

Working with families with a member suffering from a chronic mental health problem: a case report

Abstract

The recovery of patients suffering from major mental illnesses involves the engagement of the families as carers. Psychoeducation, based on behavioral family therapy, assists the families in this role.

It aims to:

- i. Inform the family about the disorder and its treatments.
- ii. Lower the expressed emotion and avoid psychiatric relapses.
- iii. Improve the communication and the problem solving ability of the family.
- iv. Empower relatives' coping strategies.
- v. Fight stigmatization and encourage the relative's involvement in the society.
- vi. Support all family members.

In this report we present a case example of a psychoeducational intervention in a single family in which both the mother and the son were suffering from schizoaffective or bipolar Type I disorders. Several characteristics of family functioning were initially assessed as also parental opinions about mentally ill persons and euthanasia. Outcome data is reported showing improvement on the levels of expressed emotion, on family functioning and communication and on relative's burden of care. Psychoeducation played a core role as an auxiliary to the pharmacological treatment of both the identified patient and his mother.

Keywords: family therapy, psychoeducation, euthanasia, five minutes speech sample, schizophrenia, bipolar disorder

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Palli Alexandra,¹ Tzeferakos Georgios²

¹University Mental Health Research Institute, Athens, Greece

²2nd Department of Psychiatry, University of Athens, Attikon Hospital, Greece

Correspondence: Palli Alexandra, University Mental Health Research Institute (UMHRI), Athens, Greece,
Email a.palli.dr@gmail.com

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Objective

Chronic illness is defined as a disease that lasts more than 3 months and cannot be prevented by vaccines or cured by medication according to the definition of the U.S. National Center for Health Statistics. It initially included diabetes, asthma and depression but the illnesses spectrum is widening including major mental illnesses. Chronic illness is greatly influenced by socioeconomic status, education, employment, and environment.¹ Its impact on patients' and families' lives can be important as it continues across the lifespan. It leads to the long-term need for patients to be treated in the community, a role played by family members in the majority of cases in western societies; while in eastern countries the burden is carried solely by the patient's relations due to the dearth of mental health services.² The needs of the carers, the international family movements like the National Alliance for Mental Illness, the evolution of the medicines for mental illnesses and most importantly the theoretical and empirical findings of the strong and negative association between family stress and patient relapse/recovery have led to the conception of psychoeducation. This therapeutic approach, based on cognitive behavioral therapy and benefiting from techniques of several therapeutic approaches, is based on four major axes: briefing the patient about his/her illness, communication and self-assertiveness training, problem solving and goal achievement techniques and psychological support. The best results are discerned when it is applied not only to the patient

himself/herself but also to his/her family members.³ A plethora of publications during the last years substantiates the positive effects of family psychoeducation on schizophrenia and bipolar disorders. The findings suggest that psychoeducation reduces relapse and re-hospitalization rates, promotes medication adherence, decreases the duration of hospitalization, improves the patient's quality of life and increases satisfaction with services.⁴⁻⁷ Nowadays psychoeducation has expanded its focus and techniques by including education in more diseases and by including more therapeutic components mainly from cognitive therapy, as to serve in a better way the needs of people suffering from several mental or physical illnesses.⁸ Here, we present a case of a family behavioral intervention applied to a patient suffering from schizoaffective disorder and his parents.

Methods

The subjects

The patient was a 23 years old sport student. He was described as a rather quiet child who had few friends and only minor conflicts. He was uncomfortable with the treatment received and had poor acceptance of the illness. He was diagnosed with schizoaffective disorder, as assessed in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). He was hospitalized once at the onset of the illness when experiencing delusions of persecution, acoustic hallucinations and thought disturbances.

The mother was a 56-year-old housewife. She had been treated since 24 years for bipolar depression I, assessed in accordance with DSM-IV-TR. She was in remission during the last four years and both her and her husband reported good pharmaceutical adherence. The woman reported having experienced two manic episodes in the first years of the illness and five depressive ones in total. She reported difficulties in managing the household without the help of her husband. She was rated to be high in terms of an expressed emotion measure, showing over involvement towards her son.

