

DEPRESSION IN THE FAMILIES OF PATIENTS WITH PSYCHOSIS

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SUMMARY

Psychosis brings burden to the families of patients with psychosis. The Zung rating scale for depression has been used to evaluate depressive symptoms in the relatives of patients with psychosis that have been attending the 'Group with a significant other' for the last five years. When we sent the Zung rating scale for depression to the families of the schizophrenic patients' (which are or were part of the 'Group with a significant other' in the last five years), the results showed 2/3 of the patients had already become depressed due to the illness' effects. This is a much more common phenomena here than in the entire population. Cooperation within the Group has positive effects, such as reducing isolation and stigmatization, while it also works encouragingly on the emotional climate – this is very important for reducing depression.

Key words: family – schizophrenia – depression - therapeutic factors of the group

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Illness in the family

The family is a social system, composed of people with mutual goals and a strong connection to each other. For most people, the family is the main source of both help and burden. Family affects the health of every individual and vice versa.

Every chronic or acute illness is for both the individual and his/her family an event of crisis, which it usually more or less successfully adapts to. The fact is that the family provides inappropriately larger amounts of help to the ill relative compared to healthcare, social and other help institutions. The family is also usually the last to stop caring for the patient.

Symptoms are expressed when there is no help and I'm alone in everything. They are also expressed because of the condition's length when it wanders into a psychotic, acute state, despite taking pills regularly. Eventually we'd become almost completely alone. He doesn't keep his relationships or even breaks them, there are few new ones. He is still at the "rehabilitation unit", I fear he will not receive work/he is not capable of working? (evaluation 2007)

An individual's experience of mental disorders is traumatic for his/her family members. Everyone experiences the same things as the individual. And the family frequently does not know how to react.

A crisis can increase the responsibility of family members and lead to quick changes. Feelings relating to the ill member of the family can differ from positive to negative. Compassion, understanding, confusion over the relatives behavior, powerlessness, tension, feelings of guilt and shame are frequent ones. The result of changed relationships can either bring the family together or cause its downfall.

The families of mentally ill patients have to confront the disturbances in family life, repetitive crises, the disturbances' persistence and sometimes even the loss of trust in the healthcare system.

When the patients of a psychiatric clinic leave the hospital, they do not receive sufficient help from centers that are specifically designed to help facilitate their lives and the lives of their families.

There is no programme that is truly well-designed for people's rehabilitation. I'm the best programme that my husband can get when he returns from the hospital. Not everyone is lucky enough to have a programme such as myself. I need a consultant to ease my burden – dr. Marušič is the best. (evaluation 2007)

A mental illness frequently brings these feelings into the patient's family:

- guilt;
- sadness;

- anger;
- disadvantage;
- injustice;
- powerlessness.

Lamb (1979) writes in his article *Empathy and advice: Counseling families of mentally ill*: "For the parents whose mentally ill child has returned from the hospital after treatment, this is a more than obvious hit. This is the greatest twist of their lives and the lives of the other family members." Kreisman, Simmons and Joy have discovered in their study (1979) that families are much less satisfied with a released patient than those of a comparison group. The difference was so great that they classified them as endangered families. Anger, disappointment and loss of hope are, in their opinion, not only a consequence of concern over the patient, but are also in greatly aware of the fact of knowing that the disorder might worsen. Similarly, Doll (1976) claims: "Family members have an almost constant feeling of hopelessness and entrapment." The families of his research were afraid that this state would never end. Thompson, Doll and Lefton (1977) have discovered that the disorder is especially strong when the patient's close one has no one with whom he could share the responsibility. Hatfield (1983) has reached a conclusion in his research that these families live in constant tension and are constantly on guard. Eating and sleeping disorders occur. The families are disappointed because they are incapable of motivating their ill family members into greater care for personal care, hygiene, money and cooperation when it comes to treatment. This manifests as increasing tension in the marriage, a feeling that their children are neglected and a shrinking of social life.

So long as I believed that I could help my daughter with my activeness and helpfulness, I've stressed myself about it and because I received a negative reaction I've realized that I need to live and accept that she is as she is and that only she can help herself. If she succeeds otherwise, she will as she will without me. However, I will probably always subconsciously carry my worries with me, and that will stress and burden me and affect my health negatively. (evaluation 2007)

In the Ljubljana University Psychiatric Hospital a study has been performed in the year 2000 (Osterman F, Dernovšek MZ et al., 2000) about methods of confronting the illness within

families of the person with psychosis. Among other things it has been discovered that most of the problems of communication occur in families where contact with the patient is frequent. The greater the amounts of positive symptoms, the lesser the relative's social interests became. The relatives' resignation was proportional to the patients' education.

