CHAPTER SIX

EMPIRICAL STUDY AND RESEARCH FINDINGS

6.1 INTRODUCTION

The aim of the study was to investigate the impact of schizophrenia on the functioning of the family and to develop social work guidelines for use by social workers in helping families to cope with patients suffering from schizophrenia. According to DSM-IV (1994:8) schizophrenia is a type of mental illness that has a negative impact on the family. The family is faced with a burden and finds it difficult to deal with such a patient. DSM–IV (1994:288) and Holmes (1994:27) stated that there are five subtypes of schizophrenia, namely, catatonic, disorganised, paranoid, residual and undifferentiated. Each subtype has its own traits.

From the researcher's own experience and the literature review, it is clear that an understanding of the behaviour and needs of patients suffering from schizophrenia as well as their families, from both an institutional and home-based care perspective, is important. In this study small samples were used during data collection, which implies that findings cannot be generalised. Respondents were chosen through dimensional sampling, which allowed for the limited inclusion of all types of schizophrenia.

From the empirical study's point of view, the study was quantitative though involving a small number of respondents in order to understand the meaning of human behaviour and explore the detailed descriptions of social reality (Dane, 1990:3). Weskoppies Hospital was chosen because it accommodates all types of mental illnesses, including all types of schizophrenia.

Dimensional sampling as a type of non-probability sampling was used to choose five types of schizophrenia. Five patients' key relatives were also interviewed. Semi-structured interviewing schedules were self-administered and conducted twice with five patients, that is one patient per schizophrenia type and conducted twice with five key relatives, that is one key relative per patient. The first interviews were conducted at Weskoppies Hospital when the respective patient's condition was stabilised, mostly one

month after admission. Arrangements were made with key relatives to be interviewed at Weskoppies Hospital. The second interviews were conducted with the same respondents, that is both patients and their key relatives, at Weskoppies Hospital one month after the patients were granted a leave of absence or when discharged to their families.

Findings during the first and the second interviews were compared to see how the family functioning had been affected. The results of the empirical study were interpreted, processed and integrated with findings of the literature study. The research consultant from the Research support group of the Department of Information Technology and a statistician from the Department of Statistics, University of Pretoria were consulted to assist with the data interpretation and analysis.

The repetition number was used because the same respondent was interviewed twice. The SAS statistical package version 8 was used to calculate frequency distributions and means. Findings were presented descriptively by making use of frequency tables, means and graphs.

In this chapter the achievement of objectives as formulated in Chapter One will be discussed. The objectives for the study were as follows:

- Select and study relevant literature to explore the phenomenon schizophrenia and family functioning from a social work perspective

- Investigate the causes of the negative impact of schizophrenia on relationships, attitudes, interaction and functioning of the family

- To investigate relevant family intervention programmes to create knowledge and insight into patients suffering from schizophrenia and their families

- To develop social work guidelines for use by social workers to guide a patient's family to cope with the impact of schizophrenia, in particular in a home-based and community context.

The hypothesis presented in Chapter One with its derivatives (sub-hypotheses) was

tested against the findings presented in this chapter. The hypothesis under discussion is as follows:

Hypothesis:

If social work guidelines are developed and family intervention programmes are emphasised, to bring about more understanding of and insight into schizophrenia on the part of the patient suffering from schizophrenia and his family, then positive relationships, interactions and functioning will occur within the family and home- and community-based care will be encouraged.

6.2 PRESENTATION OF FINDINGS

The semi-structured interview schedules were divided into seven sections to measure the impact of schizophrenia on the functioning of the family within an ecosystem framework. The seven sections were as follows:

- Biographical data
- Schizophrenia
- Family functioning within an ecosystem framework - Ecological context
- Family functioning within an ecosystem framework - Acculturation and migration
- Family functioning within an ecosystem framework - Family organisation
- Family functioning within an ecosystem framework - Family life cycle
- Family functioning within an ecosystem framework - Family intervention programmes for schizophrenia.

6.2.1 BIOGRAPHICAL DATA

In this sub-section the following findings of the respondents and their key relatives are discussed: residential address, age, sex, qualification, occupation, ethnic group, religious denomination, marital status, when the patient started to show schizophrenic symptoms, his first hospital admission date, and the type of schizophrenia that the patient was suffering from.

- Residential address/area

Patients and key relatives were from the following areas: one African male diagnosed as a disorganised patient and his mother were from Atteridgeville (Pretoria - Gauteng Province); one white male diagnosed as an undifferentiated patient and his mother were from Fairie Glen (Pretoria - Gauteng Province); one white male diagnosed as a paranoid patient and his mother were from Lynnwood Glen (Pretoria – Gauteng Province); one African female diagnosed as a catatonic patient and her mother were from Kwaggafontein (Mpumalanga); and one white female diagnosed as residual type and her son were from Thabazimbi (North West Province). Thus Gauteng, Mpumalanga and North West Provinces were involved/included in the study.

Figure 3: Residential areas

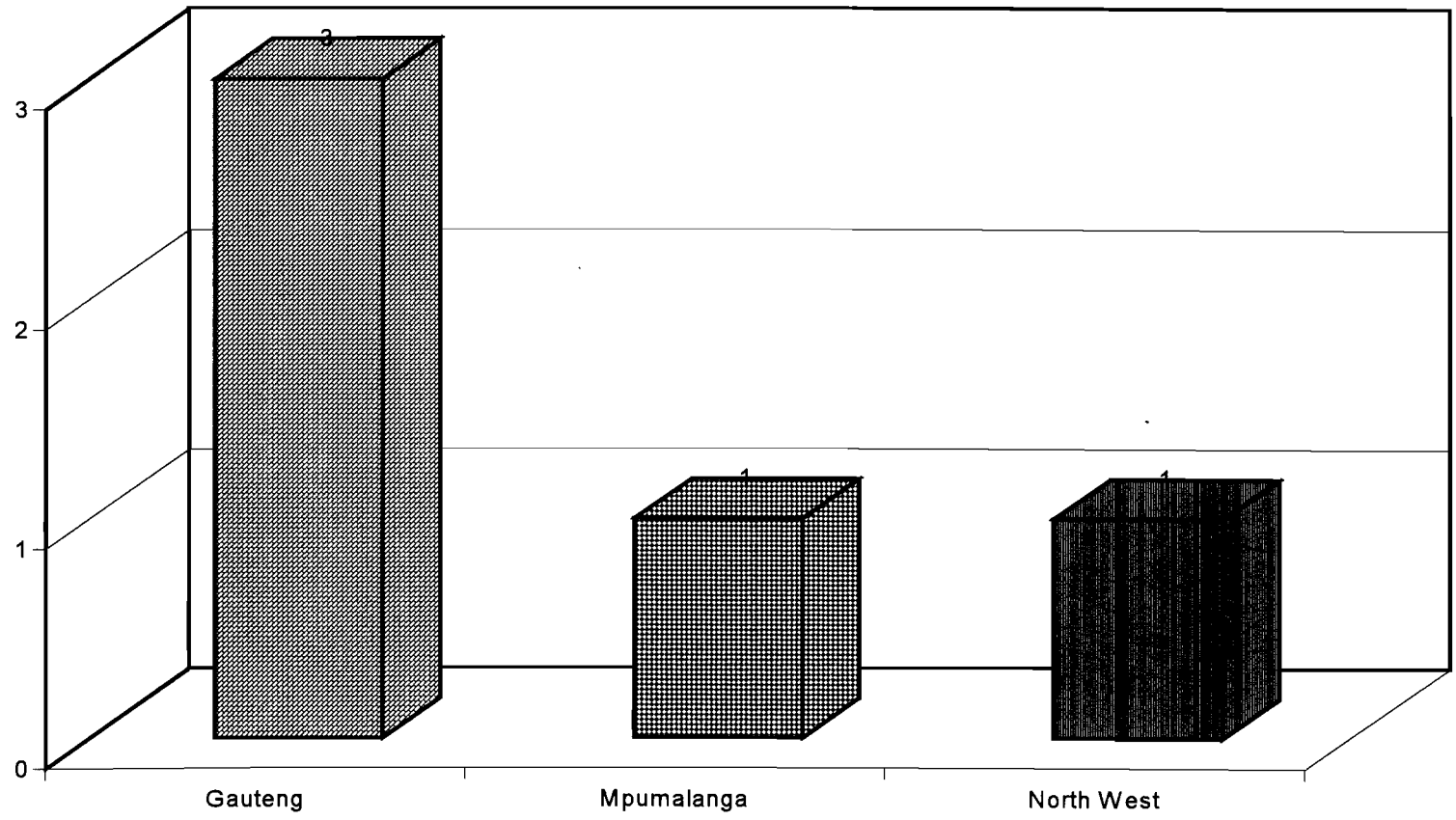

Figure 3: Residential Area

Three patients and three key relatives were from Gauteng province. This could be because Weskoppies Hospital falls under Gauteng province even though it caters for all provinces.

- Age

In Table 2, the age distribution of the respondents is indicated.

Table 2: Age distribution

Age Range	Patients	Key Relatives
21 – 30 years	2	1
31 – 40 years	1	
41 – 50 years	2	1
51 – 60 years		1
61 – 70 years		2
Total	**5**	**5**

Two of the patients in the study group were within the age range 21 - 30, one within the age range 31 - 40 and two between 41 – 50 years. Gillis (1986:75) and DSM-IV (1994:281) state that in the majority of cases the illness commences between puberty and adolescence and that almost two-thirds of patients suffering from schizophrenia are between the ages of 15 and 30 or older. This sample, however, is too small for findings to be generalised. Relatives' ages were found to be between 21 - 30, 41 - 50, 51 - 60, and 61 - 70. Two of them were in the age group 61 - 70. This data correlates with the age categories of the patients.

- Sex distribution

In Figure 4, the sex distribution of the respondents is indicated

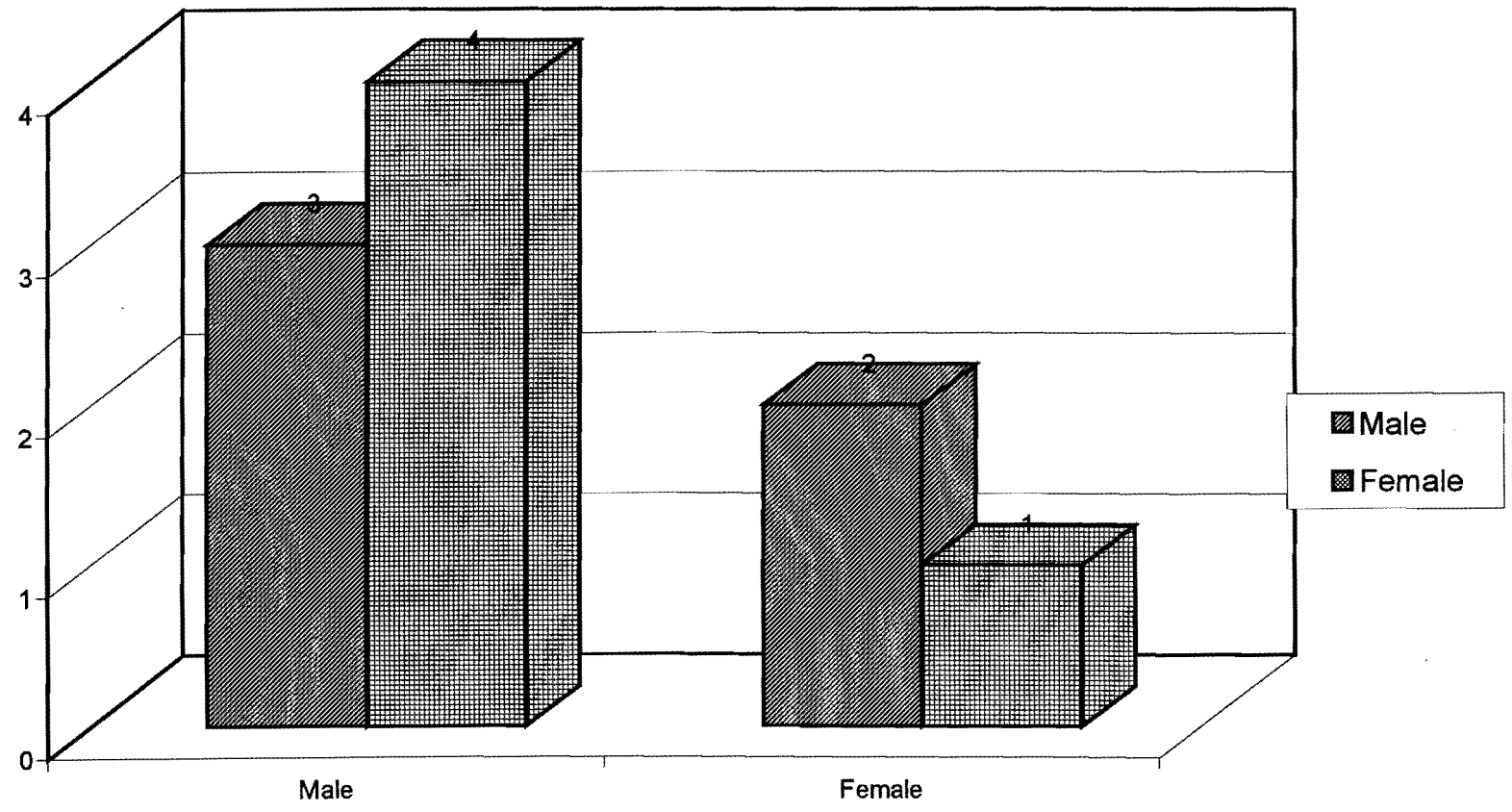

Figure 4. Sex distribution

Three of the patients suffering from schizophrenia were males. At Weskoppies Hospital there are more male wards than female wards. Four of the patients' key relatives were females and only one male was found to be a key relative. This indicates that caregivers are mostly women (mothers). Kuipers (1993:207) confirms that caregivers are mostly women.

- Qualifications

Table 3 indicates the respondents' qualifications.

Table 3: Qualifications

Qualification	Patients	Key Relatives
Up to Std. 6	1	1
Std. 7 – 8	1	1
Std. 9 – 10	1	2
Diploma	1	1
Incomplete degree	1	
Total	**5**	**5**

The researcher placed no restriction on qualification categories to be included in the study, however, what were found was that patient's qualifications ranged from less than Standard 6 to an incomplete degree. A person can thus suffer from schizophrenia irrespective of qualification, race, ethnicity, culture, religion, occupation or marital status. The key relatives' qualifications ranged from less than Standard 6 to a diploma.

- Occupation

One of the patients had no occupation, one was a general labourer, another had studied civil engineering but did not complete the degree due to his illness. One patient was a dental technologist (diploma) and one a matron at a university hostel. Of the key relatives, two were pensioners, one a shop manager, one a receptionist and one an artisan. Clearly, schizophrenia is an illness that impacts on people from all walks of life.

- Ethnic group

Table 4 below, indicates the respondents' ethnicity.

Table 4: Ethnic group

Ethnic group	Patients	Key relatives
South Sotho	1	1
Zulu	1	1
English	1	
Afrikaans	2	3
Total	**5**	**5**

The languages spoken by patients and by most significant relatives in the group were as follows: South Sotho, spoken by one patient and one key relative; Zulu, spoken by one patient and one key relative; English spoken by one patient; and Afrikaans spoken by two patients and three key relatives. From this study, it was found that schizophrenia occurs amongst all races and in all spheres of life, however, it may manifest in different ways because of cultural differences. (Confer Gillis, 1986:73.)

- Religious denomination

Respondents' religious denomination is indicated in Table 5.

Table 5: Religious denomination

Religious denomination	Patients	Key Relatives
Catholic	1	
Dutch Reformed (N.G.)	1	3
Zion Christian Church (ZCC)		1
St. John	1	1
Victory fellowship	1	
Hatfield Church	1	
Total	**5**	**5**

All five patients and their key relatives interviewed belonged to various religious denominations. It was also found that some patients belonged to a different church from their key relatives.

- Marital Status

The marital status of respondents is illustrated in Figure 5.

