

Social support of chronically mentally ill patients*

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Summary

Aim: The assessment of social support system for mentally ill people, participating in a local rehabilitation programme in the Targówek district of Warsaw.

Method: The sample consists of 92 participants with serious mental illnesses. Bizon's Social Support Inventory and Social Support Map were used.

Results: Patients' individual social networks were small (9 persons on average) but had a broad scope of functions. Therapists from community rehabilitation services are the biggest group of people included in the individual network of social support. Lack of emotional support is observed.

Conclusion: Participation in a local system of rehabilitation improves the quantity and quality of individual systems of social support given to chronically mentally ill patients.

schizophrenia / social support

INTRODUCTION

Chronically ill patients with mental disorders find it difficult to function socially, which leads to their material and social deprivation, occasional marginalization, and finally to social exclusion. These can be prevented through rehabilitation and social support programmes, involving people who find it very difficult to cope with everyday life and social contacts because of their mental illness or disability. Two techniques are considered particularly helpful here: living and social skills training and providing support to local communities, both fairly standard in contemporary social psychological care for mentally ill patients [1].

The results of research into the social support networks for patients suffering from schizophrenia show their serious malfunctioning. While most of us (members of the general public) indicate approximately 40 people in their support networks, the mentally ill patients name up to 20 persons (including their families, friends, neighbours and colleagues), and the chronically mentally ill patients have only 4-5 people in their networks, mostly relatives [3]. The research projects carried out by Simon [4], Clinton et al. [5] and Goldberg et al. [6] reveal that schizophrenic patients, especially those who are chronically ill, have much worse social support networks in terms of quantity (on average 4-5, up to 10 persons; 3 persons in the case of seriously ill patients) and quality of care. Most patients receive support from close family (parents, spouses or children), less frequently from friends and other relatives. Therapists organizing rehabilitation programmes were among the least mentioned sources of support.

Additionally, schizophrenic patients find it particularly difficult to find emotional support.

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Clinton et al's. research [5], mentioned above, has indicated that 60% of schizophrenic patients reported the need for more emotional support, advice and trust-based relationships.

The lack of emotional elements of support is especially relevant in the case of chronically ill patients, those isolated and deprived of a family network. They feel that the support given to them in social rehabilitation systems is mostly formal in character. Emotional support, understood as part of 'functioning out-of-institution', is more difficult to find in those systems [7, 8]. Crosswell [2] also shares the opinion that schizophrenic patients find it especially difficult to gain emotional support, so it would be ideal to organize the support systems with both formal and emotional, less institutionalized elements. Harvey [9] thinks that the main deficiency in social support systems for the mentally ill is the lack of interaction with people outside of the formal treatment or rehabilitation structures.

Social contacts provide some of the most essential elements relevant to the quality of one's life. Low life satisfaction observed in schizophrenic patients is related to weak and inadequate social networks and interpersonal deficits [10, 11, 12]. Therefore, some of the most effective tools, leading to increased life satisfaction in chronically mentally ill patients, would have to provide both psychiatric treatment and accessibility to non-medical facilities providing social support [13, 14]. In the case of chronically ill people, who have spent many years in psychiatric hospitals, social support is absolutely essential in the rehabilitation process [15, 16].

The 'Mental Health Protection Act' [17], and the changes it introduced into the social care system, has initiated a dynamic development of local, non-medical community care for chronically ill people in Poland. Some of the best facilities for the mentally ill are those which offer psychiatric healthcare in conjunction with social support. The facilities offered in the Warsaw district of Targówek are among the finest examples of such coordinated care.

The psychiatric treatment system in Targówek comprises a psychiatric ward, daytime care centre, community care team and a clinic, which has been operating there since the late 1970s.