Škerbinek in Kogovšek (1998) have evaluated a long term 'Group with a significant other', and found that two thirds of relatives are very worried about the illness. Blinc – Pesek and Kogovšek (2004) found that in the Group of parents of young patients with psychosis 2/3 of mothers and 1/2 of fathers very worried about the illness. The themes of discourse in both groups show great social isolation, diminished interests and feelings of being rejected by other people sometimes even health professionals. Relatives often complain of not feeling well, difficulties in performing everyday tasks, etc.

Thank you for accepting me in the group. It is of great help. Sometimes I feel like a patient myself. (Evaluation 2007)

My feeling is that the group would be more beneficial if we had a more active leader, the themes for the next meeting should be chosen in advance. Each group member could think about the next theme in this may prevent being lost in depression.

Now the group more or less passively listens to the experiences of the patients, their complaining about destiny. They should be actively included in the debate with general themes like friendship, telling lies, education, love..., which would have beneficial effects on their well being. It would be interesting to have expert's lecture from time to time. (Evaluation 2007)

All the cited reports recognize many depressive symptoms in relatives of patients with schizophrenia. Our clinical experience confirms this finding. Some relatives seek help, most need to be encouraged to do so, mostly because of their belief that they cannot be helped.

In our latest evaluation of our 'Group with a significant other' special attention was paid to the depressive symptoms in the relatives. Zung's self rating scale of depressive symptoms was sent to them as part of an anonymous questionnaire. As many as two thirds answered that they had been depressed at the time of the disease onset in their

relatives with psychosis. The capacity for feeling pleasure has been greatly diminished. Sexual activity is often not perceived as pleasurable; they often feel their lives are empty. Physical symptoms of depression like weight loss are rare. They feel that they are not being useful.

The biggest depression comes when everything falls apart, when the loved one is away or when there is a relapse and you can't help and there is no one to give advice. If you need advice you have to pay for it and this is a vicious circle. Psychiatrists don't pay enough attention to the core problems in the families. They are like glass shoes somewhere far away only for the patients to use and not the relatives that face problems not knowing their nature. (Evaluation 2007)

When my relative's disease got worse I felt depressed. There are different phases. (Evaluation 2007)

Signs of disease appear before they get treatment. (Evaluation 2007)

Depression, crying, hopelessness, no optimism –they sometimes come. (Evaluation 2007)

Every group member answered that the group helps them a lot in overcoming depression. They often say that the group is the only place where they can openly talk about their problems and they can see that they are not alone. They say that one of the main benefits is that they don't feel guilty any more and that they get useful advice how to live with psychosis in their families.

You helped me get through some difficult times and gave me hope for the rehabilitation of my daughter; you may not even know how much you have helped her. Your friendly approach towards the patient is most important, so keep on.... (Evaluation 2007)

The group offers a possibility to:

- *get an expert consultation,*
 - *save what can be saved,*
 - *learn to use humor to help oneself.*
- (Evaluation 2007)*

The group helps:

- reduce isolation;
- reduce stigma;
- improve the emotional climate;

- improve the communication between the family members.

The first three are much related to depression.

Isolation starts diminishing at the beginning of group therapy in spite of the group being an unnatural way of socializing. Members start spontaneously socializing even outside the group. Social functioning improves partly because of new patterns of interactions that are introduced in the group.

There is a lot of stigma in the families of patients with psychosis. Exchange of experience is important for the reduction of stigma. When there is enough safety in the group, the members start talking about shame, guilt, fear, etc. They are often blamed and called responsible for the psychotic illness in their relatives. Many families with an ill member have experienced not being accepted in their social environment. It is important that the group offers acceptance which leads to a better self-image.

Overprotectiveness is common and has adverse effects on the emotional climate. Boundary problems are very common. Patients in the group are encouraged to take more responsibility than at home or in hospital. By doing so they help their family members to become less worried and overprotective. There are specific techniques in group family therapy that deal with overinvolvement. Relatives often openly criticize overprotectiveness and rejection behaviour in other families. Other group members usually take such comments with understanding. There is some pressure on the families, but there are always some members that support the family with great sensitivity. Members that are involved in dysfunctional relationships with their relatives are often sensitive and supportive to other patients. Interpreting this helps develop better relationships within the families.

Conclusion

We are aware that all families do not benefit from our family treatment in the same degree. The fact that all evaluated family members that reported being depressed during their family member's illness answered that group therapy helped them is promising. One of our previous evaluations proved that feelings of guilt in relatives of patients with psychosis diminish with the length of group treatment.

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