International Journal of Enhanced Research in Medicines & Dental Care, ISSN: 2349-1590
Vol. 1 Issue 8, October-2014, pp: (1-6), Available online at: www.erpublications.com

Family pathology and social support in relapse among Bipolar Affective Disorder and Schizophrenia Patients

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Abstract: Delivery of mental health services is changing world wide including India. Practice has shifted from an instrumental model of care to community based and family involvement based techniques. Despite that centrally, the views and experiences of family on the utility of the present classification system have been little studied. Present study was aimed to assess the difference of family pathology and social support in the relapsed of bipolar affective disorder and schizophrenia patients. On the basis of purposive sampling technique 60, (30) Bipolar Affective Disorder and (30) Schizophrenia patient, who are relapsed and came to RINPAS OPD for the treatment and referred for hospitalization were selected. Family pathology is high in the families of patients with schizophrenia in comparison to Bipolar Affective Disorder Patient's family but the social support is poor in the families of patients with schizophrenia in comparison to Bipolar Affective Disorder Patient's family.

Keywords: Family Pathology, Social Support, Relapse.

INTRODUCTION

Worldwide, there have been major changes in the delivery of mental health services over the past 25 years. Practice has shifted from an instrumental model of care where treatment was centered on the individual and minimal consideration was given to the family and/or significant others (social support and expressed emotion). Despite that centrally, the views and experiences of family on the utility of the present classification system have been little studied. The term "social support" is often used in a broad sense, including social integration. However, Social integration refers to the structure and quantity of social relationships, such as the size and density of networks and the frequency of interaction, but also sometimes to the subjective perception of embeddedness. Social support, in contrast, refers to the function and quality of social relationships, such as perceived availability of help or support actually received. It occurs through an interactive process and can be related to altruism, a sense of obligation, and the perception of reciprocity.

The combined family and individual approach emphasizes the understanding of mutually reciprocal relationships between life stress, environmental context, and the onset of mood disorder symptoms (Hudson and Rapee 2005). Available evidence suggests that the prevalence of psychopathology among children in the family or foster care is higher than would be expected from normative data (Raghavan et al, 2008). Family is the main socializing agent for the child and is important in all aspects of a human development. From family, an individual gets emotional, financial, mental support and is able to cope with his/her problems with the help of the members of the family. Scientific observations on mental disorders and mental patients have indicated that family contributes significantly to the development of mental disorders. The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past decade. Clinical work and research on families, theories of family structure and dynamics had their beginning since 1940s with the work by Social scientist. It is indicated that family has a crucial role in the development of mental disorders. Mental disorders develop as a result of family pathology or faulty communication or interpersonal relationship. Although the individual is affected, yet the whole family is sick because of inter or intrapsychic problems (Keiter & Miller, 1999).

Spiegel & Wissler (1986) identified family environment as a predictor of psychiatric rehospitalization according to them family environment was a better predictor of rehospitalization than clinical status, indicating the importance of family

support in the community adjustment of chronic psychiatric patients. A high level of criticism of subjects by family members is associated with greater risk of rehospitalization (Sullivan et al, 1995). Education of the family members regarding the illness has direct relationship with relapse if the communication took place in a healthy manner it improves the clinical position of the patients (Cassidy et al, 2001). These findings suggest that the socio-cultural context shapes the pathways by which family processes are related to the course of illness. Moreover, the warmth findings suggest that families may contribute to preventing relapse Lopez et al (2004). Family focused treatment techniques are more effective rather than only pharmacological management (Rea et al, 2003). Family systems have been highly influential in the study of recurrent psychiatric disorders. This study will examine the role of family pathology and social support and its effect on relapses of schizophrenia or bipolar disorder, and randomized trials of family intervention in these populations.

AIM

To assess the role of family pathology and social support in relapse in the schizophrenia and bipolar affective disorder patient.

OBJECTIVE

- To find out the role of family pathology in relapse in the schizophrenia and bipolar affective disorder patient
- To find out the role of social support in relapse in the schizophrenia and bipolar affective disorder patient
- To see the gender difference in the area of family pathology and social support in relapse in the schizophrenia and bipolar affective disorder patient
- To see the difference of family pathology and social support in relapse in the schizophrenia and bipolar affective disorder patient
- To see relationship between family pathology and social support.

METHODOLOGY

In the present study 60 (30 Bipolar Affective Disorders and 30) Schizophrenia) patients, who are relapsed and came back to RINPAS OPD were selected on the basis of purposive sampling technique.

