Schizophrenia: problems of separation in families

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Background. In the past, family relationships of people with schizophrenia have mainly been investigated from a clinical viewpoint. The perspective of family development has generally been overlooked in this area of research.

Aim. This paper reports a study exploring problems of development and detachment in families with an adult child with schizophrenia.

Method. Using in-depth interviews, 51 parents of people with schizophrenia were questioned about their living situations and relationships with patients.

Findings. Spatial separation from the family home was often complicated or even prevented entirely, with patients permanently living in their parents’ household or in the same neighbourhood. Many patients remained dependent on their parents’ emotional, practical and financial support. Typically, the parent–child relationship was re-intensified, often with a concurrent loss of social contacts outside the family. From a biographical point of view, schizophrenia often caused problems for families by making parenthood permanent and lifelong parental support necessary. Many parents had to revise their expectations of both their ill child’s development and their own personal plans.

Conclusion. From the viewpoint of family psychology, schizophrenia is a serious obstacle to development that affects both patients and their parents. Family-related support should increasingly take into account the issue of the difficult detachment of patients from their parents.

Keywords: schizophrenia, family, parents, adult child, burden, separation, nursing

Background

In psychiatric research, family relationships of people with schizophrenia are mainly viewed from three different angles. Aetiology- and prognosis-related studies investigate the role of patients’ familial background in the development and course of schizophrenia. The concepts of double bind (Bateson et al. 1956) and of the schizophrenogenic mother

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(Lidz & Lidz 1949) have become widely known, even outside psychiatric research. While the thesis that parents' ‘pathogenic’ behaviour and communication patterns are a crucial cause of schizophrenia is now considered outdated, there are numerous studies verifying that emotional climate in the family, in the sense of expressed emotion, plays a significant role in the course of the illness. Parents’ critical, hostile or overprotective behaviour is accompanied by an increased risk of both further inpatient stays at psychiatric hospitals and psychotic relapses (Vaughn et al. 1982, Kavanagh 1992, Smith et al. 1992, Bebbington & Kuipers 1994, Barrowclough & Parle 1997).

In addition to familial relationships, social network research tries to document all aspects of patients’ social relationships, and their correlations with illness characteristics. These studies show that people with schizophrenia usually have fewer social relationships than healthy persons or patients with other mental disorders. An intact social support system generally seems to have a positive effect on a patient’s illness prognosis. As schizophrenia progresses, the patient’s social network gets smaller and co-patients and family members become more important. The parents of people with schizophrenia often remain the most important people in their lives, as only a few patients marry or live in a stable partnership (Angermeyer 1995).

Contrary to the patient-centred perspectives of the two above-mentioned research traditions, caregiver burden studies investigate the impact of mental illness on the patient’s family. Numerous publications document the high degree of objective and subjective burden on relatives of people with schizophrenia (Loukissa 1995, Baronet 1999). Many studies describe the severity and frequency of psychotic symptoms and behaviours as the most important factor in determining the degree of burden that relatives experience (Perlick et al. 1992, Reinhard 1994). The nature of symptoms also seems to be of importance, as negative symptoms are more burdensome than positive symptoms (Provencher & Mueser 1997, Tucker et al. 1998). Female relatives often experience a heavier burden than their male counterparts, especially if they share the same household with the patient (Jones & Jones 1994).

Our paper explores relationships between people with schizophrenia and their parents from the perspective of family psychology, an approach which has generally been overlooked in the research literature. Carter and McGoldrick’s (1989) model of family development serves as the theoretical point of reference. A central idea is that family members have to manage normative biographical transitions (e.g. children starting school or death of a spouse) and role shifts in the family (e.g. parenthood) together. Stromwall and Robinson (1998) point out that ability to cope with developmental tasks inherent in the family lifecycle is seriously disturbed by schizophrenia. In most cases, schizophrenia starts early in life, posing a special developmental risk, as it coincides with the developmental tasks of adolescence and early adulthood, such as separation and detachment from parents, occupational training, and development of sexual relationships. As ‘detachment’ is a developmental task that has to be managed by both parents and children, this situation can be accompanied by specific demands and problems for both sides.

