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Schizophrenia in adolescents and the family system

Empirical research shows that chronic diseases have specific, idiosyncratic functions in the family, and give real, psychosocial advantages (like tightening loosened family relations or helping solve interpersonal conflicts). This leaves the question – can schizophrenic disorders have similar function in the family system as a chronic somatic disease? We have analyzed systemic family traits in families with schizophrenic young patients (50 families). The reference samples were two kinds of families: families with schizophrenic adults and families without any chronic disease or chronic illness ("healthy families"). The subjects of analysis were coefficients of the systemic features, identified by factor analysis according to author's proposal. Oneway Anova was used to compare indexes between three groups of families. The results show that mental disorder in adolescents participates in the life of the whole family, having similar functions to the functions of chronic somatic diseases. They also suggest that, from the family members' point of view, schizophrenic disorders in a teenagers has different quality compared to schizophrenic disorders in an adult.

Keywords: *mental illness in the family, systemic traits*

Introduction

The concept of „schizophrenia" was introduced by the Swiss psychiatrist E. Bleuler in 1911 and it means literally „splitting of the mind" (gr. *schizo* - split, *fren* - mind, will). Attempts to define unambiguous criteria and causes of the disease have been made since observations of schizophrenia began. For a certain time, people have been more conscious that the term „schizophrenia" contains several various varieties of this disorder (Wierzba, 2001). American Psychiatric Association suggests that schizophrenia is probably a common final stage of several diseases that differ in origin, course and the final result (Carson et.al 2003) and as of now, this suggests the notion that schizophrenia has a provisional character (Andreasen & Carpenter, 1993). The detailed image of schizophrenia consists of many specific symptoms that may change during the life span and may vary from culture to culture. These main symptoms include: disorder of thinking and perception, lowered mood, abatement of feeling, disorder of the identity and escape to one's own world (Carson op. cit., 2003).

Epidemiological data suggests that schizophrenia is recognized only in adults and its first symptoms appear after the age of twenty. There have been numerous cases, however, of diagnosing the schizophrenia at young people just entering adulthood are known (from the age of 18 to early twenties), but it is generally said that the beginning of the disease falls in the period between fifteen and forty five. Schizophrenia in men is diagnosed equally often as in women; in men it begins somewhat earlier - the early twenties, while women in their late twenties.

Psychiatrist B. Morel, in his detailed description of schizophrenia in youths, noticed that an individual who has so far been clever and active becomes low, closed in on themselves and their physical, moral and intellectual functioning undergoes drastic deterioration in the after-effect of the disease. He called it „dementia praecox" to distinguish this state from the progressive atrophy of intellectual efficiency, characteristic for the age of the involution.

Research concerning the role of psychosocial factors in the formation of the schizophrenia focus mostly on the questions of the impact of family, stress and emotion (Carson, op. cit., Czabała et. al., 2001). In the 1950s, when the investigations on the role of family in schizophrenia began, the opinions burdened parents with the fault when the knowledge of their children's disease emerged. Emotional coldness, a parent's hostility, lack of parental competences and rejection

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of a child were claimed to be the responsible factors. At present, this hypothesis is denied because it is based on incorrect and oversimplified understanding of the origin of schizophrenia; accusing the parents neither explains the disease nor helps in treatment. Moreover it may even make the family situation worse because of the lack of sufficient support and thus add to the already existing burdens (Carson op. cit., Tomczyk, 1999). However, there are some research indicating a larger frequency of emotional disorders and conflicts in families with schizophrenic patients (Hirsch & Leff, 1974; Carson op. cit.), yet it is impossible to decide on the direction of the impact: from parents to their offspring or vice versa.

Regardless of the origins of schizophrenic disorders, family members stimulate more and more pathological behaviors in each other. Parental attempts to acclimate to pathologic behaviors of their schizophrenic children often has negative impacts on their own behavior and communication patterns (Mishler & Waxler, 1968; Liem, 1974).

Two-way effect is probably the most important discovery in the studies on schizophrenic families. On the one hand functioning of the family as a system doubtlessly "regulates behavior, development and health of its members" (Carson op. cit., p. 719). However, simultaneously, as the basic foundation of the systemic understanding of the family state „everything what happens with the individuals in the family, influences functioning the whole system" (Praszkier, 1992, p.7). Thus the child's disease appears to be a twice as much difficult situation.

