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## **Family therapy as predictor of wellbeing and recovery among patients with schizophrenia**

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**Abstract**--The study investigated family therapy as a predictor of well-being among Schizophrenic patients. Family therapy is a therapeutic approach used to help people with schizophrenia deepen their family connections to get through stressful times. The study adopted a descriptive survey design. Two hundred and ninety-seven (297) schizophrenic patients participated in the study. An adapted and validated questionnaire with a reliability coefficient of  $r = 0.77$  was used for data collection. Four (4) trained research assistants helped in data collection. Frequency count, simple percentages, Pearson Product Moment Correlation (PPMC) and Regression Analysis were used as statistical tools. Hypotheses were tested at 0.05 alpha level. The study established a significant relationship between family therapy and the health of schizophrenics ( $r = .605$ ,  $n = 297$ ,  $p < 0.05$ ). A significant relationship also exists between family therapy and the emotional stability of schizophrenics ( $r = .527$ ,  $n = 297$ ,  $p < 0.05$ ). In the same vein, there is a significant relationship between family therapy and the recovery of schizophrenics ( $r = .606$ ,  $n = 297$ ,  $p < 0.05$ ). It was established that family therapy jointly predicts the well-being and recovery of schizophrenics. This implies that family therapy had a significant relationship with the health, emotional stability and recovery among schizophrenics. It was concluded that early detection and intervention by the families and medical team would improve the clinical condition of the schizophrenics. It was

recommended that family bonding should be encouraged. Consistent interactive communications could improve the social functioning of schizophrenics.

**Keywords**---family therapy, health, emotional stability, recovery, schizophrenia.

## Introduction

The absence of mental disorders is usually associated with psychological well-being. Generally, patients with mental disorders have lower welfare than the general population [1]. An individual's psychological well-being is inversely proportional to the severity or number of symptoms of natural disturbances such as schizophrenia. Approximately one percent of the population is affected by schizophrenia, a chronic and disabling psychiatric illness [2]. Patients and family members affected by schizophrenia experience significant levels of distress: Only 14% of patients recovered within five years of a psychotic episode [3] and only 10% to 20% of patients were working [4]. Around 50% to 80% of patients with schizophrenia were in close contact with their relatives and friends in Western countries [5].

Besides the patients with schizophrenia, their families are also adversely affected [6]. With the end of the traditional institutional model of treatment in psychiatric hospitals, a greater focus has been placed on family relationships and the degree of burden placed on family members. Families and individuals living with schizophrenia are adversely affected by its social and emotional consequences [7]. The resulting effect is that caregivers often neglect relatives' needs from the time the disorder is diagnosed in an individual [8]. Uncertainty about diagnosis, prognosis, and appropriate treatment can contribute to anxiety and stress among caregivers [9]. Additionally, families must adjust very quickly to their new role as informal caregivers [10], for which they are often unprepared [11].

Based on the research reports of Muela and Godoy [12], family interaction is involved in causing relapses of the patient and influences the course of the disease, rather than being the cause of it. Upon their return home from hospital admission or their first contact with mental health services, patients' relatives become the primary support system, even more than medical personnel [13]. In addition, individuals or family members are responsible for assisting each other in overcoming psychological disorders. The purpose of treatment and any efforts made to restore the patient's condition is not simply to be free from disorders but also to realise psychological well-being in the long run.

It has been studied extensively [14-15], and those studies demonstrate that the psychological well-being of the individual is essential, whether they are healthy or suffering from psychological problems, including those with schizophrenia. Thus, it would be reasonable to devote research and clinical resources to determine in greater detail the caregivers' needs for improving the family environment and, consequently, improving the patient's recovery.

This article, therefore, seeks to investigate the effect of family therapy on the well-being and recovery of patients with schizophrenia. This study was designed:

1. To investigate how family therapy predicts health status, emotional stability and recovery among schizophrenic patients.
2. To identify specific support from any member of the family in the treatment of schizophrenics.
3. To determine different roles played by members of the family in the management of schizophrenics.