Among the basic services provided within the community rehabilitation system are the facili-

ties created in 1997 and 1998, such as the occupational therapy workshop, specialist care services, community self-help centre with protected accommodation, patients' club and professional development centre. The system was created, and is currently functioning, through the close cooperation of psychiatric treatment facilities (initially The IPIN 4th Psychiatric Clinic, currently The 2nd Psychiatric Clinic at the Medical Academy), social care system, a charity (The Bródno POMOST Association) and the local government of the former municipality and today's district of Targówek. The following features are specific to this system:

- it involves a substantial group of patients living in the local community
- it is stable (the facilities have been operating according to the same formula for quite a few years)
- the medical and non-medical facilities create a closely cooperative system

In the initial stages of the system, the activities undertaken by the community care team in Targówek essentially reduced psychiatric hospitalization [18]. Further reduction of psychiatric hospitalizations and visits to the day care centre was observed in the first two years after the opening of the other community facilities (occupational therapy centre, community self-help centre and specialist care services) [19].

Aim of the study

The main aim of this research was the evaluation of the existing social support systems and of the significance of the institutional support given to the mentally ill patients, under the care of community facilities of the Targówek district. Its main goals can be summarized as follows:

- quantitative evaluation of the social support system, provided to the persons serviced by the community care system
- identification of the support functions and their sources

Thanks to the data gathered in this research it will be possible to present a kind of photograph-

ic survey of the local social support system for the mentally ill patients, four years into its existence.

MATERIAL AND METHODS

The data regarding the subjects researched and their social support network was collected between 1st September and 5th December 2001, both individually and by trained interviewers at the social facilities and in the patients' homes. The following tools have been used:

1. A Questionnaire and Z. Bizon's Social Support Map, which make it possible to evaluate the size of the support network. The carers are grouped into 8 general categories, called 'areas' (cohabitants, closest relatives, work colleagues, neighbours, acquaintances, therapists and other significant people) [20].
2. Z. Bizon's Social Support Inventory allows for the evaluation of the type of support, measurement of its size and the range of support that a studied person can count on. The inventory takes into account 8 types of support (supporting functions), such as giving advice, helping out, protection, nursing, providing help in emergencies, giving consolation, cheering up, sharing personal problems and so-called unconditional support [21].

Both tools allow for the gathering of exhaustive data, characteristic of the individual social support programmes, and they have been widely used in the research on the social functioning of mentally ill people and alcoholics [22].

A questionnaire regarding details of the illness, prepared especially for the purpose of this research, with such data as the time frame of the illness, the age at which the patient fell ill, his or her hospitalizations; socio-demographic data, such as age, education, status, monthly income and the use of community social support facilities.

Subjects

The researched cohort comprised 92 people who have used the social support facilities for longer than 3 months. There were 57 women and 35 men. The average age in the group was 47.

Only 11 people (12% of the group) were married. The remaining 88% were single. Most of the subjects had received a primary or vocational education (53%), followed by secondary (43.5%) and higher education (3.3%). 94.6% of people have been granted disability status - group I or II. The average duration of mental illness was 16 years and the average number of hospitalizations was 8. Amongst the diagnoses, it was psychotic disorders and schizophrenia which were most often identified (80.5%). Affective disorders and vari-

Table 1 The number of participants in the programs offered by the facilities and the average period of remaining under care, prior to the study date

| Type of facility | Number of participants | % | Average period of remaining under care (in months) |
|------------------|------------------------|------|--|
| OTW | 25 | 27.2 | 21.58 |
| CHC | 26 | 28.3 | 29.62 |
| SCS | 41 | 44.5 | 27.88 |

ous syndromes of organic origin were much less common (9.8% and 9.7% respectively).

Summarizing, one can say that the researched group comprised mostly single people with psychotic disorders, mostly chronically ill schizophrenic patients, who have been hospitalized many times. All subjects have used at least 3 community facilities for longer than 3 months, such as occupational therapy workshop (OTW), community self-help centre (CHC) and specialist care services (SCS) – Tab.1.

As specified in Table 1, the community self-help centre provided the longest period of assistance, followed by specialist care services. The occupational therapy centre offered the shortest time of care. Specialist care services were utilized by 44.5% of the patients, and in the studied group 13 persons (14.1%) have regularly used the 'Promyk' club in the afternoons.

