THE IMPACT OF SCHIZOPHRENIA ON FAMILY FUNCTIONING: A SOCIAL WORK PERSPECTIVE

by

SUSIE RUTH MOJALEFA

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DECLARATION

I declare that this research study entitled: "The impact of schizophrenia on family functioning: A social work perspective" is my own work and that all sources I have consulted have been indicated and acknowledged by means of complete references.

S. R. MOJALEFA

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SUMMARY

As a social worker working in a mental health hospital, the researcher became aware of an increase in the number of deteriorating patient-family and patient-friend relationships. In addition, there was an increase in the relapse of discharged patients suffering from schizophrenia. Against this background, the researcher was motivated to investigate the impact of schizophrenia on the relationships, interactions and functioning of the family.

The objectives of the study included the following:

- To undertake a literature study of the phenomenon of schizophrenia and family functioning from a social work perspective
- To investigate the impact of schizophrenia on relationships, attitudes, interaction and functioning of the family
- To investigate relevant family intervention programmes and develop social work guidelines for use by social workers to guide the family to cope with the impact of schizophrenia, particularly in the home and community.

A quantitative research approach was chosen 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 type of research for the study was applied. As an outcome of determining the negative impact of schizophrenia on family functioning, guidelines were developed for social workers to guide the patients and their families, through family intervention programmes, to cope with the negative impact of schizophrenia and to rebuild their family life.

A descriptive research design was chosen to reveal the potential relationship between the lack of insight into schizophrenia and the negative impact of schizophrenia on family functioning.

A pilot study was undertaken to test the validity of the semi-structured interviewing

schedules. Through dimensional sampling, five patients were selected for the research, diagnosed respectively as catatonic, disorganised, paranoid, residual and undifferentiated. In addition, the patients' key relatives[1] who were also the caregivers, were selected as respondents.

Semi-structured interviewing schedules were self-administered and conducted twice with the same patients and their key relatives. The first interviews were conducted mostly one month after the respective patients' admission to the hospital, once their conditions had been stabilised. The second interviews were conducted with the same respondents one month after the patient had been granted a leave of absence or discharged to be with his[2] family at home.

The research findings indicated that there is a negative impact on family functioning when a patient in the family suffers from schizophrenia. The reasons for this impact can be consolidated in a lack of insight in schizophrenia as a type of mental illness and an inability to cope with the impact of the illness in the recovery process. Research findings confirmed the need for family intervention programmes designed and implemented by social workers.

Social work guidelines were developed by the researcher in collaboration with social workers from Weskoppies Hospital. The social workers were engaged in a focus group which was conducted by the researcher and a co-interviewer from North Gauteng Mental Health. The proposed guidelines for social workers for family intervention programmes involving the patient suffering from schizophrenia and his family reflects an integrated perspective derived from the literature survey, empirical research findings and the findings from the social workers' focus group.

Derived from the proposed guidelines, specific recommendations are made for social work family interventions. In conclusion, recommendations are made with regard to further research in this field of research.

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1 The term "key relative" also refers to the caregiver throughout this research study.

2 Throughout this research study the words "he", "him", "his", "himself" refer to both the female and male gender.

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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

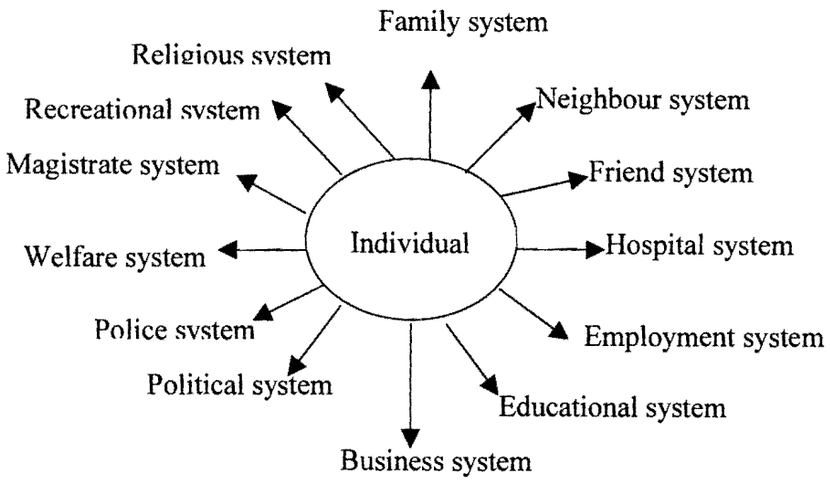

Figure 1: Ecological context, adapted from Zastrow (1996:56) and Becvar and Becvar (2000:147)

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.

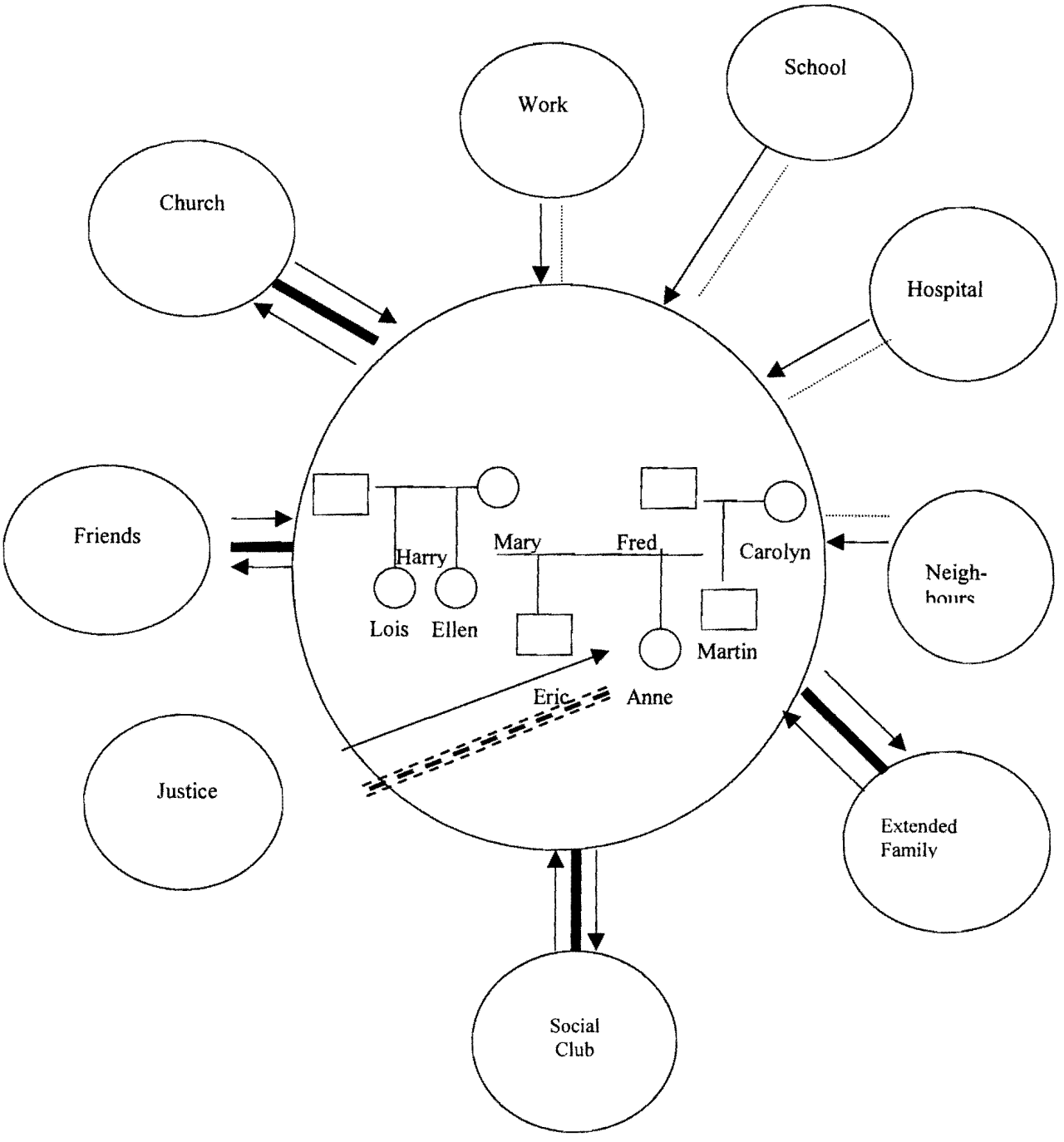

Figure 2: Ecomap graph, adapted from Becvar and Becvar (2000:148)

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.

CHAPTER FOUR

SCHIZOPHRENIA AND FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK

4.1 INTRODUCTION

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

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

4.2 THE IMPACT OF SCHIZOPHRENIA ON FAMILY FUNCTIONING

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

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

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

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

4.2.1 EXPRESSED EMOTION (EE) AND FAMILY INTERACTION

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

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

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

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

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

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

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

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

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

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

4.2.2 COMMUNICATION AND SCHIZOPHRENIA

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

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

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

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

4.2.2.1 Communication deviance (CD)

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

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

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

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

4.2.3 PATIENT AND FAMILY ATTITUDES

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

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

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

4.2.3.1 Relatives' attitudes to schizophrenia

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

- Accepting the patient

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

- Rejecting the patient

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

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

4.2.3.2 Attitudes of patients suffering from schizophrenia towards the family

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

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

4.3 GENERAL FAMILY BURDEN

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

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

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

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

4.3.1 OBJECTIVE BURDEN

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

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

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

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

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

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

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

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

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

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

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

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

- Relationship problems within the family

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

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

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

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

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

4.3.2 SUBJECTIVE BURDEN

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

4.3.2.1. Feelings and family interaction

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

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

- Anger

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

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

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

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

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

- Anxiety

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

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

- Guilt and blame

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

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

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

- Embarrassment and shame

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

- Rejection

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

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

- Stigma

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

- Loneliness

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

- Depression

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

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

- Withdrawal

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

- Empathic suffering

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

- Grief

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

- Threat to security

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.4 FAMILY ADJUSTMENT TO SCHIZOPHRENIA

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

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

- Life cycle changes

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

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

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

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

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

- Siblings' attitudes

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

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

- Phases of the illness and episodes of treatment

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

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

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

4.5 ROLE PLAYERS IN THE CARING PROCESS

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

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

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

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

- Psychologist: Helps the mentally ill patient to manage his stressful situation

- Occupational therapist: Teaches patients handcrafts while still hospitalised, thereby enabling the patients to help themselves after discharge (Breakey, 1996:8)

- Psychometrician: Studies and understands the mental processes of the mental patient and administers psychological tests (Bellack, 1984:131)

- Psychiatric nurse: Renders the prescribed psychiatric treatment, which involves medication such as drugs and psychotherapy. Also renders some kind of follow-up (Bellack, 1984:131) to see whether the medical treatment has been taken correctly. This may, however, differ from one mental institution to another

- Psychiatric social worker: Completes a psychosocial report, for instance to enquire into the patient's history and life-style prior to the onset of his illness (Hudson, 1982:225). Renders after care services to the discharged patients and their families

- Patient's relatives: Provides information about the patient's history of health and illness, provides support, gives advice and comfort to the patient and his family, especially during the acute phase of the illness (Bellack, 1984:184)

- Patient suffering from schizophrenia: Explains his life history, how he is affected mentally and how he will cooperate with the treatment plan. Garland (1983:89) states that the patient, as part of the team, needs to be respected and emphasises that it is important to listen to what he feels about his own treatment.

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

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

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

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

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

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

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

4.6 CONCLUSION

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

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

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

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

CHAPTER FIVE

INTERVENTION PROGRAMMES FOR SCHIZOPHRENIA

5.1 INTRODUCTION

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

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

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

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

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

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

- Primary intervention:

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

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

- Secondary prevention

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

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

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

- Tertiary prevention

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

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

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

5.2 FAMILY INTERVENTION PROGRAMMES

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

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

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

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

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

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

5.2.1 PSYCHO-EDUCATIONAL PROGRAMMES

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

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

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

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

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

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

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

5.2.1.1 Intervention programmes in hospitalised setting

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

- Information regarding services

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

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

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

- In-patient crisis groups for relatives

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

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

- Crisis intervention

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

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

- Psycho-educational workshop

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

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

5.2.1.2 Intervention programmes for the family within a community based context

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

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

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

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

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

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

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

- Psycho-educational workshop

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

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

- Education for relatives

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

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

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

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

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

- Education groups

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

Group sessions consist of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2.2 BEHAVIOURAL PROGRAMMES

