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"You don't give me flowers anymore": an analysis of gift-giving to medical and psychiatric inpatients

Abstract Background: If someone is admitted to hospital, it is customary for them to receive gifts from their friends and relatives. To assess the degree to which the mentally ill receive this type of support, this study set out to assess the level of gift-giving to the mentally ill compared with the physically ill during hospital admissions. Method: Subjects were 33 psychiatric and 23 medical female inpatients. Assessment was with a short interview on the subject of gifts received. Confounders were controlled for, in particular the number of family members who knew of the admission. Results: Medical patients received significantly more flowers: odds ratio 8.8 (95% confidence interval 1.6–64.2, $P = 0.004$); get-well-soon cards: OR 5.7 (95% CI 1.4–25.3, $P = 0.006$) and other gifts: OR 5.7 (95% CI 1.4–23.6, $P = 0.004$). Adjustment for the potential confounders did not significantly affect the associations. Conclusions: The results suggested that during hospital admissions, the behaviour of relatives and friends of mentally ill patients is rejecting. The authors suggest that more education for relatives may help to improve this picture.

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Introduction

Stigma

In his book entitled *Stigma*, Goffman (1963) described a theory of rejection of, among others, the mentally ill. However, he pointed out that "closeness permits one to see qualities other than the flaw". In other words, those who were close to the mentally ill person would not reject them so strongly. This proposition has been held up by empirical research evidence (Link and Cullen 1986; Trute et al. 1989). Research into the attitudes and behaviours of close kin (i.e. mothers, fathers, spouse and children) has produced contradictory results. One review concluded that families tend to be tolerant, and continue to care for their mentally ill family members (Kreisman and Joy 1974). On the other hand, Rawnsley et al. (1962) showed that there was only a small amount of visiting to psychiatric inpatients, and a more recent study also showed that psychiatric inpatients received few visitors, when compared to medical patients (Bernstein et al. 1980).

Gift exchange

In the West, gift-giving is a recognised cultural response to the admission to hospital of a friend or relative. In broader perspective, gift-giving is part of a complex web of non-economic reciprocal exchange between individuals, which is universal in all cultures (Mauss 1966). At any point in time, in any social group there are obligations to give and receive gifts and to make return gifts.

There are gender and age factors that influence the amount of gift-giving. For example, women receive more than men (Cheal 1986) and older people give more, and receive less (Caplow 1982; Garner and Wagner 1991).

Marshall Sahlins (1972) identified an unselfish category of giving, which he named "generalised reciprocity".

"Generalised reciprocity", is generous giving at a time of need. Giving gifts and help to relatives and friends who are ill, in hospital, is an example of this type of exchange. No return is expected from the recipient unless, at some stage in the future, the original donor was to become ill *and* the recipient was in a position to help.

The "sick role"

There are links between the giving of gifts during illness and the conceptualisation of the "sick role" (Parsons 1952). When someone becomes ill, they are seen by society as (1) not to blame for their inability to function in their usual social role, (2) in need of help, and (3) dependent on others. It is easy to see how this constellation of attitudes would result in family and friends giving help to hospitalised patients, in the form of gifts.

On the other hand, there is evidence that many psychiatric disorders and psychiatric symptoms elicit the opposite set of attitudes to those associated with the sick role (Vaughn 1977; Weiner 1980; Lewis and Appleby 1988). People with psychiatric disorders are thought to be responsible for much of their behaviour, and therefore do not usually receive sympathy and help from others.

Hypothesis

To illuminate further the attitudes and behaviour of the public towards their mentally ill friends and relatives, this study set out to compare the amount of gift-giving to psychiatric inpatients compared to medical inpatients. The theories of stigma, gift-exchange and the "sick role" outlined very briefly above, supported by the research literature reviewed, led to the following hypothesis: while in general the mentally ill would receive fewer gifts than the physically ill, this would not be true of cases where there were kin (i.e. mother, father, siblings, children) who knew of the admission. In these cases, the hypothesis was that the mentally and the physically ill would receive an equal amount of gifts.

