

CHAPTER FOUR

SCHIZOPHRENIA AND FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK

4.1 INTRODUCTION

A patient suffering from schizophrenia must be understood in relation to his family members, relatives, neighbours and the community at large as well as other external environmental systems.

In this chapter the relationships, the interaction and the functioning of families with a patient suffering from schizophrenia will be discussed in relation to the ecosystem framework. The discussion will focus on the impact of schizophrenia on family functioning; general family burden; family adjustment to schizophrenia; and the relationship with various role players in the caring process.

4.2 THE IMPACT OF SCHIZOPHRENIA ON FAMILY FUNCTIONING

Family functioning is defined as the expected interaction and relationships occurring amongst family members and the community (Kavanagh, 1992:258). Family functioning has to do with family members' integration with one another within the family system and within the external systems. Social functioning aims at improving the functioning of patients suffering from mental health problems and facilitating on optimal quality of life (Weller & Muijen, 1993:39). Family functioning may be disturbed if one family member, who is suffering from schizophrenia, performs strange and unacceptable behaviours which impact negatively on family functioning.

A mental illness such as schizophrenia affects the relationships of the entire family system. Internal relationships and roles have to be adjusted to accommodate the illness. For instance, if a father becomes mentally ill and becomes dependent on the care of his wife, he displaces their children to some extent, as the mother can devote less time and attention to them. If the illness is long-term the mother may have to assume the role of

the breadwinner and supporter of the family and in consequence of her changed family status, her relationships with both husband and children are likely to change. In general, within a family system, a change in a member's major social role, such as the assumption of the role of the patient, brings about changes in the role relationships of the entire family. Such changes imply that the previous balance of family relationships is disturbed and a new, changed balance has to be achieved for the continued functioning of the family unit (Miles, 1981:123). The patient suffering from schizophrenia may thus disturb the social functioning of the family subsystems and the entire family as a system, making a review of the family roles necessary.

Relationships between the patient suffering from schizophrenia and his relatives may also be disturbed because of negative attitudes and disrupted communication patterns. The effect is exacerbated even more if the communication style and attitudes of the patient's family are negative towards him. This could even impact negatively on the patient's recovery process.

4.2.1 EXPRESSED EMOTION (EE) AND FAMILY INTERACTION

Studies of life events and family environmental factors have provided empirical support for the idea that schizophrenic symptoms are exacerbated by stressful circumstances (Docherty, *et al.* 1998:461-467). It is recognised that people diagnosed with schizophrenia in families where there are high levels of criticism, hostility or over involvement, have more frequent relapses. (Compare Droogan and Bannigan, 1997:46-47; Bentsen, Notland, Munkvold, Boye, Ulstein, Bjorge, Uren, Lersbruggen, Oskarsson, Berg-Larsen, Lingjaerde and Malt, 1998:125-138; Shimodera, Mino, Inoue, Izumoto, Kishi and Tanak, 1999:372 - 376 and Bentsen, Boye, Munkvold, Notland, Lersbryggen, Oskarsson, Ulstein, Uren, Bjorge, Berg-Larsen, Lingjaerde & Malt, 1996:662-630.) If the patient suffering from schizophrenia lives in a stressful environment, such as being criticised and labeled as a mad person by relatives and friends or colleagues at work, he may not feel loved or accepted and may eventually suffer a relapse.

A stressful environment in the family system and in other systems may lead to high expressed emotion (EE), which may cause relapse. Expressed emotion (EE) is a measure of the family environment indexed by criticism, hostility and marked emotional over-involvement. It is a reliable predictor of psychiatric relapse across a wide range of psychopathological conditions (Hooley, 1998:374-378; Boye, Bentsen, Notland, Munkvold, Lersbryggen, Oskarsson, Uren, Ultstein, Bjorge, Lingjaerde & Malt, 1999:41).

Expressed emotion refers to an index of particular emotions, attitudes and behaviours expressed by relatives about a family member. It is a concept relating to the content of communication and it expresses a familiar milieu of warmth, criticism or emotional over-involvement in the home environment. (Compare Gamble and Midence, 1994:12; Brewin, MacCarthy, Duda and Vaughn 1991:546; Persad, *et al.* 1992:92 and Rund, Olie, Borchgrevink & Fjell 1995:220-221.) Expressed emotion is defined operationally by an assessment interview. It describes negative or intrusive attitudes that relatives express about the patient and it is a measure of the emotional temperature within the family (Atkinson & Coia, 1995:7). Thus, negative remarks and harsh communication towards the patient by family members or other people may affect the patient adversely.

Highly expressed emotion families tend to be over-involved, hostile or critical; whereas low expressed emotion families appear warm, understanding, and tolerant (Barrowclough, TARRIER & Johnstone, 1996:691). Kavanagh (1992:256), Drake and Osher (1987:274), Giron and Gomez-Beneyto (1995:365) and Magliano, Guarneri, Marasco, Tosini, Morosine and Maj (1996:224-228) add that highly expressed emotion is correlated with negative relative behaviours toward the patient, such as criticism and intrusiveness. Such behaviours are stressful behaviours for patients as they indicate ongoing subjective tension and there is evidence of prolonged autonomic arousal when high expressed emotion relatives are present. However, highly expressed emotion is also associated with high levels of criticism of their relatives by patients, poor coping with stress and greater conditional probabilities of reciprocation of verbal negativity between patient and relatives (Magliano, *et al.* 1996:224-228).

Kuipers (1993:208), Smith, Birchwood, Cochrane and Georges (1993:11) and Lebell, Marder, Mintz, Mintz, Thompson, Wirshing, Johnston-Cronk and Mckenzie (1993:751) are all of the opinion that patients returning to live with high expressed emotion families have a less favourable outcome in the following nine months. High levels of burden and expressed emotion are related to each other (Jackson, Smith & McGorry, 1990:245).

A two-year study was conducted on a sample of Spanish patients on the influence of family expressed emotion on the course of schizophrenia. The condition was that the emotions expressed by the key relative towards the patient and his behaviour constitutes the best prognostic indicator of relapse nine months after hospital discharge. Other studies have indicated that the relative capacity of expressed emotions is equally valid when taking into account other variables of prognostic value, such as age, symptom patterns and pre-morbid adjustment (Montero, Gormez-Beneyto, Ruiz, Puche & Adam, 1992:217; TARRIER, Barrowclough, Porceddu & Fitzpatrick, 1994:830).

Conley and Baker (1990:898) believe that family response and reaction to mental illness of a family member has a major impact on the long-term outcome of the disorder. Emotional over-involvement and high levels of criticism of the patient on the part of family members are highly predictive of symptomatic relapse. Families are usually the primary social resource for patients. Patients suffering from schizophrenia in particular, depend largely on relatives in times of stress. The longer the patients remain ill, the less able they are to develop new sources of support.

Cole and Reiss (1993:114) found that following discharge from hospital, patients returning to a household in which one or more family members were high in expressed emotions were much more likely to suffer a relapse during the follow-up interval than those patients who returned to families with neither critical nor emotionally over-involved relatives (Cole & Reiss, 1993:144; Goldstein, 1985:9; Lebell, *et al.* 1993:752).

In analysing high expressed emotion, it can be concluded that a lack of understanding and insight into the mental illness - in this case, schizophrenia - may increase the number of hospital re-admissions of psychiatric patients.

According to Gamble and Midence (1994:13), research workers and health care professionals, committed to both reducing the suffering caused by schizophrenia and to improving the quality of life of patients and their families, have introduced a new psychosocial approach. The aim of the approach is to educate families in order to clarify misunderstandings about the illness. It helps families become less over-involved, critical, or hostile towards the patients and more understanding of the condition. Expressed emotion is directly related to communication deviance and could cause a relapse in the patients' functioning both within and outside hospital care.

4.2.2 COMMUNICATION AND SCHIZOPHRENIA

Communication as defined from an ecosystemic approach is a two-way process between the patient, family members and mental health professionals and is utilised as an instrument for building a therapeutic milieu within and outside hospital care. It is essential that patient care, both within and outside the hospital, takes place in a therapeutic milieu or a therapeutic community. A therapeutic milieu is one in which a group of people, such as the patient, family members and mental health professionals, is involved and reflects a multi-disciplinary team approach to the illness (Green & Kolevzon, 1984:12).

According to Falloon, *et al.* (1988:194), the manner in which family members communicate their thoughts and feelings may, and usually does, have a major effect on the course of schizophrenia. In times of crisis, ineffective patterns of communication can impede coping efforts and even exacerbate psychiatric symptoms. Effective communication can reduce family tension, enhance coping efforts and reduce the likelihood of symptomatic exacerbations. Communication can therefore either contribute to the improvement of the conditions that schizophrenia patients suffer from or worsen them. In addition, the behaviour or attitude of relatives or society may also improve or worsen the patient's condition. For instance, if the patient's relatives show dislike for the patient, such a patient may suffer a relapse brought on by feelings of depression and rejection.

The family is usually brought to therapy when they have identified the patient as having problems or as being the problem. When a family labels one of its members in this manner, the identified patient's symptoms can be assumed to be a system maintaining or a system-maintained device. The symptoms may be an expression of a family dysfunction (Minuchin, 1985:110). The family functioning is now disturbed by the patient's feelings, thoughts and behaviour.

According to Atkinson and Coia (1995:23), the way a family reacts to a member with schizophrenia depends, mostly or in part, on the way they perceive mental illness and the practical impact of the illness on themselves. If the patient's relatives indicate some disruptive behaviour towards the patient, communicative deviance may occur.

4.2.2.1 Communication deviance (CD)

The communication style in families with patients suffering from schizophrenia requires explanation. Gillis, Highley, Roberts and Martinson (1989:382) state that several reviews have concluded that communication in families of patients suffering from schizophrenia is unclear, disordered or identifiably different from that of normal families or families who have members with other psychiatric disorders. Families living with a patient suffering from schizophrenia may develop communication problems: this is termed communication deviance, the unclear or incomplete communication of ideas and perceptions. Families with communication deviance cannot focus on a single subject and their interactions are characterised by distractions and incomplete ideas.