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

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

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

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

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

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

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

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

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

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

5.2.3. PHASES OF AN INTEGRATED FAMILY INTERVENTION PROGRAMME

- *Phase one*

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

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

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

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

- *Phase two*

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

- *Phase three*

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

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

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

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

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

- *Phase four*

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

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

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

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

5.3 CONCLUSION

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

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

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

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

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

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

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

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

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

CHAPTER SIX

EMPIRICAL STUDY AND RESEARCH FINDINGS

6.1 INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hypothesis:

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

6.2 PRESENTATION OF FINDINGS

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

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

6.2.1 BIOGRAPHICAL DATA

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

- Residential address/area

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

Figure 3: Residential areas

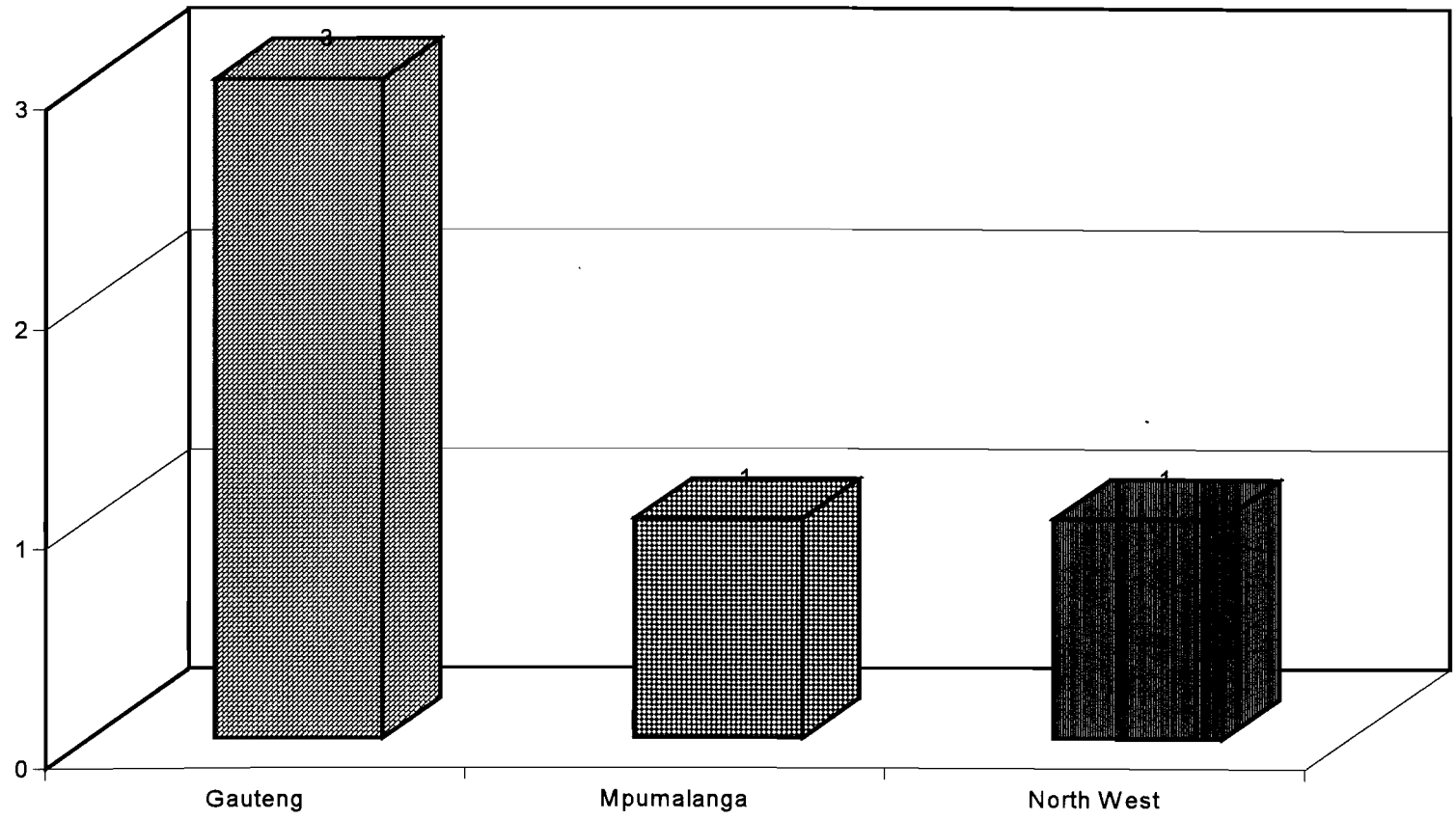

Figure 3: Residential Area

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

- Age

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

Table 2: Age distribution

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

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

- Sex distribution

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

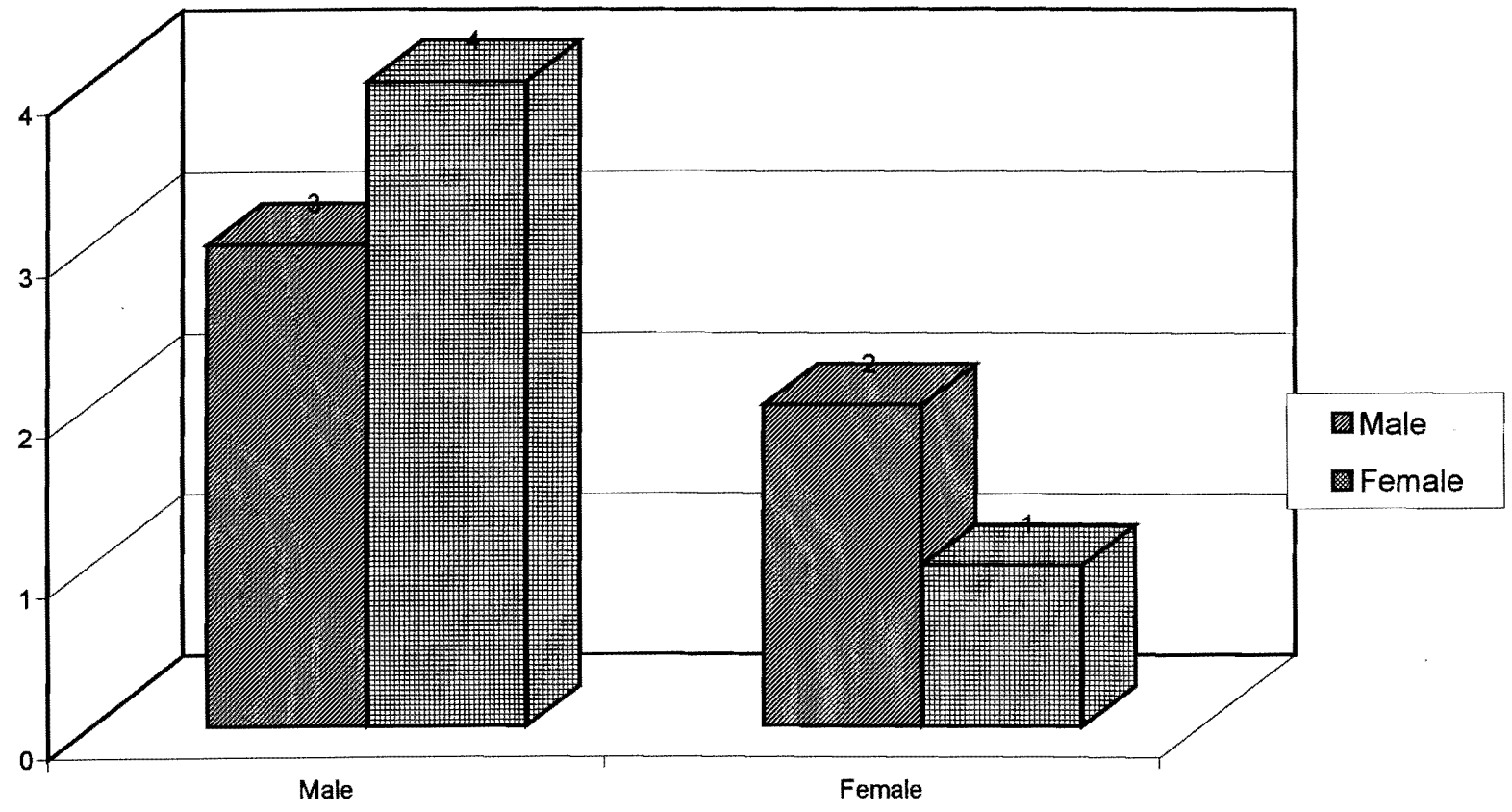

Figure 4. Sex distribution

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

- Qualifications

Table 3 indicates the respondents' qualifications.

Table 3: Qualifications

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

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

- Occupation

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

- Ethnic group

Table 4 below, indicates the respondents' ethnicity.

Table 4: Ethnic group

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

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

- Religious denomination

Respondents' religious denomination is indicated in Table 5.

Table 5: Religious denomination

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

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

- Marital Status

The marital status of respondents is illustrated in Figure 5.

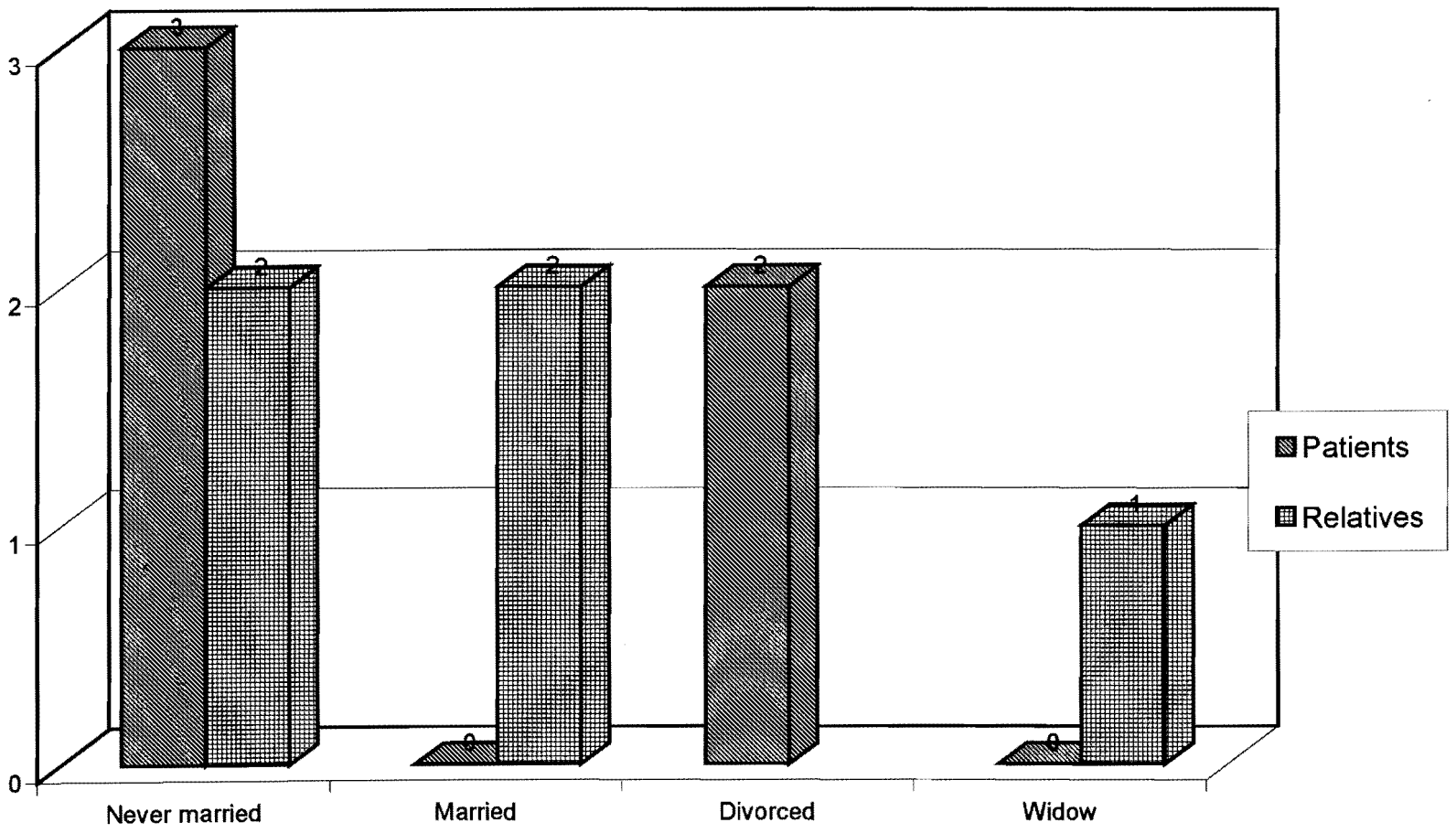

Figure 5: Marital status

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

- First time experience of schizophrenia

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

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

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

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

- First hospital admission date

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

Table 7: First hospital admission date

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

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

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

- Total hospital admissions and reasons for admissions

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

Table 8: Reasons for admission

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

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

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

- Schizophrenia types

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

Table 9: Types of schizophrenia as diagnosed

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

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

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

- Most significant relatives

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

Table 10: Patient - relative relationship

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

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

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

6.2.2 SCHIZOPHRENIA

- Understanding of schizophrenia

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

Table 11: Understanding of schizophrenia

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

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

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

- Symptoms of a patient suffering from schizophrenia

Schizophrenia symptoms are indicated in Table 12.

Table 12: Symptoms of schizophrenia

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

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

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

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

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

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

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

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

- Patient's behavioural characteristics

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

Table 13: Patient's behavioural characteristics

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

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

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

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

6.2.3 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - ECOLOGICAL CONTEXT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 19: Patient-friend relationship