## **Literature Review**

### **Family therapy**

Family therapy models emphasise the relationship between improved family functioning and caregiver well-being and a decreased risk of patient relapse [16]. In family therapy, relationships are emphasized rather than analyzing subconscious impulses or traumas experienced by an individual during early childhood. The process is also referred to as systemic therapy. Psychosis patients and their families often benefit from family intervention. Psychoeducation also improves treatment coordination between family members and treatment teams by promoting a better understanding of the illness among family members. During the 1980s, as medication changed and awareness of the importance of families in treatment increased, new family interventions emerged [17].

In place of the term 'family therapy,' interventions distinct from systemic family therapy were described as family management, psychoeducational family therapy, or family care. Family management and family psychoeducation are frequently used to contrast non-systemic interventions with family therapy because they emphasise education and skills development to improve coping and reduce stress [18]. The study of family therapy for schizophrenia has almost exclusively focused on improving patients' mood and anxiety symptoms. Regarding ethics, caregiver mood and anxiety should be considered separately from patient functioning as outcomes of interest.

The burden and stress of caring for a loved one with schizophrenia is considerable [19-20]. For instance, 40% of Mexican American caregivers of family members with schizophrenia showed clinically significant symptoms of depression [21]. Family therapy promotes family unity, promotes team-focused problem solving, and encourages family participation in shared activities, in addition to reducing the burden of caregivers and the symptoms of patients. Although family interventions do not have a unique approach, evidence-based approaches usually include psychoeducation, stress reduction, emotional processing, cognitive reappraisal, and structured problem-solving [22].

The intervention consists of a combination of psychotherapeutic strategies for working with the relatives of people with psychosis. It aims to develop a collaborative relationship between the family and the treatment team to help patients progress toward recovery [22-23]. The appropriateness of perceived social support depends on such factors as cultural context, life events, individual

characteristics, and the relationship between the provider and recipient [24]. While mental health professionals always deliver interventions, these differ in theoretical orientation, modality, and duration.

### **Early history of family therapy**

Family therapy started after World War II in the United State of America Influenced by psychoanalysis, psychiatrists turned from biological and genetic theories to environmental theories to explain severe adult mental illnesses. According to some experts, families have been linked to schizophrenia since the end of the 19th century [25-27]. The theories suggest that some family members developed schizophrenia because of a disturbed family environment and confusing communication patterns.

One broad principle posited that there are issues within the family system that results in a family member becoming the designated patient who is presented for treatment. Following this principle, diagnostic labels were avoided, and biological explanations were rejected. Despite no empirical support for the earlier constructs, the traditional systemic family therapy field grew rapidly during the 1960s and 1970s. Research shows that distorted family interaction is not associated with schizophrenia [28-29].

It is also important to note that the theories did not lead to effective methods for preventing or treating schizophrenia, instead often parents were stigmatised as the cause of the problem [17]. Consequently, mental health professionals who adopted these constructs ignored the requests of family members for information or support. Patients were removed from their toxic environment because their mental health problems were perceived as the parents' fault, primarily that of the mothers [17]. Consequently, relatives were not shown much sympathy.

### **Methodology**

For this study, a descriptive survey was conducted using an ex post facto design. This was because it examined independent variables already existing with a constant independent variable. Four hypotheses were tested based on the objectives of the study:

1. There is no significant relationship between family therapy and health status of schizophrenic patients;
2. There is no significant relationship between family therapy and the emotional stability of schizophrenics;
3. There is no significant relationship between family therapy and the recovery process of schizophrenic patients; and
4. There is no significant joint relationship between the independent variable (family therapy) and the dependent variables (health, emotional stability, and recovery) of schizophrenic patients.

## **Sample and sampling technique**

The study included 297 patients with schizophrenia who had benefited from family therapy. The sample for the study was selected using the purposive sampling technique. The purposive sampling technique was appropriate because the study was only interested in the collection of responses from patients with schizophrenia who had at one time or another been exposed to family therapy to improve their well-being and recovery.

