

FAMILY INTERVENTION AND SUPPORT IN SCHIZOPHRENIA

*A Manual on Family Intervention For
The Mental Health Professional*

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CHAPTER I

INTRODUCTION

Who should use the manual?

This manual is to be used by persons with a Post-graduate degree and training in the area of mental health such as:

Counseling
Psychology
Social Work

Psychiatry
Psychosocial Rehabilitation
Nursing

1. They should preferably have some prior **experience in counseling and interviewing** families of and persons with mental disorders.
2. They should preferably have attended **training workshops** to learn the required techniques and skill.
3. They must **know the contents** of this manual thoroughly before beginning any intervention.

In which settings should it be used?

They should be working in a Psychiatric setting with Out-patient and/ or In-patient facilities, such as:

Hospitals
Medical colleges
Rehabilitation centers

Mental hospitals
Nursing homes
Counseling centers

How does one use the manual?

1. The manual consists of **eleven** chapters.
2. **Chapters II** describes the *basic theoretical knowledge* required by the intervention worker for conducting family interventions
3. **Chapter III** describes the *skills and techniques* that the intervention worker must acquire in order to successfully do the intervention.
4. **Chapters IV to IX** describes the *contents of the family intervention sessions*. The chapters consist of guidelines that the intervention worker must know before conducting a session as well as the content to be covered within the session.

5. **Chapter X** addresses certain relevant issues for the intervention worker. These will help the intervention worker to work more effectively under stress.
6. **Chapter XI** describes the application of the family intervention through *case vignettes*.
7. **Chapter XII** describes the *outline* of the intervention- the preferred order of conducting the sessions.
8. **Modules I-VI** are each a brief summary of the chapters IV to IX. They are to be used during the session. The intervention worker should however, be familiar with the content of the respective chapters when using it.
9. The **Bibliography** consists of the *publications* that the intervention worker should read before beginning the interventions
10. **Appendix I** consists of the *Psychoeducation Booklet*, the contents of which the intervention worker must be familiar with before covering the Psychoeducation Module (Module II).
11. **Appendix II** consists of the *Session Recording Form*. After each session, the intervention worker must record its details in the first page. The second page (*Helpful Aspects of Therapy*) is to be recorded by the family after each session. The intervention worker may record the verbatim answers of the family if they are illiterate or unable to record the details.
12. The Sessions Recording Forms should be reviewed before the next session to retain the continuity of the sessions.
13. The chapters in this manual are arranged in the preferred order of conducting the sessions. However, this may not always be practically possible. The intervention worker should be familiar with the content of all the sessions and be prepared for such circumstances.

The format of the intervention can vary from providing information to individual family members to a group of family members of one or more affected members, from structured to unstructured (when the family member visits during a crisis) and with/ without the use of audiovisual aids.

CHAPTER II

MANAGEMENT OF SCHIZOPHRENIA

Management of Schizophrenia

Schizophrenia is one of the more persistent and disabling mental illnesses that an individual can suffer from. It is generally accepted that a certain defect in the brain – chemical or structural, or both – causes a **predisposition** to schizophrenia, which may then be brought on by external causes such as stress or emotional upheaval. The illness is not inherited but rather the tendency to get it can be inherited. Scientists generally agree that schizophrenia is a group of conditions rather than one simple disease. A cure for it is to be discovered.

Although a cure has not yet been found, it may be successfully treated. A number of people suffer from only one episode and never have further episodes. However, many will have periods when the symptoms return-these are called **relapses**. A few will have symptoms all the time. For most, it is a life long illness. Thus, about 25% of diagnosed schizophrenics **recover fully**, another 50% make a **partial recovery** and in 25% of cases, those affected require **long term care** for their persistent and severe symptoms.

Neuroleptic drugs (pharmaceutical compounds which affect the chemicals in the brain) are the main form of treatment. They work on several levels. They can have an immediate *calming effect, reducing anxiety, agitation and restlessness* in the affected member with symptoms of schizophrenia. It generally takes up to **four weeks** for the medications to help reduce what are called the positive symptoms of schizophrenia, that is the hallucinations, delusions and thought disorders.

Over the long term, the medications reduce the risk of relapse. Most of the drugs presently available are not as effective for the “negative” symptoms such as loss of motivation, withdrawal from relationships, lack of interest in people and activities and lack of observable emotional responsiveness. In some cases, these medications can deaden sensation, so that they seem to make the symptoms worse.

Living with a person with schizophrenia is extremely difficult. They may behave oddly, talk to themselves, spend all day lying in bed and take a long time to get things done. Changes in routine can make them feel unsettled or having to face an examination can bring about another episode. Since things happening around them more easily upset persons with schizophrenia, the home atmosphere and the way daily problems are handled are equally important.

Schizophrenia should not be treated with neuroleptic drugs alone, but also in conjunction with family interventions.

What are Family Interventions?

In family interventions, a mental health professional provides support and understanding of the illness for the affected individual and family members. They work together on planning treatment, provide mutual support and understanding of the disease. Family intervention gives the family insight into the symptoms that warn of an impending acute episode so that medication may be adjusted with the aim of averting a relapse. Family interventions also help the family to cope with a chronically mentally ill member as well as reduce the burden faced by the families.

Why involve the family?

There are a number of reasons for this:

1. Family members and relatives are the main **caretakers** of a mentally ill member. They supervise the medication intake, and provide emotional, social and financial support for the affected member.
2. When a family member is first affected by Schizophrenia, the relatives usually do not know what is wrong. They notice the odd behaviours and may consider it a passing phase. They may attribute it to addiction or other explanations and do not consider the possibility of an illness. Watching a family member develop these behaviours can be upsetting. They will have **fears and anxieties** about the causes of these behaviours and the affected member's future.
3. The family may want to help in the treatment of the individual but may not know how to do so and may feel helpless. The family may not have knowledge about schizophrenia or know the importance of complying with **medication**.
4. They may feel that they are responsible in some way for the causation of these behaviours and thus feel **guilty**.
5. They may feel they are being **blamed** for the affected member's problems. They can become defensive about their role in the affected member's treatment.
6. The presence of an affected member changes the routine family life. The family members will have extra household chores, as the affected member is unable to contribute. Trying to keep the family life as normal as possible while simultaneously trying to help the affected member is **frustrating**.
7. The family may find the affected member's behaviour embarrassing and painful. They may avoid their normal socialization with others due to the **stigma** of having a mentally ill member.
8. The affected member, while symptomatic, may become **violent** and be perceived as dangerous by the family.
9. They may feel **angry** with the affected member especially when they feel that the affected member is 'lazy' or not trying to control their behaviours.

10. Families may experience severe **stress**, or marital discord or depression associated with living with this illness unless they receive help and support.
11. The probability of the affected member relapsing is greater when the family's behaviour with them tends to be over-involved, hostile, critical and dissatisfied (the components of **expressed emotions**).
12. Although the family does not "cause" schizophrenia, the way they interact with the affected member and cope with the illness can determine the '**course**' of the illness.
13. Family members become more involved or preoccupied with the affected member and each other than with non-related friends or neighbours and tend to withdraw from them. This increases the family isolation. They have fewer people to turn to for emotional or practical support (**social support**). The advantages of having social contacts are that they:
 - a) Can be useful as temporary distractions from experiencing the pain of having a schizophrenic member.
 - b) They provide general support and recreation to help the family members relieve their tensions.
 - c) Prevents the family member from focussing and spending too much energy on the affected member, and
 - d) Provide support in times of crisis.
14. Due to the illness, the family experiences **burden**. This can be of two types:
 - a) **Objective burden**: such as *economic drain (medication and hospitalizations), sleep disruption, interference's with daily routine, disruption of relatives' leisure time and career, tension from fear of unpredictable behaviour, difficulties in communicating with the affected member, strained family relationships and reduced social supports.*
 - b) What the illness means to the family constitutes **subjective burden**. This includes a *sense of defeat, feelings of guilt, inadequacy, helplessness, confusion, anger, disappointment and depression* following the realization that the affected member is no longer what they had hoped. This influences the way the family interacts with the affected member.

How effective are Family Interventions?

Family interventions designed to reduce the risk of relapse developed as a result of the burden experienced by the family members after hospitalization. Despite variations in the format, four clinical trials (Falloon et al, 1982, Hogarty et al, 1986 Goldstein, 1978, and Leff, 1982), revealed a substantial reduction in relapse rates for the family based intervention in comparison either to regular drug treatment or with drug plus individual therapy. Because of the clear relationship between expressed emotion and relapse (Kuipers and Bebbington, 1988), most interventions concentrate on diminishing the level of expressed emotion through education, training and therapy.

Effectiveness studies of these interventions have demonstrated a strong effect in preventing relapse consistently (Lam, 1991).

What does Family Intervention involve?

You will be seeing the family and the affected member when the affected member has been hospitalized and/ or on an Out Patient (OP) basis. They may be at any one of the following stages:

- a) When the affected member is **acutely symptomatic** and the family has been informed of a diagnosis of schizophrenia. This could be the first episode of the illness or when the affected member has had a relapse.
- b) When the affected member is in the **recovering phase**-the affected member is no longer acutely symptomatic.
- c) During follow-ups when the affected member is **maintaining well** on treatment.

As the families that you meet may be in different phases of the illness, they may have different **needs** and expectations. They will come from different backgrounds and will have already consulted other professionals. The needs of the family per se will differ from that of the affected member's.

Some of the needs of the families may be:

1. To understand the nature of the illness
2. How to cope with the psychiatric symptoms
3. How to manage medication
4. Assistance during times of crisis.
5. To get links to community service

The needs of the affected members are associated with their disabilities. Persons with schizophrenia differ in their disabilities. A **disability** is defined as, any restriction in the ability to perform an activity in a manner or within the range considered normal for that affected member. The areas of psychiatric disability that the person may present with are:

1. Personal disability:

- a.) Problems with self-care and inadequate functioning in tasks of daily living: The affected member may need supervision in the following areas: washing, shaving, bathing, changing clothes, toilet habits, and eating habits.
- b.) Low levels of activity: the affected member may sit doing nothing at all or spend time lying in bed awake. They may have to be helped in doing simple tasks.
- c.) Slowness in performing activities: The affected member may take a long time to do routines like washing their face. They may not complete a task, which they have started.

2. **Social functioning:**

- a.) Social withdrawal: the affected member may prefer to stay alone, and/ or may not talk to guests. They may prefer to leave the room when people sit there. They may refuse to attend social functions.
- b.) Lack of interest in what is happening in the world around them: The affected member may stop reading newspapers, watching TV, etc. They may lose interest in local, national and international events.

3. **Occupational functioning:**

- a.) Failure to take up an income generating activity: The affected member may show no interest in getting a job. They may refuse to work even when jobs are offered.
- b.) Failure to function adequately in an income generating activity: The affected member may not attend work regularly. They may be frequently absent, late or may complain about work. When they work, they may not do it well.
- c.) Failure to function adequately in household and domestic activities: The affected member may not do the household work as adequately as before the illness.

4. **Disability in the family role:**

- a.) Has difficulties participating in family activities: The affected member may stop participating in family activities such as eating together, conversing with each other. They may not contribute to family discussions or decisions on financial matters, purchasing things, etc.
- b.) Has difficulties playing the role of a spouse: The affected member may stop talking to their spouses about their day to day affairs. They may not ask about their spouse's needs and difficulties. They may not show affection. The spouses may find it difficult to share problems and difficulties with them.
- c.) Has difficulties playing the role of a parent: The affected member may not show interest in children's education. They may stop doing activities like playing, feeding and dressing them.

How to do Family Interventions?

1. Before approaching the affected member and the family, you should know some details about the affected member's illness. Reading the person's **case file** or by speaking to members of the treating team will help. See the affected member and the family only after the medication has been prescribed.
2. It would be preferable to see the family privately in a separate room. If this is not possible, speak to the family in a place where you will be segregated from others and where there will be **minimum interference and distractions**.

3. As an Intervention Worker, you will be seeing the family and the affected member together over a number of sessions. The duration of each should be not more than **45 minutes**.
4. The frequency of these sessions should be about **once**, spread over 6 weeks. If the affected member is an in-patient, then you may be able to see them more frequently until their discharge.
5. During engagement, families often provide the information that you may have intended to assess in later sessions. Use this information as starting points for obtaining further details, or for discussion in your sessions. If the information provided is sufficient, do not ask questions that elicit the same information again.
6. Some families tend to introduce new or old issues towards the end of the session. Reassure them that it is not possible to address all issues in one session and that you will discuss them in forthcoming sessions. You should wind up the session by summarizing all that had been discussed in the session and what the family plans to do between sessions.
7. Focus on the **family's behaviour between sessions**. This will help you to assess whether the family is applying what has been discussed in the sessions. It may also reveal areas that will need focus in future sessions.
8. Across your sessions, try to maintain the **continuity** in the topics and areas that you are discussing with the family. Show the relationship between the skills that you are training them in and their problem areas. Link them such that the family is able to see the inter-relationships between for example, handling communication and emotions, managing difficult problems and their difficulties.

Overview of Family Intervention

- a.) Initially you will need to **assess** the family to understand their knowledge of the illness, their needs, the approaches they have adopted to solve their problems, the effect of the illness on the affected member's functioning, etc. These will influence the content/ focus of your future sessions. You can also assess the family to determine how the family functions-the roles, burdens perceived by them, etc.
- b.) You will need to educate the family (**Psychoeducation**) about the symptoms of the illness. Following which, you will need to clarify the details of the treatment (neuroleptic drugs) and answer their doubts regarding them. The family will have to be educated on the causes of schizophrenia. Some families may need to be taught how to detect signs of a relapse and what to do in such situations.
- c.) Assist the family in identifying their maladaptive coping responses to the affected member's illness, which hinder the affected member's improvement. You will assist them to acquire better coping responses (**Basic Interventions**).
- d.) The affected member and the family will face a number of difficulties in coping with the illness. Guide them on how to approach these issues and solve them as a family. Jointly identify areas

of discord, assist and guide them (**Assessment and Management of Difficult Problems**) to discuss and choose the most appropriate alternative. You may also need to assist them to revise decisions that are not beneficial.

- e.) The communication patterns within a family change when there is a mentally ill member. As mentioned earlier, the presence of “expressed emotions” may adversely interfere with the affected member’s improvement. Identify these patterns of communication within the family and train (**Handling Communication and Emotions**) them to use more effective means of communicating with each other as well as with the affected member.

Your approach to the families will remain essentially the same with modifications depending on the needs of the family and affected member in question.

CHAPTER III

ENGAGING AND MAINTAINING THE FAMILY IN TREATMENT

SESSION I

Objective: Your objective is to recruit the family for intervention to provide for the maximum recovery of the affected member and to assist the family in coping better with the consequences of the illness. You also have to maintain the family in the intervention.

Guidelines for speaking to a family:

1. As mentioned in Chapter II (**Management of Schizophrenia**), you should be familiar with the details of the affected member's' illness (diagnosis, symptoms, psychiatric history) before approaching the family.
2. For the intervention to be effective, you need the **trust and confidence** of the family. This is achieved over a number of sessions by **paying attention** to and **listening carefully** to their concerns and by showing **empathy** and an **understanding** of the family's problems.
3. The family knows the person and their resulting problems better than you do. Therefore, avoid adopting a position of **superior knowledge** when interacting with family members. Avoid using **technical terms**. Speak in a **simple and clear language**.
4. There is usually one member in each family who makes most of the decisions for the family- this could be the father or the mother or both in the case of a shared leadership. There are families where although the father is considered the leader of the family, the mother may actually be making all the decisions for the family. Some families may not have any particular member fulfilling this role. This 'leader' initiates and aids the family in implementing decisions and therefore plays a vital role. The intervention may prove more effective if you **work with or through the leader**.
5. Provide opportunities for them to **express their worries and concerns** about the affected member's illness. Allow them to also speak about how they feel about the affected member after the illness. Family members feel relieved after disclosing these preoccupations. It also strengthens the bond between you and the family. You do not need to **agree** with them and should not be **judgmental**. You also do not need to provide **quick solutions or suggestions** to their problems.
6. Every family member may not be able to meet you each time. Be prepared to **deal with the main caregivers** only. Emphasize that the joint effort of you and the family is more effective in the long term than the family alone caring for the affected member or professionals alone attending to them.

7. As the caregivers may not be able to meet you regularly, use as effectively as possible, the time that you spend with them to discuss the issues in a **systematic and thorough manner**. Refer to previous discussions that you have had with them and when they appear uncertain or reluctant to try a new task, **reassure** them.
8. Observe **the way the family members interact** with each other over sessions, before forming an impression of the communication skills or problem solving abilities they have. This will provide you with time to decide how much input you may need to invest in that particular family.
9. Family members tend to disagree on how to settle family problems. Listen to what **all** the members have to say before guiding them as to how they could resolve the issue. You must **remain neutral and not take sides** with any member as this can adversely effect how the rest of the members perceive you in their future interactions. Do not disagree or contradict the caregiver's approach or opinion on how to solve their problems with the affected member in the affected member's presence. This will adversely affect the relationship between the caregiver and the affected member as well between the caregiver and you.
10. As mentioned in the previous chapter, you need to **be flexible** in your approach with the family. The family may come to you with needs different from what you may have planned to address in that session. Ascertain whether there is a crisis that needs to be addressed immediately or whether it should be approached in later sessions. At times, a problem may be solved only when other smaller problems are first resolved. For example, if the family wants the affected member to be employed, this can be achieved only if he is able to pay attention, be motivated to work, be able to do the work satisfactorily, be able to communicate effectively enough to pass a job interview, etc.
11. Look for the **positive assets** of the family, even if you find it difficult. Highlight these positives to the family in a feedback of their achievement. This increases their *confidence and sense of improvement*. Their simple and commonsense methods are effective.
12. If the family does not acknowledge any positive changes, **do not argue** and attempt to prove therapeutic efficacy as the family will respond by showing you how you are wrong. Instead, you should repeat that changes are slow. Try to understand why the family is frightened to admit that change has occurred.
13. Some families may not take you as seriously as they should or you may find yourself having to comply with many of their wishes and get a sense of not being in control of the sessions. You should make it clear to the family that there are certain **expectations** that you have of them concerning the sessions. Families will need to understand that it is preferable that they keep their appointments or to inform if they are unable to as you may not be able to see them whenever they want you to. The family should try to come on time (allow some time for reasonable delays like traffic). The family should not intrude on your personal life by visiting you at your home. It is up to your discretion as to how much of your personal details you do not mind sharing with the family. Provide a contact number for the family to use during a crisis only.

14. You may need to do a **home visit** when there is a crisis. The family will tend to treat you as a guest. They may be grateful and may express this by offering hospitality. There is normally an exchange of pleasantries when you arrive and when you leave, but you should not allow it to go on for too long. They may offer you something to eat and drink. Never accept alcoholic drinks and if you suspect that the family has gone out of the way to prepare something for you, discourage them from offering it. Be alert to the timing at which they offer the tea, biscuits etc. It may be at a time when they are uncomfortable with the discussion and may wish to divert your attention. You can then ask them to defer it to a later time. Ensure that the family is aware of the time and date of your next session with them.

A. Engaging a family

What is it?

Engagement consists of offering positive, pleasant, polite contact, while sharing appropriate care and concern for the family's problems. This must be offered consistently even if the family has a negative response. A family is most likely to accept help at a time of crisis, for example, after an admission to hospital. The advantage of beginning with psychoeducation is that you are offering something that the family is desperate for-information.

What are the strategies involved?

The general strategy is to offer positive contact at the pace, which the family will allow. **Persistence** is often necessary, as refusal of first contact is common. Being **flexible** as to time of visit, not becoming angry when arrangements break down and continuing to offer another contact will often enable enough trust to be built up for the family to risk a meeting. You should:

- 1) Be immediately available: The crisis that brings the family to the hospital provides an opportunity to show the family that a treatment experience can be helpful one. Thus the initial contact should be made before the crisis has passed or diminished, since this is when they are most likely to be open and in greatest need.
- 2) Focus first on the present crisis: This involves listening to their feelings about what they have been through, discovering other present or potential stresses in their lives, explaining the procedures and policies of the treatment system and making them feel comfortable in a strange and confusing environment.
- 3) Avoid treating the family as the patient: You must demonstrate that you respect their priorities and concerns and recognize all that they have done to help. You must also communicate your belief that the family has taken a positive and necessary step in seeking professional help for the affected member. The family should be helped to feel that they would be entering a cooperative relationship with the treatment team to help the affected member.
- 4) Connect with the affected member: you should make brief individual contacts with the affected member (even when severely ill) as this allows a beginning relationship even before including the affected member in family sessions.

What are the strategies for families that refuse?

1. Request a **trusted third party** to introduce you informally who can reassure the family about your involvement.
2. You should have some **statements** explaining the reasons for wanting to work with the family. “ I would like to see how you are managing now that ____ will be returning home soon” or “ I want to find out how things are at the moment and see if I can help you with any problems that may come up”.
3. At times, you may meet only one member of the family. Once this contact has been made, you should make it clear that you would like to meet all those who have reasonable contact with the affected member such as those who live in the same house, are key members such as parents or spouses.
4. It is important to convey to the family that everyone who is involved in caring for the affected member attend the sessions. To do so, you could post several letters to all the family members stating the time and date of the next session. You should not assume that the family members would pass on the message. An individual letter will be received and read.
5. Usually in the acute phases of the illness, the affected member does not engage. They may also not engage if they feel that listening to the family’s complaints are unproductive. You must make it clear to the affected member that everyone will have their say in the sessions and that all problems can be brought up and listened to.
6. Despite all efforts, there are some families where only a few members will engage. It is important to work with whosoever will attend. They may be able to persuade other members to join in. Continue to ask for absent members.

What skills are needed for engagement?

1. Listening

Accurate and active listening is important for developing an effective working relationship, helping the family members to talk, and helping the family members to experience and express their feelings. You will need to physically convey your interest and attention by:

- a) Leaning forward slightly: this indicates your involvement and encourages the affected member to speak.
- b) Maintaining good eye contact: you should not however stare, as the family members may feel dominated. Looking down or away too often may indicate tension and boredom. Good eye contact allows you to see the facial expressions that the family members are making.
- c) Appropriate facial expression: a friendly, relaxed facial expression, including a smile, usually demonstrates interest. However, it would be inappropriate when a family member begins crying or becomes agitated. Your facial expression needs to show that you are tuned to their verbal and bodily messages.
- d) Use of head nods: each head nod can be viewed as a reward to the family, giving the message that you are paying attention. It need not signify that you agree with everything that they say, but rather that you are interested.
- e) Relaxed body posture: a relaxed body posture, without slumping or slouching, contributes to conveying the message that you are receptive. If you sit in a tense manner, the family may think or feel that you are preoccupied with your own personal agendas and unfinished businesses and that you are not fully aware of them. A stiff body posture, finger drumming, fidgeting, may indicate tension.