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

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

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

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

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

- Occurrence of negative patient-friend relationships

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

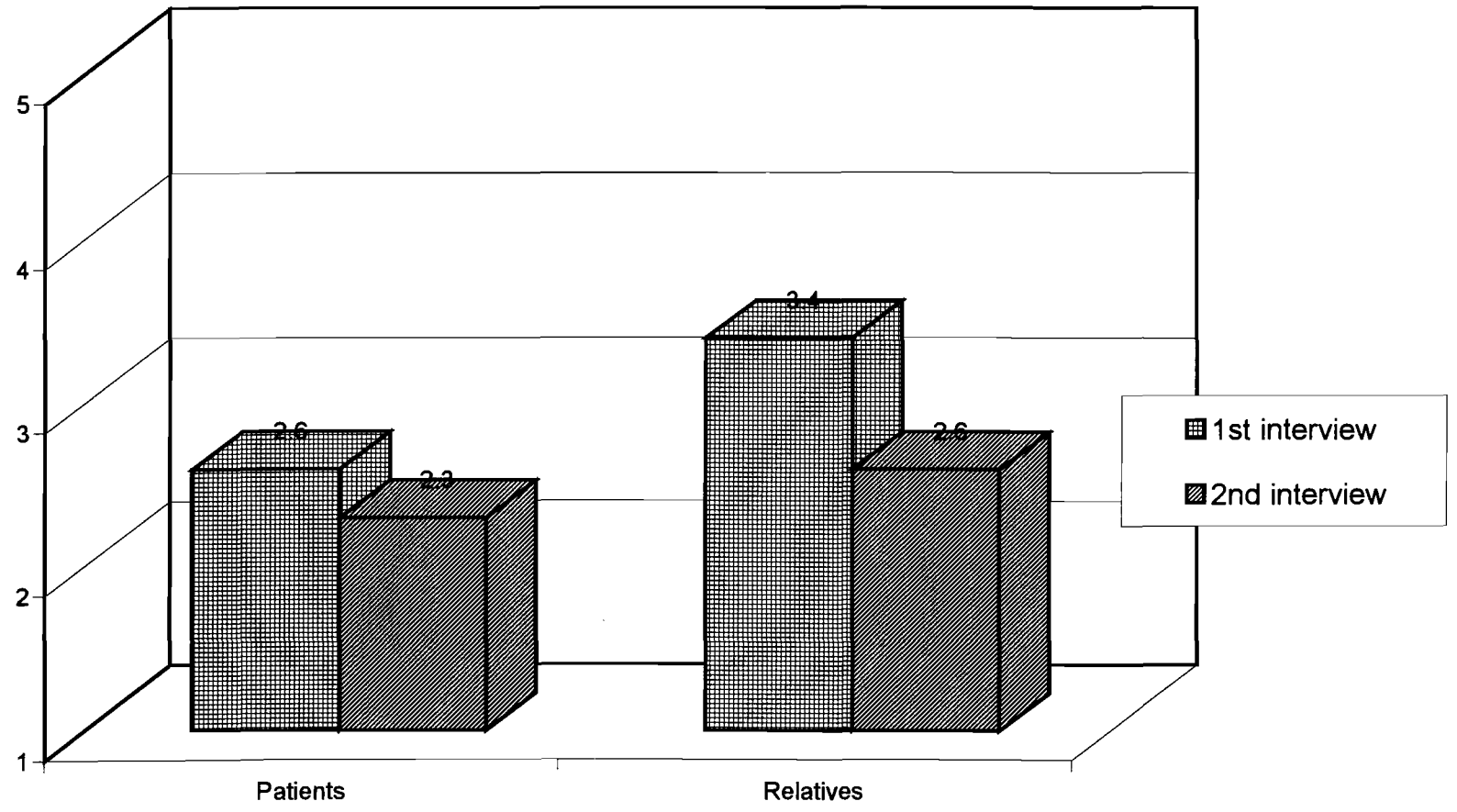

Figure 6: Patient-friend relationships

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

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

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

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

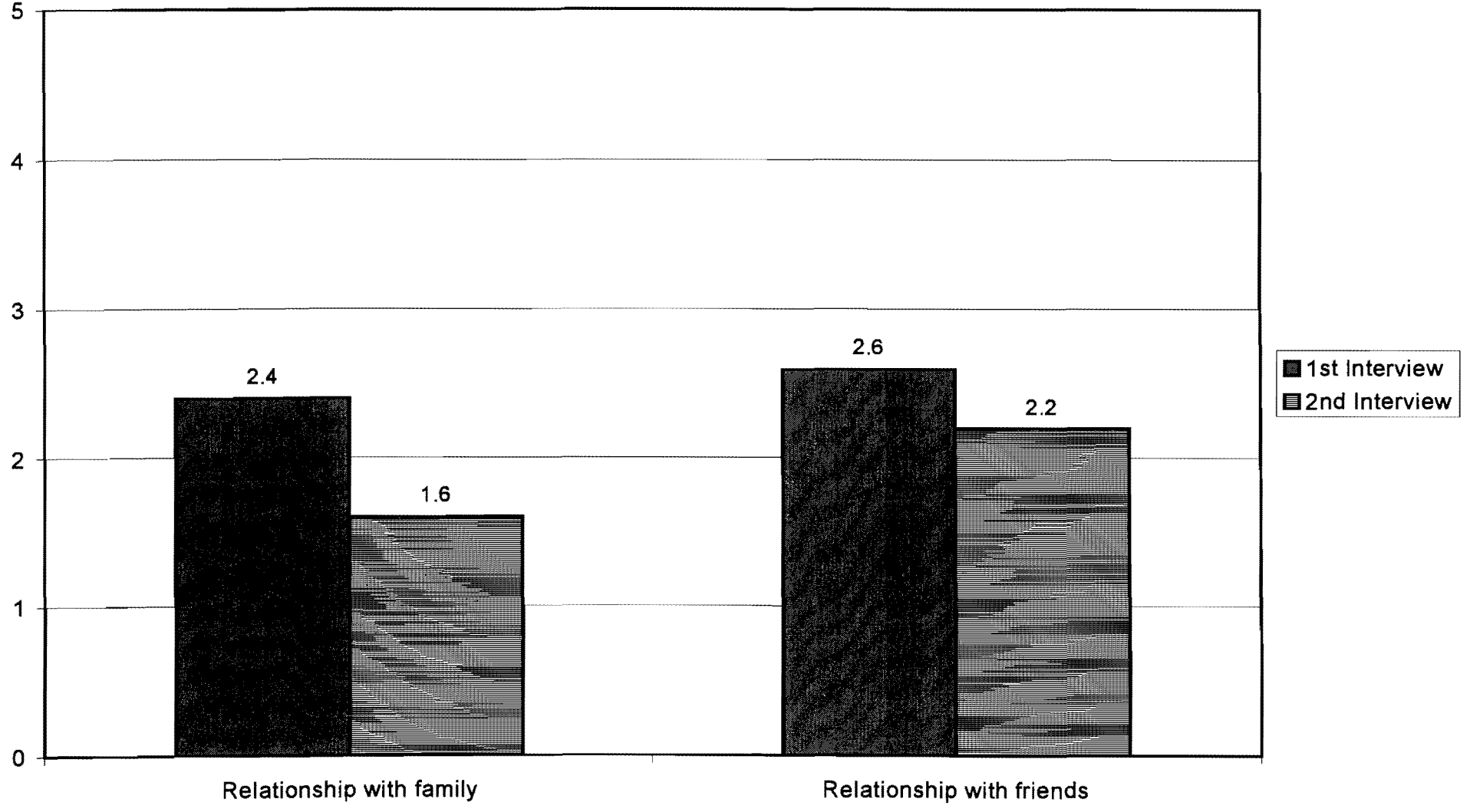

Figure 7: Comparison of patient-family and patient-friend relationships, as seen by the patient

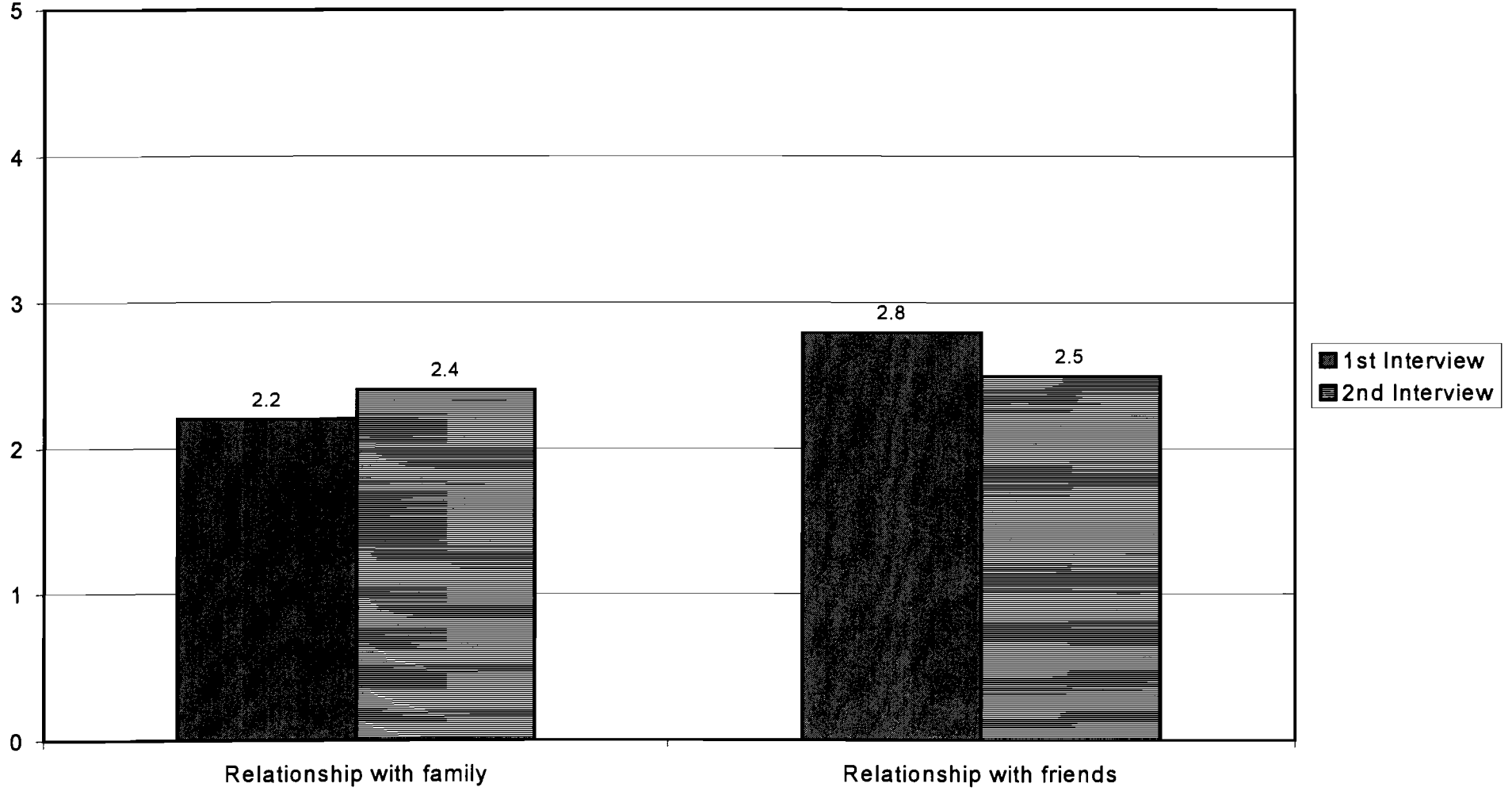

Figure 8: Comparison of patient-family and patient-friend relationships, as seen by the key relative

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

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

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

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

6.2.4 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK-ACCULTURATION AND MIGRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

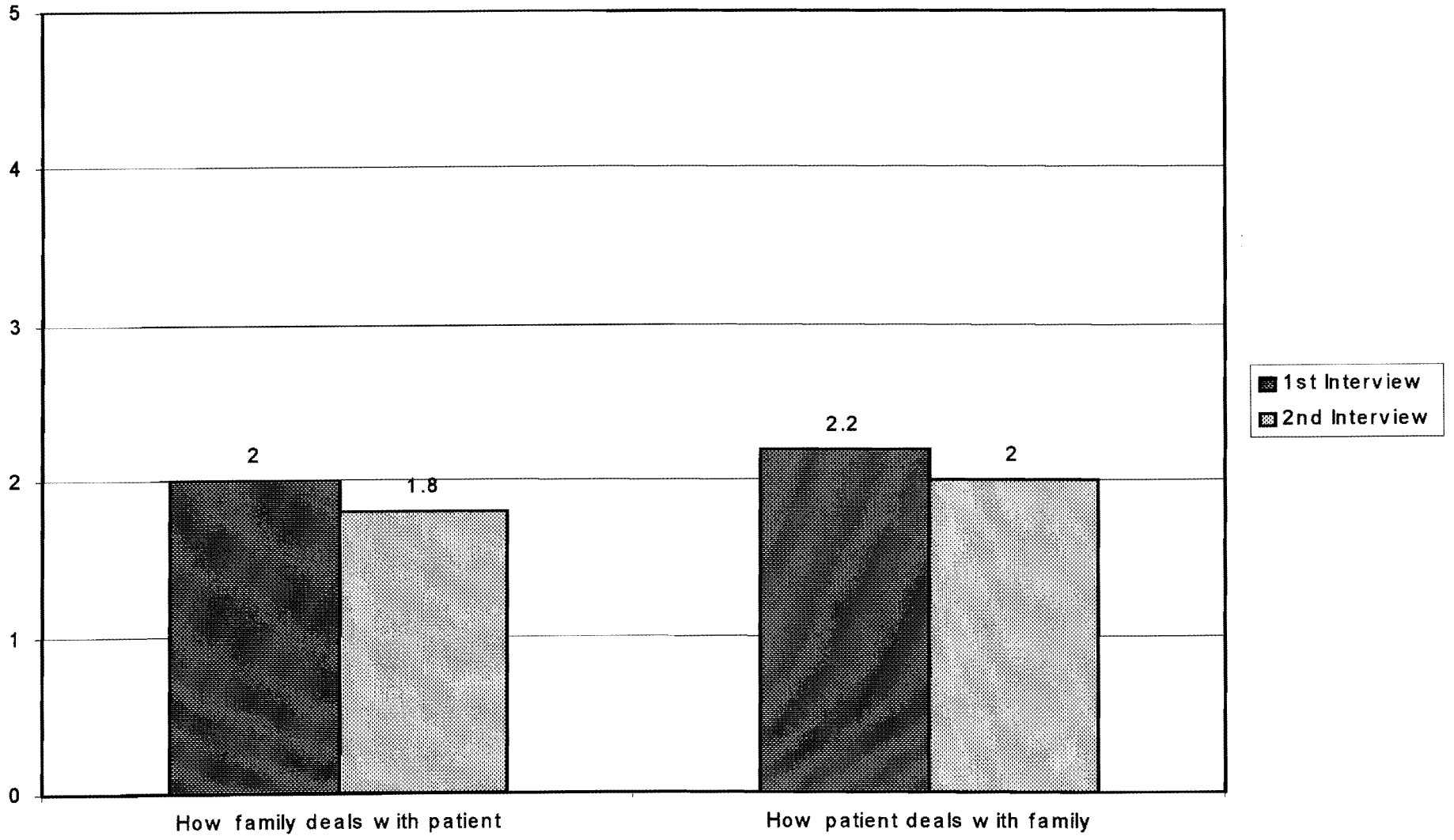

Figure 9: Comparison between how the family deals with the patient and how the patient reciprocates, as seen by the patient

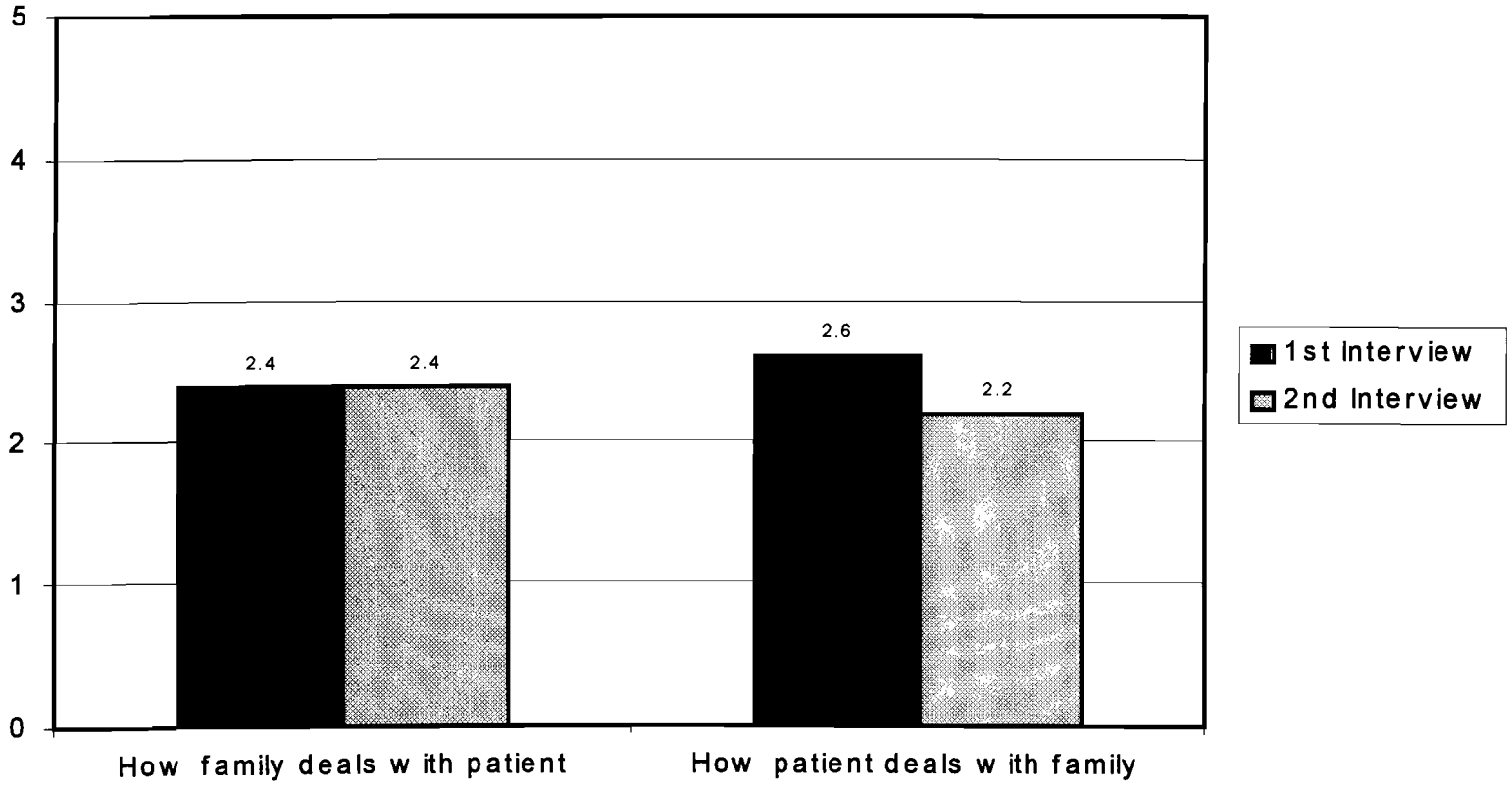

Figure 10: Comparison between how the family deals with the patient and how the patient reciprocates, as seen by the key relative