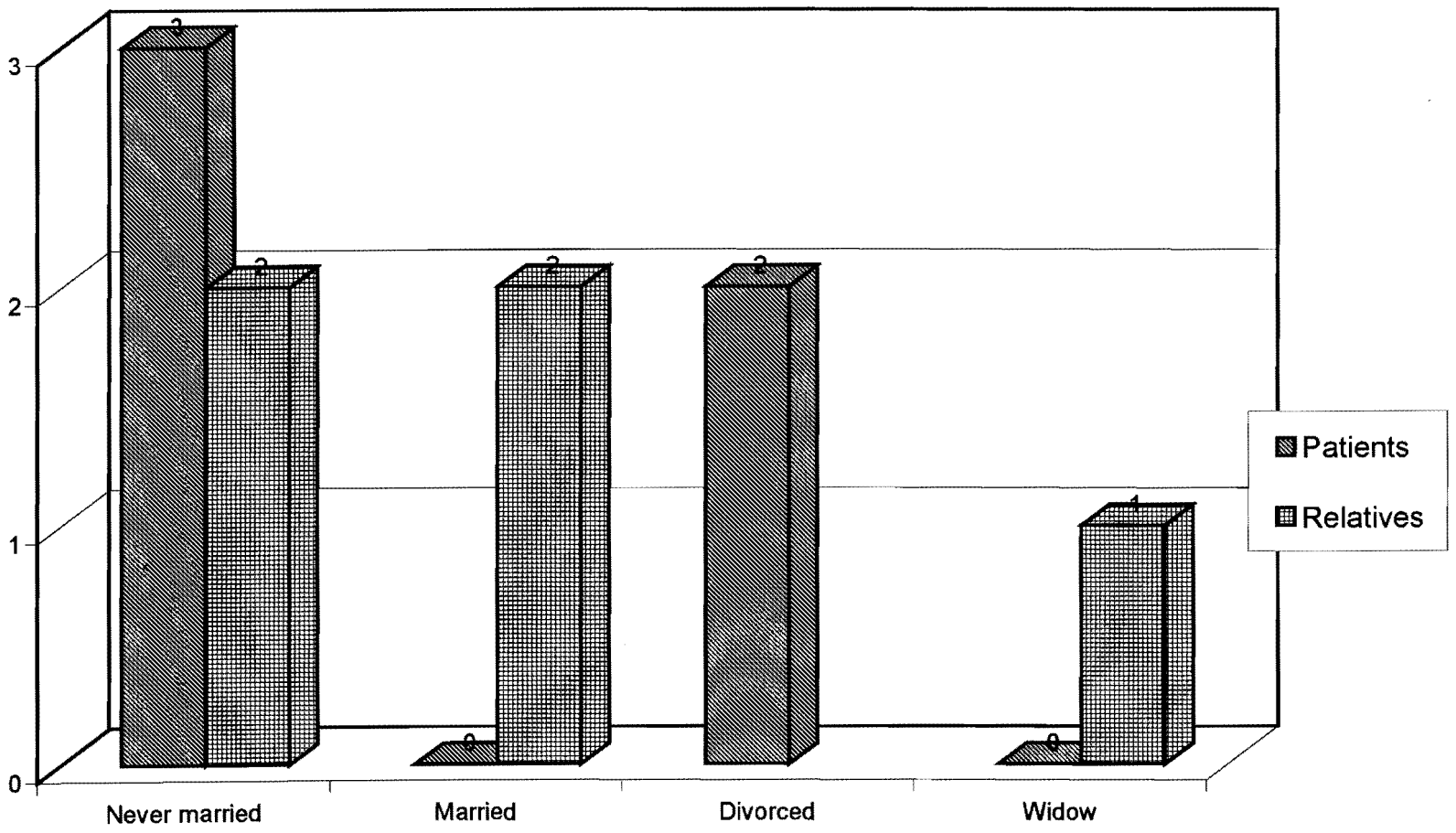

Figure 5: Marital status

Three patients had never been married and two were divorced. Although the sample was small, it indicates that schizophrenia can affect the marriage relationship. This is in agreement with Marsh (1992:11) who states that schizophrenia strains the marital relationship. With regard to relatives, three were unmarried and two married.

- First time experience of schizophrenia

Table 6 indicates the period that the patient had been suffering from schizophrenia at the time of the interview.

Table 6: Number of months/years that the patient had been suffering from schizophrenia at the time of the interview

Months/Years	1st Interview	
	Patients	Key relatives
4 months	1	
1 year		1
9 years	1	1
11 years	1	1
13 years	1	1
19 years	1	1
Total	**5**	**5**

One male who was diagnosed as disorganised schizophrenic stated that he had started to suffer from schizophrenia four months before the first interviews. His mother said he started to become a patient suffering from schizophrenia twelve months before the interview. One male who was diagnosed as a paranoid patient explained during the interview that he had started to suffer from schizophrenia nine years before (1989). However, his mother stated that the patient had started to suffer from schizophrenia eleven years before (1987). The respondent diagnosed as an undifferentiated patient and his mother mentioned that the patient had started to suffer from schizophrenia thirteen years before (1985). The respondent diagnosed as residual and her son stated that the patient had started to suffer from schizophrenia nineteen years before the interviews (1980). Tsuang (1982:17), DSM–IV (1994:274), Holmes (1994:267) and Gillis (1986:77) state that schizophrenia affects the patient's thinking. The fact that four patients and their four key relatives gave similar answers needs to be contextualised in the small sample for the study.

- First hospital admission date

The first hospital admission date per respondent is illustrated in Table 7.

Table 7: First hospital admission date

Year	Patients	Key relatives
1982	1	1
1985	1	1
1987	1	1
1994	1	1
1998	1	1
Total	**5**	**5**

The disorganised patient started to become mentally ill during 1998 which was also the year that he was first admitted. Although the paranoid patient's first admission date was during 1994 he had started to become mentally ill in 1989. The catatonic patient's first admission date correlates with the year that she started to become mentally ill, that is 1987. Similarly, the undifferentiated patient's first hospital admission date and onset year for this mental illness correlates, namely 1985. The residual patient's first hospital admission date was during 1982, while she started to become mentally ill during 1980.

It was interesting that all five patients and their most significant relatives gave the same information. It shows that even if the patient was mentally ill, he could still manage to remember his first year of hospital admission. Such patients' conditions were improving, helping them to remember certain things. As mentioned above, DSM-IV (1994:274) and Holmes (1994:267) state that schizophrenia affects the patient's mind.

- Total hospital admissions and reasons for admissions

The time period of suffering from schizophrenia is a determinant for the frequency of admission to a hospital. Table 8 indicates reasons for admission.

Table 8: Reasons for admission

Reasons for admission	1st Interviews		2nd Interviews	
	Patients	Key Relatives	Patients	Key relatives
Not taking medication regularly (relapse)	1	2		2
Unemployment		1		
Abnormal behaviour	2	3	1	5
Psychological behaviour		1		
Not sure		1		
Total	**3**	**8**	**1**	**7**

Relapse caused by not taking medication or irregular intake of medication and unacceptable behaviour such as aggressiveness and wife abuse were seen as the main reasons for patients' admission. The finding was in agreement with DSM-IV (1994:288) and Holmes (1994:266), who state that the patient suffering from schizophrenia is recognised by his unacceptable behaviour. The finding was also in agreement with Atkinson and Coia (1995:29) and Tsuang (1982:69) who state that patients who returned to hospital were more likely to come from marital partner abuse rather than from parental homes. When the patient relapses, he behaves in an unacceptable manner, which is not tolerated by the family and society. It is therefore in the best interest of all the parties that the patients are re-admitted to hospital.

Irregular intake of medication or a complete stop of medication may cause a relapse. A relapsed patient may be uncooperative and violent, which may cause negative relationships, negative attitudes and negative interaction between the patient and his family. Social work guidelines as proposed in objective four of this study would help families to cope with patients suffering from schizophrenia.

- Schizophrenia types

In Table 9, the types of schizophrenia from which the patient respondents suffer are indicated.

Table 9: Types of schizophrenia as diagnosed

Schizophrenia types	Patients	Key Relatives
Paranoid	1	1
Catatonic		
Disorganised		
Undifferentiated	1	1
Residual	1	1
Unaware	2	2
Total	**5**	**5**

One white male patient was aware that he was diagnosed as a paranoid schizophrenic, one white male patient was aware that he was diagnosed as an undifferentiated patient and one white female patient knew that she was diagnosed as a residual patient. One African male patient diagnosed as a disorganised type and one African female diagnosed as a catatonic patient were not aware of the type of mental illness they were suffering from. The African key relatives also did not know the type of mental illness their family members were suffering from, unlike the white key relatives.

It seemed as if white respondents generally had some insight into schizophrenia as a type of mental illness as opposed to the African respondents. Not knowing the type of mental illness shows that there is a lack of insight into schizophrenia on the part of both patients and their families. Although the reasons for this might be numerous, the fact is that education by means of family intervention programmes is necessary to bring about knowledge and insight into schizophrenia.

- Most significant relatives

The patient's significant relatives are indicated in Table 10.

Table 10: Patient - relative relationship

Key relative	
Mother	4
Son	1
Total	**5**

Four of the patients' most significant relatives were their mothers. These women were the ones taking care of the patients. This was in agreement with Kuipers (1993:207),

supported by Backlar (1994:95), Winefield & Harvey (1994:559) and Weleminsky (1991:119) who all state that single mothers, who are also the caregivers, are vulnerable. They lack resources and skills to cope with the patients suffering from schizophrenia.

6.2.2 SCHIZOPHRENIA

- Understanding of schizophrenia

Table 11 indicates the patients' and key relatives' understanding of schizophrenia.

Table 11: Understanding of schizophrenia

Understanding of schizophrenia	1st interviews		2nd interviews	
	Patients	Key Relatives	Patients	Key Relatives
Abnormal conduct in a normal society	4	2	4	3
Stress	1	1	2	
Head injury	1	1		1
Witchcraft		1	1	1
Shortage of certain medicine in the brain (chemical imbalance)	1		1	
Loneliness	1	1		1
Total	**8**	**6**	**8**	**6**

Four patients and two key relatives in the first interviews; and four patients and three key relatives in the second interviews explained that schizophrenia is a type of mental illness that causes the patient to act abnormally in a normal society. The findings were in agreement with the views of DSM-IV (1994:274), Holmes (1994:265), Hatfield (1990:70) and Gillis (1986:76). The patient who was diagnosed as disorganised said during the first interview that he understood schizophrenia in terms of unacceptable behaviour in a normal society. During the second interview, however, the same patient said he understood schizophrenia in terms of witchcraft and stress. His mother supported his view on stress. (Confer Cockerha, 1992:276.) The patient who was diagnosed as residual said that schizophrenia could be understood in terms of stress resulting from divorce and head injury.

During the first interview the patient who was diagnosed as a catatonic patient said schizophrenia could be explained by loneliness, such as longing to have a husband. During the second interview, she said working hard and the accompanied stress cause schizophrenic illness. Falloon, *et al.* (1988:7) supported the view that stress causes schizophrenia. The diagnosed catatonic patient's mother said during both interviews that schizophrenia was understood in terms of witchcraft. Mojalefa (1994:91) found that mental illness is perceived in terms of witchcraft in the black communities; it is seen as the cause of schizophrenia. This perception contributes to the lack of insight into schizophrenia in black communities. This finding confirms that family intervention programmes are necessary to increase knowledge of schizophrenia.

- Symptoms of a patient suffering from schizophrenia

Schizophrenia symptoms are indicated in Table 12.

Table 12: Symptoms of schizophrenia

Symptoms of schizophrenia	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key Relatives
Disturbance of thinking	4	4	4	3
Aggression	1	3	3	2
Patience		1	2	2
Violence	1	2	2	1
Patient loses interest in everything	1	2	3	3
Patient remains immobile in abnormal postures		2		
Patient has rapid mood changes	1	3	4	2
Patient moves up and down even late at night		1		
Patient has delusions and hallucinations	1		3	
Patient receives disability grant	4	1		
Patient talks to himself		1		
Patient cries in a strange way and is mute for a certain period			1	
Patient is naked			1	
Total	**13**	**21**	**23**	**13**

Four patients and four key relatives during the first interviews; and four patients and three key relatives during the second interviews stated that disturbed thoughts are a symptom of schizophrenia. Tsuang (1982:17), DSM-IV (1994:274), Holmes (1994:266), Gillis (1986:77), Cotterill (1994:21) and Sue, *et al.* (1981:284) support this view and stated that thought disturbance is one of schizophrenia's symptoms. During the second interview there were some limited improvements seen by key relatives concerning patients' thought disturbances.

One patient and three key relatives during the first interviews and three patients and two key relatives during the second interviews stated that aggression is a symptom of schizophrenia. This is in agreement with DSM-IV (1994:274), Holmes (1994:267) and Cotterill (1994:21). During the second interview two key relatives stated that aggressiveness had diminished in the patients. On the other hand, it was found that even if the patients were no longer aggressive, they continued to lose interest in everything in life. This was supported by three patients and three key relatives during the second interviews and is also supported by Stafford-Clark, *et al.* (1990:144) and Cook and Fonteine (1991:545). One patient and three key relatives during the second interviews stated that patients had rapid mood changes. This is supported by Holmes (1994:269) and Clark (1996:784) who said that the emotions of patients suffering from schizophrenia could best be described as inappropriate or situationally inconsistent.

Two patients in the first interviews said that they remain immobile in abnormal postures. DSM-IV (1994:288), Gillis (1986:78), Sue, *et al.* (1981:284), Kaplan and Sadock (1988:113) all support the finding that, specifically, the catatonic patient remains immobile in abnormal postures.

During the second interview three patients also mentioned delusions and hallucinations as common symptoms they experienced. DSM-IV (1994:274), Holmes (1994:205), Gillis (1986:76) and Hatfield (1990:70) state that delusions and hallucinations are two schizophrenia symptoms. From patients' responses, it can be deduced that even if there are some improvements in the patients' conditions, delusions and hallucinations may still be common.

Other symptoms mentioned by respondents were as follows: moves up and down, even

during the night when other people are sleeping, repeats sentences, talks to himself, cries in a strange way and then remains quiet for two to three months and walks naked. All these symptoms stated are mentioned by Uys (1994:31), Tsuang (1982:56), Kendell and Zeally (1993:401), Allwood and Gagiano (1997:197) and DSM- IV (1994:273).

From the above findings it can be concluded that there are various symptoms of schizophrenia that can prompt the family to take the patient for medical treatment before the condition deteriorates.

- Patient's behavioural characteristics

The patient's behavioural characteristics are indicated in Table 13.

Table 13: Patient's behavioural characteristics

Characteristic	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
Aggressive		2	3	1
Friendly	2	2	5	2
Patient	1		2	
Co-operative	1	1	4	2
Moody	1	2	4	2
Emotionally stable		1	1	2
Impatient		1	1	1
Quiet	1			1
Argumentative		1		
Total	**6**	**10**	**20**	**11**

Behavioural characteristics of a patient are linked to the patient's symptoms. The symptoms are early signs of schizophrenia. Behavioural characteristics are the way the patient behaves almost every day. Being friendly, co-operative and moody were stated as the patients' most dominant behavioural characteristics. Limited improvement of the patients' condition was reported during the second interviews. Although patients were co-operative, they were still moody. These findings were in agreement with DSM-IV (1994:288), which states that a patient suffering from schizophrenia has a tendency to be moody.

Two key relatives during the first interviews and three patients and one key relative during the second interviews talked about aggression as a behavioural characteristic of a

patient suffering from schizophrenia. This view was supported by Cockerha (1992:276). The patient's aggression may cause negative relationships, interactions and attitudes between the patient and his family, especially if the family does not have insight into schizophrenia as a type of mental illness.

6.2.3 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - ECOLOGICAL CONTEXT

The patient-family relationship as seen by patients and key relatives is indicated in Table 14.

Key for Table 14:
1 = not at all
2 = very rarely
3 = sometimes
4 = most of the time
5 = always

Table 14: Patient-family relationship, as seen by the patient and the key relative

Patient-family relationship	1st Interviews										2nd Interviews									
	Patients					Key Relatives					Patient					Key Relatives				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Strained relationship	3		2			3		2			4	1		1		4		1		
The whole family's life changed negatively	1	2	1	1	1	2		3			4		1			3		2		
Every relationship within the family is affected		1	1	2		1		3	3	1	3	1	1			2	1	1		1
Key relative is frustrated because patient cannot function alone	2	1				1		2		1	3		2				2	1	1	
Patient is included in decision-making	2	1	1		1			3	1	1	1		3		1		1	2		2
Patient still has a role to perform	2	1	1		1			3	1	1	1		3		1		1	2		2
Patient gives key relatives problems	4		1			3		1		1	3	1	1			4	1			
Other family members are not interested in the patient					1				1										1	
Total	**14**	**6**	**7**	**3**	**4**	**10**	**0**	**15**	**6**	**5**	**19**	**3**	**11**	**1**	**2**	**13**	**6**	**9**	**2**	**5**

Three of the patients and three of the key relatives during the first interviews explained that there were no strained relationships between patients and key relatives (caregivers) except those that occurred between the patient and other family members. During the second interviews, four patients and four key relatives stated that they experienced happy relationships between caregivers and patients, however, strained relationships occurred between patients and other family members.

The key relatives interviewed supported the patients' views and stated that they did not experience strained relationships with the patients. The key relatives explained that they had no choice but to tolerate the patients. They said they had not been trained, but they were forced to look after the patients, as they were the only persons available to supervise them. They admitted that it was strenuous for them to handle these patients. In this context it is evident that there are elements of strain in caregivers and patient relationships. This finding is supported by literature. (Compare Marsh, 1992:11.) It shows, however, that the caregivers who were the respondents for this study forced themselves to be positive and supportive in the relationship since they knew the patients had nobody else to care for them. Furthermore, they indicated that other family members were not interested in the patient. They distanced themselves from and rejected the patient. Marsh (1992:11), Keeney and Ross (1992:171) and a Guide for the professions, Report No. 119 (1986:6) all state that there are strained relationships in the family if one member is suffering from schizophrenia. It was, however, found during the second interviews that other family members' attitudes had changed positively towards patients as their recovery progressed, in that they showed love and support, for example, by visiting the patients.

During the first interviews, it was found that the relationships within the family were affected by the patient's abnormal behaviour. The family wanted the patient to be hospitalised in order to avoid stress, fear and embarrassment. The key relatives (caregivers) experienced stress because they were the only persons who could look after the patients. Two patients in the first and three patients in the second interviews did not realise that they might be frustrating their family members with their abnormal and unacceptable behaviour while they could not function alone and needed supervision. This statement is in agreement with Boss, *et al.* (1992:433), Falicov (1995:378), Zastrow (1996:56), Hartman (1979:33), Potgieter (1998:54), Jackson and Smith

(1997:19) and Becvar and Becvar (2000:147), who all state that living things are dependent on each other for survival. The patient should understand the impact of his interaction on the family since an individual cannot isolate himself within the system. There must be co-operation and assistance within the family system to avoid confusion and frustration.