2. Empathy

This involves communicating that you have understood the crux of the family member's surface thoughts and emotions. Good empathic responding indicates a basic acceptance of the family members as people. It avoids sending out discouraging messages to the family that stop their flow of talk and emotions. Good empathic responses are made in easily comprehensible language. They provide an opportunity for the next statement to be a continuation of the family's original train of thoughts.

3. Reflecting content

The literal meaning of what the family member said is mirrored or restated in slightly different form. You should use simple and direct language and avoid psychological jargon.

4. Reflecting feelings

This involves firstly, identifying the family member's feelings correctly and then secondly, correctly expressing their level of intensity. You will need to use your judgement in choosing how much of the family member's feelings you want to reflect as this depends on whether the family member acknowledges their feelings and to what degree. Sometimes, the family member may both smile and clench their fists at the same time. You will need to decode this mixed message.

5. Using silence

If you speak too much, this acts as a barrier to family members talking. Keeping silent gives them space and encouragement to get more deeply in touch with their thoughts and feelings. Whether a long silence is appropriate depends on what the family member has been saying and their body messages during the silence. A silent family member can mean any of the following:

- a) The family member is generally uncommunicative
- b) They need time to sort out their feelings
- c) They are afraid to disclose more
- d) They have come to the end of a thought or theme.

B. Maintaining the family in treatment

What are the factors influencing it?

Once the family attends the first session, the main task is to **maintain** them in treatment. This is influenced by:

- a) Whether the families have had **bad experiences** (actual or perceived) with professionals in the past and are skeptical about the present offer of help.
- b) Whether they have different or **unrealistic expectations** of intervention.
- c) Whether the families have been coping for a number of years and are therefore **pessimistic** about the future or have resigned themselves that nothing can be done.
- d) Whether the family members feel **blamed** for the illness and are worried that your intervention will reveal this
- e) Whether they fear that any change will make the situation **worse**, and not better, and therefore, the current status with all its problems, is better.
- f) Whether the **timing and place** of the sessions are realistic and convenient for the family.

Why is it necessary to maintain the family?

If the family's reluctance to engage is not tackled then no matter how skilled your intervention is, the family will not take it up. Hence, it is extremely important to determine the families past experience with professional help, their expectation of therapy this time and their pessimism. You will have to try to infuse **hope** and convey what can be **realistically expected** from your intervention. Conveying the message that this type of family intervention has been shown to **prevent relapse** and that change will be **slow and gradual** can achieve this.

There are however some families who appear resistant to the intervention. These families may have certain characteristics such as being defiant, argumentative, thwart attempts to improve their circumstances, deny factors associated with the illness and the affected member deteriorates progressively. These families should be **referred** for intense Family Interventions.

After engaging the family, you should

1. Have some information on the psychiatric history of the affected member
2. Have formed a working relationship with the family or engaged the family
3. Have been able to ensure that the family will maintain in treatment.
4. Identify reasons for family not wanting to maintain in treatment.

In the box above, achieving the first item will help you in your future discussions with the family and will help in pinpointing some of the areas that you may need to cover in your psychoeducation sessions. By achieving the second and third items, you will be able to collaborate with the family and do the intervention. The last item will have to be addressed in your initial as well as future sessions with the family.

CHAPTER IV

ASSESSMENT

SESSION I

Objective: To determine the family's knowledge of the affected member's illness, as well as the effect of the illness on the family's functioning.

Guidelines:

1. Knowledge of the affected member's **past and present symptoms** (content of their delusions, nature of hallucinations, behaviours related to these symptoms as well as negative symptoms) in detail is necessary.
2. Prior understanding of the **family's attitudes and beliefs about the illness** in general and the symptoms of the affected member, in particular will help to foster an interactive mode of information presentation for the psychoeducation sessions.
3. You should speak to the whole family together, preferably in the absence of the affected member. You should address the question to the family as a whole and then ask each of the family members for their **individual opinion**.
4. Although your primary objective is to assess the family, be prepared to answer the family's questions. It is unlikely that you will be able to gather all the details of your assessment without the family questioning you about the illness. Judge whether it is appropriate to answer every question now or some of them later, as planned.

1. **Knowledge about illness:**

- To begin with, ask the family as to whether they think something is wrong with the affected family member or not. Almost all the family members should agree that something is wrong.
- If so, ask them what do they think is wrong with him/her? The responses to this could vary depending on whether this is the first episode of the affected member or whether the affected member has had numerous episodes in the past. If it is the first episode, the family may or may not report any of the psychiatric symptoms, i.e., they may be unable to say that the affected member has "hallucinations" or "delusions". They will instead report the "effect or influence" of hallucinations or delusions on the affected member's behaviour. Thus, they may reply that the affected member has odd behaviours such as laughing and talking to himself, saying odd things that do not make sense, not doing well in work or school, withdrawing from social contacts with others, etc.
- Ask the family what illness does the affected member have. The family members may not have been told the diagnosis or if they have been, may not understand it. If they do not know the diagnosis, you must tell them. This leads to the family wanting to know more details about it.

Judge how much to tell them at this point. You could give them some information on the course, causes and prognosis of the illness.

- If the family member's do know what the diagnosis is, then ask each family member to tell you what he or she thinks schizophrenia means. This will allow you to assess what the family knows or thinks they know about schizophrenia. It will also reveal some of their fears and misconceptions about the illness. They may think it is similar to "multiple personality" or "split personality".
- Ask the family members what they think are the symptoms of schizophrenia. Family members may give you answers (as previously mentioned) which indicate that they know the behavioural repercussions of the illness. Some family members may also mention other behaviours which are not a part of the illness but which are behaviours which the affected member does of his own volition. Assess whether the family is able to differentiate between actual symptoms and willful behaviours.
- Ask the family what they know about the treatment options available for schizophrenia. Some families may be aware of only medication and not of other therapies, or places that offer vocational rehabilitation.
- Find out from the family about their knowledge of the medications. Do they know what each of the medicines are given for? What is the relationship between the medications and the symptoms? What are the side effects of the medication?
- Ask the family what they think will be the course and outcome of the illness. Most families expect the illness to be cured with medication. They do not usually expect the affected member to take medication for several years or when asymptomatic. They may not be aware that the affected member may not fully recover from an episode or that there may be many episodes.
- Finally, enquire as to what they think are the causes for the illness. Most family members will not consider structural or chemical changes as being primarily responsible for the illness. They may wonder if they are responsible for the affected member's illness in some way because of their behaviour (bad parenting or unhappy marriage) and therefore feel guilty, angry or responsible. Some family members may think that "black magic," or "evil spirits" cause it. Parents may wonder if it has been inherited and may blame the other spouse if they have a relative with a psychiatric illness.

2. Burden

- These questions are more relevant for families who are living with an affected member for a number of years than those living with a first episode affected member. Assess the objective burden of the family by asking the family members to describe the consequences of living with a schizophrenic member. Ask them to describe the differences that they now observe in their family life, how it has affected them financially, in terms of their physical well being, leisure time, social supports from others, etc.

- To ascertain the subjective burden, ask the family members to each describe how they feel emotionally about having a schizophrenic relative, how they feel when they are around the relative, and their expectations of the relative. Some of the possible emotional responses that the family may have are listed in the section entitled Family Responses. Other responses of the family are: frustration (since the affected member is unable to communicate clearly with them or for being “lazy”), anger (at the affected member for having the illness or the restrictions that it has imposed on them), sadness (as the affected member may be unable to fulfill expectations of a bright career), hopelessness and pessimism.

3. Needs

- You may have already formed an impression of what the family wants from you while engaging the family and while enquiring about the burdens they perceive. If not, ask the family members what they expect to receive from you. Ask them what are the problems they would like to solve in the care of the affected member.
- The families may also come to you with their own needs. Some families may expect you to provide information about the illness. They will want to know about the treatment, the cause of the illness, the prognosis and chances of recovery. They may also want to know about the effectiveness of different treatments like homeopathy, ayurvedic, etc.
- The family may ask you for advice on how to keep the affected member clean and tidy. The affected member may be unable to care for himself and may need family supervision.
- They may ask you about how to get the affected member employed meaningfully or in some appropriate activity. They could ask you about the availability of day-centers or vocational training.
- If the affected member is violent or harms himself, the family may need help to handle this.
- The affected member may have (before the illness) been contributing towards the daily household work or looking after children. The family may not be able to cope after the illness. Not all families find this problematic.
- If the affected member is married, the spouse may have an unsatisfactory relationship with the affected member. Sexual problems are common. Unmarried affected members may feel lonely. They have difficulties in maintaining close relationships and in finding a partner.
- You can raise some of these concerns in future sessions, preferably during the problem solving skills sessions, as some may not be an immediate priority in the management of the affected member.

4. Social supports

- Most families over time gradually become isolated from their families and friends. Ask the family members what they each do to distract themselves from the problems of living with the affected member. Do they have contacts outside of the family whom they can spend time with

aside of working hours? Does the family approach anyone outside the immediate family at crisis times?

- If not, what are the difficulties experienced by the family in doing so? Are these contacts able to provide support? What kind of support do they provide? Do they offer to supervise the affected member while the family goes out? Do they offer financial support? Do they advise the family as to what they should do? Do they listen to the problems of the family and help them emotionally to cope?
 - Does the affected member have any contacts outside of the family as well? Do these contacts visit the affected member during or after episodes of the illness? How do they help the affected member?
5. **Family responses:** Ask the family members how they feel about their relative having schizophrenia.
- They may *deny* or have difficulties accepting that the relative has schizophrenia. This is a response commonly seen when the family first receives the diagnosis of schizophrenia. They may not fully accept it later either.
 - They may get *angry* that the affected member has the illness. They may feel envious of others. They may think “why did this happen to me”. They make promises to cure the illness. Such as “I promise to pray everyday if he is cured of this illness.”
 - They may feel *depressed* when they are unable to cope. The financial burdens, the affected member’s inability to work, stigma, etc increase this feeling.
 - They continue to *hope for a cure*, the discovery of new medication that will improve the symptoms. This helps them to cope during their suffering.

After assessing the family, you should:

1. Know what is the level of understanding and knowledge the family has about the illness.
2. Be able to evaluate the objective and subjective burden experienced by the family members
3. Determine the primary needs of the family
4. Determine whether the family has and makes use of social supports
5. Know the psychological responses of each of the family members towards the schizophrenic member

The first item will help you to plan how much information on schizophrenia is to be given in the psychoeducation session. Information from the second, third and fourth items can be used as problems that need to be addressed in the problem-solving sessions. The last item will influence the attitude or approach of the family to the affected member, the way in which they communicate with each other and whether they approach social supports or not.

DETAILED ASSESSMENT OF THE FAMILY

When you initially met the family, the family would have perceived you as someone who will provide information on how to resolve the affected member's illness. One of the disadvantages of only providing information to the family is that they do not perceive the illness as something that the family as a whole unit can work together to resolve. It also results in only one or two members of the family sharing the responsibility of caring for the affected member. Their greater stress load will interfere with their own daily responsibilities as well as their interactions with the affected member and the remaining family members. Gradually, with your guidance the family will be able to view the problem from this perspective.

In order to get a better understanding of the patterns of behaviour in the family; the following should be kept in mind through sessions with the family.

How to assess the family in more detail?

1. What are the roles of each family member?

- In every family, each member contributes to the functioning of the family in the roles that they play. There are expectations of certain members to fulfill these roles and they may be held accountable. To determine the family member's roles, ask them questions like: which all members help in the household chores? Or who are the breadwinners of the family? When the family members are upset, which member do they approach to discuss their problems with? Which family member is responsible for maintaining the family rules? When they fulfill these roles, are they meeting the expectations of other family members? You may get responses that indicate the father, mother, (or both) contribute to the financial status of the family. The mother may manage the household routine and be the one to whom family members turn to for emotional support. The father may enforce discipline amongst the children.
- Some members may have too many roles to play-for example, in a single parent family; the parent has to be the breadwinner, the housekeeper as well as parent the children. This can be stressful. The schizophrenic member will be unable to fulfill their roles and this increases the load of the other members who have to substitute for the affected member.

2. How do the family members communicate?

- Observe the way the family members communicate with each other and with the affected member during your sessions. It may take a number of sessions before you are able to accurately understand their communication patterns. Ideally, a family should be able to communicate clearly, directly, using verbal and non-verbal communication, and with the feelings of other members taken into consideration.
- In some families, there may be unequal communication between all members. Some family members may talk much more than others, excluding others from participating, especially the affected member. Some family members may not listen or pay attention to what other members are saying, especially the affected member.

- Family members may not speak clearly and directly to one another. For example, if the father is strict, then the children may not speak to him directly about their needs but may instead ask the mother to speak on their behalf.
- Family members may talk about the affected member or other family members as though they were not present. For example, it is easier for the family member to say, "He's a lazy person" than telling the affected member, "You are a lazy person".
- Members may state one thing but may behave in a contradictory manner. They may also make ambiguous statements. These can confuse the affected member as well as other members as to how they should respond or behave.
- There may also be a predominance of non-verbal communication than verbal (gestures, facial expressions), feelings of family members may not be discussed and family members may or may not react positively or negatively to other member's behaviours as expected.
- Affected members with schizophrenia are unable to assert themselves and may be left out of the conversation.
- Observe if family members are critical about the affected member's behaviour. Do they specifically mention what they disapprove of, how it is of concern to them and what are the consequences of it or do they make general statements?
- Do the families make hostile comments about the affected member, such as "he is good for nothing" or do they appear to reject the affected member ("I don't want to be with him any more"). Do other family members share similar negative attitudes as well?
- Are the family members extremely anxious or worried about the affected member or his welfare? For example, "I worry about him all the time. I do not know what to do. I cannot cope. I've been so depressed since he got ill". On the other hand, are they over concerned and their reactions are closely linked with the affected member. For example, "when he feels sad, so do I. Every time he falls ill, so do I."
- Do the family members sacrifice their needs to look after or care for the affected member and is it necessary? For example, "I gave up my job to look after him" or "we never see anyone or go anywhere. It's just the two of us". Do they over-indulge the affected member? For example, "we let him do whatever he wants, otherwise he gets upset and since he is ill, we want to do everything we can to help him".
- Are the family members over-protective? Do they treat the affected member in an age-inappropriate manner? For example, they do not let the affected member go out alone or with friends because they are afraid of what might happen.
- Do the family members express positive feelings for the affected member-his abilities, skills and positive attributes? Do they enjoy the affected member's company and do things together? Do they have a warm tone when talking about the affected member?

3. Is the family cohesive?

- Based on your observations of the family's communication styles and emotional behaviours, assess whether the family perceives a sense of unity, a "we" feeling. Family members may be attached or detached to each other in healthy as well as unhealthy ways.
- The members could be emotionally over involved in the lives of the other members or they may be disinterested and not involved at all. These are disruptive to the family functioning.
- Rituals, such as eating meals together and other joint activities, strengthen the parent-children bonds as well as the marital bond within the family.

4. How does the family cope?

- Ask them how they have handled crises in the past? Preferably, ask this in the context of a specific situation that may have occurred to the family. For example, what did the family do when the affected member had previous relapses or how did they respond when they first observed the affected member's deterioration in normal functioning?
- What was each individual's contribution? Who took the initiative to solve the problem? How did they solve the problem? Were they able to effectively solve the problem or did it recur? Was the family confused and unable to solve the problem? Were they able to cope?
- The answers to the above indicate their ability to solve problems and how they will cope with the affected member. Family's members may unite on such occasions and be supportive; or they may turn to other relatives to help them. They may alternatively be unable to cope and have to visit a professional for support.

A more detailed family assessment will help you to identify:

1. The roles of family members and dysfunctional roles
2. The communication patterns of the family
3. Problem solving abilities and coping
4. Problem areas-weaknesses and deficits
5. Family risk factors for relapse
6. The strengths and resources of the family

The first three items should guide you as to who the essential family members are, and will provide the basis for your problem solving and communication skills training sessions. They will also identify the fourth and fifth items. These will indicate at topics you need to focus more on for the particular family. You can use the findings of the final item to achieve this.

**WHEN YOU ARE FAMILIAR WITH CHAPTER III & IV, USE MODULE I (page no.: 83)
TO CONDUCT THE FIRST PART OF SESSION I (ASSESSMENT OF THE FAMILY).**

READ CHAPTER V TO CONDUCT THE SECOND PART OF SESSION I (PSYCHOEDUCATION)

CHAPTER V

PSYCHO-EDUCATION

SESSION I

What is psychoeducation?

Psychoeducation is a process by which you impart knowledge of the illness to the family, and with your continual assistance, modify their attitudes. You also formulate and implement better coping skills and other preferred interactions with the affected member.

Objective:

To educate the family about all the relevant aspects of schizophrenia. The information that you will provide is given in the Psychoeducation Booklet in Appendix I. These sessions should enable them to understand the illness and care more effectively for their affected family member. It will also allow you to determine the family's perception of the illness, how their beliefs influence their behaviour and how amenable they are to seeing the illness from a different perspective.

Sessions:

You may be unable to complete the psychoeducation in one session and may need to take more sessions to do so. The sessions should be tailored to the individual affected member's symptoms and circumstances. It covers the causes, symptoms and prognosis of schizophrenia, the treatment and management.

Who to include:

- If there are many relatives, you should assess each relative's knowledge in individual sessions and then present the information to the family collectively. You may decide whether to include the affected member in the family sessions. Otherwise, the affected member can have a separate information-giving session.
- Seeing the family in the absence of the affected member may be preferable as the relatives may want to ask questions about the affected member, which they may feel uncomfortable asking in his presence. The affected member may also disrupt the session by being unable to concentrate, showing inappropriate emotions or their speech may be disturbed, etc, if the affected member is actively symptomatic.
- When you have more than two families to educate, you can have all the family members of both the families present and do the session for the group.

Mode: You can provide the psychoeducation:

- a) In a lecture format-in that you will do most of the speaking to a family.
- b) With more than one family at a time-in a group setting.
- c) Provide them with reading material on schizophrenia to go through first and then later clarify their doubts
- d) Present it in the form of video footage for the family.

Guidelines on providing psychoeducation:

1. Remember that even if the family members do accept most of the information, they rarely change their beliefs about causation
2. The family's view of the affected member's condition may not change immediately in response to the psychoeducation, but will gradually change later.
3. Allow them time to **ask questions** and pause after each theme to allow them to respond.
4. You may need to **encourage** some families to ask questions or voice their disagreements with the information provided.
5. Due to the above, be prepared to **discuss and clarify** the information with the family.
6. Avoid **over-loading** the family with too much information or medical jargon.
7. Use **analogies** to explain concepts that are difficult to understand. Use examples from the history of the affected member.
8. **Listen** and understand the family's view of the illness.
9. Be **sensitive** to the distress experienced by the family members, such as when the affected member is violent, suspicious or has delusions that the spouse is unfaithful, etc. Be alert to this and address it in future sessions.
10. If you do not know the answers to their questions, admit **uncertainty**. Assure them that you will provide the information in the next session and do so.
11. They may **ask the same questions repeatedly** over a number of sessions. You need to be patient in answering them and when negotiating differences that they perceive in the affected member's condition and your scientific explanation of the illness.

Educating the family

The diagnosis

- Some families may feel afraid or distressed when they hear that the affected member has 'schizophrenia'. It is important that they are aware of the diagnosis. If not, they may assume other causes to be responsible for the affected member's behaviour and treat the affected member the way they think is more suitable.
- Another drawback of not knowing the diagnosis is that the family may think the affected member has more control over his or her symptoms than he or she actually has. They may then conclude that medication is unnecessary and at times, even harmful. They may also doubt whether the affected member is pretending to have an illness.
- Terms like schizophrenia and psychosis may be confusing for them. Clarify their doubts. They may feel uncomfortable using the term 'schizophrenia' with their friends or relatives, as they may feel stigmatized. They can use terms (such as 'breakdown') which they are comfortable with to describe the illness to others.
- Some families associate schizophrenia with violence. When the affected member is not violent, they may not then accept the diagnosis. They may be afraid that the affected member may become violent later. You will need to clarify such fears and doubts by stating that not all schizophrenic-affected persons become violent. Most are shy and fearful.

The symptoms

- Use examples from the affected member's behaviour to educate the family about their symptoms.
- You may notice that families often find it difficult to focus on the symptoms of schizophrenia. They usually tend to talk about specific experiences of the illness. This is normal.
- Inform the family that each affected member has a different symptom pattern. The affected member can have different symptoms at different phases of the illness. This is important, as family members may not pay attention to you when you speak of symptoms that the affected member does not have.
- Emphasize that the affected member's positive symptoms cannot be easily understood. They are thoughts, ideas, and voices that go in inside the affected member's head. The family can see their indirect effects through the affected member's behaviour.
- Emphasize that the symptoms are real to the affected member. Thus, the affected member cannot control them. They will neither be able to resist answering the voices they hear nor can they be dissuaded from their fears. They are not doing it on purpose.
- Emphasize that negative symptoms (like lethargy, absence of emotion, amotivation) cannot be easily overcome by the affected member.

- Ensure that the family does not form the impression that all the problems are outside the affected member's control. They will otherwise be over protective of the affected member and feel guilty if the affected member makes demands on them.

Causes of schizophrenia

- Families usually have their own theories as to why the illness may have occurred. These are problematic only when the family acts upon such beliefs as the sole cause of the illness. For example, if they think the affected member is too sensitive or imaginative, they may then try to talk the affected member out of delusional ideas or protect them from stress.
- Family members may think they caused or could have prevented the illness in some way, especially if an incident precipitated the illness. Such theories make the relatives guilty and depressed. They may blame it on a failure in the affected member's exams or a love affair, bad parenting, superstitious beliefs.
- You may need to answer doubts such as whether the affected member will be able to have children, and will they inherit the illness. You can answer such questions by telling the families that the children will not inherit the illness. They may or may not however, inherit the tendency to develop the illness. If they do, then some develop the illness with exposure to little stress; whereas others with massive stress.

