

# **What I have learned from relatives: How they react to strange behaviour of their sick family member**

**Ce am învățat de la membrii familiei: cum fac aceștia față comportamentelor ciudate ale rudei bolnave**

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Conferinta “Sănătatea mintală în secolul 21: Ajutor și autoajutor pentru membrii familiei”

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**1977**

**Heinz Katschnig:**

***Cealalta parte a schizofreniei:  
pacienti acasa***

**1978**

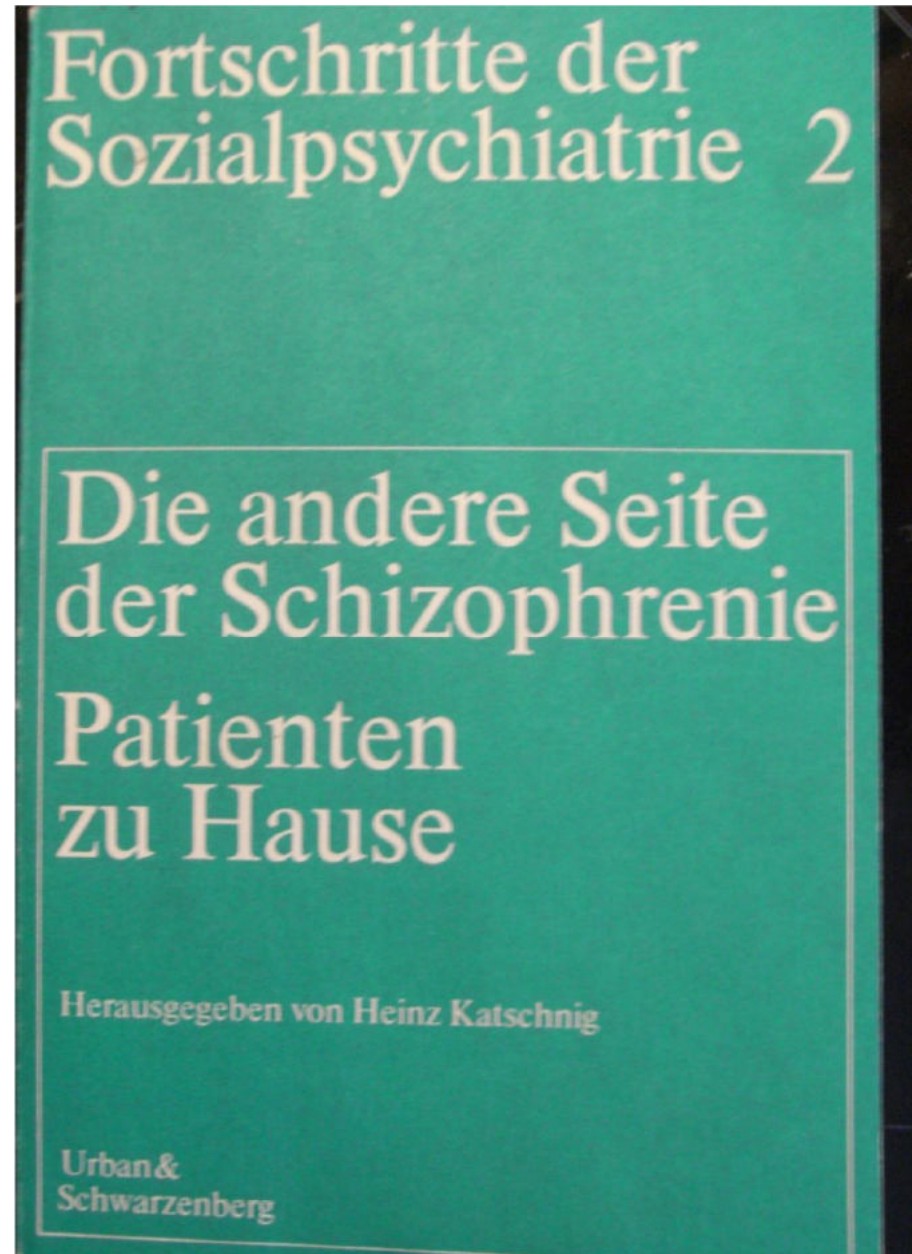
**HPE Family association**

**1 selfhelp group 8 persons**

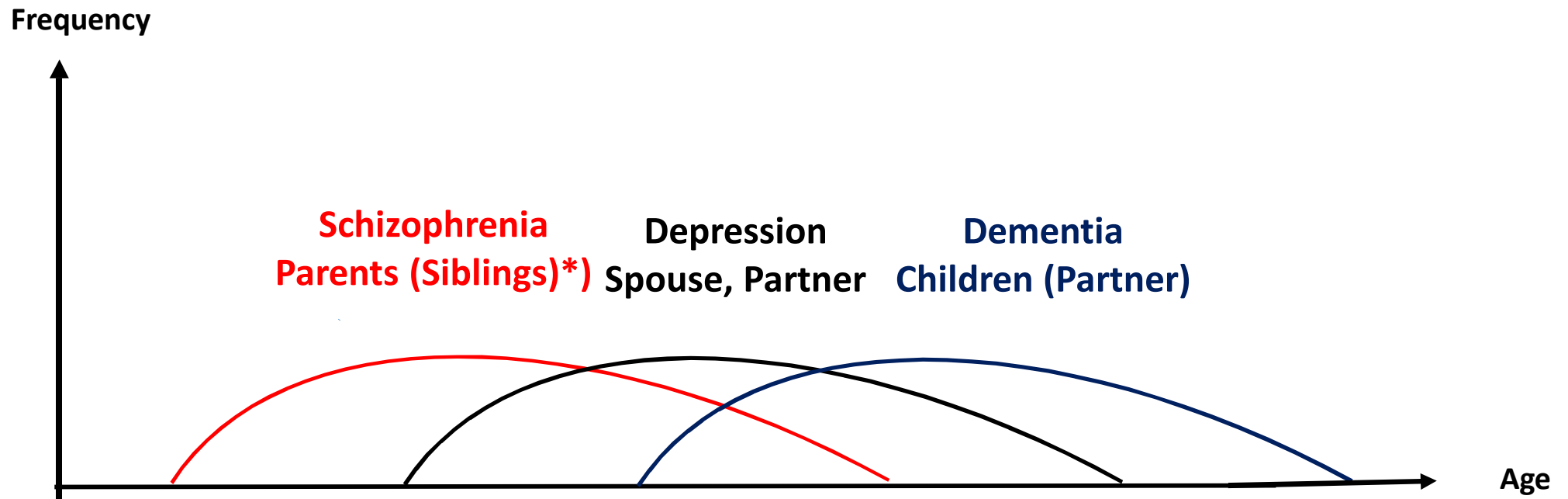
**2018**

**HPE 2.500 members**

**100 selfhelp groups**



## Age at onset of specific mental disorders and the types of relatives most commonly involved



\*) They have a long common history before disease onset

## **Traditional “roles” of the relatives of the mentally ill**

1. Informant
2. Transmitter of genes
3. Have caused schizophrenia through their behaviour
4. Victim of schizophrenia

# Victim: Burden on family members 1

- **Material** burden (e.g. giving up a job in order to stay at home)
- **Stigma** fears > Social **isolation**
- **Burn out**, depression
- **Confusion** about
  - **Cause** of schizophrenia? Brain disease? Behavioural causes? > Feelings of guilt
  - **Who has to do what?** Psychiatry? What can I do?
  - Which is the „**correct**“ **therapy** ? Medication? Psychotherapy? Alternative medicine?