Inclusion Criteria

- Patients and Parents Both were available
- Who had given informed consent
- Patients had diagnosed as schizophrenia or Bipolar Affective Disorder
- Age between 18 to 65 year
- Having past episode

Exclusion Criteria

- Parents were not available
- Any psychiatric or Physical co morbidity with parents
- Who had score above the cut of criteria of GHQ 12

Tools

- Semi structured Socio Demographic Data Sheet
- GHQ- 12(Goldberg & Hiller, 1979)
- Family Pathology Scale (Veeraraghavan & Dogra; 2000)
- Social Support Questionnaire (SSQ; Nehra et. al., 1995)

General Health Questionnaire

The GHQ (Goldberg & Hiller, 1979) is a 60 items self administered screening test, which is sensitive to the presence of psychiatric disorders in individuals presenting in primary care settings and non-psychiatric clinical settings. The GHQ is not designed to detect symptoms that occur with specific psychiatric diagnoses, rather, provide a measure of overall psychological health or wellness. The GHQ-12 is a shorter version of the GHQ containing 12 items. GHQ-12 is generalized in Indian setup and frequently used for research purpose.

Family Pathology Scale

Scale was developed by Prof. Vimala Veeraraghavan and Dr. Archna Dogra (2000). The family pathology scale indicates the extent to which maladaptive behaviour is present amongst the family members in their interaction with each other. A total no. of 100 items were prepared in the statement which had to be rated on a three point scale, with (1) Indicating low/no family pathology (never response). (2) Indicating average family pathology (occasional response) and (3) Indicating high family pathology (most often response)

Social Support Questionnaire

The scale has developed by Nehra. et al (1995). This scale measures perceived social support i.e. social support perceived by the subject. It has total 18 items. The total score indicates the amount of perceived social support. Higher score indicates more perceived social support and lower score indicates less social support. Test Retest reliability was found to be 0.59. Concurrent validity has been found to be significant at 0.0level.

RESULTS

Table 1 summarizes the descriptive statistics of the study participants (N=60). Participants equally selected for both the diagnosis, maximum participants coming between 21-40 years age (70%BAD and 76.67% schizophrenia). There were more men (86.67%) and most of them had 12 years or more formal education (56.67% BAD, 50% schizophrenia). More than half the participants in both groups (60% BAD & 70% Schizophrenia) are married, belongs to Hindu religion (70% BAD & 63.34% Schizophrenia) and came from rural background (73.33% BAD & 70% Schizophrenia) and joint family (93.33% BAD, 86.67% Schizophrenia). Maximum participants in both the groups do not perform any independent reproductive work and they are from lower socio economic status. The sample represents the inpatient population of the psychiatric hospital at the time of assessment and is therefore rather heterogeneous. The relatively low employment rate is due to the fact that one-third of the sample had their first psychiatric admission during the last 2 years, indicating that people are coming from rural background and low socio- economic status mechanisms of vocational rehabilitation not yet taken place or not exist at gross root level.

Table 2 shows comparison between both the bipolar affective disorder and schizophrenia participants in reference to social support and family pathology. 90% of participants in schizophrenia group having poor or low social support from their family but in bipolar affective disorder group 56.67% participants have good social support from their family. Level of social support is significantly high for people with bipolar affective disorder. 73.34% bipolar affective disorder and only 20 % schizophrenia participants reported no family pathology. 40 % participants from schizophrenia group and only 6.67% bipolar affective disorder participants reported high family pathology. Family pathology is higher in the families of schizophrenia participants in comparison to bipolar affective disorder participants.

Table 3 is showing correlation between social support and family pathology of participants. Result is showing negative correlation between family pathology and social support. Table reveals that if social support increases family pathology reduces simultaneously.

DISCUSSION

Social support can be measured as the perception that one has assistance available, the actual received assistance, or the degree to which a person is integrated in a social network. Support can come from many sources, such as family, friends, pets, organizations, coworkers, etc. Present study reveals that social support is better in the patients with bipolar affective disorder in comparison to schizophrenia similarly Vaughn and Leff (1981), Day (1981), and Sokolovsky et al. (1978) has also reported that lack of social support increase the risk of subsequent disorder and relapse as well. Healthy family interaction pattern and social support, or lack of it, is considered to be a strong prognostic factor of ill health, and

rehospitalization. Similarly previous study found that lack of social support is a risk factor in serious mental illnesses such as schizophrenia (Leff & Voughn, 1985).

