Addis Ababa University
College of Education and Behavioral Studies
School of Psychology

Problems and Coping Mechanisms of Persons with Schizophrenia: Implications for Psychosocial Interventions

By
Tihtena Teklu

September, 2014
Addis Ababa

Addis Ababa University
College of Education and Behavioral Studies
School of Psychology

Problems and Coping Mechanisms of Persons with Schizophrenia: Implications for Psychosocial Interventions

By
Tihtena Teklu

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Counseling Psychology

Advisor: Kassahun Habtamu

September, 2014
Addis Ababa

Addis Ababa University
College of Education and Behavioral Studies
School of Psychology

Problems and Coping Mechanisms of Persons with Schizophrenia: Implications for Psychosocial Interventions

By
Tihtena Teklu

Approval of the Board of Examiner:

Advisor

Name____________________Signature__________________Date______________

Internal Examiner

Name_____________________Signature__________________Date_____________

External Examiner

Name_____________________Signature__________________Date_____________

Acknowledgements

First of all I would like to thank Addis Ababa University, College of Education and Behavioral Studies, School of Psychology for giving me this opportunity to work on this issue. It helped me to broaden my knowledge, and understanding and to challenge my capacity. I am pleased to thank my parents and siblings, and Ron and Grettle Hibert for their financial support. I am very grateful of my advisor, Ato Kassahun Habtamu, for his helpful comments. Special thanks goes to Amanuel specialized Mental Health Hospital education department, especially to Ato Habitom Birhane and Ato Getenet Ayanaw for their wonderful cooperation in my stay and to all the participants for their willingness and precious times. Moreover, I am pleased to say thank you to all of those who have been helping me for the success of this thesis.

Abstract

The major purpose of this study was to investigate the problems and coping mechanisms of persons with schizophrenia and find out implications for possible psychosocial interventions.

Despite intensive research for decades the causes of schizophrenia are largely unknown. Schizophrenia creates a big concern because it causes chronic disability, family disappointments, marital problems, financial disadvantages and destroys the education opportunities for those that are affected by the illness at early age. Like everyone, those living with schizophrenia typically have important goals for themselves in the areas of relationships, work, and living. The patients need to be understood and be helped so that they can be functional again. To give them help, one understand their major problems and how they are trying to cope up with the problem they are facing right now and draw possible psychosocial interventions.

The study is fully qualitative based on in -depth interviews and focus group discussions. To analyze the data interpretive phenomenological analysis was used. Persons with schizophrenia, health workers, and caregivers of persons with schizophrenia were participated on this study.

Persons with schizophrenia suffer from different problems mainly unemployment, economic crisis and dependency, discrimination and isolation, poor awareness, abuses and poor medical support and medical side effects. Among participants common copping mechanism is social withdrawal. In addition emotional regulation on females and self distraction on males are observed. The very sound medical side effect implied is fatigue. Although Amanuel Specialized Mental Health implements Bio-psycho-social intervention, bother caregivers and patients were unaware of the service.

Table of Contents

Chapter-One

Introduction

1.1 Background of the study 1

1.2Statementoftheproblem 3

1.3ResearchQuestions 4

1.4Objectives of the study 4

1.5 Significance of the study 5

1.6 Delimitation of the study 5

1.7 Limitation of the study 6

Chapter-Two

Literature Review 7

2.1 Introduction 7

2.2TypesofSchizophrenia 8

2.3 Symptoms and diagnostic criteria 10

2.4 Prevalence of schizophrenia 16

2.5 Prognosis of schizophrenia 17

2.6 Etiology of Schizophrenia 18

2.7 Problems of Persons with schizophrenia 23

2.8 Coping mechanisms 27

2.9 Treatment and support for persons with schizophrenia 28

2.10 Psychosocial interventions for persons with schizophrenia 29

Chapter Three

Research Methods and Procedures 32

3.1 Study area 32

3.2 Research Design 32

3.3 Study Participants 33

3.4 Sampling procedures 33

3.5 Methods of data collection 34

3.6 Method of data analysis 35

3.7 Ethical considerations 36

Chapter Four

Results 37

4.1 Socio-demographic characteristics 37

4.2 Hypothetical pointes 40

4.3 Introductions 41

4.3.1 Unemployment Vs economic crises Vs dependency 41

4.3.2 Discriminating & Isolation 43

4.3.3 Poor Awareness 46

4.3.4 Lack of consistent support 49

4.3.6 Medical Supports and Side Effects 52

4.3.7 Coping Mechanisms 54

Chapter Five

Discussion 56

5.1. Unemployment Vs economic crises Vs dependency 56

5.2 Discriminating & Isolation 57

5.3 Poor Awareness 57

5.4 Lack of consistent support 58

5.5 Addiction 59

5.6 Medical Supports and Side Effects 60

5.7 Coping Mechanisms 61

Chapter Six

6. Conclusion and Recommendation 63

6.1 Introduction 63

6.2 conclusion 63

6.3 Recommendations 64

References

Appendices

Topic/interview guide (English version)

Topic/interview guide (Amharic version)

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Schizophrenia is a severe mental disorder, experienced by many sufferers as a living nightmare, corollary to disturbances in thinking, emotional responsiveness, and behavior (Caldwell &Gottesman, 1992; Jefreyw and Laurie, 2008). Schizophrenia involves severe disruptions in virtually all aspects of psychological functioning. It includes psychosis or a break with reality, shows symptoms of hallucinations (e.g., hearing voices), delusions (beliefs with no basis in reality), disturbances in speech, and several other symptoms (Arthur, Stephanie. and Denise, 2008; Gordon, 1990; Paul, 2005; Frank, Jonathan, & Miles, 2005).

As noted by Heinrichs (1993), schizophrenia depletes the mind's resources, just as severe brain damage depletes these resources. But while persons suffering from brain damage experience a world that is stripped of its meaning in many respects, those suffering from schizophrenia experience a world that has become, in Heinrich's words, "excessively, terrifyingly rich." Though schizophrenia is described as a single disorder, many experts believe that it may actually involve several different and distinct disturbances (Bellak, 1994).

Onset is usually late adolescence or early adulthood, mostly in the age group 15-35 years (Arthur, Stephanie, and Denise, 2008). When the onset is in childhood or adolescence, which is far rare, there is more severe impairment of interpersonal, academic, or occupational achievement (WHO, 2013).

According to the World Health Organization (WHO, 2013), schizophrenia is affecting about 7 per one thousand people; worldwide it affects about 24 million people and 90% of the untreated cases of schizophrenia are in the developing world. Studies showed that people with

schizophrenia live shorter compared with the general population; and when compared with other mental disorders, having the diagnosis of schizophrenia carried a higher risk of mortality (Abebaw, et al, 2011). Studies have found a two to three fold increase in all causes of mortality compared with the general population (Caldwell, &Gottesman, 1992). Factors contributing to premature death in people with schizophrenia include suicide, untreated somatic conditions, and adverse effects of psychotropic medications to mention a few (Abebaw, et al, 2011).

Schizophrenia creates a big concern because it causes chronic disability, family disappointments, marital problems, financial disadvantages and destroys the education opportunities for those that are affected by the illness at early age. For example, if the patient is a parent and the only bread winner for the family, then it creates an atmosphere of disability for the whole family, it creates unemployment for the entire family. An employed patient may eventually lose his or her job because of stigma and low work performance. Moreover, the illness may cause economic burden to the family as the patient may depend very much on financial support from close family members. Besides, the education of the children is usually affected because the sick parents are emotionally detached from the family unit. If the patient is a child, also it destroys the family's hopes when the child they invest in is affected by the illness (Kokanovic, Petersen, &Klimidis, 2006; Ababi, 2008). And On the other side, the families may have more concern for the other children who are well and neglect the patient (Ababi, 2008; Jana, 2003).

The schizophrenic individual typically experiences social and occupational dysfunction (Arthur, Stephanie, and Denise, 2008). Major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset of the disorder. Social stigma is one of the challenges that families with schizophrenia confronted (Gordon, 1990; Ababi, 2008). Because of the social stigma communities may avoid the family members. Some

people use to mock the patients that could cause them to become violent or isolated in the community. Thus, this stigma impact recovery of the patient and it may prolong the duration. Understanding the major problems and coping mechanism of persons with schizophrenia gives one step ahead in giving effective support. Here in Ethiopia many people have a biased view about schizophrenia. Besides the illness, both persons with schizophrenia and their family members pass through lots of problems, burdens, social isolation, economical and psychological crisis. And most of the time the treatment mostly focuses on the patient (with pharmacological treatment): ignored the probability of the psychological distress that they are going through (Bertram, 2001).

1.2 Statement of the problem

Most of the time in Ethiopia when mental illness appears in the family, it is considered as a curse . . . a curse that affects all the futurity of the family. People don't go for treatment on time because of the labeling that the community is going to give. In addition, the family will also be on shock because of the illness severity, and prefer to stay at home and waited what will the next phenomenon is going to be. Left untreated, however, schizophrenia can have a profoundly negative effect on the lives of individuals, families, and communities (Ababi, 2008). Because the illness may cause unusual, inappropriate, and sometimes unpredictable and disorganized behavior, people who are not effectively treated are often shunned and the targets of social prejudice. Beside the medication the family tries to take to spiritual areas, traditional medicines and even to witchy crafts (Makhanya, 2012). Family keeps them (persons with schizophrenia) mostly chained, at home with a closed door (Ababi, 2008; Long, 1997).

People living with schizophrenia may also face poverty and homelessness, and are at risk for suicide. These all things by itself lower the recovery and put pain in the family (National

Alliance on mental Illness (NAMI), 2008). After facing this situation though the patient put in to care at the hospital, it is very difficult to the family to understand what the patient is really facing as a problem in life or in his/her environment because of the family understanding of schizophrenia, the patients new way of behavior and expression and the caregivers burden as they go through in this process. Like everyone, individuals living with schizophrenia typically have important goals for themselves in the areas of relationships, work, and living. The patients need to be understood and be helped so that they can be functional again (Long, 1997).

To give help to these families and persons with schizophrenia, it is a must to understand their major problems and how they are trying to cope up with the problem they are facing right now. Hence, this study was planned to investigate the problems and coping mechanisms of persons with schizophrenia and find out implications for possible psychosocial interventions.

1.3 Research Questions

- What are the major problems that persons with schizophrenia are facing as they live with the illness?
- How do persons with schizophrenia cope up the problems they encounter in their daily life?
- What are the psychosocial intervention people with schizophrenia are having?

1.4 Objectives of the study

1.4.1 General Objective

This study is designed to explore the problems and coping mechanisms of persons with schizophrenia and to find out implications for possible psychosocial interventions.

1.4.2 Specific Objectives of the study

- To explore the major problems that persons with schizophrenia are facing as they live with the illness.
- To assess the coping mechanisms of persons with schizophrenia from problems that they encounter in their daily life
- To figure out the possible implications of the study for psychosocial interventions.

1.5 Delimitation of the study

This study is delimited to investigating major problems and coping mechanisms of persons with schizophrenia,, in Addis Abeba, Amanuel Mental Specialized Hospital. The study tried to investigate problems that persons with schizophrenia are facing and how they are trying to cope up with this daily. In addition, it tried to look in to the possible psychosocial interventions that persons with schizophrenia are getting to improve their life and cope up with the situation.

1.6 significance of the study

This study would be important to

- Give practical insight on the major problems and coping mechanisms of persons with schizophrenia.
- Pave way for further investigation on persons with schizophrenia on their problems and coping mechanism.
- Give the concerned body (professional who worked on schizophrenia, health workers, hospitals and nongovernmental organizations who works on mental illness) to use it as a standing point for understanding and providing prevention and interventions works.

- It gives convenient implication and used as an input in developing psychosocial intervention or improves the current one.

1.7 Limitation of the study

The limitation I have faced was that the patients were discharged sooner. Because of this it was difficult to get stable clients for the in-depth interview. Besides getting the patients, conducting focus group discussion was difficult since most of them were not present at the hospital compound. Since participants in this study are fewer in number the conclusions and recommendations may not be used as generalized points.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The word "schizophrenia" is less than 100 years old. The disease was first identified as a discrete mental illness by Dr Emile Kraepelin in 1887 and the illness itself is generally believed to have accompanied mankind through its history. Written documents that identify Schizophrenia can be traced to the old Pharaonic Egypt, as far back as the second millennium before Christ. Depression, dementia, as well as thought disturbances that are typical in schizophrenia are described in detail in the Book of Hearts. The Heart and the mind seem to have been synonymous in ancient Egypt (Neel, 2012). According to Theocharis (2005), the physical illnesses were regarded as symptoms of the heart and the uterus and originating from the blood vessels or from purulence, fecal matter, a poison or demons. A recent study into the ancient Greek and Roman literature showed that although the general population probably had an awareness of psychotic disorders, there was no condition that would meet the modern diagnostic criteria for schizophrenia in these societies. At one point, all people who were considered "abnormal," whether due to mental illness, mental retardation, or physical deformities, were largely treated the same (Bernheim and Lewine, 1979).

Early theories supposed that mental disorders were caused by evil possession of the body, and the appropriate treatment was then exorcising these demons, through various means, ranging from innocuous treatments, such as exposing the patient to certain types of music, to dangerous and sometimes deadly means, such as releasing the evil spirits by drilling holes in the patient's skull (Rosenhan, 1973).

One of the first to classify mental disorders into different categories was the German physician, Emile Kraepelin, and he used the term "dementia praecox" for individuals who had symptoms that we now associate with schizophrenia (Hoff, 1994). The nonspecific concept of madness has been around for many thousands of years and schizophrenia was only classified as a distinct mental disorder by Kraepelin in 1887. He was the first to make a distinction in the psychotic disorders between what he called dementia praecox and manic depression. Kraepelin believed that dementia praecox was primarily a disease of the brain, and particularly a form of dementia (Robbins, 1993). And he named the disorder 'dementia praecox' (early dementia) to distinguish it from other forms of dementia (such as Alzheimer's disease) which typically occur late in life (Kraepelin, 1899; Ödegard, 1967). He used this term because his studies focused on young adults with dementia.

In 1911 the term ‘schizophrenia’ was coined by the Swiss psychiatrist Paul EugenBleuler, and is derived from the Greek words ‘schizo’ (split) and ‘phren’ (mind) (Neel, 2012). However, contrary to common belief, schizophrenia does not refer to a person with a split personality or multiple personality. Bleuler had intended the term to refer to the dissociation or ‘loosening’ of thoughts and feelings that he had found to be a prominent feature of the illness (Theocharis, 2005; Long, 1997). Schizophrenia is mental disorder for which no clear cause is known, affects the way a person acts, thinks, and sees the world (Long, 1997; Jeanne, & Melinda, 2013). People with schizophrenia have an altered perception of reality, often a significant *loss* of contact with reality.

2.2 Types of Schizophrenia

The kind of symptoms that indicate a person has schizophrenia differ between affected people and may change from one year to the next within the same person as the disease progresses.

Different subtypes of schizophrenia are defined according to the most significant and predominant characteristics present in each person at each point in time (Michael, 2013). In general, schizophrenia is classified in to four groups; Paranoid, Catatonic, Disorganized, and none specified (Jeanne, & Melinda, 2013). *Paranoid* schizophrenia is the most common subtype of all (Michael, 2013). Its main future is the presence of auditory hallucinations or prominent delusional thoughts about persecution or conspiracy by a person or an organization. It could also be feeling harassed or treated unfairly. People with paranoid-type schizophrenia can exhibit anger, aloofness, anxiety, and can be argumentative (Christina, 2001). People with this subtype have a better functionality relatively. Though the reason is not clear most of them do not exhibit symptoms until later in life and have achieved a higher level of functioning before the onset of their illness. People with the paranoid subtype may appear to lead fairly normal lives by successful management of their disorder (Michael, 2013).

Catatonic-schizophrenia includes extremes of behavior, including Catatonic excitement and Catatonic stupor. In catatonic stupor, a dramatic reduction in activity in which the patient cannot speak, move or respond. Virtually all movement stops, and may be extremely resistant to any change in his or her position, even to the point of holding an awkward, uncomfortable position for hours (Michael, 2013). On occasion an individual with catatonic schizophrenia may deliberately assume bizarre body positions, or manifest unusual limb movements or facial contortions. Sometimes, people with catatonic schizophrenia pass suddenly from a state of stupor to a state of extreme excitement. During this frenzied episode, they may shout, talk rapidly, pace back and forth, or act out in violence—either toward themselves or others and also exhibits overexcitement or hyperactivity, in which the patient may mimic sounds (echolalia) or movements (echopraxia) around them (Christina, 2001).