The study

Aim

The aim of this study was to explore problems of development and detachment in families with an adult child with schizophrenia.

Design

A qualitative design, based on narrative interviews, was used.

Participants

Fifty-one parents of people with schizophrenia were questioned about their present living situation and illness-related burdens. They were recruited in the city of Leipzig, Germany (500 000 inhabitants) from psychiatric inpatient, day care and outpatient facilities. First, patients with schizophrenia who had identified their parents as the most important relatives in their lives were informed about the study. If they agreed to their parents being interviewed, the latter were contacted by telephone or mail. Of 74 parents contacted, 42 mothers and nine fathers agreed to participate. The average age of participants was 60 years (range 36–85). The average age of the 51 patients was 33 years, and most had been having psychiatric treatment for 11 years at the outset of the study. In order to record patients’ functional impairment levels, the psychiatrist in attendance made a quantitative assessment using Axis V of the DSM-IV Global Assessment of Functioning (GAF) (American Psychiatric Association 1994). Patients’ average GAF-value of 52 showed that they had a moderately severe level of impairment.

Data collection

Experienced psychologists, trained in the technique of narrative interviews, conducted the interviews in participants’ homes (Riessmann 1993). First, participants were asked to
talk about their changed situation due to the mental illness (What has changed for you since your son’s/daughter’s illness?). The interviewer intervened as little as possible during interviews. As soon as discussion of a topic was completed, or long gaps in the conversation occurred, participants were prompted to continue their narration with questions such as ‘What bothers you most at the moment?’ and ‘Was there anything lately which was an extreme burden for you?’ In addition, the interviewer could generate concrete narration and descriptions of situations by means of narrative-deepening questions, especially in cases in which participants had a strong tendency towards argumentative or abstract description. On average, interviews lasted 30 minutes. After each interview, a detailed document was produced; this summarized the main interview topics, the interviewer’s observations and other information that had not been recorded.

Data analysis

A two-step data analysis process was adopted. First, all 51 cases were subjected to a global analysis using the summary document, sociodemographic data and other contextual information. In the second step, individual interviews were selected and transcribed for a comparative individual case analysis; sampling followed the criteria of theoretical relevance and theoretical saturation with regard to the question investigated (Strauss & Corbin 1990). More precisely, interviews in which the impact of schizophrenia on relationships between patients and their parents was a central theme were gradually selected for in-depth analysis. Sampling procedures were designed to generate as broad a range of subject-relevant categories as possible, and sampling continued until no more categories could be generated. Twenty-one parent interviews from the data pool were selected and analysed. Validation of sampling and findings was ensured by regularly discussing them in a research colloquium (Legewie 1987).

Findings

Global analysis of interviews showed that most study participants mentioned illness-related problems of development and detachment in some way. A comparative synopsis of subject-related individual case analyses produced a range of different aspects of problems (see Figure 1).

Complicated spatial separation

Many parents perceived complicated spatial separation of patients as a developmental issue of special importance. Moving out of the parental home, starting an independent life and getting married were often permanently prevented by schizophrenia. At the time of the interviews, 41% of patients still lived with their parents or had moved back in with them. Most of these patients developed schizophrenia in adolescence and had never lived on their own. In some cases, they moved back in with their parents after they had lived in a flat of their own for some time. This could happen after long and severe illness episodes, loss of employment or separation from their spouses.

Seven participants reported that their child refused to move out of the family home despite their parents’ wishes. Some
felt helpless about the patient’s refusal to move into their own flat or residential care, and others were ambivalent. Some participants reported having a guilty conscience about their adult child. They did they want to be perceived by either society or their children as ‘bad parents’ who ‘throw their children out of the nest’ despite the latter’s illness and dependence on their help. In other cases, parents feared direct confrontation and hoped that they could change the patient’s opinion gradually, through indirect influence. However, there were parents who experienced living with their ill son or daughter as unproblematic or even advantageous. Especially in traditional milieus, it is often accepted, or even taken for granted, that adult children continue to live in their parental home if they do not get married and have children. In other cases, positive aspects of permanently living together were perceived, e.g. if a parent died and the patient assumed parts of their former role in the family, such as household duties or joint activities during spare time.