Medication

- Discuss with the family and emphasize the need for regular treatment as prescribed and not an erratic treatment by the family.
- Emphasize that medication will need to be taken for a long period of one to two years or, even indefinitely. The duration of the treatment depends on the recovery and not the duration of illness before the treatment.
- Some families may feel that the medications are like "sleeping tablets" and are addictive if used for a long time. They may then decide that the affected member should learn to cope without the medication. Clarify that this is not so and that the medications reduce the positive symptoms.
- Discuss with the family and emphasize the need for continuing the medication even when the affected member appears better. The medications control the symptoms. Inform them that the underlying problem will still be present. By continuing the medication, they can prevent symptoms from recurring.
- Should the family ask, you should be able to explain how the medications work. Explain that schizophrenia develops from a malfunctioning of chemicals in the brain. The medication works by compensating for this malfunction. This usually involves restoring a chemical imbalance. The result of which will be fewer hallucinations and delusions.

- Discuss and explain the common, unwanted side effects of medication. Reassure them that by changing/ reducing medication or by adding other medications it can be eliminated.
- If family members enquire, state that Electroconvulsive therapy (ECT) may be indicated for catatonic patients and for patients who for some reason cannot take anti-psychotics. Patients who have been ill for less than one year are the ones most likely to respond.

Course and prognosis

- Most families expect the affected member to be cured-that is, to not have any more episodes. They may assume that the affected member does not require further treatment and that the illness will not recur. Discuss remissions and relapses in schizophrenia and the need for longer treatment duration.
- Inform them that there are good chances that the affected member can recover from an episode and have a near normal life. Reassure them that they may recover up to 60-70% with medicines and other treatments. This statement should be made depending on the severity and chronicity of the illness. It would be inappropriate for affected members who have a long history of symptoms and poor social functioning.
- For chronic affected members, your discussions should focus on reduction of symptoms and improvement of the affected member's ability to live independently. Discuss rehabilitation programs and family support to help the affected member return to living a normal life.
- Inform the family that there are possibilities of the affected member having future episodes of schizophrenia. This statement helps the family to continue the medication for long periods and prevents them from being disappointed when the affected member has a relapse.

After your session, you may have been able to achieve the following:

- Impart information on the facts of schizophrenia
- Clarified the doubts, misconceptions the family may have had regarding the illness
- Reassured the family that there is hope for the affected member to get better
- Motivated the family to comply with medication as prescribed.
- Engaged and maintained the family in treatment

**WHEN YOU ARE FAMILIAR WITH THIS CHAPTER, USE MODULE II (page no.: 87)
TO CONDUCT THE SECOND PART OF SESSION I (PSYCHOEDUCATION OF THE FAMILY).**

CHAPTER VI

BASIC INTERVENTIONS WITH THE FAMILY

SESSION II

Objective: To facilitate the family in managing the affected member better by improving their interactions in the home setting. The aim is to avoid further episodes and hospitalization.

Sessions:

Suggest to them the appropriate ways of responding to the affected member. Help them to identify the inappropriate responses that they may be performing, so they may be able to recognize and modify them. You will need two to three sessions to achieve this, as family members may want to discuss each suggestion in detail.

Who to include:

It would be preferable if all the family members are present for this session. If this is not possible, then the primary caregivers or the leader of the family should attend. The affected member may also be included in these sessions.

Mode: You can present this:

- a) In the form of a lecture format for an individual family
- b) For a group of different families
- c) Use overhead projectors.

Guidelines for basic interventions:

1. Inform the family members that the suggestions you provide will not have an **immediate effect**. It will take time and will be a difficult process for the family.
2. Should family members be discouraged at the slow rate of improvement and wish to discontinue, emphasize the importance of the intervention in **preventing future episodes** and in maintaining the affected member's improvement.
3. Reinforce that the family can influence the **course** of the affected member's illness. The goal of the family members must be for the affected member to return to **as normal as possible functioning**. Point out to them that there is hope for improvement by following the suggestions you provide.
4. Help the family to identify inappropriate behaviours that they may have begun to use in their interactions with the affected member. To do so, use examples that you have obtained from

the family or observed during the assessment sessions. Some of the areas that you should highlight are given below (**Refer Identifying Inappropriate Responses of the Family**).

5. Point out to the families that although they may consider their responses to be normal and appropriate, they are not and are **unlikely to be successful** for long.
6. Be **empathic** or the family will feel you are unappreciative of the efforts they have made to try to cope. They may then be unreceptive to trying new ways of coping.

Suggestions to be given to the family

1. Comply with medication:

- Prepare the family for the possibility of the affected member discontinuing the medication when they feel better/ to stop the side effects. Explain that the negative side effects of medicines reduce quickly after stopping medication. The positive effects takes longer to reduce after the medicines have been stopped. Thus, it may falsely appear that the affected member is doing well and that medication is not required.
- Remind them that the support of the family members is required when the affected member is resistant or forgets to take the medication.

2. Normalize the family routine:

- Discuss with the family the disadvantages of making the affected member the **center of their lives**. Tell them that since schizophrenia is a long-term illness, they may become too stressed to be able to look after the affected member. They may also develop problems of their own. This could result in the affected member feeling guilty and responsible. The affected member could then perceive himself as a burden to his family. He would not see his family as a place to seek support.
- Encourage them to as far as possible, resume the **daily routines** that were present before the illness. If there were no routines or they appear disruptive, help them to make a daily routine. This routine should also include time for leisure, celebration of festivals, birthdays, etc.
- Advise them to attend to the **needs** of other family members. They should not always support the affected member when he is unreasonable and then be stricter with other members of the family.

3. Revise expectations:

- The affected member is often expected to revert to their former **roles** and behaviours after hospitalization. The family feels disappointed when the affected member is unable to do so. Discuss and encourage them to have **realistic expectations** of what the affected member can do.

- The family should be encouraged to view the affected member as having a **serious physical illness**, which requires a long time for resting. The family will otherwise tend to view a brief hospitalization to mean the affected member does not have a serious illness.
 - Once the affected member's symptoms are stable, some affected members can be inactive, sleep more and appear not motivated. They may also be restless and be unable to perform small tasks. Reassure the families that these are a normal part of the course. Discourage them from viewing the affected member as "lazy."
 - Encourage them to **compare** the affected member's current behaviour with that of how it was a month or more ago. (They should however, not compare the affected member's current behaviour with others.) This allows the family members to recognize the positive changes that have occurred and to have expectations that are more appropriate.
4. **Set limits:** Inform them that just because the affected member is ill, the family does not need to/ should do whatever the affected member asks. Instead they should set limits on the undesirable behaviours by:
- Help them to identify **what behaviours they will and will not tolerate**. Help them to decide which behaviours are **intolerable** (violent and bizarre) and which are irritating (based on a consensus). When the behaviour occurs, they must immediately set limits so as not to form a pattern of behaviours. For example, if the affected member hits a family member, they should try to stop them from doing so each time. Instruct them not to tolerate the behaviour for some time and then later try to stop the affected member.
 - Advise them to **avoid discussing** with the affected member the reasons for setting the limit or how they feel about it. Train them to only state that the behaviour is unacceptable, without explaining why.
 - Advise the family to **be specific in their requests and to use specific reminders** when they want the affected member to do a task. Advise them against, for example, expecting the affected member to do household chores unless they have been specifically told what to do and how often to do it. The affected member may forget and need reminders.
 - Help the family to identify **which reinforcers are most effective**. They can identify material reinforcers (such as money, food, etc) and activity reinforcers (for example, if the affected member does the chores then they can watch TV or be taken for an outing).
 - Assist them in identifying a variety of reinforcers so that the affected member is not bored. Initially **material or activity reinforcers** should be used with social reinforcers (smiling, praise, patting them). Later the material reinforcers should be reduced but the social ones continued.
 - When the affected member behaves well, instruct them to praise the behaviours immediately. This will **positively reinforce** that behaviour. They should state which behaviour they are praising or reinforcing. This will help the affected member to link the positive reinforcement with the behaviour.

- Demonstrate to them how they can **simplify tasks** for the affected member by breaking it up into a number of small steps. The affected member should be reinforced when the first step is completed. They can then provide a clue as to what the next step is and reinforce it when performed. This should be done for every step until the task is completed.
- As the affected member may be unable to perform the task correctly the first time, the behaviour will have to be **shaped** to resemble the task more accurately. Instruct the family to reinforce those responses that approximate the desired behaviour and ignore those unlike the desired response.
- When the affected member behaves in an undesirable way, the **social reinforcements are stopped**. The affected member should be taken away from the others for a short period and returned when desirable behaviours are shown. For example, when the affected member disturbs others by shouting, then they should be taken to another room and not spoken to until they stop shouting. The material and activity reinforcers that they usually receive should be removed.
- Irrespective of the affected member's age, **limits should be set**. Discuss with the family the necessity for the affected member to behave in an age-appropriate manner and encourage them to modify their expectations of the affected member's behaviour. For example, an adult should not have tantrums.
- Discuss with the family the necessity for insisting on the **affected member complying with their limit setting**. They should however, not set limits when they are unable to enforce them.
- Point out to the family that they will probably be unsuccessful the first few times they attempt to set limits. It may take a number of weeks. Encourage them to **not give up trying**.

5. Selectively ignore

- Discuss with them the improbability of solving all their problems at once.
- Advise them to select one or two issues, which they wish to focus on. They should ignore the others until they are successful in solving the selected ones.
- Instruct the family that they must, however, not ignore behaviours such as suicidal threats, violence or other psychotic behaviours. The approach to be adopted for these problems are addressed in the chapter "**Addressing and Handling Difficult Problems**"

6. Reduce stress: Remind them that the affected member has a lower tolerance for stress.

- Instruct the family to reduce fights, conflicts, rejection and nagging behaviours.
- Discuss with them how being over enthusiastic, showing extreme concern and encouragement can be upsetting for the affected member, and discourage them from doing so.

- Advise them that should the affected member wish to withdraw and be alone, the family should allow it.
- To avoid the affected member withdrawing completely, discuss with them opportunities or activities to offer the affected member to engage in, such as going out. Prepare them to accept the possibility that the affected member will refuse.

7. Simplify communication:

- Affected members often do not respond immediately when spoken to. There may be a pause or delay before they communicate. Advise the family members to **avoid speaking on the affected member's behalf** when this occurs. Advise them to **wait for the affected member to respond**. Remind them that the affected member can contribute to the conversation.
- Advise them to avoid the tendency to **assume** what other members are thinking about, want or need, even before they say so. Encourage them to speak only for themselves. Advise them to accept what other members say even if they do not agree with it.
- Advise family members against talking about **complex and emotional topics** in the presence of the affected members. Especially during times of crisis. They should also avoid detailed conversations, which the affected member will find confusing.
- At times when the meaning behind the affected members communication cannot be easily understood, family members often try to discover the hidden meaning in it. Discuss with them the advantages of instead **asking the affected member to speak more clearly**. Be empathic with the family's frustrations in dealing with these odd conversations.
- Encourage them to be **appreciative of the affected member's positive behaviours**, and to encourage the affected member when having difficulties.
- **Generalized comments** should be avoided. For example, if an affected member does something inappropriate, they should not make comments such as "He is useless" or "She can never do anything right" or other similar comments.
- Advise them to **avoid vague or unclear and ambiguous statements**, as these are difficult for the affected member to interpret.

8. Identify warning signs:

- Review with the family the significance and meaning of possible warning signals.
- Signals differ from patient to patient. Inform the family that there are numerous warning signs. These help in avoiding another episode or hospitalization.
- Advise the family to observe whether these warning signs are fleeting or are present continuously for at least a week and/ or appear to be increasing. If the latter, the family should consult the treating team.

- Some warning signals for the family to look out for are: alterations in routine habits (like sleeping and eating), becoming easily irritable, muttering to self, changes in personality or bizarre behaviour.

9. **Enhancing social networks:**

- Family members at times adopt the attitude that they should not trouble others with their problems. They may also worry about the reactions of others. Discuss with the family the benefits of discussing their problems with others like relatives, friends, neighbours, religious or social organizations as it will help in reducing their distress. It also helps them to generate new and better solutions to their problems and prevents them from using the same unsuccessful tactics in solving their problems.
- Use the reasons stated in the introduction chapter (**Why involve the Family? Point # 13**) when discussing with them about the need for improving their social contacts. Point out to them that they will not be able to care for the affected member for a long time unless they look after themselves as well.

Identifying Inappropriate Responses of the Family

- a) Adapting and normalizing the situation: Family members usually adapt their routine to include the affected member's behaviours. This is usually a slow and gradual process of adaptation that helps the affected member to maintain a role in the family, but as the affected member becomes unable to do so due to the illness, the family members find it difficult to adjust. You should be able to get this information from the "coping" part of the assessment.
- b) Coaxing and rational persuasion: Family members tend to convince the affected member that their unusual ideas and beliefs are untrue and to persuade them to behave in more acceptable manner. Family members think that it is possible for the affected member to control their symptoms. You should be able to get this information by asking the family what they say to the affected member when he is symptomatic. If not, ask the family members if they have ever made such statements.
- c) Making sense out of nonsensical communication: Even though it becomes apparent that the affected member does not make sense, some family members may still try to understand the meaning of the affected member's often bizarre and nonsensical statements. They may try to determine the essence of the message or to look for something realistic in what the affected member says.
- d) Ignoring: Family members sometimes hope that the affected member will gradually stop behaving the way they do-hoping that it will go away. At times, they ignore the illness symptoms or deny the significance of it, or try not to think about it. This is ineffective when the symptoms are extreme.
- e) Providing constant supervision: Family members are unable to predict the affected member's behaviours. So, they tend to constantly supervise the affected member's behaviour. This gives

them some kind of control over the situation. They feel it protects the affected member. However, it is difficult for the family to maintain this constant supervision for a long time.

- f) Reducing their own activities: The family members gradually begin to plan their routines and activities to care for the affected member. This may involve actually looking after the affected member and supervising him so that he does not harm himself or others. Family members become exhausted and eventually use even their spare or free time to do the minimum necessary house work.
- g) Ignoring the needs of other family members: Caring for the affected member becomes a full time job. The emotional needs of the other members become secondary or the caregivers may not have enough time and energy to look after the others. This results in others feeling uncared for or neglected, and family relationships deteriorate.

At the end of this session, you should have been able to achieve the following:

1. Empower the family with better coping behaviours
2. Provided suggestion/ advice to the family on their role in preventing future episodes through compliance with medication, revising their expectations, simplifying their communication, reducing stress and identifying early warning signs.
3. Assisted the family on how to normalize their family routines, how to set limits and selectively ignore affected member's behaviours.
4. Helped the family to identify inappropriate means of responding to the affected member so that they could recognize and modify them.

**WHEN YOU ARE FAMILIAR WITH THIS CHAPTER, USE MODULE III (page no.: 91)
TO CONDUCT SESSION II
(BASIC INTERVENTIONS WITH THE FAMILY)**

CHAPTER VII

ASSESSING AND HANDLING DIFFICULT PROBLEMS

SESSION II AND III

A. Assessment:

- In your first session, as well as in other sessions, you would have obtained information on the family's *approach* to problems, the *coping ability* of the affected member and the family, their *successfulness* or unsuccessfulness in solving problems. These will mostly be unsuccessful or successful for a short period.
- With the help of specific examples and this information, point out to the family, the approach they adopted and their success in the short term as well as the long term.
- Inform the family of the strengths you have identified in them. These can be abilities, interests and resources available to the affected member as well as the family members. Family members can include other strengths that you may not know about. Relate how these can be used to help obtain the desired outcomes or goals.
- Family members often compare the affected member's previous functioning with their current level. They may not consider skills and abilities that the affected member previously had to be present still. They may feel some skills (like driving a car, etc) are not worth mentioning.
- If the affected member is unable to suggest any interests, ask the affected member to describe what they used to enjoy doing. This can be added to the strength list.

B. Teaching Problem solving skills

Objective: To assess the problem solving skills of the family and help the families to understand the need for it. Teach them an effective and uniform method of problem- solving through discussion, and by solving problems as a family and not individually.

Sessions:

You will need 1-2 sessions. Initially assess the problem solving skills of the family. Then teach the family the steps involved and help them to practice these skills.

Who to include:

The family members as well as the affected member should attend the sessions.

Mode:

To train the family to learn the steps, you can:

- a) Have a discussion with the family
- b) Give them home work assignments and feedback on their performance
- c) Within a session, give them assignments
- d) Do a role-play using actual problems reported by the family.

Guidelines for teaching problem solving skills:

1. It will not be easy to get the family and the affected member to **agree** on what the problems are. For, example, one family member may be preoccupied with the untidiness of the affected member, whereas the others may not think it important.
2. Discuss with the family the reasons for not giving the affected member very difficult tasks, as they may be unable to do it. It may require too much concentration, decision-making, planning, physical activity etc. The affected member may not be ready or able to fulfill the requirements necessary.
3. Be prepared for the affected member and the family members to not carry out the agreed upon plans. This may be because they feel the benefit is not worth the effort to achieve it or/ and may doubt their usefulness.
4. Due to the unpredictability of the illness, the intervention should be **flexible** to accommodate new or urgent problems. However, you should not be handling crisis problems every session. Ask the family if they have had any new problems since the last session. Consider these in conjunction with the continuing problems that remain unsolved.
5. Family members may divert your focus on a single problem by raising other equally important problems. Resist this politely but firmly by explaining that they can progress by dealing with one problem at a time. This is an opportunity for you to '**role-model**' to the family on how to solve problems.
6. Ensure that the **first problem** chosen to solve is easy for them to achieve or to solve in a short time period, like one to two weeks. This will give them immediate feedback and reinforcement of their efforts.
7. Some problems associated with a severe and chronic course of illness may continue indefinitely. For example, the affected member may be unable to resume his previous occupational level, to live without some support, to maintain many friendships and social activities, etc.

Homework and Role Plays

- As mentioned earlier, there are different means of training the families. You can initially explain to the family and the affected member the different stages of problem solving.
- To train the family to use these steps, give them homework assignments. For one of the problems identified, the family can generate solutions, weigh the advantages and disadvantages of them and then choose the best alternative. They can in the next session discuss with you the difficulties or ease they had in following the steps. Clarify their doubts as well.
- Allocate enough time to go through homework thoroughly. If the agreed upon solution has been successful, positively reinforce the affected member and the family members involved. Encourage other family members to praise and value any change, however small it may be. This provides a model for the family to not devalue small changes and to recognize that it is one of the aims. Encourage the family to try the solution again and to practice it whenever the opportunity arises.
- You can also train the family within a session. You can be a passive observer while the family discusses solving their problems. You can in your discussions afterwards, reinforce them as well as point out areas that they could improve on.
- You can ask the family to do a role-play. This is similar to in-session training. Here you can ask the family to pretend that the affected member is demonstrating one of his problem behaviours, say violence, and ask the family to solve the problem.

Steps of Problem Solving Skills

1. Identify the problems:

- Ask them to make a list of problems or areas that they feel require change. They can make their own individual lists if necessary.
- Ask the affected member to include areas relating to their relatives. Ask them to describe things that are problematic for them because of the family as well as those that are mainly a problem to them.
- The problems generated should be reviewed and then ordered by the family. This can be in terms of priority and how realistically change can be achieved in the short term.
- Discuss and demonstrate to them how these can be translated into family needs. For example, if one of the problems is that the affected member does nothing all day, rephrase this to “he needs to do more activities”. If it is irritability, then it could be “she needs to learn to cope with irritability”. This helps the family to focus on what can be done.

- The affected member should see these needs, as important to them or as related to other needs that have a high priority for them. There should be some interest or incentive for them to achieve it.
- Explore each family member's views about the problem. The affected member's experiences related to the problem are also valuable. For example, if the affected member wakes up late, it could be due to tiredness from over-sedation or they may have nothing to look forward to. The solution would then depend on the affected member's experience.

2. **Listing out solutions:** Guide the family on how they can solve the problems that they have identified by:

- Asking the family and the affected member to list out 4-5 possible solutions for each of the agreed upon problems.
- Ask each person to contribute to the discussion, as they can offer different perspectives.
- Note down all the solutions generated by them.
- Do not become **personally involved** in suggesting or choosing solutions.

3. **Weigh the advantages and disadvantages:**

- For each of the solutions, ask each of them to generate the advantages of applying it.
- Ask them to consider the consequences of applying it to the whole family.
- They must also consider whether the solution will be successful over a long period or short period
- Then ask each of them to generate what are the disadvantages of each of the solutions in a similar manner.
- Ask them to also consider whether the solution is practical and whether they will be able to do it. For example, when the affected member is violent it may not be possible for the family to restrain the affected member.
- Ask them to consider any possible obstacles they may encounter and how they will handle these obstacles. For example, for the violent affected member, they may decide to ask the affected member to go to another room. If this is ineffective, then they should have an alternative solution to apply like asking the family member directly involved to go to another part of the house or to leave the house for some time. If the affected member listens only to another person, then the family should consider contacting that person during such a situation. If the person is unavailable or if they are unable to cope, they may then need to call the police.

4. **Select the best solution:**

- Ask them to discuss and choose what they feel would be the best solution for each of their problems. Tell them that the solution they choose should have the most positive overall outcome.
- Read out or remind the family members (when appropriate), about the advantages and disadvantages they had earlier felt applied to that solution.
- When they all agree that a particular solution is the best option, review with them the reasons for making this decision. Ensure that they have considered all relevant factors that might influence it.
- Ensure that the family chooses a solution that the affected member is able to achieve. It should not be at a level much higher from his current level of functioning. For example, if the affected member wakes up at noon, then the goal can be for the affected member to wake up at 10:30 am instead of 8 am. They can include a range of preferred activities for the affected member to do when he gets up. These will act as incentives or positive reinforcers.

5. **Implement the solution:** Through discussions guide the family to plan each step that is involved in implementing the solution.

- All the family members and the affected member should agree upon the details of the plan.
- Through discussion, specify the participation of the family members and the affected member in each goal step. This will involve who does what, when, how, with whom and with how much help.
- Review after a week or in the next session, how successful they were in implementing the solution.
- Affected members usually have difficulty in initiating behaviour. The family members may need to use prompts to execute the plans. Discuss the kind of prompts that the family will use and ask them to practice them in your presence. The relative should be able to perform this prompting in a neutral way. It should not sound like or be misunderstood as “nagging”.
- When the affected member appears uninterested in performing the task, advise the family to discuss the advantages and disadvantages of doing it with them. They can also note down the advantages for the affected member to review.
- Your assessment may have indicated that the family members were previously over-protective, critical or intrusive in similar situations. Advise the families to be passive in such situations. They should let the affected member carry out the plan while they stand back. If prompting or assistance is necessary, then they should find a friend or less-involved relative to do this.
- Discuss all the possible eventualities and what they would do if the planned outcome is not achieved. For example, the affected member may not agree to do a task because they feel

agitated. Then the relative should know what to say or how to reassure the affected member so that the task can be done.