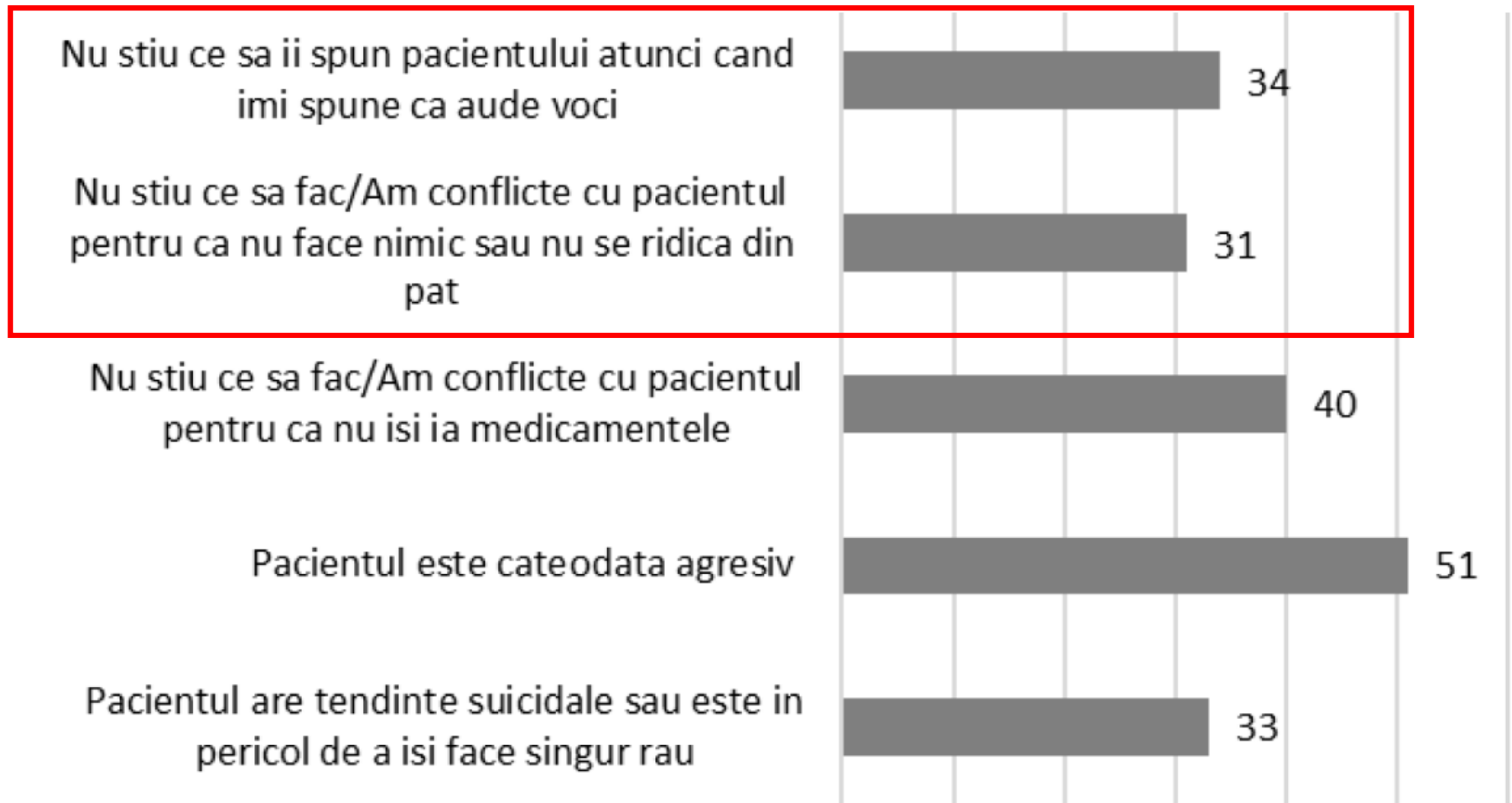
## Victim: Burden on family members 2

Not to know how to react to strange behaviour  
strange ideas (delusions), hallucinations, inactivity

Is the patient bad or mad?