At the time of the interviews, 59% of patients no longer lived in the parental home, but had their own flat or lived in accommodation for people with mental health problems. Nevertheless, all study participants were in close contact with their sons and daughters. Most parents said that they saw their adult child several times per week, or even on a daily basis. They often sought a compromise solution with regard to the location of the flat; this involved a spatial separation but allowed comprehensive care-taking. Many patients, therefore, had a flat in their parents’ neighbourhood or even in the same house. Conversely, only a few parents stated that they saw their adult child rarely or at irregular intervals. This situation arose in relationships that were full of conflict and in which close contact was, at least temporarily, avoided or with patients who were either not impaired or were only moderately impaired between acute illness episodes, leading parents to think that intensive care-taking was not necessary.

Complicated emotional detachment

Schizophrenia also complicates patients’ emotional detachment from their parents. This is particularly true for those living in the same household on a long-term basis, but also occurs when patients have their own residences. Interviewees reported that, because of their adult children’s illness, they remained or had again become the most important people in their children’s lives. Out of a joint experience of illness, a very close emotional relationship could develop, atypical for adult children and their parents. Although extremely burdening family conflicts could arise in the course of the illness, parents occasionally had the impression that they were the only close person that their child could relate to. They felt increasingly responsible for the care of their ill child. Many study participants saw this re-intensification of the parent-child relationship as a permanent return to an earlier stage of the relationship:

He is very close to us. That’s because of the illness. He now trusts us very much because we were the ones who cheered him up and helped him all the time. What many parents experience with their children of that age – K. is now 23 – is that they slowly break loose, find friends or a girlfriend, and that they lead their own lives. With us, that just didn’t happen, or at least, only to a limited extent... He hasn’t broken free from us yet and that’s why we still feel burdened, because he’s like a young child you want to help to get along in life. (Mother, aged 49, of a 23-year-old son)

Re-intensification of the parent-child relationship could result in reduced social contacts outside the family. At first, this related to the adult child’s contacts; friends or acquaintances withdrew because of the illness or patients themselves felt unable to maintain relationships or make new friends. Thus, for some of the patients, the relationship with their parents was the only social contact outside the ‘psychiatry scene’. However, many parents also felt insecure with regard to their own friends and acquaintances, because they feared prejudice and lack of understanding, for example. This could lead to a ‘withdrawal into the family’ during the course of the illness, with contacts inside the family assuming greater importance. The main reason behind this development was that more solidarity and tolerance was expected (and also demanded) from the family than from acquaintances or friends.

Complicated emotional detachment could result in an asymmetrical parent-child relationship. Many patients remained dependent on their parents’ emotional and practical support, and parents felt responsible for their ill child. Many participants, and especially mothers, described this situation as a chronic burden and said that their own needs had to go unfulfilled in order to support patients. However, not all parents perceived the close emotional relationship with the patient as problematic or burdening. These parents emphasized positive aspects of the relationship, such as the advantages of living together. In addition, they did not feel that the close parent-child relationship restricted the realization of their own needs. This was either because they judged that the level of necessary care-giving was relatively low, or because they had low expectations about a personal life beyond the parent role.

Continuing financial dependency

Approximately one-third of parents reported a problem of separation that resulted from the financial situation of their
ill child. Because of the early onset of schizophrenia, many patients were neither eligible to receive a pension, nor trained to pursue a profession. The developmental tasks of entering the job market and becoming financially independent, which are characteristic of early adulthood, could often be only partially completed by patients, or could not be attempted at all. Patients’ chances of independent living could often only be guaranteed by welfare aid and additional financial support from parents. This situation could be experienced as very burdensome, especially as the future course of the illness could not be predicted and many parents were insufficiently informed about relevant legal regulations. In the beginning, financial support was often seen as a temporary solution; parents’ hopes rested on their adult children practising a profession and becoming financially independent in the long-term, despite schizophrenia.