Table 2. Numerical values of individual social support systems of the subjects studied

| Ranges of numerical values of support systems | Number of the studied persons | % of the researched group |
|---|-------------------------------|---------------------------|
| 1 – 4 | 11 | 12.0 |
| 5 – 10 | 47 | 51.1 |
| 11– 15 | 27 | 29.3 |
| 16 – 20 | 6 | 6.5 |
| > 21 | 1 | 1.1 |

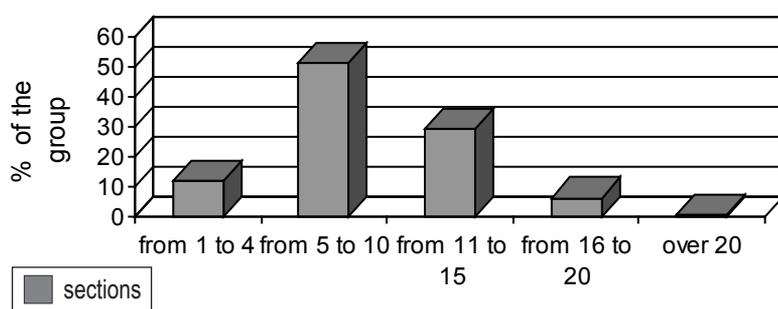


Figure 1. Numerical values of individual social support systems of the the studied persons

Table 3. The average number of people in the individual areas of social support in the case of the 92 studied persons

| The area of support system | Average number of persons in the area | Standard deviation |
|----------------------------|---------------------------------------|--------------------|
| Therapists | 2.66 | 1.44 |
| Closest relatives | 2.16 | 1.73 |
| Cohabiting persons | 1.25 | 1.15 |
| Other relatives | 1.15 | 1.34 |
| Other acquaintances | 0.82 | 1.25 |
| Neighbours | 0.68 | 1.04 |
| Other people | 0.52 | 0.52 |
| Work colleagues | 0.29 | 0.29 |

Work colleagues are the least frequently represented (0.29 on average). It is only in case of 2 (2.2%) out of all the researched persons that the therapists haven't featured at all in their social support system. Work colleagues haven't featured at all in the support systems of 76 per-

RESULTS

Quantitative evaluation of the individual social support systems

Two variables characteristic of social support have been investigated here: its numerical value and range. The numerical values of individual social support systems of the subjects are presented in Tab. 2 and Fig.1.

Amongst the studied persons, 51.1%) mentioned 5 to 10 people in their social support system, and fewer – 29.3% - mentioned 18 to 20 people in their systems. The average number of people comprising the support systems in the researched group was slightly over 9.

Out of all the areas of individual social support systems of the persons remaining in care of the community facilities, the therapists are the most numerous group (2.66 on average) with close relatives and cohabiting persons coming second.

sons (82.6%), neighbours haven't been identified by 54 people (58.7%), other acquaintances by 48 people (52.2%), cohabiting persons in by 30 (32.4%), distant relatives by of 35 (38.0%) and the closest relatives were not mentioned by 14 people (15.2%).

Range of social support functions

The data on the range of support (the number of functions providing support in terms of : giving advice, providing emergency help, providing consolation, sharing personal problems, providing unconditional support, helping out, backing-up and nursing) are presented in Tab. 4 and Fig. 3.

Table 4. Range of social support received.

| Range | Number of subjects | % of people in the group |
|---------------------------|--------------------|--------------------------|
| Selective /1-2 functions/ | 1 | 1.1 |
| Narrow /3-4 functions/ | 4 | 4.3 |
| Average /5-6 functions / | 11 | 12.0 |
| Broad /7 – functions / | 76 | 82.6 |