Disorganized schizophrenia generally appears at an earlier age than other types of schizophrenia. As Michael (2013) describes, its onset is gradual, rather than abrupt, with the person gradually retreating into his or her fantasies. The distinguishing characteristics of this subtype are disorganized speech, disorganized behavior, and blunted or inappropriate emotions. People with disorganized schizophrenia also have trouble taking care of themselves, and may be unable to perform simple tasks such as bathing, dressing, or feeding themselves. People with disorganized schizophrenia subtype sometimes suffer from hallucinations and delusions, but unlike the paranoid subtype, their fantasies are not consistent or organized (Jeanne & Melinda, 2013).

None-specified schizophrenia is characterized by some symptoms seen in all of the above types, but not enough of any one of them to define it as another particular type of schizophrenia. The symptoms of any one person can fluctuate at different points in time, resulting in uncertainty as to the correct subtype classification. Other people will exhibit symptoms that are remarkably stable over time but still may not fit one of the typical subtype pictures (Michael, 2013; Christina, 2010; Jeanne & Melinda, 2013).

2.3 Symptoms and diagnostic criteria

People diagnosed with schizophrenia do not always have the same set of symptoms; a given patient’s symptoms may change over time. Since the nineteenth century, doctors have recognized different subtypes of the disorder, but no single classification system has gained universal acceptance. Some psychiatrists prefer to speak of schizophrenia as a group or family of disorders (‘‘the schizophrenias’’) rather than as a single entity. The symptoms of schizophrenia can appear at any time after age six or seven, although onset during adolescence and early adult life is the most common pattern (Andreasen, 1984). There are a few case studies in the medical literature of schizophrenia in children younger than five, but they are extremely rare (Christina, 2001).

The onset of symptoms in schizophrenia may be either abrupt (sudden) or insidious (gradual). Often, however, it goes undetected for two to three years after the onset of diagnosable symptoms, because the symptoms occur in the context of a previous history of cognitive and behavioral problems. And patient may have had panic attacks, social phobia, or substance abuse problems, any of which can complicate the process of diagnosis (Long, 1997;NAMI, 2000).

In most cases, however, the patient's first psychotic episode is preceded by a prodromal (warning) phase, with a variety of behaviors that may include angry outbursts, withdrawal from social activities, loss of attention to personal hygiene and grooming, anhedonia (loss of one's capacity for enjoyment), and other unusual behaviors (NAMI, 2000).

Schizophrenia is characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self. The array of symptoms, while wide ranging, frequently includes psychotic manifestations, such as hearing internal voices or experiencing other sensations not connected to an obvious source (hallucinations) and assigning unusual significance or meaning to normal events or holding fixed false personal beliefs (delusions) (Jeanne & Melinda, 2013). No single symptom is definitive for diagnosis; rather, the diagnosis encompasses a pattern of signs and symptoms, in conjunction with impaired occupational or social functioning (William, 2007).

In schizophrenia we observe "Negative symptoms" and "Positive symptoms". Negative symptoms refer to the absence of normal behaviors found in healthy individuals. Common negative symptoms of schizophrenia include:

Lack of emotional expression:– Inexpressive face, including a flat voice, lack of eye contact, and blank or restricted facial expressions.

Lack of interest or enthusiasm:– Problems with motivation; lack of self-care.

Seeming lack of interest in the world: – Apparent unawareness of the environment; social withdrawal (Jeanne and Melinda, 2013).

Speech difficulties and abnormalities – Inability to carry a conversation; short and sometimes disconnected replies to questions; speaking in monotone. **Positive symptoms** are characterized by an exaggeration of functioning, which includes reflect an excess or distortion of normal functions, such as delusions, hallucinations, disorganized speech, and extremely disorganized or catatonic behavior (Brian, 2010).

Virtually we could set the schizophrenia symptoms characteristic in to five basics: delusions, hallucinations, disorganized speech, disorganized behavior, and the so-called "negative" symptoms (Jeanne and Melinda, 2013). However, the signs and symptoms of schizophrenia vary dramatically from person to person, both in pattern and severity. Not every person with schizophrenia will have all symptoms.

Delusion is a firmly-held idea that a person has despite clear and obvious evidence that it isn't true. Delusions are extremely common in schizophrenia, occurring in more than 90% of those who have the disorder. Often, these delusions involve illogical or bizarre ideas or fantasies (Michael, 2013). Further, See the table below:

	Common schizophrenic delusions
Delusions of persecution	Belief that others, often a vague "they," are out to get him or her. These persecutory delusions often involve bizarre ideas and plots (e.g. "Martians are trying to poison me with radioactive particles delivered through my tap water").

Delusions of reference –	A neutral environmental event is believed to have a special and personal meaning. For example, a person with schizophrenia might believe a billboard or a person on TV is sending a message meant specifically for them.
Delusions of grandeur –	Belief that one is a famous or important figure, such as Jesus Christ or Napolean. Alternately, delusions of grandeur may involve the belief that one has unusual powers that no one else has (e.g. the ability to fly).
Delusions of control –	Belief that one's thoughts or actions are being controlled by outside, alien forces. Common delusions of control include thought broadcasting ("My private thoughts are being transmitted to others"), thought insertion ("Someone is planting thoughts in my head"), and thought withdrawal ("The CIA is robbing me of my thoughts").

Hallucinations are sounds or other sensations experienced as real when they exist only in the person's mind. While hallucinations can involve any of the five senses, auditory hallucinations (e.g. hearing voices or some other sound) are most common in schizophrenia. Visual hallucinations are also relatively common. Research suggests that auditory hallucinations occur when people misinterpret their own inner self-talk as coming from an outside source. Schizophrenic hallucinations are usually meaningful to the person experiencing them. The voices are those of someone they know. Most commonly, the voices are critical, vulgar, or abusive. Hallucinations also tend to be worse when the person is alone (Jeanne and Melinda, 2013).

Autobiographical accounts by people who have recovered from schizophrenia indicate that these hallucinations are frightening and confusing (WHO, 1992). Patients often find it difficult to

concentrate on work, studies, or formerly pleasurable activities because of the constant ‘‘static’’ or ‘‘buzz’’ of hallucinated voices.

Fragmented thinking is characteristic of schizophrenia, which results disorganized speech. Externally, it can be observed in the way a person speaks. People with schizophrenia tend to have trouble concentrating and maintaining a train of thought. They may respond to queries with an unrelated answer, start sentences with one topic and end somewhere completely different, speak incoherently, or say illogical things (Jeanne and Melinda, 2013). Schizophrenia disrupts goal directed activity, causing impairments in a person’s ability to take care of him or herself, work, and interact with others results disorganized behavior. One can laugh at a funeral, or have emotional indifference or maybe the person shows infantile behaviors like baby talk, giggling and accompany with peculiar facial expressions and mannerisms.

	Signs of disorganized speech in schizophrenia
Loose associations	Rapidly shifting from topic to topic, with no connection between one thought and the next.
Neologisms	Made-up words or phrases that only have meaning to the patient.
Perseveration	Repetition of words and statements; saying the same thing over and over.
Clang	Meaningless use of rhyming words (“I said the bread and read the shed and fed Ned at the head").

-

According to Jeanne and Melinda (2013) when we come to the diagnostic criteria for schizophrenia we better relay on the standardized one. There are two medical reference book;

Diagnostic and Statistical Manual of Mental Disorders (DSM), medical reference book published by the American Psychiatric Association (APA) that describes and classifies all known mental illnesses and emotional disorders and the International Classification of Diseases (ICD), published by the World Health Organization. The DSM and ICD are both categorical systems of classification, in which each mental illness is defined by its own unique set of symptoms and characteristics. Both provide an objective, standardized way to determine if a person has a mental illness. There are no blood tests or other laboratory procedures to diagnose most mental illnesses. Instead, mental health professionals must use their own judgment to determine if a person is mentally ill (Christina, 2001).

Common Disorganized Behavior signs (Christina, 2001)
A decline in overall daily functioning
Unpredictable or inappropriate emotional responses
Behaviors that appear bizarre and have no purpose
Lack of inhibition and impulse control

Diagnosis requires careful observation of the person's symptoms and behaviors and evaluation of the person's personal and medical history. These medical references help to assure an accurate diagnosis by providing a common reference for therapists and researchers to use in communicating about mental illness. But in addition the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) acknowledges that its present classification of subtypes is not

fully satisfactory for either clinical or research purposes; and states that ‘‘alternative sub-typing schemes are being actively investigated” (Jefreyw and Laurie, 2008).

Both medical references set duration of minimum a month for the schizophrenia disorder to occur, and symptoms like delusion, hallucination, disorganized speech and behavior, catatonic behavior, social dysfunctional and others too (Angela, 1998).

2.4 Prevalence of schizophrenia

According to WHO (2013), schizophrenia is a severe form of mental illness affecting about 7 per thousand people, mostly in the age group 15-35 years. The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) (American Psychiatric Association, 1994), reported that the prevalence of schizophrenia is ‘‘usually estimated to be between 0.5% and 1%.’’ This overestimate is often repeated in textbooks (Murray, 1997). More over as of David, Joy, John, and Sukanta, (2005) study the prevalence of schizophrenia ranges from four to seven per 1,000 persons, depending on the type of prevalence estimate used. Countries from the developing world have a lower prevalence of schizophrenia.

On the basis of combined prevalence estimates, there was no significant difference 1) between males and females; 2) between urban, rural, and mixed sites; or 3) across epochs: and the prevalence of schizophrenia is higher in migrants than native-born individuals (David, Joy, John, and Sukanta, 2005). .

The distribution of prevalence estimates differed significantly when sorted by economic status, with developed countries having higher estimates than less-developed economies (David, Joy, John, and Sukanta, 2005). Finally, the distribution of prevalence estimates differed significantly when sorted by latitude. Estimates from higher latitudes were associated with higher estimates compared with middle and low latitudes, On the basis of absolute latitude, the latitudes divided

into three equal bands, namely, “low” (equator to 30°), “medium” (30°–60°), and “high” (above 60°). .

Schizophrenia affects about 24 million people worldwide and 90% of the untreated cases of schizophrenia are in the developing world, is a major concern as the onset of the illness occurs early (15-35 years of age) (WHO, 2013). Regardless of the exact magnitude and precision of prevalence estimates, the numbers speak to a deeper, human dimension. Many people with schizophrenia have persisting symptoms; despite the best mix of interventions we can offer (David, Joy, John, and Sukanta, 2005).

2.5 Prognosis of schizophrenia

Early intervention and early use of new medications lead to better medical outcomes for the individual. The earlier someone with schizophrenia is diagnosed and stabilized on treatment, the better the long-term prognosis for their illness. Wide variation occurs in the course of schizophrenia. Some people have psychotic episodes of illness lasting weeks or months with full remission of their symptoms between each episode; others have a fluctuating course in which symptoms are continuous but rise and fall in intensity; others have relatively little variation in the symptoms of their illness over time; at one end of the spectrum, the person has a single psychotic episode of schizophrenia followed by complete recovery; at the other end of the spectrum is a course in which the illness never abates and debilitating effects increase (Long, 1997). Numerous international studies have demonstrated favorable long-term outcomes for around half of those diagnosed with schizophrenia, with substantial variation between individuals and regions (Harrison, Hopperk, Craig, et al., 2001). One retrospective study found that about a third of people made a full recovery, about a third showed improvement but not a full recovery, and a third remained ill (Harding, et al., 1987)

A clinical study using strict recovery criteria (concurrent remission of positive and negative symptoms and adequate social and vocational functioning continuously for two years) found a recovery rate of 14% within the first five years (Robinson, et al., 2004). A 5-year community study found that 62% showed overall improvement on a composite measure of symptomatic, clinical and functional outcomes (Harry, et al. 2007). Rates are not always comparable across studies because an exact definition of what constitutes recovery has not been widely accepted, although standardized criteria have been suggested (Burns, 2009). Research by Castle, Sham, and Murray (1998) showed that that 25% of peoples with schizophrenia after 10 years of treatment completely recovered and 35% of peoples with schizophrenia after 30 years of get much improved, relatively independent.

Several factors are associated with a better prognosis: female gender, acute vs. insidious onset of symptoms, older age of first episode, predominantly positive (rather than negative) symptoms, presence of mood symptoms and good pre-morbid functioning (Davidson, &McGlashan, 1997; Lieberman, et al. 1996). Evidence is also consistent that negative attitudes towards individuals with schizophrenia can have a significant adverse impact, especially within the individual's family (Bebbigton, & Kuipers, 1994). Family members' critical comments, hostility, authoritarian and intrusive or controlling attitudes (termed high 'expressed emotion' or 'EE' by researchers) have been found to correlate with a higher risk of relapse in schizophrenia across cultures.

2.6 Etiology of Schizophrenia

Scientists still don’t know exactly what causes schizophrenia, but they do know that the brains of people living with schizophrenia are different, as a group, from the brains of those who don’t live with the illness (NAMI, 2008). Research suggests that schizophrenia has something to do with

problems with brain chemistry and brain structure (NAMI, 2000). The etiology of schizophrenia is multi-factorial, including genetics, structural brain abnormalities and neurotransmitter imbalance (American Psychiatry Association, 2000). There is now evidence linking measures of the social environment (captured by notions such as social capital, social fragmentation, and ethnic density); social experiences over the life course (exposure to childhood adversity such as severe privation or abuse); adult social disadvantage; racial discrimination, and alcohol or substance use/abuse with the onset of psychotic disorders (Croudace. et al, 2011).

2.6.1 Environmental factors

Environmental components are either shared by individuals in the same household, (whether related or not) or unshared. Components of the environment include psychosocial, biological and physical factors experienced by the individual from the moment of conception, through development, birth and maturation. Monozygotic twins may experience different prenatal and postnatal factors such as adequacy of blood supply, position in the womb and birth complications (Cannon et al, 1998). Later, they may experience different home and school environments, as well as different marital experiences, occupational events or surroundings (Reiss et al, 1991; Pike &Plomin, 1996). Such differences in environment are likely to be meaningful, as non-shared environmental influences accounted for almost all of the variance in liability to schizophrenia attributable to environmental effects in several twin studies (Kendler et al, 1994; Kety et al, 1994; Cannon et al, 1998).

The importance of environmental factors is made more apparent by the nature of their interactions with genetic determinants. Genes and environmental factors were formerly thought to be mainly additive, with the outcome reflecting the sum of their influence; in fact, they are interactive as well (Kendler, 1995). To date, there are at least two features of the environment

that are candidate risk factors for schizophrenia: psychosocial factors and delivery/birth complications. And the biological are genetic and hormonal problems (Ming, Stephen, and William, 2013).

Several adoption studies provide evidence of genetic-environmental interactions. Kinney et al (1997), using the Danish sample, found elevations of the Thought Disorder Index (TDI) (Johnston HYPERLINK "#ref-27"&HYPERLINK "#ref-27" Holzman, 1979) in biological relatives of patients with schizophrenia, compared with normal controls.

In contrast, elevations of the Thought Disorder Index were not evident in the adoptive relatives of either subjects suffering from schizophrenia or control subjects in findings from the Finnish adoption studies (Tienari, 1991; Tienari et al, 1994; Wahlbergl et al, 1997). Wahlberg et al, (1997) showed that young adult offspring of mothers with schizophrenia were more likely to show symptoms of thought disorder when they were raised by adoptive mothers who themselves showed elevated levels of ‘communication deviance’. In contrast, adoptees that were raised by adoptive parents with low communication deviance were less likely to show thought disorder. This pattern was not evident in control adoptees, which showed no discernible relationship between thought disorder in the adoptees and communication deviance in the adoptive parents. In other words, these findings did not detect the presence of a ‘schizophrenogenic environment’ for individuals who did not demonstrate a preexisting genetic liability. These examples support the view that genetic factors alone do not explain the development of schizophrenia, and that interactions with the environment provide important mediating variables (Ming, Stephen, and William, 2013). In the general essence, environmental events (expressed emotion, life events and biological factors) combined with schizotoxic cause schizophrenia.

As for the environmental factors involved, more and more research is pointing to stress, either during pregnancy or at a later stage of development. High levels of stress are believed to trigger schizophrenia by increasing the body's production of the hormone cortisol. Beside the above points research showed to several stress-inducing environmental factors that may be involved in schizophrenia, including prenatal exposure to a viral infection, low oxygen levels during birth (from prolonged labor or premature birth), exposure to a virus during infancy (Jeanne and Melinda, 2013).

2.6.2Biological factors

2.6.2.1 Genetic factors

The degree of risk of schizophrenia in members of families with one or more patients with schizophrenia correlates with the degree of biological relatedness between the relative and the patient: the closer the relationship, the higher the level of risk. Yet even if an individual has an identical twin with schizophrenia, or two affected parents, the risk is nowhere near 100% (Murray, 1997). In the case of identical twins with one affected member, the genetic predisposition is present in both individuals, but is expressed only in the twin who has undergone certain environmental experiences as well (Jana, 2003). Gottesman & Bertelsen (1989) showed that the offspring of identical twins who were discordant for schizophrenia showed similar (elevated) rates of developing the disorder, regardless of whether their parent was the affected or the unaffected twin. Individuals with a first-degree relative (parent or sibling) who has schizophrenia have a 10 percent chance of developing the disorder, as opposed to the 1 percent chance of the general population.

