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Review Article On The Influence Of The Family In The Management Of Clients With Schizophrenia

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Abstract

Schizophrenia is a chronic and severe mental disorder affecting 20 million people worldwide. Schizophrenia is characterized by distortions in thinking, perception, emotions, language, sense of self and behavior. The exact causes of schizophrenia are unknown. Research suggests a combination of physical, genetic, psychological and environmental factors can make a person more likely to develop the condition. Poor parent child relationships and dysfunctions family systems like dominant mother and recessive father, broken family can also cause schizophrenia. Research into expressed emotion reveals that family dynamics are an important but controversial predictor of relapse of positive symptoms.Schizophrenia negatively impacts many different aspects of the lives of both patients and their caregivers. Close relatives, especially mothers, act as the major carers for patients with schizophrenia. With the movement away from institutionalized care for psychiatric patients, the respite afforded by this care is being replaced by greater contact with families. If a patient is in regular contact with family members, it is reasonable to engage these relatives in the patient's care. Families both need and want education, coping and communication skills, emotional support and to be treated as collaborators in the management of a relative's illness. There is an important role played by the family in the life of schizophrenic clients, so it is is very essential to take care of their health..

Keywords: Schizophrenia, family, contact, education, coping, communication skills, health

Introduction

Schizophrenia is a chronic and severe mental disorder affecting 20 million people worldwide. Schizophrenia is characterized by distortions in thinking, perception, emotions, language, sense of self and behavior. Common experiences include hallucinations (hearing voices or seeing things that are not there) and delusions (fixed, false beliefs).Worldwide, schizophrenia is associated with considerable disability and may affect educational and occupational performance.

People with schizophrenia are 2-3 times more likely to die early than the general population. This is often due to preventable physical diseases, such as cardiovascular disease, metabolic disease and

infections. Stigma, discrimination and violation of human rights of people with schizophrenia is common. Schizophrenia is treatable. Treatment with medicines and psychosocial support is effective. Facilitation of assisted living, supported housing and supported employment are effective management strategies for people with schizophrenia.

MAGNITUDE AND IMPACT

Schizophrenia affects 20 million people worldwide but is not as common as many other mental disorders. Schizophrenia also commonly starts earlier among men.

Schizophrenia is associated with considerable disability and may affect educational and occupational performanc

SYMPTOMS

Schizophrenia is a psychosis, a type of mental illness characterized by distortions in thinking, perception, emotions, language, sense of self and behavior. Common experiences include:

- hallucination: hearing, seeing or feeling things that are not there;
- delusion: fixed false beliefs or suspicions not shared by others in the person's culture and that are firmly held even when there is evidence to the contrary;
- abnormal behavior: disorganized behavior such as wandering aimlessly, mumbling or laughing to self, strange appearance, self-neglect or appearing unkempt;
- disorganized speech: incoherent or irrelevant speech; and/or
- disturbances of emotions: marked apathy or disconnect between reported emotion and what is observed such as facial expression or body language.

ETIOLOGY

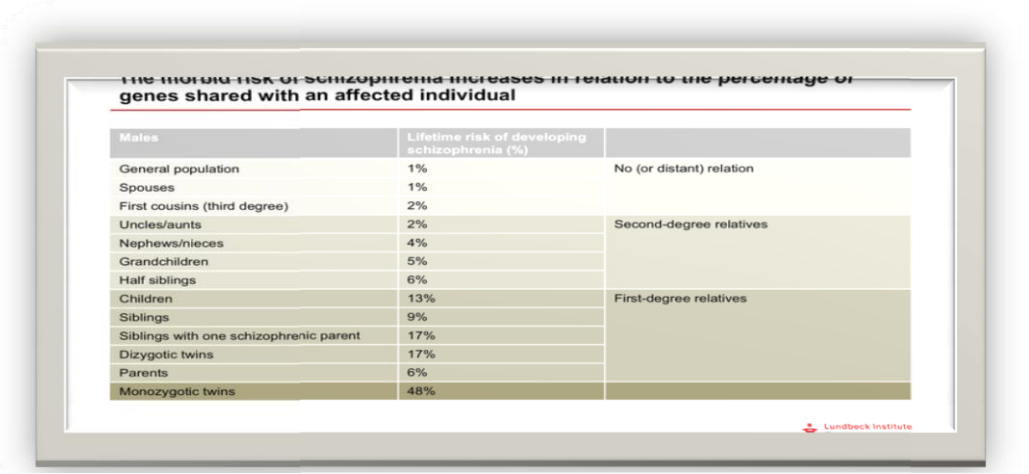
The exact causes of schizophrenia are unknown. Research suggests a combination of physical, genetic, psychological and environmental factors can make a person more likely to develop the condition. Some people may be prone to schizophrenia, and a stressful or emotional life event might trigger a psychotic episode. However, it's not known why some people develop symptoms while othersdo not.

