

Family relational dynamics among individuals living with schizophrenia

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Abstract

This research focuses on the “family dynamics of schizophrenic patients”. It took place at the UHC – Frantz Fanon of Bejaia, with a research group composed of 6 schizophrenic patients hospitalized in the psychiatric ward and their close family. As part of this research, we adopted a clinical approach, the case study and used three tools: the semi-directive interview, the genogram and the test of the Five Minutes Speech Sample. From then on, this research attempts to make a modest contribution to the study of families in psychiatry. The objective of this research was to know, understand and describe the functioning and Expressed Emotions [EE] of the families of schizophrenic patients. Referring to the systemic approach, this study revealed for all of our cases, the presence of a dysfunctional family dynamics with high level of EE for 4 of them.

Keywords: Family Dynamics; Schizophrenic Patients; Hospitalization; Expressed Emotions; Systemic Approach

Résumé

La présente recherche porte sur la « dynamique familiale des patients schizophrènes ». Elle s'est déroulée au CHU – Frantz Fanon de Bejaia, auprès d'un groupe de recherche constitué de six patients schizophrènes hospitalisés au service psychiatrique et de leur proche famille. Nous avons adopté une démarche clinique, celle de l'étude de cas et utilisé trois principaux outils : l'entretien semi-directif, le génogramme et le test du Five Minutes Speech Sample. Cette recherche tente d'apporter une contribution à l'étude des familles de patients schizophrènes en psychiatrie avec pour objectif de connaître, comprendre et décrire leur fonctionnement et Emotions Exprimées [EE] des familles de schizophrènes. En faisant référence à l'approche systémique, cette étude a révélé pour la totalité de nos cas, la présence d'une dynamique familiale dysfonctionnelle avec un haut niveau d'EE pour 4 d'entre eux.

Mots clefs : Dynamique Familiale ; Schizophrènes ; Hospitalisation ; Emotions Exprimées ; Approche Systémique.

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1. Introduction

the most widespread and extensively explored mental disorder in psychiatry is undoubtedly the “schizophrenia spectrum disorder.” According to the WHO, it affects approximately 50 million people worldwide. Yet despite its global prevalence, this illness remains, to this day, poorly understood, misinterpreted, and stigmatized. As a result, in addition to facing their own inner conflicts, individuals with schizophrenia must also confront society’s bewildered gaze, which often regards them as a source of shame and dishonor. This is especially true in a society such as ours — Algerian society — where prejudices, superstitions, illiteracy, religious beliefs, and the importance placed on appearances and social judgment are widespread.

Schizophrenia is characterized by severe cognitive and emotional dysfunctions, including hallucinations, delusions, disorganized speech and behavior, and inappropriate emotions. Its origins involve genetic, biological, psychological, and social factors (Caron, 2006). It is a serious and generally chronic disorder that can affect every aspect of the person’s daily functioning. Regarding treatment, beginning in the 1950s, the introduction of neuroleptics by Delay J. and Deniker P. led to a major movement of deinstitutionalization of psychiatric patients. Today, with adequate treatment, individuals suffering from mental disorders can relatively lead productive lives and play an essential role in their communities. However, medication alone is not sufficient: “Although we now have means (hospitalization and effective medications) to reduce delusion, agitation, or to respond to acute emergencies, we lack the necessary mechanisms to provide individuals — whose illness has become chronic — with a plan that can prevent progression toward mental disability and the slide into social exclusion. (...) Few hospital structures offer long-term hospitalized patients therapeutic activities that prepare them for social reintegration. Upon discharge, the patient is left to fend for himself,” states Boudarene M. in the Algerian Health Monthly, January 2015.

It should be noted that relapses can disappear in more than 80% of individuals with schizophrenia after one year of treatment combining neuroleptics with family intervention. Patients with the best prognosis are indeed those who receive support from their families; their involvement is therefore essential. However, the family is often itself a victim of the patient’s mental disorder: both because of the burden imposed by the patient’s condition (treatments, care, supervision, etc.) and because of the manifestations of the illness (paranoia, persecutory delusions, etc.), which are frequently directed toward family members. The symptomatology and psychosocial dysfunctions characteristic of schizophrenia can therefore generate a very heavy burden for relatives of individuals suffering from this condition (Koukia & Madianos, 2005).