Communication deviance (CD) refers to an inability of the patient to establish and maintain a shared focus of attention during transactions with another person (Goldstein, 1985:9; Cole & Reiss, 1993:143). The patient's speech is characterised by speech fragments, unintelligible responses and comments, gross indefiniteness, contradictory information and inconsistent references, disruptive behaviour and peculiar language. This can have an adverse effect on the functioning of the family. Communication deviance concerns the formal aspects of communication. Communication deviance, problem-solving difficulties, criticism, and negative effects are all related to higher levels of patient disability and longer histories of hospitalisation (Rund, *et al.* 1995:221-

225). Contradictory information and fragmented speech amongst family members may affect the patient's emotions and the patient's social behaviour. The family's behaviour towards the member who is suffering from schizophrenia links high expressed emotion to communication deviance since both these phenomena explain the patient's relapse and both are the products of a negative communication style.

Marsh (1992:36) provides recent evidence that expressed emotions and communication deviance may be related: relatives with high levels of expressed emotions may be more likely to have relatively high levels of communication deviance. Expressed emotion and communication deviance can thus both trigger the patient's relapse. The way the family members act or behave towards the patient suffering from schizophrenia can therefore have an impact on both the patient and the family.

4.2.3 PATIENT AND FAMILY ATTITUDES

Attitude may be explained as one's perception of a person or a thing. Negative attitudes towards the patient can affect the patient. The patient's abnormal behaviour can also affect the rest of the family members negatively. According to Wing (1980:235) and Gelder (1989:314) patients' relatives describe two major problems which a patient's behaviour can cause in the home. One problem is that patients may be withdrawn and lead almost completely solitary lives, even though living under the same roof as their families. The other problem is that some patients are excessively active or behave in a socially embarrassing way. Patients who behave violently, aggressively, or in an embarrassing manner, drawing public attention to the fact that they are ill, present obvious difficulties for their families. Social withdrawal is, however, far more widespread. A patient's withdrawal from outside contact can lead to a great suffering and frustration in his family.

Patient's relatives are often unsure as to how to help a patient to fill the long series of empty hours stretching between breakfast and bedtime. Some feel the patient's inactivity might be self-protective and that these periods of doing nothing are important in keeping him from relapsing. Some patient's relatives fear that allowing the patient to

spend too many hours in complete inactivity might lead to increasing withdrawal. Some encourage the patient to take up some hobby or interest (Wing 1980:237).

4.2.3.1 Relatives' attitudes to schizophrenia

The role of attitude in the relationship between the patient suffering from schizophrenia and his family needs to be examined. According to Falloon, *et al.* (1988:198), one of the factors affecting coping styles in families is the attitude held by family members toward their disabled relative. Attitude is the trigger that determines families' internal and external reactions to stressful events in their lives. Attitudes can affect interaction by predisposing family members to act in ways that indicate acceptance or rejection of their disabled relative. The relative's attitudes towards the patient suffering from schizophrenia may be characterised by acceptance or rejection, depending on the patient's behaviour.

- Accepting the patient

Acceptance will make the patient suffering from schizophrenia feel loved by his family members. Miles (1981:134) states that the problems associated with having a mentally ill member in the home often cause the family to adjust their daily lives and, above all, their level of expectation, so that after a period of time earlier hopes and goals are abandoned and even forgotten. Whether a family is willing and able to accept the mentally ill family member depends not only on its motivation and internal resources but also on the support it receives from its social network. It has been argued that families living in a close-knit network of kin group and friends, all of whom know each other well and reside in the same neighbourhood, will receive more support than families in a loose-knit network, where friends, kin and neighbours are geographically scattered and not in contact with each other.

- Rejecting the patient

Rejection means unacceptance, implying that the patient is rejected. Not all families accept the burden of living with a mentally ill relative. Even in cohesive, closer-knit

communities rejection may be accepted practice. The reason may be that the neighbours may become hostile to the mentally ill patient. They may expose and stigmatise both patients and their families (Siassi, Spiro & Crocetti 1973:233-234). A good indicator of rejection is the separation or divorce of married couples following mental illness of one partner (Miles, 1981:140; Phelan, Bromek & Link, 1998:116-120; Sharpe, 1988:50). Rejecting the patient suffering from schizophrenia may, in return, cause him to suffer a relapse.

4.2.3.2 Attitudes of patients suffering from schizophrenia towards the family

The patient suffering from schizophrenia may be against his relatives' way of handling him and may misunderstand them, due to his mental condition. In a recent study (Atkinson & Coia, 1995:30), patients living in the community appeared to view their relationship with their parents as tenable whilst hospital-based patients reported their relationships to be untenable, seeing their parents as being disturbed. This group of patients was also more likely to be admitted to hospital sooner when a crisis developed. Furthermore, the patients' understanding and conceptualisation of their illness may not coincide with that of their family. Conflicts may arise between sociological and biological viewpoints, which may lead to varying degrees of perceived stigmatisation (Atkinson & Coia, 1995:30). The patient suffering from schizophrenia may prefer hospitalisation as opposed to staying at home if his relationship with relatives does not seem stable.

The attitudes of patients towards their relatives depends on the resources their relatives have: their physical health and age, their social assets, including their marital relationship and social networks, their material assets and their psychological strengths and coping skills (Kuipers, 1993:207; Kuipers, 1991:105). The patient may develop negative attitudes such as hatred towards his father, for instance, if the latter is separated from the family members and does not support them financially or socially.

4.3 GENERAL FAMILY BURDEN

Burden may be stress related. "Family burden" may be described as some of the

difficulties experienced by families who live with a mentally ill member (Gillis, *et al.* 1989:375; Breakey, 1996:233). “Burden on the family” refers to the consequences for those in close contact with a severely disturbed psychiatric patient. The issue has become significant since families have become more actively involved in long-term interaction with and care for their mentally ill relatives. “Burden” refers to the presence of problems, difficulties or adverse events which affect the lives of significant others in close contact with the psychiatric patient, for example, members of the household or the family (Schene, 1990:289). It has been extensively documented that living with and coping with someone who is severely mentally ill can cause problems, traditionally described as a family burden. (Compare Anderson & Reiss, 1986:26; Fadden, Beddington & Kuipers, 1987:287; Kuipers, 1993:207; Kuipers, 1991:105 and Atkinson & Coia, 1995:32.)

Mental health professionals have become increasingly aware of the burden on relatives who care for a psychiatric patient and of the importance of helping these families to improve their ability to cope. Despite recognition of the distress that relatives experience, the specific determinants of family burden are not well understood. Family burden implies that the patient suffering from schizophrenia’s relatives/family members experience some kind of problem as a result of the patient’s behaviour. The patient suffering from schizophrenia may also experience some burden in living with people who do not understand him or in being subject to rules that are difficult for him to obey.

The concept “general burden” is divided into two dimensions, namely an objective and a subjective dimension. Objective aspects refer to actual disruptions to daily life and financial costs, whereas subjective aspects include the level of distress experienced by the relative as a consequence of the giving role (Barrowclough, *et al.* 1996:691; Solomon, Draine, Mannion & Meisel, 1996:42).

4.3.1 OBJECTIVE BURDEN

“Objective burden” is the disruption of family routine, employment, social and leisure activities in relation to those outside the family. Some studies also include financial costs and assessment of family members’ physical and mental health (Roberts,

1988:375; Falloon, *et al.* 1984:32; Lefley & Johnson 1990:271). “Objective burden” may be explained in terms of tangible things (problems), which can be observed by others, and includes quantitative, measurable problems such as finance. (Compare Atkinson & Coia, 1995:32; Hatfield, 1990:21 and Schene, 1990:289.)

Relatives of patients suffering from schizophrenia commonly report the following indices of objective burden:

- Financial and employment difficulties
- Difficulties in leisure activities
- Relationship problems within the family.

Because schizophrenia typically occurs in early adulthood and is likely to affect long-term earning and development capacity, higher levels of burden occur if the patient has formerly been working in families where earning capacity and commitment have not yet been established. The loss of potential earnings is easy to underestimate, but at the very least the family's lifestyle is likely to be more impoverished than before (Kuipers, 1993:207).

Difficulties may arise because caring for a patient with a persistent psychiatric disorder limits opportunities for an adequate income. The most severe problems occur when the patient was formerly the breadwinner, particularly if circumstances prevent another relative from taking over this role. (Compare Fadden, *et al.* 1987:287; Lefley & Johnson, 1990:39 and Schene, 1990:290.)

Relatives report practical, objective problems related to a loss of employment and financial hardship which place them under financial stress. These problems appear to be worse when the carer is the spouse of the patient who was formerly earning and who had good pre-morbid functioning (Atkinson & Coia, 1995:36; Lefley & Johnson, 1990:39).

Due to unemployment and financial problems, multiple problems such as crime, depression and lack of food may occur at home.

- The effect on the social functioning and leisure activities of relatives

Families of patients with schizophrenia increasingly experience social isolation, which usually means a limitation in the family's social and leisure activities. (Compare Atkinson & Coia, 1995:35; Fadden, *et al.* 1987:286; Winefield & Harvey, 1994:559; L'Abate, *et al.* 1986:19 and Schene, 1990:290.)

Carers are likely to face restrictions in their social activities and to have reduced social networks of their own. They may remain isolated in their own homes with few other social contacts. The stigma of mental illness in the family is still widespread and may contribute to their social isolation (Kuipers, 1993:207; Tsuang, 1982:69).

Friends, neighbours and the community at large seem to isolate relatives of patients suffering from schizophrenia. Family members often feel like hiding the patients because they are embarrassed by them. For example, the patient's family can no longer enjoy their leisure time by visiting friends and taking part in sports because of the stigma attached to mental illness and the supervision that the patient requires. As a result, family members often experience relationship problems both within and outside the family.

- Relationship problems within the family

With the onset of an illness (within the family) the family's social life becomes primarily family centered. Within this circumscribed existence the patient often becomes the focus of the family, forcing other family members into the background. If the illness or impairment is more severe and enduring, the potential for family disruptions is greater (Turk & Kerns, 1985:15).

