THE ROLE OF THE CLINICAL SOCIAL WORKER IN A TREATMENT AND REHABILITATION PROGRAMME FOR SCHIZOPHRENIC PATIENTS AND THEIR FAMILIES

by

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TO THE MEMORY OF MY DAD, CHARL DE VILLIERS († JULY 1987)

AND A SPECIAL FRIEND, OOM KAI († AUGUST 1976)

AND FOR MY MOM, VIDA DE VILLIERS.

They contributed most meaningfully and significantly to my forming of a philosophy about life and fellow human beings.

ABSTRACT

Continued study towards understanding schizophrenia and the impairments it can cause, is regarded as essential in the meaningful fulfilment of the educative and diagnostic contributions which the social worker can make in a comprehensive treatment and rehabilitation programme (involving patients and their families).

The first section of this descriptive dissertation focuses on aspects like terminology, definition, and the most recent diagnostic criteria, in an endeavour to contribute theoretically towards understanding the illness. The complexity of the diagnostic process is emphasized, and the recent revision of the criteria (1987) is seen as indicative of continuous efforts towards improved diagnosis, treatment and rehabilitation. Previous studies, improved pharmacology and more sophisticated neurophysiological examining led to a change in focus with regard to aetiology and the development of the vulnerability-stress-coping-competence model which brought new hope with regard to outcome of treatment.

Section Two highlights several interventions which the clinical social worker can undertake as psychotherapist, group and family therapist, as well as educator on primary, secondary and tertiary levels, from this model and within the psycho-educative perspective. The Neuro B programme, Stikland Hospital, Bellville, is described in Section Three, as an example of a presently operating, comprehensive programme where these interventions can be holistically implemented. Particulars about 56 patients who have been involved in the programme are highlighted in Section Four, while Section Five deals with the opinions of former patients and their families concerning involvement in the programme - elicited by two sets of questionnaires.

The final chapter focuses on a summary of the dissertation, conclusions and implications for practice.

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PREFACE

The writer hopes that this descriptive study may not only capture the interest of students and professionals in the field of psychiatric rehabilitation, but that further research is generated as a result of this study.

Psychiatric hospitals have, irreversibly, become part of the present trend towards discharging increasing numbers of patients back into the community. As a social worker in this field since 1982, the writer shared the hopes and aspirations of numerous patients for a life of optimal functioning in the community. Ways by which these patients can be prepared for life after discharge from hospital will, therefore, become increasingly important.

Full particulars about the Level System and Weekly Roster used at Neuro B are included in the appendices, in the hope that they could be instrumental in developing similar programmes.

M.J. WESSELS

BELLVILLE

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Former residents, as well as parents, relatives and spouses of former residents of Neuro B, were not only meaningfully involved by responding to the questionnaires but they also responded by means of numerous telephone

calls, notes and letters of encouragement. Without them, the Neuro B programme would never have been possible. Former residents who were tragically called up for Higher Duty - **ALETHE**, **ROY** and **GAVIN** - you are sadly missed and will always be remembered.

Working as a member of a therapeutic team, such as Neuro B, is a most fulfilling and enriching experience, and has enhanced my competence in many ways. My memories of the following people are particularly positive: **SISTERS MARLENE MEYER, RIA PRETORIUS, BETS VAN ZYL, LIDIE GOUWS, MARIANNE MARAIS; NURSES JOAN PRETORIUS** and **J. VISSER**, as well as **DR JOHNNY VAN EEDEN**. Present team members with whom I am able to continue my career in a most fulfilling way are: **DR JOHANN SCHEEPERS, MISS SHERRILENE CLASSEN, SISTERS ALEYDA BRAND** and **GINA LITTLE**, as well as the **REVEREND CHARLIE HOLZKAMP**.

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> IF A MAN DOES NOT KEEP PACE WITH HIS COMPANIONS,
> PERHAPS IT IS BECAUSE HE HEARS A DIFFERENT DRUMMER.
> LET HIM STEP TO THE MUSIC HE HEARS,
> HOWEVER MEASURED OR FAR AWAY.
>
> - Thoreau -

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INTRODUCTION

Clinical social work renders services from a holistic perspective in milieus where "individuals have to adjust to society" (Orten, 1987:76). Psychiatric rehabilitation programmes open possibilities for the re-adjustment of patients after discharge from hospital, and the clinical social worker should therefore be able to make a contribution within programmes like these.

Vitas (1987) regards psychiatric rehabilitation as tertiary prevention (as described by Kaplan, 1980). The focus is on the preparation of the patient, concentrating on his abilities, impairments and endeavours to improve and restore the levels of his functioning, to ensure optimal functioning after discharge. As chemotherapeutic and other interventions like psychotherapy and group therapy are also offered in these programmes, secondary prevention (or treatment) is another aspect of the programme where the clinical social worker's contribution will be valued. These programmes are also linked with the community, and primary prevention also becomes of the utmost importance.

Whether the role of the clinical social worker is that of diagnostician, psychotherapist, group therapist, family therapist or family educator from the psycho-educative perspective, the intervention will be influenced by the stance he/she takes with regard to the aetiology, treatment and rehabilitation possibilities of the illness.

According to Tsuang, the illness has been studied more than any other mental illness because of the threat to life and happiness.

> Of all the mental illnesses responsible for suffering in society, schizophrenia probably causes more lengthy hospitalizations, more chaos in the family

> life, more exorbitant costs to individuals and governments and more fears than any other (Tsuang, 1982:x).

As far as research is concerned, Zubin and Steinhauer (1981) identify a period of delay with regard to active research, compared with the period of the 1950's and 1960's, when hospitals were overcrowded and many new interventions were undertaken because of improved pharmacology. They do, however, have an appreciation for efforts made to describe phenomena and symptomatology (for example, efforts which resulted in producing improved classification systems, like the DSM III).

This work is presented in five sections:

Section I concentrates on the illness itself.

Section II relates to treatment and rehabilitation aspects.

Section III discusses the Neuro B Programme, Stikland Hospital.

Section IV relates to patients who completed the programme, and

Section V examines the results of questionnaires, with discussion and implications for further research.

In Section I important terminology is explained, for example, that the term "schizophrenia" was first introduced by Eugen Bleuler, to replace the term "dementia praecox" first used by Emil Kraepelin in 1896 (Wing, 1978a: Tsuang, 1982). The term "schizo-affective" was first used by Kasanin (1933) to include cases with a sudden onset and marked emotional turmoil. The term is subsequently used to describe both schizophrenic and affective symptoms (usually depressive) (Wing, 1978a).

The terms "acute" and "chronic schizophrenia" need to be looked at as well, since these terms have also been controversial. Some researchers felt that some symptoms could be regarded as chronic, for example, "chronic poverty syndrome", while others have different opinions. It also has implications for treatment, as acute symptoms are seen to be responding more effectively to phenothiazine treatment. This should never lead to the stance that only acute conditions are treatable (Wing, 1978a).

The definition of schizophrenia has been difficult, and Carpenter and Strauss (1974) felt that it remained an ill-defined term, despite efforts towards defining.

Janzarik, according to Hoenig (1983), recommends a clear understanding of the concept, and the researcher's own view of the illness is emphasized by him.

Atkinson (1985) describes the illness as a psychosis where the focus of the disturbance lies in the functioning of the patient, without organic cause. She also describes further symptomatology and characteristics with regard to thought processes, perception, attention, volition, motor-activity, emotion and interpersonal relationships.

The importance of correct diagnosis is emphasized by Atkinson (1986), as this influences not only treatment and rehabilitation interventions, but also the patient's concept of himself. The label given to the patient and the aspects he internalizes, will affect his image of himself and his future perspective with regard to being a fully integrated and optimal functioning individual.

With regard to classifications done through the years, these all contributed towards a more effective way of describing symptomatology and, eventually, to improved diagnoses. Contributions of the early researchers have been very important, for example, those of Emil Kraepelin (1896-1926), who distinguished between "dementia praecox" and affective disorders and focused on the illness without taking the person and his circumstances into account. Eugen Bleuler (1857-1939) focused on the division ("split") of the psychic functions. Jaspers (1910) made a major contribution by emphasizing the understanding of the patient (his personality and circumstances) without sacrificing diagnosis. The contribution of Kurt Schneider (1887-1967) was the classification of 11 first rank symptoms which lead to improved diagnostic interventions (Hoenig, 1983).

That the concept of schizophrenia was debatable is described by Hoenig (1983) in an account of Wyrsch:

> At a congress in Basel in 1929 the south-west German psychiatrists with their speaker Mayer-Gross on the one side and the Swiss psychiatrists with their leader Eugen Bleuler on the other, gave each other a two-day battle which, however, ended undecided, as is proper for such struggles, because scientific congresses are of course not parliamentary sessions or church councils (Hoenig, 1983:551).

As far as aetiology is concerned, Tsuang (1982) stresses the fact that recent research has dispelled several myths with regard to the causes of schizophrenia, for example, that influence of the family or social class can cause schizophrenia.

Zubin and Steinhauer (1981) identify six models for studying the aetiology of schizophrenia, namely, the developmental, learning theory, ecological, internal environment, neuro-physiological and the genetic models. As none of the six previous models could provide a definite answer to the question of aetiology, these authors suggested a seventh model, the vulnerability model, which integrates the contributions of the previous models, taking the stance that interaction of several factors is important for a schizophrenic episode to develop. The vulnerability model also favours the opinion that patients suffering from schizophrenia can live an optimal life in the community.

place. A further improvement came about when chemotherapy and social treatments were combined to supplement each other (Vaughn & Leff, 1976).

These historical developments influenced rehabilitation possibilities. According to Tricoridis (1987), Wing defines rehabilitation as

> ... the process of identifying, preventing or minimizing the causes of social disablement accompanying psychiatric disorders, while at the same time helping the individual to develop and use his or her talents to acquire confidence and self-esteem through success in social rules (Tricoridis, 1987:1).

The trend in the world and in South Africa tends to be to discharge increased numbers of patients back into the community. Although facilities and resources are still lacking, the government favours the establishment of rehabilitation programmes, as patients need to be equipped for successful adjustment in the community. Rehabilitation interventions are seen as forms of tertiary prevention by Vitas (1987), as prevention of further relapses of the illness can be brought about.

That treatment and rehabilitation of the schizophrenic patient require special skills can be assumed if Atkinson's (1986) point of view is taken into account, namely, that regression in the case of the schizophrenic patient is to the level of primary narcissism. It should be taken into account that regression to the oral stage and the minimal influence of the superego will have complications for therapy, treatment and rehabilitation. The role of secondary prevention with regard to these interventions is, therefore, of the utmost importance.

Section III focuses on the Neuro B Treatment and Rehabilitation Programme which started operating in July 1984. The historical background, aims and objectives, referral methods, admission procedures, and description of the total programme and the multidisciplinary team approach are given. The interventions with regard to the patients as well as the family, mainly through the psycho-educative model, are highlighted. Information about similar programmes at other psychiatric hospitals is obtained.

Previous research with regard to rehabilitation programmes evidenced a positive outcome, for example, Baker, Woods and Anderson (1977), as well as research done by Paul and Lentz (1977).

That types of programmes also influence outcome, are highlighted by programmes whose original hypotheses were not confirmed by results, for example, Spadoni, Smith and Hines (1969), and Ryan and Bell (1983).

Section IV highlights the most important information from the files of the 56 patients who were involved in the programme. Present circumstances and past functioning are looked at in the case of 53 patients, as three patients died as a result of suicide.

Section V takes a look at the responses elicited by two sets of questionnaires, one set for former residents and one set for their parents, relatives and spouses. They could respond to questions about the sufficiency of education about their illness, the role of medication, whether they would recommend the programme, and to questions about activities in the programme (in the case of former residents). Parents could respond to questions about the functioning of their offspring, as well as activities within the programme, and whether they were sufficiently educated about the illness.

The final chapter is a summary of the dissertation and looks at conclusions and aspects of value for further research.

The writer attempts to show that similar programmes do fulfil a need and have a place in rehabilitation, and that the clinical social worker can make a major contribution.

SECTION I

UNDERSTANDING ASPECTS OF SCHIZOPHRENIA

Arieti (1979) sees the study of the condition as highly recommendable, as this enables the researcher to explore the richness and the creativeness of the human mind and spirit, and to the realization that the condition is not just a negative experience.

By studying schizophrenia

> ... we can examine in a unique way the great enigma of the human being, his eternal wavering between truth and illusion, his constant uncertainty between love and hate, his conflict between his desire to embrace his fellow man and his fear of him (Arieti, 1979:21).

By studying schizophrenia we also explore a world of imagination. Arieti feels that the normal person finds himself a prisoner of reality, while the schizophrenic becomes a fugitive from it. Strauss, Bowers and Keith (1984) are of the opinion that the patient reaches a threshold where the encounter with reality from his own internal autistic world becomes so painful that he/she tries to exclude reality from his/her actions and thinking.

As for the clinical social worker, the continuous study of the condition, which should be a career-long commitment, will enable her/him to fulfil the expected roles with competence but also with deep caring for the patient. The clinical social worker will be able to learn much from the patient himself, sharing this experience with somebody who cares deeply.

Now regarded as a functional disease, in other words a disease that causes impaired functioning in the individual (as will be discussed on pages 14 to

16) with possible changed or dysfunctional biochemistry, the outcome, with correct chemotherapy and other types of treatment and rehabilitation - can become more positive than in the days of Kraepelin.

An important change with regard to terminology in the revised DSM-III (1987), is the word "disturbance", replacing the word "illness" that was used previously. Through the years, many attempts have been made towards refining terminology and definition. At the beginning of this study it should, therefore, be worthwhile to highlight some relevant terminology to increase the understanding of the disturbance.

CHAPTER 1

1.1 RELEVANT TERMINOLOGY

"Dementia Praecox" means "madness of the young" and was first used by Emil Kraepelin in 1896. It was soon discovered, however, that not only young people were affected and that some did recover.

"Schizophrenia" replaced the above term in 1911, used by Eugen Bleuler (Gillis, 1986). Translated literally, schizophrenia means "split-mindedness", as Bleuler saw the splitting of the personality, rather than the outcome, as the most important characteristic of the condition (Kaplan & Sadock, 1985).

Gillis (1986) sees the term as complicated, because the illness or disturbance manifests itself in different stages. Acute presentations are, for example, different from the chronic state, while positive and negative symptoms also confuse, for example, the florid delusions, hallucinations and disturbed behaviour, on the one hand, and the dullness, inertia and withdrawal on the other.

Gelder, Gath and Mayou (1983) see the predominant clinical features in the acute phase as delusions, hallucinations and interference with thinking. Atkinson (1985) stresses the fact that the patient is very ill in this phase and that hospitalization usually is necessary. Chemotherapy is most important in this phase, to control the symptoms of the illness.

The consideration of "acute" or "chronic", therefore, has to do with the course of the illness. The main features of the chronic phase of the illness are seen to be apathy, lack of drive, slowness and social withdrawal. These often are called "negative symptoms" and seem to be related to poorer outcome (Gelder, Gath & Mayou, 1983). It can also be called "secondary symptoms", resulting from the sufferer's response to the acute attack. Delusional thinking or hallucinations may persist (Atkinson, 1986).

The DMS III-R (1987) makes a distinction between a period of at least six months duration but less than two years for sub-chronic conditions and a duration of more than two years for chronic conditions, when schizophrenia is diagnosed.

Other conditions that are sometimes confused with schizophrenia are:

Schizophreniform Disorder. According to Fox (1981) this term was coined by Langfelt and has been separated from the classification of schizophrenia because of research evidence that it may be associated with turmoil and confusion, as well as a better prognosis, a tendency towards acute onset and resolution, more likely recovery to premorbid level of functioning and no increased incidence of schizophrenia among family members. Schizophrenia and schizophreniform disorder are distinguished mainly by duration. The DSM III-R (1987) confirms the better prognosis and outcome, as well as the lack of evidence whether the condition is linked to schizophrenia or not.

Schizo-affective Psychosis. (In DMS II and DSM III-R it is referred to as Schizo-affective Disorder).

Procci (1976) emphasizes the controversy surrounding this term, first introduced by Kasanin in 1933. Kraepelin distinguished between the two conditions, "dementia praecox" (having a deteriorating course) and manic-depressive illness (with a better outcome), but this term was used when symptoms of both conditions were present, but mainly depressive. Some researchers like Kolb (1973) and Lehman (1975) saw a close link to schizophrenia. DSM I and II also favoured this approach. Others saw a closer link to manic-depressive illness, like Klein and Davis (1969).

Fox (1981) indicates that the lack of criteria in the DSM III with regard to this condition was because researchers could not reach any consensus with regard to definition.

The DSM III-R (1987) emphasizes the fact that this concept presented one of the most controversial aspects of psychiatric nosology. It emphasizes the temporal relationship of schizophrenic and mood symptoms and recommends that the term be changed to "Schizomood Disorder" (DSM III-R, 1987:209).

The DSM III-R also has diagnostic criteria for the disorder. These will be highlighted later.

1.2 DEFINITION

Many researchers stressed the difficulty with regard to defining schizophrenia, for example, Carpenter and Strauss (1974), Gelder, Gath and Mayou (1983), Gillis (1986).

Arieti defines the condition as

> ... an abnormal condition of the mind that affects only human beings; drastically changes their modes of thinking, feeling and dealing with the world; makes

> them confuse fantasy with reality and lead them to maladaptive ways of living (Arieti, 1979:22).

According to Fox (1981), DSM III regards schizophrenia as a mental disorder with a tendency towards chronicity, which impairs functioning and which is characterized by psychotic symptoms involving disturbances of thinking, feeling and behaviour.

The definition, according to the DSM III, serves a number of goals:

- to improve reliability in diagnosis
- to reflect research findings to relate diagnosis more closely to prognosis and treatment
- to minimize the stigma of labelling
- to achieve clinical acceptability while reducing differences with European colleagues.

(The definition according to DSM III-R (1987) has been revised and will be given later under diagnostic criteria).

Atkinson (1985) stresses the fact that the condition can be seen as a psychosis, where the disturbance occurs in the functioning of the individual without the presence of organic causes. She then gives a description of the condition, according to the following symptoms;

1.2.1 <u>Disorders of Thought</u>

1.2.1.1 Disturbances in the <u>form</u> of thought;

1.2.1.1.1 Associations (unusual or illogical associations between words which makes it difficult to understand the patient)

1.2.1.1.2 Concrete thinking (inability to think in abstract terms and patients are often, for example, unable to explain proverbs abstractly)

1.2.1.1.3 Grammatical distortions (changing of the order of speech)

1.2.1.1.4 Poverty of speech (vagueness and lack of detail in speech)

1.2.1.1.5 Autistic thinking (personal ideas, themes or associations intrude into the logical sequence of thought)

1.2.1.1.6 Disturbances of expression, in the form of word salad, neologisms and thought blocking. (Word salad is the use of a steam of disjointed, unrelated words expressed verbally or in writing, which makes no sense; neologisms are words made up by the patient that nobody else understands; thought blocking is the sudden halts in the thinking process and the experience of "blankness").

1.2.1.2 Disturbance in <u>Content</u> of thought:

1.2.1.2.1 Delusions - Primary and Secondary (a false belief held by the individual which is unacceptable to everybody else and cannot be changed by reason or argument)

(a) Thought insertion (the patient believes that thoughts are put into his head by an outsider/agency)

(b) Thought withdrawal (the experience of losing of thoughts, without the patient's co-operation)

(c) Thought broadcast (the patient's experience of the broadcast of his thoughts to others)

(d) Delusions of control (the patient's experience of being controlled by outside forces)

(e) Ideas of reference (everyday events are experienced as having special meaning, for example, a telephone call at a certain hour can be experienced as a warning)

1.2.1.2.2 Insight (the patient lacks insight into his condition and will, for example, not realize that he needs treatment).

1.2.2 <u>Disturbance of Perception</u>

1.2.2.1 **Hallucinations** (the patient's experience of something without appropriate, relevant or adequate sensory stimulation)

1.2.2.1.1 Auditory: audible thoughts, voices conversing, voices commenting

1.2.2.1.2 Visual hallucinations (things or people are seen that are not physically present)

1.2.2.1.3 Tactic hallucinations (the patient's experience of painful or unpleasant sensations)

1.2.2.1.4 Olfactory hallucinations (the patient's experience of a smell which does not really exist)

1.2.3 Disorder of Attention (problems in concentration, for example, to finish tasks)

1.2.4 Disorder of Volition (the loss of motivation)

1.2.4.1 Somatic passivity (the patient may experience an inteference in his functioning by some outside agency)

1.2.4.2 Alien control (the patient may experience that his thoughts, feelings or activities are being controlled)

1.2.4.3 Negativism (doing the opposite of what he is asked to do or what he intends to do).

1.2.5 Motor Disorder

1.2.5.1 Catatonia (the patient may remain in rigid, bizarre positions for long periods, for example, standing on one leg)

1.2.5.2 Mannerisms and Posturing (for example, facial grimaces or ritual movements)

1.6 Disorder of Emotion
1.6.1 Flat affect (little or no emotion is expressed)

1.6.2 Emotional incongruity (inappropriate mood, for example, the patient may laugh while telling one of his unhappiness).

1.7 Disturbances in interpersonal relationships (withdrawal from relationships, or isolation)

The above description from Atkinson (1985) is worthwhile studying, as it gives a good indication of the many areas of human functioning that can be influenced by the condition. Impairment usually takes place in the abovenamed functions of the individual. (Not all patients are affected in the same way. For example, some may experience more impairment in their social functioninhg, while others may have major motivation or concentration problems).

Many attempts have been made over the years to define and redefine the condition in order to improve diagnostic endeavours and treatment.

1.3 INCIDENCE, PREVALENCE AND MORTALITY IN SCHIZOPHRENIA

The incidence rate is the number of new cases that appears in a given population within a given period, while the prevalence rate is the number of cases divided by the total number of persons surveyed within a year.

Gillis stresses the fact that schizophrenia occurs amongst all races and in all parts of the world, manifesting itself in different ways because of cultural differences. He gives an overall incidence rate of 0,6% of the population (Gillis, 1986:73). Kaplan and Sadock see the incidence rate as 1 per 1 000 of the population. For the age group 15 and over, the rates are given from 0,30 per 1 000 to 1,20 per 1 000 (Kaplan and Sadock, 1985:194) (United States figures). The revised DSM III gives a rate of between 0,2% to 1% for Europe and Asia (DSM III-R, 1987:192).

Incidence and prevalence rates are influenced by diagnostic criteria and various high rates were found in the past which researchers felt were perhaps unreliable because of different criteria used before. (Incidence rates as high as 9,0 per 1 000 were, for example, found in Denmark by Fremming in 1951, acording to Gelder, Gath and Mayou (1983)).

Wing (1978a) points out that schizophrenia can begin at any age, but the onset is commoner amongst younger age group. The risk period is between 20 to 39 years. Males tend to be younger at the time of onset - more often before 34 years of age. Over the age of 35, women are more likely to develop schizophrenia than men (Tsuang, 1982).

Mortality

Kaplan and Sadock (1985) stress the fact that mortality amongst schizophrenics is high because of the high incidence of suicide. In about 1% of cases they might mutilate their bodies, for example, cutting of parts of their bodies.

Suicide is a tragic and real danger, and it may occur without clear warning. The patient may feel depressed or he may react on the commands he receives from hallucinatory voices.

Suicide rates can be as high as 4% (Kaplan and Sadock, 1985:214) in a group of schizophrenics, and the most significant factor is said to be the patient's experience of rejection. This can be the most traumatic stressor for schizophrenics.

Allebeck and Wistedt (1986:50) note that suicide mortality can be ten times higher among male schizophrenics, and 18 times higher among female schizophrenics, than it is in the general population.

The most crucial time when the patient considers suicide is, apparently, during the early stage of the illness, when neither the patient nor his family members are aware of the onset of the illness. The patient usually does not understand what is happening to him, while his parents or relatives may be either unaware of his inner struggles or blame him for his symptoms (Kaplan and Sadock, 1985).

1.4 CONTRIBUTIONS OF THE EARLY RESEARCHERS WITH REGARD TO DIAGNOSIS AND DIAGNOSTIC CRITERIA

Gelder, Gath and Mayou (1983) point out that it was believed in the 19th century that only one psychosis existed, the so-called "Einheit psychose", as it was called by Griesinger. All mental disorders were seen as expressions of this condition.

Morel (1860) recommended a classification system based on cause, systems and outcome. In 1862 the name démence précoce was given to a disorder which he described as starting in adolescence and leading first to withdrawal, odd mannerisms, self-neglect and eventually to intellectual deterioration. Kahlbaum (1874) described catatonia, and Hecker (1871) wrote an account on a condition he called hebefrenia. It is clear that different types of the condition had been already identified at that stage.

Emil Kraepelin (1855-1926)

Gillis (1986), as well as Gelder, Gath and Mayou (1983), point out that Kraepelin argued against the idea of a single psychosis and suggested the distinction between organic and functional psychosis. The latter he divided into dementia praecox and manic-depression. He regarded hebefrenia and catatonia as subclasses of dementia praecox, and eventually distinguished four sub-types, namely, catatonic, hebefrenic, paranoid and simple (Gelder, Gath and Mayhou, 1983; Kaplan and Sadock (1985). He separated paraphrenia from dementia praecox on the grounds that it started in middle life and was thought to be free from the changes in emotion and volition found in dementia praecox.

Although Kraepelin saw **dementia praecox** as progressing to chronic deterioration, he did report 13% complete recovery of the condition and 17% improvement (these patients could live in the community successfully).

