

The Causes of Functional Psychoses as Seen by Patients and Their Relatives

II. The Relatives' Point of View

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Summary. The concepts of relatives of patients suffering from functional psychoses regarding the causes of the illness were investigated using the same methodological approach as with the patients. Relatives, like patients, favoured psychosocial over biological explanations. However, when compared pairwise the concordance between relatives and patients was very low. Some methodological refinements recommended for further research are proposed.

Key words: Functional psychoses – Relatives' concepts of etiology

Introduction

In the first part of our paper we described the aetiological concepts of the patients (Angermeyer and Klusmann 1988). We will now consider the relatives. From a review of the literature it appears that relatives have been investigated for aetiological concepts more frequently than patients.

Rose (1959) questioned the relatives of mostly schizophrenic long-stay patients in a Veterans Administration hospital in the United States. Their answers revealed a great deal of guilt concerning the mental illness of their sick family members and tended to shift the responsibility to external factors, often citing seemingly obvious and socially acceptable causes such as war or somatic disorders. Relatives who were less closely related to the patient were rather more prepared to acknowledge the importance of psycho-

logical factors such as "lack of love, security and understanding".

Freeman (1961) asked the relatives of 649 patients with functional psychoses about their aetiological theories. Psychological explanations tended to be favoured by younger relatives and by the more highly educated. Relatives very often gave psychological factors without explicitly making the patients themselves responsible for their illness. No difference with respect to aetiological theories was found between relatives of schizophrenic and manic-depressive patients. The number and duration of hospital admissions were not related to any particular attitudes towards aetiology on the part of the relatives. There was no demonstrable relationship between the aetiological theory of the relatives and the course of the psychosis as defined by the readmission rate, psychopathology and degree of social adaptation (Freeman and Simmons 1963).

In a survey of relatives of chronic schizophrenic patients made in Greece, the majority regarded psychological factors as having a causal relationship to the psychosis: 26% cited family reasons, 26% traumatic life events occurring outside the family, and only 12.8% mentioned hereditary factors (Alivisatos and Lyketsos 1964).

We find Hohl's (1983) investigation, in which he interviewed the relatives of psychotic patients, particularly interesting. By far the most common cause mentioned belonged to the category "psychic causation" and from this "influence of others" was most frequently chosen, the blame for the occurrence of the illness being put on a third party. Apart from these "others", groups of people or institutions were often held responsible. "It seems reasonable to ex-

plain the frequent occurrence of such extrapunitive explanations as being produced by a scapegoat mechanism. Explanations of this sort serve to relieve the relatives' own guilt feelings and at the same time to stabilize relationships within the family by promoting solidarity" (p. 148). Relatives rarely see themselves as being to blame. Their causal models are usually multifactorial, including psychological, somatic and hereditary or constitutional components. There was, however, one significant difference: "The relatives unlike the psychiatrists do not think in terms of endogenous causation, overwhelmingly preferring theories involving exogenous or reactive principles, that is they trace the disturbance back to non-hereditary factors – traumatic experiences, stressful life events and somatic changes (p. 150). Their "exogenous" explanations involve psychosocial explanations rather than somatic factors. They considered the disturbances to be more the result of a single traumatic experience than that of drawn-out stress with traumatic events having a cumulative effect.

Findings parallel to these were made by Dewald (1979). The parents of schizophrenic patients based their suppositions about the cause of their child's illness on a concept which was both multifactorial and "exogenous". Many of them held the opinion that mental illness resulted from external conditions or events (overwork or stress at school or at work) but also mentioned mental strain, traumatic experiences and somatic causes. Only relatively seldom did they postulate that the family had caused the illness. The less-educated parents tended to assume that a somatic disease was the cause of the illness. There were no significant differences between the sexes.

In a study conducted by McGill et al. (1983), parents of schizophrenic patients frequently named stress and other environmental factors as causes of the illness (25%), followed by drugs (16%), genetic factors (12.5%), and lastly metabolic brain disturbance (11%); 34% of those asked said that they did not know what caused the illness.