Bowen (1988:26) states that when parents and their patients are brought together in a living situation in a hospital ward, and the designated patient is purposely left ambiguous, the family conflict becomes more fluid and shifting. Parents begin to develop intense anxiety and conflict. Such a family can accurately be called a disturbed family. Owing to the patient's unacceptable behaviour, the patient suffering from

schizophrenia and his family members may not understand one another . These misunderstandings may disrupt the family system's functioning, as well as the family's functioning in outside systems.

Two related problems, namely the loss of reciprocity and increased reliance on relatives, lead carers to seek outside help, such as institutions for the treatment of schizophrenia (Atkinson & Coia, 1995:36). Family relationships become altered: for example, parents who try to cope with a mentally ill child may pay less attention to the other children and expect more of them from an earlier age.

Families of patients suffering from schizophrenia tend to be quietly totalitarian, controlling, suppressive of the autonomy and potential for separation of individual members. Subtle attacks are made on the perception and viewpoints of the patient, especially those that happen to be in conflict with the views of other family members. They are defined as bad, crazy or destructive to others in the family and the absence of validation and support for them is combined with equally subtle bribery or rewarding for remaining disabled. In particular, such families leave no room for the constructive expression of aggression by the schizophrenic member (Bowen, 1988:27).

4.3.2 SUBJECTIVE BURDEN

“Subjective burden” describes the psychological reactions that family members experience, for example, feelings of loss, depression, anxiety and embarrassment in social situations (Magliano, Fadden, Madianos, Caldas de Almeida, Held, Guarneri, Marasco, Tosini & Maj, 1998:412; Gillis, *et al.* 1989:375). The patient's caregiver or the relatives may experience feelings of guilt, worry, depression, anxiety and fear because of the patient's behaviour which perhaps stem from their lack of insight into how to supervise such a patient.

4.3.2.1 *Feelings and family interaction*

“Subjective burden” includes negative feelings such as anger, anxiety, guilt and blame,

embarrassment and shame, rejection, stigma, loneliness, depression, withdrawal, emphatic suffering, grief and threat to security, all of which will be briefly described below.

- Anger

Living with a patient suffering from schizophrenia gives rise to a wide variety of emotional responses. Families may deny that there is a problem, particularly at the beginning of an illness. They may try hard to admit that all difficulties are in the past and that problems will not recur. They may have negative emotions, that is, they are likely to feel angry, they may sometimes reject the patient and wish he was not living with them, or that they could leave (Kuipers, Leff & Lam, 1992:32). This type of anger may lead them into hating the patient.

Kuipers, *et al.* (1992:32) and Conley and Baker (1990:898) state that families are subjected to many chronic stressors throughout the illness of a family member. Consequently they feel a great deal of resentment and anger towards the patient; however, these feelings are rarely expressed. Family members identify the patient as an ill person who is unable to behave differently and who deserves empathy. The patient's relatives may be angry with him but at the same time love him or feel pity for him.

According to Marsh (1992:86), anger is almost always present. It is often a legitimate and appropriate response to a devastating reality; it may also represent the use of defense mechanisms which provide some protection from unbearable pain. There are many sources and objects of anger. Sometimes there is anger at fate or at God, reflecting a sense of betrayal and injustice. Sometimes the anger is turned inward, directed at personal imperfection or shortcomings. Sometimes there is anger at other members of the family simply because they do not share the burden. There may be anger towards professionals and the system for real deficiencies or towards the family member with mental illness, for exhibiting symptomatic behaviour or for not getting better. The patient may also feel angry towards the family members. These feelings of anger indicate that families need to understand more about the illness in order to cope with their feelings and to deal with the negative impact of schizophrenia.

Likewise, patients suffering from schizophrenia also often experience anger, for instance, for being hospitalised. The feeling of anger is a response to a threat, a hurt, or a loss (Cook & Fontaine, 1991:10). The patient may feel oppressed and rejected by the family members and perhaps even by society.

Anger may be related to helplessness and hopelessness. Hospitalised patients may feel helpless because of loss (of independence, income, job), change (in body image), or fear (of the disorder and lack of control). The patients experience hopelessness when they perceive no end to suffering and are presented with a chronic diagnosis (Cook & Fontaine, 1991:9; Bennett, 1980:15). In summary, the patient suffering from schizophrenia may perceive himself as a useless person, which can worsen his condition.

- Anxiety

Both the patient's family and the patient suffering from schizophrenia may experience a feeling of anxiety. The presence of anxiety is not necessarily unhealthy but is a measure of stress in the family and indicates some need for transformation (L'Abate, *et al.* 1986:19). The family members, and often friends as well, may experience anxiety and stress due to the fact that the schizophrenic's condition is unpredictable, including the possibility of suicidal tendencies.

Patients may also experience anxiety as a result of the fear of being hurt or of losing something valued (Cook & Fontaine, 1991:9). The patient suffering from schizophrenia may start to worry and become frightened of being looked down upon as a worthless person. This may lead to feelings of helplessness and despair.

- Guilt and blame

Sometimes patients' families blame themselves, feeling that they may have caused the patient to suffer from schizophrenia. Hatfield (1990:30) and Kuipers, *et al.* (1992:32) are also of the opinion that patients' families suffer from a great deal of self-blame. They feel culpability for behaviours that may in some way have triggered

decompensation, if not the disorder itself. They may feel guilty about leaving a loved one in unpleasant and sometimes hated surroundings while making more self-protective life decisions for themselves. When family members cannot cope with the patient suffering from schizophrenia, perhaps due to a lack of insight into mental illness, they feel that they have contributed towards the patient's illness. This leaves them with feelings of guilt and culpability.

The patient's feeling of guilt may be related to his philosophy of suffering. If the patient believes suffering is a punishment there will be a search for wrongdoing. If the belief is that the suffering is an intrusion of evil, the patient may feel personally responsible and therefore guilty (Cook & Fontaine, 1991:10; Bennett, 1980:23).

- Embarrassment and shame

The very symptoms by which people are diagnosed as having a mental illness are a source of shame to many parents. In the acute stages of the illness, mentally ill patients may appear bizarre to those around them. They may say they are hearing things inaudible to others and they may neglect personal hygiene. They behave as though something is wrong with them, act crazily and families invariably react with shame. Families suffer not only directly because of their relative's behaviours; they also suffer empathetically because of their relatives' shame and embarrassment (Hatfield, 1990:28). In essence, the family members feel ashamed and embarrassed by the way the patient reacts and his strange behaviour.

- Rejection

Both patients suffering from schizophrenia and their families may experience real or perceived rejection from relatives, friends, and the society as a whole (Kuipers 1992:60). This sense of rejection, according to Kavanagh (1992:60), is often mixed with feelings of guilt, anger, inadequacy or hopelessness because of a sense of failure and a fear of not being accepted by others. As a result, patients' families often isolate themselves. They avoid contact with people whom they fear might look down on them. Some patients' families even go to the extent of moving to a new neighbourhood in

order to conceal the fact that their relative had had a major nervous breakdown. Hatfield and Lefley (1987:557) support Kuipers, *et al.* (1992:60) and state that the behaviour of patients with psychotic disorders may further isolate the patients' family, diminish its reputation, and jeopardize relationships with friends and neighbours. The patient's family may find it difficult to accommodate the patient suffering from schizophrenia and will institutionalise the patient rather than keeping him in a home care environment. A lack of insight into schizophrenia as a mental illness may also result in such a response.

- Stigma

Stigma is a mark of disgrace on those whom society brands as deviant. For the patient, it means a constant series of rejections as well as exclusion. The patient's family takes on this stigma as a shared burden with relatives. The family thinks carefully about whom to tell of the disorder and, at times, spends much energy contriving to conceal it (Hatfield, 1990:31). The stigma attached to schizophrenia can be linked to a lack of insight into mental illness.

- Loneliness

The family of patient may feel isolated from friends whilst the patient himself may feel separated from his loved ones, especially when hospitalised (Cook & Fontaine, 1991:10). As a result, neither party experiences the company and closeness of friends.

- Depression

Sometimes there are severe feelings of depression amongst the family members of the patient suffering from schizophrenia. The patient may himself become depressed as a result of the loss and difficulties of rebuilding his life, as well as from the rejection by family members and society. In elderly carers there is an inevitable worry about the future, for instance about who will look after the patient when the caregiver is dead. There may be general anxiety and confusion about what has happened and what the future holds (Kuipers, 1992:33).

Marsh (1992:86) explains that family members, especially parents, may experience depression when one member is suffering from schizophrenia. Family members describe the experience of dysphoria, including feelings of helplessness and hopelessness, decreased energy, loss of interest and pleasure in their usual activities, feelings of worthlessness and fearfulness.

- Withdrawal

When one member is suffering from schizophrenia, the adaptive resources of families are inevitably drained and often depleted. Feelings of isolation and withdrawal reflect the heroic demands of coping, as well as the sense of living in a society that has little understanding and compassion (Marsh, 1992:87 & Damodaran, 1993:221).

- Empathic suffering

The subjective burden of family members generally includes empathic suffering for the family member who is suffering from schizophrenia. There are many familial characteristics that increase the level of empathic pain, including familial bonding, love, sympathy, and empathy. As time passes, empathic suffering may become the strongest component of the subjective burden (Marsh, 1992:87).

- Grief

Grief is in a family when a member suffers from an illness that may be chronic and often disabling. In the case of a patient suffering from schizophrenia, this may be grief for the loss of the person they used to know or grief for the loss of their hopes and aspirations for him (Kuipers, et al. 1992:55). According to Cockerha (1992:275), by the time hospitalisation takes place, most families have come to believe that their deviant family member is indeed mentally disturbed.