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

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

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

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

- Interaction of family with patient

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

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

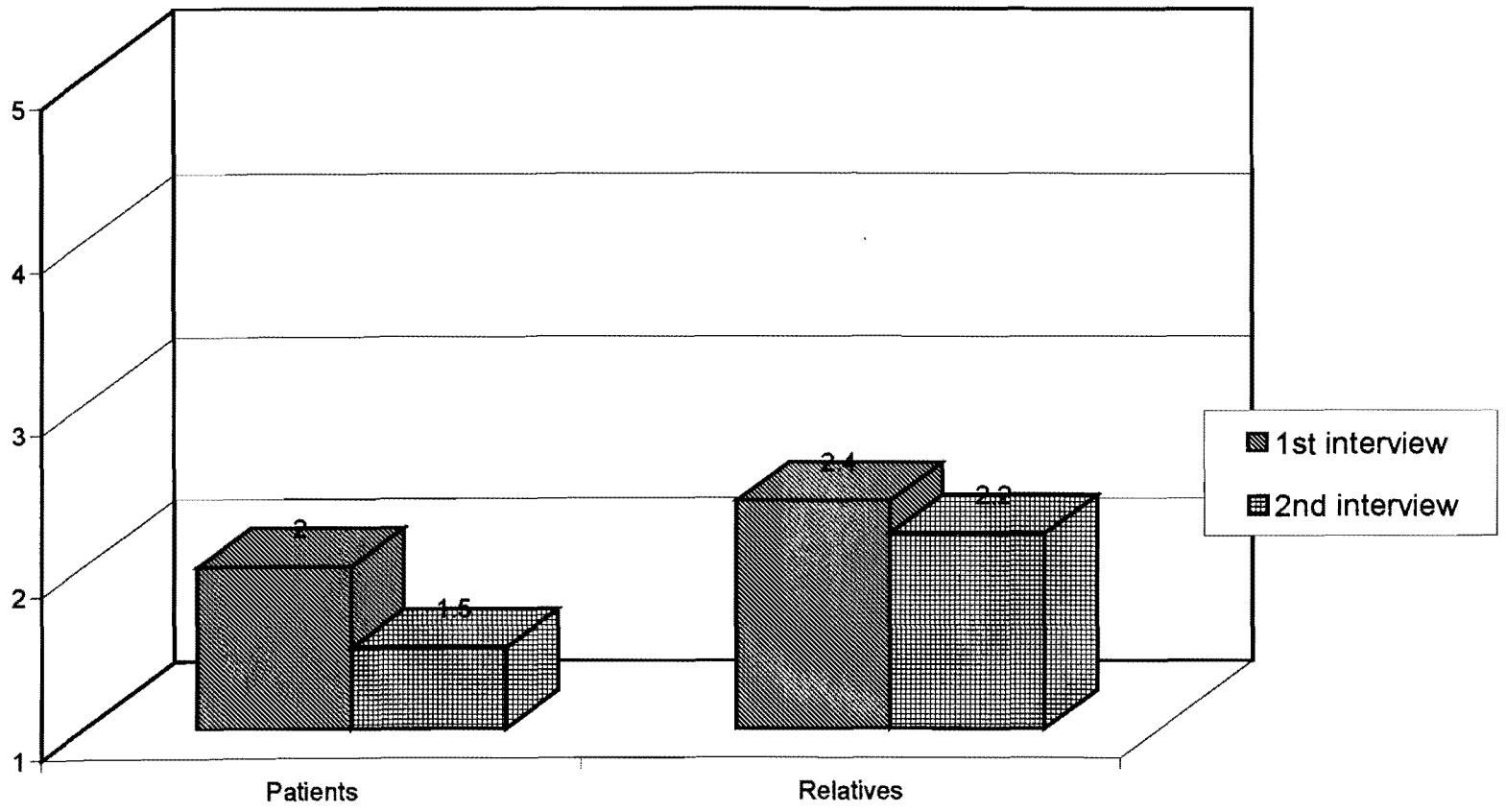

Figure 11: Interaction between family members and the patient

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

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

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

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

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

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

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

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

- Burden experienced by the family

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

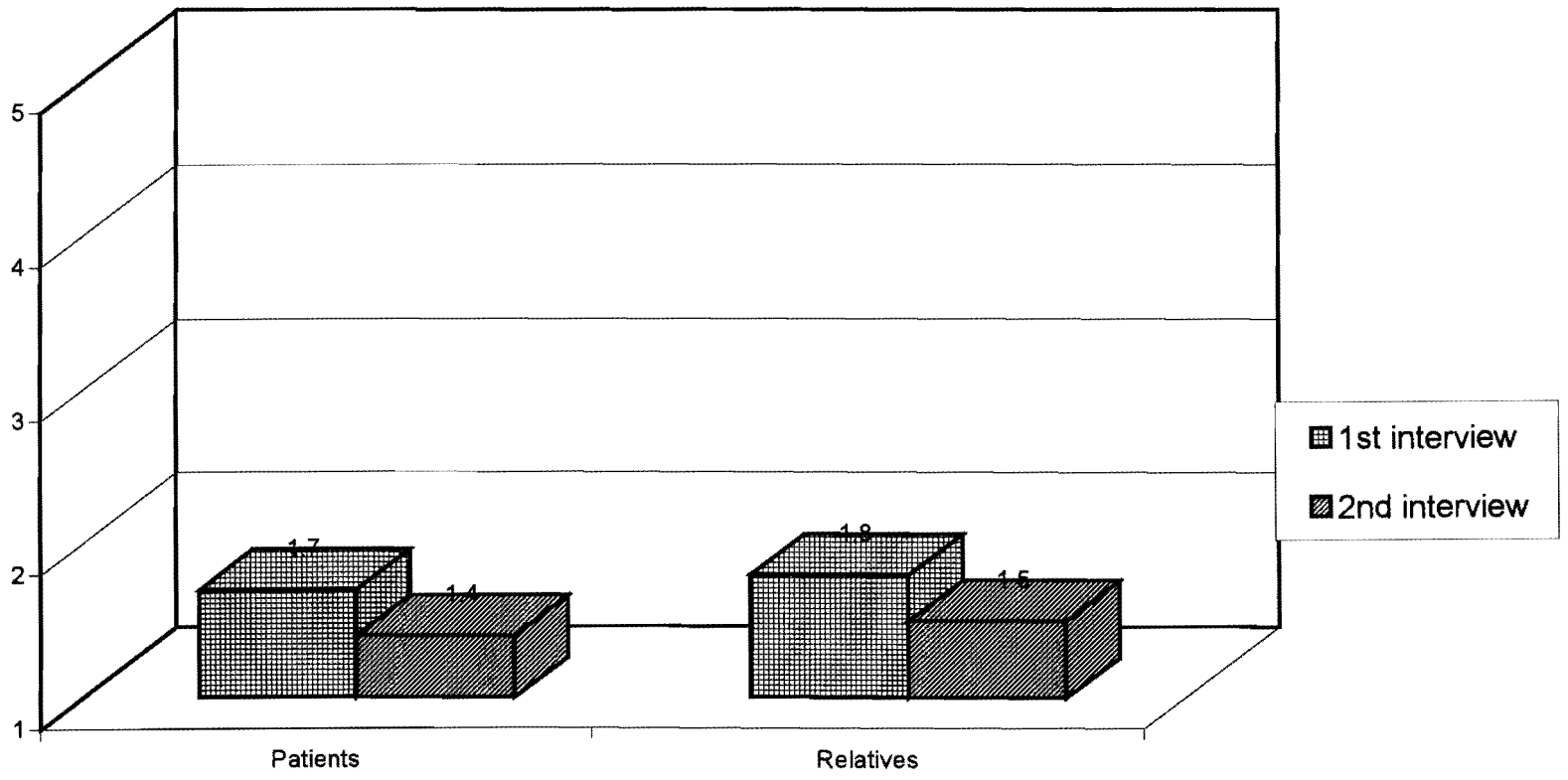

Figure 12: Burden experienced by the family

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

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

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

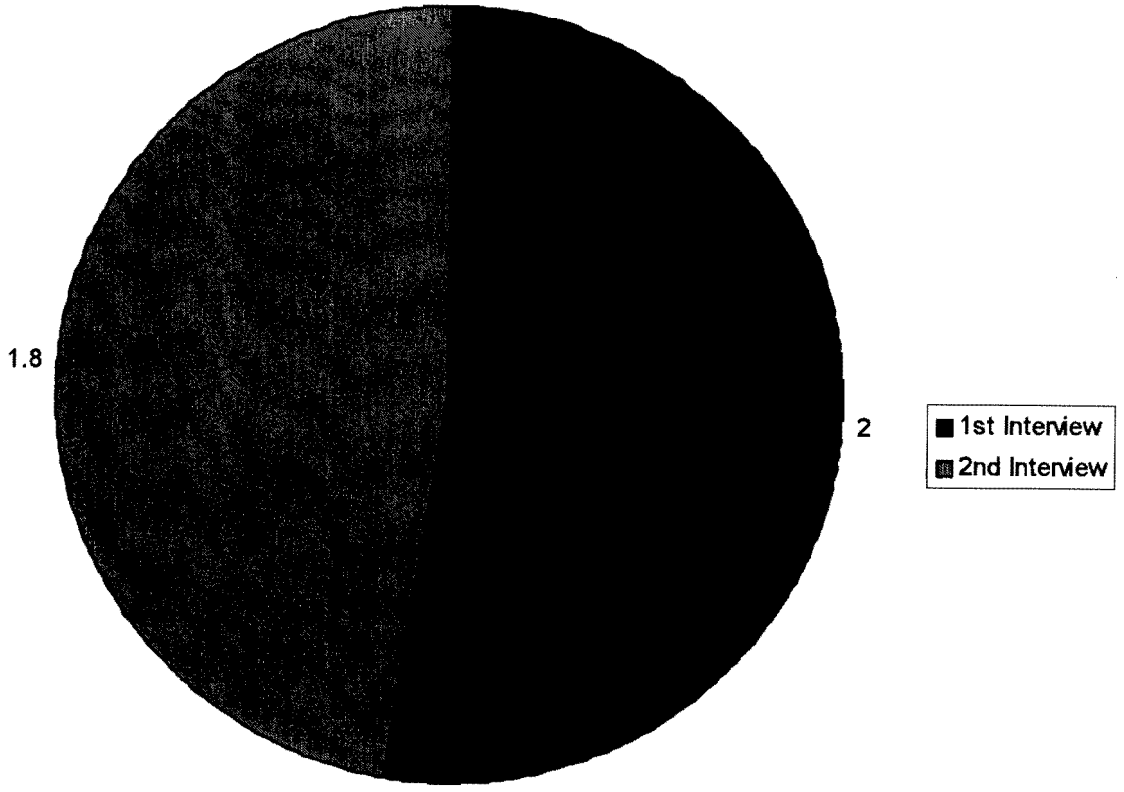

Figure 13: Burden on the family, as seen by the patient

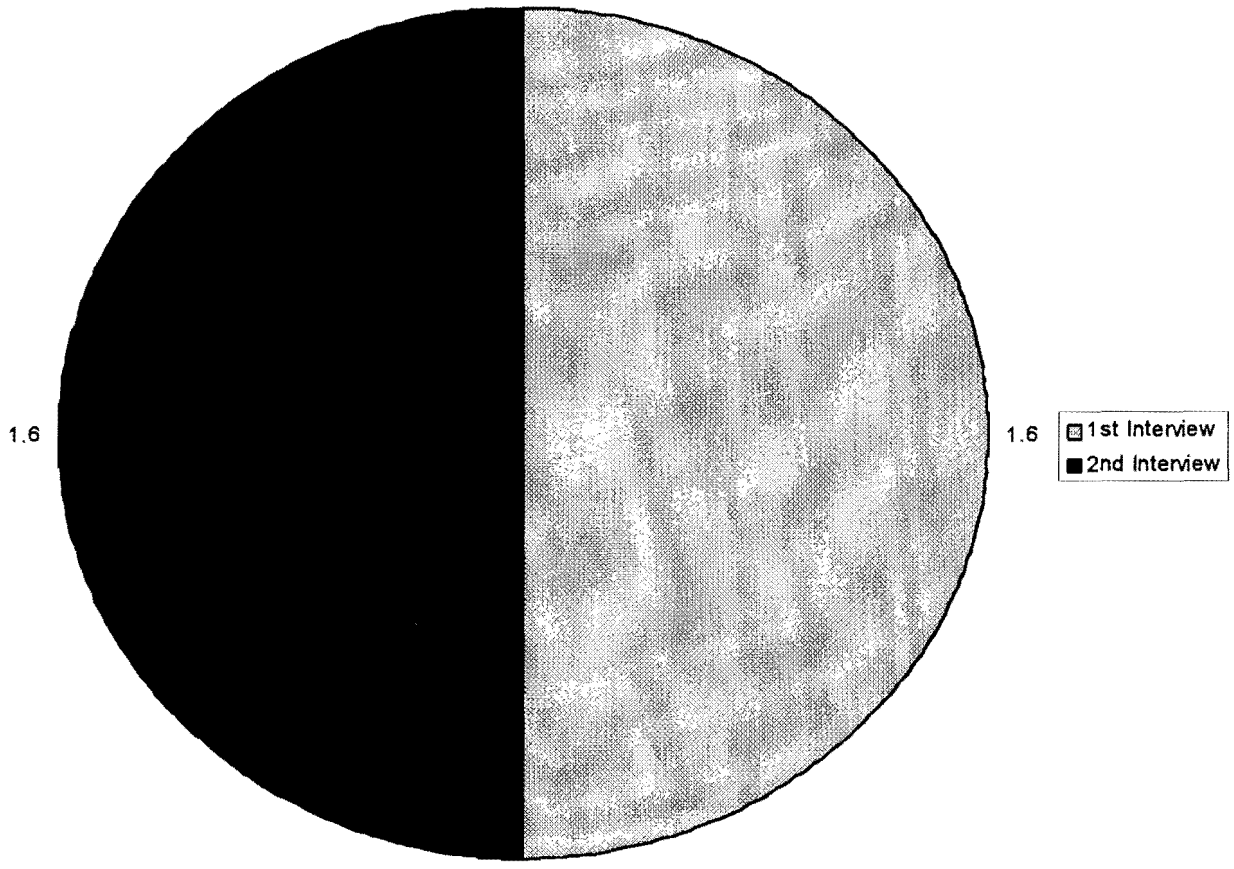

Figure 14: Burden of the family, as seen by the key relative

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

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

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

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

6.2.5 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - FAMILY ORGANISATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Communication style between the patient and family members

