BRIEF COMMUNICATIONS

MEASUREMENT OF DISTRESSFUL PSYCHOTIC SYMPTOMS PERCEIVED BY THE FAMILY: PRELIMINARY FINDINGS

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Introduction

Behaviour of patients suffering from Schizophrenia can cause a lot of distress and problems to the family in particular and the society in general. It is surprising that very little has been done by way of systematic survey to discover the relatives' own experiences and hardships resulting from a schizophrenic individual in the family. Creer and Wing (1975) interviewed relatives of 80 people diagnosed as suffering from schizophrenia in order to discover what problems had recently been experienced. The commonest distressful behaviour were those associated with social withdrawal such as little interaction, slowness, lack of conversation, few leisure interests and self neglect. Gibbons et al (1984) used semi-structured interview schedule to assess the disturbed behaviour and altered social performance of patients from the relatives' point of view and found offensive behaviour, rudeness and violence as most distressful followed by irritability, odd ideas, overactivity and selfneglect.

To address these very important issues in the management of schizophrenia we are carrying on a prospective study to assess and rate distressful symptoms in psychotic patients. A scale has been devised which might prove to be useful in documenting the nature and severity of such distressful symptoms (Chaturvedi and Gopinath 1986). The first step towards this was an open interview with key relatives of schizophrenics to identify the various symptoms felt as distressful. In this report we are presenting the nature and severity of symptoms considered as distressful in psychotic patients. The nature of distressful symptoms in a group of patients with psychotic depression have been recorded and compared here with those of the schizophrenic patients.

Material and Methods

New cases diagnosed as Schizophrenia and Major depressive disorder by Research Diagnostic Criteria (1978) were included in the study for assessment. Patients with organic problems, alcoholism, drug dependence or mental retardation were excluded. First degree relative or spouse accompanying the patient were interviewed and data recorded on a proforma designed specifically for this purpose. The semi-structured interview proforma recorded details regarding the following.

i) Identifying data of the patient.
ii) Identifying data of the relative.
iii) Demographic variables of both - patient and first degree relative or spouse.
iv) Clinical details as type of onset, precipitating factor, presence of family history or past episodes.
v) Clinical diagnosis as per RDC as well as subtype.

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After establishing adequate rapport, the key relative accompanying the patient was interviewed regarding the patient’s behaviour at home. They were then asked to enumerate various behaviours or manifestations of his illness which caused ‘distress’ to the family members. Relatives were encouraged to mention as many behaviours as possible, irrespective of the amount of distress. Later the relatives were asked to specify the amount of distress, in terms of score from 0 to 100 (0: no distress; 100: Maximum possible distress), caused by each of the symptoms reported. Possible ways of handling such behaviours were advised. Percentage frequency of various symptoms were derived.

**Results**

25 patients were included for evaluation. The mean age was 28.2 (± 7.2) years. There were 13 males; 15 had less than matriculate education; 15 were from urban background and 12 cases were unmarried. The clinical diagnosis was schizophrenia in 14 and Major depressive disorder in 11. Distressful symptoms in both, the schizophrenic patients and major depression patients are given in the table. It was observed that the common distressful symptoms in schizophrenics were - not caring for personal hygiene (58%), wandering away (43%), not working (36%), being destructive (22%), being assaultive (22%), talking nonsense and showing odd behaviour in 14% each. The distressful symptoms in depressives were - not working (55%), suicide attempts (36%), poor sleep (36%), not eating (24%), lack of conversation, fearfulness and being socially withdrawn in 18% each, and suspiciousness in 10%. The mean number of distressful symptoms reported per patient was found to be 2.7. In all 17 behaviours were found to be distressful by the family members.

**Table**

| Symptom                      | (%) |
|------------------------------|-----|
| 1. Not working               | (44) |
| 2. Not caring for self       | (32) |
| 3. Wandering tendency        | (24) |
| 4. Not doing household tasks | (20) |
| 5. Attempting suicide        | (16) |
| 6. Not sleeping              | (20) |
| 7. Tearing clothes           | (12) |
| 8. Being destructive         | (12) |
| 9. Not eating food           | (12) |
| 10. Talking nonsense         | (8)  |
| 11. Showing odd behaviour    | (8)  |
| 12. Not talking much         | (8)  |
| 13. Being fearful            | (8)  |
| 14. Social withdrawal        | (8)  |
| 15. Being suspicious         | (8)  |
| 16. Being abusive            | (12) |
| 17. Being assaultive         | (12) |

**Discussion**

Creer and Wing (1975) had observed various behavioural characteristics in schizophrenics which were perceived to be distressful by the family. They had found similar distressful behaviours as in the present study. Platt (1985) has discussed different rating scales which are used for measuring the burden of psychiatric illness on the family. Most of the scales measure occupational, financial and social consequences rather than personal distress caused by the behaviour of the patient.

Numerous definitions of burden exist in the literature but these share a common underlying frame of reference. Burden is considered as the effect of the patient upon the family, or the impact of living with a psychiatric patient on the way of life and health of family members or the difficulties felt by the family of a psychiatric patient.
P. S. GOPINATH AND S. K. CHATURVEDI

(Goldberg and Huxley 1980, Brown 1967, Pai and Kapur 1981). Recently, however, there have also been attempts to distinguish between the occurrence of a problem and its alleged etiology, i.e., the extent to which it is caused by the patient's behaviour (Spitzer et al 1971, Platt et al 1983). We, however, propose here that the 'distress' due to patients' behaviour to be different from the 'burden'. The 'distress' is the subjective experience of the family members as a reaction to patients' behaviour. Thus it is a function of various factors as perception, knowledge, attitudes towards mental illnesses. It is also related to coping skills. Perhaps, distress increases and reduces with time or with exacerbations. The 'distress' is in addition to the "burden". It would be interesting to see the inter-relationship between distress and burden.

We also feel that distress seems to be related to the expressed emotions. In some of our patients, not attending to work or not earning, not caring for hygiene, were considered most distressful and the relatives reacted by criticising, expressing hostility and irritability. There are also indications in this study that the nature of distressful symptoms are different in schizophrenics and depressives.

Based on these symptoms, we have devised a "Scale for Assessment of Family Distress" (SAFD). Currently, the scale is undergoing standardisation and would after refinement provide an important tool to measure family distress and the nature and extent of distressful symptoms.

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