Moreover, numerous studies have blamed the family, particularly in cases where parents in general—and mothers in particular—are assigned responsibility for the onset of the disorder in their child. For instance, Pankow G. (1977) observed that parents rely on their child to feel reassured and to compensate for a lack of identity. The child is thus subjected to the mother’s desire, and the relationship becomes marked by a double bind—meaning that the

mother responds in ways opposite to what the child expects. Even earlier, in 1956, Bateson G. described a mode of intrafamilial communication based on paradox or *double binds*. According to him, mothers of future schizophrenic patients tend to transmit two contradictory messages (or orders), generating confusion in the child. The schizophrenic person would therefore be the product of an already dysfunctional family. Similarly, Spiegel J.P. (1957) hypothesized that the patient is merely a symptom of the family's pathology, and that treating them outside their family context yields poor results. The family must thus be treated as a bio-social unit in order to reestablish a new balance. Indeed, the family is the primary group into which a human being is immersed from the very beginning of life. It is also a place where bonds are formed; the relationships and interactions that develop within it make the family a dynamic entity. When this family dynamic is disrupted by the presence of a suffering member, that individual becomes the symptom of the family system. The psychological distress generated by this mechanism becomes overwhelming and occupies the entire relational space of the household. These pathogenic interactions prevent the affected person from coping with the situation and may even destabilize the entire family structure.

In reality, there is an infinite variety of families whose functioning can only be understood through evaluation tools. Exploring relational patterns can help reveal how a family operates. Each family has its own dynamics, expressed in its own way. These dynamics can be influenced by numerous factors, such as the number of children or the family's cultural background. We may refer to **pathological family dynamics** when families are confronted with various types of psychiatric disorders.

Functional or “Healthy Family”: The term “healthy” refers to health, and the health of a family can be understood as a certain state of balance. A healthy family may experience difficulties; its equilibrium may be threatened. But instead of maintaining this balance at all costs (for example, by pretending everything is fine), a functional family is capable of overcoming its problems by entering a process that leads to a new balance. There is no single way to be a healthy family; each one finds its own solutions and develops its own model. The systemic approach has shown that a functional family can be understood as a system constantly seeking balance — a **dynamic balance** between stability/homeostasis (closure) and flexibility/adaptability (openness).

Famille dysfonctionnelle ; la famille devient dysfonctionnelle quand elle n'est plus capable d'assumer les changements et quand la rigueur de ses règles l'empêche de s'ajuster à son cycle et au développement de ses membres. Le dysfonctionnement familial est dû à l'incompétence de celle-ci et à l'inaccomplissement de ses fonctions basiques. Les familles qui identifient un membre comme problématique impliquent une structure dysfonctionnelle, caractérisée en général par des limites diffuses ou rigides, par une absence d'alliance parentale, par une incohérence hiérarchique, des conflits entre les différents membres.

In continuity with the previously cited research, our study was dedicated—on a smaller scale—to exploring the interactions within families of individuals with schizophrenia in Algeria, specifically the family dynamics that govern these groups.

The research process, including the preliminary survey and the main investigation, was conducted in the psychiatric department of the University Hospital Center (CHU) Frantz Fanon in Bejaia. This specialized care unit hosts a specific population whose general issues include mental illness and the notion of psychiatric dangerousness. Most of the patients encountered in this setting suffer from psychotic disorders, the most severe form being schizophrenia. As mentioned earlier, although this disorder is highly prevalent, it remains poorly understood and obscure. We were particularly struck by the representations, judgments, and neglect directed both toward individuals with schizophrenia and toward their families. Nevertheless, very few clinical psychology studies have focused on families of individuals with schizophrenia in Algeria; thus, we addressed the following question:

Research Question: *What is the family dynamic of families with a member diagnosed with schizophrenia?*

Hypothesis: *The family dynamic in families with a member suffering from schizophrenia is dysfunctional; that is, it forms a family system characterized by conflict and stress among its members, with poor communication and a high level of Expressed Emotion (EE).*

Our objectives were therefore to identify, understand, and describe the functioning of families of individuals with schizophrenia, placing the family and the patient on the same level so as to detect and observe the disturbances that arise within the family as a result of their relative's suffering—considering that the family may itself suffer or be a source of suffering.

