A COMPARATIVE STUDY OF ATTITUDES OF THE KEY RELATIVES TOWARDS ‘SCHIZOPHRENIC PATIENTS’ AND ‘PATIENTS OF DISTURBED FAMILY’

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SUMMARY

Forty six key relatives of ‘Schizophrenic Patients’ who were hospitalised in Department of Psychiatry, K. G’s, Medical College, Lucknow were administered ‘Attitude Questionnaire’ which covered five variables: Number of critical comments about some one else in the home; Hostility; Dissatisfaction; Warmth and Emotional Involvement. Forty one key relatives of ‘Disturbed Family’s Patients’ matched for sex and residence, were assessed on similar parameters. There was significant difference only in the area of ‘Dissatisfaction’.

An attitude is a dispositional readiness to respond to certain situations, persons or objects in a consistent manner which has been learned and has become one’s typical mode of response (Freeman, 1971). An attitude has a well defined object of reference. The degree or strength of a person’s attitude may vary from extremely positive through a gradation to extremely negative. In western countries, there are many studies which use questionnaires to measure ways in which the attitudes of parents of schizophrenics differ from other parents (Mark, 1953; Freeman and Grayson, 1955; Zuckerman et al., 1958; Klebanoff, 1959; Horowitz and Lovell, 1960; Guertin, 1961; Sharp et al. 1964; Farina and Holzberg, 1967).

According to Hirsch and Leff (1971) the body of work which uses questionnaires to identify characteristic attitudes of the parents of schizophrenics is heterogenous and confusing because of lack of continuity between the various studies. Workers using questionnaires have been more systematic in developing the research instruments than workers using the more clinically oriented methods (Brown et al., 1962; Rutter and Brown, 1966; Bell, 1968; Brown et al., 1972). These clinically oriented studies shed a different light on the way in which the attitude and behaviour of parents may influence the development of schizophrenia.

Inspite of the new methods of treatment and care introduced, the schizophrenic patients are still liable to relapse with a recurrence of florid symptoms and great suffering can be caused to all concerned (Brown et al., 1962). It has been observed that onset of florid symptoms is often preceded during the previous three weeks by a significant change in patient’s social environment (Brown and Birley, 1968; Birley and Brown, 1970). Other studies have focussed on the influence of more persistent environmental factors such as emotions expressed towards the patient by the relations with whom they are living (Brown and Rutter, 1966; Brown et al., 1972; Berkowitz et al., 1981). Few workers have found that close emotional ties with parents or wives indicate a poor prognosis (Brown

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The family interview deals with what happened at home before admission as well as with feelings expressed during the interview towards particular people in the home or towards recent events. Brown and Rutter (1966) recorded the expression of both negative and positive feeling and used two types of scales. One is simple account of the number of negative and positive statements and the second is an overall judgement based on total interview. The variables which were taken into account are critical comments about someone else in the home, dissatisfaction, hostility, warmth and emotional over-involvement. Brown et al. (1972) proved their hypothesis that a high degree of expressed emotion (mentioned earlier) is an index of characteristics in the relatives which are likely to cause a florid relapse of symptoms independently of other factors such as length of history, type of symptomatology or severity of previous behavioural disturbances.

The studies which have been reviewed mainly deal with attitudes of relatives towards the genesis of schizophrenia. To the best of our knowledge, the studies of Brown et al. (1962, 1972) and Berkowitz et al. (1981) are the only clinical oriented studies in which the attitudes of key relatives affecting course and outcome of schizophrenia have been studied. For this reason we have selected variables from the studies of Brown et al. (1962 and 1972). A separate questionnaire based on these criteria has been prepared (Sethi et al., 1982).

The present study aims to explore the attitudes of key relatives towards the 'schizophrenic patients' and to compare the attitudes of key relatives towards 'Disturbed Family's Patients'.

MATERIAL AND METHODS

The measurement of the attitudes of key relatives towards their patients has been done with the use of 'Attitude Questionnaire' developed by Sethi et al. (1982). This 'Attitude Questionnaire' is based on the methodological background as taken by Brown et al. (1962 and 1972) in his studies. In all five variables have been taken into consideration which are as follows:

1. Number of critical comments about someone else in the home.
2. Hostility
3. Dissatisfaction
4. Warmth
5. Emotional Over-Involvement

For each variable six questions were designed to measure the attitude of the respondent on a six point continuum of direct psychological enquiry with a view to elicit the response in 'Yes', 'No' or 'Indefinite' from very high to very low intensity through a gradation.

Sample—

The sample consists of 46 key relatives of 'schizophrenic patients' who were hospitalised at the Department of Psychiatry, K. G.'s Medical College, Lucknow. Another group consisted of 41 key relatives of 'Disturbed Family's Patients' who were admitted in the same hospital. Disturbed family has been defined operationally. One of the following should be present for categorising 'Disturbed Family'.

1. When there is evidence of overt conflict between the individuals who share the intense relationships characteristic of the family.
2. When a family of patient consisting of a domineering, hostile mother and a passive, dependent father. The weaker partner diverts hatred of the spouse towards the spouse's favoured child.
3. When a family of patient consisting of disappointed mother or father who relies on the children for support and comfort. The
partners live together in mutual isolation and the family splits in two groups.