Angermeyer and Döhner (1980) analysed group discussions in which parents of young male schizophrenic patients took part and concluded that the aetiological theories are far from temporally stable. They changed frequently and were often contradictory in themselves. The fathers often blamed the mothers for making the sons ill by being overprotective and spoiling them. The mothers on the other hand had evolved more sophisticated explanations, which avoided putting the blame on the family.

Lefley's (1985) investigation differs markedly from those just mentioned. He questioned a group of people (social workers, nursing staff, psychiatrists, psychologists) working in psychiatry, all of whom had

someone with a chronic psychosis in the family, about what they considered to be the aetiology of the illness. More than 70% put genetic, constitutional or biochemical factors in first or second place! The family and the parents were rarely considered to play an important part in the causation. Most of those questioned (84%) reported that their ideas had been changed by having psychiatric illness in the family.

The particular questions which we will try to answer in our study are these:

1. What concepts do the closest relatives adopt about the aetiology of functional psychosis in a member of the family?
2. How similar are these theories to those of the patients?
3. Do they tend to favour a single or a multifactorial aetiology?
4. Do the theories of relatives and patients become more similar the longer the illness lasts?

Methods

The first interview was conducted during inpatient treatment. Between 2 and 4 months after a patient's discharge from the hospital we carried out a second interview with 153 out of the original group of 198 patients; 45 patients could not be interviewed either because they refused or had moved away or had been discharged to a long-stay institution or hostel or remained or were again in the hospital. At the end of the interview, which was primarily designed to investigate their social circumstances, we asked patients to name someone close to them whom we could also interview. Of the patients, 110 named a relative and agreed to our questioning them; 84 of these (76%) actually came to be interviewed. A good two-thirds of them were women, 23% under 40, 38% between 40 and 60 years old. The largest group were mothers (40%), the second largest marital partners (27%). The socio-demographic and clinical characteristics of the associated patients were not different from those of the total group (see Angermeyer and Klusmann 1988).

Between 2 and 4 months after discharge of the patient we carried out a comprehensive interview with the relative, during which we asked the open-ended question: "What do you think caused the illness?" After noting down the answer we presented the checklist with 30 items in the Likert format (Angermeyer and Klusmann 1988).

Results

Relatives' Theories About the Causes of Psychotic Illness

The answers to the open-ended question belonged most frequently to the category "recent psychosocial factors", succeeded by "personality factors" and "family". Biological factors were in fourth place. Only two relatives mentioned esoteric causes. Figure 1 shows that the order of precedence of the five categories is the same as was derived from the patients' answers.

Figure 2 summarizes the answers to the 30 items on the checklist, an answer being judged to be posi-

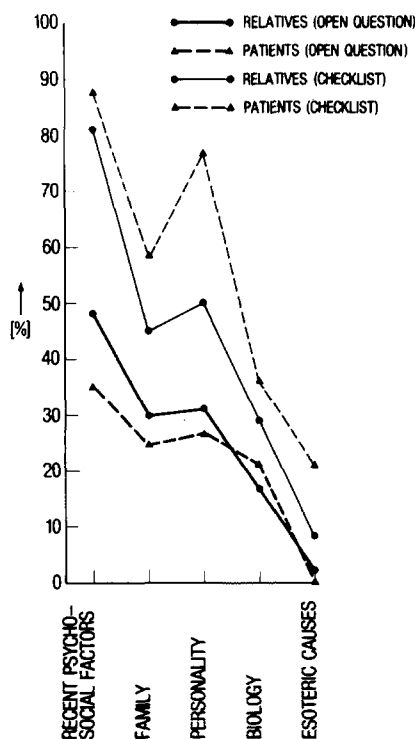


Fig. 1. Causes of illness named by relatives and patients in response to the open-ended question (for comparison the responses to the checklist allotted to the same aetiological categories, are also given)

tive when the cause suggested was considered as least possible. The patients' replies are also listed for comparison. One can see at once that the profiles of both groups are very similar. Using Bonferoni's alpha adjustment in view of the multitude of statistical tests applied (Grove and Andreasen 1982), we found only one significant difference. The relatives selected "society" as a possible cause less frequently than the patients did.