Two patients during the first interviews said they were not included in decision-making by family members, including key relatives (caregivers), and that they felt bad about that. This view is in agreement with Backlar (1994:132), who states that patients are excluded from decision-making. During the second interviews, only one patient said he was excluded from decision-making. This shows that when the patient's condition indicates some improvement, the patient becomes more accepted and is given responsibility at home. Three patients and four key relatives in the first interviews, and three patients and two key relatives in the second interviews stated that patients still have a role to perform at home when their state of mental illness improves. Three patients and four key relatives said that they did not have relationship problems, especially with key relatives who were always supportive.

Table 14 reveals that negative relationships, attitudes, communication and frustrations, especially between the patient and his family members occurred when the patient's condition did not improve. This confirms the negative relationship between the patient and his family members.

- Disturbance of patient's thinking and strained relationships, as seen by the key relative

Table 15 indicates the comparison between disturbance of thinking and strained relationships, as seen by the key relative.

Table 15: Disturbance of patient's thinking and strained relationships, as seen by the key relative

Strained relationships	Disturbance of thinking			
	1st Interview		2nd Interview	
	Yes	No	Yes	No
Not at all	2	1	3	1
Sometimes	2			1
Total	**4**	**1**	**3**	**2**

A mean comparison was made between the patient's disturbance of thinking in relation to the strained relationship within the family as seen from the perspective of the key relatives in the two interviews. During the first interview, the strained relationship between the patient and his family was evident. The relationship improved during the second round of interviews. What became apparent in this round of interviews was an improvement in the patient's condition, which created a positive relationship between the patient and his family.

- Comparison between patient's disturbance of thinking and his role performance, as seen by the key relative

Table 16 indicates a comparison between a patient's disturbance of thinking and his role performance, as seen by the key relative.

Table 16: Comparison between patient's disturbance of thinking and patient no longer having a role to perform, as seen by the key relative

Patient has no role to perform	Disturbed thinking			
	Key relatives			
	1st Interview		2nd Interview	
	Yes	No	Yes	No
Not at all	4	1	2	
Very rarely				1
Always			1	1
Total	**4**	**1**	**3**	**2**

During the first interview, four key relatives said patients did not have any role to perform. During the second interviews only two key relatives said that patients had no role to perform. Generally, the patient should be given a role to perform when his condition improves.

- Comparison between patient's disturbance of thinking and patient's problematic behaviour towards his family

Table 17 demonstrates a comparison between patient's disturbed thinking and his problematic behaviour towards his family, as seen by the key relative.

Table 17: Comparison between patient's disturbed thinking and patient's behaviour towards his family, as seen by the key relative

Patient gives family problems	Disturbed thinking			
	Key relatives			
	1st Interview		2nd Interview	
	Yes	No	Yes	No
Not at all	2	1	3	
Very rarely			1	1
Sometimes	1			
Always	1			
Total	**4**	**1**	**4**	**1**

Generally, it was revealed in both interviews that the family experienced some problems resulting from the patient's behaviour, even when his condition was improving. From Table 17, it can be deduced that the families need to have more insight into the patient suffering from schizophrenia to cope with him.

- Comparison between patient's disturbed thinking and patient's relationship within the family, as seen by the key relative

Table 18 shows the comparison between the patient's disturbed thinking and his relationship within the family.

Table 18: Comparison between patient's disturbed thinking and patient's relationship with his family, as seen by the key relative

Every relationship within the family is affected	Disturbed thinking			
	Key relatives			
	1st Interview		2nd Interview	
	Yes	No	Yes	No
Not at all		1	1	1
Very rarely				1
Sometimes	3		1	
Always	1		1	
Total	**4**	**1**	**3**	**2**

Generally, patient-family relationships were sometimes affected as a result of disturbed thinking. An improvement occurred in the relationship between patient and family members as and when the patient's condition improved.

- Patient-friend relationship as seen by patients and key relatives

Table 19 provides the rating for the patient-friend relationship.

Key for Table 19:
1 = Not at all
2 = Very rarely
3 = Sometimes
4 = Most of the time
5 = Always

Table 19: Patient-friend relationship

Patient-friend relationship	1st Interviews										2nd Interviews									
	Patients					Key Relatives					Patients					Key Relatives				
	1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
Friendship deteriorated	1		1		3	1		1	2	1		2			3	1		1	1	1
Friendship remains good	3	1			1	2	1	1		1				2	3	1		2		1
Patient feels accepted	1			1	3	2		1		2			2	2	1	1		1		2
Patient is excluded from decision-making	2		1		2		1	1	1	1	2	1	2			1		1	1	1
Patient is feared						3			2							4				
Patient gets more support from friends	2		2	1		3	1	1			1		1	2		1		2		1
Family hides the patient's illness															1					
Patient does not have friends										1										
Total	**9**	**1**	**4**	**2**	**9**	**11**	**3**	**5**	**5**	**6**	**3**	**3**	**5**	**6**	**8**	**9**	**0**	**7**	**2**	**6**

During the first interviews three patients and one key relative, and three patients and one key relative during the second interviews stated that there was always deterioration in friendships. Hatfield and Lefley (1987:557) and Kuipers, *et al.* (1992:60) state that patients suffering from schizophrenia experienced friendship deterioration. One of the explanations given by patients was that the friends hid themselves. Aromando (1995:59) states that schizophrenia exhibits impaired functioning in such areas as work, interpersonal and social relationships and self-care. One key relative said that deterioration of friendship was caused by the patient's violent and aggressive behaviour. During the second interview it was indicated that friendship improved because of the patient's improved condition. Friends accepted these patients when their conditions improved. Two patients and one key relative in the first interviews, but no patient and only one key relative during the second interviews said that friends always excluded patients from decision-making. Kavanagh (1992:60) agrees that patients suffering from schizophrenia were excluded from decision-making by friends.

During the first and the second interviews, patients indicated that friends tended to avoid rather than fear them. Three key relatives during the first interviews and four key relatives during the second interviews said friends did not fear patients. Marsh (1992:86) and Cockerha (1992:275), however, confirm that friends do fear patients. Bearing the small sample in mind, these findings reveal that patients are more avoided than feared by friends.

During the first interview, two patients and three key relatives indicated that patients do not get support from their friends. During the second interviews, one patient and one key relative indicated that patients do not get support from friends.

These findings partially confirmed the hypothesis for this study, indicating that a lack of insight into schizophrenia by family members and by the community/society, impacts negatively on the functioning of the family with regard to attitudes, relationships and behaviour. If social work guidelines can be developed and family intervention programmes emphasised to help families to cope with patients suffering from schizophrenia, especially at home, then positive attitudes, relationships and functioning will occur within the family and within society.

- Occurrence of negative patient-friend relationships

Figure 6 illustrates the occurrence of negative patient-friend relationships.

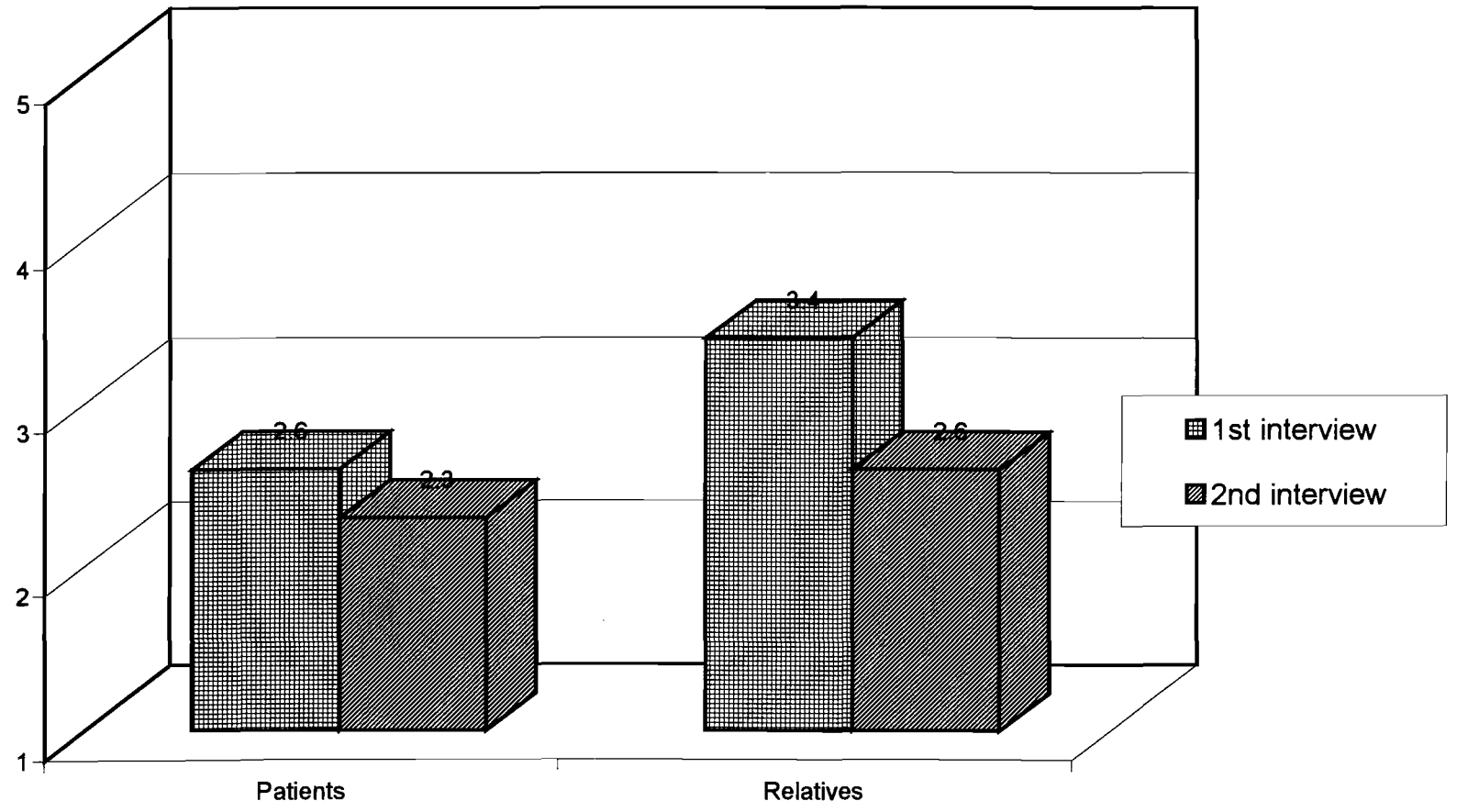

Figure 6: Patient-friend relationships

Figure 6 illustrates a slight alleviation of negative patient-friend relationships between the two interviews. During the patient's first interview the mean was 2.6, and 2.3 during the second. Key relatives' mean during the first interviews was 3.4 as opposed to 2.6 during the second interviews.

- Comparison between patient-family relationship and patient-friend relationship as seen by the patient and the key relative.

Figures 7 and 8 indicate the comparison between the relationship between the patient and his family and that between the patient and his friends, as seen by the patient and key relative, respectively.

Key for Figures 7 and 8: 1 = Negative response
5 = Positive response

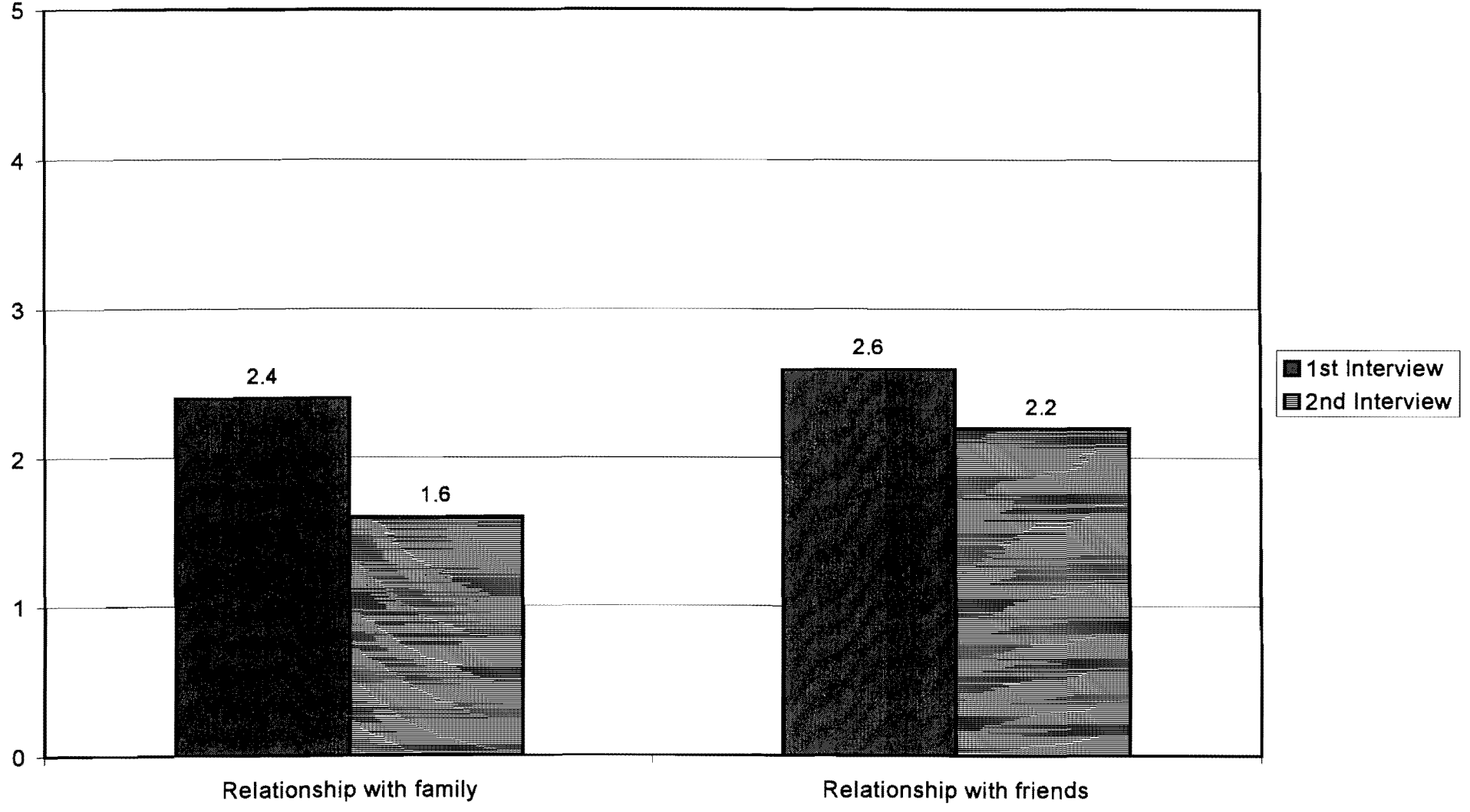

Figure 7: Comparison of patient-family and patient-friend relationships, as seen by the patient

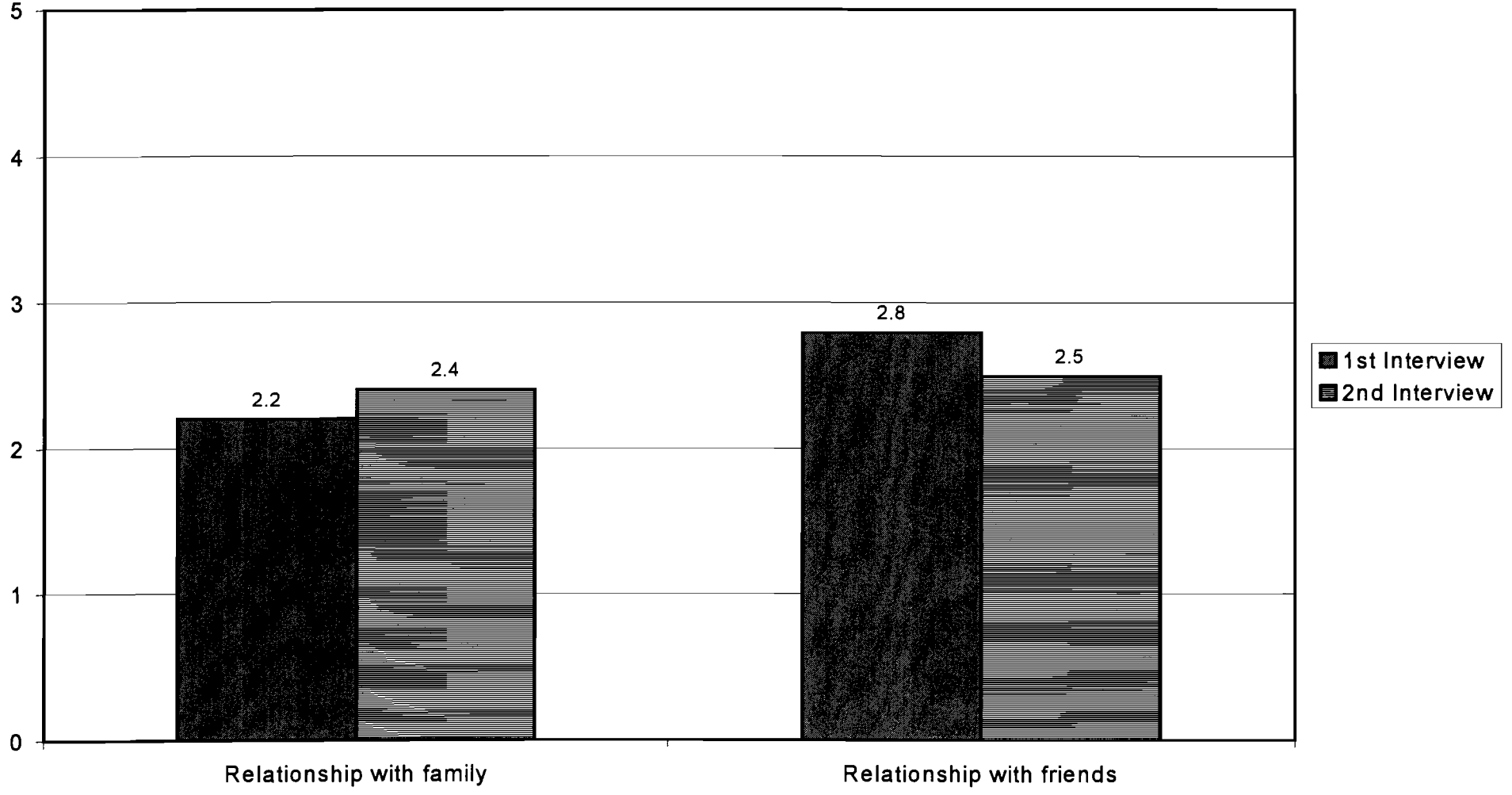

Figure 8: Comparison of patient-family and patient-friend relationships, as seen by the key relative

Figures 7 and 8 were drawn using the negative response and/or the negative questions to generalise how the patient perceived his relationship with his family and his relationship with his friends.