Some parents had difficulties in assessing whether their adult children were really not able to earn their own living or whether they were using their mental disorder as an excuse for avoiding employment and not making serious efforts to find a job. In these cases, parents felt resentment and anger towards patients’ continuing requests for financial support. Thus, some participants felt exploited and had the feeling that their ill child was ‘living off’ them:

Well, he lives here. I’m doing his laundry, and he’s got expensive appliances that need electricity. We know that he needs the little money he earns on the side for himself and he says that he couldn’t give us money. So, he probably thinks he could live like this forever. (Mother, aged 49, of a 26-year-old son)

Parents had a growing impression that patients who had already experienced schizophrenia for a long period of time and whose employment status had not changed, would remain permanently dependent on their financial support. Against this backdrop, different possibilities for guaranteeing patients’ long-term financial stability were considered, including voluntary pension-scheme contributions or accumulating financial reserves.

Parental support in managing everyday life

The more patients were impaired by schizophrenia, the more they needed practical support from parents in managing their everyday lives. Among other things, parents accompanied their children to meetings with official authorities and doctors, or to facilitate communication with employers and landlords. They also undertook various tasks in patients’ daily lives, such as preparing meals, doing laundry, cleaning and tidying, and supervising personal hygiene. In many cases, parents also checked whether patients were taking their medication regularly and at the correct dosage. Parents’ caring activities also included attempts to keep stress and burdens away from their adult children, for instance by taking over exhausting tasks such as corresponding with authorities, or by shielding them from unpleasant occurrences such as stressful mail or bill reminders, and family disputes. The impetus for these actions was often their worry that patients might be overtaxed or fall acutely ill again because of a loss of strength caused by the illness. Parents had already had the experience of, or were at least sensitized by professionals to, even moderate burdens of everyday life posing a risk of relapse to the patient. Many parents were also trying to motivate their ill child to pursue pleasant activities in everyday life and offering stability by providing a fixed structure to each day. While some parents reported that they had been encouraged by doctors or other professional helpers, others’ actions were based on the intuitive idea that they could prevent psychological crises or acute relapses:

Tomorrow we’ve got to go to the doctor and after that we will go to our garden. I always have to take him there to take his mind off things. If I leave him at home, then it’s all over. Then he’ll fall into a hole. The people from the garden next to us are very nice, sometimes they pick him up or he can chat with them. Then he doesn’t start to brood about things. If he just sits there, all he does is brood and that’s not good for him…One only understands a little about the illness. I’m just doing what I think, but I think what I’m doing is right the way to do it. (Mother, aged 69, of a 35-year-old son).

Nevertheless, if a psychotic episode recurred, parents acted as ‘first-aid givers’. Parental support included emotional backup and practical helping measures in crisis situations such as panic attacks and suicide attempts, providing motivation to seek professional help, and accompanying the patient on visits to the doctor or hospital. During inpatient stays, parents’ help included regular hospital visits and taking over patients’ duties during their absence.

Insecurities and ambivalence about help and support

Some parents experienced a dilemma: to what extent was their help necessary, dispensable or even damaging. On the one hand, they often experienced patients as helpless and unworldly, and thought that they could not manage everyday life without them. On the other, many were quite aware that their help and support unintentionally hindered their ill child from developing more independence. They experienced a conflict between giving anticipated or demanded help and exerting influence and the danger of crossing borders and
diffusing responsibility. In this context, professional advice about reducing the intensity of care was felt to be correct but unrealistic:

Mother: I’d be glad if he didn’t need us so badly. He never cleans or tidies his flat by himself. I don’t know, is it wrong that I’m doing it or should we just leave him alone? Do you know, I’ve got my doubts about what I should do.

Interviewer: You worry that he would let himself go if you were not there?

Mother: I do worry, that’s a fact. Do you understand? [begins to cry].