- Discuss coping responses for the family members. For example, if the affected member has to do a task independently and the relative is concerned that it may be risky, you will need to discuss the risks and the strategies for dealing with their worries. These may need to be rehearsed in your presence.
- Inform them that despite planning for all eventualities, it may not work out the way they had planned. Reassure them that sometimes things will be different from what they expected when they try it out. They will need to discuss and plan it again in the next session. They should not persist when they have repeatedly failed to achieve the step.

6. Review the solution:

- Review the progress made in your next session with them. Reinforce them for their efforts and their success. Reinforce the family positively when there has been a partial success as well.
- You may need to change, abandon or adopt new steps. Analyze what went wrong with the plan when they were unable to solve problem. Do not feel angry, blame them or become pessimistic about the family when there is no visible progress.
- Reassure the family that any failures to solve the problem are due to **planning failures**. You can tell them that “the task was too difficult”, “it was set too soon”, or “it was not planned well” or that they were not ready for it yet. This is important, as otherwise the affected member’s motivation will reduce. The family members may also assume that the affected member is “not trying”.
- Ask the affected member to rate on a scale of 1-10, the ease or difficulty they perceived in performing the step. This will help you understand the subjective difficulty of the task. Modify the plans to make the goals easier for the affected member to accomplish.
- The problem should be looked at again or a new problem chosen. A new solution may have to be agreed upon, taking into account the obstacles causing the failure. The family will have to repeat the problem solving stages again.

7. Maintenance and generalizations of the solution:

- If the affected member has been able to attain a targeted goal, then plan for them to continue doing so. Plan how to generalize the success to other activities and situations.
- In order for the affected member to continue with the task, discuss with the family what the possible reasons for the affected member to discontinue could be. They will need to consider the difficulties that the affected member may experience and how they can overcome such problems. They can use the previous steps to do solve these problems.

- For generalizing the solution, they need to identify situations that are similar to the achieved goal. For example, if the affected member usually avoids leaving the house and the targeted goal involved the affected member visiting a friend. Then can they identify other places of similar ease or difficulties that the affected member can go to? They could extend the distance or time away from home, or they could include other interests of the affected member into the outing.

After training the family, they should be able to:

1. Understand the need to solve problems effectively.
2. Learn the stages of problems solving.
3. Be able to identify their problems and generate solutions as a family.
4. Be able to decide on an appropriate solution and apply it.
5. Be able to recognize ineffective solutions and revise them.
6. Be able to maintain effective solutions to problems.
7. Be able to generalize this technique to other problems and situations.

C. Management of problems faced by the affected member

Objective: To assess the areas of daily functioning in which the affected member lacks. To educate, train and guide the family and the affected member on how the affected member can perform these daily tasks that are required for his independent survival.

Sessions:

You will need 3-4 sessions to assess the family and achieve the objective. You may need to review and discuss these techniques even in later sessions with the family.

Who to include:

You will have to speak to both the family and the affected member. You may need to demonstrate some of the skills as well.

Mode:

- a) Modeling
- b) Role-play

Guidelines:

1. Using examples, educate the family on some of the basic learning principles that will be used in the intervention. (**Refer to Setting Limits in the Chapter Basic Interventions with the Family**). Ideally, the family should learn how to use the behavioural principles and apply them to solving problems on their own without your assistance and guidance.

2. Discuss how positive and negative reinforcers increase or decrease the frequency of certain behaviours and how they can shape maladaptive behaviours to adaptive ones. Explain why complex behaviours need to be broken down into smaller tasks.
3. The family may have particular (and possibly valid) fears that an affected member cannot manage to travel on a bus or cross the road. Discuss the reality and likelihood of the negative outcome. Narrow down the fears from the general to the more specific ones and then the real problems if they exist, can be worked on.
4. Encourage them to adopt realistic but achievable aims which help the affected member to function as an adult again despite any residual problems. This may not be possible in all areas of functioning, as some long-term affected members may always need help with some aspects of daily living. Areas of competence should be identified and developed.
5. Identify the problematic areas. Arrange them in a hierarchy to know the most distressing problem, which can be focussed on first.
6. There should be agreement between them on small achievable tasks for the affected member to tackle.
7. Make a list of reinforcers-at least 5 material and 5 verbal reinforcers. The reinforcers should be considered valuable by the affected member, be able to motivate them and should be easily accessible by the family. The verbal reinforcers should be words commonly used by the family. The affected member should be able to understand them.
8. Initially the family should be instructed to use material reinforcers. They can later slowly withdraw these and introduce verbal and social reinforcers. They should use the reinforcers adequately to reinforce the affected member.
9. The affected member will find it difficult to do the task when it is presented as a whole for him. Hence, for each of the problem tasks, teach the family how they can **break** it up into a series of or sequence of small steps. The completion of all the small steps should achieve the targeted task.
10. The initial targets or steps should be simple and easy to achieve. They should be undemanding at first to reduce the possibility of failure. Gradually increase the targets until the affected member reaches a satisfactory level.
11. Motivate the family for the need to train the affected member. Point out to the family that by continuing to do the affected member's roles and tasks, the affected member will not become independent or improve. Reassure them that it is possible for the affected member to become self-sufficient to some extent.
12. Reduce the family's expectations of the affected member's performance by emphasizing that impairments linger for some time after an episode. Discuss with them the need for not being critical of the affected member's efforts. They should not make disparaging comments about the affected member's efforts.

13. Prepare families with chronically affected members to train the affected member for longer periods than others. They may become exhausted when they do it for long periods and so should be advised to adopt a less intensive training plan.
14. Motivate these families to actively participate. Motivate and encourage them to persevere and be patient.
15. Motivate the affected member to participate, to have belief in the training. Do this by helping them to understand the benefits of this training. Whenever the affected member attempts to achieve the target or does so, you as well as the family members, friends and peers, can praise and encourage them. This will motivate the affected member to continue.
16. The family should keep a record or diary of the affected member's performance each time. Monitor the changes in duration, frequency and intensity of the behaviour. This will help you to monitor progress and give an appropriate feedback to them.
17. Check whether the family is correctly following the suggestions given. This is important as their incorrect behaviours could result in the affected member discontinuing the training.
18. Do not expect immediate results. The recovery may be slow. Some affected members take longer than others do.

Assessment:

- Before assessing the affected member's current level of disability, obtain information from the family about his **previous level of functioning**. Ask the family to describe what all tasks the affected member used to do. You may need to ask specifically about areas that they have not mentioned.
- Ask the family about the **quality** of the work that the affected member used to do i.e. how well the affected member used to do the work. This should serve as a reference for how to plan the treatment. Did the family members have to prompt the affected member to do the work or would he do it spontaneously?
- Ask the family to describe their normal routine and practices. This will help you to plan your intervention to meet their needs and requirements.
- What does the family expect the affected member to do? Are these **expectations** realistic?
- Ask the family and the affected member to describe how the affected member spends his time. Ask the family members as well as the affected member, if possible, to describe the activities which the affected member is currently able to perform without assistance, with assistance, and activities which the affected member should be doing but is not. For the former, how well is he able to do the task? How often does he do the tasks? Does he complete the task?
- Does the affected member do any of the tasks without prompting? What kinds of **prompts** do the family use-verbal or physical? How many times do they have to prompt the affected

member before he does the task? Once he begins to do the task, do the family members monitor the work, ignore the affected member or are they required to be present to ensure that the work is completed?

- Ask the affected member if he is uninterested in doing the tasks. Does he get afraid or feel anxious when he has to do the tasks? Does he lack confidence or is he afraid of failure?
- What can be used as **reinforcers**- either verbal or material, to motivate the affected member to do the task?
- Are there sufficient natural resources such as regular supply of water for the affected member to bathe?

1. ACTIVITY SCHEDULE

Most affected members do not use their time productively. They may spend the day doing nothing in particular. Families as a result often complain that the affected member is 'lazy'. This can be overcome by constructing a schedule of activities for the affected member to do. It is important for the affected member to follow an activity schedule for the following reasons:

1. It will keep the affected member **engaged** in useful tasks
2. The affected member will be able to learn **punctuality** and improve his knowledge of time
3. It will improve his **memory, attention, concentration and judgmental abilities**
4. It will **distract** the affected member from becoming engrossed in the hallucinations and delusions.
5. It will help him to **develop problem-solving abilities**
6. It will improve his **initiation and independence**
7. It will improve his **self-confidence**

An activity is specific goal oriented behaviour. Activities like doing puzzles, telling stories, playing games, singing, dancing, creative writing are non-productive. Productive activities could be tasks like making a collage, stitching, making baskets, etc. When selecting an activity, it should meet the following **criteria**

- a) Be goal directed
- b) Have meaning to the affected member-meet his individual needs
- c) Involve mental and physical participation
- d) Be related to his interests and leisure activities
- e) Be adaptable, gradable and age-appropriate

An activity schedule involves the affected member 'doing' something i.e. being participative, involved and productive. It should be a **combination of work, rest, leisure, self-care and sleep**. Tasks should be gradable i.e., the affected member should begin from a lower level of difficulty and then move to higher levels. For example, initially an affected member can hang the clothes and fold them when dry. Later he could wash the clothes, hang them to dry, fold them and replace in the

wardrobe. Tasks should not be time consuming and elaborate. When negotiating the activities that the affected member should do, you should:

1. Offer a wide variety of **choice** from which the affected member should choose
2. Give careful **instructions** on how to do the task
3. Ensure that the affected member has the **capacity** to do the task
4. Ensure that there is a high probability of **success**
5. **Correct** the errors
6. **Encourage and compliment** the affected member when he does it right
7. **Advance** the affected member to higher levels as he becomes competent in a task
8. Encourage the affected member to have a **sense of responsibility** for advancement in tasks

The following is an example of an activity schedule. You can form similar activity schedules for your affected member after considering his age, sex and needs. The family members may be required to supervise the affected member in certain tasks. They should not pressurize the affected member to complete the activity schedule in any form. They can occasionally remind the affected member should he forget, to try to follow the schedule. A copy of the schedule can be affixed in the affected member's room.

7:00 am:	Awaken, brush teeth, brush hair, shave, basic hygiene, etc
7:15 am:	Tidy bed, exercise
7:30 am:	Bathe
7:45 am:	Say prayers
8:15 am:	Eat breakfast
8:30 am:	Wash plate and glass, tidy table
8:45 am:	Do productive work
9:45 am:	Rest or tea/coffee break
10:00 am:	Wash clothes
10:30 am:	Do productive work
11:30 am:	Household activities like cooking, tidying rooms, and folding clothes
12:30 pm:	Lunch
12:45 pm:	Wash plate, glass and tidy table
13:00 pm:	Rest
14:00 pm:	Productive work
16:00 pm:	Tea and converse with family members
17:00 pm:	Go for an evening walk
17:30 pm:	Free time
18:30 pm:	Shopping for groceries
19:30 pm:	Household tasks like helping in the cooking or other activities
20:30 pm:	Eat dinner
20:45 pm:	Wash plate and glass and tidy table
21:00 pm:	Watch TV
22:00 pm:	Sleep

2. PERSONAL HYGIENE:

- a) Brushing teeth: The affected member may or may not be brushing their teeth daily. Even when they do brush daily, they may not do so adequately. This leads to poor dental and oral hygiene. You will need to teach them the right way to do so.
- Insist that the affected member brush his teeth daily. The family members should be asked to ensure that this occurs. You can either demonstrate how to do so or you can tell them how.
 - Break the task into small steps. Pick up the toothbrush, then the toothpaste. Hold the toothbrush in the non-preferred hand and apply the toothpaste with the preferred hand. Place the toothbrush in the mouth and brush the teeth in a uniform 'up and down' manner for few minutes before rinsing and repeating two to three times. Demonstrate how to clean the tongue. Demonstrate how to wash the face, take the soap and apply it. Wash the face clean of soap and dry with towel.
- b) Bathing: The affected member may not be bathing or may be doing so with assistance from family members. You will need to tell them how to do so. First, establish the frequency with which the family wants the affected member to bathe- daily or alternate days.
- The affected member should take clean clothes and a towel with him to the bathroom. The affected member is to undress and keep the used clothes separately for washing. Collect sufficient water in a bucket at the required temperature. With the help of a mug, the affected member is to pour the water over body. When the body is thoroughly wet, the affected member is to take the soap and apply it all over the body. After which he is to take the mug and pour water over himself until the soap is completely washed away. He must then take the towel and wipe himself dry. He should then put on the clean clothes. It should not take more than 10-15 minutes to bathe everyday.
 - The family members and the affected member should decide how often the affected member should wash and oil hair. You may have to demonstrate step by step how the affected member is to wash hair (using a shampoo or soap) and dry with a towel. You may also have to demonstrate the different means by which the affected member can keep his hair free of lice and dandruff. Hair can be styled or trimmed once in 4-6 weeks (for affected members with short hair).
- c) Grooming:
- *Nails*: The affected member should have short and clean nails on his fingers and toes. You can demonstrate how the affected member is to use a nail cutter. The family can supervise the first few attempts of the affected member to ensure that he cuts it safely and neatly.
 - *Shaving*: You will need to demonstrate to the affected member how to shave his face. This will require showing him the steps involved such as: applying the shaving cream to the brush and applying it on the lower jaw. The right angle at which to hold the shaver and how to shave. To wash and towel dry the face afterwards.

- *Hair*: Show the affected member how to brush their hair. They must do so daily. In the case of women affected members, you may also need to show them how to braid their hair and tie it in the style they are comfortable with. They should try to maintain a neat appearance over the day.
- d) Basic Hygiene: This is a sensitive issue and you must be careful when you discuss this topic so as not to offend the affected member or the family. The affected member should be encouraged to have clean and regular toilet habits. You can demonstrate how to wash hands after using the toilet.
- For women affected members, you may also need to discuss how to maintain hygiene during menstruation. It would be preferable, if you are a male, to have a female colleague do this, as the affected member may feel uncomfortable. You may need to discuss with the affected member about the consequences of poor hygiene. You will need to discuss with the affected member to choose from the various options of materials available for this purpose and how they are to be used. Also discuss disposal and washing of soiled clothes. You should mention that these options be used for the next menstruation cycle.
- e) Keeping personal clothes clean and in order: The affected member may or may not have washed clothes before their illness. Those who have washed clothes and continue to do so may need to improve their skills. In some families, the family members may not be in the habit of washing their own clothes. They may have a maidservant to wash them or may use a washing machine. You can emphasize that paid help, washing machines may be unreliable, and therefore it is better to be self-reliant. It would be ineffective to insist on the affected member washing his own clothes when the family members do not perceive this as a need. The affected member can however be taught how to fold their clothes and stack them neatly in the wardrobes. However, if family members do wash their own clothes, the affected member can be taught to do so.
- You and the family members can teach the affected member the steps involved in washing clothes. You can ask him to express any doubts he may have. The family members can demonstrate how to wash and dry clothes.
 - The affected member should be encouraged to wash his clothes. He can begin by washing only a few items at a time and later increase the number of clothes. Clarify their doubts and give positive feedback in the next session.
 - The family members can demonstrate how to fold clothes using different items of clothes. The affected member should be encouraged to fold clothes.
 - Discuss the need for stacking and storing clothes in a neat manner. Family members can demonstrate how to arrange clothes in a wardrobe or box (whichever the family uses). The affected member should be encouraged to stack their clothes after washing and folding them.
- f) Dressing: The family members must ensure that the affected member has clean clothes and under clothes to wear everyday. The clothes must be chosen with regard to the weather or the occasion. Affected members are to maintain a neat appearance through the day.

- g) Eating habits: The affected member should be provided regular meals at regular times.
- The affected member should be told to wash his hands (with soap preferably) before eating the food.
 - The affected member is to take a plate and glass of water and place it at the table where he is going to eat.
 - The affected member should serve the food in sufficient quantity.
 - Let the affected member eat with his preferred hand or spoon. He must try to do so without spilling the food.
 - After finishing, the affected member should wash his hands, rinse his mouth and then towel dry face and hands.
 - The affected member should wash his plate and glass after eating. The family should teach him the steps involved in washing utensils.
 - The affected member can clean the table after eating. The family should demonstrate how this is to be done.

3. HOUSEHOLD TASKS

- The family should encourage the affected member to tidy his bed upon awakening. They should demonstrate how to fold the blanket, straighten the bed sheets and pillows.
- The family should encourage the affected member to change and wash the bedclothes as often as they usually do.
- The family should encourage the affected member to keep his room neat and clean. He should be encouraged to pick up fallen items and replace them. He should clean the floor if something has been spilt. Family members should demonstrate how this should be done.
- The affected member can dust their room at least every alternate day. He should sweep and mop the room everyday. Family members can demonstrate these tasks to the affected member.
- Encourage the affected member to participate in other household tasks. He can assist with the kitchen tasks by cleaning and cutting vegetables, can help set the table with plates, glasses, and the food containers. He can be asked to clear the table after meals, can wash, dry and replace the utensils in the appropriate places. He can also dispose the garbage in the dust bin.

4. MANAGING MONEY

- The family may need to teach the affected member to recognize the various denominations for both coins and notes.

- The family members should encourage the affected member to purchase things required for the family and him. Family members can initially give the affected member the exact amount to be spent. Later, the affected member should be encouraged to pay the appropriate amount, collect the correct balance and return home with the items.

5. PUBLIC TRANSPORT:

The affected member should learn to travel independently whether by bus or train. The family should teach him traffic rules-traffic signals, road crossing.

- The family should help the affected member familiarize the route to the bus stop. He should be informed of the bus route and number to take.
- If he is unsure, instruct him to ask his co-passengers or bystanders at the bus stop.
- The affected member is to ensure that he enters the correct bus before buying the ticket.
- If he is in doubt, he is to clarify with the bus conductor before boarding.
- The affected member should be told to carry sufficient money for travelling to and fro.
- The affected member is to state destination clearly to the conductor while paying for the ticket.
- The affected member is to retain the ticket until he alights.
- If the affected member is unsure of the route, he is to be instructed to check with the conductor as to which stop he should alight.
- The affected member is to behave well with the co-passengers.

6. CONVERSATIONAL SKILLS:

The affected member should learn to have meaningful, clear and socially appropriate conversation. He should be able to understand and express messages adequately.

- You can ask the affected member to repeat simple words and then later more complex words and sentences. These should be related to what the affected member should have to use in his daily life. The affected member has to pronounce the words correctly.
- Teach the affected member common greetings with its appropriate expression. Encourage the affected member to use them with the family within and outside the sessions. This will help the affected member to learn how to initiate conversations.
- Have conversations with the affected member. It should be on simple themes. For example, requesting family members to give something, buying something at a shop, meeting a new affected member, traveling in a bus, etc. These themes should be prepared before the session

and should be related to the affected member's needs. You can also give homework in the form of topics (of interest) to learn about which are then to be described and talked about in the next session.

- The affected member should be given the feedback in the form of suggestions afterwards. Encourage the affected member to be clear, loud, maintain eye to eye contact while talking. Encourage them to talk spontaneously, to initiate and maintain a conversation, to give elaborate answers etc. Encourage them to clarify doubts when necessary and to express appropriate feelings.
- You can reverse roles so that the affected member can observe and learn better. Use actions like hand movements, gestures etc to accompany the conversations.
- The affected member should practice with the family members between sessions. Family members are encouraged to have positive reactions to the affected member, to encourage them and to use reinforcements appropriately.

7. EMPLOYMENT/ EDUCATION:

Some families may be impatient for the affected member to go back to work or school. Others may be hesitant because of past experiences when the affected member was unable to tolerate the stress and had a relapse. It should be attempted only if the affected member has been stable for several months. All the family members should agree to it, so that they can be supportive and help in the problem solving. Educate the family that the skills necessary to be in employment or education are complex. These include:

- a) Ability to keep time
- b) Tolerance of a routine
- c) Independence
- d) Some motivation to do well
- e) Ability to pay attention to details
- f) Ability to understand and incorporate advice from supervisors or teachers
- g) Ability to communicate and mix with fellow workers or students
- h) Be able to recognize early signs of the illness and deal with them

Preparation for employment or education should be over a period of time. A graded approach can be used. Start with small steps and then increase the difficulty.

- ◆ The household chores can be used as practice for concentration, independence, taking responsibility and tolerance of routine. Gradually the number of tasks and the length of time can be increased.
- ◆ Homework practice can involve the affected member getting up at certain time to do certain tasks.

- ◆ Attending day care or vocational programs for some time will help them to practice time keeping, tolerance of routine and being able to stick to a job.
- ◆ The affected member should decide whether to inform the employer of the illness. Help the affected member by telling him the advantages and disadvantages of either decision.
- ◆ The affected member may have to look for a less ambitious job than they had previously.
- ◆ Prepare the family members for setbacks
- ◆ The affected member can begin by doing a part time job or returning to education part time.

For affected members who are very disabled, it will not be realistic to expect them to get back to work. You can help the family to view “running the home” and attending day care as work.

8. Coping with stigma

The affected member may have had many years of isolation due to which they may lack confidence, get embarrassed or feel threatened easily. They may fear rejection because they have had a mental illness. They may also be afraid because of their experiences of the responses and reactions of others to their psychotic symptoms.

- Thus you should be empathic but encourage the affected member to have realistic expectations.
- Help the affected member to weigh the advantages and disadvantages of continuing to isolate oneself from the society.
- Persuade the affected members that having the occasional symptom should not block their ability to socialize. Graded tasks and task assignments should be used to persuade affected members to go out and mix more easily. The family members can accompany the affected member the first few times.
- Persuade affected members to talk to the appropriate people in the right context about their illness without feeling shame. They should have the choice to tell or not to tell others about their experiences without feeling that it is very shameful and should be concealed. They would be unable to receive support from others.

9. Managing symptoms

- a) *Cognitive strategies*: These strategies attempt to control the symptoms by a change in the cognitive or thought processes.
 - Attention-switching The affected member switches their attention from one subject to another by focussing attention on distracting thoughts. For example, teaching the affected member to

concentrate on a positive and reinforcing image such as a pleasant holiday or a scenery when they experience a delusional thought or an hallucination.