But schizophrenia is only influenced by genetics, not determined by it. While schizophrenia runs in families, about 60% of schizophrenics have no family members with the disorder.

Furthermore, individuals who are genetically predisposed to schizophrenia don't always develop the disease. Consideration of genetic-environmental influences may also help us to understand the nature of at least some environmental risk factors. Just as geneticists search the entire genome for all of the many genes that affect susceptibility to schizophrenia, so must environmental researchers search the entire 'environment' for all environmental risk factors that affect the disorder (Brian, 2006). When we understand the sum and interaction of all effects from the genome and from the environment, we will have solved the puzzle of schizophrenia (Irving, Sherrell, and Steven, 2008). The examination of developmental abnormalities such as pregnancy and delivery complications, especially in conjunction with genetic risk factors, has provided useful information on precursor states for schizophrenia (Buka et al, 1999). For example, patients with schizophrenia have experienced a greater number of labor and delivery complications at birth than have normal controls (Lewis HYPERLINK "#ref-38"&HYPERLINK "#ref-38" Murray, 1987; Geddes HYPERLINK "#ref-21"&HYPERLINK "#ref-21" Lawrie, 1995; Jablensky, 1995;Tsuang, Faraone, HYPERLINK "#ref-66"&HYPERLINK "#ref-66" Lyons 1993). Among these complications is pre-eclampsia, which results in foetal hypoxia, and leads to a nine-fold increase in the risk for subsequent schizophrenia (Kendell et al, 1996).

Basic knowledge about brain chemistry and its link to schizophrenia is expanding rapidly. Neurotransmitters, substances that allow communication between nerve cells, have long been thought to be involved in the development of schizophrenia. It is likely, although not yet certain, that the disorder is associated with some imbalance of the complex, interrelated chemical systems of the brain, perhaps involving the neurotransmitters dopamine and glutamate. In addition to abnormal brain chemistry, abnormalities in brain structure may also play a role in schizophrenia. Enlarged brain ventricles are seen in some schizophrenics, indicating a deficit in

the volume of brain tissue. There is also evidence of abnormally low activity in the frontal lobe, the area of the brain responsible for planning, reasoning, and decision-making. Some studies also suggest that abnormalities in the temporal lobes, hippocampus, and amygdala are connected to schizophrenia's positive symptoms (Christine et al, 2001). But despite the evidence of brain abnormalities, it is highly unlikely that schizophrenia is the result of any one problem in any one region of the brain (Jeanne & Melinda, 2013).

2.6.3 Triggers of schizophrenia

The main psychological triggers of schizophrenia are stressful life events, such as bereavement, losing your job or home, a divorce or the end of a relationship, or physical, sexual, emotional or racial abuse. These kinds of experiences can trigger someone already vulnerable to it. Beside this, drug misuse increases the risk of developing schizophrenia or a similar illness. Particularly cannabis, cocaine amphetamines, may trigger some symptoms of schizophrenia, especially in people who are susceptible. Using amphetamines or cocaine can lead to psychosis and can cause a relapse in people recovering from an earlier episode. Three major studies have shown teenagers under 15 who use cannabis regularly, especially 'skunk' and other more potent forms of the drug, are up to four times more likely to develop schizophrenia by the age of 26 (Jeanne & Melinda, 2013).

2.7 Problems of Persons with schizophrenia

Schizophrenia may develop so gradually that the family and even the person with the disease may not realize that anything is wrong for a long period of time (NAMI, 2000). Families of patients with schizophrenia face many challenges including the practical, day-to-day problems and issues related to having a family member with a mental illness, such as loss of income and disruption of household routines. Beside this, the illness, the word "mad", which mostly is used

in the community, has an influence both on the family and the patient including on the progress of the patient (Ababi, 2008).

The effect of schizophrenia is wide; it touches all the aspects of life and goes up to country level. Beside the personal life it goes way beyond and challenges the probability of staying alive. Schizophrenia is often called a 'life shortening disease' (Allebeck, 1989). Mortality is increasingly recognized as a crucial outcome measure for quality of care patients with schizophrenia receive. Several studies reported that people with schizophrenia live shorter lives compared with the general population (Gupta, and Guest, 2002).

One of the reasons for live shortening event is suicide. People with schizophrenia have a high risk of attempting suicide. Any suicidal talk, threats, or gestures should be taken very seriously. People with schizophrenia are especially likely to commit suicide during psychotic episodes, during periods of depression, and in the first six months after they've started treatment. Beside People with schizophrenia frequently develop problems with alcohol or drugs, which are often used in an attempt to self-medicate, or relieve symptoms (Angela, 1998; Jeanne & Melinda, 2013). In addition, they may also be heavy smokers, a complicating situation as cigarette smoke can interfere with the effectiveness of medications prescribed for the disorder (Jeanne & Melinda, 2013).

Since schizophrenia affects thought and emotion the person is unable to follow the life routine like working, education, and govern personal life too. Schizophrenia causes significant disruptions to daily functioning, both because of social difficulties and because everyday tasks become hard, if not impossible to do. A schizophrenic person's delusions, hallucinations, and disorganized thoughts typically prevent him or her from doing normal things like bathing, eating,

or running errands. Relationships suffer because people with schizophrenia often withdraw and isolate themselves (Abebaw. et al, 2011; Jeanne & Melinda, 2013).

It is clear that people with schizophrenia and their family face psychological, social, economical and even spiritual problems. This things in return put them in lot of burden that the family could face even other forms of psychological problem (Long, 1997). Intangible costs entail pain and suffering as well as changes in quality of life (Ababi, 2008). According to Ababi (2008) although central to complete understanding of the impact of illness, intangible costs are not ordinarily considered in assessing the economic burden of illness because they have not been successfully quantified in a monetary sense. Such costs cannot be expressed in monetary terms, but are nevertheless significant. They include effects on the patient (e.g., despair and the side effects associated with medication) and on the caregiver (e.g., isolation, uncertainty, stress). Collectively, these may be treated as intangible costs or as important facets of patient or career quality of life, the effects of which are to cause social withdrawal and to push up the direct costs of treatment (Abebaw, et al, 2011).

The stigma associated with schizophrenia is a barrier to those trying to rehabilitate themselves (Long, 1997). It is also a very real problem for their families. Therefore, those involved with schizophrenia are concerned about the dozens of misconceptions about the illness. Schizophrenia is a disease that is not well understood and is greatly feared (Maluo, 2012).They believe that people with schizophrenia are violent and dangerous. A limited number, of course, but media publicity about particularly frightening and bizarre crimes of violence committed by people with mental disorders has left the public with the impression that most persons with schizophrenia are violent (Ababi, 2008). However, wide differences in the effect that schizophrenia has on different people and the difficulty in understanding the actions of someone in a deeply psychotic

state, whose thinking is thoroughly confused, reinforce the public's concern. Some believe that people with schizophrenia have weak personalities and have "chosen" their madness. Many believe that schizophrenia is the result of bad parenting and childhood trauma. One parent stated that he was often accused of abandoning his daughter when he took her to the hospital. Another parent said that clerks in stores ignored her son when he asked for help or tried to make a purchase. Some religious groups hold the view that the illness is one of God's punishments (Long, 1997).

Poverty is one of the difficulties to the family which hinders not to keep them stand stood. Poverty creates the conditions for malnutrition, illness, social strife, political instability, and despair; studies indicate that poverty is one of the prime indicators of mental illness (Brand, 2001). With this regard one can envisage the severity of mental health problems for Ethiopia with its large proportion of population living in poverty (Ababi, 2008). Especially the stigma and the social isolation are strong on the family's who are under poverty more. This stigma affects the family day to day life and life understanding schema. Internalized stigma is found to be a major problem among persons with schizophrenia in Ethiopia (Assefa, Shibre, Aster, Fekadu, 2012). Internalized stigma has the potential to substantially affect adherence to medication and is likely to affect the recovery process.

Relapse can occur for a number of reasons, as well as for no apparent reason (Jefreyw,.& Laurie, 2008). Sometimes the ill person has stopped taking medication for a long enough period of time for acute symptoms to reappear. Sometimes the individual is simply physically exhausted, or is using alcohol or street drugs in an effort to feel "better" briefly. Sometimes the cause may be something that can be dealt with quite easily. Health care professionals warn that relapse can occur during a period called "self-cure." Usually, such an attempt occurs three to five years after

a diagnosis of schizophrenia has been made. It is a time when the ill individual, tired of the disease, decides to take matters into his or her own hands. He or she may-stop taking prescribed medication, may join a cult, may try to "exorcise" the illness out of the body, may do strenuous exercise to get rid of it, and may consume vast quantities of vitamins or herbal medicines, and so on (Hoff, 1994).

Poverty increases the complication of the problem (Maluo, 2012). People with schizophrenia need lots of attention and follow ups, but sometimes having the all time medication become difficult. Poor hygiene, poor nutrition and neglect will complicate more the problem.

2.8 Coping Mechanisms

Coping mechanisms represent a crucial component of our capacity to maintain emotional homeostasis. Without them the conscious mind would be much more vulnerable to negatively charged emotional input, such as that pertaining to anxiety and sadness (Brand, 2001). Within this we can see three levels: Matured, intermediate, and immature coping/defense mechanisms.

Mature defenses, including humor, sublimation, anticipation, and altruism, and suppression, represent well-orchestrated composites of less mature defenses (Kaplan, Saddock, & Grebb, 1994; Vaillant, 1974). These mature defenses involve relatively minor cognitive distortions, largely consisting of an attenuation of unwelcome experience (Steiner et al., 2001).

Intermediate/neurotic defenses, such as intellectualization, rationalization, repression, isolation, reaction formation, and displacement are expressed by everyone, particularly during difficult periods of life (Freud, 1949; Kaplan et al., 1994; Vaillant 1974; Weinberger, 1990). These intermediate/ neurotic defenses involve a greater degree of cognitive distortion than the mature ones and frequently represent an attempt to cope with significant internally or externally generated stress.

Immature defenses involve the most extreme cognitive distortions and can actually impair reality testing at times. They are most commonly encountered when there is severe stress and in personality disorders, such as projection with Paranoid Personality Disorder (Alexander, 1948; Vaillant, 1994). Research showed Psychopathological state and defense mechanisms of the examined patients underwent positive changes during therapy. Correlations were found between the predominance of positive or negative symptoms used rationalization more frequently in the initial phase of the investigation, and dissociation in the final phase, while those with predominantly negative symptoms, more often used passive aggression and devaluation in the respective stages (Lukasz, 2008).

2.9 Treatment and support for persons with schizophrenia

Treatment for schizophrenia involves both medication and supportive counseling (Long, 1997). Medications are the cornerstone of symptom management but are not themselves sufficient to promote recovery. Rehabilitation strategies involving work, school, and relationship goals are also essential and need to be addressed in creating a plan of care (National Alliance on Mental Illness (NIMA), 2008).

Schizophrenia can usually be successfully managed. A cure for schizophrenia has not yet been found, but most people’s symptoms can be improved with medication. The primary medications for schizophrenia, called antipsychotics or neuroleptics, help relieve the hallucinations, delusions, and, to a lesser extent, the thinking problems people have with the illness (NIMA, 2008; Angela, 1998). These drugs are thought to work by correcting an imbalance in the chemicals that help brain cells communicate with each other (NIMA, 2008).

Supportive therapy "may provide a patient with friendship, encouragement, practical advice such as access to community resources or how to develop a more active social life, vocational

counseling, suggestions for minimizing friction with family members, and, above all, hope that the person's life may be improved (Angela, 1998). Discussions focus on the here-and-now, not the past, and on problems of living encountered by the patient as he or she tries to meet the exigencies of life, despite a handicapping brain disease (Torrey, 1988).

Over the years, a considerable amount of controversy has surrounded ECT (electro compulsive therapy). Since its introduction in 1938, this form of treatment has undergone many refinements. Today, the patient is put to sleep and given a muscular relaxant. A small amount of electric current is then applied to the patient's temples (Andreasen, 1984).It has proven highly beneficial in the treatment of depression. It is also sometimes used with patients in depressive episodes of bipolar illness (manic depression). Although it does not appear to be especially helpful with schizophrenia, it is occasionally given to patients who present serious safety risks and do not respond to medication. In 1985, the report of the Electro-Convulsive Therapy Committee, an interdisciplinary committee appointed under the Ministry of Health Act in Ontario, recommended that this form of treatment continue to be available for those who freely choose it, but that its use should be surrounded by special safeguards (Long, 1997).

2.10 Psychosocial interventions for persons with schizophrenia

Comprehensive care for schizophrenia involves not only drug treatments, but also the provision of ongoing support, valid information and, where appropriate, therapies or rehabilitative strategies (Long, 1997). A growing number of psychologists say recovery is possible with psychosocial rehabilitation (Patrick, 2000). In all situations, supportive therapy involves the teaching of such life skills as managing medication, learning to socialize, handling finances, and getting a job (NHS Center for reviews and dissemination, 2000). Through psychosocial support we can organize different integrated interventions like supportive educational interventions;

Individual psycho educational interventions, family intervention; Skills training; Life skills, Social skills, Vocational skill: Problem symptom focused therapies; individual therapy, family therapy and support group: and other community based cares to mention few (NIMA, 2008). Intensive treatment program integrating routine care with motivational interviewing, cognitive behavior therapy, and family intervention resulted in significant improvement in the main outcome of patients general functioning when compared with routine care alone ((Patrick, 2000).

According to Christine, et al.(2001), there were also significant benefits to patients in terms of some secondary outcomes, including a significant reduction in positive symptoms, a reduction in symptom exacerbations, and an increase in percent of days of abstinence from drugs and alcohol averaged over the 12-month period. In a randomized controlled study, comparing at-home family therapy with clinic-based individuals, supportive care in the community management of schizophrenia, in 36 patients taking neuroleptic maintenance medications, the family-treatment approach sought to enhance the stress-reducing capacity of the patient and his or her family through improved understanding of the illness and training in behavioral methods of problem solving. The results at the end of nine months revealed the superiority of this approach in preventing major symptomatic exacerbations (Torrey, 1988).The underlying assertion explains that many services can be provided more efficiently and effectively in the community than in the hospital. Patients returning to the community should be assessed to determine what stage they are at with respect to independent living and what supports they may need (Long, 1997). And the opportunities to participate in rehabilitation programs vary from person to person, from family to family. It is crucial to help schizophrenic person to follow their progress in the community and providing advice and assistance when needed.

Family therapy can significantly decrease relapse rates for the schizophrenic family member. In high-stress families, schizophrenic patients given standard aftercare relapse 50-60% of the time in the first year out of hospital. Supportive family therapy can reduce this relapse rate to below 10 percent (Prashant and Shevonne, 2010). This therapy encourages the family to convene a family meeting whenever an issue arises, in order to discuss and specify the exact nature of the problem, to list and consider alternative solutions, and to select and implement the consensual best solution (Long, 1997). Keep in mind that a family support group can supply all sorts of ideas and advice about handling the practical concerns of day-to-day living that the caregiver and the person with schizophrenia are facing.

People with schizophrenia often have a difficult time performing ordinary life skills such as cooking and personal grooming as well as communicating with others in the family and at work (John, 2013). Therapy or rehabilitation therapy can help a person regain the confidence to take care of themselves and live a fuller life. Group therapy, combined with drugs, produces somewhat better results than drug treatment alone, particularly with schizophrenic outpatients. Positive results are more likely to be obtained when group therapy focuses on real-life plans, problems, and relationships; on social and work roles and interaction; on cooperation with drug therapy and discussion of its side effects; or on some practical recreational or work activity. This supportive group therapy can be especially helpful in decreasing social isolation and increasing reality testing (Long, 1997).

CHAPTER TREE

RESEARCH METHODS AND PROCEDURES

3.1 Study Area

This study was conducted in Amanuel Mental Specialized Hospital, Addis Abeba. Amanuel Specialized Mental Health Hospital was established in 1937. When the hospital was established, at first, it was not established for mental health care. But, later in 1956 it basically became a mental hospital. In 1996 the hospital got the current name Amanuel Specialized Mental Health hospital at the federal level (Federal Ministry of Health and Amanuel Specialized Mental Health Hospital, 2012).

Currently the hospital has 214 health professionals and 320 administrative workers. Moreover, it serves 400 out patients per a day and has 300 inpatients. Now, Amanuel Specialized Mental Health Hospital is building its other branch around Kotebe to increase the quality and the standard of the service it is providing. The Hospital's vision is to be the best center for comprehensive health care, mental health research and training by 2015. It is also the Hospital's vision to reduce morbidity, mortality and mental disability through the provision of quality preventive, curative and rehabilitative services as well as through capacity building, training and research (Federal Ministry of Health and Amanuel Specialized Mental Health Hospital, 2012).