The causes most frequently selected by relatives were the same as those indicated by the patients: "stressful life events", "loneliness", "problems in marriage or partnership", "constant strain in school or at work". Both groups equally frequently held the opinion that "avoidance of problems of everyday life" could have played a part in the development of the psychosis. Between 20% and 50% of both patients and their relatives felt that the cause might be located in other personality traits of the patient, in the family, in some of the biological factors suggested, or in vitamin deficiency.

The same result was obtained when only the likely or very likely causes were included, i.e. even when the grouping of response categories changed the order of precedence of the items was preserved. In no in-

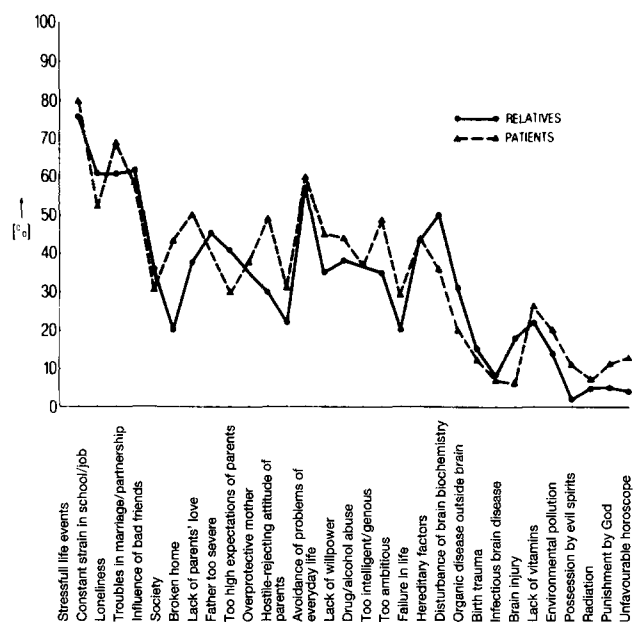


Fig. 2. Causes of illness given by relatives and patients with functional psychoses in response to the 30-item checklist

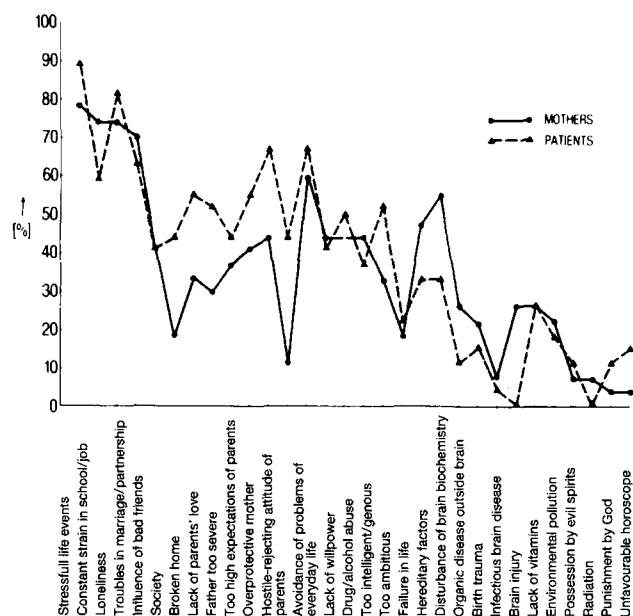


Fig. 3. Causes of illness given by mothers and their schizophrenic children in response to the 30-item checklist

stance was there a significant difference in the frequency of response between relatives and patients compared as whole groups.

One subgroup which we will consider separately consists of the mothers of schizophrenic patients. Which causes were favoured by those who have themselves been implicated by family research in the production of schizophrenic disorder (Angermeyer 1982)?

How do they assess the aetiological role of the family in particular? Figure 3 shows that the mothers do in fact tend to play down the influence of the family compared with their schizophrenic offspring. At the same time they tend to assign more importance to biological factors. However, these differences do not reach statistical significance in our sample of 25 mothers.