According to the patient's perception (in Figure 7), his relationship with the family and his relationship with his friends were sometimes negative and sometimes positive. Both relationships improved during the second interviews. The mean for patient-family relationships was 2.4 during the first interview and it improved to 1.6 during the second interview. The mean for patient-friend relationships was 2.6 during the first interview and 2.2 during the second interview, which indicates improvement in the relationship.

According to the key relative's perception (in Figure 8), patient-family relationships and patient-friend relationships were sometimes positive and sometimes negative. The patient-friend relationship improved during the second interview as compared to the patient-family relationship.

When comparing Figures 7 and 8, it can be concluded that patient-family and patient-friend relationships were seen as sometimes positive and sometimes negative by both the patient and the key relative.

6.2.4 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK-ACCULTURATION AND MIGRATION

Table 20 gives an indication of how the patient is treated by his family.

Key for Table 20:
1 = Not at all
2 = Very rarely
3 = Sometimes
4 = Most of the time
5 = Always

Table 20: Rating of how patient's family deals with patient

Family handling	1st Interviews										Second Interviews									
	Patients					Key relatives					Patients					Key relatives				
	1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
Fear	5					3	1	1			5					4		1		
Frustration	3		2			1		3			3		2			3		2		
Worry		1		1	3			1	2	2	1		1		3			2	1	2
Bitterness	4					5					4		1			5				
Anger	4					3		2			3	1	1			3		2		
Happiness				1	3				1	4			1		4			1		4
Anxiety	2			1	1	1	1	1	2		3		1	1				2	1	2
Empathy		1		1	2			1	1	3	1		4			1		1	1	2
Guilt	3		1			3		1			5					3		1		1
Depression	3		1			3		2			3		1			3		1		1
Blame	5					4	1				4					5				
Shame			4	1				3	2				4		1			2	2	1
Stress	3		1	1		3			1	1	3		1			2		1	1	
Acceptance					5					5					4					5
Total	**32**	**2**	**9**	**6**	**14**	**26**	**3**	**15**	**9**	**15**	**35**	**1**	**17**	**2**	**12**	**29**	**0**	**16**	**6**	**18**

During the first interviews, five patients and three key relatives said that key relatives are not afraid of the patient; during the second interviews five patients and four key relatives expressed the same sentiment. However, other relatives such as brothers and sisters seemed to be afraid of the patient. This finding was confirmed by Marsh (1992:86) and Cockerha (1992:275) who state that family members fear patients suffering from schizophrenia.

Three patients and two key relatives during the first interviews; and three patients and two key relatives during the second interviews said that key relatives are always worried because patients suffer from schizophrenia. One of the explanations given by patients was that their key relatives were concerned and wanted to see them cured and employed and prospering in life. The caregivers explained that they were worried and frustrated because if they died the patients would suffer as they were seen as being most supportive of the patient. According to the DSM-IV (1994:8), the whole family experiences worry when a patient suffers from schizophrenia.

Four patients and five key relatives during the first interviews; and four patients and five key relatives during the second interviews claimed that key relatives were not bitter towards patients. Marsh (1992:2), however, indicates that family members are bitter towards patients.

Four patients and three key relatives during the first interviews; and three patients and three key relatives during the second interviews stated that key relatives were not angry with patients. Within the larger family context, Kavanagah (1992:60), Magliano, *et al.* (1998:412) and Gillis, *et al.* (1989:375) agree that family members display anger towards patients suffering from schizophrenia.

Findings revealed that a positive attitude and relationship exists between the patient and his caregiver. Other family members, however, only appear and show love or concern when the patient's condition has improved. This situation may improve by gaining insight into schizophrenia through family intervention programmes.

Three patients and three key relatives during the first interviews; and five patients and three key relatives during the second interviews said that caregivers do not have guilt

feelings towards patients. Kavanagh (1992:60), Hatfield (1990:30), Kuipers, *et al.* (1992:32), Bennett (1980:23) and Atkinson and Coia (1995:32) all agree, however, that family members do have guilty feelings.

Five patients and four key relatives in the first interviews; and four patients and five key relatives in the second interviews stated that key relatives do not blame the patients for being mentally ill. Five patients and five key relatives during the first interviews; and four patients and five key relatives during the second interviews stated that key relatives do not reject the patient suffering from schizophrenia. Kuipers, *et al.* (1992:60), Damodaran (1993:22) and Kavanagh (1992:60) indicate that family members reject patients.

- How the patient deals with the family as seen by the patient and by the key relative

Table 21 indicates how the patient deals with the family as seen by patient and key relative.

Key for Table 21:
1 = Not at all
2 = Very rarely
3 = Sometimes
4 = Most of the time
5 = Always

Table 21: How the patient deals with the family, as seen by the patient and by the key relative

Patient handling	1st Interviews										2nd Interviews									
	Patients					Key relatives					Patients					Key relatives				
	1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
Blame	4		1			2	1		2		3	1	1			2		3		
Fear	3		1			4		1			5					5				
Anxiety	1		3		1	2		2		1	4	1				2		2		
Happiness			2		2			3	1	1				1	4			4		1
Anger	2		2			1		4			4		1			1		4		
Depression	3		1		1	1		3	1		1	1	2			2		2		
Guilt	4					3		2			5					3		2		
Bitterness	4		1			1	1	1	1		4		1			3		1	1	
Worry	2	1			2	1		1		3							3		2	
Empathy	2			1	1	1		2	1	1			3	1		1		2		1
Stress	3		2			1		4			3	1	1			2		1		
Mourning	5					5					5					5				
Embarrassment	3		2			1		3	1		5					3		2		
Total	**36**	**1**	**15**	**1**	**7**	**23**	**2**	**26**	**7**	**6**	**39**	**4**	**9**	**2**	**4**	**29**	**3**	**23**	**3**	**2**

Four patients and two key relatives during the first interviews; and three patients and two key relatives in the second interviews stated that patients do not blame their key relatives for being mentally ill or for how key relatives treat them. Rather, patients blame other relatives who reject them. Hatfield (1990:30) confirms that family members blame and reject the patient suffering from schizophrenia.

Three patients and four key relatives in the first interviews; and five patients and five key relatives during the second interviews stated that patients do not fear key relatives, but may fear other family members. Marsh (1992:2) and Atkinson and Coia (1995:32) state that the family experiences negative emotions such as fear, worry, bitterness, anger and depression when one member is suffering from schizophrenia.

In the first interviews two patients and in the second interviews four patients said that they were not angry with their key relatives at all. This view was contrary to the opinion of the key relatives who explained that patients did not want to be corrected and that this made them angry.

In the first interview, two patients said they were sometimes angry with their key relatives and gave reasons such as their key relatives hospitalising them or saying hurtful things, such as asking them why they could not work. This usually happened when the patient was uncooperative or refused to be advised.

Four patients and one key relative in the first interviews; and four patients and three key relatives in the second interviews stated that patients were not bitter towards key relatives. It was reported that patients became bitter with other relatives who showed little concern for them.

During the first interviews, two patients and three key relatives said patients were always worried about their key relatives as they were the only ones looking after them. During the second interview none of the patients said they worried about caregivers. This indicates that there were some improvements in the patients' condition, which led to them being more independent.

Three patients and one key relative in the first interview; and three patients and two key relatives in the second interviews said patients do not cause key relatives stress. Three patients and one key relative in the first interviews; and five patients and three key relatives in the second interviews stated that patients do not embarrass key relatives. This view was in contrast to Hatfield (1990:28) who states that patients embarrass their family members, especially when they behave in an unacceptable way. According to this view, the key relatives do not feel being embarrassed by the patients, although other family members do.

- Comparison of how the family and the patient interact with each other

Figures 9 and 10 indicate how the family and the patient interact with each other, from the perspective of both patient and key relative.

Key for Figures 9 and 10: 1 = positive response
5 = negative response

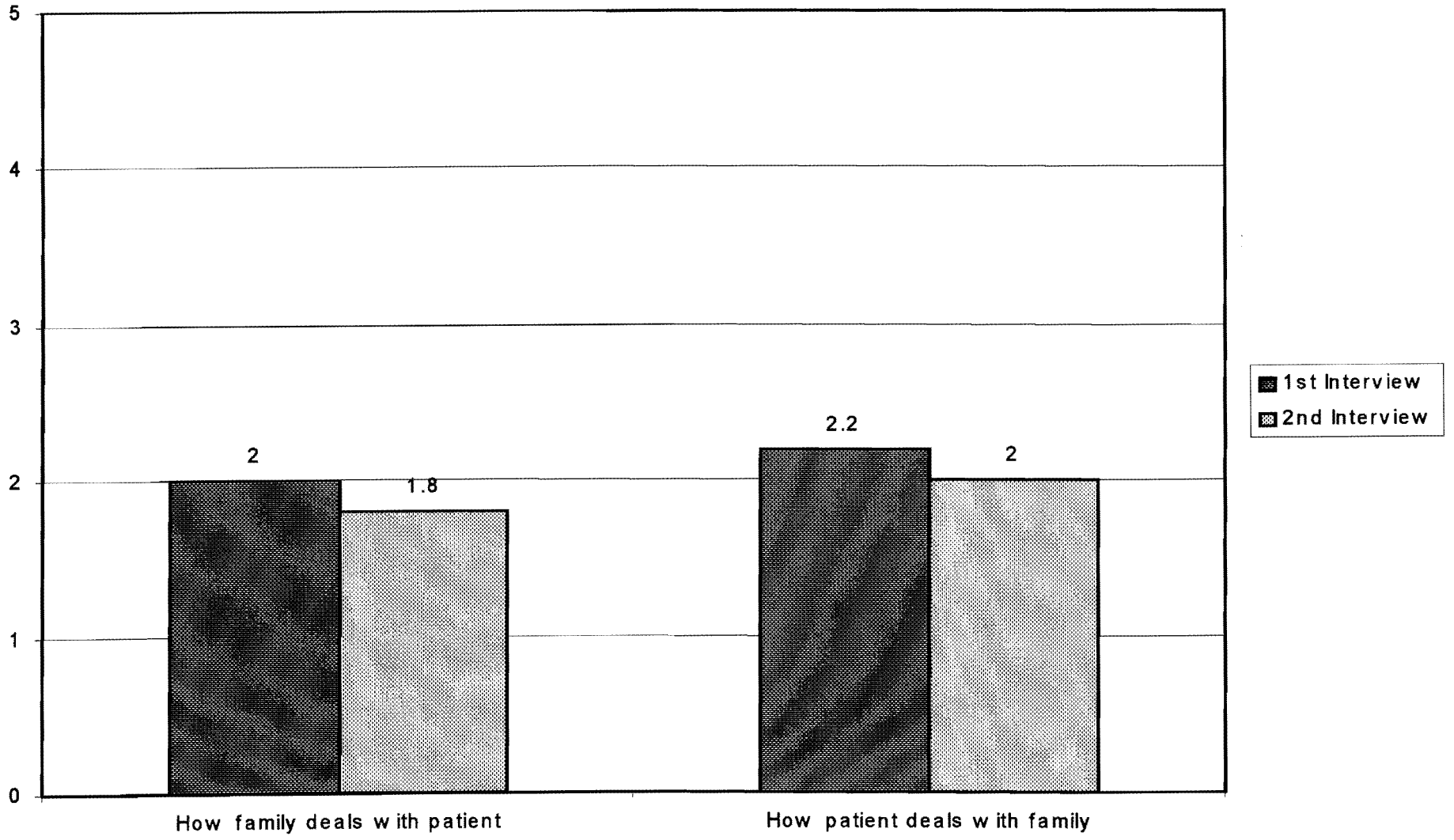

Figure 9: Comparison between how the family deals with the patient and how the patient reciprocates, as seen by the patient

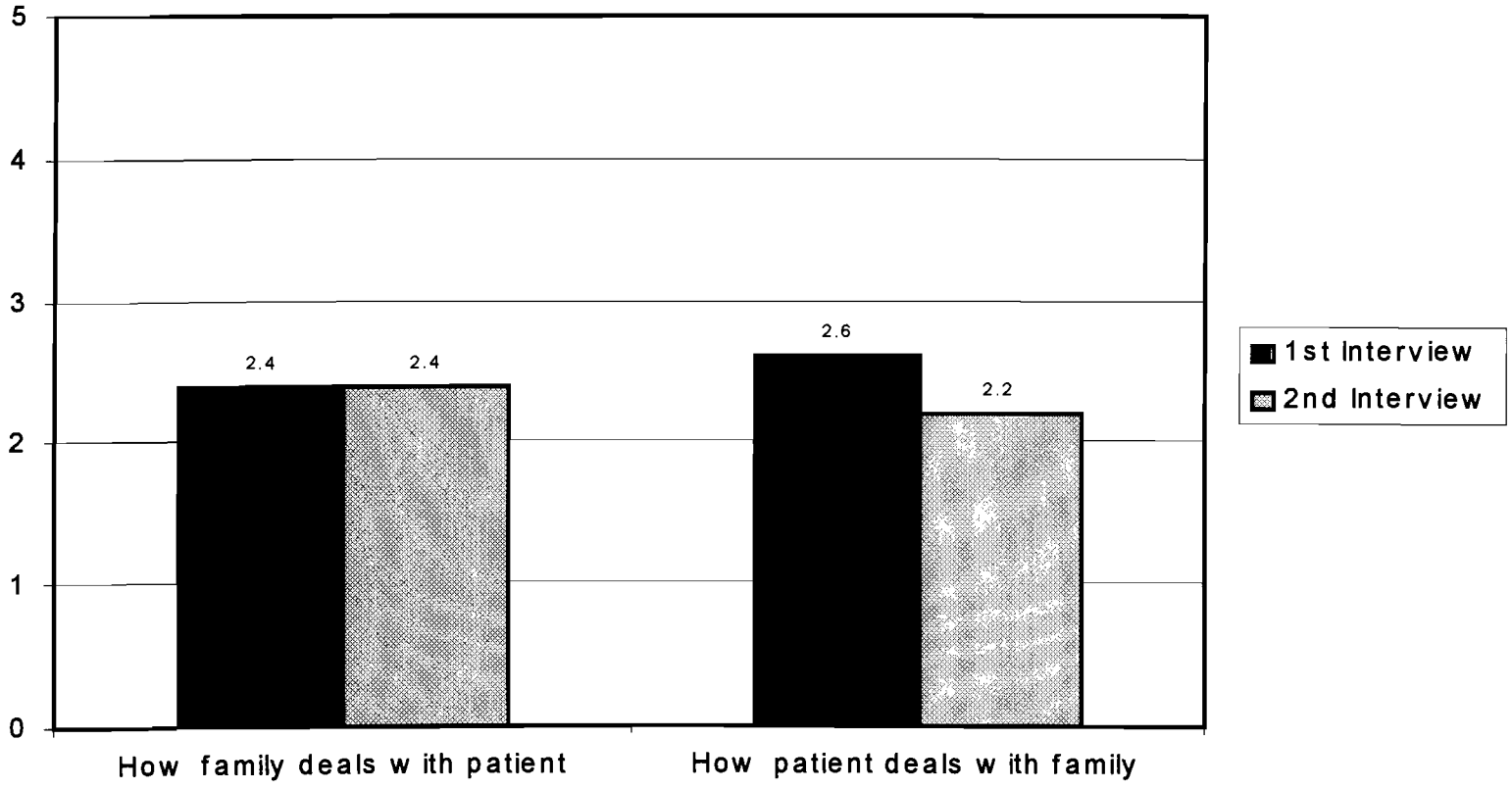

Figure 10: Comparison between how the family deals with the patient and how the patient reciprocates, as seen by the key relative

According to Figure 9, the patient's perception of the way patient and family deal with each other was generally not that bad. Negative interaction between the patient and his family did sometimes occur and during the second interview it appeared that there had been some improvement in this regard.

According to the key relative's perception, as indicated in Figure 10, the family's manner of dealing with the patient was sometimes seen as a problem and sometimes not in both interviews. This indicates that, according to the key relative, the family could sometimes not deal with or interact with the patient.

The manner in which the patient deals with his family, according to the key relative, as indicated in Figure 10, revealed some improvements during the second interviews. Generally, the manner in which the patient dealt or interacted with his family was also seen as sometimes good and sometimes bad.

When comparing Figures 9 and 10, it can be concluded that the relationships as well as the ways patients and their families interact with each other were seen as varied. This suggests that the patient and his family need more knowledge about schizophrenia. Family intervention programmes as well as social work guidelines should be developed to help families to cope with schizophrenia all the time, even when the patient's condition has not yet improved.

- Interaction of family with patient

Figure 11 explains the interaction between family members and the patient.