3.2 Research Design

The design for this study is qualitative. Qualitative design would help to investigate the problem in a better way; it also gives freedom to the researcher so that the researcher would stretch and see different aspects of the issue as per the need and wideness of the research. Qualitative research is a form of content analysis covering a spectrum of approaches ranging from empirical phenomenological psychology to interpretive phenomenological psychology, depending on the

data source. Qualitative research includes ethnography, phenomenology, grounded theory and historical research. A number of features are common to all approaches but the origins of the approaches are different. Ethnography, for example, originates from anthropology, which is concerned with the study of culture. Phenomenology has its base in philosophy and is concerned with the 'lived experience' as perceived by the informant, while grounded research has been developed from the discipline of sociology (Holloway & Wheeler1996).

Historical research offers an understanding of past events (Rosalind, 1997). When working with person with schizophrenia and their caregivers/family, the researcher did not pressurize them to describe how they experience problems in related to schizophrenia in their life, but allowed them ample time to respond in a way they felt suitable.

It also helps the researcher to generate an in-depth account that will present a lively picture of the research respondents' reality (Kvale, 1996).

3.3 Study Participants

Informants participated in this study, including persons with schizophrenia admitted in Amanuel Specialized Mental Hospital, and now are stable, and are able to express their thought, emotions and experiences clearly. A total of 8 persons with schizophrenia, 4 females and 4 males, and 15 caregivers were selected and participated in the study. In addition, 2 key mental health workers (a psychiatrist and clinical psychologist) participated.

3.4 Sampling procedures

For this study, purposive sampling technique was employed. Purposive sampling refers to judgmental sampling that involves the conscious selection by the researcher of certain participants to include in the study (Hallet, 1999). With the help of concerned bodies from the Hospital, persons with schizophrenia were listed and based on the current mental stability and

ability to express their thought, emotion and experiences, eight persons with schizophrenia were selected. Also caregivers and mental health workers selected too.

3.5 Methods of data collection

In-depth interviews were used to tap the knowledge and experiences of those with information relevant to the problem at hand. It provides a situation where the participants' descriptions can be explored, illuminated and gently probed (Kvale, 1996). Guiding questions are prepared for facilitating the in-depth interview. Beside questions were developed spontaneously in the course of the interaction between the interviewer and interviewee (Fontana & Fray, 1994). According to Hallett (1999), this approach reflects the open and accepting style of interviewing that seeks to elicit the genuine views and feelings of respondents. The common ground in Interpretative phenomenological interviews is that by their nature the interviews put the researcher in the role of the research instrument "through which data are collected" (Laverty, 2003). Anyone with relevant information is a potential candidate for in-depth interview. But for the current consumption, the focus was on persons with schizophrenia. Based on this, data gather in voice recording, transcribed and coded, that are related with the problems and coping mechanisms of person with schizophrenia.

Focus group discussion is among the most often used techniques in social science researches. In this study I conducted two focus group discussions. Caregivers of person with schizophrenia participated in this focus group discussion. In each group I had 7 to 8 participants brought together to talk about problems and coping mechanisms that persons with schizophrenia are facing and the possible psychosocial intervention that are currently available. Based on this, data gather in voice recording, transcribed and coded, that are related with the problems and coping mechanisms of person with schizophrenia.

3.6 Methods of data analysis

In this study, the collected data obtained from the person with schizophrenia analyzed using the interpretative phenomenological analysis approach. Since this research tried to see experiences of persons with schizophrenia, the phenomenological approach was best suited. Phenomenology is a science whose purpose is to describe particular phenomena: their nature and meanings. The life-world comprises the world of objects around us as we perceive them and our experience of our self, body and relationships. It is the “locus of interaction between ourselves and our perceptual environments and the world of experienced horizons within which we meaningfully dwell together”. It is all about “experience”, studying it as it is lived (Eckartsberg, 1998: Streubert& Carpenter 1999).The focus is on the way things appear to us through experience or in our consciousness. Also Langdridge (2007) defines phenomenology as a discipline that "aims to focus on people's perceptions of the world in which they live in and what it means to them. It also helps the researcher to generate an in-depth account that will present a lively picture of the research respondents’ reality (Wilson & Hutchinson, 1991; Wertz, 2005; Laverty, 2003).

We would see different types of phenomenology methods out of it, given that this research deals with the participants’ lived experiences interpretive phenomenology analysis helped to meet the object of study. Interpretive phenomenology is focused on subjective experience of individuals and groups. It is an attempt to unveil the world as experienced by the subject through their life world stories. Interpretive phenomenology is concerned with the life world or human experience as it is lived. The focus is toward illuminating details and seemingly trivial aspects within experience that may be taken for granted in our lives, with a goal of creating meaning and achieving a sense of understanding (Wilson & Hutchinson, 1991; Streubert and Carpenter, 1999). Here each participant’s interview sessions had been recorded with a digital voice

recorder. And the gathered voices data transcribed and coded. The coded data transformed in to themes and interpreted using interpretive phenomenology

3.7 Ethical consideration

Ethical clearance was obtained from Amanuel Specialized Mental Hospital prior to data collection and official permission was requested from the Hospital to conduct the study. And any ethical obligations that were recommended by the hospital considered on any activities. All participants were informed about the purpose of the study so that they became part of the study based on their will, with written consent. In addition, all the informations gained from the participants kept confidential. And during presentations and reporting, the participants are addressed with pseudo names.

CHAPTER FOUR

RESULTS

4.1 Socio-demographic characteristics of the participants

4.1.1 Participants of persons with schizophrenia

Menor

Menor is 30 years old. She was schooled up to grade 4. Both of her parents have passed away. She has 3 sisters and 2 brothers. But one of her sisters is passed away. She is Muslim. She is not married. She has no permanent place to live, but tried to live with her siblings who are married. She stated that there is no know genetic predisposes in their family. Currently she has no income. Menor is living with schizophrenia for the last 7 year.

Minabe

Minabe is 26 years old. She has completed her high school. Both of her parents are alive. She has 2 brothers and 2 sisters. She is Muslim. She is not married. She lives with her older brother. Minabe states both of her grandparents in her father's side and her other grandmother used to have mental health problem and currently they are not alive. She went to Arab country and worked for 2 years and 6 months. Currently she has no income. Minabe is living with schizophrenia for the last three years.

Ereq

Ereq is 30 years old married woman, and has 5 children. She is illiterate. She is a house wife. There is no genetic predisposition that is known. She is Muslim. She is living with her husband and children. The onset of the problem was 5 month later after she gives birth to her 5 born children. She reported rare use of substance 'chat'. Ereq has live with schizophrenia for the last 3 years.

Minalu

Minalu is a 53 years old woman. She has a diploma in accounting and secretary, and later trained in sewing. She has a sister. She is Orthodox Christian. Minalu is not yet married. She is living with her mother and her father has passed away. Currently she tries to work handicraft and sell although it is not giving her enough income for her living. There is no genetic predisposition that is known. Minalu is living with schizophrenia for the last 23 years.

Muna

Muna is 49 years old. He is illiterate. He is Muslim. Muna is not yet married. He used to live with his mother. But because of the side effect that happened while electroconvulsive therapy is given hospital, he has stayed for more than five years. He was addicted to 'chat'. His father passed away before long time. His mother is blind he was the one who supported her. He was a vendor but currently he has no income. There is no known genetic predisposition. Muna is living with schizophrenia for the last 12 years.

Amel

Amel is 38 years old man. He is a civil engineer. He has 3 sisters. He is Muslim. Amel is not married. The family is economically well. He lives with his father, and his mother has passed away. He reported his mother had mental illness. He is addicted to smoking, drinking and chewing "chat". For 7 years he straggles with his illness and job. For the last 4 years he completely stopped working. Currently he has no income. Amel is living with schizophrenia for the last 11 years.

Wisttet

Wisttet is 36 years old man. He has finished his education with medical Doctor. He has 2 brothers. He is Orthodox Christian. Wisttet is not married. He lives with his mother. His mother

lives with pity trade and have economic problem. His father has schizophrenia. His older brother also has the disorder. He is addicted to smoking, drinking and chewing “chat”. For 2 years he straggles with his illness and job. For the last 5 years he completely stopped working, and currently has no income. He has lived with schizophrenia for the last 7 year.

Bewileta

Bewileta is 34 years old man. He has finished elementary school. He has 2 sisters and 3 brothers. He is orthodox Christian. Bewileta is not married. He lived with his mother. His father had disappeared for a long time and believed he has passed away. There is no known genetic predisposition. He is addicted to smoking, drinking and chewing “chat”. Before he was working as a daily laborer, and now sometimes he tries to work like carrying easily material for people, but it can be say he is not working. He has lived with schizophrenia for the last 14 years.

4.1.2 Participants of caregiver’s of persons with schizophrenia and mental health workers

In this focus group discussion, both parent & siblings & other relatives who are taking care of the person with schizophrenia had participated. In the focurs group discussion, fifteen people had participated & four of them have schizophrenia disorder in the family. In addition, key mental health workers, one psychiatrist and one clinical psychologist who worked at Amanuel hospital, in in-depth interview, had participated.

Focus Group Discussion with caregivers of people with schizophrenia

FGD 1				FGD 2	
Period of ill	Number participant	Relationship With the patient		Period of ill	Number participant
6 month to 2 years	1	Husband		6 month to 2 years	2
3 years to 5 years	3	Sister Mother Cousin		3 years to 5 years	2
6years to 8 years	2	Mother Sister		6years to 8 years	2
9 years to 11 years	-----			9 years to 11 years	1
12 years to 14 years	1	Mother		12 years to 14 years	1

4.2 Hypothesis

Based on the finding the following are the hypothetical points:

•People with schizophrenia face unemployment, economic crisis and dependency.

•People with schizophrenia face discrimination and isolation.

•The neighborhood that People with schizophrenia are living have poor awareness on schizophrenia.

•People with schizophrenia face lack of consistent support.

•People with schizophrenia are vulnerable to addiction, especially male.

•People with schizophrenia have a difficulty of getting medical support and suffer from the drug side ffects.

4.3 Introductions

Seven themes were explicated from the qualitative data collected via the interviews: *1) Unemployment, economic crisis, and Dependency 2) Discrimination and Isolation 3) Poor Awareness; how people with schizophrenia are perceived by others: 4) Lack of consistent support: 5) Addiction: 6) Poor Medical support and medical side effects 7) Coping mechanism*

4.3.1 Unemployment, economic crises, and dependency

After their illness the participants are facing problems with their working environment. Some couldn't resist the load and stress their profession requires and are struggling. Others never get back to employment. Beside the illness, unemployment of the participants increases economic crisis which later results dependency. For most respondents employment has a greater deal in their life. Their dreams and needs are linked on their employment. Dimensional change form employment directly to dependency. Beside the patients were family supporter and they had strived to get the jobs they right now had left. For them it was their means for what the need and their independence too. Participants demonstrated what can be called of a 'sign up for new living style'. Starting new living style; very chained with invisible bars were the one awaiting them after the illness. Waiting the good will of people to gave them.

"If I wouldn't be sick while I was as Arab country, I still now would be working. I would be working till now; I would have been worthwhile to my parent and to myself. I would have my own house, some think that I can work and will not be dependent on others; I would live by life

properly. Write now everyone thinks that I am uncountable person for a job or any activities." (Minabe, age 26)

Economic crisis cannot be seen as a separate entity, as long as the family or caregivers gets in to economic also patients gets economic crises. According to all two groups participating in the Focus and mental health professionals, the economic crisis that the family goes through after the patient's illness was very challenging. It is not usual to clients/patients to get a job, earn a living after they get sick and have own family. Some of the clients/patients were the supporter of the family member, even the extended one. Most families go back to the previous life and even become unable to support the patient economically. Since clients are dependent on the family patients cannot get what they needed in their life timely. Caregivers mentioned they spend all the assets both the patient's and the family accumulated throughout their life, had been spent. Kokate (a mother) explains the challenge she faced:

"My son was the one who was supporting me, as you look me I am getting old and my son was the one who used to support me. He worked at government organizations. Later when he gate ill I spent all the assets we have. I sell the land we have and ox too, and exhaust all the money I have." (Kokate, age 62.)

Most caregivers and patients are facing drawdown of life. Unemployment is not just patient's issue; it is linked with family economic status. Unemployment goes far beyond getting money; family proud and hope. It affects the hope the family has to life, a hope for a better life. Mental health workers implies that when these clients/patients get ill and stayed at home, it creates brokenness in the family psychologically, economically and socially too. They lost the cultural pride, a child grown up and support the family. They were figures and the hope of the family where parents dream came true. Stating this it doesn't mean that patient have no effect, yes it

does affect their economic condition. At old ages parents tart to work earn money so that they can take care of the family. Wisttet explained his situation that the family is passing through:

"She [my mother] had have a dream, right? She makes her son educated and become graduated in medical doctor. Then when I get in to such problem and became unable to work... what will she feel? . . . she is the one who knows how. Before time while I was working, the family's economic status has been improved. But later when the child [I] become dependent, not only that my situation she (my mother) costs lots of money for my medication. Five years since I have stopped working!" (Wisttet, age 37)

Respondents implies other life costs like transportation, clothing, and other sanitation material became difficult to get too. Since persons with schizophrenia lately end up unemployed, their situation required them to hand their need to be fulfilled on the good will of their parents, siblings, relatives & friends. Some time parents and siblings are reluctant. On the other hand parents and sibling need to be take cared by the sons & daughters who now become schizophrenic & have no were to go to share their despair.

4.3.2 Discriminating & Isolation

People with schizophrenia are discriminated and isolated by the community. Most respondents explain patients face discrimination by their family, friends and neighbors. Discrimination experienced in the context of social relationships. For most patients, the diagnosis of schizophrenia resulted in a reduction of social contacts. Mostly friends and relatives reduced their social contact and consequences people with schizophrenia hesitate with social contacts and start to isolate themselves from the contacts they used to have.

"I used to have many friends and also have a good relation with my relatives. After my illness I realize my friends are withdrawing from the friendship. As the time has gone all are withdrawing

more and more. Right now I prefer to be by myself because they don't need me anymore." (Amel, age 38)

Mental health professionals explain people with schizophrenia faces discrimination both from the family and the community. This thinking generates because of the community believe on mental illness is caused by God punishment or evil spirit possession:

"When someone became mentally sick, the community believed the family has curse or the patients are possessed with evil spirit." (Clinical psychologist, at Amanuel Specialized Mental Health Hospital)

All respondents describe family members and relatives face discrimination, sometimes from the extended family or from the family members by itself too. The neighborhood considers the family as a punished one from God because of some kind of curse or they are worshiping devil. Or blame them for getting this illness, as if they choose to be sick.

"Seven years ……since by brother gets sick. Seven years! These whole years I was the only person to take care him. I asked my relatives to support me, but they said this is Allah's cures by helping you we don't want to bring such a cure to our house. The neighbors, Ya-Allah, they laugh at me whenever they saw me… they took all the cattle we have. When I asked them why they did this, they said they have asked permission from my sick brother… Ya-Allah!" (Shemsiya (Sister), ager 37)

Sometimes some inpatients have no visitor or caretaker until their discharge from the hospital. Minalu describes the reaction of her friends; incurious on her:

"Who do need to have an ill person as a friend, they don't visit me, and they left me long time ago." (Minalu, age 53)

Patients agreed in stating that those not affected by mental illness have little understanding or the behavior of people with schizophrenia and the difficulties they are faced with. Instead, patients were often ignored by neighbors and family members. Relatives, too, observed how friends of the patients gradually stayed away, did not come to see them at the hospital, or that they shied away from speaking with them.

Their social environment, most people with schizophrenia faced negative reactions, such as the reduction of their person to ''being crazy, irresponsible for one's actions, being someone who cannot be trusted''. They were increasingly carefully watched over, and every somewhat conspicuous detail was ascribed to the illness. Patients are not welcomed to participate in different gatherings like weddings. Since people with schizophrenia are seen as 'crazy' the family prefers to avoid them:

"I am not completely welcomed to be part of the family in weddings or other ceremonies. If I am in the ceremony, I would be kicked out even from the compound. The thinking I might disturbed hover in their mind . . . or I don't know what they think!" (Menor, age 30)

Furthermore, the community most of the time labels people with schizophrenia, hit them and make them up- set, give them names with the intension of insulting and that provokes to be hostile towards people and to their environment.