Agreement Within Patient-Relative Pairs with Regard to Aetiological Concepts

We have just demonstrated that relatives and patients as groups placed categories of aetiological factors in the same rank order. This does not necessarily mean that there is agreement within each patient-relative pair. In Table 1 we have therefore listed how often both gave answers to the open-ended question which belong to the same category, how often only one of the pair chose a particular category, and how often both rejected a particular category. As an example, recent psychosocial factors were named by both relative and patient in 21 of the 80 pairs. In 7 pairs these factors were given by the patient only, and in 18 by the relative only. In 34 pairs neither mentioned them at all.

In order to test the degree of agreement between relatives and patients, we calculated Cohen's kappa for all five categories except "esoteric causes". Applying Fleiss's (1981) criteria, the only reasonable agreement can be found with respect to the role played by the family and by biological factors.

Table 2 summarizes the answers to the 30 items in the checklist in the same way as Table 1 summarizes those to the open-ended question, showing how often the four combinations occurred between relatives and patients and the degree of agreement between them. A moderate level of agreement was only found with regard to the importance of problems in marriage or partnership and of drug or alcohol abuse.

Table 1. Agreement between relatives and patients on the causes of the illness: open question (80 pairs)

	Patient: Relative:	+	+	-	-	Kappa
		+	-	+	-	
Recent psychosocial factors		21	7	18	34	0.37
Personality		12	10	13	45	0.31
Family		14	6	10	50	0.50
Biology		9	8	5	58	0.48
Do not know		5	12	7	56	0.20

+ = category chosen, - = category not chosen

Conceptual Patterns

In order to find out whether the relatives gave a mono-causal or a multifactorial model we used the method already employed in the study of the patients. If a relative gave at least one of the six items in a category as likely or more than likely, we considered that category as having been chosen (see Angermeyer and Klusmann 1988). As did the patients, the relatives usually named not just one but several causes. The most common combination was "recent psychosocial factors" with "family" and "personality" (17.9%). "Recent psychosocial factors" occurred alone in 11.9%, together with "personality factors" (11.9%) and "family" (9.5%). None of the five categories on offer were selected by 11.9% of the relatives.

Convergence of the Aetiological Concepts of Relatives and Patients During the Course of the Illness

According to our hypothesis the aetiological theories of relatives and patients should become increasingly similar during the course of the illness. We therefore compared the degree of agreement between relatives and patients in two groups, one of which is composed of patients whose first admission had taken place less than 2 years previously and the other composed of patients who had been ill for a longer time. Contrary to our expectations we found no difference in the degree of agreement between the two groups.

Discussion

At the level of group comparisons patients and relatives did not differ very much in the frequency of choices from the checklist of possible aetiological factors. However, if patients and relatives are compared pairwise, marked discrepancies are revealed. Therefore, the similarity of the groups in terms of average tendencies only shows a similar style of using aetiological concepts in general; it does not imply a concordance on the individual level. There may be many reasons for this: (a) different ways of interpreting the meaning of the items; (b) different understanding of what has to be considered a causative factor; (c) different bases of information about possible aetiological factors in the life of the patient; (d) different concepts of what may have caused the illness (equivalent informational background provided). Only the last factor can be taken as representing true conceptual differences. Ideally the other factors should be monitored, but this would require extensive methodological refinements. As there is much debate among experts about what might be the causes of psychotic ill-

Table 2. Agreement between relatives and patients on the causes of the illness: 30-items questionnaire (84 pairs)