- Attention narrowing This method can be adopted for a short time only. Examples are thought stopping, or when the affected member clears their mind or blanks out their thoughts.
- Self instruction The affected member instructs themselves or engages in a covert dialogue either to assess a situation or to cue behaviour. They can relabel illness-related experiences and it prompts positive coping strategies. Examples are “The voices are not real, they cannot hurt me and are just a part of my illness” or “ I must concentrate on relaxing and slowing my breathing”.
- Rational restructuring This method works well with some affected members only. It is difficult to apply when the affected member has either no insight or is completely convinced by the symptoms. The affected member can test the experience of psychotic symptoms in reality. This involves generating alternative hypotheses to prove the symptom to be real or illness-related. Evidence to support or refute these hypotheses are then collected and evaluated.

b) *Behavioural strategies*: These attempt to control the symptoms by a change in action.

- Engaging in solitary activities This involves some element of distraction and is used to decrease the affected member’s level of arousal. The affected member engages in an activity in response to their symptom that does not involve others. For example, the affected member could go for a walk alone, read, exercise, make something etc.
- Social withdrawal This involves actively disengaging from social contact. It is an escape or avoidance response and can have severe long term consequences in terms of isolation. It should be used carefully. It should be used as a means of gradually building up tolerance to social situations and as a temporary stress reduction technique. Goals should be set for gradually increasing their length of tolerance of social situations before the affected member disengages. It should be used as a rest period and then the affected member should re-enter the social interaction. For example, the affected member can withdraw from the conversation and not leave the room.
- Engaging in social interaction This helps the affected member to cope as well as to normalize their level functioning. Conversations may help to interrupt and inhibit the internal events like psychotic symptoms.

c) *Physiological strategies*: These attempt to control the symptom by producing a change in the affected member’s physiological state.

- Relaxation and/ or breathing exercises The various methods of relaxation such as progressive muscle relaxation or breathing exercises can help in distracting and reducing the arousal of the affected member.

D. Management of problems faced by the family

a.) What to do in a crisis? Or how to manage the affected member when acutely symptomatic?

The family will be unable to reason with acute psychosis. Advise the family members to:

- Not express irritation or anger. They should attempt to keep their emotions under control.
- They should decrease other distractions (TV, radio) immediately.
- Advise the family to calmly ask anyone (friends, guests) who are present to leave.
- They should speak quietly, firmly and with simplicity to the affected member.
- They should express understanding for what the affected member is experiencing.

b.) What to do when the affected member is violent?

The family can first identify the precipitating behaviours and events. Encourage the family to use problem solving steps. Encourage them to suggest methods of dealing with a potential violent behaviour. Some possible solutions are:

- Asking the affected member to go to another room or asking the involved family member to go to another part of the house or to leave the house.
- The family can also contact the **police** and explain what they are experiencing. They can seek their help to obtain treatment, to control the violent behaviour or admission.
- They could contact the treating **doctor** and ask for advice.
- Inform them that they can also write to the **magistrate** for admitting the affected member.

They can also suggest preventive measures such as keeping knives and other objects away from the reach of the affected member.

c.) What to do if the affected member refuses to take medication?

Some affected members do not believe they are ill. They may accept as fact their hallucination, delusions or perceptions of reality, however unreasonable they may be. These affected members are difficult to maintain on medication. If the family or you attack these beliefs, you can lose both the affected member's trust and your own credibility. Certain specific techniques can be used, such as:

- Through negotiation, encourage the affected member to give the treatment and medication a fair **trial** to see if it can help. Help the affected member to appreciate that the medication may 'decrease anxiety' or make them more comfortable.

- The family can introduce **benefits** or privileges, which the affected member can obtain if they agree to medication.
- If affected member terrorizes family members or behaves in dangerous way to others or home, the family can use an **ultimatum**. They could say that the affected member must take medication and maintain a minimum level of appropriate behaviour or they cannot live at home.
- Replace oral medication with medications given by **injection**. This also helps remove the family from the role of having to monitor affected member's by counting their pills or continually asking them if they have taken their medication that day.

d.) How to cope with stigma?

Families often cope better if there is a larger network from which they can ask for help or find relief. The usual excuses that the family gives for not going out are: "I am too tired", "I do not have the time", and "my son (affected member) needs me or cannot be left alone. Although there may be some truth to this, it is important that they be pushed so break out of their isolation. You can frame it as "You need to look after yourself to help the affected member" or "the affected member needs to be on their own to encourage independence" or "everyone in the family needs to look after themselves in order to cope". Family members should break out of their isolation by

- Forming relationships outside the immediate family
- Set graded tasks where the family can make short outings to test their fears of being rejected or looked down on.
- Gradually increase the difficulty of the tasks

e.) How to cope with the affected member's sexuality?

Some families may refuse to talk about sexuality. It may be felt to be too painful, culturally unacceptable or inappropriate and problems will be denied. It is not necessary to insist that a family face these issues. If it is an area where the family identifies problems, then you should facilitate solutions.

Parents may find it difficult to cope with the fact that the affected member is likely to have sexual needs and may choose partners who the family members may not approve of or welcome. These partners could be other affected members. They may also have casual sexual contacts. Risks such as AIDS, pregnancy are understandable fears in the caregivers. You should

- Aim for a realistic and frank **discussion** of sexual needs in adult affected members. This is not an issue for all affected members.
- Sexuality needs privacy and acceptance by the rest of the family- ways of achieving this may have to be discussed. The family's **fears** of risk of pregnancy and diseases have to be brought in the open. Clarify whether affected member has taken responsibility for himself or herself. Look at the likelihood of various negative outcomes-the families worst fears may not be realistic.

- Encourage the family to openly discuss their worries of pregnancy-whether the baby will inherit the illness, whether the affected member will be able to look after the baby or whether the affected member should have the baby at all. Encourage the family to discuss the options and come to some agreement.

f.) How to cope with the affected member drinking alcohol/ smoking cigarettes/ drinking numerous cups of coffee or tea?

This is an emotional issue. Some families have the misconception that the affected member's illness started because they mixed in bad company and used alcohol or drugs. They misattribute the cause of the illness entirely to this. Make clear to the family that although they have the effect of enhancing vulnerability to the onset of the illness or relapses, they on their own do not cause the illness. The family may otherwise blame the affected member for causing their illness.

Drinking alcohol:

- Inform the affected member of the danger of drug use and its harmful effects such as its effect on tranquilizers or they may become violent when demanding money for drinks or when drunk.
- They should be advised against any substance abuse.
- Complete abstinence may not be possible or necessary.
- Help the family and the affected member to discuss the potential problems related to alcohol intake
- Affected members can be helped to experiment with how much alcohol they can take without getting intoxicated.
- Advise the affected member against more than 2 drinks a day.

Cigarette smoking-help the family members to set limits with regard to specific problem behaviour related to smoking (e.g., smoking in bed, limits to the use and emptying of ashtrays, etc)

Coffee or tea-explain how this can lead to shakiness, nervousness, excitement, restlessness and sleep problems

- Explain how it is difficult to differentiate between the effects of too much caffeine intake from anxiety, nervousness and excitement which may be part of the schizophrenic process itself. It is also difficult to separate from akathisia.
- Amount of caffeine intake should be moderated.

g.) **Suicide**

- If families comment that they wish the affected member dead during the sessions, interrupt and immediately comment on and reframe the remark positively. Discuss and reassure them that there are positive aspects of the affected member.
- Establish the reality of suicidal feelings and possible actions. Affected members may have warning signs of these feelings-either as part of a relapse or part of new feelings of depression.
- Encourage the affected member to share feelings of loss and hopelessness- that they may never recover fully and life may be too difficult for them from now on. If the affected member can share these feelings and warning signs or the relatives are familiar with it, then the action that can and should be taken can be rehearsed with the family.
- They can make a telephone call to their doctor, the treating team or to the emergency services if they are very concerned.
- If risk level significant, frequent monitoring or hospitalizations may be necessary.
- If the affected member becomes depressed or hopeless, discuss lowered expectations and help them to come to terms with it. Can use “collapsing time” technique to discuss how they can make progress in a very long time span such as one or two years-you may be able to look back over previous years and find evidence of this.

h.) **Marital issues/ Separation / divorce**

Your focus is to help the couple to cope more effectively with the illness and their relationship. Clarify repeatedly of your commitment, support and positive intent. Ask for periodic feedback to insure that no misunderstanding or alienation has occurred.

Avoid

- aligning with one of the partners
- assuming the role of the adversary or champion of either partner

Marital: spouses must learn to play multiple roles as the illness may recur.

1. Address marital issues such as impact of the illness, negative symptoms, and secondary gains.
2. The discrepancies between the affected member's past and present functioning may be significant. Help the couple to mourn past competencies before beginning to assess, negotiate and eventually assume redefined roles.
3. Consider **role reversal** of conventional roles. The wife may go out to work while the husband cares for the home, children, or both. If this is not possible for a male affected member, negotiate carrying out tasks such as mending or fixing things, which represent a valued contribution.

4. For a female affected member undertaking a conventional role, help may be needed in improving skills such as shopping, budgeting and cooking. Distinguish between lack of opportunity to exercise a skill and basic lack of the necessary skill.
5. The healthy spouse should be encouraged to **reward** the affected member with praise for successfully completing small tasks.
6. As affected member improves, aim for a more **balanced relationship** with affected member being given greater responsibilities. This should be accomplished in such a way as that it does not allow for the affected member's role to dominate either spouse's view of the affected member or the marriage.
7. Encourage spouse to find same sex confidante.
8. Suggest better **communication skills** such as initially encouraging the affected member to make more sense, reinforcing clarity and limiting bizarre communications. Later helping them to make their needs better known to each other. Help them to translate their complaints and concerns into measurable and achievable goals. Reframe events and behaviours positively (**Refer Chapter VIII Handling Communication and Emotions**)
9. Re-establish a **warm relationship** by using the following three strategies:
 - a) Ask each partner to say something positive about the other affected member. If they complain they cannot think of anything positive currently, the ask them to remember a positive aspect of the affected member in the past.
 - b) Ask each partner to say something they would like the other affected member to do for them and negotiate for this to be carried out. Ensure that the task is within the affected member's capabilities.
 - c) Find something that the partners would enjoy doing together outside the home and set them the task of trying it. If they complain there is nothing at present that they enjoy doing together then get them to review the history of their relationship to find a suitable activity.
10. Avoid emotionally charged issues to reduce the risk of overstressing the affected member.
11. Review **medication** to ascertain effect on libido, erection and ejaculation. A spouse may interpret a reduction in their partner's sexual interest and activity as a sign of loss of love and affection. It is important therefore to give an alternative explanation.
12. If alterations in medication are unhelpful or not possible, and they want further help, refer them to a therapist specializing in sexual problems.
13. Make up for the loss of sexual relationship by adopting a less threatening kind of intimacy such as hugging or cuddling etc.

Separation: Despite your best efforts, the partners may remain irreconcilable. Under these circumstances, you should help them to separate in as constructive a manner as possible.

- Assess how serious and soon it may occur.

- Discuss the pros and cons of such a decision fully as at times, the desire to leave may be related to a temporary sense of frustration or a need for a time out rather than a genuine wish to terminate the relationship. If so, then focus on finding ways to increase support for the spouse.

- Assist the spouse to express guilt about deserting the affected member and explore anxieties about possible disastrous outcomes such as suicide or destitution.

- Negotiate short term treatment contracts to include:
 - a) Establishing a time schedule that helps to ease the abruptness of this change
 - b) Help each partner to better understand the reasons for the dissolution of the marriage
 - c) Help each spouse to plan for the separation-possible sources of emotional and practical support for the affected member need to be identified and brought in so that they are not left completely isolated.
 - d) Establish ways of coping before the associated stress and pain occurs.

- If there are children in the household, their welfare must also be considered.

Divorce:

- Help them to separate with minimum of stress and chaos, hopefully after an acute episode when the affected member is at their best.

- Avoid judging the behaviour of the departing spouse-leaving someone who has a mental illness is difficult.

- Assist the spouse to express their ambivalence guilt and anxiety.

- Do not implicitly or explicitly suggest to either spouse that there is a right or wrong way to behave under these circumstances.

- Facilitate whatever decisions either spouse feels must be made.

Reviewing Home work

Review the homework to ensure that the family and the affected member are learning and practicing accurately the skills.

- Ask the affected member and the family whether they had practiced the homework assigned previously.

- If they have not, determine the difficulties they experienced in doing so. If they are pessimistic, encourage and motivate them.
- If there were difficulties in implementing it, clarify these details and encourage the family and affected member to use problem solving approach to overcome it.
- If they have done their homework, ascertain whether they are doing it correctly. Correct them if they are not.
- Ask the affected member how successfully and competently he was able to perform the task
- Ask the family the same question.

By doing so, you will be able to:

1. Assess the level of competence achieved by the family and the affected member in that area
2. Assess the level of interest and motivation of the affected member and the family in learning (or teaching) the skill
3. Assess the efficacy of your training.

If the affected member has been able to successfully do the task, you and the family members should praise the affected member. If the affected member has been unable to do so, do not let the family members criticize him. They should instead encourage him to improve before the next session.

If the affected member is consistently unable to perform the task, you should explore the barriers preventing them from achieving the goal. For example, are the family members constantly critical of the affected member's efforts? Does he have opportunities to do the tasks? Do the family members do the task for him? Such issues should be addressed.

Conclude the review of homework by setting new goals based on the affected member's earlier performance.

After these training sessions, the family:

1. Should perceive a need for the affected member to do tasks independently
2. Should understand the behavioural principles involved
3. Should be able to encourage and teach the affected member to re-acquire skills that were lost or impaired.
4. Be able to maintain the skills gained.

**WHEN YOU ARE FAMILIAR WITH THIS CHAPTER, USE MODULE IV (page no.: 94)
TO CONDUCT SESSIONS II TO V
(ASSESSING AND MANAGEMENT OF DIFFICULT PROBLEMS WITH THE FAMILY)
READ CHAPTER VIII FOR HANDLING COMMUNICATION AND EMOTIONS WHICH IS ALSO
COVERED IN SESSIONS IV AND V**

CHAPTER VIII

HANDLING COMMUNICATION AND EMOTIONS

SESSION IV AND V

Objective: To help family members learn effective clear communication, for sharing information, feelings and needs.

Session: After an assessment of the family's strengths and weaknesses in communication, you will have to instruct and guide the family in various communication skills. You will need 2-3 sessions to do so.

Who to include: Family members and the affected member

Mode: The various means by which you can train the family are:

- a) Guidance
- b) Homework assignments
- c) Role-play
- d) Modeling

Guidelines:

1. In your interactions with the family and the affected member, and especially during the sessions on problem solving, you would have observed certain characteristic patterns of communication within the family. (**Refer: 'How do families communicate' in Detailed Assessment of the Family and 'Identifying Inappropriate Responses of the Family' in Basic Interventions with the family**).
2. You may have noticed that families who have high levels of emotional tension and cope with numerous problems have a different pattern of communication. They may speak in a manner, which is difficult to interrupt. They may have lost the ability to listen to others and so speak in repetitive monologues which are unaffected by another affected member's response to their statements. The affected member may be left out of the conversation.
3. Based on these and other observations, you will need to assess what are the strengths and weaknesses of their communication pattern. The guidelines for making these observations are given in the assessment chapter. Ascertain if the family's communication involves:
 - a) Criticism: A critical comment is an unfavorable comment upon the behaviour or personality of the affected member. These are evident in the content of the remarks that family members make and the tone of voice that family members use. For example, " He just sits in his room all day long' shows a critical content and " he just *sits* in his room *all day long*" shows the critical tone.

Most of the critical feelings are due to misunderstandings of the affected member's behaviour, especially the negative symptoms. The psychoeducation, problem solving skills training as well as the management of difficult problems should help the family and the affected member to understand and overcome it.

- b) Hostility: These are comments that negatively evaluate the affected member as a affected member, rather than criticisms of specific things they do or fail to do. They are directed against the affected member rather than the behaviour. They can be generalizations from a specific criticism (" she doesn't wash the dishes properly, she's not good at anything"). It can be in the form of a rejecting comment, such as not wanting the affected member back or an expression of dislike ("I don't want to be with him anymore").
- c) Emotional over-involvement: It refers to a number of specific behaviors and emotional responses that are viewed as over concern responses. Some of them are: self-sacrificing behaviour, exaggerated emotional responses, extreme over-protectiveness, and extreme preoccupation with affected member's illness, emotional displays during sessions and emotional distress.

To differentiate between what is normal or usual concern from this, you can examine their responses to the illness (which are understandable given the severity of the illness) but which are unhelpful in solving the affected member's problems and may serve to increase their distress.

- d) Warmth and positive remarks: Warmth includes statements of sympathy, concern and empathy for the affected member, concern for the well being of the affected member as a affected member and indications that the family members enjoys the affected member's company and doing things together. A warm tone when talking about the affected member also indicates a positive attitude. Positive remarks refers to statements that specify the affected member's abilities, skills and positive attributes.
4. You should be able to conclude which aspects of the communication need to be changed and which need to be retained. In your sessions with the family, you must focus on improving the latter.
 5. Your communication with the affected member and each family member will **model** for the family how they should be speaking to each other.
 6. You must not show irritation, anger, and make critical or rejecting comments to the affected member as well. You must try to remain calm, talk in an even tone and not be shocked or upset by the family's behaviour. You will be modeling a constructive resolution to differences in opinion. You are thus the only example that the family will be exposed to on how this can be done. You must also not "take sides" with family members as this will leave others feeling neglected and misunderstood.
 7. You must avoid being critical of the family members. You should be firm and affected member in your approach when insuring that family members follow the rules of communication. They may need frequent reminders of the rules.

8. Use examples from the conversations that the family members have had in your presence.
9. Value each member's point of view (even if it is expressed poorly). This ensures that all members feel they are contributing to the session.
10. Point out to the family that they also communicate through their gestures, facial expressions, and body positions. This can reflect their interest or appreciation as well as their annoyance and lack of interest. Teach the family the listening skills. (**Refer: 'Listening skills' in Engaging and Maintaining the Family**).
11. You can instruct the family as to what are the "do's and don'ts" of communication.

The Do's and Don'ts of Communication

- a) You can tell a "noisy" family, for example, that **only one affected member should speak at a time**, as it is difficult to listen to two people at the same time. This will help the family members to increase their self-control. It will also help them to show more respect for what the other affected member has to say.
- b) You can also tell the family other rules such as they **should talk to a affected member, not talk about them**. This reduces the expression of negative emotions like hostility and criticism. It also prevents the affected member who is being talked about from feeling as though he was not present.
- c) You must ensure that all family members get an **equal opportunity to talk**. This will involve controlling the talkative ones and encouraging the quieter ones to share their views. As the affected member is usually left out, you can allot some time for him to speak. Family members should not interrupt during this time. If the affected member feels pressured to speak, you can reassure him by stating that it is okay if he does not speak, but should he do so, the others will keep quiet and listen.
- d) Encourage the family members to **listen** to the contributions of other members. You can do this by stating that other members are saying something important and they should listen to it. You can then ask the listener to repeat what was said in his or her own words. This also reduces arguments and conflicts since family members are being listened to.
- e) You could also, if necessary, introduce rules of turn taking and listening by giving each family member say, two minutes time to speak their views.
- f) If family members speak in a muddled or unclear way, you can state that you are not quite clear as to what their message is. You can then ask them to clarify what they had said earlier.
- g) **Non verbal** communication includes:
 - Eye contact & Facial expression
 - Posture
 - Body language
 - paralinguistic (loudness, tone, pitch, rate, affect, duration)

Expressing feelings

- Demonstrate to the family, using examples from their conversations, how they can express their feelings in a clear and direct way. Advise them to not blame the affected member or other family members and to avoid global statements like “all of us feel.” Instead, train them to take responsibility by using “I” when expressing their own feelings.
- Allow the family members to admit to having negative feelings. Do not be shocked or surprised by them. These negative emotions exist and you should listen to them.
- Ensure that family members do not use the negative feelings to attack other family members during sessions. You need to be vigilant for such comments and prevent them from causing arguments and upset feelings.
- Family members may state that they wish that the affected member is dead and may say so in the affected member’s presence. You should immediately **interrupt, comment on and reframe** the remark. You could say that the family member feels this way because they are concerned that the affected member’s quality of life was so poor, that he would be better off dead. Reassure them that there are still positive aspects about the affected member.
- If a family member appears angry in a session, you can defuse this by ensuring that they **specify** what it is that they are angry about. You must help the family to move from general statements (“you are lazy all the time”) to a specific behaviour (“I want you to get up in the morning”). This helps you to identify the problem and solve it through problem solving training.
- Family members should not use the sessions to argue. However, when this occurs, you should be able to control the session and not let it become uncontrolled.

Positive Communication

- You can reframe the anger that the family member has by saying how the feeling reflects how much they care about the affected member. It helps the family to channel their feelings into making changes rather than being destructive and hopeless.
- Family members may tend to ignore or minimize the positive interactions and accomplishments of the affected member. You will need to encourage the family members to **recognize, focus on and reward small positive behaviours**. They should not over-reinforce. Recognition and expression of positive and supportive comments help the family to become more hopeful. It also encourages the affected member to attempt positive behaviour.
- You can ask the family members to each say something positive, to ask what they like about each other. If they become silent, you can offer some suggestions about positive things that they have noticed. The family members should be encouraged not to neglect or take for granted positive behaviour.
- You can also check whether positive comments have been heard and registered by asking the family member to repeat what has been said about them.

Handling expressed emotions

(Refer 'Expressed Emotions' in Management of Schizophrenia and Guideline 3 of this section).

- Help the family to avoid “mind reading” as well as tendencies to ignore confrontative messages.
- When family members make rejecting comments (“I can’t live with you any more”), you must help the family member to learn to reframe this in a more positive manner. For the above statement, the family can instead say, ‘I feel so upset and I wish things were different’.
- When the family members are worried, they may say, “I can’t let you live on your own”. This can be reframed as “I am worried that you may not be able to manage and that some harm may happen to you.”
- You can use a role-play as well. You could put a critical or hostile family member into the role of the affected member and ask the affected member to demonstrate how that family member behaves towards him. This forces the family member to empathize with the affected member’s experiences.
- When family members are over-involved, you can draw their attention to what would happen to the affected member after they are ‘gone’. You can thus emphasize the need for the affected member to be independent and care for himself or herself.
- Show family members how their fears of what will happen to the affected member if they were to leave them are often exaggerated. You can check with the family the likelihood of such fears occurring.

