CHAPTER ONE

GENERAL INTRODUCTION AND ORIENTATION

1.1 INTRODUCTION

Mental illness in one form or another is one of the illnesses that exists in human life (Schlesinger, 1985:27). Schizophrenia is a type of mental illness with subtypes such as catatonic, disorganised, paranoid, residual and undifferentiated (DSM-IV, 1994:288; Holmes, 1994:275; Gillis, 1986:78). Some patients suffering from schizophrenia are institutionalised while others live with their families. This requires home- and community- based care. Within an ecosystem framework, both these categories of patients affect family functioning because they are still members of families and of the community system. This illness disturbs the family system's functioning and the homeostasis of the family (Keeney & Ross, 1992:171; Marsh, 1992:33).

Stability and change are parts of the family process in every family system and therefore family members need to adapt to different situations such as stress and illness. Miller (1978:81) refers to a pathological process when one or more changes occur for a significant time, causing unstable interaction or an insufficient adaptation process which makes recovery difficult. For healthy family functioning to continue when trauma occurs, the members need to adapt and develop coping mechanisms during an adaptation process.

In addition to understanding the impact of schizophrenia on the functioning of the family from a social work perspective, the researcher focused briefly in this study on the motivation for the choice of this subject, as well as on the formulation of the problem, the aim and objectives, hypotheses and the research methodology. The researcher also focused on literature studies, which included models for family intervention programmes. She concentrated on the ecosystemic approach, which was utilised as the theoretical framework for this study. Key areas in the literature study included the assumptions, key comparative parameters and techniques of the ecosystem framework, schizophrenia as phenomenon with its subtypes and, finally, the phases and the

characteristics of family functioning. Data was collected for the empirical work from a quantitative research approach. In conclusion, social work guidelines were recommended to guide social workers in helping families to cope with patients suffering from schizophrenia.

1.2 MOTIVATION FOR THE CHOICE OF THE SUBJECT

During the 18th century, most mental patients were placed involuntarily in hospitals or in prisons (Hatfield & Lefley, 1987:5-7; Theron & Louw, 1989:11). In South Africa during the period 1826 to 1875, these patients were put on Robben Island and then gradually placed in psychiatric hospitals (Theron & Louw, 1989:12 and Mental Health Act, 1973, Section 38). These mental patients were separated from their families and institutionalised. Psychiatric medicine was developed in 1950 which made it possible for mental patients to be placed in the community. This idea of using medicine only, was not successful because there were no other resources in the community, such as clinics and mental health programmes, for the patients and their families to provide home- and community-based care (Theron & Louw, 1989:12).

Even today one of the main problems is that family members, including the patients, still do not understand mental illness, specifically schizophrenia. A lack of insight into mental illness such as schizophrenia causes the patient, his family and the community to behave negatively towards one another (Guide for the professions, 1986:6; Marsh, 1992:11).

From the researcher's clinical experience of working with mental patients, she realised that there is a lack of insight into mental illness, in particular schizophrenia, especially in families. For example, one paranoid patient murdered his mother and cut off her genital organs and breasts. According to the relatives' interpretation, the patient acted intentionally with the motive of selling the organs to a traditional doctor in order to get rich.

According to the DSM-IV (1994:8) and Hatfield (1990:32), schizophrenia is a type of mental illness that frustrates the family. The family and patient experience a burden of

feelings such as anger, worry and depression because of the negative relationship between the patient and family. The family also experiences a burden related to loss of employment, social isolation and limitations on leisure activities caused by having to supervise the patient (Atkinson & Coia, 1995:35-36). The community needs to be resourceful. On one hand, there should be mental hospitals for institutional care when necessary and, on the other hand, basic needs such as family homes, food, clothes and services such as employment, clinics, education and police services to promote home- and community-based care. This will help patients and families to meet their needs within the home and the community.

There are different models from the different professions of medicine, psychiatry and psychology to treat patients suffering from schizophrenia (Marsh, 1992:26). From a social work point of view, the ecosystem perspective makes it possible to treat the patient within his family and the environment. Social work guidelines are needed to inform patients and families about schizophrenia in order to encourage home- and community-based care (Dixon & Lehman, 1995: 639). A lack of such guidelines will impact on effective social services to the schizophrenia patient and his family. When social workers, on the other hand, can render services according to specific guidelines, they can evaluate the effectiveness of services and adapt intervention strategies according to the needs of the patient and his family. Social work guidelines can ensure the rendering of accountable social services, to the patient and his family.

1.3 PROBLEM FORMULATION

When a member of the family suffers from schizophrenia this illness impacts negatively on the family's interaction, relationships and functioning. Some of the factors indicate that the family and patient experience negative emotions such as anger, frustration and worry because this illness affects their understanding of each other. The family experiences a loss of employment, social isolation and also faces a burden because they find it difficult to deal with such a patient and his unpredictable behaviour (Atkinson & Coia, 1995:36). They become embarrassed and consider hiding the patient (DSM-IV, 1994:8), which indicates that the family cannot cope with such a patient.

The family, and the community in general, seem to lack insight into mental illness, including schizophrenia. A patient suffering from schizophrenia is seen as a burden which the family cannot cope with. Contributing to this view is the fact that the patient sometimes relapses and needs to be readmitted (DSM-IV, 1994:8). Johnson and Schwarz (1994:9) found that although the patient suffering from schizophrenia takes medication the readmission rate is still high. The families seem to be in favour of institutional caring rather than home- and community-based care. Generally it seems that the negative impact of schizophrenia on family functioning is caused by a lack of knowledge and insight into this mental illness, which affects the positive relationships between the patient, family and the community.

There are various models available to address schizophrenia today. The biological model focuses on biological factors (Kaplan & Sadock, 1988:343), whereas the psychological model focuses on the individual and considers a neurotic influence (Marsh, 1992:30). The bio-psychosocial model, which is used at Weskoppies Hospital, focuses on the patient as a whole and on the patient's illness but not on the patient's family within the environment (Shannon, 1989: 38). This means that the social worker, as part of the team, must implement different social work methods in order to meet the patients' and families' needs as part of the community (Shannon, 1989:38).

These different models are important because they focus on the needs of the patient. The social worker, as part of the mental health team, therefore also needs to understand them. For the diagnosis of mental illness-schizophrenia, the DSM -IV model makes use of five axes for mental illness-schizophrenia classification (DSM-IV, 1994:26). Although the medical model is important for diagnosis and medical treatment, it fails to function on its own since the patient must be treated within his family and community context. It will be argued in this study that, from a social work point of view, the ecosystem framework provides a useful theoretical framework.

The researcher supports Dixon and Lehman's view (1995:639) that there seem to be no social work guidelines for guiding families to cope with patients suffering from schizophrenia. In view of the lack of such guidelines, this study was undertaken to investigate the impact of schizophrenia on family functioning. This resulted in the

development of social work guidelines for guiding families to cope with schizophrenia.

1.4 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to investigate the impact of schizophrenia on the relationships and functioning of the family and to develop social work guidelines, from an ecosystem framework perspective, for social workers to guide families to cope with patients suffering from schizophrenia.

The objectives of the study were to:

- Select and study relevant literature to explore the phenomenon schizophrenia and family functioning from a social work perspective
- Investigate the causes of the negative impact of schizophrenia on relationships, attitudes, interaction and functioning of the family
- Investigate relevant family intervention programmes to develop more knowledge and insight into patients suffering from schizophrenia and their families
- Develop social work guidelines for use by social workers to guide the schizophrenic patient's family in coping with the impact of schizophrenia, in particular in a home- and community-based context.

1.5 HYPOTHESIS FOR THE STUDY

A hypothesis is a statement that one has reason to believe is true but for which adequate evidence is lacking (De Vos, 1998:42). A hypothesis is thus a tentative explanation for certain facts, which will become part of a theory as soon as it is confirmed by sufficient evidence (De Vos, 1998:116). Berger and Patchner (1988:35) define a hypothesis as a statement about the nature of the relationship between two or more variables. Hypotheses carry clear implications for testing the stated relations. (Compare Bless & Higson-Smith, 1997:11; Royse, 1992:17; Grinnell, 1997:91; Neuman, 1997:111, De Vos, 1998:116; Bailey, 1994:53.)

There are various types of hypotheses, such as one-directional and two-directional hypotheses (in statistical form a one tailed or two-tailed hypothesis) (De Vos, 1998:118; Grinnell, 1997:93). A relational hypothesis can state one of several types of relationships between variables. A hypothesis may assert that two variables are associated in a direction – positively or negatively – which is referred to as a one-directional hypothesis (De Vos, 1998:118). Grinnell (1997:94) supported De Vos (1998) and stated that a one-tailed research hypothesis simply predicts a specific relationship between the independent variable and the dependant variable. A two-directional hypothesis is a hypothesis asserting that two variables are simply associated in some manner, without indicating in which direction the association lies (De Vos, 1998:118; Grinnell, 1997:94).

For the purpose of this study, a two directional hypothesis is chosen because the variables seem to be associated in some manner without indicating in which direction that association lies.

The following two-directional hypotheses, with their derivatives, were formulated for this research study:

1. Negative impact of schizophrenia on the relationship, interaction and functioning of the family is caused by lack of insight into schizophrenia as a type of mental illness by both the patient suffering from schizophrenia and his family.

2. Insight into schizophrenia as a type of mental illness can be developed through family intervention programmes.

3. Developing social work guidelines may help the family of a patient suffering from schizophrenia and the patient himself to understand schizophrenia, increase the ability to cope with such a patient at home and encourage home and community-based care.

Hypothesis:

If social work guidelines are developed and relevant family intervention programmes are emphasised to bring about more understanding of and insight into schizophrenia on the

part of the patient suffering from schizophrenia and his family, then positive relationships, interactions and functioning will occur within the family and home-and community- based care will be encouraged.

1.6 RESEARCH APPROACH

Quantitative and qualitative research are both research approaches attempting to describe and explain social reality. They are both techniques used for data collection (Grinnell, 1985:274; Neuman, 1997:2).

The researcher has chosen the quantitative research approach to describe the relationships between the lack of insight into schizophrenia as a type of mental illness and the negative impact of schizophrenia on family functioning.

The quantitative research method attempts to study only those variables that can be objectively measured. The quantitative research method is a language of variables, hypotheses, units of analysis, and causal explanation. The emphasis in quantitative research is on the relationship among variables (Neuman, 1997:14; Grinnell, 1985:273), and therefore quantitative research is linked or related to descriptive research design.

The purpose of the quantitative research method lies in the testing and validation of predictive, cause-effect hypotheses about social reality (Grinnell, 1985:266). According to Schurink (1998:241), supported by Bailey (1982:8), the quantitative paradigm is based on positivism, which takes scientific explanation to be nomothetic (that is, based on universal laws). Its main aims are to measure the social world objectively, to test hypotheses and to predict and control human behaviour. In contrast, the qualitative paradigm stems from an antipositivistic, interpretative approach, is idiographic, thus holistic in nature, and the main aim is to understand social life and the meaning that people attach to everyday life (Schurink, 1998:241). The researcher has chosen the quantitative approach to test the said hypothesis and to guide or manage the behaviour of the patient suffering from schizophrenia and his family by developing their insight into schizophrenia by means of education. Although the primary focus is on the quantitative approach, the researcher will utilise the qualitative approach to formulate

social work guidelines for intervention with the patient suffering from schizophrenia and his family.

Schurink (1998:242) states that in terms of ontology the quantitative researcher believes in an objective reality, which can be explained, controlled and predicted by means of natural (cause-effect) laws. Human behaviour can be explained in causal deterministic ways and people can be manipulated and controlled. In contrast, the qualitative researcher discards the notion of an external objective reality. To the qualitative researcher, behaviour is intentional and creative, and it can be explained but not predicted (Schurink, 1998:242). In this research study, through the application of the quantitative approach, the researcher intended to find the solution that would describe the impact of schizophrenia on family functioning.

In terms of epistemology, the quantitative researcher sees himself as detached from, not part of, the object that he studies. The researcher can therefore be objective – he does not influence the study object and is not influenced by it. In contrast, the qualitative researcher is subjective because he interacts with the subject (Schurink, 1998:242). It was necessary in this study for the researcher to be objective, implying that she was not influenced by the respondents and could collect data objectively.

The quantitative approach differs from the qualitative approach since the qualitative researcher is concerned with:

- Understanding rather than explaining
- Naturalistic observation rather than controlled measurement
- The subjective exploration of reality from the perspective of an insider as opposed to the outsider perspective that is predominant in the quantitative paradigm (Schurink, 1998:243).

Quantitative research tends to utilise data collection methods such as social surveys, structured interviews, self-administered questionnaires and census data (Grinnell,

1985:267). The researcher has chosen a semi-structured interview schedule as an instrument for data collection. The quantitative approach furthermore often goes hand-in-hand with applied research. A quantitative approach and applied research both aim at developing knowledge and addressing the application of research in practice (Fouché & De Vos, 1998:69).

Reid and Smith (1981:87-89) and Bailey (1982:8) added that in the quantitative approach the researcher's role is that of an objective observer and studies are focused on specific questions or hypotheses that ideally remain constant throughout the investigation. Data collection procedures and the type of measurement are constructed in advance of the study and applied in a standardised manner. Interviewers or observers are not expected to add their own impressions of interpretations. Measurement is focused on specific variables that are quantified through frequency counts, as is applied in this research study. Analysis proceeds by obtaining statistical breakdowns of the distribution of the variables and by using statistical methods to determine associations of differences between variables (De Vos, 1998:358).

In contrast to a quantitative approach, when working from a qualitative perspective, the researcher attempts to gain a first-hand holistic understanding of phenomena and data collection becomes shaped as the investigation proceeds. Methods such as participant observation and unstructured interviewing are used. Qualitative methodology rests on the assumption that valid understanding can be gained through accumulated knowledge acquired first-hand by a researcher (De Vos, 1998:358). For the qualitative research, the focus group was selected as data collection. Utilisation of focus group is a research method used during data collection which can be classified as a form of intervewing. In essence, this method is an open discussion between specifically selected persons under the leadership of a group leader who is trained and experienced in handling group dynamics (De Vos & Fouché, 1998:90). According to Schurink (1998:314), focus group implies that the discussion takes place in a group that is limited to the specific theme under investigation.

1.7 TYPE OF RESEARCH

Intervention research is the exciting new view of applied research in the caring professions. Intervention research is a concept which grew from collaboration between the two major pioneers in the field of developmental research, Thomas and Rothman. Developmental research here denotes the development of a technology or, better termed, a technological item essential to a profession such as medicine, nursing, psychology or social work (De Vos, 1998:9).

Intervention research as conceptualised here is targeted at addressing the practical application of research. Three main types of intervention research are identified:

- Empirical research to extend knowledge of human behaviour relating to human service intervention – referred to as intervention knowledge development (KD)
- The means by which the findings from intervention knowledge development research may be linked to and utilised in practical application – referred to as intervention knowledge utilisation (KU)
- Research directed at developing innovative interventions – referred to as intervention design and development (D & D) (Fouché & De Vos, 1998:69).

Despite the relevancy of intervention research for this study, the researcher has chosen to do traditional research because it is directed primarily at what has come to be known as knowledge development. Traditional research draws its methods largely from the behavioural sciences and uses them to examine research questions relevant to social work and social welfare. This model of research in social work is often referred to as the behavioural science model because its objective is to make contributions to knowledge of human behaviour. Its objectives are exploratory, descriptive or explanatory and its goal is pure or basic research and also some form of applied research (De Vos, 1998:9).

By utilising traditional research for this study, the researcher will be able to find explanations for why there may be a negative relationship between the patient suffering from schizophrenia and his family members.

Developmental research, in contrast with traditional research, is very different and was not well known until the beginning of the 1980s. This research model developed owing to the need of professions such as social work, engineering, medicine and all other fields dealing with applied and practical matters for a technology. Technology, in this context, consists of all the technical means by which such a profession achieves its objectives (De Vos, 1998:9).

Thomas (1984, 1989 in De Vos, 1998:10) again distinguishes between traditional research methods, in which the focus of enquiry is on contributing to knowledge about human behaviour, and the developmental approach, which emphasises the means by which innovations in the human services may be developed. He adds that the outcomes of developmental research are likewise different from those of traditional research. Instead of yielding findings that shed light on some aspect of human behaviour, the outcomes of developmental research are "products" that are the technical means of achieving the objectives of a profession. The results of this study are expected to make some contribution to human behaviour, for instance understanding how the patient suffering from schizophrenia behaves, how to cope with the illness and the patient.

In summary, the quantitative approach and traditional research methods were chosen by the researcher in order to describe the relationships between variables, hence hypothesis testing, descriptive research design and pilot study (De Vos, 1998:387; Bless & Higson-Smith, 1997:41). The researcher has chosen traditional research because traditional research, according to Bailey (1982:3), is also concerned with gathering data that can help to answer questions about various aspects of society and can thus enable one to understand society. The researcher would like to understand schizophrenia and how it affects the functioning of the family in order to provide professional guidelines for patients and families to cope with the impact of the illness.

In traditional research, a survey could be used to gather data for testing theory (Bailey, 1982:4). The researcher utilised a survey for the research, confirming the choice of doing traditional research. Traditional research methods and a quantitative approach were utilised in the study. In intervention research both quantitative and qualitative approaches are combined. Prospective researchers are strongly advised to decide on only one of these approaches and to avoid combinations (De Vos, 1998:356) since these can be highly problematical.

Most authors in the field of social work research, for example, state clearly that their books are written from a quantitative point of view. Pragmatically, to use both paradigms adequately and "accurately consumes more pages than journal editors are willing to allow, and extends postgraduate studies beyond normal limits of size and scope" (De Vos, 1998:358). Using both paradigms in a single study can be expensive, time-consuming and lengthy. Also, researchers (and university departments) are seldom trained in the skills necessary to conduct studies from more than one paradigm; individuals learn one paradigm, and their perspective becomes the dominant view in their research (De Vos, 1998:358). Following these notes and explanations, the researcher has chosen traditional research which is simpler, not very expensive or lengthy and concentrates on one paradigm, namely the quantitative approach.

In addition, the qualitative approach was utilised to engage social workers in the formulation of social work guidelines for intervention with the patient suffering from schizophrenia and his family. The focus group for this study consisted of eleven participants – social workers from Weskoppies Hospital joined by one senior social worker from North Gauteng Mental Health, who also acted as co-interviewer.

The aim of the focus group discussion according to Schurink, Schurink and Poggenpoel (1998:314), was to obtain more relevant ideas in order to develop quality social work guidelines to enable the patient suffering from schizophrenia and his family to cope with schizophrenia.

The discussion consisted of interviewing questions which, according to Schurink, *et al.* (1998: 319), were classified into the following categories:

- Introductory question which introduces the general topic of the discussion

- Key questions which are important questions to develop social work guidelines. Open-ended questions were encouraged because they allowed the participants to describe their views concerning social work guidelines (Schurink, *et al.* 1998: 319). Follow-up questions or probing were used as techniques to encourage all members to participate. A summary of the main points of view was used when concluding the focus group discussion.

1.7.1 APPLIED RESEARCH

The researcher has chosen applied research because its purpose is to develop and utilise knowledge, which addresses the application of research in practice (Fouché & De Vos, 1998:69). Social work guidelines could be developed through applied research. The purpose of developing social work guidelines in this study is to enable the patient's family, as well as the patient, to cope with schizophrenia. Applied research is thus chosen because it provides possible solutions to practical problems.

Applied research aims at contributing towards practical issues of problem-solving, decision-making, policy analysis and community development (Terre Blanche & Durrheim, 1999:41 & Bailey, 1982:21). Hedrick, Bickman and Rog (1993:4) supported this view and stated that applied research addresses the problems and discovers practically significant relationships or effects. The researcher has chosen applied research because it aims to study variables that are hoped to produce societally significant results, effects and criteria or practical significance (Hedrick, *et al.* 1993:3). The researcher would like to investigate how the lack of insight into schizophrenia is affecting family functioning. In applied research, data is collected in the field and outside the laboratory, unlike in basic research. In applied research, lengthy negotiations are engaged to obtain permission for access to the data (Hedrick, *et al.* 1993:6). The researcher indeed underwent lengthy negotiations to obtain permission from the ethics committees to conduct a research study or to collect data at Weskoppies Hospital.