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

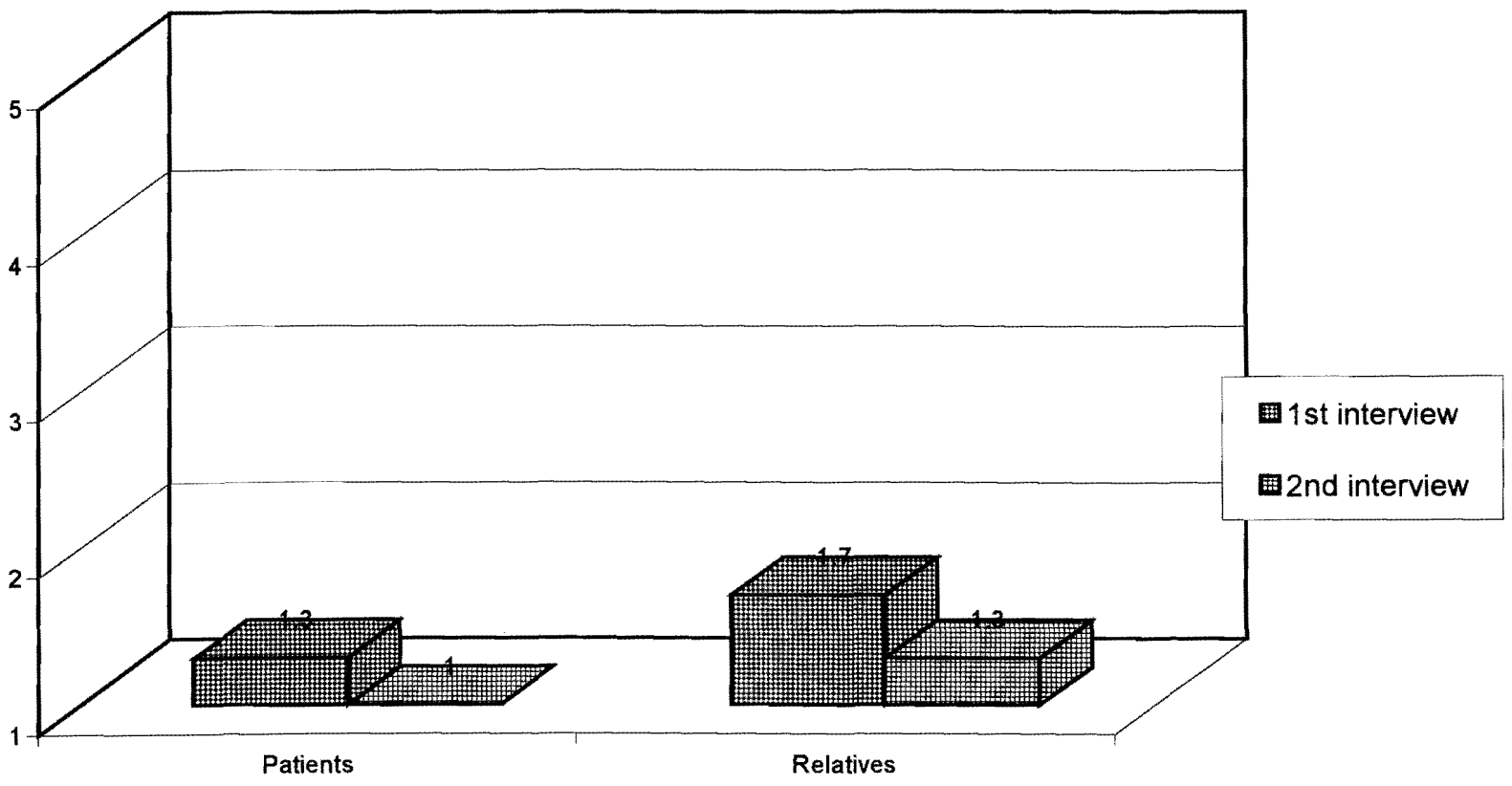

Figure 15: Communication style between the patient and family members

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

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

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

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

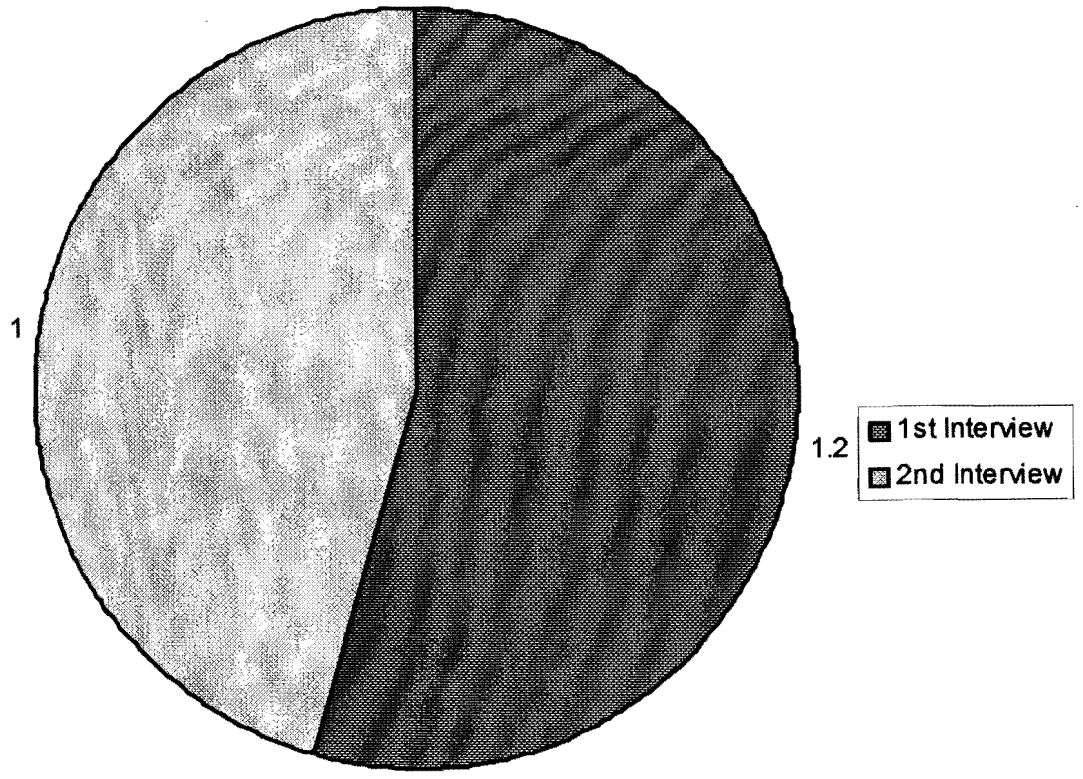

Figure 16: Communication between the patient and the family, as seen by the patient

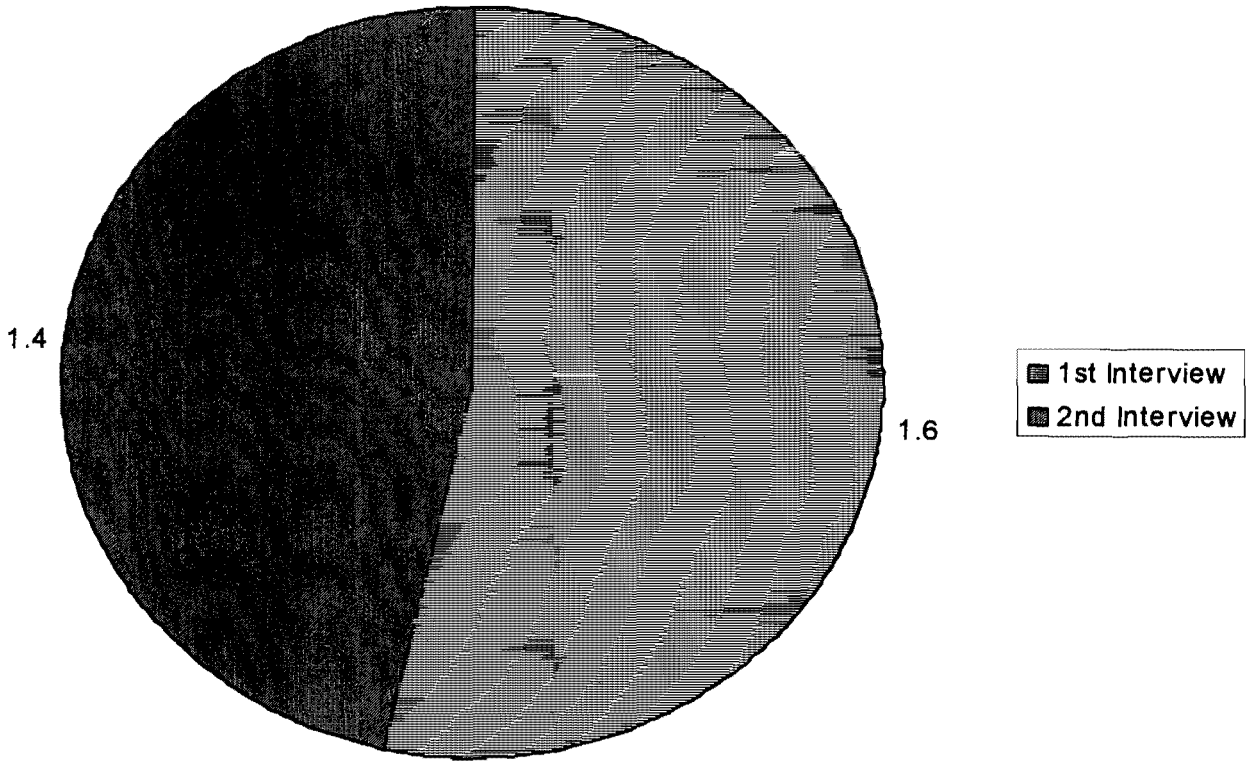

Figure 17: Communication between the patient and the family, as seen by the key relative

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

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

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

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

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

Table 25: Causes of relapse

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

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

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

- Place where the patient prefers to live

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

Table 26: Patients' preferred place of residence

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

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

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

6.2.6 FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK – FAMILY LIFE CYCLE

- Patient's life history

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

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

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

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

- Patient's pleasure in sexual activities

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

Table 27: Patient's pleasure in sexual activities

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

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

- Patient-peer group relationship

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

Table 28: The quality of patient-peer group relationship

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

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

- Patient's upbringing

Patient's upbringing is indicated in Table 29.

Table 29: Patient's upbringing

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

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

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

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

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

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

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

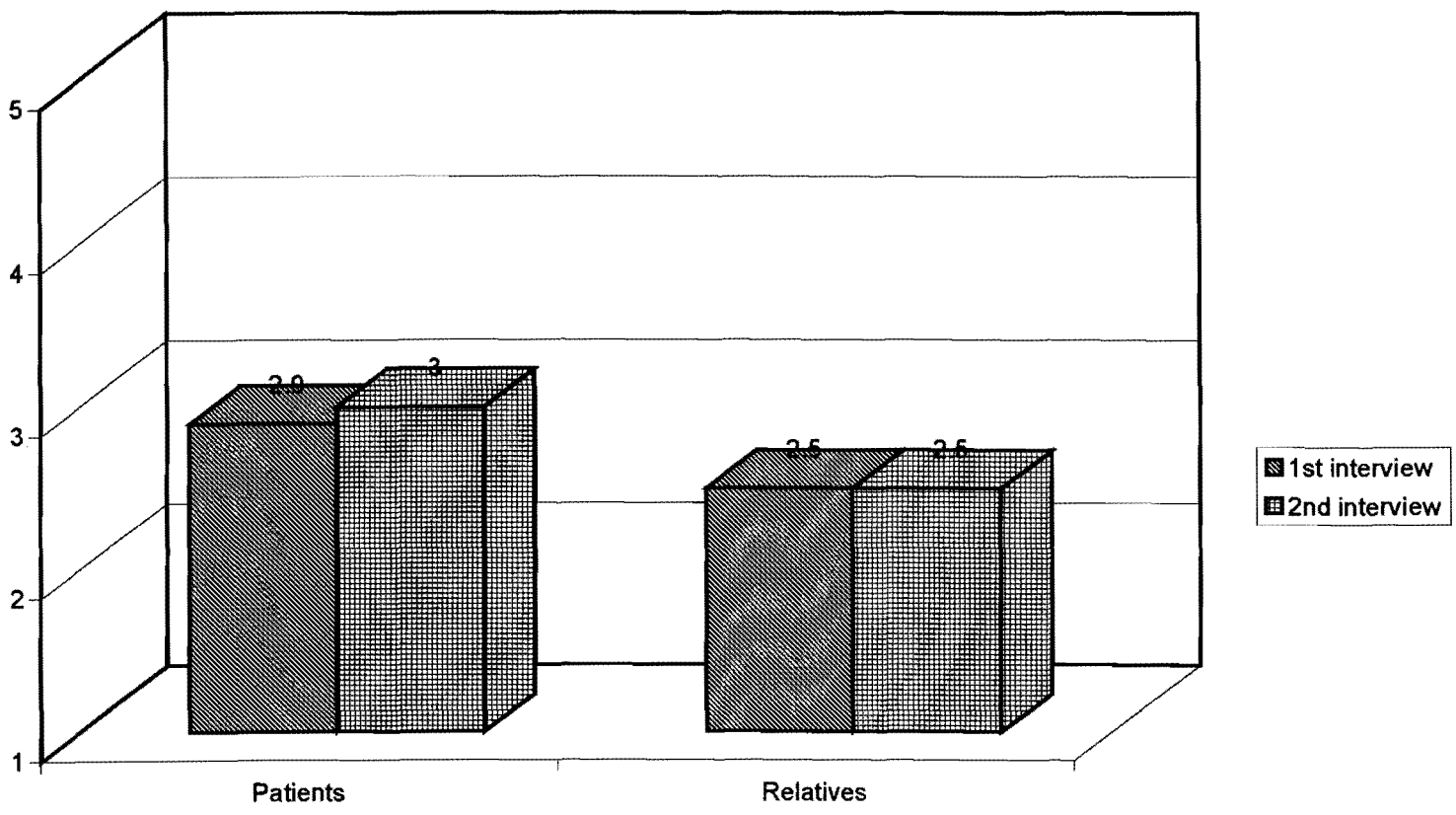

Figure 18: Socio-economic status reported by patient and key relative

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

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

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

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

Table 30: Socio-cultural factors affecting patient

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

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

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

- Patient's employment history

Table 31 indicates patient's employment history.