Eugen Bleuler (1857-1939)

Gelder, Gath and Mayou (1983) stressed that Bleuler founded his work on Kraepelin's, also acknowledging the work of Carl Jung. Bleuler was the director of Burghölzli Clinic and Professor of Psychiatry in Zürich. He first used the term schizophrenia in 1911, focusing less on prognosis, but emphasising the splitting of the psychic functions that he saw as being of main importance in the condition.

Where Kraepelin failed to stress the importance of the experience of the patient, this was emphasized by Bleuler (Kaplan and Sadock, 1985). His main contribution was the introduction of a hierarchy of symptoms to replace the mere description of clinical phenomena. He had a more optimistic view with regard to outcome, but felt that there was no cure, merely improvement of the condition.

The contributions of the following researchers are briefly mentioned, according to Gelder, Gath and Mayou (1983):

Kurt Schneider (1887-1967)

Schneider identified symptoms which he called "symptoms of the first rank", namely, hearing thoughts spoken aloud, third person hallucinations, hallucinations in the form of commentary, somatic hallucinations, thought withdrawal (or insertion), thought broadcasting, delusional perception, feelings or actions experienced as made or influenced by others.

Karl Kleist (1929)

Kleist accepted Karepelin's main diagnostic framework and tried to distinguish various subdivisions within schizophrenia. He attempted to match these sub-types with specific kinds of brain pathology.

Leonhard (1957)

Leonhard distinguished two subgroups of schizophrenia:

(a) Systematic (catatonias, hebephrenias and paraphrenias).

(b) Non-Systematic (affect-laden paraphrenia, schizophasia and periodic catatonia).

Scandinavian psychiatrists have been influenced by Jaspers' distinction between process schizophrenia and reactive psychoses. In the late 1930's, Langfeldt suggested a distinction between true schizophrenia (with a poor prognosis) and schizophreniform states (with a good prognosis).

Zubin and Steinhauer (1981) stress that the more recent researchers, like M. Bleuler (son of Eugen Bleuler), have a more optimistic view with regard to outcome. In a 1979 research study of 208 schizophrenic patients, Bleuler found that many could live outside hospital. 30% of re-admissions were the result of socio-economic reasons and not psychiatric relapses. Other researchers who share the view of a more positive outcome are Wing (1978a) and Atkinson (1985, 1986).

By the late 1960's there were different diagnostic systems for different countries: in Britain and continental Europe, psychiatrists used Schneider's approach to diagnosis, while in the United States of America a wider basis existed for diagnosis.

Some criteria which were used for diagnosis in the past are:

Cross-Sectional - Schneider's first rank symptoms were used in Britain, leading to high reliability in diagnosis but not to effective outcome-prediction. It was also found that these symptoms could also be present in mania and depressive-disorder.

Other cross-sectional definitions of schizophrenia can be found in ICD 9 and CATEGO (the research diagnostic system where schizophrenia is mainly diagnosed on the symptoms of thought intrusion - broadcast or thought withdrawal, delusions of controlling voices discussing the patient in the third person or commenting on his actions).

Longitudinal Criteria - Research Diagnostic Criteria (RDC) were developed from the Feighner criteria (which were developed at Washington University, St Louis, and include both longitudinal and cross sectional criteria). The criteria used in DSM III were developed from those of the Feighner and Research Diagnostic systems. (Not only is the presence of symptoms significant but so is the patient's level of functioning after stabilization of the condition, as well as the length of time required for stabilization of the condition).

Present classification systems and diagnostic systems have, therefore, developed as a result of the contributions of many researchers over a long period of time.

1.5 DIAGNOSTIC CRITERIA AND TYPES OF SCHIZOPHRENIA

The importance of correct diagnosis can never be emphasized enough. It is not only of absolute importance for treatment interventions (Atkinson,

1986) but also because it affects the patient's response to treatment and his behaviour. The patient may not only take over a "sick role", but will expect others to treat him likewise.

Pope and Lipinski (1978) emphasize that mis-diagnosis may expose large numbers of patients to increased social stigma, potentially irreversible neuroleptic damage due to overuse of neuroleptic drugs, or even death.

Although diagnosis is not regarded as a primary task of the clinical social worker, her/his contribution in a therapeutic team is of the utmost importance. The obtaining of collateral and a history of the illness from as many significant others as possible is an area where the clinical social worker can often make a contribution, to ensure that the correct diagnosis is made.

The distinction between schizophrenia and other illnesses is not always easy, and Pope and Lipinski (1978) indicate that many of the Schneiderian first-rank symptoms were reported in 20% to 50% of patients with bipolar affective illness.

Kaplan and Sadock (1985) point out that the presence of hysterical symptoms can often colour the clinical picture, especially during the acute phase. This can complicate the process of diagnosis. Other phenomena which can be regarded as problematic are obsessive symptoms that can be present.

The following considerations are important in making a meaningful contribution towards the distinction between schizophrenia and other psychiatric illnesses:

- the clinical social worker should be acquainted with the diagnostic criteria of other possible conditions, for example, bipolar-affective illness, schizophrenoform-disorder and schizo-affective disorder. In this regard the DSM-III-R (1987) is an important source of information

- collateral about the symptoms of the first onset of the condition, duration of previous relapses, the level of functioning after the stabilization of the condition, the type of medication the patient best responded to and other relevant information can be obtained from the family and significant others, and will be informative when decisions relevant to diagnosis are being made

- in the case of the first onset, it is important that sufficient time be allowed when considering the different diagnostic options, for example, in the case of schizophrenia where a period of six months' duration is required.

It is relevant for the clinical social worker to know the diagnostic criteria for schizophrenia as well as schizo-affective disorder, as this will improve her/his observational skills. She/he often finds it important in the educative role, when families and relatives have to be informed about the illness.

In the past, educating relatives and patients about the illness was greatly neglected. McGill, Falloon, Boyd and Wood-Siverio (1983) see this as being due to the fact that there was often diagnostic uncertainty amongst the professionals themselves. The fact that diagnostic criteria are often revised, for example, DSM III-R (1987), can be seen as a positive step towards the refining of diagnostic interventions.

Diagnostic criteria for schizophrenia, according to DSM III-R (1987) (1987:194-195) are as follows: (These are taken directly from the revised DSM-III as they are the most recent, now also being used at Stikland Hospital.)

A. Presence of characteristic psychotic symptoms in the active phase: either (1), (2) or (3) for at least one week (unless the symptoms are successfully treated):

  (1) Two of the following:

    (a) delusions

    (b) prominent hallucinations (throughout the day for several days, or several times a week for several weeks, each hallucinatory experience not being limited to a few, brief moments)

    (c) incoherence or marked loosening of associations

    (d) catatonic behaviour

    (e) flat or grossly inappropriate effect.

  (2) Bizarre delusions (i.e. involving a phenomenon that the person's culture would regard as totally implausible, for example, thought broadcasting, being controlled by a dead person)

  (3) Prominent hallucinations (as defined in (1)(b) above), of a voice with content having no apparent relation to depression or elation, or a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

B. During the course of the disturbance, functioning in such areas as work, social relations and self-care is markedly below the highest level, achieved before onset of the disturbance (or when the onset is in childhood or adolescence, failure to achieve the expected level of social development).

C. Schizo-affective Disorder and Mood Disorder with Psychotic Features have been ruled out (i.e. if a Major Depressive or Manic Syndrome has ever been present during an active phase of the disturbance, the total duration of all episodes of a mood syndrome has been brief, relative to the total duration of the active and residual phases of the disturbance).

D. Continuous signs of the disturbance for at least six months. The six-month period must include an active phase of at least one week (or less if the symptoms have been successfully treated), during which there were psychotic symptoms characteristic of schizophrenia (symptoms in A above), with or without a prodromal or residual phase, as defined below:

Prodromal phase: a clear distinction in functioning before the active phase of the disturbance that is not due to a disturbance in mood or to a Psychoactive Substance Use Disorder, and that involves at least two of the symptoms listed below.

Residual phase: following the active phase of the disturbance, persistence of at least two of the symptoms noted below, these not being due to the disturbance in mood or to a Psychoactive Substance Use Disorder.

Prodromal or Residual Symptoms:

(1) Marked social isolation or withdrawal

(2) Marked impairment in role functioning as wage earner, student or home-maker

(3) Marked peculiar behaviour (for example, collecting garbage, talking to self in public, hoarding food)

(4) Marked impairment in personal hygiene and grooming

(5) Blunted or inappropriate effect

(6) Digressive, vague, over-elaborate or circumstantial speech, or poverty of speech, or poverty of content of speech

(7) Odd beliefs or magical thinking, influencing behaviour and inconsistent with cultural norms, for example, superstitiousness, belief in clairvoyance, telepathy, "sixth sense", "others can feel my feelings", overvalued ideas, ideas of reference

(8) Unusual perceptual experiences, for example, recurrent illusions, sensing the presence of a force or a person not actually present:

(9) A marked lack of initiative, interests or energy. Examples: Six months or prodromal symptoms with one week of symptoms from A; no prodromal symptoms with six months of symptoms from A; no prodromal symptoms with one week of symptoms from A and six months of residual symptoms.

E. It cannot be established that an organic factor initiated and maintained the disturbance

F. If there is a history of Autistic Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present.

The early researchers have already distinguished between different types of schizophrenia. The following types are given according to the revised DSM-III-R (1987).

TYPES OF SCHIZOPHRENIA

According to the DSM III-R (1987), diagnostic criteria are as follows for the various types of schizophrenia:

Disorganized Type: DSM III-R (1987:197)

A type of schizophrenia in which the following criteria are met:

A. Incoherence, marked loosening of associations, or grossly disorganized behaviour

B. Flat or grossly inappropriate effect

C. Does not meet the criteria for catatonic type

Catatonic Type: DSM III-R (1987:196)

A type of schizophrenia in which the clinical picture is dominated by any of the following features:

A. Catatonic stupor (marked decrease in reactivity to environment and/or reduction of spontaneous movements and activity) or mutism

B. Catatonic negativism (an apparently motiveless resistance to all instructions or attempts to be moved)

C. Catatonic rigidity (maintenance of a rigid posture against efforts to be moved)

D. Catatonic excitement (excited motor activity, apparently purposeless and not influenced by external stimuli)

E. Catatonic posturing (voluntary assumption of inappropriate or bizarre posturing).

Paranoid Type: DSM III-R (1987:197)

A type of schizophrenia in which there are:

A. Preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme

B. None of the following: incoherence, marked loosening of associations, flat or grossly inappropriate effect, catatonic behaviour, grossly disorganized behaviour.

Undifferentiated Type: DSM III-R (1987:198)

A type of schizophrenia in which there are:

A. Prominent delusions, hallucinations, incoherence, or grossly disorganized behaviour

B. Does not meet the criteria for any of the previously listed types, or meets the criteria for the Paranoid, Catatonic or Disorganized type.

Residual Type: DSM III-R (1987:198)

A. Absence of prominent delusions, hallucinations, incoherence or grossly disorganised behaviour

B. Continuing evidence of the disturbance, as indicated by two or more of the residual symptoms listed in criteria D of schizophrenia.

1.6 SCHIZO-AFFECTIVE DISORDER

Included in the revised edition of the DSM III (DSM III-R, 1987) are now, for the first time, also diagnostic criteria for schizo-affective disorder. In the 1980 edition there was no consensus about this aspect, and no criteria were given. These criteria are quoted directly, as they are of importance for this study. In the Neuro B programme, treatment and rehabilitation interventions focus on patients who suffer from the impairment caused by both the conditions (schizophrenia and schizo-affective disorder).

According to the DSM III-R (1987:210), these criteria are:

A. A disturbance during which, at some time, there is either a Major Depressive or a Manic Syndrome concurrent with symptoms that meet the criterium of schizophrenia

B. During an episode of disturbance, there have been delusions or hallucinations for at least two weeks, but no prominent mood symptoms

C. Schizophrenia has been ruled out, i.e. the duration of all episodes of a mood syndrome has not been brief relative to the total duration of the psychotic disturbance

D. It cannot be established that an organic factor initiated and maintained the disturbance.

When the diagnosis is made, the diagnostician can specify whether it is a bipolar type (current or previous Manic Syndrome) or depressive type (no current or previous Manic Syndrome).

The Neuro B Programme, Stikland Hospital, which will be discussed in greater detail later, mainly focuses on the patient who falls within the chronic group. This is the patient who has passed the active, acute phase of the illness and who falls within the group described as suffering from residual symptoms (see the section on Residual Symptoms of the Classification Criteria for Schizophrenia, as given).

These patients suffer from impairment in some aspects of their functioning (for example, lack of drive and concentration), as a result of continued relapse of the illness. In the past these patients were confined to chronic wards of psychiatric hospitals for the rest of their lives, but with the new trend in treatment and rehabilitation these patients can now be prepared to resume their lives optimally outside the hospital.

Diagnosis remains complicated and diagnostic interventions often differ from one psychiatric hospital to another, while psychiatrists also differ in opinion amongst themselves. The result is that a patient may be diagnosed differently by several psychiatrists, adding to her/his confusion with regard to her/his illness, and complicating her/his response to treatment. The clinical social worker has a major contribution here, to report various aspects of the clinical picture, using her/his observation skills. Obtaining information about the patient's behaviour and functioning in the past will add to a more accurate diagnosis being made, and will facilitate effective planning for treatment.

CHAPTER 2

AETIOLOGY

Through the years, many theorists and researchers have contributed towards the search for causes of schizophrenia. Zubin and Steinhauer (1981) describe the following six models in terms of which aetiology was studied:

1. Learning Theory (ineffectual social and interpersonal relationships)
2. Ecological (socio-economic and minority status)
3. Internal Environment (biochemistry and psycho-pathology)
4. Developmental (factors like attachment, socialization, prenatal complications, nutritional deprivations, season of birth)
5. Genetic (dysfunctional chromosomes).
6. Neurophysiological (emphasis on the study of functioning of the brain of the schizophrenic).

2.1 LEARNING THEORY MODEL AND THEORIES OF SCHIZOPHRENIA

Some of the research efforts in the learning theory model resulted in the fact that many parents and relatives felt guilty about the illness of their offspring/family, as the research mainly concentrated on finding the cause of schizophrenia in ineffectual social and interpersonal relationships. In the 1960's, when these research findings were prevalent, the goals of interviewing family members focussed very specifically on finding the causes of the illness in the family. Social workers at that time were no exception, adding to the experience of families that they might be responsible for the illness of their offspring. Two very controversial theorists who shared this opinion were Cooper and Laing. (Theorists like Szasz also shared this opinion but only Cooper and Laing's approaches will be highlighted because of their controversial stances).

The stance which these latter theorists took is seen as totally different from the conventional or medical approach, where schizophrenia is regarded as an illness, where the diagnosis of symptoms is important to establish the prognosis and treatment interventions. Within this conventional approach, schizophrenia is seen as caused by the interaction of several contributing factors, for example, biochemical, structural, genetic and social gestures.

Cooper and Laing, however, see schizophrenia as an experience which is the result of faulty relationships, especially within the family. Cooper (1967) sees it as an inability to develop through the normal social learning life situations and a regression to a state of insanity.

He defines schizophrenia as follows:

> Schizophrenia is a micro-social crisis situation in which the acts and experience of a certain person are invalidated by others for certain intelligible cultural and micro-cultural (usually familial) reasons, to the point where he is elected and identified as being "mentally ill" in a certain way, and is then confirmed (by a specifiable but arbitrary, labelling process) in the identity schizophrenic patient by medical or quasi medical agents (Cooper, 1967:2).

Laing, according to Siegler, Osmond and Mann, defines schizophrenia as follows, within his conspirational model. (It is referred to as Laing's conspirational model as he (Laing) believes that parents and professionals "conspire" to get the patient into hospital).

> Schizophrenia is a label which some people pin on other people, under certain social circumstances. It is not an illness, like pneumonia. It is a form of alienation which is out of step with the prevailing step of alienation. It is a social fact and a political event (Siegler, Osmond & Mann (1969:948)).

Within his psychodelic model, Laing defines schizophrenia as:

> ... a natural way of healing our own appalling state of alienation called normality. Madness need not be all breakdown ... It may also be breakthrough. It is potentially liberation and renewal as well as enslavement and existential death. It is not an illness to be treated, but a "voyage". Socially, madness may be a form in which often ... through quite ordinary people, the light begins to break through the cracks in our all-too-closed minds (Siegler, Osmond & Mann, 1969:953).

Cooper (1967) sees the aetiology of the condition in the system of relationships in which the labelled person participates, while Laing, according to Siegler, Osmond and Mann (1969), recommends the studying of the social system to find the cause of the condition.

These psychiatrists' views with regard to treatment, staff members and the hospital added to their controversy. Cooper (1967) feels that the mental hospital often extends and reduplicates the faulty interrelationships of the family, and he sees the hospital as another societal institution where individual personalities are "murdered", and where only "bodies are cared for" (Cooper, 1967:97). Laing, according to Siegler, Osmond and Mann, sees the hospital as a place where human beings are humiliated and invalidated. Cooper sees staff as also being indoctrinated into the tactics to humiliate patients and to violate their rights. Laing emphasizes the "conspiracy" of staff with the family to get the patient to treatment (Siegler, Osmond & Mann, 1969:948).

Treatment is regarded by Laing (according to Siegler, Osmond & Mann, 1969) as the process whereby the patient changes his subjective experential perspective to that of the objective view of the therapist.

Chemotherapy is of no importance and is only used to relieve symptoms.

These psychiatrists also objected to the fact that psychiatric patients did not have rights.

> The "committed" person, labelled as patient and specifically as "schizophrenic", is degraded from full existential and legal status as human agent and responsible person to someone no longer in possession of his own definition of himself, unable to retain his own possessions, precluded from the exercise of his discretion as to whom he meets, what he does (Siegler, Osmond & Mann, 1969:948).

Other contributors within the learning theory model are:

1. Fromm-Reichmann (1948). The mother's attitude was described by Fromm-Reichmann as overprotective, hostile and characterized by an inability to understand her children's feelings. She coined the term "schizophrenogenic mother", and it was believed that these types of attitudes could cause schizophrenia, as the child never matured emotionally. Tsuang (1982) emphasized that it was not taken into account that these mothers could have developed this attitude as a result of the child's illness. Arieti (1979) stresses that adverse assessments of the mothers of schizophrenics were made during a time when drastic changes occurred in the sociological role of women in general. It was a period which immediately preceded the women's liberation era, when women experienced difficulty in remaining submissive while at the same time wanting to assert their equality. Arieti (1979) feels that no mother can cause

schizophrenia in her child as the child also experiences his circumstances in his own unique way. Childhood experiences, and particularly the mother-child relationship, are only aspects of a whole life.

2. <u>Bateson, Jackson, Haley and Weakland</u> (1956) introduced the concept of the double-bind. These researchers focused on language and communication to be of primary importance within the families of schizophrenic patients. Bateson identified five ingredients of the so-called double-bind situation, of which the contradictory messages to which the child is exposed are regarded as being of main importance in the aetiology of communication deviances. Leff (1978) emphasizes that the patient is caught up in an intolerable situation where, whatever decision he makes, he will be punished. For example, this kind of interaction was believed to be linked with the poverty of speech syndrome or social withdrawal.

3. <u>Lidz, Cornelisen, Terry and Fleck</u> (1958). According to Leff (1978), these theorists identified two types of family structure which they considered to be of importance in the aetiology of schizophrenia:

    (a) The "Marital Skew" occurs when one parent yields to the abnormalities and eccentricities of the other. In these families the mothers are found to be the dominant figures, while the fathers are passive, providing a poor male identity figure. Mothers then turn to their sons for the emotional security which the husbands are unable to provide. These observations were mainly made in the families of male schizophrenic patients. Atkinson (1986) stresses the total inadequacy or excessive dominance of the parent.

(b) "Marital Schism". These marriages are characterized by conflict between the parents - each parent tries to fulfil his own needs and, in the process, competes for the child's support in the battle against the other parent. Tsuang (1982) commented that these families usually had a female child suffering from schizophrenia. Atkinson (1986) stresses here the coldness and hostility of the one parent and the destructiveness towards each other.

Leff (1978) and Tsuang (1982) commented, however, that the same characteristics were also found in families where patients had other psychiatric illnesses, or even in families with no psychiatric illnesses. It is also emphasized that Lidz only did research on a few families and that these characteristics were not found in schizophrenic families only.

4. <u>Wynne, Singer, Ryckoff, Day and Hirsh</u> (1958). Leff (1978) emphasizes that the term "pseudomutuality", which Wynne coined, focused on disjointed, fragmented and irrational patterns of interaction within the family of the schizophrenic. These dysfunctional patterns of interaction were thought to be causative of schizophrenia because of the influence on the cognitive development of the offspring within these families and eventually the development of the characteristic thought disorder of the schizophrenic. According to Wynn, there are feelings of meaninglessness, pointlessness and emptiness underlying these inabilities to communicate, and these attitudes are transmitted within these families.

Leff (1978) is of the opinion that these patterns, although present, could not be seen as the cause of schizophrenia. He stresses that the families who were studied were referred because of deviant communication, and it was logical that these patterns would be present in all the families.

Rund (1986) confirmed that communication deviance is an outstanding characteristic of schizophrenia families, but not the cause of the illness.

Theorists who contributed towards the description of the family interactional basis of schizophrenia are:
Bowen (1960, 1978); Haley (1959); Laing (1964, 1965); Scheflen (1978); Searles (1959); Polazolli (1978) and Whitaker (1978).

Hoover and Franz (1972), in their study of the siblings in the families of schizophrenics, could find no relation between family relationships and aetiology of schizophrenia.

Leff (1979) emphasizes the following aspects about the family:

(a) Many of the theories were not easily testable on a practical level, for example, the double-bind concept could not be easily defined and tested

(b) The theories fail to explain why the patient becomes ill, while a sibling remains well under similar adverse conditions

(c) It appears as if the theorists' views of schizophrenia have been determined by their theories of family pathology, rather than vice versa

(d) Studies often failed to take the precaution of blind interviewing. Often the diagnosis of offspring were known when comparisons took place between families with schizophrenic members and those without. Confounding was not always ruled out

(e) There was a lack of agreed definitions, e.g. "role", "dominance", etc. Researchers consequently did not always measure the same aspects of family interaction

(f) The vast majority of studies were involved with the study of families only after the member developed schizophrenia. This situation made the evaluation of relevant factors before onset very difficult.

Dell (1980) is of the opinion that the contribution of the family theorists should be seen in perspective. It should be taken into account that theorists like Bateson, Wynne and Singer did not propose a different aetiology of schizophrenia, but that they contributed to a redefinition of the condition. These theorists merely identified the patterns of communication, without claiming that they were causes. Dell feels that the contribution of these theorists could have been misunderstood in the past, and that a linear pattern of cause and effect within a family can hardly be studied.

2.2 THE ECOLOGICAL MODEL

Within the ecological model, it was thought that factors like socio-economic status, minority status and physical and social characteristics could be linked with the causes of schizophrenia.

Cooper (1978) mentions the research of Barry and Barry (1961) on social class while he, himself, is of the opinion that social isolation could not be found a cause of schizophrenia. Wender, Rosenthal, Kety, Schulsinger and Welner (1974) support the so-called "downward drift" hypothesis, where the higher rate of low socio-economic status amongst schizophrenics is seen as a consequence of their pathology. They sink lower in the social hierarchy because, socially, they become increasingly ineffectual. As far back as 1963, Goldberg and Morrison could not find any link between socio-economic deprivation and the causes of schizophrenia.

2.3 INTERNAL ENVIRONMENT MODEL

According to Zubin and Steinhauer (1981), the focus of the research within the internal environment model was on the biochemistry and psychopathology. Kety contributed much to research in the field of metabolic processes, synaptic mechanisms, hormones and the influence of these processes on perception, cognition, attention, motivation and other emotional conditions. Metabolic and biochemical factors could, however, not be singled out as causative of schizophrenia. This is also confirmed by Arieti (1979).

The transmethylation hypothesis was studied during this time. In 1959 it was discovered that a biochemical process occurs in the normal brain, whereby norepinephrine is changed to epinephrine. This process is called transmethylation. Many researchers were of the opinion that an abnormal change in this process could be linked with schizophrenia. Others thought that a deficiency in the brain of a substance called serotin could be linked with schizophrenia. Arieti (1979) stressed that none of these theories could provide that schizophrenia is caused by dysfunctional biological processes alone.

2.4 DEVELOPMENTAL MODEL

Zubin and Steinhauer (1981) also stress that developmental factors could not be singled out in the search for etiological factors. Factors like winter birth and cerebral injury after birth may play a role, but could not be singled out as being of sufficient causal meaning. This was also confirmed by De Lisi, Crow and Hirsch (1986), who reported on findings of the international biannual workshop on schizophrenia which was held in Austria in January 1986.

Baron and Gruen (1988) stress the greater incidence of winter births in individuals suffering from schizophrenia. They are of the opinion that a greater prevalence of viral infections might interact with genetic vulnerability, and that this could be a contributing factor that more schizophrenics tend to be born in winter. They could, however, not single this out as the cause of schizophrenia. It must, therefore, be concluded that the developmental model has also not yet produced definite results in the search for causes.

2.5 GENETIC MODEL

Much research was done in the genetic field and the genetic model is seen as the most advanced of the six models, according to Zubin and Steinhauer (1981).

The fact that the offspring of schizophrenics are at risk was supported by Hanson, Gottesman and Heston (1976), and by Haier, Rosenthal and Wender (1978) in their study of adopted-away offspring of schizophrenics. Heston (1966) also supports the genetic link with schizophrenia, as well as Marcus, Auerbach, Wilkinson and Burack (1981).

Arieti (1979), as well as Gottesman and Shields (1982), are of the opinion that geneticists were not able to determine Mendelian laws in schizophrenia. (A Mendelian law describes a pattern of transmission of hereditary traits, as originally defined by Gregor Mendel, a monk). In terms of this law, traits are transmitted by genes, but Gottesman and Shields (1982) emphasized that no simple recessive or dominant gene theory for the transmission of schizophrenia could be proven through research. No individual schizophrenia-related gene has yet been identified, according to these authors.

According to Arieti (1979), a child has a 4% to 10% risk of developing schizophrenia with a parent or sibling suffering from the condition. In identical twins the chances are 40 times greater that the other twin will also develop schizophrenia.

He emphasizes, however, that whatever genetic factors operate in schizophrenia, they only provide a biological disposition for the illness. If genes carry this predisposition, these genes must be activated by other factors to develop the illness. No combination of genes has been found that could explain the distribution of schizophrenia in families.

Many families/parents have questions about the genetic transmission of the illness. Stancer and Wagener (1984) suggest that the clinician (and in many cases it will be the clinical social worker) should provide the family with information. They then can decide whether to be referred to a geneticist for an expert opinion.

2.6 THE NEUROPHYSIOLOGICAL MODEL

The neurophysiological model focuses on the study of the functioning of the brain in an effort to find the cause of schizophrenia. Research of importance is:

Gur (1977) found a link between left hemisphere dysfunction (left temporal lobe) and schizophrenic-like symptoms, and it can possibly account for the prevalence of thought disorder in schizophrenia. He confirmed this again in later studies (1979).

According to Gur, Flor-Henry (1976) had already confirmed left temporal lobe abnormalities in a comparison of EEG's of schizophrenics, manic-depressives and controls. Another study mentioned by Gur is that of Inguar and Franzen (1974), where abnormalities in the blood supply to the left hemisphere seem to be prevalent in some schizophrenics.

Baumont and Dimond (1973) found a possibility of articulation dysfunction between the two hemispheres of the brain, resulting in change in the efficiency of the corpus callosum (also confirmed by Strauss, Bowers and Keith (1984)).

Weinberger, Bigelow, Kleinman, Klein, Rosenblatt and Wyatt (1980) confirmed the presence of ventrical enlargement in the brains of some schizophrenics.

These researchers also name the following researchers who confirmed structural abnormalities: Johnstone, Crow, Frith and colleagues (1976); Weinberger, Torrey, Neophytides and others (1979); Weinberger, Torrey and Wyatt (1979).

Another group of researchers who confirmed that there are primary structural deficits in some schizophrenics (in and around the anterior area of the left hemisphere) is Golden, Graber, Coffman, Berg, Newlin and Block (1981).

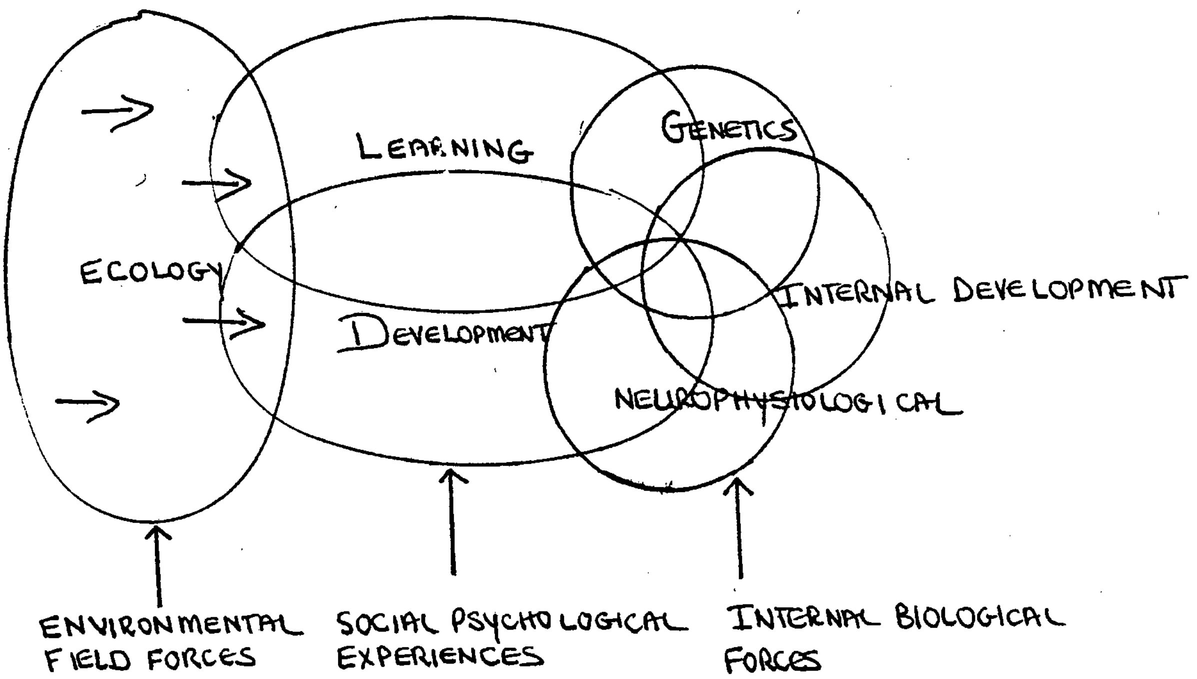
Cadet (1984) stresses the disorders of the isodendritic core of the brainstem.

That structural and functional abnormalities in the brains of some schizophrenics are present, is also confirmed by Anthony and Liberman (1986) who emphasize the research of Weinberger and Kleinman (1986). A more recent study by Pakkenberg (1987) confirmed reduced volumes of the total brain, cortex and central grey matter, as well as enlarged ventricles in the brains of schizophrenics.

Despite all the research, no single model could be seen as contributing towards a single cause for schizophrenia.

Zubin and Steinhauer (1981:478) present the following figure to summarise the various models and to demonstrate the interrelationship:

FIGURE 2.1: ZUBIN & STEINHAUER



Between the two poles of the genetic model and the ecological model, the internal environment and the neurophysiological models lean towards the genetic, while the learning theory and developmental models lean towards the ecological.

2.7 VULNERABILITY MODEL (VULNERABILITY-STRESS-COPING-COMPETENCE MODEL)

Zubin and Steinhauer (1981) also mention a seventh model, as none of the previously mentioned models could provide a sufficient cause with regard to aetiology. This model, the vulnerability model, integrates the contributions of each oof the others and provides for their interaction. Within this model, it is emphasized that no single factor in itself may cause schizophrenia, but the interaction among factors may be a predisposition. Such an individual may sometimes never develop an episode, depending on the degree of his/her vulnerability, type and degree of life events, and moderating variables present like social networks, premorbid personality and the physical, social and cultural factors within the environment.

With regard to the degree of vulnerability of a person, two types of vulnerability can be distinguished. Inborn vulnerability depends on elements from the genetic, neurophysiological and internal environment milieus, while acquired vulnerability represents the influence of prior experience (factors from the ecological, developmental and learning theory milieus are here seen as important). Some traumatic experiences may, therefore, influence some individuals, while others may not.

As far as triggering events are concerned, according to Zubin and Steinhauer (1981) these can be every day events which can lead to a crisis, and are not always dramatic incidences.

Another important group of factors is found in the environment of the individual, for example, the social support systems, the networks, or the family members. Also important within this model are the premorbid coping skills of the individual. Premorbid competence may be high or low, depending upon the degree of vulnerability and the presence of triggering events.

This model assumes that the patient is not condemned to a life of disability and degeneration. Schizophrenia is regarded as episodic and some patients then come through these episodes and can continue their life, while others would be entering other episodes. Within this model, the idea of rehabilitation becomes very important and patients can then be prepared effectively for life after discharge from hospital.

The model has been extended and is now called the Vulnerability-Stress-Coping-Competence model (Anthony and Liberman, 1986). The complex interaction between the various factors are taken into account, but the patient can be protected by several factors like the coping and competence which he/she can obtain through rehabilitation programmes which provide skill building and a supportive environment. Antipsychotic medication remains important.

If stressors can be identified in advance, rehabilitation interventions could be planned more effectively. The research of Vaughn and Leff (1976) and those of Brown, Birley and Wing (1972), as well as those of Brown and Birley (1968) and Birley and Brown (1970), then become very important. They found that schizophrenic patients are particularly responsive to their social environment. They identified the so-called high EE families and low EE families. The atmosphere in the high EE families were influenced by a high incidence of critical comments, hostility and emotional over-involvement when the illness of the patient was under discussion by relatives or families. Research by Tarrier, Vaughn, Lader and Leff (1979) also confirmed these findings and the possibility of relapse, should schizophrenics live under these circumstances.

Sturgeon, Kuipers, Berkowitz, Turpin and Leff (1981) also confirmed these findings and stress that the patients living in these circumstances experience a chronic state of high arousal that can be linked with relapse.

According to Arieti (1979), the stress threshold which must be crossed before a relapse occurs is different for each person and vulnerability cannot always be detected effectively. Certain experiences can be extremely stressful for some, while not affecting others at all. Not only over-stimulation in the environment can influence the schizophrenic, but also understimulation, and a relapse can be precipitated by boredom and a lack of meaningful activities.

With regard to research over the years concerning aetiology, Strauss, Bowers and Keith (1984) come to the following conclusions:

- No single genetic factor or triggering experience could be linked with the causation of the condition
- The interaction of various factors like biological, chemical, genetic, psychological and environmental can cause a predisposition for the condition to develop.

The therapeutic team at the Neuro B Clinic, of which the writer is a member, shares the opinion that schizophrenia is an illness, caused by the complicated interaction of dysfunctional bio-physiological, neuro-chemical processes in the brain of the individual, and is influenced by sociological, psychological, environmental and genetic factors which can determine the course of the illness.

The team agrees with Gillis (1986) about the deteriorating course of the illness for most patients, and that it can cause impairment in the functioning of the individual over a wide spectrum of his life. Arieti's (1979) opinion is shared that relapses of the illness should be avoided at all cost, as every relapse can cause further impairment.

The medical model approach of Beels and McFarlane (1982) is found useful, whereby schizophrenia is seen as a collection of psychiatric syndromes that occur in vulnerable individuals. Diagnosis is very important and chemotherapy is vital in the acute phase, to stabilize the patient, and in the chronic phase to maintain the patient's condition. Without chemotherapeutic intervention the patient will be unable to benefit from other treatment modalities, as the symptoms of the illness then interfer with his functioning (Kaplan & Sadock, 1985, Anthony & Liberman, 1986).

Factors from all the models, as given by Zubin and Steinhauer (1981), are taken into account. The team agrees with Arieti (1979) that the predisposition to develop the condition can be transmitted genetically. The opinion is shared that individuals suffering from schizophrenia are very vulnerable and very sensitive to stimuli from their environment. It is, therefore, important that stimuli from the environment should be monitored, depending on how every individual is uniquely influenced. In this regard the research of the systems and communication model which brought the importance of the environment of the schizophrenic patient forward has significance.

A useful tool with regard to the assessment of stimuli from the environment and in obtaining information about the presence of a family history of mental illness (and, therefore, also schizophrenia), is the genogram. The responses of patients can, for example, give an indication of how stressful he/she experiences relationships with other family members, while responses about family mental illness can also be obtained. This information can assist the clinical social worker to monitor stressful experiences of the patient in his/her environment.

As the clinical social worker also renders services towards the family, he/she will often be confronted by the question of aetiology. Parents want to know what their contribution was with regard to the development of the illness, and very often the social worker has to explain the interrelationship of all contributing factors to parents.

With the new trend in psychiatry, relatives and families become allies and co-workers for the therapeutic team, and this would never have been possible without the results of research over the years (proving the condition as an illness, and not the results of mistakes which the family made in the upbringing of the child).

Despite the impairment in functioning experienced by most patients, it is believed that most patients can still be discharged after hospitalization and that various professions can assist them to be rehabilitated to live outside the hospital, under circumstances where they can optimally function.

The treatment and rehabilitation programme at Neuro B is, therefore, aimed at assisting the patient to ensure an optimal life outside the hospital.

Davis (1971) stresses the fact that Harry Stack Sullivan was one of the first theorists to recognize that schizophrenic patients could be treated. He saw the basic approach of treatment as being that of understanding the patient, and this will not materialize unless the illness is understood. The reader has already been introduced to some aspects of schizophrenia in the first section of this dissertation.

SECTION II

PSYCHIATRIC TREATMENT AND REHABILITATION

Gillis (1986) regards the best treatment of schizophrenia as primary prevention, but as the cause of the condition is not known with certainty, the focus should be on contributing factors.

Treatment, or secondary prevention, can take place within the hospital or outside it. With the acute onset of the illness most patients are usually hospitalized. In this phase chemotherapy is the main intervention for controlling the florid psychotic symptoms of the illness (Atkinson, 1985; Gelder, Gath and Mayou, 1983). Chemotherapy is also used to maintain the patient during the chronic phase (usually the lowest possible dose).

Past treatment modalities were often negatively portrayed in the media, for example, electro-convulsive therapy that was given without anaesthetic, or insulin coma where the patient was kept in a coma for a considerable period of time. Another intervention which added to stigmatization was the fact that patients were bound in wet sheets (Atkinson, 1985; Kaplan and Sadock, 1985).

Treatment interventions have rapidly improved since the 1950's, when Chlorpromazine entered the limelight. Patients could leave hospitals and could be discharged back into their communities, as this drug proved to be more successful in controlling the acute symptoms of the illness and improved the patient's functioning.

As patients were discharged it soon became necessary to deal with the patient in the family and the patient in the community, which led to the fact that more family members and more people in the community became the focus of treatment interventions. This approach for treatment, which includes chemotherapy, the therapeutic relationship, social support, rehabilitation and retraining, is also recommended by the Merck Manual of Diagnosis and Therapy (1982).

DEFINITION AND DESCRIPTION

Vitas (1986:58) stresses the meaning of the word "rehabilitation", namely, "to restore original functioning capacity". He favours the definition by Kaplan (1980), as it implies that the pursued goals are maximal functioning and optimal adjustment of the patient, through physical, mental, social and vocational preparation by taking cognisance of his abilities and disabilities. Kaplan also stresses the aim of tertiary prevention in order to alleviate relapses of the illness. (As the patient is taught different skills to re-enter the community successfully, he/she increases competence in coping , improved self-image and the ability to live optimally despite suffering from the illness. These factors can contribute towards a decrease in the relapse rate).

Tricoridis (1987) quotes the definition of Wing and his colleagues (1981), which describes psychiatric rehabilitation as being the process by which the causes of social impairment (as a result of psychiatric illness) are identified, prevented or minimized, while simultaneously assisting the individual to develop and use his talents, the eventual aim being to increase the patient's self-confidence and self-esteem.

The importance of recovery of social and instrumental role functioning to the fullest possible extent, through learning procedures and environmental support, is stressed by Anthony and Liberman (1986). Wallace (1986) emphasizes the teaching of physical, emotional and intellectual skills which are necessary to live, learn and work in specific environments.

As previously mentioned, interventions aimed at treatment and rehabilitation will be influenced by the stance which the clinician adopts towards the aetiology of the illness. Anthony and Liberman (1986) suggest the vulnerability-stress-coping competence model whereby it is understood that psychosocial protective factors can reduce the impact of stresses and the probability of relapse, if the illness is considered to be of bio-chemical origin. It is believed that an individual's ability to cope can, to a certain extent, protect him/her against the stressful influences of life. Rehabilitation programmes offer opportunities to build up and acquire social skills, thus enabling the patient to obtain support from the environment and, eventually, assisting him/her to function optimally in the community.

Psychiatric rehabilitation is undertaken from a specific philosophical point of view, based on certain assumptions: impaired and disabled persons do not only need skills and environmental supports, but these skills and supports can also lead to improved functioning in specific roles (Anthony and Liberman, 1986), better coping with stress and even reduced relapse rates (Liberman, Mueser, Wallace, Jacobs, Eckman and Massel, 1986). Strategies (development of patient skills and environmental resources) are aimed at optimal role fulfilment on physical, emotional, social and intellectual levels (Anthony and Liberman, 1986) and the reduction of relapses (Wallace, 1986).

Anthony and Liberman (1986) distinguish three overlapping phases in the process of rehabilitation:

(a) Assessment

Current deficits, impairment, psychopathology, strengths and skills are identified and assessed with regard to the patient as well as the type of resources which he/she can utilize in the environment (also emphasized by Wallace (1986)). Rogers, Cohen, Danly, Hutchinson and Anthony (1986) identify this as the diagnostic phase.

It is important to know that dysfunction or abnormality in certain brain areas can cause impairment in specific areas of functioning. Attention is again drawn to the findings of Gur (1979), who stresses the possible link of deficits in the left hemisphere in brains of schizophrenic patients and impairments such as poor self-care, social withdrawal, abandonment of family responsibilities and employment incapacity.

When the clinician assesses a chronic schizophrenic patient, certain impairments are associated with the disease (as indicated in Section I, where residual characteristics were discussed). Catterson, Bennett and Freudenberg (1963) also recognise the importance of assessment, as well as Bennett (1978).

(b) Planning Phase

Goals are set and interventions chosen, and patients are taught to achieve the set goals (Rogers and co-workers, 1986). Anthony and Liberman (1986) stress that the patient's level of functioning be raised to the level required by his/her environment. This planning, in conjunction with environmental manipulation is undertaken at this stage.

(c) Intervention Phase

The rehabilitation plan now takes place, to teach and improve the patient's skills and to assist him/her to adapt to the environment - to improve support or to lessen the demands, or to develop resources (Rogers and co-workers, 1986).

Liberman, Mueser, Wallace, Jacobs, Eckman and Massel (1986) identify a basic rehabilitation model, which involves the patient in role-playing, with modelling, prompting, feedback and reinforcement by the therapist. These authors also distinguish the problem-solving model, where general strategies are utilised for dealing with a vast variety of social situations. Role-playing not only enhances behavioural performance but it also focuses on the patient's ability to perceive and respond to incoming social stimuli (how the patient perceives social messages from his/her environment).

Anthony and Liberman (1986) feel that these interventions should only be undertaken when a trusting, mutually respectful and empathetic relationship exists between the therapist and patient while, for best results, Liberman and co-workers (1986) recommend a comprehensive rehabilitation programme with the characteristics of continuity of care, supportive community services and the availability of chemotherapeutic interventions.

Several authors acknowledge that psychiatric rehabilitation is a lengthy and complicated process. Olshansky (1980) refers to patients' impairments such as untidiness, over-dependency and their break from reality - which may complicate deinstitutionalization. Glynn and Mueser (1986) regard this as an ongoing challenge to mental health practitioners, and Liberman (1986:540) sums it up:

> But it is schizophrenia that poses the greatest challenge to the rehabilitation practitioner.

Olshansky's (1980) opinion is that it is imperative to recognize the chronicity of schizophrenia and the limitations in its treatment and rehabilitation, if one is to obtain significant improvement in the patient. He believes that it is only possible to achieve this by encouraging the patient to accept the importance of suitable work where he can achieve competence and self-fulfilment (even sheltered employment). Olshansky, therefore, recommends that general psychiatrists should open the door to colleagues who specialize in rehabilitation psychiatry.

The fact that a person who suffers from schizophrenia is an unique individual, is most important during the course and outcome of the illness (Strauss, 1986). Patients can, to a certain extent, control their symptoms and decide what type of assistance they require; also they are able to make decisions as to whether to co-operate with the treatment or not.

Strauss sees the meaning and value of psychiatric rehabilitation as being an opportunity for the person, as an individual suffering from the disease, to again integrate his functioning:

> The rehabilitation field needs to pursue actively the possibility that it can help with the basic process of reintegration and that this process may be a major aspect of healing and perhaps even recovery (Strauss, 1986:722).

That he considers rehabilitation as valuable, is evident:

> ... I would like to praise, but encourage, motivate, and even spread some guilt to push further those involved in rehabilitation research and practice to integrate their work and training more completely with the notion of the person as a person and with an enquiring mind about the still unknown nature of mental disorders (Strauss, 1986:722).

HISTORICAL PERSPECTIVE

Liberman and co-workers (1986) state that the need for psychiatric rehabilitation results from the fact that anti-psychotic drugs alone cannot remedy the negative symptoms of mental disorders and that there are often serious side effects to such medication; nor can drugs teach patients the necessary coping and survival skills. These needs, therefore, have to be met through various other interventions.

Liberman (1986:541) comments on the problem of the "revolving door" (hospital-admission-brief-treatment-discharge-relapse-readmission) which has to be addressed, as it confirms the insufficiency of symptomatic treatment and aftercare. He mentions factors, supported by the research of Anthony and Liberman (1986), which play a significant role in considering psychiatric rehabilitation as a possible solution to the "revolving door" problems:

(a) Rehabilitation in psychiatry was inspired by successes in physical rehabilitation and has developed its own vulnerability-stress-coping-competence model, as discussed earlier.

(b) The moral therapy era of the nineteenth century influenced psychiatric rehabilitation, as the focus of therapy falls on a comprehensive assessment of various disablements in the areas of work, play and social activities, as also the recognition that structured activity has therapeutic value.

(c) Since the two World Wars, vocational rehabilitation programmes have improved tremendously and an increasing number of physical rehabilitation programmes are being commenced, to include and assist patients with psychiatric disabilities.

(d) Community mental health supports the need for preparation of the patient to improve his/her functioning when resettled outside the institutionalised environment.

(e) Psychosocial rehabilitation centres, such as Fountain House in Observatory, and Horizon House in the USA, provide examples of successful multi-service, psychosocial rehabilitation centres, where schizophrenic patients are assisted to cope with their environment rather than succumb to it; health induction rather than symptom induction is encouraged, and there is firm belief that most psychiatrically disabled patients can be productive. These centres teach patients the necessary skills, over a wide spectrum of functioning, to enable them to live optimal lives in the community.

As mentioned previously, the increasing trend in the Republic is to utilize rehabilitation facilities to prepare patients for lives of optimal functioning in their communities.

CHAPTER 3

TREATMENT AND REHABILITATION INTERVENTIONS FOR THE PATIENT

(Secondary and tertiary prevention)

3.1 CHEMOTHERAPY

It is of the utmost importance that the patient is chemotherapeutically stabilized before any other treatment intervention is undertaken. According to Kaplan and Sadock (1985), the patient will only benefit from other treatment interventions if he is chemotherapeutically stabilized.

Hyman and Arana (1987) stress the following principles of prescribing psychiatric medication:

3.1.1 The medical condition of the patient should be known to the practitioner and the interaction of the drugs that could either increase the toxicity of prescribed drugs or decrease the effectiveness of the psychiatric drug

3.1.2 Diagnosis should be accurate to ensure effective treatment

3.1.3 Specific target symptoms should be identified, which should be evaluated after chemotherapy has been given (to evaluate whether these conditions respond to treatment)

3.1.4 Adequate dosages should be given

3.1.5 Patients should be told and educated about possible side-effects, for example, a dry mouth

3.1.6 Dosages should be kept as simple as possible

3.1.7 Influence of alcohol or other drugs should be evaluated

3.1.8 Careful supervision is needed in the case of psychotic patients who cannot verbalize how the dosages are affecting them

3.1.9 Observations about the patient's response to chemotherapy should be documented.

1.10 Consultation is recommended when there is doubt about the diagnosis.

Schizophrenic patients usually respond to one or more of the phenotiazines (according to Atkinson, 1985), such as (the brand name is given in parenthesis):

Chlorpromazine (Largactil, Thorazine); **Thioridazine** (Melleril); **Trifluoperazine** (Stelazine); **Fluphenazine decanoate** (Modecate); **Fluphenazine enarthate** (Moditen); **Flupenthixol decanoate** (Depixol); **Fluspirilene** (Redepin); **Haloperidol** (Haldol, Serenace); **Trifluperidol** (Triperidol); **Pimozide** (Orap).

At Neuro B Clinic the following, long-acting chemotherapeutic drugs are used:
Fluphenazine decanoate (Modecate); **Clopenthixol** (Clopixol); **Flupenthixol** (Fluanxol) and **Pipotiazine Palmitate** (Piportal). Good response is received from **Clopenthixol** (Clopixol), which is the drug most recently evaluated at Stikland Hospital.

Clozapine (Leponex) is used as well, having recently been tested in Europe, according to Hyman and Arana (1987). This is described as a non-neuroleptic drug, with less motor side effects than others drugs evidence.

Gillis (1986) emphasizes the importance of these drugs. They do not cure, but control symptoms of the illness - such as delusions, hallucinations, psychomotor overactivity, impulsiveness or paranoid reactions. He also stresses that the so-called negative symptoms, or secondary symptoms, like the impairment which the patient has suffered from previous attacks, are usually not changed to any significant extent. Other treatment modalities here are of importance, for example: Psychotherapy, group therapy, industrial therapy, and so on.

These drugs can also cause many side effects which can add to a patient's suffering, for example, dry mouth, constipation, drowsiness, blurred vision, akathisia (patients experience this condition "as an intensely unpleasant need to move") (Hyman and Arana, 1987:28), and the patient is very restless. Rigidity or stiffness may be experienced, or akinesia (diminished spontaneity) (Atkinson, 1985).

Side effects also mentioned by Hyman and Arana (1987) are: acute dystonia (acute muscular rigidity and cramping, usually in the muscles of the neck, tongue, face and back), thickness of the tongue, or difficulty in swallowing. These conditions are very uncomfortable and frightening for the patient, and they are treated with anticholinergic drugs like **Benztropine** (Cogentin); **Biperiden** (Akineton); **Procylidine** (Kemadrin), or **Trihexyphenidyl** (Artane, Tremin).

Some patients develop a most serious idiosyncratic reaction to neuroleptic drugs, called Neuroleptic Malignant Syndrome (NMS). The symptoms of NMS are rigidity, fever and autonomic instability (for example, instability of blood pressure - both hyper and hypostolic). Patients are usually confused and often mute, and seizures or coma might also be present. Death can occur if the condition is not properly diagnosed. Death usually occurs as a result of respiratory failure, but is also known to occur from cardiovascular collapse, arrhythmias or renal failure. The treatment of the condition usually involves adjusting the neuroleptic drug to the lowest possible dosages of a lower-potency drug, such as Thioridazine, while interventions like adequate hydration, cardiac monitoring, monitoring of urine output and renal function should also be undertaken. Sodium dantrolene might help to relax the muscles and may decrease rigidity and hyperthermia.

The clinical social worker can make a valuable contribution by motivating the patient to take his medication regularly and informing the patient of the effects of the medication. Patients should be aware that, for optimum efficacy, the medications must be taken as prescribed. This education of the patient with regard to his medication is also recommended by McGill, Falloon, Boyd and Wood-Siverio (1983). Therefore, the clinical social worker should have a sound knowledge of medication and its effects and side-effects (Nelsen, 1975). It is often necessary for the social worker to explain side-effects of medication to the patient and his family, especially during home visits when the medical staff is not present. The patient who knows that his decreased sexual drive might be the result of the Mellaril which he is taking can be motivated to discuss this with his psychiatrist and another drug might be substituted.

After the acute phase, maintenance on chemotherapeutic drugs is regarded as being of vital importance. Not only is this emphasized by Gelder, Gath and Mayou (1983) but research findings by Leff, Hirsch, Gand, Rhode and Stevens (1983) also proved this. They found that relapses are more likely to occur when patients stop taking their medication. These findings have also been confirmed by Hogarty, Ulrich, Mussare and Aristigueta (1976).

Some long-acting drugs are given in the form of monthly intramuscular injections, for example, **Fluphenazine decanoate** (Modecate). These injections simplify aftercare, as patients then remain chemotherapeutically stabilized for at least one month. Any person involved in the after care of psychiatric patients can confirm that discontinuation of drugs is a major problem, resulting in relapse and possible re-admission to the psychiatric hospital. The patient suffering from schizophrenia is no exception and, even more so, is the patient who does not understand his illness. The patient who is still in the phase where he denies his illness may easily stop medication. The clinical social worker can, in such a case, play a vital role by motivating the patient not to discontinue his medication.

As medication is not the only factor for consideration when relapse of the condition is at stake, stressful life events should also be monitored, as proved by the research of Schwartz and Myers (1977b).

The patient's family and community are decidedly important, with regard to both acute cases and chronic cases of schizophrenia. Beels and McFarlane (1982) recommend the approach of Goldstein, Rodnick, Evans, May and Steinberg (1978) for acute cases, and the Anderson or Falloon-Liberman model for the treatment and follow-up of long term (chronic) patients. These will be discussed later.

3.2 PSYCHOTHERAPY

Much controversy surrounds the question of whether the patient suffering from schizophrenia has the ego strength to cope with the demands of psychotherapy. Gelder, Gath and Mayou (1983) stress the possibility that this intervention may cause over-stimulation and subsequent relapse. However, they emphasize that there is a lack of evidence as to whether psychotherapy is meaningful to the schizophrenic patient, or not. Kaplan and Sadock (1985) see this type of intervention as being different from psychotherapy undertaken with neurotic patients. The focus is more on everyday, practical day-to-day coping rather than depth interpretations of internal motivations or solving parent-child conflicts.

As far as the relationship between therapist and patient is concerned, Kaplan and Sadock (1985), as also Nelsen (1975), emphasize that relationship-building might be a difficult and lengthy process, characterized by long silences, awkwardness, inappropriate discussion or apparent disinterest. The schizophrenic patient is lonely, but also defends against closeness and trust. The patient may become suspicious, anxious, hostile or regressed with the therapist who attempts to build the relationship. The patient might also expect the therapist to meet all his needs, for example, inappropriate sexual demands and over-dependency. Frustration might follow when the therapist cannot meet his demands, and the patient may lose interest in therapy, thinking that the therapist does not really care.

Kaplan and Sadock (1985) warn that the therapist may easily feel anger, disappointment, irritation, embarrassment, guilt, frustration and inadequacy as a result of the resistances which the patient presents. They stress, however, that the schizophrenic patient does appreciate a therapist who understands him and his psychosis, and who does not feel upset by what he/she discloses to the therapist.

In approaching the schizophrenic patient, Kaplan and Sadock (1985) consider M. Bleuler's three principles of importance:

(a) There should be a steady, quiet appeal to the patient's healthy ego, and his dignity and responsibility should be appreciated.

(b) The patient's attention should be stimulated by dramatizing reality. This will ensure that the patient awakens from his world of autism.

(c) The environment of the patient should not be too demanding or over-stimulating.

There should be flexibility in interventions. The therapist, for example, may take the patient out for meals or may receive and accept gifts. The aim should always be that the therapist wants to convey that she/he wants to understand the patient, that she/he has faith in the patient's potential as a human being - no matter how disturbed, hostile or bizarre he may be at that particular moment.

Manfred Bleuler has indicated, according to Kaplan and Sadock (1985), that the therapist should accept the patient as a brother or a sister, rather than observing the patient merely as a person who displays inappropriate behaviour and is different from the therapist. The approach which these authors recommend is that of simple directness, sincerity, appreciation of personal distance and privacy. Exaggerated warmth might seem threatening to the patient.

Nelsen (1975) warns that the therapist should guard against giving mixed messages. Such issues should be addressed immediately they arise. The clinician can spell out how she/he can help, the limitations which are experienced, and what the patient himself needs to attempt. Unrealistic hopes and expectations should be discussed and dispelled.

Empathy is of prime importance in the therapist's approach, and the patient's strengths should always be emphasized. Atkinson (1985) stresses the long term, one-to-one relationship in which support and practical help and advice are given to the patient, helping him to come to terms with his situation.

Some chronic patients will benefit more from psychotherapy than others, depending on the degree of impairment as a result of schizophrenia, and also depending on whether a non-threatening, supportive and empathetic relationship can be established between therapist and patient.

The American Journal of Psychiatry recently published an account by a patient who emphasized the value of psychotherapy, combined with chemotherapy. This patient stressed that he/she also had to deal with the emotional factors of the illness which he/she expressed as follows:

> Even if medication can free the schizophrenic patient from some of his torment, the scars of emotional confusion remain, felt perhaps more deeply by a greater sensitivity and vulnerability (1986:68).

The difficulty experienced in establishing a relationship with, and trust in, the therapist was emphasized by the patient, but the value of the relationship was also established. The patient regarded this relationship, together with psychotherapy, as being the most important aspects in his/her treatment, thus enabling him/her to carry on with life. In the above article, the patient strongly recommended psychotherapy as

> ... [a] fragile ego left alone remains fragile. It seems that there must be some balance that can be achieved so that schizophrenic patients can receive the benefits of psychotherapy with therapists who are sensitive to their special needs and can help their egos emerge, little by little.

Tuma, May, Yale and Forsythe (1978) addressed the question of whether personality characteristics and behaviour of therapists may influence treatment outcome in schizophrenic patients. The work of Rogers (1967), and of Truax and co-workers (1971), are mentioned. They stressed qualities such as empathy, warmth and unconditional regard as being characteristics of effective therapeutic interaction. Other factors which need evaluation with regard to the therapist are: ego strength, stress tolerance, ability to cope with aggression and dependency, conveyance of acceptance and compassion, intellectual resources, knowledge and skills with regard to specific treatment interventions. These authors stress the need for further research in this field.

The writer concludes that there is a place for psychotherapy as an intervention in the treatment of schizophrenia. Certain principles and the approach to be adopted are important, however, to ensure optimal results for the patient, while the therapist should be prepared for involvement on a long-term basis.

From this relationship, the patient's coping abilities are also discussed and assessed. This process of assessment, as part of the process of rehabilitation, can lead to the planning of more appropriate ways of coping with life.

Anthony and Liberman (1986) stress that the process of rehabilitation starts directly when the florid symptoms of the condition stabilize. The areas which can be focused on are: self care (including medication and symptom management); family relations; peer and friendship relations; avocational and employment; money management; residential living; recreational activities; food preparation, as well as choice and use of public resources. Competence in the abovenamed areas may improve the long-term prognosis of the patient.

Glynn and Mueser (1986) recommend the use of assessment and evaluation procedures to measure the impact of interventions. They mention the Clinical Frequencies Recording System (CFRS) to evaluate patient behaviour, functioning, progress, and staff responses to patients' behaviour. Other procedures which can be used are the Time-Sample Behavioural Checklist (TSBC), which gives particulars about the functioning and response in areas like appropriate facial expression, social orientation, appropriate current activities and crazy behaviours (for example, laughing loudly and inappropriately in public).

Wallace (1986) reviews several assessment instruments which are suitable for the measuring of functional living competencies of patients, for example, the Katz Adjustment Scale (1983) (for the assessment of symptoms, expected activities, recreation and leisure activities); Personal Adjustment and Role Skills Scale (PARS, 1968) (to assess symptoms, substance abuse, general community functioning); Social Behaviour and Adjustment Scale (SBAS, 1980) (to assess symptoms, role performance, objective burden, household distress); Psychiatric Status Schedule (PSS, 1970) (to assess symptoms and instrumental role performance). Others are Psychiatric Evaluation Form (PEF), Current and Past Psychopathology Scale (CAPDS) and Social Adjustment Scale (SAS). Wallace does point out that none of the abovenamed scales is totally adequate in the assessment of living skills.

Lukoff, Liberman and Nuechterlein (1986) recommend interviewer-rated instruments to assess symptomatology.

Brady (1984) recommends the use of questionnaires and direct behavioural observations in simulated social situations (role play), or in real situations, to assess the patient's type and degree of impairment. Responses on questionnaires might be influenced by misinterpretation, and this has to be taken into account. The patient's response in a real situation can be assessed much more effectively. In Neuro B, for example, patients are taken on outings into the community. Their responses in different situations, for example in a restaurant, are then assessed and discussed, with a view to learning better coping strategies should the patient experience problems in this regard.

Once the assessment is completed, planning is implemented to teach the goals of improved functioning. Brady (1984) recommends the following strategies to improve social skills: instruction, coaching, modelling, behavioural rehearsal (role play), feedback, social reinforcement, homework assignments (in Neuro B, this latter strategy is an important one, which is usually undertaken during week-ends at home), and generalization training (where patients enter into natural situations, for example dances, to practise skills). At Neuro B, patients have, for example, the opportunity to socialize with parents during parent/family meetings. An aspect emphasized by Liberman and colleages (1986) is problem-solving. Spencer, Gillespie and Ekisa (1983) stress the significance of video-tapes, remedial drama and discussion. They found video-tapes to be most effective in the training of social skills.

At Neuro B, patients have the opportunity of developing a therapeutic relationship with various members of the team, over a period of six months and even longer. Trust can therefore develop during this time, which also enables the clinician to continue the relationship throughout the rehabilitation process, and when the patient is discharged and followed up in the community in an after care programme.

3.3 GROUP THERAPY

Another intervention which can be meaningfully used is that of group psychotherapy, which can apply to both the inpatient or the outpatient. As treatment conditions have changed in psychiatric hospitals, this intervention has become more meaningful for numbers of schizophrenic patients. Yalom (1983) even recommends this intervention for confused, psychotic inpatients. Often these patients were considered unsuitable for group therapy, but Yalom feels that they, too, can benefit, providing the therapist uses special techniques to involve them in the group. As the Neuro B programme does not cater primarily for psychotic patients, further discussion would be inappropriate here. Suffice to say that Yalom's recommendations in this regard are highly valued in the treatment of psychotic patients.

The group situation is also the place where skills training, to a great extent, can take place. Neuro B offers a six-month programme and the team members are in a fortunate position where they have group members remaining in the group for a considerable length of time. (Other inpatient wards may experience a rapid turnover in their group members). The patients of Neuro B do, however, experience several handicapping factors and they have to contend with these, together with their existential problems of ordinary living, such as loneliness, isolation, conflict with authority, anger, intimacy and dependency. Yalom (1983) stresses the group members' need for support and, therefore, the importance of a positive, non-judgmental and accepting therapist-patient relationship. The patient should experience the value of a therapist who values him, respects him, and appreciates his dignity.

Schizophrenic patients are often inclined to view the group sessions as threatening. Therefore, the group therapist has a special role in creating an atmosphere in which even this type of patient will feel free to express his feelings and ideas.

Another factor which is to the advantage of the group therapist is that all members in the group suffer from the same illness, i.e. schizophrenia, together with the advantage that team members remain constant during the group sessions. Cohesion can, therefore, be reached amongst group members, and the patient-therapist relationship has time to develop.

In the inpatient setting, group psychotherapy is merely a part of other treatment interventions, such as chemotherapy, psychotherapy or industrial therapy. The following recommendations from Yalom (1983) are particularly meaningful in the Neuro B programme:

3.3.1 That groups should meet daily to improve their cohesiveness and to facilitate group interaction. This is useful with schizophrenic patients, where the formation of relationships with the therapist and with other members in the group is a lengthy process.

3.3.2 The fact that a group consists of between six and ten patients allows sufficient time for involvement of each member.

3.3.3 Therapeutic groups need to be goal oriented. Goals should be realistic, considering the degree of the illness. (The severely impaired patient who has poor social skills should, for example, have sufficient time to adjust to being in the group situation before his verbal participation is anticipated).

3.3.4 Therapeutic factors, also mentioned by Yalom, which lead to meaningful group experiences for patients, are:

3.3.4.1 Giving them hope that they will also benefit

3.3.4.2 The realization that others in the group have similar problems

3.3.4.3 Information they obtain within the group can help them to try out new behaviour, for example, self-relaxing exercises

3.3.4.4 The patients realize that they can assist others if they share their own experiences

3.3.4.5 The patients can be re-educated to using more appropriate behaviour in coping with life, instead of persisting with the patterns which they have practised in their primary family group situation. A method of re-education favoured by Anthony and Liberman (1986), for example, is problem solving

3.3.4.6 Social skills training can be implemented, using role play and other techniques. Spencer, Gillespie and Ekisa (1983) found video-tapes to be most effective in social skills training

3.3.4.7 Patients can benefit by modelling the therapist and fellow group members. This is stessed by Brady (1984), Liberman and his colleages (1986) as being especially valuable in shaping, coaching, feedback and reinforcement of behaviour.

3.3.4.8 Patients can learn how to openly express their feelings

3.3.4.9 Existential themes in therapeutic groups focus interaction on situations such as isolation, death, feedom, responsibility and meaninglessness, and group members can discuss their experiences

3.3.4.10 Group cohesion is of vital importance for the patient who lacks meaningful relationships outside the group

3.3.4.11 Inter-personal learning is possible - the behaviour which the patient displays in the group situation will be similar to that which he displays outside the group. Maladaptive, interpersonal patterns which are identified within the group can be focused upon immediately and the patient can be taught more appropriate forms of coping.

Yalom (1983) emphasizes certain strategies of leadership for such groups:

3.3.5.1 Structural importance is stressed, characterized by the therapist's decisive but flexible personal style, modelling behaviour to the patient, and even sharing her/his own feelings with the patient

3.3.5.2 Orientation and preparation of the session by introducing new members and stating the goals of the group

3.3.5.3 Consistent, coherent group procedure is important for poorly functioning patients; however, in the early stages of group psychotherapy this is imperative

3.3.5.4 From an approach of support, the patient's contributions are acknowledged, i.e. what he says is taken seriously. The therapist will also discourage self-defeating behaviour and encourage positive behaviour. The patient must always be treated with dignity

3.3.5.5 Certain situations such as anger and conflict are sometimes evident in the group situation, and they need to be dealt with as they arise. Patients should be encouraged to follow the therapist's modelling, thus being motivated to talk about any disagreements before their feelings become out of hand

3.3.5.6 Therapist self-disclosure, when used appropriately, facilitates in building up trust in the therapeutic procedure.

Yalom (1983) stressed the following major differences between inpatient and outpatient groups:

Outpatient groups serve as more independent treatment interventions, while inpatient groups are usually part of a comprehensive system of other treatment interventions. Patients who form part of out-patient groups also have less contact with one another between group meetings. They live in the community and have to cope on their own between meetings, and this can increase their need for the meetings where they feel supported and accepted. The writer has experienced this particular phenomenon, where out-patient support groups are eagerly attended because patients experience warmth and acceptance within them.

Davis (1971) used outpatient group psychotherapy to enable chronic schizophrenic patients to remain in their communities. Davis found that the establishment of a group relationship was most difficult because of the apathy and dependency which the patients exhibited on the therapist. Payn (1978) also experienced this when he introduced outpatient group pharmacotherapy. He found that patients derive more benefit from group interaction than they do from individual contacts, even though the group process is slow and, initially, the members of the group focus their attention on the leader of the group.

Payn (1978) defines group pharmacotherapy as being the group meetings of patients where they first meet each other and receive their prescriptions. While the prescriptions are being made up, the members continue with their discussions. Payn's main goals are to get the patients to converse with one another, then to express their feelings, to recognize and modify inappropriate feelings and, eventually, to change their behaviour. He describes the results:

> Pharmacotherapy alone would, at best, only keep the patients out of the hospital. Pharmacotherapy in a group leads them to feel that someone cares about them. And as this feeling grows, a new feeling emerges: they care about someone (Payn, 1978:99).

Davis (1971) records the following benefits achieved through group treatment: socialization - schizophrenic patients have a desperate need for others yet they have a difficulty in relating to others. Once they have adjusted to their group situation, they are able to socialize better and also experience the sense of meaning something to somebody else. At the same time, their interest in life can be stimulated, thus decreasing feelings of isolation and apathy.

Group psychotherapy, therefore, plays an important role in treating and rehabilitating the schizophrenic patient - even those who are severaly disturbed or impaired - providing the therapist evidences special characteristics and skills which she/he is able to utilize fully in setting out to achieve optimal functioning of the patient.

Atkinson (1985) mentions other treatment interventions like industrial and occupational therapy, where the patient is assessed, evaluated and trained towards optimal functioning in a work or employment situation. The occupational therapist plays a major role in these interventions, and as part of a therapeutic team this therapist's contribution is of tremendous importance.

3.4 TREATMENT AND REHABILITATION PROGRAMMES

Over the years, several programmes incorporating treatment and rehabilitation interventions have been described. Spadoni, Smith and Hines (1969: 549) reported negative results in a milieu setting which operated on the principle of family therapists where schizophrenia was regarded as a disturbance of communication which developed as a result of pathalogic interaction with the patient's parents. Milieu treatment alone was being provided and psychotic behaviour was seen to be distinguished messages which had to be decoded by staff members, by way of interpretation or confrontation. No drugs were used and the authors reported "distressing results".

Ryan and Bell (1983) also report a negative outcome with their research, where treatment interventions were undertaken from a psychoanalytic perspective and focused on difficulties in the early parent-child relationship. These findings indicate that the programme's emphasis, on revealing the patient's feelings and transference phenomena, led to neglect of the practical psycho-social problems.

Glynn and Mueser (1986) report on Paul and Lentz (1977), whose research compared traditional hospital treatment with two comprehensive treatment and rehabilitation programmes which aimed at enhancing the patient's functional independence. Their findings indicated that a social learning programme - based on learning principles such as associative learning, problem-solving, reinforcement, modelling and punishment - was most effective.

Gunderson (1980) feels that the following characteristics of the programme are highly relevant to a positive outcome:

3.4.1 Distribution of responsibilities and decision-making between staff and patients.

3.4.2 Clarity of the programme, as far as its aims and objectives are concerned, as well as roles and leadership.

3.4.3 A high level of staff-patient interaction.

Baker, Woods and Anderson (1977) focused their research on a programme with these characteristics:

3.5.1 Individual therapy.

3.5.2 Chemotherapy.

3.5.3 Education in cooking.

3.5.4 Contact with the community, by means of holiday camps and bus outings.

3.5.5 Staff members wore ordinary clothes rather than uniforms, to promote staff-patient communication. Patients were also properly prepared for discharge.

The average hospitalization period was one year, and the findings of this research were positive, in that patients could maintain an optimal level of functioning outside the hospital environment, once they had been prepared through this programme.

Vinutha, Kshama, Sreenivas, Maheswari and Venkataramaiah (1980) also reported a postive outcome with their research, where they conducted a four-month, eight-step programme in Asia, to prepare patients for life in the community - particularly life in halfway houses.

Positive findings were also the outcome of research conducted by Dincin and Witheridge (1982), who used a comprehensive rehabilitation programme which focused on individual casework, vocational rehabilitation, social rehabilitation (particularly problem-solving training), the provision of residential facilities, and an academic programme where basic skills were taught.

It will be impossible to establish the perfect rehabilitation programme, but Bennett (1978) emphasizes some important variables, apart from the fact that programmes should be tailored to meet the needs of the individual:

3.6.1 Rehabiliation can change disabilities, attitudes and competence, but this is a slow process

3.6.2 There should be a balance between over-stimulation and under-stimulation as both these conditions, even in a treatment and rehabilitation programme, can lead to a relapse. Anthony and Liberman (1986), as well as Strachan (1986), agree that over-stimulating rehabilitation programmes can cause relapses.

3.6.3 The process of rehabilitation should take place in a series of steps, during which social expectations are gradually increased.

3.6.4 Bennett summarizes the characteristics of successful programmes by stressing the provision of opportunities for patients to develop skills and competence together with other people. These skills will then enable them to deal with the needs, demands and challenges of society. An incentive system of rewards and punishment, as well as an evaluative system, should form part of the programme so that the patient may experience support when he/she faces emotional discomfort in trying to cope. At the same time, the opportunity should exist for the correction of inappropriate behaviour and responses.

CHAPTER 4

TREATMENT AND REHABILITATION INTERVENTIONS INVOLVING THE FAMILY

It is an undeniable fact that social workers are usually involved with families. Over the years, historical developments have shaped and influenced the interventions and roles of social workers. The field of psychiatric social work is no exception. Recent developments in rehabilitation have involved the treatment and rehabilitation process, as families are most often the major sources of support for the patient.

Pharmacological advancements since 1950 have enabled more patients to live outside of the hospital environment, thus extending the services of the social worker to include family members, relatives and significant others in the community. The realization that schizophrenia is an illness brought about by bio-chemical dysfunctioning in the brain, and that it is not the result of family interactions, brought other significant changes to the role of the clinical social worker. Leff (1979) describes how eager professionals are to experiment with new ideas in treatment. This also occurred when family theorists started their work in the 1950's. The contributions of Bateson, Lidz and Wynn were eagerly studied and implemented in treatment models in the 1960's. As is often experienced with new interventions, the work of these theorists with schizophrenic families brought disillusionment some thirteen years later, when effectiveness was found to be severely lacking.

As professionals looked for other causes outside the family, the medical model came into perspective and, as a result, more sophisticated assessment tools were implemented, for example, the CAT-scan.

In research which followed, the focus was not only on the bio-chemical causal factors but family research continued, focusing on factors which were considered important with regard to the course of the illness. The research of Brown, Birley and Wing (1972) and Vaughn and Leff (1976) is important in this context, emphasizing that family stressors can influence the course of the illness. This research was confirmed by Moline, Singh, Morris and Meltzer (1985) on a mixed population of Caucasian and Black subjects.

The change in focus is also emphasized by Lewine (1982), Beels and McFarlane (1982) and Clarkin and Glick (1982). These latter researchers emphasize that the family theorists have now moved to new target populations, for example, families disrupted by divorce, drug abuse and other problems.

Apart from the fact that family therapy, as recommended by the family theorists, was ineffective with schizophrenic families, it also proved to be harmful. The experiences of Terkelsen (1983) and Grunebaum (1984) are important in this context. They observed that it was hardly possible for the patient to remain in on combined family discussions because of his symptoms and impairment. The patient invariably dropped out of therapy while the family members desperately needed support and assistance to cope with the patient. It became clear that a different philosophy was needed, as were different goals, strategies and techniques, when a schizophrenic patient and his family were being treated.

Regarding the philosophy of family therapy with schizophrenics and their families, Anderson (1977) recommends the combination of the medical model and the family theory models: the patient's illness is seen as the focus, while the importance of the influence of family variables are taken into account. Bernheim (1982) emphasizes that the aim in this type of family therapy is not to cure the illness but rather to relieve as much of the stress as possible and to increase the ability of both patient and family to live with the illness more effectively. As family members become part of the therapeutic team, the words "family treatment" are recommended in preference to "family therapy" (Hogarty, Anderson, Reiss, Kornblith, Greenwald, Javna and Madonia (1986)).

Primarily, the therapist does not focus on changing the family structure and helping the patient become independent like in family therapy. Some patients are so impaired and as a result so dependent on their families, that this intervention can cause a relapse of the condition. The therapist realizes that the patient may remain impaired indefinitely, therefore she/he will concentrate on supporting the family, educating them and helping them to see to their own needs as a family (Bernheim, 1982).

Before the type of intervention recommended by recent researchers is examined , the needs of patient's family members are highlighted.

4.1 THE INITIAL CONTACT

Whether the patient is admitted to hospital for the first time, or more than once, an admission is never easy on the family.

Anderson (1977) emphasises the turmoil of the family's circumstances. Admission could be the last resort in a line of previous mishaps for the family - several other treatment efforts could have failed and they are, perhaps, over a long period the observers of declined functioning in their child. Feelings of guilt and shame, together with feelings of being failures as parents, are often present. Other experiences might be those of hopelessness, despair and anger. Grunebaum (1984) and Atkinson (1985) emphasize the emotional pain which parents experience when they have to contend with a child which is suffering the acute symptoms of schizophrenia. Kanter and Lin (1980), Costell, Reiss, Berkman and Jones (1981), Scharfstein and Libbey (1982), Terkelsen (1983), Bernheim (1982) and others, like Arieti (1979), also refer to these experiences of the parents.

A couple's need for support in their confusion was recently expressed to the writer by parents who followed an ambulance which was conveying their son (a high school pupil) to hospital, for admission after a psychotic breakdown. What made this situation even more traumatic for the parents was the fact that this particular admission was in terms of Section 9 of the Mental Health Act (certification). As events leading up to their child's admission had taken place after hours, there was nobody available to explain the various procedures to them and to help alleviate their bewilderment. All too often, unfortunately, staff members will have too little time to meet the needs of the family in such a crisis.

The role of the clinical social worker is, however, of tremendous importance in such a crisis. Anderson (1977) recommends immediate contact with the family, that is, on their child's admission to hospital or as soon as possible thereafter. Hospital procedures should be clearly explained, and informative attention given to the experiences which the parents are going through - this is essential in the formation of the therapeutic relationship which will be required for the remainder of the treatment programme. Families are usually most receptive to assistance which is offered them during a crisis period such as this.

At the time of admission, only essential information is obtained from parents and relatives. Long interviews are liable to cause them additional stress and increase their own feelings of guilt and despair. The personal style of interviewing by staff members and the clinical social worker can, if not caringly approached, add to the parents' feelings of guilt and responsibility for their offspring's condition. Nelsen (1975) mentions various factors which affect parents during admission procedures, for example, disguised accusations and biased questioning. Certainly any questions relating to a family history of psychiatric illness need to be handled with support, dignity and total understanding.

Appleton (1974) mentions that staff have been known, through their attitudes and behaviour towards the patient's family, to instil feelings of rejection in the family from the outset. Beels and McFarlane (1982) stress that after World War II, when all problems were linked with the psycho-social aspects of life, the mother of the child was often blamed for his/her problems. Weitzman (1985) points out that it is not only schizophrenic patients who often come from dysfunctional families - various dysfunctional patterns are also present in families of anorectic patients, child abusers and drug addicts.

4.2 ORIENTATION OF THE FAMILY TO THE TREATMENT AND REHABILITATION PROGRAMME

Here, the role of the clinical social worker ensures adequate explanation of treatment interventions and assuring the parents of the vital importance that they co-operate in the treatment and rehabilitation programme. Information about the onset of the illness, the various stressors, and information about the programme will be provided to the parents. Kanter and Lin (1980) point out that the limitations of services should be mentioned, in order to assist the family to set realistic aims. The family should, for example, know that time is an important factor in the treatment of any psychiatric illness, in contrast to some physical conditions which can be treated and cured within days. It is not uncommon for parents to express their frustration when their child's condition does not appear to improve over a time period of three months or longer.

Not only are interviews with individual families meaningful, but group orientation meetings are recommended by Scharfstein and Libbey (1982) and Beels and McFarlane (1982). These help to bridge the gap between the home and the hospital environments. These orientation groups utilize concepts of family theory (to form an alliance with the family); group theory (where it helps to talk about problems and for parents to be aware that there are others, like them, in similar circumstances), and of patient education theory (that education of the relatives/parents eventually leads to successful adjustment of the patient). Scharfstein and Libbey (1982:575) emphasize this aspect:

> Involving families of the institutionalized chronic mentally ill in ongoing therapy and guidance does not stand a chance of being successful if we cannot ensure support and cooperation from the families and institutional staff.

Should parents'/relatives' needs for support not be met, or should they feel guilt as a result of staff behaviour, Terkelsen (1983) mentions that the following reactions can result: parents may reject the therapist; they may deny the seriousness of the illness by minimizing the symptoms, or they may desperately try to repair the presumed damage. If, for example, they feel responsible for their child's condition because of marital conflict, they may superficially try to solve their problems. The consequences of this self-help could place additional stress on the patient's siblings and other members of the family.

Atkinson (1986) and Gunebaum (1984) emphasize the fact that grief is an important emotion, and that parents should be allowed to mourn as they see and observe their child in circumstances which are totally unfamiliar to them. As the treatment period proceeds, their child's impairment will become more and more obvious to them, and parents come to realize that they have lost the child they used to know. The impairment of inappropriate behaviour, loss of insight, deficits in thinking and problems in relating to others are obvious manifestations of schizophrenia, noted in patients who are referred to the Neuro B programme. Parents need assistance in working through all the stages of the mourning process.

Parents also have deep concern and many questions arise about the future of their child, for example, what will happen to the child when they (the parents) die or are unable to cope. These aspects of involvement with the parents are existential to a great extent, as the tragedy of the illness brings feelings of hopelessness, meaninglessness and despair.

Members of the therapeutic team at Neuro B often experience this mourning of the parents when they are confronted with the tragedy of this illness, which jeopardizes the bright young lives and chances of their offspring. The approach of Yalom (1983) is very useful, concentrating not only on the reality of the illness but also on the hope that patients will be able to function optimally through treatment and rehabilitation programmes.

The question does arise: what should be the characteristics of therapy interventions with this particular type of family?

4.3 FAMILY TREATMENT : ACUTE SCHIZOPHRENIA

Beels and McFarlane (1982) recommend the model of Goldstein, Rodnick, Evans, May and Steinberg (1978) for patients suffering from acute schizophrenia, as also for their families. These researchers reported a 0% relapse rate for patients whose families were involved in this type of programme, as compared with a 48% relapse rate for patients whose families were uninvolved in the programme. (It must be stressed that the patients were also chemotherapeutically stabilized).

In this model, the family therapy offered is a six-session, crisis-oriented family approach, with the following objectives:

4.3.1 Assistance to patient and family to accept the fact that the patient has a psychosis

4.3.2 Assistance in identifying stressors which could be an added burden on the patient and the family

4.3.3 Realization that the patient is vulnerable and sensitive to his environment

4.3.4 Avoiding factors which can encourage a relapse.

The primary goal in therapy is to help the patient and significant others to experience the event of psychosis more positively; to talk about it openly and not to "hide it away". From an open perspective, they might be helped to set more realistic future goals for the patient.

4.4 FAMILY TREATMENT AND REHABILITATION : CHRONIC SCHIZOPHRENIA

Beels and McFarlane (1982), as also Atkinson (1986), emphasize the models of Falloon, Liberman, Lillie and Vaughn (1981) and Anderson, Hogarty and Reiss (1980). These contributions are in terms of the psycho-educative approach and are characterized by:

4.4.1 Patients and their families are seen separately, initially, in order to allow both parties to express their feelings openly, including any negative feelings which they would feel unable to discuss in the presence of each other, or while the patient is still psychotic

4.4.2 Aims are: educating the family and patient about schizophrenia and management; the use of medication; improving communication skills to promote more positive, less critical, interaction; improving the coping ability of family members within the family network; increasing, where appropriate, the independent living skills of the patient; reduction of family stress

4.4.3 These models make use of educational seminars and homework assignments in order to increase the potential for learning. During these seminars, aspects such as diagnosis, phenomenology, theories of etiology, and treatment are highlighted, while parents have home assisgnments where they experiment in the areas of communication and problem-solving strategies, in order to decrease the influence of highly emotional expression - a factor which has been found to be relative to relapse in schizophrenia

This educational programme incorporates different stages (Anderson, Hogarty and Reiss, 1980). During Phase (i) the therapist joins the family for initial contact and orientation, as previously described.

Phase (ii) concentrates on the education, during workshops, of the family members, as previously discussed.

Phase (iii): The family and patient are interviewed together again, after the patient has also been educated about the illness and after chemotherapeutic stabilization. Home assignments and tasks are of vital importance in this phase.

Phase (iv) focuses on maintenance of the patient in the family and the community.

During Phases (iii) and (iv), some of the contributions of the family theorists can be utilized. The aim is not to investigate the etiology of the illness but rather to use the information to improve effectiveness of the family in coping with the patient. Skills in problem solving and more effective communication can be taught through role rehearsals in typical day-to-day situations, and this can lead to a more supportive and understanding home environment for the patient.

Nelsen (1975) stresses the value of combined sessions with the patient and his family, emphasizing the diagnostic value of observing family dynamics. The patient's impairment, for example, with regard to appropriateness of effect, reality testing, judgment, frustration tolerance, or the ability to question or admit negative feelings, can be observed - but so can the family members' responses to these impairments be noted.

Bernheim (1982) recommends a similar intervention, which he calls "Supportive Family Intervention", with similar focus points, namely, the education of the family with regard to coping with the patient in every day life situations, as well as understanding that realistic aims should be set. Hunter (1985) and Glick and Spencer (1985) advise a similar intervention to benefit both patient and family appropriately and effectively. Other authors in favour of this approach are McGill, Falloon and Boyd-Siverio (1983). They recommend family sessions at home. Liberman, Wallace, Falloon and Vaughn (1981) are of the opinion that the problem of the so-called "revolving door" (a pattern of frequent discharge from and re-admission to hospital) can be minimized through these programmes.

Important considerations in the education of families are:

4.4.3.1 That highly-expressed emotion in families has been found to be linked with relapses among schizophrenics. The earlier findings of Brown, Birley and Wing (1972) and Vaughn and Leff (1976) have been confirmed by more recent research by Leff, Kuipers, Berkowitz and Sturgeon (1985) and Vaughn, Snyder, Jones, Freeman and Falloon (1984). Moline, Singh, Morris and Meltzer (1985) concur, namely, the increased possibility of relapse when patients are subjected to hostility, criticism and over-involvement in his/her home environment.

4.4.3.2 The findings of Klein, Person and Itil (1972) are important. They stress that in the life of the schizophrenic patient recent social events are far more powerfully related to outcome of treatment than remote events such as childhood experiences. Family therapists can, therefore, concentrate on present family behaviour and response towards the patient, rather than on the solution of childhood traumas.

4.4.3.3 Family members are becoming more and more involved in treatment interventions. Miller and Cantwell (1976) looked at the role of siblings in the treatment of retarded brothers and sisters. This also brings the schizophrenic patient's siblings into focus. The age or developmental stage of the sibling or child is of vital importance here, and the clinical social worker can play a major role in educating these members of the family about the illness. It has been this writer's experience that a four year old girl alerted her father about her schizophrenic mother's suicidal intentions, and a re-admission could be arranged. The writer was personally involved with the education of this young girl and her six year old brother, prior to this specific incident.

Play therapy could be a useful intervention in this context, depending upon the age of the children or siblings.

The importance of trusting relationships with family members, such as adolescents, can never be over-emphasized. The clinical social worker should recognize and understand the stigma which youngsters have to live with when their sibling suffers from schizophrenia.

4.4.3.4 Many professionals seek solutions to questions about the outcome of treatment in schizophrenic patients. McGlashan (1986) came to the following conclusions with regard to important variables during different follow-up phases:

0-9 years after discharge: characteristics of the patient's pre-morbid functioning were the most important factor in whether the patient could function optimally after discharge.

10-19 years after discharge: family functioning was seen as the most important aspect.

20 years and over: here family genetics proved to be of importance. A family history of the illness seems to increase vulnerability to schizophrenia.

This researcher considered the following variables important for a good outcome: lower incidence of schizophrenia in the family; better pre-morbid instrumental functioning and when there were affective signs and symptoms present, especially depression during the illness.

4.4.3.5 These educational programmes can be extended to groups of families (multiple family groups) as well as groups of relatives. Beels and McFarlane (1982) stress the advantages of the multiple group situation:

4.4.3.5.1 It is possible for families to slow down, to come to terms with the illness, by observing, by experiencing, that other parents are in similar circumstances

4.4.3.5.2 The opportunity for a family to offer advice, thus cultivating that family's sense of personal expertise. These groups often have the atmosphere of a self-help network, where members experience support and compassion

4.4.3.5.3 Individual experiences and differences will be discussed, emphasizing that the illness may differ with regard to onset, course and outcome

4.4.3.5.4 Group members can be involved in behavioural tasks and may feel that they are doing something constructive. Usually parents or relatives feel hopeless, helpless and isolated. They can, in this situation, work towards a better understanding of the illness.

Strachan (1986) stresses the meaning and value of recent developments in the field, whilst Falloon and his colleagues (1985) also offer a family behavioural problem-solving management intervention. Apart from psycho-education, the family members are also taught skills training in communication: a clear communication is enhanced by active listening, being specific about requests, and the expression of positive and negative feelings; and problem-solving: the family members are trained to pinpoint a problem, to discuss possible solutions, evaluate consequences, select the best strategy to solve the problem, to implement the strategy and to review results. Simultaneously, the patient's medication is decreased to the lowest possible dosage.

Strachan concluded that psycho-education should be supplemented by skills training of family members.

Hogarty and his colleagues (1986) obtained their best results in a programme which concentrated on family psycho-education, social skills training and maintenance therapy. In this study, the training of the patient to change the emotional environment in which he was living, was successfully undertaken.

Strachan (1986) summarizes the psycho-educative programmes:

> Goldstein and his colleagues (1978): focused on crisis intervention and did not offer psycho-education. Falloon and his colleagues (1986): concentrated on problem solving and communication training of family members. Hogarty and his colleagues (1986): stressed the survival skills and management of the patient.

4.5 ASSISTING RESISTANT FAMILIES

Some families are resistant to treatment programmes because of previous experiences with professional staff and because, in the past, their own needs have not always been met. Scharfstein and Libbey (1982) stress that the family's pain must be acknowledged. Beels and McFarlane (1982) feel it is important to distinguish whether the family's resistance is due to defensiveness or unco-operativeness.

Anderson (1977) recommends these steps to prevent family resistance:

4.5.1 Establishing immediate contact

4.5.2 Getting family members involved

4.5.3 Structuring of availability - some members can only be seen after hours, and this needs to be taken into account

4.5.4 Creation of a good working climate

4.5.5 Appointment of a family representative

4.5.6 Conduction of controlled, but supportive, family therapy meetings

4.5.7 A variety of treatment formats should be provided

4.5.8 Adequate after care should be planned.

The therapist should be prepared for treatment once the family's anxieties begin to lessen as as they become more receptive to information and treatment plans.

At Neuro B, parents are part of the programme, and regarded as extended members of the therapeutic team. Initially, they are seen separately from other parents, during which session they are introduced to the hospital team, and session procedures are explained to them. During follow-up sessions, important information is obtained from them from time to time and they are involved in the week-end assignments which patients should perform. Parents have an important feedback role to play vis-a-vis the hospital staff - which will be highlighted later in this dissertation.

Neuro B also offers an educational programme once monthly, and a support group for parents. Before the patient is discharged, the clinical social worker commences joint sessions with him/her and the family, which continues after the patient's discharge from hospital.

4.6 THE FAMILY AND AFTERCARE

It is the writer's opinion that successful treatment and rehabilitation interventions can only be maintained by effective aftercare of the patient. Fenton, Tessler and Struening (1979) found that patients could be successfully cared for at home, providing that the services of a multidisciplinary team were available to assist the family. Lurie and Ron (1971) emphasize the relevance of effective aftercare in the successful integration and reassimilation into the community of patients discharged from hospital.

Groups of parents and their offspring begin meeting during the last phase of hospitalization. Problems addressed during these meetings are usually those of (a) the stigma of psychiatric hospitalization; (b) assertion of parental control (whether the parents should, for example, consider independence for their child in view of his illness and the possibility of relapses in the future); (c) conflicting parent-child expectations (for example, planning for a career), and (d) communication difficulties.

Kanter and Lin (1980) suggest an aftercare programme with a focus on creating a therapeutic milieu in the patient's home. These interventions should, ultimately, commence whilst the patient is still hospitalised. Together with other treatment interventions (such as chemotherapy), the aim is to analyse family approaches to various situations, encouraging the family to develop coping skills, and the successful integration of the family into other available resources. In this regard, Beels and McFarlane (1982) emphasize that exposure to other families in similar situations will decrease the feelings of isolation and high emotional expression which are often present in the family which feels it is "alone" with its problem. An educational programme for aftercare, with similar aims and objectives as those for the hospitalised patient, is also suggested by McLean, Greer, Scott and Beck (1982).

It is, therefore, concluded that educational programmes for aftercare should commence prior to the patient's discharge from hospital, but that they can also be utlized for outpatients and families who have not previously been involved in similar rehabilitation programmes.

Important considerations for effective aftercare of the schizophrenic patient are:

4.6.1 Schizophrenic patients are sensitive to their environment - this has been indicated by physical responses to their environment (Tarrier, Vaughn, Lader & Leff, 1979) - and their reactions to life stressors (Wallis, 1972; Schwartz & Myers, 1977a). Over-stimulation proves to be stressful and so does under-stimulation, leading to boredom and a feeling of meaninglessness (Wing, 1978b).

Because of this, Schwartz and Myers (1977b) recommend that patients be placed in aftercare programmes which consider the patient's unique responses to his/her environment. Aftercare will be far more effective if the placement is arranged to suit the needs of each individual patient.

4.6.2 Evaluation of medication is always important as some patients respond less effectively than others to neuroleptic drugs (Marder, Van Kammen, Docherty, Rayner & Bunney, 1979; Carpenter, 1986). Where chemotherapeutic maintenance is required, programmed intervention can assist the patient to avoid any relapses (Leff, Hirsch, Gaird, Rhode & Stevens, 1973; Wing, 1978b).

4.6.3 Combined interventions, such as chemotherapeutic maintenance and family education programmes, assist the patient to function optimally in an empathetic, supportive and stimulating atmosphere in the home environment (Wing, 1978b; Hogarty, Schooler, Ulrich, Mussare, Ferro & Herron, 1979; Hogarty, Goldberg, Schooler & Ulrich, 1974; Hogarty, Goldberg & Schooler, 1974; as well as Falloon, Boyd, McGill, Williamson, Razani, Moss, Gilderman and Simpson (1985)).

4.6.4 Daycare centres can be valuable in providing families with assistance in caring for patients and, certainly, can reduce emotional strain on the family (Byrne, O'Connor and Fahy, 1974).

CHAPTER 5

TREATMENT AND REHABILITATON INTERVENTIONS INVOLVING THE COMMUNITY

Apart from parents, family and relatives there are other systems involved in caring for schizophrenic patients or having contact with them from time to time. It is of major importance that all individuals who care for these patients need to be able to recognize the symptoms of a possible relapse or, should one occur, to know when the patient needs to be readmitted to hospital.

The clinical social worker, who is usually seriously involved in a search for reliable caregivers, should be aware of each patient's vulnerabilities, as well as his/her response to the illness. This can only be established if the social worker cultivates a relationship of trust with the patient. Caregives need to be assessed in terms of the patient's needs and with total consideration being given to his/her vulnerabilities and impairment (Schwartz & Myers, 1977b). In this regard, clinical social workers have an educative role, in instructing staff of daycare centres, halfway-houses, boarding houses, or any centre which relieves the family in its tasks of caring for the patient. Today, many schizophrenic patients are able to live outside the hospital environment because staff members of the various centres have been educated to cope with their problems.

Churches and the police are two other systems which have contact with schizophrenic patients. It has been this author's unfortunate experience with some ministers of religion who focus chiefly on prayer-healing, that some schizophrenic patients have been encouraged to forego medication, with the result that when a relapse is evident the patient has a greater existential problem as he/she often feels more rejected by God. Some patients go so far as to imagine they are being punished by God, and they may lose all hope in life. Ministers of religion need to be fully enlightened as to the major role of chemotherapeutic maintenance in keeping a schizophrenic patient's condition stabilized, particularly as most patients regard their ministers of religion with respect and are readily prepared to accept their advice.

Because there are now more schizophrenic patients living in their communities, it follows that police intervention will be required more often. The author has often felt the necessity for an educative programme for the police. A recent incident, where policemen were shot by a psychotic patient, appears to have initiated an education programme at the police college in Pretoria, where policemen will be trained to deal more effectively with such patients.

In every day life, the clinical social worker is often required to assist with this type of education. For example, it is not unusual for a clinical social worker to accompany the police when they fetch a psychotic patient. In such cases, it is the social worker who knows the patient best and is able to advise the police on the most appropriate strategy to adopt.

Before any situation deteriorates to the extent where police assistance is required, caregivers, community staff and all who are involved with the patient should be educated on the illness, maintenance of chemotherapy and admission procedures, to ensure that the patient does not become a danger to himself or to others.

The primary prevention role of the clinical social worker should never be under-estimated. The education of teachers, for example, can assist in the early detection of the illness in high school pupils since the first signs and symptoms of schizophrenia very often appear during these years. An early diagnosis combined with chemotherapeutic care can reduce a schizophrenic patient's impairment. The author knows of a specific case where a high school pupil was successfully treated through the Neuro B programme. She has been able to resume her studies, although not on a full study programme, but she copes with as much work as she is able to under the circumstances. In this case, impairment has been restricted because of early diagnosis and timely chemotherapeutic intervention.

It is also imperative that general practitioners be better educated about schizophrenia and medical schools are, more and more, realising the necessity for this. With early recognition of the symptoms and accurate diagnoses by general practitioners, combined with correct interventions for prevention, fewer schizophrenic patients should need to be hospitalised.

Beels (1979) emphasizes the meaning of developing supportive networks for schizophrenic patients. This intervention has already been recommended by Speck and Ruveni (1969). Friends and neighbours visit and assist families in caring for schizophrenic patients on a weekly basis. Through this particular intervention, which can begin while the patient is still hospitalised, links with other patients and their families can be extended, to the ultimate benefit of the patient, who will feel less rejected on discharge as he/she will find the necessary support is available. This support is so essential after a patient's discharge from hospital.

Successful treatment and rehabilitation programmes, therefore, provide a variety of interventions on chemotherapeutic, individual, group, family and community levels. Chemotherapy is helpful in reducing the effects of schizophrenia in order to increase the patient's ability to benefit more effectively from the other interventions. Strategies like patient skill development, can then be taught, thus assisting the patient to cope more effectively in the areas of social, family and vocational functioning. Patients are thus assisted to assume responsibility for their own lives and to function in society as actively and independently as possible. At the same time, environmental supports are developed to sustain the individual in the community (Anthony & Liberman, 1986).

To summarize the various roles of the clinical social worker within a psychiatric treatment and rehabilitation programme for schizophrenic patients and their families, the following will be highlighted:

* the obtaining of collateral from family members and significant others enables the clinical social worker to contribute towards the complicated process of diagnosis

* as far as the different treatment and rehabilitation interventions are concerned, the contributions are on secondary and tertiary prevention levels by fulfilling the roles of educator on the illness and the medication, with regard to the patient as well as his family, from the psycho-educative perspective. Other interventions require the role of psychotherapist, group and family therapist. Families are no longer just educated - they are also trained in certain skills to ensure that they cope more effectively after the patient's discharge

- as these programmes are also community based, the clinical social worker also encounters the role of educator of other systems in the community and is, therefore, also engaged in primary prevention.

The next chapter will introduce the reader to the treatment and rehabilitation programme at Stikland Hospital, where the writer is a member of the therapeutic team.

SECTION III

CHAPTER 6 - NEURO B - STIKLAND HOSPITAL

6.1 HISTORICAL PERSPECTIVE

The current treatment and rehabilitation programme at Neuro B, Stikland Hospital (Neuro B) commenced in 1979-1980, when a treatment and rehabilitation programme was established as a result of the many re-admissions being experienced, particularly with schizophrenic patients. It was established that the increasing rate of re-admissions was, chiefly, due to the fact that these patients were not properly prepared for discharge from hospital and that they lacked the necessary skills to cope with aspects such as personal care and a structured daily programme. Since 1980, additional activities have been introduced into the rehabilitation programme, with the assistance of the Department of National Education.

During 1980-1981, a six-month programme was established, with a therapeutic team consisting of a medical assistant, social worker, occupational therapist and the ward staff. The Department of National Education maintained an active interest in the patient, whilst parent groups (which met once a month) were also introduced. The parents who attended these group meetings were educated about schizophrenia, and they also played an active role in fundraising.

In the early years, the goals of the programme were to assist patients to be as independent as possible. One of the advantages was that they became accustomed to using public transport. Patients were also required to join the local library, thus encouraging them to have meaningful contact with community facilities.

Since August 1980, patients from other wards within Stikland Hospital have also been admitted to Neuro B, so as to afford them the opportunity of preparing for discharge from hospital. Ages of patients ranged from 30 to 35 years and, apart from an occupational programme, attention had been focused on functional evaluation, such as self care, preparation of meals, money management, creative activities like sport, handwork and various other hobbies. There were regular outings to restaurants, museums and other community facilities. Criteria for admission to the past programme were: a diagnosis of schizophrenia, an average intelligence quotient (IQ), and the patient being apsychotic.

Problems with previous programmes seemed mainly to lie with the constant turnover in staff. However, in spite of this handicap, many patients succeeded in making the transition to work in the community while living in the ward, and parent group meetings were eagerly attended by parents. The findings were that most patients could attain a higher level of functioning once they had been involved in the programme.

During 1982 and 1983, the programme became increasingly unstructured as a result of constant staff turnover, and there was an increasing admission of patients who had poor prognoses and little chance of succeeding with the programme.

Owing to the increasing admission rate of young, schizophrenic patients to Stikland Hospital in 1983, renewed efforts were made to re-establish a structured programme. The hospital's Board gave its authorisation and the present programme commenced in July 1984. Although the present programme is, in many ways, based on the 1980 programme, it is now supplemented by a level system (see page 111 and Appendix A).

6.2 SELECTION CRITERIA

6.2.1 Diagnosis of schizophrenia or schizoaffective disorder.

6.2.2 Patients should be apsychotic on admission to the ward.

6.2.3 Age - between 18 and 35 years.

6.2.4 Patients must be motivated and willing to remain in the programme for six months.

6.2.5 No patients who suffer impairment due to alcohol or substance abuse are admitted to the ward.

6.2.6 Patients have an average, or above average, IQ.

6.2.7 No patients with criminal records are admitted.

6.3 REFERRAL PROCEDURE

Patients are referred to Neuro B by general practitioners in private practice, and other hospitals such as Tygerberg, Groote Schuur and Libertas, or by clinical psychologists who are practising in the community. Many of the patients who are referred are first admitted into Stikland Hospital's other admission wards. Necessary information regarding the patient's psychiatric history, employment, psycho-social background and other relevant information is then obtained, and the patients are screened prior to admission to the Neuro B programme.

6.4 THE THERAPEUTIC TEAM

The therapeutic team consists of:

- the psychiatrist, who acts as consultant
- medical assistant (medical doctor)
- nursing staff
- occupational therapist
- clinical social worker, and
- minister of religion.

It is often necessary to conduct IQ tests, to establish a patient's level of functioning and to plan for his/her future career. The services of the hospital clinical psychologists are then obtained. They are also available for psychotherapeutic interventions.

Parents are regarded as an extension of the team and, as such, they are educated to play a positive role, for example, they are helped to evaluate week-end activities for the patient.

6.5 AIMS AND OBJECTIVES

The programme's main objectives are to enable patients to reach their optimum level of functioning, by:

6.5.1 enabling them to work and reside outside the hospital environment, or

6.5.2 to live outside the hospital and work within it, or

6.5.3 to live within the hospital and work outside.

The various members who comprise the therapeutic team have additional aims and objectives. For example, the medical assistant evaluates the clinical condition of the patient, with a final evaluation being made at the end of the six-month period. The medical assistant is also responsible for prescribing medication and evaluating its effectiveness for the patient.

Members of the nursing staff accept responsibility for the patient whilst he/she is in the ward, and they attend to aspects such as self care, self medication, ward duties, and also the care and functioning of the patient after hours and during week-ends for those patients who remain in the ward.

The occupational therapist evaluates the degree of impairment, particularly with regard to the patient's employment ability. This therapist plans strategies to overcome problems caused by the patient's inability to concentrate, lack of endurance and lack of drive in the work situation. Improving the patient's ability to work is a prime aim of this programme, as is the placement of the patient in suitable employment.

Apart from the diagnostic contribution which the clinical social worker can make within the programme, other contributions have been discussed in Chapter 3.1 (education with regard to the taking and side-effects of medication); psychotherapy (Chapter 3.2); group therapy involving both in-patient and out-patient groups (Chapter 3.3). Family treatment and community involvement are discussed in Chapters 4 and 5.

The patients' religious needs are attended to by the minister of religion, who ensures that patients are visited regularly by their own ministers of religion once they have been discharged from hospital.

The overall goals are, therefore, supplemented by the aims of each individual team member.

6.6 THE PROGRAMME

6.6.1 General Information

Patients are admitted in groups of between six and sixteen in February and July of each year, for a period of six months. All patients on the programme are contracted to remain within the programme for this length of time.

The programme, which is based on learning theory and behavioural therapy principles, uses a level system. Patients start on level D and progress to level A during the six months on the programme. Requirements become increasingly more demanding for progress to the next level, so as to prepare patients for their discharge. These requirements are based on the here-and-now, every day practical aspects of the patient's functioning.

At level D, the patient's functioning is, for example, evaluated on physical aspects, such as self care, clothing, making of beds, and other basic skills. Psychological evaluation is noted with regard to the patient's ability to accept responsibility, communication with others, self-discipline and insight. Social activities, religious needs and activities, as well as employment habits, endurance, work motivation and production speed are other aspects which are evaluated.

Level A sees evaluation, with a view to discharge, taking place on aspects such as leadership, realistic future planning, insight with regard to schizophrenia.

Appendix A gives detailed information into the various levels and the requirements which patients are expected to meet prior to progress to the next level. The ultimate aim of this level system is to prepare the patient for discharge from the hospital back into the community.

Patients are evaluated on a 4-point, weekly scale, with once-monthly individual assessments. These individual assessments take the form of indepth discussions with the patient, concerning his/her progress. The patient thus has an opportunity to discuss various aspects of improvement on the different levels of functioning and with coping skills.

6.6.2 Activities in the Programme (A copy of the Weekly Roster is in Appendix B)

A full programme is provided for patients between the hours of 6.30 a.m. and 10.00 p.m., on a daily basis. This programme includes ward duties, such as the making of beds and tidying up of the ward as these are basic functions which they will be required to perform once they are discharged from hospital. Patients on level A, who have been specifically selected by their group, act as directors and assist with the evaluation of self care and basic duties of new patients who are automatically placed on level D.

For the major part of the day, patients are involved with the occupational therapy department, where their impairment is evaluated or are they are prepared for suitable employment. There is ample scope for patients to take part in sport and recreation. Therapeutic outings, social evenings/ activities and contact with other young people in the community are also arranged for patients.

Individual team members are available to patients, and the following groups are also there for them:

* The doctor's group enables patients to discuss their illness, its symptoms, and how to cope with the illness. Patients are encouraged to read appropriate literature about their illness and to ask questions. The aim of this group is to provide patients with information about the illness, thus helping them to come to terms with impairments and to identify the initial symptoms of a relapse once they are out in the community again. Patients are taught the basic principles of self-medication and, in fact, during the last phase of hospitalization they are taught the proper procedures in this regard. They also learn about possible side-effects of medication.

* A week-end report-back group conducted by the clinical social worker, enables patients to discuss experiences which they have had over the week-end. Existential aspects pertaining to the stigma and experience of suffering from of their illness, the way it affects themselves and others in their community, interpersonal problems with family or relatives, financial and residential problems, all form part of the patients' contact with the "outside world" and are dealt with here (Chapter 3.3).

* Religious education and activities for patients are an important aspect of treatment, and patients are in contact with other young

people in the community who visit them in hospital.

- Towards the end of the programme (during the last two months of it), groups are also available to help patients improve their self-image. This group concentrates particularly on self care, dieting, choice of clothing for different occasions, and aspects such as self-acceptance and the appreciation of others.

Social skills' training focuses on communication, assertiveness, socialisation with others, coping with critical comments, and leadership. This training also deals with the improvement of observation, listening, and group co-operation. Skills' training also provides practical training, for example, with the preparation of meals. Staff members are invited to attend functions where the patients have prepared the food and, at times such as these, ideas about recipes, etiquette and table manners can be exchanged.

The above groups can be successfully conducted by the clinical social worker. At Neuro B the occupational therapist conducts them as different groups are divided amongst staff members. Other important aspects which receive attention during the programme are: money management, taking care of clothing, fitness, sport, and recreation (for example, pottery).

Therapeutic outings are undertaken once a month, when patients are taken to restaurants, museums and other facilities in the community, such as shopping centres and bioscopes. The aim of these outings is to help patients to practise social skills, improve group cohesion and encourage socialization between group members, to use public transport and to be in regular contact with the world outside the hospital. At the same time, these are ideal opportunities for patients to relax and for team members to observe them.

Apart from daily activities, an evening programme is available. Once a month the patients plan a social evening. This can involve inviting patients from other wards or people from outside the hospital, for braais, videos or dances. Initially, the staff plans these evenings but patients are expected to accept responsibility for the planning and to become more and more responsible for the functions towards the end of the treatment programme.

Other evenings see patients around the television set, or reading the newspapers. They then report back on what they have seen or read. These activities encourage their concentration and memory skills development. They also report back on their other activities, such as outings and social evenings, in order to stimulate observation skills and thought processes. Patients are also encouraged to find their own evening entertainment, such as reading and hobbies.

The programme appears to be a very involved one, if one considers that the patients' bedtime is 10 p.m. Therefore, the patients' endurance skills are gradually increased over the six-month period. Initially, patients are allowed to rest during their lunch breaks but, gradually, they are assisted to cope with longer hours. Circumstances and situations are, as far as possible, simulated with the environment outside the hospital.

Patients also make plans for Friday evenings, Saturdays, Saturday evenings and Sundays. Their activities include shopping, household tasks, recreation and socialization with family and relatives. Patients are, however, prevented from total withdrawal to their own rooms for week-ends (a situation that is commonly experienced with schizophrenic patients). Parents and relatives are required to complete a questionnaire by way of a report back on how the patients functioned over the week-end.

Since 1984 this intervention, where the patients plan activities themselves and participate in successful interaction and socialization, as well as increased involvement in the community and recreation activities, has proved most successful - as reported by parents and relatives. This intervention also encourages parents to act as extended team members.

Apart from the service provided to the patient who is involved in the programme, the family and relatives are also involved. Not only is each family treated as an individual unit by the staff who obtain information from them, but they are provided with advice and support should they need it. Family evenings take place once a month, when families are educated about schizophrenia and how to cope effectively with the sick member of their unit. In 1987 a parent's support group was established, for parents whose children have completed the programme (Chapter 4).

A well established after-care programme exists for patients, during which they are chemotherapeutically maintained and involved in follow-up clinics. Two types of after-care groups are offered - a social-support group and a work follow-up group. Home visiting, where the principles and aims of the programme are extended, is also provided. The therapeutic team, therefore, endeavours as far as possible to maintain links with patients who have been discharged from hospital (Chapters 3.3 and 4.6).

The most recent development is an after-care residential facility, which opened in April 1988. This house, "Cleveland Lodge", accommodates patients who have been discharged from hospital after completing the programme. It is providing an excellent opportunity for extension of the programme, and ensures effective after-care and the patients' successful re-establishment in the community.

6.7 THOUGHTS WITH REGARD TO THE PROGRAMME

6.7.1 Financing

The question of finance is a most important one, as a period of six months is involved. Many patients who are admitted to the programme are on disability grants and, according to governmental policy, they are allowed to receive their grants for only three months whilst hospitalised. Financial evaluations are done by the clinical social worker.

Patients require the minimum of pocket money during the six month programme and during this time they are invariably assisted by parents or relatives. The usual Provincial hospital accounting procedures apply to patients of Neuro B. Some patients are members of medical aid funds, either their own or their parents. For others who are unemployed, with no outside financial assistance, the ordinary procedures are adopted as for other patients in similar circumstances. Nobody is turned away for financial reasons.

6.7.2 Contracting with Residents

Patients in Neuro B have resident status. The team endeavours, as far as possible, to assist them in coping optimally with their illness, thus enabling them to live optimally in spite of the illness. This approach is also favoured by Paul and Lentz (1977), who advise communication of the fact that patients also have certain responsibilities, one of which is the undertaking of basic tasks.

Residents also contract to stay for the full period of six months. Steckel (1982) sees this as an intervention which specifically outlines and the psychotic episode subsides, however, the patient continues with the programme.

Relapses are regarded as learning situations, where the patient is free to discuss the re-appearance of symptoms and the degree of decline in functioning which often accompanies these psychotic episodes. It is usual for patients to feel useless and hopeless when they suffer relapses, and it is possible for them to lose hope about ever being able to manage successfully on their own after discharge from hospital. At times such as these, patients need much support and motivation. The approaches of Frankl (1968) and Yalom (1980) have proved useful to the Neuro B team in its efforts to motivate the relapsed patient to a more meaningful way of life, despite the impairment of schizophrenia.

Because of this impairment, not all patients are able to attain level A, and some cannot meet all their weekly commitments. Team members attempt to provide each patient with opportunities for advancement, and individual, optimal levels of functioning are taken into account. Some patients can take a year to achieve the goal of proper self-care.

6.7.4 Diagnostic Considerations

As mentioned previously, the diagnosis of schizophrenia is a controversial and complicated process. Although the Neuro B programme does not aim primarily at altering the diagnoses of patients, this has been possible in some cases. A six-month period provides an excellent opportunity to observe the patient in most circumstances, to obtain collateral and to evaluate functioning. These are the words of a patient, known to the author, who had been wrongly diagnosed prior to entering the programme:

> Die terugtrekking van my diagnose het my met blydskap vervul en elke personeellid het 'n bydrae gelewer ... en ek probeer altyd u werk in my gebede op te dra.
>
> (Translation: The withdrawal of my diagnosis filled me with joy and every staff member made a contribution ... and I always try to remember your work in my prayers).

6.7.5 Sensory Integration Therapy

The Department of Occupational Therapy, Stikland Hospital, introduced this therapy to the Neuro B programme. As the original occupational therapist is no longer attached to this hospital, this therapy will be resumed once the new encumbent of the position is trained to conduct it. Ayres (1983) regards sensory integration therapy as a speciality of occupational therapy.

Because schizophrenia coincides with biochemical dysfunctioning, tactile, vestibular, proprioceptive, speech and language problems are often present. If there is poor integration between the two hemispheres of the brain, the patient may experience problems in distinguishing left from right, or there may be poor eye-hand co-ordination.

It has often been observed that schizophrenic patients have difficulty in raising their hands above their heads, or playing games like tennis or badminton, as a result of poor integration. With stimulation, these handicaps can be alleviated. Patients often enjoy the exercises which take place in the form of games.

6.7.6 Physical Activities

The programme provides ample time for the patient to participate in sporting activities. In this way, patients are able to re-enter life outside the hospital setting. Some patients have been able to participate in netball and cricket matches for outside sports' clubs, whilst they have been involved in the programme.

Levin (1983) found that depression and anxiety decreased significantly in chronic schizophrenic patients who were participants in a ten-week jogging programme. There is much to positively recommend the inclusion of physical activities in such a programme.

6.7.7 Working with The Therapeutic Team

The therapeutic team who commenced the Neuro B programme in 1984 was subjected to high staff turnover, and at the beginning of 1988 several new members joined the team when others left. The advantage of this turnover in staff has been that more people are being trained to run such a programme and they, in turn, are able to train others. Rogers, Cohen, Danley, Hutchinson and Anthony (1986) regard the advantage of training new staff as a challenge, because the structure, service pattern, roles, values and functions of the programme are then also subjected to modification and improvement. Staff changes also enable aims and objectives to be reconsidered and planning interventions can be readjusted.

During a time of retrospection, the Neuro B team felt that limitations are present in the programme's individual reward system. A token system is now evaluated, whereby patients are given more meaningful rewards for positive behaviour. Paul and Lentz (1977) and Steckel (1982) found that meaningful rewards initiate new behaviour, reinforcing and shaping positive behaviour and, ultimately, boosting the patient's self-esteem.

Another change which is presently being considered to the Neuro B programme is that of including patients who suffer from impairment as a result of other psychiatric illnesses, like bipolar affective illness. It is anticipated that the July 1988 intake will include patients from this category, as well as schizophrenic patients.

The author regards her position as a member of the therapeutic team at Neuro B as a most meaningful opportunity to learn more about schizophrenia. Getting to know one's fellow human beings during their suffering, and helping them in their endeavours to cope with the illness, is a tremendously emotional experience and a privilege. There is also the fulfilment of learning from other members of the team, in a united effort to offer the patient an optimal life and functioning.

The Department of Occupational Therapy at Stikland Hospital has played a major role in the initiation and implementation of the Neuro B programme, and it is with respect that the author acknowledges this department's major role in assisting schizophrenic patients towards a better life and future.

6.7.8 Other Available Facilities

Neuro B at Stikland Hospital appears to be the only centre in South Africa which offers a specific, comprehensive programme for schizophrenic patients. Lentegeur and Valkenberg Hospitals, however, do offer treatment and rehabilitation facilities for impaired psychiatric patients in general, and these two hospitals have rehabilitation wards for this purpose.

Sterkfontein Hospital concentrates on impairment caused by various types of psychiatric illness, and distinguishes between patients with lower and higher functioning levels. This hospital's interventions are then adjusted to meet the patient's abilities.

Weskoppies Hospital offers a daily programme for schizophrenic patients who are inpatients in various wards. This programme aims to rehabilitate patients towards successful re-adjustment in the community. Out-patients are also included in the programme.

Certain parent-support groups have also come into being. In Rondebosch, Cape Town, a strong parent-support group offers a well-established service to parents, while Stikland's parent-support group started meeting in 1987. Pretoria's parent-support group is known as "YANA - You are not Alone". A similar group in Port Elizabeth established "Carehaven", an after-care centre where discharged patients can reside. Other after-care centres are located in Johannesburg (Gordonia) and Rondebosch (Arran House), where patients can also reside once they have been discharged from hospital.

Stikland Hospital has recently established a halfway house for schizophrenic patients, "Cleveland Lodge", which is showing signs of becoming a promising residential facility for discharged patients, as mentioned on page 116.

SECTION IV

CHAPTER 7

PATIENTS INVOLVED IN THE NEURO B PROGRAMME

A total of 56 patients (33 males and 23 females) have been involved in the programme since it commenced in 1984. In this section some descriptive particulars from their files will be highlighted, together with an account of their present circumstances and level of functioning.

Three patients have died since 1984 - two males and one female. Their particulars are excluded when discussing the present functioning of the patients. Patients on the February 1988 intake to the programme are also excluded, as they will only complete their six month programme in August 1988.

It must also be taken into account that patients from the previous intake, who form part of the sample group, were only discharged from hospital during May/June 1988, and they have hardly had time to adjust in their communities.

7.1 SELECTED DESCRIPTIVE INFORMATION FROM FILES

This information is collated in Table 7.1 (Males) and 7.2 (females):

TABLE 7.1: SELECTED DESCRIPTIVE INFORMATION FROM FILES (MALES)

(n = 33)

NO.	MONTH OF BIRTH	CULTURE/ LANGUAGE	MARITAL STATUS	OCCUPATION PRIOR TO ONSET	AGE AT ONSET (YEARS)	SCHOLASTIC ACHIEVEMENTS
1	Sept	A	N/M	U student	20	U graduate
2	Mar	A	N/M	Driver	31	Std 6
3	Feb	A	N/M	Appren technician	23	Std 8
4	Nov	A	N/M	Scholar	18	Std 10
5	Apr	A	N/M	Scholar	19	Std 9
6	May	A	D	Police service	20	Std 10
7	Sept	E	N/M	U student	23	U graduate
8	June	A	N/M	Scholar	19	Std 9
9	Dec	A	N/M	Prison Service	21	Std 10
10	Dec	A	M	Dept of Transport	35	Std 10
11	Mar	A	N/M	U student	22	Std 10
12	Oct	A	N/M	U graduate	25	U graduate
13	June	A	N/M	U student	19	Std 10
14	Oct	A	N/M	U student	20	Std 10
15	Sept	G	N/M	Clerk/U student	27	Std 10
16	Nov	A	N/M	Scholar	16	Std 10
17	Mar	E	N/M	Scholar	16	Std 9
18	Feb	GR	N/M	U student	27	U graduate
19	Oct	A	D	Scholar	17	Std 10
20	Nov	A	N/M	Scholar	16	Std 9
21	May	E	N/M	Chef	24	Std 9
22	Aug	A	M	Farmer	24	Std 10
23	Nov	A	N/M	U student	31	U graduate
24	Sept	E	N/M	Scholar	16	Std 8
25	Sept	A	N/M	Clerk	20	Std 10
26	Feb	A	N/M	U student	18	U graduate
27	Aug	A	N/M	Clerk	22	Std 10
28	Feb	A	N/M	Army	21	Std 10
29	Aug	D	M	Mechanic	27	Std 6
30	July	A	N/M	Clerk	22	Std 10
31	Nov	A	N/M	Scholar	17	Std 9
32	Jan	A	N/M	Army	21	Std 10
33	Nov	E	N/M	U student	20	Std 10

KEY:

E = English
A = Afrikaans
G = German
GR = Greek

N/M = Never Married
M = Married
D = Divorced
U = University

TABLE 7.1.1: SELECTED DESCRIPTIVE INFORMATION FROM FILES (FEMALES)

(n = 23)

NO.	MONTH OF BIRTH	CULTURE/ LANGUAGE	MARITAL STATUS	OCCUPATION PRIOR TO ONSET	AGE AT ONSET (YEARS)	SCHOLASTIC ACHIEVE-MENTS
1	May	A	N/M	U student	22	U graduate
2	Apr	A	N/M	Scholar	16	Std 9
3	Mar	A	D	Clerk	18	Std 10
4	July	A	N/M	Clerk	24	Std 9
5	June	A	N/M	U student	21	U graduate
6	June	G	N/M	U student	19	Std 10
7	Jan	A	N/M	Student nurse	22	Std 10
8	Nov	E	D	Clerk	26	Std 10
9	May	A	M	School teacher	28	Teach/Dipl
10	Jan	E	M	Clerk	27	Std 10
11	June	A	N/M	College student	18	Std 10
12	Mar	A	D	U student	25	U graduate
13	Dec	A	N/M	Scholar	19	Std 9
14	Aug	A	N/M	U student	22	Std 10
15	June	A	D	U lecturer	35	U graduate
16	Oct	E	N/M	Scholar	16	U graduate
17	June	A	D	Housewife	18	Std 10
18	Aug	A	N/M	Clerk	19	Std 10
19	Mar	A	N/M	U student	17	Std 10
20	Nov	A	N/M	Scholar	18	Std 8
21	Oct	A	N/M	Scholar	16	Std 9
22	Nov	A	N/M	Scholar	14	Std 10
23	Oct	A	N/M	School teacher	22	U graduate

KEY:
E = English
A = Afrikaans
G = German
GR = Greek
N/M = Never Married
M = Married
D = Divorced
U = University

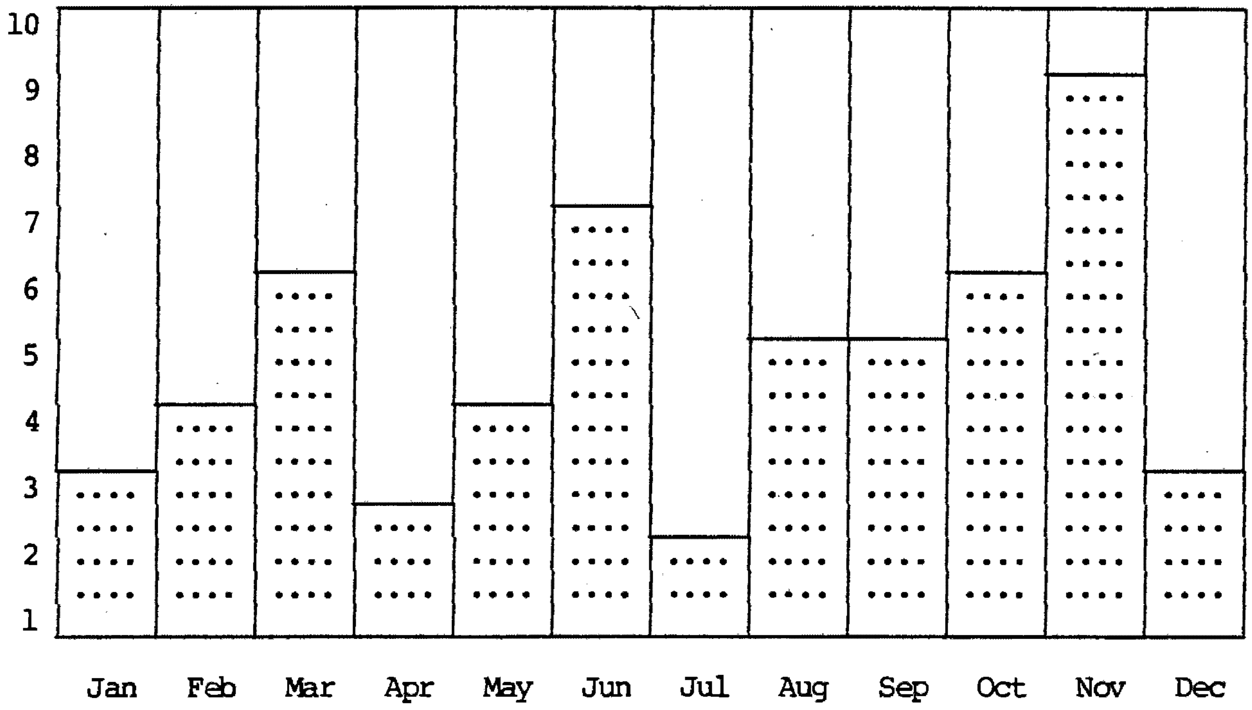
7.1.1 Gender

33 males (58,9%) and 23 females (41,1%) have been involved in the Neuro B programme since 1984. More men than women have also been referred for the July 1988 intake.

7.1.2 Months of Birth

Figure 7.1 gives an indication of the incidence of schizophrenia according to the months in which the patients were born:

FIGURE 7.1.2: MONTHS OF BIRTH



Many researchers have explored the possibility that schizophrenia is more prevalent amongst those born in the winter months, and Baron and Gruen (1988) mention some studies which report an 8% increase among such patients. However, no definite conclusions have been reached with this hypothesis. The possibility of brain injuries at birth or viral infections between birth and onset of schizophrenia have been investigated, also without any definite conclusions being drawn as to whether or not they are specific contributors to the illness.

Many of the patients referred to in this study were in fact born during the South African spring months. A wide selection of variables could have contributed to schizophrenia in these patients. Detailed research into the birth circumstances of each patient needs to be conducted, but it is beyond the scope of this study.

7.1.3 Culture and Language

A breakdown of schizophrenic patients into the various language/culture groups is as follows:

Afrikaans patients	:	46
English patients	:	7
German patients	:	2
Greek patients	:	1

Neuro B ward forms part of Stikland Hospital, which serves the northern suburbs of Cape Town, together with Stellenbosch and the West Coast, as well as the Worcester region. Occupants of these regions are, in the main, Afrikaans-speaking. The programme also accommodates members of other language groups and the present intake has a Portuguese patient.

7.1.4 Marital Status

An analysis of the sample's marital status is given below:

MALES			FEMALES		
Never married	:	28	Never married	:	16
Married	:	2	Married	:	2
Divorced	:	3	Divorced	:	5
Total		33	Total		23

Many patients who fall into the "Never Married" category were still scholars and are unlikely to have been married whilst at school. This needs to be taken into account for the various age groups before meaningful conclusions can be drawn.

7.1.5 Occupation Prior to Onset of Illness

Research data reveals the following incidence of the various occupations in relation to male and female patients of the sample group:

MALES	OCCUPATION	FEMALES
10	University students	6
3	Technicians, drivers and mechanics	0
9	Scholars	6
4	Clerks	4
2	Army trainees	0
3	Government employees	0
1	Chefs	0
1	Farmers	0
0	Housewives	1
0	School teachers	2
0	University lecturers	1
33	TOTAL	23

7.1.6 Average Age at Onset of Illness

Average ages of male and female patients from the sample group at the onset of schizophrenia are: (these ages of onset are often only the age at which the patient is treated for the first time. In some cases the first symptoms of the illness appeared long before this time, but were not correctly diagnosed).

MALES : 21,7 years

FEMALES : 20,9 years.

7.1.7 Scholastic Achievements Prior to Onset of Illness

An analysis of the sample group reveals the scholastic achievements of male and female schizophrenic patients:

MALES	SCHOLASTIC ACHIEVEMENTS PRIOR TO ONSET OF SCHIZOPHRENIA	FEMALES
6	University graduates	6
0	Teacher's Diploma	1
17	Std 10	11
6	Std 9	4
2	Std 8	1
0	Std 7	0
2	Std 6	0
33	TOTAL	23

The high incidence of patients in the Std. 10 and University categories is remarkable. Without the impairment of their illness they would have been able to make a significant contribution to the economy.

7.2 PRESENT CIRCUMSTANCES OF FORMER RESIDENTS

It is interesting to note the present circumstances of former patients, divided into male and female groups:

TABLE 7.2: PRESENT CIRCUMSTANCES OF FORMER RESIDENTS
(Males: n = 31)

NO.	PRESENT OCCUPATION/JOB	FINANCIAL PARTICULARS (DG = Disability Grant)	RESIDENTIAL PARTICULARS	PREVIOUS ADMISSION	RETURNED OR RE-CONTRACTED	FUNCTIONING
1	Bookkeeper	DG	Boarding House	Several	Yes	Good
2	Lorry-driver	DG	Boarding House	Several	No	Good
3	On long-term ward programme	*	*	Several	No	Optimal
4	Sheltered employment	DG	Aftercare Centre	Several	Yes	Good
5	On long-term ward programme	*	*	Several	No	Optimal
6	Unemployed	DG	Boarding House	Several	No	Good
7	Died while on programme	*	*	*	*	*
8	On long-term ward programme	*	*	Several	No	Optimal
9	Back with same firm	Open labour mkt	Family	1st adm	Yes	Very Good
10	Back with same firm	Open labour mkt	Family	1st adm	Yes	Very Good
11	Unemployed	Family maint.	Family	1st adm	No	Good
12	Day-patient	DG	Family	1st adm	Yes	Good
13	Back with same firm	Open labour mkt	Hostel at work	Several	Yes	Very Good
14	Hospital post	DG	Halfway House	Several	Yes	Good
15	Clerk	Open labour mkt	Family	1st adm	Yes	Very Good
16	Lorry driver	Family business	Family	Several	No	Very Good
17	Scholar	DG	Aftercare Centre	1st adm	Yes	Very Good
18	Clerk	Family business	Family	Several	No	Very Good
19	Unemployed	DG	Aftercare Centre	Several	No	Good
20	Hospital post	DG	Boarding House	1st adm	Yes	Very Good
21	Hospital post	DG	Own Room	Several	No	Very Good
22	Unemployed	Independent	Family	Several	No	Optimal
23	Bookkeeper	Open labour mkt	Own Flat	Several	No	Good
24	Died while on programme	*	*	*	*	*
25	Hospital post	DG	Family	Previous	Yes	Very Good
26	Unemployed	Independent	Family	Several	No	Good
27	Unemployed	Independent	Family	Several	Yes	Good
28	Technician	Open labour mkt	Work Hostel	Several	No	Very Good
29	Sheltered employment	*	Hospital	Several	No	Optimal
30	Unemployed	DG	Family	Several	No	Optimal
31	No particulars known	*	*	1st adm	No	Unknown
32	Clerk	Independent	Family	Previous	Yes	Very Good
33	Clerk	Independent	Family	1st adm	Yes	Very Good

TABLE 7 2.1: PRESENT CIRCUMSTANCES OF FORMER RESIDENTS

(Females: n = 22)

NO.	PRESENT OCCUPATION/JOB	FINANCIAL PARTICULARS	RESIDENTIAL PARTICULARS	PREVIOUS ADMISSION	RETURNED OR RE-CONTRACTED	FUNCTIONING
1	Clerk	Open labour mkt	Own Flat	1st adm	Yes	Very Good
2	Unemployed	DG	Family	Several	No	Optimal
3	Switchboard operator	Open labour mkt	Halfway House	Several	Yes	Very Good
4	Unemployed	DG	Family	Previous	Yes	Good
5	DIED AFTER COMPLETING PROGRAMME	*	*	*	*	*
6	Unemployed	DG	Boyfriend	Several	Yes	Good
7	On long-term ward programme	*	*	1st adm	Yes	Optimal
8	On long-term ward programme	*	*	Previous	Yes	Optimal
9	Housewife	Husband support	Husband & fam	Previous	Yes	Good
10	Housewife	Independent	Boyfriend	1st adm	Yes	Very Good
11	Part-time jobs	Independent	Family	Previous	Yes	Very Good
12	Accountant	Family business	Family	Several	Yes	Very Good
13	Unemployed	DG	Family	Several	No	Optimal
14	On long-term ward programme	*	*	Several	No	Optimal
15	Hospital post	DG	Boarding House	1st adm	No	Good
16	Student	DG	Family	Several	Yes	Very Good
17	Housewife	DG	Family	Several	Yes	Optimal
18	Unemployed	DG	Family	1st adm	No	Optimal
19	Protected employment	DG	Family	Previous	Yes	Very Good
20	Scholar	DG	Family	Previous	No	Very Good
21	Sheltered employment	DG	Aftercare Centre	Previous	Yes	Optimal
22	Day patient	DG	Halfway House	Several	Yes	Very Good
23	School teacher	Open labour mkt	Family	Previous	Yes	Very Good

KEY: DG = Disability Grant
Previous Admissions : Five or less
Several previous admissions : more than five

7.2.1 Present Occupation/Job

It is interesting to note that many patients from the sample group are gainfully employed:

MALES	OCCUPATION/JOB	FEMALES
3	Open labour market	2
2	Lorry drivers	0
2	Sheltered employment	1
2	Accountants/bookkeepers	1
4	Hospital posts	1
1	Scholars, students	2
0	Protected employment (family arrangements) or part-time	2
0	School teachers	1
0	Housewives	3
3	Long-term wards	3
7	Unemployed	5
1	Day patients	1
1	Unknown	0
4	Clerks	0
1	Technician	0
31	TOTAL	22

7.2.2 Financial : Income

Here we have an indication as to the way in which the sample group obtains its income:

MALES	INCOME	FEMALES
6	Salary : open labour market	3
11	Disability grants	12
5	Maintained by family	3
2	Disability grant and limited income (family firm)	0
2	Paid by family firm	1
4	No income (resident in hospital)	3
1	Unknown	0
31	TOTAL	22

When the group's sources of income are compared with their qualifications, the fact that most receive disability grants is indicative of their impaired functioning in vocational abilities.

7.2.3 Residential Particulars

As is evident from the analysis below, families are the main caregivers for this particular group of patients, and the importance of family education is, therefore, stressed.

MALES	RESIDENTIAL PARTICULARS	FEMALES
13	Family	12
5	Halfway house/aftercare centre	3
0	Cohabiting with opposite sex	2
4	Boarding house	1
2	Own flat/room	1
2	Hostel at work	0
4	Resident in hospital	3
1	Unknown	0
31	TOTAL	22

7.2.4 Previous Admission Particulars

Some patients have undergone a previous admission, or several previous admissions, prior to their admission to Neuro B. For the purpose of this study, the number of previous admissions is taken as five or less (that is, five or less than five admissions), whereas several previous admissions are taken to be more than five. Other's admissions to the programme coincided with their first admission to a psychiatric hospital.

MALES	NUMBER OF ADMISSIONS	FEMALES
9	First admissions	5
2	Previous admissions	8
20	Several previous admissions	9
31	TOTAL	22

7.2.5 Patients Who Recontracted or Returned for a Second Rehabilitation Period

MALES	RECONTRACT/RETURN	FEMALES
2	Returned	2
12	Recontracted	14
14	TOTAL	16

Some patients are doubtful whether they will cope with the period of six months, but for the abovenamed patients, extended periods were necessary. This fact is indicative of the long period of time that is needed to ensure some improvement in functioning.

7.2.6 Present Level of Functioning

For the purpose of this study, Very Good functioning indicates a level of functioning where patients are psychiatrically stabilized and functioning on a higher level than before they entered the programme.

Good functioning means a level of functioning which is maintained by patients who, although significantly impaired by schizophrenia, are able to live optimally outside the hospital.

Optimal functioning indicates a level of functioning where patients require maximum support from family or the staff of care-centres, and who are unable to live independently at all.

It is important to know that all 52 patients are functioning in one way or another. (Particulars about one patient are unknown).

MALES	LEVEL OF FUNCTIONING	FEMALES
13	Very Good	10
11	Good	4
6	Optimal	8
1	Unknown	0
31	TOTAL	22

Should one look at functioning after completion of the programme, it should be taken into account that the level system, itself, provides the opportunity to improve functioning. The patients who are classified as having "very good" functioning, as indicated above, are presently able to maintain a high level of functioning after they have completed the programme. Some have, as mentioned above, only recently been discharged from the programme. More time is needed to meaningfully assess whether they can maintain this level of functioning over a longer period.

Future research could be undertaken on a longer term than at present, and one can also investigate the various aspects which might influence relapses at different stages after discharge (McGlashan, 1986).

Another important factor is that although patients who are classified as having "optimal functioning" are in a chronic ward, they also function better than they would at home, and this is the only way to maintain some level of functioning in their specific cases. An interesting development is that one of these patients has now stabilized to such an extent that hopes exist for her to be discharged to "Cleveland Lodge" - the halfway house. This is indicative of the fact that time is a most important factor. In at least one other case (also a member of this particular group), the gains were only observed long after she had completed the programme. This patient is now entering the open labour market.

The categories of functioning, namely, "very good", "good" and "optimal" are, for the purposes of this dissertation, only used to help the reader form some opinion about the patients' levels of functioning.

SECTION V

CHAPTER 8 : RESULTS OF SURVEYS : OBTAINED BY QUESTIONNAIRES

Questionnaires were used to highlight the opinions of former residents and their parents (or relatives and spouses) about the following:

In the A section of the Resident Questionnaire, respondents had the opportunity to answer questions about themselves (for example, to give their opinions about the relevance of medication, their functioning, and the like). In the B section, their opinions about some aspects of the programme were requested.

Appendix C is a copy of the letter which accompanied both Questionnaires. Appendix D is a copy of the Resident Questionnaire and the Parent/Relative/Spouse Questionnaire is shown in Appendix E.

8.1 QUESTIONNAIRES FOR FORMER RESIDENTS

The number of former Neuro B residents is 53, as three patients died as a result of suicide. There was uncertainty about the address and whereabouts of one male patient, but a Questionnaire was sent to his last-known home address.

As respondents were granted the opportunity of remaining anonymous, it was hoped that they would feel free to answer the questions honestly.

Of the 53 questionnaires which were sent out, 38 were returned - a percentage of 71,69%. This is obviously a reflection of the contact which the therapeutic teams attempts to maintain with former residents. At present, a considerable number of former residents live in South West Africa, Pretoria, Durban and the Eastern Cape. Occasional telephone contact with them, or their relatives, is virtually the only method of present contact with them.

Responses on the following Questions are highlighted:

In A section, Question 4 aimed at eliciting responses about the adequacy of education about schizophrenia whilst patients were on the programme, while Question 5 focused on the relevance of taking medication. These two aspects are regarded by the Neuro B team as being vitally important, as functioning and optimal living are highly dependent on chemotherapeutic stability.

Questions 6, 7 and 8 highlighted opinions about patients' general functioning, relationships and work abilities.

In the B section, Questions 1, 5 and 9 dealt with the relevance of the programme, while Questions 2 and 3 requested information about the way in which the former patient had benefitted from the programme. Questions 6 and 7 focused on aspects of the programme from which former patients felt they had gained the most or the least benefit.

Responses revealed much misunderstanding between Questions 2 and 3 and 6 and 7. This could have been due to the questions being unclear. They may have been better understood if the writer had stipulated more clearly, for example, how Questions 2 and 3 actually related to how the former residents' functioning had changed, or how or what they had gained, as a result of their involvement in the programme. Questions 6 and 7 could have been clearer if the word "activities" had been used, rather than the word "aspects". A copy of the weekly roster could also have been sent to patients, to refresh their memories, as some of the respondents completed the programme as far back as 1985.

Responses to Section A of the former Resident Questionnaire are as follows:

TABLE 8.1.1 : RESPONSES TO QUESTION 4

SUFFICIENCY ABOUT EDUCATION ON THEIR ILLNESS

RESIDENTS' RESPONSES	NUMBER	%
Sufficient education	31	81,6
Insufficient education	4	10,5
Inappropriate responses*	3	7,9
TOTAL	38	100,0

* By inappropriate responses is meant that the question was not answered appropriately, for example, responses about other issues were given rather than a reply to the question asked.

TABLE 8.1.2: RESPONSES TO QUESTION 5
RELEVANCE OF MEDICATION

RESIDENTS' RESPONSES	NUMBER	%
Medication important	35	92,11
Medication not important	1	2,63
No answer	1	2,63
Inappropriate response	1	2,63
TOTAL	38	100,00

TABLE 8.1.3: RESPONSES TO QUESTION 6
GENERAL FUNCTIONING

RESIDENTS' RESPONSES	NUMBER	%
General functioning improved	32	84,21
General functioning partly improved	5	13,16
Inappropriate response	1	2,63
TOTAL	38	100,00

TABLE 8.1.4: RESPONSES TO QUESTION 7
RELATIONSHIPS

RESIDENTS' RESPONSES	NUMBER	%
Relationships improved	27	71,06
Relationships not improved	2	5,26
Uncertain	1	2,63
Inappropriate response	1	2,63
Still have problems	7	18,42
TOTAL	38	100,00

TABLE 8.1.5: RESPONSES TO QUESTION 8
WORK ABILITIES

RESIDENTS' RESPONSES	NUMBER	%
Improvement in work abilities	33	86,84
No improvement in work abilities	3	7,90
No change...............................	1	2,63
Inappropriate response	1	2,63
TOTAL	38	100,00

RESPONSE OF FORMER RESIDENTS TO SECTION B OF QUESTIONNAIRE

Respondents replied to the question on whether the programme contributed towards better adjustment, as follows:

TABLE 8.1.6: RESPONSES TO QUESTION 1
WHETHER THE PROGRAMME CONTRIBUTED TOWARDS BETTER ADJUSTMENT

RESIDENTS' RESPONSES	NUMBER	%
Positive responses	35	92,11
Negative responses	3	7,81
TOTAL	38	100,00

TABLE 8.1.7: RESPONSES TO QUESTION 5
WERE EXPECTATIONS MET?

RESIDENTS' RESPONSES	NUMBER	%
Expectations were met	32	84,21
No response	1	2,63
Positive and negative response	1	2,63
Negative responses	4	10,53
TOTAL	38	100,00

TABLE 8.1.8: RESPONSES TO QUESTION 9
WOULD RESIDENTS RECOMMEND THE PROGRAMME?

RESIDENTS' RESPONSES	NUMBER	%
Would recommend the programme	32	84,21
No response	1	2,63
Positive and negative response	1	2,63
Negative responses	4	10,53
TOTAL	38	100,00

Questions 2 and 3 deal with gains which former residents report with regard to functioning and with regard to aspects of the programme which they found most beneficial. Questions 6 and 7 focus on aspects of functioning that were reported as being the least improved, and aspects of the programme which were of least benefit. Responses to Questions 2 and 6, and 3 and 7 will be dealt with simultaneously.

TABLE 8.1.9: RESPONSES TO QUESTIONS 2 AND 6

ASPECTS OF THE PROGRAMME WHICH IMPROVED RESIDENTS' FUNCTIONING OR FROM WHICH THEY GAINED

ASPECTS OF IMPROVED FUNCTIONING/GAINS	RESPONSES
Readjustment	2
Life adjustment and hope	2
Maturity and clear thinking	1
Drive	1
Socialization and drive	1
Socialization, drive and concentration	1
Socialization and self-care	3
Socialization	6
Socialization and structured leisure time	1
Self-confidence	2
Concentration	1
Endurance, discipline and independence	1
Improved work abilities	1
Independence	1
Communication	1
Socialization and money management	1
Self-care and assertiveness	1
Endurance	1
Self-care	1
Diagnostic gains, psychiatric stabilization and reduced depression	3
Insight with regard to illness, physical calmness	2
Regular meals and sleep	1
Weight loss	1
Daily routine	1

TABLE 8.1.10: RESPONSES TO QUESTIONS 2 AND 6

ASPECTS OF THE PROGRAMME WHICH FORMER RESIDENTS FOUND MOST BENEFICIAL

(to be linked with Table 8.1.9)

BENEFICIAL ASPECTS OF THE PROGRAMME	RESPONSES
Self-care programme	2
Self-image groups	3
Religious tuition	1
Sensory integration therapy	1
Staff motivation	6
Occupational therapy	3
Groups	1
Medical involvement	3
Week-end programme	1
Full programme (helped to regain perspective)	2
System of evaluation	1
No response	6
Inappropriate response	4
Uncertain	5
TOTAL	76

TABLE 8.1.11: RESPONSES TO QUESTIONS 3 AND 7

LEAST IMPROVED FUNCTIONING

AREAS OF FUNCTIONING LEAST IMPROVED	RESPONSES
Social adjustment, self assertiveness, socialization, insight into illness, concentration, leader, self-confidence	15

TABLE 8.1.12: RESPONSES TO QUESTIONS 3 AND 7

LEAST BENEFICIAL ASPECTS OF PROGRAMME

(to be linked with Table 8.1.11)

LEAST BENEFICIAL ASPECTS OF THE PROGRAMME	RESPONSES
Problems with staff	1
Routine and discipline too strict	4
Duration of programme too long	4
Late bedtime and week-ends in	2
Too much leisure time	1
Sensory integration therapy	2
Self-image group	2
TV	1
Injections	1
Not properly prepared for discharge	1
Programme not pleasant	1
<u>Other factors</u>	
Stigma of hospitalization	1
Finances	2
Mix with the wrong kind of people	1
Uncertain	6
No response	15
Inappropriate response	3
TOTAL	76

8.2 QUESTIONNAIRE FOR PARENTS, RELATIVES OR SPOUSES

Of the 50 Questionnaires sent out, 32 were received back - a response of 64%. This could have been higher if more parents had been living nearer to Stikland Hospital. Many parents live in South West Africa, Pretoria, Durban and the Eastern Cape, and are not within easy travelling distance of the hospital. It was, therefore, not possible for them to be actively involved in the programme.

Many parents, relatives or spouses are still interested in the Neuro B programme, a fact which is revealed in the many telephone calls confirming this interest, which the writer received from recipients of the Questionnaire. Fifteen letters of appreciation were received from parents, with identification as to who the respondents were.

The Questionnaire comprises an A and B section. Section A focuses on the condition of the former resident, while Section B highlights aspects of the programme as experienced by parents/relatives/spouses.

8.2.1 Section A of the Parents/Relatives/Spouses Questionnaire

Question 4 aimed to elicit responses about the patient's condition while still in the programme, while Question 7 focused on present functioning. From the responses it is clear to the writer that many responses did not take this difference into account. The responses are given as they appear on the Questionnaires, but respondents concentrated chiefly on the patient's present condition.

This could have been due to the fact that the writer did not stress what was required when responding to the question. Many respondents also appeared unable to remember, and stated this on the Questionnaires. Another factor is that the last number of patients were only discharged from Neuro B in June 1988 - a very short time before the Questionnaires were mailed out. It is felt, therefore, that there was insufficient time for a proper evaluation of the patient's condition, especially where parents did not reside near the hospital.

Responses to Questions 4 and 6 can, therefore, not be regarded as being a true indication of how patients' conditions were in comparison with their present condition.

TABLE 8.2.1: RESPONSES TO QUESTION 4
PATIENTS' INITIAL FUNCTIONING

PARENTS/RELATIVES/SPOUSES REPLIES	NO. OF RESPONSES	%
Indication of improvement	13	56,23
No indication of improvement	3	9,37
Improvement in some respects	6	18,75
Improved except for concentration	1	3,13
Improved except for communication	1	3,13
Improved but still easily influenced	1	3,13
Improved but still has problems with table manners	1	3,13
TOTAL	32	100,00

TABLE 8.2.2: RESPONSES TO QUESTION 7
PRESENT FUNCTIONING

PARENTS/RELATIVES/SPOUSES REPLIES	NO. OF RESPONSES	%
Improved functioning	18	56,25
Functioning has deteriorated	2	6,25
Functioning unchanged	4	12,52
Improved concentration and drive	3	9,37
Improved drive	1	3,12
Improved except for concentration	3	9,37
No response	1	3,12
TOTAL	32	100,00

8.2.2 Section B of the Parents/Relatives/Spouses Questionnaire

Questions 1, 2, 3(d), 4, 5 and 6 will be highlighted here (aspects of the programme).

TABLE 8.2.3: RESPONSES TO QUESTION 1
EDUCATION ABOUT THE ILLNESS

PARENTS/RELATIVES/SPOUSES RESPONSES	NUMBER	%
Positive responses	27	84,38
Negative responses	3	9,37
No responses	2	6,25
TOTAL	32	100,00

TABLE 8.2.4: RESPONSES TO QUESTION 2
CONTACT WITH THE THERAPEUTIC TEAM

PARENTS/RELATIVES/SPOUSES RESPONSES	NUMBER	%
Sufficient	27	84,38
Negative responses	2	6,25
Insufficient because of distance	3	9,37
TOTAL	32	100,00

TABLE 8.2.5: RESPONSES TO QUESTION 3(d)
INVOLVEMENT : PARENT SUPPORT GROUP

(Question 3(d) refers to the support group for parents whose children have been discharged from hospital).

PARENTS/RELATIVES/SPOUSES RESPONSES	NUMBER	%
Involved	7	21,87
Not involved, because of distance	13	40,62
Not involved	12	37,51
TOTAL	32	100,00

Question 4 relates to suggestions asked for in the Questionnaire. Eleven of the 32 respondents made suggestions with regard to the following:

TABLE 8.2.6: RESPONSES TO QUESTION 4
SUGGESTIONS

ASPECTS RELATING TO STAFF	NO. OF RESPONSES
Staff turnover should be reduced	1
More individual meetings with head of team ...	1
Attitude of staff should be less strict	1

ASPECTS RELATING TO PATIENTS	NO. OF RESPONSES
More time required for rest	1
Financial assistance	1
More household tasks should be part of the programme	1
Higher and lower functioning patients should be separated	1
More professional work opportunities needed ..	1

ASPECTS RELATING TO TREATMENT	NO. OF RESPONSES
More alternative methods of treatment than medication required	1
More self-image groups	1
More time for interaction between parents and offspring	1
More seminars for parents	1

A total of 12 suggestions was made by respondents.

TABLE 8.2.7: RESPONSES TO QUESTION 5
LIMITATIONS

PARENTS/RELATIVES/SPOUSES RESPONSES	NUMBER	%
Could not name limitations	22	68,76
Named limitations	9	28,12
Uncertain	1	3,12
TOTAL	32	100,00

TABLE 8.2.8: LIMITATIONS NAMED BY PARENTS/RELATIVES/SPOUSES

LIMITATIONS NAMED BY PARENTS/RELATIVES/SPOUSES	NO. OF RESPONSES
<u>Issues relating to staff</u>	
More clinical psychologist involvement	1
<u>Programme activities</u>	
More physical exercise/individual attention	2
Greater stress on parent-child interaction	1
<u>Others</u>	
More attention to medication	1
Creation of professional job opportunities	1
Parents should have opportunity to report back .. on former residents on a regular basis	1
Not enough financial back-up for patients	1
Programme too long	1
TOTAL	9

Question 6 relates to whether parents/relatives/spouses would recommend the programme. 31 respondents answered positively - 96,88%.

Reasons given as to why they would recommend the programme were as follows:

TABLE 8.2.9: RESPONSES TO QUESTION 6
REASONS WHY PROGRAMME WOULD BE RECOMMENDED

REASONS NAMED BY PARENTS/RELATIVES/SPOUSES	NO. OF RESPONSES
Staff were of great help	2
Programme lead to adjustment in life, the community, and gives hope	3
Patients' conditions improved, they can accept illness, good results are obtained	6
Other reasons:	
For rehabilitation	1
Prevented admission to long-term ward	1
TOTAL	13

If one compares responses to Question 9 of the former resident questionnaire with Question 6 of the parents' questionnaire, about recommending the programme, it is observed that the majority of former residents (as well as parents, spouses and relatives) responded positively.

It is clear that although the programme is not an instant, miracle solution (people still have limitations after completion of the programme, as indicated by responses to Questions 3 and 7 of the B Section of the residents' questionnaire, and 4 and 7 in A Section of the parents' questionnaire), it is still recommended by both parents and former residents.