You might think that’s absurd, but there are things where I say to myself, ‘Oh Lord, if he doesn’t do that now, what will happen to him? He must learn this! One day I won’t be there anymore’. (Mother, aged 72, of a 50-year-old son)

Insecurity and doubts could also occur when the patient moved out of the family residence. Some parents worried that the adjustments and requirements of an autonomous life might increase the risk of the illness taking a turn for the worse. In other cases, parents were afraid that a separate living situation would result in reduced controllability of the illness. This might occur because symptoms and conspicuous behaviours which, as experience had shown, signal a renewed psychotic episode could not be recognized early enough to take appropriate countermeasures.

Parents trying to dissociate from the patients

Nine of the 51 participants felt that they were not able to have close contact with patients or live with them on a long-term basis. Various practical aspects of care-giving (worries, doubts and the feeling of having no spare time) demand a great deal of strength. Some parents abdicated responsibility because they thought it unbearable that they should always have to put their own needs after those of their ill child. These parents wished to have more distance from patients and justified this by citing health problems resulting from long-term care-taking and the mental burdens connected with it. In other cases, they argued that patients would have better chances of learning to be independent if they did not continue to give a high level of support.

Feelings of ambivalence could develop when parents made efforts to find relief and distance themselves from their ill children. They often had difficulty in achieving a balance between their sense of responsibility and their wish for greater distance from the patient. Essentially, they wanted more independence for the patient and more personal freedom for themselves but, at the same time, they were aware of how limiting this wish was and they hesitated to take the appropriate steps. Sometimes, in an effort to find relief, a social worker was introduced and relieved parents of certain aspects of care-giving, especially those, such as regulating financial matters, likely to lead to conflict. Another strategy for changing the situation was asking patients to move into a flat of their own or actively supporting such a move. If patients could not manage independent housekeeping or if parents thought that they were not capable of living alone, appropriate help was offered or residential care was considered. Other parents tried to find more freedom and breaks for themselves by making binding arrangements with the patient about fixed visiting hours or responsibilities:

Mother: He’s got the key for the house. He can come over whenever he wants to, and on the weekend he’s here most of the time anyway. But we said to him ‘During the week, we need our peace’. That might sound a bit hard now but we just couldn’t go on like this.

Interviewer: That’s like walking a ridge between dissociation and responsibility for him.

Mother: Yes, always! Yes, and that was the reason why we didn’t want to have him here in the house anymore. (Mother, aged 68, of a 32-year-old son)

Some participants reported that they saw no alternative to breaking off contact with the patient, at least temporarily. These parents saw ending contact as their last chance to protect themselves, especially after extreme escalations of conflict or in the face of unhealed psychological wounds or permanent tensions. In these families, one parent maintained contact with the patient at least sporadically, while the other parent behaved in a rejecting or reserved way. Mothers, in particular, seemed to have doubts about losing contact with their ill child.

Biographical interpretation of permanent parenthood

In the context of their own life stories, parents perceived schizophrenia as a significant event that had far-reaching consequences for the family’s everyday life and for their own future plans. It was a slow and difficult process for parents to accept that many of their wishes, expectations and dreams about the development of their children would never come true. In particular, social comparisons with former classmates who were not ill or with patients’ brothers and sisters, were always associated with feelings of sorrow and bitterness:

Mother: It’s not very pleasant when you see that other children are developing in a different way. Well [stops, close to tears] it’s not so easy, to accept that.

Interviewer: That the others have progressed differently?

Mother: Yes, right.

Interviewer: …and have chances your son has never had?

Mother: Yes, that’s right, even though he was, as I said, a smart child,
an intelligent man and has got lot of skills. He is talented at music and he loved to draw and paint, and that’s very sad, when you can’t make anything of your skills and talents. That’s terrible. (Mother, aged 58, of a 32-year-old son)

During the course of the illness, parents realized that patients’ psychosocial impairments would probably remain and make an independent life impossible. They expected to be responsible and take care of their ill child for a period of time that could not be foreseen. By contrast, parents of less impaired patients who experienced longer symptom-free phases felt that they were on permanent ‘emergency standby’; they expected patients to be highly dependent on their help when a new psychotic relapse occurred. In both cases, parents were faced with the problem of a permanent parenthood, which included the requirement of taking care of the patient for as long as they live and guaranteeing intense care in case of need.