Key for Figure 11: 1 = Positive response
5 = Negative response

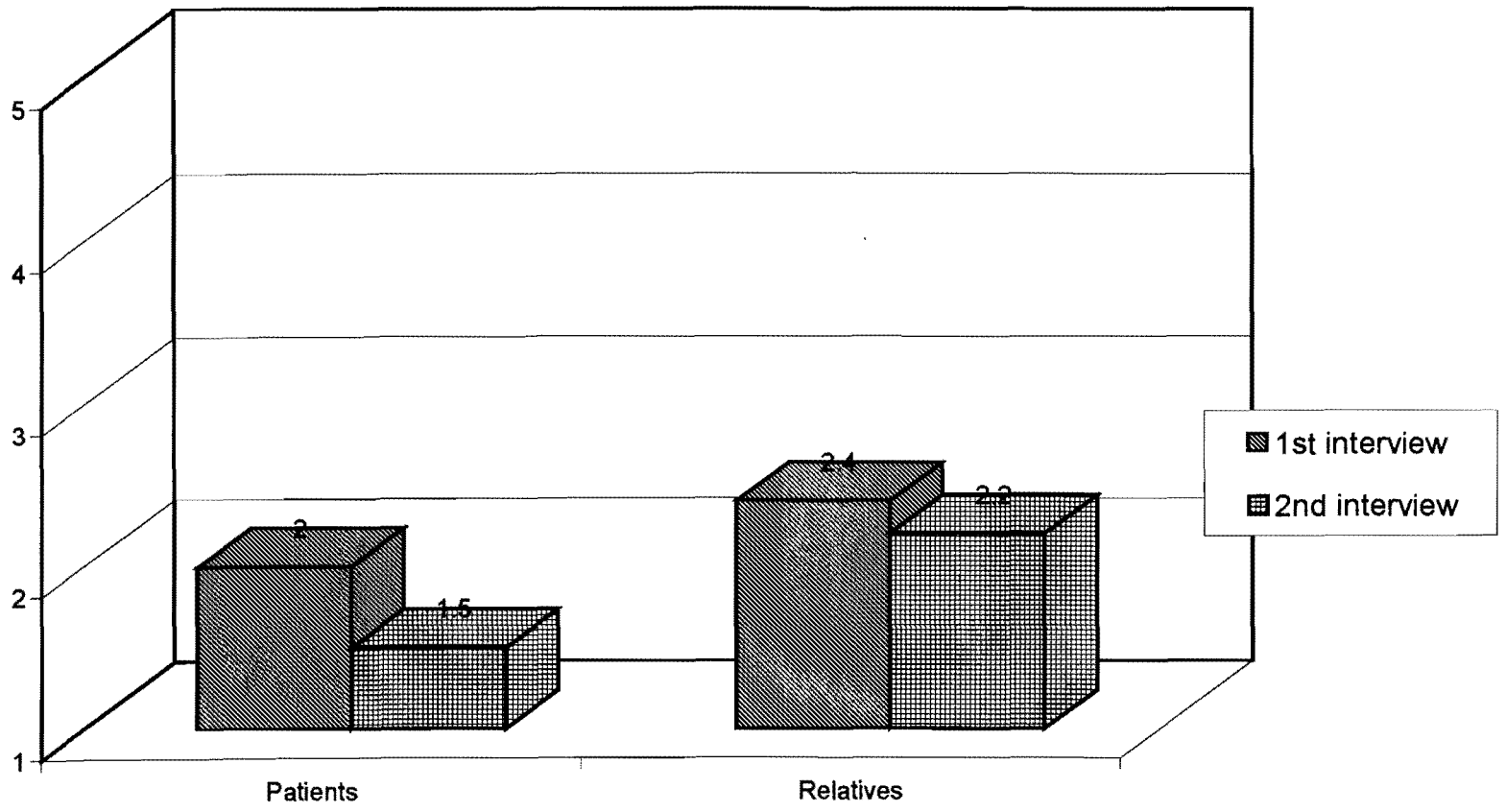

Figure 11: Interaction between family members and the patient

From Figure 11, it can be inferred that the attitudes between the patient and his family members are indicated as negative by both patients and key relatives, especially during the first interviews when the patient's condition is still very bad.

- The extent of burden the family experiences because of the patient

The researcher investigated the degree of burden that might occur within the family when a member suffers from schizophrenia. The extent of this burden is indicated in Table 22.

Key for Table 22:
1 = Not at all
2 = Very rarely
3 = Sometimes
4 = Most of the time
5 = Always

Table 22: Rating the extent of the burden experienced by the family because of the patient's condition

Burden	1st Interviews										2nd Interviews									
	Patients					Key relatives					Patients					Key relatives				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
A caregiver keeps on working					5					5					5					
A caregiver loses leisure time	4	1				3		1	1		4	1				4	1			
A caregiver still has friends					4	1				4					5					5
Family members experience financial problems	1	1			3	1	1	3			1		2	1	1	1		3		1
Family members blame themselves	3		1			5					5					5				
Family members are close to one another			2	2	1	1		3	1					2	2	1			2	2
Family members blame God	4					5						4				4				1
A caregiver experiences burden of patient's violence	4		1			3	1			1	3		1			3	1	1		
Total	**16**	**2**	**4**	**2**	**13**	**19**	**2**	**7**	**2**	**10**	**13**	**5**	**3**	**3**	**13**	**18**	**2**	**4**	**2**	**9**

Table 22 shows that the caregivers, that is, the patients' key relatives, did not experience an objective burden as such. For instance, the caregivers continued to be employed, and to have leisure time in which to visit their friends. Falloon, *et al.* (1984:32), Lefley and Johnson (1990:171), Schene (1990:289), Fadden, *et al.* (1987:286), Winefield and Harvey (1994:559), Kuipers (1994:207), Tsuang (1992:69), L'Abate, *et al.* (1986:19) and Atkinson and Coia (1995:36) state that caregivers will be challenged by having to continue with their work and having no leisure time because they have to look after the patients.

Four key relatives stated that they were experiencing financial difficulties because they were the only ones financing the patient. Family members are very rarely close to the patient because of the patient's mental illness. Four patients and five key relatives in their first interview and four key relatives during the second interviews explained that family members do not blame God for having such a patient in the family. This finding is in contrast to Marsh (1992:86) who said the patient's family blames God for causing the patient's mental illness. Obviously, one's religion and cultural perception will be a determinant in such a view.

- Burden experienced by the family

Figure 12 indicates a mean comparison of the burden experienced by the family when living with a patient suffering from schizophrenia.

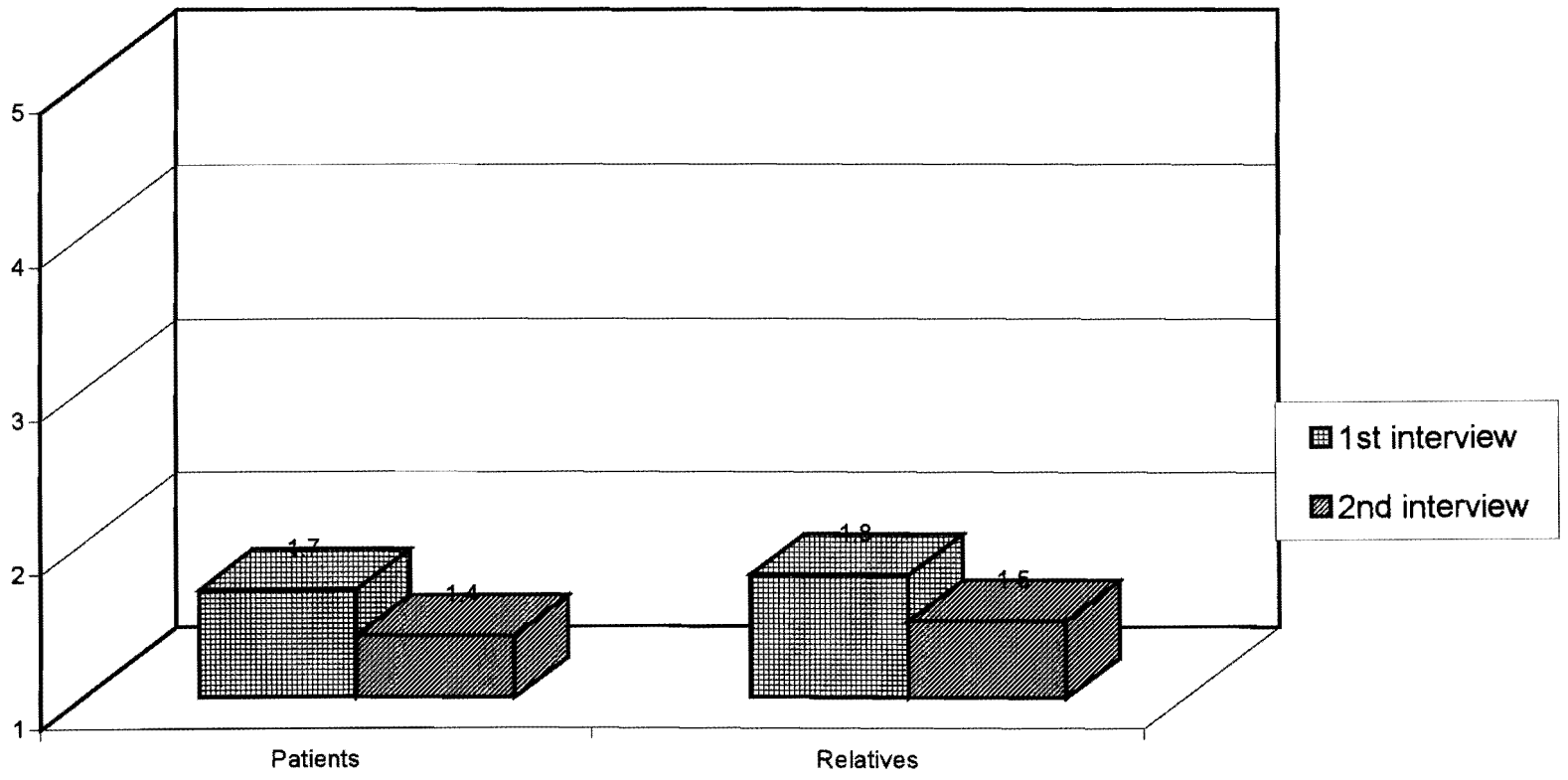

Figure 12: Burden experienced by the family

The mean comparison in Figure 12 indicates that there was improvement between the first interviews and the second interviews with regard to burden experienced by family members and key relatives. During the first interview, the mean for patients was 1.7 and during the second interview it was 1.4. It can be concluded that as long as the patient's condition improves, the burden experienced by the family will be reduced.

- How the patient presents a burden to his family, as seen by the patient and the key relative

Key for Figures 13 and 14: 1 = positive response
5 = negative response

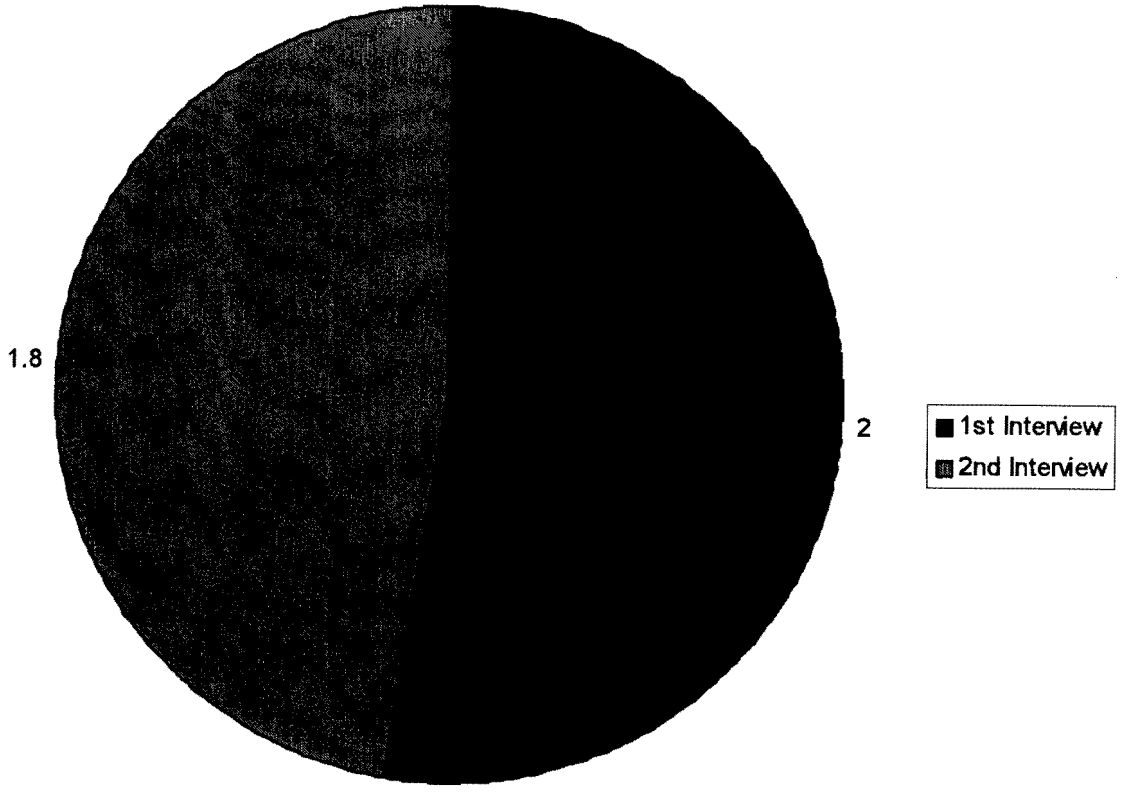

Figure 13: Burden on the family, as seen by the patient

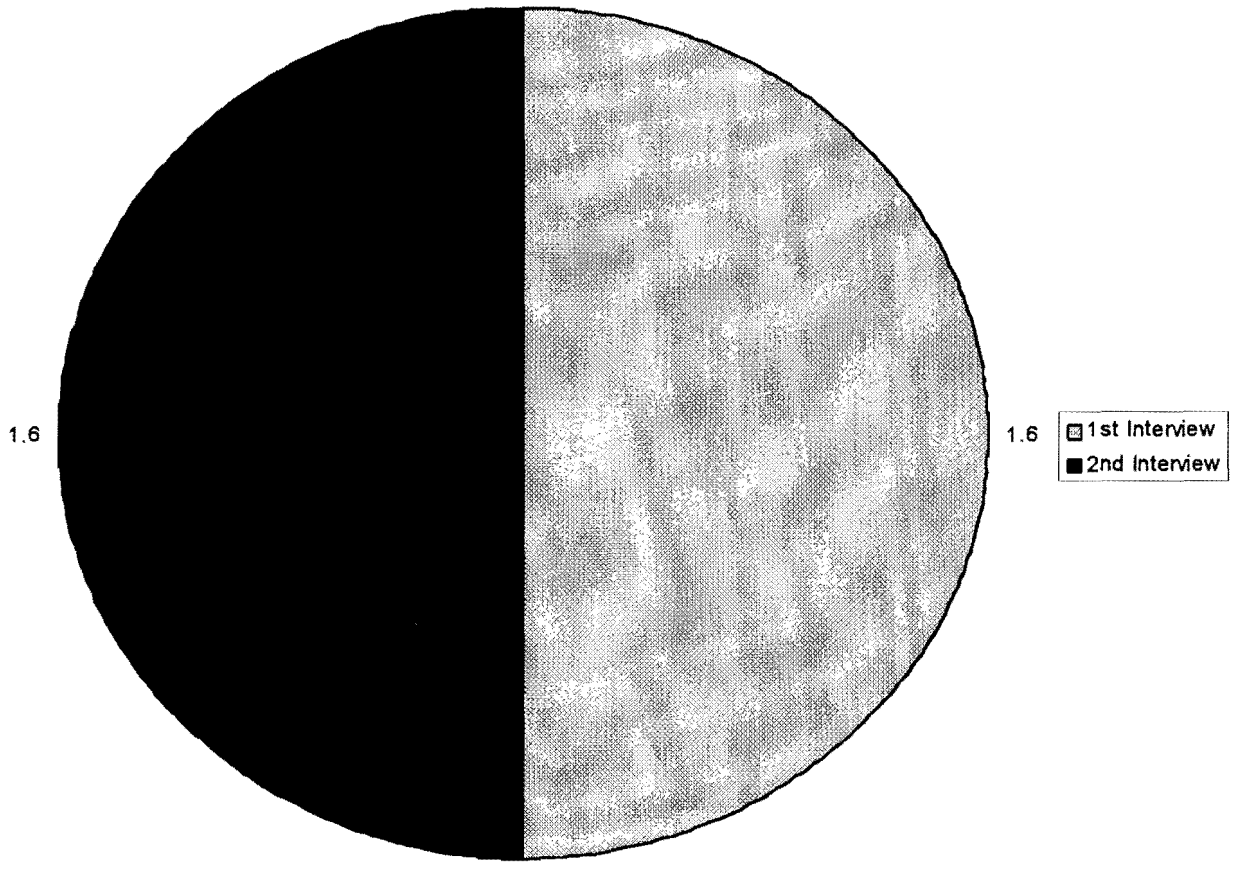

Figure 14: Burden of the family, as seen by the key relative

Figures 13 and 14 show a comparison between how the patient's burden towards his family is viewed by the patient himself and by the key relative.

According to the patient's view (Figure 13), the patient's behaviour was sometimes problematic and caused some burden to his family. During the second interviews, the burden was reduced and the patient-family relationship improved.

According to the key relative's view (Figure 14), the burden on the family caused by the patient was not so severe and it remained constant in both the first and the second interviews.

When comparing Figures 13 and 14, it is evident that the patient-family relationship improves as the patient's condition improves. However, even when the patient's condition did improve, the family still had to deal with specific problems. In Figures 10 and 14 this finding is confirmed by the mean that remained the same for both interviews, namely 2.4 and 1.6 respectively. The need for family intervention programmes, is emphasised by this finding.