Applied research aims only to generalise the findings of a study to the specific context under study in order to assist decision-makers in drawing conclusions about the particular problems they are dealing with (Terre Blanche & Durrheim, 1999:4). Applied research planning is both a science and an art. The conduct of applied research can be viewed as consisting of two phases, planning and execution, encompassing four stages within those phases. In the planning phase, the researcher is concerned with defining the scope of the research (stage 1) and developing a research plan (stage 2). During execution, the research plan (design, data collection and analysis, and management procedures) is implemented fully and monitored (stage 3), followed by reporting and follow-up activities (stage 4) (Hedrick, *et al.* 1993:11; Singleton, Straits, B.C, Straits, M.M. & McAllister, 1988:306). In this research study, the researcher followed the above stated two phases for conducting the research.

1.8 DESCRIPTIVE RESEARCH DESIGN

Research design is a plan for how a research study is to be conducted (De Vos & Fouché, 1998:77; Wechsler, Reinhertz, Hyg & Dobbin, 1981:85). A research design involves developing strategies for executing scientific inquiry. It involves specifying precisely what the researcher wants to explore and determining the most efficient and effective strategies for doing so. Appropriate research designs enable the social scientist to make observations and interpret the results (Babbie, 1992:43).

The researcher chose the descriptive research design because it can provide precise information on the characteristics of respondents (Royse, 1992:44). The researcher's respondents were the patients suffering from schizophrenia and their key relatives. The objective of the descriptive research design is to reveal potential relationships between variables. Descriptive research studies aim to describe phenomena. Descriptive research studies furthermore seek accurate observations and focus on validity (accuracy) and reliability (consistency) of the observations and, especially if it is a positivist study, the representativeness of sampling (Terre Blanche & Durrheim, 1999:40; Grinnell, 1988:220; Dane, 1990:7 & Collins, 1985:20). Wechsler, *et al.* (1981:86) also stated that descriptive designs are used to provide detailed information about the interrelationship of certain variables concerning the phenomenon in question. Descriptive studies can

link two variables and establish correlations. The researcher investigated the correlation between the lack of insight into schizophrenia and the negative impact of schizophrenia on family functioning.

However, this study cannot claim any representativeness of sampling, for two reasons: the sample is much too small, and it was not drawn randomly. The result is therefore viewed as impressionistic only, offering only a broad and tentative basis for suggesting certain social work guidelines for the patient's family in a home- and community-based context. Semi-structured interview schedules were used as a tool for data collection determining the relationship between variables (Bless & Higson-Smith, 1997:43), the variables being the negative impact of schizophrenia on family functioning and the lack of insight into schizophrenia as a type of mental illness.

1.9 RESEARCH PROCEDURE AND STRATEGY

Research procedure and strategy are seen as the processes applied by the researcher when conducting research. According to De Vos (1998:38), the modern research procedure has the following description:

- It originates with a problem
- It ends with a conclusion
- It is based upon observable facts, called data
- It is logical
- It is orderly
- It is guided by a reasonable statement (the hypothesis)
- It confirms or rejects the reasonable statement (the hypothesis) on the basis of what the data and only the data, dictate
- It arrives at a conclusion on the basis of what the data, and only the data, dictate
- The conclusion resolves the problem.

The research procedure is largely circular in configuration, because it begins with a problem and ends with that problem resolved (De Vos, 1998:39). The researcher investigated the impact of schizophrenia on family functioning from the ecosystem

framework. Relevant literature was selected and studied to investigate, conceptualise and identify operational assessment areas in family functioning from the perspective of the ecosystem framework. This was used to develop semi-structured interview schedules, one for the patients and one for key relatives. The semi-structured interview schedules were written in English and interpreted in the ethnic language understood by each respondent. The information gained was utilised to develop social work guidelines to help patients' families, as well as the patient, to cope with schizophrenia.

1.10 PILOT STUDY

"Pilot study" is defined as the process whereby the research design for a prospective survey is tested. The pilot study is indeed a prerequisite for the successful execution and completion of a research project. The pilot study forms an integral part of the research process. It offers an opportunity to test the interview schedule with, for example, the kind of interviewer and the kind of respondent who will be utilised in the main investigation. It must be executed in the same manner as the main investigation is planned (Strydom, 1998:178-182).

For the purpose of this study, under pilot study the following four components were described: literature study; consultation with experts; overview of the feasibility of the study; a pilot test of the measuring instrument and the semi-structured interview schedules.

1.10.1 LITERATURE STUDY

Computer printouts comprising books and journals available in the information services centre and an inter-library loan service for locating national and international sources were used through the assistance of the information experts at the University of Pretoria.

Literature from other disciplines such as psychiatry, psychology and medicine, including nursing, were sufficient for the study of schizophrenia as a type of mental illness. It appears that social work books on mental illness and social work guidelines to educate families in care of patients in a home-based and community-based care context are still

lacking. Research reports and literature focus more on institutional care as opposed to home- and community-based care. This is in contrast with the present government paradigm shift and transformation (White Paper for Social Welfare, 1997:82).

In analysing the concept schizophrenia and the impact of schizophrenia on family functioning, the researcher came to the conclusion that family functioning can be divided into four assessment areas, namely an ecological context, migration and acculturation, family organisation and a family life cycle. All these four assessment areas were included and discussed in this study.

1.10.2 CONSULTATION WITH EXPERTS

The purpose of consulting with experts is to bring unknown perspectives to the fore or to confirm or reject the researcher's own views (Strydom, 1998:181). It was valuable to consult with the following experts in different fields and professions:

- Prof. J. D. Kriel, lecturer in the Department of Anthropology at the University of Pretoria. He was consulted to help the researcher to compare and understand the cultural beliefs in relation to mental illness with special reference to schizophrenia

- Dr S. Olivier, Welfare Officer in the then National Department of Health and Social Welfare. The aim of this consultation was for the researcher to discuss the problem and determine the relevancy of the research topic in as far as the National Department of Social Welfare focuses on community-based care

- Mrs M. Viljoen, Head: Social Work Department of Weskoppies Hospital and ethics committee member at Weskoppies Hospital. The purpose of this consultation was to inquire about the feasibility of the study from an institutional point of view. She was also consulted for the purpose of identifying relevant sources and references

- Mrs A. Kotze, Head: Social worker for YANA (Home for Schizophrenia). The purpose of this consultation was to get some more relevant literature, sources, and references and to discuss the study topic with her since she works with patients

suffering from schizophrenia. She is regarded as a specialist in the field of mental illness

- Prof. Roos, psychiatrist at Weskoppies Hospital and one of the Weskoppies ethics committee members. The aim of consulting him was to echo the relevance of the study and to inquire about relevant sources on the topic

- Research Panels: Weskoppies Hospital and Pretoria Academic Hospital ethics committees. The researcher attended both Weskoppies and Pretoria Academic Hospital ethics committees. The aim of attendance was for the committee to know and understand the aim of the research study before the researcher could be granted permission to collect data for the empirical research. Research proposals together with the measuring instrument, the interviewing schedules, were submitted

- Mrs E. Mauer, Research support group, Department of Information Technology of the University of Pretoria. The aim of consulting a member of the information-technology research group was to obtain assistance in analysing the data collected through the use of the SAS statistical package version 8, to calculate frequency distribution

- Mrs N. Strydom of the Department of Statistics of the University of Pretoria was consulted in conjunction with the research support group for data analysis.

1.10.3 OVERVIEW OF THE FEASIBILITY OF THE STUDY

As a senior employee of the then Department of Health and Social Welfare, placed at Odi Community Hospital (Mabopane), the researcher was allowed to make arrangements for the study to proceed. From personal experience of talking to experts and families in the community, it was found that there was a need for social work guidelines to help patients and families to cope with schizophrenia.

Patients were available at Weskoppies Hospital and arrangements were also made with patients' key relatives for data collection. Access to the files was easy. Permission from respondents was granted through consent letters (Hedrick, *et al.* 1993:6). Since

Weskoppies Hospital caters for all provinces, it was easy for the researcher to interview respondents from different cultures and various provinces by using dimensional sampling. After the research proposal and semi-structured interview schedule were submitted to the ethics committees of Weskoppies and the Pretoria Academic Hospital, permission was granted to conduct the research study.

Sufficient literature from different professions, such as psychiatry, medicine and psychology on mental illness and specifically schizophrenia, was found and used as described in Chapter 3 of the research report.

1.10.4 PILOT TEST OF SEMI-STRUCTURED INTERVIEW SCHEDULES

The pilot study included one patient and his key relative. The interview was conducted twice to test and measure the validity and reliability of the semi-structured interview schedule (Grinnell, 1989: 238) and to test whether the formulation of questions could be understood by the respondents. The researcher used the language spoken by each respondent although the semi-structured interview schedules were in English. Time spent on questions for patients was approximately one hour and 25 minutes and time spent with key relatives was about one hour. It was found that some questions elicited similar answers from respondents. Therefore, one of the questions had to be cancelled when formulating the final semi-structured interview schedules.

1.11 DESCRIPTION OF THE RESEARCH POPULATION, BOUNDARY OF SAMPLE AND SAMPLING METHOD

The research population, boundary of research, sample and sampling method will be briefly described.

1.11.1 RESEARCH POPULATION

For the quantitative research, the researcher included five patients, that is one patient per schizophrenia subtype, and five key relatives during data collection. Different cultural groups were included in the study and the respondents were Afrikaans, English, Swazi,

Zulu, and South Sotho (Grinnell, 1989: 133). The population was also diverse in other ways, including females and males, different ages and types of families such as single and marriage relationships. One similarity was that the patients were in Weskoppies Hospital and diagnosed as individuals suffering from schizophrenia, through using the DSM-IV model.

The research study was confined to the geographic areas of the three Pretoria suburbs; Faerie Glen, Lynnwood Glen and Atteridgeville, as well as Thabazimbi and Kwaggafontein. This means that the patients who were interviewed came from three provinces, namely Gauteng, Mpumalanga and North West.

1.11.2 SAMPLE AND SAMPLING METHOD

Sampling involves decisions about which people, settings, events, behaviours and/or social processes are observed. The main concern in sampling is representativeness. The aim was to select a sample that would be representative of the population about whom the researcher aimed to draw conclusions. Representative samples are especially important in descriptive surveys that are used to estimate accurately the properties of populations (Terre Blanche & Durrheim, 1999:44).

Dimensional sampling is a non-probability, that is, not a random sampling type. Dimensional sampling is basically a multi-dimensional form of quota sampling. The idea is to specify all dimensions (variables) of interest in the population and then to make sure that every combination of these dimensions is represented by at least one case (Bailey, 1994:95; De Vos, 1998:199). The researcher has chosen one schizophrenia patient per schizophrenic subtype, one paranoid type, one residual type and one differentiated type, and one key relative per subtype patient. Dimensional sampling entails that only a few cases are studied in depth (Strydom & De Vos, 1998:199). Dimensional sampling, according to Bailey (1994:95), has the following important functions:

- It explicitly delineates the universe to which the researcher eventually wishes to generalise

- It spells out what appears to be the most important dimensions along which the members of this universe vary and develops a typology that includes the various combinations of values on these dimensions

- It uses this typology as a sampling frame for selecting a small number of cases from the universe.

The researcher has chosen dimensional sampling since it is a method designed for studies in which only a small sample is desired so that each case drawn can be studied in more detail than is possible in a large-scale study. The dimensional-sampling method is designed to make sure that even though it works with a small number of respondents, it differs from other sampling methods with small numbers of respondents because some needed values of variables are represented (Bailey, 1994:95). According to Singleton, *et al.* (1988:305), the general strategy, sometimes called dimensional-sampling, is to sample relevant dimensions of units rather than units themselves. With regard to the social workers, all fourteen social workers employed at Weskoppies Hospital were invited to join the focus group. Eleven of these social workers, holding various job ranks/positions and from diverse cultures, participated.

1.12 STATISTICAL ANALYSIS

The research consultant from the Research Support Group of the Department of Information Technology and a statistician from the Department of Statistics, University of Pretoria, were consulted. The SAS statistical package version 8 was used to calculate frequency distribution and means. The findings were presented descriptively by making use of frequency tables, means and graphs.

1.13 ETHICAL ISSUES

Since human beings are the objects of study in the social sciences, this brings its own

unique ethical problems to the fore, which would never be relevant in the pure, clinical laboratory settings of the natural sciences. Social workers increasingly realise that it is very important to recognise and deal with ethical aspects if the research study's goal is to be successful (Strydom, 1998:23).

The following ethical issues are identified by Strydom (1998:24):

- Harm to experimental subjects and/or respondents
- Informed consent
- Deception of subjects and /or respondents
- Violation of privacy, actions and competence of researchers and
- Release or publication of the findings.

1.13.1 HARM TO EXPERIMENTAL SUBJECTS AND/OR RESPONDENTS

Respondents were thoroughly informed beforehand about the potential impact of the investigation. The purpose of this information was to allow the respondents to withdraw from the investigation if they wished to. The researcher obtained assistance from the Weskoppies Hospital nurses in charge of the patients in choosing patients who were not violent and who could somehow understand the purpose of the study (Dane, 1990:44 & Strydom, 1998:25).

1.13.2 INFORMED CONSENT

Obtaining informed consent, according to Grinnell (1985:105) and De Vos (1998:26), implies that all possible or adequate information on the goal of the investigation, the procedures which will be followed during the investigation, the possible advantages and dangers to which the respondents may be exposed, and the credibility of the research be rendered to potential subjects or their legal representatives. Emphasis must be placed on accurate and complete information so that subjects will fully comprehend the investigation and consequently be able to make a voluntary, thoroughly reasoned decision about their possible participation.

For the purpose of this study, the researcher obtained informed consent from the respondents and it was explained that their participation was voluntary and that they could withdraw from the participation if they wished.

1.13.3 DECEPTION OF SUBJECTS AND/OR RESPONDENTS

Deception of subjects refers to withholding information or offering incorrect information in order to ensure participation of subjects when they would otherwise possibly have refused it (Covey, Covey & Callanan, 1993:230). The researcher did not deceive the respondents. All the questions were explained straightforwardly for the purpose of this study.

1.13.4 VIOLATION OF PRIVACY

The right to privacy means that the individual has the right to decide when, where, to whom and to what extent his attitudes, beliefs and behaviour will be revealed (Strydom, 1998:28). This principle can be violated in a variety of ways.

The researcher explained to the respondents that principles of confidentiality and non-judgement would be practised during data collection. Interviews were transparent, meaning that the researcher did not hide anything.

1.13.5 ACTIONS AND COMPETENCE OF RESEARCHERS

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. Even well intended and well-planned research can fail or can produce invalid results if the researcher and/or fieldworker is not adequately qualified and equipped (Sieber, 1982:14; Strydom, 1998:30).

The researcher explained and clarified the purpose of the study to the ethics committees of Weskoppies Hospital and Pretoria Academic Hospital. The purpose of the study was also explained to the respondents. The manner in which ethical issues would be honoured was explained. Consequently, a research proposal together with the

measuring tool, semi-structured interview schedules for patients and key relatives, were submitted and discussed by the ethics committees (Strydom, 1998:30).

1.13.6 RELEASE OR PUBLICATION OF THE FINDINGS

This research report, compiled as accurately and objectively as possible, will serve as a guide to future researchers who conduct research on the topic under investigation in this study (Strydom, 1998:32).

The researcher included shortcomings and limitations of the study in the research report. Subjects should be informed about the findings in an objective manner (De Vos, 1998:33).

1.14 SHORTCOMINGS AND LIMITATIONS OF THE STUDY

The researcher concentrated on patients' key relatives. Only one mental institution, namely Weskoppies Hospital, was chosen for empirical work and only patients suffering from the mental illness schizophrenia were involved. Some of the patients took time to understand and respond relevantly to the question(s), depending on the specific subtype of schizophrenia they were suffering from. The researcher had to repeat the questions, especially to the patients, until the questions were fully understood.

The literature study included national and international reading material and focused more on psychiatry, medicine and psychology as opposed to social work. The lack of social work literature in the field of study emphasises the importance of this research.

Due to the small size of the research sample, the findings cannot be generalised to the entire population. In addition, the medical terms used in this study do not exist in African languages which posed a further challenge to the researcher.

1.15 DEFINITIONS OF KEY CONCEPTS

The key concepts relevant to the study will subsequently be defined.

1.15.1 FAMILY

Families constitute a population and are a basic unit of analysis. A family is defined in an inclusive sense to be composed not only of persons related by blood, marriage or adoption but also sets of interdependent but independent persons who share some common goals, resources and a commitment to each other over time. Family members operate as autonomous individuals but are also mutually dependent on each other (Boss, Doherty, La Rossa, Schumm & Steinmetz, 1993: 435).

The family is a system consisting of members. The family as a system must be related to other environmental systems such as neighbours, hospitals, police stations and churches for it to function properly (Zastrow, 1996:56).

According to Conley and Baker (1990: 898) the family is usually the primary social resource for patients. Patients suffering from schizophrenia in particular, depend largely on relatives in times of stress. The longer the patient remains ill, the less able the family is to develop new resources of support. It can be concluded that if one family member is suffering from schizophrenia, the whole family is affected. For the purpose of this study, key relatives who are regarded as the patient's most significant relatives were interviewed as respondents.

1.15.2 FAMILY FUNCTIONING

The concept family functioning is defined as the proper way in which family members should relate to and interact with each other according to the expected norms and values of society. The family functions properly if it also relates and interacts well with society (Guide for the professions, 1986: 6). According to Kavanagh (1992: 258), family functioning is defined as "the expected good relationships and interaction occurring amongst the family members".

Family functioning aims at improving the functioning of patients suffering from mental health problems and facilitating an optimal quality of life (Weller & Muijen, 1993:39). The family can function properly if the members interact well and establish positive relationships among themselves and with the environment.

It can be concluded that family functioning is the result of interaction and relationships amongst the members of the family.

The researcher, with the help of a co-interviewer conducted a group discussion with eleven participating social workers from Weskoppies Hospital. The aim of this discussion was to elicit ideas for the development of quality social work guidelines which will enable the patient's family to cope with schizophrenia.

1.15.3 GUIDELINES

Hornby (1985:383) defines guidelines as advice on policy or information about a place. For the purpose of this study, social work guidelines were developed to help patients' families and patients themselves to cope with schizophrenia and to encourage home-based and community-based care. Guidelines are thus seen as a road or map to follow to avoid getting lost.

1.15.4 HOME-BASED CARE

"Home-based care" is one of the paradigm shifts in the welfare policy, namely to phase out institutions and encourage home-based and community-based care (Financing Policy, 1999:5). The patient suffering from schizophrenia is encouraged to be with his family members within the community and to be cared for by the family and supported by the community.

Educational information on the importance of taking care of patients suffering from schizophrenia within a caring home environment will inform the move to do away with institutionalisation (White Paper for Social Welfare, 1997:82). Families and patients need to be educated on schizophrenia in order to be able to cope with such patients at home.

1.15.5 ECOSYSTEMIC APPROACH

The ecosystemic approach can be seen as the mirror used by social workers to define the

interaction or relationship between a family member, his family as a system and other environmental systems such as schools, hospitals, shops, police stations, magistrates courts, home affairs offices, employment sectors, telecommunication sectors and the transport sector (Barker, 1992:71).

According to Fawcett (1993:9), the ecosystemic approach is the notion that the whole, namely the family, is greater than the sum of its parts, the individual members. The ecosystemic approach thus explains that the individual person is a part of the family system and also connected to other community systems such as church and health clinics. The person is seen in relation to his family and the environment.

Zastrow (1996:56), supported by Hartman (1979:33), states that the ecosystemic approach is defined in terms of the ecological perspective that living things are dependent on each other for survival. A person cannot be treated in isolation. From the above definitions, one can summarise the ecosystemic approach as a framework for interaction and relationships occurring between the individual family member, his family and other community and environmental sectors. If the family member suffers from schizophrenia, his behaviour will affect the family members, friends, neighbours and his schoolwork.

1.15.6 KEY COMPARATIVE PARAMETERS AS ASSESSMENT AREAS

1.15.6.1 Ecological context

The ecological context is defined as an orientation in social work and other professions that emphasises the environmental context in which people function. Important concepts include the principles of adaptation, transaction and goodness of fit between people and their environments, reciprocity and mutuality (Barker, 1988:46; Germain & Gitterman, 1980:5).