"Sometimes the neighborhood gives them some names that make time really upset. They call them like "Bichichu" (Informal for insult; some sone who lost their mind) or "Qewe" (Informal for insult; some sone who lost their mind) and drive them angry and provoke them to be hostile. Sometimes they (neighborhood) shouted on them saying hit him again and again which creates a very tense feeling on the clients/patients. Especially for person with paranoid

illusions/hallucinations it is very clear how stressful their situation could be." (Psychiatrist at Amanuel Specialized Mental Health Hospital)

Further, there was agreement among the patients and caregivers that one single contact with psychiatry was sufficient to put a life-long stamp on them, a stigma, which, in turn, determined their social identity in various interaction situations they entered. Nevertheless, People with schizophrenia have their treatments and follow it well, relatives still struggle to keep them far away and felt that they are not claim enough to mingle with them.

"The illness is not something you expect to happen. When you are learning bla. . .bla.... You have your own dream, and then it disappeared! And your way will be diverted to another direction, it hurts, hurts . . . I have faced crisis!" (Wisttet, age 37)

In general, all social life that person with schizophrenia revolving in wrong way; full of self isolation, isolation, and discriminations from friend and families and make them think that they are 'incurious'.

4.3.3 Poor Awareness

A Pivotal moment: the need to be understood

The experience of understanding by the family members or friends or relatives and neighbors is an imperative standard of living for people with schizophrenia, to be functional again. Patients described a period during which their worlds were "turned upside down" after they become ill. Becoming schizophrenic is not something you planned or that you can control over the situation unless you get medical and family support through understanding the person with schizophrenia. Persons with schizophrenia explain the difficulty they face in being understood by family and relatives. Sometime their need over looked and counted as they are simply daydreaming, not seen seriously. Mistakes that are happened be seen very seriously and the family misunderstood

and nag the patients. Search for proof to their misdeeds. As persons with schizophrenia explain, it seems the family counts them as they couldn't understand their speech . . . expressed in hurtful. Minabe who had schizophrenia expresses this as follows:

"Their general problem is they (my family) never say she is doing this because she is ill. . . They never let me go with my mistakes, they never say she is doing this because she is not healthy . . . They don't understand me . . . they just say why this and why that! They nag me a lot. While we have a clash they said to me die and let us be in peace or get 'edir' payment. Or if we could break you & build you: if we could break you & fix you…they think I don't understand and feel. " (Minabe, age 26)

Understanding is the hardest thing they cloud get. Mental health workers agreed on words that threw towards the clients affected the way the respondents looked their family. Most patients agreed that trying to fit in to the family structure is though and this is because the family always thinks that they are sick and not well to be understood as if there is nothing to be understood in their mind.

"Caregivers, just since patients get mental illness, the care givers/family members accepted them as "ill, sick" expected the patients to play the role of "sick" all the time."

Caregiver had lack of knowledge on how they should communicate with them, how to handle them and what to expect from patients, and what really schizophrenia is within the patient. Lack of such understanding impair feeling and worsen patients situation.

Not having proper health care and follow-ups

Almost all participants went to hospital after they have tried different ways for longer time, some for years. As caregivers from FGD implies they prefer to go to spiritual hospital than coming to psychiatry care. Caregivers wander to different place for the sake of better intervention and lack

to bring patients to the right places on the right time. Zinash with a son who gate schizophrenia before 3 years explains her situation:

"I thought my son can no longer be settled, I tried everything I could and meander to all direction but no change has been taken palace. Rather I felt like he was becoming terrifying person. Later all the neighbors told me that I should go to Addis Ababa takes him to Emanuel hospital. I waited at motel for a month to get a bed. Later I get a bed and started his medication. Now we have stayed for two months. I said I made a mistake in keeping my boy for 3 years. I feel like I am the one who makes him suffer. He could have been much better if I could have brought him to here earlier."

On the first moments of the participants illness, inevitably impacted the family members and try to take in to different places and when they (caregivers) think it is hopeless they bring them to psychiatry help. All patient respondents took to different place for intervention. They went to witch houses, traditional medicine makers, holy water baptism and so on. Most of respondents come to psychiatry help after the family tried everything and get frustrated with no improvement other than cost.

". . . Three years since I get sick. Till that time I was very healthy, not even had headache. . . I used to take 'abisho' traditional medicine. And we do have our people at 'Sillitte' and I frequently went there to. This is my first time to come to here (Amanuel specialized mental hospital). . .Before coming to Amanuel, I went to 'awaqi bet' but I didn't get better. (Muna, Eriq,Minabe)"

The community has poor awareness towards the disorder and its medication. Believing that the children, siblings, spouse or any members of the family that she or he is having schizophrenias is a challenging thing. That is why people with schizophrenia are taken to different place before

coming to hospital . . . the caregivers doesn't want to accept that people with schizophrenia really have the illness. By the time when they came to hospital, for some it will be too late for recovery which makes the recovery process struggle full.

4.3.4 Lack *of consistent support*

People with schizophrenia get all of a sudden being required to come to terms to be under the care of their parents, siblings, spouse or anyone on a regular basis, often for lengthy period of time. It was inevitable that the life style and typical functioning and structure of the family were going to change. The impact of living with schizophrenia was enormous and in some cases calamitous.

Minabe stated that nobody really comfort her:

"My families said are you not young? Why do not you wear neat wash properly or something? Why do you lose hope while you are young? At the same notion they critics me, the only thing they worry is there name." (Minabe, age 26)

Sometimes patients are unable to get the follow ups and protection that they needed to their life. Family and sibling get in to thinking that they are burdens and try to push them away. Amel describe the way his parents look over:

"They mostly get angry on me, they prefer to stay far instead of taking responsibility, even by the time when have to be admitted they are not willing. It seems like they are tired of me." (Amel, age 38)

Proper and consistent follow ups and acceptance are important to patients. Such a thing will contribute to their lives stability. In addition to this, family, sibling and relatives felt burdened while patients live with them. Especial to though whose parents are passed away the problem get more severe and patients pushed away. Caregivers and health workers agreed that clients/patients

have to wait for someone to buy or gave them whatever they wanted to have. This responsibility goes back to the family or relative . . . otherwise they end up on street. Menor describe the situation as follow:

"If my parent were alive I would not be like this. . . I have a problem of living place . . . I move from place to place. Especial when I feel hurt, I just look on them I feel amazed then left them. Last time I stayed on a street for a week. Unless and otherwise they support me to live in their house how can I get to their home." (Menor, age 30)

Mental health workers agreed that mostly caregivers concerned only on the medication (tablet) and forgot that the patients needed emotional support. And on the other hand care givers get confused on how to give emotional support to the patient so rather caregivers choose to be become tired and hopless, keep silent whatever happened. As the mental health workers mentioned sometimes the caregivers feel that the patients do not understand them if they encouraged the patients or be able to analyze what the caregivers are saying. So persons with schizophrenia lack emotional attachment.

"*Beside this people with schizophrenia needed different follow ups especially on a day to day activities like washing, clothing, medical follow ups checked if the table is taken and . . . soon. Caregivers really do not get in what kind of functional depression they are going through. They needed a day to day care and support until they persist, which persons with schizophrenia lacks." (Clinical Psychologiest at Amanuel Specialized Mental Health Hospital))*

4.3.5 Addiction

This theme is limited to male respondents and the second focus group with care givers. Patient could be addicted before or after their illness. In both sides substances have the ability to

influence behavior and actions, beside other complications addiction have. The respondents were addicted to cigarette, alcohol, and 'chat'.

People with schizophrenia, beside the illness, the addiction worsen their health situation. They used it as time passing but through time the addiction get stronger. Especially if patient's friends are too addicted, and since patients had nothing to cost on their time, the patients sat for ours using substance which raised their dependency level to substances. Bewileta who suffer from addiction describes:

"When I get ill I become more smudge in to substances. I chew 'chat' for hours, smoke and drink. I do not know why I mostly do it but since I do not have anything to do, I just pass time. Although I am trying to minimize the intake I use, I found it difficult to do so." (Bewileta, age 34)

Addiction misbalances patient's judgments and thinking. The worst part when patients are addicted was they prefer to stop their medication than stopping their addiction. Patients trapped in to self distraction situations. As they get to use the substance, the more they lose their self. The substance will make the patients to regress. Amel explains how much trouble addiction gave him:

"I chew 'chat', smoke and drink alcohol . . . to me using 'chat' is compulsive, and I just do not want to use it. When you use chat you later want to use alcohol. Then 'chat' hallucinates and alcohol makes you suffer. And in the morning you have hangover of the chat and alcohol. This dangers substance will not let you have natural or human being behavior. And later on you found yourself, had stopped your medication and hallucinations are haunting you." (Amel, age 38)

Substance addiction corrupts the thinking persons with schizophrenia had. And make people in no position to do the right thing and to decide on the right opinions and stands. Addiction is the

other ordeal that people with schizophrenia are facing. Amel and Wisttet sates with the same word why they mostly stop the medication beside other reasons; thinking the complication:

"I just stopped the medication because I was using substance, I was afraid of its complication and beside, the medicine was very heavy and using it with substance. . . I couldn't control myself for not using the substance . . . though!" (Amel, age 38; Wisttet, age 36)

4.3.6 Poor Medical Supports and Side Effects

Medical support (drug treatment and psychosocial intervention)

The very important thing that persons with schizophrenia need is medical support. Insufficient medical support affects the respondent's treatment. Beside drug treatments psychotherapy is essential to. But the participants clearly states that they not aware of such. Some of the patients clearly asked to get psychotherapy service and they are told that there is none as such service. Wisttet explained that he had asked because he needed the psychotherapy:

"They (nurses) have told me that there was psychotherapy but later they said that there is no psychotherapy service. I have only seen a person who takes progress report, not a psychologist." (Wsttet, age 36, Medical doctor)

Caregivers also are unaware of the psychotherapy service that is availed at Amanuel Specialized Mental Health Hospital. All the caregivers and patients explained they have health progress checkups and follow ups but didn't mention that psychotherapy provided to them on their stay other than progress follow-ups as psychotherapy and they have no idea about the service. Lack of psychotherapy affects the person's progress to functionality. Having psychotherapy increases the ability to have insight more, modify their life style and cope up with their problems with maturity. Yet mental health workers mentioned to help people with schizophrenia resist their problems the hospital follows the "Bio-psycho-social model": said it is a model where they

include medication psycho-education and social support (mostly home visit, which is very rare). At the hospital if the patient admitted to hospitals three times in a year or two times with six month, the social workers would visit the client/patient home setting and try to help get improved. The participants state that even though the patients have relapses caregivers wouldn't bring the patients to hospital care. This case challenges the social support designed by the hospital.

At the hospital psycho education is prepared for caregivers/family. When we come to services that are delivered for peoples with schizophrenia community work is very important: which is not implemented very well. People with schizophrenia are part of the community.

"So that, beside big psychiatry hospitals, expanding community psychiatry is very important and rehabilitation programs including day to day life style rehabilitation, vocational rehabilitation, support group, rehabilitation institutes for those who are in need of it and other." (Psychiatrist at Amanuel Specialized Mental Health Hospital)

Lacking psychosocial intervention hinders the progress the patient and the community should have and that people with schizophrenia can be productive citizen to themselves, for the family, community to the country too.

Medical side effects

Beside the illness medical side effects are problematic issues to those who are affected with it. In regards to side effects, different people explain different points. Medical side effects are like second illness some happened for a moment others happened for a longer time and may be it can be lifelong problem. The common medical side effect that is pointed out by all respondents is fatigue cased by drug. Most participants shared the heavy fatigues that the patients are facing

after they started medication. Mostly feel unable to wake up in the morning and go to work. Most of the respondents mention that they were unable to work.

"The medicine was making me sleepy; it used to make me sleep until 11-12am" . . . "the medicine is very heavy I am always in fatigue" . . . "the medicine by itself was very difficult and I couldn't endure."(Menor, Amel and Wisttet).

The fatigue is something difficult to deal with and be a hindrance in patient's life not to precede forward.

4.3.7 Coping Mechanisms

This theme refers to the experiences people with schizophrenia endured as they had no choice but to undertake living with the illness. Not only were the participants required to withstand the illness nature and the medical side effects which accompanied their life.

"Illness adaptation is the hardest part which is even difficult to understand what is yours and what is not, because after all it is you. Schizophrenia by itself affects personality and the persons functioning." (Psychiatrist at Amanuel Specialized Mental Health Hospital)

There is no common coping mechanism that the respondents uses all have their own way of coping mechanisms. . . all uses coping mechanisms. But for all respondents' social withdrawal, emotional regulation among female patients and self distraction among male patients are the commonalities.

Persons with schizophrenia can feel that they are not wanted among the community and prefer to with draw from the social contact they have,

"*I have stopped all the contact I use to have, since the illness disturbs other people. I do not need other people."*

Some prefer to hide into addictions; Amel in the same rhythm tries to distract himself from the environment that he is haunted:

”I do not go purposely to chew ‘chat’ or drink. But the delusion really disturbs me, other family things too. But especially the delusion is a chaos so I take ‘chat’ and continued other things. But never you get improved rather exacerbate.”

Some tried emotional regulation; they tried to come to the terms to cope with their issues:

“. . .. While they beat me I get angry and I just go out and tell to everyone what my families are doing on me!” . . . “I will sleep for two days or three days or more and I don’t want to see any one.” (Minabe, Eriq)

People with schizophrenia try to survive and cope up with their problem in their own way. It could be mature or immature but they are struggling to cope up with their issues in the way they prefer. Coping mechanism have their own role in patient’s lives. It helped them feel protected in their own system.

CHAPTER FIVE

DISCUSSION

5. INTRODUCTION

This study highlighted the value of examining the problems persons with schizophrenia are experiencing and the coping mechanisms they are using and its implication to psychosocial intervention.

5.1 Unemployment Vs economic crises Vs dependency

Before the participants get ill all of them have a job and support their family and their own self too. Participants reveal that their life changed in an instance when they become with schizophrenia disorder. One of the instances is in ability to secure job. With different reasons either with the work load that their profession requires or with lack of proper guidance, all the participants are unemployed. A combining data from 37 different countries found that on average, 81 per cent of people diagnosed with schizophrenia were unemployment, with (Haro et al., 2007).

Studies show that most individuals with severe mental illness face a range of barriers in gaining employment (Marwaha& Johnson, 2004; World Health Organization, 2001). As this study implies unemployment put a loud on the family and the patient since the unemployment goes with economic crisis and dependency both patients and care givers will be under pressure. Similar to our study, another study by Marwaha and Johnson (2004) conclude that low employment rates are heavily influenced by the social and economic pressures faced by the individuals, the reality of the labor market, and psychological and social barriers to working. Schizophrenia, long considered the most chronic, debilitating and costly to treat (Social Psychiatry and Psychiatric Epidemiology, 1990).

5.2 Discrimination and Isolation

People discriminate and isolate persons with schizophrenia with different reasons. Some even not allowed participating in family gathering or having peace full communication. Although person with schizophrenia are stereotyped but relationships suffer because people with schizophrenia often withdraw and isolate themselves (Abebaw. et al, 2011: Jeanne & Melinda, 2013). In this study as it agreed with in respondents, persons with schizophrenia discriminated and isolated among the community, then by the family later they isolated themselves. Beside this, the illness, the word "mad", which mostly is used in the community, has an influence both on the family and the patient including on the progress of the patient (Ababi, 2008). Also in this study patient are labeled as 'crazy' or face name callings like 'Qewe' and 'Bichichu'. And such discriminations results gap between the patient and the community.

Another study shows schizophrenic patients, 13% of stigma and discrimination was experienced through imbalances and injustices inherent in social structures, political decisions and legal regulations. Almost half of the stigmatization experiences described by the patients concern this area (49%). Relatives (39%) and mental health professionals share the view that the reduction of social contacts in the interaction with others is the most central area in which stigma is encountered by those suffering from schizophrenia (Schulze, 20003).

5.3 Poor awareness

Difficulty patients experienced in the awareness level that the caregivers have towards the patients and the disorder. The inabilities to run the day to day life styles that person with schizophrenia faces is a challenge since caregivers may not understood it very well. Almost all participants express that they hadn't come to psychiatry help by the time they get in and when regression happens. Most spend a longer time wandering to different traditional medicine maker,

witch or holly water baptism. Washington (2010) maintains that, African/Black psychology holds that all sets are interconnected, that spirit infuses all living things, and that there is a component of the Divine within all things (Makhanya, 2012). And the first help needed to come from the spiritual infuses then to other.

Yet in ability to come on to help on time affects the patient's recovery process. In this study patients suffer from poor awareness mainly the in ability that the patients are not been understood and the in ability to come to the psychiatry help one time is the problems that all patients experience that associated as a hindrance to the recovery process. Similar to this study discrimination and isolation associated with schizophrenia is a barrier to those trying to rehabilitate themselves (Long, 1997). It is also a very real problem for their families. Therefore, those involved with schizophrenia are concerned about the dozens of misconceptions about the illness. Schizophrenia is a disease that is not well understood and is greatly feared (Maluo, 2012). However, wide differences in the effect that schizophrenia has on different people and the difficulty in understanding the actions of someone in a deeply psychotic state, whose thinking is thoroughly confused, reinforce the public's concern. Some believe that people with schizophrenia have weak personalities and have "chosen" their madness. As it is stated in our study, some view that the illness is one of God's punishments (Long, 1997).