Method

The setting for this study was a London psychiatric hospital (the Maudsley) and a London teaching hospital (King's), which are located on opposite sides of the same street. Both groups of patients lived in the same catchment area of inner city London. The sample was restricted to females, as gender differences were likely. The psychiatric subjects were a heterogeneous group of patients with a range of serious mental illnesses, mainly cases of schizophrenia, hypomania and depression. Some were admitted formally under Sections of the Mental Health Act, but patients on the psychiatric intensive care unit for high levels of psychiatric dis-

turbance were excluded. The medical patients were also a heterogeneous group. Patients having surgical or obstetric admissions were not used as a comparison group, as it was thought that the relatives' anxiety about death would be likely to lead to high numbers of flowers and gifts being given. The medical patients were typically suffering from chronic illnesses such as diabetes, ulcerative colitis, multiple sclerosis or chronic heart disease, and had been admitted on a number of previous occasions. As in the psychiatric group, medical patients on the medical intensive care unit were excluded.

It was decided that all subjects had to have been inpatients for at least 3 days, but an upper limit of admission time was not made, as it was realised early in the data collection, that the longer someone had been in hospital the more chance there was that they would have received a gift at some stage.

Patients were approached on the wards and written informed consent was obtained for a short (15 min) structured interview to be administered. The interview was designed by two of the authors (A.W. and S.W.). Questions were asked about the gifts that had been received during the admission so far. Also, the number of kin who knew of the admission was assessed; this was done simply by asking the subject to list the people who knew of the admission. An attempt was not made to quantify the emotional closeness of the relationships described, as this was thought likely to co-vary closely with the amount of gift-giving. Information was also gathered about a number of other factors that could explain a difference in gifts received by the two groups. One of these (the number of visitors) was used in preference to the number of visits, because the variable "visitors" had a stronger association with the outcome variables than "visits". Other factors measured and used in the analysis were: whether the subject was in employment, if they were living alone or with others, if they were keeping their admission secret, how long they had been in hospital, how long they had been ill, how many times they had been in hospital before, and their age.

Some qualitative observations were also made of the type of flowers and gifts received.

Analysis

A retrospective cohort design was employed. To detect a four-fold difference between the groups, with 80% power, 24 subjects were required in each group. The data were analysed using the EGRET package, using odds ratios (ORs) to measure the strength of the associations. An OR is a ratio of two odds – the higher the ratio the stronger the association. The OR was selected for the analysis because it is a test that does not assume the normal distribution, and which could also be used later in the analysis in a stratification analysis of potential confounders. For the calculation of ORs, dichotomous variables are required. The outcome variables were made into categorical variables by using the median as a cut-off. However, the associations were checked at cut-offs above and below the median.

There was not enough statistical power to do a multivariate analysis. The potential confounders were therefore analysed one at a time using the Mantel Haentzel method. This is a weighted average across the two strata of the outcome variable as defined by a categorical potential confounder variable. To do this analysis, all the continuous potential confounder variables were made into categorical variables by using the median as a cut-off. However, the stratification analysis was also checked using cut-off points above and below the median, to check that confounding effects were not being missed.

Identifying the confounding effect of "kin" on the associations was part of the hypothesis, so it was particularly important that any confounding effect was not missed. Therefore, three ways of constructing this variable were used and each tested in the analysis. These were (1) the presence of parents or spouse, (2) the presence of a spouse, or parents, or children aged 16 years or over, or siblings and (3) a cut-off at the median number of kin.

Results

Altogether 24 medical and 37 psychiatric inpatients were approached for interview. One medical and four psychiatric patients refused to take part, leaving 23 medical and 33 psychiatric patients. Unfortunately the data collection from medical patients had to be stopped prematurely, because a nursing manager withdrew co-operation from the project.

The psychiatric patients had been in hospital longer than the medical patients (median 27 vs 14 days, OR 7.2, 95% CI 1.8–30.1, $P = 0.001$). They had been ill for a longer time (median 60 vs 24 months, OR 3.3, 95% CI 1.1–10, $P = 0.02$) and were younger in age (median 35 vs 52 years, OR 4.6, 95% CI 1.3–17.1, $P = 0.008$).