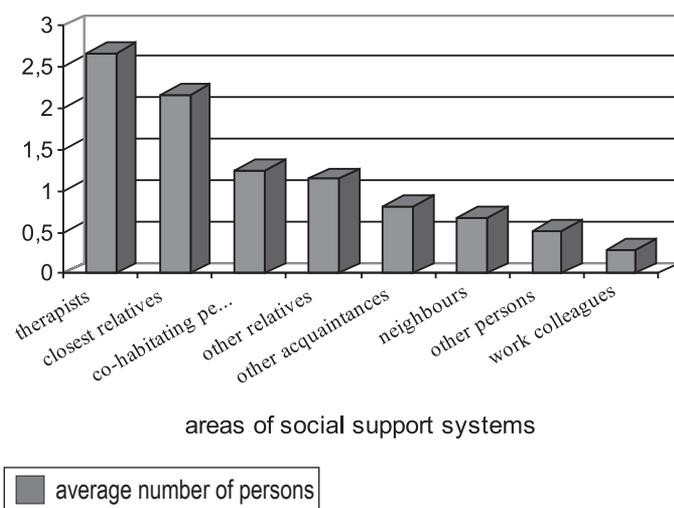


Figure 2. The average number of people in the individual areas of social support in case of the studied persons

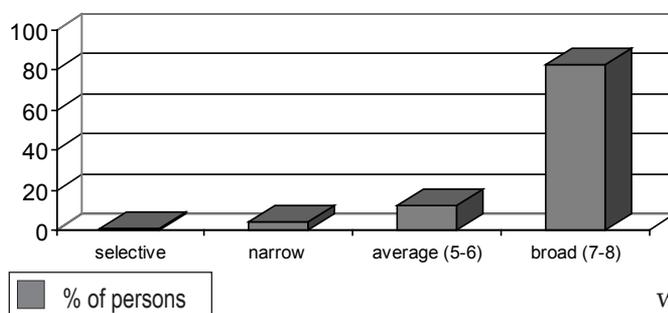


Figure 3. Range of social support received by the researched persons

As shown in the table and the diagram, 94.6% people in the studied group have at their disposal support systems, which are able to meet an essential number of the functions required. The data on the average number of people providing support within the range of individual functions is similar.

Table 5. Average number of people providing support within the individual functions.

Figure 4. The percentage of people reporting deficits in having their needs met within the individual functions were as follows: advising – 3 persons (3.3 %), protection – 5 persons (5.4%), helping out – 6 persons (6.5%), nursing – 6 persons (6.5%), consolation – 7 persons (7.6%), emergency help – 14 persons (15.2%), sharing personal problems – 22 persons (23.9%). The functions classified as “emergency help” and “sharing personal problems” have revealed most deficits: 23.9% of the studied group had no-

body to share their “most personal problems and worries” with. However, most of the requirements of the functions related to the formal aspects of support, such as provision of nursing care, protection and consolation have been mostly met.

DISCUSSION

The studied group comprises chronically mentally ill patients with an average duration of illness of 16 years and 8 hospitalizations on average. Most of the subjects (88%) are single.

In this group, the number of members of the social support network is rather low - 9 on average, with a maximum of 18 people – which according to Crosswell [2] is still higher than in the group of chronically and seriously mentally ill patients researched by Pattison [3] (up to 4-5 supporting people), schizophrenic patients researched by Clinton [5] (up to 5 people) and Goldberg (4.18 people on average) [6].

The most numerous group, providing help within the support system of the research subjects are the therapists (2.66 therapists on average), whereas very few of those asked (2.2%) complained of having no assistance at all within the “therapists” area. These results differ from those revealed in the research of Clinton and Goldberg mentioned above and Simon [4], where the subjects mentioned their closest relatives and friends as the most frequently used supporters, and the therapists and professionals were least frequently mentioned. So it is the therapists who make the support system of the group investigated in this research more numerous than in the other research quoted above. At the same time, this group is broadly comparable with the patients investigated by Nystrom, Lutzen [7], Bengtsson – Tops, Hansson [8], Crosswell [2] or Harvey [9]. These are the patients for whom the lack of out-of-institution social support has proven most problematic. The scope of support received by the group investigated by us can be characterized as broad, as almost 95% of the studied persons declared that they have access to 7 out of 8 functions of support, although there are deficits within individual func-