6.2.5 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - FAMILY ORGANISATION

Table 23 indicates the most significant caregiver according to the patient and the key relative.

Table 23: The most significant caregiver according to the patient and the key relative

1st interviews		
Significant caregiver	**Patients**	**Relatives**
Mother	4	4
Son	1	1
Total	**5**	**5**

The main significant caregiver was found to be the mother and, in one case, a patient's son. Four patients and four key relatives said that the most significant caregiver was the patient's mother. This view is in agreement with Kuipers (1993:207) who said that caregivers were mostly women. It illustrates the fact that mothers tend to be tolerant,

loving, and able to cope whilst being employed, acting as housekeepers and continuing to be supportive of the patient.

- Communication style between the patient and the family, as seen by the patient and the key relative

Table 24 indicates the communication style between the patient and the family members, as seen by the patient and the key relative.

Key for Table 24:
1 = Not at all
2 = Very rarely
3 = Sometimes
4 = Most of the time
5 = Always

Table 24: Communication style between the patient and the family, as seen by the patient and the key relative

Communication style	1st Interviews										2nd Interviews									
	Patients					Key relatives					Patients					Key relatives				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Family members cut patient short					5					5					5					4
Family members allow patient to talk	5					5					5					4			1	
Family members gossip about the patient negatively					5			1		4					5			1		4
Family members talk nicely to patient				2	3				2	3	5					4			1	
Total	**5**	**0**	**0**	**2**	**13**	**5**	**0**	**1**	**2**	**12**	**10**	**0**	**0**	**0**	**10**	**8**	**0**	**1**	**2**	**8**

Five patients and five key relatives during the first interviews; and five patients and four key relatives during the second interviews explained that family members cut the patient short when talking, except key relatives who always talk nicely and listen to patients. Positive communication between the patient and family members occurs only when the patient's condition improves. Kavanagh (1992:256) and Giron and Gomez-Beneyto (1995:365) state that patients suffering from schizophrenia are often cut short while still talking.

All the patients and four key relatives in both the interviews stated that key relatives do not gossip about the patient. This view was in contrast to Kavanagh (1992:256) and Giron and Gomez-Beneyto (1995:365) who state that the family always gossips about the patient.

Three patients and three key relatives during the first interviews; and five patients and four key relatives during the second interviews stated that caregivers always talk nicely to the patient. However, Cole and Reiss (1993:744), Kavanagh (1992:256) and Giron and Gomez-Beneyto (1995:365) have experienced that family members do not talk nicely towards patients suffering from schizophrenia.

In the context of this study, it is clear that the type of relationship between the patient and his family and key relatives respectively, will determine the nature of the communication between them.

- Communication style between the patient and family members

Figure 15 indicates the means in the communication style occurring between the patient and family members

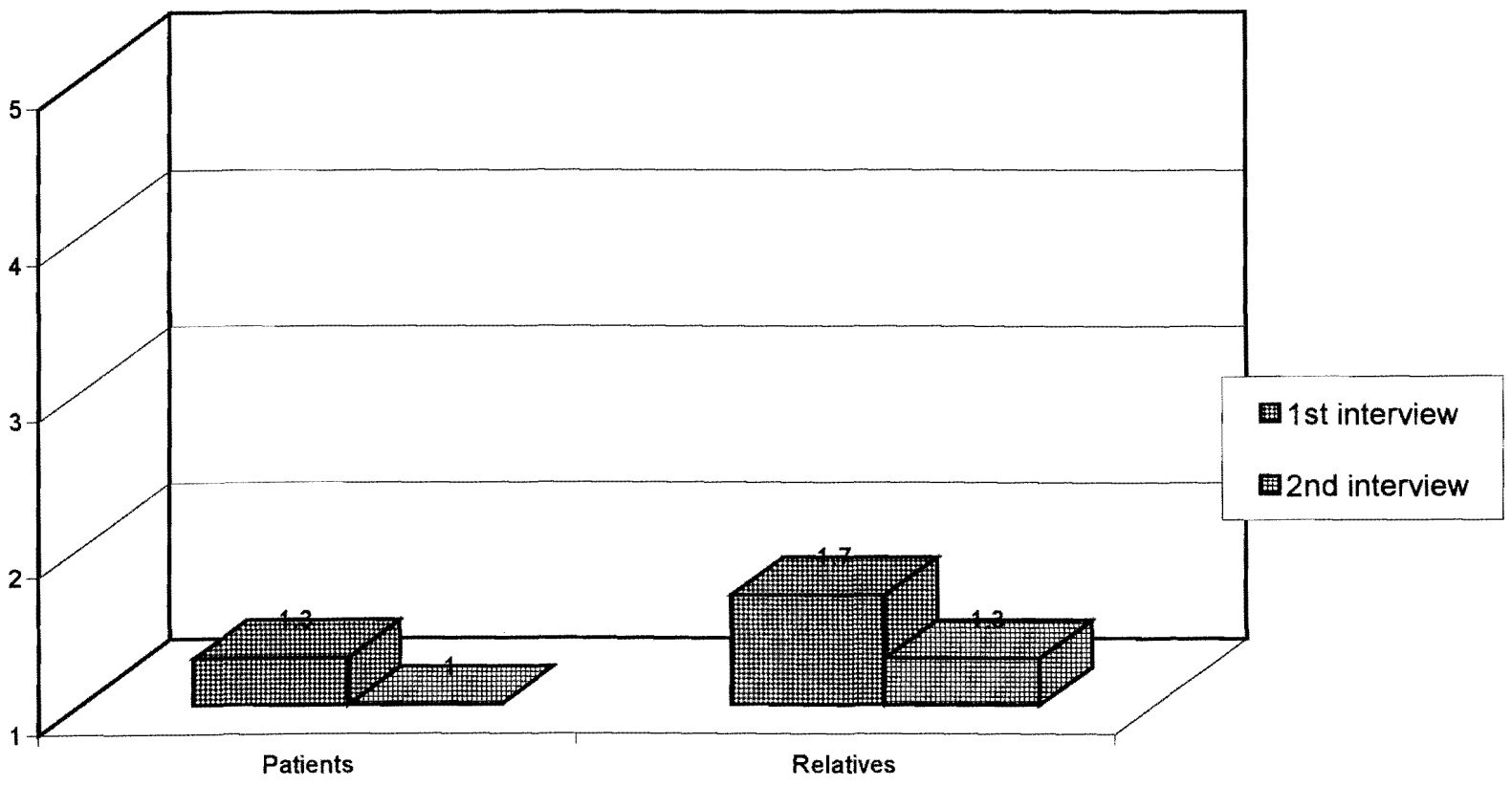

Figure 15: Communication style between the patient and family members

The patients' mean during the first interviews was 1.3 and 1 during the second interviews. Thus, there was an improvement in communication between the patient and family members because the patient's condition had improved.

- Comparison of communication style between the patient and his family, as seen by both the patient and the key relative

Figures 16 and 17 indicate the type of communication style that exists between the patient and the key relative from the perspective of both the patient and the key relative.

Key for Figures 16 and 17: 1 = negative response
5 = positive response

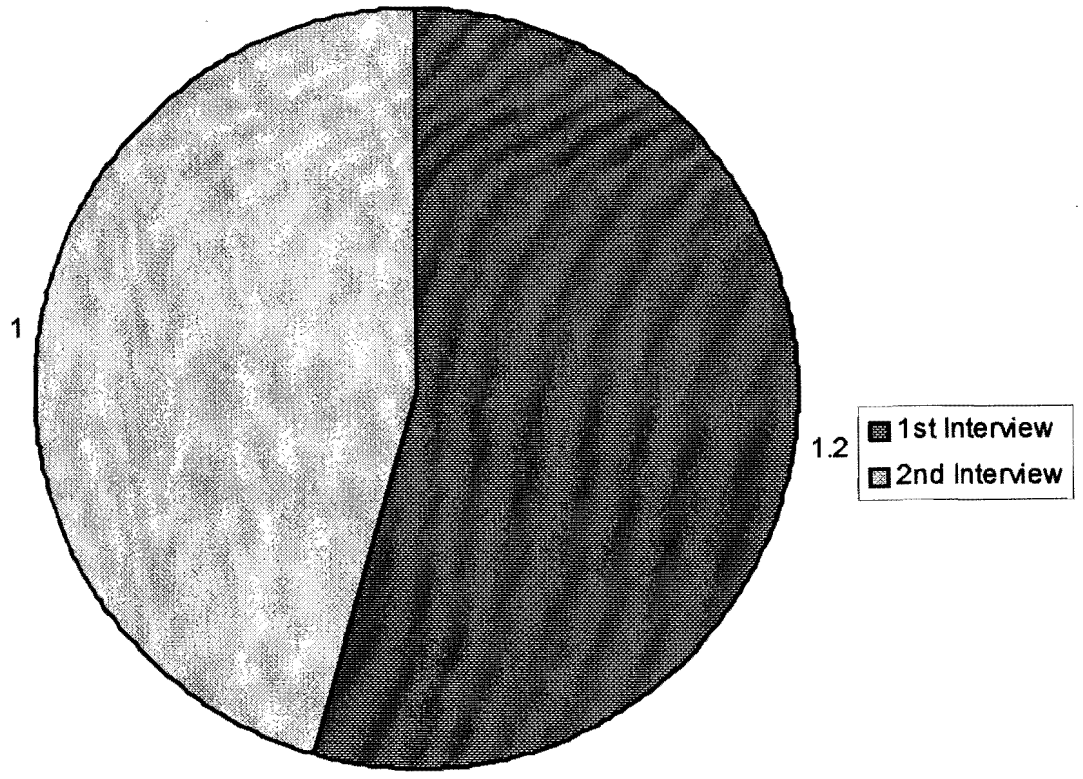

Figure 16: Communication between the patient and the family, as seen by the patient

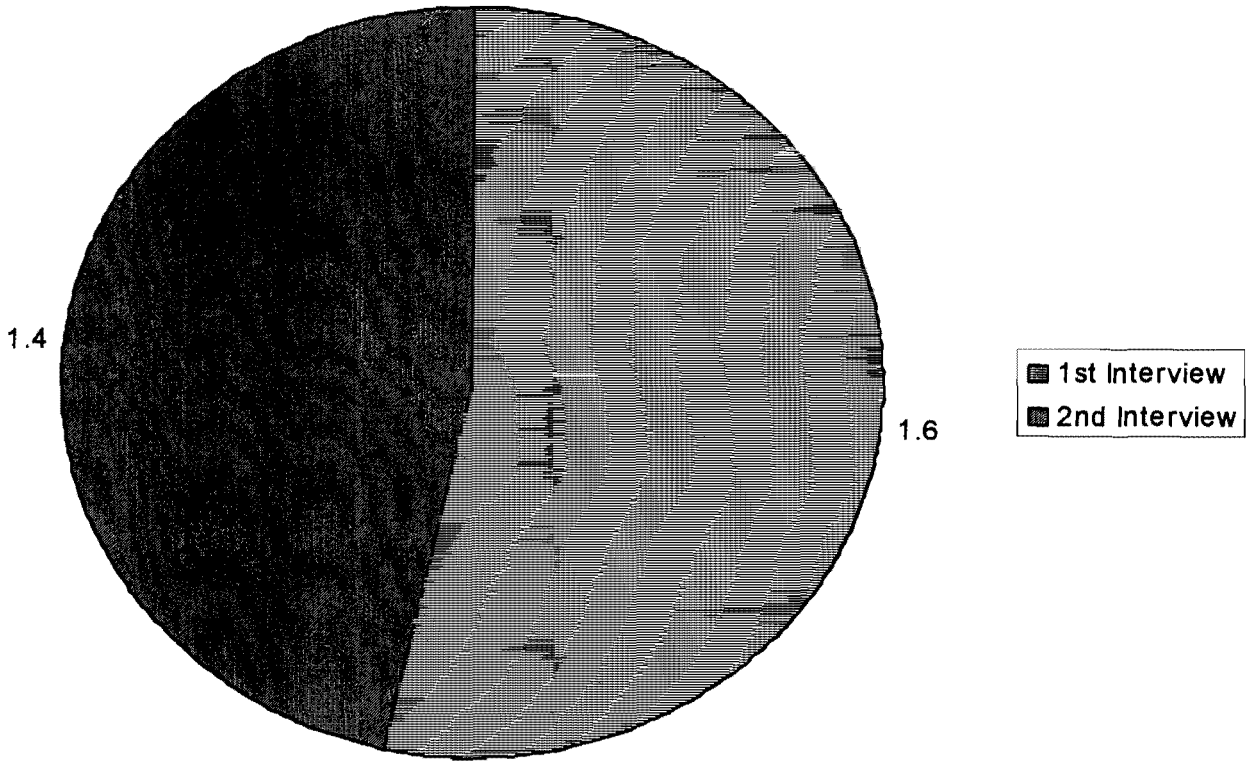

Figure 17: Communication between the patient and the family, as seen by the key relative

According to the patient's view, as illustrated in Figure 16, communication improved between the patient and his family during the second interviews. Patients perceived their communication with their families as both negative and positive from time to time.

According to the key relative's view, as illustrated in Figure 17, the communication style between the patient and the family also improved during the second interviews, with a mean of 1.6 in the first interview as compared to a mean of 1.4 in the second interviews. In this relationship, too, there were both negative and positive elements.

It can be argued that all human relationships have elements of both negative and positive communication styles. However, if it is directly related to schizophrenia as in the case of the respondents, it confirms that the family can benefit from intervention programmes which will help them to cope with the situation.

- Causes of relapse as understood by the patient and the key relative

Table 25 indicates the causes of relapse as understood by the patient and the key relative.

Table 25: Causes of relapse

Relapse causes	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
	Yes	Yes	Yes	Yes
When relatives criticise patient	1		1	1
When relatives do not support patient's ideas			4	
When relatives shout at patient				2
Disapproval of relatives		1	1	
Rejection by relatives	1		1	1
When too much is expected from patient	1	1	2	2
Unemployment	2		1	1
Financial problems	1	1	1	
Defaulting on treatment	3	1	2	2
Loneliness	1		1	1
Boredom		1	1	1
Disappointment			1	1
Stress			1	
Homelessness				1
Total	**10**	**5**	**17**	**13**

Table 25 indicates the main cause of relapse according to patients and key relatives was defaulting on treatment, which is in agreement with Kleefler and Koritar's (1994:376) view. Defaulting on treatment has to do with lack of insight into schizophrenia by both the patient and his family members including the key relative. Family intervention programmes and social work guidelines are necessary to help both patients and families to gain knowledge and develop skills for coping with schizophrenia.

Criticism by relatives, rejection of patients, unemployment, financial problems, boredom, disapproval and disappointment were found to be the minor causes of relapse. The findings coincided with those of Conley and Baker (1990:898), Cole and Reiss (1993:144), Goldstein (1985:9), Kuipers (1993:209), Marsh (1992:2) and Atkinson and Coia (1995:32) who all stated that criticism, rejection, unemployment, financial problems and boredom cause relapse.

- Place where the patient prefers to live

Patients' preferred place of residence is indicated in Table 26.

Table 26: Patients' preferred place of residence

Preferred place	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
Mental hospital		1		1
Home with family	4	4	4	3
Own house	1		1	1
Total	**5**	**5**	**5**	**5**

Four patients and four key relatives during the first interviews; and four patients and three key relatives during the second interviews wished that patients could live with their families at home. This view was in contrast to Kleefer and Koritar (1994:373) and Tarrier and Barrowclough (1990:430), who say that families prefer hospital-based care. This view can be attributed to the current tendency of community-based care in society. However, the relationship between a family and a patient will be an important determinant, as illustrated by the respondents in this study.

One patient in the first interview and one patient and one key relative in the second interview wished that the patient could live in his own house because there was a stepfather at home who did not care for the patient. In this case the patient's biological father was divorced from the patient's mother. One key relative who is the patient's son stated that his mother should remain in hospital because there is no place for her to live at home. He explained that his mother would be visited by the family. This indicates that the patient was somehow not accepted by the family within a home setting.

6.2.6 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK – FAMILY LIFE CYCLE

- Patient's life history

The researcher included questions (see semi-structured interviewing schedules Addendums A and B) on the life cycle of the patient, including questions about birth history, developmental milestones, temperament and personality traits.

The reason for the inclusion of these questions was that the social workers at Weskoppies Hospital include these questions in the psycho-social report they have to write for individual patients.

The researcher included these questions to determine whether there is any direct relationship between schizophrenia and the patient's birth history, developmental milestones, his temperament, personality traits, habits and behaviour while he was young.

The researcher could not find any evidence from literature that certain people are more prone to becoming schizophrenic as a result of the above-mentioned aspects. This finding was confirmed by respondents. The researcher will therefore not reflect the respondents' views on sections 6.1 to 6.8 of the semi-structured schedules since they will not contribute to any conclusions with regard to the research topic.

- Patient's pleasure in sexual activities

Patient's pleasure in sexual activities is indicated in Table 27.

Table 27: Patient's pleasure in sexual activities

Sexual activities	1st Interviews				2nd Interviews			
	Patients		Key relatives		Patients		Key relatives	
	Yes	No	Yes	No	Yes	No	Yes	No
Pleasure	3	2	2		3	4	2	0
Unknown		1	2	1		1	3	0
Total	**3**	**3**	**4**	**1**	**3**	**5**	**5**	**0**

Three patients and two key relatives during the first interviews; and three patients and two key relatives during the second interviews explained that patients found their sexual relationship pleasant.

- Patient-peer group relationship

Table 28 indicates the quality of the patient-peer relationship.