Improving affected member’s communication patterns

- Social interactions of the affected member reduce after the illness. The affected member may need to develop or redevelop conversational skills and increase his awareness of others before this can resume. The affected member may have lost his ability to make “small talk” or the sensitivity to understand the impact of his words and behaviour on others.
- Discourage the family members from ‘speaking for’ the affected member. The family members should learn to wait for the affected member’s response. They should learn to recognize that the affected member is capable of contributing to the conversation.
- Within the sessions, social conversation and problem solving between family members can provide a practice ground for the affected member to communicate in a clear, simple and direct manner. You can give the family non-controversial topics to discuss. Observe the manner in which they speak. Reinforce the correct behaviours and encourage them to improve on the other areas. You may need to demonstrate to them how they should have reframed the sentence. In this manner, you will model for the family the appropriate communication skills.

- You can also give the family homework assignments to practice at home. You can review how successful they were in the next session. Make them negotiate daily activities, household chores and roles in the family.
- Family members must be discouraged from ignoring, reinterpreting or trying to make sense of unclear messages from the affected members. Inform them that tolerating poor communication gives the message that affected members need not learn to be clear in interactions with others. Encourage the families to say that they do not understand what the affected member is saying or that it was unclear and could the affected member repeat what he had said.

After training the family, they should:

1. Know and follow certain rules while communicating with each other
2. Take responsibility for their own feelings
3. Be able to express positive and negative statements
4. Should be able to make specific statements about each other
5. Avoid hostile, rejecting and intrusive comments

**WHEN YOU ARE FAMILIAR WITH THIS CHAPTER, USE MODULE V (page no.: 101)
WHILE CONDUCTING SESSIONS IV AND V
(HANDLING COMMUNICATION AND EMOTIONS WITH THE FAMILY)**

CHAPTER IX

TERMINATION AND FOLLOW-UP

SESSION VI

The intervention will have to end at some point. *Initially sessions are held once a week, they can then be held once in two weeks and later once a month.* The family will have to be warned ahead of time of the leaving date so that they can prepare themselves for it.

Should you need to leave before completing the intervention, introduce the replacement Intervention Worker to the family before you leave. If you have completed the intervention, you can leave a telephone number with the family, should they wish to contact you.

1. You should prepare the family for the **recurrence of old problems** and/ or the appearance of new ones as being part of the nature of schizophrenia. The family should try to solve these problems as they had during the intervention. They should contact you only when they are unable to cope.
2. The family may feel angry or upset when you terminate the intervention. They may feel that they need your continuous support to care for the affected member. Reassure the family by giving specific examples of how they have learnt to solve and handle their problems during the intervention. Encourage the family to be **independent** and confident to deal with any issue.
3. **Review** the changes that have occurred as a result of the intervention with the family. Identify the positive changes in their attitudes, behaviour, and communication with the affected member. Highlight their ability to resolve problems. Identify the positive changes in the affected member's activity levels, his independence in doing tasks related to his personal care and household chores.

At times, the family members may not accept that changes have taken place. Do not force them to admit that changes have occurred.

4. There may be rare occasions where the family expresses that they wish to stop the intervention before it is appropriate to do so. This may leave you shocked, angry or rejected. You should handle it by:
 - ◆ First determine the type of termination being considered. The affected member and the family may decide to stop the family intervention but the affected member may wish to continue the medication. This provides a link with the family and allows for continued monitoring of the affected member. It might also later lead to an opportunity for restarting the family intervention should the need arise.
 - ◆ Not attempting to **prove** to the family the value of your work together as this will lead to confrontations and arguments.

- ◆ **Accepting** what the family says.
 - ◆ If possible, try to find out what the problem is. If it is something specific, then you may be able to change your approach or deal with the problem.
 - ◆ If the family is uncooperative, then you should try to arrange a final session in order to say goodbye and to do some work on leaving. Arrange this session after a few weeks so that the family has time to calm down.
 - ◆ Review the progress made and rehearse coping strategies for any emergencies with the family. Tell the family that you can be contacted (by leaving a telephone number) even if they reject it.
 - ◆ You should not show the family that their decision and behaviour affect you. Stress that although termination has occurred, you will remain available to the affected member and the family should the need arise. Inform them that you would like to see them again should they change their mind and wish them well for the future.
 - ◆ You can also after a few weeks telephone them to see how they are managing. The family will realize that you are willing to be involved and are still concerned.
5. When the families visit you on follow-up, you should review what has occurred since their last visit-their abilities to solve problems that arose, their communication patterns with the affected member and other members, the progress of the affected member's functioning, homework given in the previous session, etc.
 6. Reinforce the positive aspects they have achieved since the last session and encourage them in areas they have failed. They may need to review ineffective solutions to their problems. They may have new problems and expect you to solve them. Encourage them to solve it on their own. You may need to remind them of the do's and don'ts of communication, the way to reinforce the affected member, how to avoid adopting maladaptive coping behaviours, etc. Fix the next appointment a couple of weeks or a month later.

**WHEN YOU ARE FAMILIAR WITH THIS CHAPTER, USE MODULE VI (Page no.: 103)
TO CONDUCT SESSION VI
(TERMINATION AND FOLLOW UP WITH THE FAMILY)**

CHAPTER X

HANDLING INTERVENTION WORKER STRESS AND BURN OUT

While working with the family, you will tend to get affected by the pain that they experience. These may remind you of your own painful memories, unfinished businesses and old conflicts. You can feel stressed by a number of other factors while working with the families. Some of these are:

1. Having to work with more than the usual number of families.
2. An inability to help distressed family and/or affected member feel better.
3. Families who do not express gratitude
4. Your own doubts about the value of the intervention
5. Inability to maintain a professional distance
6. Inability to stop thinking about the family and/or affected member after leaving work
7. Isolation from other professionals
8. Professional conflicts with colleagues
9. Dislike of the family and /or affected member
10. Sexual attraction to a family member and/ or affected member

The stress that you may feel is usually related to the beliefs that you may have. If you have high goals of perfection, you are more likely to experience a higher level of stress. This is because you feel frustrated at being unable to meet your high expectations. You may then view the slow progress of the family and affected member as evidence of your failure, incompetence and inadequacy. The most stressful beliefs are:

- a) "I should always work with maximum enthusiasm and competence".
- b) "I should be able to cope with any emergency that arises".
- c) "I should be able to help every family and affected member."
- d) "If the family and/ or affected member does not make progress, it is my fault".
- e) "I should not apply for leave when I know that a particular family and /or affected member needs me".

- f) "My job is my life"
- g) "I should be able to work with every family and affected member"
- h) "I should be available at all times".
- i) "Their needs come before mine".
- j) "I am the most important affected member in their life".
- k) "I am responsible for their behaviour".

You may feel that when you are able to help another, that you are able to have an impact on their lives, to have power to control others. This makes you feel important, significant and that they need you. When you are able to do this, you feel you are making a significant difference in their lives. When you are unable to, you may feel you are not making a difference and are not reaching clients.

You must recognize that your work will have an impact on your life. You must do something in order to avoid burnout (described below). It can also affect your personal and professional life. You must avoid assuming complete responsibility for the success or failure of your intervention or you will create your own stress. The family also has a responsibility for what they choose to do with their and the affected member's life. You must accept your own limits. You must share the responsibility for success of the intervention with the family and affected member.

BURN OUT

What is burn out?

The term "**burn out**" is used to refer to a state of physical, emotional and mental exhaustion. It results from repeated emotional pressures. It is often associated with intense involvement with people over a long time. There are three dimensions defined in the burnout syndrome:

- (1) emotional exhaustion, feelings of being emotionally overextended and exhausted by one's work,
- (2) depersonalization, an unfeeling and impersonal response towards clients and
- (3) A reduced sense of personal accomplishment, which has been conceptualized as feelings of inadequate personal achievement accompanied by a diminished sense of self-esteem, and a tendency to evaluate oneself negatively with regard to one's work with clients.

This problem is critical for people like you, working in the human service field. With the emphasis on giving to others, there is often not enough focus on giving to oneself. It is an occupational hazard that most professionals face at one point or another. It is important to be prepared for it. It can prevent you from communicating hope and providing a healthy model to your clients.

What characteristics indicate burn out?

- You feel physically depleted and have feelings of hopelessness and helplessness
- You lose concern for your clients
- You begin to treat people with whom you work in ways that are detached and dehumanizing
- You become cynical towards your clients
- You often blame your clients for your problems
- You experience frustration and psychosomatic ailments.
- You may begin to cope with prolonged stress by abusing drugs
- Your therapy sessions lose their excitement and spontaneity
- You fall behind in paperwork.
- Your social life suffers
- You are reluctant to explore the causes and cures of your burned out condition.

What are the causes of burn out?

There are a number of causes of burnout. You must keep these in mind if you are to avoid it.

- Responsibility: You should not feel responsible for what the family and affected member does or does not do. Do not assume total responsibility for the direction the intervention is taking. Do not have extremely high expectations of yourself.
- Clients: this is a factor when you have to constantly work with clients whom you don't like, who are unmotivated yet demanding, who do not appreciate or value you. Working with people who resist change, with those who do not want to be helped and with those people for whom the chances of change are small because of the nature of their illness.
- Problems outside of your work situation such as marital, health etc, which you are unable to resolve. These can interfere with your ability to work effectively.
- Investing a lot of your emotional and personal energy to others and receiving a comparatively lesser amount back.
- Being placed under a constant pressure to produce results within a certain time. The time frame to produce the work and the pressure being applied should be unrealistic.
- Having to do the same form of helping repeatedly without any variation.

- Having to work in an atmosphere where there is a lot of criticism but no support from your colleagues.

How to avoid burn out?

- How you approach your tasks and what you get from them is more important than how much you are doing.
- Learn to set limits with demanding clients.
- Learn the value of humour-it helps keep things in perspective
- Develop a circle of colleagues whom you can trust. Meet with them to discuss difficult cases, personal concerns.
- Have activities, hobbies and interests beside your work. These can serve as a distraction so that it does not dominate.
- Keep in mind your most important professional objectives. Avoid getting involved in unrewarding tasks and forgetting your priorities.
- Learn the value of expressing negative feelings about your work, rather than keeping your reactions to yourself.
- Attend to your health by exercising and eating well.

You will find working with families with a schizophrenic member emotionally demanding. Most families will at some point feel overwhelmed by a sense of hopelessness and despair. They may feel that despite their best efforts and your input, the affected member is not progressing. You may feel affected by this and also come to believe that there is no hope and that nothing can help. You need to remember that these feelings stem from the family and that there is always something, however small, that can be done which will lead to improvement.

It would be preferable if you have a support group of colleagues with whom you could meet once a month. You can bring these feelings to the group. The group can help you by generating new ideas and ways of tackling the problems when you feel you are stuck. The support of the group should sustain you through the family's phases of hopelessness.

CHAPTER XI

CASE VIGNETTES

Case Vignette 1

Joseph, a 21-year old First year Engineering student, diagnosed with Residual schizophrenia was referred for family intervention. He complained of being unable to concentrate on his studies, as he could not focus for more than a few minutes. He spends all his time in bed or sitting outside near the shops smoking beedis. He picks up beedis from the roads. His parents ask him to study but he says that he will start the next day.

After engaging the family for the intervention, the intervention worker assessed the family in detail, their knowledge of illness and Joseph's daily routine. The assessment revealed that the father often criticized his capabilities as a student and perceived his negative symptoms as "laziness". The mother gave him the money for buying beedis. She believed that her son would be cured completely if the right poojas were offered.

From the assessment of his daily routine, the intervention worker inferred that he woke up late partly due to sedation and partly due to habit. His routine consisted of watching TV for a short time after which he went back to sleep and then wakes up for lunch. He then goes to a nearby shop and sits outside it smoking stubs of beedis. In the evening he comes home and often gets into an argument with his father on the issue of not showing any interest in studies. The intervention worker inferred that the family had an inadequate knowledge about the illness, its treatment especially rehabilitation and that the family's communication patterns were not healthy.

During the psycho-education sessions, various aspects related to causation, treatment, and rehabilitation were explained to the family. The families own beliefs about the illness were examined. A special emphasis was made on the negative symptoms of schizophrenia as the family attributed his amotivation to laziness. The critical and generalized comments by the father reduced after these sessions.

The family was encouraged to discuss what they each expected from the affected member in terms of duties and responsibilities. The duties elicited were weighed to see if they were realistic. The intervention worker helped the family to form realistic expectations. The intervention worker helped them to identify his positive behaviours and encouraged them to be more appreciative of them, and to encourage him when faced with difficulties. The family members concluded that Joseph was not ready to return to college as he was unable to tolerate a routine. The intervention worker and the family members negotiated an activity schedule with him.

As there was a day care center near to their residence, Joseph was encouraged to go there. He was placed in the typing section as he had attention deficits. To make the vocational input more meaningful to his needs he was encouraged to type his class notes. He later said that this was an useful exercise.

Over the next month, his attention span improved and he developed a work routine. He continued to smoke beedis – but only twice a day. His routine ensured that he was either at home or the vocational center. Later the family discussed his progress with the intervention worker and it was decided that he was ready for attending tutorials thrice a week. He also continued to attend the vocational training institute and was shifted to the computer section. He continued to perform satisfactorily, typing his class notes into computer files. In addition, he also learnt a few other basic programmes.

During the follow up sessions, it was found that the family's communication patterns had improved, they encouraged him more. Criticisms had reduced to great extent and the family had improved in their ability to express positive comments to each other as well as to Joseph. The need to do this continually was stressed and the family was seen for booster sessions for a period of two years. Joseph was able to complete his course.

Case Vignette 2

Syeda, 28-years old, illiterate housewife with two children aged 1 ½ and 6 months old, diagnosed as Undifferentiated Schizophrenia was referred for family intervention. She has occasional hallucinatory behaviours, 'forgets' to feed her 6-month old baby, is unable to bathe the children and often leaves them in their soiled clothes for hours. She is unable to do much of the household chores without her mother-in-law's assistance and has no other relatives or friends to help her. When her mother-in-law is ill, the children's health is at risk.

During engagement, Syeda's husband initially claimed that his presence was not required at the sessions as it concerned 'woman's work'. The intervention worker pointed out to him that Syeda's current difficulties in performing the household chores and looking after the children was a result of her symptoms. Other areas such as her ability to interact with him as a spouse and companion may also have been affected. Her symptoms thus affected all the members of the household- his mother, himself and their children. By attending sessions, these issues could be addressed. The intervention worker also pointed out that it was important for all the family members to attend so that they could all learn how to cope mutually and so that there would be consistency in their approach to the problems, they face.

Assessment indicated that the mother-in-law was the leader of the family. Syeda is able to complete the household tasks with prompting from her mother-in-law, who looks after the children. When unsupervised, alone at home, or if the mother-in-law is ill, she spends her time lying in bed. She forgets to feed, bathe and clean the children. Occasionally she sits in a corner muttering and laughing to herself. The husband spends long hours at work to avoid Syeda. The husband is quiet when his mother criticizes Syeda's inability to look after her children and to complete the housework. He is contemplating divorcing her and remarrying. He is afraid that his children will develop the illness and that he will have no heir to the family business.

The intervention worker discussed the psycho-education material with them with special emphasis on the genetic causes of schizophrenia, the relationship of stress and relapses, positive symptoms and the difference between negative symptoms and willful behaviour. The mother-in-law was frequently reminded in other sessions about the latter. The intervention worker also discussed basic interventions about revising their expectations, simplifying their communications with her and reducing stress. The intervention worker taught the family problem solving techniques and encouraged them to discuss within sessions how to approach the problem of Syeda's fulfillment of the housework. During these discussions, the intervention worker guided them how to positively reframe their anger and criticism as well as how to communicate positive aspects and reinforce her verbally for the tasks she is able to do.

An activity schedule was established. The intervention worker negotiated for Syeda to be more involved in looking after the children. Syeda would initially supervise the children while the mother-in-law cooked or went shopping. Simpler household tasks were assigned such as washing the dishes, setting the table, sweeping the floors. The intervention worker reviewed the routine at each session, corrected errors and encouraged the family. The tasks were then gradually shaped and increased in complexity. Complex tasks such as cooking was broken down into simpler steps and she was verbally reinforced for her efforts. Specific reminders and requests were used.

Sessions were held with the couple alone to discuss their marital issues. Discussions revealed that the husband contemplated divorce only because he was upset and unsure as to how to cope with her when symptomatic. The intervention worker discussed and clarified issues related to the impact of the illness, negative symptoms and what should and should not be done when the affected member is acutely symptomatic. Syeda was also taught certain coping techniques to manage the auditory hallucinations. Syeda raised the issue of the husband's lack of participation in the family routines. Role reversal of conventional roles was discussed. The husband agreed to come home earlier and to assist her with looking after the children. Through joint discussions, the couple identified tasks that they would like to do together and the intervention worker assigned it as between session homework tasks for the couple. These were reviewed in subsequent sessions. The couple was encouraged to build a warm relationship and to discuss and solve their problems jointly.

Case Vignette 3

Vimala, 21-years old, educated up to SSLC, diagnosed as Undifferentiated Schizophrenia at 17 was referred for family intervention. She refuses to attend the nearby vocational institute. She often says she wants to get married. She cleans the house rarely and only if the parents force her to. When asked to learn to cook, she says that her mother will criticize and blame her for it not being up to the mark. She spends most of her time watching TV. Occasionally she hits her grandfather, saying that he is smiling at her.

Assessment of the family revealed that the parents expected Vimala to conform to stereotypical feminine behaviour by staying indoors, helping in the kitchen, etc. However, she did not do so. They attributed her illness and her poor performance in academics after the onset of the illness to this. She hit her father when symptomatic. The family constantly supervised her. The communication pattern was characterized by critical comments, blame from the parents and hostile remarks from Vimala. The family members often tried to make sense out of her communications.

Sessions on psycho-education were provided to the family with emphasis on the onset and nature of the illness. The intervention worker emphasized that the illness affects the affected member's ability to study and that a particular type of lifestyle does not cause schizophrenia. The intervention worker also helped the family to understand her negative symptoms ('laziness') as amotivation and that hitting the grandfather was not willful behaviour but due to a delusional misinterpretation that he was mocking her.

The intervention worker discussed with the family about the need to revert to a normal family routine. The expectations of the family for Vimala were assessed and the intervention worker discussed with the family about revising expectations to more appropriate ones, instead of comparing her behaviour with that of others. The skills required for continuing her education were also discussed. The intervention worker helped the family to identify positive assets and to acknowledge and verbally reinforce these behaviours. The intervention worker helped the family to identify effective reinforcers and these were used to shape desirable and undesirable behaviours. Limit setting for hitting the grandfather was started. The feasibility of reducing the face to face interaction with the grandfather was also discussed. The intervention worker reviewed their progress over the sessions and helped them to improve their approach and reinforce the family for their efforts.

The communication pattern of the family was addressed during the sessions on limit setting. The intervention worker also examined her repeated wish to get married. This was found to be due to the parent's constant supervision of her and "nagging". The intervention worker initiated discussions on the likelihood of the parent's fears of leaving the affected member unsupervised. They were also encouraged to discuss as a homework assignment the need for her to be more independent for her to survive in their absence. These were reviewed in the next session.

The family was advised to avoid making global comments, to be more appreciative of her efforts and to encourage her when facing difficulties in doing tasks. The intervention worker also pointed out that their body language, the tone and facial expressions conveyed meaning as well. The family was also guided on how to make specific rather than general statements of her behaviour. They were encouraged to avoid mind reading and adopting an offensive position with the affected member. They were helped to use "I feel " statements and to reframe negative comments positively. Role-plays were held within sessions to practice these skills; and the intervention worker helped the family and affected member to improve their communication with each other. The family was also discouraged from trying to make sense of Vimala's unclear communications.

The intervention worker helped the family to initiate a daily routine for her with activities that she likes doing such as helping with the shopping and escorting the younger brother to the bus stop. Using problem solving, they identified that the mother was critical of her attempts at cooking due to her expectations. Through discussions, the mother was encouraged to revise her expectations. The affected member was encouraged to cook simple things such as making tea, toast, boiling eggs etc. The mother was encouraged to reinforce her more regularly. The cooking was also included into her activity schedule. Once this was regularized, the family was encouraged to discuss with her the advantages and disadvantages of joining for vocational rehabilitation. After negotiations, the affected member accepted to initially attend the vocational institute thrice a week and then more often if she enjoyed it.

Case Vignette 4

Manish, 23-years old, Second year B.Sc. student, diagnosed as paranoid schizophrenia at 18 years was referred for family intervention. After 3 hospitalizations, the positive symptoms are controlled. He wants to be a scientist and spends his time writing formulas for chemical compounds. His parents accuse him of avoiding his studies and doing unnecessary calculations. Whenever asked to study he refuses, as he is very intelligent. He does not bathe for days at times and skips meals.

Assessment revealed that in spite of his positive symptoms being uncontrolled, Manish was able to complete two years of graduation. He was premorbidly above average in intellectual functioning. His performance in the previous six months indicated a decline. His attention, concentration and memory for recent events were impaired. His inability to study appeared to be due to the negative symptoms as well as cognitive deficits due to the illness. Manish however stated that writing formulas for chemistry kept him engrossed in his studies. All the family members were of the opinion that he was avoiding his studies. The parents expect Manish to be completely "normal" since the positive symptoms are now controlled and are frustrated that he is not. They suspect that he does not bathe or study on purpose. The parents are worried that Manish is a bad example for his younger brother who may too develop the illness by watching him.

Psycho-education sessions included Manish, his parents and his brother. The intervention worker focused the discussions in detail on negative symptoms, course and causes of the illness. The intervention worker helped the family to differentiate between willful behaviours and negative symptoms. The family concluded that Manish's behaviour were due to negative symptoms and did not constitute willful behaviour. The intervention worker explained the causes of the illness and reassured the family that the younger brother would not develop the illness by watching Manish. The intervention worker explained to the parents about limit setting should the younger brother willfully misbehave. The intervention worker also discussed normalizing their family routine, attending to the needs of other family members as well as consistent parenting approaches.

The intervention worker explained the course of the illness and addressed the parent's expectations of Manish based on this. The issue of cognitive decline was also addressed. They were provided with literature concerning the recovery of patients with schizophrenia, which enabled them to identify with the long-term nature of the illness. The intervention worker helped the family to revise their expectations of Manish. It was explained to them that Manish's interest in becoming a scientist and his preoccupations with writing formulae were methods that he found to cope with his cognitive deficits. They were cautioned about building up their hopes concerning any particular occupation or trade that they wanted Manish to take. The intervention worker discussed with them the benefits of going at Manish's pace, rather than expecting certain standards of success especially academically. The parents decided to consider vocational or diploma courses that were similar to his interests but did not require academic pressure. They were all educated about the early warning signs of relapse.