Is the patient willingly presenting this behaviour or is it the illness?

## 4.6. Comportamentele pacientului datorate bolii



## New “role” of the relatives of the mentally ill

1. Informant
2. Transmitter of genes
3. Have caused schizophrenia through their behaviour
4. Victim of schizophrenia
5. Proactive co-player in coping with mental illness in a common sense fashion



# **What I have learned: How families deal with strange behaviour of a member**

- 1. When the strange behaviour of an adolescent family member begins**
2. Dealing with psychotic symptoms
3. Dealing with inactivity

# 1. Denial

„It is only a puberty crisis“

„He has taken drugs“

„She is fooling us“

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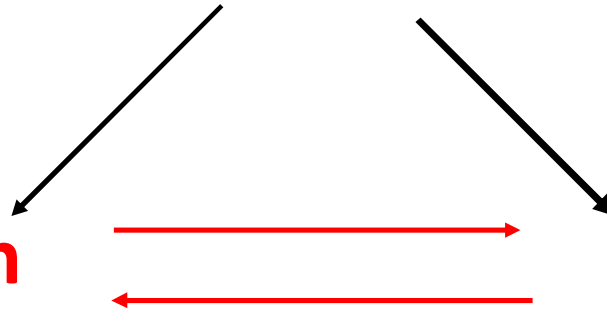
„She is fooling us“

But when the behaviour persists or comes back  
and psychiatry gets involved,  
denial is not possible anymore

**1. Denial**

**2a Depression**

**2b Rebellion**



## **What I have learned: How families deal with strange behaviour of a member**

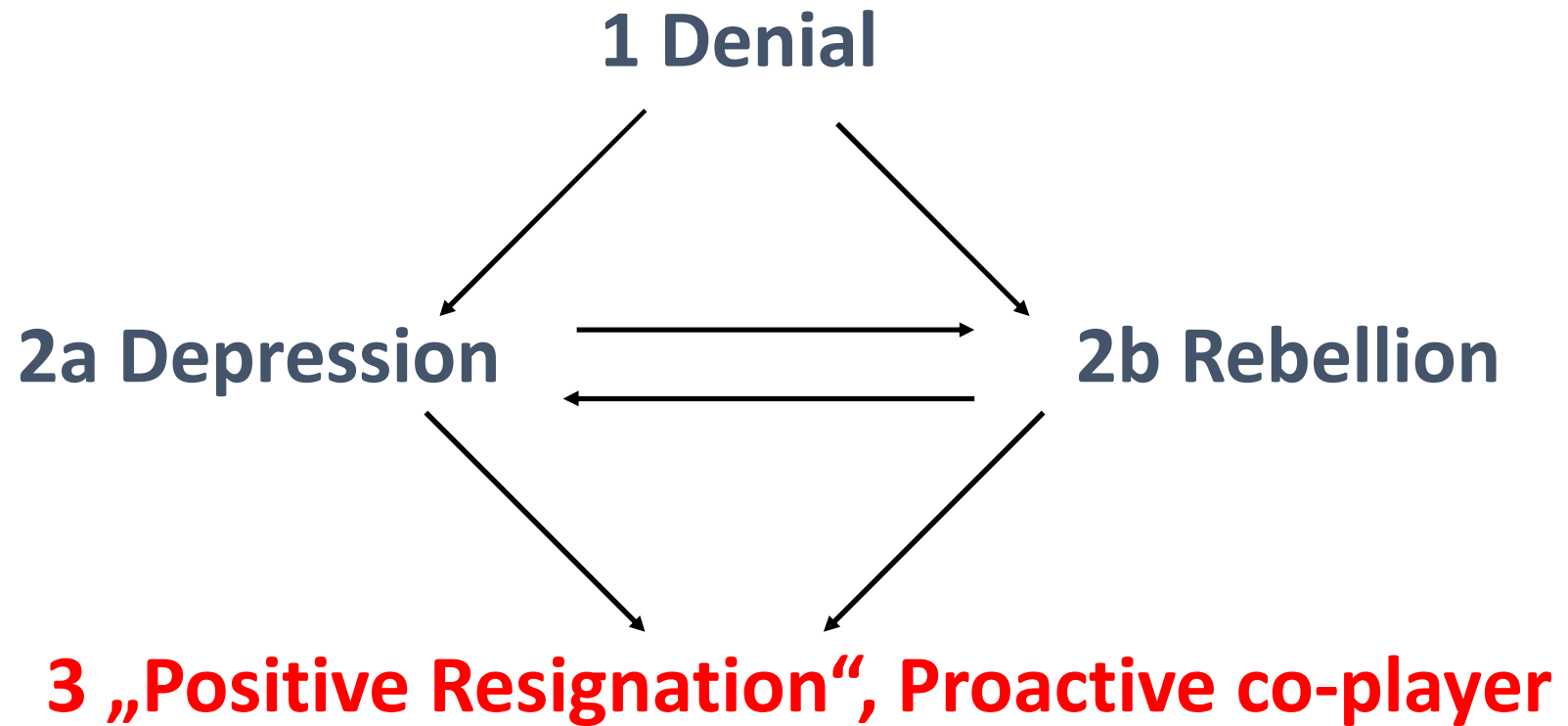
1. When the strange behaviour of an adolescent family member begins
2. **Dealing with psychotic symptoms in the depression/rebellion phase**
3. Dealing with inactivity