The ecological context may be defined as the individual within his interrelations context (Nelson, *et al.* 1986:113). From the ecological context perspective, the person is seen in relation to his family and other systems. The ecological context is also related to the ecosystemic approach.

Boss, *et al.* (1993:420) and Lewis (1991:93) state that the nature of humans as social beings implies interaction with others in a social environment. The emphasis on relationships indicates the importance of the ecological relationships between humans and their environments, such as the health and the safety of the environment, material goods and the physical resources that are utilised by families. In summary, the ecological context shares similar explanations with the ecosystemic approach, stressing that the individual is seen in relation to his family and other systems.

1.15.6.2 Family life cycle

The concept "family life cycle" is defined as how developmental stages and transitions in the family life cycle are culturally patterned (Falicov, 1995:378). The family is thus expected to adapt during and through the whole family life cycle because of the different tasks to be achieved.

The process or transition from infancy to adulthood, retiring from work, old age and finally death, is regarded as the family life cycle. Each transitional stage or cycle has processes, such as an adult period in which one is expected to be married, depart from family of origin and have children (Falicov, 1988:13; Feldman & Scherz, 1979:123; Burnham, 1986:32).

In conclusion, the family life cycle is seen as the developmental stages each family member is expected to find himself in and to pass through. A patient suffering from schizophrenia can, for instance, disturb these stages; it may be difficult for such a patient to run his family life properly and this will affect his adulthood and marriage stages negatively.

1.15.6.3 Family organisation

The concept "family organisation" is defined as the diversity in the preferred forms of cultural family organisation and the values connected to those family arrangements (Falicov, 1995:378). It indicates that in each family, organisation plays an important role, and includes aspects such as patterns, norms, values and communication.

Family organisation is concerned with the consistency and patterning of family systems. The elements of a system are organised and predictable. The three principles that describe this organisation are:

- Wholeness, which emphasises the importance of the organised entity for understanding the component parts of the family system, forms a single entity with its own characteristics

- Boundaries, which are concerned with the family's internal organisational characteristics and arrangements of various subsystems. It describes the power structure (parent in control) in the family. This organisation is regarded as the first core concept in the ecosystemic framework. (Compare Marsh, 1992:32; Jacob, 1987:35 and Goldenberg & Goldenberg, 1996:42.)

Family organisation refers then to how the family as a system arranges itself according to the rules and order applicable to that family.

1.15.6.4 Migration and acculturation

Migration and acculturation are defined as the diversity in origin of the family members; the when, why and how they live and their future aspirations (Falicov, 1995:378). Migration and acculturation thus explain the history of each family member, their respective past experiences, their problem-solving skills and how their future plans are influenced.

Migration and acculturation means moving from one environment to another and, in the process of doing so, undergoing changes. The individual who has migrated must learn to adapt to a new environment with different cultural norms and values (Compton & Galaway, 1984:140).

1.15.7 MENTAL HEALTH

Mental health is the way individuals react adequately to those who suffer from mental

illness in order to make them feel comfortable about themselves, allowing them to experience emotions freely without being bowled over by fear, anger, love, jealousy, guilt or worry. They should be made to think for themselves, accept responsibilities and make their own decisions. They should be subjected to new experiences and ideas and deal with their problems as they occur (Gillis, 1986:3).

In the White Paper for Social Welfare (1997:130), mental health is defined as the total well being of the individual, that is physical and psychological health as well as a healthy social functioning. In conclusion, mental health has to do with an overall good health condition, including the mind, body and socialisation of a human being. This implies that the patient suffering from schizophrenia experiences a condition of bad mental health.

1.15.8 MENTAL HEALTH PROFESSIONALS

Mental health professionals are the multidisciplinary team members such as the psychiatrist, psychologist, psychiatric social worker, psychiatric nurse and occupational therapist. The patient and his relatives are important partners in the mental health team and each team member has a role to perform.

1.15.9 MENTAL ILLNESS

The concept "mental illness" refers to a range of disorders related to, and as yet incompletely elucidated, a complex of physiological, psychological and sociological factors leading to acute or chronic physical, emotional and/or behavioural disabilities. Many mental disorders are accompanied by a distortion of personality functions associated with greater or lesser distortions of the affected person's social relationships and economic status (Schlesinger, 1985:27).

Mental illness implies a distortion between mental and physical disorders, that is, a reduction; it is anachronism of mind/body dualism (DSM-IV, 1994: xxi). Mental illness has thus to do with thought disturbance of which schizophrenia is one of the mental illness types.

Sewpaul (1993:188) defines mental illness as the result of several interacting factors, including biological, psychological, psycho- and social determinants. Sewpaul (1993:188) further states that the family constitutes a vital component of mental health and concludes that the family has an impact on the mental health status of its members as it protects them through the quality of interpersonal relationships, the provision of reassurance, comfort, encouragement and the striving for fulfillment. Mental illness can thus be associated with stress in family relationships.

1.15.10 SCHIZOPHRENIA

Schizophrenia is a psychosis. It is a severe type of mental disorder in which the person's ability to recognise reality and his emotional responses, thinking processes, judgment and ability to communicate are so affected that his functioning is seriously impaired. Hallucinations and delusions are common features (Warner, 1994:4).

According to DSM-IV (1994: 79), schizophrenia as a type of mental illness is a disturbance that lasts for at least six months and includes at least one month of active phase symptoms such as hallucinations, delusions, catatonic, disorganised, paranoid, residual and undifferentiated. Schizophrenia is a type of mental illness with specific subtypes.

1.15.11 SCHIZOPHRENIA TYPES

1.15.11.1 Catatonic type

The catatonic type manifests most noticeably in abnormal behaviour, such as excitement, retardation, and stupor that can occur separately or in consecutive phases (Gillis, 1986: 78). This is a rare type of schizophrenia, usually characterised by a lack of motor movement or waste flexibility (Holmes, 1994: 275). It means that this type of a patient can act abnormally, for instance remaining in one position in a dangerous place for a long period of time. This behaviour can affect the functioning of the family.

The essential feature of the catatonic type of schizophrenia is a marked psychomotor disturbance that may involve motoric immobility, excessive motor activity, extreme negativism, mutism, and peculiarities of voluntary movement, scholalia or echopraxisa. Echolalia is the pathological, parrot-like and apparently senseless repetition of a word or phrase just spoken by another person (Clark, 1996:405; Straube & Halweg, 1990:18).

1.15.11.2 Disorganised type

The disorganised subtype is characterised by a marked thought disorder with emotional disturbance and periods of wild excitement, which may alternate with periods of depression. The essential features are disorganised speech, disorganised behaviour and flat or inappropriate affect. Silliness and laughter that are not closely related to the content of the speech (Holmes, 1994:275 & Gillis, 1986:78) may accompany the disorganised speech affect.

According to DSM-IV (1994: 288) individuals diagnosed with this disorder act in an absurd and incoherent way that conforms to the stereotype of crazy behaviour. Their affect is typically blunted for real-life situations, but a silly smile and childish giggle may be present at inappropriate times. Such a patient may thus somehow act like a fool and his thinking process is thoroughly disturbed. This behaviour affects the good relationships of the whole family.

1.15.11.3 Paranoid type

The dominant symptoms of the paranoid type are delusions of persecution and grandiosity (Holmes, 1994: 276). Patients suffering from the paranoid type of schizophrenia constitute the largest group. Paranoid patients are as a rule more intelligent than the others. From the onset of the illness they are suspicious and bound to misinterpret things and events in a way which is disparaging to them (DSM-IV, 1994:287).

The above definition indicates that paranoid patients can misinterpret things and have suspicious minds and therefore such a patient's behaviour can disturb the functioning of the family.

Sue, *et al.* (1981:294) indicates that the paranoid patient does not trust other people, due to hallucinations and delusions. Such a patient may also act violently, suspecting that another person would like to harm him. Due to suspicious and violent behaviour, this patient may present a danger to other family members. The delusions may be multiple, but are usually organised around a coherent theme. Hallucinations are also typically related to the content of the delusional theme (DSM-IV: 1994 & Weiner, 1997:304).

1.15.11.4 Residual type

Individuals who are diagnosed with residual schizophrenia have had at least one schizophrenia episode in the past and currently show some signs of schizophrenia such as blunted emotions, social withdrawal, eccentric behaviour, or thought disorder, but these symptoms are generally muted. Furthermore, symptoms such as hallucinations and delusions are infrequent or vague (Holmes, 1994: 276).

According to DSM-IV (1994: 289), there is further evidence of the disturbance as indicated by the presence of negative symptoms (for example, flat affect, poverty of speech) or two or more attenuated positive symptoms. The course of the residual type may be time-limited and represents a transition from a full-blown episode to complete emissions. In summary, this patient cannot carry the responsibility of a parent, for instance, because of his behaviour and his thinking and speech disturbance.

1.15.11.5 Undifferentiated type

Undifferentiated schizophrenia is diagnosed when individuals show mixed or undifferentiated symptoms that do not fit into the disorganised, catatonic, or paranoid type. These individuals may exhibit thought disorder, delusions, hallucinations, incoherence, or severely impaired behaviour (Holmes, 1994:276). DSM-IV (1994:289) states that the undifferentiated subtype stipulates the presence of symptoms such as delusions or frequent auditory hallucinations and disorganised behaviour. The above statements indicate that family members will be affected by patients' behaviour.

In summary, schizophrenia is a type of mental illness which includes schizophrenia

types with common features such as hallucinations and delusions, thought disturbances, unpredictable and inappropriate behaviour. These features affect the family functioning because they are unpredictable.

1.15.12 TEMPERAMENT

Temperament is defined as a person's disposition or nature, especially as this affects his way of thinking, feeling and behaving (Hornby, 1985:889). Any abnormality or unusual behaviour that may be shown, for example in the developmental stages of that person, may be associated with his temperament.

1.16 SCOPE OF STUDY

The research report consists of the following chapters:

Chapter One provides a general orientation to the study.

In **Chapter Two** the impact of schizophrenia on family functioning is described from a theoretical framework.

Chapter Three explains schizophrenia as a type of mental illness.

Chapter Four explains schizophrenia and family functioning within the ecosystem framework.

In **Chapter Five** family intervention programmes for schizophrenia are presented.

Chapter Six reflects and discusses the results of the empirical study.

Chapter Seven presents the conclusions and recommendations of the study and the proposed social work guidelines to assist families in coping with patients suffering from schizophrenia.

CHAPTER TWO

THE IMPACT OF SCHIZOPHRENIA ON FAMILY FUNCTIONING: A THEORETICAL FRAMEWORK

2.1 INTRODUCTION

From a theoretical perspective, there are various models which can be implemented to understand the functioning of the schizophrenic patient. These include biological, psychological and bio-psychosocial models, all of which can provide an inter-disciplinary team with a general overview of the functioning of a patient suffering from schizophrenia.

These models, however, especially the biological and psychological models, do not facilitate an understanding of the impact of schizophrenia on family functioning. The ecosystemic approach can fill the gaps caused by this limitation since it explains in detail the patient as part of the family, society and the environment (Burnham, 1986:25). For the purpose of this study the ecosystemic approach serves as a theoretical framework for understanding the schizophrenic patient (as a system) in relation to his family (as a system) and to other systems in the community.

In this chapter, various models which are used to understand the patient suffering from schizophrenia will be discussed (Becvar & Becvar, 2000:147). These models will each be discussed in relation to an ecosystemic perspective in order to contextualise an understanding of the impact of schizophrenia on family functioning. The ecosystemic approach as a theoretical framework will in turn be discussed with reference to assumptions, key comparative parameters as assessment areas and techniques.

2.2 MODELS FOR UNDERSTANDING THE SCHIZOPHRENIC PATIENT

Insight into the functioning of the schizophrenic patient as an individual can be obtained through an understanding of the biological, psychological and bio-psychosocial models.

In the discussion that follows, each of the models will be defined and evaluated against the need for a wider ecosystemic perspective of the impact of schizophrenia on the family.

2.2.1 BIOLOGICAL MODEL/PERSPECTIVE

The biological perspective explains mental illness in terms of biological factors. The biological viewpoint, according to Carson, Butcher and Mineka (1996:68) is also referred to as the medical model, focusing as it does on mental disorders as medical diseases, the primary symptoms of which are behavioural rather than physiological or anatomical. The perspective of this model is that mental disorders are thus viewed as diseases of the central nervous system, the autonomic nervous system, or the endocrine system, either inherited or caused by some pathological process. Neither psychological factors nor a person's psychosocial environment are believed to play a causal role in the mental disorder (McKenry & Price, 1994:108; Carson, *et al.* 1996:68).

According to this model, environmental factors cannot be contributory causes of a person's mental illness. According to Marsh (1992:26) and Kaplan and Sadock (1988:347), many biological factors appear to be involved in serious and persistent mental illness, including genetics, the neurochemistry of the brain, and the structure of the brain. There are technological advancements in all of these areas that have facilitated the search for biological factors. These include such brain imaging techniques as computerised topographic (CT) and position-emission topographic (PET) scanning. All of these techniques have revealed brain abnormalities in some individuals with mental illness. Many factors have been implicated including viral infections, head injury, immunological dysfunction and neuro-developmental disorders (Carson, *et al.* 1996:460).

The biological model thus focuses on biological factors as the cause of mental illness and does not consider the influence of the patient's family, culture and environment.

2.2.2 THE PSYCHOLOGICAL MODEL

Psychological models are largely concerned with the understanding and treatment of individuals (Marsh, 1992:30). The respective psychological models include the psychodynamic, cognitive-behavioural, and existential-humanistic models. The psychodynamic model underscores the role of early childhood. In contrast, the cognitive-behavioural model focuses on present cognitions and behaviour, and on the strategies that can modify maladaptive patterns of thinking and behaviour. The existential-humanistic model also focuses on the present, with an emphasis on the innate potential of human beings for growth and self-actualisation.

Marsh (1992:30) and Kaplan and Sadock (1988:263) are of the opinion that there are a number of general considerations that pertain to the suitability of psychological models in professional practice with families. Firstly, some of the psychological models are characterised by questionable scientific adequacy. Such problems include the absence of a reasonably precise set of interrelated and consistent propositions from which hypotheses can be derived; the absence of verifiable propositions; the wide gap between theoretical constructs and empirical observations; the inaccessibility of the contents of the therapeutic encounter; and language that is often more metaphoric than scientific. Secondly, all the psychological models have had an enormous neurological influence. They have enriched professional thinking and practice in countless ways, offering many insights into human personality and psychopathology. Thirdly, from the perspective of clinical efficacy with families, psychological models offer a relatively poor match for this population. Fourthly, those psychological models that do direct attention towards the family, such as psychoanalysis, tend to view families from a limited and negative perspective. Fifthly, in those models that incorporate negative assumptions regarding families, there is the risk that such assumptions will undermine the relationship between family and the professional.

Lastly, all the psychological models have potential value for individual family members who seek personal therapy themselves in order to deal with the mental illness of their relative or with other mental health problems that may be present (Marsh, 1992:30). This is also a useful model because it offers helps in stress management. It can,

however, be concluded that psychological models have a number of limitations from an ecosystemic perspective in professional practice with families, since they tend to focus more on the individual client than on the family system.

In order to determine the value of the psychological models from an ecological perspective, the advantages and disadvantages of the models need to be considered. Psychological models focus on the patient's early childhood history, his behaviour and his intellectual growth.

The researcher is of the opinion that these models do not take the patient's family and his culture and environment into account when explaining mental illness.

2.2.3 THE BIO-PSYCHOSOCIAL MODEL

The bio-psychosocial medical model was developed in response to the limitations of the traditional biomedical model in integrating all the relevant data for a particular disease. The bio-psychosocial model is derived from an ecosystemic approach (Kales, Stefanis & Talbot, 1990:95; Allwood & Gagiano, 1997:36). It is significant that the bio-psychosocial model originated from the "mother" body called the ecosystemic approach, which means one can expect some similarities between these two approaches.

According to Carson, *et al.* (1996:114), supported by Allwood and Gagiano (1997:36), the bio-psychosocial viewpoint acknowledges the interaction of biological, psychosocial and sociocultural causal factors in the development of abnormal behaviour. It is therefore important that the patient suffering from schizophrenia, for example, be treated in his totality, taking into consideration his physical complaints, and any psychological and social factors (Wiener & Breslin, 1995:172; Allwood & Gagiano, 1997:36).

Shannon (1989:38) emphasises that for the mental patient to be treated effectively, he must be understood as part of other systems such as the family. An understanding of the patient's cultural and social dimensions, taking into consideration his psychological and behavioural aspects, is also essential. As far as this researcher's knowledge is

concerned, the bio-psychosocial model has proved very successful at mental hospitals such as Weskoppies.

In summary, the biological model focuses on factors such as genetics and brain injuries as the causes of mental disorder. The psychological model focuses on the patient's thinking and behaviour. These two models do not consider the patient as part of the family, neighbours or outside environment.

The bio-psychosocial model focuses on the patient and his family, taking into account socio-cultural factors that affect the patient; hence it is derived from the ecosystemic approach. The researcher chose the ecosystemic approach because it also discusses the patient as a unique person, the patient as part of the family system, the patient's life cycle, boundaries and the relationship between the patient and other subsystems and external systems.

2.3 ECOSYSTEMIC APPROACH

The ecosystemic approach can be seen as the frame or mirror used by social workers to define the interaction or relationship between the family member, his family as a system and other environmental systems such as schools, hospitals, shops, police stations, magistrate courts, home affairs offices, employment sectors, telecommunication sections, political systems and the transport section (Barker, 1992:71). Underlying the ecosystemic approach is the notion that the whole, the family, is greater than the sum of its parts, the individual member (Fawcett, 1993:9). The ecosystemic approach thus explains the person in relation to his family and the environment.

According to Zastrow (1996:56), supported by Hartman (1979:33), the ecosystemic approach is defined in terms of the ecological perspective which states that living things are dependent on each other for survival. This means that a patient cannot be treated in isolation but only in consultation with his family and his environment.

Individuals in families are also members of classrooms, neighbourhoods, businesses and society (Duhl, 1983:59). Each living system always exists in context (time and space)

with other living systems at the same levels, as well as with non-living systems. This totality is often referred to as the ecosystem (Duhl, 1983:598; Potgieter, 1998:54).

Since the ecosystemic approach also deals with the concept "system", it is necessary to define this concept. A system is usually thought of as a whole consisting of interdependent and interacting parts, or as a set of related units. It is described as a set of interrelated elements with a capacity for certain kinds of performance. Each component of the set is related to at least some other component in a more or less stable way within a particular period of time and space (Compton & Galaway, 1984:118).

Helton and Jackson (1997:19) state that the family as a system might be analysed in terms of its own internal functioning as well as of its relationship to larger social systems. The family is therefore a system because it consists of family members (subsystems) who interact and relate among themselves (and with other systems).

Fawcett (1993:3) stated that a family cares for itself. It is a separate entity larger than each of the members. It has feelings: sadness, happiness, high points and lows. The family, and not the individual, is the real molecule of society, the key link in the social chain of being. The above definitions reveal that family members form part of society.

According to Helton and Jackson (1997:1), families have always been identified as the most basic social group in society. Individuals arrange themselves in groups as a way of meeting basic physiological needs and the need for safety and security, and of fostering psychological development. Such groupings or constellations provide a cadre of emotional sustenance and ongoing social support. Family members are enhanced socially within the context of the family. As individual family members interact with one another, they learn what is acceptable and unacceptable in human relationships (Manor, 1984:7; Helton and Jackson, 1997:1). Other sectors such as schools, hospitals, and magistrates courts are also called systems because they share some common goals. They have appropriate elements or units that interact with one another. The flow of information and interaction depends on the openness and closedness of the systems.

- Open and closed systems

Systems are classified as open or closed. According to Cook and Fontaine (1991:44), supported by Fawcett (1993:10), the central concept in the theory of social systems is the view of the system as open, which means that an essential factor of a system's continuity and change is its engagement in interchanges with the environment. The open system receives input from and provides output to its environment. It is because of this quality of openness that human systems grow and evolve toward increased order and complexity , or negative entropy (Compton & Galaway, 1984:119; Manor, 1984:7). Thus, the information is able to flow from one system to the next through the openness of the systems.

Closed systems do not interact with other systems; they neither accept input from nor provide output to them. Such systems have a quality called entropy, which means that, over time, they tend towards less differentiation (Compton & Galaway, 1984:119; Manor, 1984:7). This means that when the system is closed, the information from that system cannot flow to the other system; information can neither be given to nor taken from other systems.