2. Methodology

the study was conducted with a research group consisting of 6 cases, meaning 6 patients diagnosed with schizophrenia and their respective families, under the guidance and expert supervision of the specialists in the psychiatric department. Although we initially intended to bring together the entire immediate family for the group interviews, we ultimately had to limit our work to only two or three family members for each patient. Through these individuals, we attempted to gather as much information as possible concerning their lifestyles, their relationships and interactions with the patient, as well as the status and roles of each member within the family.

For confidentiality purposes, the patients' real names were replaced with those of historical figures sharing certain characteristics with them. These included: the patient nicknamed Lucrezia Borgia, due to her close relationship with her father and elder brother and a family environment as tumultuous as that of the original; Bill Gates, because of his studies in computer science and his relatively comfortable social status; Sweeney Todd, due to his profession as a barber; Charles Darwin, for his studies in biology; Branwell Brontë, the only son among several sisters; and finally Alfred Douglas, so named for his delicate features.

Summary Table of the Research Group Characteristics.

Name	age	Education Level	Occupation	Marital Status	Close Family	Participants (Family)
Lucrece Borgia	3	1st year of middle school	/	Single	Parents + two brothers	Parents
Bill Gates	2	Final year (CAP)	/	Single	Mother + four sisters	Mother + sister
Sweeney Todd	4	2nd year of high school	Hairdresser & shopkeeper	Single	Parents + 2 sisters + 1 brother	Mother + 2 sisters
Charles Darwin	6	3rd year of university	/	Single	Parents+ 3brothers + 1 cousin	Parents
Branwell Brontë	8	Intermediate	/	Single	Parents + 4 sisters	Parents + 1 sister
Alfred Douglas	7	Final year	Pastry chef	Single	Parents + 2 sisters + 1 brother	Brother

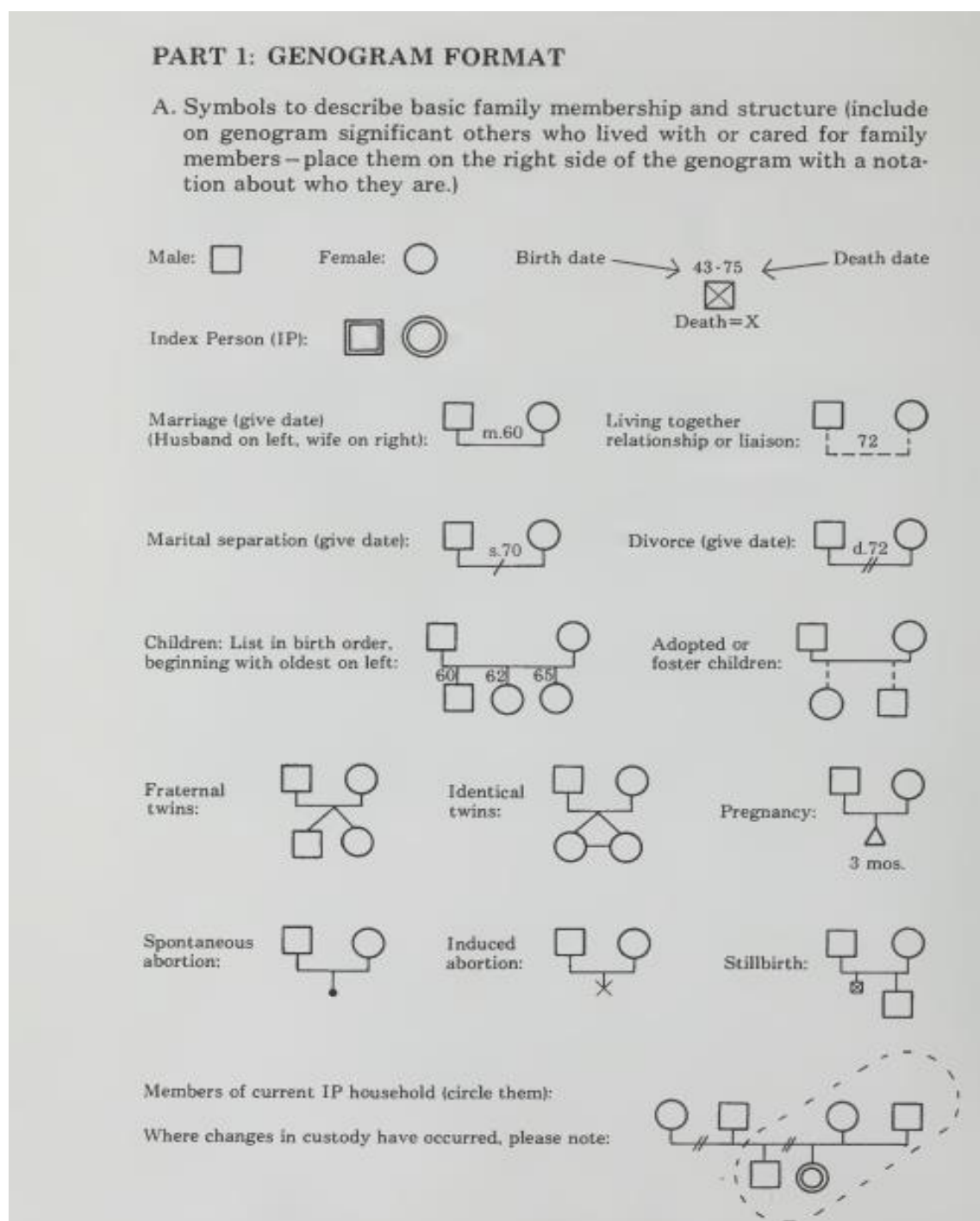
To achieve this, we prioritized the systemic approach because of its unifying and integrative capacity (without neglecting the valuable contributions of other approaches), and we adopted the language commonly used by psychiatrists, influenced as we were by the research setting. In this sense, and in continuity with the literature review on the topic, we selected as indicators of family dynamics the notion of communication, expressed both through language and behavior, noting that communication is an essential component of interaction and thus of family dynamics; as well as the notion of Expressed Emotion (EE), a specific concept referring to the attitudes of relatives toward the patient and whose measurement tool allows for an assessment of the emotional climate between an individual and a family member. To collect the information necessary for our research, after obtaining the informed consent of the participants, we began by conducting a semi-structured interview with the patients.