## **Instrument**

Data was collected using a structured questionnaire tagged “Predictors of well-being and recovery among patients with schizophrenia” (PWRPwS) [ $\alpha = 0.77$ ], with sections A to C. Section A was the demographic section that sought information, such as age, gender, tribe, marital status, religion, and educational qualifications. Section B was the well-being questionnaire. The 12 items of the well-being questionnaire (W-BQ12) were simple statements (e.g., *I feel afraid for no reason at all*) and had four response options from 0 (*not at all*) to 3 (*all the time*), which were identical for all 12 items.

There were three subscales of four items each: negative well-being (all negatively worded items), energy (two positively worded and two negatively worded items), and positive well-being (all positively worded). Scores ranged from 0 to 12 for each subscale (higher scores indicated a more positive mood for that label). Section C contained a mental well-being scale (WEMWBS) developed and validated in the United Kingdom. The scale consisted of 14 items covering both hedonic and eudaimonic aspects of mental health, including positive affects (feelings of optimism, cheerfulness, relaxation), satisfying interpersonal relationships, and positive functioning (energy, clear thinking, self-acceptance, personal development, competence, and autonomy).

## **Data analysis**

Descriptive statistics was adopted for the study. Frequency count and simple percentages were used for the demographic characteristics while Pearson Product Moment Correlation (PPMC) and Regression Analysis were used for Section B of the instrument. Hypotheses were tested at 0.05 level of significance.

## **Ethical considerations**

The purpose of the study was explained to the participants in their native language by trained research assistants. The consent form was printed in English and given to each participant in compliance with ethical guidelines. The consent form was then filled out and signed by each participant once sufficient comprehension was achieved. The profiles and responses of participants were kept confidential.

## Results

### Demographic characteristics

The results showed that 72 (24.2%) of the respondents were younger than 20 years old; 111 (37.4%) were within the 21-30 years age group; 63 (21.2%) were 31-40 years; 24 (8.1%) were 41-50 years; 12 (4.0%) were 51-60 years and 15 (5.1%) were 61 years and older. The results further showed that 165 (55.6%) of the respondents were male while 132 (44.4%) were female. Also, 198 (66.7%) of the respondents were Yorubas; 78 (26.3%) were Igbos and 21 (7.1%) were Hausas.

It was also revealed that 120 (40.4%) of the respondents were single, 141 (47.5%) were married, and 36 (12.1%) were separated. The results showed that 168 (56.6%) of the respondents were Christians; 93 (31.3%) were Muslims, 24 (8.1%) were traditional worshippers, and 12 (4.0%) belonged to other religious groups not disclosed in the study. In terms of education, it was revealed that 123 (41.4%) of the respondents had secondary education, 123 (41.4%) had NCE or HND certificates respectively, while only 51 (17.2%) had a university education.

The results are hereby presented in Tables 1 to 4.

Hypothesis 1: There is no significant relationship between family therapy and health status of schizophrenic patients.

Table 1: Pearson Product Moment Correlation (PPMC) showing the relationship between family therapy and health of schizophrenic patients

Variable	Mean	Std. Dev.	N	R	P-value	Remark
Health of patients	17.7980	3.9940				
Family therapy	19.5253	4.3192	297	.605*	<.001	Sig.

\* Sig. at 0.05 level

It is shown in Table 1 that there was a significant relationship between family therapy and the health status of schizophrenics ( $r = .605$ ,  $n = 297$ ,  $P (.000) < 0.05$ ). Hence, family therapy had a positive influence on the physical health status of patients with schizophrenic illness. The hypothesis was rejected

Hypothesis 2: There is no significant relationship between family therapy and the emotional stability of schizophrenic patients.