5.4 Lack of consistent support

Most of participants faces neglect which goes up too homelessness. Study that shows physical and sexual abuse on the patients is not available. But study show 10% of the patients suffers from homelessness (Schulze, 20003). Lack of support and treatment could cause the patients to be ill more and lower their recovery and functional level. The more they get neglected the further their recovery troubled, vulnerable to different other problems. Findings adjusted for

ethnicity revealed that homeless had higher rates of a concurrent diagnosis of alcohol abuse, drug abuse, and antisocial personality disorder (Pamela, Cristina, Serafín, and Lemos, 2008). Beside from the participants view especially care givers prefer to neglect the patients since it is not clear to them how they can help the clients or make them listen and understand. Professionals added persons with schizophrenia face lot struggle in lacking support and care from family and beloved once. Study shows persons with schizophrenia face neglect in different ways some have no one to look after them, others struggle with lack of emotional support and homelessness too (Harrison, et al. 2001; Harvey, et al. 2007).

5.5 Addiction

Although reasons are not clearly identified participants report experience of addiction. In this study the male participants showed addiction with three different substances ‘chat’, smoking and drinking. I can say all of the participants use these substances for a lengthy period of time. Study showed that more than 70% of patients with chronic schizophrenia are nicotine dependent (Ziedonis, Kosten, Glazer, and Frances, 1994). Goff et al (1992) compared cigarette-smoking versus nonsmoking schizophrenic patients with regard to gender and age factors, as well as neuroleptic dose. As a result, smokers were significantly more likely to be men, and to have had an earlier age of onset and a greater number of previous hospitalizations. Furthermore, smokers received significantly higher doses of neuroleptics than nonsmokers. In a recent study, Weiser et al investigated a sample of more than 14 000 adolescents followed over a period of 4 to 16 years, and found that adolescents who smoked more than 10 cigarettes per day at, initial evaluation were significantly more likely to be hospitalized for schizophrenia during the follow-up period. Thus, either smoking might, be used as self-medication of symptoms, or abnormalities in nicotinic transmission might be involved in the patho-physiology of schizophrenia (Gabriele, et

al 2006). In one such study it was found that "substance-abusing patients with schizophrenia were 13 times more likely than non-substance-abusing patients to be noncompliant with antipsychotic medication." Among the reasons for this association is the fact that psychiatrists often tell patients to not drink alcohol when on medication (they therefore stop medication so they can drink) and the fact that some medications counteract the effects of the alcohol or drugs, so the person cannot experience their desired high(. Munetz, Grande, Chambers, 2001). Beside as this study shows males are the one who are addicted to substances. Similar study shows gender is also a factor in the specific patterns of observed substance use among persons with. For example, the overall rates of abuse and dependence for schizophrenia. Most drugs tend to be higher among males than females (NIDA, 2010).

5.6 Poor Medical support and Medical side effects

Coming to drug treatments, some participants claimed as reason individuals with schizophrenia fail to take their medications. Participants explain that while taking the drugs, they suffer from heavy fatigues. Although anti-schizophrenic drugs significantly increased the practitioner's ability to effectively treat the symptoms of schizophrenia, they were not, and are not, perfect by any means.

It is true that anti-schizophrenic drugs significantly increased the practitioner's ability to effectively treat the symptoms of schizophrenia yet not the perfect approach. Psychotherapy treatment and other rehabilitation work show have been done to fully help people with schizophrenia to function in more improved ways. Thanks to Amanuel Mental Health Specialized hospital drug treatments are available to all community with different economic level. Beside structure the responsible body needs to have look variety of rehabilitation and intervention works.

Studies show the 20% rate of schizophrenia can be lowered by preventive counseling (Bleuler, 1978). Move over moral treatment was succeeded by physical treatments whose proponents claimed to be more scientific. These treatments did not require understanding the patient and had economic advantages for the public sector. The ensuing myth of incurability was reassuring (Alexander and Selesnick, 1966; Bockoven , 1972; Whitaker, 1992). But EugenBleuler noted that when he read Freud and applied psychoanalytic ideas to his patients at Burgholzli, three times as many were discharged (Federn, 1943). Study shows 28% favorable outcome before 1925; 49% from 1956 to 1986 when psychotherapy was most likely to be offered; and 36% from 1986 to 1994 (Hegarty et al., 1994). Beside psychotherapy different interventions has to be give to persons with schizophrenia. Life skills intended to promote independent functioning in daily living. These programmers could include group or individual training in managing money, organizing and running a home, domestic skills and personal self care. In addition to the life skill vocational skills can be given to people with schizophrenia as to support professional carriers or other suitable training as per the person's capacity (Effective Health Care, 2000).

5.7 Coping Mechanisms

Coping mechanisms represent a crucial component of our capacity to maintain emotional homeostasis. Without them the conscious mind would be much more vulnerable to negatively charged emotional input, such as that pertaining to anxiety and sadness. Social withdrawal, self distraction, and emotional regulation, are the coping mechanism the participants uses. Coping mechanisms represent a crucial component of our capacity to maintain emotional homeostasis.

Immature psychological defense mechanisms include: splitting, idealization and devaluation, projection, hypochondriasis and somatization, undoing, acting-out, schizoid fantasy, and denial (Kaplan et al., 1994; Vaillant, 1994; Weinberger, 1990). In general, the greater the degree of

cognitive distortion, the less adaptive the defense mechanism is, largely because more extensive cognitive distortions progressively reduce conscious awareness and, consequently limit efforts to improve adverse states. Immature defenses also make the unreal seem too real, and hence are less reality adequate (Vaillant, 1977). However, under high stress situations, including the self-generated disturbances seen in personality disorders and severe mental illness generally, more extreme defenses play an important role in safeguarding the self. For example, intolerable aggressive urges are seen as coming from others through the use of projection.

Using immature coping mechanisms have it of side effect as it is stated on the above. Statistically significant changes in defense mechanisms were present in the mature factor of defense mechanisms and in two separate immature mechanisms: autistic fantasies and displacement (Łukasz, 2008). Psychologist need to work with coping mechanisms the participants/patients are using is important.

CHAPTER SIX

CONCLUSION AND RECOMMONDATION

6.1 Introduction

This chapter attended the major conclusions drawn from the chapter on Result and the implications of the findings are stated so as to recommend solutions.

6.2 Conclusion

Beside the experience of being with schizophrenia, having different problems challenged them. The emotions and feelings associated with the desire to go back to the previous self and coping with the current one goes throughout their entire life. Their role as family supporter and independent person had been jeopardized and compromised. All the interviewees demonstrate an irrefutable problem that they are facing in their respective lives. Being unemployed, economic crisis and dependent, discrimination that come from the beloved ones and others, and the Self Isolation that ranks in their lives gives them lots of struggles. Adjacent to the above poor awareness about people with schizophrenia, affects the patients. The negligence that people with schizophrenia are facing is painful experiences. Although most of them have started addiction before they get ill, they are unable to control it. This problem is show on male patients. Persons with schizophrenia try to cope with their problems through different coping mechanisms. These all problems trapped them that they may not live a life to its fullest. Drug medication, although help to control the psychotic futures; it has its own side effects. Rehabilitation process mostly depends on drug treatment and psychotherapy and other rehabilitation programs are not given full emphasis.

6.3 Recommendation

Based on the finding and discussions the following are recommendations:

- Life skill rehabilitations and vocational rehabilitation are essential to alleviate the economic crisis that both people with schizophrenia and caregivers are facing.
- Beside mental health caring hospitals rehabilitation centers with different life skill and vocational rehabilitation programmers have to be developed and implemented intensively.
- Professional psychologists have given emphasis while counseling on coping up with the new life styles that persons with schizophrenia are going to have and in helping the care givers to understand the recovery process.
- Awareness raising projects have to be well developed so that the care givers and also the persons with schizophrenia have improved knowledge about the disorder and the managing way.
- In coincidence to the above, helping the community to understand psychosis; nature of the disorder; consequences, treatments and coping mechanisms is important to both sides.
- In all levels, persons with schizophrenia should not be overlooked as they are part of the community and deserve all cares and supports.
- Policy makers, legal institutes, educational institutes, community workers, Medias, both governmental and nongovernmental health related institutes have to work in harmony to raise awareness among the community.
- So proper information on the drug side effects and managements systems should be given to both the patients and care givers.
- Side to side to psychotic treatment, addiction should be seen as a co-morbid to it and get proper treatment as well.

- Health care institute has to improve their treatment packages and follow the intensive implementation of the package.
- Psychotherapy should be provided intensively to persons with schizophrenia and their care givers.
- Policy makers, universities and psychological associations has to give emphasis on pressurizing health and rehabilitation institutes to implement psychotherapy and researchers has to provided effective approaches that can assist the therapists beside different theories.
- Clients and parents should be aware of the possible services that they can get from the hospital.
- Psychotherapists have to work on helping people with schizophrenia to develop effective coping mechanisms and care givers too.
- In addition suitable counseling rooms and places are essential to conduct group and individual counseling sessions.
- Health policy makers and psychology professional associations have to work on the essentiality of psychological aids to mental health and well being.
- Government and private health sects and policy maker should work on developing Rehabilitation programs.
- Government and private health sects also have to work on community psychiatry in addition to institutionalization.
- Finally, further studies have to be done on persons with schizophrenia and coping mechanisms. And also studies should be done on possible psychosocial intervention.

Reference

Ababi, Z.G. (2008). Economic Burden of Schizophrenia and Bipolar Disorders in Ethiopia: Addis Ababa-Ethiopia.:AddisAbaba University.

Abebaw,F., Girmay, M., Asfaw, W., Atalay A., Gunnar K., Lars J., S. et al. (2011). Five-year mortality in a cohort of people with schizophrenia in Ethiopia, Psychiatry. Ethiopia, A.A: BioMedCentrla. Retrieved from http://www.biomedcentral.com.

Alexander, F. (1948). Fundamentals of psychoanalysis. New York: W.W. Norton & Company.

Alexander, F. G., and Selesnick, S. T. (1966). The History of Psychiatry, Harper & Row,New York.

Allebeck, P. (1989). A Life-Shortening Disease: Schizophrenia. Schizophrenia Bull, 15,81-89.

American Psychiatric Association.(1994). Diagnostic and statistical manual of mental disorders: DSM-IV, 4th ed. Washington, DC: American Psychiatric Association. p 886.

American Psychiatric Association.(2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: American Psychiatric Association Retrieved from http://www.schizophernia.com

Andrew, R. G. (2006). Essentials of Abnormal Psychology.New Jersey, John Wiley & Sons, Inc.Hoboken.

Andrews, G., Corry, J., Issakidis, C., Lapsley, H., & Sanderson, K. (2003). Cost effectiveness of current and optimal treatment for schizophrenia. Journal of Psychiatry, 183, 427–435.

Andreasen, C. (1984). The Broken Brain: The Biological Revolution in Psychiatry. Harper & Row, Publishers, Inc.

Angelo, B. (1998).Schizophrenia and public health. Nation for mental health: Geneva. Retrieved from http://HYPERLINK "http://www.who.int/mental_health"www.who.int/mental_health.

Annegers, F., Begly, E., Coan, S., Lewis, C., Swann, C., &Schnapp, B. (2001). The lifetime cost of bipolar disorder in the US An estimate for new cases in 1998. USA: Pharmacoeconomics, 483-495

Arthur, F., Denise, D., & Stephanie, F. (2008).Clinical Psychology. New Jersey: by John Wiley & Sons, Inc Hoboken.

Assefa, D., Shibre, T., Asher, L.,& Fekadu, A. (2012). internalized stigma among patients with schizophrenia in Ethiopia: a cross-sectional facility-based study: BMC Psychiatry. Retrieved from http://www.ncbi.nlm.nih.gov.

Bebbington, P., Kuipers, L. (1994). The predictive utility of expressed emotion in schizophrenia: an aggregate analysis. Psychological Medicine, 24.

Bellack, A.S. (1999). Treating substance abuse among patients with schizophrenia. Psychiatr Serv, 50:75-80

Bernheim, K. F. & Lewine, R. R. (1979). Schizophrenia: Symptoms, Treatment, Causes. New York: Norto

Bertram, P. K. (2001). The Tragedy of Schizophrenia without Psychotherapy. USA: Michigan State, The American Academy of Psychoanalysis and Dynamic Psychiatry.

Bleuler, M. (1978). The Schizophrenic Disorders: Lang-term Patient and Family Studies,

Yale University Press. New Ha ven and London.

Brand, U. (2001).Careers' perspectives ActaPsychiatrScand: Mental health care; Germany, 104 (410): 35- 40.

Brian, S. (2006). What Causes Schizophrenia?. Retrieved from http://www.Psychcenter.com/disorder/schizophrenia.

Brian, K. (2010). Understanding Schizophrenia. Retrieved from http://HYPERLINK "http://www.healthline.com/"www.healthline.com.

Bockoven, S. (1975). "Comparison of Two Five-Year Follow-Up Studies: 1947 to 1952 and 1967 to 1972; American Journal of Psychiatry, 132, 796-801

Buka, S. K., Goldstein, J. M., Seidman, L. J., et al. (1999). Prenatal complications, genetic vulnerability, and schizophrenia: the New England longitudinal studies of schizophrenia. Psychiatric Annals, 29, 151 -156.

Burns, J. (2009). Dispelling a myth: developing world poverty, inequality, violence and social fragmentation are not good for outcome in schizophrenia. Johannesbg. Afr J Psychiatry, 12(3):200–5.

Caldwell, B., &Gottesman, I.(1992). Schizophrenia - a high-risk factor for suicide: Clues to risk reduction, Suicide and Life- Threatening Behavior, 22, 479–93.

Cannon, T.D., Kaprio, J., Lonnqvist, J., et al. (1998). The genetic epidemiology of schizophrenia in a Finnish twin cohort. A population-base modeling study. Archives of General Psychiatry, 55, 67 -74.

Castle, D., Sham, P., and Murray, R. (1998). Differences in distribution of ages of onset in males and females with schizophrenia. Schizophrenia Research, 33,179-183.

Christina, D. (2001). Early life risk factors for schizophrenia: studies of foetal and perinatal complications. Sweden Stockholm: Kompendiet, Göteborg.

Christine, B., Gillian, H., Nicholas, T., Shôn, L., Jan, M., Rob, B., N., et al. (2001). Randomized Controlled Trial of Motivational Interviewing, Cognitive Behavior Therapy, and Family Intervention for Patients With Comorbid Schizophrenia and Substance Use Disorders. UK: West Pennine, Manchester, and Stockport Health Authorities and Tameside. Retrieved from http://ajp.psychiatryonline.org/article.aspx.

Croudace, T., Errazuriz, A., Jackson, D., Kirkbride, J., McCrone, P., Morgan, C., M. et al. (2011). Systematic Review of the Incidence and Prevalence of Schizophrenia and Other Psychoses in England; Conducted for the Department of Health. Policy Research Program. UK, England.

David, C., John, McG., Joy, W.,&Sukanta, S. (2008). Schizophrenia: A Concise Overview of Incidence, Prevalence, and Mortality. Retrieved http://epirev.oxfordjournals.org.

David C., Joy W., John, McG.&Sukanta, S. (2005). A Systematic Review of the Prevalence of Schizophrenia:PLoSMedicineMay, 2,141. Retrieved http://HYPERLINK "http://www.plosmedicine.org/"www.plosmedicine.org

Davidson. L, McGlashan, TH. (1997). The varied outcomes of schizophrenia.Canadian Journal of Psychiatry, 42.

Edwards, B., Higgins, D., Gray, M., Zmijewski, N., & Kingston, M. (2008).The nature and impact of caring for family members with a disability in Australia (Research Report No. 16). Melbourne: Australian Institute of Family Studies.

Effective Health Care. (2000). Psychosocial interventions for schizophrenia. Royal Society of Medicine Press.

Federal Health control Minister Amanuel Mental Specialized Hospital. (2012), The second MSC IN ICCMH Graduates bulletin, Joint program between University of Gonder and

Amanuel Mental Specialized hospital on integrated clinical and community mental health; Ethiopia, Addis Ababa.

Fedem, P. (1943), Psychoanalys is of psychosis: I, Psychiatric Quarterly, 17, 3-19.

Frank, D. F. and Jonathan, F., & Miles, H. (2005). Abnormal Psychology: Psychology text book. UK, Oxford: The British Psychological Society and Blackwell Publishing Ltd.