- Threat to security

When a patient suffers from schizophrenia his relatives react to insecurity with feelings

of anxiety and tension. There are constant fears that the mentally ill patient may hurt himself or others. For instance, suicide threats or attempted suicide set families on edge. Many patients' families, although never assaulted, live in fear of the relative who is suffering from schizophrenia. They take protective measures such as putting locks on doors and the hiding of sharp instruments (Hatfield, 1990:32). A violent patient suffering from schizophrenia, and who has suicidal tendencies, may not only present a threat but may also cause depression within family members.

According to Hatfield and Lefley (1987:557), relatives who are frequently exposed to the patient's abusive behaviour and socially offensive incidents often experience the patient's conflicting with neighbours; losing or squandering money; poor personal hygiene, property damage and fire hazards; having sleep reversal patterns that keep the household awake and rejection of medications in spite of known patterns of relapse.

In summary, both the patient suffering from schizophrenia and his relatives are subjected to specific burdens that impact on the family's functioning. In order to deal with these burdens effectively both the patient and his family have to understand schizophrenia as a mental illness and to develop insight into dealing with its negative impact.

4.3.3. THE EFFECT OF A PATIENT'S BEHAVIOUR ON CAREGIVERS

Kuipers (1993:207) is of the opinion that families are severely burdened, both objectively and in terms of the emotional impact of the disorder, by the demanding and often unsupported role of caring for a relative with schizophrenia. This burden may affect the carer's own well-being, particularly as caring is likely to last for a lifetime, without respite. It is now well documented that the caring role in schizophrenia is likely to affect most aspects of family functioning (Kuipers, 1993:207). It is likely that the more demanding the patient's supervision becomes, the more strained the family members will become.

According to Kuipers (1993:207), the people who care for patients suffering from schizophrenia include parents, spouses, and occasionally siblings or an offspring. While

most potential caregivers are mothers, a substantial proportion of male carers exist in other categories. Studies of families of patients with mental illnesses demonstrate that even in two-parent families, one person, usually the mother, typically fulfils the major caregiving tasks. In a few cases, a sibling, where the dynamics are somewhat different but the burden may be almost as great, fulfils the single caregiving tasks. Siblings can be stigmatised, alienated, and ostracised because of a brother's/sister's illness. Many siblings find the bizarre and offensive behaviour hard to bear, and distance them both emotionally and geographically from the problem. The multiple roles that the single parent is often forced to play generate both physical and emotional stress. The parent is much more likely to become emotionally over-involved and research on expressed emotion shows this is likely to be damaging to the patient as well as burdensome to the parent (Backlar, 1994:102).

Backlar (1994:95), Winefield and Harvey (1994:559) and Weleminsky (1991:119) conclude that single mothers are particularly vulnerable to stress. Single mothers most often lack resources, are less likely to have the energy to gather information with regard to the illness and available help and are less able to be of support to the patient. Regardless of whether the main caregiver is male or female, parent or sibling, coping with a major mental illness in the family may lead to burnout in the one who shoulders the responsibility alone.

Relatives living with patients suffering from chronic schizophrenia may also experience some of the following problems (Kavanagh, 1992:257):

- unemployment
- psychological stress from coping with patients' disturbed behaviour
- persistent disruption of household routines, for example, night time waking and irregular eating habits
- coping with the social withdrawal and awkward interpersonal behaviour of the patient.

According to Kavanagh (1992:258), common problems that families have to contend with while living with a member suffering from schizophrenia are:

- the withdrawal from activities outside the home
- sleeping in during the day
- lack of responsiveness to the rest of the family
- failing to assist with household chores, crazed talk and socially embarrassing behaviour.

In order to deal with a member suffering from schizophrenia and the negative impact of the illness on the family, it is important that the family be empowered through information on the illness and through developing coping skills to help them adjust to and cope with schizophrenia as a type of mental illness.

4.4 FAMILY ADJUSTMENT TO SCHIZOPHRENIA

The family of a patient suffering from schizophrenia will have to adjust to the following changes which may occur within the family:

- Life cycle changes
 - Siblings' attitudes
 - Phases of the illness and episodes of treatment.
- Life cycle changes

Within the context of the family life cycle, adult development is inevitably disrupted by the advent of mental illness in the family. The psychosocial costs of living with family members with psychological disturbances have been investigated and it was found that respondents living with psychologically disturbed relatives had the highest scores on measures of depression and anxiety, and that those living with a parent with mental illness showed the highest levels of psychosocial dysfunction (Marsh, 1992:68).

As already indicated, mental illness can bring fear, violence, discord, anxiety, and other stresses to the family cycle. The bizarre behaviour of the deranged family member can create an intolerable situation in which hospitalisation is a welcome respite. In the aftermath of hospitalisation, the remaining family members may feel a strong sense of

embarrassment, guilt and shame about what has happened (Cockerha, 1992:275). The family members have to understand schizophrenia and its negative effects in order for them to be able to adjust to the illness.

When a family member becomes mentally ill, there is an inevitable shift in roles due to the loss of role functions of the patient. How that shift is made depends on the role formerly played, that is, wife-mother, husband-father, adult-child or child of a mentally ill parent. In addition to the loss of role function, there is the strain imposed by the energy that is required for the caretaking (Hatfield, 1990:44). According to Hatfield (1990:44), the presence of mental illness in a parent complicates the rearing of children as well as the marital relationship. The remaining parent must bear the entire burden of childcare, homemaking and financial support. During any stage of the family cycle, a single-parent household is at a disadvantage. The presence of a mental illness such as schizophrenia exacerbates this situation still further.

Lefley and Johnson (1990:40) are of the opinion that the mentally ill child patient is dependent on his parents. Parents take up the cause of seeking treatment and coping with the patient's behaviour. Amongst the two commonly heard concerns are questions of guilt and long-term care. On the other hand, spouses of the mentally ill have many problems, many of which centre on role performance. Traditionally, the husband's role has been to work and provide financial support for the family and the wife's role has been to manage the household and care for the children. These roles may now have to be reversed.

- Siblings' attitudes

The siblings of a member of the family suffering from schizophrenia may feel isolated since more attention is given to the patient. According to Lefley & Johnson (1990:40), siblings are the neglected group of relatives of the mentally ill. Siblings also worry about their own sanity and dread the day when they may have mixed feelings about the care provided by their parents for the mentally ill family member. They feel left out of what is going on in the family because no one encourages them to understand the disturbed person's behaviour. Problems which may arise include such child behaviours

as changed performance at school and altered peer relations. Siblings are often expected to adjust by themselves in order to cope with schizophrenia within the family system.

- Phases of the illness and episodes of treatment

As already indicated in Chapter 3, schizophrenia manifests stages such as the acute and the chronic stages. The family with a patient suffering from schizophrenia needs to understand these stages in order to adjust to the patient's behaviour.

According to Atkinson and Coia (1995:41) and Hudson (1982:24), responses probably vary with the phase of the illness. During the acute phase, patients' relatives tend to be sympathetic, supportive and make considerable efforts to hold things together, but the chronic phase of the illness can present more difficult problems. The patient who is withdrawn may cause relatives to feel devalued and less respected, particularly if their opinions regarding the treatment and management of the illness are ignored.

If the family with a patient suffering from schizophrenia manages to adjust to and cope with a patient, it may be easy for both parties to maintain a good relationship during the caring process. However, support from mental health professionals is important to maintain a positive relationship between the patient and his family.

4.5 ROLE PLAYERS IN THE CARING PROCESS

Mental health professionals such as psychiatrists, psychologists, psychometricians, occupational therapists, psychiatric nurses and psychiatric social workers, as well as the patient suffering from schizophrenia and his relatives, form a multi-disciplinary team which helps to treat and rehabilitate the patient, and to prevent a deterioration in behaviour.

The respective roles of each disciplinary team member are as follows:

- Psychiatrist: A team leader in planning treatment and supervising the execution of the plan. Part of the role is to draw particular skills from other team members, to

train them in psychopathology and therapeutic methods and to develop the whole team into a unit that provides state-of-the-art services to its patient population (Breakey, 1996:8)

- Psychologist: Helps the mentally ill patient to manage his stressful situation
- Occupational therapist: Teaches patients handcrafts while still hospitalised, thereby enabling the patients to help themselves after discharge (Breakey, 1996:8)
- Psychometrician: Studies and understands the mental processes of the mental patient and administers psychological tests (Bellack, 1984:131)
- Psychiatric nurse: Renders the prescribed psychiatric treatment, which involves medication such as drugs and psychotherapy. Also renders some kind of follow-up (Bellack, 1984:131) to see whether the medical treatment has been taken correctly. This may, however, differ from one mental institution to another
- Psychiatric social worker: Completes a psychosocial report, for instance to enquire into the patient's history and life-style prior to the onset of his illness (Hudson, 1982:225). Renders after care services to the discharged patients and their families
- Patient's relatives: Provides information about the patient's history of health and illness, provides support, gives advice and comfort to the patient and his family, especially during the acute phase of the illness (Bellack, 1984:184)
- Patient suffering from schizophrenia: Explains his life history, how he is affected mentally and how he will cooperate with the treatment plan. Garland (1983:89) states that the patient, as part of the team, needs to be respected and emphasises that it is important to listen to what he feels about his own treatment.

The multi-disciplinary team members need to work cooperatively with one another for care of patients to be effective. Garland (1983:11) states that forming a good relationship in a team is at the heart of the mental health caring process.

All role players have an important role during the caring process; however, the role of the patient's relatives is the most crucial as they know the history of the patient. In this capacity they should thus be valued by the mental health professionals. According to Atkinson and Coia (1995:41), relatives' attitudes towards mental health professionals are often set by their first experience of services. During the first contact with professionals relatives may be ignored, despite their knowledge and lifetime involvement with the patient. Yet, despite not being consulted, they are expected to care for the patient once the acute episode of the illness has passed. When they are not given their place and their involvement is not acknowledged, their expectations, fears, anxieties and exchanged information can result in a negative attitude towards mental health professionals. This may impact negatively on interactions with services and result in less than helpful patient management. In addition, professionals tend to forget that patients' families often deal with multiple agencies: medical, social and legal, and those who have different views on and attitudes to mental illness. They have to distil information from these multiple contacts, taking what is helpful in managing their particular problems and rejecting what is not. On the other hand, some patients' families may never be satisfied with the services provided no matter how excellent they are (Atkinson & Coia, 1995:42).