Table 2: Pearson Product Moment Correlation (PPMC) showing the relationship between family therapy and the emotional stability of schizophrenic patients

Variable	Mean	Std. Dev.	N	R	P-value	Remark
Emotional stability	14.1919	3.3501				
Family therapy	19.5253	4.3192	297	.527*	<.001	Sig.

\* Sig. at 0.05 level

Table 2 shows that there was a significant relationship between family therapy and the emotional stability of schizophrenic patients ( $r = .527$ ,  $n = 297$ ,  $P (.001) < 0.05$ ). Hence, family therapy had a positive influence on emotional stability of patients with schizophrenic illness. The hypothesis was rejected.

Hypothesis 3: There is no significant relationship between family therapy and recovery of schizophrenic patients.

Table 3: Pearson Product Moment Correlation (PPMC) showing the relationship between family therapy and recovery of schizophrenic patients

Variable	Mean	Std. Dev.	N	R	P-value	Remark
Recovery of patient	14.3333	3.4465				
Family therapy	19.5253	4.3192	297	.606*	<.001	Sig.

\* Sig. at 0.05 level

It is shown in Table 3 that there was a positive significant relationship between family therapy and recovery of schizophrenic patients ( $r = .606$ ,  $n = 297$ ,  $P (.000) < 0.05$ ). Hence, family therapy had a significant influence on the recovery of patients with schizophrenic illness. The hypothesis was rejected.

Ho 4: There is no significant joint relationship between the independent variable (family therapy) and the dependent variables (health status, emotional stability, and recovery) of schizophrenic patients.

Table 4: Summary of regression analysis showing the relative contribution of Family Therapy on Health, Emotional stability, and recovery of schizophrenic patients

Model	Unstandardised Coefficient		Standardised Coefficient	T	Sig.
	B	Std. Error	Beta Contribution		
(Constant)	-			-	
Health	2.75	.861		3.204	.002
Recovery	.8	.041	.219	5.716	.000
Emotional stability	.237	.046	.307	8.386	.000
	.385	.046	.245	6.935	.000
	.316				

Table 4 reveals the relative contribution of the independent variable to the three dependent variables, expressed as beta weights, viz: health status ( $\beta = .219$ ,  $P < .05$ ), recovery ( $\beta = .307$ ,  $P < .05$ ), and emotional stability ( $\beta = .245$ ,  $P < .05$ ) respectively. Hence, it could be deduced that family therapy jointly influences health status, emotional stability and recovery of schizophrenic patients.

## **Discussion of Findings**

The results revealed that there was a significant relationship between family therapy and the health status of schizophrenic patients. This implies that the health of a schizophrenic patient could improve through family therapy or support. This is in line with the previous submission of Pharoah et al. [30], that family psychoeducation has been established as an evidence-based practice that primarily targets avoiding the relapse and rehospitalisation of patients with schizophrenia.

In addition, caregivers' knowledge and self-efficacy have been consistently enhanced by this intervention. The finding is supported by Roncone et al. [31], who reported significant improvements in social functioning of 36 people with schizophrenia who participated in family therapy for three months. The beneficial effects of these interventions are often attributed to a positive change in relatives' attitudes [32].

Family therapy helps in encouraging compliance with treatment and improving social functioning. It is important to note that the health of the schizophrenic patient usually improves when they have relatives around them. An individual's well-being can be negatively affected by poor relationship quality, intense caregiving for family members, and marital dissolution [33]. Using standardised and averaged outcomes of depression, anxiety, anger, and perceived stress, Hazel et al. [34] demonstrated that multiple-family group treatment reduced the integrated distress of caregivers.

Furthermore, this intervention consistently improved caregivers' knowledge and self-efficacy, but whether it positively affected their psychological wellbeing, care burden, or expression of emotion remains unclear [35]. Relationships within a family can assist an individual in coping with stress, engaging in healthier behaviours, and enhancing self-esteem, leading to an improved quality of life. In the same vein, family therapy requires a collaborative relationship between the family and the treatment team to help patients make progress towards recovery. Psychoeducational interventions have been found to improve caregivers' negative emotions involving anxiety, depression, or anger [36-37].