The instruction was: “We will ask you a few questions about yourself and your family in order to better understand how things are going between you and how you live together.” The duration of the interview varied from one patient to another; it was shorter with those who were less talkative, particularly regarding issues related to their illness. The missing details in their narratives were then gathered directly from their medical records. Our interview guide was prepared in French and translated into Arabic and Kabyle. The participants in our study—patients and family members alike—most often responded using a mix of French, Kabyle, and Arabic. Another key tool of our research was the Five-Minute Speech Sample (FMSS). It was administered to certain family members in order to measure EE and to identify their attitudes toward the patient. This test consists of an audio recording in which the relative speaks uninterrupted for five minutes about their thoughts and feelings regarding the patient. The recording is then listened to and coded according to levels of critical attitudes and emotional overinvolvement (Bout, 2015).

Both the content and the tone of the speech sample are analyzed. The system includes four categories: the initial statement, the relationship, criticism, and emotional over involvement. The last two categories are largely based on those used in the Camberwell Family Interview (CFI). Studies have shown that the FMSS is reliable and provides

evaluations comparable to those derived from the CFI (Hendrick, 2002). To better illustrate the information collected about the families, we considered it useful to employ a genogram. This is a graphic representation of a family constellation across several generational levels. It can provide information regarding names, surnames, and filiation; it can also include dates of birth, marriage, illness, or death. Certain significant events may thus stand out clearly, particularly those concerning the identified patient (Benoit, Malarewicz, Beaujean, Colas, & Kannas, 1988).