Grunebaum and Friedman (1988:1183-1187), Weleminsky (1991:110) and Bernheim (1990a:1353) all mention the importance of collaboration between mental health professionals and the patients' family. The patient's family has a chance to be heard and to relate its own account of the patient's illness, his life and that of the family. All in all, the patients' relatives need to be involved and valued by the mental health professionals because they have important information to share about the patient's illness.

The rules and practices of a mental hospital should be imparted to the patient's family as soon as possible after the patient's admission. It must be made clear to the family that they are not to be blamed for the illness (Grunebaum & Friedman, 1988:1186). Relatives need to know something about the nature of the illness, its prognosis and the treatment methods to be applied to their ill family member.

Conley and Baker (1990:898) mention that previous negative experiences with mental health professionals can be a source of family opposition to the patient's discharge. Patients' families often see mental health professionals as unwilling to educate them about the illness of their family member. Although they often appreciate therapeutic intervention by professionals, families seem to respond more favourably to psycho-educational intervention than to therapies that focus on the disturbed family system. One of the most significant concerns patients' families have, when facing a relative's discharge, is that their quality of life will suffer severely, particularly if the mentally ill family member will be returning to the home.

Feldman and Scherz (1979:269) state that the social worker's task is to help those families already confronted with problems in personal and social functioning to master their problems. Just as with all the professional role players, the role of the patient and his key relative needs to be considered, valued and respected within the mental health team.

Social welfare programmes, rehabilitation services, agencies of various types, training and employment needs and many types of counselling, all with a primary focus on helping families and individuals to cope with a problem, are of importance to the families and their communities.

4.6 CONCLUSION

The family as a system is faced with huge demands and challenges when living with a patient suffering from schizophrenia. Problems experienced by such a family system can be described in terms of objective and subjective burdens. In the case of objective burdens, the patient's relatives, especially the caregiver who in many cases is a mother, may lose her job, remain unemployed, face financial difficulties and no longer have (enough) leisure time to socialise with outside systems. The patient may also lose his job, be unemployed and no longer socialise with friends who may stigmatise him.

In the case of subjective burdens, both the patient's relatives as well as the patient himself may experience negative feelings such as anger, guilt, blame, embarrassment, shame, rejection, stigma, depression, withdrawal and loneliness. These feelings need to be acknowledged by the professional team. The role-players included in the mental health professional team are: the psychiatrist, psychologist, psychometrician, occupational therapist, psychiatric nurse, psychiatric social worker, the patient's relatives and the patient himself.

Mental health education can help patients and their families to understand schizophrenia as a type of mental illness, and can assist the family in understanding their role in the treatment and support of the patient. To assist families in dealing with the member with schizophrenia and the negative impact of the illness on family functioning, social workers require specific guidelines for intervention.

In Chapter 5, family intervention programmes to develop understanding and insight into schizophrenia as mental illness will be discussed.

CHAPTER FIVE

INTERVENTION PROGRAMMES FOR SCHIZOPHRENIA

5.1 INTRODUCTION

In this chapter programmes for family intervention and behavioural problem solving are discussed. These programmes can be regarded as intervention strategies to provide patients suffering from schizophrenia and their relatives with more insight into schizophrenia as a type of mental illness.

In this context, an “intervention” refers to professional assistance, including education, provided to a patient and his family to guide the client in becoming independent. According to Barker (1991:120), intervention is an interceding in or a coming between groups of people, events, planning activities or an individual’s internal conflicts. Intervention includes “treatment” and also encompasses the other activities social workers use to solve or prevent problems or to achieve goals for social betterment.

A “programme” is defined in this context as educational sessions on schizophrenia as a type of mental illness held with patients and their relatives . Falloon, *et al.* (1993:15), supported by Dixon and Lehman (1995:63), list the goals of intervention programmes for psychiatric illness as being able to:

- Assist every participant to achieve the personal goals he considers most important
- Help each person to deal efficiently with the stress he is experiencing; help each family to work together, helping each other to manage their stresses and burdens. This is achieved mainly through regular family meetings in the home, where a structured problem-solving approach is routinely employed
- Enhancing the clinical management of any stress-related disorder to which any household member is highly vulnerable. This, according to Falloon, *et al.* (1993:15), can be accomplished through an increased understanding of the disorder which allows for better preparation for major episodes, efficient stress management

order to prevent episodes that might be triggered by stress, specific strategies to cope with problems that might arise during the course of the disorder, compliance training and understanding of optimal drug treatment. Therefore, by participating in intervention programmes, the patient and his family can increase their efficiency in coping with the stress and burdens caused by schizophrenia.

Intervention programmes can be implemented at any one or more of the following levels: primary, secondary or tertiary.

- Primary intervention:

Primary intervention is the prevention of occurrence of a disorder that had not previously existed in an individual up to that point (Fawcett, 1993:240). Clark (1996:790) defines primary intervention as an activity that stops a problem before it occurs. It leads to a reduction in incidence. According to Maforah (1987:52) and Malevu (1985:59), primary intervention encompasses the development of educational programmes to assist the community at all levels in acquiring an understanding of the basic dynamics of human behaviour. The strong element of education in primary prevention may enable the population to handle stress effectively. Maforah (1987:52) states further that mental health education, which falls under primary prevention, should have a two-fold aim:

- Reduction of stigma by overcoming ignorance and fear
 - Provision of the means for providing preventative care and post-hospital supervision in the community. A programme at the primary prevention level may be implemented with the aim of preventing the occurrence of schizophrenia.
- Secondary prevention

Secondary prevention is the reduction of prevalence by reducing the duration of illness. It generally takes the form of implementing a screening programme to detect the illness at an early stage, followed by appropriate and energetic treatment (Breakey, 1996:328;

Fawcett, 1993:241). Gillis (1986:242) supports the above-mentioned authors and believes that prevention of mental disorders through secondary prevention can be effected by the early detection and active treatment of cases, so that the total number of ill people at any one time can be diminished. The objective here is the early recognition of the illness and the effective treatment thereof.

Rieman (1992:11-12) and Maforah (1987:58) explain a special form of mental health education under secondary prevention, that is mental health consultation. This has received much attention. The purpose of consultation is to enhance knowledge, improve skills, modify attitudes and change behaviour in order to provide better services for the patients. This consultation will be useful to the family in the sense that their knowledge will be enhanced and their attitudes will be modified. In return, the family can start to develop positive interpersonal relationships with the mentally patient in their family.

- Tertiary prevention

Tertiary prevention is the implementation of procedures or interventions that prevent chronicity of a mental illness such as schizophrenia. Techniques for relapse prevention in schizophrenia provide a good example of tertiary prevention in psychiatry (Breakey, 1996:330). Tertiary prevention has to do with rehabilitation and aftercare as well as the reconstruction of services.

In many instances, secondary and tertiary preventative measures for schizophrenia are very similar. Secondary prevention may entail referring patients for diagnosis and treatment; educating both the patient and the family about the disease and about medication and other aspects of treatment; motivating compliance and monitoring the effects and possible side-effects of treatment. Similarly, tertiary prevention involves referring for assistance with exacerbations of schizophrenia; educating patients and their families to prevent recurrent schizophrenic episodes and knowing the signs and symptoms of exacerbation; encouraging continued compliance with a treatment regime and mentoring the client's psychological health (Clark, 1996:791).

In summary, primary, secondary and tertiary prevention indicate respective levels at which intervention programmes can be implemented, both during the hospitalised phase as well as after the patient has been discharged and placed back in the family and/or in the community.

5.2 FAMILY INTERVENTION PROGRAMMES

Intervention programmes applicable to the patient suffering from schizophrenia and his family include psycho-educational as well as behavioural problem-solving programmes. Family intervention programmes are divided into four phases. Phase one is applicable when the patient is hospitalised; the others become applicable when the patient has been discharged and placed back in the family and/or in the community.

The aim of family intervention programmes is to assist caregivers in coping with patients suffering from schizophrenia, especially in dealing with problems and in providing an opportunity for modifying the patient's feelings of resignation and hopelessness. Helping the patient's relatives to solve problems of any kind, however, depends on the professional's willingness to take these problems seriously (Falloon, et al. 1993:15).

According to Hudson (1982:25) and Walsh (1988:138), the aim of family intervention programmes, specifically with regard to schizophrenia, is to enable patients suffering from the illness, and also their relatives, to obtain knowledge and skills on the diagnosis, symptoms, causes, treatment and management of the illness.

Collaboration between the professional team and the patient and his relatives, is essential for the effectiveness of educational programmes. For those with an African cultural background, the traditional healer is an important resource who needs to be included in the multi-professional team. Traditional African treatment of mental illness takes place within a group setting, which includes the patient's family and the community. Traditional healers should be consulted since mental illness is also perceived in terms of witchcraft and culture (Mojalefa, 1994:138).

Mental health professionals should provide information about the psychiatric illness and should offer practical advice and information about community resources available to the patients' families (Falloon, *et al.* 1988:273; Mueser, Bellack, Wade, Sayers & Rosenthal, 1992:674).

According to Simon, McNeil, Franklin and Cooperman (1991:323-333), McFarlane, Link, Dushay, Marchal and Crilly (1995:127-144) and Goldstein (1994:54), on the case of psycho-educational programmes, the professional, for instance the social worker, elicits the co-operation and collaboration of the family by teaching them to understand mental illness and to respond appropriately to its manifestations.

5.2.1 PSYCHO-EDUCATIONAL PROGRAMMES

Psycho-education can be any combination of education therapy and support. The purpose of psycho-education is the prevention of a relapse by the patient suffering from schizophrenia (Solomon, *et al.* 1996:41) by training patients' families to become long-term caregivers and by improving the quality of life for family members (Sharpe, 1988:541). Drake and Osher (1987:275) state that psycho-education teaches caregivers to implement appropriate limits and to monitor their own tolerance levels.