According to this researcher's perspective, open and closed systems indicate the relationship or interaction between systems, including environmental systems. With regard to the closed system, there is no interaction with the environment. The openness and closedness of a system highlights the purpose of boundaries, which will be discussed later in this chapter.

In conclusion, the ecosystemic approach views the individual as a unique subsystem of the family. In return, the family as a system relates to other environmental systems. This approach is therefore chosen as the theoretical framework for this study because it allows the patient to be viewed and treated as a human being who relates to his family and other subsystems in the environment.

There are, however, key comparative parameters and techniques to be discussed within the ecosystemic approach, which could be utilised to determine the impact of schizophrenia on the social functioning of the family.

2.3.1 ASSUMPTIONS

The following assumptions describe the relationship between the individual and other systems. These assumptions, to be described briefly, are as follows: circularity, the mind is social: change, stability, double description, information and fitness. Individuals are best understood within their interrelational contexts. Ross and Bilson (1989:28) state that from the open system or **circularity** point of view, when family members interact with one another, it means that they influence one another. Although one member cannot cause another's behaviour, he may influence it. A relationship is circular because of its mutuality and reciprocity. In other words, within the relationship there is always mutual interaction. The circularity helps the therapist to understand that the behaviour of family members is interwoven with their interaction and beliefs (Ross & Bilson, 1989:31; Nelson, *et al.* 1986:114). If one member is suffering from schizophrenia, the family's interaction may be disturbed.

A comprehensive systematic view of the family focuses on the evolving relationships of the family members within their environmental, historical, developmental, and ideological contexts (Nelson, *et al.* 1986: 114). For the purpose of this study the patient suffering from schizophrenia should be treated not in isolation but in relation to every other family member and his family as a whole, including the wider social systems.

One useful assumption underlying the ecosystemic approach is that the **mind** is **social.** This refers to interaction patterns within the family. Mental phenomena are assumed to reflect social phenomena. Mental problems therefore may be regarded as problems in patterns of social phenomena. This is not to say that these approaches do not accept biological or psychological aspects of human behaviour, but it does emphasise that the mental significance of any particular behaviour or event may be derived from its social context (Tomm, 1984: 117). There is a definite relationship between the person's way of thinking and his way of socialising or interacting. The mind of the patient who

suffers from schizophrenia is ill or disturbed and such a patient may not interact positively with his family members, neighbours or the society at large. This condition calls for external help for the person suffering from schizophrenia as well as support for family members referred to a mental hospital, or those receiving treating and counselling elsewhere.

Systems indicate characteristics of both stability (homeostasis) and change (transformation) (Tomm, 1984:15). **Change** and **stability** are two processes which stand in a complementary relationship to each other (Ross & Bilson, 1989:42). This means that stability and change, as part of the family functioning process, interact together and affect each other in every family system (Keeney & Ross, 1992:171). The family has to adapt and change to ensure stability over time, for example, when a child is born or when death occurs, but it also has to adapt to the changes within society. The patient suffering from schizophrenia, as well as the whole family, needs to adapt and adjust to changes to maintain stability both within the family and outside in the environment.

Double descriptions rather than singular descriptions enable the person to construct a systemic view of human relationships and interaction. When two people interact, each member has a particular view of his flow of interaction. If an observer combines both of these views, a sense of the whole system will emerge. These multiple views are called double description, as opposed to binocular vision (Keeney & Ross, 1992:32). The interactions between a family member who is suffering from schizophrenia and the entire family, including the community members, may not flow smoothly because his mental illness may cause the patient to react irrelevantly during the communication process, or to become violent towards the entire family and to society as a whole.

According to Bateson (1979:132) "in order to get from one level of description to another, an act of double description is required, or, views from every side of the relationship must be juxtaposed to generate a sense of the relationship as a whole". It means that as many as possible of the family members have to share specific views about the problem and interactions within the family relationship. Keeney (1983:38) says that the value of double description is that it is an epistemological tool that enables

one to generate and discern different orders of pattern. As two eyes can derive depth, two descriptions can derive pattern and relationships. Ross and Bilson (1989:33) argue the "fundamental premise of double description is that the difference between the two descriptions creates information". It is therefore important to include all the family members' views to gather information about the family's problem, its behavioural interaction and the solution to this problem. If the family has evolved into a pattern of increasing constraints, which include symptomatic behaviour, the therapist would try to enable the family to find a pattern of greater underlying freedom, in the search for alternative solutions (Tomm, 1984:121).

According to Ross and Bilson (1989:42), it is important to remember that the family's culture, norms and beliefs are aspects which help it to bring order to and prevent further problems in their interaction. The cultural norms of the society, such as greeting one another, will govern the family.

Each member of the family performs his own actions and if these actions have a negative impact other members are affected. The negative behaviour, such as violence on the part of the schizophrenic patient, may affect the relationship of the family, relatives and neighbours in such a way that the police are forced to intervene.

According to Bateson (1979:84), information is "news of difference" because of different views from family members. Bateson (1979:84) also states, "A difference is not material and cannot be localised. If this apple is different from the egg, the difference does not lie in the apple or in the egg, or in the space between them. Difference cannot be placed in time". Within a given situation there are many differences within the various perceptions and contexts. It is therefore necessary for the social worker to gain key information about meaningful differences through questions to the patient and the family members, especially key relatives.

Fitness as an assumption refers, on one hand, to the way in which every family member fits in. It infers, on the other hand, how unfitness causes family imbalance. In nature, it is known that all living things are dependent on each other for survival. Keeney (1983:187-188) state that relationships between human beings may be disturbed not

only by members interacting in a defined group, but also through the ecological system. According to Germain and Gitterman (1980:5), the concept of fit applies both to organisms and environments: to the fitness of the environment and the fitness of the organisms each with the other, and through which both prosper. Thus, if the patient suffering from schizophrenia is not receiving treatment, he will relapse and will be rejected by society, including the family.

The assumptions discussed above provide explanations of the view of the interaction between the individual and other systems in the ecosystemic approach.

Following these assumptions, there are also key comparative parameters used as assessment areas in the ecosystemic approach, which will be briefly discussed below.

2.3.2 KEY COMPARATIVE PARAMETERS AS ASSESSMENT AREAS

The four key comparative parameters of the ecosystemic framework include the ecological context, migration and acculturation, family organisation and family life cycle. The ecological context refers to the diversity of where and how the family lives and how it fits into its environment. Migration and acculturation refers to the diversity in terms of the origins of the family members, how they live and their future aspirations. Family organisation refers to the diversity of preferred forms of cultural family organisation and the values connected to those family arrangements. Family life cycle refers to how developmental stages and transitions in the family life cycle are culturally patterned (Falicov, 1995:378).

It is necessary for the purposes of this study to explain the four key comparative parameters as assessment areas to be utilised in detecting the relationship between the schizophrenic patient, his family and society, and in developing social work guidelines to help families to cope with patients in a home based care context.

2.3.2.1 Ecological context

The ecological context is defined as an orientation in social work and other professions that emphasise the environmental context in which people function. Important concepts include the principles of adaptation, transaction and goodness of fit between people and their environments, reciprocity and mutuality (Barker, 1988:46; Germain & Gitterman, 1980:5). In simple terms, the ecological context is the persons-in environment.

Figure 1 demonstrates the person-in environmental context

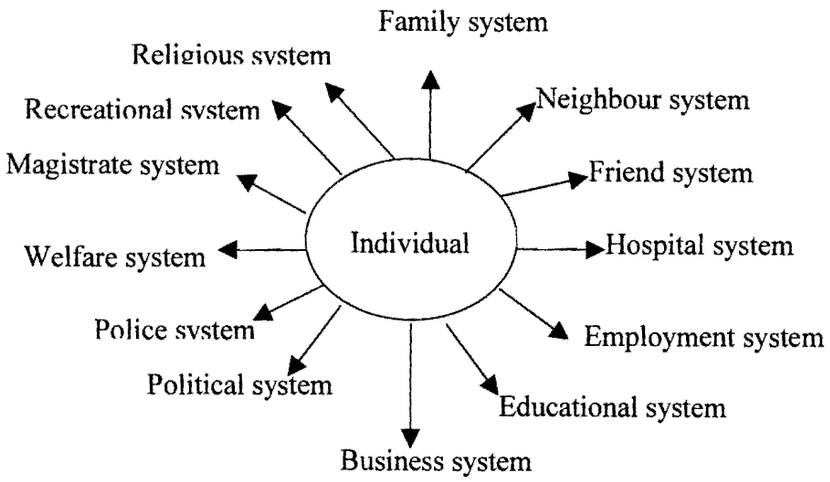

Figure 1: Ecological context, adapted from Zastrow (1996:56) and Becvar and Becvar (2000:147)

From Figure 1 it can be inferred that there is a direct link between ecosystemic approaches and ecological context. From an ecological context perspective, the person is seen in relation to his systems, such as the family and others. The main emphasis is on the idea of understanding the individual in relation to other systems. Nelson, *et al.* (1986:113) and Turk and Kerns (1985:6) added that individuals are best understood within their interrelational context. A comprehensive, systematic view of the family focuses on the evolving relations of the family members within their environmental, historical, developmental and ideological context.

isolation, but only within the context of his family members and the community to which he belongs, including the environment. For instance, if one member in the family is suffering from schizophrenia, his whole family should be interviewed in order to find out how the relationships or interaction between patient and family are affected, how the patient interacts with the community to which he belongs and how the patient relates to the available resources such as hospitals and aftercare services. It is also important to know whether the family members receive assistance from, for example, the police, in order to get to hospital in the case of violence on the part of the schizophrenic patient. These factors must be examined within the ecological context

problems may occur within the family and his active participation within the community may be disturbed. All this will become a burden borne by the relatives.

Zastrow (1996:56), supported by Lewis (1991:94), state further that people are regarded as active reactors to their environment and should be seen as dynamic and reciprocal interactors with those environments. The emphasis here is on the fact that a person is seen in his environment, which implies interaction with many other systems. With this conceptualisation of the person-in-environment, social work can focus on three separate areas. First, it can focus on the person and seek to develop his problem-solving, coping and developmental capacities. Secondly, it can focus on the relationship between the individual and the systems he interacts, linking him with necessary resources, services and opportunities. Thirdly, it can focus on the systems and seek to reform these (Zastrow, 1996:56). Through the application of the ecosystemic approach, it is clear that social workers can help the schizophrenic patient to develop coping skills and to improve his self-esteem. This approach also allows them to encourage good relationships between the patient and his relatives.

2 3.2.2 Acculturation and migration

Acculturation is the learning of and adaptation to a culture that is not an individual's own. According to Falicov (1995:380), it is difficult for a person to adapt to another culture. For instance, even in the marriage between partners of different cultures, such as when an African person marries a white person, misunderstandings arise. For example, black culture believes in ancestors, witchcraft and traditional healing whereas white culture in general has nothing to do with ancestor worship, witchcraft and traditional healing. The same applies to a schizophrenic patient whose culture it is to believe in witchcraft and ancestral worship; he will prefer traditional treatment (Mojalefa, 1994:48 - 59). Such a patient has learned from his forefathers and from his culture that traditional treatment is best for mental illness because it is perceived in terms of witchcraft. It is only through acculturation (fusion of culture) that some Christians will accept medical treatment, for example.

The individual as a subsystem of the family system and as part of environmental systems needs to adapt to changes that should have been brought about by acculturation and environmental changes. The African patient suffering from schizophrenia may find it difficult simply to accept medication or to be hospitalised.

For the social worker, migration means moving families from one place to another and within the ecosystemic framework it is important to focus on when, where and how the family migrates. Migration can cause disorientation, anxiety, trauma or post-trauma because of losses which are caused by changes and adaptation.

The same trauma, grief, mourning and feelings of anxiety are experienced by the schizophrenic who is forced by relatives to go to hospital or to receive treatment that he is unsure about. The family members also experience feelings of grief and anxiety about their handling of such a patient, in and outside the hospital setting. The community may also experience feelings of anxiety about how to handle such a patient.

If the social worker is to develop guidelines to help a patient's family to cope with the schizophrenic patient in a home-based care context, it is important to focus on the patient's historical background to establish more about his adaptation pattern, his handling of his fears, frustrations and disappointments, his role fulfillment and personal values. The cultural grouping to which the patient belongs and his family of origin's position in the community, his social background (education, class, religion, culture, status and mental and intellectual development and attitudes and values), influence the expectations of the patient (Compton & Galaway, 1984:140). It is necessary for the social worker to understand the culture of the patient and to find out how the patient adapts to change.

2.3.2.3 Family organisation

Family organisation refers to the consistency and patterning of family systems. The elements of a system are organised and predictable. The three principles that describe this organisation are:

- Wholeness, which emphasises the importance of the organised entity to an understanding of the component parts of the family system; the family forms a single entity with its own characteristics

- Boundaries towards outside elements which pertain to the system and family subsystem; the family members are bound by time and space

- Hierarchies, which are the family's internal organisational characteristics and arrangements of various subsystems. They describe the power structure (parent in control) in the family. This organisation is regarded as the first core concept in the ecosystemic framework. (Compare Marsh, 1992:32; Jacob 1987:35 and Goldenberg & Goldenberg, 1996:42.)

In every subsystem, family system and other environmental systems, the issue of openness and closedness occurs to allow information to flow, or to block the unwanted information from flowing from one subsystem to another. Each family is patterned according to its size and type.

There are different forms of family organisation. These include the nuclear, single and extended family, each with its own communication style, values, rules and boundaries that are part of its particular cultural background. The type of family relationship also plays an important role when focusing on the organisation. The dominant relationship between husband and wife in the nuclear family will differ from the dominant relationship in the single parent family, which may be between the mother and the oldest child. According to Falicov (1995:384), in pre-industrial and more traditional or religious settings, and in working-class families, the central, emphasised relationship may still be the parent-child relationship in an extended family setting. This suggests that the central and dominant relationship is influenced by the type, pattern and organisation of each family system. The research of Falicov (1995:381) throws light on the family organisation because the crucial point is the cultural code, which influences the preferred central relationship. In each family system, cultural codes include the boundaries that regulate the hierarchy (the gender generation power balance), the values associated with personal individual and family connectedness, communication styles

(direct or indirect) and emotionally expressivities (high or low) among family members and with outsiders.

Family organisation entails the patterning of each family with its members as subsystems. Patterning is also linked to the culture of that family. The patient suffering from schizophrenia can disturb or affect the patterning of the family.

The family organisation includes the following components, which will be discussed below; family rules and roles, stability and change, subsystems and boundaries, feedback, hierarchy; communication styles and values.

- Family rules and roles

Every family is governed by particular rules and roles. Rules may be simple, such as who cooks the meals or who is in charge of making major decisions. Roles and rules can be useful to organise families, or they can lead families to feel dissatisfied or constrained. In therapy, families learn which rules and roles are uncomfortable or no longer working effectively. They also learn to develop new rules and roles that can lead to more satisfying interactions. (Compare Annunziata & Jacobson-Krom, 1994:25 and Feldman & Scherz, 1979:67.)

Each family member has his own role to perform. When one member is suffering from schizophrenia, he is unable to function in his particular role and it subsequently needs to be performed by another family member, or to be shared. This may frustrate the entire family. According to Jacob (1987:92) and Barker (1992:77), roles consist of prescribed and repetitive behaviour involving a set of reciprocal activities with other family members. Successful role integration is achieved when all essential roles have been allocated, agreed on and enacted. When roles are integrated, family members know what is expected of them and what they in turn can expect from others.

It can be concluded that when one member is suffering from schizophrenia, he will frustrate or affect the entire family because he will not be able to perform his expected role, such as being the breadwinner or looking after the children. A family is a

cybernetically rule-governed system (Goldenberg & Goldenberg, 1996:44). The interaction of family members typically follows organised, established patterns based on the family structure; these patterns enable each person to learn what is permitted or expected of him as well as of others with regard to the family transactions. A family's rules reveal its values, help set up family roles consistent with these values and in the process provide relationships within the family system with dependability and regularity. The family rules determine the way people pattern their behaviour, thus rules become the governing principles of family life, providing guidelines for future interactive patterns. Rules are formulas for constructing and maintaining family relationships (Goldenberg & Goldenberg, 1996:44).

In general, each family system, like all other systems, is governed or patterned by rules and roles which maintain order within the system.

- Morphostasis (stability) and morphogenesis (change)

As discussed previously under assumptions, stability (morphostasis) and change (morphogenesis) are an integral part of family organisation. It is necessary for the family as a system as well as other systems to change or stabilise where necessary.

The tendency towards stability is known as homeostasis and has the function of protecting the family organisation from chaos or disintegration (Burnham, 1986:33; Tomm, 1984:115; Hoffman 1981:50). In this period of stability, there will be a range of acceptable behaviours permitted by a particular pattern.

Hoffman (1981:50) defines morphostasis (stability) as the process of maintaining constancy in the face of environmental vagaries. This is achieved through the error-activated process known as negative feedback. Goldenberg and Goldenberg (1996:50) emphasise that family stability is actually rooted in change, that is, to the degree that a family is functional, it is able to retain sufficient regularity and balance to maintain a sense of adaptability and reserve a sense of order and sameness at the same time. Successfully negotiated change creates a stronger and more stable family system.

Morphostasis denotes the system's tendency toward stability, a state of dynamic equilibrium.

The capacity for change indicates the family's ability to find a new organisation more appropriate to changed circumstances. It means that, at times, a system needs to change its basic structure. This process involves positive feedback or sequences that work to amplify deviation, as in the case of a successful mutation that allows a species to adapt to changed environmental conditions (Zastrow, 1996:55; Burnham, 1986:34).
The above statements show that stability and change are unavoidable phenomena within systems. During any transition, changes are expected. Stability and change also go hand in hand with boundaries within subsystems and systems.

- Subsystems and boundaries

Subsystems are those parts of the overall systems assigned to carry out particular functions or processes within the system as a whole. According to Fawcett (1993:9), a family commonly comprises a number of co-existing subsystems. The husband-and-wife dyad constitutes a subsystem; as do the mother-child, father-child and child-child dyads. Because each family member may belong to several subsystems simultaneously, he enters into different complementary relationships with other members. For example, a woman can be a wife, mother, daughter, sister and niece simultaneously. The most enduring subsystems are the spousal, parental and sibling subsystems. Through interaction with parents, children learn to deal authoritatively with people of greater power, while strengthening their own capacity for decision-making and self-direction (Boss, *et al.* 1993:333; Goldenberg & Goldenberg, 1996:54).

Boundaries are defined as a close circle around selected variables, where there is less interchange of energy or communication across the circle than there is within the circle. This is a way of circumscribing the spatial and emotional territory of relationships (Compton & Galaway, 1984:120; Fawcett, 1993:10; Burnham, 1986:19).

The boundary separates the system from the other elements of the environment, making it a distinguishable entity. This notion is useful in assessing family functioning as it

The boundary separates the system from the other elements of the environment, making it a distinguishable entity. This notion is useful in assessing family functioning as it allows the therapies to analyse particular systems conceptually, one at a time, as they interact with the family as a system (Potgieter, 1998:58). According to Germain and Gitterman (1980:209), the subunits, those interacting parts of the family structure, are demarcated by subsystem boundaries, where such boundaries are neither firm nor clear. The boundary between the marital and the sibling subsystems must be clear and firm, so that children are free to work out issues of sharing, loyalty, gender, identification and reciprocal socialisation without parental interference. If the boundary between family and environment is unclear, or too loose, members will lack clarity about who and what belongs inside and outside the family, and hence will be unclear about role responsibility and expectations (Imber-Black, 1988:69).

Rigid boundaries may be characterised by a family's stereotyped denial of entry to other systems and their isolation from extra familial sources of information. Boundaries between various larger systems also affect the family's larger system relationship. All healthy systems have well-defined, semi-permeable boundaries and ways of maintaining these boundaries (L'Abate, Genahl & Hansen, 1986:12; Imber-Black, 1986:70).

It is thus clear that boundaries exist to delineate subsystems and systems. Boundaries are also there to bring in certain information such as positive feedback and to block the flow of certain information in the case of negative feedback. Where there are no boundaries there are no subsystems or systems, there are no clear territories, and this may hinder the healthy social functioning of the family in relation to the environmental systems.