A family in which mental disorder occurs is in an unusually difficult situation. It carries a huge burden of emotional, behavioral and financial problems caused by the disease. For the example, parents often feel guilty and responsible for their child's disease, and the reaction to these emotions may be the excessive care or, on the other hand, criticism and hostility towards the child.

Consequently, what is the relationship between parental subsystem and their child's disease? A clinical study of fourteen marriages with schizophrenic offspring found that none of them functioned in a healthy manner. Eight of them were facing divorce; they lived in the condition of the incessant conflict while the remaining six couples modified some elements of behavior for the sake of maintaining their relationship; the phenomenon of pathological „collusion" occurred. The serious disorders of behavior in a parent (e.g. imaginary treatment of certain elements of the reality) were treated by the spouse as normal and well founded (Lidz, Fleck & Cornelison, 1965).

Lidz and others also tried to explain why a brother or sister of an ill child manages to avoid destructive influence of the pathological family situation. They claim that the specificity of a family situation is diversified and every child in the family has his/her own experiences. A certain child may, for example, experience disturbances in the family more strongly than his/her sibling as a result of parents' over-carefulness (Carson op. cit.).

Poor communication is one of the most important pathogenic features of the family. Bateson (1959; 1960) emphasized the role of internally conflicting and unclear communication in the families with schizophrenic patient. The notion „double bind" is used to characterize such type of communication.

Double bind occurs when one parent sends to a child conflicting thoughts, feelings and demands at the same time (when, for instance, verbal information is inconsistent with the nonverbal one). Exemplification of the above mentioned phenomenon might be a situation when mother assures her child about her love and acceptance and simultaneously rejects him/her emotionally and shows fear of closer relation with him/her.

The internally conflicting and chaotic communicating pattern in the family makes it impossible for the „recipient" to learn to interpret and send information accurately, which leads to typical schizophrenic disorders like ambivalence or autism (Birchwood & Jackson, 2004; Barbaro, 1999). However, the hypothesis of pathogenic role of the double bind communication has not been reliably confirmed (Carson op. cit.). Authors claim that this type of communication also occurs in different fields of social life e.g. artistic activity, humor or some therapeutic interventions (Barbaro, 1999).

Inconsistent and unclear communication was defined as "communicational aberration" or „aberration of transactional style" and is labeled as the most important element of parents destructive influence on children who in the later age will become schizophrenic patients (Singer, Wynne & Toohey, 1978; Wynne, Toohey & Doane, 1979). The results of longitudinal research on teenage non-schizophrenic patients of psychiatric hospitals confirmed suggestions mentioned above (Doane et. al., 1981; Goldstein & Strachan, 1987). One should remember here that genetic reasons of communicational disorders in the family and psychotic symptoms are also probable, However. Such possibility was undermined by the Finnish research, in which the relationship between the communicational aberration at adoptive parents and serious psychical disorders at adopted children was proved (Tienari, 1994).

Systemic theory is one of the most popular psychological approaches attempting to explain the formation of schizophrenic disorders (Czabała op.cit.). It shows dependence between the functioning of a family as a system and origins of schizophrenic disorders as well as the process of the disease. The specificity of schizophrenic families is disturbance in family structure, especially erosion of subsystems borders and ambiguity of roles. A child living in disturbed family system is excessively burdened with solving mature conflict and sometimes is forced to play the role of an adult person (for instance, as a foster partner for

one of his/her parent). Social isolation, beliefs in external world hostility, confusion, prohibition for expressing negative emotions towards family members connected with the demand of unconditioned loyalty and excessive closeness between them are often mentioned as important traits of schizophrenic families, too (*Ibidem*).

We also cannot ignore the aspect of development when considering cases in teenagers. According to many theories of family development such families are in the fourth phase of family life cycle; that is, in the phase when the children leaving home (McGoldrick & Carter, 1982; Ostoja-Zawadzka, 1997). The question is: Can they really leave?

From the systemic point of view, every following stage in the family life cycle is possible when all tasks of the previous stage have been executed. If it happens too early, a threat of disturbances, like symptoms in a certain family member, may occur. In other words, the disease appears when the patient's family has difficulties with moving on to the following developmental stage. Symptoms are the signal of interruption or disturbance in this process and they show that the family has problems and that it stopped in the system's development and is not ready to move on to the next phase yet.