GENETICS

Schizophrenia tends to run in families, but no single gene is thought to be responsible. It's more likely that different combinations of genes make people more vulnerable to the condition. However, having these genes does not necessarily mean you'll develop schizophrenia. Evidence that the disorder is partly inherited comes from studies of twins. Identical twins share the same genes. In identical twins, if a twin develops schizophrenia, the other twin has a 1 in 2 chance of developing it, too. This is true

even if they're raised separately. In non-identical twins, who have different genetic make-ups, when a twin develops schizophrenia, the other only has a 1 in 8 chance of developing the condition. While this is higher than in the general population, where the chance is about 1 in 100, it suggests genes are not the only factor influencing the development of schizophrenia.

Figure 1



BRAIN DEVELOPMENT

Studies of people with schizophrenia have shown there are subtle differences in the structure of their brains. These changes are not seen in everyone with schizophrenia and can occur in people who do not have a mental illness. But they suggest schizophrenia may partly be a disorder of the brain.

Postmortem studies of schizophrenic brains have reported a significant increase in the average number of dopamine receptors in approximately two thirds of the brain studied. Ventricular enlargement is the most consistent finding however sulci enlargement and cerebellar atrophy are also reported,

NEUROTRANSMITTERS

Neurotransmitters are chemicals that carry messages between brain cells. There's a connection between neurotransmitters and schizophrenia because drugs that alter the levels of neurotransmitters in the brain are known to relieve some of the symptoms of schizophrenia. Research suggests schizophrenia may be caused by a change in the level of 2 neurotransmitters: dopamine and serotonin. Some studies indicate an imbalance between the 2 may be the basis of the problem. Others have found a change in the body's sensitivity to the neurotransmitters is part of the cause of schizophrenia.

PREGNANCY AND BIRTH COMPLICATIONS

Research has shown people who develop schizophrenia are more likely to have experienced complications before and during their birth, such as:

- a low birth weight
- premature labor
- a lack of oxygen (asphyxia) during birth

It may be that these things have a subtle effect on brain development.

PSYCHOLOGICAL FACTORS

Poor parent child relationships and dysfunctions family systems like dominant mother andrecessive father, broken family can also cause schizophrenia.

TRIGGERS

Triggers are things that can cause schizophrenia to develop in people who are at risk. These include:

STRESS

The main psychological triggers of schizophrenia are stressful life events, such as:

- bereavement
- losing your job or home
- divorce
- the end of a relationship
- physical, sexual or emotional abuse

These kinds of experiences, although stressful, do not cause schizophrenia. However, they can trigger its development in someone already vulnerable to it.

DRUG ABUSE

Drugs do not directly cause schizophrenia, but studies have shown drug misuse increases the risk of developing schizophrenia or a similar illness. Certain drugs, particularly cannabis, cocaine, LSD or amphetamines, may trigger symptoms of schizophrenia in people who are susceptible. Using amphetamines or cocaine can lead to psychosis, and can cause a relapse in people recovering from an earlier episode. Research has shown that teenagers and young adults who use cannabis regularly are

more likely to develop schizophrenia in later adulthood.

HOW A FAMILY REACT TO A DIAGNOSIS OF SCHIZOPHRENIA

GRIEF AND STIGMA: THE FAMILY'S RESPONSE TO AN OMINOUS DIAGNOSIS

Resolution of grief is also complicated by the stigmatization of mental illness. In one recent study, it was found that half the parents and spouses of recently hospitalized psychiatric patients concealed the hospitalization to some degree. The hospitalization of a female relative was more than twice as likely to be concealed as that of a male relative. Because a diagnosis of mental illness is often concealed from those outside the family unit, it may not attract the same attention and support that anovert source of grief, for example a death, would. This has been termed "disenfranchised grief"

Following structured interviews with thirty families with schizophrenic members, Tessler et al. proposed a model of grieving in families with chronic mental illness. This attempts to include the social context of the family and their interactions with health-care professionals within a bio psychosocial framework. While each stage is not exclusive, nor would all families go through each stage in the order shown, this model offers a means of understanding a family's reaction to the diagnosis of schizophrenia. Conceptualizing the worries and stresses of each stage allows a greater understanding of the family's experience and offers opportunities for therapeutic interventions.