Table 31: Patient's employment history

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

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

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

- Families' insight into schizophrenia

Table 32 indicates families' insight into schizophrenia.

Table 32: Families' insight into schizophrenia

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

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

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

- Manner in which families can gain knowledge

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

Table 33: Manner in which families gain knowledge about schizophrenia

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

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

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

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

- Educational group sessions

Table 34 proposes who should attend educational group sessions.

Table 34: Who should attend educational group sessions

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

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

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

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

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

- Needs of a discharged patient suffering from schizophrenia

Table 35 indicates the needs of a discharged patient.

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

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

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

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

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

- Relatives' care of the patient

Table 36 indicates the relatives' care of the patient.

Table 36: Relatives' care of the patient

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

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

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

- Type of assistance that families receive from mental health professionals

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

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

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

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

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

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

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

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

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

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

Table 38: Other needs shared by patients and key relatives

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

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

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

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

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

6.3 SUMMARY OF THE RESEARCH FINDINGS/RESULTS

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

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

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

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

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

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

CHAPTER SEVEN
CONCLUSIONS, RECOMMENDATIONS AND SOCIAL WORK GUIDELINES

7.1 INTRODUCTION

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

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

7.2 OBJECTIVES OF THE STUDY

The objectives of the study were as follows:

7.2.1 OBJECTIVE 1

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

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

7.2.2 OBJECTIVE 2

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

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

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

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

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

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

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

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

7.2.2 OBJECTIVE 3

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

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

Themes for discussion in educational sessions could include the following:

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

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

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

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

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

7.2.4 OBJECTIVE 4

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

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

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

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

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

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

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

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

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

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

- Understanding of schizophrenia

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

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

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

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

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

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

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

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

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

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

- Treatment

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

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

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

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

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

- Caregivers

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

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

- Social work interventions

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

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

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

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

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

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

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

7.4 HYPOTHESIS

The researcher investigated the following hypothesis in the study:

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

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

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

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

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

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

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

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

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

7.5 RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

- Medical treatment with fewer side effects should be introduced

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

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

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

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

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

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

- Sampling should reflect a representative number of respondents

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

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

- All ethnic groups should be included in the study

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

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ADDENDUM A

SEMI-STRUCTURED INTERVIEWING SCHEDULE FOR PATIENTS SUFFERING FROM SCHIZOPHRENIA

INSTRUCTION: PLEASE ANSWER ALL THE QUESTIONS BY GIVING THE INFORMATION AND MARKING A CROSS NEXT TO THE ANSWER OF YOUR CHOICE FOR SECTIONS I AND II.

I. BIOGRAPHICAL DATA

Key answers:

YES	NO
1	2

1.1. Respondent number — V1 [ ][ ] 1-2

1.2. Card number — V2 [ ] 3

1.3. Repetition number — V3 [ ] 4

1.4. File number — V4 [ ][ ][ ][ ][ ] 5-9

[ ][ ][ ][ ][ ]

1.5. Date of researcher's interview — V5 [ ][ ][ ][ ][ ] 10-15

Y	Y	M	M	D	D

1.6. Residential address ..... — V6 [ ][ ] 16-17

.....

.....

1.7. Age

V7 ☐ 18

18 – 20	21-30	31-40	41-50	51-60	61-70	71-80	81+
1	2	3	4	5	6	7	8

1.8. Sex

V8 ☐ 19

F	1
M	2

1.9 Qualification

V9 ☐ 20

None	Less and up to 6	7 - 8	9 -10	Diploma	Degree	Post-degree	Other Specify
1	2	3	4	5	6	7	8

1.10 Occupation

V10 ☐☐ 21-22

None	1
General labourer	2
Domestic worker	3
Teacher	4
Nurse	5
Pensioner	6
Priest	7
Other – specify	8

1.11. Ethnic group

V11 ☐ 23-24

Tswana	1
North Sotho	2
South Sotho	3
Zulu	4
Swazi	5
Xhosa	6
Ndebele	7
Shangaan	8
Venda	9
English	10
Afrikaans	11
Coloured	12
Indian	13
Other – specify	14

1.12. Religious denomination V12 ☐ 25-26

Lutheran	1
Catholic	2
Dutch Reformed/ N.G.	3
Weselyan/Methodist	4
Presbyterian	5
Anglican	6
Zion Christian Church (Z.C.C.)	7
Pentecostal (I.P.C.C.)	8
St John	9
Apostolic	10
Redeemed	11
Ethiopian	12
Baptist	13
None	14
Other – specify	15

1.13. Marital status V13 ☐ 27

Unmarried	1
Married	2
Separated	3
Divorced	4
Widowed	5
Cohabitating	6

1.14. When did you start showing signs of schizophrenic illness for the first time? V14 ☐☐☐ 28-30

1.15. First hospital admission date (year) V15 ☐☐ 31-32

Y	Y

1.16. Total hospital admissions and reasons for admissions V16 ☐ 33

Once	Twice	Thrice	Four times	Five and more
1	2	3	4	5

Motivate ..... V17 ☐☐ 34-35

..... V18 ☐☐ 36-37

1.17. Schizophrenia subtype as diagnosed V19 ☐ 38

Paranoid	1
Catatonic	2
Disorganised	3
Undifferentiated	4
Residual	5
Unaware	6

1.18. Patient's most significant relative

V20 ☐☐ 39-40

Father	1
Mother	2
Brother	3
Sister	4
Spouse	5
Son	6
Daughter	7
Paternal grandfather	8
Paternal grandmother	9
Maternal grandmother	10
Maternal grandfather	11
Extended family relative	12
Other - specify	13

II. SCHIZOPHRENIA

V21 ☐ 41

2.1. What do you understand by schizophrenia?

V22 ☐☐ 42-43

Motivate .....

V23 ☐☐ 44-45

.....

2.2. What do you think the symptoms of a patient suffering from schizophrenia are? Motivate.

Symptoms	**YES**	**NO**	**MOTIVATION**
Disturbance of thinking	1	2	
Aggressive	1	2	
Patience	1	2	
Violence	1	2	
Patient has no interest in anything	1	2	
Patient remains immobile in abnormal postures	1	2	
Patient has rapid mood changes	1	2	
Others - Specify	1	2	

V24 ☐ 46

V25 ☐ 47

V26 ☐ 48

V27 ☐ 49

V28 ☐ 50

V29 ☐ 51

V30 ☐ 52

V31 ☐☐ 53-54

V32 ☐☐ 55-56

2.3 Describe your behavioural characteristics. Motivate.

V33 ☐ 57

Character	**Yes 1**	**No 2**	**Motivation**
Aggressive	1	2	
Friendly	1	2	
Violent	1	2	
Patient	1	2	
Co-operative	1	2	
Moody	1	2	
Emotionally stable	1	2	
All of the above	1	2	
Other – specify			

V34 ☐ 58

V35 ☐ 59

V36 ☐ 60

V37 ☐ 61

V38 ☐ 62

V39 ☐ 63

V40 ☐ 64

V41 ☐☐ 65-66

V42 ☐☐ 67-68

III. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK – ECOLOGICAL CONTEXT

INSTRUCTION: PLEASE ANSWER ALL QUESTIONS BY USING THE FOLLOWING RATING SCALE(S) AND USING THE YES, NO KEY ANSWERS. MARK A CROSS NEXT TO THE ANSWER(S) OF YOUR CHOICE

Key answers

1 = not at all	and	1 = none
2 = very rarely		2 = poor
3 = sometimes		3 = average
4 = most of the time		4 = good
5 = always		5 = very good

and

Yes	No
1	2

3.1 Rate your relationship with family members since you started to suffer from schizophrenia by using the following key:

Family relationship	Key	Motivation
Strained relationship	1 2 3 4 5	
The whole family life changed negatively	1 2 3 4 5	
Every relationship within the family is affected	1 2 3 4 5	
Family members become frustrated because you cannot function alone	1 2 3 4 5	
You are included in decision making	1 2 3 4 5	
You still have a role to perform	1 2 3 4 5	
You give family members problems	1 2 3 4 5	
Other - specify		

V43 ☐ 69

V44 ☐ 70

V45 ☐ 71

V46 ☐ 72

V47 ☐ 73

V48 ☐ 74

V49 ☐ 75

V50 ☐☐ 76-77

V51 ☐☐ 78-79

3.2 Respondent number

3.3 Card number

3.4 Repetition number

V52 ☐☐ 1-2

V53 ☐ 3

V54 ☐ 4

3.5. Rate your present relationship with friends by using the following key:
1 = not at all; 2 = very rarely; 3 = sometimes;
4 = most of the time; 5= always.

Friend relationship	Keys	Motivation
Friendship remains good	1 2 3 4 5	
You feel accepted	1 2 3 4 5	
You are excluded from decision making	1 2 3 4 5	
You are not feared	1 2 3 4 5	
You get more support from friends	1 2 3 4 5	
Other – specify		

V55 ☐ 5

V56 ☐ 6

V57 ☐ 7

V58 ☐ 8

V59 ☐ 9

V60 ☐☐ 10-11

V61 ☐☐ 12-13

IV. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - MIGRATION AND ACCULTURATION

4.1. Rate how your family members handle you by using the following key.
1= not at all; 2-very rarely; 3 = sometimes;
4= most of the time; 5= always

Family - Handling	Key	Motivation
Fear	1 2 3 4 5	
Frustration	1 2 3 4 5	
Worry	1 2 3 4 5	
Bitterness	1 2 3 4 5	
Anger	1 2 3 4 5	
Happiness	1 2 3 4 5	
Anxiety	1 2 3 4 5	
Empathy	1 2 3 4 5	
Guilt	1 2 3 4 5	
Depression	1 2 3 4 5	
Blame	1 2 3 4 5	
Shame	1 2 3 4 5	
Stress	1 2 3 4 5	
Acceptance	1 2 3 4 5	
Other – specify		

V62 ☐ 14

V63 ☐ 15

V64 ☐ 16

V65 ☐ 17

V66 ☐ 18

V67 ☐ 19

V68 ☐ 20

V69 ☐ 21

V70 ☐ 22

V71 ☐ 23

V72 ☐ 24

V73 ☐ 25

V74 ☐ 26

V75 ☐ 27

V76 ☐☐ 28-29

V77 ☐☐ 30-31

4.2 Rate how you handle your family members by using the following key:
1= not at all; 2 = very rarely, 3= sometimes;
4= most of the time; 5= always.

Patient - Handling	**Key**	**Motivation**
Blame	1 2 3 4 5	
Fear	1 2 3 4 5	
Anxiety	1 2 3 4 5	
Happiness	1 2 3 4 5	
Anger	1 2 3 4 5	
Depression	1 2 3 4 5	
Guilt	1 2 3 4 5	
Bitterness	1 2 3 4 5	
Worry	1 2 3 4 5	
Empathy	1 2 3 4 5	
Stress	1 2 3 4 5	
Mourning	1 2 3 4 5	
Embarrassment	1 2 3 4 5	
Other		

V78 ☐ 32

V79 ☐ 33

V80 ☐ 34

V81 ☐ 35

V82 ☐ 36

V83 ☐ 37

V84 ☐ 38

V85 ☐ 39

V86 ☐ 40

V87 ☐ 41

V88 ☐ 42

V89 ☐ 43

V90 ☐ 44

V91 ☐☐ 45-46

V92 ☐☐ 47-48

4.3 Rate to what extent you think the following occur because of you, by using the following key:
1= not at all; 2= very rarely; 3= sometimes; 4= most of the time; 5= always

Burden	Key	Motivation
A caregiver keeps on working	1 2 3 4 5	
A caregiver loses his leisure time	1 2 3 4 5	
A caregiver still has friends	1 2 3 4 5	
Family members experience financial problems	1 2 3 4 5	
Family members become angry towards each other	1 2 3 4 5	
Family members blame themselves for causing the illness	1 2 3 4 5	
Family members are close to one another	1 2 3 4 5	
Family members become angry with God	1 2 3 4 5	
Caregiver experiences burden because of your violent behaviour	1 2 3 4 5	
Other – Specify		

V93 ☐ 49
V94 ☐ 50
V95 ☐ 51
V96 ☐ 52
V97 ☐ 53
V98 ☐ 54
V99 ☐ 55
V100 ☐ 56
V101 ☐ 57
V102 ☐☐ 58-59
V103 ☐☐ 60-61

V FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK – FAMILY ORGANISATION

5.1. Who do you think is the main caregiver? Motivate.

Caregiver	Yes	No	Motivation
Female/Mother	1	2	
Male/Father	1	2	
Other –specify			

V104 ☐ 62
V105 ☐ 63
V106 ☐☐ 64-65
V107 ☐☐ 66-67

5.5 Explain the communication style between you and family members by using the following key.
1= not at all; 2= very rarely; 3= sometimes; 4= most of the time; 5= always.