The results also revealed that family therapy significantly predicted the emotional stability of schizophrenic patients. This implies that the family is a primary source of care for the patient suffering from a schizophrenic illness. Findings have demonstrated that stress undermines health and well-being [38], and strained family relationships are particularly problematic. Stressors may negatively affect well-being when social support is lacking [39].

In addition, support can promote well-being by enhancing self-esteem, resulting in a more positive view of oneself [39]. The feeling of self-worth may be enhanced for those receiving support from their family members. Symister et al. [40] suggest that enhanced self-esteem may be a psychological resource that promotes optimism, positive effects, and improved mental health. Families can regulate one another's behaviour (social control), encourage one another to behave more healthily, and utilise health care services more effectively [41-42]. However, the

stress in relationships may also lead to health-compromising behaviours as a coping mechanism for stress [43].

The results further revealed that family therapy significantly predicts recovery of the schizophrenic patient. This implies that family therapy has a positive impact on the patient's recovery. Family therapy significantly reduces readmission and relapses. It has also been pointed out that family therapy improves social functioning on both sides; that is, of both patient and the family members. It is reasonable to expect that the warm bonds formed with one's family would remain stable over time [44].

The present finding is consistent with Wel, Bogt, and Raaijmakers [45], that family bonds have a lasting effect on the well-being of adolescents and young adults. Rejecting parenting (characterised by a lack of emotional warmth) has been associated with low self-esteem, low self-acceptance, and the inability to be self-directed [46]. Family bonds appear essential to well-being as independent adults [45]. According to Avenevoli and Merikangas [47], the relationship between depression in parents and children's depression or other problems can be explained or modified by a combination of broad (e.g., stress), specific (e.g., parenting skills), and structural factors (e.g., divorce).

An individual adjustment to depression is affected by parenting behaviours associated with depression, although more research needs to be conducted to determine the effects of specific types of parent behaviour. The emotional expression of parents influences the emotional development of their child. A study by Haft and Slade [48] revealed that securely attached parents tend to be more competent, sociable, and more comfortable dealing with different kinds of relationships. It is a fundamental tenet of attachment theory that caregivers' responses to perceived threats conveyed by the child's affective manifestations provide an individual with the context to organise their emotions.

## **Conclusions**

The research gave rise to the conclusion that family therapy significantly predicted the health status, emotional stability, and recovery of schizophrenic patients. The literature reviewed for this study pointed to the fact that family therapy, together with other medical care, reduced the symptoms of schizophrenia. The findings also suggested that the management of schizophrenia involved all other health care systems and not just family therapy alone. Thus, managing schizophrenic cases with other aspects of medical care and coupled with family therapy could yield greater achievements. Psychosocial interventions, such as individual therapy, social skills training, family therapy, vocational rehabilitation, and supported employment, goes a long way in treating schizophrenia. Most individuals with schizophrenia require some form of daily living with family support. It was concluded that early detection and early intervention by the families and medical teams would improve the clinical condition of the schizophrenics.

### **Implications of this study for social work**

1. Social workers build relationships with families. They work with parents to bring greater safety and stability to family life or, if necessary, help find another home for the client. Their work often results in a brighter future for the patient and family members who rely upon them.
2. Social workers provide a variety of supportive services that help reduce stress in family life, including individual and family counseling, advice on parenting practices, child and respite care, financial and housing assistance, sharing of tasks and responsibilities, skills acquisition, and access to information and services.
3. Clinical social workers are licensed to conduct individual and group therapy with schizophrenics. Social workers are not to prescribe medications, but they are often important mental health team members. They are involved in the daily care, helping the client to secure social services, insurance, or services of income. They also help in housing and financial management issues.
4. Social workers help clients to figure out what they need to accomplish while living in and participating in the community.

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### **Conflict of interest**

The authors confirm no conflict of interest for the data presented in this paper.

### **Data Access Statements**

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

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