As in previous research, the psychiatric patients were less likely to have received many visitors than the medical patients (median 4 vs 10, OR 0.3, 95% CI 0.1–0.9, $P = 0.02$). However, the number of previous admissions, and number of kin who knew of the admission, were similar for both groups.

When the medical patients were compared to the psychiatric patients, there was a strong association between medical inpatient status and receiving flowers, "get-well-soon" cards and other gifts (see Table 1). However, adjustment for the number of kin who knew of the admission did *not* reduce the discrepancy between the medical and psychiatric groups. The first method of gauging kin (see analysis section) produced little effect on the main ORs, and the second and third methods increased the strength of the association in favour of the medical patients. The results presented in Table 1 are those using the third method (median cut-off), as this method resulted in the fewest cells with small numbers in the contingency tables.

The number of "visitors" reduced the strength of the association, although, the association with flowers and other gifts remained statistically significant, and the association with get-well-soon cards remained of border-line significance. The remaining potential confounders did not affect the strength of the association (see Table 1).

The first part of the hypothesis was therefore confirmed: psychiatric inpatients were found to have received significantly fewer flowers, get-well-soon cards and other gifts than medical patients had. On the other hand, the second part of the hypothesis was found to be false: psychiatric patients with kin who knew of the admission were *still* less likely to receive flowers and gifts than medical patients.

Qualitative observations

From a qualitative point of view, medical patients usually had a few bunches of flowers on display by the bedside, whereas the psychiatric group in general would have small pot plants or single stems inside their bedside

Table 1 Odds ratios (ORs), with 95% confidence interval (CI) and *P*-value, for receipt of flowers, get-well-soon cards and other gifts, in female medical inpatients compared with female psychiatric inpatients, presented in unadjusted form and adjusted for individual potential confounders: number of visitors, number of kin who knew of admission, employment status, living situation, admission kept secret, length of admission, length of illness, previous admissions and age

Type of Gift	Unadjusted OR (95% CI) P-value	Adjusted OR for:								
		No. of visitors	No. of kin who knew of admission	Employment status	Living situation	Admission kept secret	Length of admission	Length of illness	Previous admissions	Age
Flowers	8.8 (1.6–64.2) P = 0.004	6.3 (0.9–55.0) P = 0.03	13.3 (1.9–98.0) P = 0.002	8.7 (1.5–64.5) P = 0.005	7.4 (1.3–59.8) P = 0.007	8.0 (1.4–60.2) P = 0.006	19.4 (2.2–172.1) P = 0.001	8.2 (1.3–60.8) P = 0.008	8.8 (1.6–64.9) P = 0.004	9.1 (1.4–65.6) P = 0.007
Get-well-soon cards	5.7 (1.4–25.3) P = 0.006	4.0 (0.8–21.6) P = 0.05	7.5 (1.7–42.6) P = 0.003	5.0 (1.3–24.7) P = 0.007	5.1 (1.3–24.2) P = 0.009	6.8 (1.6–40.3) P = 0.003	5.8 (1.2–29.5) P = 0.01	5.0 (1.3–26.9) P = 0.009	5.4 (1.4–26.0) P = 0.006	5.2 (1.2–24.8) P = 0.01
Other gifts	5.7 (1.4–23.6) P = 0.004	4.0 (0.9–19.2) P = 0.03	8.8 (1.8–44.5) P = 0.002	5.5 (1.4–23.8) P = 0.005	5.0 (1.3–22.3) P = 0.01	7.4 (1.7–34.3) P = 0.002	4.5 (1.0–22.9) P = 0.02	5.1 (1.2–22.0) P = 0.01	5.9 (1.5–28.0) P = 0.004	5.4 (1.3–24.8) P = 0.008

lockers. On the other hand, two medical patients with stigmatising conditions (one with AIDS and another with tuberculosis) received only a single stem and no flowers respectively. In the psychiatric group there was variation as well. Two psychiatric patients who had taken overdoses in the context of acute losses and acute depression received many bunches of flowers, cards and gifts.