1. REALISE that schizophrenia is not rare. It may seem to be but that's because it's not "talked about". Even within Australia's small population there are about half-a-million people who, like you and me, will face this illness in their immediate family.	8. PAY GREAT ATTENTION to the needs of the other members of the family.
2. LEARN as much as possible, as soon as possible, about schizophrenia: its cause, its course, its outcome.	9. TAKE HEED that unlimited unconditional self-sacrifice on behalf of someone with schizophrenia is fatal to effective caring and coping.
3. NEVER BECOME a moth around the flame of self-blame: it can destroy your chance of coping, FOREVER. It can destroy YOU. Free yourself with the modern knowledge that schizophrenia is NOT caused by the relatives.	10. BE AWARE that spending massive amounts of time with the person who has schizophrenia can make matters worse.
4. SEEK professional helpers who are EFFECTIVE. Identify them by their compassionate natures, informative style, eagerness to have you as their ALLY, and ability to ensure you receive comprehensive education in understanding and coping with schizophrenia.	11. MAINTAIN AND ESTABLISH friendships, activities and hobbies, particularly those that take you outside of the home.
5. CONTACT a self-help group for families with schizophrenia.	12. SET YOUR SIGHTS on maximum appropriate independence for your relative AND FOR YOURSELF.
6. ACCEPT that with an illness as complex as schizophrenia, the promptings of our natural instincts are often an unreliable guide to coping and caring. We, the relatives, DO need training.	13. DON'T BE SURPRISED to discover that in the end, it is the ability to change, to look at things differently, that distinguishes relatives who will cope, from those who will not.
7. GET TO KNOW the origins of the pressures, the ever-increasing pressures, to which we, the relatives are subject to.	14. TAKE very great CARE of yourself.

(Alexander K. Understanding & coping with schizophrenia: 14 principles for the relatives. Melbourne: Wilkinson Books, 1991.)

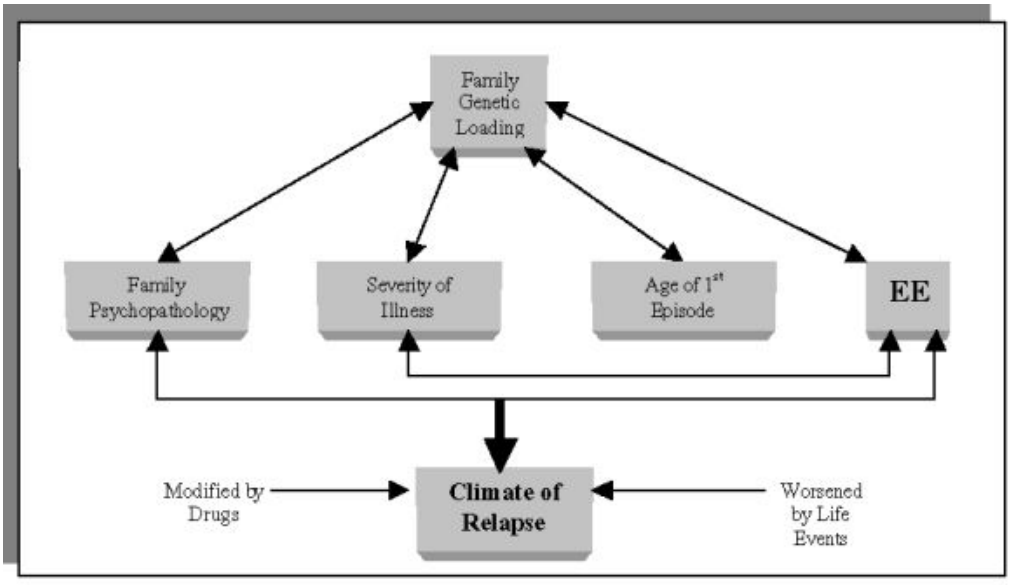
Table: 1 Stages of Grieving. A Model of Family Response to Mental Illness

Expressed Emotion and the Family

Expressed emotion (EE) comprises critical or emotionally over-involved attitudes and behaviours displayed by one or more parents to their schizophrenic offspring. Research into expressed emotion reveals that family dynamics are an important but controversial predictor of relapse of positive symptoms. Important studies by Brown el al. and Vaughn et al. established the detrimental effects of poor neuroleptic medication and high face-to-face contact (over 35 hours per week) on relapse rates in patients living in high-EE families. A recent meta-analysis showed a 48% median relapse rate in a high-EE environment, versus 21% in a low-EE environment

Expressed emotion is associated with the degree of sub-clinical psychopathology in schizophrenic patients. Relatives who score highly on EE assessments tend to listen less effectively and talk more in family interviews. Romney contended in a recent meta-analysis that sub-clinical formal thought disorder is commoner in relatives of schizophrenics. Furthermore first-degree relatives of schizophrenic probands are 15-times more likely to develop psychopathology than controls with schizotypal personality disorder and other non-affective psychoses aggregating in these families.