Tarrier and Barrowclough (1990:408) explain the aim of psycho-education programmes as being to reduce patients' family stress, increase family tolerance and reintegrate the patient into the outside world. The objective and subjective burden of the patient's relatives are somehow dealt with and facilitates the patient's acceptance by his family members and the community.

According to Gillis, *et al.* (1989:380), a psycho-educational programme attempts to decrease the patient's vulnerability through medication and to improve the stability of family involvement by addressing family anxiety, knowledge, deficits and management needs. If the patient continues to take his medication and if, at the same time, he and his family can develop insight into schizophrenia, then a positive relationship between the patient and his family members, including the outside systems, can be developed and/or maintained (Zastrow, 1996:56; Becvar & Becvar 2000:147).

The major aims of educational programmes on schizophrenia are: to convey information on the rationale for treatment, including medication; to reduce relative's guilt and/or blame, particularly about the etiology of schizophrenia; to encourage realistic expectations regarding the prognosis and to give practical advice about the management, including ways of reducing expressed emotions (Atkinson & Coia, 1995:71; Solomon, *et al.* 1996:41).

The various psycho-educational approaches, whether providing information, support, skill training or a combination of these, are effective because they all address what the relatives of a patient want and need (Solomon *et al.* 1996:41). Furthermore, the psycho-educational programme includes the engagement of families as partners, the granting of some control over intervention to patients' families. They encourage patients' families not to blame themselves for their relative's illness and, finally, view patients' families as pathogenic units (Solomon, *et al.* 1996:41). The patients' relatives learn more skills to cope with their family member who is suffering from schizophrenia and share their views or opinions about schizophrenia as a type of mental illness.

A psycho-education programme is able to address, in particular, the burdens experienced by patients' families, for example stress, grief, anger, lack of leisure time and changes in their financial situation. A psycho-education programme's objective is to orient families about mental illness and its treatment; to help patients' families to realise that others in their situation have similar feelings and experiences; and to provide guidelines for dealing more effectively with their mentally ill relatives, other family members and the mental health system (Mueser, Bellack, Wade, Sayers & Rosenthal, 1992:674).

Through psycho-education the patient's relatives find some relief because they become empowered to deal with anger and other negative emotions resulting from the patient's illness.

5.2.1.1 Intervention programmes in hospitalised setting

It is necessary that the patient's relatives, together with the psychiatric unit, are informed about hospital services in order to ensure that the intervention programmes in the hospital setting are implemented effectively.

- Information regarding services

Information about the psychiatric unit, including the roles of the staff members and how they can be contacted, procedures for obtaining passes, visiting rules, the ward schedule and the rules and regulations of the unit, is given to family members at the earliest opportunity. A meeting can be held once or twice a year for the relatives of patients with chronic mental illness. The aim of this would be to break down any isolation by getting to know the relatives and encouraging them to share their concerns about their role in caring for the patient. Meeting relatives face-to-face in a pleasant, sociable and non-threatening atmosphere allows the hospital staff to offer a better service (Atkinson & Coia, 1995:78). It is therefore important that patients' families be informed about what a psychiatric unit is in order to work hand in hand with the mental professional team.

Feedback to the patient's family while the patient is still hospitalised will prepare them for the fact that he will not be hospitalised permanently, but will one day be discharged and have to receive treatment at home. There are psycho-educational programmes that are applicable to the patient suffering from schizophrenia while he is still hospitalised. According to Straube and Hahlweg (1990:224), phase one, which involves contact with the family in twice-weekly meetings while the patient is hospitalised, is also applicable.

Kleefler and Koritar (1994:376) mention the following psycho-education programmes as being applicable when the patient suffering from schizophrenia is still hospitalised: in-patient crisis groups for relatives, crisis intervention, and psycho-educational workshops.

- In-patient crisis groups for relatives

In-patient crisis groups for relatives are seen as the first stage of a psycho-educational programme. The treating psychiatrist, primary nurse and family clinician see the family within one week of admission. The objective is to clarify the diagnosis, address the problem of denial, discuss family concerns, and establish a therapeutic alliance. The patient is not included since most of the patients are clinically too psychotic for the meeting to have any relevance for them. During the patient's hospitalisation, relatives are offered weekly or bi-weekly meetings with the family clinician (Kleefler & Koritar, 1994:376).

The mental health team, including the patient's family, works together. They meet while the patient is hospitalised. The purpose of meeting is to provide the family with some clarification of the patient's diagnosis, address the problem of denial and encourage the families to visit as well as to support the ill family member.

- Crisis intervention

Crisis intervention starts immediately upon admission to the acute care ward. Engaging the family immediately is essential to address the problem of denial, to promote a working relationship with the treatment team, and to comply with a treatment programme. The family has to cope with the anxiety and bewilderment of the pre-admission period and, after admission, with the diagnosis of a chronic mental illness. Understanding and addressing the emotional needs of the family at this time is crucial in enlisting their co-operation. It was found that until the anxiety is addressed clinically, education on the illness is either not retained at all or is only imperfectly retained (Kleefler and Koritar, 1994:376). Crisis intervention deals thus with a patient in the acute phase of schizophrenia.

During the acute stage of the patient's illness, the family may also deny the patient's condition. It is therefore essential that family and mental health professionals work together as a team. The denial problem can then be addressed in order to help the family to accept the patient.

- Psycho-educational workshop

An all-day psycho-educational workshop adapted from the model developed by Anderson (1983) in Kleefer & Koritar (1994:396) provides structured information for relatives about the illness, medication, and community resources. This workshop is also seen as a phase of a psycho-educational programme. The workshops could be held every two months on a particular day, and are organised and presented by the family clinician. In order to be effective, there should be at least ten participants. During a typical year, this would involve about 20 families or 60 individuals, depending on the intake number. Families may attend while their relative is still hospitalised or during post-discharge, depending on the clinical progress (Kleefer & Koritar, 1994:376). The aim of these workshops is to inform the patient's relatives about schizophrenia, to stress the importance of regular medication, to make families aware of available community resources and to encourage home-based care.

The above-mentioned intervention programmes are mostly applicable when the patient suffering from schizophrenia is still hospitalised.

5.2.1.2 Intervention programmes for the family within a community based context

Families are given information about applicable services when the patient is returned to his family and/or to the community. Family meetings can be held as a way of passing on information. These meetings should include the patient. The major task, according to Kleefer and Koritar (1994:376), would be to clarify the expectations of the family and of the patient, when he has been discharged and is back with his family and/or within the community.

Within the new trend of psychiatric care, community-based care is regarded as a very important service. The White Paper for Social Welfare (1997:82) as well as the Financing Policy (1999:9) support and promote community-based treatment and development, particularly in under-serviced areas. More appropriate community-based structures should be developed, for example day-care centers, outpatient services and mobile clinics. Services should be centralised within the community environment and

support and capacity building to communities should be provided through regular developmental assessment and programmes which continuously strengthen the community's development.

Cunningham (1992:11) mentions different levels of professional guidance and care that may be obtained, for instance the medical resource. There are also the community services resources, which take the form of outpatient care clinics and psychiatric community centres. Mental health societies care for families in the community and bridge the gap between the patients in hospital and the family.

Home-based care and community-based care services must be encouraged because the patient cannot be hospitalised permanently and needs finally to go back to his family and/or community. The family members, in particular, will have to cope with such a patient when he returns home. That is why educational programmes must be implemented to guide patients and relatives to a better understanding of schizophrenia as a type of mental illness.

Psycho-educational programmes as well as behavioural problem-solving programmes are applicable when a patient suffering from schizophrenia is discharged and placed back with his family and/or in the community system. According to Straube and Hahlweg (1990:224), the second, third and fourth phases are also applicable at this point. These phases will be discussed in detail under the heading "phases".

The following are the psycho-educational programmes applicable when the patient is within his family and/or his community: psycho-educational workshop; education for relatives and education groups. (Compare Weleminsky, 1991:119 and Johnstone, 1993:256.)

- Psycho-educational workshop

The patient's family may attend some educational training workshops during the patient's post-discharge (Kleefler & Koritar, 1994:376). The aim of these workshops

will be to inform the patient's relatives about schizophrenia, the importance of regular medication and the use of available community resources.

- Education for relatives

Educational sessions are presented in a family's home. According to Atkinson and Coia (1995:71), Mueser, *et al.* (1992:674), Johnstone (1993:256), Weleminsky (1991:119) and Barrowclough, TARRIER, Watts, Vaughn, Barmrah and Freeman (1987:1-8), the aim of these educational sessions is to inform the patient's relatives about schizophrenia, its diagnosis, symptoms, etiology and treatment. Each session lasts for two to three hours and occurs as soon as the patient is discharged from the hospital (Atkinson & Coia, 1995:71). The sessions will be discussed briefly.

Session 1: Focuses on the nature of schizophrenia. Topics such as the symptoms, which include delusions and hallucinations, and the fact that the cause of schizophrenia is still unknown, are discussed (Atkinson & Coia, 1995:71). The patient is interviewed simultaneously but separately and given the same information as the relatives. In the latter part of the session, the patient and his relative(s) are seen together, and further questions are encouraged. At the end of the session, the relatives are given an appointment for session two, one week later. They are asked to take the booklet away with them and read it thoroughly (Barrowclough, *et al.* 1987:2). The aim of this session is thus to educate both relatives and patients and to give them a better understanding of schizophrenia.

Session 2: Focuses on treatment. In this session the following topics are discussed: the importance of regular medication, the effectiveness of major tranquilizers and the negative impact of street drugs on schizophrenia (Atkinson & Coia, 1995:71). Family members also want to know how to deal with strange, delusional behaviours and how to prevent attacks against family members (Lefley & Johnson, 1990:55; Weleminsky, 1991:110). The aim of the session is to gain insight into schizophrenia as a type of mental illness.