- Feedback

Feedback results from the interaction between the system and its environment. It is the exchanging of energy within and between system boundaries. It is a process responsible for receiving, interpreting and transmitting information within the system boundary and its environment (L'Abate, *et al.* 1986:112; Potgieter, 1998:57). L'Abate, *et al.* (1986:12) further state that a feedback system enables the family members to interact

with each other and with the environment in an attempt to maintain a balance between internal and external needs.

This explanation indicates that feedback is a way of bringing about communication between subsystems, the family as a system and the environmental systems. As already stated, the system can thus maintain stability and change through feedback. Feedback is also linked to the strata of each system or each subsystem.

- Hierarchy

Hierarchy is a dimension which pertains to the arrangement of family subsystems, including parental, marital, sibling and extra familial subsystems. Hierarchy has come to mean simply any arrangement in strata. According to Fawcett (1993:11), any given system, as already discussed under subsystems and boundaries, consists of smaller systems called subsystems and is embedded within larger systems called suprasystems. For example, the sibling subsystem is located within the family system, which in turn is part of a community, a nation suprasystem. Family subsystems have their own interdependence and mutual influence among their members, with their own relationship boundaries. In families, hierarchy and the related issue of power are major concerns. A parental subsystem, for example, may be viewed as a higher echelon than an offspring subsystem, and may exercise parental authority over the latter. Hierarchical organisation is important in decision-making and clarity of family roles, particularly during periods of stress (Marsh, 1992:102; Boss, *et al.* 1993:332). Therefore, when a parent suffers from schizophrenia, the impact on the family functioning could be more severe than if the sufferer were a child. The clarity of family roles may be affected because that parent, who is now a mental patient, may no longer be capable of performing his role.

- Communication style

As discussed previously, communication may be viewed as a two-way process that takes place between the individuals within the subsystem or within the system. Communication can be verbal and non-verbal (Barker, 1992:44; Jacob, 1987:9).

Barker (1992:80) stated that in as far as values and norms are concerned, families differ on what may seem to be quite minor issues; these include such matters as whether children should have set bedtimes and when these should be, who should wash the dishes or iron the clothes, and just how much responsibility for household chores children of different ages should be given. When one member is suffering from schizophrenia, he may not live according to the societal norms and this may affect the entire family functioning.

Communication is thus a feedback between the subsystems and systems. If one member is suffering from schizophrenia he can cause a strained relationship in the family and within the environment due to the way he interacts and behaves. Negative communication may cause the patient to suffer a relapse.

- Values

Values are human conceptions of what is good, right and worthwhile (Boss, *et al.* 1993:436). "Value" is defined as an explicit conception, distinctive of an individual or characteristic of a group, the desirable that influences the selection from available modes, means and ends of action. Values permeate the family systems and are an integral part of family processes. They guide decision-making and human action. When studying a family ecosystem, one must explicitly define the values and goals that each individual holds, those that are shared by the family as an unit, as well as those operative in the social-cultural environment (Boss, *et al.* 1993:436).

Barker (1992:80) stated that in as far as values and norms are concerned, families differ on what may seem to be quite minor issues; these include such matters as whether children should have set bedtimes and when these should be, who should wash the dishes or iron the clothes, and just how much responsibility for household chores children of different ages should be given. When one member is suffering from schizophrenia, he may not live according to the societal norms and this may affect the entire family functioning.

2.3.2.4 Family life cycle

The process or transition from infancy to adulthood, retiring from work, old age and finally death, is regarded as the family life cycle. Each transitional stage or cycle comprises particular processes; in adulthood, for instance, one is expected to be married, depart from family of origin and have children (Falicov, 1988:13; Feldman & Scherz, 1979:123; Burnham, 1986:32). This statement shares similar information with the ecological context because the transitional process is emphasised. Adaptation is necessary to adjust to new transitional phases.

with each other and with the environment in an attempt to maintain a balance between internal and external needs.

This explanation indicates that feedback is a way of bringing about communication between subsystems, the family as a system and the environmental systems. As already stated, the system can thus maintain stability and change through feedback. Feedback is also linked to the strata of each system or each subsystem.

- Hierarchy

Hierarchy is a dimension which pertains to the arrangement of family subsystems, including parental, marital, sibling and extra familial subsystems. Hierarchy has come to mean simply any arrangement in strata. According to Fawcett (1993:11), any given system, as already discussed under subsystems and boundaries, consists of smaller systems called subsystems and is embedded within larger systems called suprasystems. For example, the sibling subsystem is located within the family system, which in turn is part of a community, a nation suprasystem. Family subsystems have their own interdependence and mutual influence among their members, with their own relationship boundaries. In families, hierarchy and the related issue of power are major concerns. A parental subsystem, for example, may be viewed as a higher echelon than an offspring subsystem, and may exercise parental authority over the latter. Hierarchical organisation is important in decision-making and clarity of family roles, particularly during periods of stress (Marsh, 1992:102; Boss, *et al.* 1993:332). Therefore, when a parent suffers from schizophrenia, the impact on the family functioning could be more severe than if the sufferer were a child. The clarity of family roles may be affected because that parent, who is now a mental patient, may no longer be capable of performing his role.

- Communication style

As discussed previously, communication may be viewed as a two-way process that takes place between the individuals within the subsystem or within the system. Communication can be verbal and non-verbal (Barker, 1992:44; Jacob, 1987:9).

The family life cycle is made up of the following stages: the unattached young adult; the joining of families through marriage; the family with young children; the family with adolescents; launching children and moving on; and the family in later life (Barker, 1992:25; Carter & McGoldrick, 1980:13; L'Abate, *et al.* 1986:25). The patient suffering from schizophrenia must then be understood in relation to the family life cycle; for instance, as a married person and a parent how does that patient interact with his spouse, children, relatives and friends?

- *Stage 1: The unattached young adult*

A primary task at this stage is to have the young adult separate from the family of origin and formulate personal life-goals in his development as an individual, before joining with another person to form a new family system. Individuals who adequately differentiate themselves from their family of origin will experience fewer vertical stressors during their new family life cycle. During this stage each person sorts out what to take from the family of origin and what they will change for themselves and build into a new family. For example, a newly married couple will sort out what they dislike about their families of origin and perhaps adopt and imitate what they like about their families of origin (L'Abate, *et al.* 1986:26; Carter & McGoldrick, 1980:13; Falicov, 1988:318). In this stage, the family member still wishes to be with his family of origin.

Young adults have to be able to think and act autonomously (Berg-Cross, 1988:7). If a young adult is suffering from schizophrenia, he is not able to think or act autonomously, and this may affect the entire family's interaction and functioning because such a patient will no longer be following the expected set of rules within the family and society.

- *Stage 2: The joining of families through marriage*

The major task for any newly married couple is adjusting to the demands inherent in the marital situation. Each spouse must learn how to deal with the everyday moods and problems of the other person. Household tasks must be organised and a division of labour decided upon (McKenry & Price, 1994:24; L'Abate, *et al.* 1986:27). When the patient is suffering from schizophrenia, he may find it difficult to cope with married life;

such a patient may fail to perform the expected tasks within the marriage, which in return will disturb the marital relationship.

Stage 3: The family with young children

For most couples, the birth of a baby signifies that they are indeed a legitimate, socially sanctioned family. Each child strengthens the bonds between husband and wife as well as the bonds between the couple and their parents. Spouses now relate to each other through children. Most of their conversations, as well as many of their plans and frustrations, centre around children (Berg-Cross, 1988:10; L'Abate, *et al.* 1986:27). The parent suffering from schizophrenia may be incapable of running his family properly and this will disrupt the family functioning.

- *Stage 4: The family with adolescents*

As soon as adolescents begin socialising outside the home with their peers and other adults, both the adolescent and his family must balance the adolescent's need for autonomy with the need to belong and to be loyal to the family. Parents need to learn how to guide these explorations while managing their own fears about their teenagers' safety outside the home and the influences to which they will be exposed (Falicov, 1995:302; Berg-Cross, 1988:11). Again, the mother who is suffering from schizophrenia will not be able to direct and discipline the adolescent child.

- *Stage 5: Launching children and moving on*

This stage deals with the launching of grown children into education and careers and then the entry of their new spouses and children. This period of time involves a re-negotiation of relationships into adult-adult behaviours between the grown children and their parents (L'Abate, *et al.* 1986:28).

The basic challenge of this stage is to separate without breaking family ties. To accomplish this task successfully, parents and children need to develop compatible expectations of the nature of their relationship. Once the children leave home, the

couple has to live alone. They can re-establish their relations, focusing on each other once again (Falicov, 1995:383). This also involves relationships that include the in-laws and the establishment of the roles of the grandparents. After many years of being a family with a certain amount of energy focused on children, they are once again a dyad (L'Abate, *et al.* 1986:28; Carter & McGoldrick, 1980:171). This stage may be seen as painful, because the parents may remain alone since their children are grown up, employed elsewhere and married and no longer staying with the parents. It will be difficult for the parent who is suffering from schizophrenia to develop compatible expectations of the nature of the family's functioning.

- *Stage 6: The family in later life*

This is the period of old age. The individual entering life's final stage needs to maintain interest in the world and a sense of humour while facing physiological decline and reduced lifestyle options. Children and grandchildren are busy with their own lives. Loneliness may occur as spouse, siblings and dear friends begin to die. One begins to prepare for one's own death by trying to understand the meaning and purpose of one's own unique family life cycle (Berg-Cross, 1988:12). It may be difficult for the older person to stay or cope with the patient suffering from schizophrenia as such a patient may need constant attention.

The family in later life may be described as the final and last stage, which is associated with death. In conclusion, the family life cycle emphasises the transitional stages that bring changes to each family member within the family system. It is expected of each family member to go through developmental stages. If schizophrenia occurs in a family it is even more difficult to move through the respective developmental stages. The techniques utilised within the ecosystemic approach to implement information or interaction about the person-in-the-environment, are discussed below.

2.3.3 TECHNIQUES

Techniques are tools to be used by the social worker to examine the relationship between the subsystems, the family system and the environmental systems. The

following techniques will be discussed: the ecomap and genogram, circular questioning, reformulation and paradoxical tasks, the creation of order and metaphor (Burnham, 1986:25; Cechin, 1987:412; Ross & Bilson, 1989:87; Duhl, 1983:131).

2.3.3.1 Ecomap and genogram

The ecomap is the family tree and the genogram is a tool for information gathering. They both provide the family with a road to follow (Burnham, 1986:25). Just as the genogram maps the family relationship, the ecomap displays the family and its relationship with other people and systems in its life space (Hartman, 1979:41).

The ecomap and genogram are therefore interlinked. The ecomap indicates to the social worker the type of family he will be working with while the genogram is used as a tool to gather information from systems.

- Ecomap

The ecomap is a tool that allows one to diagram the various systems and the relationships among them, which characterise the larger context of the client. The ecomap pictures the family in its life situations; it identifies and characterises the significant nurturing or conflict-laden connections between the family and the world. It demonstrates the flow of resources and energy into a family system as well as depicting the outflow of family energy to external systems (Becvar & Becvar, 2000:147).

Within an ecosystemic approach, the family system chooses resources and assistance from outside systems. That is why Hartman (1979:34) states that an ecomap leads a family to assess whether they have an excess of resources, whether they are already stressed, or are without sufficient support. The ecomap explains a good deal about the extent to which the boundary around the family is open. This notion explains the relationship between open and closed systems, including the boundaries as discussed above.

According to L'Abate, *et al.* (1986:55), the ecomap is used to present a picture of the family's structural behaviours. The process of mapping invites active participation, because it is the family's map and no one knows their world as they do. The task of mapping is shared, and the participatory relationship is expressed in action, as the social worker and family tend to move closer and become jointly involved in a project. The kinds of material and relationships that may emerge from the mapping process are varied, and may range from a rather simple and straightforward assessment of the resources available, to a complex analysis of the different ways various family members relate to the world. A family can thus have many resources and interests.

Therefore, the ecomap indicates how the family, as well as extended family members, friends and community, have a relationship of mutual aid, taking into account the stress that exists as in any family. For example, other members' concern and relationship with the member who is suffering from schizophrenia could be mapped (L'Abate, *et al.* 1986:55; Hartman 1979:37).

Figure 2 demonstrates an example of a graphic explanation of an ecomap.

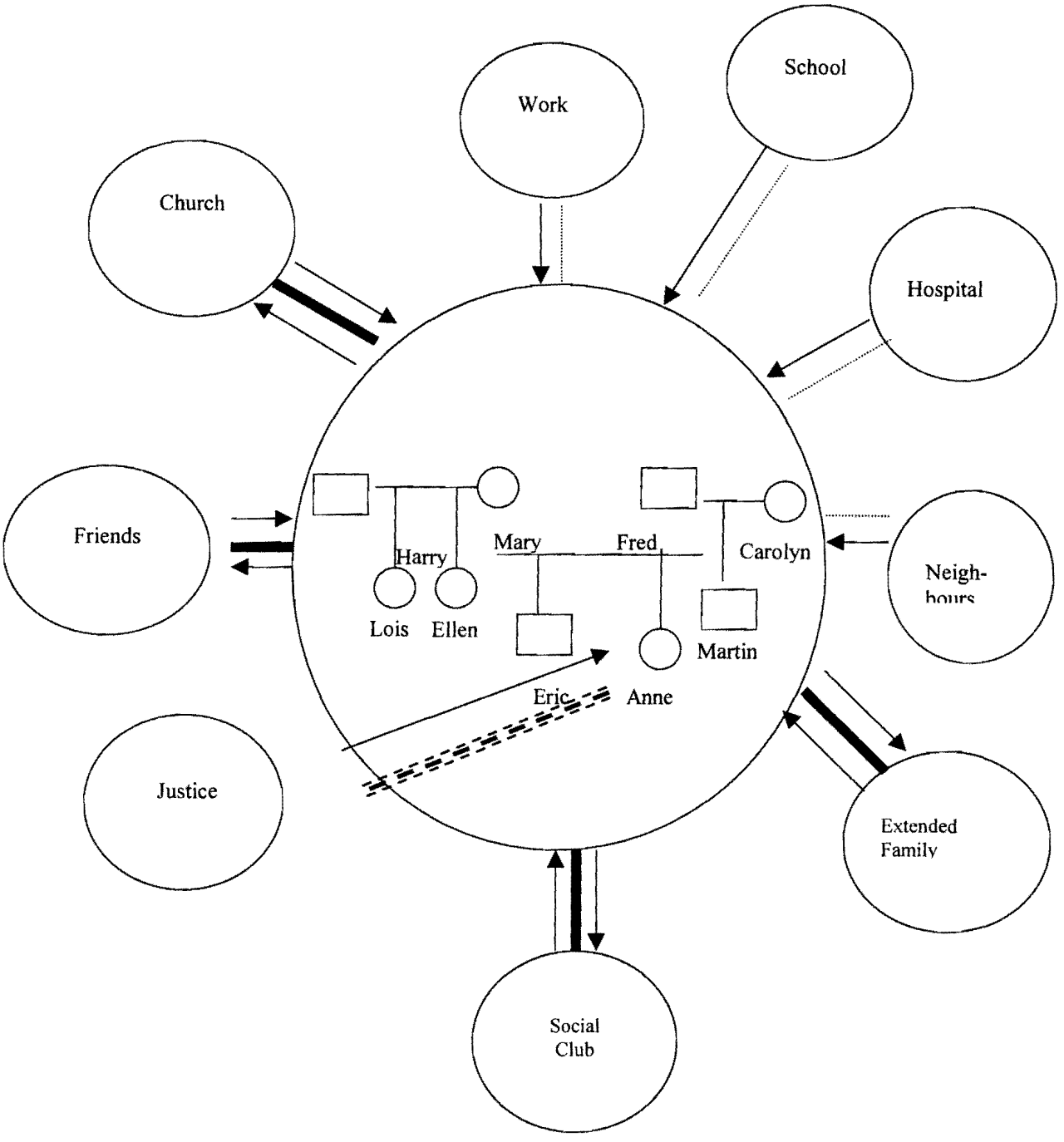

Figure 2: Ecomap graph, adapted from Becvar and Becvar (2000:148)

Key:

Strong relationships
Tense relationships
Stressful relationship
Energy flow

Figure 2 indicates that there is a direct link between the family member as part of a family system and the family's environmental systems such as work, school, neighbours, extended family, social groups, medical institutions, religious institutions and legal systems. There is that mutual relationship between the family member and the family's environment. Also to be considered is the impact of such implicit factors as the national economy, social policies, science and technology, the media, as well as language (Becvar & Becvar, 2000:148). Figure 2 indicates that the ecomap and the ecological context, demonstrated in Figure 1, are linked. Both Figures 1 and 2 see the individual as a system in the environment or related to the environment.

- The genogram

The genogram is a planning tool or a therapeutic technique that allows the social worker and the family to examine the family in its intergenerated context. According to Cook and Fontaine (1991:123), supported by Becvar and Becvar (2000:163) and Wachtel 1982:335), the genogram is a map that provides a graphic picture of family structure and emotional process over time.

As a tool for information gathering, the genogram includes the following characteristics of the family: cultural and ethnic origins, socio-economic status, religious affiliation, physical location of the family members, frequency and type of contact between family members as well as the people or systems by whom and with whom contacts are made. Date of marriages, deaths, and other significant events provide further information about the family system. Information about the openness or closedness of each relationship in the family system can provide data on the emotionality and rules regarding emotionality in the family systems. The genogram provides a visual mapping that may help family members see patterns and relationships in a new light (Becvar & Becvar, 2000:163; Barker, 1992:95). It is clear then that the genogram can be used by the researcher, together with other sources of information, to interview the patient suffering from schizophrenia and to elicit the historical background of the patient as well as to determine the relationship between the patient, his family and the outside systems. The genogram can be used to help the family, the community and the patient to maintain a healthy understanding of each other (Wachtel, 1982:337).

The genogram indicates how all the family members are related to the identified patient. The genogram can contain information about health, behaviour, strengths or problems (Barker, 1992:98). The social worker can use the genogram as a problem-solving technique that can solve problems within a family system as well as in relation to outside systems.

The genogram provides a picture of a family over time. It makes the life history of a family over three or four generations available for observation. It helps to bring to the surface naming patterns, major family events, occupations, losses, family migrations and dispersal and role assignments of family members. It also helps families to feel the power and importance of their roots - which helps them to appreciate the meaning of biological family roots to a child they might bring into their home (Hartman, 1979:100). The genogram serves thus as a picture in which information about the family, such as family life history and family members' interaction and the relationships within the family and the outside systems, can be represented and observed.

Burnham (1986:38) is of the opinion that the genogram has been presented as a way of organising information systematically by mapping relationships, tracing intergenerational patterns and identifying the transitions through which they evolve. It can help social workers to organise their thoughts before and between intervention sessions. (See Figure 2.)

2.3.3.2 Circular questioning

Circular questioning, which is part of the circularity discussed earlier in this chapter, is a tool utilised for information gathering, mostly through questioning. This technique represents an original contribution to the ways in which systemic hypotheses may be evaluated using the verbal mode. The theme is to gather information by asking questions in terms of differences and hence relationships. In addition to the usual direct questions, family members are asked in turn to comment on the thoughts, behaviour and dyadic relationships of the other members of the family (Burnham, 1986:110; Keeney & Ross, 1992:171).

The aim of circular questioning is to identify the point in the history of the system when important coalitions underwent a shift and the consequent adaptation to that shift became problematic for the family. The information sought by circular questions is the differences in relationships before and after the problem occurred (Penn, 1982:272).

A social worker is able to perceive simultaneously the verbal answer to a question and the non-verbal responses of the family members. The triadic information gained is more useful in the evaluation of a triadic hypothesis. The range of questions is inexhaustible but must always be linked to a hypothesis if it is to be useful. It is common to observe the strange and eager anticipation of family members as they wait to hear how another person perceives their relationship. Triadic questioning may be used when important members are absent or even dead. For example, "Suppose that your father was still alive today, what do you think his opinion would be about your husband's mental illness, namely schizophrenia?" (Burnham, 1986:111 & Nelson, *et al.* 1986:114).

2.3.3.3 Reformulation and paradoxical tasks

Reformulation and paradoxical tasks can also serve as techniques within the ecosystemic approach. Reformulation and paradoxical tasks are described as providing information, allowing for news of difference, which makes a difference. The news of difference is the information gained or exchanged when elements of a system interact (Ross & Bilson, 1989:87).