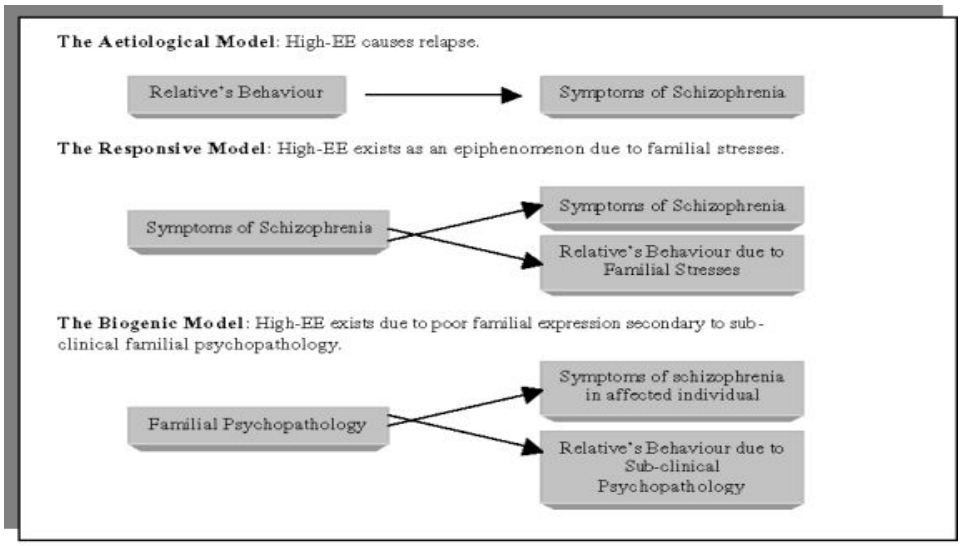
Figure 2



(Eva FJ, Puri BK. Expressed emotion and a hypothetical model of relapse in schizophrenia. *Med Hypotheses* 1994; 45: 99-105.)

While the mechanisms of action and exact significance of high-EE in the course of schizophrenia are unclear, it is clear that families have a role in the course of the illness. Unidirectional models of EE and schizophrenia are probably oversimplifications

Unidirectional Models for the role of high expressed emotion and relapse in schizophrenia



(Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. *Br J Psychiatry* 1992; 160: 601-620.)

Figure 3

Table 2: Stages of Griving. A Model of Family Response to Mental Illness

***Table 2**: Stages of Grieving. A Model of Family Response to Mental Illness*

Stage 1: Initial Awareness	*"We just thought we had a difficult child – we didn't recognise the mental illness."*
Stage 2: Denial	*"When he first got ill, I thought he was on drugs."*
Stage 3: Labelling (At the time of a dramatic crisis which requires more drastic action than calling the family doctor or consulting the school counsellor.)	*"It was when she attacked her father in the car."*
Stage 4: Faith in Mental Health Professionals	*"Yes, we trusted the psychiatrists. If you have a broken leg, you go to the doctor."*
Stage 5: Recurrent Crises	*"When he first got ill, I thought he was on drugs."*
Stage 6: Recognition of Chronicity	*"It's an incurable situation is what we're finding. I still find it hard to accept."*
Stage 7: Loss of Faith in Mental Health Professionals	*"Years ago, we being 'dummy parents' thought the experts knew what they were doing."*
Stage 8: Belief in the Family's Expertise	*"When somebody is in the home with you all the time, you get to know when medication is working and when it isn't."*
Stage 9: Worrying About the Future	*"The future is the biggest question on my mind. My husband is 60 and I'm 59. And we hope to live forever, as long as our son does. Who's going to care about him as much as we do?"*

(Tessler RC, Killian LM, Gubman GD. Stages in family responnet o mental illness: an ideal type. *Psychosoc Rehab J* 1987; 10: 4-16.)