Table 5. Average number of people providing support to the studied persons within the individual functions

| function | Average number of people | SD |
|---------------------------|--------------------------|------|
| sharing personal problems | 1.35 | 1.18 |
| helping out | 1.54 | 0.89 |
| advising | 1.76 | 1.22 |
| unconditional support | 1.87 | 1.34 |
| emergency help | 2.16 | 2.59 |
| protection | 2.24 | 1.97 |
| nursing | 2.36 | 1.48 |
| providing consolation | 2.38 | 1.83 |

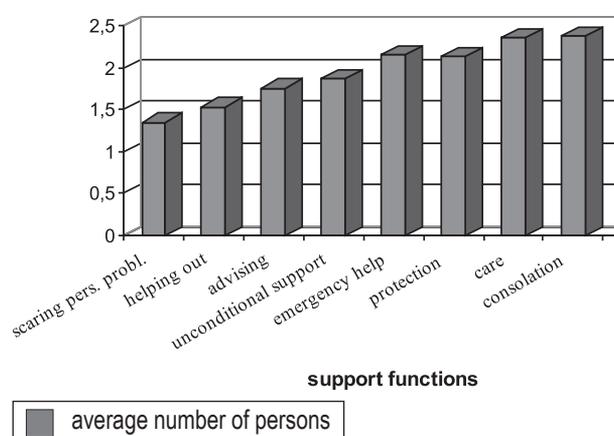


Figure 4. Average number of people providing support to the studied persons within the individual functions

tions. This is especially significant with regards to the function of “sharing personal problems” where 24% of the researched group had nobody to share their most personal problems and worries with, so the emotional dimension of support was entirely absent in their case.

The investigated systems do, however, to a large extent meet the requirements of the formal aspects of support giving, such as provision of nursing care, protection and consolation, which confirms Crosswell’s observations of schizophrenics, who find it particularly difficult to gain emotional support, and shows that it is not easy to build up efficient support systems that comprise both formal and emotional elements.

These outcomes are in accord with the results of American research conducted in 1998 [5], where 60% of schizophrenic patients reported

the need for increased emotional support, especially in the areas of advice and trust-related matters, and also of Swedish research, conducted by Nystorm and Lutzen [7], where the support given within social rehabilitation programs was mostly perceived as ‘formal’.

Our results correspond with Bengtsson-Toms’ and Hansson’s theses, dating back to 2001 [8], emphasizing the relevance of non-formal, out-of-institution sources of support, which satisfy the need for emotional support to a considerably higher degree. This indicates the importance of family network and out-of-institution social contacts, and reveals the need for creating support networks for the families and friends of mentally ill people and also for creating a wider social impact, aimed at a change of social attitudes, towards more approval and openness for mentally ill patients living in our local communities.

CONCLUSIONS

The system of community facilities of social support and rehabilitation in the Targówek district provides care for chronically mentally ill patients, which makes it easier for them to function outside of the hospital, and enhances the quality of their lives. Individual support systems are additionally complemented, quantitatively and functionally, through the therapists provided by the community services.

The research supports the problem, previously discussed in the literature, of the deficits in emotional support for chronically ill schizophrenic patients, who use the institutional social support systems but are affected by the lack of close relationships and social interactions outside of the institutions.

The deficit in emotional aspects of the support received by the research subjects emphasizes the need to create support networks for the families and friends of mentally ill people. It also highlights the importance of activities aimed at promoting attitudes of approval and openness towards the mentally ill people living in local communities.

REFERENCES

1. Bustillo J, Lauriello J, Horan W, Keith S. The psychosocial treatment of schizophrenia: An Update. *American Journal of Psychiatry* 2001, 158: 163–175.