(4) When in a family of the patient, the mothers had a schizoid pattern of interpersonal relationship characterized by a limited affective life, poor self control and an inability to feel themselves into the inner life of other people. They were found to be lacking in understanding and respect for the child as an independent person.

Each key relative of either ‘schizophrenic patient’ or ‘disturbed family’s patient’ was given following instructions before administering ‘Attitude Questionnaire’—

“The following is a list of questions related to your patient and his/her illness. Kindly read each question carefully and give the answer in ‘Yes’, ‘No’ or ‘Indefinite’ which ever you think is applicable in your case. There are no ‘right’ or ‘wrong’ answers. Please answer whatever comes first in your mind. You may ask for clarifications if you do not follow any question. Your answers will be kept confidential”.

OBSERVATIONS AND RESULTS

Table 1. Sample Distribution of the Study

|       | Key Relatives of S.P. | Key Relatives of D.F.P. |
|-------|-----------------------|------------------------|
| Urban | Male                  | Female                 |
|       | 11                    | 12                     |
| Rural | Male                  | Female                 |
|       | 16                    | 12                     |
| Total | 46                    | 41                     |

*Schizophrenic Patient.
**Disturbed Family’s Patient.

Table-1 reveals the sample distribution of the study relating to sex and residence of the key relatives of both groups.

Table-2 shows the means, standard deviations and ‘t’ values of the two groups for five variables. There was significant difference only in the area of ‘Dissatisfaction’.

Table 2. Means, S. D’s and ‘t’ values of the two groups for 5 variables and their significance

| Variables          | Key Relatives of S.P. (N=46) | Key Relatives of D.F.P. (N=41) | t  | p   |
|--------------------|-----------------------------|-------------------------------|----|-----|
|                    | M  | S.D. | M  | S.D. |     |     |
| Critical comments  | 0.48| 2.72 | 0.20| 3.14 | 1.24| N.S.|
| Hostility          | 0.48| 2.67 | 0.49| 2.78 | 0.02| N.S.|
| Dissatisfaction    | 0.33| 3.12 | 0.98| 2.43 | 2.03| <.05|
| Warmth             | 1.03| 2.52 | 1.98| 2.45 | 1.93| N.S.|
| Emotional over-involve-ment | 2.13| 2.80 | 2.68| 2.06 | 1.20| N.S.|

DISCUSSION

There are several criticisms about the value of the family interview as a research instrument (Eron et al., 1961; Becker & Krug, 1965). Inspite of these criticisms, it is premature to reject the interview as a research instrument. Comparatively little attention has been paid to its methodological problems. There is no other practical method of collecting much of the material. In addition, during an interview a considerable amount of direct observation of behaviour is possible. Brown and Rutter (1966) aimed to improve the family interview as a research instrument in which an equal amount of attention has been directed to obtain descriptions of family life and to make direct observations of behaviour shown in the interview itself. In research interviews subjective material is usually obtained by the use of standard questioning. In interviews of any length, however, such material often arises spontaneously and much of it consists of actual expression in contrast to self reports of feeling. It is
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possible for both to occur together in the same statement and either may be made spontaneously or in response to a direct question.

One of the major aims of this study was to check on the feasibility of accurately rating feelings expressed during the interview situation. Of the workers employing interview techniques, the well known clinical descriptions of 'marital divorce' (Brown et al., 1958) and 'pseudo-mutuality' (Wynne et al., 1958) are all based on uncontrolled intense observation of a few cases which generated hypotheses but in no way tested them. Witmer (1934) found no difference between schizophrenics and manic depressives in terms of extreme parental friction, while Prout and White (1950) found no difference in marital disharmony between parents of schizophrenics and of normal controls. Gerard and Siegel (1950) found significantly more discord and mutual hostility in the parents of schizophrenics than in normal controls. Fisher et al. (1959) used better controls and found that the parents of schizophrenics verbalised more hostility towards their spouses than the parents of neurotics and normals. Farina and Colleagues (Farina, 1960; Farina and Dunham, 1963; Farina and Holzberg, 1967 and 1968) found that parents of schizophrenics were more hostile than the parents of tuberculosis patients.

In this study we could not observe significant difference in attitudes of key relatives of schizophrenic patient and of disturbed family's patients in the areas of critical comments, hostility, warmth and emotional overinvolvement. Thus the present questionnaire is able to elicit adequate information in the above mentioned areas and the information elicited is quite reliable, because the identified 'Disturbed Families' did not show significant difference from the 'Schizophrenic Families'.

In the area of 'Dissatisfaction' the key relatives of 'Schizophrenic Patients' expressed significantly less dissatisfaction than reported by key relatives of 'Disturbed Families'. The reason for this may be that schizophrenics who were overtly sick and the family knew the handicap hence did not express much dissatisfaction.

In our setting the questionnaire which is more objective and less time consuming is a better and more reliable instrument over the techniques used by certain western workers (Mark, 1953; Farina and Holzberg, 1967; Fisher et al., 1959) which are applicable more in their culture. Our population responds better to direct interrogation and it is difficult to elicit information on subtle techniques.

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