For many parents the permanent responsibility was a ‘natural’ thing. Offering their children a high degree of solidarity and accepting restrictions when their children needed help were an integral part of their parental role. In some cases, feelings of guilt caused a sense of special responsibility, as with parents who thought that their parenting had contributed to development of the disorder. As mentioned above, this permanent responsibility was often, but not always, experienced as burdensome. Some parents also saw positive aspects of the continuing, close parent–child relationship and, for them, the responsibility connected with it was no special burden.

In other cases, permanent parenthood was perceived as an obstacle to realizing personal plans for life. Illness-related problems of separation and detachment were a personal restriction, especially for those who, as well as their parental role, had high demands relating to their ‘own lives’. These parents were disappointed and dissatisfied with their situation; they were expecting that, after the stage of parenting, they would be able to concentrate on their personal needs, both vocational and private. These plans now had to be moderated, or even abandoned, because of their child’s mental disorder.

Worries and fears: what will happen after my death?

Older parents, in particular, said that they were increasingly occupied with the question of who would take responsibility for patients when their own illness or death intervened. Some parents were afraid that their son or daughter would become lonely, degraded or even homeless without their care. The idea that the patient would be put into residential care for mentally ill people and would not cope there made many parents depressed:

Mother: I cook for him. I do his laundry. He’s so clumsy; he’s like a 36-year-old child! Well, I don’t know what’ll happen later, I just don’t know. I have to talk to the doctor again, to see whether she’s going to put him in a home or whatever. What else could happen? (Mother, aged 76, of a 36-year-old son)

Some participants also said that if they themselves became ill or in need of care, they could not rely on their child’s help. These parents were aware that patients could only give back some of the support and help that they had provided, often for many years. Comparing their situation to that of families with healthy adult children, parents of people with schizophrenia thought that solidarity between different generations was not possible or was only possible to a limited extent. This made them feel disappointed and sad.

Discussion

The results of this study correspond with the principal findings of psychiatric research with family caregivers. In the case of schizophrenia, mostly the parents of those affected assume the role of main caregiver. For many patients, their parents are the most important permanent social contact (Angermeyer 1995).

First of all, this concerns the housing situation. Based on his longitudinal study, Salokangas (1997) assumes that almost half of the people with schizophrenia questioned live with their parents on a permanent basis. In our study 41% of the ill sons/daughters also still lived in the same household with their parents. Because of this, parents are confronted with considerable restrictions and burdens. We can confirm Tuck et al.’s (1997) description, according to which parents of those with schizophrenia perceive this disorder as a destructive force that disrupts and radically transforms the normative family life trajectory and is accompanied by various experiences of loss. As in other studies, we found that parents often felt trapped in a hopeless situation when living with their son/daughter, a situation with which they felt over-burdened. This concurs with the findings of Deger-Erlenmaier (1994), Solomon and Draine (1995) and Tucker et al. (1998).

When interpreting the results of this study, the fact that mostly mothers were interviewed deserves special attention. In the first place, the predominance of female study participants could be attributed to a systematic selection effect when deciding on participation in the study: apart from those cases where only one parent was available for interview (e.g. because the parent was widowed or divorced), the decision...
What is already known about this topic

- People with schizophrenia usually have only a few social contacts and, for the majority, their parents are the most important people with whom they have relationships.
- Considerable emotional burdens can arise for these parents, and family life is greatly affected.
- Critical, hostile or overprotective behaviour by parents increases risk of further psychotic relapses and hospital stays.