Social support and social networks shows a vigorous relationship with mental health outcomes present study reveals that poor level of social support increase the relapse rate similarly Lack of social support increases the risk of subsequent disorder in the face of adversity and make vulnerable to rehospitalization. In this regard studies by Alloway & Bebbington (1987) and Cohen & Wills (1985) suggested that social support serves as a protective buffer. Another longitudinal study with schizophrenia population, (Nuechterlein & Dawson 1984) reported that social and occupational impairment and absence of environmental protectors such as supportive family members' supportive network including treatment facilities were found to have a direct relationship with its poor outcome. These poor outcomes again cause the relapse and increase the rate of rehospitalization. Developing countries mentally ill patients faced lesser degree of environmental stressors as they have strong social network, which is further helpful for a lesser relapse rate then the western countries (Verghese et al., (1989).

Present study also reveals that family pathology is higher in the schizophrenia group in comparison to bipolar affective disorder group. Leff and Vaughn, (1985) stated that good family interaction pattern reduce the chances of relapse in the schizophrenia patients. Similar to present findings in a previous study of male patients with chronic schizophrenia, (Corin and Laugzon 1992) reported that the presence of good social relationship predicted better outcome. A supportive, non stressful environment with more open discussion of family feelings may actually predict lower rates of relapse or hospitalization, as was previously noted by Keitner and miller (1990).

Supportive family atmosphere and perhaps strong social network and therapeutic treatment (neuroleptic medication and other comprehensive therapy) may have major effects on outcome of schizophrenia as previously also hinted by Vaughn & Leff (1981), Day (1981) Sokolovsky et al. (1978) Kumar (1984).

Poor family support and presence of family pathology increase the chances of relapse previous study by Nuechterlein & Dawson (1984) also reported that social and occupational impairment and absence of environmental protectors such as supportive family members' supportive network including treatment facilities were found to have a direct relationship with its poor outcome.

CONCLUSION

Family is having very important role in the day to day life of human beings. If it showed strong cohesion and support towards the members it plays a protective as well as developmental role of them. Another hand if family is having faulty communication pattern and poor social support it increased the risk of poor adjustment and relapse as well.

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Table I: Socio demographic profile of the patients

Variable		Schizophrenia N=30 (%)	BAD N=30 (%)	Chi Square	df	P value
Age	Up to 20	2 (6.67)	3 (10)	1.691	3	.639
	21-40	21(70)	23 76.67)			
	41-60	6 (20)	4 (13.33)			
	>60	1(3.33)	0			
Sex	Male	27 (90)	25 (83.34)	.577	1	.448
	Female	3 (10)	5 (16.66)			
Education	Illiterate	6 (20)	4 (13.33)	2.996	4	.559
	Primary	7 (23.34)	11 (36.67)			
	Inter	12 (40)	13 (43.33)			
	Graduate	4 (13.33)	2 (6.67)			
	Above	1 (3.33)	0			
Marital status	Married	18 (60)	21 (70)	.659	1	.417
	Unmarried	12 (40)	9 (30)			
Religion	Hindu	21 (70)	19 (63.34)	2.418	3	.490
	Islam	4 (13.33)	7 (23.33)			
	Christian	0	1 (3.33)			
	Other	5 (16.67)	3 (10)			
Domicile	Urban	7 (23.34)	8 (26.66)	.090	2	.956
	Semi-Urban	1 (3.33)	1 (3.33)			
	Rural	22 (73.33)	21 (70)			
Type of family	Joint	28 (93.33)	26 (86.67)	.741	1	.389
	Nuclear	2 (6.67)	4 (13.33)			
Occupation	Service	0	4 (13.33)	6.037	4	.196
	Agriculture	8 (26.66)	7 (23.34)			
	House wife	3 (10)	5 (16.66)			
	Domestic work	8 (26.66)	8 (26.66)			
	Unemployed	11 (36.67)	6 (20)			
Monthly income of the family	5000	11 (36.67)	17 (23.33)	2.857	2	.240
	5001-15000	16 (53.34)	12 (40)			
	15001-25000	3 (10)	0			
	>25000	0	1 (3.33)			

Table: II Social Support and family pathology

Variable		Schizophrenia	BAD	Chi square	df	P value
Social Support	Poor	27	13	14.700	1	.000
	Good	3	17			
Family Pathology	None	6	22	18.286	2	.000
	Average	12	6			
	High	12	2			

Table III: Correlation between Family Pathology and Social Support

	social support	Family Pathology
social support	1	-.849**
Family Pathology	-.849**	1

**. Correlation is significant at the 0.01 level