COPING STRATEGIES OF THE RELATIVES OF SCHIZOPHRENIC PATIENTS

R.CHANDRASEKARAN, SIVAPRAKASH B.& S.R.JAYESTRI

ABSTRACT

Families caring for a member with a chronic severe mental illness like schizophrenia have to cope with a lot of burden and distress. The coping styles used by these families and their relationship to burden has not been studied in Indian families. This study aims to identify the coping styles adopted by the relatives of schizophrenic patients. 44 patients with schizophrenia and 44 relatives from an outpatient psychiatric clinic were assessed. Resignation, an emotion-focused coping strategy, was found to be more commonly employed by the relatives, than other strategies. Majority of the relatives failed to maintain social contacts. Levels of burden and negative symptoms correlated significantly with the resignation strategy. Analysis of the coping strategies of the relatives is essential before clinical interventions with families are planned to improve the coping skills of the carers.

Key words: coping strategies, schizophrenia, family, relatives, burden

The caregivers of schizophrenic patients are exposed to high levels of burden and distress. As a result of the paucity of organized care, families have been part of mental health care all through the history of India. In addition, there is also evidence to suggest that family involvement in patient-care continues to be preference of families (Kulhara & Wig, 1978), and thus family members serve as the main source of support for schizophrenic individuals. One of the areas which has been subjected to extensive research, is expressed emotions. Expressed emotions have been identified to play a crucial role in the relapse of schizophrenia (Bebbington and Kuipers, 1994), and psychosocial interventions have been developed to reduce the relapse rate by lowering expressed emotions (Birchwood, 1992). In India, as part of a WHO collaborative study of determinants of outcome of severe mental disorders (Wig et al., 1987), a cross-cultural aspect of expressed emotions was studied. The proportion of families categorized as having high EE was 8% in a rural sample and 30% in an urban sample. It is thus apparent that, expressed emotions, as a concept, plays a relatively less significant role in Indian families. In the Indian context, it would be more relevant to study the factors influencing the carer's burden and the level of adjustment to various life situations. One way of approaching the issue is to study the various coping strategies employed by the carers in response to behavioural changes in patients. This may provide information on the carer's level of adjustment to various stressful situations in the process of caring for a schizophrenic patient.

Birchwood and Cochrane (1990) found that relatives of patients with schizophrenia employed a broad style of coping in response to behavioral...
changes in patients. Scazuza and Kuipers (1999) concluded that the ways of coping are influenced by the relatives perception of the situation. They also found that avoidance strategies are found to be less effective in reducing the distress of caregivers than problem-oriented strategies. Budd et al. (1998) showed that coping style is associated with carer burden. Other factors that have been linked with coping strategies include presence of active psychotic symptoms, and the level of expressed emotion among the relatives (Scazuza & Kuipers, 1999).

Little is known about the ways in which families cope while caring for a relative with schizophrenia in a developing country. Studying coping styles could be a useful way of generating information that can guide management strategies. This study aims to look at the different coping styles used by relatives to cope with schizophrenic patients, and to identify the factors that correlate with the coping style.

MATERIALS AND METHODS

This study was conducted at the Department of Psychiatry, JIPMER, Pondicherry, between July, 2000 and November, 2000. Patients and their relatives were recruited from the outpatient department of Psychiatry unit which conducts a regular follow-up clinic for schizophrenia once a week. Patients were to meet the following criteria for inclusion in the study:

1. Age between 18 and 45.
2. Diagnosis of schizophrenia according to ICD-10 DCR (WHO, 1993).
3. One adult relative living with the patient, in the same environment, for at least 12 months, and involved directly in giving care to patient.
4. No hospitalization, or exacerbation of symptoms which required an increase in dosage of medication in the last 6 months.
5. Consent for participating in the study.

The following instruments were used to collect data:

a) A semi-structured proforma to collect information on demographic characteristics of patients and relatives, and other relevant clinical information.
b) Family coping questionnaire (Magliano et al., 1996)

The family coping questionnaire is a self-administered questionnaire consisting of 27 items divided into seven sub-scales (information, positive communication, social interests, coercion, avoidance, resignation, and patient's social involvement). This scale has a satisfactory content validity and intra-rater reliability. The three factors identified through factor analysis (problem-oriented coping strategies, emotionally focussed strategies, and maintenance of social interests in association with avoidance) accounted for 70.9% of the total variance.
c) Family burden interview schedule. (Pai & Kapur, 1981).
d) Brief Psychiatric Rating Scale (Overall & Gorham, 1962).
e) Scale for the Assessment of Positive Symptoms (Andreasen, 1984).
f) Scale for the Assessment of Negative Symptoms (Andreasen, 1983).

Patients symptoms were assessed with brief psychiatric rating scale, scale for assessment of negative symptoms, and scale for assessment for positive symptoms (R.C), and relatives were assessed with the family coping questionnaire and the family burden interview schedule (S.B). The family-coping questionnaire was translated into the local language with the help of a bilingual expert. The back-translated version was found to be similar to the original version. The inter-rater reliability (C.R & S.B) of the translated version of the coping questionnaire was found to be satisfactory. The agreement as measured by K varied between .62 to .71 for the various sub-scales. All analysis was done using Statistical Package for Social Sciences, Version 6.0.