Figure: Genogram Iconography

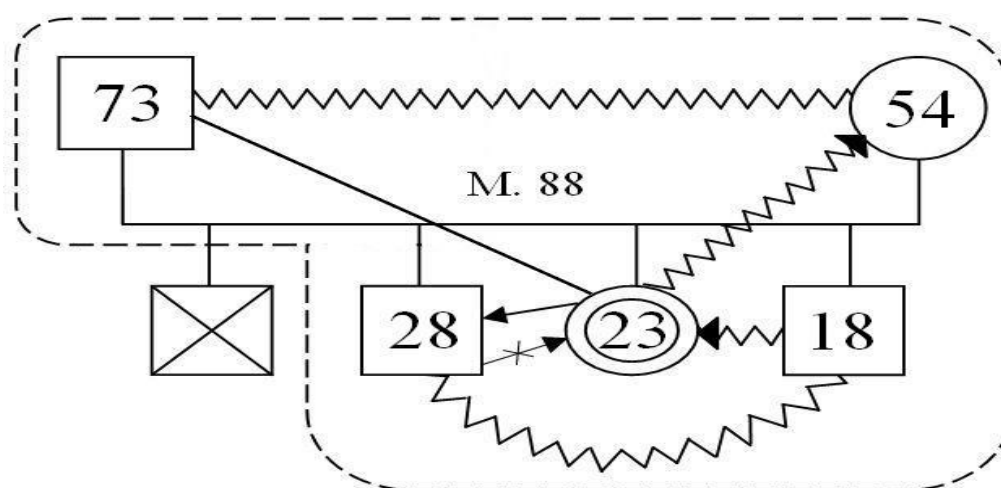


McGoldrick, M., & Gerson, R. (1985). *Genograms in Family Assessment*. New York: W.W. Norton & Co.

The genogram is all the more useful in research insofar as it allows us to build a relationship with the family based on solutions to their specific problems. Genogram questions reach the very core of family experiences: births, illnesses, death, and emotionally charged relationships. Its structure provides a precise framework for discussing the full range of family experiences, identifying and bringing to awareness difficult situations such as illness, loss, and conflict (McGoldrick & Gerson, 1985). In the present case, it was used to illustrate the information gathered during the interviews, to obtain an overall view of the families, and to observe/detect the particular characteristics of each system in a visual and concise manner.

3. Résultats

Case No. 1: Family of the Patient “Lucrèce Borgia”



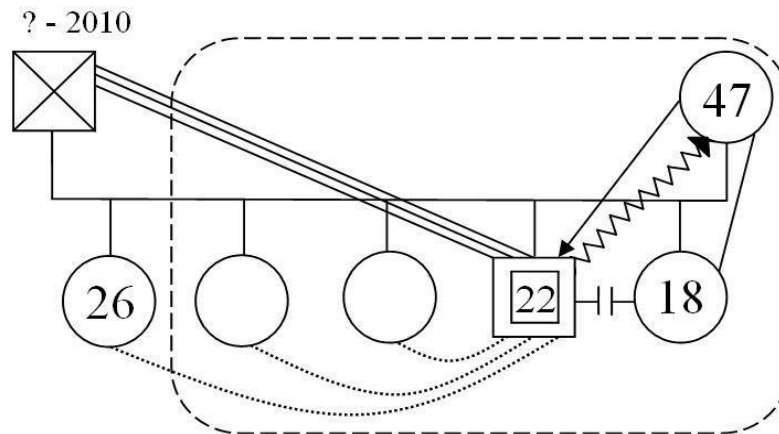
Genogram of Case No. 1: The Borgia Family

According to the data obtained from our semi-structured research interviews with Lucrèce and her family, as well as from administering the FMSS test to the parents, we observed the presence of the notion of the double bind (Bateson). We found a mother who raises her daughter with the aim of preparing her for marriage (taking care of everything necessary), yet who simultaneously discourages her from getting married because of her illness (as she believes her daughter risks being “walked over”).

We also observed what Lidz describes as a “deviant” parental couple, with a passive father who does not invest himself in the education of his children and does not accept his daughter’s illness, thereby compromising her care. We further describe an older brother idolized by his sister but who has a negative influence on her; a younger brother who is violent toward her; and, overall, a family so conflict-laden that it pushes the patient to sink deeper into her illness.

In the FMSS, both parents obtained a high level of EE, which is not a good sign regarding the evolution of Lucrèce's illness. Indeed, as noted by authors Leff J. and Vaughn C. (1985), among others, families with high levels of EE are more prone to intolerance, intrusion, and the use of inappropriate and rigid strategies for managing the patient's difficulties — which is precisely what we observe in this family.