With regard to medication management, it is emphasised in session two that regular tablet taking is very effective for the treatment of schizophrenia. In an all-day, multi-family session, the usual types of phenomenology, onset, course, treatment, and outcome of the illness are described (Falloon, *et al.* 1988:262; Atkinson & Coia, 1995:75). Educational programmes in the form of pamphlets from the local health authority should be produced. Questions utilised in the session are as follows: What is schizophrenia? What are the symptoms of schizophrenia? What can help? (Atkinson & Coia, 1995:75).

In this session patients and their relatives are guided on the nature of schizophrenia and the importance of regular medication. The programme does not explain the importance of socialising and a positive relatedness as a way of reducing stress and preventing a relapse. The researcher therefore doubts the effectiveness of this programme. It seems as if the programme covers aspects such as how to manage disturbed behaviour and how to deal with high expressed emotion, but not social integration/interaction.

- Education groups

The two components of the education groups are education and support. The programme consists of ten sessions. The group meets fortnightly at a place and at a time convenient for the patient's relatives (Atkinson & Coia, 1995:139). Problem-solving and goal setting are used and relatives are encouraged to draw on their own practical experiences to help each other. As the group progresses relatives provide more support to each other and are able to deal with more emotional issues, thus reducing their own stress (Atkinson & Coia, 1995:139).

Group sessions consist of the following:

Session 1: The focus of the session is on what schizophrenia means to the patient's relatives. This is an introductory session, because relatives will be keen to air their own views. The aims are to discuss the concept of mental illness, in particular schizophrenia, and to allow families to feel comfortable with the diagnosis and to identify with their personalised subjective model of the illness. To ensure the

participation of the family in the group at the start of the session, relatives are asked to comment on why they have come and to share their expectations of the group. The participants of the session then express their personal understanding of schizophrenia. Individual group members are encouraged to discuss the perception of their relative's problems and what explanations they have for their relative's behaviour. Depending on the relatives' view of schizophrenia, the illness model can gradually be introduced and related to what relatives have been saying (Atkinson & Coia, 1995:142 and Drake & Osher 1987:275).

Relatives are then encouraged to think realistically about what they can expect from the group, which will lead them into a discussion of the structuring of the group; how it will be run, what the sessions will cover and other administrative points. Standard group rules are set, for example, allowing all group members space to speak, confidentiality and the vital arrangements for tea and coffee. All relatives who attend session 1 are encouraged to attend subsequent sessions (Atkinson & Coia: 1995:143).

Session 2: Evolves around the question of what schizophrenia entails. This session discusses the symptoms of schizophrenia and its diagnosis. It is important to describe all the symptoms that may occur and a list should be provided in the relative's handbook. The relationship of symptoms to behaviour should be discussed. An explanation is given on how the diagnosis is made; how symptoms and behaviour are grouped together to classify an illness and produce a diagnosis (Atkinson & Coia, 1995:144).

Negative symptoms often produce behaviour which is interpreted by relatives as laziness, fear of work, personality problems or indifference, and generally not related to schizophrenia as an illness. It is important to explore with relatives their understanding of such behaviour and to offer an alternative explanation within an illness model. Whilst it is important to share common symptoms, it is also important to emphasise that not all patients will have the same symptoms or the same severity of illness (Atkinson & Coia, 1995:144).

Session 3: The group now searches for the reasons for the occurrence of schizophrenia in the family and the causes of schizophrenia. This can be connected to the beliefs that if a “cause” is found then so will a “cure”. Causal beliefs held by relatives are also likely to affect the way they view the symptoms and behaviour of the ill relative and how they treat him (Atkinson & Coia, 1995:145). No one knows exactly what causes schizophrenia and this will be one of the central messages of this session. This session will discuss genetic, biochemical, neurological, environmental, psychological and family factors as the contributory factors towards the causes of schizophrenia. The session should end by encouraging families to look forward to what can be achieved rather than to looking back (Atkinson & Coia, 1995:147).

Session 4: The treatment of schizophrenia is discussed. A number of general principles of treatment should be conveyed; not least that treatment not only involves medication but also psychotherapy, social therapy, behavioural therapy, occupational therapy and so forth. It must be known that medication does not equal treatment, but is only an important component of the treatment process, a factor often forgotten in health service provision. Both the advantages of taking medication regularly and the side effects of medication should be discussed (Atkinson & Coia, 1995:148). This session should also introduce the range of social therapies available and the rationale for their use. Therapies to improve social functioning, quality of life, occupational status and the activities of daily living are now established. The role of the occupational therapist, psychologist or nurse is important to the success of these techniques and should be described (Atkinson & Coia, 1995:148).

Session 5: The problems experienced by relatives are discussed. This session explores how living with someone who suffers from schizophrenia affects the rest of the family, and how these problems might be managed. This session must acknowledge that taking the role of carer is difficult and should point out that problems with this role are common and indeed normal. Relatives may find such a role burdensome. The concept of and differences between subjective and objective burdens is introduced using lists and common examples. It needs to be explained that subjective burdens, or the way relatives perceive the problem, can often be more troublesome than objective burdens, or the reality of the problem. Relatives should focus on listing their own problems in

these terms and focus on those that they perceive as most stressful (Atkinson & Coia, 1995:149).

The whole issue of being a carer should be covered. Common themes to be explored include the following: how they have been selected or have selected themselves to be primary carers; what this means to them in terms of burdens; neglect of themselves or other members of the family; how they can cope with these issues and resentment at being left to cope alone, not being valued or supported in the carer role; and being increasingly pressured to take on extra care. This session is specifically designed to help the relatives deal with the impact that the person with schizophrenia has on the family. It must be made clear to the relatives that the groups are a service to them, aimed solely at giving them information and support in order to reduce their personal stress (Atkinson & Coia, 1995:149).

Session 6: This session focuses on the family and schizophrenia and looks at the problems the relatives have if one of the members is suffering from schizophrenia. Blaming the family for the illness or implying any causal relationship must be avoided. The relationship between the carer and the cared for is explored. The important issue of stress is once again raised, and the fact that people with schizophrenia handle stress badly is examined. The main focus of the session is to discuss the mediating factor of stress between the patient's relative and the patient, how they may both either contribute towards, or negate, high levels of stress. This session introduces some concepts relating to high expressed emotion, over-protectiveness and over-involvement. Relatives should be encouraged to contribute suggestions on how they have coped in similar situations. When relatives share solutions to problems it can lead to an improvement in coping techniques (Atkinson & Coia, 1995:151; Persad, *et al.* 1992:92).

Session 7: Creating a low-stress environment. This session picks up on points raised in the last two sessions, looking at using the knowledge gained on stress and its effect on schizophrenia to maximise family functioning for the benefit of each family member. Strategies are offered for reducing stress within the household, and relatives are invited to contribute their own ideas (Gillis, *et al.* 1989:328; Atkinson & Coia, 1995:157).

Session 8: Managing disturbed behaviour. The overall aim of this session is to provide positive practical guidelines in order to help the patient's relatives cope with disturbed behaviour within the home. The group may offer suggestions on the setting of limits, responding to delusions or hallucinations, managing suicide attempts, and dealing with verbal and physical aggression. Relatives also have to consider how they manage their own distress and the effect that severely disturbed behaviour has on their own well-being. Distress to them has to be minimised and techniques to alleviate the problem should be discussed in the group (Atkinson & Coia, 1995:153).

Sessions 7 and 8 are aimed at establishing a positive relationship between families and their members suffering from schizophrenia. In session 7 strategies and methods or guidelines are offered to the families on how to cope with patients in order to alleviate the stress and burdens if possible. In session 8, relatives are still offered some guidelines on how to cope with delusions and hallucinations.

Session 9: Using services and dealing with crises is discussed. This session provides a comprehensive overview of services available to people with schizophrenia, what they do and what services are lacking. Patients' relatives describe their problems in dealing with services, including the availability thereof. It is helpful to discuss what may be expected of services, and what they can and cannot provide (Atkinson & Coia, 1995: 153).

Families may go to the wrong person for the wrong thing and a description of the role of individual health professionals is useful, particularly the duty of the hospital doctor. In addition, much support and guidance can be found outside the health-care system and this should be explored in relation to the local situation (Atkinson & Coia, 1995:153).

Dealing with health-care professionals can be intimidating, and guidelines are provided for getting the most out of the doctor or the health worker. Role-play can be used in this session, if relatives are comfortable with this, to practice dealing with professionals. This can help determine the best manner in which to articulate their requests or overcome feelings of intimidation. A list of telephone numbers, and a prior arrangement with the general doctor or the patient's consultant to contact them in times

of relapse, is useful and may speed up the process in times of a crisis (Atkinson & Coia, 1995:154).

Session 10: Where do relatives go from here? The overall message of this session is to get relatives to think positively about the future. In closing, patients' relatives can raise what they covered in the previous weeks. They can bring up new or previously covered issues, or discuss changes that the group has helped them to make and how successful these have been. In this session, there is an opportunity to comment on the usefulness of the group and to discuss follow-up meetings and the type of ongoing support they would like to receive. Goal-setting may help patients' relatives to consider how they plan to manage their relationship with the patient suffering from schizophrenia and reduce their own personal stress in response to the caring role. A list of support groups available within the area should be provided. A clear description and handouts of all the voluntary organisations in the area can also be provided (Atkinson & Coia, 1995:154; Barrowclough, *et al.* 1987:7).

Session 9 emphasises that patients and their families must be made aware of the available resources within the community. Alternatives must be provided in the case of the resources not being available. In session 10 the families are guided in thinking about and having specific directions about the future. They need to be guided on how to handle patients suffering from schizophrenia.

In summary, an education group programme is more detailed and does more than simply provide information. The patient's relatives not only share their practical experiences and problems encountered in living with patients suffering from schizophrenia, but also guide one another with regard to solutions as a way forward. Active participation amongst the group members is strongly encouraged.

At the end of the sessions, the patient's relatives will be expected to have a clearer picture of schizophrenia as a type of mental illness. This includes an understanding of the nature of schizophrenia, the possible symptoms, the treatment, the problems experienced by patients' relatives, how to overcome them, how to reduce stress, how to manage the disturbed behaviour and what services and resources are available for

assistance. Finally, the programme encourages the patients' relatives to think positively about the future, even when living with a patient suffering from schizophrenia.

