

DYNAMIC INTERACTION BETWEEN  
PSYCHOTIC PATIENTS AND THEIR FAMILY MEMBERS

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# DYNAMIC INTERACTION BETWEEN PSYCHOTIC PATIENTS AND THEIR FAMILY MEMBERS<sup>1</sup>

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## **Introduction**

Psychotic illness is a major problem in mental health. The prevalence is one percent (Kaplan & Sadock, 1998), meaning that approximately 2 million Indonesians or 180,000 Australians suffer from this illness. Aside from an enormous financial cost, there is a considerable burden of care for the family and this includes the burden of social stigma and psychological distress. The seriousness of the problem is magnified by the fact that patients need long term care.

The nature of psychotic illness has been studied intensively. At first, the focus of investigation was mainly on biological factors which involved genetic research and studies of brain abnormality. These studies indicate that biological factors establish the vulnerability for developing psychotic illness (Nuechterlein, 1987). Psychosocial factors must be present for this illness to unfold. Similarly, a treatment which is solely biologically oriented does not

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provide good results. A number of studies indicate that a treatment which combines biological and psychosocial approaches lead to a better result (Birchwood & Spencer, 1999)

The significance of the psychosocial factors in the outcome of psychotic illness is demonstrated by the WHO outcome studies (Hopper, in press). There have been three cross nation research projects coordinated by the WHO that is the IPSS (International Pilot Study of Schizophrenia), the DOSMed (Determinant of Outcome of Severe Mental Disorder), and the ISoS (International Study of Schizophrenia). These studies are designed to compare samples from developed and developing countries. The developed countries were represented by samples from Denmark, UK, Russia, Czechoslovakia and the USA, while the developing countries were represented by Nigeria, Columbia, India and China. The findings are shown in the following table.

Table 1  
WHO Outcome Studies  
Percentages “Best” vs “Worst”  
In Developed and Developing Countries

Study / Follow up / Diagnostic	Developed Countries	Developing Countries
IPSS (1967 - ) 2 Yr. 5 Yr	35 vs. 33 23 vs. 24	52 vs. 19 38 vs. 14
DOSMed (1976 - ) 2 Yr All Ss ICD-9 Sz	33 vs. 17 32 vs. 19	49 vs. 11 49 vs. 13
ISoS 15 Yr. F-U ICD-10 Sz ICD-9 Sz All psychosis	37 vs. 38 40 vs. 33 45 vs. 30	53 vs. 27 58 vs. 23 58 vs. 22

Source: Hopper, In press

The above table shows that the percentage of best outcomes of psychotic illness in developed countries are lower than in developing countries, while the worst outcomes are higher in developed countries than in developing countries. In other words, the course and outcome of psychotic illness are better in developing countries than in developed countries. This result is remarkably consistent across the three studies for brief and long-term follow-up period and for various diagnostic groupings (ICD-9, ICD-10 or all psychosis).

Several hypotheses have been proposed to explain this surprising finding which include cultural interpretations of mental illness, family factors, the availability of meaningful work, the characteristics of mental health systems, socio-environmental factors and characteristics of the illness itself (Desjarlais et al., 1995). Most of these hypotheses are concerned with psychosocial factors. Thus, the WHO studies suggest the need to understand the psychosocial aspects of psychotic illness in developing countries. This paper discusses the interaction between psychotic patients and their families

## **Family Study of Psychosis**

The family has received a serious attention from scientists investigating psychosocial aspects of psychotic illness. There appear to be two category of approaches of family studies of psychotic illness, divided in terms of the direction of putative causal influence. The first approach is concerned with the influence of the family on psychotic illness (“F → P”), while the second approach focuses on the influence of patients’ illness on the family (“F ← P”).

## **The Influence of the family on the patient (F→P approach).**

The early studies of psychosocial aspect of family can be traced back in the 1930s in which focused of the research was primarily on the role of parents, especially mothers, in the development of schizophrenia (Parker, 1982). These studies reached its peak in the formulation of the theory of schizophrenogenic mother. While the schizophrenogenic mother focuses on individual member of the family. While this early theory paid more attention to the role of a single family member in the development of psychotic illness, the subsequent theories developed later such as double bind theory, family skew/schism, and communication deviance, focus on the family as a whole unit with special attention given to the interaction and communication of the family.