Case No. 2: Family of the Patient "Bill Gates"

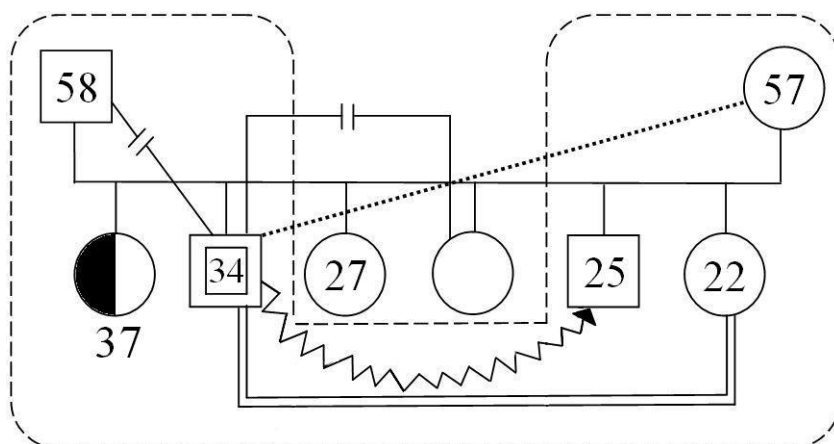


Genogram of Case No. 2: The Gates Family

Based on the results obtained from our three research tools, the Gates family appears to be disrupted, particularly due to maladaptive coping strategies that have been in place since the father's death (to whom the patient was especially close), namely the early imposition of responsibilities on the only son.

We observed the recent onset of the illness in this young patient, as well as his anosognosia. It is also noteworthy that there is an apparent emotional distance between Bill and his family. Since the beginning of his recent disorder, communication between him and the female family members (mother and sisters) has decreased to virtually nothing. The patient had previously been close to his youngest sister, but this changed as they grew older and especially since the onset of his disorder. We observed a mother focused on her son (with the continued presence of a double bind), as well as hostility from the son toward his mother. Furthermore, this household, divided between France and Algeria, sometimes experiences physical separation, as in the case when Bill was left alone for several months in Algeria. In the FMSS, the younger sister displayed an absence of criticism and emotional overinvolvement toward her brother, along with neutral feelings (such as "we get along fairly well") or even positive feelings (such as "we communicate easily and spend a lot of time together"). This allowed us to assess a low level of expressed emotion (EE) within this family. Such a low level of EE may primarily reflect the family's dissatisfaction regarding the patient.

Case No. 3: Family of the Patient “Sweeney Todd”

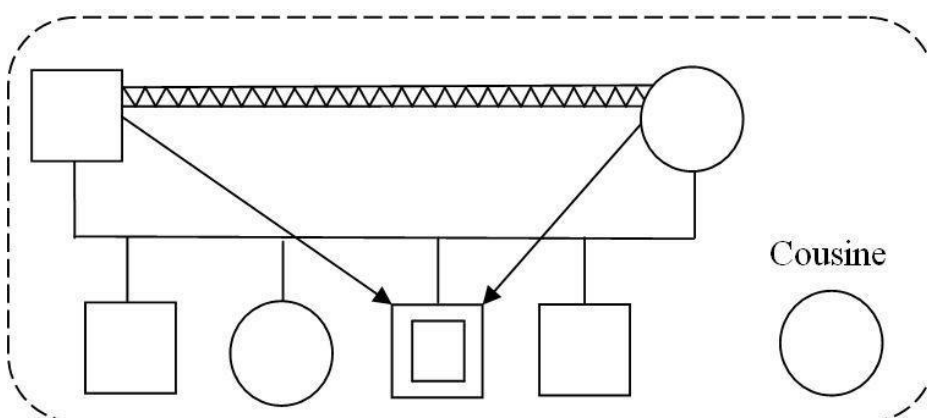


Genogram of Case No. 3: The Todd Family

Based on the results obtained from the use of each of the research tools selected, the Todd family exhibits a disturbed family dynamic characterized by an inability or refusal of the family network to respond to the patient's need for attention, as well as difficulty among family members in communicating with the patient due to the fear he inspires in them. For his part, the patient shares very little with them, particularly with his parents and younger brother, whom he argues with and even threatens. He experiences a sense of disengagement from his family.