The paradoxical technique is defined as the interventions in which the social worker apparently promotes the aggravation of problems rather than their removal. Emphasis must be on the word "apparently" since a social worker using a paradoxical intervention is anticipating that the family will actually resolve the problematic sequence by defying the social worker's injunction to persevere in maintaining it (Ross & Bilson, 1989:88).

Paradoxical interventions are increasingly being used to change those homeostatic patterns of behaviour and beliefs that seem to be particularly rigid or entrenched and are thought not to be modifiable by direct, logical means (Burnham, 1986:154). Reformation and paradoxical tasks may be used as the method of intervention, changing

the rigid behaviour of an individual. The social worker may intervene to help the schizophrenic patient and his family to develop a strong or good relationship between each other. A good relationship is also linked to proper order being maintained in the family.

2.3.3.4 Creation of order

The mind of every individual works to create order, integration, and coherence. In living systems spontaneous order occurs. In problematic systems, however, the order is maintained by rigid patterns of interaction through more of the same solutions by the family members and the wider ecology of the family (Ross & Bilson, 1989:74).

Cechin (1987:411) stated that the social worker's job is to help the family system to evolve more aesthetic patterns by presenting them with different options. Through interacting with a family one identifies patterns of interaction in a way that finds its own script. Order must be maintained within the family system and within other systems in order to avoid misunderstandings between systems. Interactions within systems will then run smoothly.

2.3.3.5 Metaphors

Metaphors are interventions of the human mind made for the purpose of integration, connecting disparately experienced realities and multiple phenomena. A brain perceiving a relation between two or more clusters of characteristics makes metaphors. A metaphor implicitly facilitates the mental process of inclusion and connection in preverbal or para- verbal awareness and the making of a connection. Metaphors are the explicit expression of that connection of unity in some symbolic, humanly created form: spoken or written words, created objects, expressions or patterns. Patterns are clusters of metaphors. Realities are clusters of patterns. Theories, epistemologies and paradigms are also metaphors (Duhl, 1983:131).

Duhl (1983:132), supported by Barker (1988:176), states that new information either forces members to think and connect new relationships, or to exclude and reject this

new information. When there is no comparison with other ways or other cultures, or when there is any diversity, there is no need to make things seem familiar; there are no mixed metaphors.

The types of metaphor include the following:

The **metaphors of identity** refer to the ways in which people know who they are, in other words, how they determine their identity. These metaphors are usually related to sex, role, task and status, carrying meaning from the outside in. These meanings progress and evolve for each person according to the culture's set rules of order and succession for each stage of life.

The metaphors of identity are also available to be utilised as **metaphors of approximation,** referring to the ways in which each person can best imagine how another person acts and experiences the world. Both such sets of metaphors are part of and connected to the **metaphors of organisation**, expressing what is called the structures and hierarchies of the culture, the ordering of relationships expressed through rules concerning roles defining who can do what with whom and when.

The above-mentioned groups of metaphors are automatically and equivalently interwoven with the **metaphors of operation,** exemplifying processes and procedures which embody the patterns of people's interactions in a relationship. Such metaphors of operation capture the standardised practices, the routines and rituals, and the movements and exchanges that happen between and among those in standardised roles. Such integrations of a sense of self, others, functions, structures, purpose and beliefs lead to an understanding of one another for different cultures (Duhl, 1983:113; Barker, 1991: 176).

Metaphors can be used by the social worker to facilitate the transfer of information between the patient suffering from schizophrenia and other people and to encourage positive interaction between them. It can be concluded that the techniques discussed here can be used by the social worker to understand the social functioning of the

schizophrenic patient as a person required to interact with his family members and other systems.

Techniques should be included in social work guidelines to help patients' families cope with patients suffering from schizophrenia, in particular in a home-based context.

2.4 CONCLUSION

This chapter discussed the models as well as the theoretical framework to be implemented to understand the social functioning of the family when one member within the family is suffering from schizophrenia. The models, namely biological, psychological and bio-psychosocial were compared to the ecosystemic approach as the chosen theoretical framework for this study.

The biological and psychological models approach the treatment of the patient from a medical and psychological perspective, for example by helping the patient with stress management. The bio-psychosocial model combines the biological and psychological models, adding the importance of regarding the patient as an individual related to other systems. This model, derived as it is from systems theory, seems to be similar to the ecosytemic approach because both approaches consider the patient suffering from schizophrenia as an individual to be treated in relation to his family and other environmental systems. The bio-psychosocial model and the ecosystemic approach are therefore inseparable.

The assumptions, key parameters and techniques are important components discussed under the ecosystemic approach. The assumptions and the key comparative parameters explain the fact that living things are dependent on each other for survival. There is a relationship and interaction between the individual, his family, church, and other systems for survival. The interaction may be controlled by openness and closedness of the system as well as by the type of boundary of the systems.

Understanding the family life cycle will assist the social worker in understanding the patient's current functioning in the context of his past. Techniques are the tools that

may be used by the social worker to gather information about the interaction and the relationship between the patient and his family and other environmental systems.

In conclusion, the ecosystemic approach provides a theoretical framework for understanding a person in relation to or in interaction with his family, his friends, neighbours, church and other systems. Social work guidelines should facilitate a process of understanding a schizophrenic patient and his family in the context of his environment.

In Chapter 3 schizophrenia as a type of mental illness will be discussed.

CHAPTER THREE

SCHIZOPHRENIA AS A TYPE OF MENTAL ILLNESS

3.1 INTRODUCTION

The psychoanalytic movement resulted in a kind of universal theory of human deviance in which all mental and emotional problems were ranged on a continuum from the minor stresses of everyday living to the severe disturbances of schizophrenia (Hatfield, 1990:4).

For the purposes of this study, it is necessary briefly to describe the concept "mental illness". **Mental illness** or **mental disorder**, according to the DSM-IV (1994:91) and Hudson (1982:187), is the global term referring to categories of mental disability. Sewpaul (1993:188) defines mental illness as the result of several interacting factors, including biological, psychological, psycho and social determinants and furthermore states that the family constitutes a vital component of mental health.. Sewpaul (1993:188) also concludes that the family does have an impact on the mental health status of its members, as it protects them through the quality of interpersonal relationships, the provision of reassurance, comfort and encouragement and the striving for fulfilment. Mental illness can thus be associated with stress in family relationships.

Mental illness or disorder or instability may occur as a result of biological factors, such as genes or heredity, or may be a disturbance of the mind. Within the context of the ecosystemic approach, mental illness may also occur as a result of life stress triggered by stressors such as unemployment, financial problems and culture. The family unit may contribute to mental illness in the family if there is a communication breakdown or if the relationship between the members is strained.

In the DSM-IV (1994:91) it is stated that mental disorders or mental illness result when people's ways of coping with life start falling apart. Mental illness, mental disorders or psychiatric illness imply a distinction between mental and physical disorders, which is a reductionist anachronism of mind and body dualism (DSM-IV, 1994:xxi).

From a social work perspective, a mentally ill patient is incapable of coping with life problems, cannot think logically and finally becomes a burden to the family as a system as well as to other related systems. Cockerha (1992:276) also believes that mental disorders might tear the very bond that forms a meaningful social fibre in the family and the community. It may introduce fear, violence, discord, anxiety and other stress factors into the family circle. The meaning of the illness to each family is determined in many ways, taking into account a variety of psychological, social, and economic variables (Hough, 1995:348).

In an ecosystemic approach, it is important to focus on the mentally ill patient as an individual, on one hand, and on how he affects the family system, on the other. This includes how he receives help from his family and also how he impacts on the community as well as the environment. The interaction between the patient and his family, the community and the environment is significant because it affects the functioning of each individual involved (Nelson, *et al.* 1986:114).

In this chapter, schizophrenia will be described as a type of mental illness. This discussion will include the etiology, symptoms, phases, classification and types.

3.1.1 SCHIZOPHRENIA AS A TYPE OF MENTAL ILLNESS

A common misconception is that a classification of mental disorders classifies people, when in actual fact it classifies the disorders that people suffer from. For this reason, DSM-IV (1994:xxii) and Holmes (1994:265), supported by Hudson (1982:3), avoid the use of such expressions as "a schizophrenic" or "an alcoholic" and instead use the more accurate but admittedly more cumbersome "an individual with schizophrenia or an individual with alcohol dependence". For the purpose of this study, the term to be used will be a patient suffering from schizophrenia.

Schizophrenia falls under AXIS 1 of the DSM-IV (1994:26) classification. The latter is used at mental institutions, and specifically at Weskoppies Hospital where the empirical study for this research was conducted. A popular belief about schizophrenia is that those who suffer from it have a "split" personality. The split is observed between the

body and the mind, not within the personality. This implies that the schizophrenic experience involves a disharmony of the thinking, feeling, and acting components of behaviour (Cook & Fontaine, 1991:530). This view explains that schizophrenia is a kind of mental illness with unpredictable conditions.

Falloon, McGill and Boyd (1988:2), supported by Lloyd (1991:218), agree that there is a common notion that schizophrenia means having more than one personality. A better explanation would be that schizophrenia means a disintegration of the personality, where a person finds it difficult to decide what is real and what is not. It is a little like having dreams when one is wide awake. This explanation reveals that a patient suffering from a schizophrenic state of mind seems to be confused.

According to Hatfield (1990:69), schizophrenia is a complicated and crippling disorder, which impinges on all aspects of a person's life. The disorder tends to be chronic and episodic, and few patients with the disease return to their pre-morbid state.

Persad, Kazarian and Joseph (1992:64) state that schizophrenia is a major mental disorder with significant devastating effects on its victims, at great cost to the society. It is an illness process that destroys the inner unity of the mind and weakens the volition and drive that constitute the essential character of human beliefs.

According to Uys (1994:31), schizophrenia is a term used to describe a group of complex, severe conditions that are the most chronic and disabling of the mental illnesses. The conditions are characterised by patients experiencing a different reality than that of people around them. This break in reality is the reason for its being called a "psychotic" condition. The reality of these patients is distorted, changeable and often frightening. The sensory perceptions may be distorted by hallucinations, of which auditory voices are the most common. Their thought processes are often confused so that they find it difficult to "think straight" or to focus on or engage in problem solving. The patient suffering from schizophrenia may behave differently and see things differently. For instance, he may destroy the radio or television because he believes that the broadcast is referring to him.

Uys (1994:312), supported by Tsuang (1982:17), DSM-IV (1994:8), Kaplan and Sadock (1988:103), Clark (1996:784), Aromando (1995:59), Stafford-Clark, Bridges and Black (1990:137) and Everett, Dennis and Ricketts (1995:285) defined schizophrenia as a group of psychoses or psychotic disorders which comprises disturbances in affect, mood, behaviour and thought processes. A client with schizophrenia exhibits impaired functioning in such areas as work, interpersonal and social relationships and self care (Aromando, 1995:59).

Warner (1994:4), DSM-IV (1994:8) and Kaplan and Sadock (1988:103) class schizophrenia as one of the functional psychoses. These are the disorders in which the changes in functioning cannot with certainty be attributed to any specific organic abnormality in the brain. Despite common features, different forms of schizophrenia may appear quite dissimilar. One patient, for example, may be paranoid and hostile in certain circumstances but may show good judgment and high functioning in many other areas of life. Another patient may be bizarre in manner and appearance, pre-occupied with delusions of bodily disorder, passive and withdrawn.

According to Clark (1996:784), schizophrenia may be defined as a severe emotional disorder marked by disturbances of thinking, mood and behaviour, with thought disorder as the primary feature. Schizophrenia is characterised by the presence of at least two of the following symptoms for a significant portion of the month: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour and negative symptoms such as flattened effect and evolution. Schizophrenia is also characterised by significant social or occupational dysfunction (Burgess, 1985:285; Everett, *et al.* 1995:45). Thus, the patient suffering from schizophrenia may behave antisocially within his family, within society and may be generally uncooperative.

It is clear that schizophrenia is a crippling and severe type of mental illness, which affects the sufferer's whole life. There is a major disturbance in the functioning of a person's thinking and ideas between the ages of 16 and approximately 45 years. This implies that the parts of the brain that control the thoughts and feelings become out of harmony with one another. The person begins to experience the world around him differently from most people and his behaviour changes markedly (Gillis, 1986:74).

This disturbed thought pattern of the patient affects the entire family. For example, the patient may become angry with a person in the street, thinking that he is laughing at him.

The definitions of schizophrenia discussed above indicate that the patient suffering from schizophrenia has disturbed thinking. This disturbed thinking may affect the patient's feelings, behaviour, actions and perceptions. The patient may feel, behave and act differently and in a strange manner. He may, for example, behave violently or laugh when the death of the relative is reported to him. The patient's relatives may feel embarrassed and think of hiding the patient. Patients suffering from schizophrenia differ from one patient to another, depending on their condition and diagnosis. Differences in sufferers from schizophrenia may also be caused to a certain extent by the individual's race and culture (Gillis, 1986:73). Gillis (1986:73) is of the opinion that schizophrenia occurs in all racial groups and in all parts of the world, but may manifest in different ways because of cultural differences. Cases occur particularly in those parts of large cities where social disorganisation such as poverty, crime and unemployment prevail. The reasons for this are not certain although it is clear that the condition of schizophrenia is exacerbated by stressful social conditions.

The recognition of schizophrenia as a mental illness is often denied by those closest to the patient. Not surprisingly, denial masks the initial psychological impact of the illness. Family members scarcely recognise prodromal schizophrenic behaviour as an indication of the onset of an enduring psychiatric condition. Rather, when confronted with such behaviour, family members tend to believe that the individual will outgrow it or to view it as a sign of temporary destabilisation. They may even attribute the behaviour to malingering (Hough, 1995:34).

Due to a lack of insight into mental illness, especially in the case of schizophrenia, the family members may not understand the process, levels or stages that the patient is experiencing, even from the simple to the acute or psychotic condition. Acute schizophrenia may, for example, severely impair mothering skills when maternal distress leads to distraction and neglect. In women with chronic schizophrenia, blunted or incongruous behaviour, emotions, poor motivation, disturbed behaviour and a lack of

response to the child's cue may all affect the mother-infant interaction (Appleby & Dickens, 1993:348). In such cases of a mother suffering from schizophrenia, close supervision needs to be imposed for the protection of the mother's baby. It is the duty of the family members, with the social worker's support, to monitor that supervision.

In summary, schizophrenia is a complex type of mental illness which impacts on the functioning of the family. According to Holmes (1994:265), schizophrenia is particularly complex and frightening because the symptoms are totally beyond the realm of experience of most people. The patient suffering from schizophrenia may thus show some suicidal tendencies or in some instances, eat or play with waste products. It is, for the purpose of this study, important to define the patient suffering from schizophrenia within the context of his family and environment. It is also important to understand the etiology, symptoms, phases, classification, and subtypes of schizophrenia which contextualise the condition as a mental illness.

3.2 ETIOLOGY OF SCHIZOPHRENIA

According to Kaplan and Sadock (1988: 320), two of the most important figures in the history of schizophrenia are the Swiss psychiatrists Emil Kraepelin and Eugene Bleuler. Holmes (1994:284) mentions that these two men offered very different views of the disorder and that the views they introduced a century ago still reflect commonly held beliefs about the illness. In 1911, Bleuler gave the name "Schiz" to schizophrenia. The Greek word "schizein" means to split and "phres" means psyche, indicating the primary and secondary symptoms.

There are different views and models to describe the etiology, the origin and causes of schizophrenia. According to Gillis (1986:74), supported by Holmes (1994:307) and Weller (1990:100), the causes of schizophrenia are unknown. However, the following etiological factors have some bearing when selecting treatment methods: genetics or biological factors, genetic-environmental factors, physical changes in the brain, metabolic factors, psychosocial factors, social factors, perinatal factors and viral infections.

3.2.1 GENETICS OR BIOLOGICAL FACTORS

Genetic factors are believed to play an important causal role in many instances of the disorder (Fernando, 1996:13; Cavenar & Brodie, 1982:294; Tantam, Appleby & Duncan, 1996:119; Stafford-Clark, *et al.* 1990:137).

The genetic or biological explanation occurs more frequently in close relatives of patients suffering from schizophrenia. No single gene hypothesis has been proved but the evidence points to the fact that what is inherited is a vulnerability to the disease, probably operating through some enzyme system to effect changes in metabolic pathways. (Compare Gillis, 1986:74; Arieti, 1978: 82; Weller, 1990:100; Holmes, 1994:307; Weiner, 1997:128 and Angermeyer & Matschinger, 1996:200.)

Genetic studies have centered on family studies, twin studies and adoption studies (Cook & Fontaine, 1991:538).

- *Family studies*: Family studies indicate that the risk of the incidence of schizophrenia ranges from eight to 18 percent and if both parents are schizophrenic, the risk jumps to between 15 and 55 percent (Kendell & Zealley, 1993:409; Cook & Fontaine, 1991:538; Gelder, *et al.* 1989:292). Schizophrenic parents may thus bear children suffering from schizophrenia.

Because social as well as genetic factors could be involved in transmission, researchers sought to gain further evidence on the relationship of genetics and schizophrenia by studying twins (Cook & Fontaine, 1991:538; Carson, *et al.* 1996:460).

- *Twin studies*: Most twin studies demonstrate a 40 to 50 percent rate of schizophrenia in a second twin where one has been diagnosed schizophrenic in identical (monozygotic) twins, and an eight to ten percent rate in fraternal (dizygotic) twins. These genetic factors are significant but not uniform. They are clustered in some families, and absent in others. This finding may indicate a variety in the causes of schizophrenia (Gelder, *et al.* 1989:293; Cook & Fontaine,

1991:538). There are possibilities that identical twins may become schizophrenic patients due to genetic factors.

- *Adoption cases*: If children born to schizophrenic mothers are adopted immediately after birth by parents who are not schizophrenic patients, the chances are that they may be patients suffering from schizophrenia and they may reflect an antisocial personality (Gelder, *et al.* 1989:294).

In conclusion, genetics plays an important role in the development of schizophrenia.

3.2.2 GENETIC-ENVIRONMENTAL INTERACTION

Schizophrenia is a stress-related, biological disorder. According to Falloon, *et al.* (1988:7), schizophrenia is probably caused by a combination of a disturbance of brain function and life stress. The exact cause is not known but whatever it is appears to produce an imbalance of the brain chemistry (Allwood & Gagiano, 1997:195).

Freeman (1989:91) views genetic-environmental and family environmental interactions as the causes of schizophrenia. Gillis (1986:75) and Tsuang (1982:49) support the view that, respectively, genetic factors and family relationships are the causes of schizophrenia. Freeman (1989:91) is of the opinion that either the genes or hereditary factors together with the environment can contribute towards the causes of schizophrenia. On the predisposing causes, genetic factors are most strongly supported by the evidence, but it is clear that environmental factors play an important role as well (Gelder, *et al.* 1989:292). Heredity together with environmental factors may also cause a family member to suffer from schizophrenia.

With respect to family environment, Freeman (1989:95) states that expressed emotion (EE), which is regarded as an operationalised measure of environmental stress in the home, has become a very powerful concept in recent research on schizophrenia.

3.2.3 PHYSICAL CHANGES IN THE BRAIN OR NEUROLOGICAL ABNORMALITIES

Historical examination indicates changes in the cells of the cortical layers in the brain of chronic schizophrenics. However, these changes are minute and variable, and their significance is difficult to assess. (Compare Gillis, 1986: 74; Holmes, 1994:312; Weiner, 1997;128 and Weller, 1990:100.)

According to Hatfield (1990:71), schizophrenia is probably a group of brain diseases in which there are both structural and functional differences between normal brains and those with schizophrenia. The limbic system of the brain is now thought to be the site of the problems associated with schizophrenia. Gelder, *et al.* (1989:298) are of the opinion that thickening of the corpus callosum and cerebella atrophy have been reported in schizophrenic patients. Patients with chronic temporal lobe epilepsy have an increased risk of developing schizophrenic symptoms.

According to Cavenar and Brodie (1982:295), biochemical theories are the theories that state that schizophrenia is caused by a biochemical alteration of the brain that is not visible even under the electron microscope. The other important biochemical theory of schizophrenia is the dopamine hypothesis. It was observed in some studies that the phenothialines block elopamine. This hypothesis was based on the observation that patients with the illness benefit from anti-dopaminergic drugs and also that abuse of drugs that stimulate dopamine transmission, such as amphetamines, produce schizophrenia-like psychosis (Tantam, *et al.* 1996:119). Brain abnormalities may thus cause a family member to suffer from schizophrenia.