	Patient: Relative:	+	+	–	–	Kappa
		+	–	+	–	
<i>Recent psychological factors</i>						
Stressful life events		53	14	11	6	0.13
Constant strain in school/job		29	16	22	17	0.08
Loneliness		38	20	13	13	0.14
Troubles in marriage/partnership		39	10	13	22	0.43
Influence of bad friends		15	11	15	43	0.30
Society		9	27	8	40	0.09
<i>Family</i>						
Broken home		21	21	11	31	0.24
Lack of parents' love		21	16	16	29	0.21
Father too severe		15	10	19	39	0.25
Too high expectations of parents		14	18	15	37	0.18
Overprotective mother		11	29	14	30	0.04
Hostile-rejecting attitude of parents		12	14	6	51	0.39
<i>Personality</i>						
Avoidance of problems of everyday life		32	19	16	17	0.14
Lack of willpower		18	20	11	35	0.24
Drug/alcohol abuse		24	13	8	39	0.48
Too bright or too intelligent		8	15	14	46	0.12
Too ambitious		20	20	9	35	0.30
Failure in life		5	19	12	48	0.01
<i>Biology</i>						
Hereditary factors		22	14	14	34	0.32
Disturbance of brain biochemistry		23	7	19	34	0.38
Organic disease outside brain		9	8	17	50	0.23
Birth trauma		2	8	10	63	0.06
Infectious brain disease		2	4	5	73	0.25
Brain injury		1	4	14	65	0.01
<i>Esoteric causes</i>						
Lack of vitamins		9	13	9	53	0.28
Environmental pollution		1	16	11	56	0.12
Possession by evil spirits		2	7	1	74	0.30
Radiation		1	5	3	75	0.15
Punishment by God		–	9	4	71	0.07
Unfavourable horoscope		–	11	3	70	0.06

+ = "Possible", "likely" or "very likely" causes; – = "no cause"

ness and as there are different causal pathways to similar patterns of psychotic decompensation, the lack of agreement between patients and relatives does not come as a surprise. On the other hand, however, even when it is not possible to identify the "true" aetiology of the illness, there are some reasons for expecting concordance at least in some cases. Most of the patients interact with their relatives on a daily basis and therefore much knowledge is shared. From this point of view consensus on an important matter such as the causes of a severe illness could be

expected, even more so if we consider the findings of family research on shared myths of such families. As such agreement is mostly absent in our results, we might conclude that these unifying processes cannot be so effective or may be counteracted, but we are also led to examine our method, mainly the checklist approach, which may not be sensitive enough to catch the flavour of such explanatory myths.

From the experience of our investigation we have been led to propose some methodological refinements (a) a rating approach to causal attributions; (b) ex-

ploration of causal chains; (c) comparison with aetiological concepts of experts.

a) Rating Approach. In our study the interviewer asked a single open-ended question about the cause of the illness. As the response to this question has been recorded without further probes, only the presence of some factor like heredity or early childhood trauma could have been detected, but not the absence, because we could not know whether a causal factor was not present, or whether it was present but not mentioned. The task of eliciting responses to specific causal categories was assigned to the checklist of 30 possible causes. As a first approach this seemed to work, but clearly this is a very rough measure, because the meaning of a checklist item is not explained in detail and thus can be interpreted in different ways. For instance, when an interviewer questioned a patient who had chosen "condition of society" as a causal factor for his psychotic illness, it was found that this patient's mother had been accused of collaboration after the war and had been punished by expulsion from her native country. As the patient had been deeply afflicted by this event when he was a child, he tried to accommodate it in the checklist and found the category "condition of society" the right place. For us this was an unexpected meaning of the item because we had expected it to reflect a propensity to feel victimized by some general features of society, such as social injustice, capitalism or consumerism.

In fact, every patient who ticked this entry in our checklist must have had specific reasons for doing so, but with our approach we were not able to learn about these specific reasons. We just presupposed a constancy of meaning. We felt that we have to group responses together in order to arrive at generalizations, but this step would be better taken after the meaning of the responses has been understood fully. Our approach was "top down" in the sense that categories were first established on an abstract level by the investigators and then offered to the patients. Next we will try a "bottom up" approach with the specific responses first and categorization building upon them. Technically the checklist would have to be transformed into an interview schedule with eliciting questions and probes to work through the topics of the checklist in a way resembling more natural conversation. Data would be obtained on two levels: investigator-based and responder-based ratings. The investigator-based rating procedure would be designed in analogy to procedures developed in life-event research (Brown 1981; Brown and Harris 1978). In addition, the self-rating approach to the checklist could still be attained, but this time would be carried through after the con-

versation with the interviewer had clarified the understanding of the items.

b) Causal Structure. With the rating approach another problem would also be solvable: the blurring of the time dimension. The causes for the first manifestation of the illness and those for the recent exacerbation which had led to the admission to hospital were easily mingled together by the patient when answering the open-ended question and even more so when browsing through the checklist of possible causes. However, the fact that so many patients failed to make this distinction must not be seen as indicating an inability to differentiate. Special efforts seem necessary to focus attention on this quality, the temporal structure of causative factors.