Table 28: The quality of patient-peer group relationship

Patient-peer group relationship	1st Interviews				2nd Interviews			
	Patients		Key relatives		Patients		Key relatives	
	Yes	No	Yes	No	Yes	No	Yes	No
Patient valued by peer group	4	2	5		4	1	4	
Patient trusted by peer group	4		5		4		4	
Patient feared by peer group		4		5		4		4
Patient isolated by peer group	1				1			
Total	**9**	**6**	**10**	**5**	**9**	**5**	**8**	**4**

Four patients and five key relatives during the first interviews; and four patients and four key relatives during the second interviews explained that their peer group valued patients during the peer group stage.

- Patient's upbringing

Patient's upbringing is indicated in Table 29.

Table 29: Patient's upbringing

Patient's upbringing	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
	Yes	No	Yes	No
Happy parental relationship	3	2	1	2
Conflict amongst siblings	4	2	5	2
Mother died before patient reached the age of ten years				
Mother still alive	5	5	5	5
Total	**12**	**9**	**11**	**11**

Conflict amongst parents, as compared to a happy relationship, dominated during most patients' upbringing. Conflict amongst siblings was more frequent than happy sibling relationships. Thus, two patients and three key relatives during the first interviews; and four patients and three key relatives during the second interviews stated that there was conflict amongst parents during the patient's upbringing. The finding was in agreement with Tsuang (1982:48) and Gillis (1986:75) who state that conflict in the family and an unhappy childhood may lead to schizophrenia.

The mothers of all patients who were interviewed were still alive. In this study the mother of patients played an important role as key caregivers. Gillis (1986:75) indicates that schizophrenia could occur when a patient's mother dies before the patient reaches the age of ten years. In this research study, all the patients' mothers were still alive.

- Rating of patient's socio-economic-health status

Three patients and three key relatives during the first interview; and two patients and three key relatives during the second interviews stated that patients did not have their own houses, but stayed with their key relatives. Patients' financial position was bad because they were unemployed and depended solely on their key relatives' assistance. Patients' health aspects were good, except for the fact that they were mentally ill. A patient with schizophrenia can recover faster if his socio-economic-health status improves. (Compare Gillis, 1986:75.)

Figure 18: Socio-economic-health status reported by patient and key relative

The means of the socio-economic health status of the patient are illustrated in Figure 18.

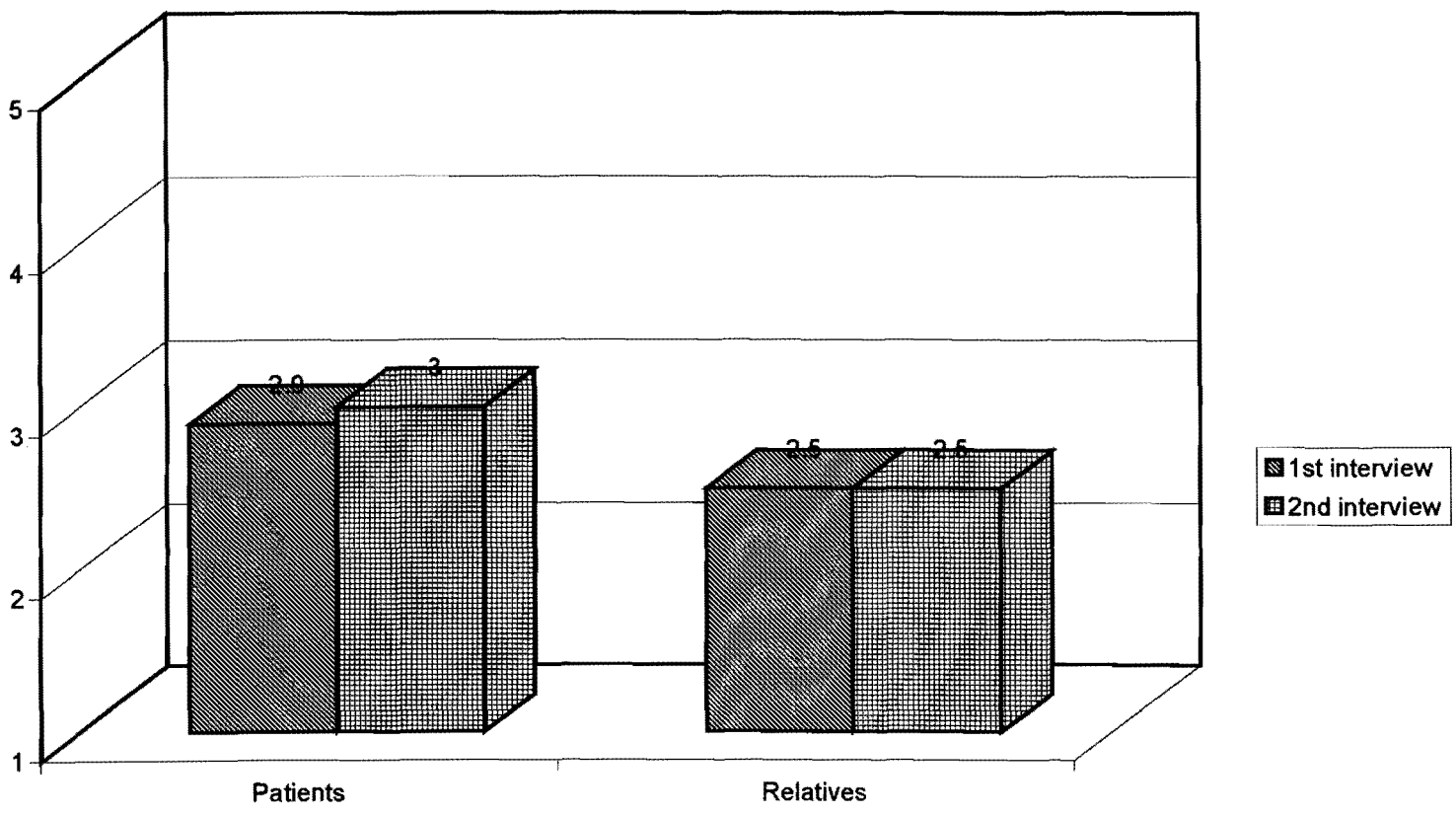

Figure 18: Socio-economic status reported by patient and key relative

Figure 18 indicates that there was no improvement between the first and the second interviews in the patient's socio-economic status. During the first interview the mean for patients was 2.9 and 3.0 during the second interview. A low socio-economic position can put stress on a patient suffering from schizophrenia, which, in turn, can impact negatively on his recovery.

- Rating of patient's socio-cultural factors affecting patient

Table 30 indicates the rating of socio-cultural factors affecting patient.

Key for Table 30:
1 = Not at all
2 = Very rarely
3 = Sometimes
4 = Most of the time
5 =Always

Table 30: Socio-cultural factors affecting patient

Socio-cultural factors affecting patient	1st Interviews										2nd Interviews									
	Patients					Key relatives					Patients					Key relatives				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Patient clashes with the law (offence)	4	1				4			1		4		1			4	1			
Patient involvement in church activities	1		1	1	2	4		1					3		2	1	1	2	1	
Patient involvement in ancestral beliefs	3		1		1	4	1				3		1		1	4	1			
Patient believes in witchcraft	4	1				4			1		3	1			1	4	1			
Total	**12**	**2**	**2**	**1**	**3**	**16**	**1**	**1**	**2**	**0**	**10**	**1**	**5**	**0**	**4**	**13**	**4**	**2**	**1**	**0**

Four patients and four key relatives during the first interviews; and four patients and four key relatives during the second interviews stated that patients had not committed a crime. Only one respondent, a diagnosed disorganised patient, had broken a car window. When it was discovered that he was mentally ill, he was brought to Weskoppies Hospital. Patients' involvement in church activities was very rare.

African patients involved themselves in ancestral and witchcraft beliefs whilst none of the white patients believed in ancestors or witchcraft. Mojalefa (1994:91) reports in her thesis that blacks perceive mental illness mostly in terms of witchcraft and of ancestral beliefs. This impacts directly on their insight into schizophrenia as mental illness and their recovery process since they neglect to take their medicine because of these beliefs.

- Patient's employment history

Table 31 indicates patient's employment history.

Table 31: Patient's employment history

Employment history	1st Interviews				2nd Interviews			
	Patients		Key relatives		Patients		Key relatives	
	Yes	No	Yes	No	Yes	No	Yes	No
Patient presently employed		5		5		5		5
Patient previously employed	4	1	4	1	4	1	4	1
Reasons for leaving the job: Dismissal		3	1	2		4		5
Resignation	2	3	1	2	1	3	2	3
Retrenchment		3		2	1	3		5
Mental illness	1		2		2		2	
Total	**7**	**15**	**8**	**12**	**8**	**16**	**8**	**19**

All patients were unemployed. Four patients had previously been employed. One diagnosed catatonic patient left his job because of his mental illness. The diagnosed residual patient left his job because of head injuries, which led to the mental illness. The diagnosed paranoid patient resigned because of his mental illness. The undifferentiated patient was retrenched.

6.2.7 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - INTERVENTION PROGRAMMES FOR SCHIZOPHRENIA

- Families' insight into schizophrenia

Table 32 indicates families' insight into schizophrenia.

Table 32: Families' insight into schizophrenia

Families' insight into Schizophrenia	1st Interviews		2nd Interviews	
	Patients	**Key relatives**	**Patients**	**Key relatives**
Minimum insight	4	4	3	4
Do not understand it	1	1		1
Relatives do not believe that patients are mentally ill			1	
Relatives do not have interest in patient			1	
Total	**5**	**5**	**5**	**5**

Four patients and four key relatives during the first interview; and three patients and four key relatives during the second interviews said that families have very little insight into schizophrenia. One patient in the first interview and one key relative in the second interviews said that families did not understand what schizophrenia entails as mental illness. One patient, during the second interviews, said her relatives did not want to believe her when she said she was suffering from schizophrenia because they seemed not to understand what schizophrenia was. One patient during the second interviews said that relatives did not show any interest in him as a patient suffering from schizophrenia.

The above-mentioned findings indicate that families do not yet understand what suffering from schizophrenia implies. The finding is in agreement with Falloon, *et al.* (1993:15) and Kuipers, *et al.* (1992:610) who state that families need to be educated about schizophrenia.

- Manner in which families can gain knowledge

Table 33 indicates the manner in which families can gain knowledge about schizophrenia.

Table 33: Manner in which families gain knowledge about schizophrenia

Educational topics	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
Families sharing ideas	4	4	5	5
Problems encountered by patients	4	3	5	5
Medical treatment	5	2	5	4
Availability of resources	3	5	4	5
Educational group sessions for patients	5	4	4	5
Problems encountered by families	4	5	4	4
Literature (books) for patients	4	3	5	4
Literature (books) for families	4	4	5	5
Psychiatrist to educate families		1	1	1
Total	**33**	**31**	**38**	**38**

Separate education topics for patients and for their families include the following: how to cope with the consequences and impact of schizophrenia; problems encountered by patients; the importance of medical treatment and the importance of using available resources, such as clinics, hospitals and police stations.

Table 33 indicates that patients and their families wish to gain knowledge about schizophrenia. The finding was in agreement with Kleefler and Koritar's (1994:376) view that separate educational group sessions for family and patients need to be conducted. Patients and key relatives agreed that booklets on schizophrenia should also be issued. Atkinson and Coia (1995:117) and Barrowclough, *et al.* (1987:2) confirm the importance of learning more about schizophrenia.

This finding confirms that patients and their families need knowledge and insight into schizophrenia as a type of mental illness.

- Educational group sessions

Table 34 proposes who should attend educational group sessions.

Table 34: Who should attend educational group sessions

Educational group sessions for:	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
Families and patients	4		3	1
Families only		4	3	4
Patients only	1	4	2	4
Those involved in major caregiving roles	3	4	4	5
Close friends	1		2	2
Other relatives not living with patients			3	3
Total	**9**	**12**	**17**	**19**

During the first interviews, four patients and no key relatives, and three patients and one key relative during the second interviews stated that families and patients should attend educational group sessions to learn more about schizophrenia. The finding from patients was in agreement with Atkinson and Coia's (1995:117) view in this regard.

One patient and four key relatives during the first interviews; and two patients and four key relatives during the second interviews explained that patients only should attend the educational group sessions. Barrowclough (1987:2) supports this finding and states that patients should attend group discussions separately from families.

During the first interviews, three patients and four key relatives, and four patients and five key relatives during the second interviews mentioned that only the most significant caregivers involved in the major caregiving roles should attend the educational group sessions because they were the ones always in contact with patients. The finding is in agreement with Falloon, *et al.* (1993:18) who state that the caregivers who are involved in the major caregiving roles should attend educational group sessions.

From the research findings, it appears that both the patient and the patient's family will benefit from educational group sessions.

- Needs of a discharged patient suffering from schizophrenia

Table 35 indicates the needs of a discharged patient.

Table 35: The needs of a discharged patient suffering from schizophrenia

Discharged patient's needs	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
	Yes	Yes	Yes	Yes
Family support	3	4	3	4
Counselling	3	3	2	4
Employment	3	3	2	3
Regular medication	4	5	5	4
After care services	2	2	1	2
To be listened to				1
Disability grant			1	
Total	**15**	**17**	**14**	**18**

Table 35 indicates that a discharged patient suffering from schizophrenia needs family support, love, care and a sense of being valued. This finding is in agreement with Backlar (1994:135) who states that a discharged patient needs to be supported socially, morally and financially by family.

The discharged patient also needs counselling to understand his illness and to accept himself as a human being. The finding was in agreement with Weleminsky (1991:123) and Kleefler and Koritar's (1994:373) views that a discharged patient needed counselling. However, such patients also needed employment, regular medication and after care services.

In summary, family support, counselling, employment, regular medication and after care services were mentioned by respondents as major needs for discharged patients suffering from schizophrenia.

- Relatives' care of the patient

Table 36 indicates the relatives' care of the patient.

Table 36: Relatives' care of the patient

Relatives' care of patient	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
	Yes	Yes	Yes	Yes
Caregiver cares	4	5	5	5
Relative not interested		2		1
Support	1		1	1
Co-operative with patient		1		
Total	**5**	**8**	**6**	**7**

The above table indicates that only the key relatives who are the caregivers were able to take care of patients suffering from schizophrenia. The explanation given was that caregivers tried their best to take care of the patients. They had compassion, were caring, provided support and gradually developed insight into schizophrenia.

It was mentioned that the caregiver needed support, either from other relatives (family members) or from the patient himself to be able to take care of him. A concern was raised by a key relative that she felt hurt by and disappointed in the patient's father, who had divorced her and abandoned the family without maintaining the patient, despite the fact that the father was a medical doctor.

- Type of assistance that families receive from mental health professionals

Table 37 indicates the type of assistance that families receive from mental health professionals.

Table 37: Type of assistance that families receive from mental health professionals

Assistance	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
	Yes	Yes	Yes	Yes
Getting help	5	3	4	5
Satisfied about provided services provided	5	3	4	4
Families see mental health professionals as willing to help them	4	1	4	1
There is collaboration between families and mental health professionals	3	2	4	4
Total	**17**	**9**	**16**	**14**

Five patients and three key relatives during the first interviews; and four patients and five key relatives during the second interviews said that families received assistance from mental health professionals in the form of the psychiatric team.

During the first interviews, five patients and three key relatives, and four patients and four key relatives during the second interviews stated that families were satisfied with services rendered by the psychiatric team. Atkinson and Coia (1995:42), however, indicate that families are not always satisfied with services they receive.

Four patients during the first and the second interviews respectively explained that families regarded mental health professionals as willing to help them. This was in contrast with Atkinson and Coia (1995:42) and Conley and Baker (1990:893) who argue that some patients' families may never be satisfied with services provided, no matter how good they are. This can be attributed to various reasons, one of which is that families find it difficult to come to terms with the fact that a family member is suffering from schizophrenia.

Three patients and two key relatives during the first interviews; and four patients and four key relatives during the second interviews said that there was collaboration between families and mental health professionals. Grunebaum and Friedman (1988:1183-1187) and Berham (1990:1333-1355) support this finding.

The key family respondents indicated collaboration between families and mental health professions and seem to be satisfied with the services they received.

- Other needs concerning the research topic that patients and key relatives wanted to share with the researcher

Table 38 illustrates other needs concerning the research topic that patients and key relatives wanted to share with the researcher.

Table 38: Other needs shared by patients and key relatives

Needs	1st Interviews		2nd Interviews	
	Patients	Key relatives	Patients	Key relatives
	Yes	Yes	Yes	Yes
Medication with fewer side effects		1		
Patient does not agree with diagnosis	1			
Relatives cannot cope with patient's relapse or unstable condition		1		
Patient must be hospitalised	1			
Patient is worried about his unacceptable behaviour	1			
Caregiver prefers traditional treatment		1		
Patient feels improvement	1			
Caregiver suggests that psychiatric team may involve other disciplines, such as dentist		1		
Patient believes that his family is not concerned about his mental illness			1	
Patient says he loves his family and the family loves him too			1	
Caregiver is worried about patient's future			1	
Caregiver appreciates this research				1
Schizophrenic patient must not take dagga			2	
Total	**4**	**4**	**5**	**1**

Table 38 reflects other needs that the respondents wanted to share with the researcher. Most of these other needs were mentioned during the first interviews by both patients and relatives. Regarding medication with fewer side effects, one relative expressed a view that a new medicine be introduced that would not have side effects such as shivering of the body when taken for a long period. It was interesting to listen to the patient who did not agree with his diagnosis as paranoid. In his view he was a schizo

affective. One key relative/mother explained that she thought of taking her daughter (the patient) for traditional treatment because she suspected witchcraft. As already indicated Mojalefa (1994:91) has found that mental illness was perceived by black communities in terms of witchcraft.