Research

Problem

A Family with teens is in a specific developmental phase, with imminent, early adolescents' leaving. The question is: can mental disorders play the similar role as chronic somatic diseases (as it was mentioned in the above quoted results)? The researcher attempted to answer that question by analyzing young schizophrenic families. The systemic dimensions of family systems were the objects of research. Three areas of family systems were taken into account:

a) mutual relations in family subsystems,
b) so called "family self-assessment"
c) the subject's opinion of the overall family functioning.

Method

Throughout the research, the Family Assessment Questionnaire (by Cierpka & Frevert, 1994) was applied. It was used for estimation of the level of the family systemic features (source features), separated in explorative factor analysis (Świętochowski, 2010 *b*).

I. With reference to overall family functioning:

a) inclusion according to the theory Family FIRO Model (Doherty et.al 1984). One can consider inclusion as a measure of family cohesion. Inclusion is the basic family trait according to Family FIRO Model mentioned above and it means the feeling of common identity and the similarity of values and opinions within the family system,

b) co-operation - is the ability to recognize and define problems accurately and to undertake common activities in order to solve them. The level of co-operation is determined by the belief that all family members fulfill their duties in troubled situations and in the face of new challenges and difficulties; it is mostly the behavioral factor,

c) agreeableness - this is the tendency to live peacefully and avoid conflicts with others in the family system; this factor is apparent in attitudes of the family members; its level expresses the feeling of community and satisfaction resulting from being a family.

II. Referring to mutual relations in dyads:

1) communicational mutuality, that is an ability for mutual conversation with another person and for acceptance his/her needs and rights,
2) the acceptance of one's autonomy,
3) feeling of emotional support (from other members of the family).

III. With reference to family self-assessment:

1) partnership understood as feeling esteemed by family members,
b) sense of security when fulfilling his/her family role,
c) care; the sense of responsibility for others.

Research sample

Fifty families with a schizophrenic adolescent (aged 19 to 22) took part in the research. Families were in a critical phase of the family life cycle on due to the impending nature of the child's departure from home. The ill persons were under the medical care of the psychiatric clinic of the Medical University, the therapeutic centre for youth „Imbryk" and the Handicapped Support Association (Towarzystwo Przyjaciół Niepełnosprawnych) in the city of Lodz.

Two supplementary groups were tested:

1) so-called healthy families, i.e. the families with no medical problems, homogeneous to the sample (N=57),
2) families with a schizophrenic adult (N=30).

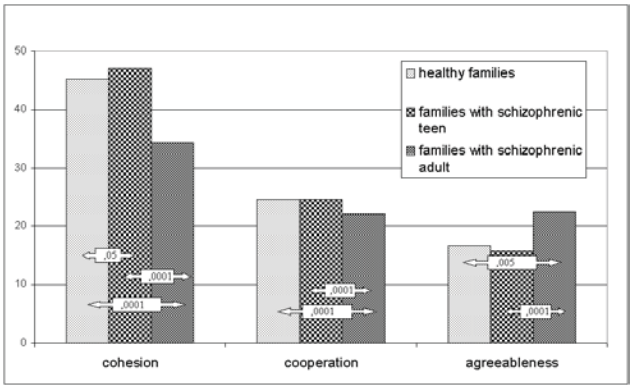
Results

General family characteristic

Results of ANOVA[1] analysis show considerable differences between sample groups within all three systemic variables ($p<0,001$), but it does not refer to all variables. As the diagram displayed in figure 1 shows, characteristics of healthy families and families with ill teens is similar. They are imperceptibly, but significantly more coherent than the latter families ($p<0,05$). They both are similar as far as level of co-operation is concerned, but at the same time, they have lower level of agreeableness. This probably suggests that they are internally conflicted. Families with

[1] Tukey's test (HSD) was applied

Figure 1. Systemic traits in general family assessment



* Tukey's HSD was used

schizophrenic adults have the decidedly lowest results in family cohesion and co-operation but on the other hand – are characterized by comparatively the highest level of agreeableness.