3.2.4 METABOLIC FACTORS

The patient suffering from schizophrenia induced by metabolic factors is less responsive to various stimuli, for example, thyroid, insulin, adrenaline, heat, cold and strong emotions. He tends to have low blood pressure, heart rate and circulation time as well as a poor peripheral vascular circulation (Gillis, 1986:74; Holmes, 1994:314).

3.2.5 PSYCHOSOCIAL FACTORS

It is evident from literature (Holmes, 1994:316) that many patients suffering from schizophrenia manifest psychological maladjustments and difficult behaviour at an early stage and have experienced an unhappy childhood with ineffective coping mechanisms. Furthermore, the families of patients suffering from schizophrenia are frequently disturbed by discord and distrust between the parents and there may also be other family members within the same family with mental illness (Gillis, 1986:75; Holmes, 1994: 316).

Studies of interactions in families having a schizophrenic offspring have focused on such factors as: schizophrenogenic mothers, faulty communication and destructive family relationships (Compare Carson, *et al.* 1996:470; Tsuang, 1982:45 and Strauss & Carpenter, 1981:85-121).

- Schizophrenogenic mothers (parents)

Hostility within the parents may lead to schizophrenic behaviour. Carson, *et al.* (1996:470) state that certain personality traits of the mothers of patients suffering from schizophrenia caused schizophrenia in a vulnerable offspring. These mothers were labeled schizophrenogenic. The reasoning behind this theory was that mothers of patients suffering from schizophrenia tended to be over-protective, hostile and unable to understand their children's feelings. These abnormal attitudes were thought to create schizophrenic behaviour in their children (Tsuang, 1982:45; Strauss & Carpenter, 1981:120). Over-protection and too much hostility from a mother who is suffering from schizophrenia may also cause a child to become a schizophrenic. Hostility and the way a parent behaves to his children may also contribute to psychosocial stress.

Angermeyer and Matschinger (1996:199-204) also view psychosocial stress within the family as the cause of schizophrenia. Sexual abuse during childhood or the effect of atomic rays has also been infrequently cited as possible causal factors (Angermeyer & Matschinger, 1996:200). Thus, stress, which affects one's mind, may ultimately cause schizophrenia.

- Faulty communication

Faulty communication is also hypothesised to cause schizophrenia. This includes double-bind theory, destructive family relationships, communication deviance (CD) and high expressed emotion (EE) (Carlson, *et al.* 1996:471; Bellack, 1984:23).

- Double-bind theory

Double-bind theory is a term used to describe a pattern of conflicting and confusing communication among members of schizophrenic families (Hudson, 1982:17). In this pattern the parents present the child with ideas, feelings and demands that are mutually incompatible. For example, a mother may verbally love and accept but be emotionally anxious and rejecting, or she may complain about her son's lack of affection but freeze up or punish him when he approaches her affectionately. (Compare Carson, *et al.* 1996:471; Tsuang, 1982:46; Strauss & Carpenter, 1981:121 and Scheflen, 1981:36). Conflicting messages may increase the chances of a family member becoming a schizophrenic.

- Destructive family relationships

Family disputes, for instance, are assumed possibly to cause schizophrenia. Carson, *et al.* (1996:471) state that an abnormal marital relationship caused schizophrenia in the offspring. Children observing the inappropriate behaviour of their parents might learn to respond with psychotic behaviour. Two kinds of abnormal marital relationships are described. The first is termed the skewed relationship and the second marital schism. The skewed relationship occurs when one parent yields to the abnormal parent who then dominates the family. This kind of relationship is commonly found among parents of male schizophrenics. The mother tends to be dominant and the father passive. Consequently, the mother is unable to find emotional satisfaction from the father and turns to the son instead (Tsuang, 1982:47, Strauss & Carpenter, 1981:85).

Marital schism occurs when there is emotional disharmony between parents who pursue their individual needs and goals at the expense of the child, often involving the child

and thus dividing the child's loyalties (Atkinson & Coia, 1995:3). This type of abnormal marital relationship is considered to be common in families of female schizophrenics (Tsuang, 1982:48; Arieti, 1978:88). It indicates that marital dispute may cause a family member to suffer from schizophrenia.

- Communication deviance (CD)

Communication deviance is a measure that reflects an inability of the parent to establish and maintain a shared focus of attention during transactions with another person. Repeated parent-offspring exchanges, characterised by high levels of parental communication deviance may contribute to disturbed thinking and communication in vulnerable offspring (Carson, *et al.* 1996:471; Docherty, Rhinewine, Labhart & Gordinier, 1998:765).

- High expressed emotion (EE)

Expressed emotion is a predictor of relapse rates in patients. Families are rated as high or low expressed emotion (EE) depending on the level of criticism, hostility, or emotional over-involvement they express towards the patient during the interview. Patients released to high expressed emotion family involvements have been found in several replication studies to have approximately a 55 percent chance of relapse during the first nine months after discharge, while those returning to low expressed emotion families have only a 15 percent chance (Bellack, 1984:23; Hooley, 1998:374-378; Carson, *et al.* 1996:471; Falloon, *et al.* 1988:1183). High expressed emotion as part of faulty communication may cause the patient suffering from schizophrenia to suffer a relapse. If the relatives criticize, are hostile to and over-involved with the patient, they may trigger the patient's relapse.

3.2.6 SOCIAL FACTORS

Environmental stress may cause a family member to suffer from schizophrenia. Docherty, Hall and Gordinier (1998:461), Falloon, *et al.* (1988:7), Bellak (1984:25) and Clark (1996:787), supported by Gelder, *et al.* (1989:303), are all of the opinion that

cultural factors, occupation and social class, place of residence, migration and social isolation may cause an individual to suffer from schizophrenia. For instance, an African may believe in witchcraft as the cause of mental illness (Mojalefa, 1994:59). A strenuous job situation and a lower social class may also cause a person to suffer from schizophrenia.

A study of inhabitants of Chicago according to Gelder, *et al.* (1989:304) found that patients suffering from schizophrenia were over-represented in the disadvantaged inner city areas. High rates of patients suffering from schizophrenia have also been reported among migrants. The reasons for these high rates are not clear, but they are probably due mainly to a disproportionate migration of people who are unsettled because they are becoming mentally ill. Patients suffering from schizophrenia often live alone, are unmarried and have few friends (Gelder, *et al.* 1989:304). Social factors as contributory factors of schizophrenia indicate that in order to remain healthy psychologically, spiritually and physically, a person should not be separated from other people and other systems. Drug and alcohol abuse, which is seen as other social factors, may also cause the onset of schizophrenia (Angermeyer & Matschinger, 1996:202).

3.2.7 PERINATAL FACTORS

Perinatal factors are constitutional factors, which, according to Gelder, *et al.* (1989:496) are believed to cause schizophrenia. Gelder, *et al.* (1989:496) state that it has been suggested that factors present at the time of birth, such as birth complications, may contribute to the etiology of schizophrenia.

3.2.8 VIRAL HYPOTHESIS

Tantam, *et al.* (1996:120) state that one influential etiological hypothesis of schizophrenia suggests that it may be a result of viral infections.

All the above-mentioned etiological factors have been hypothesised as the causal factors of schizophrenia, even if there is still no definite proof of the cause of schizophrenia.

3.2.9 ONSET

Onset may be described as the period or stage when a person is diagnosed as a patient suffering from schizophrenia. Schizophrenia may have a gradual or a sudden onset (Kemp, 1994:27). When the onset is very sudden one should keep in mind the possibility of the illness being due to the effects of drugs, because substances such as amphetamines, L.S.D. and mescaline sometimes produce appearances quite indistinguishable from schizophrenia (Munro & McCulloch, 1969:226).

According to Gillis (1986:75), the DSM-IV (1994:281), Tantam, *et al* (1996:111), Longhorn (1984:133) and Munro and McCulloch (1969:226), the great majority of illnesses commence between puberty and adolescence, between the ages of 15 and 30. Although schizophrenia can occur at any age from seven to 70, the onset is usually in adolescence or young adult life (Kendell & Zealley, 1993:401). One of the greatest periods of stress, especially for young men, is early adult life. At this time young men are striving to get a good job, develop close friendships and establish their independence. In women, the major life stress is delayed till childbirth and child rearing and that is why schizophrenia usually starts later in women (Falloon, *et al.* 1988:7). However, schizophrenic syndromes may occur in later life, even in old age. The condition may appear quite unexpectedly, without any obvious psychological or physical stress or intense emotional disturbance. The onset is usually characterised by isolated incidences but even if it appears more acutely, there is usually an indication in the patient's background of a tendency to withdrawal, paranoia, fears or a behaviourally disturbed childhood. Adolescence and the adult stage may be concluded as the primary periods when a person starts to suffer from schizophrenia.

The way a family reacts to a member developing schizophrenia mostly or in part depends on the way they perceive mental illness and the practical impact of the illness on themselves (Atkinson & Coia, 1995:33; DSM-IV 1994:289).

Hatfield (1990:72) states that families are deeply concerned about the future of their mentally ill relatives. Families should be given the assurance that a fairly independent and satisfying life is possible for patients suffering from schizophrenia. According to

Tsuang (1982:56), at the onset the patient begins to feel that everyone, including strangers, is trying to harm him and he can hear his thoughts as if they were spoken aloud. Patients hear voices even when they know they are alone. The person suffering from schizophrenia can sometimes sense that something is wrong, but does not see himself as a patient who needs professional help. The well-meaning attempts of relatives and friends to reason or even argue with the sufferer usually develop into heated disputes. Even if the person suffering from schizophrenia agrees to visit the doctor, he may become very upset if the doctor suggests a psychiatric consultation. Eventually, the relatives, friends and even the doctor become persecutors in the patient's delusional system.

It is at this stage that the admittance of the patient to hospital for an examination may prevent further deterioration. In most cases, patients can be persuaded to go voluntarily, but if they refuse or become violent and dangerous to themselves or others, involuntary admission through legal commitment procedures may be necessary.

The researcher is of the opinion that if the family and other relatives understand the onset of schizophrenia and its consequent behavioural symptoms, the person suffering from schizophrenia could be referred for professional help at an early stage of the illness. In return, the impact on family functioning can also be reduced. The social worker, as part of the psychiatric team, needs to have knowledge of causal factors and the onset of schizophrenia to be able to support both the patient and the family.

As a type of mental illness, schizophrenia can be identified by specific symptoms. These symptoms serve as an indication of the severity of the disturbance and as a guide for professional help.

3.3 SYMPTOMS OF SCHIZOPHRENIA

Schizophrenia symptoms may be described as the signs indicating that the patient is suffering from a certain type of mental illness. According to Carson, *et al.* (1996:448), supported by Burgess (1985:281), schizophrenic disorders sometimes develop slowly and insidiously. In such cases, a person may become reclusive, gradually seeming to

lose interest in the surrounding world, spending much of his time daydreaming, losing emotional responsibility and behaving in mildly socially inappropriate ways, such as grimacing peculiarly or failing to appreciate social proprieties. This pattern of symptoms has traditionally been referred to as process schizophrenia - that is, it develops gradually over a period of time, not in response to obvious discrete stressors, and tends to be long lasting. The outcome of process schizophrenia is considered generally unfavourable, partly perhaps because the need for treatment is usually not recognised until the behaviour pattern has become firmly entrenched. Poor premorbid (referring to personality features existing before the occurrence of actual disorder) or chronic schizophrenia are alternative terms referring to this pattern (Kendell & Zealley, 1993:401).

Schizophrenia is diagnosed by recognising certain characteristic symptoms. These symptoms involve changes in a person's thoughts and feelings and, to a lesser extent, in his behaviour. A diagnosis is made from what the patient tells the psychiatrist (Falloon, *et al.* 1988:3; Allwood & Gagiano, 1997:200). This means that a psychiatric team may be able to recognise or conclude that the patient is suffering from schizophrenia after being convinced of certain signs and features from that person during case conferences.

Schizophrenia is a disturbance that lasts for at least six months and includes at least one month of active-phase symptoms, i.e. two or more of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, negative symptoms (DSM-IV, 1994:273; Holmes, 1994:270). According to DSM-IV (1994:274) and Berenbaum, Taylor and Cloninger (1994:475) the signs and symptoms are associated with marked social or occupational dysfunction. The characteristic symptoms of schizophrenia involve a range of cognitive and emotional dysfunctions that include dysfunctions in perception, inferential thinking, language and communication, behavioural monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition, drive and attention (Stafford-Clark, *et al.* 1990:144; Cook & Fontaine, 1991:545). These aspects may be observed in the deterioration of the patient's level of functioning, whether on a social level or in his interrelationships. For instance, the patient may become disinterested socially.

Holmes (1994: 265) and DSM-IV (1994: 274) are in agreement with regard to the types of schizophrenia symptoms that have been identified, namely cognitive, mood, somatic and motor symptoms.

3.3.1 COGNITIVE SYMPTOMS

Probably the most obvious and most important symptoms of schizophrenia are cognitive. These symptoms include hallucinations, delusions, disturbed thought processes and cognitive flooding (Holmes, 1994:265; Allwood & Gagiano, 1997:197; Bellack, 1984:6; Tantam, *et al.* 1996:112). **Hallucinations** are perceptual experiences that do not have a basis in reality. An individual who hears, feels, smells or sees things that are not really there is said to be hallucinating (DSM-IV, 1994: 275; Holmes, 1994:265, Sue, Sue, & Sue, 1981:284; Johnstone, Humphreys, Lang, Lawrie & Sandler, 1999:25). Auditory hallucinations are the most common. These frequently involve the hearing of voices that comment on the individual's behaviour, criticise this behaviour, or give commands. Patients suffering from schizophrenia may behave abnormally due to these hallucinations.

Kendell and Zealley (1993:401) state that tactile and somatic hallucinations, in which the individual imagines tingling or burning sensations of the skin or internal bodily sensations, are also common. Finally, visual and olfactory hallucinations (seeing or smelling things that are not there) are also observed in persons with schizophrenia, but these types of hallucinations are less common. It is important to realise that for individuals suffering from hallucinations, these appear to be real perceptions; they are unable to distinguish hallucinations from real perceptions (Holmes, 1994:265; DSM-IV, 1994:275; Sue, *et al.* 1981:284).

Delusions are erroneous beliefs that are held, despite strong evidence to the contrary. Some delusions are bizarre and patently absurd, while others are possible but unlikely. The most common delusions are those of persecution, in which individuals think that others are spying on them or planning to harm them in some way (Gelder, *et al.* 1989:268). Also common are delusions of reference in which objects, events, or other people are seen as having some particular significance to the person. For example, one

patient believed that if a woman across the room folded a newspaper in a certain way, it was a sign that spies were following him. Patients suffering from schizophrenia also experience delusions of identity in which they believe that they are someone else (Costello, 1993:108; Johnstone, *et al.* 1999:25). Schizophrenia may be regarded as a dangerous type of mental illness because the patient may harm others due to delusions and the misinterpretation of objects and events.

Common examples of this include delusions that patients are Jesus, Joan of Arc, or some other famous person. In many cases, individuals with schizophrenia develop very elaborate delusional systems involving many interrelated delusions and the hallucinations they experience are often related to these delusions. In one case, the stomach pains (somatic hallucinations) felt by an individual with schizophrenia were taken as evidence that he had been poisoned (delusions of persecution) (Holmes, 1994:266; Gillis, 1986:76; Hatfield, 1990:70; Arieti, 1978:39). Arieti (1978:78), supported by Stafford-Clark, *et al.* 1990:148) states that the patient may give some definite interpretations to facts or feelings that are not supported by observations made by other people. In other cases these delusions may be pleasant in content and even grandiose (Costello, 1993:108). Such an example is the patient who believes that she is a queen or that a great actor is going to marry her. The way the patient perceives external stimuli will be altered, for she hears or sees things in a distorted way. An old man on the street for example, looks exactly like the patient's grandfather. These beliefs and behaviours can severely affect the functioning of the family.

The **disturbed thought processes** indicate that, in addition to problems of **thought content**, there also appear to be problems in *how* patients with schizophrenia think (Allwood & Gagiano, 1997:197; Munro & McCulloch, 1969:220). According to Holmes (1994:267), it has been suggested that the thought processes of these individuals can be characterised by a "loosening" of the associative links between thoughts, so that the individual frequently spins off into irrelevant thoughts. A patient may be talking about his coat and then with no apparent transition, will begin talking about medieval castles in Spain (Falloon, *et al.* 1988:3). Because persons with schizophrenia tend to include irrelevant ideas in their thoughts and conversations, their thought processes have been described as over-inclusive. The phrases used by patients suffering from

schizophrenia are generally grammatically correct, but the thoughts expressed are disjointed and do not make sense when put together. Because of the apparent random nature of their thoughts, the utterances of patients suffering from schizophrenia have been described as flights of ideas or word salads (Holmes, 1994:267; Gillis, 1986:77; Butler & Pritchard, 1983:7). The patient may appear to be confused and as such may not be allowed to make decisions.

Cognitive flooding (stimuli overload) refers to an important element in the cognitive experience of patients suffering from schizophrenia, involving an excessive broadening of attention that results in what may be termed cognitive flooding or stimulus overload (Tantam, *et al.* 1996:112). Many patients suffering from schizophrenia lack the ability to screen out irrelevant internal and external stimuli. It is as though the "filter" that most people have for eliminating extraneous stimuli is missing or dysfunctional. As a consequence, patients suffering from schizophrenia are forced to attend to everything around and within them and they feel as if they are being flooded, to the point of being overloaded, with perceptions, thoughts and feelings. Although cognitive flooding is not listed as a symptom of schizophrenia in DSM-IV, Holmes (1994:269) regards it as an effective way of conceptualising the nature of cognitive problems experienced by some individuals with schizophrenia. Some patients suffering from schizophrenia may appear flooded with information and may say whatever they feel like, relevant or not.

Cognitive symptoms of hallucinations, delusions, disturbed thought processes and cognitive flooding impact very negatively on family functioning. Both the patient and the family need support and guidance in dealing with these symptoms.

3.3.2 MOOD SYMPTOMS

The moods of patients suffering from schizophrenia are typically described as "blurred", "flattened" or "inappropriate". In other words, these patients are not as emotionally responsive as they should be to environmental or interpersonal situations. For example, when hearing of a death in the family or watching a very funny film, a patient suffering from schizophrenia may remain impassive and show little or no emotional response (Tantam, *et al.* 1996:118). Yet, in other situations, the same person may be emotionally

volatile but in a way that is inappropriate and inconsistent with what would be expected in the situation. For example, when discussing an injury or some other serious topic, the individual or patient may burst into laughter (Burgess, 1985:282).

Overall then, the emotions of patients suffering from schizophrenia can best be described as inappropriate or situationally inconsistent. When interpreting the emotional responses (or lack thereof) of patients suffering from schizophrenia, it is usually assumed that they give the wrong response to a situation (Allwood & Gagiano, 1997:196). An alternative interpretation is that they give the right response to a wrongly perceived situation. That is, instead of responding incorrectly to the objective or external situation as it is perceived by others, the patient suffering from schizophrenia may be responding correctly to his own idiosyncratic interpretation of the situation (a delusion), to some internal response (a hallucination) or to some competing thought (stimulus overload) (Holmes, 1994:269; DSM-IV, 1994:288). The inappropriate or situationally inconsistent emotional responses of the patient suffering from schizophrenia affect the family functioning very negatively because behaviour cannot be predicted. This can lead to tense family relationships.

3.3.3 SOMATIC SYMPTOMS

The DSM-IV classification model does not list any somatic symptoms for schizophrenia, but over the years a considerable amount of attention has been given to somatic responses. Although the evidence is inconsistent and contradictory, the somatic symptom that has attracted most attention is general physiological arousal (heart rate, blood pressure, sweating palms). In some studies patients suffering from schizophrenia were found to be more physiologically aroused than normal individuals, while in other studies less arousal was observed among patients (Holmes, 1994:270; Cook & Fontaine, 1991:534). The conflicting findings may be due to the possibility that different levels of arousal are associated with different phases of the disorder. For example, it may be that patients with acute cases of schizophrenia are over-aroused but those with chronic cases are under-aroused. It is also possible that the level of arousal is a function of the types of delusions experienced. Patients who believe that others are plotting to kill them will probably be more aroused than patients who think that they are already dead (Holmes,

1994: 270)]. The physiological arousal therefore needs to be viewed and understood by the family in relation to other symptoms.

