Counselling Families with Mentally Ill

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Mental illness, in general, and chronic mental health problems, in particular, cause a lot of distress to the affected individuals as well as their families. Families of the mentally ill experience emotional strain and a series of changes in their family functioning. A family counsellor needs to understand the family dynamics, the emotional climate and level of organisation of the family. In this article, the author has outlined the purpose and goals for counselling families with mentally ill members. The skills required by a family counsellor for such purpose are also given. The author has recommended a four phased appraoch to to counsell and empower families with mentally ill individuals.

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INTRODUCTION

Research provides compelling evidence that the family plays an important role at every stage of a person's illness or disability, either by enhancing or retarding the healing process. The capacity of the family to make adaptive changes required by the mentally ill individual's condition is an important determinant for the outcome of the mentally ill individual, as well as the family unit. Any illness or disability is always of significance, since it influences the relationships of people with each other.

Mental illness, in general, and chronic mental health problems, in particular, cause a lot of distress to the affected individuals as well as their families. The nature and intensity of the problems depend on various factors like the type of illness, course, prognosis, treatment availability, utilisation of services, family and community support, levels of personal and social functioning of the mentally ill, deviance, tolerance, and so on (Gopinath and Chaturvedi, 1992; Ranganathan, Nirmala and Pandankatti, 1991).

Sheperd (1984) and Wing and Morris (1981) describe three levels of disability in the chronically mentally ill:

- Primary disability, which includes dysfunctions arising out of the illness;
- Secondary disability, which arises from the experience of the illness (adverse personal reaction); and
- Social disability which includes stigma, unemployment, poverty and lack of sense of belonging.

Due to these disabilities, mentally ill individuals become a burden to the family and as well as the society.

The most common variables associated with the family burden are the mentally ill individual's aversive behaviour, adverse effects of the mentally ill and the poor role performance of the mentally ill individual. Significant mediators include strengthening social support and coping skills (Macurin and Boyd, 1990).

Families of the mentally ill experience emotional strain and a series of changes in their family functioning. This is in relation to the structural changes in the family, normative conflicts underlying family care, changes in normal care in relation to the preferred locus of control and their conception of mental illness (Carr, 1990). The other problems that are expressed by the families of the mentally ill are economic strain, feelings of anxiety, guilt, helplessness and delayed grief reaction (Franks, 1990; Hanson, 1995; Miller, Dworkin, Ward and Barone, 1990).

Some of the needs expressed by families with mentally ill are access to accurate information about the illness, advice on every day problems, the need on part of the counsellor to have an insight into the family's attitude towards the illness, and recognise the stigma of mental illness that the families feel (Main, Gerace and Camilleri, 1993).

Many families of the mentally ill express that their experiences of grief and loss are impaired by the characteristics of mental illness and the mixed messages from the mental health system (Riebschleger, 1991). A family counsellor needs to understand the family dynamics, the emotional climate and level of organisation of the family. A counsellor should have effective communication and conflict management skills to make the family more cohesive, to manage conflict, to obtain a greater locus of control, and to feel more autonomous and empowered (Mills and Hansen, 1991).

Hence, services for preservation of the families with mentally ill should include education, treatment and empowerment. The focus should be on treating vs. teaching of the families, promoting retention of information, the provider family relationship, meeting the family

needs, encouraging formation of supportive family groups, struggle with concerns of stigma of mental illness, daily management of problem behaviours, responses to repeated crisis, and access to available community resources (Mc Peak, 1989; Pfeiffer and Mostek, 1991).

FAMILY HEALTH AND ILLNESS CYCLE

FIGURE 1: The Family Health and Illness Cycle

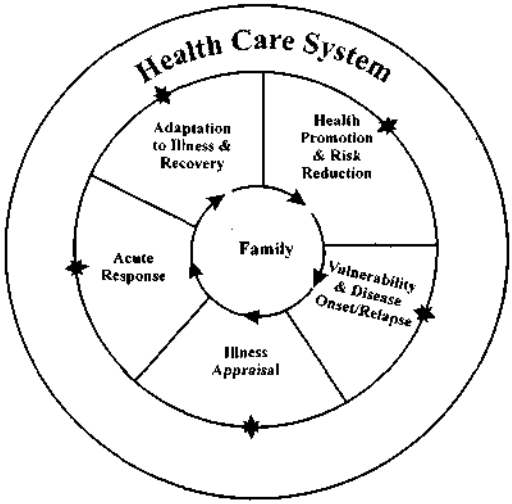


Figure 1 illustrates the family health and illness cycle (Doherty and Campbell, 1988) and gives a family's longitudinal experience with health and illness. The category family *health promotion and risk reduction* refers to family beliefs and behaviour patterns that either help family members stay healthy or put them at long-term risk for developing disease(s).

The next category, family *vulnerability and disease onset/relapse* refers to life events and experiences of the family that render family members more immediately susceptible to becoming ill or relapsing from a chronic illness. The principal body of research on this topic examines how family stress, stemming from either internal or external events renders family members susceptible to illness.

Family *illness appraisal* refers to the family beliefs about a family member's illness and to the family decisions about how to deal with the illness episode.

Family *acute response* refers to the immediate aftermath of illness for the family. This family experience is likely to be tied closely to family illness appraisal, since the early response to an illness episode is influenced by the family's assessment of its seriousness. An example of acute response is the adjustment a family must make in the period following an acute attack of schizophrenia. The family experiences a crisis situation and normal coping patterns are inadequate.

Family *adaptation to illness and recovery* refers to how a family reorganises itself around a chronic illness or disability of a family member, and to the ways in which a family adapts to the recovery of an ill member. This is a phase where the family has to promote the continued recovery or stabilisation of the family member's health, while simultaneously maintaining its ability to nurture other family members and maintain its place in the community.