In scientific discourse causal processes are described in terms such as "personal dispositions", "vulnerability", "triggering events" and so on. These concepts do not belong to common language but, although sometimes clumsily, they can also be expressed in ordinary language. Therefore, a differentiated account of causal processes that have led to an illness does not seem to depend on technical language. As this is an unusual intellectual task for many patients, some pivotal structure seems to be required of the interviewer that can be given by the same set of eliciting questions that is to be used to cover the whole range of causal attributions, supplied with an extra section on causal ordering.

c) Experts' Concepts. The concept of causation held by a patient may be entirely correct, partly distorted, or simply fantastic. How could we know which causal assumption is correct? At least we should have a reference account from which to measure the soundness of the concept. The best candidate is the expert's view. Surely, when faced with the same patient, different experts would not agree completely on assumptions about possible causes, but they are at least expected to share some general principles of interpretation and to exclude improbable or fancy views. Their assessment is the baseline against which we have to gauge the correctness of the causal attributions of patients and their relatives. In a comparative investigation both views should ideally be assessed using the same method. This raises the question of common ground between laymen and experts. As laymen often have only crude concepts of what causes a troubled mind, the task would be to compare undifferentiated concepts with differentiated ones, which would call for a smallest common denominator: a language which captures basic aetiological concepts and is understandable to both sides. Such a language is required when aetiological concepts are to be compared directly.

However, this is not the only approach, because there is no reason to restrict ourselves to the notion of an aetiological concept being a set of quantified dimensions. In fact, this is not the way most of us think about illness causation or would describe it in a conversation. The natural way to describe the development of an illness is oriented toward its outstanding features, looking for coherence and meaning. Two different observers can compare their views about these matters without having to transform their observations to quantitative common ground. Take as an example the ethnographic comparison of two cultures. The standard method is to select a series of topics and to describe the cultures from different perspectives, e.g. the way they conceive of death, initiation, sexual relations and so on. Later in analysis, some recurrent features of style may become visible and lead to comparisons on a more abstract level. Comparing two aetiological concepts could be considered a similar task. Comparison would work in terms of topically related accounts, which may have quantitative aspects but basically refer to different stories about the same thing. Like in ethnographic research it would be an achievement in itself to report and analyse these different stories, but the level of the single case probably would not satisfy us in the same way as ethnographers are satisfied with their studies. We need to generalize findings to larger groups. This can probably be approached by conceiving ideal types and using rating procedures to identify them, but basically quantification would not be the strength of such an approach.

Finally, let us briefly comment on the implications of our findings for clinical practice. As we have seen, almost all patients and relatives had developed some ideas about the causes of the illness that were not necessarily in agreement with the tenets of psychiatric science. Rather than dismissing those lay concepts that diverge from the experts' opinion as erroneous or naive, they should be taken seriously by the clinicians, as they serve important functions in the process of coping with the illness (Helman 1981). For example, being able to explain the cause of the illness may give some sense of mastery and help to reduce the anxiety provoked by the experience of the psychosis. Information about the assumed causes of the illness may provide some clues as to how patients and relatives deal with the illness (e.g. whether they tend to blame themselves or others for it). Besides giving some insight into individual psychodynamics, the comparison of the aetiological concepts held by different family members may reveal interesting aspects with regard to the relationships within the family.

Since patients and relatives actively search for explanations for the occurrence of the psychosis (Katschnig and Konieczna 1984), clinicians are well advised to take the initiative and to discuss this issue (like others such as the prognosis of the illness) with them – the more so as the aetiological concepts endorsed by patients and relatives are likely to influence their help-seeking behaviour and compliance with treatment.

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