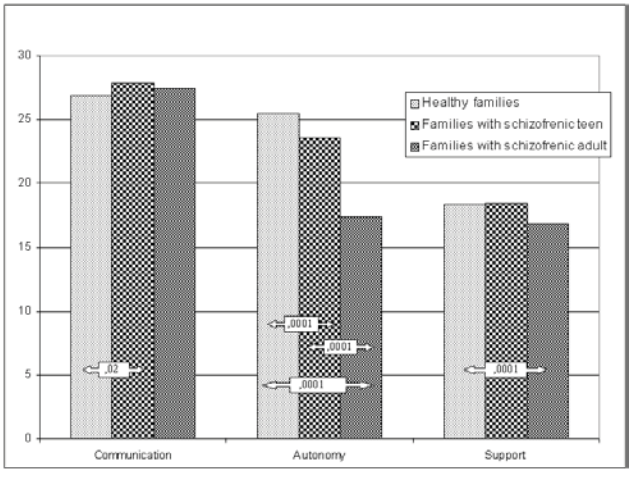
The most coherent families are those with a psychotic adolescent, which is probably the effect of very close parent-child relations. The disease causes a remarkably „prolonged" feeling of the family community. Openness probably does not significantly influence this phenomenon, as its level is generally not very high in schizophrenic families. The result in cohesion is in the healthy families slightly (but statistically significantly) lower, which is probably due to similar level of family traits such as: attachment, openness, similarity of attitudes and values. The decidedly smallest amount of cohesion is found in families with adult schizophrenic patients.

The family co-operation (i.e. the ability to recognize and define problems accurately and to undertake common activities in order to solve them), as well as the belief that all family members fulfill their duties and tasks - are equally high in the „healthy" families and in the families with an ill adolescent. The lowest cooperation is in the families with an ill adult. However, in the latter group, agreeableness is the highest. It may be the evidence of concentration on each other and of avoiding conflicts. This suggests the limitations in expressing oneself and communicating opinions openly. The lowest result in families with ill adolescents suggests large stress and direct conflicts (in spite of high cohesion in these families).

Bilateral relations

The estimation of mutual relations between family members was the subject of this family feature, therefore we obtained much more data concerning the problem. In the sample of families with ill teens there were 335 opinions, families with the ill adult - 372, and in the sample of healthy families - 466. Results of ANOVA show great differentiation between groups in two variables: Accepting Other's Autonomy and Feeling of Support ($p<0,0001$ both). Results are less differentiated as far as the dimension of

Figure 2. Systemic traits in bilateral relations.



Communication is concerned, although F coefficients are significant as well ($p<0,03$).

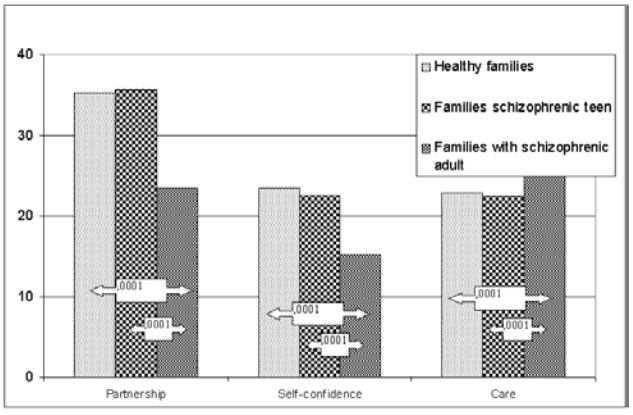
Openness in communication is generally the highest in the families with schizophrenic adolescents, which is consistent with results mentioned above. This is an evidence of great respect for one's opinions and convictions in these families. We may also hypothesize that a child's mental disease seems incredible for his/her parents and something bizarre and inexplicable and, as a result, efforts are made to persuade eccentric behaviors. Similar expectations may characterize the families of ill adults, though they are probably less motivated to have mature conversations and patiently listen to incapacitated persons. This might be the reason of lower openness in such families. The lowest level of openness we can observe is found in so-called healthy families. Probably their members believe that in normal families moderate communicational openness is a normal situation and does not demand any correction.

The acceptance of individual autonomy is highest in „healthy" families and slightly lower in families with ill adolescents and the lowest in families with adult schizophrenic patients. The members of „healthy" families may maintain feeling of freedom and they respect their personal borders with each other. In families with schizophrenics, there are many more attempts of enforcement of submissiveness, obedience and agreement. Result in a support scale corresponds with the result of inclusion. The "healthy" families and families with schizophrenic teens have relatively the highest level of mutual trust. The detailed results are showed in figure 2.

Self evaluation of family members

As far as family self-evaluation is concerned, results differ remarkably among groups ($p<0,0001$). The index distribution is similar to the distribution of general family estimation; however, the level of systemic variables in families with schizophrenic teens is similar to this in healthy families. Relatively the highest level of partnership

Figure 3. Self evaluation in family context.



can be seen in these families, but at the same time their self-confidence and protectiveness are lower in comparison with healthy families (though, these differences are not statistically important).