In summary, the discussed intervention programmes may be relevant when the person suffering from schizophrenia is hospitalised as well as when the patient is discharged and placed back with his family and/or within the community. These programmes are important in preparing and helping the patient's relatives to cope with the negative impact of schizophrenia.

In addition to educational programmes, a behavioural problem-solving programme can be utilised as an intervention programme when the patient suffering from schizophrenia is placed back with his family and/or in the community.

5.2.2 BEHAVIOURAL PROGRAMMES

The behavioural family therapy approach to treatment of schizophrenia has been developed over the past ten to 15 years. The goal of the approach is to provide comprehensive long-term community care for patients suffering from schizophrenia, by utilising the problem-solving potential of their natural support systems (Straube & Hahlweg, 1990:228). This is achieved through a careful behavioural analysis of the family support system - its strengths as well as its deficits - followed by specific treatment of functional deficits. All family therapy sessions are conducted in the home to take full advantage of the entire family unit as a powerful agent for effecting social learning and reinforcement (Straube & Hahlweg, 1990:228). This behavioural problem-solving programme is also used as a means of helping patients' families to cope with stressful life events and to reduce family tension (Straube & Hahlweg, 1990:229).

The main focus of behavioural problem-solving programmes is behavioural family management with the whole family in order to develop family problem-solving and communication skills. The aim is to enable the family to shield the patient from stress and it is often defined as cognitive and behavioural strategies for stress management (Smith & Birchwood, 1990: 656; Lefley & Johnson, 1990:107; Atkinson & Coia,

1995:55). The patient's relatives will gradually be guided to coping independently with the stress of living with their ill relative.

The behavioural problem-solving programme also comprises several sessions. The first two sessions, which include the patient, are of an educational nature, giving information about schizophrenia and providing a rationale for the programme. The patient is expected to remain on oral medication given flexibly and at the lowest dose possible, as this will promote a better response to psychological intervention. The sessions are held at the patient's family home on a weekly basis for the first three months, fortnightly for the next three months and thereafter monthly for a period of three months. At the end of this intervention period, families are invited to attend multi-family groups held on a monthly basis.

Patients' families are taught problem-solving skills, including identifying a problem, generating solutions, evaluating potential consequences, agreeing on the best solution/strategy, implementing the solution and, finally, reviewing the outcome. The family is expected to work on problems between the meetings (Atkinson & Coia, 1995:55; Tofler & Harvey, 1999:606-607). Communication training is aimed at changing the way emotion is expressed and encouraging active listening, making specific requests and expressing both positive and negative feelings clearly. An important part of behavioural problem-solving programmes is the availability of a 24-hour service for crisis management (Atkinson & Coia, 1995:55).

According to Lefley and Johnson (1990:107), behavioural management skills can be as useful to patients' families as they are to hospital staff, particularly when the patient is at home. These strategies can help distinguish between behaviours that are under voluntary control and those that are not. Stress management skills can also be taught with good effect to family members. Learning to use exercise, hobbies, socialising, relaxation exercise, cognitive imagery, meditation and related techniques often help to minimise the deleterious effects of chronic mental illness within the patient's family. Patients' families can often offer good information about those situations their ill relatives handle well or poorly, which environmental circumstances are likely to be

perceived by the patient as being stressful, and the sort of management strategies that are likely to work in their own situation.

The behavioural problem-solving programme guides the patient's relatives on how to behave and how to approach the patient in order for them to understand each other, especially within the home setting.

In summary, family intervention programmes such as psycho-educational and behavioural problem-solving programmes are found to be useful, providing the patient's relatives with basic knowledge, insight and skills on coping with schizophrenia as a type of mental illness. The value of the discussed family intervention programmes lies in the fact that they can be implemented in a hospitalised setting as well as in a family and community environment.

When the psycho-educational and behavioural programmes are integrated, the respective sessions of the two programmes can manifest in a dynamic intervention programme unfolding in four phases.

5.2.3. PHASES OF AN INTEGRATED FAMILY INTERVENTION PROGRAMME

- *Phase one*

The first phase, in the period in which the patient suffering from schizophrenia is still hospitalised, involves two sessions per week with the patient's relatives. The patient does not attend these sessions. The aim of these two sessions is to develop a relationship with the relatives and also to reduce anxiety, guilt and frustration (Atkinson & Coia, 1995:53; Kleefer & Koritar, 1994:376). According to Kleefer and Koritar (1994:376), the aim of these two sessions is to:

1. Develop a therapeutic alliance with the family
2. Establish the clinician as the family ombudsman
3. Elicit reactions to the illness, and
4. Mobilise family concern and support.

This phase is supportive and empathic, with limited discussion about practical coping issues relating to the hospital management and discharge plans (Kleefler & Koritar, 1994:376).

Phases two, three and four are applicable when the patient is returned to his family and/or the community.

- *Phase two*

Phase two focuses on education for the family. It consists of a one day survival workshop that includes four or five patients' families. Patients and siblings are encouraged to attend, but the patient is excluded. Specific family management strategies for stress reduction and coping with the illness in the family are outlined. The guilt these families may harbour about their role in causing schizophrenia or about what they should have done to prevent the illness is discussed openly and realistically. The importance of clear family communication is stressed (Atkinson & Coia, 1995:53). At the conclusion of the workshop, families tend to feel substantially less isolated and usually opt to participate in a monthly multiple family group to continue sharing their burden and offering support to each other (Straube & Hahlweg, 1990:235). The relatives are encouraged to feel more confident and prepared to become long-term caregivers of patients suffering from schizophrenia.

- *Phase three*

This is the family therapy stage. Family sessions involve fortnightly meetings for a minimum of six months, with both relatives and the patient (Atkinson & Coia, 1995:53). The family management strategies outlined in the survival skills workshop are individualised and applied to the specific concerns and problems of each family. The patient now becomes an active participant in the family sessions and his gradual resumption of role functioning is a major theme of the sessions. The second major issue dealt with in this phase is the reinforcement of structure within the family to allow increased "psychological space" for the patient and other family members (Straube & Hahlweg, 1990:235). The need for exceptional patience is stressed. As the patient

becomes less withdrawn, more ambitious tasks are assigned, relating to a return to appropriate work and social functioning. Families are educated in the appropriate use of therapeutic resources such as when and how to seek professional help. Neurotic therapy with intramuscular fluphenazine is continued at optimal level throughout this phase of management (Straube & Hahlweg, 1990:235). The aim of phase three is to develop a feeling of acceptance of the patient now that he is back in the family system.

The family sessions in phase three are also directed towards educating patients and their families about the nature, course, etiology and treatment of schizophrenia. The family is asked to share their perceptions and experiences. The patient is encouraged to lead the discussion about his experiences of the illness. Frequently, in these sessions, family members come to understand for the first time how frightening, disruptive and alien the symptoms of schizophrenia can be to a patient. Symptoms such as auditory hallucinations and delusions are discussed. Theoretical material related to the etiology and treatment of schizophrenia is also presented. It is explained that although the exact causes of schizophrenia are unknown, schizophrenia appears to be related to a biochemical defect in the brain that can produce psychotic symptoms at times when the patient is under stress.

Individuals who develop symptoms of schizophrenia are probably born with a vulnerability to this and are neither responsible nor to blame for it; nor is the family. It is an illness similar in a sense to diabetes or hypertension, in that although there is no cure, there are very effective treatments that can reduce and often eliminate symptoms for long periods of time, allowing a gradual return to premorbid levels of functioning. Although families do not cause schizophrenia, they may influence its cause. There are many ways in which families can help maximise the patient's levels of functioning, as well as minimising the chances of relapse; therein lies the rationale for a family therapy approach (Straube & Hahlweg, 1990:228).

The family sessions in phase three of a family intervention programme enlighten the patient's family in particular and improve their understanding of schizophrenia as a mental illness.

- *Phase four*

Finally, Phase four is attained when the patient is able to perform expected roles in the community through work or school and when the family is coping effectively with this increased autonomy and role functioning. At this time, the family can opt for one of these alternative treatments:

1. Maintenance family therapy with contact decreased to once a month or less
2. More intensive family therapy with confrontation of long standing family conflicts and interpersonal communication deficits.

This phase usually begins a year after discharge and continues for up to two years (Straube & Hahlweg, 1990:226).

In this last phase, the patient continues with his regular medication and is accepted and supported by his family. He can live a normal life, be employed and take part in decision-making. The effectiveness of family intervention programmes, however, depends on how collaboration between the patient, the patient's relatives and the professional team is maintained.

5.3 CONCLUSION

The main emphasis in Chapter Five is the discussion of family intervention programmes for both patients suffering from schizophrenia and their relatives. The focus of family intervention programmes is to bring knowledge, insight, skills and support to families of patients suffering from schizophrenia.

The family intervention programmes discussed in this chapter include psycho-educational and behavioural problem-solving programmes. The psycho-educational programmes are seen as the dominant programmes in family intervention. These programmes are deemed applicable both when the patient suffering from schizophrenia is still hospitalised as well as when he is discharged and placed back with his family and/or within the community.

The psycho-educational programmes relevant when the patient suffering from schizophrenia is still hospitalised include:

1. In-patient crisis groups for relatives
2. Crisis interventions
3. Psycho-educational workshops.

The psycho-educational programmes which are applicable when the patients suffering from schizophrenia are discharged and placed back with their families and/or within the community are:

1. Education for relatives and/or
2. Education groups.

A behavioural problem-solving programme is implemented when the patient suffering from schizophrenia is at home and/or within his community. This programme can be effectively integrated with psycho-educational programmes. An integrated family intervention programme can be implemented through four phases. Phase one is applicable only when the patient is still hospitalised. The other phases are applicable when the patient suffering from schizophrenia is at home with his family members and/or living in his community.

The family intervention programmes discussed in this chapter are targeted at a tertiary level of prevention.

In Chapter Six, the empirical study and research findings will be discussed.