3.3.4 MOTOR SYMPTOMS

The range of motor symptoms in schizophrenia is wide. Straube and Hahlweg (1990:19) state that some patients with the disorder remain immobile for long periods of time, whereas others are very agitated and exhibit a high level of activity. Other motor symptoms include unusual facial grimacing and repetitive finger and hand movements. Many of patients' movements appear random and purposeless, but in a few cases they are related to patients' delusions. For example, individuals with delusions of persecution may direct excessive activity towards hiding or defending themselves from their persecutors (Holmes, 1994:270; DSM-IV, 1994:288; Butler & Pritchard, 1983:21; Berenbaum, *et al.* 1994:475).

The essential features of schizophrenia, viewed from a holistic perspective, are a mixture of characteristic signs and symptoms, both positive and negative, that have been present for a significant period of time during a one-month period, with signs of the disorder persisting for at least six months (DSM-IV, 1994:274; Holmes, 1994:282; Cook & Fontaine, 1991:533). The positive and negative symptoms of schizophrenia are reflected in Table 1.

Table 1: Negative and positive symptoms of schizophrenia (Holmes, 1994:282)

POSITIVE SYMPTOMS	NEGATIVE SYMPTOMS
- Hallucinations	- Flat mood
- Delusions	- Poverty of speech
- Thought disorders	- Inability to experience positive feelings
- Bizarre behaviour	- Apathy

Positive symptoms are so called because they are active or florid symptoms. They are also behaviours not usually found in normal individuals (Straube & Hahlweg, 1990:20; Holmes, 1994:282). According to Cook and Fontaine (1991:533) and Shriqui and Nasrallah (1995:109), the positive behavioural characteristics also include catatonic excitement, stereotypes, echopractic, echolalia, and verbigeration. The term catatonic

excitement is used to describe the hyperactive behaviour that may occur during the acute phase. The excitement may become so great that it threatens the safety of the patient suffering from schizophrenia or those around him. Stereotypes are repetitive meaningless movements or gestures, such as grimacing, particularly in the perioral area. Some patients exhibit echopraxia, the imitation of an observed person's movements and gestures; echolalia is the repetition of an interviewer's question in answer to the question and verbigeration is a senseless repetition of the same word or phrase that may continue for days (Cook & Fontaine, 1991:533; Straube & Hahlweg, 1990:20). These behavioural characteristics are associated with hallucinations and delusions, including thought disorders.

Negative symptoms, on the one hand, reflect defects or limitations and the absence of behaviours usually found in normal individuals. Negative behavioural characteristics are catatonic stupor, posturing, minimal self-care, social withdrawal, stilted language and poverty of speech (Cook & Fontaine, 1991:533). The term catatonic stupor is used to describe a reduction of energy, initiative and spontaneity. There is also a lack of natural gracefulness in body movements that results in poor co-ordination. Activities may be carried out in a robot-like fashion. The patient is posturing when he holds unusual or uncomfortable positions for a long time. The patient's self-care may become minimal and he may have to be reminded to bathe, shave, brush teeth and change clothes. Social withdrawal is noticed when greetings are not returned or when conversations are ignored. Stilted language refers to the use of formal and quaint language in social situations. Patients are described as having poverty of speech when they say very little on their own initiative or in response to questions from others; they may be mute for several hours to several days (Allwood & Gagiano, 1997:202; Cook & Fontaine, 1991:533; Carson, *et al*. 1996:448).

The most consistent finding is that negative symptoms are associated with poor pre-morbid adjustment. For example, according to Holmes (1994:282), before being diagnosed as suffering from schizophrenia, individuals with primarily negative symptoms share poorer social and sexual functioning; progress less well at school and perform worse in work settings.

There also appears to be a tendency for negative symptoms to be associated with lower scores on intelligence tests. With regard to gender, it was found that men were consistently more likely to suffer from negative symptoms than women. The reason for the gender differences is not clear, but it reflects a less optimistic view of males suffering from schizophrenia (Holmes, 1994:283).

A clear understanding of the symptoms of schizophrenia enables family members to identify the illness and to embark on a process of coping with the different phases of schizophrenia.

3.4 PHASES OF SCHIZOPHRENIA

The phases can be described as the stages the patient suffering from schizophrenia goes through. Understanding this process helps the family members and the social worker to understand the patient's condition, behaviour and needs during each phase. Individuals who suffer from schizophrenia are thought to go through the following phases: prodromal, active, residual and the burned-out phase (Kendell & Zealley, 1993:401; Stafford-Clark, *et al.* 1990:142; Holmes, 1994: 272; Arieti, 1978:43). In order to understand the patient's condition, behaviour and needs during each phase family members and the social worker must have information about each phase.

3.4.1 PRODROMAL PHASE

Some patients first go through a prodromal phase, in which intellectual and interpersonal functioning begins to deteriorate. Johnstone, Humphreys, Lang, Lawrie and Sandler, (1999:33) state that during this phase some peculiar behaviour appears, emotions become inappropriate and unusual perceptual experiences begin to occur. This phase can last from a few days to many years. In cases in which the prodromal phase is prolonged and the individual shows an insidious downhill course, the long-term prognosis is usually poor (Holmes, 1994:272, Arieti 1978:43; Kendell & Zealley, 1993:401). During this stage, the patient's condition may also be unpredictable. Patients' families may find it difficult to deal with them.

3.4.2 ACTIVE PHASE

The second phase is the active phase, in which the symptom patterns are clear-cut and obvious. Hallucinations, delusions and disorders of thought and language become identifiable and behaviour may become more grossly disorganised (Holmes, 1994:272; Johnstone, *et al.* 1999:33).

The patient's thought appears to be disturbed. This active phase may also be associated with the acute phase (Gelder, *et al.* 1989:270; Kemp, 1994:27) because in these phases, distortions in thinking, disturbances in feelings and behaviour, delusions and hallucinations are the characteristics shown. According to Gelder, *et al.* (1989:270) the acute syndrome features are the following: prominent persecutory ideas with accompanying hallucinations, gradual social withdrawal and impaired performance at work, and the odd idea that other people can read one's thoughts. This active and/or acute phase may thus be identified in a patient who gradually isolates himself from family members and friends.

3.4.3 RESIDUAL PHASE

Thirdly, some patients go through a residual phase that is similar to the prodromal phase in that the symptom picture again becomes less clear. Symptoms such as hallucinations and delusions may still exist, but they are less active and less important to the individual (Kendell & Zealley, 1993:401). Associated with the muting of symptoms is a general blunting or flattening of mood and often a general decline in intellectual performance. This combination of symptoms often makes it impossible for the patient to return to the pre-morbid level of social and occupational functioning (Holmes, 1994:272; Arieti, 1978:43).

This residual phase is also linked to the chronic phase because in both phases there is a disorder of motor activity and catatonic symptoms such as being mute and immobile for a certain period (Gelder, *et al.* 1989:273). Lack of drive and social withdrawal are reported in the patient during these phases (Kemp, 1994:27; Gelder, *et al.* 1989:273). It

may be difficult for the family members to deal with such a patient who may be anti-social and whose behaviour is unpredictable.

3.4.4 BURNED-OUT PHASE

Burned out patients do not show many of their original symptoms of schizophrenia, but they show a very serious deterioration in social skills. They may eat with their dirty hands, urinate in their clothing, and be completely insensitive to people around them (Holmes, 1994: 272; Arieti, 1978:43).

In order to cope with a family member suffering from schizophrenia, the family needs to understand the respective phases that describe the level of the patient as well as the condition of the patient at a certain level. The social worker likewise needs to understand the phases in order to help the family members to deal with a patient in a particular phase of schizophrenia. Schizophrenia in the respective phases is manifested differently in the context of the different types of schizophrenia.

3.5 CLASSIFICATION AND TYPES OF SCHIZOPHRENIA

A psychiatric team formed to classify and diagnose mental illness uses the DSM-IV model. Schizophrenia falls under Axis I of the DSM-IV (1994:26) classification. This model is also used to describe the types of schizophrenia. The DSM-IV model developed from the previous DSMs and is the model the researcher utilised to describe the diagnosis of schizophrenic subtypes. Although it is a medical model, it is useful for the psychiatric team for diagnosis and is utilised by social workers as members of the team. According to the DSM-IV (1994:287-289), supported by Arieti (1978:49-56), Butler and Pritchard (1983:20), Gillis (1986:78-80), Holmes (1994:274-276), Kemp (1994:27) and Sue, *et al.* (1981:291-294), there are five types or subtypes of schizophrenia, namely catatonic, disorganised, paranoid, residual and undifferentiated. Each subtype has its own essential features and symptoms but some of these features and symptoms are common to several types, for example, delusions and hallucinations occur in every subtype. The five subtypes are discussed briefly below.

3.5.1 CATATONIC TYPE

The catatonic type has a sudden onset and may create a state varying from stupor to acute excitement. In the patient, according to Allwood and Gagiano (1997:202), Cook and Fontaine (1991:531) and Tantam, *et al.* (1996:116) it is most commonly typified by the patient sitting or standing for long periods in a fixed position. In practice this form of the illness is now quite rarely seen, perhaps because anti-psychotic drugs are now so widely used (Arieti, 1978:53; Butler & Prichard, 1983:21; Holmes, 1994:275). The essential feature of the catatonic type of schizophrenia is a marked psycho meter disturbance that may involve motoric immobility, excessive motor activity, extreme negativism, mutism, peculiarities of voluntary movement, echolalia or echopraxia. Motoric mobility may be manifested by catalepsy (waxy flexibility) or stupor. The excessive motor activity is purposeless and is not influenced by external stimuli. There may be extreme negativism that is manifested by the maintenance of a rigid posture with failed attempts to move the patient and resistance to all instructions. Echolalia is the pathological, parrot like and apparently senseless repetition of a word or phrase just spoken by another person. (Compare DSM-IV, 1994:288; Kaplan & Sadock, 1988:113; Gillis, 1986:78; Stafford-Clark, 1990:405; Straube & Hahlweg; 1990:18 and Sue, *et al.* 1981:293.)

Additional features of this type include stereotypes, mannerisms and automatic obedience or mimicry. During severe catatonic stupor or excitement the patient may need careful supervision to avoid self-harm or harm to others. There are potential risks from malnutrition, exhaustion, hyperprexa or self-inflicted injury (DSM-IV, 1994:288).

According to Burgess (1985:283) and Carson, *et al.* (1996:454), excitement, retardation and stupor may all occur separately or as consecutive phases. The excitement may take different forms, from mild restlessness to acute delirium in which the patient destroys things, runs up and down, and interferes with others; in other words, manifesting uncontrolled and senseless behaviour. Such a patient may be very impulsive, his actions motivated by delusions or hallucinations, such as that God is telling him to break windows. Speech often becomes grossly disordered and variations and word salad occur (Gillis, 1986:78; Sue, *et al.* 1981:293; Kendell & Zealley, 1993:405).

When analysing the catatonic subtype, it is clear that such a patient will have an impact on the family functioning because of his inappropriate behaviour. The patient may destroy property in the home or even burn the house down because of his delusions and hallucinations. The patient may remain mute and stand in one position, perhaps in a busy road. Such behaviours frustrate and strain the resources of family members since the patient needs constant supervision. This could mean that the caregiver has to give up his job in order to look after the patient. Family members of such a patient need to be educated on his behaviour as well as on how to deal with this behaviour.

3.5.2 DISORGANISED TYPE (HEBEPHRENIC)

The disorganised type is characterised by a thought disorder with emotional disturbance and periods of wild excitement, which may alternate with periods of depression. (Compare DSM-IV, 1994:288; Arieti, 1978:52; Kaplan & Sadock, 1988:112; Gillis, 1986:78; Allwood & Gagiano, 1997:202; Cook & Fontaine, 1991:532; Tantam, *et al.* 1996:116 and Butler & Pritchard, 1983:20.)

Sue, *et al.* (1981:291) and Carson, *et al.* (1996:456) support the above description by stating that the disorganised type exhibits severe disintegration and regressive behaviours starting at an early age. Individuals diagnosed with this disorder act in an absurd, incoherent, or very odd manner which conforms to the stereotype of crazed behaviour. They appear typically blunted in real-life situations, but a silly smile and childish giggle may be present at inappropriate times.

According to the DSM-IV (1994:288), Weiner (1997: 3) and Holmes, (1994:275), the essential features of the disorganised type of schizophrenia are disorganised speech and behaviour, and flat or inappropriate affect. The disorganised speech may be accompanied by silliness and laughter that are not closely related to the content of speech.

Uys (1994:314) states that the behavioural disorganisation (that is, lack of goal orientation) may lead to severe disruption in the patient's ability to perform the activities of daily living, for example, showering, getting dressed or preparing meals. Patients

regress fairly quickly and may lose control of their bladder and bowels and become increasingly inaccessible and withdrawn. This subtype is usually also associated with poor pre-morbid personality, early and insidious onset, and a continuous course without significant remission (DSM-IV, 1994:288). Because of the severity of the disorders, many affected individuals are unable to care for themselves and become institutionalised (Sue, *et al.* 1981:291; Gelder, *et al.* 1989:287).

With regard to family functioning, the patient will not be able to communicate effectively because of his disorganised speech and behaviour. Neither will the patient be in a position to perform his daily living activities, for example, to control bladder and bowels. This will eventually place great strain on family members. For this reason, the social worker must prepare the family members for the behaviour of such a patient.

3.5.3 PARANOID TYPE

Patients suffering from the paranoid type of schizophrenia constitute the largest group. Paranoid patients are, as a rule, more intelligent than other types. From the onset of the illness they are suspicious and bound to misinterpret things and events in a way which is disparaging to themselves (DSM-IV, 1994:287; Holmes, 1994:276; Carson, *et al.* 1996:457). The essential features of the paranoid type of schizophrenia are the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning. Delusions are typically persecutory or grandiose, or both. However, delusions with other themes, for example jealousy, religion or somatisation, may also occur. These patients feel persecuted, they see plots in everything that happens around time, they feel that chance encounters in the street are planned and that voices on the radio are making references to them. (Compare DSM-IV, 1994:287; Kaplan and Sadcock, 1988:113; Arieti, 1978:50; Butler and Pritchard, 1983:21; Gillis, 1986:80; Carson, *et al.* 1990:457; Uys, 1994:314; Burgess, 1985:284; Allwood & Gagiano, 1997:202 and Holmes, 1994:276.)

Sue, *et al.* (1981:294) indicate that, due to hallucinations and delusions, the paranoid patient does not trust other people. Such a patient may also act violently, suspecting that another person intends to do him harm. Due to his suspicious and violent behaviour,

this patient may pose a danger to other family members. The delusions may be multiple, but are usually organised around a coherent theme. Hallucinations are also typically related to the content of the delusional theme (DSM-IV, 1994:287, Weiner, 1997:304; Kendell & Zealley, 1993:405).

Arieti (1978:50); DSM-IV (1994:287) and Holmes (1994:276) are of the opinion that delusions are more frequent in the paranoid type of schizophrenia than in the other types. Most delusions and hallucinations may be considered to be metaphorical or compensatory. For example, a patient may believe that his wife is putting poison in his food and every time he eats he tastes the poison (Arieti, 1978:51; Allwood & Gagiano, 1997:202). As a result, the paranoid patient may start refusing prepared food, believing that he is bewitched. It becomes difficult for the family to cope with such a patient, especially if that patient is the husband or wife, when marital disputes will occur.

Gillis (1986:80) and Uys (1994:314) state that paranoid patients might feel that supernatural forces are influencing them and auditory hallucinations, usually of an unpleasant nature, are frequent. When deterioration and bizarre symptoms are present, the conditions are known as paranoid schizophrenia, but when the personality remains recognisably intact, except for an encapsulated system of bizarre ideas usually with a persecutory flavour, it is called paranoia.

Associated features include anxiety, anger, aloofness, argumentativeness and violence. The patient may have a superior and patronising manner and either a stilted, formal quality or extreme intensity in interpersonal interactions. The persecutory themes may predispose the patient to suicidal behaviour, and the combinations of persecutory and grandiose delusions, to violence (DSM-IV, 1994:287, Holmes, 1994:276; Cook & Fontaine, 1991:532).

The onset tends to be more altering in life than the other types of schizophrenia and the distinguishing characteristics may be stable over time. These patients show little or no impairment on neuropsychological or other cognitive testing. Some evidence suggests that the paranoid type may be considered less debilitating than the other types of

schizophrenia, particularly with regard to occupational functioning and capacity for independent living (DSM-IV, 1994:287).

The paranoid type of schizophrenia seriously strains the functioning of the family, however. Due to the suspiciousness of the patient, all efforts of family members to support the patient may be viewed as a threat.

3.5.4 RESIDUAL TYPE

The diagnosis of residual schizophrenia is reserved for those individuals who have in the past experienced at least one episode of schizophrenia but appear to be in remission. There is, however, continued evidence of the disturbance as indicated by the presence of negative symptoms or two or more attenuated positive symptoms (DSM-IV, 1994:289; Holmes, 1994:276, Sue, *et. al.* 1981:294; Burgess, 1985:285).

Negative symptoms include the flat affect, poverty of speech or two or more attenuated positive symptoms such as delusions and hallucinations. The course of the residual type may be time-limited and represent a transition from a full-blown episode to complete remission. However, it may also be continuously present for many years, with or without acute exacerbations (Holmes, 1994:276). According to Burgess (1985:285) and Cook and Fontaine (1991:533), the residual type is a category used when there has been at least one episode of schizophrenia. This type is called chronic, and common features are emotional blunting, social withdrawal, eccentric behaviour, illogical thinking and loose associations.

The residual type of schizophrenia, strains the functioning of the family. Family members need to learn to cope with this reality.

3.5.5. UNDIFFERENTIATED TYPE

Undifferentiated schizophrenia is diagnosed when an individual shows mixed or undifferentiated symptoms that do not fit into disorganised, catatonic, or paranoid type.

These individuals may exhibit thought disorder, prominent delusion, hallucinations, incoherence, or severely impaired behaviour (DSM-IV, 1994:289; Holmes, 1994:276; Sue, *et al.* 1981:294; Burgess, 1985:285; Cook & Fontaine, 1991:533; Carson, *et al.* 1996:452).

The undifferentiated type of schizophrenia makes the behaviour of the patient very unpredictable. The family members, in return, will find it difficult to understand the patient and will not know how to respond adequately to his disturbed behaviour.

In order to respond appropriately to the family member suffering from schizophrenia, family members need to understand the type of schizophrenia that he is suffering from. This will guide the family to respond appropriately and will also provide knowledge as to how the family functioning can be positively maintained.

3.6 CONCLUSION

Schizophrenia is a complicated and severe chronic type of mental illness. It may also be a dangerous illness since the patient's condition is unpredictable. The causes of schizophrenia are still unknown but heredity, heredity together with environmental stress, brain abnormalities, psychosocial factors, social factors and other constitutional factors are suggested as contributory factors. Schizophrenia symptoms include cognitive, mood, somatic and motor symptoms which can be categorised into positive and negative symptoms. Features and symptoms of schizophrenia are therefore linked to disturbance of thinking, feelings and behaviour. The patient may think people are against him because of false beliefs. He may feel isolated and act violently.

The patient goes through phases during the process of his illness, namely the prodromal, active, residual and burned-out phases. It is important that family members understand the phases in order to stabilise the patient's condition and also to allow the family to continue to function as normally as possible.

As a broader concept, schizophrenia is divided into five types, namely catatonic, disorganised, paranoid, residual and undifferentiated. Paranoid schizophrenia is

regarded as the dominant type. Delusions and hallucinations, however, are regarded as the common features and symptoms of each type. The patient suffering from schizophrenia belongs within a family context. The functioning of the family and family members may be affected by the patient's way of thinking, behaviour and feelings of disturbance. The family needs to understand the impact of schizophrenia as mental illness on the entire functioning of the family. Knowledge will provide understanding and empowerment, whereas guidelines will provide the know-how to facilitate more effective role functioning for both the patient and the family.

In Chapter 4 schizophrenia and family functioning in relation to the ecosystem framework will be discussed.