Freud, S. (1949). Repression. In collected papers. London: The Hogarth Press,4. (Original work published in 1915)

Fontana, A. and Frey, JH. (1994). "Interviewing the art of science" in NK Denzin and YS Lincoln (eds) Handbook of Qualitative Research, pp. 361-376.

Geddes, J. R. &Lawrie, S. M. (1995). Obstetric complications and schizophrenia: a meta-analysis. British Journal of Psychiatry, 167, 786 -793.

Gerald, C. (2009). Theory and practice of counseling and psychotherapy, 8thed.USA: Thomson Brook.

German, E., José, M., &Rogelio, L. (2003). A Conceptual History,Schizophrenia: International Journal of Psychology and Psychological Therapy, 3.

Goff, D.C., Henderson, D.C., and Amico, E. (1992). Cigarette smoking in schizophrenia: Relationship to psychopathology and medication side effects. American Journal of Psychiatry, 149,1189-1194,.

Gottesman, I. I., & Bertelsen, A. (1989). Confirming unexpressed genotypes for schizophrenia. Risks in the offspring of Fischer's Danish identical and fraternal discordant twins. Archives of General Psychiatry, 46, 867 -872.

Gordon, G.T. (1990). Schizophrenia: A Handbook for Families. Schizophrenia Society of Alberta, Manitoba Schizophrenia Society, Inc.

Gordon, R. (1987). An operational classification of disease prevention: Preventing mental disorders: a research perspective. Rockville, Department of Health and Human Services: 20–26.

Gupta, R.D., Guest, J.F. (2002). Annual cost of bipolar disorder to UK society. British: Journalof Psychiatry, 180, 227-233.

Hegarty, JD., Baldessarini ,RJ., and Tohen, M. (1994). One hundred years of schizophrenia: A meta-analysis of the outcome literature. Am J Psychiatry,151,1409–16

Heinrichs, RW. (1993). Schizophrenia and the brain. Conditions for a neuropsychology of madness.Am Psychol, 48(3):221-33.

Hallett, S. (1999). Behavioural, Family Therapy for Psychiatric Disorders, 2nd edn," New York university press.

Harding, CM., Brooks, GW., Ashikaga, T., Strauss, JS., Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia". American Journal of Psychiatry.

Harrison, G., Hopper, K., Craig, T., et al. (2001). Recovery from psychotic illness: a 15- and 25-year international follow-up study. Journal of Psychiatry, 178.

Haro, JM., Ochoa, S., Gervin, M., Mavreas. V., and Jones, P. (2007). Assessment of remission in schizophrenia with the CGI and CGI-SCH scales (Letter). Acta Psychiatr Scand, 115, 163–4.

Harvey, C.A., Jeffreys, S.E., McNaught, A.S., Blizard, R.A., King, M.B. (2007). The Camden Schizophrenia Surveys III: Five-Year Outcome of a Sample of Individuals From a

Prevalence Survey and the Importance of Social Relationships. International Journal of Social Psychiatry,53 .

Hoff, P. (1994). Emil Kraepelin und die PsychiatriealsklinischeWissenschaft. Berlin: Springer.

Holloway, F. (1991). Case management for the mentally ill: looking at the evidence. International Journal of Social Psychiatry, 37, 2-13.

Holloway, F., and Carson, J. (1998). Intensive case management for the severely mentally ill: controlled trial. Br J Psychiatry, 172, 19–22

Irving, G., Sherrell, A., and Steven, M. (2008).Schizophrenia and Genetic Risks: A Guide for Genetic Counseling, 2nded. National Institute of Mental Health. National Institute of Health: Rockville, Maryland.

Jablensky, A. (1995). Schizophrenia: recent epidemiologic issues. Epidemiologic Reviews, 17, 10-20.

Jana, S. (2003). Family living with severe mental illness. USA, Texas: EBSCO Publishing.

Jefreyw, W. & Laurie,F. (2008). The Gale Encyclopedia of mental health, 2nded. The Galle Group.

Jeanne, S. [Segal], and Melinda S. [Smith]. (2013). Schizophrenia Treatment and Recovery: Practice Guidelines for the Treatment of Patients with Schizophrenia . American Psychiatric Association.

John, G. (2013). Schizophrenia Treatment. Retrieved from http://psychcentral.com/disorders/sx31t.htm.

Johnston, M. H. &Holzman, P. S. (1979). Assessing Schizophrenic Thinking: A Clinical and Research Instrument for Measuring Thought Disorder. San Francisco, CA: Jossey-Bass.

Jose, M. & Helen, K. (2001). Long Term Mental Health Care for People with Severe Mental Disorder: Europian Union.

Journal of Clinical Psychiatry, Vol 67(3), Mar 2006, 443-452. Retrieved from http://dx.doi.org/10.4088/JCP.v67n0316

Kaplan, H., Saddock, B., & Grebb, J. (1994). Synopsis of psychiatry: Behavioral sciences clinical psychiatry, (7th ed.). Baltimore: Williams & Wilkins.

Kendell, R. E., Juszczak, E. & Cole, S. K. (1996). Obstetric complications and schizophrenia: a case control study based on standardized obstetric records. British Journal of Psychiatry, 168, 556 -561.

Kendler, K. S. (1995). Genetic epidemiology in psychiatry: taking both genes and environment seriously. Archives of General Psychiatry, 52, 895 -899.

Kety, S. (1974). From rationalization to reason. American Journal of Psychiatry, 131, 957–963.

Kinney, D. K., Holzman, P. S., Jacobsen, B., et al. (1997). Thought disorder in schizophrenic and control adoptees and their relatives. Archives of General Psychiatry, 54, 475 -479.

Kraepelin, E. (1899). Psychiatry EinLehrbuch, (6th ed). Leipzig: Barth.

Kokanovic, R., Petersen, A., &Klimidis, S. (2006). "Nobody can help me... I am living through it alone." Experiences of caring for people diagnosed with mental illness in ethno-cultural and linguistic minority communities. Journal of Immigrant and Minority Health, 8(2), 125–135.

Kuhn, R. (2004). EugenBleuler's concepts of psychopathology".tr. Cahn CH. Hist Psychiatry,15 (3): 361–6.

Kvale, S. (1996). InterViews: An Introduction to Qualitative Research Interviewing. California: Sage.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. International Journal of Qualitative Methods, 2(3). Article 3. Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf

Lieberman , JA, Koreen AR, Chakos M, et al. (1996) Factors influencing treatment response and outcome of first-episode schizophrenia: implications for understanding the pathophysiology of schizophrenia. Journal of Clinical Psychiatry, 9.

Lewis, S. W. & Murray, R. M. (1987).Obstetric complications, neurodevelopmental deviance and risk of schizophrenia.Journal of Psychiatric Research, 21, 413 -421.

Long, P.(1996). Retrieved from http://psychcentral.com/disorders/sx31t.htm.

Long, P. (1997). Schizophrenia: A Handbook for Families. Canada: Minister of Supply and Services Canada. Retrieved from http://www.mentalhealth.com.

Łukasz, C. (2008). Changes in defence mechanisms of people suffering from psychotic disorders and receiving therapy in the Day Treatment Centre. Archives of Psychiatry and Psychotherapy, 4 : 27–32

Makhanya, M.S. (2012). The traditional healers and caregivers' views on the role of traditional Zulu medicine on psychosis. University of Zululand.

Maluo, M. (2012). Knowledge and Attitude of caregivers of patients with Schizophrenia in port mores. Pacific Journal of Medical Sciences, 10(1). Retrieved from www.pacjmedsci.com.

Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment. Social Psychiatry and Psychiatric Epidemiology, 39(5), 337-349.

Michael, B.(2013). Types of Schizophrenia. MediLexicon International Ltd, Bexhill-on-Sea, UK

Ming, T., Stephen, F., and William, S. (2013). Genes, environment and schizophrenia, The British Journal of Psychiatry, Retrieved from http://bjp.rcpsych.org.

Morgan, R. F. (1999). Electroshock Treatment over Four Decades: The Case Aga inst, Morgan Foundation Publishers, Mangilao, Guam.

Munetz, MR., Grande, TP., and Chambers, MR. (2001). The incarceration of individuals with severe mental disorders.Community Ment Health J, 37, 361–372.

Murray, R.M. (1997). Schizophrenia: The essentials of postgraduate psychiatry, 3rd ed. Cambridge: Cambridge University Press.

National Alliance on mental Illness. (2008). Understanding Schizophrenia and Recovery: Arlington, VA. Retrieved from National Alliance on mental Illness www.nami.org.

National Alliance on mental Illness. (2009). Schizophrenia, you are not alone: Arlington, VA. Retrieved from National Alliance on mental Illness www.nami.org.

Neel, B. (2012). Living with Schizophrenia.

NHS Center for reviews and dissemination. (2000). Effective Health Care: Psychosocial interventions for schizophrenia. UK: Royal Society of Medicine Press, 6, (3).

Ödegard, Ö. (1967). Changes in the prognosis of functional psychoses since the days of Kraepelin. British: Journal of Psychiatry, 113, 813-822.

Os J, Burns T, Cavallaro R, et al. (2006). Standardized remission criteria in schizophrenia.ActaPsychiatricaScandinavica, 113.

Pamela. G., Cristina.J., and Serafín, L. (2008). Primary caregivers of schizophrenia outpatients: Burden and predictor variables. Science direct Psychiatry Research,158, 335–343.

Patrick, McG. (2000). New hope for people with schizophrenia: American psychology association, 31(2), 24. Retrieved from http://www.apa.org/monitor/feb00/schizophrenia.aspx

Paul, B. (2005). Abnormal Clinical Psychology,2nded. New York, USA: Two Penn Plaza.

Pike, A., & Plomin, R. (1996). Importance of nonshared environmental factors for childhood and adolescent psychopathology. Journal of the American Academy of Child and Adolescent Psychiatry, 35, 560 -570.

Prashant T. and Shevonne M. (2010). Caregivers in schizophrenia: A cross Cultural Perspective, Indian J Psychol Med, 32(1): 29–33

Reiss, D., Plomin, R. & Hetherington, E. M. (1991). Genetics and psychiatry: an unheralded window on the environment. American Journal of Psychiatry, 148, 283 -291.

Robbins, M. (1993). Experience of schizophrenia: an integration of the personal, scientific and therapeutic. USA: New York. The Guilford press.

Robinson, DG, Woerner MG, McMeniman , M, Mendelowitz, A., Bilder, RM. (2004). Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. American Journal of Psychiatry, 161(3):473–9.

Rosalind, G. (1997). Gender and the Media. London. King's college.

Rosenhan, D. (1973). On being sane in insane places. Science journal, 179 (4070): 250–8.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. Social Science & Medicine, 56(2), 299-312.

Streubert, HJ., And Carpeter, DR. (1999). Qualitative research in Nursing: Advancing the Humanistic perspective. Lippincott, Philadelphia.

Tienari, P. (1991). Interaction between genetic vulnerability and family environment: the Finnish adoptive family study of schizophrenia. ActaPsychiatricaScandinavica, 84, 460 -465.

Tienari, P., Wynne, L. C., & Moring, J., et al .(1994). The Finnish adoptive family study of schizophrenia. Implications for family research.British Journal of Psychiatry, 163 (23), 20 -26.

Theocharis., K. (2005). Notes on the History of Schizophrenia.German Journal of Psychiatry ISSN 1433-1055. Retrieved from http://www.gjpsy.uni-goettingen.de

Torrey, E. (1988). Surviving Schizophrenia: A Family Manual. United States: by Harper & Row Publishers, Inc.

Tsuang, M. T., Faraone, S. V. & Lyons, M. J. (1993).Identification of the phenotype in psychiatric genetics.European Archives of Psychiatry and Clinical Neuroscience.

Vaillant, G. (1994). Ego mechanisms of defense and personality psychopathology. Journal of Abnormal Psychology, 103(1), 44–50.

Walsh, M., (1985). Schizophrenia: Straight Talk for Families and Friends. New York, N.Y.:William Morrow and Company Inc.

Weinberger, D. (1990). The construct validity of the repressive coping style. Repression and Dissociation. Chicago: University of Chicago Press.

Whitaker, L. C. (1992). Schizophrenic Disorders,' Sense and Nonsen se in Conceptu alization, Assessmellt, and Treatment, Plenum Press, New York.

Wilkinson, G. (1986). Political dissent and "sluggish"; schizophrenia in the Soviet Union (Res Ed).Br Med J, 293 (6548), 641–2

William, McF. (December 11, 2007). Schizophrenia: Psychological and Social Causes and Treatments, Schizophrenia Daily News Blog. Retrieve from http://www.schizophrenia.com/sznews/archives/005839.html .

Wilson, H., & Hutchinson, S. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. Qualitative Health Research, 1, 263-276.

World Health Organization.(1992). International Statistical Classification of Diseases and Related Health Problems-10th Revision, 1. Geneva: Author.

World Health Organization (2001). World Health Report 2001—Mental health: New understanding, new hope. Geneva: World Health Organization. Retrieved from http://www.who.int/whr/2001/en/whr01_en.pdf.

World Health Organization. (2001). World health report 2001: mental health : new understanding, new hope. Geneva: World Health Organization.

World Health Organization (2013). Schizophrenia, Geneva: Nation for mental health. Retrieved from the official website of World Health Organization http://www.who.int/mental_health.

Wyatt, R.J., Henter, I. (1995). An economic evaluation of manic-depressive illness-1991 SocPsychiatry.PsychiatrEpidemiol, 30, 213-219.

Wahlberg, K. E., Wynne, L. C., & Oja, H., et al. (1997). Gene-environment interaction in vulnerability to schizophrenia: findings from the Finnish adoptive family study in schizophrenia. American Journal of Psychiatry.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology.Journal of Counseling Psychology, 52, 167–177.

Wilson, H., & Hutchinson, S. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. Qualitative Health Research, 1, 263-276.

Ziedonis, D., Kosten, T., Glazer, W., Frances, R. (1994). Nicotine dependence and schizophrenia. Hosp Community Psychiatry, 45, 204— 206.

Appendix

I

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Informed consent form and questionnaire

Introduction:

This study is anticipated to assess Problems and Coping Mechanisms of Persons with Schizophrenia and their Caregivers: Implications for Psychosocial Interventions, in the case of Amanuel Mentally Specialized Hospital.

You are invited to participate on this study. If you are willing to participate, you need to understand and sign the agreement form. Subsequent to, you will be interviewed by the data collector. You do not need to write your name or to tell your name to the data collector and all your response and the results obtained will be kept confidentially by using coding system.

Procedure:

After you understand and sign the agreement form, you will be interviewed by data collectors. You do not need to write your name or to tell your name to the data collector and all your responses and the results obtained will be kept confidentially, by using coding system no one will have access to your response and is used only for the purpose of this study..

Risk/Discomfort:

By participating in this study, you may fill that it has some discomfort while you sit for the interview. We hope you will participate in the study for the sake of the benefit of the research result. There is no risk in participating in this research.

Benefits:

If you participate in this research, there may not be direct benefit to you but your participation is likely help us to meet the research objective. Ultimately, this will help us to improve services for the community.

Incentives:

You will not be provided any incentives or payment to take part in this project.

Confidentiality

The information collected from this research will be kept confidential. Information will be stored in a file, without your name, only code number is used. All the information you provide is confidential and is used only for the purpose of this study.

Right to refuse or withdraw:

You have full right to refuse from participating in the research. You can choose not to respond to some or all question if you do not want to give your response. You have also full right to withdraw from this study at any time you wish without losing any of your right.

Person to contact:

This research was reviewed and approved by the ethical committee of Addis Ababa University. If you have any question you can contact the researcher and you may ask any time you want.

1. Contact address of investigator: -

Tee: 0913068573

Email: tihtenateklu@yahoo.com

If you agree to participate in this study, please sign below

Signature____________________
Date_________________________
Code of respondent:-________________________
Thank you in advance for your cooperation.

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Topic Guides

For people with schizophrenia

Socio-Demographic characteristics

1. Name---
2. Gender---
3. Age -------------------------------
4. Schizophrenia type--
5. Educational level--
6. Marital status ------------------------------
7. Occupation --

Family status

1. With whom do you live? -----------------------------
2. Do you have siblings/children?--
3. Parents/guardian situation --

Health status

1. Is there any history of mental illness in your family? -----------------
2. Are you taking other medication beside the current on? --
3. Any substance use? --

Questions related to problems and coping mechanisms

1. What kinds of problems are you facing after you become ill?
2. Are you facing problems related to economic, social, and family, health, social support, stigma, medication side effects?
3. How did your family react and treat you? Did they treat you and accept you as before?
4. How do you comment your communication with your friends and family members?
5. Do your friends still with you, do you have a contact?
6. Do you have good relationship with your family members?