## **How relatives may deal with strange behaviour/psychotic symptoms in the depression/rebellion phase**

- Not taking it seriously („joke“, „nonsense“)
- Accepting („folie à deux“)
- Pseudo-acceptance
- Distract, calm
- Try to convince the patient that the strange ideas are wrong, the hallucinations are not possible
- .... abandon the patient

# Dealing with psychiatry

- Latent criticism
- Open criticism





# **What I have learned how families deal with strange behaviour of a member**

1. When the strange behaviour of an adolescent family member begins
2. **Dealing with psychotic symptoms in the „positive resignation“ phase**
3. Dealing with passivity - optimal stimulation

## How relatives may deal with strange behaviour/psychotic symptoms

- Not taking it seriously („joke“, „nonsense“)
  - Accepting („folie à deux“)
  - Pseudo-acceptance
  - Distract, calm
  - .... abandon the patient
- 
- Optimal solution: Let the patient understand „I accept that you have such experiences, see things like this, but please also accept that I do not see it like that“  
= Accept the patient as a person, but also keep reality perspective

## **What I have learned: How families deal with strange behaviour of a member**

1. When the strange behaviour of an adolescent family member begins
2. Dealing with psychotic symptoms – I accept, please also accept
3. **Dealing with inactivity - optimal stimulation**

### 3. Dealing with inactivity of the patient

- Is the patient „bad“ or „mad“? > Realize that it is often impossible to react in a „correct way“
- Vulnerability-stress-coping model – if too much stress > patient withdraws, medication reduces vulnerability
- Optimal stimulation: no overstimulation (Expressed emotion research!), but also no understimulation

## **Dealing with psychiatry in the „positive resignation“ phase**

- Latent criticism
- Open criticism
- Balanced attitude to medication:  
pharmacophilia vs. pharmacophobia
- Families as partners of psychiatry

## New “role” of the relatives of the mentally ill

1. Informant
2. Transmitter of genes
3. Have caused schizophrenia through their behaviour
4. Victim of schizophrenia
5. Proactive co-player in coping with mental illness in a common sense fashion
  - Self-help groups - Learn from other family members – tell each others’ stories and how they cope, provide mutual support (existing group in Cluj, last Thursday each month, 17-19h, facilitated by AT!),
  - Relatives and professionals become partners
  - Trialogue

**Mulumesc  
pentru  
atentia  
dumneavoastra!**