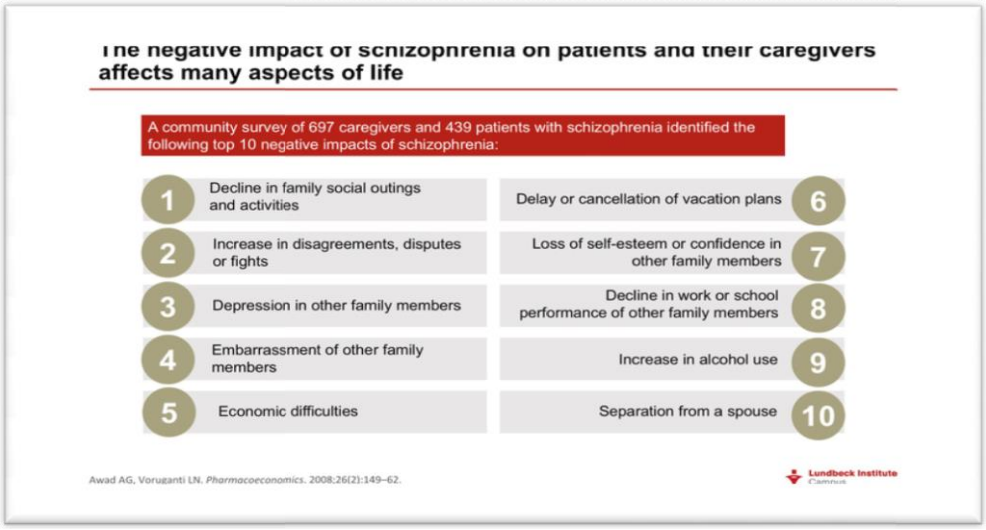
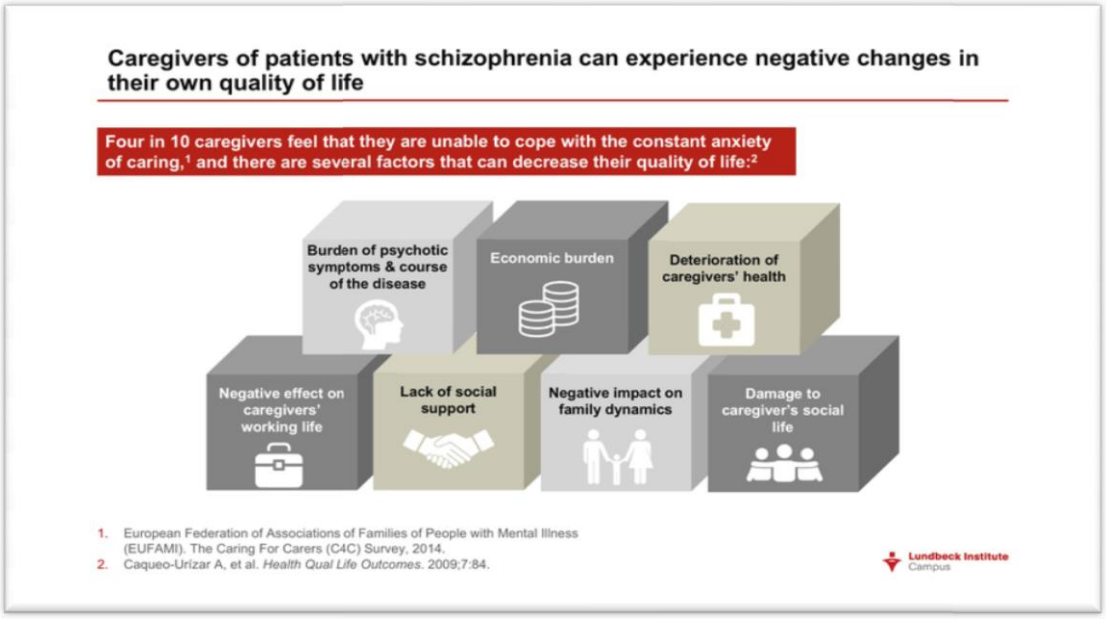


Figure 4

Schizophrenia negatively impacts many different aspects of the lives of both patients and their caregivers (e.g. economic, physical health, social aspects) .A community survey thatincluded 697 caregivers and 439 patients with schizophrenia identified the top 10 negative impacts of schizophrenia in descending order of frequency. Patients and caregivers have varying and at times conflicting perspectives and expectations, which need to be reconciled to achieve balance.(Awad.A.G,Vorugantii.L.N,pharmoeconomics,2008;26(2):149(62))

Figure 5



Decreases in the quality of life of caregivers may be associated with the burden of being acaregiver, lack of social support, course of the disease, and problems with family relationships.