2. Croswell C, Kuipers L, Power M. Social networks and support in long term psychiatric patients. *Psychological Medicine* 1992, 22: 1019—1026.
3. Pattison F, Defrancisco D, Wood P, Frazier, Crowder JA. psychosocial kinship model for family therapy. *American Journal of Psychiatry* 1975, 132 (12): 1246 —1251.
4. Simon S. Social networks: their relevance to mental health nursing. *Journal of Advanced Nursing* 1994, 19: 281—289.
5. Clinton M, Lunney P, Edwards H, Weir R, Barr J. Perceived social support and community adaptation in schizophrenia. *Journal of Advanced Nursing* 1998, 27: 955— 965.
6. Goldberg R, Rollins A, Lehman A. Social network correlates among people with psychiatric disabilities. *Psychiatric Rehabilitation Journal* 2003, 26 (4): 393 — 402.
7. Nystrom M, Lutzen K. Psychiatric care service – an exploration of the professional world encountered by persons with long – term mental illness. *Scand J Caring Sci* 2002, 16: 171—178.
8. Bengtsson – Tops A, Hansson L. Quantitative and Qualitative aspects of the social network in schizophrenic patients living in the community, relationship to sociodemographic characteristics and clinical factors and subjective quality of life. *Social Psychiatry and psychiatric Epidemiology* 2001, 47(3): 67—77.
9. Harvey C. The Camden schizophrenia survey. The psychiatric, behavioral and social characteristics of the severely mentally ill in an inner London health district. *British Journal of Psychiatry* 1996, 168: 410—417.
- 10 Gupta S, Kulhara P, Veram S. Quality of life in schizophrenia and dysthymia. *Acta Psychiatrica Scandinavia* 1998, 97: 290—296.
11. Bengtsson – Tops A, Hansson L. Clinical and social needs of schizophrenic outpatients living in the community: the relationship between needs and subjective quality of life. *Social Psychiatry and Psychiatric Epidemiology* 1999, 34: 513—518.
12. Rudnick A, Kravetz S. The relation of social support – seeking the quality of life in schizophrenia. *The Journal of Nervous and Mental Disease* 2001, 189: 258—262.
13. Mares A, Young A, McGuire J, Rosenhacka R. Residential environment and quality of life among seriously mentally ill residents of board and care homes. *Community Mental Health Journal* 2002, 38(6): 447—457.
14. Barton R. Psychosocial rehabilitation services in community support systems: a review of outcomes and policy recommendations. *Psychiatric Services* 1999, 50(4): 525—534.
15. Torres A, Mendez L, Merino H, Moran E. Improving social functioning in schizophrenia by playing the train game. *Psychiatric Services* 2002, 53(7): 799—801.
16. Mowbray C, Bybee D, Collins M. Integrating vocational services on case management teams: outcomes from a research demonstration project. *Mental Health Services Research*. 2000, 2(1):51—66.
17. Ustawa z dnia 19.VIII. 1994. O ochronie zdrowia psychicznego Dz.U. nr 111 z1994. poz. 535.
18. Prot Herczyńska K. Wpływ różnych form opieki poza szpitalnej na koszty leczenia pacjentów z rozpoznaniem schizofrenii. *Post. Psychiatr. Neurol* 1995, 4: 299—313.
19. Załuska M., Paszko J. Znaczenie środowiskowych placówek rehabilitacji i oparcia społecznego dla ograniczenia hospitalizacji psychiatrycznych. *Psychiatria Polska* 2002, 6: 953—966.
20. Bizoń Z, Bernstein E, Kraśko N, Ostrowska I. Charakterystyka otoczenia społecznego pacjentów alkoholików. W: *Zagadnienia alkoholizmu i innych uzależnień. Materiały XXXV Zjazdu Psychiatrów Polskich, Warszawa, 1989.* p. 11—16.
21. Bizoń Z, Bernstein E, Kraśko N, Ostrowska I. Społeczny system podtrzymania u osób uzależnionych od alkoholu. In: *Zagadnienia alkoholizmu i innych uzależnień. Materiały XXXV Zjazdu Psychiatrów Polskich, Warszawa. 1989.* p. 18—24