The intervention worker explained to Manish in detail about the nature of cognitive deficits. He was reassured that intelligence alone was not sufficient to study and write exams. Methods to study and improve his attention were taught. To improve his motivation he was asked to develop short-term achievable goals leading to a long-term goal such as completing the course and getting a job. Each exam and test were considered short-term goals with the possibility of working on science projects during the holidays as an incentive. His brother and father would assist him during these projects with minimal exceptions. His family members were also encouraged to develop a list of reinforcements to appreciate his efforts. These would then be used with instruction and gentle reminders to have a bath or to study. The intervention worker encouraged the family when they positively reinforced Manish.

Case Vignette 5

Nithya, 31-years old teacher diagnosed as Paranoid schizophrenia was referred for family interventions. She complains that her parents are trying to kill her and are doing so in order to prevent her marriage to the local MLA. She was brought to the hospital after she had thrown hot water on her father for refusing to allow her to go and talk to him. She was later found breaking objects at home. Her brother and cousin later managed to tie her and bring her to the out patient department of the hospital where she was screaming and shouting abuses at everyone. The family members were highly disturbed and her parents angry. Their neighbours had already complained that she was causing a nuisance and would be reported to the police if nothing were done.

Nithya's behaviour appeared to be a response to persecutory delusions and hallucinations. She was quickly calmed down using medication by the treating team and admitted to the in-patient facility of the hospital.

The intervention worker found the family members angry and hostile towards Nithya, and listened empathetically as the family members ventilated their feelings. Once the family members were calmer, the intervention worker reframed their angry positive statements as a reflection of their concern for Nithya. They were then educated about schizophrenia in detail. The nature of delusions and hallucinations were discussed with them. The intervention worker explained to them that Nithya's behaviour was in response to her symptoms and not because she was "vengeful or did not love them". She acted out on the symptoms and misconstrued the responses of the family as being hostile. This resulted in aggressive behaviour that was distressing for the family. The intervention worker explained to the family about the need to identify and prevent triggers to her violent behaviour, how they could contact the police or the treating teams for assistance when they are unable to control her.

In later sessions, it was assessed that the family members found it difficult to express positive statements or warmth to her. The intervention worker helped the family members learn to reframe their general statements to more specific ones, and to avoid confronting the patient but to listen and respond without getting angry. The intervention worker helped them to recognize and focus on positive behaviours. Role-plays were used for the family to practice these skills. The family was encouraged to discuss the issue of marriage with the patient once she was asymptomatic.

Once the patient had responded to medication she was seen in a few individual sessions to explain to her the nature of her illness and the treatment options. She appeared to understand that delusions were controlling her behaviour and that in reality there were no enemies. Her belief of being in love with the local MLA was also discussed with her.

As the school had terminated her employment after becoming symptomatic, she wanted to work again. The family members did not support this, as they wanted to supervise and control her behaviour. The intervention worker helped the family to recognize the difficulties in constantly supervising her and pointed out the need to keep her active. Nithya wanted to work as a secretary. The intervention worker helped her to assess the requirements of her job and whether she would be able to perform her duties. She agreed to first enroll in an institute to learn typing and then later if she was able to tolerate a routine, a secretarial course.

CHAPTER XII

OUTLINE

Ideally, the intervention should follow this order:

Module I	Assessment	Session I
Module II	Psychoeducation	Session I
Module III	Basic Interventions with the family	Session II
Module IV	Assessment of Difficult problems	Session II & III
Module IV	Management of Difficult Problems	Session IV & V
Module V	Handling Communication and Emotions	Session IV & V
Module VI	Termination and follow up	Session VI

However, you may not always be able to follow this order with all the families.

Some families may come to you in a crisis. In such cases, after engaging the families ascertain if the crisis must be addressed quickly. You may then skip the Assessment module. You can cover it in later sessions or you may get the information that you require as the families describe the details surrounding the crisis. It is important that the Psychoeducation module be addressed initially as this will help clear some of the family's misconceptions. It would be preferable to do the Assessing Difficult Problems or the Communication and Emotions modules after that. You may need to do them simultaneously with some families. You can then approach the Management of Difficult Problems module.

For families with long-term affected members, after the Assessment and Psychoeducation modules, the Management of Difficult Problems module may be more relevant. You can identify the areas by using the Assessing Difficult Problems module. You can then discuss the Basic Interventions with the Family module in this context. If your assessment indicates high expressed emotions, you may also include the Communication and Emotions module simultaneously

MODULES

MODULE I	ASSESSMENT
MODULE II	PSYCHO-EDUCATION
MODULE III	BASIC INTERVENTIONS
MODULE IV	ASSESSING & MANAGING DIFFICULT PROBLEMS
MODULE V	HANDLING COMMUNICATION & EMOTIONS
MODULE VI	TERMINATION AND FOLLOW- UP

MODULE I

ASSESSMENT

WHEN YOU ARE FAMILIAR WITH CHAPTER III AND IV (Page no.: 13 & 20)
USE THIS MODULE TO CONDUCT THE FIRST PART OF SESSION I
(ASSESSMENT OF THE FAMILY)

Notes for the Intervention Worker:

What is the purpose of this module?

The purpose of this module is to ascertain the level of knowledge that the family members have about the affected member's illness and how it has affected their functioning as a family.

How will I cover the module?

It can be covered in one session by going through the questions given below with the caregiver.

Who should attend this module?

You should gather this information from the principal caregiver, that is the affected member who is most involved with providing care for the affected member with schizophrenia. The principal caregiver is usually one of the family members living with the affected member with schizophrenia. Ensure that it is not a family member or a neighbour or friend who is living elsewhere.

What is the content of this module? This module covers areas on the family's:

- Knowledge of schizophrenia
- Burden experienced
- Needs
- Social supports
- Responses
- Illness effects on affected member

Knowledge about illness:

- a) What is _____ suffering from?
- b) Do you think _____ has a mental illness? Yes/ **No**/ Not sure
- c) What is the name of the illness that _____ has? _____
- d) What do you know about schizophrenia? **Nothing** / Details if knows
-

e) Do you know what the symptoms of schizophrenia are? **No** Yes(Detail)

f) What do you think is the cause of schizophrenia? (Tick responses given only)

Bad parenting Stress Black magic Evil spirits Inherited Others_____

g) For how long do you think _____ will have this illness?

Will be cured completely Unsure Forever May have future episodes

h) Do you know what treatment is available for schizophrenia? **No / Yes (detail as below)**

Medicines ECT(shock) Individual/Family therapy Vocational training Others

i) What do you know about the medicines for schizophrenia? **Nothing**

Side effects Will reduce/ cure symptoms Sedative Addictive Others_____

j) For how long do you think _____ will have to be treated?

Burden:

a.) What are the problems that you face as a result of this illness?

Financial difficulties Household routine disrupted Leisure activities disrupted

Family interaction disrupted Social life disrupted Physical health

Mental health (strain/tension/sadness/anger/frustration) Others_____

b.) How much of a problem is this for you?

0 _____ 10
Not a lot Mild Moderate Severe

c.) Who faces these problems? _____

d.) How does these problems make you feel?

What does the family need?

a.) Does the family have the basic needs?

Accommodation Food Money Water

b.) Does the family have access to services like:

Telephone Transport Education Medical care Benefits

c.) Do the family need assistance in basic functions like:

Looking after the home Child care Finance

d.) Does the family need help in managing the affected member in the following areas?

Companionship Intimate relationships Sexual expression Physical health

Self care Alcohol/drugs Psychotic symptoms Safety of self/others

Daytime activities Psychological distress Others _____

Social support:

a.) Who helps you with _____ illness? (*Name actual number of people who do help. What is the total number of adults and children (below 16 years) in the family?*)

b.) Who else helps you when you are in need?

Extended family other relatives friends neighbours social or religious organizations

c.) Who do you go to during a crisis?

d.) How do they help you?

Family Responses to the illness:

(The intervention worker should rate most of these responses based on the earlier interview or knowledge of the family)

a.) Intervention worker to rate the caregiver's response to the knowledge that their relative has schizophrenia

Denial Confused Anger Depressed Hopeful Coping well

b.) What are the expectations that the family members have for the affected member?

c.) How does the family respond to the affected member's unwanted behaviours? Do they:

Set limits Ignore the affected member Reinforce the behaviours
Others _____

d.) How does the family communicate with the affected member?

Speak for the affected member Interpret affected member's messages Hostile Critical
Over involved Warm Positive Others_____

e.) How does the family generally communicate?

Assume another's thoughts Make generalized comments All talk at the same time
Speak in a vague or unclear manner Do not listen to one another
Others_____

f.) How does the family manage a crisis? **Unable to manage**

Discuss together Ask others for assistance 1 or 2 members only are involved
Others_____

g.) Are the solutions adopted effective?

Effect of illness on the affected member

a.) What are the tasks the affected member could do before the illness?

Education/employment Daily living skills Travel alone Converse with others
Household tasks Manage money Keep active
Others_____

b.) How did the affected member do the tasks before:

On their own or with prompting? Did the task well or not?

c.) What all tasks can the affected member do now?

d.) How often does the affected member do the task without prompting?

e.) What kind of prompts do the family use?

Module II

PSYCHO-EDUCATION

WHEN YOU ARE FAMILIAR WITH CHAPTER V (Page no.: 27)
USE THIS MODULE TO CONDUCT THE SECOND PART OF SESSION I
(PSYCHOEDUCATION OF THE FAMILY)

Notes for the Intervention Worker:

What is the purpose of this module?

The purpose of the module is to educate the family members about schizophrenia. This will enable them to understand the illness and care more effectively for their affected family member. It will also allow you to determine the family's perception of the illness, how their beliefs influence their behaviour and how amenable they are to seeing the illness from a different perspective.

How will I cover this module?

This module can be covered in one session. The sessions should be tailored to the individual affected member's symptoms and circumstances (you should review this information from the case file). You should also review Module I (Knowledge about Illness).

Who should attend this session?

It is important that as many of the involved family members as possible attend this session, not just the principal caregiver. This is because

- a) Sharing the caregiving roles will ease the strain on the principal caregiver, and
- b) Even if the other family members are not directly involved in providing care, it is important that they recognize and understand what it is that the principal caregiver is dealing with.

What is the content of this module?

There are four sections to this module: It covers the causes, symptoms and prognosis of schizophrenia, the treatment and management.

- 1) *Schizophrenia*: This is a general introduction to the illness
- 2) *What to expect in schizophrenia?* This covers the typical course of schizophrenia, including the types of symptoms and problems that the caregiver might expect at different stages in the illness.

- 3) *What causes schizophrenia?* This section gives some basic information, and can be used particularly to deal with any myths or misconceptions
- 4) *What is the treatment for people with schizophrenia?* This section covers the necessity for compliance, the relationship of symptoms with medication, and side effects. Misconceptions about medications can also be addressed.

Emphasis of Family Intervention Sessions

1. The family is **not sick** and hence is **not being treated**
2. You are there to **deal** with some of the problems they have as a result of their family member suffering from schizophrenia
3. The family members are **valuable assets and allies** of the treating team in helping affected members.

A. Schizophrenia

- ◆ It is a **mental** illness
- ◆ Schizophrenia is not a rare illness. **1 / 100 people** suffer from it during their lifetime.
- ◆ It starts mainly in young people between the ages of **15 and 30**.
- ◆ It may occur at any time.
- ◆ Both **men and women** can suffer from it.

B. What to expect in schizophrenia?

1. Symptoms:

- ◆ Affected members will have symptoms due to the illness (**positive symptoms**) such as ... *(give examples of the affected member's hallucinations, delusions, etc).*
- ◆ Qualities taken away by the illness are called **negative symptoms** *(give examples of affected member's lack of drive, motivation, etc).*
- ◆ They may have *Language difficulties* such as talking in a way hard to follow, making up new words, using odd expressions, or speaking very little.
- ◆ They may also have *Odd habits* like.... *(Give examples of affected member's peculiar mannerisms or habits, standing or sitting in unusual ways).*
- ◆ They may also show *Changed feelings and emotions* such as little or no emotions, not show normal affection for family and friends, laugh or cry when they are not feeling happy or sad.

2. Course:

- ◆ Most will **get better with treatment**.
- ◆ About **one in four people** have an attack from which they make a complete recovery and then stay well for years.
- ◆ A small number **do not respond to treatment** and will have symptoms all the time.
- ◆ Affected members can have **relapses**.

- ◆ Between attacks, they may not be the same way they were before (*give examples of negative symptoms*).
- ◆ These are partly the result of the medication, partly due to the illness itself and partly due to the affected member's, own attempts to avoid becoming upset and ill again.
- ◆ Some of these improve particularly if the family can manage to be supportive and encouraging.

C. What causes schizophrenia?

1) Genetic

- ◆ Schizophrenia can be **inherited**.
- ◆ This does not mean that the affected member should not have children in case they will be affected.
- ◆ It does not mean that if one family member gets it, the others will also.
- ◆ If your close relative like a sibling or parent suffers from it, then your chances of getting it are higher.
- ◆ Schizophrenia can also occur when there are no other relatives who have it. It is not the illness that is inherited but the **tendency** to get it.
- ◆ No clear genetic pattern has been found for schizophrenia

2) Imbalance of brain chemistry

- ◆ Schizophrenia is probably caused by a disturbance in the working of the brain.
- ◆ **Chemicals** in the brain are affected and this produces the positive symptoms.
- ◆ **Dopamine** is the name of one of the many chemicals in the brain. There may be too much dopamine produced.
- ◆ Certain **medication** improves the symptoms of schizophrenia-these are made up of chemicals.
- ◆ It is thought that these help to balance the chemicals in the brain.

3) Relation with stress

- ◆ Stress may act as a **trigger** to bring on the illness.
- ◆ Major stressful events can make schizophrenia worse or trigger off a relapse of symptoms.
- ◆ The more things they have to cope with in life, the more likely they are to have an attack.
- ◆ Once a affected member has schizophrenia, the environment (family, work) can help him.
- ◆ If they tend to push, nag or criticize them, this may make things worse.
- ◆ If too much is done for them and they do nothing, this too can make them worse.

4) Family

- ◆ There is **no evidence** that a family's influence on a affected member can cause schizophrenia.
- ◆ Poor child care or an unhappy childhood does not cause schizophrenia.
- ◆ Families can play an important part by helping the affected member to stay well.

Clarify any **MYTHS** that the family may have regarding the cause of the illness such as

- *evil spirits*
- *black magic/witchcraft*
- *addiction*
- *other local explanations*

D. What is the treatment of schizophrenia?

1. Medication is the **main** form of treatment.
2. Medical treatment does not **cure** the illness.
3. Medication is used to **reduce** the symptoms & to **prevent** further attacks, or the symptoms getting worse.
4. Some people recover well and are able to lead normal lives.
5. Most need to stay on medication for a **long time**, sometimes the rest of their lives.
6. The medications are not **addictive**.
7. There are several **types** of drugs used with different brand names, in the form of **tablets or injections**.
8. The medications work by blocking the transmission of **dopamine**.
9. **Negative symptoms** are often not improved by medication.
10. The **effects** are not always seen immediately.
11. The medication have to be taken **regularly** (even when they feel well) to prevent further attacks and remain well.
12. There is a high risk of **relapse** in the first year associated with stopping medication.
13. Even for those taking medication regularly the risk of relapse is about 20%.
14. The medication can sometimes produce unwanted **side effects**. These are not usually serious can should be discussed with your doctor.
15. Reducing the dose may get rid of these side effects, or they may need to take another tablet which acts as an antidote. Sometimes changing from one type of medication to another will relieve side effects.
16. ECT's may be indicated for catatonic patients and for patients who for some reason cannot take anti-psychotics. Patients who have been ill for less than a year are the ones most likely to respond.

MODULE III

BASIC INTERVENTIONS WITH THE FAMILY

WHEN YOU ARE FAMILIAR WITH CHAPTER VI (Page no.: 32)
USE THIS MODULE TO CONDUCT THE FIRST PART OF SESSION II
(BASIC INTERVENTIONS WITH THE FAMILY)

Notes for the Intervention Worker:

What is the purpose of the module?

The purpose of the module is to educate the family about their role in the intervention and management of the affected member by teaching the family how to interact with the affected member in the home setting, with the aim of avoiding further episodes and hospitalization.

How will I cover the module?

You will need one session to cover the module. You can present this in the form of a lecture format for an individual family or present it for a group of different families. You can supplement your session with the use of overhead projectors

Who should attend this session?

It would be preferable if all the family members are present for this session. If not, then the primary caregivers or the leader of the family should attend. The affected member may also be included.

What is the content of the module?

The module covers two sections.

- 1) *Suggestions*: provide the family with more appropriate means of responding to the affected member
- 2) *Identifying inappropriate responses of the family*: Identify the incorrect behaviours that the family members may be performing with the affected member. Explain how they are not helpful.

Suggestions for the family (Refer manual for details)

- 1) Comply with **medication**
- 2) Normalize the **family routine**
- 3) Revise **expectations**

4) **Set limits**

- Identify intolerable and irritating behaviours
- Identify what will be tolerated and what will not
- identify effective reinforcers-material, activity or social
- Use specific reminders and requests
- Simplify task
- Positive reinforcers
- Shape behaviour
- Undesirable behaviour-stop reinforcers
- Be persistent and not give up

5) **Selectively ignore**

6) **Reduce stress**

7) **Simplify communication**

- Avoid speaking on affected member's behalf
- Wait for affected member to respond
- Avoid complex and emotional topics in affected member's presence
- Avoid detailed conversations
- Avoid interpreting affected member's messages
- Request affected member to speak clearly
- Avoid making general comments about the affected member
- Be appreciative of affected member's positive behaviours
- Avoid mind reading
- Speak for oneself and not for others
- Avoid vague or unclear and ambiguous statements

8) **Identify warning signs**

- Inability to sleep; day/night reversal
- Social withdrawal, isolation, fear and suspicion
- Skipping classes/ not going to work; avoiding going out
- Inability to concentrate, staring, vagueness
- Drug or alcohol abuse; repetitive actions, food fads
- Deterioration in personal hygiene; eccentric dress
- Frequent moves or trips or long walks leading nowhere
- Unusual sensitivity to stimuli (noise, light); low tolerance to irritation
- Undue preoccupation with spiritual or religious matters
- Bizarre behaviour
- Conversation that does not make sense-very abstract, seemingly deep but not logical or coherent; obsessed with one idea.

9) **Enhance social networks**

- Family members, extended family and friends are not likely to be most helpful in dealing with the impact of the illness.
- Contact other families of affected members with schizophrenia

- Contact national or local associations for people living with schizophrenia.

10) Other basic suggestions:

- Evenly distribute the roles amongst the family members to reduce burden on the primary caregiver.
- Involve the affected member in some of the chores.
- Follow family rituals such as eating meals together or other activities

Identifying Inappropriate Responses of the family

- a.) Adapting and normalizing the situation
- b.) Coaxing and rational persuasion
- c.) Making sense out of nonsensical communication
- d.) Ignoring
- e.) Providing constant supervision
- f.) Reducing their own activities
- g.) Ignoring the needs of other family members

MODULE IV

ASSESSING AND MANAGING DIFFICULT PROBLEMS

WHEN YOU ARE FAMILIAR WITH CHAPTER VII (Page no.: 38) USE THIS MODULE TO CONDUCT THE SECOND PART OF SESSION II AND SESSIONS III TO V (ASSESSMENT AND MANAGEMENT OF DIFFICULT PROBLEMS)

Notes for the Intervention Worker:

What is the purpose of the module?

The purpose of the module is to assess the problems of the family and then to teach them an effective and uniform method of solving their problems as a family. The purpose of this module is also to educate, train and guide the family and the affected member to cope with specific difficult problems that they may face as a result of the illness.

How will I cover the module?

You will need two sessions. You will need to identify the problems of the family, the problem solving skills of the family and then teach the family the steps involved and help them to practice these skills. You can do this through discussions, home work assignments, modeling and role plays.

Who should attend the module?

Preferably all the family members as well as the affected member.

What is the content of this module? (Refer manual for details)

This module has four sections.

- 1) *Assessing the problems*: Obtain information on the family's approach to problems, the coping ability of the affected member and the family, their successfulness or unsuccessfulness in solving problems.
- 2) *Teaching problem solving skills*: with the help of this information, teach the family a uniform method of problem solving
- 3) *Management of problems faced by the affected member* : Guidance to help the affected member recover skills lost after the onset of the illness.
- 4) *Management of problems faced by the family*: Guidance for the family to help them cope with problems they face due to the affected member's illness.

Some common problems that **affected members** may face are:

- a) How to actively spend their time
- b) Personal hygiene
- c) Household tasks
- d) Managing money
- e) Public transport
- f) Conversational skills
- g) Unemployment or education
- h) Coping with stigma
- i) Managing symptoms

Some common problems that **family** members may face as a result of the illness are:

- a) What to do in a crisis? Or managing the affected member when acutely symptomatic
- b) What to do when the affected member is violent?
- c) What to do when the affected member refuses medication?
- d) How to cope with stigma?
- e) How to cope with the affected member's sexuality?
- f) How to cope with affected member drinking alcohol, coffee/ tea or smoking cigarettes?
- g) What to do when the affected member is suicidal?
- h) Issues related to marriage, separation or divorce

I Assess the family's problem solving ability

Get a description of how the family has handled a problem.

II Teach problem solving skills

- 1) **Identify** the problems (about 4-5 solutions)
- 2) List out the possible **solutions** of each of the solutions.
- 3) Weigh the **advantages and disadvantages** of each solution
- 4) **Select** the best solution
- 5) **Implement** the solution (over the next few days or week)
- 6) **Review** the solution
- 7) **Maintaining and generalizing** the solution

III Management of Problems faced by the affected member:

10. **Activity Scheduling:** While selecting an activity, ensure that it is:

- Goal directed
- Has meaning to the affected member
- Involves mental and physical participation
- Related to interests and leisure activities
- Adaptable, gradable and age-appropriate.

Negotiating activities:

- Offer wide variety of choice
- Careful instructions
- Affected member has the capacity
- Ensure probability of success
- Correct errors
- Encourage and compliment
- Advance to higher levels
- Sense of responsibility for advancement in tasks.