The father was a pensioned 61-years-old highly educated captain. He had travelled for many years around the world and always took advantage of educational opportunities to advance his knowledge and skills. He displayed low aggression, avoiding critical comments towards his family members and non-over-involving. He retired as early as possible (11 years ago) in order to take care of his wife and later on, his son. In the self-rating scale he showed very high subjective and objective burden and a lack of well-being, as evidenced by sleep disturbances and high anxiety, mainly about the future. He strictly denied any kind of psychiatric medications for himself.

Assessments

The family was referred by the psychiatrist treating the patient. At the moment of referral the patient was treated with Olanzapine and experienced only negative symptoms; such as withdrawal, body and hygiene neglect, cognitive and concentration disturbances and lack of interests. The mother was euthymic. The intervention took place at the house of the family in Athens, in collaboration with the Family and Couple Therapy Unit of the University Mental Health Research Institute. Prior to the intervention as well as at its conclusion, assessments of each family member as well as of the family as a whole took place. They focused on exploring relative's knowledge about the disease, the levels of expressed emotion of each family member, the degree of family burden and of family cohesion, communication/problem solving difficulties and strengths as also the opinion towards mental illness and euthanasia. For the data collection validated or adapted questionnaires were used. For expressed emotion the Five Minutes Speech Sample interview was used.^{9,10} In regard to euthanasia, the feelings and opinions of the father were stated by three open questions based on a research instrument used in public opinion surveys. His feelings about the legislation, about the reasons he would consider euthanasia acceptable in general population and about the limitations for it to occur were asked. Pharmacological compliance was assessed by the combination of a compliance-focused interview with the patient and a compliance-focused interview with relatives.

Treatment

The sessions were devoted as following:

- i. 6 sessions regarding education about the illness
- ii. 10 sessions regarding communication skills
- iii. 8 sessions regarding problem solving and goal achievement
- iv. 2 supportive sessions related to the management of the symptomatology of the mother that led to the interruption of her participation in the family therapy. These sessions focused on handling the crisis occurred by that, on motivating the mother to accept psychiatric care and on supporting the other members.

- v. The intervention delivered was extended to 26 sessions spread over 14 months. The duration of each session was 90 min. The structure of each session consisted of a 30-40min presentation of the topic of the day, followed by an exercise related to the issue, a discussion and homework. All family members took part with the mother skipping attendance in 5 of them (4-9th session) while she was experiencing mainly hypomanic symptoms.

Results

It has been found that after the intervention the knowledge of the illness was enriched for all family members. Optimism about the future management of the illness was reported. The high levels of maternal expressed emotion were lowered. The family cohesion and ability to communicate and set goals/solve problems was raised. The objective burden became less for all relatives after the intervention. The subjective burden of the mother changed in a positive direction too, but the father reported high subjective burden even after the intervention. In regard to euthanasia, the father was found positive to euthanasia for physical but not for mental illnesses.

Discussion

We presented a case of psychoeducational intervention applied to three family members, two of which were suffering from chronic mental illness. In order to effectively respond to that situation, we have chosen to educate the family not only with regard to schizoaffective disorder but also to psychotic and affective disorders in general. By use of this method we expected to achieve a better understanding of the illness of the mother and not only of the identified patient.

More important therapeutic goals were achieved. The patient obtained knowledge of his illness and became aware of the benefits of pharmaceutical therapy which led to improvement of his compliance. His understanding of the disorder was improved and his ability to recognize his symptoms. A change in the mothers expressed emotion levels was reported too, as her over involvement was minored by the end of the intervention. Her ability to recognize her mood state had also improved. This change contributed greatly to the improved quality of life of the whole family. Concerning the father, the objective burden was lessened but the subjective burden kept on being high at the end of the intervention. Nonetheless, he was found to be more optimistic about the future and to experience lower anxiety symptoms.

At the beginning, the family was found to experience stigmatization and to have lost contact with the majority of friends and relatives, as well as having low cohesion and sparse family rituals and activities. At the end of the intervention the family unit was found to have a higher family cohesion, approaching the rituals discerned among the general population. Also with respect to problem solving, a change was recorded in that family members meeting all together to discuss a problem.