7. Do your friends and family members encourage, tolerate and be there for you whenever you need them?
8. Is there anyone who supports you financially?
9. How do you comment your communication with the community you are living with?
10. Do you go to different community gatherings?
11. Do the people in the community isolate and stigmatize you?
12. What problems do you face in your relationship you're your parents/guardian/spouse/children?
13. Do you think you are worth to the family?
14. Do you have hostile environment at your home? Do they complain because you are not taking care of yourself like before?
15. What kind of support did you get at the hospital? How much did it help you?
16. Medication
17. Psychosocial; individual counseling, group counseling, liking with support group, vocational rehabilitation
18. Do you think with the support you will get, you will be able to live your life independently in the future?
19. How do you manage the economic, social, familial, and health, problems you are facing?
20. What kind of activities or methods do you use to cope-up?

For family members /Caregivers

Socio-demographic characteristics

1. Name---
2. Gender--
3. Age -----------------------------
4. Relationship with the patient -----------------------------------

Questions related to problems and coping mechanisms

1. When did the problem happen to the patient?
2. What kinds of support did you get at the hospital, as a family?
3. How to manage medication in cooperation with the patient?
4. Psychosocial support including; stress and burnout management, individual and group counseling, liking with support group, vocational rehabilitation, networking?
5. Do you think with the support you get, will be able to live your life in a better way and help the patient to cope-up?
6. What kind of problems does the patient is facing after he\she becomes ill?
7. Is he\she facing problems related to economic, social, and family, health, social support, stigma, medication side effects?
8. How did he\she feels about the family\guardian? Did he\she treat and accept the family/guardian as before?
9. After he\she faces this illness what kind of activities or methods do the patient using to cope-up?

For health care workers

Socio-demographic characteristics

1. Name--
2. Gender --
3. Position ---

Questions related to problems and coping mechanisms

1. From your experience, what are the major problems of people with schizophrenia?
2. Economic, social, medication, psychological.
3. How do you help the patients to cope-up with these problems? Any difference while they are inpatient and outpatient?
4. How patients and caregivers cope-up their own problems by their own?
5. What should be done to improve the life of schizophrenic person?

Appendix

II

አዲስ አበባ ዩኒቨርሲቲ
የትምህርት እና ስነ-ባህሪ ኮሌጅ
የስነ-ልቦና የትምህርት ክፍል

የመረጃና የስምምነት ውል ቅጽ

መግቢያ

ይህ ጥናት የተዘጋጀው የስኪዞፍሬኒያ ህመምተኞች እና ቤተሰቦቻቸው የሚያጋጥማቸውን ችግር እንዲሁም በምን መልኩ ሊቋቋሙ እንደሚችሉ ከሳይኮሶሻል ድጋፍ አንፃር በማየት ለማጥናት ሲሆን ጥናቱም በአማኑኤል የአይምሮ ስፔሻላይዝድ ሆስፒታል ነው::

በዚሁ ጥናት ላይ እርስዎ ተሳታፊ እንዲሆኑ ተጋብዘዋለል፡፡ በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ከሆኑ በደንብ ሊረዱት እና የመረጃና የስምምነት ውል ቅጽ ሊፈረም ይገባል፡፡ በመቀጠልም መረጃውን የሚሰበስበው ሰው ቃለመጠይቅ ያከናውናል፡፡ ስም መጻፍ ወይንም መረጃውን የሚሰበስበው ሰው ስም መንገር አያስፈልግም፡፡

አተገባር

በዚህ ጥናት ለመሳተፍ ፈቃደኛ የሚሆኑ ከሆነ ተሳታፊ በመሆንዎ በጣም ደስተኞች ስንሆን የጥናቱን ዓላማ በግልጽ እንድረዱና የስምምነት ውሉን እንድፈጽሙልን እነፈልጋለን፡፡በዚህ መሰረትም መረጃውን የሚሰበስበው ሰው መጠይቅ የሚሞላት ይሆናል፡፡ማንኛውም ከተሳታፊ የሚሰበሰብ መረጃ ምስጢራዊነቱ የተጠበቀ እንዲሆን ሚስጥራዊ ቁጥር የምጠቀም ሲሆን መረጃውም ለሌላ ጉዳ የማይውል መሆኑን አሳውቃለሁ፡፡

ሊደርስ የሚችል ጉዳት

በዚህ ጥናት ተሳታፊ በመሆንዎ ምክንያት የሚደርስብዎ ምንም ዓይነት ጉዳት የለም ምናልባት መጠይቁን ለመሙላት የሚወስዱት ጊዜ እንጂ፡፡ጥናቱ ወደፊት ሚደረጉ ጥናቶችን ለመደገፍ ትልቅ አስተዋጽኦ እንደሚያደርግዉ ተስፋ አደርጋለሁ፡፡ በዚህ ጥናት በመሳተፍዎ ሊደርስ የሚችል ጉዳት የለም፡፡

ጥቅም

በዚህ ጥናት ተሳታፊ በመሆንዎ በቀጥታ ሊያገኙት የሚችሉት ጥቅም ባይኖርም የእርስዎ ተሳትፎ የጥናቱን አላማ እንድናሳካ ይረዳናል፡፡ በዋነኝነት ለማህበየሚስጠውን አገልግሎት ለማሻሻል ጠቃሚ ሀሰቦችን ለመሰንዘር ጠቃም ነዉ፡፡

ጥቅማጥቅም

በዚህ ጥናት ተሳታፊ በመሆንዎ ምንም ዓይነት ማበረታቻ ወይም ክፍያ አይሰጥዎትም፡፡

ሚስጥራዊነት

በዚህ ጥናት ፕሮጀክት የሚሰበሰበው መረጃ ሚስጢር እንድሆን ጥንቃቄ ተደርጎበታል፡፡የሚሰበሰበውም መረጃ የተሳታፊው ስም የማያካትት ፤ ሚስጥራዊ ቁጥር ብቻ ይሆናል፡፡

በጥናቱ ያለመሳተፍ ወይም የማቋረጥ መብት

በዚህ ጥናት ያለ መሳተፍ መብትዎ ሙሉ ሙሉ የተጠበቀ ነው፡፡ለጥያቄዎቹ በሙሉ ወይም በከፊል መልስ አለመስጠት ይችላሉ፡፡

እንድሑም በፈለጉት በማናኛውም ሰዓት ማንኛውን መብትዎን ሳያጡ የማቋረጥ ሙሉ መብት አለዎት፡፡

ማግኘት የሚችሉአቸው ሰዎች

ይህ ምርምር ፕሮጀክት በአዲስ አበባ ዩኒቨርሲቲ የምርምርና ሥነ-ምግባር ኮሚቴ የሚጸድቅ ነው፡፡የበለጠ መረጃ ለማግኘት ከፈለጉ በሚከተሉት አድራሾች ማግነት ይችላሉ፡፡

●ትህትና ተክሉ (ዋና ተመራማሪ)

ስልክ፡- 0913068573

ኢሜል፡- tihtenateklu@yahoo.com

በጥናት ለመሳተፍ ፈቃደኛ ከሆኑ እባክዎን ከዚህ በታች ይፈርሙ፡፡

ፊርማ-----------------------------------

ቀን-------------------------------------

የመላሽ መለያ ቁጥር---------------------

ስለምታደርገው/ጊው ትብብር በድጋሜ አመሰግናለሁ፡፡

አዲስ አበባ ዩኒቨርሲቲ

የትምህርት እና ባህሪ ጥናት ኮሌጅ

የስነ-ልቦና የትምህርት ቤት

የጥናታዊ ጽሁፉ መምሪያ ጥያቄ

ሀ. ከህመሙ ጋር ላሉ ሰዎች

የግለ ድህር

1. ስም---
2. ፆታ -------------------------------
3. እድሜ--------------------------------
4. የስኪዞፍራኒያ መደብ-------------------------------------
5. የትምህርት ደረጃ ----------------------------------
6. የጋብቻሁናቴ--
7. የስራ ሁኔታ--

ቤተሰብሁኔታ

1. ከማን ጋር ነው የምትኖረው/ሪው? ---------------------------------
2. እህት፤ወንድም/ልጆች አሉህ/ሽለ? ----------------------------------
3. የቤተሰብ/የአሳዳጊ ሁኔታ---

የጤናሁኔታ

1. በቤተሰብ የአይምሮ ህመም ያለበት አለ?----------------
2. ከአሁኑ በተጨማሪ ሌላ መድሀኒት ትወስዳለህ/ጃለሽ?-----------
3. አደንዛዥ/አነቃቂ እጽ ትወስዳለህ/ጃለሽ?---------------------------

መጠይቅ

1. ታመምክ/ሽ ወዲህምንአይነትችግሮችንእየተጋፈጥህ/ሽ ነው?

   - እያጋጠመህ/ሽ ያለው ችግር ከኢኮኖሚ፣ ማህበረሰብአዊ፣ ከቤተሰብ፣ የጤና፣ የወዳጆች ድጋፍ፣ መድሎ፣ እየወሰድከው/ሽው ያለው መድሀኒነት የጎንዮሽ ጉዳት ጋር ተያያዥነት አለው?
   - ቤተሰቦችህ/ሽ በምን መልኩ ለሁኔታህን/ሽን ምላሽ ሰጡ እናም በምን መልኩስ ቤት ውስጥ ትስተናገዳለህ/ጃለሽ?

2. ከጓደኞችህ/ሽ ጋር እና ከቤተሰብ ጋር ያለህ ተግባቦ በምን መልኩ ታየዋለህ/ሽ?

   - ጓደኞችህ/ሽ አብረውህ/ሽ አሉ፤ ትገናኛላችሁ?
   - ከቤተሰቡ አባላት ጋር ጥሩ አይነት ግኑኝነት አለ?
   - ጓደኞችህ እና ቤተሰብህ ያበረታቱሃል፤ ይታገሱሃል፤ እንዲሁም በምትፈልጋቸውግዜ ካጠገብህ ይሆናሉ? \ ጓደኞችሽ እና ቤተሰብሽ ያበረታቱሻል፤ ይታገሱሻል፤ እንዲሁም በምትፈልጊያቸውግዜ ካጠገብሽ ይሆናሉ?
   - በገንዘብ የሚያግዝህ/ሽ ሰውአለ?

3. ከአካባቢህ/ሽ ሰዎች ጋር ያለህ/ሽ ተግባቦ ምን መልኩ ታየዋለህ/ሽ?

   - ሰዎች በብዛት የሚገኙበት ቦታዎች ላይ ትገኛለህ/ሽ?
   - በአካባቢህ/ሽ ያሉ ሰዎች ይነጥሉሃል/ሻል፤ ያገሉሃል/ሽል?

4. ከቤተሰብ/አሳዳጊ/የትዳር አጋር/ልጆች ጋር ባለህ/ሽ ግንኙነት የሚያጋጥሙህ/ሽ ችግሮች ምንድናቸው?

   - ለቤተሰቦችህ ጠቃሚነኝ ብልህ/ሽ ታስባለህ/ቢያለሽ?

- የ ቤትህ/ሽ ውስ ጠአ ካ ባ ቢ ጠን ካ ራ ግ ጭት ያ ለ በ ት ነ ው ? እ ራስ ህ ን /ሽ ን እ ን ደ ቀ ድሞው መጠበ ቅ ስ ላ ል ቻ ል ክ /ሽ ይ ኮ ን ኑ ሀ ል /ሻ ል ?

5.ከሆስፒታሉ ምን አይነት ድጋፍ እያገኘህ/ሽ ነው? ምንያህልስረድቶሀል/ሻል?

- መድ ሀ ኒ ት
- ሳ ይ ኮ ሶ ሻ ል ፡ - የ ግ ል እ ና የ ቡድን ምክ ክ ር ፣ ከ ደ ጋ ፊ ቡድኖ ች ጋ ር መገ ና ኘ ት ፣ የ ስ ራ ተ ሃ ድሶ
- በ ምታገ ኘ ው/ኚ ው ድ ጋ ፍ ለ ወ ደ ፊ ት ኑ ሮ ህ ን /ሽ ን በ ራ ስ ህ /ሽ እ ን ድ ት ኖ ር /ሪ ያ ስ ች ለ ኛ ል ብ ል ህ /ሽ ታ ስ ባ ለ ህ /ቢ ያ ለ ሽ ?

6.እየተጋፈጥካቸው/ሻቸው ያሉትን የኢኮኖሚ፣ ማህበረሰብአዊ፣ ከቤተሰብ፣ የጤና ችግርህን/ሽን እንዴት ትቆጣጠራቸዋለህ/ሪያቸዋለሽ?

- ች ግ ሩ ን ለ መቋ ቋ ም ምን አ ይ ነ ት እ ን ቅ ስ ቃ ሴ ወ ይ ም ዘ ዴዎ ች እ የ ተ ጠቀ ምክ /ሽ ነ ው?

ለ. ከህመሙ ጋር ያሉ ሰዎች ቤተሰቦች

1. ስም---

2. ፆታ -----------------------------

3. እድሜ-------------------------------

4. ከታማሚው ጋር ያለ ዝምድና --

መጠይቅ

1. የአይምሮ ህመም ያጋጠማት/መው መቼ ነው?

2. ህመምተኛው ከቤተሰቡ ጋር ያለው ተግባቦት እንዴት ነው?

- ቤተሰቡ ለህመምተኛው ምን አይነት ድጋፍ እየሰጠ ነው?
- ቤተሰቡ ከህመምተኛው ጎን እንደቆመነው? ቤተሰቡ ከህመምተኛው ጋር ግንኙነት አለው?
- እንደ ቤተሰብ፤ህመምተጋውን፤ ታበረታታላችሁ፤ ትታገሳላችሁ፤ እንዲሁም በሚፈልጓችሁ ግዜ ካጠገባቸው ትሆናላችሁ?
- ህመምተኛውን በገንዘብ የሚያግዝ ሰው አለ ?

3. እንደ ቤተሰብ ከሆስፒታሉ ምን አይነት ድጋፍ አገናችሁ? ምንያህልስረድቶህል/ሻል?

- ከህመምተኛው ጋር በመተባበር የመድሀኒት አወሳሰድን መቆጣጠር?
- ሳይኮሶሻል ድጋፍ የሚጠቃልለውም፡- ውጥረትን እና ልሽቀትን መቆጣጠር፣ የግልና የቡድን ምክክር፣ ከደጋፊ ቡድኖች ጋር መገናኘት፣ የስራ ተሃድሶ፣ ከሚመለከታቸው አካላት ጋር ግንኙነት ማግኘት

4.በምታገኘው/ኚው ድጋፍ ለወደፊት ኑሮህን/ሽን በራስህ/ሽ በተሻለ መልኩ እንድትኖር/ሪ ያስችለኛል ብልህ/ሽ ታስባለህ/ቢያለሽ ስለዚህም ህመምተኛው ችግሩን እንዲቋቋም መርዳት የምትችል/የምትችይ ይመስልህል/ ይመስልሻል?

5.ህመምተኛው ከታመመ ወዲህ ምን አይነት ችግር እየገጠመው ነው ?

- እያጋጠመው ያለው ችግር ከኢኮኖሚ፣ ማህበረሰብአዊ፣ ከቤተሰብ፣ የጤና፣ የወዳጆች ድጋፍ፣ መድሎ፣ እየወሰደው/ችው ያለው መድሀኒነት የጎንዮሽ ጉዳት ጋር ተያያዥነት አለው?

- ስለ ቤተሰቡ በምን ስሜት አለው/ላት? እንደ ቀድሞው ቤተሰቡን ግስተናገዳል/ግዳለለ እንዲሁም ይቀበላል/ትቀበላለች?

ሐ. ለባለሞያዎችየ

1. ስም---

2. ፆታ--

3. የስራድርሻ-------------------------------------

መጠይቅ

1. ከልምድህ/ሽ የስኪዞፈርኒክ ህመምኛ በዋነኝነት የሚያጋጥማቸው ችግር ምንድን ነው?
   - ኢኮኖሚያዊ፣ ማህበረሰባዊ፣ የሚወሰዱ መድሀኒቶች ጋር፣ ስለልቦናዊ
2. ህመምተኛው በምን መልኩ ችግሩን/ሯን እንዲቋቋም/እንድትቋቋም ትረዳላችሁ? በሆስፒታሉ ተኝተው ሲታከሙ እና ተመላላሽሲሆኑ ልዩነቶች አሉ?
3. ህመምተኛው/ዋ ችግራቸውን በራሳች ችንዴት እየተቋቋሙ ነው?
4. የስኪዞፈርኒክ ህመምኛውን ህይወት ለማሻሻል ምን መደረግ አለበት?

Declaration

I, the undersigned, declared that this thesis is my original work and the best of my knowledge has not been presented in any other university, and that all source of material used for this thesis has been duly acknowledged.

Declared by

Name_Tihtenat Teklu____Signature__________________ Date ______________

Confirmed by advisor

Name__Kassahun Habtamu__Signature_________________ Date _______________

____.

Place and date of submission.