RESULTS

44 patients and 44 relatives were included in this study. 20 were men and 24 were women. The mean age of the patients was 28.5 (2.4) years (range 18 to 45 years). The mean duration of
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TABLE 1

| COPING STRATEGIES       | Never | Ever* |
|-------------------------|-------|-------|
| Information             | 60    | 40    |
| Positive communication  | 63    | 37    |
| Social interests        | 79    | 21    |
| Coercion                | 68    | 32    |
| Avoidance               | 65    | 35    |
| Resignation             | 29    | 71    |
| Patient's social        | 66    | 34    |

* ever includes sometimes, often, always

TABLE 2

| COPING BEHAVIOUR SUBSCALES AND SCORES ON THE MEASURES OF NEGATIVE SYMPTOMS, POSITIVE SYMPTOMS AND FAMILY BURDEN |
|---------------------------------------------------------------|
| Coping Behaviours                                           |
|                                                              |
| Pearson's Correlation Coefficient (r)                        |
|                                                              |
|                                                              |
| Family burden                                              |
| Negative symptoms                                          |
| Positive symptoms                                          |
| Psychopathology                                            |
|                                                              |
| Information                                                | .02  | .37  | .24  | .24  |
| Positive communication                                     | -.02 | .07  | -.09 | -.09 |
| Social interests                                           | -.37 | -.39 | -.35 | -.27 |
| Coercion                                                   | .07  | .25  | .29  | -.05 |
| Avoidance                                                  | -.11 | .06  | .28  | -.3  |
| Resignation                                                | .49* | .40* | .27  | -.07 |
| Patient's social involvement                               | .20  | .40  | -.01 | .20  |

*p<0.01, **p<0.001

illness was 4.2 (2.1) years. 24 were married at the time of interview. 32 relatives were women and 12 relatives were men. The mean age of the relatives was 44.2 (8.1) years. The relatives comprised of 12 spouses and 32 parents. The mean scores on BPRS for the study sample was 30.2 (8.7). The mean SAPS and SANS were 14.5 (6.2) and 43.1 (16.2) respectively. The coping strategies did not vary according to relatives and patients' socio-demographic characteristics.

Table 1 shows the distribution of various coping strategies employed by the relatives. 71% of the relatives had used resignation strategies. 79% of the relatives failed to maintain social contacts. 60% of the relatives did not seek information about the illness. Only one-third of the relatives ever attempted active social involvement of the patients, coercion, and avoidance strategies. Table 2 shows the relationship between coping strategies and measures of negative symptoms, positive symptoms, psychopathology and family burden. Resignation, as a coping strategy, had a significant and positive correlation with burden. Similarly, resignation correlated positively with the presence of negative symptoms. Coping style was not associated with positive symptoms and psychopathology.

DISCUSSION

The present study examined the coping strategies employed by the relative of schizophrenic individuals, and the various determinants of the strategies employed. Though relatives used various coping strategies, it is evident that resignation, which is basically an emotional reaction to the situation, has been employed more often than other strategies. It is also evident that the majority of relatives failed to maintain social contacts. This is expected to have a significant influence on the well being of the individual. Another significant finding is that two thirds of relatives did not attempt to use problem-solving strategies (information seeking, positive communication, and patient's social involvement). This is in contrast to the finding of Scasifuca and Kuipers (1999) who reported that relatives used more problem-focused strategies. Strategies like avoidance and resignation are employed when the situation is protracted and considered unchangeable (Lazarus & Folkman, 1991; Magliano et al. 1999) and help to reduce distressing emotions. The sample included in this study has a higher proportion of negative symptoms. The patients attending the Psychiatric Unit of this hospital are primarily treated with psychotropic drugs and do not receive adequate inputs of other forms of intervention like family intervention which may prove beneficial in reducing the impairment related to negative symptoms. As the currently available psychotropic drugs are
yet to make a significant impact on the negative symptoms of the schizophrenic patients, the relatives might have perceived the situation as unchangeable. Cultural beliefs may also play a significant role in shaping coping strategies. An average Indian assumes a more fatalistic attitude towards life and future and accepts sufferings with a sense of resignation (Verma 1982).

Resignation showed a significant positive correlation with negative symptoms. Resignation shown by the care-giver can have an adverse effect on the patient's level of motivation, and this may influence the negative syndrome and hence may have an adverse impact on the clinical and social outcome of the patient's illness. Resignation also showed significant correlation with family burden. This has been demonstrated in another study which showed that higher levels of burden correlated significantly with resignation (Budd et al., 1998). Such emotion-focused strategies, when employed are usually ineffective. This can increase the burden on the family and the risk of high expressed emotions among the family members (Magliano et al., 1999).

Certain limitations of this study need to be mentioned. No attempt was made to use a blind procedure while interviewing patients and relatives. The study has a cross-sectional design and one cannot be sure of the precise nature of association between the variables. The results are not generalizable to other situations such as psychotic excitement, as the study has been conducted on a stable schizophrenic population. The family coping questionnaire used in this study has not been standardized for the local population. The influence of psychological morbidity among the relatives on the family burden has not been evaluated in this study.

This preliminary study in a relatively stable schizophrenic outpatient population shows that the caregivers show high levels of resignation while coping with the patient's illness. The use of the resignation strategy has a positive correlation with feelings of burden, which indicates that this strategy is not useful in reducing the burden. It is apparent that these relatives are in need of psychological help while caring for schizophrenic patients. Analysis of the coping strategies of the relatives is essential before clinical interventions with families are planned to improve the coping skills of the carers.

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