Communication	Key	Motivation
Family members allow you to explain	1 2 3 4 5	
Family members gossip about you negatively	1 2 3 4 5	
Family members talk to you nicely	1 2 3 4 5	
Other – specify	1 2 3 4 5	

V108 ☐ 68

V109 ☐ 69

V110 ☐ 70

V111 ☐☐ 71-72

V112 ☐☐ 73-74

5.3 Respondent number

V113 ☐☐ 1-2

5.4 Card number

V114 ☐ 3

5.5 Repetition number

V115 ☐ 4

5.6

5.6 What makes you relapse? Motivate

Relapse	Yes 1	No 2	Motivation
Criticism	1	2	
Support of your ideas	1	2	
Disapproval	1	2	
Appreciation	1	2	
Acceptance	1	2	
When too much is expected from you	1	2	
Other – specify			

V116 ☐ 5

V117 ☐ 6

V118 ☐ 7

V119 ☐ 8

V120 ☐ 9

V121 ☐ 10

V122 ☐☐ 11-1

V123 ☐☐ 13-1

5.7. Where do you prefer to stay? Motivate

Place to stay	**Yes 1**	**No 2**	**Motivate**
Mental Hospital	1	2	
Home with parents and/or family	1	2	
Hostel	1	2	
Other - specify			

V124 ☐ 15

V125 ☐ 16

V126 ☐ 17

V127 ☐☐ 18-19

V128 ☐☐ 20-21

V1. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - FAMILY LIFE CYCLE

6.1. Were there any abnormalities during the period that your mother was expecting you? Motivate

Period before birth	**Yes 1**	**No 2**	**Motivation**
Planned pregnancy	1	2	
Healthy during pregnancy	1	2	
Other - specify			

V129 ☐ 22

V130 ☐ 23

V131 ☐☐ 24-25

V132 ☐☐ 26-27

6.2. Were there any abnormalities during your birth? Motivate.

Birth	**Yes 1**	**No 2**	**Motivation**
Complications during birth	1	2	
Caesarian	1	2	
Normal birth	1	2	
Other – specify			

V133 ☐ 28

V134 ☐ 29

V135 ☐ 30

V136 ☐☐ 31-32

V137 ☐☐ 33-34

6.3. Were there any abnormalities during your developmental milestones? Motivate.

Developmental milestone	Yes 1	No 2	Motivation
Unknown	1	2	
Other – specify			

V138 ☐ 35

V139 ☐ 36

V140 ☐☐ 37-38

V141 ☐☐ 39-40

6.4. Were there any abnormalities in your temperament? Motivate.

Temperament	Yes 1	No 2	Motivation
Unknown	1	2	
Other – specify			

V142 ☐ 41

V143 ☐ 42

V144 ☐☐ 43-44

V145 ☐☐ 45-46

6.5. Were there any abnormalities in your personality traits? Motivate.

Personality traits	Yes 1	No 2	Motivation
Unknown	1	2	
Other – specify			

V146 ☐ 47

V147 ☐ 48

V148 ☐☐ 49-50

V149 ☐☐ 51-52

6.6. Did you have any of the following habits during childhood?

Habits	Yes 1	No 2
Nail biting	1	2
Thumb sucking	1	2
Sleep walking	1	2
Other - specify		

V150 ☐ 53

V151 ☐ 54

V152 ☐ 55

V153 ☐☐ 56-57

V154 ☐☐ 58-59

6.7. Did you exhibit any of the following behavioural problems?

Patient's behaviour	**Yes 1**	**No 2**	**Motivation**
Stealing	1	2	
Honesty	1	2	
Lying	1	2	
Use dependency substances	1	2	
Other – specify			

V155 ☐ 60

V156 ☐ 61

V157 ☐ 62

V158 ☐ 63

V159 ☐☐ 64-65

V160 ☐☐ 66-67

6.8 How were you educated sexually?

Sexual development	**Yes 1**	**No 2**	**Motivation**
Through books	1	2	
Through parents	1	2	
Through friends	1	2	
On your own	1	2	
Other – specify			

V161 ☐ 68

V162 ☐ 69

V163 ☐ 70

V164 ☐ 71

V165 ☐☐ 72-73

V166 ☐☐ 74-75

6.9 Respondent number

6.10 Card number

6.11 Repetition number

V167 ☐☐ 1-2

V168 ☐ 3

V169 ☐ 4

6.12 Do you find sexual activities pleasant?

Sexual activities	**Yes 1**	**No 2**	**Motivation**
Unknown	1	2	
Other – specify			

V170 ☐ 5

V171 ☐ 6

V172 ☐☐ 7-8

V173 ☐☐ 9-10

6.13 Explain the quality of the relationship between you and your peer group.

Quality	Yes 1	No 2	Motivation
You were valued	1	2	
The peer group trusted you	1	2	
The peer group feared you	1	2	
Other – specify			

V174 ☐ 11
V175 ☐ 12
V176 ☐ 13
V177 ☐☐ 14-15
V178 ☐☐ 16-17

6.14 Were the following present in your upbringing?

Upbringing	Yes 1	No 2	Motivation
Happy parental relationship	1	2	
Conflict amongst siblings	1	2	
Mother died before the age of ten	1	2	
Mother still alive	1	2	
Other -specify			

V179 ☐ 18
V180 ☐ 19
V181 ☐ 20
V182 ☐ 21
V183 ☐☐ 22-23
V184 ☐☐ 24-25

6.15 Rate your status by using the following key:
1= none; 2= poor; 3= average; 4= good; 5= very good.

Status	Key	Motivation
Your housing status	1 2 3 4 5	
Your financial position	1 2 3 4 5	
Your health status	1 2 3 4 5	
Other – specify		

V185 ☐ 26
V186 ☐ 27
V187 ☐ 28
V188 ☐☐ 29-30
V189 ☐☐ 31-32

6.16 Rate the following factors by using the following key:
1= not at all; 2= Very rarely; 3= sometimes; 4= most of the time; 5= always

Factors	**Key**	**Motivation**
Clashes with the law (offence)	1 2 3 4 5	
Involvement in church activities	1 2 3 4 5	
Involvement in ancestral beliefs	1 2 3 4 5	
Involvement in witchcraft beliefs	1 2 3 4 5	
Other – specify		

V190 ☐ 33
V191 ☐ 34
V192 ☐ 35
V193 ☐ 36
V194 ☐☐ 37-38
V195 ☐☐ 39-40

6.17 Employment

Employment history	**Yes** **1**	**No** **2**	**Motivation**
Are you presently employed?	1	2	
Do you presently relate well with your colleagues?	1	2	
Were you employed before the illness?	1	2	
Were you dismissed?	1	2	
Did you resign?	1	2	
Were you retrenched?	1	2	
Other - specify			

V196 ☐ 41
V197 ☐ 42
V198 ☐ 43
V199 ☐ 44
V200 ☐ 45
V201 ☐ 46
V202 ☐☐ 47-48
V203 ☐☐ 49-50

VII FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAME-WORK - FAMILY INTERVENTION PROGRAMMES

7.1. Do you think your family has insight into your illness?

Yes	No
1	2

V204 ☐ 51

Motivate:

V205 ☐☐ 52-53

V206 ☐☐ 54-55

.....

7.2. Can families gain knowledge through group sessions about patients suffering from schizophrenia by discussing the following topics?

Educational Topics	Yes 1	No 2	Motivation
Families ideas	1	2	
Symptoms	1	2	
Medical treatment	1	2	
Available resources	1	2	
Educational group sessions for patients	1	2	
Problems encountered within families	1	2	
Literature for patients	1	2	
Literature for families	1	2	
Other -specify			

V207 ☐ 56

V208 ☐ 57

V209 ☐ 58

V210 ☐ 59

V211 ☐ 60

V212 ☐ 61

V213 ☐ 62

V214 ☐ 63

V215 ☐☐ 64-65

V216 ☐☐ 66-67

7.3 Who do you think should attend educational group sessions?

Group sessions for:	Yes	No	Motivation
Families and patients	1	2	
Families only	1	2	
Patients only	1	2	
Main caregivers	1	2	
Close friends	1	2	
Extended family	1	2	
Other –specify			

7.4 Respondent number

7.5 Card number

7.6 Repetition number

7.7 What does a discharged patient suffering from schizophrenia need?

Discharged Patient needs	Yes 1	No 2	Motivation
Family support	1	2	
Counselling	1	2	
Employment	1	2	
Regular medication	1	2	
After-care services	1	2	
Other – specify			

7.8 Do you think relatives are able to take care of patient suffering from schizophrenia?

Yes	No
1	2

Motivate: .....
.....

V217 ☐ 68
V218 ☐ 69
V219 ☐ 70
V220 ☐ 71
V221 ☐ 72
V222 ☐ 73
V223 ☐☐ 74-75
V224 ☐☐ 76-77
V225 ☐☐ 1-2
V226 ☐ 3
V227 ☐ 4
V228 ☐ 5
V229 ☐ 6
V230 ☐ 7
V231 ☐ 8
V232 ☐ 9
V233 ☐☐ 10-11
V234 ☐☐ 12-13
V235 ☐ 14
V236 ☐☐ 15-16
V237 ☐☐ 17-18

7.9. What kind of assistance do families get from mental health professionals? Motivate.

Assistance	**Yes 1**	**No 2**	**Motivation**
Assistance	1	2	
Satisfied about services	1	2	
Willing to help families	1	2	
Collaboration	1	2	
Other – specify			

7.10. What are other needs that might be shared concerning the patient suffering from schizophrenia and the family?

.....

.....

Thank you for your co-operation.

V238 ☐ 19

V239 ☐ 20

V240 ☐ 21

V241 ☐ 22

V242 ☐☐ 23-24

V243 ☐☐ 25-26

V244 ☐☐ 27-28

V245 ☐☐ 29-30

ADDENDUM B

SEMI-STRUCTURED INTERVIEWING SCHEDULE FOR KEY RELATIVES OF PATIENTS

INSTRUCTION: PLEASE ANSWER ALL THE QUESTIONS BY GIVING THE INFORMATION AND MAKING A CROSS NEXT TO THE ANSWER OF YOUR CHOICE FOR FOR SECTIONS I AND II.

I. BIOGRAPHICAL DATA

Key answers:

Yes	No
1	2

1.1. Respondent number — V1 ☐☐ 1-2

1.2. Card number — V2 ☐ 3

1.3. Repetition number — V3 ☐ 4

1.4. Date of researcher's interview — V4 ☐☐☐☐☐☐ 5-10

Y	Y	M	M	D	D

1.5. Residential address ..... V5 ☐☐ 11-12

.....

1.6. Age V6 ☐13

18 - 20	21-30	31-40	41-50	51-60	61-70	71-80	81+
1	2	3	4	5	6	7	8

1.7. Sex V7 ☐14

F	1
M	2

1.8 Qualification V8 ☐15

None	Less & up to 6	7 - 8	9 -10	Diploma	Degree	Post-degree	Other Specify
1	2	3	4	5	6	7	8

1.9. Occupation V9 ☐☐ 16-17

None	1
General Labourer	2
Domestic Worker	3
Teacher	4
Nurse	5
Pensioner	6
Priest	7
Other - specify	8

1.10. Ethnic group

V10 ☐☐ 18-19

Tswana	1
North Sotho	2
South Sotho	3
Zulu	4
Swazi	5
Xhosa	6
Ndebele	7
Shangaan	8
Venda	9
English	10
Afrikaans	11
Coloured	12
Indian	13
Other - specify	14

1.11 Religious Denomination

V11 ☐☐ 20-21

Lutheran	1
Catholic	2
Dutch Reformed/ N.G.	3
Weselyan / Methodist	4
Presbyterian	5
Anglican	6
Zion Christian Church (Z.C.C.)	7
International Pentecostal (IPCC)	8
St John	9
Apostolic	10
Redeemed	11
Ethiopian	12
Baptist	13
None	14
Other – specify	15

1.12. Marital status

V12 ☐ 22

Unmarried	1
Married	2
Separated	3
Divorced	4
Widowed	5
Cohabitating	6

1.13. When did your patient start showing signs of schizophrenic illness for the first time?

V13 ☐☐☐ 23-25

1.14. First hospital admission date

V14 ☐☐ 26-27

Y	Y

1.15. Total hospital admissions and reasons for admissions

once	twice	thrice	fourth	Fifth and more
1	2	3	4	5

V15 ☐ 28

V16 ☐☐ 29-30

V17 ☐☐ 31-32

Motivate .....

.....

1.16. Your relationship to the patient

V18 ☐☐ 33-34

Father	1
Mother	2
Brother	3
Sister	4
Spouse	5
Son	6
Daughter	7
Paternal grandfather	8
Paternal grandmother	9
Maternal grandmother	10
Maternal grandfather	11
Extended family relative	12
Other - specify	13

V19 ☐ 35

1.17. Schizophrenia subtype as diagnosed

Paranoid	1
Catatonic	2
Disorganised	3
Undifferentiated	4
Residual	5
Unaware	6

II. SCHIZOPHRENIA

V20 ☐ 36

2.1. What do you understand by schizophrenia?

Motivate .....

.....

V21 ☐☐ 37-38

V22 ☐☐ 39-40

2.2. What do you think the symptoms of a patient suffering from schizophrenia are? Motivate.

Symptoms	**YES**	**NO**	**MOTIVATION**
Disturbance of thinking	1	2	
Aggression	1	2	
Patience	1	2	
Violence	1	2	
Patient has no interest in anything	1	2	
Patient remains immobile in abnormal postures	1	2	
Patient has rapid mood changes	1	2	
Other - specify			

V23 ☐ 41

V24 ☐ 42

V25 ☐ 43

V26 ☐ 44

V27 ☐ 45

V28 ☐ 46

V29 ☐ 47

V30 ☐☐ 48-49

V31 ☐☐ 50-51

2.3. Describe the patient's behavioural characteristics. Motivate.

V32 ☐☐ 52

Character	Yes 1	No 2	Motivation
Aggressive	1	2	
Friendly	1	2	
Violent	1	2	
Patient	1	2	
Co-operative	1	2	
Moody	1	2	
Emotionally stable	1	2	
All of the above	1	2	
Other - specify			

V33 ☐☐ 53
V34 ☐☐ 54
V35 ☐☐ 55
V36 ☐☐ 56
V37 ☐☐ 57
V38 ☐☐ 58
V39 ☐☐ 59
V40 ☐☐ 60-61
V41 ☐☐ 62-63

III. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK - ECOLOGICAL CONTEXT

INSTRUCTION: PLEASE ANSWER ALL QUESTIONS BY USING THE FOLLOWING RATING SCALE(S) AND USING THE YES, NO KEYS ANSWERS. MAKE A CROSS NEXT TO THE ANSWER(S) OF YOUR CHOICE

Key answers

1 = not at all	and	1 = none
2 = very rarely		2 = poor
3 = sometimes		3 = average
4 = most of the time		4 = good
5 = always		5 = very good

and

Yes	No
1	2

3.1 Rate the patient's relationship within the family since it became known that he is suffering from schizophrenia by using the following key:
1= not at all; 2= very rarely; 3 = sometimes;
4 = most of the time; 5 = always

Family relationship	Key	Motivation	
Strained relationship	1 2 3 4 5		V42 ☐ 64
The whole family life changed negatively	1 2 3 4 5		V43 ☐ 65
Every relationship within the family is affected	1 2 3 4 5		V44 ☐ 66
Family members become frustrated because he cannot function alone	1 2 3 4 5		V45 ☐ 67
Patient is included in decision-making	1 2 3 4 5		V46 ☐ 68
Patient still have a role to perform	1 2 3 4 5		V47 ☐ 69
Patient gives family members problems	1 2 3 4 5		V48 ☐ 70
Other - specify			V49 ☐☐ 71-72 V50 ☐☐ 73-74

3.2 Respondent number — V51 ☐☐ 1-2

3.3 Card number — V52 ☐ 3

3.4 Repetition number — V53 ☐ 4

3.5. Rate the patient's present relationship with friends by using the following key:
1 = not at all; 2 = very rarely; 3 = sometimes;
4 = most of the time; 5= always.