He perceives his sisters' marriages as a form of abandonment but denies this, claiming that he is happy for them. In the FMSS, all of the patient's female relatives scored high on expressed emotion (EE), indicating excessive emotional involvement, characterized both by fear toward the patient and, on the other hand, their desire for his recovery.

Case No. 4: Family of the Patient “Charles Darwin”



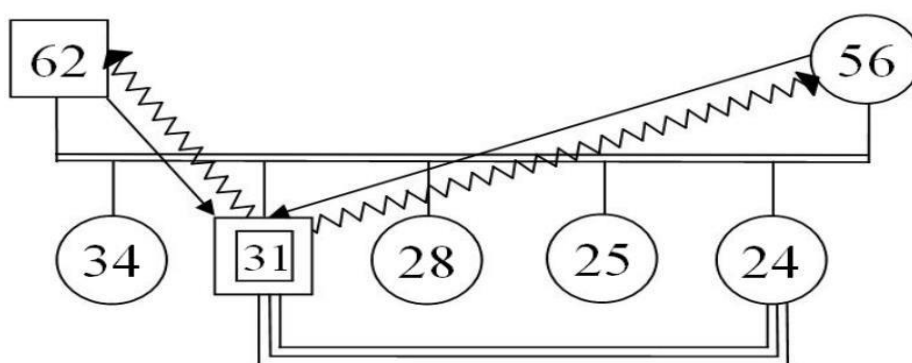
Genogram of Case No. 4: The Darwin Family

Based on all the information gathered from Charles and his parents, we learn the following: First, Charles tends to isolate himself in solitary activities (such as sports or

jogging) rather than risk engaging with others; he has no friends. Second, although his parents are present, they too often make decisions on his behalf and do not listen to him sufficiently; the mother is intrusive and constantly monitors him. We describe the parents as close to each other but in disagreement regarding how to approach and educate their son. The mother favors a strict approach, while the father prefers a gentler method.

Tensions are present in the household, with the mother being rather severe and authoritarian. There is no information about siblings, but the relationship appears distant, with “each keeping to their own corner.” In the FMSS, both parents scored low on expressed emotion (EE). Indeed, both parents conveyed a certain neutrality and a great deal of calm in their discourse.

Case No. 5: Family of the Patient “Branwell Brontë”

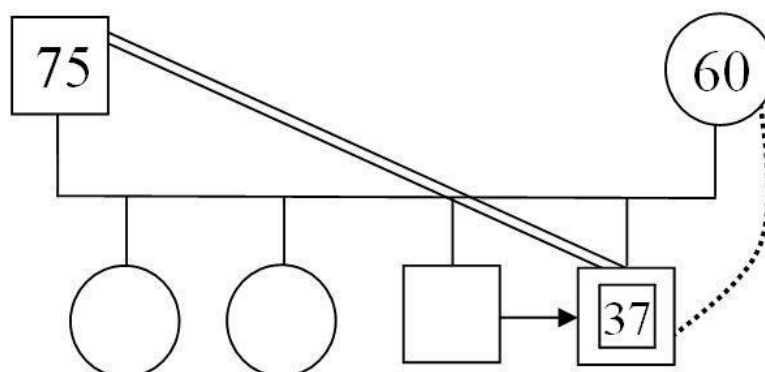


Genogram No. 5: The Brontë Family

The results of the interview with the patient reveal his hostility toward his parents. Although his relationships with the other family members are good, the conflicts with his parents are sufficient to create tension within the household. As the “only son” in the family, Branwell occupies a privileged position, receiving considerable attention from all family members. He has a close, almost enmeshed relationship with his youngest sister.

The administration of the FMSS to the patient’s sister indicates a high level of expressed emotion (EE) in this family

Case No. 6: Family of the Patient “Alfred Douglas”



Genogram of Case No. 6: The Douglas Family

Based on the data collected from semi-structured interviews conducted with the patient and then his older brother, it appears that this family lacks empathy toward Charles. It is a rigid and traditionalist family that tends to think and act on behalf of the patient (the patient has no say regarding his future or marriage). The brother also exhibits noticeable “agitation” during each hospital visit. Communication within the family is poor, and there is a fragile sense of belonging—the patient shows some reserve toward his family and finds it difficult to confide in them. As a result, the outside world is experienced as a major source of satisfaction for the patient.

