when I can better support myself or have better health then I could live in a group. I don't want to stay in the hospital. A although I can live here in a group, it lacks love and there is no faith." (PJ-10)

" If possible, I hope I can return to the hospital in two weeks so returning home for two weeks should be fine. Thereafter I'll live in XX (rehab home in hospital) and never return home." (PG-9)

" Since the home is a shelter from the storm, every one naturally wishes to go home. But when there is no respect, the home changes. Why else would so many patients not go home when they can? I want to go home, but I also know that the final place of acceptance may not be home. They may not be able to accommodate me, like when my brother threatened to move out." (PG-6)

DISCUSSION

Exploring the Basic Attributes of Patients

The ages of the10 patients in this study encompassed the various life stages from adolescence to middle age; 5 patients were young adults. They had been ill from 3 to 14 years, and all patients were currently in the rehab ward in the hospital. After analysis of the data, it appears that patients from different wards shared similar problems with changes in living environment and social recognition. Their future expectations on how to find a job, own a house and support themselves were also similar. Thus, it can be presumed that patients with the same diagnosis and currently in the stable phase of disease are worried about similar things. Eight patients were not married, one was divorced and one was getting a divorce. Patient G (facing divorce) reported extreme changes in the place of acceptance during disease progression, while Patient D described the emotional loss and negativity that came after divorce. The patients' education ranged from junior high-school graduate to master's degree candidate. There was no correlation between the level of education and the living environment of the place of acceptance, emotional interactions or social recognition. The results of this study also showed that different genders felt different levels of change in terms of feelings. For example. Patients B, E and F were all men, and they clearly described changes in their ability to work and concerns about finances, as well problems with social recognition. In contrast, women patients such as Patients D, G and J, described their emotional needs and the loss of emotional interaction in their places of belonging, and their experiences were filled with emotional desire and loss. The meaning of a home to different genders was also explored in this study.

Exploring a Place of acceptance

The data on changes in the place of acceptance shows that the concept of the place of acceptance refers to a physical living environment, social recognition and existence of emotional interaction. Naturally each patient may not report that all three are lacking, but perhaps the loss of one was especially memorable. The meaning of this place of acceptance is similar to that mentioned by Saegert, who said that the home is a standard physical space to perform activities and a standard for values. A family is composed of 2 notions, materialization and symbolization, which refer to a private space far from work and a place to share emotions and to retreat, which contains independence and closeness [5]. The home provides us with various standards so that we may place ourselves in this world. It provides a place of recognition so that we may link meaningfully with this world [2].

" Home", actually may encompass three different concepts, which are the living place, family and home. " My home is very spacious" refers to the living place, while " I have a warm house" refers to the home. The living place is a physical environment. We might discuss its characteristics such as size, lighting and design, but it must continuously be personalized, managed and invested with emotions to become a home. A home represents the psychological, social and cultural meanings we afford it. However, the place we call home may not always be a living place; it may be a small park, city or country [6]. For patients, changes in the living environment or even negative family interactions brought about by disease mean that the original home does not appear to have the concepts of living place, family and home. Thus mentioning the place of acceptance expresses the current state for patients who do not have a home but desire one. Yet according to the definition, it would be difficult to attain a home as the disease progresses. The place of acceptance stated by the researcher refers to the place where the patients had decided to stay which could satisfy their emotional needs and offer physical and psychological social recognition. Why not call this a Home? At the end of this process the patients may not return to a family or form a family. Possibly, they will live in an environment that they may believe to replace a home or to which gives them emotional support. This environment may be a medical facility or rehabilitation institution. It is not defined as a home, although perhaps more support may be given. Therefore the researcher has called it a " place of acceptance", which can completely accommodate the patients. Pi stated that a home may be a park or city. Thus the meaning of a place of acceptance encompasses many levels and places important for patient independence. Furthermore, the understanding of the place of acceptance may become a focus for healthcare professionals.

Dovey stated that our physical environment aids in creating meaning and structure for our lives, and the feeling of living is usually closely related to self recognition.