Literature review of 37 studies (1998–2008) that assessed factors associated with the quality of life of caregivers of people with schizophrenia. A systematic search was carried out using the following electronic databases: MEDLINE via PubMed, Web of Science, and PsycINFO. The following keywords were used: “quality of life”, “burden”, “schizophrenia”, “families”, “caregivers”, and a combination of these. Despite differences between countries, studies carried out in different parts of the world show similar outcomes. Evidence suggest that physical, emotional, and economic distress negatively affect caregivers’ QoL as a result of a number of unfulfilled needs, such as restoration of patient functioning in family and social roles, economic burden, and lack of spare time, among other factors. Several studies stated that appearance of psychotic symptoms or the course of the disease produce an important level of burden. Working life was also significantly affected. Caregivers often need to leave their jobs, modify their working hours, or change to another job. Moreover, in some cases, stress seemed to be associated with a triple shift: job, household duties, and patient care. Economic issues produce concern in caregivers because of expenses in different areas, e.g. drug therapy and treatment. There is a difference between developed and developing countries – in countries such as Chile, Nigeria, and India, caregivers expressed more concern in this dimension, likely caused by scarcity of community and health resources.(European Federation of Associations of Families of People with Mental Illness (EUFAMI). The Caring For Carers (C4C) Survey, 2014. , Caqueo-Urízar A et al. Health Qual Life Outcomes. 2009;7:84.)

Involving the Family in Treatment

Close relatives, especially mothers, act as the major carers for patients with schizophrenia. With the movement away from institutionalized care for psychiatric patients, the respite afforded by this care is being replaced by greater contact with families. If a patient is in regular contact with family members, it is reasonable to engage these relatives in the patient’s care. Families both need and want education, coping and communication skills, emotional support and to be treated as collaborators in the management of a relative’s illness.

Models of the etiology of schizophrenia since the 1940’s have included the schizophrenogenic mother, the double bind theory[54] and marital skew and schism. These blame the family for the emergence and prolongation of schizophrenia in a relative. Despite the lack of empirical evidence for such theories, covert blame on the family has often led to a therapeutic misalliance with the physician. This leads to rejection of the therapist and creates an atmosphere of adversity and mistrust with poorer outcomes for the patient.

In response to evidence of the negative impact of high expressed emotion on the course of schizophrenia, family-oriented psychosocial interventions were developed. These view the family as a resource in need of education, training and support rather than as a pathogenic unit. Goals of family therapy include support, family education, the reinforcement of medication compliance and family empowerment. All recently developed family intervention programs begin with basic educational sessions. Subsequent sessions encourage the setting of realistic expectations and encompass cognitive behavioral techniques such as training in stress management and problem-solving skills. These provide family members with both information about schizophrenia and strategies for managing common problems.

Ample evidence exists for the efficacy of family interventions for schizophrenia. Living in a family environment improves clinical and functional recovery following psychosis. In a seminal study by Leff et al., patient care including a family intervention consisting of psycho-education, relatives' support groups and at-home family sessions reduced nine-month relapse rates to 8%, compared with 50% in the group receiving pharmacotherapy and case management alone. Most studies replicate the protective effects of family therapy on relapse versus routine care alone. Family interventions have also been shown to significantly reduce expressed emotion and hospitalization and increase medication compliance.

Involving family members as collaborators in the treatment of a schizophrenic relative is also beneficial for the clinician's management of a case. Issues can be discussed with patients and key relatives in the context of a "family consultation" This is an opportunity to share both the family's observations, which offer a unique insight into the patient's environment and the clinician's specialized knowledge. This consultation should exist without an initial assumption that family relationships are problematic. Family members retain the right to decide on appropriate courses of action and in what way this should be a family responsibility. In this way, appropriate strategies can be devised to encourage patients to participate in programmes of social or vocational rehabilitation, or develop systems of behavioral contracting at home. Cognitive strategies such as fostering appropriate detachment and reducing criticism can also be undertaken in this environment.

FUTURE DIRECTIONS

While it is clear that family intervention is more effective than "routine care" in preventing relapse, no clear advantage has been found for any one format of family intervention. New studies are

required to determine the “critical ingredients” of family interventions. The scope of patient groups and evaluated outcomes should be expanded. Together with further research, advances in therapy should also include funding for provision of increased family services for education, support and day-care.

CONCLUSION

From the introduction, etiology, treatment and future there is an important role played by thefamily in the life of schizophrenic clients, so it is is very essential to take care of their health.

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