### *Studies on parental characteristics of schizophrenia*

The first clinical study of parental characteristic of schizophrenia was reported by Kasanin *et al.* (cited by Parker, 1986). From the study of the childhood history of 45 schizophrenic patients, they found that there was evidence of maternal rejection of two patients and maternal overprotection of 33 patients. Despite methodological weakness, numerous subsequent supported a parental pattern of family with a schizophrenic patient. This families were characterized by a dominant, overprotective but basically rejecting mother and a passive and ineffectual father (see Parker, 1986).

Based on the studies of parental characteristics of schizophrenia and psychoanalytic thoughts, in 1948 Fromm-Reichmann formulated a well-known theory of *schizophrenogenic mother*. According to this theory, the origins of the schizophrenic reaction pattern lay in a contradictory pattern of relations with the mother. On the one hand

these mothers were perceived as cold, distant, lacking in warmth and affection, and thereby expressing rejection; on the other hand they were also domineering and seen as overprotective. Following this model, Cheek (1968) investigated the characteristics of the fathers of patients suffering from psychotic illness. He found that in a schizophrenic family, the role of the father tended to be passive and peripheral, but on occasions, harsh and dominant

The studies of the characteristics of schizophrenic parents have been criticized as lacking empirical evidence (Hatfield, 1987b). However, they played a role in pioneering family interaction theory which shifted the focus from investigating an individual family member to studying the family as a whole unit. Concepts related to social structure, such as family structure, role, norm, value, interaction and communication, were also introduced.

#### *Studies on family communication*

Bateson (1972) focused his attention on the interpersonal communication patterns within the family. Based on his observation of what was being said by family members and how it was being expressed, he proposed a *double bind* hypothesis. According to this theory a schizophrenic patients repeatedly receives either verbal contradictory messages, or a contradiction between verbal and nonverbal communication.

Similar to Bateson, Wynne *et al.* (1965) also concerned the communication and interaction within a family, focusing on a *pseudo mutuality* relationship. This term was used to described the bonhémie often displayed by families in public situations to mask the underlying conflicts. Wynne argued that disordered communication is the core problem of

families with mentally ill relatives. In these families communication and interaction are disjointed, fragmented, and blurred. The schizophrenic behavior, they proposed, is the result of internalization process of family's system.

The structure of family was the concern of Lidz' theory of *marital schism* and *skew* (Lidz *et al*, 1965). He observed that in families exhibiting marital schism and skew structure, both the parents are in open conflict and compete for the loyalty of the child. The family is in chronic discord and disequilibrium. Lidz argued that the children become caught in the middle of this pathological family structure. In this view, any attempt to please one parent was viewed as a rejection by the other.

Unlike the theory of the schizophrenogenic mother which was based on clinical experiences, the theories of family interaction, structure and communication derived from natural observation, intensive case studies and family therapy sessions. However, they shared a psychoanalytic interpretation (Hatfield, 1987). More objective studies were developed by Mishler & Waxler (1975) and their colleagues by employing an experimental method to study family interaction processes.

#### *Study on Expressed Emotion*

The investigation of the family as a whole interacting unit is a better way of determining the psycho-social aspect of psychotic illness, compared to the study of individual family member. Leff & Vaughn (1978) made another important contribution when they explored the emotional dimension of communication and interaction in their theory on Expressed Emotion (EE). According these authors, there are five types of emotion within families that are directed toward patients. They included in positive

emotions of warmth and positive remarks, as well as negative emotions such as critical comments, hostility, and emotional over-involvement,

The main difference between earlier studies of family environment of schizophrenia and EE research is that the latter body of studies did *not* propose that family emotion was a factor that caused schizophrenia. However, a large number of studies indicated that EE had a significant influence on the course of the illness (Butzlaff & Hooley, 1998; Wearden *et al.*, 2000). This suggests that discharged patients returning to live to a family with high EE score are more likely to relapse compared to those who return to a low EE family.