Our understanding of ourselves mostly comes from our living place and the experiences gained there [7]. Comparatively, this is an important fact demonstrated by the research topic, namely the severe changes in the living environment, emotional interaction and social recognition brought about by the disease which affect patients' self recognition and meaning of living. How did the researcher comprehend the importance of the concept of place of acceptance? When a disease develops, the patient is often regarded only as a sick person. Professional treatment targeting this " disease" often neglects the changes in living space, environment and values brought on by the symptoms. Negligence of this fact means that patients are treated without individuality. In evaluating how patients adapt to disease progression, emphasis is only placed on managing the diagnosis. Yet the changes that come from the disease and where to go after stabilization also require careful attention. One study showed that the social separation, depression and poor nutrition which develop from being homeless often worsen psychiatric disease and drug addiction." Being homeless" equals not existing in society. Being homeless is an unpredictable life event that brings on strong emotions that may lead to severe psychological trauma. In addition, different genders have different meanings for family [5]. Women appreciate a home through feelings, like a part of one's self, a shelter, a place of caring, a carefree place, a place where one's emotions and warmth can safely exist, a place to share one's inner self and a place to develop abilities. To men, the meaning of a home resides in physical attributes, such as architectural design, a room, a corridor, a long term place to stay, a bed, a place to learn and additional space., These correlate with the discussion on patient attributes in this research. During the interviews male patients mentioned of their feelings towards a home or place of acceptance less often. They cared for the physical place to live, They wanted to find a job for economical stability and to have the respect of family members, with the home as their a place to live. In contrast, female patients described their desire for home and pity and loneliness when loosing a family. This gender difference was clearly evident. It is possible that tradition requires men to work and support their families, while the women stay in the house. Therefore, even though both have taken up the sick role, both genders still regard themselves by social standards and strive to meet social norms. Due to prejudice, male patients strive to achieve social requests to be " normal".

Eight of the 10 patients in this study, clearly felt that they were labeled by others. This changed their original function and place in their families even to the point of stripping them of their roles as wife, parent, brother or older family member. This decreased the concern and respect they received. Under the various changes, the patients temporarily stayed within the medical institution while learning to fight against the symptoms. The desire for a place of acceptance slowly appeared with time. It has been proposed that chronically ill patients actually hold images, plans and hopes for the future [8]. It is known that a friendly supportive society and medical environment may form a shelter for patients from their disease. If this doesn't occur, their condition only worsens and adds to the psychological strain and disease pressure. Therefore, this study presumes that a supportive environment will bring symptom stabilization and psychological support for schizophrenic patients. Thus the search for a place of acceptance is an important core concept for this study. The third part of the study results aimed to reconstruct the meaning of " place of acceptance" . This reflected the patients' inner expectations of a desired environment and the emotional functions it should carry. Based on this, provision for a living environment, emotional interaction with people and friendly social acceptance all aid patients in facing their disease. By infusing patients with caring emotions, it is hoped that the changes brought about by their disease may be balanced and may also become a source of power to combat symptoms and consequent changes.

ACKNOWLEDGMENTS

The author would like to thank the Taipei City Psychiatric Center for permission to conduct this study, as well as the 10 patients for their trust and sharing of their life experiences.

REFERENCES

1. Wu CY: "A Study of Female Hobos: The Meaning of Home and the City Life Experiences." Unpublished master's thesis. Postgraduate Architecture and Township Program, National Taiwan University, 2000.
2. Dovey K: Home Environments. New York: Plenum Press, 1985, pp 145.
3. Despres C: The meaning of home: Literature review and directions for furture research and theoretical development. J Archit Plann Res 1991; **8**:96-115.
4. Hu YH: Qualitative Research—Theories, Approaches and Local Female Case Studies. Taipei: Ju Liu Publising, 1996, pp 141-150.
5. Charmaz K: Discovering chronic illness: Using grounded theory. Soc Sci Med 1990; **30**:1161-1172.

6. Bi HD: The Meaning of Home. Res Appl Psychol 2000; **8**:55-147.
7. Trans. by Wei, CF: Environmental Psychology. Taipei: Wu Nan Publishing, 1995, pp 253.
8. Saeǵert S, Winkel G: New space for woman. Boulder CO: Westview Press,1980, pp 109.
9. Chiou CH: "The Drug Administration Experiences of Bipolar Affective Disorder Patients: The Journey of Gradual Awareness of Outside Aids and Self Control." Unpublished mater's thesis. Postgraduate Nursing Program of National Cheng Kung University, 2001.