Friend relationship	Key	Motivation	
Friendship remains good	1 2 3 4 5		V54 ☐ 5
Patient feels accepted	1 2 3 4 5		V55 ☐ 6
Patient is excluded from decision making	1 2 3 4 5		V56 ☐ 7
Patient is feared	1 2 3 4 5		V57 ☐ 8
Patient gets more support from friends	1 2 3 4 5		V58 ☐ 9
Other - specify			V59 ☐☐ 10-11 V60 ☐☐ 12-13

IV. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAME-WORK - MIGRATION OR ACCULTURATION

4.1. Rate how patient's family handles the patient by using the following key.
1= not at all; 2-very rarely; 3 = sometimes;
4= most of the times; 5= always

Family - Handling	Key	Motivation
Fear	1 2 3 4 5	
Frustration	1 2 3 4 5	
Worried	1 2 3 4 5	
Bitterness	1 2 3 4 5	
Anger	1 2 3 4 5	
Happiness	1 2 3 4 5	
Anxiety	1 2 3 4 5	
Empathy	1 2 3 4 5	
Guilt	1 2 3 4 5	
Depression	1 2 3 4 5	
Blame	1 2 3 4 5	
Shame	1 2 3 4 5	
Stress	1 2 3 4 5	
Acceptance	1 2 3 4 5	
Other. Please Specify		

V61 ☐ 14

V62 ☐ 15

V63 ☐ 16

V64 ☐ 17

V65 ☐ 18

V66 ☐ 19

V67 ☐ 20

V68 ☐ 21

V69 ☐ 22

V70 ☐ 23

V71 ☐ 24

V72 ☐ 25

V73 ☐ 26

V74 ☐ 27

V75 ☐☐ 28-29

V76 ☐☐ 30-31

4.2 Rate how the patient handles the family by using the key below.
1= not at all; 2 = very rarely, 3= at sometimes;
4= most of the time; 5= always.

Patient - Handling	**Key**	**Motivation**
Blame	1 2 3 4 5	
Fear	1 2 3 4 5	
Anxiety	1 2 3 4 5	
Anger	1 2 3 4 5	
Happiness	1 2 3 4 5	
Depression	1 2 3 4 5	
Guilt	1 2 3 4 5	
Bitterness	1 2 3 4 5	
Worry	1 2 3 4 5	
Empathy	1 2 3 4 5	
Stress	1 2 3 4 5	
Mourning	1 2 3 4 5	
Embarrassment	1 2 3 4 5	
Other. Please specify		

V77 ☐ 32

V78 ☐ 33

V79 ☐ 34

V80 ☐ 35

V81 ☐ 36

V82 ☐ 37

V83 ☐ 38

V84 ☐ 39

V85 ☐ 40

V86 ☐ 41

V87 ☐ 42

V88 ☐ 43

V89 ☐ 44

V90 ☐☐ 45-46

V91 ☐☐ 47-48

4.3 To what extent do you think the following burden might occur because of the patient suffering from schizophrenia? Using the following key:
1= not at all; 2 = very rarely, 3= at sometimes;
4= most of the time; 5= always.

Burden	**Key**	**Motivation**
A caregiver keeps on working	1 2 3 4 5	
A caregiver loses his leisure time	1 2 3 4 5	
A caregiver still has his friends	1 2 3 4 5	
Family members experience financial problems	1 2 3 4 5	
Family members become angry towards each other	1 2 3 4 5	
Family members blame themselves for causing the illness	1 2 3 4 5	
Family members are close to one another	1 2 3 4 5	
They do not blame God	1 2 3 4 5	
Caregiver experiences burden because of the patient's violence	1 2 3 4 5	
Other - Specify		

V92 ☐ 49

V93 ☐ 50

V94 ☐ 51

V95 ☐ 52

V96 ☐ 53

V97 ☐ 54

V98 ☐ 55

V99 ☐ 56

V100 ☐ 57

V101 ☐☐ 58-59

V102 ☐☐ 60-61

V FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAMEWORK – FAMILY ORGANISATION

5.1 Who do you think is the main caregiver? Motivate

Caregiver	Yes	No	Motivation
Female/Mother	1	2	
Male/Father	1	2	
Other -specify			

V103 ☐ 62

V104 ☐ 63

V105 ☐☐ 64-65

V106 ☐☐ 66-67

5.2 Explain the communication style between the patient and family members by using the following key.
1= not at all; 2= very rarely; 3= sometimes; 4= often;
5= always.

Communication style	Key	Motivation
Family members allow the patient to explain	1 2 3 4 5	
Family members gossip about the patient negatively	1 2 3 4 5	
Family members talk to patient nicely	1 2 3 4 5	
Other - specify		

V107 ☐ 68

V108 ☐ 69

V109 ☐ 70

V110 ☐☐ 71-72

V111 ☐☐ 73-74

5.3 Respondent number V112 ☐☐ 1-2

5.4 Card number V113 ☐ 3

5.5 Repetition number V114 ☐ 4

5.6 What causes the patient to relapse? Motivate.

Relapse	**Yes 1**	**No 2**	**Motivation**	
Criticism	1	2		V115 ☐ 5
Support of patient's ideas	1	2		V116 ☐ 6
Shouting at the patient	1	2		V117 ☐ 7
Disapproval	1	2		V118 ☐ 8
Acceptance	1	2		V119 ☐ 9
When too much is expected from the patient	1	2		V120 ☐ 10
Other - specify				V121 ☐☐ 11-12

V122 ☐☐ 13-14

5.7 Where do you prefer the patient to stay? Motivate.

Place to stay	**Yes 1**	**No 2**	**Motivate**	
Mental Hospital	1	2		V123 ☐ 15
Home with parents and/or family	1	2		V124 ☐ 16
Hostel	1	2		V125 ☐ 17
Other - specify				V126 ☐☐ 18-19

V127 ☐☐ 20-21

V1. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAME-WORK - FAMILY LIFE CYCLE

6.1. Were there any abnormalities during the period before the patient was born? Motivate.

Period before birth	**Yes 1**	**No 2**	**Motivate**
Planned pregnancy	1	2	
Healthy during pregnancy	1	2	
Other - specify			

V128 ☐ 22

V129 ☐ 23

V130 ☐☐ 24-25

V131 ☐☐ 26-27

6.2. Were there any abnormalities during the patient's birth? Motivate.

Birth	**Yes 1**	**No 2**	**Motivation**
Complications during birth	1	2	
Caesarian	1	2	
Normal birth	1	2	
Other - specify			

V132 ☐ 28

V133 ☐ 29

V134 ☐ 30

V135 ☐☐ 31-32

V136 ☐☐ 33-34

6.3. Were there any abnormalities during the patient's developmental milestones? Motivate.

Developmental milestone	**Yes 1**	**No 2**	**Motivation**
Unknown	1	2	
Other - specify	1	2	

V137 ☐ 35

V138 ☐ 36

V139 ☐☐ 37-38

V140 ☐☐ 39-40

6.4. Were there any abnormalities in the patient's temperament? Motivate.

Temperament	**Yes 1**	**No 2**	**Motivation**
Unknown	1	2	
Other - specify	1	2	

V141 ☐ 41
V142 ☐ 42
V143 ☐☐ 43-44
V144 ☐☐ 45-46

6.5. Were there any abnormalities in the patient's personality traits? Motivate.

Personality traits	**Yes 1**	**No 2**	**Motivation**
Unknown	1	2	
Other - specify	1	2	

V145 ☐ 47
V146 ☐ 48
V147 ☐☐ 49-50
V148 ☐☐ 51-52
V149 ☐ 53

6.6. Explain the patient's childhood habits.

Habits	**Yes**	**No**	**Motivation**
Nail biting	1	2	
Thumb sucking	1	2	
Sleep walking	1	2	
Other - specify			

V150 ☐ 54
V151 ☐ 55
V152 ☐☐ 56-57
V153 ☐☐ 58-59

6.7 Did the patient exhibit the following behavioural problems? Motivate.

Patient's behaviour	Yes	No	Motivation
Stealing	1	2	
Honesty	1	2	
Lying	1	2	
Use dependency substance	1	2	
Other - specify			

V154 ☐ 60

V155 ☐ 61

V156 ☐ 62

V157 ☐ 63

V158 ☐☐ 64-65

V159 ☐☐ 66-67

6.8 How was the patient educated sexually?

Sexual development	Yes	No	Motivation
Through books	1	2	
Through parents	1	2	
Through friends	1	2	
On his/her own	1	2	
Other – specify			

V160 ☐ 68

V161 ☐ 69

V162 ☐ 70

V163 ☐ 71

V164 ☐☐ 72-73

V165 ☐☐ 74-75

6.9 Respondent number

6.10 Card number

6.11 Repetition number

V166 ☐☐ 1-2

V167 ☐ 3

V168 ☐ 4

6.12 Does the patient find sexual activities pleasant?

Sexual activities	Yes 1	No 2	Motivation
Unknown	1	2	
Other – specify			

V169 ☐ 5

V170 ☐ 6

V171 ☐☐ 7-8

V172 ☐☐ 9-10

6.13 Explain the quality of the relationship between the patient and the patient's peer group.

Quality	Yes	No	Motivation
The patient was valued	1	2	
The peer group trusted the patient	1	2	
The peer group feared the patient	1	2	
Other – specify			

V173 ☐ 11

V174 ☐ 12

V175 ☐ 13

V176 ☐☐ 14-15

V177 ☐☐ 16-17

6.14 Were the following present in the patient's upbringing?

Upbringing	Yes	No	Motivation
Happy parental relationship	1	2	
Conflict amongst siblings	1	2	
Mother died before age of ten	1	2	
Mother still alive	1	2	
Other – Please specify			

V178 ☐ 18

V179 ☐ 19

V180 ☐ 20

V181 ☐ 21

V182 ☐☐ 22-23

V183 ☐☐ 24-25

6.15. Rate the following factors by using the following key:
1= none; 2= poor; 3= average; 4= good; 5= very good

Status	Key	Motivation
Housing status	1 2 3 4 5	
Patient's financial position	1 2 3 4 5	
Patient's health status	1 2 3 4 5	
Other - specify		

V184 ☐ 26

V185 ☐ 27

V186 ☐ 28

V187 ☐☐ 29-30

V188 ☐☐ 31-32

6.16. Rate the following factors by using the following key:
1= not at all; 2= very rarely; 3= sometimes; 4= most of the times; 5= always

Factors	**Key**	**Motivation**
Patient's clashes with the law (offence)	1 2 3 4 5	
Patient's involvement in church activities	1 2 3 4 5	
Patient's involvement in ancestral beliefs	1 2 3 4 5	
Patient's involvement in witchcraft belief	1 2 3 4 5	
Other - specify		

V189 ☐ 33

V190 ☐ 34

V191 ☐ 35

V192 ☐ 36

V193 ☐☐ 37-38

V194 ☐☐ 39-40

6.17. Employment

Employment history	**Yes** **1**	**No** **2**	**Motivation**
Does the patient have any form of employment?	1	2	
Any good relationship with colleagues with regards to the patient?	1	2	
Was the patient employed before illness?	1	2	
Was the patient dismissed?	1	2	
Did the patient resign?	1	2	
Was the patient retrenched?	1	2	
Other - specify			

V195 ☐ 41

V196 ☐ 42

V197 ☐ 43

V198 ☐ 44

V199 ☐ 45

V200 ☐ 46

V201 ☐☐ 47-48

V202 ☐☐ 49-50

VII. FAMILY FUNCTIONING WITHIN AN ECOSYSTEM FRAME-WORK - FAMILY INTERVENTION PROGRAMMES

7.1. Do you think families have insight into a patient's illness?

Yes	No	Motivation
1	2	

V203 ☐ 51

V204 ☐☐ 52-53

V205 ☐☐ 54-55

7.2 Can families gain knowledge through group sessions about patients suffering from schizophrenia by discussing the following topics?

Educational topics	Yes 1	No 2	Motivation	
Families ideas	1	2		V206 ☐ 56
Symptoms	1	2		V207 ☐ 57
Problems encountered with patients	1	2		V208 ☐ 58
Medical treatment	1	2		V209 ☐ 59
Available resources	1	2		V210 ☐ 60
Educational group sessions for patients	1	2		V211 ☐ 61
Problems encountered within families	1	2		V212 ☐ 62
Literature for patients	1	2		V213 ☐ 63
Literature for families	1	2		V214 ☐ 64
Other -specify				V215 ☐☐ 65-66
				V216 ☐☐ 67-68

7.3 Who do you think should attend educational group sessions?

Group sessions for:	Yes	No	Motivation
Families and patients	1	2	
Families only	1	2	
Patients only	1	2	
Main caregivers	1	2	
Close friends	1	2	
Extended family	1	2	
Other -specify			

7.4 Respondent number

7.5 Card number

7.6 Repetition number

7.7. What does a discharged patient suffering from schizophrenia need?

Discharged Patient's needs	Yes	No	Motivation
Family support	1	2	
Counselling	1	2	
Employment	1	2	
Regular medication	1	2	
After care services	1	2	
Other - specify			

V217 ☐ 69

V218 ☐ 70

V219 ☐ 71

V220 ☐ 72

V221 ☐ 73

V222 ☐ 74

V223 ☐☐ 75-76

V224 ☐☐ 77-78

V225 ☐☐ 1-2

V226 ☐ 3

V227 ☐ 4

V228 ☐ 5

V229 ☐ 6

V230 ☐ 7

V231 ☐ 8

V232 ☐ 9

V233 ☐☐ 10-11

V234 ☐☐ 12-13

7.8. Do you think relatives are able to take care of a patient suffering from schizophrenia?

Yes	No
1	2

Motivate: .....
.....

7.9. What kind of assistance do families get from mental health professionals? Motivate.

Assistance	**Yes 1**	**No2**	**Motivation**
Assistance	1	2	
Satisfactory services	1	2	
Willing to give education	1	2	
Collaboration	1	2	
Other -specify			

7.10. What are other needs that might be shared concerning the patient suffering from schizophrenia and the family?
.....
.....

Thank you for your co-operation.

V235 ☐ 14

V236 ☐☐ 15-16

V237 ☐☐ 17-18

V238 ☐ 19

V239 ☐ 20

V240 ☐ 21

V241 ☐ 22

V242 ☐☐ 23-24

V243 ☐☐ 25-26

V244 ☐☐ 27-28

V245 ☐☐ 29-30

ADDENDUM C

GUIDING QUESTIONS FOR THE FOCUS GROUP

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

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

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