Comparatively, in families with an ill adult, persons are treated as helpless patients; the attitudes towards them are caring and protective, whereas their partnership is very low. We may suppose that psychological borders in such families are floating and blurred. Low self-confidence in such families may be the consequence of conditionings mentioned above.

Members of healthy families and families with schizophrenic teen are involved in partnership relations and, at the same time, are the most neutral. They are convinced about fulfilling their family roles and duties properly. Furthermore, they are trustful, which does not refer to families with schizophrenic adults, where a lot of tension and anxiety occurs. The results in protectiveness scale are the highest in the latter families. It may be due to the fact that they show more interest in others.

Interpretation of results; final conclusions

Diagnosis of schizophrenic disorder in the family activates many specific processes organized by specific psychological mechanisms that are revealed to be the source traits of a family system. As it was proved, the comparatively high level of co-operation characterizes all families, and their members have feelings of obligation to support others. This may reinforce adaptation to the disease, because mechanisms mentioned above soften possible conflicts and tensions that have appeared in the process of taking care of a chronically ill person. There are also no serious communicational problems in dyadic relations, although it does not exclude any problems in communication at all (further I shall come back to this issue).

Results differentiate the sample groups of families in most dimensions. In relation to cohesion, communication, readiness for support and feeling of partnership are concerned, the families with schizophrenic teen have relatively the highest indexes in variables mentioned above. Their members seem to be closer with each other and more prepared to give them support, particularly in difficult situations. Their structure is more democratic than in other families. Consequently, in many important areas their functioning is even better than the functioning of 'healthy families' (the ones without any disease diagnosed). One can say that the teenager schizophrenic disorder is – while it sounds paradoxically - beneficial for a family system. This result is generally convergent with results of research on families with chronic somatic diseases (Świętochowski, 2010 *a*). Such an observation reinforces the hypothesis that every chronic disease that is not due to the sudden and obvious dysfunction of an organism or certain organ may play the instrumental role in the family system by setting and maintaining the family homeostasis. Empirical studies suggest that chronic illness may act as an idiosyncratic mechanism, bringing measurable psychosocial advantages for the family. Among others, it may tighten loosened connections or facilitate conflict solutions. In many cases the consequence of the disease may be blocking the family development by the delay in moving on to the „empty nest" phase of family existence (de Barbaro, 1997; Ostoja-Zawadzka, 1997; Świętochowski. 2004, 2010 *a*).

One should also pay attention to the source traits of families with the adult schizophrenic. In most dimensions their dynamics suggests their destructive function in the family system. The level of cohesion falls; co-operation, autonomy, feeling of partnership and self-confidence of family members are lower. However, protectiveness and agreeableness distinctly increase. Both may suggest the tendency to omit problem subjects, probably associated with the disease (but not necessarily, as low cohesion may suggest).

In summary, adult schizophrenic patients are treated by their families as completely helpless and dependent persons who need special care and who should be controlled. At the same time, in the families with schizophrenic teens, family processes become more expressive and disclose all differences and even inner conflicts. Thus a teens' disease makes up the essential context in which family weaknesses and imperfection can be concealed.

The results presented in this paper have given good reason to return to the matter of the parental role in their child's symptoms of mental disorder. As the observations have shown, certain situations parents may be interested in focusing their (and their surrounding's) attention on poor and helpless child to demonstrate their own kindness and love. It also helps in shifting their own problems and marital conflicts to unconsciousness. So adult and teen

schizophrenic disorders may actually be two different diseases with similar symptoms but with different determinants and consequences.

Due to multidimensional etiology of schizophrenia its treatment should be complex as well. (e.g. Wing, 1986; Ciompi, 1986; Zubin, 1986; Hirsch et. al., 1986; Hogarth & Anderson, 1986; Finzen, 1986; McGlashan, 1986, after: Cechnicki, 1992). It should include pharmacological therapy, social and environmental interventions and individualized psychological interventions (Birchwood & Jackson op. cit.; Cechnicki, op. cit.). Conjoint family therapy seems to be particularly essential as far as families with psychotic adolescents are concerned. It should help keep the whole family system in dynamic homeostasis without identifying any family member as a patient. Releasing parents and spouses of feeling of guilt seems to have special meaning in the therapy of schizophrenic patients.

Psychological education should accompany systemic therapy in families with adult patients. It should contain training of communication, solving everyday problems and conflicts, coping with stress, and, last but not least, education about schizophrenia and coping with it (Barbaro op. cit.).

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