The programme does make a difference, however, and can be regarded as instrumental in some aspects of improved functioning, to educate patients and their families about schizophrenia, while it gives hope for new ways of adjustment in cases where functioning is virtually non-existent.

CHAPTER 9

SUMMARY AND CONCLUSIONS : IMPLICATIONS FOR PRACTICE

1. The theoretical content in Section I was an effort to contribute towards understanding the various aspects of the illness. Not only are particulars about terminology of importance when individuals are educated, but so is the inclusion of the most recent diagnostic criteria. The fact that these criteria were revised as recently as 1987, is an indication of continuous study in the field. Improved diagnostic criteria lead to refined diagnostic procedures which will affect treatment and rehabilitation interventions more positively. The inclusion of the criteria for schizo-affective disorders can also be seen in this light.

   Continued studies, improve pharmacology and the development of more sophisticated neurophysiological examination methods eventually led to increased confirmation of the bio-chemical origin of the illness and that chemotherapy, in combination with other interventions, is the most meaningful in treatment and rehabilitation of schizophrenics.

   It is, therefore, essential that the clinical social worker stays abreast of recent research findings, and also utilizes experience, observation and listening skills to be able to contribute meaningfully to the diagnostic process and to fulfil the role of educator with regard to the illness.

   Many questions remain unanswered. However, as also proved by the findings of the 1986 Bi-annual International Workshop on Schizophrenia, no single causal factor can be identified and linked with aetiology in schizophrenia. This presents a challenge to psychiatry and research has to continue. That research and studies still continue is, for example, indicated by recent research on season of birth as a risk factor (Baron & Gruen, 1988).

2. While studies continue in the search for aetiology, treatment and rehabilitation interventions are undertaken in terms of the vulnerability-stress-coping-competence model, preparing the patient for optimal life after discharge from hospital. The clinical social worker's contributions, by fulfilling the roles of psychotherapist, group and family therapist, as well as family educator on levels that include primary, secondary and tertiary prevention, are highlighted in Section II. These interventions involve the patient, the family and the community. Of special importance here is the psycho-educative perspective, in terms of which education is undertaken - especially with families.

3. As an example of a comprehensive treatment and rehabilitation programme where the above interventions are utilized, a description of the Neuro B Programme is given. Interventions are from a holistic perspective, where the total person in his total circumstances is approached.

4. The most important particulars from the files of the 56 former residents who were involved in the programme were highlighted, as well as information about the present circumstances and level of functioning of 53 of them. (Three patients died as a result of suicide). As a result of the illness, some patients can only function

optimally while others show major gains. Involvement in the programme seemed to be instrumental in improved functioning.

5. Two sets of questionnaires were used to elicit opinions of former residents and their parents (or relatives, or spouses). The majority of the former residents were of the opinion that they were sufficiently educated about their illness during the programme, that medication can prevent relapse, that their expectations were met during the programme, and that they would recommend the programme to others in similar circumstances. The majority of parents (also relatives and spouses) felt that they were adequately educated about the illness of their child (relative, or spouse), that they had meaningful contact with the therapeutic team, and that they would recommend the programme to someone else in similar circumstances.

6. With regard to the future, activities within the programme will be further developed - to meet the needs of residents. Planning, for example, is undertaken to introduce a meaningful system to stimulate participation of residents.

7. As this programme is now also linked with the residential possibilities of a halfway house, "Cleveland Lodge", more possibilities for long-term research will become a reality, like for example the Chestnut Lodge follow-up studies, where significant long-term research was undertaken (McGlashan, 1984(a) and (b); 1986).

8. Research in various fields will continue, for example, in the medical field, on medication and diagnostic evaluations. In the field of

psycho-social aspects of the illness, enormous possibilities can be explored, for example, the use of play therapy in the education of the young child in the family in helping him to come to terms with his parent's illness. The most recent research within the psycho-educative perspective concentrates much on combining psycho-education with the teaching of skills to parents and relatives, and this is a most important aspect which the clinical social worker is about to explore within this context.

Another field in which research will continue is that of occupational therapy, and the way in which patients can be assisted to experience their religion more meaningfully. It is, therefore, evident that many future research possibilities can be explored from this particular programme, while the clinical social worker's role will become increasingly more demanding and important.

9. That the programme also offers hope for some parents can be seen in a note from one of the parents who responded to a question, as follows:

> Ons kan nie 'n idee vorm wat tans die toestand sou wees waarin ons kind sou verkeer het indien hy nie opgeneem was nie.
>
> (Translation:
> We cannot imagine what our child's present condition would be had he not been admitted.)

10. The programme, therefore, has undoubtedly many possibilities for involving patients and their families in meaningful treatment and rehabilitation interventions. It is also clear that a clinical social worker can make a worthwhile contribution within such a programme.

---o0o---

APPENDIX A

THE LEVELS OF THE PROGRAMME - "D" TO "A"

NEURO CLINIC B : LEVEL "D"

A. PHYSICAL

DATE					
1. Getting up					
2. Bed making					
3. Bathing					
4. Shaving: Men/Ladies					
5. Tidying up of ward					
6. Self-care: (a) Hair					
(b) Dressing					
(c) Make-up					
(d) Manicure					
(e) Pedicure					
(f) Oral hygiene ..					
7. Wardrobe					
8. Medication					

B. PSYCHOLOGICAL FUNCTIONING

1. Responsibility: (a) Punctuality at activities					
(b) Ward duties					
2. Insight into functioning					
3. Insight into work abilities ..					
4. Inter-dependency					
5. Body-image					
6. Communication: (a) Towards fellow residents .					
(b) Towards family/relatives .					
(c) Towards staff					
7. Behaviour					
8. Emotional stability					
9. Problem-solving methods					
10. Self discipline					
11. Etiquette					

C. SOCIAL

1. Evening exercises					
2. Socializing at meals					
3. Sport activities					
4. Evening activities					
5. Week-end activities					
6. Leisure activities					

D. PASTORAL

1. Attending church services					
2. Pastoral groups					

E. OCCUPATIONAL THERAPY DATE					
1. Work habits: (a) Personal presentation					
(b) Social presentation					
2. Work competence					
3. Work endurance: (a) Physical					
(b) Psychological					
4. Production speed: (a) Accuracy					
(b) Quality of work					
5. Motivation for work: (a) Intrinsic					
TOTAL					
PERCENTAGE					
PASS %					

A 50% PASS IS REQUIRED

DATE PROMOTED TO LEVEL "C" ....

NEURO CLINIC B : LEVEL "C"

A. PHYSICAL

DATE					
1. Getting up					
2. Bed making					
3. Bathing					
4. Shaving: Men/Ladies					
5. Tidying of ward					
6. Self-care: (a) Hair					
(b) Dressing					
(c) Make-up					
(d) Manicure					
(e) Pedicure					
(f) Oral hygiene					
7. Wardrobe					
8. Medication					
9. Washing & ironing					

B. PSYCHOLOGICAL FUNCTIONING

1. Responsibility: (a) Punctuality at activities					
(b) Ward duties					
2. Insight into illness					
3. Insight into functioning					
4. Insight into work abilities					
5. Inter-dependency					
6. Body-image					
7. Self-image					
8. Communication: (a) Towards fellow residents					
(b) Towards family/relatives					
(c) Towards staff					
9. Behaviour					
10. Leadership					
11. Emotional stability					
12. Realistic future planning					
13. Problem-solving methods					
14. Professional objectives					
15. Self discipline					
16. Etiquette					

C. SOCIAL

1. Evening exercises					
2. Socializing at meals					
3. Sport activities					
4. Evening activities					
5. Week-end activities					
6. Leisure activities					
7. Integration with community					

D. PASTORAL	DATE				
1. Attending church services					
2. Church activities					
3. Pastoral groups					

E. OCCUPATIONAL THERAPY

1. Work habits: (a) Personal presentation					
(b) Social presentation					
2. Work competence					
3. Work endurance: (a) Physical					
(b) Psychological					
(c) Coping with stress					
4. Production speed: (a) Accuracy					
(b) Quality of work					
(c) Quantity of work					
5. Motivation for work: (a) External					
(b) Internal					
TOTAL					
PERCENTAGE					
PASS %					

(A pass of 70% is required)

DATE PROMOTED TO LEVEL "B" ....

REMARKS: ....

....

....

....

....

....

....

....

NEURO CLINIC B : LEVEL "B"

A. PHYSICAL

DATE					
1. Getting up					
2. Bed making					
3. Bathing					
4. Shaving: Men/Ladies					
5. Tidying of ward					
6. Self-care: (a) Hair					
(b) Dressing					
(c) Make-up					
(d) Manicure					
(e) Pedicure					
(f) Oral hygiene					
7. Clothing - suitability					
8. Medication					
9. Washing & ironing					

B. PSYCHOLOGICAL FUNCTIONING

1. Responsibility: (a) Punctuality at activities					
(b) Ward duties					
(c) With regard to own needs					
2. Insight into illness					
3. Insight into functioning					
4. Insight into relapse symptoms					
5. Insight into work abilities					
6. Inter-dependency					
7. Body-image					
8. Self-image					
9. Communication: (a) Towards fellow residents					
(b) Towards family/relatives					
(c) Towards staff					
10. Behaviour					
11. Leadership					
12. Emotional stability					
13. Realistic future planning					
14. Problem-solving methods					
15. Professional objectives					
16. Attitude regarding discharge					
17. Self discipline					
18. Etiquette					

C. SOCIAL

1. Evening exercises					
2. Socializing at meals					
3. Sport activities					
4. Evening activities					
5. Week-end activities					
6. Leisure activities					
7. Integration with community					

D. PASTORAL

DATE					
1. Attending church services					
2. Church activities					
3. Pastoral groups					

E. OCCUPATIONAL THERAPY

1. Work habits: (a) Personal presentation					
(b) Social presentation					
2. Work competence					
3. Work endurance: (a) Physical					
(b) Psychological					
(c) Coping with stress					
4. Production speed: (a) Accuracy					
(b) Quality of work					
(c) Quantity of work					
5. Motivation for work: (a) External					
(b) Internal					
TOTAL					
PERCENTAGE					
PASS %					

(A pass of 80% is required)

DATE PROMOTED TO LEVEL "A" ....

NEURO CLINIC B : LEVEL "A"

A. PHYSICAL

DATE					
1. Getting up					
2. Bed making					
3. Bathing					
4. Shaving: Men/Ladies					
5. Tidying of ward					
6. Self-care: (a) Hair					
(b) Clothing					
(c) Make-up					
(d) Manicure					
(e) Pedicure					
(f) Oral hygiene					
7. Clothing - suitability					
8. Medication					
9. Washing & ironing					

B. PSYCHOLOGICAL FUNCTIONING

1. Responsibility: (a) Punctuality at activities					
(b) Ward duties					
(c) With regard to own needs					
2. Insight into illness					
3. Insight into functioning					
4. Insight into relapse symptoms					
5. Insight into work competence					
6. Insight: work circumstances					
7. Inter-dependency					
8. Body-image					
9. Self-image					
10. Communication: (a) Towards fellow residents					
(b) Towards friends					
(c) Towards family/relatives					
(d) Towards staff					
(e) Towards employer					
11. Behaviour					
12. Leadership					
13. Emotional stability					
14. Realistic future planning					
15. Family relationships					
16. Problem-solving methods					
17. Professional objectives					
18. Attitude regarding discharge					
19. Self discipline					
20. Etiquette					

C. SOCIAL

DATE					
1. Evening exercises					
2. Socializing at meals					
3. Sport activities					
4. Evening activities					
5. Week-end activities					
6. Leisure activities					
7. Integration into community					

D. PASTORAL

1. Attending church services					
2. Church activities, e.g. youth meetings					
3. Pastoral groups					

E. OCCUPATIONAL THERAPY

1. Work habits: (a) Personal presentation					
(b) Social presentation					
2. Work competence					
3. Work endurance: (a) Physical					
(b) Psychological					
(c) Coping with stress					
4. Production speed: (a) Accuracy					
(b) Quality of work					
(c) Quantity of work					
5. Motivation for work: (a) External					
(b) Internal					
TOTAL					
PERCENTAGE					
PASS %					

(A maintaining level of 80% is required)

APPENDIX "B"

WEEKLY ROSTER

NEURO B CLINIC

PATIENT'S NAME: ....

NEURO B CLINIC : WEEKLY ROSTER

MONDAY

TIME	ACTIVITY	
06h30-07h00	Getting up	....
07h00-07h30	Evaluation by directors (residents) and of ward duties	....
07h30-07h45		
07h45-08h30	Breakfast and medication	....
08h30-09h30	*Administrative meeting	....
09h30-10h00	Occupational therapy	....
10h00-10h15	Tea	....
10h15-11h30	Occupational therapy	....
11h30-12h00	Individual appointments with staff members	....
12h00-12h30	Lunch and medication	....
12h30-14h00	Appointments with team members	....
13h00-14h00	Week-end report back group	....
14h00-15h00	Appointments with family members ...	....
	Social skills group	....
	Occupational therapy	....
15h00-15h15	Tea	....
15h15-16h00	Appointments with family (staff) ...	....
	Occupational therapy	....
16h00-16h30	1st & 3rd weeks: doctors' information group	....
	2nd week: preparation for cooking group	....
	4th week: rehabilitation group (budgeting and other)	....
16h30-16h45	Withdrawal of funds	....
16h45-17h00	Medication	....
17h00-17h45	Personal chores, eg. letter-writing, ironing, etc.	....
17h45-18h15	Fitness group in hospital hall	....
18h15-19h00	Supper	....
19h00-20h00	Entertainment assignments	....
20h00-21h00	Leisure time and TV	....
21h00-21h15	Medication	....
21h15-21h30	Leisure time and TV	....
21h30-22h00	Bath and preparation for bed	....
22h00-06h30	Bed-time	....

* At the administrative meeting residents fulfil the roles of secretary and chairman and Minutes are taken. At the same time, residents' skills are improved in these areas.

TUESDAY

TIME	ACTIVITY	
06h30-07h00	Getting up	....
07h00-07h30	Evaluation by directors (residents) and of ward duties	....
07h30-07h45	*Climate meeting	....
07h45-08h30	Breakfast, medication and washing-up	....
08h30-09h30	Sensory integration therapy (presently not on programme)	....
09h30-10h00	Occupational therapy	....
10h00-10h15	Tea	....
10h15-11h30	Rehabilitation group (budgeting and other practical matters)	
	Occupational therapy	....
11h30-12h00	Residents' individual appointments with the team	....
12h00-12h30	Lunch and medication	....
12h30-14h00	Individual appointments with team members	....
	Leisure time	....
14h00-14h30	Occupational therapy	....
14h30-15h00	Occupational therapy	....
15h00-15h15	Tea	....
15h15-16h30	Occupational therapy	....
16h3016h45	Draw money	....
16h45-17h00	Medication	....
17h00-17h30	Physical exercise	....
17h30-18h00	Supper	....
18h00-19h00	Personal chores, eg. letter-writing, ironing, etc.	....
19h00-20h00	Entertainment assignments	....
20h00-21h00	Leisure time and TV	....
21h00-21h15	Medication	....
21h15-21h30	Leisure time and TV	....
21h30-22h00	Bath and preparation for bed	....
22h00-06h30	Bed time	....

* The Climate meeting is attended by staff and patients, where general matters regarding the ward are discussed. Patients also report back on TV and other news matters while they have the opportunity to make appointments with staff members. They can make complaints known to staff on these occasions.

WEDNESDAY

TIME	ACTIVITY	
06h30-07h00	Getting up	....
07h00-07h30	Evaluation by directors (residents) and of ward duties	....
07h30-07h45	Climate meeting	....
07h45-08h30	Breakfast and medication	....
08h30-09h30	1st & 2nd week: groups presented by nursing staff	....
	3rd week: Outing	....
	4th week: Occupational therapy	....
09h30-11h45	1st week: preparation for evening social and making purchases	....
	2nd week: Cooking - lunch in ward ..	....
	3rd week: Outing	....
	4th week: Occupational therapy	....
	4th week: Monthly level evaluation .	....
11h45-12h00	4th week: Monthly level evaluation .	....
	Residents' individual appointments with the team	....
12h00-12h30	Lunch and medication	....
12h30-14h00	Individual appointments with team members	....
	Leisure time	....
14h00-14h30	1st, 2nd & 4th weeks: Occupational therapy	....
	3rd week: Outing	....
14h30-15h00	1st, 2nd & 4th weeks: Occupational therapy	....
	3rd week: Outing	....
15h00-15h15	Tea	....
15h15-16h30	1st, 2nd & 4th weeks: Occupational therapy	....
	3rd week: Outing	....
16h3016h45	Draw money	....
16h45-17h00	Medication	....
17h00-17h45	Preparation for evening of entertainment	....
17h45-18h15	Physical fitness: hospital hall	....
18h15-21h45	1st week: Social evening	....
	2nd week:	
	3rd week: Hospital entertainment, e.g. dance	....
	4th week: Family evening	....
21h45-22h00	Medication	....
22h00-06h30	Bed time	....

THURSDAY

TIME	ACTIVITY	
06h30-07h00	Getting up	....
07h00-07h15	Evaluation by directors (residents) and of ward duties	....
07h15-07h30	Weigh-in group	....
07h30-07h45	Climate meeting	....
07h45-08h30	Breakfast and medication	....
08h30-09h00	Sensory integration therapy (not being presented at the moment)	....
09h00-10h00	Self-image group	....
10h00-10h15	Tea	....
10h15-11h30	Rehabilitation group (budgeting, Wills, etc)	....
11h30-12h00	Residents' individual appointments with the team	....
12h00-12h30	Lunch and medication	....
12h30-14h00	Appointments with team members	....
	Leisure time	....
13h00-14h00	Pastoral group	....
14h00-15h00	Special group discussions and lectures, e.g. family planning	....
15h00-15h15	Tea	....
15h15-16h30	Sport activities	....
16h3016h45	Draw money	....
16h45-17h00	Medication	....
17h00-17h30	Physical exercise	....
17h30-18h00	Supper	....
18h00-19h00	Personal chores, eg. letter-writing, ironing, etc.	....
19h00-20h00	Visits by family/relatives/friends	....
20h00-21h00	Leisure time and TV	....
21h00-21h15	Medication	....
21h15-21h30	Leisure time and TV	....
21h30-22h00	Bath and preparation for bed	....
22h00-06h30	Bed time	....

FRIDAY

TIME	ACTIVITY	
06h30-07h00	Getting up	....
07h00-07h15	Evaluation by directors (residents) and of ward duties	....
07h30-07h45	Climate meeting	....
07h45-08h00	Breakfast and medication	....
08h00-08h30	Packing for week-end/Ward Rounds ...	....
08h30-10h00	Clothing maintenance group	....
	Pottery	....
	Occupational therapy	....
10h00-10h15	Tea	....
10h15-11h45	Pottery	....
	Occupational therapy	....
11h45-12h00	Appointments with team members	....
12h00-12h30	Lunch and medication	....
12h30-14h00	Appointments with team members	....
	Leisure time	....
14h00-15h00	Occupational therapy	....
15h00-15h15	Tea	....
15h15-16h30	Occupational therapy	....

APPENDIX "C"

LETTER ACCOMPANYING QUESTIONNAIRES

Maretha Wessels
99-1119 x 5

Neuro B
Stikland Hospital
Private Bag X13
BELLVILLE
7535

18 April 1988

Sir/Madam/Ms

RESEARCH : NEURO B REHABILITATION PROGRAMME

As you know, Stikland Hospital is a Training Hospital and research has been undertaken here from time to time in order to evaluate and improve treatment and services. Research has been done, for example, with regard to the efficiency of several types of medication, electro-convulsive therapy, as well as depression.

Presently research is being done with regard to the Neuro B programme, firstly for my own study purposes (for the Masters Degree in Clinical Social Work), but also for utilization by the Hospital itself.

Attached is a Questionnaire on which you will have the opportunity to:

A. Respond to questions about yourself, mainly focusing on your functioning, if you are presently in the programme, or have been in the past.

Parents, relatives or spouses will receive the opportunity to respond to questions about the functioning of their child, relative or spouse.

(Two types of Questionnaires have been prepared - one for parents and relatives and the other for residents and former residents).

B. Evaluate several aspects of the programme, by responding to a different Questionnaire.

You/...

You are free to remain anonymous as we are interested in your well-considered, honest and frank opinion.

As you know, the Neuro B programme, which started in July 1984, has a rehabilitation goal, focusing on the meaningful and optimal functioning of the residents.

Everybody involved in the programme, ex-residents as well as their parents, spouses or relatives, are now requested to give their opinion in this regard.

This will enable us to evaluate the programme meaningfully, with a view to future planning, adjustment and continuation.

Your well-considered and honest opinion, whatever it may be, on the Questionnaires will, therefore, be appreciated, as well as the prompt return in the envelope that is included for this purpose.

Please feel free to contact me during office hours (tel. 021-991110) should you have any questions or problems.

Thank you for your co-operation.

MARETHA WESSELS

APPENDIX "D"

QUESTIONNAIRE FOR RESIDENTS/FORMER RESIDENTS

A. **WITH REGARD TO YOURSELF**

1. Gender: MALE FEMALE

(Please indicate where applicable)

2. Are you presently:

STILL IN NEURO B RE-ADMITTED DISCHARGED

(Please indicate ✓ where applicable)

3. In the case of re-admission, what do you regard as the most important reasons?

....

....

....

4. With regard to your condition:

Do you think that you received sufficient information and particulars about your illness during your stay in Neuro B?

(Please indicate ✓ where applicable) YES NO

Please give reasons for your answer:

....

....

....

5. With regard to your medication:

Do you regard the regular taking of medication as important? (If you were told by your doctor that you should take it permanently).

(Please indicate ✓ where applicable) YES NO

Please give reasons for your answer:

....

....

....

6. **With regard to your General Functioning:**

Are you able to identify any changes in your functioning since you started the programme?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Could you kindly motivate your answer:
(For example, changes in social behaviour, drive, concentration, insight, thought processes).

....

....

....

....

7. **With regard to your relationship with others:**

Are you able to identify any changes since you started the programme?
(For example, can you socialize more easily?)

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Could you please elaborate:

....

....

....

....

8. **With regard to your work skills/abilities**

Have you experienced any changes since admission to the programme?
(For example, with regard to endurance, concentration).

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Elaborate on your answer, if applicable.

....

....

....

....

B. WITH REGARD TO THE PROGRAMME

1. Do you think that the programme contributed towards a more successful adjustment?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Elaborate, if necessary.

....

....

....

2. In your opinion, how did you benefit <u>the most</u> from your participation in the programme?

....

....

....

3. How did you benefit <u>the least</u>?

....

....

....

4. What were your expectations when you started the programme?

....

....

....

5. Would you say that your expectations were met?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Please elaborate:

....

....

....

6. Which aspects of the programme helped you to adjust the most, given your present circumstances?

....

....

....

....

7. Which aspects of the programme helped you least, considering your present circumstances/adjustment:

....

....

....

....

8. Should you meet someone with the same illness as yourself, would you recommend the programme to him or her?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Could you kindly elaborate:

....

....

....

....

APPENDIX "E"

QUESTIONNAIRE FOR PARENTS/RELATIVES/SPOUSES

A. WITH REGARD TO YOUR SON/DAUGHTER/RELATIVE/SPOUSE

1. Your son/daughter/relative/spouse is/was involved with the Neuro B programme (presently or in the past).

Gender: ☐ MALE ☐ FEMALE

(Please indicate ✓ where applicable)

2. During which year/years was he/she involved? ....

3. For how long? ....

4. Did you observe or experience any change with regard to his/her functioning while he/she was involved in the programme? (For example, social behaviour, concentration, work abilities, self care, illness, thought processes or adjustment in general).

....

....

....

Please give particulars:

(a) With regard to any changes that you observed:

....

....

....

(b) How long after admission (approximately) could you observe any change?

....

(c) What aspects of his/her functioning improved most during involvement in the programme?

....

....

....

(d) What aspects of his/her functioning improved least during involvement in the programme?

....

....

....

5. Is your son/daughter/relative/spouse back in the community?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

6. If discharged, when ....

7. How is he/she functioning presently?
(For example, with regard to social behaviour, work abilities, self care, drive, concentration, adjustment to society in general)

....

....

....

8. If there was a change in his/her functioning after discharge, how long after discharge did this take place?
(If applicable) ....

What kind of change took place (if applicable):

....

....

....

9. Was he/she re-admitted to hospital after completion of the programme?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

If the answer is "yes", how many admissions? ....

What would you regard as the most important reasons for these admissions?

....

....

....

B. WITH REGARD TO THE PROGRAMME

1. Do you think that you received enough information with regard to the illness of your son/daughter/relative/spouse?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Will you please elaborate on your answer:

....

....

....

2. Do you think that you had enough opportunity to have contact with the therapeutic team which was involved with the treatment of your son/daughter/relative/spouse?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Please give reasons for your answer:

....

....

....

3. In your opinion, what is the value of the following:

(a) Family/parents' evenings: ....

....

....

....

(b) Week-end tasks: ....

....

....

....

(c) Individual interviews with members of the therapeutic team?

....

....

....

(d) Are you involved in the parent support group?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Would you like to become involved in the parent support group?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Are you aware of the aims and objectives of the group?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

What would you say are the aims and objectives of this group?

....

....

....

4. Are there any suggestions that you would like to make with regard to the alteration or improvement of the programme?

....

....

....

5. Which limitations in the programme, in your opinion, need attention?

....

....

....

6. Should you meet somebody with a similar psychiatric problem to your son/daughter/relative/spouse, would you recommend the programme?

(Please indicate ✓ where applicable) ☐ YES ☐ NO

Could you please motivate your answer:

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....

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