The EE concept and its measurement have been the subject of a great deal of scholarly research. It is among the most widely investigated psychosocial constructs in psychiatry (Jenkins & Karno, 1992) and the most importance contributor to the development of a new body of knowledge within the psychosocial study of psychotic illness (Barrett, 1996). Increasing numbers of investigations have explored many aspects of EE and its application in other area of health care research (Wearden, *et al.*, 2000) Despite considerable debate concerning the meaning and measurement of EE in different cultures, the EE concept and its measurement have been adopted in many different countries (Hashemi & Cochrane, 1999) A family intervention program has also been developed as part of a comprehensive therapy for schizophrenia, in which the family is trained to lower the EE score.

### **The Influence of the patient and his or her illness on the family (F ← P)**

There is no doubt that the theories in the first category have made significant contributions both to our understanding of the nature of psychotic illness and to the

providing of a better treatment for patients. However, in these studies the family is treated as an “object” that causes and influences the course of psychotic illness. The responses of family members as human beings and their burden of care are ignored. These studies have also been criticized as blaming the family which in turn put a further psychological burden on the family (Hatfield, 1987). This criticism has stimulated the emergence of a new direction of studies which focuses on the impact of patients’ illness on the family life. This new body of research increased sharply after the deinstitutionalization policy was imposed which led to the responsibility of care being given to the family (Hatfield, 1987).

Many facets of family responses have been studied intensively including cognitive, behavioral, and emotional responses (Kreisman & Joy, 1974; Leafley, 1987). The cognitive responses embrace the family interpretation of illness (Guarnacia, 1984) and meaning seeking (Terkelson, 1987b; Yarrow *et al.*, 1967). The behavioral responses include care seeking behavior and the use of mental health care resources (Holden & Lewin, 1982). Emotional responses include family burden and distress (McElroy 1987). It has been reported that the level of stress among family members of the mentally ill are invariably high. They live in a constant tension, worry, fear and anger. Therefore family members often use many kinds of resources to cope with and adapt to such difficulties (Hatfield & Leafley 1987; Scazufca & Kuipers, 1999). Apart from emotional burden, the family also experience economic burden as result of long-term medication and disability (Knapp *et al.*, 1999). Social stigma related to biological inheritance is another burden (Flynn, 1987). Several studies also explore the family difficulty in interacting with mental

health care provider (Holden & Lewin, 1982), including the burden of participating in family therapy (Hatfield, 1987).

## **Cross cultural family studies of psychotic illness**

Most of the studies on the influence of family on psychotic patients and their illness were conducted in Western countries, in contrast the EE studies have been studied across several cultures (Jenkin & Karno, 1992; Hashemi & Cochrane, 1999). Similarly, there have been a large number studies on family care and response to psychotic illness cross culturally.

Rungreangkulkij (2001) found that Thai mothers interpret the illness as caused by *karma*, a Buddhist belief that one's life was determined by his/her past life. In response to the illness Thai mothers practice *thum-jai* i.e. "...a combination of being accepting, patient and understanding, reasonable and having a sense of obligation" (ibid). Similarly Jenkins *et al* (1986) found that Mexican American families tend to accept schizophrenia as a legitimate illness, therefore they have a high willingness to tolerate deviant behavior, and a strong social economic support networks available to family members allow the sharing and the buffering of the problem. A multicultural study of caregivers' attitude in North America has been conducted by Guarnacia (1998). This study found that African American families showed more involvement and used culturally based resources more often, whereas European American families are more likely to seek help from mental health professionals. Interestingly, European American families have been reported to suffer a greater burden than African American parents (Howirtz *et al.*, 1995)

## **Conclusion**

The history of mental health care system records the new movement characterized by moving patients out of the confined hospital. Starting in 1950's, this movement swings the pendulum into a different direction. In the past, in the asylum era, it was believed that the best treatment for mentally ill patients was in an institution located in a calm, peace, natural rural setting. The value is now reversed. Both mental health scholars and mental health providers believe that the best treatment for the patients is in the community, their real own natural setting. In this situation, the role of family is vital as the primary caregiver. In this paper I demonstrate that there is a dynamic interaction between psychotic patients and their family members. A number of studies indicated that family condition influenced patients course of illness. On the contrary, patients illness influenced family everyday life we will be able to identify the need of each parties for the best interventioan programs.

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