11. **Personal hygiene:**

- Brushing teeth
- Bathing
- Grooming
- Basic hygiene
- Keeping personal clothes clean
- Dressing
- Eating habits

12. **Household tasks**

13. **Managing money**

14. **Public transport**

15. **Conversational skills**

16. **Employment/education:** The affected member should have the following necessary skills:

- Be able to keep time
- Tolerate routine
- Independence
- Be motivated to do well
- Be able to pay attention to details
- Be able to understand and incorporate advice from superiors
- Be able to communicate and mix with colleagues
- Be able to recognize early signs of illness and deal with them.

17. Coping with stigma

- Be empathic but encourage realistic expectations
- Help the affected member to weigh the advantages and disadvantages of continuing to isolate oneself
- Persuade affected members that the occasional symptom should not block their ability to socialize
- Graded tasks and task assignments should be used to persuade affected members to go out and mix more easily
- The family members can accompany the affected member the first few times
- Persuade affected members to talk to the appropriate people in the right context about their illness without feeling shame (should not feel it is so shameful that they need to hide it)

18. Managing symptoms

- Cognitive strategies (attentions-switching, attention narrowing, self instruction rational restructuring)
- Behavioural strategies (engaging in solitary activities, social withdrawal, engaging in social interaction)
- Physiological strategies (relaxation and/ or breathing exercises)

IV Management of Problems faced by the Family:

a) What to do in a crisis? Or how to manage the affected member when acutely symptomatic?

- The family will be unable to reason with acute psychosis
- Should not express irritation or anger- keep their emotions under control
- Decrease other distractions (TV, radio) immediately
- Calmly ask anyone (friends, guests) present to leave
- Speak quietly, firmly and with simplicity
- Express understanding for what the affected member is experiencing

b) What to do when the affected member is violent?

- Identify precipitating behaviours and events to avoid future occurrences.
- Keep knives and other objects away from the affected member.
- Ask the affected member to go to another room
- Ask the involved family member to go to another part of the house or to leave the house.
- Contact the police and explain what they are experiencing. Seek their help to obtain treatment, to control the violent behaviour or admission.
- Contact the treating doctor and ask for advice
- Write to the magistrate for admitting the affected member

c) **What to do if the affected member refuses to take medication?**

- Through negotiation, encourage the affected member to give the treatment and medication a fair trial to see if it can help.
- Help them to appreciate that the medication may 'decrease anxiety' or make them more comfortable.
- Introduce benefits or privileges which the affected member can obtain if they agree to medication. Emphasize these benefits
- If affected member terrorizes family members or behaves in dangerous way to others or home, the family can use an ultimatum. They could say that the affected member must take medication and maintain a minimum level of appropriate behaviour or they cannot live at home.
- Approach treating team for alternatives such as injectable medications to be prescribed.

d) **How to cope with stigma?** Family members should break out of their isolation by

- Forming relationships outside the immediate family
- Use reasoning such as "You need to look after yourself to help the affected member" or "the affected member needs to be on their own to encourage independence" or "everyone in the family needs to look after themselves in order to cope".
- Set graded tasks where the family can make short outings to test their fears of being rejected or looked down on.
- Gradually increase the difficulty of the tasks

e) **How to cope with the affected member's sexuality?**

- Aim for a realistic and frank discussion of sexual needs in adult affected members
- Sexuality needs privacy and acceptance by the rest of the family-ways of achieving this may have to be discussed
- The family's fears of risk of pregnancy and diseases have to be brought in the open.
- Clarify whether affected member has taken responsibility for himself or herself.
- Look at the likelihood of various negative outcomes-the families worst fears may not be realistic
- Encourage the family to openly discuss their worries of pregnancy-whether the baby will inherit the illness, whether the affected member will be able to look after the baby or whether the affected member should have the baby at all.
- Encourage the family to discuss the options and come to some agreement.

f) **How to cope with affected member drinking alcohol/ smoking cigarettes/ drinking numerous cups of coffee or tea?**

Drinking alcohol:

Clarify that some substances do have the effect of enhancing vulnerability to the onset of the illness or relapses, but on their own they do not cause the illness (to ensure that affected member is not blamed for causing their illness).

- The affected member should be informed of the danger of drug use and its harmful effects (on tranquilizers, becoming violent). They should be advised against any substance abuse.

- Complete abstinence may not be possible or necessary.
- Help the family and the affected member to discuss the potential problems related to alcohol intake
- Affected members can be helped to experiment with how much alcohol they can take without getting intoxicated.
- Advise the affected member against more than 2 drinks a day.

Cigarette smoking-

Help the family members to set limits with regard to specific problem behaviour related to smoking (e.g., smoking in bed, limits to the use and emptying of ashtrays, etc)

Coffee or tea-

Explain how this can lead to shakiness, nervousness, excitement, restlessness and sleep problems

- Explain how it is difficult to differentiate between the effects of too much caffeine intake from anxiety, nervousness and excitement which may be part of the schizophrenic process itself. It is also difficult to separate from akathisia.
- Amount of caffeine intake should be moderated.

g) Suicide

- If families comment that they wish the affected member dead during the sessions, interrupt and immediately comment on and reframe the remark positively
- Discuss the positive aspects of the affected member
- Establish the reality of suicidal feelings and possible actions
- Encourage the affected member to share feelings of loss and hopelessness that they may never recover fully and life may be too difficult for them from now on.
- If risk level significant, frequent monitoring or hospitalizations may be necessary.
- If the relatives are familiar with the feelings or warning signs, they should take action such as contacting the treating team, a general practitioner or emergency services.
- If the affected member becomes depressed or hopeless, discuss lowered expectations and help them to come to terms with it. Can use "collapsing time" technique.

i.) Marital issues? Separation or divorce?

Marital: spouses must learn to play multiple roles as the illness may recur.

- Address marital issues such as impact of the illness, negative symptoms, secondary gains
- Consider role reversal of conventional roles.
- As affected member improves, aim for a more balanced relationship with affected member being given greater responsibilities.
- Help couple to mourn past competencies
- Encourage spouse to find same sex confidante.
- Suggest better communication skills such as initially encouraging the affected member to make more sense, reinforcing clarity and limiting bizarre communications. Later helping them to make their needs better known to each other.

- Avoid emotionally charged issues to reduce the risk of overstressing the affected member.
- Review medication to ascertain effect on libido, erection and ejaculation.
- If alterations in medication are unhelpful or not possible, and they want further help, refer them to a therapist specializing in sexual problems.
- Make up for the loss of sexual relationship by adopting a less threatening kind of intimacy such as hugging or cuddling etc.

Separation: assess how serious and soon it may occur.

- Discuss the pros and cons of such a decision
- Negotiate short term treatment contracts to include:
Establishing a time schedule that helps to ease the abruptness of this change,
Help each partner to better understand the reasons for the dissolution of the marriage,
Help each spouse to plan for the separation,
Establish ways of coping before the associated stress and pain occurs.

Divorce:

- Help them to separate with minimum of stress and chaos, hopefully after an acute episode when the affected member is at their best.
- Avoid judging the behaviour of the departing spouse.

MODULE V

HANDLING COMMUNICATION AND EMOTIONS

WHEN YOU ARE FAMILIAR WITH CHAPTER VIII (Page no.: 64)
USE THIS MODULE TO CONDUCT SESSIONS IV AND V
(HANDLING COMMUNICATION AND EMOTIONS)

Notes to the Intervention Worker:

What is the purpose of this module?

The purpose of the module is to help family members learn effective clear communication, for sharing information, emotions and needs.

How should I cover this module?

This module can be covered in two sessions. You can use homework assignments, role-play, modeling and guidance. Many times it may be necessary to use these techniques together with the earlier module

Who all should attend this module?

All the family members and the affected member.

What is the content of the module? (Refer manual for details)

The module consists of two sections:

1. The Do's and Don'ts of communication.
2. Handling communication

THE DO'S AND DON'TS OF COMMUNICATION

- a) **Only one** affected member should speak at a time
- b) Family members should **talk to** a member, not talk about them
- c) All family should get **equal opportunity** to talk
- d) Family members should **listen** to the contributions of others
- e) Rules on **turn taking**
- f) **Clearly** state messages
- g) **Non verbal** communication includes:
 - Eye contact and Facial expression
 - Posture
 - Body language
 - paralinguistic (loudness, tone, pitch, rate, affect, duration)

HANDLING COMMUNICATION

a.) **Expressing feelings**

- Clear and direct expression of feelings
- Should not blame affected member or other family members
- Avoid global statements (all of us feel...)
- Take responsibility for opinions (I feel...)
- Do not use negative feelings to attack other family members
- Reframe positively any negative comments about the affected member
- Ensure that they specify what they are angry about
- Move from general statements to specific behaviours

b.) **Positive communication**

- Reframe angry statements as indicators of how much the family cares or concerns
- Encourage family members to recognize, focus on and reward small positive behaviours
- They should not over-reinforce
- Family members can say something positive-what they like about each other-not to neglect or take for granted positive behaviour
- Check if positive comments are heard and registered by family members

c.) **Handling expressed emotions**

- Avoid mind reading
- Avoid confrontative messages
- Help family members to reframe rejecting or worried comments positively
- Use role play-for both affected members and critical or hostile family members
- For over-involved families, draw their attention to what would happen after they are "gone".
- Show how fears are exaggerated –check likelihood of occurrence

d.) **Improving affected member's communication patterns**

- Discourage family from speaking for the affected member.
- Family members have to wait for the affected member's response
- Use social conversation and problem solving as practice
- Observe how they speak, reinforce correct behaviours and encourage improvement on other areas
- Demonstrate how to reframe sentences
- Give homework assignments and review in next session
- Negotiate daily activities, household chores and family roles
- Discourage family members from ignoring, reinterpreting or trying to make sense of unclear messages from the affected members.
- Inform them that tolerating poor communication gives the message that affected members need not learn to be clear in interactions with others.
- Encourage the families to say that they do not understand what the affected member is saying or that it was unclear and could the affected member repeat what he had said.

MODULE VI

TERMINATION AND FOLLOW UP

WHEN YOU ARE FAMILIAR WITH CHAPTER IX (Page no.: 70)
USE THIS MODULE TO CONDUCT SESSION VI
(TERMINATION AND FOLLOW-UP WITH THE FAMILY)

Notes to the Intervention Worker:

What is the purpose of this module?

The purpose of the module is to gradually ease the family out of the intervention and thereby reduce their reliance on the intervention worker to assist them in caring for the affected member. It also covers the areas that should be addressed during follow-ups with the family.

How should I cover this module?

This module can be covered in one session. Between follow-ups you can assign homework assignments for the family and the progress achieved can be assessed during the follow up.

Who all should attend this module?

All the family members and the affected member.

What is the content of the module? (Refer manual for details)

The module consists of two sections:

1. Issues related to termination of sessions
2. Areas to be covered during follow ups

Issues related to termination of sessions

- Remind them about the termination of sessions
- Space out the sessions from once a week to once in two weeks and gradually once a month
- Encourage them to be confident of independently solving their problems
- Review with them the changes that they have effected during the intervention-do not force them to admit changes.
- Highlight the positive changes in behaviour, communication and functioning of the affected member (*use specific examples*).
- Highlight the skills (like problem solving skills) that they have acquired and how they have been able to apply it effectively using specific examples.
- Prepare them for the possibilities of old as well as new problems occurring.
- Encourage them to solve their problems on their own and to contact you only in crises or when they are unable to cope.
- Rehearse coping strategies

Areas to be covered in follow ups

- a) Review what has occurred since their last visit.
- b) Assess their abilities to solve problems, improve communication, and the functioning of the affected member. Review or remind them of the skills if necessary.
- c) Review homework assignments
- d) Reinforce positive aspects
- e) Encourage them in areas they have been unsuccessful in.
- f) Assign homework for the next follow up
- g) Fix the next appointment

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APPENDICES

APPENDIX I: PSYCHO EDUCATION BOOKLET

APPENDIX II: SESSION RECORDING FORM

APPENDIX III: HELPFUL ASPECTS OF THERAPY FORM



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PSYCHO-EDUCATION BOOKLET ON SCHIZOPHRENIA

SCHIZOPHRENIA-WHAT IS IT?

- ◆ You have noticed that your relative is not their **usual self** (*give examples of the affected member's symptoms*).
- ◆ People who have these sorts of experiences suffer from what is called **schizophrenia**. It is an illness and it affects people in different ways.
- ◆ It gives rise to experiences which seem completely real to the people suffering from it but are hard to explain. Because the affected member cannot explain what is happening, it is not easy for other people, like yourself, to realize that many of the odd or upsetting things that they do are caused by the illness.
- ◆ It is more hard because it is a **mental** and not a physical illness, and so there are no outward signs of there being anything wrong. (*Example, unlike arthritis*)
- ◆ Schizophrenia is not a rare illness-**1/ 100 people** suffer from it during their lifetime.
- ◆ It starts mainly in young people between the ages of **15 and 30**. It may occur at any time.
- ◆ Both **men and women** can suffer from it.

WHAT TO EXPECT IN SCHIZOPHRENIA?

Symptoms:

1. Doctors diagnose schizophrenia when a affected member has certain **key symptoms**. They find this out from what the affected member tells them.
2. Affected members suffering from schizophrenia can have very different experiences, however certain things happen to almost everyone at some stage of the illness.
3. The doctors categorize the symptoms of schizophrenia as “positive” or “negative”. Symptoms due to the illness are referred to as **positive** (*give examples of affected member's hallucinations, delusions, etc*) and those qualities taken away by the illness are called **negative** (*give examples of affected member's lack of drive, motivation, etc*). These may also be caused by medication. These negative symptoms are part of the illness and the affected member is not being lazy or hurtful.

4. **Positive symptoms:** These are the type of symptoms that the affected member experiences, these are changes and distortions in their perceptions and thoughts. *Explain the different symptoms with reference to the affected member's symptoms.*
 - Disturbances in thinking (thought broadcast, thought withdrawal, thought alienation, thought insertion, etc)
 - Delusions (reference, persecution, grandiosity, etc)
 - Hallucinations (auditory, visual, olfactory, etc)

5. **Negative Symptoms:** These appear as changes in the affected member's behaviour-decreases or absences of behaviour. *Explain the different symptoms with reference to what the affected member has as well as what could occur in the future:*
 - Absence of **motivation** or motivation to do anything
 - A general **inactivity** and a decrease in all activity levels (hobbies, leisure, self care)
 - An inability to show **emotion** (appears flat or disinterested)
 - Inability to **enjoy activities** that used to give pleasure
 - An apparent **disinterest** in conversation and talking
 - An apparent difficulty to **get on with people** even close relatives, so that contact with others will be avoided.

6. **Other symptoms**
 - *Language difficulties* (talk in a way hard to follow, make up new words or use odd expressions or speak very little)
 - *Odd habits* (peculiar mannerisms or habits, standing or sitting in unusual ways).
 - *Changed feelings and emotions* (show little or no emotions, not show normal affection for family and friends, laugh or cry when they are not feeling happy or sad).

Course:

- ◆ Most people will **get better with treatment**. They will think more clearly and many of the unusual ideas will go away.

- ◆ About **one in four people** have an attack of schizophrenia from which they make a complete recovery and then stay well for years.

- ◆ A small number **do not respond to treatment** and will have symptoms all the time.

- ◆ Most affected members although they recover from an attack, will have periods when the symptoms recur. These periods are called **relapses**. These may occur within weeks of recovery or may happen years later. During future attacks new kinds of odd behaviours can appear but often the same pattern repeats itself.

- ◆ Between attacks, they may not be the same way they were before (*give examples of negative symptoms*). These are not being done to annoy you. They are partly the result of the medication, partly due to the illness itself and partly due to the affected member's, own attempts to avoid becoming upset and ill again.

- ◆ Some of these improve particularly if the family can manage to be supportive and encouraging.

WHAT CAUSES SCHIZOPHRENIA?

Current research is unable to identify a single cause for schizophrenia. There may be a number of contributory factors which influence its occurrence.

1) Genetic

- ◆ Schizophrenia can be **inherited**.
- ◆ This does not mean that the affected member should not have children in case they will be affected.
- ◆ It does not mean that if one family member gets it, the others will also.
- ◆ If your close relative like a sibling or parent suffers from it, then your chances of getting it are higher.
- ◆ Schizophrenia can also occur when there are no other relatives who have it. It is not the illness that is inherited but the **tendency** to get it.
- ◆ No clear genetic pattern has been found for schizophrenia

2) Imbalance of brain chemistry

- ◆ Schizophrenia is probably caused by a disturbance in the working of the brain.
- ◆ **Chemicals** in the brain are affected and this produces the symptoms of hallucinations, delusions and thinking difficulties.
- ◆ **Dopamine** is the name of one of the many chemicals in the brain. Too much dopamine may be produced in those with schizophrenia.
- ◆ Certain **medication** improves the symptoms of schizophrenia-these are made up of chemicals. It is thought that these help to balance the chemicals in the brain.

3) Relation with stress

- ◆ Stress may act as a **trigger** to bring on the illness.
- ◆ Major stressful events such as a death in the family, loss of job or breakup of relationship can make schizophrenia worse or trigger off a relapse of symptoms.
- ◆ The more things they have to cope with in life, the more likely they are to have an attack. Changes and conflicts can also bring on further attacks.
- ◆ Once a affected member has schizophrenia, the environment (family, work) can help him. People can **support** them to regain their former skills.
- ◆ If they tend to push, nag or criticize them, this may make things worse.
- ◆ If too much is done for them and they do nothing, this too can make them worse.

4) Family

- ◆ There is **no evidence** that a family's influence on a affected member can cause schizophrenia.
- ◆ Poor child care or an unhappy childhood does not cause schizophrenia.
- ◆ Families can play an important part by helping the affected member to stay well.

Schizophrenia is **NOT** caused by

- *Evil spirits*
- *Black magic/witchcraft*
- *Addiction*
- *Other local explanations*

WHAT IS THE TREATMENT FOR PEOPLE WITH SCHIZOPHRENIA?

The treatment of schizophrenia requires medical treatment and psychosocial rehabilitation.

Medication

1. Medication is the **main** form of treatment.
2. They help to stop the voices in their head, make them less anxious and restless and help them to think more clearly, They protect them against the stresses coming from their own experiences and everyday life.
3. Medical treatment does not **cure** the illness.
4. Medication is used to
 - **Reduce** the symptoms of an attack of the illness
 - Once the symptoms have improved, the same medication is used to **prevent** further attacks or the symptoms getting worse.
5. Some people recover well and are able to lead normal lives. Most have continuing trouble with the symptoms and need to stay on medication for a **long time**, sometimes the rest of their lives.
6. The medications are not **addictive**.
7. There are several **types** of drugs used in the treatment of schizophrenia, with different brand names. Medication can be given in the form of **tablets or injections**.
8. The injections have the same effect as the tablets but can be given less often. This is because one injection lasts for several weeks.
9. The medications work by blocking the transmission of **dopamine**. They belong to different chemical families.
10. Some of the symptoms are often not improved by medication. These are most often the **negative symptoms**.
11. Once started the **effects** cannot always be seen immediately. They may take days, or even weeks before they improve.
12. When first treated with drugs, the dose is usually **increased** until the illness begins to get better. Once the affected member is recovering, it is possible to reduce the dose.
13. Some people react differently to different chemical structures. The correct medication and the correct dosage may be different from one affected member to another. It may take time to find the right amount to stabilize your relative.

14. The medication have to be taken **regularly**. They are not like “Crocin” which you take when you have a fever. Even when they feel well, they have to take the medication to prevent further attacks and to remain well.
15. Similar to how there is no sudden improvement when they start the medication, there is no sudden change if they stop it.
16. The illness does not return immediately. It can take months until symptoms reappear depending on the amount of difficulties the affected member has to cope with.
17. There is a high risk of **relapse** in the first year associated with stopping medication.
18. Even for those taking medication regularly the risk of relapse is about 20%.
19. Unfortunately, the medication can sometimes produce unwanted **side effects**. These are not usually serious can should be discussed with your doctor.
20. Some of the side effects are:
 - Drowsiness
 - Restlessness
 - Muscle stiffness
 - Shakiness
 - Sensitivity to sunburn
 - Increased appetite
 - Dizziness when standing up suddenly
 - Tardive dyskinesia
21. Reducing the dose may get rid of these side effects, or they may need to take another tablet which acts as an antidote. Sometimes changing from one type of medication to another will relieve side effects.
22. Some of these effects can be avoided by avoiding too much sun, standing up slowly and watching their diet.
23. Electroconvulsive therapy (ECT) may be indicated for catatonic patients and for patients who for some reason cannot take anti-psychotics. Patients who have been ill for less than one year are the ones most likely to respond.

Medication is not the only thing that helps in the treatment of schizophrenia. The atmosphere in the home and the way daily problems are tackled are equally important.

SESSION RECORDING FORM

SESSION NO. _____ MODULE NO. _____ TOTAL DURATION OF THE SESSION: (Minutes)

1. THE SESSION PARTICIPANTS WERE: (Please tick whichever applicable)

Affected member	Father	Sibling	Spouse
Mother	Children	Any Other	Please Specify _____

2. THE EMOTIONAL ATMOSPHERE DURING THE SESSION INDICATED THAT FAMILY MEMBERS WERE: (Please tick whichever applicable)

Co-operative	Interested or keen
Some members were co-operative, others were not	Disinterested
Hostile about the intervention	Upset/ emotional
Happy about the intervention	Any other? (Please specify) _____

3. THE INTERVENTION DONE IN THE SESSION WAS: (Please tick whichever applicable)

Engaging and rapport building with the family	Assessing difficult problems
Assessment	Handling difficult problems
Educating the family about schizophrenia	Handling communication and emotions
Teaching the basic interventions for the family	Terminating the intervention or follow ups with the family

4. ADDITIONAL DETAILS OF THE SESSION:

5. CHAPTERS REFERRED TO IN PREPARATION FOR THE SESSION: (PLEASE TICK)

Management of schizophrenia	Assessing difficult problems
Engaging and maintaining the family	Management of difficult problems
Assessments	Handling Communication and emotions
Basic interventions with the family	Termination and follow up
Psychoeducation	Handling Intervention Worker stress and burn out
Psychoeducation booklet	

6. WHILE CONDUCTING THE SESSION, YOU WERE: (PLEASE TICK)

Confident	In control	Irritated
Unsure	Had no control	Any other? (Please specify) _____

7. REASONS FOR ABOVE? AREAS TO IMPROVE ON?

8. ANY HOME WORK GIVEN IN THE SESSION:

9. PLAN FOR NEXT SESSION:

