PSYCHOSOCIAL FACTORS AND RECIDIVISM OF THE INDIAN SCHIZOPHRENIC PATIENT

by

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to

The patients in whose interest this study was undertaken

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ABSTRACT

A study on the influence of psychosocial factors on 30 schizophrenic patients was undertaken. The patient population was selected on the basis of :

(a) being resident in the Pietermaritzburg area.

(b) having one or more admissions to the psychiatric hospital (Fort Napier).

(c) having a diagnosis of schizophrenia.

The social questionnaire was completed after home visits were made to the patient and his family.

The initial hypotheses:

(a) poor psychosocial factors result in readmission to the hospital;

(b) adequate facilities would result in the readmission rate of the mentally ill decreasing;

(c) patients who lived in high EE homes have a higher relapse rate than those returning to low EE homes;

have been confirmed in the study.

The study has shown that the psychosocial aspects of schizophrenia must receive attention, together with medical treatment if relapse is to be prevented. The success of rehabilitation rests largely on finding the optimal balance for each patient.

Better co-ordination of referrals should increase the number of people who establish outpatient contacts and more important, increase the number of visits each person makes.

SAMEVATTING

'n Studie oor die invloed van psigososiale falitore op 30 skisofreniese pasiënte is gedoen. Die pasiënte is geselekteer op die basis van :

(a) Woonagtig in die Pietermaritzburg gebied
(b) Met een of meer opnames in die psigiatriese hospitaal (Fort Napier) en
(c) Met 'n diagnose van skisofrenie.

Nadat die pasiënt en sy gesin tuis besoek was, is die sociale vraelys oor elkeen ingeval.

Die oorspronklike hipotheses, naamlik :

(a) swak psigososiale falitore het hertoelating in die hospitaal tot gevolg
(b) die aantal hertoelatings van sielsickes sal daal indien voldoende fasiliteite beskikbaar is
(c) pasiënte wat in hoë EE huise inwoon, het 'n hoër voorkoms van terugval, as diegene in lae EE huise;

is in die studie bevestig.

Die studie het getoon dat die psigososiale aspelite sowel as mediese behandeling van skisofrenie aandag moet kry, om terugval

te voorkom. Die sukses van rehabilitasie berus daarin om die optimale balans vir elke pasiënt te vind.

Verbeterde ko-ordinasie van verwysings behoort die aantal persone wat kontak maak met buite pasiënte, en nog belangriker, die aantal besoeke van elkeen, te vermeerder.

CHAPTER 1

INTRODUCTION

1.1 ORIGIN OF STUDY

Mental illness remains one of the most serious medical and social problems in the world today, whether measured by the number of people affected, by the suffering and stigmatisation experienced by the mentally ill and their families, by loss of productive human resources to the community or by the cost of the institutional and community care and treatment of the mentally ill (Black, 1967; Freeman et. al., 1979; Gallagher, 1980).

The study of mental illness has been approached from the particular perspectives of many disciplines. Theoreticians and researchers in the field of clinical psychology, psychiatry, physiology, and psychopharmacology have presented conceptualisations and reports dealing with the etiology, treatment and outcome of mental illness. According to Spitzer and Denzin (1968) the failure of these disciplines to provide a sound empirically tested theory of mental illness can be attributed to the neglect of the social processes involved in the development and

resolution of disturbed behaviour, as well as to a failure to question some of the fundamental assumptions on which the study of the phenomenon of mental illness is based.

The last two decades have seen a growing awareness of the social aspects of mental illness. Through the efforts of socially oriented psychiatrists and psychologists, sociologists, and to an extent, cultural anthropologists, the importance of numerous social variables has been established. Research has demonstrated an association between mental illness and such factors as social class, residential mobility, family dynamics, hospital social structure, and many additional social variables. As a result it is now commonly recognised that the environment of the patient plays a significant role in shaping the characteristics and course of mental illness. (Spitzer and Denzin, 1968).

1.2 WHY STUDY ASPECTS OF SCHIZOPHRENIA

The seriousness of the problem of mental illness is also emphasized by Black (1967),when he states that : "..... mental illness, when viewed from the perspective of community needs, presents

a problem of staggering proportions in terms of the numbers of people affected and the costs of services". (p.5).

Estimates indicate that there are approximately 120 million people in the world who are mentally ill and furthermore, that one out of every ten persons of any population has at some or other time been mentally ill. (Clausen, 1979). Whatever may be the accuracy of these estimates, however, it appears that there is a great deal of ignorance in respect of mental illness. According to Srole et. al., (1962) there exists "..... an enormous misunderstanding of all matters pertaining to mental health ..... great confusion prevails ..... most people have literally no understanding that mental illness is an illness ..... we know all too little of what people know and do not know about mental health, what personal anxieties lie behind their resistance, what prejudices and misconceptions stand in their way of learning ....." (pp 4-5).

The return of the discharged patient to the same stressful situation that led to hospitalisation often leads to readmission. The patient's family, his colleagues at work, his friends and

society at large, all have some involvement with the mentally ill person. The present study is primarily directed at understanding the linkages between social and psychological characteristics of patient's family settings and family members. The research is restricted to an analysis of Indian patients diagnosed as schizophrenic at the Fort Napier Hospital, Pietermaritzburg where the researcher is employed as a social worker.

1.3 HYPOTHESES

Several hypotheses were investigated, namely:

(i) Poor psychosocial factors result in readmissions to the hospital.

(ii) Adequate facilities would result in the readmission rate of the mentally ill decreasing.

(iii) Patients who lived in high EE (expressed emotion) homes have a higher relapse rate than those returning to low (EE) homes.[1]

1. The work on EE by (Brown, Birley and Wing, 1972) revealed that measures of overinvolvement, hostility, and critical comments made by the patient's relatives (usually the parents) at the time the patient was admitted to the hospital possessed powerful prognostic information about the likelihood of relapse.

1.4 IMPORTANCE OF RESEARCH

1. The high cost of hospitalising patients and the increase in readmissions are factors that underscore the need for local research efforts in this field.
2. There is a need to determine the processes affecting patients leaving mental hospitals and causing them to be readmitted later.
3. The aim of psychiatric social work is to promote the rehabilitation of persons with mental disorders, to achieve and restore maximum social functioning.
4. It is of importance especially to social workers in the psychiatric field to determine how supportive influences in the environment could be maximised and damaged ones reduced.
5. Discussions with a number of senior mental health personnel have emphasised that such a study is long overdue.

High readmission rates at mental hospitals, especially at the mental hospital where the researcher is presently employed indicate the need to investigate the factors leading to rehospitalisation.

1.5 RESEARCH METHODOLOGY

The research design formulated for the study is descriptive and exploratory.

The study is descriptive because it aims at portraying accurately the characteristics of individuals and a group, and sets out to determine the frequency with which certain things occur eg.

(a) The extent of the problems of schizophrenic patients

The study also aims at studying the relationship between psychosocial factors and recidivism of schizophrenic patients.

The study may also be considered as exploratory because it aims at gaining familiarity with a phenomenon, namely the relapsing schizophrenic patient.

1.5.1 LITERATURE STUDY

Relevant literature was consulted throughout the research period, although the main literature sources were reviewed in the early stages of the research.

1.5.2 PILOT STUDY

The main research was preceded by a pilot study which consisted of structured interviews with five Indian schizophrenic patients. This was undertaken to determine the feasibility of the questions posed in the interview schedule.

1.5.3 THE INTERVIEW SCHEDULE

In its final form the Interview Schedule consisted of sections on the patients' demographic characteristics some of which were obtained from the hospital records. The data included age, sex, marital status, occupation, psychiatric diagnosis, number of previous psychiatric hospitalisations, status of discharge (against medical advice), readmission (voluntary or involuntary), aftercare arrangements, home conditions, attitudes of family members and community, family interaction and rating by the interviewer.

Information extracted from the files, particularly medical information was fragmented, often incomplete or written illegibly. Other research

has pointed to the difficulty of using medical records for research purposes. (Dunn and Etter, 1962).

Appointments were made for interviews with parents or relatives by telephone calls or home visits. The questionnaire was administered to the patients together with their relatives whenever possible.

1.5.4 SELECTING THE SAMPLE

The researcher scrutinised all the patients hospital files. The sample was selected according to the following criteria :

1. Patient must be diagnosed as schizophrenic.
2. The patient must have been readmitted to the Fort Napier Hospital after initial discharge, one or more times.
3. The patient must be living in Pietermaritzburg areas. This decision was based on time and travelling considerations. A sample of 30 males and females were selected on this basis.

1.5.5 COLLECTING AND CHECKING THE DATA

Home visits undertaken by the researcher were made to the patient. Relatives and the patient were consulted in the completion of the questionnaire which took approximately two to three hours to complete.

As data was collected, the questionnaires were examined for completeness, comprehensiveness, consistency and reliability.

1.5.6 ANALYSING THE RESULTS

The process of analysis included tallying the interview replies or observations; tabulating the data and performing statistical computations.

1.5.7 LIMITATION OF THE RESEARCH DESIGN

The aim of any research is to obtain complete and accurate information. Attempts have been made to do this by including at the end of the Interview Schedule a rating by the interviewer.

Small sample numbers have been critised in previous research. However, in view of the fact that this was a mini-thesis, the sample of 30 patients seemed to be a feasible number to work with.

Representativeness of sample ie., only the Pietermaritzburg patients were represented and this did affect the results as discussed later eg., patients living in the same area as the hospital received better aftercare services than those at a distance.

1.6 DESCRIPTIONS OF KEY CONCEPTS USED IN THIS STUDY

1.6.1 WHAT IS SCHIZOPHRENIA

The diagnosis of schizophrenia still relies on descriptions of the patient's behaviour, mental state and history; there are no objective and quantifiable diagnostic aids available from the laboratory.

One of the biggest problems in attempting to review research and theoretical literature on schizophrenia is due to the "lack of any consistent definition of schizophrenia". (Blatt and Wild, 1976, p.1). Because of this diagnostic

unreliability, the interviewer is forced to accept that he is reading reports of people called schizophrenic. Likewise, "there seems to be little choice but to study people called schizophrenic". (Fontana, 1966, p. 214).

The most popular belief today is that schizophrenia is not a single disease entity but rather a family of diseases with similar outward manifestations but differing etiologies. (Baxter and Melnechuk, 1980).

For the purpose of this study the term schizophrenia would be determined in terms of the diagnostic criteria as set out by the D.S.M. III (The Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Williams, 1980).

According to the D.S.M. III (Williams, 1980) the essential features of this group of disorders are:the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving multiple psychological processes, deterioration from a previous level of functioning, onset before age 45, and a duration of at least six months. The disturbance

is not due to an Affective Disorder or Organic Mental Disorder. At some phase of the illness schizophrenia always involves delusions, hallucinations or certain disturbances in the form of thought.

1.6.2 RECIDIVISM

The term recidivism has been used in this study because of its frequent use in the hospital where the researcher is employed. Recidivism in the hospital situation means the frequent readmission or rehospitalisation of psychiatric patients.

Most of the studies of the determinants of adequate functioning in the community have used remaining out of hospital as the criterion for successful functioning. Rehospitalisation, according to Fontana (1975) "represents one of the most serious and clearcut manifestations of the breakdown in social arrangement which are necessary for people to live together in toleration if not in harmony." p. 231.

Studies of patients returning to the community usually use rehospitalisation as a measure of

functioning for the very practical reason that such data are readily available. However, another factor supports such a practice - the high readmission rate which accounts for a great percentage of admissions to mental hospitals. The factors that separate readmitted psychiatric patients from those who are not readmitted provide important clues to the social control of mental illness.

Today patients are being hospitalised for shorter lengths of time and may require periods of respite to compensate for the brief treatment. Rehospitalisation may not necessarily be an index of community readjustment as much as an indication that the patient was released prematurely.

There are those researchers however who feel that rehospitalisation is a valid indicator of unfavourable community adjustment. Most of these researchers agree that rehospitalisation does not yield a total picture of ex-patients functioning since there are undoubtedly some who remain in the community but cannot perform the social roles expected of them. Studies using rehospitalisation as an evaluation index overlook

these types of individuals, but they do identify extreme groups of ex-patients since the avoidance of rehospitalisation is a minimum standard for evaluating the persons ability to cope with the real world.

1.6.3 READJUSTMENT

The rehabilitation and readjustment of schizophrenic patients entering extramural life is affected by a multitude of factors. Some of these as Serban (1980) points out are inherent in the patients' condition; others are basically environmental in nature. In the first category are the effects of deterioration of the patient brought about by lengthy institutionalisation, a matter which has received wide currency in recent literature. The residual thought defect, even in the absence of florid psychotic symptomatology is another factor affecting outcome in the community since it interferes, to a significant extent, with readjustment efforts by distorting the perception of the social expectations of the community milieu, and by impairing the ability to deal with social roles.

Several factors are of particular importance in the rehabilitation of the schizophrenic patient in the community. One of these is the support of and the quality of interaction with family members in whose care many of the patients are released. Closely related to this variable are the attitudinal expectations of the family regarding the patient's social functioning, specifically his ability to fulfill social roles as a productive member of the community. The third crucial factor is the continuation of treatment on an outpatient basis and the following through on the recommended medication programme.The fourth variable of great importance in the rehabilitation procedure is determined by the patient's level of awareness of his difficulties in coping with the community demands, and of his deviant behaviour which affect his willingness and motivation to seek help voluntarily before the stresses experienced in extramural living culminate in another enforced hospitalisation.

Among the environmental factors of considerable importance for the readjustment of former patients, all too often ignored in the enthusiasm of rehabilitative efforts within the community

settings, is the interest and availability of the family as a supportive force in the readaptation of schizophrenics.

1.6.4 CONCEPT OF EXPRESSED EMOTION

An index of relatives' emotional attitudes has been termed expressed emotion (EE). Relatives' EE status is based on ratings on three factors that are not mutually exclusive: criticism, hostility and emotional overinvolvement (EOI). Criticism and hostility are based on either negative emotion (judged by tone of voice) or a 'clear statement of resentment, disapproval, dislike or rejection.' Marked emotional over-involvement tends to be found in parents rather than in other relatives and is best characterised by excessive anxiety, overconcern, or over-protectiveness toward the patient. It is rated on the basis either of feelings expressed in the interview or of behaviour reported outside it. Using empirically derived cutting scores, investigators classify relatives as either high or low in EE attitudes. Schizophrenic patients who return to high EE homes - that is, homes characterized by high levels of critical or hostile attitudes toward the patient and/or by

excessive emotional involvement have a greater relapse rate than those who return to low EE homes.

1.7 DIVISION OF REPORT

The remainder of this research report is divided into four sections. Chapter Two contains a review of relevant literature and research on the issues in the etiology of schizophrenia; Chapter Three contains information on the value of socio-demographic data for the prediction of outcome in schizophrenia; Chapter Four contains the results and discussion of results. The researcher's conclusions and recommendations are included in Chapter Five.

CHAPTER 2

ISSUES IN THE ETIOLOGY OF SCHIZOPHRENIA

2.1 INTRODUCTION

Since a relationship between the cause and the outcome of schizophrenia has been always assumed, a summary review of the major theories of etiology of schizophrenia appears to be warranted as a starting point for the present study.

As Serban (1980, p.1) points out, the elusiveness in identifying the etiology of schizophrenia for years resulted in a broad interpretation of its cause, with explanations ranging from psychosocial, cultural factors to purely genetic ones. Regardless of a particular emphasis, the etiological hypotheses may be divided into three major conceptual formulations- two representing opposing points of view, the psychosocial one versus the organic one, while in the middle is the psycho-organic one, reflecting a more conciliatory position. Interestingly enough, each one of these approaches presents supporting arguments, based on empirical data which could justify, at least up to a point, their concept of schizophrenia.

Yet, neither one is able to clarify the whole gamut of schizophrenic reactions. This will explain why, in the framework of psychosocial hypotheses (psychological, cultural or psychodynamic concepts) several distinctive theories are vying for acceptance as major explanations for the development of the disease .

To quote White and Watt : "like the six blind men, investigators have studied schizophrenia with exhaustive thoroughness from virtually every perspective - genetic endowment, physiology, biochemistry, the nervous system, intellectual functions, emotions, adjustment and defense, early experiences, social environment - and not arrived at a compelling portrait of "the nature of the beast"! (1981, p. 469).

Since the darkness has not been dispelled, the account presented here must reflect the same inquisitive bewilderment.

2.2 GENETIC FACTORS

The interest in the possibility of genetic influences in schizophrenia has a long history.

From the time the condition was first described in the late 1800's, it was observed that the disorder seemed to occur in some families more frequently than in others. According to Kisker (1977) current evidence for genetic influences in schizophrenia comes from family-risk studies, twin studies and adoptee studies.

2.2.1 FAMILY RISK STUDIES

Wings (1978) criticism, after a review of the family studies, is that one cannot say that schizophrenia is genetically transmitted but that there is support for the notion of a predisposition to schizophrenia.

Despite the uncertainties, the family studies support the hypotheses that genetic factors are implicated in the etiology of schizophrenia but they do not rule out the alternative hypotheses of a shared family environment.

2.2.2 THE TWIN STUDIES

Some of the most persuasive evidence for genetic influences in schizophrenia comes from the comparison of monozygotic and dizygotic twins.

These studies point out that while the genetic predisposition is present to the same degree in both members of the twin pair, the ability to resist psychosocial stress is a learned reaction that cannot be the same in any two people, no matter how biologically similar they are.

The most critical problem of interpretation remains. Since the twins have been reared together, a common environment rather than common genetic factors could account for the concordance rates. The only conclusive data on this question would have to come from studies in which monozygotic twins were reared apart from very early childhood, enabling the relative contributions of heredity and environment to be separately determined. The number of such pairs is small. Of the 16 cases in the literature ten were concordant and six discordant (Rosenthal, 1970). The concordance rate of this limited sample was 62,5%. This finding certainly supports the view that a predisposition for schizophrenia is genetically transmitted. Because of the small sample size, however, the data canot be regarded as conclusive.

2.2.3 ADOPTEE STUDIES

The most important and compelling line of evidence comes from studies in which the parent and child generations have been separated so that the child is not reared by the biologic parent. All the findings taken together mean that a schizophrenic psychosis is more likely to develop in individuals who carry a certain inherited predisposition. The contribution of genetic determinants, even if it is a small one, is incontrovertible (White, 1981). Clearly, the adoption studies do not rule out environmental factors - even family environmental factors- in the complex etiology of schizophrenia but such factors would appear not to be specific to the parents of schizophrenics. They could be very common in the population but interact unfavourably with a high risk genetic predisposition to schizophrenia.

The family, twin and adoption studies present consistent support for the hypothesis that genetic as well as environmental factors are involved in the etiology of schizophrenia. They refute different purely environmental objections. If this point of view is accepted it means one can turn with greater confidence

to genetically oriented family studies on clinical or biological lines. There is disagreement, however about how much weight should be given to the evidence.

Advances in biological and social psychiatry will eventually lead to progress in understanding the interaction between genes and environment. Meanwhile,Wing (1978) writes that any attempt to explain schizophrenia that ignores the genetic dimension is bound to be inadequate, it will hamper progress and be to the detriment of patients and their relatives.

2.3 THE INFLUENCE OF THE FAMILY

The immediate family act as the most important mediator between the individual and the wider society. As such the family provides the major socioemotional environment to which a psychiatric patient returns. The family can add to or detract from the intimate social environment which is needed by a person seeking to return to society.

Thus as Spitzer and Denzin (1968) indicate, it might be expected that the posthospital success of the patient would depend in large part upon the kind of family to which he belongs and upon its attitudes, perceptions and acceptance of him.

2.3.1 FAMILY THEORIES OF SCHIZOPHRENIA

Interest in families grew in the 1930's and 1940's with the work of Sullivan and Fromm-Reichmann. It is clear that parents play a vital part in those events of infancy that are assumed to be the starting point for schizophrenic developments. Therefore it is not surprising that the parents of schizophrenics have been the object of close psychological scrutiny.

Fromm-Reichman (1948) coined the term "schizophrenogenic" and described "schizophrenogenic mothers" as aggressive and domineering but insecure. Others have indicated that these mothers are rejecting, cold, overprotective and impervious to the feelings and needs of others. Such mothers are said to produce schizophrenia in their offspring. Available studies have typically described a somewhat inadequate,

indifferent, or passive father who appears detached and humourless - a father who rivals the mother in his insensitivity to others' feelings and needs. Frank (1965) however has indicated that there is no such person as the schizophrenogenic mother.

Suinn (1975) proposed that the search for one single type of trait, or even a consistent cluster of traits which characterises all schizophrenogenic mothers and fathers will always be futile as this approach is too narrow. There is a need, rather, to focus on family dynamics.

The family theories of schizophrenia can be divided into three groups : parental thought disorders, deviant family communication patterns or styles and double-bind research. The theories of Lidz (parental thought disorders), Wynne (deviant family communication patterns), and Bateson (double bind), all deem language and/or communication in the family to be of primary significance in the appearance of schizophrenic phenomena within the family.

2.3.2. THE LIDZ APPROACH

Lidz theory evolved from the recognition that the serious disturbances of the family settings derived from the profound egocentricity of one or both parents; that the disturbances of language and thought that form the critical attribute of schizophrenic disorders are largely types of egocentric cognitive regressions to developmental stages described by Piaget and Vygotsky; and that the parent's disturbed styles of communication, which are manifestations of their egocentricities are essential precursors of the patient's cognitive regression that occurs when he cannot surmount the essential developmental tasks of adolescence. (Lidz et. al., 1957). Lidz more than other theorists, tends to stress Oedipal issues in the genesis of schizophrenia. One of the few testable hypotheses derived from his work is the expectation that the same-sex siblings ought to be more disturbed than opposite sex siblings.

2.3.3 WYNNE AND SINGER'S APPROACH

Wynne et. al., (1958) found that schizophrenic family relationships often had the appearance of being mutual, understanding and open, but

in fact were not. This condition they termed pseudo-mutuality. They found that schizophrenics came from families in which a tendency to rigid roles and family mythologies makes it difficult for any one member to change or grow without causing drastic upheaval in the family as a whole.

There is little doubt that there are abnormal patterns of communication in the families of many schizophrenics, but the significance of this observation in relation to the actual causation of the condition remains obscure.

2.3.4 THE BATESON MODEL

According to Bateson et. al.,(1956) one factor in the development of schizophrenia is exposure, during childhood, to excessive 'double-bind' communication from the parents. Rational thinking and conduct depend on the learned capacity to distinguish clear meaning in situations, to filter out the important and relevant facts from the "booming and buzzing" confusion of the world, and to think, speak and act coherently with respect thereto. The ability to do this

is not innate but is learned from the way in which parents order their existence. If the parental world itself is highly confused, full of uncertain and shifting meanings and if the double-bind method of communication is extensively used, the child never learns to order its world and schizophrenia results.

Although the double-bind theory has been a popular and widely known explanation, it is not supported as a factor of great etiological significance by any available data. Most of the literature on the double-bind hypothesis is uncontrolled and descriptive and therefore limited, according to Zealley, et. al., (1978).

2.3.5 FAMILY ENVIRONMENT RESEARCH (EE)

According to Goldstein (1978) recent years have witnessed a rekindling of interest in the role of the family in schizophrenia. While it is not possible to specify a single stimulus to this renewed interest, a number of factors seem significant.

First, the trend towards deinstitutionalisation of schizophrenic patients and the emphasis upon community based care often places patients back in some sort of family environment. Examination of these family environments has revealed that some families cope well with this newly assigned caretaker role but that many experience considerable difficulty in reabsorbing a family member who frequently manifests a number of residual symptoms. Concern with the nature of the family environment and its impact on the newly discharged schizophrenic patient has revived interest in the family's role in schizophrenia in general.

Secondly, the work by Brown and his colleagues (1972) and later by Vaughn and Leff (1976) provided empirical evidence that deleterious aspects of the family environment could be specified and measured with standardised procedures. These investigators developed an index of relatives' emotional attitudes, which they termed expressed emotion (EE). Relatives EE is based on ratings on three factors that are not mutually exclusive: criticism, hostility, and emotional overinvolvement (EOI). Using empirically

derived cutting scores, these investigators classify relatives as either high or low in EE attitudes. Schizophrenic patients who return to high EE homes ie,homes characterised by high levels of critical or hostile attitudes toward the patient and/or by excessive emotional involvement have a likelihood of relapse over a nine month follow up period. The EE variable, assumed to reflect ongoing intrafamilial attitudes and processes suggested a particular sensitivity of the schizophrenic patient to discriminable attributes of the family emotional environment.

Third, the past ten years have witnessed a number of research programme concerned with the developmental antecedents of adult schizophrenia. These studies have focused on populations believed at greater than average risk for schizophrenia, which are identified and studied before the onset of the clinical form of the disorder or its prodomal phases. These samples are then followed from some earlier life period until they enter the risk period for adult schizophrenia. Several of these projects have included measures of intrafamilial characteristics

in their early assessments so that the value of familial predictors of the likelihood of the onset of a schizophrenic episode can be evaluated. These studies have involved a higher level of sophistication in the assessment of family relationships and more precise specification of family paramaters than was the case in earlier family research. Some of the variables measured have been derived from these earlier studies of families containing adult schizophrenic offspring as for example the Wynne - Singer concept of communication deviance. Others have been derived from the work on family factors associated with the course of schizophrenia involving interpersonal derivatives of the EE dimensions. (Goldstein and Doane, 1982, p.692).

2.3.6 EVALUATION OF THE FAMILY THEORIES

1. In 1981, Shapiro criticised family theories based on observations made after the appearance of illness in one member of the family. Thus what is observed and reported may be a consequence, rather than a cause of the schizophrenia.
2. Reviews of family influences in schizophrenia have suggested that family variables can function as prognostic variables, but the etiological significance of family variables remains uncertain.

3. A major criticism of family theories of schizophrenia is that not all siblings in the family become schizophrenic. Even when heredity is the same and the environment is similar, as in the case of identical twins reared together, 20 to 70% of the pairs (depending on the study) are discordant for schizophrenia.

4. There are five observations that can be made about the effort to research the family theories of schizophrenia.

(a) The research is naive and epistemologically confused, if not misguided. Few researchers have realised that some of the family theories propose, not a different etiology of schizophrenia, but a redefinition of what schizophrenia is.

(b) In accordance with the holism of systemic epistemology, no part of the pattern can be dualistically understood as causing another part of the pattern.

(c) The work of Singer and Wynne on communication defiance is seldom corrrectly understood.

(d) Probably the only valid transactional research is that conducted by Singer and Wynne and by Reiss. These have addressed

themselves to family interaction without seeking dualistic, linear causal effects in the family. Although these researchers investigated transactional phenomena, however, they did not demonstrate that family interaction causes schizophrenia.

(e) How can an evaluation of whether family interaction causes schizophrenia be made within a theory that specifically denies the validity of such dualistic causality?

2.3.7 INTERVENTION EFFORTS WITH FAMILIES CONTAINING SCHIZOPHRENIC MEMBERS

The awareness that family members are increasingly responsible for the aftercare of a schizophrenic relative and that specific attributes of the family environment may be particularly noxious has led to renewed interest in family intervention programmes designed to prevent relapse and foster social recovery.

Goldstein (1982) writes that unlike previous approaches in which family therapy was frequently set in opposition to pharmacological agents, more recent efforts accept the importance of

such agents and ask whether family intervention can provide additional protection against relapse in the aftercare period. The family intervention programmes which have emerged in recent years are more pragmatic. A major emphasis is placed on familial education about schizophrenia, crisis management and strategies for coping with the interpersonal stresses of family life.

Goldstein and Doane write that although a family intervention programme substantially reduces relapse during the first year after discharge, longer-term follow-ups are needed to evaluate whether such programmes merely delay relapse or whether they increase the likelihood of a patient's being able to continue to remain minimally symptomatic in the community for more extended periods. (1982, p. 699).

Considering the enormous and demoralizing impact of repeated rehospitalisations on a patient and his relatives, the achievement of even a short-term reduction in relapse rates is an impressive accomplishment.

The research on the family influences appears to indicate a number of promising leads for unravelling the role of the family with regard to the onset, course, and treatment of schizophrenia. Particularly striking are the following trends:

1. The attempt to integrate the research on family factors related to onset of schizophrenia with those predictive of course within a comprehensive theoretical and empirical model.
2. A shift in ideology regarding the family of the schizophrenic patient. Previously, because of evidence of disturbed intrafamilial relationships, mental health professionals, alternatively rejected or isolated the patient's family. Currently there is a growing recognition that with proper support systems and intervention, the family of the schizophrenic patient can be a positive factor in aftercare.
3. The development of specific family-oriented intervention programmes designed to modify key aspects of family relationships believed stimulative of relapse.

4. A growing acceptance of the multi-model pattern of treatment in which both family-oriented, psychosocial interventions and maintenance pharmacotherapy are viewed as essential components of a comprehensive aftercare treatment package for schizophrenic patients.

Goldstein et. al., (1982) writes that these trends are very exciting and positive, but it is important to point out that recent developments in aftercare related to the EE concept have involved a rather special group of schizophrenic patients - those still connected with their families and likely to return home after a period of hospitalisation. The typical schizophrenic patient in the U.S.A., does not return home to his family but usually enters a board and care facility or fends for himself in depressed areas of the cities. New and imaginative models for aftercare still must be developed for this class of anomic patients.

2.4 THE PSYCHOLOGICAL FACTORS

Shapiro (1981) notes that each major group of theories has its own inherent problems, and

psychoanalytic theories are no exception:

(i) Few of the major psychoanalytic theorists have explicitly presented statements on the etiology of schizophrenia (Redlich, 1952).

(ii) Accounts of psychoanalytic treatment of schizophrenics have described upper-class populations which leads to further methodological difficulties.

(iii) Psychoanalytic theories are second and third order inferences, often greatly removed from observable, experimentally reproducible events.

(iv) A general dynamic genetic formulation is open to the criticism that not everyone with these dynamics becomes schizophrenic.

(v) The cardinal sign of schizophrenia - the presence of a formal thought disorder is difficult for psychoanalytic theories to explain (Rapaport, 1951).

(vi) A developmental theory of schizophrenia must explain how the preschizophrenic survives for some 18 years before psychotic symptoms erupt. He or she survives with many ego functions intact - the very ones that will disintegrate during the acute psychotic break.

(vii) Many theoretical hypotheses remain untested and are at odds with well established data from cognitive and developmental studies.

Shapiro (1981) stresses the need for further efforts to integrate psychoanalytic developmental theory with recent cognitive and psychological findings. Such a task is feasible and would greatly clarify developmental understandings.

2.4.1 THE SOCIAL LEARNING THEORY

Ullmann and Krasner's (1975) "sociopsychological model explains schizophrenic behaviour as the product of failure of reinforcement for a sequence of behaviour". After repeated failure of reinforcement, the schizophrenic learns to stop paying attention to environmental cues. "The crucial behaviour from which other indications of schizophrenia may be deduced, lies in the extinction of attention to social stimuli to which 'normal' people respond". (p. 359). This accounts for the deficits in attention and thinking that often characterise schizophrenic behaviour.

Ullman and Krasner see schizophrenia as a social role. According to this theory, patients chose to "talk crazy" because hospital staff members attend more to them when their verbalisations are bizarre than when they are quiet and rational.

Nathan and Harris (1980) criticise Ullman and Krasner's theories. They suggest that in addition to problems in replicating these findings, questions should be raised about what can logically be concluded from any study demonstrating that a hospitalised mental patient can create a particular impression in an interview or testing situation. The fact that a person diagnosed as schizophrenic can look "less sick" if told how to do so, does not in itself justify the conclusion that schizophrenia is nothing more than the adoption of a social role.

Nathan and Harris (1980) point out that Ullman and Krasner's (1975) theory has other weaknesses which must skirt the bounds of probability in explaining all schizophrenic behaviours according to the "failure of reinforcement" concept. Ullman and Krasner according to Nathan et. al., show a curious willingness to posit a theory unsupported by empirical data, despite their strong insistence on such data in connection with other theories.

The strength of this theory however, is its insistence that schizophrenic behaviour is no different from deviant behaviour emitted by non-schizophrenics.

2.4.2 EXPERIENTIAL THEORY

Laing (1964) holds phenomenological views about the etiology of schizophrenia. He believes that all aspects of the schizophrenic patient's environment contribute to his or her behaviour. For Laing the schizophrenic psychosis is a normal reaction to an abnormal situation.

Nathan and Harris (1980) disagree with Laing that schizophrenia is simply a means used by some people to detach themselves from intolerable living conditions. They state that they have seen far too many schizophrenic patients from tranquil, loving family situations and far too many perfectly normal people enmeshed in chaotic families to accept this view. They acknowledge, however, that Laing's hyperbolic, exaggerated views on schizophrenia have "shaken up" the establishment which has been forced to examine its facile assumptions and explanations.

There is little evidence that experiencing schizophrenia can make a "better person" of the patient as Laing suggests. Nor is there much evidence to support Laing's assertion that schizophrenia is caused by familial experiences.

2.4.3 BIOCHEMICAL AND PHYSIOLOGICAL CHANGES

A large number of researchers have carried out biochemical investigations of schizophrenia, pursuing the hypothesis that a biochemical or metabolic error is at the basis of the disorder. Life is characterised by an incredibly large number of metabolic processes however, so that it has not been an easy task to isolate the hypothetical process responsible for schizophrenia.

Two of the major areas of current investigation are as follows:

(a) TARAXEIN

Heath et. al., (1958) found that taraxein, a substance in the blood of schizophrenic patients, caused schizophrenic behaviours when injected into the bloodstream of non-schizophrenic volunteers. Though

Health et. al., published extensive empirical data in support of the theory, other experimenters have failed to confirm the findings. (Whittingham et. al., 1968).

(b) NEURAL TRANSMISSION DYSFUNCTION

Carlsson and Lindqyist (1963) indicated that far too much dopamine or noradrenalin at receptor sites might be an etiologic factor. It can be questioned by the dopamine hypothesis, buttressed by an impressive array of experimental data has not been fully accepted. Wyatt et. al., (1978) attributes this fact to the lack of consistent changes in metabolites or enzymes related to the catecholamines, including dopamine, which have been detected in the brains of schizophrenic patients. Hence, the possibility that dopamine may play a secondary or mediating rather than primary role in the etiology of schizophrenia remains, and the dopamine hypothesis continues as suggestive but not definitive.

2.4.4 EVALUATION

Even if suported by additional research, however, these studies indicate only that a particular biochemical is associated with schizophrenia. The deviant chemical could be produced after, rather than before, the onset of the disorder.

2.5 OTHER POSSIBLE HIGH RISK FACTORS

Mednick et. al., (1975) attribute the difficulties in understanding the causes of schizophrenia to our inability to separate cause from consequence. However, the most promising efforts are the high risk studies which provide long-term follow up of populations at risk for schizophrenia. Children are considered to be at high risk by virtue of having been born to a schizophrenic parent.

There are many pitfalls in researching high risk populations:

1. There is a difficulty in finding families that meet the study's specifications, in enlisting co-operation of all their members, and in following them for the extended duration of a longitudinal study.

2. Care must be taken in determining that the "well" spouse in a schizophrenic family is indeed clinically evaluated as normal.
3. The selection of the critical variables in the parents and children appropriate to each child's stage of development also poses complex problems.
4. No valid scales are available to permit proper weighing and balancing of the importance of genetic and environmental factors.
5. The study by Mednick (1962) has not paid off well in terms of isolating specific environmental factors. What it has done is to show once again that having a schizophrenic parent is a good predictor of psychological disorder, including schizophrenia.

These high risk studies are still in their infancy. Not enough time has yet elapsed for most index cases to pass the age of risk for schizophrenia. Clearly high-risk studies are the path for the future with, it is hoped, increased attention to identification of subgroups at risk through biochemical markers.

2.6 THE STIGMA OF MENTAL ILLNESS

As Spitzer and Denzin, (1968) point out, despite considerable efforts to remold the public's image of the mental patient, hospitalisation for psychiatric reasons continues to result in invidious evaluations of the patient by his community associates. As a consequence of current attitudes toward mental illness, feelings of shame, inferiority, and disgrace on the part of patients and their family members are looked upon as almost inevitable concomitants of hospitalisation. The current attitudes toward mental illness that are held by community members and their resulting detrimental effects on patients and their families, are often regarded as a major barrier to the reintegration of formerly hospitalised persons into the community.

2.6.1 DEFINITION OF STIGMA

According to Gallagher (1980) much of the literature on the life of the ex-mental patient is couched in terms of the stigma attached to mental illness.

Cumming and Cumming (1957) write that the word stigma is often used to describe the way in which society stamps those who have been mentally ill. Its literal meaning is "a stain on one's good name," or a "loss of reputation".

Gallagher (1980) notes that today stigma refers to the disgrace itself rather than any bodily evidence of it. The person who is or was mentally ill is stigmatised because he is deeply discredited for his failure to live up to societal expectations and frequently rebuffed whenever he attempts social intercourse.

Cumming and Cumming (1957) add that whether it is a visible mark or an invisible stain, stigma acquires its meaning through the emotion it generates within the person bearing it and the feeling and behaviour toward him of those affirming it. These two aspects of stigma are indivisible since they can each act as a cause or effect of the other.

2.6.2 RESEARCH INTO PUBLIC ATTITUDES

Gallagher (1980) notes that research into public attitudes toward the mentally ill has become polarised into two schools of thought:

(i) those who contend that society stigmatises the mentally ill and

(ii) those who believe society accepts the mentally ill and is compassionate toward them.

The former perspective is linked with the traditional view of mental illness which characterises the mentally ill as unpredictable, bizarre and violent. The latter perspective represents the psychiatric ideology which views the mentally ill simply as sick persons who can be treated and cured, just like people with physical ailments. The traditional view is usually learned during early childhood and is reinforced by the mass media, whereas the psychiatric ideology is usually developed through higher education.

Some empirical studies report that the public is somewhat tolerant of mental illness and does not automatically stigmatise mental patients (Cumming, 1957). However these findings usually apply only to people of higher educational background or to those who were socialised in a more liberal cultural milieu, such as that of the 1960's.

Many people do not consider the mentally ill to be legitimately sick. They see them as a separate class of beings who are dangerous and incapable of cure. (Nunnally, 1961). These attitudes are largely responsible for the rejection experienced by ex-patients. Even patients themselves fear the "mental patient!" (Giovannoni and Ullman, 1963). This situation is depressing, particularly because neither patients nor ex-patients typically live up to their popular portrayal as uncontrolled monsters. In fact, ex-patients are less likely to act violently or commit crimes than are those who have never been judged mentally ill. (Giovannoni and Guree, 1967).

2.6.3 INFLUENCE OF MASS MEDIA

Much research indicates that the mass media has an enormous influence on societal pressure. Attitudes created toward the mentally ill are particularly slow to change because they have been hardened through years of biased reporting. Consequently, ex-patients are relegated to extremely difficult lives in the comunity. Patients report that the fact of their illness was used as a threat which blocked communication

with friends and family, resulted in feelings of low self-esteem and seriously diminished their chances for meaningful employment. (Miller and Dawson, 1965).

2.6.4 STIGMA AND TYPE OF ILLNESS

A number of studies indicate that neurotics are not stigmatised to the same degree as are the psychotics. This is because more serious illnesses typically involve more bizarre, disruptive, and unpredictable behaviour which is perceived as overtly more threatening by others. (Dohrenwend and Chin-Shong, 1967, p. 417).

Another factor which influences the degree of stigma is the type of treatment the patient receives. Swanson and Spitzer (1971), state that stigma declines when the patient is released from the hospital. Also more stigma is suffered by those who have been patients in a state mental hospital than by those who have been in private hospitals. Miller (1967, p 182-184) notes that this is especially true for those who were involuntarily committed.

2.6.5 SOCIAL STATUS AND STIGMA

A considerable number of studies report that attitudes toward the mentally ill are largely determined by social class. However it is apparently not social class per se which affects attitudes but the educational component of social class.

Studies have shown a positive relationship between education and the psychiatric ideology. As the amount of formal education a person receives increases, so does the likelihood that he will hold the psychiatric view of mental illness. This is because educational experiences provide the individual with more accurate information about mental illness (Bord 1970, p. 497).

Gallagher (1980) adds, that since lower-educated people have little knowledge about mental illness, they have a narrow definition of it so that they consider only extremely disordered behaviour to be abnormal. The other explanation is that mental illness is more common among less-educated (lower class) people and consequently they are more tolerant of abnormal behaviour because they are regularly exposed to it.

2.6.6 PREVALENCE OF STIGMA

Stigma tends to be found in varying degrees in different social settings, but it is by no means limited to specific sectors of society. On the contrary, it is a widespread social problem that can cause considerable hardship to both the ex-patient and his family.

2.6.7 RESPONSE TO COMMUNITY BASED PSYCHIATRIC SERVICES

Freeman et. al., (1979) and Gallagher (1980) point out that public response to community based psychiatric services have not been favourable. A number of public education programmes have tried to make the general public better informed about the nature of mental illness. The sponsors of these programmes have in most cases presumed that informing community members would reduce the stigma associated with mental illness and help the community to accept the mentally ill and community-based programme.

However, "while such programmes have succeeded in making people better informed about mental illness, they have not succeeded in changing their basic attitudes". (Freeman et. al., 1979).

Angrosino (1978) emphasises that in planning community mental health services, policy-makers and practitioners "..... must take into account prevailing community attitudes and potential motivations, in as much as these will condition the provision, delivery, and aceptance of services". (p. 291).

Public education programmes should strive toward a reduction in the overall antagonism of community members towards mental illness and foster more sympathetic relationships between mental patients and their associates. It is then possible that the more liberalised outlook of the general public and the reduced feelings of stigma could result in less resistance to treatment for mental illness, particularly on an outpatient basis.

If these changes in attitude are successful, the public should, ideally, accept a policy de-emphasising large state mental hospitals and be in favour of the move to include mental health treatment facilities in general medical hospitals and outpatient programmes.

It is clear therefore that the fostering of community acceptance of the mentally ill is a prime challenge and is absolutely essential for the success of the efforts of those engaged in the development of new mental health programmes.

2.7 A SUGGESTED MODEL

Ciompi's (1981) suggestion and contribution to the field of schizophrenia warrants discussion.

Ciompi (1981) writes that the past decades have been marked by significant progress in various fields of schizophrenia research. Drugs, new methods of behavioural, social and family therapy, as well as modernised psychiatric hospitals have resulted in considerable improvement in the treatment of schizophrenic patients. In addition, a multitude of community-based halfway facilities for flexible crisis intervention and gradual social and vocational rehabilitation have contributed to these favourable developments. Nevertheless the treatment of schizophrenics still suffers from many serious shortcomings. Many patients are exposed to an appalling discontinuity in long-term treatment by successive teams and institutions or to an often quite antitherapeutic environment

or an inappropriate attitude of the professional staff. In Ciompi's opinion such shortcomings are primarily due to the absence of a differentiated understanding of the disease with adequate integration of the multiple biological and psychosocial factors involved.

According to Ciompi (1981) in practically all modern research, especially genetics research, a great variety of factors must be implicated in the development of schizophrenia. On the somatic and biochemical side, the importance of genetic influences has been confirmed. However as genetic influences are not completely independent of environmental influences, it seems reasonable to attribute at least half of the variance as due to nongenetic factors.

The inherited disturbance is generally held to be some specific vulnerability which leads to manifest illness only under certain adverse conditions. The nature of this vulnerability is not clear, although biochemical and psycho-physiological defects, possibly related to synaptic transmission, are often suspected. (Iversen, 1978).

A particular difficulty of schizophrenics- to handle complex information - seems to be the common denominator of the multiple cognitive disorders which are currently being explored with increasing interest (Broen and Storm,1967; Poljakow 1973; Venables 1978; Chapman 1979).

On the other hand, there are also obvious connections between the aforementioned cognitive disorders and the striking inconsistencies and contradictions in the intrapsychic organization and in the interpersonal communications of schizophrenics.

Combined with Ciompi's (1981) observations these data suggest that the long term course of many forms of schizophrenia is more affected by social variables than by "endogenous" disease factors. Ciompi supports the importance of psychosocial variables as compared to psychopathological ones, in the socio-professional rehabilitation of chronic schizophrenics (Ciompi et. al., 1979). Other findings emphasise the impact of environmental influences on the long term course of the illness. These environmental factors include the effects of social under-and overstimulation, hospital infrastructure and systems of care, family attitudes, and other socio-economic and cultural

factors (Birley and Brown,1970;Wing ,1978; Brown et. al., 1972, Vaughn ,1976 , Beck 1978; Leff 1978, Sartorius et. al., 1978). Thus "chronic schizophrenia" could even be predominantly a kind of "social artifact". (Ciompi 1980 a).

As shown by Figure 1 (partly derived from Bleuler (1981)) the above considerations and findings can be integrated into a differentiated, multi-causal model of schizophrenia with three successive phases, possibly induced by different clusters of causes.

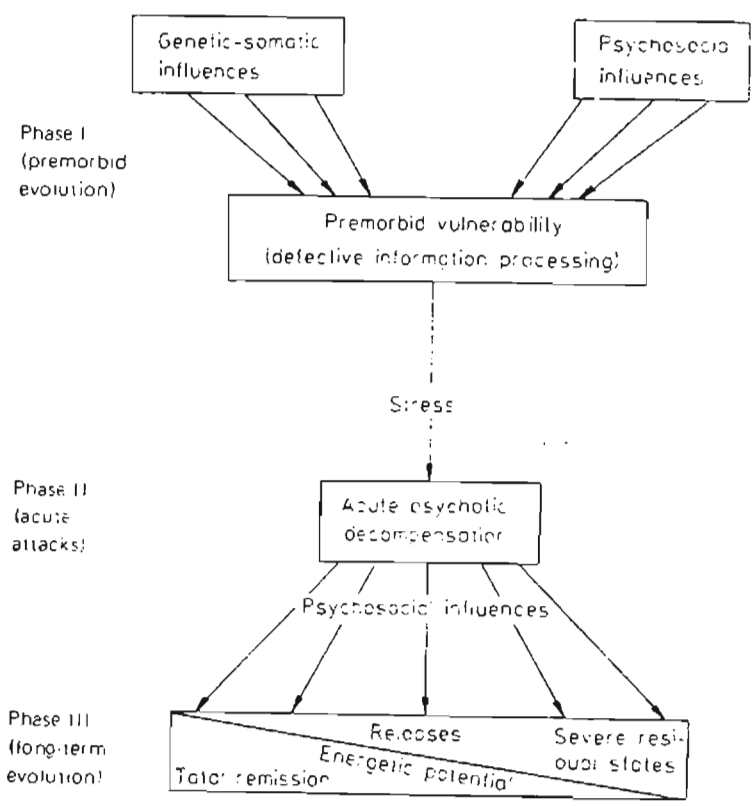


FIGURE 1 THREE PHASE MODEL OF SCHIZOPHRENIA

(Ciompi in Stierlin et. al., 1983, p. 56)

In the premorbid phase variable combinations of genetic, organic, and biochemical factors with psychogenic and sociogenic factors prepare a vulnerable terrain characterised mainly by a particular hypersensitivity and a diminished capacity to handle complex information. In the acute phase this vulnerable coping system becomes unbalanced as a result of (relatively) overwhelming demands such as those related to stressful life events, crisis necessity of change, and adaptation. This entails a gradual increase of tension, agitation, confusion and ambivalence. Finally, complex biochemical and psychosocial processes lead in vicious circles to the generation of productive psychotic symptoms, such as depersonalisation and derealisation, cognitive and affective inadequacies, delusions and hallucinations.

After an acute psychotic breakdown, a great variety of possible evolutions - ranging from complete remission and repeated acute relapses to chronic residual states of different degrees - is typical for the third phase. The most plausible explanation for this phenomenon is the variable

pattern of multiple psychosocial influences in interaction with the preexisting impaired coping capacities. Under particularly unfavourable cirumstances, including chronic understimulation combined with active defensive withdrawal, a massive reduction of the energetic potential in the sense of severe chronicity and/or institutionalisation might occur. Different subgroups of schizophrenia could be characterised by different evolutionary pathways through the mentioned clusters of influences.

2.8 SUMMARY

In concluding the review of causal factors in schizophrenia, it may be pointed out that research on the causation of human behaviour is, as Shakow (1969) expressed it, "fiendishly complex", even with normal subjects.

"Research with disturbed human beings is even more so, particularly with those with whom it is difficult to communicate such as schizophrenics. The marked range of schizophrenia, the marked variance within the range and within the individual, the variety of shapes that the psychosis takes, and both the excessive and compensatory behaviours that characterise it, all reflect this special

complexity. Recent years have seen the complication further enhanced by the use of a great variety of therapeutic devices such as drugs, that alter both the physiological and psychological nature of the organism. Research with schizophrenics, therefore, calls for awareness not only of the factors creating variance in normal human beings, but also of the many additional sources of variance this form of psychosis introduces". (Shakow, 1969, p. 618).

Perhaps the most obvious and important conclusion is that the study of schizophrenia requires a truly interdisciplinary approach and that no single disease entity can work in isolation on this important, peculiarly human disease.

CHAPTER 3

SOCIODEMOGRAPHIC DATA AND PREDICTION OF OUTCOME IN SCHIZOPHRENIA

3.1 INTRODUCTION

According to Serban (1980, p.61) in the search for differentiating criteria for good and poor prognosis in schizophrenia, sociodemographic characteristics have received wide currency, particularly before the use of psychotropic drugs. However, age, education, occupation, work history, and marital status have continued to maintain a relevant and allegedly meaningful prognostic status.

3.2 AGE

One of the most frequently employed demographic characteristics has been age at the onset of illness, since schizophrenia itself attested to the early appearance of the disease. Although Bleuler (1950) widened the concept of schizophrenia to include various groups of psychoses under the same title, age not only persisted as a significant variable in its prognosis, but also gained additional importance. Patients who

developed schizophrenia at age 30 or later were assumed to have better prognosis than those who exhibited the illness under the age of 30. (Bender, L. 1956).

For adult schizophrenics, age still holds relevance in as much as the age at the onset appeared to influence the course of the lifetime social adjustment of the patients. It was observed that schizophrenics developing symptoms at an early age, had a significantly poorer outcome than did those who became ill at a more advanced age (40 years or older) (Astrup, G, et. al., 1962). Odegaard (1960, pp. 1124-1133) also reported that low age at first admission correlated significantly with poor outcome.