This is a family that continues to act and make decisions for the patient. Furthermore, a high level of expressed emotion (EE) was observed in the FMSS administered to the close family member.

4. Discussion

All the results reported above allow us to observe that the dynamics of the families included in our research group (namely the Borgia, Gates, Todd, Darwin, Brontë, and Douglas families) appear to be dysfunctional. Notably, in addition to a complete lack of understanding of the patient’s pathology, there is poor or even absent communication, and tense or conflictual relationships between members of the six families. Consequently, our hypothesis regarding the dysfunction of family dynamics in patients with schizophrenia was confirmed.

However, we encountered a number of obstacles that, at one point or another, hindered our progress. One such obstacle was the chosen approach—systemic therapy—because, despite the documentation we consulted, mastering it proved far from straightforward. We also observed that studying a system, in this case the family, is as complicated as bringing it together. Among our six cases, we were unable to meet or interview any of the families in their entirety (that is, all household members in direct relation with the schizophrenic patient). Scheduling appointments with the patients’ relatives proved difficult; we had to speak with them only when they were willing and available, often during visits or when they came for the patient’s needs (bringing personal items, for example). The busy hospital schedule did not make matters easier, as we had to wait for a room to become available for the interviews and could not occupy it for long. Additionally, we had to ensure that patients were in a stable state and able to participate. It should be noted that patients are admitted precisely because they are not in their best condition; they are often disturbed and weakened. Many also refused to participate in our research. Beyond consent, hospital stays varied in length, sometimes ending before we could complete the work with a patient. Nevertheless, this represents a humble attempt and a first, highly enriching experience.

The individuals we met during this research, whether schizophrenic patients or their relatives, were all unaware of the existence of this pathology and its characteristics. We therefore wish to highlight the lack of psychoeducation (particularly for families). The effectiveness of psychoeducation for both patients and their families in improving therapeutic adherence and social functioning is now well established. It would therefore be highly beneficial to invest in this practice to reduce the frequency of patient relapses. Indeed, schizophrenia should not be a taboo subject. Greater awareness would benefit everyone—the

patient as well as their family. Ignorance of the disorder hinders its management and leads to disturbances first within the patient's family and, on a larger scale, within society.

In conclusion, our research may not be representative, but it aspires to authenticity. We have sought to provide as faithful a glimpse as possible into the reality of families of individuals with schizophrenia and their dynamics in Algeria. We are committed to continuing this work and additionally encourage other students and researchers to explore family dynamics in greater depth

Conclusion

The findings of this exploratory study highlight the complexity of family relational dynamics when a member is diagnosed with schizophrenia. Across all six cases examined, the family systems displayed significant dysfunctions marked by communication difficulties, emotional tensions, maladaptive coping strategies, and, in most cases, elevated levels of Expressed Emotion (EE). These factors contribute to a relational climate that may hinder the patient's recovery and increase the risk of relapse, as widely documented in the literature.

The data also reveal that despite the profound suffering endured by the individual with schizophrenia, the family itself is often equally affected. A lack of understanding of the disorder, stigma, fear, and the heavy caregiving burden can distort interactions, amplify conflicts, and reinforce rigid or chaotic relational patterns. In several families, elements such as the double bind, parental discord, emotional overinvolvement, or hostility toward the patient were clearly evident, confirming the relevance of systemic theories in understanding schizophrenia within its familial context. However, the diversity of the profiles studied shows that no single family dynamic can be generalized to all cases. Each family presents its own specificities, vulnerabilities, and resources. Some families demonstrated neutrality, cohesion, or emotional stability despite the presence of a psychotic disorder, suggesting that protective relational factors also exist and deserve further investigation.

Overall, this research underscores the importance of integrating family assessment and intervention into the therapeutic process for individuals living with schizophrenia. Strengthening communication, reducing expressed emotion, providing psychoeducation, and helping families reorganize their roles and interactions could significantly improve both family functioning and patient outcomes. Considering the scarcity of studies on this topic in Algeria, this work also highlights the necessity of developing more systematic research and tailored clinical programs addressing family needs in the context of severe mental illness.

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