A key relative also explained how difficult it was to cope with a patient suffering from schizophrenia, especially during a relapse period. Another caregiver wished that other disciplines such as a dentist be involved in the treatment because his mother/patient had dirty teeth, which were not attended to. One key relative said that she appreciated this kind of a research study, since it would help the families. During the second interviews, two patients explained that patients suffering from schizophrenia should not take dagga because it could cause a relapse.

From the above-mentioned discussion, it is clearly difficult for families to cope with a member suffering from schizophrenia. Families need to be guided to cope with patients being discharged from hospitals who are then placed in home-based or community-based care.

6.3 SUMMARY OF THE RESEARCH FINDINGS/RESULTS

This chapter discussed the findings and results concerning the investigation on the impact of schizophrenia on family functioning. Dimensional sampling was used in this study, which indicated trends with reference to the impact of schizophrenia on family functioning. Although the small sample did not make provision for generalisation, the findings did provide direction towards guidelines for dealing with the impact of schizophrenia on family functioning.

The caregivers, who were found mostly to be the patients' mothers, had no choice but to love, accept and support the patients who were suffering from schizophrenia. Caregivers, however, experienced stress because they were the only people looking after the patients for most of the day. They did not have all the skills, but did take care of the patients. Patients' other relatives and community members avoided them and lost interest in them because of their unacceptable behaviour. By the second interviews the patients' condition had improved as a result of the treatment. The patients were no

longer aggressive or as violent as they had been at the time of the first interviews. By the second interviews the patients were gradually being accepted by other relatives and by the community as a result of their improved condition.

When the patient is still hospitalised caregivers can continue to be employed and enjoy leisure time. Caregivers indicated that it was not always easy to supervise or to take care of the patient after he had been discharged. They had to arrange for leave from work in order to look after the patient properly, and to take him to the clinic to get his medication. On the other hand, since the patient wished to be at home, it was necessary for his family to learn coping skills to deal with the impact of schizophrenia.

The findings confirmed that family intervention programmes are necessary to develop insight into schizophrenia as a mental illness.

In Chapter 7 the conclusions and recommendations will be discussed. Social work guidelines for use by social workers will be proposed to guide families to deal with the impact of schizophrenia on family functioning.

CHAPTER SEVEN
CONCLUSIONS, RECOMMENDATIONS AND SOCIAL WORK GUIDELINES

7.1 INTRODUCTION

Based on the objectives and hypothesis of the study, conclusions were made regarding the impact of schizophrenia on the relationships, attitudes, interaction and functioning of the family. It will be indicated in this chapter how the four objectives of this study were achieved. In addition, it will be argued whether the hypothesis as presented in Chapter One, with its derivatives (sub-hypotheses) was confirmed by these results.

With reference to objective four, specific guidelines for social workers to intervene with patients to deal with the negative impact of schizophrenia on family functioning will be discussed. Finally, recommendations will be made based on the results of this study.

7.2 OBJECTIVES OF THE STUDY

The objectives of the study were as follows:

7.2.1 OBJECTIVE 1

To select and study relevant literature to explore the phenomenon schizophrenia and family functioning from a social work perspective.

A comprehensive literature study was done to explore and investigate the phenomenon schizophrenia and family functioning from a social work point of view. Most of the literature used was from health disciplines such as psychiatry and nursing. This objective was achieved since an in depth study was done to describe the phenomenon schizophrenia and the impact thereof on family functioning.

7.2.2 OBJECTIVE 2

The second objective of the study was to investigate the causes of the negative impact of schizophrenia on the relationships, attitudes, interaction and functioning of the family. The researcher determined through both the literature study and empirical research that a lack of insight into schizophrenia as a type of mental illness contributed to the illness having a negative impact on the patient as well as his family and the family's functioning.

Table 8 (page 166) indicated that patients were admitted more than once to mental hospitals because they were not taking medication regularly or had even stopped taking their medication. One of the reasons for this behaviour was that patients and their families did not have insight into schizophrenia as a type of mental illness, in particular with regard to the role of medicine in the recovery process of the illness.

In addition, the African respondents indicated a further lack of insight impacting on the patient and his family, namely that they did not know what the type of schizophrenia that the patient had been diagnosed with entailed.

Table 11 (page 168) and Table 30 (page 221) explain that the African respondents related mental illness to cultural behaviour such as witchcraft and ancestral worship, which contributes to a further lack of insight into schizophrenia as a type of mental illness. These beliefs can result in the patient suffering a relapse because he relies on traditional treatment, which in turn contributes to the negative impact on the functioning of the patient's family. The lack of insight was further confirmed by respondents indicating in Table 32 (page 223) that they did not understand what schizophrenia as a type of mental illness entailed and that they wished to be involved in family intervention programmes. (Confer Table 34 page 225.)

The strained relationships between the patient and his relatives/family members (confer Table 14 page 173) and the fact that the patient was not accepted by his family members, can also be attributed to a lack of insight into schizophrenia. The caregivers also experienced stress from lack of support from the patient's relatives during the caring process. They also indicated that they did not always have the coping skills to

deal with the patient and the impact of schizophrenia. This resulted in caregivers who sometimes became impatient and wished the patient to be hospitalised, in particular when the patient was not co-operative.

Family members felt angry with the patient and blamed him (confer Table 20 page 187) and in return the patient blamed his family members for not taking an interest in him and for distancing themselves from him. (Confer Table 21 page 190.) In Table 19 (page 179) it is indicated that the lack of insight into schizophrenia as a type of mental illness not only impacts on the family, but also on the friends of the patients. Patient-friend relationships deteriorated because the patient's friends avoided him. However, when the patient's condition improved, the friendships seemed to improve as well.

In conclusion, objective two was achieved since the negative impact of schizophrenia on family functioning and other systems, such as friendships, were determined. It was also confirmed that this negative impact on family and other relationships could be attributed to a lack of insight into schizophrenia as a type of mental illness.

7.2.2 OBJECTIVE 3

The third objective of the study was to investigate relevant family intervention programmes to bring more knowledge and insight to patients suffering from schizophrenia and their families.

From a literature perspective, the following family intervention programmes were found to be relevant: Psycho-educational programmes where the family and patients respectively are engaged in educational group sessions. The group sessions can be for patient's relatives, including their caregivers, extended families and their friends.

Themes for discussion in educational sessions could include the following:

- Participants' understanding of schizophrenia as a type of mental illness
- The symptoms of schizophrenia

- The reasons schizophrenia occurs
- Schizophrenia treatment
- Problems experienced when living with a patient suffering from schizophrenia
- How to cope with a patient suffering from schizophrenia.

In the case of patients, similar themes can be discussed in educational group sessions. Literature (books/brochures) for patients and their families can also play an important role in education, provided the patients and their families are literate.

Psycho-educational programmes may be applied both when the patient is still hospitalised as well as when the patient is being discharged. A discharged patient needs family support, counselling, employment and after care services.

Objective three was achieved by studying literature on possible interventions for both patients and their families. The empirical findings of this study confirmed the relevance of these interventions, for example educational group discussions.

7.2.4 OBJECTIVE 4

The fourth objective for the study was to develop social work guidelines for use by social workers in guiding the patient's family in coping with the impact of schizophrenia, in particular in a home and community based context.

The proposed guidelines are a result of the integration of the literature study, findings from the quantitative study and findings from the focus group of social workers at Weskoppies Hospital. Of the eleven social workers who were engaged in the focus group, one was an assistant director with seventeen years of experience of working in the field of mental illness; eight were chief social workers with different periods of experience, ranging from fifteen years to eleven years of working in the field of mental illness; whilst two were social workers, one with four years' experience and the other one with of less than a year's experience of working in the field of mental illness. The

seniority of these social workers is an indication of their years of experience in the field of mental illness, in particular.

7.3 SOCIAL WORK GUIDELINES FOR INTERVENTION WITH THE PATIENT SUFFERING FROM SCHIZOPHRENIA AND HIS FAMILY

The questions for the focus group based on an integration of literature and the quantitative research findings included the following:

1. How can the patient and his family become more informed about schizophrenia as a type of mental illness?

2. How can the family of the patient become involved in the patient's treatment?

3. What should be the focus of social work interventions to treat schizophrenia patients in a holistic (family and community) context?

The researcher had a co-interviewer, a senior social worker from North Gauteng Mental Health, with thirteen years' experience of working with mental illness. Data was captured by audio-cassette and the researcher and the co-interviewer wrote up the findings according to specific themes.

The guidelines will be outlined under four categories, namely understanding of schizophrenia, treatment, caregivers and social work interventions.

- Understanding of schizophrenia

In order for the patient and his family to understand schizophrenia as a type of mental illness, the social worker must provide them with information on schizophrenia. The social worker is regarded as an important source of information for both patient and family on the doctor's diagnosis of the specific type of mental illness.

The social worker should start where the patient and the patient's family are respectively in terms of their understanding of schizophrenia as a type of mental illness and should not assume either what they know or do not know. Patients and families, on

the other hand, should indicate their knowledge and skill limitations with regard to the illness and how to deal with it.

The social worker therefore informs and educates the patient and family about the diagnosis. This information should be repeated to the patient and the family several times, until they fully comprehend the impact of the illness and how they should deal with it.

It is the duty of the social worker to ask the patient and the family whether the psychiatrist has informed them about the patient's diagnosis and to follow up on this if they need further explanation.

Depending on the patient's condition of stability, the social worker must take responsibility for engaging the patient and his family as part of the multi-disciplinary team. This implies that the family must understand the importance of attending case conferences or ward rounds. By attending, they can share their experiences, fears and questions with the team and contribute to proposals as to how the family and patient can continue building their relationship after discharge.

The social worker can organise patient and family support groups. The aim of the support groups is to provide participants with a forum to share their experiences and to help one another develop coping skills. Topics for group sessions can include aspects such as:

- Understanding schizophrenia
- Symptoms of schizophrenia
- Medication and coping skills.

The group sessions will promote not only understanding, but also insight into schizophrenia as a type of mental illness.

The social worker must make the patient's family aware of the fact that the patient should gradually reassume his responsibilities and duties as the recovery process progresses.

- Treatment

It is essential that the social worker understands the importance for the mentally ill patient of regular intake of medication. Whilst the psychiatrist prescribes the medication, it is usually the task of the social worker to explain the important role of medicine in the recovery of the patient. There is a direct relation between the use of medication and the patient- family relationship and the integration of the patient into the community. The social worker must explain to both the patient and his family what a relapse entails. For example, medication taken irregularly may cause relapse. According to the focus group conducted with Weskoppies social workers, statistics indicate that 75-80% of the patients suffer a relapse because they do not take their medication, while 15-20% of patients suffering from schizophrenia relapse because they are not accepted by their families and by the community. If medication is not taken at all or not taken regularly, the patient will relapse.

The social worker must make the patient and his family aware that they are the primary source (persons) responsible for ensuring that medication is taken regularly, hence both the patient and his family need to comply with medication. It is also the task of the social worker to make the patient and his family aware of the side effects of the medication and to prepare them for these. The social worker should brief the patient's family on their involvement in controlling the regular intake of medication. Over-involvement of the family may also cause a relapse because the patient may depend solely on the family. The families over-involvement will, however, only be necessary if the patient's condition is still unstable. Knowledge and understanding of the role and impact of medication is important since it has a direct correlation with the behaviour of the patient and thus impacts on the overall functioning of the family.

It is the duty of the social worker to form networks with clinics and hospitals and to be involved in patient support groups as well as family support groups. Networks and support groups play an important role in educating the patient and his family on various issues related to schizophrenia as mental illness.

From a strength perspective, the social worker should recognise the existing coping skills of the family since they have managed to cope with the patient for many years. In

other words, the social worker should emphasise the ability inherent in the family to deal with patients suffering from schizophrenia. The social worker should also play a role in engaging the family as an important member of the multi-disciplinary team.

- Caregivers

If the patient's caregiver is depressed and fails to cope with the patient the social worker should encourage him to join support groups to share his experiences and problems with other caregivers and to find out how they cope with schizophrenia.

The social worker must facilitate the empowerment of the patient's family to start accepting him as a person suffering from schizophrenia since it will promote acceptance of the patient by the community. The patient and his family need to be supported by the community. The social worker can engage in community work projects, which break down the stigma of mental illness and promote knowledge and skills as to how to deal with the mentally ill patient. Just as the patient needs to be integrated within the family, so the family needs to be integrated within the community. The social worker can liaise with other welfare organisations to add a prevention focus to their work, that is to promote mental health while working with children and families, for instance.

- Social work interventions

The social worker can act as mediator and can guide or encourage patients to involve themselves in community work projects or programmes which can generate income. Involvement of patients in such community projects will also keep them occupied, avoiding idleness and boredom and encouraging them to regard themselves as people of value. In addition, this will prevent the patient from relapsing. The social worker should thus link the patient with available resources which implies that the social worker needs to know and identify these resources and how and where to access them.

The social worker should engage employers and encourage them to employ the discharged psychiatric patients under the social worker's guidance and supervision. The Employment Equity Act No. 66 of 1995, section 6 (1), states that all persons should be employed irrespective of race, gender, sex, ethnic or social origin, sexual orientation,

age, disability or religion. The focus group felt that disabled persons could also include a psychiatric patient. Alternatively, if the patient cannot be employed for the whole day, he could be employed for certain hours. For instance, in Canada the policy is that a psychiatric patient will work for specific hours of the day and will then be replaced by another psychiatric patient, meaning that perhaps three patients may share a job in a single day.

It is the duty of the social worker to strive to alleviate poverty, especially in rural areas, by initiating relevant poverty alleviation programmes for psychiatric patients. Day care facilities may be relevant for psychiatric patients and could serve as a place where patients can meet during the day and engage in various activities which will help them to generate income and at the same time monitor their health and medicine intake to prevent relapse.

The social worker has the responsibility of finding a suitable place within the community for the discharged patients to live. It is therefore emphasised again that the social worker should be aware of the resources in the community in order to keep the discharged psychiatric patients within the community. For instance, YANA (You Are Not Alone) is a home for discharged patients suffering from schizophrenia. However, social workers should not only find a home but should also conduct group work with those patients within a community-based placement such as YANA. Social workers should motivate patients to attend such group sessions on a regular basis. The purpose of attending group sessions is to allow patients to share their experiences and to gain more insight into schizophrenia as a type of mental illness.

In summary, the social work guidelines proposed as a result of this study cover the guidance of the patient, his family and the community in dealing with the impact of schizophrenia in such a way that the patient can be fully integrated in his family and the community.

In this section the focus of the discussion was on the achievement of the objectives of the study.

7.4 HYPOTHESIS

The researcher investigated the following hypothesis in the study:

If social work guidelines are developed and relevant family intervention programmes are emphasised to encourage more understanding and insight into schizophrenia, for both the patient suffering from schizophrenia and his family, then positive relationships, interactions and functioning will occur within the family and home- and community-based care will be encouraged.

It is evident from this study's literature survey and research findings that social workers need guidelines for their interventions with schizophrenia patients and their families.

Findings that confirmed the need for specific, focused guidelines for intervention were as follows:

1. A lack of insight into schizophrenia (ranging from the patient, caregivers, family, friends and the community)

2. A lack of support for the patients and their families

3. Relapse due to various reasons, in particular failure to take medication

4. The beliefs in traditional treatment impacting on the patient's recovery

5. The breakdown of relationships between the patient and his family, within the family, between the patient and friends and between the patient/family and the community.

The respondents confirmed their need to be guided through educational and support intervention programmes to an understanding and the ability to cope with the negative impact of schizophrenia on the patient and his family's functioning. The hypothesis has thus been confirmed by the study.

7.5 RECOMMENDATIONS

The recommendations for this study are based on an integrated perspective formed from the literature survey, the empirical research and data from the focus group:

- The social worker must have knowledge and experience of schizophrenia as a type of mental illness so that he can empower the patient and the patient's family in dealing with schizophrenia

- Social workers should attend psychiatric seminars, workshops, conferences, in-service training and meetings in the field of mental illness as part of their continuous education

- The patient's relatives as well as the patient whose condition is stable should be members of the multi-disciplinary team

- The social worker has a role to play in removing the stigma attached to schizophrenia within families and the community

- The social worker should organise and encourage support groups for both patients and their families

- The patients and their families should receive some education in the form of booklets/brochures and other materials, which explain schizophrenia as a type of mental illness. All official languages should be used when writing these booklets and materials

- Day care facilities and homes for discharged patients should be established if there is no home-based care available

- Importance of regular medication should be emphasised by social workers on a continuous basis. They should inform patients of the side effects of the medicines and the value and importance of regular intake

- Medical treatment with fewer side effects should be introduced

- Traditional healers should form part of the multi-disciplinary team because African people also value traditional treatment

- To serve the mentally ill patient and his family effectively, social workers should receive specific training at university level. The possibility of psychiatric social work as a specialisation field within the social work profession should be investigated for the purpose of registrations at the South African Council for Social Service Professions

- The patient with schizophrenia should be treated holistically. The ecosystemic approach is recommended for this purpose

- The social work guidelines as outlined in this study should be implemented and adapted or refined

- With regard to further research in this field, the following recommendations are made:

Research should be conducted on the impact of mental illnesses, including schizophrenia, on the functioning of the family. As a guideline, the following recommendations for such a research study are made:

- Sampling should reflect a representative number of respondents

- The patient's other relatives (not only the caregiver) as well as close friends should be interviewed

- More than one mental hospital (from all the provinces) should be consulted when collecting data, in particular from the social workers, but also from other inter-disciplinary team members

- All ethnic groups should be included in the study

- Guidelines for social workers with regard to family intervention programmes targeting the patient, the family and the community, should be provided.