According to our experience, two aspects of this case study are of particular interest:

- i. The approach of the father about euthanasia. During the measurement of the Expressed Emotion by the interview technique of the F.M.S.S. he elaborated on the difficulties and the burden he experienced as single care of two mentally ill persons and referred to euthanasia. He reported about his discussions with an American psychiatrist whose help he

repeatedly asked for during professional trips to the USA.¹¹ Once, while describing the extreme burden and the depressive and anxiety symptoms related to it, the psychiatrist posed to him a philosophical question, by asking his stands on euthanasia. The father himself got very upset, was confused and did not know how he felt about such an approach but he kept thinking about it for the next time. He emphasized that there are many days when his son was suffering so much by intensive psychotic symptoms and when his wife was suffering so much by depressive symptoms that their lives seem unbearable. By the third day, he answered to him that euthanasia would never be an option whilst they are still young and there is still hope for new treatments in the future. He additionally added that he will take care of them as he is a captain and a good captain leaves a sinking ship last and so should all families be this way. This position of the father is consistent with the rare international research in this topic where a positive opinion towards euthanasia in mental illness tends to be supported when patients with depression and multiple suicide attempts or personality disorders.¹²

- ii. The fact that the mother was included in the family therapy though suffering from chronic mental disorder. She was euthimic for the last four years and at the present time she was able to attend the sessions. Although she was strictly willing to participate in the role of a mother and not of a patient, her level of awareness about her own difficulties raised as also the acceptance of the illness. Previous experiences with spouses and brothers and sisters suffering from mental disorders themselves also support the clinical finding that the ill relative profits from psychoeducation in relation to his own illness and not only to the one of the identified patient.

Finally, a limitation should be mentioned. We applied the intervention to a family with more than one mentally ill person and that could have compromised the anticipated beneficial results of psychoeducation. It could be expected that a prior psychoeducational intervention focusing to the mothers' illness would have lead to even better results.

Conclusion

We reported that a family psychoeducation intervention was effective in a patient with schizoaffective disorder. The knowledge of the patient about the illness as well as of his parents was significantly improved. It was also found that the levels of the expressed emotion of the family members were lowered, an improvement that affects the family atmosphere and protects the patient from future relapses. The parents themselves reported less burden ascribed to the illness, a higher family cohesion and an amelioration of the family atmosphere. Euthanasia of mentally ill persons was found to be a subject of consideration for the relative. An integrated behavioral family intervention applied in a systematic manner during a long period of

time is proven to be useful and highly feasible in a clinical setting to treat patients with chronic mental illnesses.

Consent

Written informed consent was obtained from a participant after an explanation of the purpose and procedure of this research.

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None.

Conflict of interest

The author declares no conflict of interest.

References

1. Centre for chronic disease prevention and control. What are chronic and non-communicable diseases? Ottawa: Public Health Agency of Canada; 2006.
2. Sartorius N, Leff J, Lopez-Ibor JJ, et al. Families and mental disorder: from burden to empowerment. Switzerland: World Health Association; 2004.
3. Falloon IRH. Handbook of behavioural family therapy. London, USA: Routledge; 2015. 460 p.
4. Colom F, Vieta E, Sanchez-Moreno J, et al. Group psychoeducation for stabilised bipolar disorders: 5 year outcome of a randomized controlled trial. *Br J Psychiatry*. 2009;194(3):260–265.
5. Colom M. Keeping therapies simple: Psychoeducation in the prevention of relapse in affective disorders. *Br J Psychiatry*. 2011;198(5):338–340.
6. Palli A, Kontoangelos K, Richardson C, et al. effects of group psychoeducational intervention for family members of people with schizophrenia spectrum disorders: results on family cohesion, caregiver burden, and caregiver depressive symptoms. *International Journal of Mental Health*. 2015;44(4):227–289.
7. Xia J, Merinder LB, Belgamwar MR. Psychoeducation for schizophrenia. *Cochrane Database Syst Rev*. 2011;6:CD002831.
8. Economou M. Psycho education: a multifaceted intervention. *International Journal of Mental Health*. 2015;44(4):259–262.
9. Hooley Jill M, Holly A Parker. Measuring expressed emotion: An evaluation of the shortcuts. *J Fam Psychol*. 2006;20(3):386–396.
10. Leeb B, Goldstein MJ, Hahlweg K, et al. Cross-national reliability, concurrent validity, and stability of a brief method for assessing expressed emotion. *Psychiatry Res*. 1991;39(1):25–31.
11. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington, DC, USA: American Psychiatric Association; 2013. 991 p.
12. Thienpont L, Verhofstadt M, Van Loon T, et al. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open*. 2015;5(7):e007454.