In general, the quality of gifts differed between the groups. While the medical group tended to have fruit and drinks on show, psychiatric patients often cited packs of cigarettes as gifts they had received.

Discussion

This study found a strong association between psychiatric inpatient status and not receiving flowers, cards and other gifts. The observed association was not explained by differences in the size of the social network of each group, as statistical adjustment for the patients who had kin who knew of the admission did not reduce this association. This association also persisted after statistical adjustment for a range of other factors, including the number of visitors, that might have explained the difference.

Methodological issues

As we relied entirely on the patients as the informants in this study, recall bias is likely to have been present. While the psychiatric patients may have been experiencing cognitive difficulties, the medical patients may equally have been frightened and in discomfort. Therefore, recall is bias is likely to have been present in both groups, so tending to equal out such an effect.

The effect of recall bias was minimised by the methodology. The interview questions were simple, neither group knew that they were being compared to another group of patients, and in the analysis only simple comparisons were made (for example between patients who received flowers and those who received none).

The groups of medical and psychiatric patients each included a heterogeneous mix of patients, but fairly represented the types of disorders found in general psychiatric and general medical inpatient populations.

Resources did not allow for matching of subjects. However, in many instances matching would have increased the differences between the groups in favour of the medical patients. For example, if the length of admission had been matched, psychiatric patients (who were admitted for longer periods than the medical group) would have received fewer gifts in the shorter time, making the medical group appear to have received even more in comparison. If matching had been possible for age (by using a younger medical group or an older psychiatric group), there would probably have also been a bigger difference in favour of the medical group, be-

cause previous research has found that the young receive more gifts than the old.

Another explanation for the results could be differences in admission procedures. Medical patients tend to stay on the ward throughout their admission, whereas psychiatric patients are often encouraged to go on home leave. The latter situation may reduce relatives' obligations to visit the hospital.

It is acknowledged that methodological improvements could be made. However, it is argued that, because the association between psychiatric status and lack of gifts was large (despite the small number of cases), and the qualitative observations supported the results, methodological improvements would not have removed the differences found in gift-giving between the medical and psychiatric groups.

Interpretation of the results

Theories of stigma, supported by research evidence, suggest that prior contact with a psychiatric patient reduces rejecting attitudes. Therefore, it was reasonable to hypothesise that both psychiatric and medical patients who had kin who knew of the admission would receive flowers, cards and gifts. However, this was not the case. After controlling in the analysis for kin, far fewer psychiatric patients received gifts than did medical patients.

We conclude that relatives and friends do not treat their mentally ill relatives as if they had "any other illness". Sadly, the stigma of mental illness has an effect even on those who have close personal ties with a mentally ill person. The results suggest that Goffman's proposition that "closeness permits one to see qualities other than the flaw" may not eliminate the powerful stigmatising effect of the mentally ill label.

According to gift exchange theory, if a gift is given to someone who is ill, there are only obligations on the recipient to make a return gift if the roles become reversed, and the original donor becomes the one who is ill and in need.

The results of this study are compatible with the view that the majority of people believe that mental illness only affects *other* people. Therefore, there is little point giving to the mentally ill, because a return gift will never be needed. The qualitative observation that patients with acute depression had a good response from relatives suggests that depressive illness is something that friends and relatives could imagine having at some stage.

This study also offers support to the view that there is no "sick role" for the mentally ill. Whereas family and friends see the physically ill as in need of help and support, the mentally ill (with the possible exception of people with depression) are expected to "pull themselves together".

These findings add urgency to the need for public education and debate about mental illness. A campaign to de-stigmatise mental illness might do better to target relatives rather than the public. Such a campaign might

include efforts to change clinical practice by providing more education for a patient's family during an acute psychiatric admission. Such efforts would easily generalise to other situations, as it is recognised that there are high rates of psychiatric illness in the community.

If people were aware that they are *not* immune, but could themselves have the bad luck to suffer from mental illness, they would be more sympathetic and therefore more willing to give assistance and support to those suffering from mental illness.

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