What this paper adds

- Schizophrenia is a serious obstacle to development that affects both patients and their parents.
- The early onset of schizophrenia during adolescence complicates normal developmental steps into adult life or prevents them completely.
- Parents of patients with schizophrenia are not only faced with the challenge of accepting lifelong responsibility for their children, but also of redefining their own life prospects.

about whether the mother or father would participate in the study was left to the parents themselves. It appears plausible that it is mostly mothers who consider themselves as the ‘responsible’ person for such research as they perform the largest part of the care and possibly have a stronger emotional closeness to the ill daughter or son. It can be assumed that the one-sided distribution of sexes in our sample illustrates the phenomenon that mothers of people with schizophrenia experience stronger burdens than fathers (Jones & Jones 1994, Sennekamp 1995).

We agree with Karp and Watts-Roy’s (1999) finding that, for parents of people with schizophrenia, their responsibilities and the question of the necessary boundaries of these are a particularly important and difficult topic. From our point of view, it is very significant that parents experience their relationships with their adult children as indissoluble, lifelong bonds. This is an important difference compared to spouses of mentally ill people, whose solidarity can terminate in situations of extreme burden (Mannion et al. 1994, Johnson 2000, Junghauer & Angermeyer 2002). Furthermore, our results support the thesis derived from Carter and McGoldrick’s (1989) family lifecycle model that schizophrenia causes considerable developmental problems for both patients and their parents. Long-term problems of separation and detachment can occur, particularly when patients suffer frequent or severe psychotic episodes, and are strongly impaired in their everyday lives. Numerous studies have shown that relatives of people with schizophrenia feel especially highly burdened if the symptoms are characterized as extremely severe by the attending physicians (Perlick et al. 1992, Reinhard 1994). Our findings show that, in these cases especially, patients’ detachment from their parents is very difficult. Parents often experience sorrow, resignation and feelings of being overtaxed in relation to the patient’s arrested development, and the possibly lifelong responsibilities resulting from this.

Our study shows, however, that not all parents perceive impeded or incomplete separation and detachment negatively. The extent to which permanent parenthood is experienced as burdensome depends not only on the severity of the illness and the degree to which the patient is in need of care, but also on individual concepts of parenthood, family and personal freedom. Parents who judge that a permanent close relationship with their son/daughter is compatible with their personal life plans may be able to make everyday arrangements that they find satisfactory. It is even possible that, in some cases, incomplete detachment of an adult child with schizophrenia ‘saves’ parents from facing developmental tasks of their own, such as redefining their partnership in the postparental phase, facing the challenge of dealing with their personal vocational identity again and finding a meaning of life that goes beyond parental responsibility.

Conclusions

From the perspective of clinical psychiatry and psychiatric nursing, our findings are highly relevant. They show that supporting patients by managing familial and spousal role requirements beyond the aims of medical treatment is an important task in integrated psychiatric interventions. Moreover, development-related support for patients themselves is important. First of all, it is desirable that patients be supported to develop higher levels of activity and autonomy, in accordance with their individual situations. In addition to regular counselling sessions, social skills training is useful for practising or improving social abilities. Furthermore, occupational therapy can strengthen endurance, self-responsibility and powers of concentration. Even the smallest progress can constitute a considerable improvement for patients and their families.

Plans for helping patients’ parents should take account of developmental tasks and obstacles to development. In addition to regular consultation hours for relatives (e.g. in a psychiatric outpatient facility), psychological counselling that deals specifically with developmental issues for all family
members (L’Abate 1990) is also possible and could be of great benefit to recipients. Outreach social work is also important, especially for parents who lack the strength or self-confidence to seek help. In addition, parents should be relieved of burdens in a practical sense, for example, by a counsellor who assumes responsibility for areas of conflict such as finances.

An important starting point for psychosocial practice is genuine involvement of the parents of people with schizophrenia in outpatient therapy is inclusion as equal partners. In practice, this involves maintaining a dialogue with parents, planning measures with their assistance and providing opportunities for their active involvement (e.g. as voluntary counsellors in facilities that offer residential care to people with mental disorders). Such an ‘emancipatory’ programme with parents can contribute to the motivation and unburdening of families. However, it also involves handing over professional competence to parents, a challenge to which we as professionals should rise.

References