Rosen et. al., (1968) found support for the relationship between early age of symptom onset and rehospitalisation. They demonstrated that a higher proportion of patients receiving treatment for schizophrenia prior to age 23, tended to be rehospitalised. This was irrespective of other indicators of premorbid competence. Stephens et. al., (1966) reported that onset of schizophrenia at the age of 20 or later served as a good prognostic indicator. Other researchers

have tended to present evidence that low age at first hospitalisation is not always related to poor outcome. Shofield and Balian (1959) for example, suggests that schizophrenics earning good post-hospitalisation adjustment ratings and who had no rehospitalisation within five years of their original discharge, had lower mean age and a more restricted age range than did the patients who had poor outcomes (rehospitalisation for 50% of the time since key admission, and difficulties requiring constant care). Bythe same token, Gabriel (1974) comparing the long term course of schizophrenia, arising late in life with that of early onset, found that patients with late onset of schizophrenia tended to have poorer social adjustment and more chronicity than those whose onset appeared at an earlier age.

In a recent long term follow up study of schizophrenics, Huber et. al., (1957), found no direct relationship between the age at onset of the disease and the prognosis. A slight tendency for a more unfavourable prognosis was found when the onset of the disease took place in the patient's fourth decade of life. Using still another criterion of outcome, the remission of

schizophrenic symptoms in acute patients within six months of hospitalisation, Walker and Kelley (1960) found age to be a nonsignificant predictor.

Serban (1980) concluded that it would appear that the relationship between age and prognosis in schizophrenia is especially confounded by the use of various outcome criteria, some of which may mask the particular effect of this variable.

3.3 EDUCATION

According to Serban (1980) educational level, per se, has received less attention as a specific prognostic indicator in schizophrenia. Traditionally, educational achievement has been combined with other demographic factors such as occupation under the rubric of social class. It is interesting to note, however, that when education was studied as one of the factors in prognosis with the stringent criterion of outcome, i.e. social adjustment from five to 11 years after hospital discharge, no significant differentiations between good and poor outcome groups was obtained. (Shofield, W, and Balian, 1959) .Huber et. al., (1975) assumed that there was a positive correlation between intelligence before disease

and psychopathological remission. Low intelligence with a corresponding poor school record handicaps the social adjustment of schizophrenics in the community (Hartmann and Meyer, 1969).

3.4 THE ROLE OF EMPLOYMENT

Gallagher (1980, p, 344) writes that occupational activity is a very useful therapy for successfully reintegrating ex-patients into the community since a job leads to increased independence and elevated self-esteem, both of which promote mental health. Steady employment in a fulfilling job is a meaningful form of social participation which simultaneously reduces the stigma of the patient label by demonstrating competence and an ability to interact with others in a normal fashion.

Having a job is importantly related to successful functioning in the community as evidenced by significantly higher readmission rates among discharged patients who are unemployed. It is unfortunate that many discharged patients remain unemployed. Patient status appears to directly prevent the discharged from seeking, obtaining,

or holding a job.

Walker and McCourt (1965), write that more patients are occupationally active during their hospital stay within hospital jobs than during their stay in the community following release. This is another example of the hostile way in which patients are treated by society.

Olshansky (1968, pp. 153-156) writes that even the most disturbed group of released patients are employable in certain jobs, provided that they have the incentive to work.

Employers' attitudes are as negative, however as those expressed by the general public.
Johannsen, W.J. (1969, p. 221) states that employers believe that mental illness connotes character weakness, and they have practical fears regarding the ex-patient's ability to handle an employment situation. According to Rothaus (1963, pp. 85-89) this is particularly a problem when the ex-patient describes his hospitalisation to a prospective employer in terms of "mental illness" or nervous "breakdown" rather than in terms of "difficulty with interpersonal problems".

Some studies report that employers express a willingness to hire former mental patients. According to Hartlage (1966, pp. 249-251) these employers are usually connected with large manufacturing businesses which have many unskilled, repetitive jobs to offer.

According to Rose (1955, pp 136-160) consideration of occupational status spanning approximately 36 years of study, suggests, most consistently, that the occupational variable reflects the incidence of schozophrenia to a greater extent than it does information regarding outcome. In this sense, it appears that unskilled labourers and the unemployed, or individuals in the lowest social class grouping, have the highest incidence of schizophrenia. Clark (1948, p 325-330) suggests that the low prestige of the occupation increases the preschizophrenics negative attitude toward themselves, accounting for the predominance of this illness in the lower classes. Occupation may also be viewed as reflecting general life style, values and behaviour, which may affect predispositions toward schizophrenia.

Some have suggested that it is not unemployment, per se, that most significantly contributes to

readmission, but the humiliation suffered by having to depend on welfare.

Easton (1974, pp. 513-517) reports that 70 percent of a group of ex-patients on welfare were re-hospitalised within a year of discharge. Gallagher (1980, p. 345) proposes special employment centres staffed by mental health specialists to act as a liaison between ex-patients and prospective employers. Unfortunately community mental health clinics, have consistently failed to deal with the plight of ex-patients, including their employment needs. This is particularly depressing because the psychological, social and economic rewards of employment can be invaluable to ex-patients seeking an accepted position in the community.

Good occupational history in the premorbid phase has been linked with good prognosis in schizophrenia (Sherman et. al., 1964). Odegaard (1958, pp. 67-77) writes that this is mainly because adequate working capacity helps keep the psychiatric patients out of the hospital and bestows on them a status of a productive and active member of their community - a factor, which in the long run determines success or failure in the post hospitalisation adjustment.

Corroboration of the importance of a work record is further emphasised in the studies of Wirt and Simmons (1959) and Aldrich and Coffin (1948) who found a significant correlation between duration of productive employment and outcome. Astrup et. al., (1962) for instance reported that among recovered schizophrenics 82% had a good prepsychotic working capacity, whereas only 56% of the deteriorated patients manifested a similar level.

At the same time, there is some evidence that when the outcome criteria are more stringent, such as community tenure performance, occupation as a sole variable appears unable to differentiate good and poor outcome groups among schizophrenics. (Shofield , et. al., 1954).

3.5 SOCIAL CLASS

Apart from genetic studies, the most consistent findings in the literature on schizophrenia have been the correlation between class and the incidence of schizophrenia.

However, the interpretation of these findings is subject to much dispute. What is the direction

of causality? Do the conditions of lower-class life "cause" schizophrenia, or does schizophrenia lead to a reduction in status and social class?

Before discussing this question, it is important to reiterate the methodological problems that consistently plague this form of research. One such problem is that lower-class psychotics are more likely to be hospitalised, and if hospitalised, are diagnosed as schizophrenics more often than their upper-class counterparts.

Some researchers have argued that it is not class per se but rather social isolation and/or lack of social integration that is pathogenic. They point out that the lower classes often consist of minority groups living in neighbourhoods where they are isolated or simply not integrated into society.

Kohn (1973) points out that lower-class people have fewer rewards and are less likely to have available alternative courses of action in times of stress.

There are also those who view social class as a by-product of generations of inadequate functioning.

All in all, however, researchers have continued to find a relation between social class and schizophrenia, whatever the methodologies employed, indicating that this data can be accepted.

3.6 MARITAL STATUS

As Gallagher (1980) points out the interpersonal life of the ex-patient is one of the most important determinants of rehospitalisation. Those with little involvement with others are particularly vulnerable to readmission, as evidenced by the unusually high rate of rehospitalisation among discharged patients who live alone. Interaction with significant others affects the community tenure and adjustment of ex-patients by encouraging them to perform at normal rates.However it is not the mere presence of significant persons in the ex-patient's life that aids readjustment, as much as it is their behavioural expectation of the discharged patient to perform an active, normal social role. Evidence for this proposition comes not only from comparisons of ex-patients living

alone with those living with others, but also from studies of the effects of different types of family arrangements.

Marital status appears to be associated with both the incidence and outcome of schizophrenia.

There is ample evidence that married persons have a lower first admission rate of schizophrenia than do the single, separated, divorced and widowed. (Norris, 1959). These differences are perceived as stemming from social factors associated with the availability of support, as well as the differential malignancy of the illness in the never married as compared with the married persons, reflected in the age of onset. Such explanations appear to be all the more plausible in view of evidence that married schizophrenics tend to be discharged earlier and have comparatively shorter hospital stays. As regards outcome, marital status has been demonstrated to be the best single demographic predictor in schizophrenic illness (Klein and Klein, 1968).

According to Serban (1980), this is not surprising when one considers that marriage reflects higher levels of premorbid adjustment, particularly on

the interpersonal level. Ample evidence has been provided by Klein and Klein (1968) that the significance of marital status in prognosis relates primarily to the better premorbid adjustment of the married patients, indicating the presence of less severe asocial personality traits. Thus, marriage as a prognostic sign appears to reflect the confluence of better premorbid functioning and personality traits rather than a demographic status per se.

Presence of a marital partner also provides certain motivations and pressures for more adequate performance upon the return to the community. Sherman and others (1964) have shown that the presence of a spouse in the community motivates the patient toward a more rapid recovery and is associated with lower rates of readmission. The investigations of Farina et. al., (1962) and of Shofield et. al., (1954) have shed further light on the role of marital status in prognosis. Farina and associates accounted for the prognostic significance of marital status in terms of the social aspects of recent sexual life and the history of personal relationships in marriage. These investigators demonstrated that it may not be marital status which becomes the differentiating variable

but rather the level of psychosocial premorbid adjustment which determines in part, the patient's outcome. Corroborating evidence comes from the study of Shofield et. al., (1954) who found superior marital adjustment in the good outcome group, particularly affection for the spouse. It is interesting to note, however, that in the study, no differentiation between the good and poor group was obtained when the variable of marital status was considered, independent of the factor of marital adjustment. This may explain why some investigators have failed to obtain significant association between marital status and outcome of schizophrenic illness (Walker and Kelley, 1960).

Marital status is a complex variable which may operate in prediction in subtle ways. As Hammer (1964) has shown a married schizophrenic patient is more likely to be reaccepted by the family unit after hospitalisation and may be more motivated to resume his family role and responsibilities than his single counterpart, for whom such expectations are non existent.

Simmons and Freeman (1968) write that patients returned to parental (nuclear) families have much lower performance levels than patients returned to conjugal (marital) families. Simply stated, the probability of rehospitalisation is noticeably

higher among patients returned to their parents than among those returned to a spouse. Husbands and wives are less tolerant of deviant behaviour than are mothers and fathers. Furthermore, spouses have higher expectations of the way in which the ex-patient should function in the community. Freeman and Simmons (1968) warn against the practice of releasing the patient to the parental family since that type of family setting can worsen the patient's condition because parents are prone to allow deviant behaviour which engenders regression.

Another factor affecting the relationship between marital status and outcome may be the tendency to discharge a schizophrenic patient more readily and at an earlier time in care of a marital partner than into his own care. However, marital status may cease to be a positive outcome variable in case of divorce, which in itself indicates the inability of the spouse to deal with the patient's aberrant behaviour.

Klein and Klein (1968) reported that although marital status is empirically related to outcome, this relationship may be entirely explained by the more asocial premorbid adjustment of the single than of the married schizophrenics. When social

aspects of recent sexual life and the quality of other close and recent social relationships are known, marital status, per se, adds very little to the prediction of outcome (Farina, et. al., 1962).

Serban (1980) suggests that in order to tap the true level of functioning of the schizophrenics in the community, one must provide a comprehensive evaluation of their social competence, encompassing in addition to the above, such areas as interpersonal relationships and other social behaviours that reflect the quality of their daily interactions in their own commmunity settings. Such an assessment would serve, a more realistic indicator of the patient's social competence as judged by accepted community standards to which these individuals must conform if there are to be productive and fully integrated members.

3.7 FAMILY SIZE

There is also a significant relationship between family size and performance in the community. According to Freeman and Simmons (1968), male patients returned to large families were very likely to be rehospitalised. This is not because the ex-patient is ignored in this type of family

setting but because fewer expectations are placed on him due to the presence of other family members who are available as functional equivalents. This reduces the expectations placed on the ex-patient as breadwinner and simultaneously undercuts his opportunities for independent action, so necessary for reintegration into society. Role performance also affects the chances of rehospitalisation among married women, as evidenced by the fact that mothers are less likely to be readmitted than non-mothers. (Richart and Millner, 1968, p. 31).

All of the research which reports a positive effect of the marital role on community adjustment of ex-patients is based on cases in which the conjugal family is intact upon release. Unfortunately this is not always the case. An alarmingly high number of marriages deteriorate to the point of separation or divorce before release (Johnston and Planansky,1968) This is particularly true when the patient is schizophrenic. A number of factors are responsible: long periods of separation result in loss of interest; financial burdens become too great for the nonhospitalised spouse; and discouragement stemming from the patient's lack of progress can lead to the spouse's denial of the patient's existence (Fisher, 1958).

Other family variables are related to community adjustment. One of these is place of residence- rural families provide a better milieu for rehabilitation than do urban families. (Michaux et. al., 1973). Although the researchers reporting the "urban-rural" finding explain it as a function of more realistic demands placed on ex-patients by rural families, it is also possible that the community quality of rural life is more conductive to patient rehabilitation. Other family variables that affect recovery relate to the relatives' knowledge of mental illness and their propensity to stigmatise the ex-patient, as evidenced by reports that recovery is greatest among those returned to family members who are young and well-educated. (Dinitz, 1962).

3.8 SUMMARY

Schanding, D. et. al. (1984, p. 170) studied the relationship between readmission and demographic and aftercare variables. They write that it is generally recognized that the factors involved in patient readmissions are complex and elusive. As a result there is little agreement among the findings of various readmission studies.

Undoubtedly, the variables of the complex question of psychiatric rehospitalisation are many, and not all of them have been adequately isolated and studies.

It is reasonable to assume that sociodemographic characteristics may not only reflect underlying premorbid functioning levels of the patient but also tend to interact with one another, producing differential predictive effects. Age of the patient at the onset of illness has a particular influence on all other demographic factors in the final prediction equation. Early onset of schizophrenic symptoms certainly affects the acquisition of social and instrumental skills, comprising such demographic factors as education, level of occupational achievement and working ability.

It is Serban's (1980) contention that some of the confusion regarding the prognostic validity of sociodemographic characteristics,whether considered singly or in an index of competence, may be clarified when these are studied in relation to well defined diagnostic entities, with predictable trends for community integration.

CHAPTER 4

RESULTS AND DISCUSSION OF RESULTS

4.1 INTRODUCTION

This chapter contains the relevant tables; an analysis and discussion of each table follows. The results will not necessarily be described according to question sequence in the Questionnaire.

The presentation of research findings has proved a difficult task because of the large number of variables that were included for the study in the hope that, by throwing the net as wide as possible, as many significant factors as possible would merge.

4.2 DEMOGRAPHIC DETAILS

4.2.1 AGE AND SEX

Table 1 indicates the age and sex distribution of patients.

TABLE 1 AGE AND SEX OF PATIENTS

AGE	MALES	%	FEMALES	%	TOTAL	TOTAL %
20-29	12	40	3	10	15	50
30-39	8	26,7	1	3,3	9	30
40-49	2	6,7	3	10	5	16,7
50-59			1	3,3	1	3,3
TOTAL	22	73,4	8	26,6	30	100

As shown by Table 1, 73,7% of the patient population were men. It is commonly believed that men are more susceptible to schizophrenia than women. A review of literature however shows that schizophrenia is as common among men as it is among women (Gallagher, 1980). In contrast to other research, the results of the present study indicates that a major proportion of the patients were men.

Results from the present study indicate that more male than female patients relapse. In the present study it is suggested that male patients are exposed to more stressful situations, than female patients.

However, in view of important changes in the female roles during post-World War II period, increased stress for women has resulted, and may now also have had an effect on women patients.

Fifty percent of the patients were between the ages 20-29 years. This is comparable to Cooper J.E. (1983) who indicates that the peak incidence occurs between 25-30 years of age and therefore if illness becomes chronic there are many years of incapacity ahead. A review of literature emphasises that schizophrenics developing symptoms at an early age have a significantly poorer outcome than those who become ill

at a more advanced age. The patient who develops schizophrenia at the age of 30 or later was assumed to have a better prognosis than those who exhibited the illness under the age of 30.

4.2.2 RELIGION

Table 2 indicates the religion of patients.

TABLE 2 RELIGION OF PATIENTS

	MALE	%	FEMALE	%	TOTAL	TOTAL %
Muslim	6	20	2	6,7	8	26,7
Hindi	6	20	2	6,7	8	26,7
Tamil	8	26,7	2	6,7	10	33,4
Christian	2	6,7	2	6,7	4	13,4
TOTAL	22	73,4	8	26,8	30	100,2

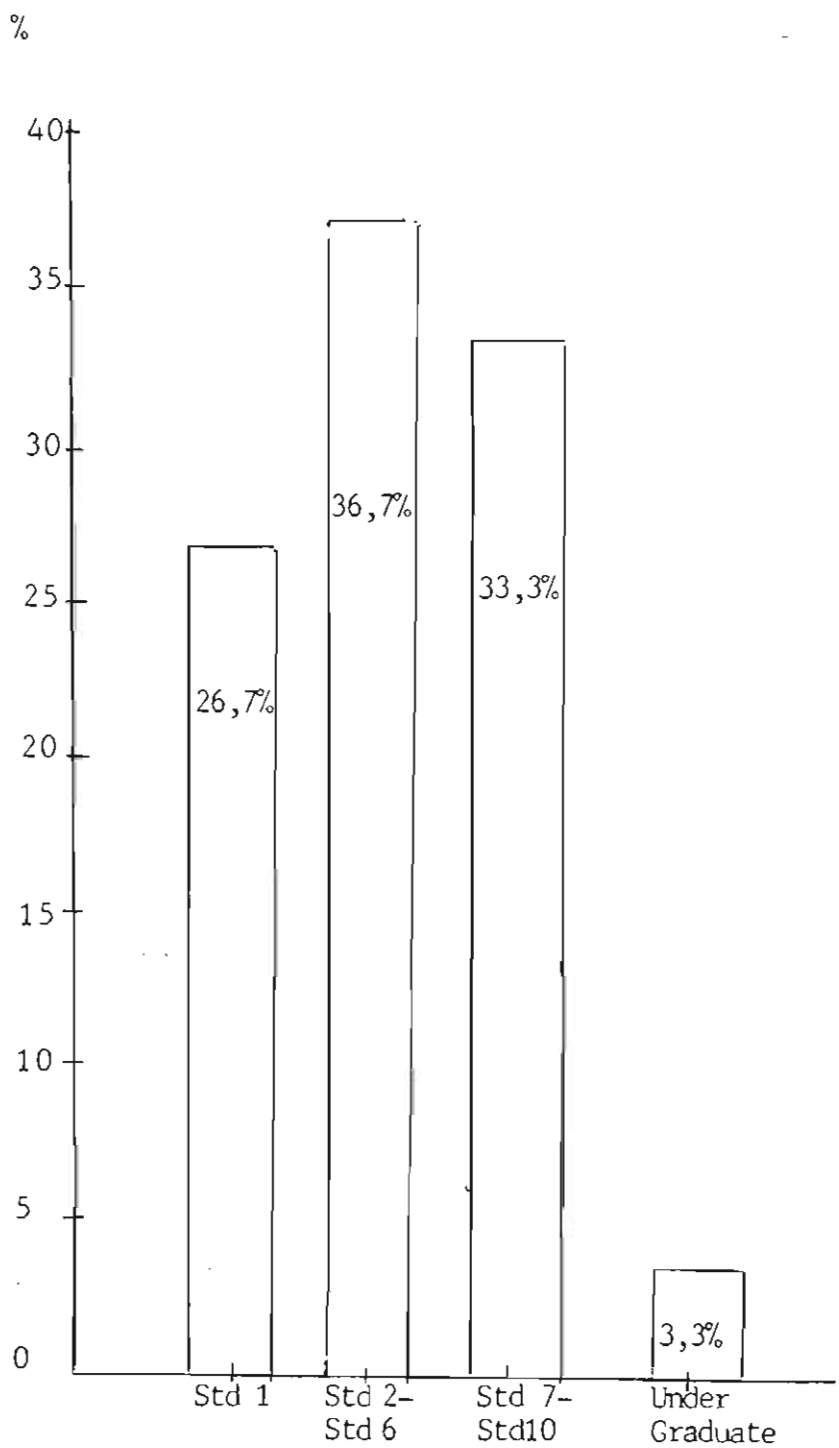
It is apparent from the above table that 26,7% of the patients were Muslim; 26,7% Hindi; 33,4% were Tamil (i.e. 60% of the patients were Hindus) and 13,4% Christian.

Although the percentages differ, they are roughly comparable to that of Meer (1969), whose figures for religious affiliation of the Natal Indian population are highest for Hindus, second highest for Muslims and then 10% for Christians. (Meer, 1969, p. 61). In the present study a higher proportion of patients are Muslim than in the Natal population.

4.2.3 STANDARD OF EDUCATION

Figure 2 indicates the scholastic level of patients.

FIGURE 2 SCHOLASTIC LEVEL OF PATIENTS



Education interacts with mental illness in an inverse way just as occupation does; those with higher levels of educational attainment have a lower reported rate of psychiatric impairment. What is noteworthy about the relationship between the level of education and prevalence of psychiatric symptoms is that it is not peculiar to Western cultures (Gallagher, 1980). This is also applicable to the present study as indicated in Figure 2.

Figure 2 indicates that 26,7% of the patients had only attained a Std 1 level of education, 36,7% of the patients Std 2 - Std 6, 10% had a high school education attained Std 7 - Std 10, 3,3% were undergraduates. Combining the figures reads that 63,4% of the patients had a scholastic level under Std 6. This would indicate that only a small percentage of the patients were equipped for more intellectual jobs. They would also be more likely, therefore, to show psychiatric impairment as indicated by Gallagher (1980).

4.2.4 MARITAL STATUS

Table 3 indicates the marital status of the patients.

TABLE 3 MARITAL STATUS OF PATIENTS

	MALE	%	FEMALE	%
Never married	13	43,3	2	6,7
Divorced	4	13,3	2	6,7
Widower/Widow	0		1	3,3
Married	5	16,7	3	10
TOTAL	22	73,3	8	26,7

As can be seen from the above table, 43,3% of the male patients had never been married. According to some authors marital status has been demonstrated to be the best single demographic predictor in schizophrenic illness.(Klein and Klein, 1968). Serban (1980). adds that marriage reflects higher levels of premorbid adjustment, particularly on the interpersonal level.

There is ample evidence that married persons have a lower first admission rate for schizophrenia than do single individuals. The presence of a spouse in the community motivates the patient toward a more rapid recovery and is associated with lower rates of readmission. The younger a patient is at the onset of his schizophrenic psychosis, the worse is his prognosis, as a rule. Patients who breakdown in childhood or early puberty seldom recover completely. Married schizophrenics have a better prognosis than single, divorced, or widowed patients: the fact that they are married is evidence that interpersonal bonds may serve as a bridge for a return to the community.

The findings of the present study indicated that the single patients did not have a good prognosis as is indicated by the high percentage of unmarried relapsed schizophrenics.

4.3 FAMILY DETAILS

4.3.1 FAMILY COMPOSITION

Table 4a indicates the family composition of the respondents.

TABLE 4a FAMILY COMPOSITION OF THE RESPONDENTS

	NO	%
Husband	1	3,3
Husband and Baby	1	3,3
Husband, Daughter and Two Sons	1	3,3
Wife	1	3,3
Wife and Ex-Psychiatric Sibling	1	3,3
Wife and Daughter	1	3,3
Wife and Four Children	1	3,3
Mother	2	6,7
Mother and Brother	1	3,3
Mother, Father, Brother	1	3,3
Mother, Father, and Two Children	1	3,3
Parents	2	6,7
Parents Two Sisters and Two Brothers	1	3,3
Parents and Eleven Children	1	3,3
Parents and Daughter	2	6,7
Parents and Two Brothers	1	3,3
Parents and Eight Children	1	3,3
Brother	1	3,3
Two Brothers and Three Sisters	1	3,3
Father and Six Children	1	3,3
Father and Eight Children	1	3,3
Sister and Brother-In-Law	1	3,3
Brother, Sister-In-Law, Children and Sibling	1 1	3,3 3,3
Daughter, Son, Three Grandchildren	1	3,3
Patient on his own	1	3,3
Patient and his Son	1	3,3
	30	99,3

As indicated by the above table, the patients came from families who were varied in composition. The specific family dynamics leading to stressful family interactions would depend on each patient's family composition.

4.3.2 EDUCATIONAL LEVEL OF RESPONDENTS

Table 4b indicates the educational level of the respondents.

TABLE 4b EDUCATIONAL LEVEL OF RESPONDENTS

	NO	%
- To Std 1	13	43,3
Std 2 - Std 6	17	56,7
TOTAL	30	100

Recovery is greatest among those patients returned to family members who are young and well-educated. The educational level of relatives is of tremendous importance as relatives are potential therapeutic agents helping the patient maintain community tenure.

The extent to which close family members are aware of the patient's condition, and are able to interact with him, despite the numerous differences in expectations and attitudes may well determine in the long run, the course of the schizophrenic's posthospital life (Serban,1980).

Table 4 b indicates that 100% of the relatives had an educational level of Std 6 and below. This suggests that the ability of the family members to interact appropriately and their understanding of mental illness is hampered by their low educational level.

4.3.3 OCCUPATION OF RESPONDENT

Table 4c indicates the occupation of the respondent.

TABLE 4c OCCUPATION OF RESPONDENTS

	NO	%
Employee at Factory	5	16,7
Sales Assistant	6	20
Barmen	4	13,3
Grantee	9	30
Unemployed	6	20
TOTAL	30	100

As indicated by Table 4c, 30% of the respondents were grantees. All the other respondents had unskilled jobs which indicates lower class status. The fact that the patient comes from a lower class family hampers his readjustment in the community.

Research indicates that higher class ex-patients function better in the community because their relatives place greater expectations on them than do the relatives of ex-patients from the lower class. Another factor is stigma which is more profound among lower-class people because they have little education. This in turn forces the returned lower-class patient into social isolation rather than to subject himself to possible ridicule or avoidance by friends and neighbours. Thus, low familial expectations, a high degree of stigma, as well as the generally depressing quality of lower-class life, are together responsible for the frequent rehospitalisation of lower-class patients (Gallagher,1980).

4.3.4 SALARY OF RESPONDENT

Table 4d indicates the salary of the respondent.

TABLE 4d SALARY OF RESPONDENT

	NO	%
100	10	33,3
100-200	5	16,7
200-300	13	43,3
300-400	2	6,7
TOTAL	30	100

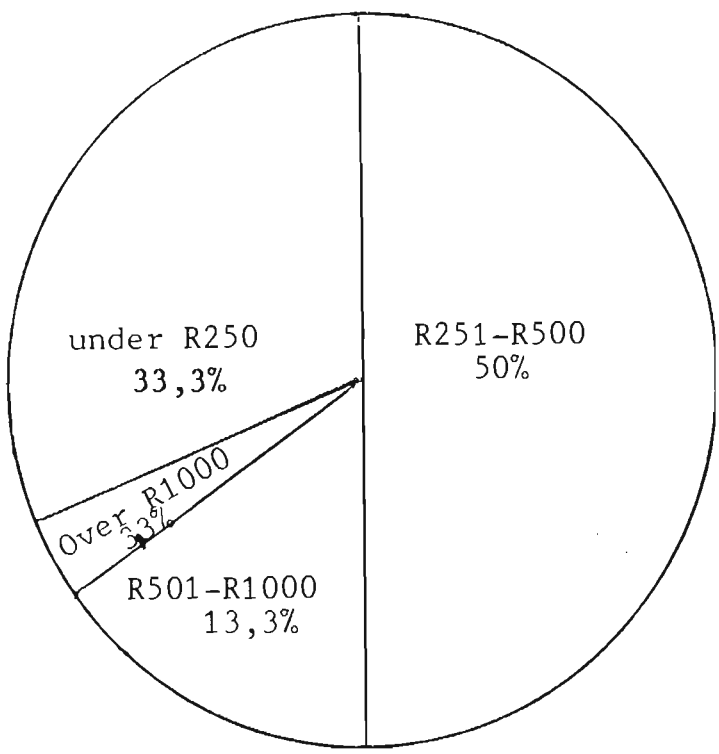
As indicated by Table 4d, more than half the patient population earned less than R200 per month; 43,3% of the patients earned between R200 - R300.

The results confirm that the respondent comes from a low income group. The stresses of not being able to make ends meet could hamper the patient's rehabilitation efforts.

4.3.5 COMBINED FAMILY INCOME

Figure 3 indicates family income of respondents.

FIGURE 3 COMBINED FAMILY INCOME



As shown in Figure 3, half of the respondent population had a combined family income of between R251 - R500. Taking an income of less than R500 per month as a low income, a relatively high number of patients were in this low income bracket. It is evident that not being able to make ends meet would in itself be stressful to the patient and make it difficult for his material needs to be adequately met.

4.3.6 FAMILY SIZE AND STRUCTURE

Table 5 indicates the family size of respondents.

TABLE 5 FAMILY SIZE OF RESPONDENTS

	NO	%
Less than 5	17	56,7
5-8	11	36,7
More than 8	2	6,7
TOTAL	30	100,1

As can be seen from the above table, 56,7% of the respondents had a family size of less than five.

The family size is to an extent restricted by City Council housing scheme rules and regulations.

Other research has stated that male patients returning to large families are very likely to be rehospitalised. The reason could be attributed to fewer expectations being placed on the patient due to the presence of other family members being available as functional equivalents (Serban,1980).

The findings of the present research indicates, that in view of the patient's small family size in terms of the quoted research, they are less likely to relapse. However, the researcher believes that cognisance must

be taken of the fact that although members of the support system lived elsewhere their strong influence cannot be overlooked. They may in fact have played an important role as extended family members.

4.3.7 BELONGING TO A NUCLEAR FAMILY

All the respondents lived in a nuclear family. South African Indian families until recent years tended to remain resident in extended families. The extended family unit usually consists of a three generational patriachal system of several nuclear families sharing patrilineal or patrilocal kinship ties as well as frequently sharing the same home, business and financial interests. In such a family, family members are involved in group decisions but usually defer to the oldest male in the family.

With increasing Westernisation and also the large scale development of housing schemes in which homes are designed for nuclear family occupation, there is a trend towards nuclearisation of the Indian family.

According to Laudau, Griffiths and Mason (1982, p2), the Indian South African group is predominantly in transition from extended to nuclear family structure.

The high percentage of the respondents living in a nuclear family is indicative of the more Western influence in their living.

4.3.8 FAMILY HISTORY OF MENTAL ILLNESS

Table 6 indicates family history of mental illness.

ILLNESS

TABLE 6 FAMILY HISTORY OF MENTAL ILLNESS

	NO	%
No	13	43,3
Yes	17	56,7
TOTAL	30	100

According to D.S.M. III (Williams, 1980) all investigators have found a higher prevalence of the disorder among family members.

As shown in Table 6, more than half of the number of patients had a family history of mental illness.

4.3.9 FAMILY MEMBERS MENTALLY ILL

Table 7 indicates the specific family members who have been mentally ill.

TABLE 7 FAMILY MEMBERS MENTALLY ILL

	NO	%
Mother	3	10
Sister	4	13,3
Daughter	1	3,3
Brother	2	6,7
Husband	1	3,3
Wife	1	3,3
More than 1 Family Member ill	5	16,7
No family members ill	13	43,3
TOTAL	30	99,9

As indicated by the above table, 16,7% of the patients had more than one family member mentally ill. This would indicate that support systems may be poor because family members themselves needed to be supervised. The cumulative effect of more than one mentally ill family member could cause an overload of stress in the family resulting in frequent relapses.

4.4 HOSPITAL DATA

4.4.1 ADMISSIONS TO HOSPITAL

Table 8a indicates the admissions to hospital.

TABLE 8a ADMISSIONS TO HOSPITAL

NO OF ADMISSIONS	NO	%
2	9	30
3	11	36,7
4	5	16,7
5	4	13,3
6	1	3,3
TOTAL	30	100

As indicated by Table 8, all the patients had two or more admissions to the same psychiatric hospital. This study does not take into account admissions to other psychiatric units.

4.4.2 TIME PERIOD

Table 8b indicates the time period of the patient in hospital.

TABLE 8b TIME PERIOD

	NO	%
-1 week	2	6,7
1-2 weeks	5	16,7
2-3 weeks	4	13,3
3-4 weeks	4	13,3
1-2 months	4	13,3
2-3 months	6	20
3-4 months	2	6,7
7-8 months	1	3,3
1 year or more	2	6,7
TOTAL	30	100

Table 8b indicates that the patients stay in hospital during his last admission was varied.

Twenty percent of the patients had a stay in hospital for 2-3 weeks months, while 16,7% had a stay of only 1-2 weeks.

In the present study, the length of hospital stay depended on the progress of each patient. On discharge, contact was made with the community staff to ensure follow-up of the patients.

Regardless of the length of hospital stay, it is highly probable that the ex-patients has some kind of problem which interfered with his attempts to rejoin society. Thus, posthospital follow-up in the community can be useful in reducing hospital recidivism (Purvis, 1970).

4.4.3 TYPE OF ADMISSION

Table 8c indicates the type of admission

TABLE 8c TYPE OF ADMISSION

	NO	%
Certified	22	73,3
Consent	6	20
Voluntary Boarder	1	3,3
Urgency	1	3,3
TOTAL	30	99,9

As indicated by Table 8c, 73,3% of the patients were certified for admission. This suggests that more than half the patient population were admitted involuntarily. The results suggest that schizophrenics are insufficiently aware of the severity of their mental condition to seek voluntary hospitalisation.

4.4.4 REASON FOR READMISSION

Table 9 indicates the reason for readmission.

TABLE 9 REASON FOR READMISSION

	NO	%
Refuses treatment	12	40
Lacks insight	3	10
Restless	3	10
Relapsed	3	10
Aggressive	2	6,7
Abuses drugs, alcohol	6	20
Side effects	1	3,3
TOTAL	30	100

As shown by Table 9, 40% of the patients were readmitted because of non-compliance of medication whilst 20% were readmitted because of alcohol or drug abuse.

It has been suggested that schizophrenic patients control their degree of social activity according to what they can tolerate and that maintenance of medication increases their level of tolerance for social stimulation. If that is so, there is a strong argument for continuing the drugs indefinitely. The consequences of further relapse are usually such that it is wise to be very cautious indeed before

stopping maintenance drugs for most schizophrenics.

The results of the present study would certainly advocate the importance of compliance with medication to prevent readmission to hospital. To ensure that patients continue taking their medication, community nursing staff are contacted with a view to supervising medication.

4.4.5 PRESENTING PROBLEMS

Table 10 indicates the presenting problems of the patient.

TABLE 10 PRESENTING PROBLEMS

	NO	%
Aggressive Behaviour	13	43,3
Alcohol and Dagga Abuse	6	20
No Insight	4	13,3
Poor Personal Hygiene	3	10
Withdrawn	2	6,7
Side Effects	2	6,7
TOTAL	30	100

As shown by Table 10, 43,3% of the patients presented with aggressive behaviour on admission whilst 20% were found to have abused alcohol or dagga.

The aggressive nature of the patient could be attributed as the reason for the patient being admitted against his will.

The present study indicates that the abuse of alcohol or dagga could be related to the patient's readmission in that it affects the patient's rehabilitation. A patient who has a predisposition to schizophrenia could suffer a breakdown by drinking alcohol or smoking dagga.

4.4.6 PSYCHIATRIC DIAGNOSIS

Table 11 indicates the diagnosis of the patient.

TABLE 11 PSYCHIATRIC DIAGNOSIS

	NO	%
Schizophrenia	14	46,7
Schizophrenia and Substance Abuse	9	30
Schizophrenia and Retardation	2	6,7
Schizophrenia and Brain Atrophy	1	3,3
Schizophrenia and Epilepsy	1	3,3
Schizophrenia and Depression	1	3,3
Chronic Schizophrenia	1	3,3
Catatonic Schizophrenia	1	3,3
TOTAL	30	99,9

As indicated by Table 11, all the patients were diagnosed as schizophrenic. However, more than half the patients had schizophrenia coupled with other illness.

4.5 PRE-DISCHARGE CONDITIONS

4.5.1 CIRCUMSTANCES UNDER WHICH THE PATIENT WAS DISCHARGED

Table 12 indicates the circumstances under which the patient was discharged from hospital.

TABLE 12 CIRCUMSTANCES UNDER WHICH THE PATIENT WAS DISCHARGED

	NO	%
Discharged whilst on abscondment	3	10
Ready for discharge	27	90
TOTAL	30	100

As indicated by Table 12, 90% of the patients were considered ready for discharge, whilst at the time of leaving the hospital 10% of the patients were discharged whilst on abscondment.

Although it has been indicated that the timing of discharge depended on the type and severity of the illness, it has been argued that discharge decisions frequently do not relate to the patient's psychopathology. It is likely that with the patients in the present study, criteria for release are not based solely on the patient's present mental health condition but more on his life circumstances. The

attitudes of the family toward the patient's relapse are more likely to affect length of hospitalisation than is the degree of the patient's impairment. Typically, the family wishes are based on factors totally unrelated to their relatives psychiatric condition, such as social freedom without the patient living at home or even the time of a vacation.

The most realistic view of discharge is that it is a process of social negotiation rather than a process of psychiatric evaluation (Gallagher, 1980).

This is applicable to the present study. The researcher having worked with the patients in the sample has found that discharge is often based on these other factors rather than on recovery from the illness.

4.5.2 VISITORS

Table 13 indicates if the patient received any visitors.

TABLE 13 INDICATION OF VISITORS

	NO	%
No	6	20
Yes	24	80
TOTAL	30	100

As indicated by Table 13, 80% of the patients had received visitors whilst in hospital.

Regular visitors provide a link between the hospital and the community. These visits would indicate to the patient that he is of importance and worth to his relatives. This increases his self esteem and should assist in rehabilitation.

However, Gallagher (1980) writes that the painstaking results of weeks of work can easily be undone in half an hour by a relative's visit. Frequently it is important that the relative at least stay away from the patient rather than risk additional stress or relapse. Thus, although visits by relatives are therapeutic, visits by stressful family members could hamper the progress of the patient.

4.5.3 WHO VISITED THE PATIENT

Table 14 indicates who visited the patient.

TABLE 14 INDIVIDUALS WHO VISITED THE PATIENT

	NO	%
Relatives	22	73,3
Pastor	2	6,7
No Visitors	6	20
TOTAL	30	100

As indicated by the above table, 73,3% of the patients were visited by relatives. This is of relevance if one is to take into account the support system of the patient. The possible stressful nature of visits by relatives, as discussed above, must also be considered.

4.5.4 INITIATION OF VISITS

Table 15 indicates whether visits were initiated on their own or by the staff.

TABLE 15 INITIATION OF VISITS

	NO	%
On their own	5	16,7
Staff	19	63,3
No visits	6	20
TOTAL	30	100

As shown by Table 15, 63,3% of the visits were initiated by the staff. Relatives had to be motivated to visit the patients. Visits by the community staff and numerous phone calls to relatives resulted in family members eventually visiting the patient. The community staff play an active role in contact with the family and patient, prior to the admission of the patient, during admission and after discharge.

4.5.5 ADVICE ABOUT AFTERCARE

Table 16 indicates the extent to which family members receive any advice from staff after discharge.

TABLE 16 ADVICE ABOUT AFTERCARE

	NO	%
No	4	13,3
Yes	26	86,7
TOTAL	30	100

Table 16 indicates that 86,7% of the respondents had received advice about aftercare.

Of tremendous importance, is the realisation that the patient cannot re-enter the community and start again exactly where he left off. Posthospital help in interpersonal relations is necessary if the patient is to retain any progress he has made in the hospital. The process of "grading stress" which is a strategy of providing opportunities for the graduated assumption of responsibilities, is one of the useful principles that can be used within any aftercare situation (Gallagher, 1980). Undoubtedly, aftercare programmes are important in the treatment of mentally disordered people. Creer and Wing's (1974) survey revealed however that virtually none of the relatives had received any sensible advice about the nature of the condition, about how to supervise medication, about the likely outcome of treatment, or about how to best respond to distubed or disturbing behaviour. It is recommended that

the treatment of every schizophrenic patient include a major focus on teaching the patient and family not only to recognise early signs of decompensation but also what steps to take to ensure the initiation of prompt and effective treatment.

4.5.6 CONTACT WITH HOSPITAL STAFF OR CLINIC FOR TREATMENT AFTERCARE ARRANGEMENTS

Table 17 indicates whether the patient was seen by any hospital staff or clinic for treatment after discharge.

TABLE 17 PATIENTS SEEN BY HOSPITAL STAFF/CLINIC

	NO	%
No	17	56,7
Yes	13	43,3
TOTAL	30	100

It is apparent from Table 17, that 56,7% of the patients had not been for aftercare treatment. One of the main problems of aftercare programmes was motivating patients to seek posthospital help. With follow-up therapy and maintenance drug treatment, a small percentage of patients in remission will relapse within a year. It is indicative from the above results that lack of aftercare treatment was related to the patient's subsequent relapse.

4.5.7 REASONS FOR BEING SEEN AT THE CLINIC

Table 18 indicates the reasons why the thirteen patients were seen at the clinic.

TABLE 18 REASONS FOR BEING SEEN AT THE CLINIC

REASONS FOR BEING SEEN	FREQUENCY	STAFF
1 For medication	regular	Mainly Community Staff but all other disciplines
2 For medication	regular	Mainly Community Staff but all other disciplines
3 For medication	regular	Mainly Community Staff but all other disciplines
4 For medication	regular	Mainly Community Staff but all other disciplines
5 For medication	irregular	Mainly Community Staff but all other disciplines
6 For medication	regular	Mainly Community Staff but all other disciplines
7 For medication	regular	Mainly Community Staff but all other disciplines
8 For medication	regular	Mainly Community Staff but all other disciplines
9 For medication	regular	Mainly Community Staff but all other disciplines
10 For medication	regular	Mainly Community Staff but all other disciplines
11 For medication	regular	Mainly Community Staff but all other disciplines
12 For medication	regular	Mainly Community Staff but all other disciplines
13 For medication	inpatient	Mainly Community Staff but all other disciplines

As indicated from the above table the main purpose for being seen at the clinic was for medication. Staff regularly seen were the community staff.

4.5.8 CONTACT WITH OTHERS OTHER THAN HOSPITAL STAFF

Table 19 indicates contact with others other than hospital staff.

TABLE 19 CONTACT WITH OTHERS OTHER THAN HOSPITAL STAFF

	NO	%
No	28	93,3
Yes	2	6,7
TOTAL	30	100

It is apparent from the above table, that 93,3% of the patients did not have contact with others, other than the hospital/clinic staff. Of the 2 patients who sought advice; one visited the child welfare society social worker whilst the other visited his moulana (i.e. priest).

4.5.9 ADVICE NOT OBTAINABLE

Table 20 indicates whether the patients relatives sought advice which was not obtained for some reason.

TABLE 20 ADVICE NOT OBTAINABLE

	NO	%
No	22	73,3
Yes	8	26,7
TOTAL	30	100

As indicated by Table 20, 73,3% of the relatives did not seek advice which was not obtained. Of the 26,7% who did not receive helpful advice, reasons were as follows:

REASONS

1. Did not ask for advice.
2. Did not know where to place the patient. He had numerous admissions to Fort Napier Hospital.
3. Did not know whether to continue with moulana's treatment or resort to modern medicine.
4. When patient became ill, did not know what to do.
5. Did not know what to do, when patient was difficult. Staff did not understand the difficulties that they encountered when they tried to stop the patient from smoking dagga.
6. Went for help to staff. Advice given but could not help with immediate problem.

7 & 8 No reasons given.

It is apparent from the results obtained by the relatives who approached hospital staff, that the help sought was not always given and that the relatives remained grappling with the problem without aid.

4.6.1 FAMILY MEMBERS AND EMOTIONAL PROBLEMS

Table 21 indicates whether family members went for help regarding emotional problems.

TABLE 21 FAMILY MEMBERS AND EMOTIONAL PROBLEMS

	NO	%
No	22	73,3
Yes	8	26,7
TOTAL	30	100

It is apparent from the above table, that the majority of the relatives did not have emotional problems for which they sought help. However, it needs to be noted that the respondents may have denied having emotional problems.

4.6.2 CONFLICT WITH THE LAW

Table 22 indicates the number of patients who had contact with the police.

TABLE 22 CONFLICT WITH THE LAW

	NO	%
No	27	90
Yes	3	10
TOTAL	30	100

	WHO	WHY
1	Police	Because her sister-in-law stole her money
2	Police	Because of dagga abuse
3	Police	Murdered Nephew

As shown in Table 22, 90% of the patients had no contact with the police. Thus, it is evident that the majority of the patient population were law abiding. This is important as it becomes clear that most of the patients were not readmitted in order to evade a pending charge.

4.6.3 THE COMMUNITY'S ATTITUDE ABOUT FORMER MENTAL PATIENT

Table 23 indicates the community's attitude about former mental patients.

TABLE 23 COMMUNITY ATTITUDE ABOUT FORMER MENTAL PATIENTS

		PROBLEM		NOT A PROBLEM		N.A.	
		NO	%	NO	%	NO	%
1	Having been a mental patient prevented him from finding or holding a job	7	23,3	12	40	11	36,7
2	Having been a mental patient made some of his friends avoid him	21	70	9	30		
3	The family felt ostracised	27	90	3	10		
4	Other						

It is apparent from the above table that 90% of the patients' families were ostracised in the community and 70% had friends which avoided them. Thus isolation within the community and difficulty of finding employment (23,3%) increased the problems for the family having the patient returned home.

4.6.4 COMPLIANCE WITH MEDICATION

Table 24 gives an indication of the patient's compliance with medication.

TABLE 24 COMPLIANCE WITH MEDICATION

	NO	%
No	17	56,7
Yes	12	40
N/A	1	3,3
TOTAL	30	100

As indicated by Table 24, more than half the patients had not complied with their medication. This is of importance as one of the prognostic factors that has emerged in the last few years has been the patient's cooperation and degree of conscientiousness in following prescribed drug maintenance therapy.

Many schizophrenic patients today can be rendered symptom-free within a few weeks or months, but they can only be maintained in this condition with continued drug therapy after they have been discharged into the community. The more often a patient neglects to take his maintenance medication, the more likely he is to suffer a relapse, and the more likely he is to deteriorate and to develop finally a permanent personality defect (Freedman et. al., 1975).

Nowadays a significant proportion of patients are managed from the start as out-patients or day-patients. This change is the result of a complex interaction between the effects of phenothiazine drugs, and some fundamental changes in the attitudes of the medical and nursing professions. The basic principles of management are the provision of an open-door hospital environment that is as humane and domestically orientated as possible, and sufficient rehabilitation services to cover patients whether they are in hospital, hostels, lodgings or at home.

This involves:

assessment of the patient and family to determine whether out-patient, day-patient or in-patient care is needed,

damping down of acute symptoms and behaviour disturbance by the use of neuroleptic drugs and sedatives;

the provision of an environment that the patient can tolerate and that fits his unique needs. (Cooper J.E., 1983).

However, although most of the above apply to the assessment for the patients in the present study, the provision of a suitable environment needs discussion. The facilities available to the patients were extremely limited. There is no hostel accommodation for patients in the Pietermaritzburg area. The only alternatives available are a return to the family; to live on their own; admission to the Benevolent Society where there is limited bedspace and mainly old residents; and a long stay in hospital. Community facilities are very limiting and this makes the task of the team members discharging the patient rather difficult.

4.6.5 REASONS FOR STOPPING MEDICATION

Table 25 indicates reasons for stopping medication.

TABLE 25 REASONS FOR STOPPING MEDICATION

	NO	%
Does not think he/she is ill	10	33,3
Problems with compliance even whilst in hospital	3	10
No insight	4	13,3
Did not stop medication	13	43,3
Total	30	99,9

As indicated by Table 25, 33,3% of the patients did not think that they were ill. This is of tremendous significance in motivating for the compliance of medication which could prevent a relapse.

4.6.6 NEED FOR A LONGER STAY IN HOSPITAL

Table 26 indicates need for a longer stay in hospital.

TABLE 26 NEED FOR LONGER STAY IN HOSPITAL

	NO	%
No	15	50
Yes	15	50
TOTAL	30	100

It is apparent from Table 26, that 50% of the respondents preferred a longer stay for the patient whilst the remaining 50% preferred a short stay in hospital.

The literature on this aspect is controversial. The highly regulated style of life in the mental hospital can cause long stay patients to develop a syndrome which is not part of their original mental disorder. The syndrome is usually referred to as institutionalisation.

Institutionalisation frequently develops in patients who have been hospitalised for two or more years. The syndrome consists of a varying combination of apathy, lack of concern for one's future, deterioration in personal habits, oversubmissiveness and an over-dependency on the hospital and staff.

Gallagher (1980) suggests that the best approach to the problem of institutionalisation is a programme which involves a minimum period of hospitalisation. However, the "short stay" approach has disadvantages as well. Even short-term patients easily accept institutional life and believe that hospital routines are intended to benefit them.

As far as the patients' in the present study were concerned the determination of the length of hospital stay was based on the acceptance of the patient by his family. Often the length of hospitalisation was unduly extended by the families refusal to have the patient home.

4.6.7 REMAIN PERMANENTLY IN HOSPITAL

Table 27 indicates whether according to the respondents the patients should remain permanently in hospital.

TABLE 27 PERMANENT STAY IN HOSPITAL

	NO	%
No	23	76,7
Yes	7	23,3
TOTAL	30	100

It is apparent from Table 27, that 76,7% of the respondents did not want the patient to live permanently in hospital. However, the researcher having worked with most of these families would have expected a lower percentage. It may have been that many families preferred not having to mention that they did not want the patient home.

4.7 REASONS FOR READMISSION

Table 28 specifies the reasons for readmission

TABLE 28 REASONS FOR READMISSION

	NO	%
1. Non-Compliance	11	36,7
2. Patient was taking drugs	6	20
3. Other		
(i) Severe side effects		
(ii) Recent change in medication did not agree with the Patient	5	16,7
(iii) Feels restless and agitated		
(iv) Social problems		
(v) Financial reasons		
4. Patient was returned home too soon from the hospital	2	6,7
5. Patients violent behaviour	6	20
TOTAL	30	100,1

As indicated from Table 28, 36,7% of the patients were readmitted because of non-compliance with medication; 20% because they were taking drugs. The discussion on non-compliance with medication would apply here as well. The large number of patients abusing drugs is noteworthy. This would certainly be related to the relapse of the patient and the problem of maintaining the patient in the family situation.

4.8 WORK SITUATION

4.8.1 Table 29a indicates work situation of the patient

TABLE 29a WORK SITUATION OF THE PATIENT

	NO	%
No	21	70
Yes	9	30
TOTAL	30	100

As indicated by Table 29a, 70% of the patients were unemployed on return home from the hospital.

Literature indicates that if the patient has a job waiting for him after he leaves the hospital, his prognosis is favourably influenced. The fact is that even the most disturbed group of released patients are employable in certain jobs, provided that they have the incentive to work. Employers attitudes have been found to be as negative as those expressed by the general public. Some have suggested that it is not unemployment per se that most significantly contributes to readmission but the humiliation suffered by having to depend on welfare. The problems faced by ex-patients in the community are enormous and are largely responsible for the present high rate of readmission to mental hospitals. Rather than being given a chance to

rejoin society through occupational activity and the mental health benefits that flow from it, they are relegated to the ranks of the unemployed, the underemployed, or welfare recipients. This is also the case with the patient population being researched.

4.8.2 Table 29b indicates the type of work undertaken by those employed

TABLE 29b DESCRIPTION AND JOB DETAILS

DESCRIPTION OF JOB	PERIOD EMPLOYED	Full/Part time	SALARY	REASONS FOR LEAVING	READ-MISSION
1. Shop Assistant	± 6 months	F.T	R160 per month	became ill	previous admission
2. Building	5 months	F.T.	R120 per month	Admitted to hospital	previous admission
3. Beeder	8 months	F.T.	R360 per month	Admitted to hospital	
4 (a) Machine Operator	± 5 months	F.T.	R130 per month	N/A	N/A
(b) Labour Work	6 months	F.T.	R130 per month	N/A	N/A
5. Machinist	1 year	F.T.	R250 per month	Admitted to hospital	
6. Gardener	few months	P.T.	R120 per month	Admitted to hospital	
7. Bookkeeper	4 years	F.T.	R250 per month	Ill	
8. Sold spices door to door	1 year	F.T.	R180 per month	Poor Salary	
9. Shop Assistant	6 months	F.T.	R60 per week	became ill	

The above description of the job situation indicates the low functioning type of jobs available to patients. The majority of patients had worked for a few months (5-8months) with one exception i.e. four years. The salary ranges were from ± R120 to R360 per month.

The majority of the patients left work because they became ill.

Literature indicates that the patient status appears to directly prevent the discharged from seeking, obtaining or holding a job. It appears that unskilled labourers and the unemployed, or individuals in the lowest social class grouping, have the highest incidence of schizophrenia. Clark (1948) has suggested that the low prestige of the occupation increases the preschizophrenics negative attitude toward themselves, accounting for the predominance of the illness in the lower class.

As is evident from the above table, the patients employed were involved with unskilled work and the above observations would apply.

4.8.3 FREQUENCY WITH WHICH PATIENT LOOKED FOR A JOB

Table 30 indicates how often the patient looked for work

TABLE 30 HOW OFTEN THE PATIENT LOOKED FOR WORK

	NO	%
Everyday	2	6,7
Most days	1	3,3
Seldom	3	10
Rarely	3	10
N/A	21	70
TOTAL	30	100

It is apparent from the above table, that 10% of the patients rarely looked for work, 10% seldom looked for a job and only 10% actually sought for a job, 70% were unemployed and eventually obtained disability grants.

Thus it is evident that only 30% of the patient population was employable.

4.8.4 PATIENTS' CONTRIBUTION TO HOUSEHOLD INCOME

Table 31 indicates patients contribution to household income.

TABLE 31 PATIENTS CONTRIBUTION TO HOUSEHOLD INCOME

	NO	%
Chief Breadwinner	1	3,3
Contributing to household income	14	46,7
Neither 1 or 2	15	50
TOTAL	30	100

As indicated by Table 31, half the patient population did not contribute to household income nor were they chief breadwinners.

4.9 HOME CONDITIONS

VISITS BY RELATIVES AND FRIENDS

Table 32 indicates how often friends and relatives visited the household of patients.

TABLE 32 VISITS BY RELATIVES AND FRIENDS

FREQUENCY	NIL	ONCE PER WEEK	MORE THAN TWICE A WEEK
Before knowledge of patient's illness	0%	30%	70%
After knowledge of patient's illness	6,7%	73,3%	16,7%

It is apparent from Table 32 that 73,3% of relatives visited once a week after knowledge of patient's illness as compared to 30% prior to knowledge of patient's illness; whilst 16,7% visited once a week after knowledge as compared to 70% who visited more than twice a week prior to knowledge of patient's illness.

Thus, the visits by relatives and friends were curtailed because of the patient's illness.

4.10 CIRCUMSTANCES AFFECTING PATIENT'S REHABILITATION

No other aspect of mental illness is as clearly determined by sociological factors as is the success or failure of the patient's attempt to rejoin society. Among numerous social variables responsible for the re-adjustment of ex-patients into the community are, employment, financial problems, the attitude of relatives toward the patient, the problems of stigma etc.

4.10.1 Table 33 indicates the circumstances affecting the patients rehabilitation.

TABLE 33 THE CIRCUMSTANCES AFFECTING THE PATIENTS REHABILITATION

	NO	%
Stigma attached to Mental Illness	21	70
Poor Neighbourhood	18	60
Family unable to accept Patients Difficult Behaviour	15	50
Emotional Problems of household members	8	26,7
Poor Housing	8	26,7
Patient unable to obtain work	4	13,3

As shown by the above table, 50% of the relatives indicated that their inability to accept the patient's difficult behaviour affected the patient's rehabilitation; 70% of the relatives indicated that the stigma attached to mental illness affected the patient's rehabilitation; 60% of the relatives blamed the poor neighbourhood for affecting the rehabilitation of the patient.

The most fundamental problem involved with discharged patients rejoining society is the stigma attached to the mental patient role. More stigma is suffered by those who have been patients in a state mental

hospital than by those who have been in private hospitals especially for those who were involuntarily committed. There are many reports of the isolation of ex-patients from society. This isolation tends to affect the relatives of ex-patients as well. Years after former patients have been living in the community their families still struggle with the burden of stigma. (Gallagher, 1980).

The patient's family plays an important role in the patient's prognosis. A number of studies in recent years have established the fact that most schizophrenics come from deeply disturbed families. Some of the important questions to be answered before making a prognosis are : Is the patient accepted by his family? As evident from the above table, 50% of the respondents indicated that the families in-ability to accept difficult behaviour affected the patient's rehabilitation.

Poor neighbourhood was frequently linked with a number of "cornerboys" or "bad elements" who abused drugs and alcohol. Sixty percent of the respondents indicated that these "bad elements" affected the patient's rehabilitation.

4.10.2 ASSESSMENT OF HOME CIRCUMSTANCES BY RESEARCHER

Table 34 indicates assessment of home circumstances by researcher.

TABLE 34 ASSESSMENT OF HOME CIRCUMSTANCES BY RESEARCHER

	NO	%
Excellent	1	3,3
Medium	8	26,7
Poor	21	70
TOTAL	30	100

Table 34 indicates that 70% of the patients came from poor home circumstances, as assessed by the researcher.

4.10.3 ATTITUDES OF FAMILY MEMBERS AND COMMUNITY

Social forces are important in the recognition and treatment of mental illness. Investigations of the effects of these forces suggest damaging consequences for prospective patients. The social psychology involved in becoming a mental patient reflects some of society's inappropriate attitudes regarding mental illness. These attitudes are based on embarassment, ignorance, shame and an exaggerated fear of the

behaviour of mentally disordered people, beliefs which reflect an underlying view of mental illness that is a problem itself.

Table 35, indicates the attitudes of family members and the community.

TABLE 35 ATTITUDES OF FAMILY MEMBERS AND COMMUNITY

	0 EXPECTED		1 DID NOT EXPECT		TOTAL	
	NO	%	NO	%	NO	%
(a) To be working full time	17	56,7	13	43,3	30	100
(b) Undertake household tasks	25	83,3	5	16,7	30	100
(c) Visit friends	27	90	3	10	30	100
(d) Visit relatives	29	96,7	1	3,3	30	100
(e) Dress and take care of themselves	30	100			30	100
(f) Help manage the family's finances	9	30	21	70	30	100
(g) Do the family's shopping	16	53,3	14	46,7	30	100
(h) Remember to do important things on time	15	50	15	50	30	100
(i) Interact normally with family members	26	86,7	4	13,3	30	100
(j) Relate normally to relatives and neighbours	27	90	3	10	30	100

The interpersonal life of the ex-patient is one of the most important determinants of rehospitalisation. However, it is not the mere presence of significant persons in the ex-patient's life that aids readjustment as much as it is their behavioural expectation of the discharged patient to perform an active, normal social role. As indicated by the above table excluding the need to help manage family's finances and the need to remember to do important things, the family members expectations were significantly higher than non expectations.

Gallagher (1980), writes that the higher class ex-patients function better in the community, because their relatives place greater expectations on them than do the relatives of ex-patients from the lower class. However, expectations could be beyond the capabilities of the patients in the present study. This thus leads to frustrations and low self esteem which could lead to isolation and subsequent relapse.

4.10.4 ON RETURN HOME

Table 36 indicates attitudes of others towards the patient on return home.

TABLE 36 ATTITUDES OF OTHERS TOWARD THE PATIENT ON RETURN HOME

		NO	%
(a)	Responsibility towards other family members	19	63,3
(b)	Patient was an extra financial problem	16	53,3
(c)	Friends did not visit	20	66,7
(d)	Patient's care was time-consuming	19	63,3
(e)	Decisions had to be made for the patient	21	70
(f)	Family routine eg meal and bedtimes were upset	11	36,7
(g)	Neighbours talked about the family	22	73,3
(h)	Family members were embarassed by the patient, causing avoidance of friends, relatives, and workmates	16	53,3

As indicated from Table 36, 73,3% of the respondents felt that neighbours talked about the family; 70% felt that decisions had to be made for the patient; 66,7% indicated that friends did not visit.

It is evident that on the patient's return home from hospital most aspects of his families life was affected negatively.

4.10.5 FAMILY MEMBERS ANGERED BY THE PATIENT'S BEHAVIOUR

Table 37 indicates the family members angered by the patient's behaviour.

TABLE 37 FAMILY MEMBERS ANGERED BY THE PATIENT'S BEHAVIOUR

	NO	%
None	6	20
Mother	6	20
Father	7	23,3
Spouse	5	16,7
Siblings	1	3,3
Other	5	16,7
TOTAL	30	100

It is apparent from the above table, that different members were angered by patient's behaviour to differing degrees.

4.10.6 INTERVIEWER'S ASSESSMENT

RATING BY INTERVIEWER

Table 38 indicates the rating by the interviewer.

TABLE 38 RATING BY INTERVIEWER

	NO	%
High EE family	20	66,7
Low EE family	7	23,3
Other	3	10
TOTAL	30	100

As indicated by Table 38,66,7% of the patients families could be described as High EE families. Although the researcher has utilised rather simplified methods of rating what she terms EE, this concept does bear similarity to that of Vaughn and Leff (1976).

Vaughn and Leff (1976) suggest that family relationships can predict the course of an established schizophrenic disorder. Whilst Vaughn and Leff's three factors of EE included criticism, hostility and emotional overinvolvement the researcher divided the factors into hostility, aggressiveness, indifference, concern and overprotectiveness.

66,7% of the patients in this study had returned to homes which were rated as High EE Homes - that is, homes characterised by high levels of critical or hostile attitudes towards the patient and/or by excessive emotional involvement. It would therefore be expected that there would be a far greater relapse rate in these patients than those returned to low EE homes. Thus the high percentage of high EE families is of significance as the emotional attitudes of relatives towards patients with whom they live has been identified as important in schizophrenic relapse.

4.10.7 IMPRESSION OF ANSWERS

		NO		YES	
		NO	%	NO	%
(a)	Co-Operative	3	10	27	90
(b)	Language or Communication problems	22	73,3	8	26,7
(c)	Good recall of facts	7	23,3	23	76,7
(d)	Untruthful	28	93,3	2	6,7
(e)	Use of Denial	27	90	3	10
(f)	Appeared depressed	29	96,7	1	3,3

A significant proportion of the respondents were co-operative, experienced no communication problems, had a good recall of facts, were truthful, did not use denial and did not appear depressed.

The significance of this is that the respondents understood the contents of the questionnaire and were able to answer accordingly.

The discussion of the main findings is presented in the next chapter.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The findings of this research will be discussed, followed by recommendations dealing with family treatment for the schizophrenic patient, the need for psychosocial rehabilitation, and finally the recommendations for future research.

5.2 RELEVANT FINDINGS

5.2.1 DEMOGRAPHIC DETAILS

According to the findings of this research approximately half the patient population were between the 20-29 age range. The relationship between early onset and poor prognosis is evident from literature reviews and as anticipated, high relapse rates would be expected.

The greater proportion of the patients were males.

More than half the patient population were Hindus. Other religious groups also had a fair proportion

of readmission. This is in keeping with the fact that schizophrenia is common in all cultures.

63,4% of the patients had a scholastic level under Std Six. Thus the majority of the patient population had a poor school record which would handicap the patient's social re-adjustment in the community.

The highest percentage of the patients fell in the "never married" range. This may be of significance as literature studies indicate that the prognosis for married patients is greater than for single patients.

5.2.2 FAMILY DETAILS

All the patients lived in nuclear families, an indication of Western influence in their living. In addition to this, the housing rules and regulations of the City Council also determined household size.

There is quite a bit of controversy in the scientific community regarding whether a large or small family is most conductive to mental health. Some argue that the material and emotional needs of the child are met better in a small family, in which the child receives considerable parental attention. Others argue that the child in a large family has more

opportunity to develop social skills through interaction with brothers and sisters. A minority opinion holds that there is no significant relationship between family size and mental health. (Chakrabortry, 1970). This was borne out in the present study, where a variety of family size and structure was found.

5.2.3 FAMILY HISTORY OF SCHIZOPHRENIA

According to the D.S.M. III (Williams, 1980) all investigators have found a higher prevalence of the disorder among family members of patients. Evidence consistent to this finding has been found in this study. More than half the patient population had a family history of mental illness.

5.2.4 FAMILY INCOME

More than 50 per cent of the patient population had a combined family income between R251 - R500. This low income was insufficient to meet the needs of the family in view of the high cost of living and was detrimental to the patient's rehabilitation.

5.2.5 FAMILY MEMBERS EDUCATIONAL LEVEL

The patient's family varied in composition. All the relatives in the present study had an educational level of Std Six or below. This low standard of education would explain some of the difficulties experienced by the relatives in their understanding of the illness, their attitudes and coping skills.

Members of the patient's family usually had unskilled jobs. The patient's progress and rehabilitation back into the community was hampered by the fact that he came from a low class home. Frequent rehospitalisation of patients seems to be caused by low familial expectations, a high degree of stigma and the generally depressing quality of lower-class life.

5.2.6 HOSPITAL DATA

All the patients in the present study had two or more admissions to the particular psychiatric hospital. The time period of their stay in hospital during their last admission varied between less than a week and more than one year. Twenty percent of the patients had remained in hospital for four months.

More than half the patients had been certified for admission (involuntary). This would give some indication as to the lack of insight of patients.

Forty percent of the patients were readmitted because of non-compliance of medication whilst 20% were readmitted because of drug or alcohol abuse. The importance of medication compliance cannot be over-emphasised. Irrespective, of the length of stay, posthospital follow up has been shown to be of utmost importance in reducing hospital recidivism.

According to the respondents, 43,3% of the patients presented with aggressive behaviour on admission whilst 20% were found to have abused alcohol or dagga. Throughout this study it became evident that there was a strong relationship between dagga and alcohol abuse and recidivism.

The overall diagnosis was that of schizophrenia but there was often some underlying problem.

5.2.7 PREDISCHARGE CONDITIONS

It is evident from the findings that of the patient population 90 per cent were ready for discharge, from the point of view of relatives and medical staff.

Whilst in hospital, 80 percent of the patients had received visitors. However these visits according to the research findings had been initiated by the staff. Thus, relatives had indicated a reluctance to visit the patient and only as a result of motivation had they eventually visited the patient.

It is well known that the stronger the family support for the posthospitalised patient, the greater the chance of his reintegration into the family life and the community at large.

5.2.8 AFTERCARE ARRANGEMENTS

The value of regular aftercare services cannot be overemphasised. A major percentage of the patient population did not attend regular aftercare treatment.

Schanding et. al., (1984) have attributed the rapid discharge, rapid relapse and readmission to social factors, noncompliance or poor compliance with pharmacotherapy during aftercare and non-attendance or poor attendance at aftercare treatment facilities. From the present study it is evident that non-compliance of medication is closely related to relapse.

It might be said that if all the schizophrenic patients had continued on medication while in the community and had received aftercare supervision perhaps all the other predicting factors would not have had the same significance for outcome.

It would be expected that the overall results especially aftercare services would be better for the group under study who came from the Pietermaritzburg area than those from other areas. The reason for this is that close contact is maintained between the community health staff and patient throughout his illness.

The researcher suggests that there is a need to institute a more structured control at the time of discharge. This would probably make the aftercare of schizophrenics more positive for the patient.

5.2.9 COMPLIANCE WITH MEDICATION

The findings in the present study indicate that schizophrenics are insufficiently aware of the severity of their mental condition to comply with medication. The results indicate that the patient's lack of insight was attributed as the reason for

non-compliance. The data point in the direction that drug therapy plays a major role in arresting or holding back the rehospitalisation of schizophrenics, providing a chance for them to readjust to the extra-mural living at a higher level.

5.2.10 THE NEED FOR A LONGER STAY IN HOSPITAL

Half of the respondents felt tht the patient should have had a longer stay in hospital as opposed to the remaining half who felt a shorter stay was beneficial. A review of literature also indicated no definite understanding of which length of time in hospital is more beneficial.

The majority of the respondents stated they did not want a permanent placement for the patient in hospital. However, from the researcher's own experience many of the relatives were reluctant to accept the patient home again.

5.2.11 REASONS FOR READMISSION

A significant proportion of the relatives attributed non-compliance of medication and the patient's use

of drugs for example, dagga smoking, as the reason for the rehospitalisation of the patient.

The relationship between non-compliance of medication and relapse has been discussed. A major proportion of the schizophrenic patients had been abusing alcohol or drugs.

5.2.12 WORK SITUATION

The findings indicated that the majority of the patients after discharge, were unemployable and dependent on disability grants. This is of significance as the prognosis is favourably influenced if the patient is employed on discharge. The present findings indicated a relationship between unemployment and relapse. The present evidence shows that dependence on public assistance impairs the readjustment efforts of schizophrenics.

Serban (1980) finds it ironical that the schizophrenics released into the community and left pretty much to their own devices, subsisting on public assistance, have been readmitted time and again, continuing the cycle as rejects of the community.

A rather smaller proportion of the patients were considered the chief breadwinner. However, this is understandable in view of the low percentage of patients employed, all of whom were involved in low functioning jobs.

5.2.13 HOME CONDITIONS

Relatives who had visited the family at least twice per week prior to the knowledge of the patient's illness had substantially reduced their visits once they were aware of the mental illness. One of the fundamental problems involved with discharged patients rejoining society is the stigma attached to the mental patient role. The public harbours such negative and hostile attitudes toward the mentally ill, that ex-patients are doomed to permanent social ostracism before they leave the hospital, even if their symptoms have disappeared. (Gallagher,1980).

The majority of the respondents considered stigma, their inability to accept the difficult behaviour of the patient and a poor neighbourhood as factors affecting the patient's rehabilitation. The

relationship between the abovenamed social factors and recidivism was apparent. As a result of the influences of these factors, the patient felt rejected and unwanted. He became amotivated and relapsed shortly afterwards.

5.2.14 ATTITUDES OF FAMILY MEMBERS AND COMMUNITY

The lack of concordance between the attitudes and expectations of patients and their close relatives becomes crucial in many cases when the patient is returned to the community in the care of his relative. The drastic contrast in expectations between the family and the patient predictably leads to continuous friction, resulting in further impairment of the latter's post-hospital adjustment. The results indicate that the discrepancy between the ex-patient's expectations and attitudes and those of his close relatives had only detrimental results. The extent to which close family members were aware of the patient's conditions, and were able to interact with him, despite the numerous differences in expectations and attitudes, may well determine, in the long run, the course of the schizophrenic's posthospital life .

The findings also indicated that most aspects of the patient's and his family's- life were affected by the attitudes of others.

The researcher suggests that if one seeks adjustment for the patient then an active effort must be made to bridge the gap between his attitudes and expectations and those of his family and the community.

5.2.15 INTERVIEWER'S ASSESSMENT

A significant proportion of the patients' lived with high EE families. The results of the present study indicatedthat patients discharged to high EE families had a greater risk of relapse. Conflict in expectations led to increased stress for the patient and ill-feeling for the family. The resultant loss of family support in the context of mounting tension resulted almost invariably in renewed breakdown.

A major proportion of the respondents were co-operative, did not experience communication problems , had a good recall of facts, were truthful, did not use denial and, and did not appear depressed. Thus,

the respondents ability to understand the questions specified in the questionnaire was within their means.

An assessment of the home circumstances was that the majority of the patients came from poor home circumstances, which would have a definite effect on the patient's chances of recovering.

5.3 RECOMMENDATIONS

5.3.1 TREATMENT FOR THE FAMILY OF THE DISCHARGED SCHIZOPHRENIC PATIENT

MacFarlane (1983) underscores the thrust of a new perspective, which states that a single-minded, family etiological theory of schizophrenia is now out of the question. The protagonists of this position take as primary the biological component in schizophrenia and see family therapy as a complementary aspect, of the treatment package and not a 'cure' for the fundamental disease.

The therapeutic consequence of this new perspective is the effective use of 'linear' interventions such as training in coping skills, reduction of stimulation,

setting of clear limits, and handling of unsettling life events. The new therapeutic movement assumes that the therapist should begin by giving the family the benefit of the doubt and offer its members directive, specific, empathic help, before embarking on family therapy of the conventional sort. Where families resist these directive interventions, systemic approaches can be considered. Family therapy, home visits, relatives' groups, respite care, rehabilitation, and comprehensive community support systems all offer help to patients and their families. The choice of one intervention or another or a combination of approaches depends on specific needs and available resources.

Goldman (1982) writes that whatever course we may take, we must remain cognisant of the potential for family burden created by a policy of deinstitutionalisation and decentralised community care. One needs to be creative in using a combination of family-oriented treatment, crisis management and a variety of more extensive public health measures if one is to see the benefits promised by the social reformers who introduced community mental health.

It seems imperative that the close relatives be made aware of the change in mental state which the patient undergoes as he moves from one situation to another, or faces a variety of events, and the importance of tolerance of these manifestations be pointed out to the family members. Through these manipulations the patients' lives can be made more bearable within the social environment since the family's support and their understanding of the patients' behaviour tends to reduce the level of stress within family settings. Although close relatives are well aware of the difficulties affecting the functioning of the patient, they are unable to understand the amount of stress which the patient experiences in internalising his own inability to respond appropriately to the environment.

The therapeutic effort must concentrate on correcting the interpretations of the patients' goals, choices, interactions to help them obtain new perspectives that will serve as alternatives to the conditions which have led to a crisis or relapses in the past.

The therapeutic approach to schizophrenic patients has to be a multiphasic, holistic, and eclectric one, according to their needs at that time. The therapist

has to use all available knowledge accumulated by the various schools of thought, based on their clinical and experiential research, in his effort to evaluate and control the symptoms and redirect and retrain the patient toward his new social re-assignment and family interaction (Serban, 1980).

5.3.2 THE CHRONIC PATIENT

It is important not to overlook the problems of the chronic schizophrenic. As Mechanic (1980) has noted in relation to the problems of psychotic patients experience in the community, the absence of appropriate skills makes it difficult for chronically mentally ill individuals to find and maintain employment, to establish functional interpersonal relationships, to enjoy adequate living quarters and to avoid difficulties with the authorities. Because of its significance for community living, training in basic living skills represents a major approach to the psychosocial treatment of the chronically mentally ill.

Structural barriers to community adjustment, such as lack of community acceptance of the chronic patient, unavailability of appropriate housing, the

poor quality of psychosocial rehabilitation programmes are extremely important and need to be examined in conjunction with client attributes in future studies of factors affecting client's adjustment to community living.

Those interested in improving the prospects for genuine community integration face several critical challenges, challenges that ought to concern mental health public educators and researchers alike.

Better co-ordination of referrals should increase the number of people who establish outpatient contacts and more important, increase the number of visits each person makes. The researcher hopes that increasing outpatient visits will reduce hospital recidivism rates in an essentially chronic population.

5.3.3 THE NEED FOR PSYCHOSOCIAL REHABILITATION : A PROCESS EVALUATION

Psychosocial rehabilitation is a rapidly growing field. One of the most significant aspects of the psychosocial rehabilitation approach is that it shifts clinical emphasis from psychopathological

symptoms to the individual's functional capacities.

Originating in 1948 at Fountain House in New York City, the most comprehensive form of psychosocial rehabilitation provides a variety of social and prevocational opportunities, an array of living arrangements, including supervised apartments, and a transitional living programmes where job opportunities for clients are obtained and extensively supported by programme staff. During the past few years, many programmes based on the Fountain House model have been developed across the country. (Turner and Tenhoor, 1978).

Turner and Tenhoor (1978) found that the majority of clients receiving services at Fountain House had lower rehospitalisation rates, stayed in the community twice as long before rehospitalisation, and spent 40 percent fewer days in the hospital.

Presently, attempts are being made to introduce the same methods and principles utilised at Fountain House to South Africa. The researcher is a member of a committee which intends to commence the rehabilitation programme in Pietermaritzburg in the beginning of 1985.

5.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The field of psychosocial rehabilitation appears to be a prime area for future research.

Research should increasingly focus on assessing the effectiveness of public education or programme-related strategies for improving public understanding and acceptance of the mentally ill.

In addition to the above it is the researcher's opinion that research into the psychosocial factors and recidivism of schizophrenic patients of all race groups should be a priority.

5.5 CONCLUSION

A variety of facilities is necessary to provide a programme of social stimulation and work training or retraining that is individually suited to the patient. The work programme will often be aimed at achieving a less ambitious level than before the illness. Ideally, a system of assessment workshops, supervised hostels and lodgings, and sheltered employment facilities should be available to the

patient, through the agency of a multi-disciplinary team of psychiatrists, psychologists, occupational therapists, social workers, and community and hospital nurses that have planned the programme. A hurried or stressful programme of rehabilitation will encourage relapse, but if insufficient stimulation is provided, or if too much is done for the patient by others, there will be a tendency for the patient to drift into an institutionalised, passive existence. The success of rehabilitation rests largely on finding the optimal balance for each patient. (Cooper, 1983).

APPENDIX A

SOCIAL QUESTIONNAIRE

STUDY NO:.....

Patient's File Number:.....

Patient's Name:.....

Address:.....

Phone Number:.....

DEMOGRAPHIC DETAILS

1. AGE:
   - 1 - Under 20
   - 2 - 20 - 29
   - 3 - 30 - 39
   - 4 - 40 - 49
   - 5 - 50 - 59
   - 6 - 60^{+}
2. SEX: Male - 0 Female - 1
3. RELIGION:
   - 0 Muslim
   - 1 Hindu
   - 2 Tamil
   - 3 Gujarathi
   - 4 Christian
   - 5 Other
4. STANDARD OF EDUCATION:
   - Std 1 - 0
   - Std 2 - Std 6 - 1
   - Std 7 - Std 10 - 2
   - Undergrad - 3
   - Diploma - 4
   - Other - 5

5. MARITAL STATUS : 0 - Never Married, 1 - Married,
2 - Divorced, 3 - Widow/Widower,
4 - Remarried, 5 - Living Together

FAMILY COMPOSITION

6. FAMILY DETAILS

	NAME	RELATIONSHIP TO PATIENT	EDUCATION LEVEL	OCCUPATION	SALARY
1.					
2.					
3.					

7. COMBINED FAMILY INCOME: Under R250 0
251-500 1
501 - 1000 2
Over 1000 3

8. WHAT IS THE SIZE OF THE FAMILY: SMALL - less than 5
MEDIUM - 5 - 8
LARGE - more than 8

9. Is this an (a) extended family (more than 2 generations living under the same roof) or (b) a nuclear family

10. Is there anyone else in the family who has been mentally ill.

No - 0 Yes - 1

1. If Yes, specify:

HOSPITAL DATA

12.	ADMISSIONS TO HOSPITAL	TIME PERIOD	TYPE OF ADMISSION	(0 - Voluntary Boarder, 1 - Consent 2 - Certified 3 - Urgency)
	1.			
	2.			
	3.			
	4.			
	5.			
	6.			

13. REASON FOR RE-ADMISSION: 1.

2.

3.

14. PRESENTING PROBLEM:

15. PSYCHIATRIC DIAGNOSIS: DSM III

PRE-DISCHARGED CONDITIONS

16. What were the circumstances under which the patient was discharged:

0 - Patient wanted to leave hospital.

1 - Family wanted him home against medical advice.

2 - Patient was discharged whilst on abscondment.

3 - He was ready for discharge.

17. (i) Did the family receive any advice from any staff about aftercare? 0 - No 1 - Yes

(ii) If Yes, what advice was given?

18. (i) Whilst in hospital did the patient receive any visitors.

0 - No 1 - Yes

(ii) If Yes, who visited him: 0 - Relatives 2 - Pastor
1 - Friends 3 - Other

(iii) Were these visits initiated on their own, or were they initiated by staff: 0 - On their own
1 - Staff

AFTERCARE ARRANGEMENTS

19. (i) Since leaving the hospital has the patient been seen by any of the hospital staff or clinic for treatment?

0 - No

1 - Yes

(ii) If Yes, why was he seen?

(iii) How frequently was he seen?

(iv) Specify which staff.

20. Did the patient see anyone not connected with the hospital for advice or care?

0 - No

1 - Yes

21. Have you or another family member wanted any advice which for some reason could not be obtained?

0 - No

1 - Yes

GIVE THE REASONS.

22. During the period the patient has been home have any family members gone for any help regarding emotional problems.

    0 - No

    1 - Yes

    If Yes, specify

23. (i) While the patient has been home, did he have any contact with the police or other legal authorities

    0 - No 1 - Yes

    (ii) If Yes, who and why?

24. Sometimes patient's have problems when they leave the hospital because of the way people in the community feel about former mental patients. While the patient was in the community did he experience any of the following problems?

	Problem	Not a Problem	N.A.
(a) Having been a mental Patient prevented him from finding a job.			
(b) Having been a mental patient made some of his friends avoid him			
(c) The family feel ostracised.			
(d) Other - Specify			

25. (i) Has the patient been taking his medication regularly.

0 - No 1 - Yes 2 - N/A

(ii) If NO, has he stopped taking his medication for any particular reason. Give the reasons.

26. Do you think the patient should have stayed longer in hospital?

1 - Yes 0 - No

27. Remained permanently in hospital?

1 - Yes 0 - NO

REASONS FOR READMISSION

28. In your opinion, which were the most important reasons for the most recent hospitalisation:

0 - the patient was returned home too soon from the hospital without being cured.

1 - the patient stayed in the hospital too long - can't adjust to ordinary life.

2 - patient's violent behaviour.

3 - non-compliance of medication which resulted in him relapsing.

4 - patient was taking drugs

5 - other, specify.

WORK SITUATION

29. Did the patient work during the time he was home from the hospital? 0 - No - 1 - Yes

If Yes to the above, then complete the following:

Description Of Job	How Long Employed	Full/Part Time	Salary	Reason for Leaving	Readmission

30. During the period he was employed, how has he related to his colleagues at work.

31. When the patient was unemployed, how often did he look for a job?

1 - every day 2 - most days, 3 - seldom, 4 - rarely 0 - N/A

32. During the period the patient was out of the hospital was he:

1 - the chief breadwinner

2 - contributing to household income

0 - neither 1 or 2

HOME CONDITIONS

33. Whilst the patient was home from the hospital, how often did you have friends and relatives coming to your home?

Before : 0 - Nil , 1 - Per Week , 2 - Per Week

After : 0 - Nil , 1 - Per Week , 2 - Per Week

34. Do you consider any of the following circumstances affected the patients rehabilitation.

	YES - 1	NO - 1
Poor housing		
Poor neighbourhood		
The emotional problems of household members.		
Patient unable to obtain work.		
Stigma attached to mental illness		
Family unable to acceot patients difficult behaviour		

ATTITUDES OF FAMILY MEMBERS AND COMMUNITY

35. Families vary in what they think their relatives should do after they come home from the hospital. Do you consider that the patient should :

	0 Expected	1 Did Not Expect	2 N/A
(a) Be working full-time			
(b) Undertake household tasks			
(c) Visit friends			
(d) Visit relatives			
(e) Dress and take care of themselves			
(f) Help manage the family's finances.			
(g) Do the family's shopping			
(h) Remember to do important things on time			

	0 Expected	1 Did Not Expect	2 N/A
(i) Interact normally with family members			
(j) Relate normally to relatives and neighbours			

36. On returning home did any of the following apply.

	Yes - 1	No-1
(a) Responsibility towards other family members was neglected because of patient's needs.		
(b) Patient was an extra financial problem		
(c) Friends did not visit		
(d) Patient's care was time-consuming		
(e) Decisions had to be made for the patient.		
(f) Family routine e.g. meal and bedtimes were upset.		
(g) Neighbours talked about the family		
(h) Family members were embarassed by the patient, causing avoidance of friends, relatives and workmates.		

37. Which family members were angered by the patient's behaviour?

0 - None 1 - Mother 2 - Father 3 - Sister

4 - Siblings 5 - Other

38. FAMILY INTERACTION WAS:

	FAMILY RATING			INTERVIEWERS RATING		
	FREQ	SOMETIMES	NEVER	FREQ	SOMETIMES	NEVER
Hostile towards patient						
Aggressive towards patient						
Indifference towards patient						
Showed concern towards patient						
Overprotective patient:						

INTERVIEWERS ASSESSMENT

39. RATING BY INTERVIEWER : High EE family - 0
Low EE family - 1
Other - 2

40. CO-OPERATIVE 0 - No 1 - Yes

LANGUAGE OR COMMUNICATION PROBLEMS 0 - No 1 - Yes

GOOD RECALL OF FACTS 0 - No 1 - Yes 2 - Doubtful

UNTRUTHFUL 0 - No 1 - Yes

USE OF DENIAL 0 - No 1 - Yes

APPEARED DEPRESSED 0 - No 1 - Yes

41. ASSESSMENT OF HOME CIRCUMSTANCES.

0 - Excellent 1 - Medium 2 - Poor

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