To summarise, it can be seen in the figure that the temporal flow of the family health and illness cycle begins with the general functioning of the families in areas such as stress management and mutual support, followed by a brief phase — vulnerability and disease onset/relapse — where there may be a pile up of psychosocial stressors that may precipitate an illness episode. The family then evaluates the symptom of the illness, the need for medical attention and seeks the advice of health care professionals. While continuing the appraisal process the family moves into the acute response phase, during which reactions to the illness are likely to involve fear and shock, followed by mobilisation of family resources. Finally, the patient stabilises after the acute episode and returns home to continue recovery and rehabilitation. In this context, the family faces the challenge of adapting to revised roles and responsibilities, either temporarily or permanently. The cycle can then be seen as beginning anew as the family confronts the challenges of reducing the risk of a repeated illness and promoting the health of the family member.

COUNSELLING FAMILIES WITH MENTALLY ILL

Purpose and Goals

The purpose and goals for counselling families with a mentally ill member are to:

- develop a supportive climate for the family;

- provide necessary information for the family to understand the mentally ill person's condition, its demands, and its consequences for individual and family living;
- alleviate feelings of anxiety, guilt, low self-esteem, and so on;
- enhance appropriate participation of the family members in the care of the mentally ill individual;
- develop new rules and skills of communication among the family members;
- assist the family to establish and enhance relationships with each other and with significant others in the social network;
- develop flexibility in making necessary shifts or role responsibilities and develop role competence;
- build family social supportiveness;
- improve the family's problem-solving capacities; and
- develop awareness of the family's own resources and provide access to essential external resources.

Some of the psychosocial problems encountered by the families with mentally ill may be related to lack of knowledge about a specific illness; cultural attitudes, and relatives who create barriers in the utilisation of medical care; dysfunctional interpersonal relationships; cognitive and emotional difficulties of the mentally ill individual and significant others; ineffective functioning of the family system; inadequate social supports; and lack of adequate resources.

Skills

Relationship

A basic ingredient to effective helping is the degree of rapport and trust established between the counsellor and the families. The counsellor has to initiate, develop and sustain a positive relationship with the family and each of its members. Such a relationship makes members free to disclose their feelings, thoughts and reactions and experience a sense of respect. The ideal client family- worker relationship is characterised by non-possessive warmth or acceptance, accurate empathy, genuineness and respect. The intensity of the relationship between the counsellor and the family varies with the purpose of service, the form, duration of treatment and the particular characteristics and needs of the family members.

Cluster of Techniques

The techniques required for working with families with chronically mentally ill are providing support and sustainment, facilitating ventilation or expression of feeling, education, exploration, direction, structuring, clarification, confrontation, use of conditioning techniques, and facilitation of a process.

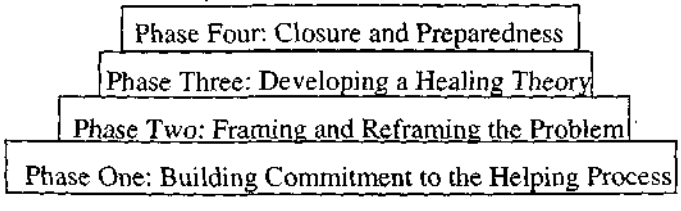
Activity oriented interventions

These are also an essential part of working with families. They include making peace with the past and the present, psycho education, developing family social supportiveness and promoting family relation skills. Other activities include exercises in communication, role play, brain storming, preparation of genograms, modelling, constructive coping, performing tasks related to role performance, demonstration and rehearsal and participation in mutually enjoyable activities. The basic idea is that skills in problem-solving and social competence can be developed through such purposefully designed activities along with facilitation of discussion.

Underlying the successful use of any procedure or technique is the professional use of self. Counsellors should be very clear about their values, and their attitudes towards mental illness and towards particular individual and families. They should clarify their role and should be clear about the rationale for selection of a particular model or procedure. They should examine their feelings, and attitudes, assumptions, evaluate their work and use feedback from the individual, families and colleagues.

Counselling Process

The following four-phased approach may be adopted to empower families with mentally ill individuals.



Phase One: Building Commitment to the Helping Process

The major tasks that have to accomplished here are:

- Clarification of the purpose of family sessions and importance of family's participation.
- Clarification of the family to the new helping situation.
- Orientation to family to the new helping situation.
- Engaging the family in determining a purpose and more specific goals.
- Initiating a working relationship.
- Enhancing motivation and getting the family ready for work.
- Contracting with the family.

Phase Two: Framing and Reframing the Problem

- Acquiring and using knowledge and skills to the defined problems.
- Using one's capacities and as well as resources both within the individual and external.
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- Restructuring and distribution of role responsibilities.
- Decision-making with regard to family members participation in the care of the mentally ill individual.
- Identifying and problem solving related to family relationships, communication and structure.

Phase Three: Developing a Healing Theory

Developing a set of propositions about a particular situation, which will be useful in explaining a current predicament and the need for assistance and predicting future outcomes. It can be developed through a continuous discussion with the family members. It provides a semantic antidote for treating and 'curing' the trauma infecting a family system.

Phase Four: Closure and Preparedness

- Involves bringing the intervention process to a successful closure.
- Family members may express a combination of positive and negative feelings. Hence this phase is either the hardest or the easiest.
- Review and evaluate the process made. Get the families to appreciate their accomplishments of successfully coping with the care of a mentally ill individual and to acknowledge how

successfully they are equipped with the resources necessary for coping with future stress.

- Complete any unfinished business.
- Continuity of care.

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