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The effects of psychological help on assertive behaviors in family members of schizophrenia patients

Aleksandra Skotnik[1], Agnieszka Samochowiec[2]

[1] Department of Psychiatry, Independent Public Healthcare Center in Gryfice
[2] Department of Clinical Psychology and Psychoprophylaxis, Institute of Psychology, University of Szczecin

Summary

Aim. The aim of this study was to determine the relationship between the use (or lack thereof) of psychological help among family members of schizophrenia patients, and their expression of assertive behavior in relation to their relatives suffering from the illness.

Material and methods. The study group consisted of 34 people who run the household with their loved ones – schizophrenia patients. In the study we used the Social Competence Questionnaire (KKS) by Matczak, and the Coping Inventory for Stressful Situations (CISS) in the Polish adaptation by Wrześniewski et al. Socio-demographic data were collected through a self-designed survey.

Results. There was a relationship between a general tendency to avoid action in a problem situation and a tendency to seek social diversion in order to cope with stress. Assertive behavior was also found to correlate with a tendency to engage in substitute activities. Greater willingness to display assertive behavior was observed in subjects who revealed a tendency to avoid thinking about the problem and seeking active solutions in a stressful situation. The analyses also showed that younger people who coped with stress by revealing an avoidant coping style exhibited a more assertive behavior.

Conclusions. Our study did not confirm the link between the use of psychological assistance by the relatives of schizophrenia patients and their expression of assertive behavior in relation to the patient. However, it proved important that younger people who coped with stress by means of avoidance-oriented strategies manifested a greater propensity for assertive behavior.

Key words: assertive behavior, schizophrenia, family

Introduction

In the postwar period up until the 1960s, it was believed that schizophrenia is the result of improper socialization or communication within the family [1]. Particular emphasis was placed on the mother–child relationship. It was believed that it was

the relationship with the mother and her child-rearing methods that had a decisive impact on the future of the offspring. Such views had become the groundwork for clinical trials, which showed that mothers of schizophrenia patients were characterized by: emotional coldness, overprotectiveness, or domination. They were, thus, called "schizophrenogenic" mothers and alleged to inhibit the growth of the ego of their children [2]. Clinical observations included other members of the family as well. Some blame was, therefore, also assigned to the father, who "was supposedly not an effective counterweight to the schizophrenogenic mother and could not help his child in setting boundaries" [3, p. 27]. Thus, the family became the most important reference group. Empirical studies were conducted on the family life of individuals with schizophrenia [3]. During that time the opinion that schizophrenia is not so much an illness as a pathological effect of family relationships became a common notion. The phenomenon was soon labeled the schizophrenogenic family [3].

Another theory was family projection theory. "The process was believed to involve several generations of a family, and its effect was the transmission of certain forms of disturbances from parents to children, then grandchildren, and so on" [4, p. 99]. The main element of this process was supposed to be the mother, whose main responsibility was the upbringing of the child. In parallel, there was a view that she was not prepared to fulfill that role. The anxiety she felt made her see her child through the prism of her own ideas about him/her. "In other words, excessive anxiety and overprotection on the part of the mother forced the child to assume the role of a dependent person, subordinated and ill. After some time, this process was to lead to the development of symptoms of behavioral disorders that appeared most often in stressful situations" [4, p. 99].

Currently, there are two basic clinical models of schizophrenia, which are called bio-psychosocial models [5]. The first one is Zubin's vulnerability model, according to which the main cause of the illness is vulnerability to harm. To some extent it is innate, but it is also shaped in the process of socialization. In a situation of chronic and severe stress, alongside the existing genetic burden, it may lead to the destabilization of mental functioning and development of the illness [5]. This model draws attention to the fact that it is the environment (including the family) that plays an important role in the life of the patient, i.e., it can be a protective factor, but also raise the risk of the illness.

The second model is the theory of expressed emotion [6, 7]. This theory is the result of research on patients' environments to which they returned after hospitalization. From the observations, there emerged two main groups: patients living with their parents or spouses and patients living with some other relatives or alone [3]. Interestingly, those belonging to the former group suffered more frequent relapses. Another significant variable was unemployment in the mother and the patient. "The theory of expressed emotion draws attention to the atmosphere within the family, reflects the emotional attitude of the family towards the patient, which is manifested by negative or positive feelings expressed directly or in their behavior. Studies suggest that regardless of whether the emotions are positive or negative, their very intensity might be too big of a burden for the patient" [3, p. 29].

The consequence of the abovementioned concepts is a conviction that the family has a significant impact on the course of the illness and the effectiveness of its treatment [8]. In the 1980s, the theory of expressed emotions was fundamental in working with families of patients with schizophrenia [3]. According to research, psychoeducational programs for families played a key role in reducing the risk of recurrence of the illness in their loved ones [3]. Relapse rate for pharmacotherapy after one year was 38%, while after 2 years 62%. Psychoeducation for the family alone, on the other hand, was associated with relapse rate of 19% after a year, and 29% after 2 years. Psychoeducation with training proved to be the most beneficial, because after a year the relapse rate was 0%, and after 2 years 25% [3]. Such results confirm the belief that the family should be understood as a partner in the treatment process that has to be cooperated with [9].

According to the belief that the family is first and foremost to blame for the illness, for many years, doctors and therapists have tried to drastically change its structure and even to separate the patient from their families. This affected the quality of relationships with doctors, therapists and medical staff [3]. 40 to 84% of families discontinued the therapy [6]. Those studies showed how much the blame for the illness caused an increase of reluctance towards the caregivers among the professionals on the one hand, and a decrease of confidence towards the medical and therapeutic staff among the families on the other [6].

Chrząstowski [10] described the burden phenomenon, which refers to the effects of suffering from schizophrenia on the members of the patient's family. The burden stems from additional roles related to care and support of the person with schizophrenia and contacts which strain caregivers' resources. He stressed that it is not only the patient that has to bear the costs associated with his/her illness, as the consequences of the diagnosis affect the entire family [10].

Research on the functioning of families indicated that for every patient diagnosed with schizophrenia, there are about 10 people in their immediate environment directly affected by the consequences of the illness [11]. Based on research results, it was found that patients with schizophrenia are most frequently under the care of their parents (46%), and in the second palace of their spouse (husband/wife/partner) (26%). In addition, caregivers are mostly women. Since they are mostly related, caregivers largely live together with the patient (81%) [11].

Caregivers of schizophrenia patients often experience the negative consequences of their involvement, both emotional and social or professional ones [12]. In addition, the care for ill relatives generates considerable costs (an average of PLN 568/month, data of 2015), which, given the reduced number of working hours, significantly contributes to the financial burden [12]. The greatest burden is, however, in the form of caregivers' own emotions and fatigue linked to functioning under stress, sacrifices and constant provision of care. This can result in the development of the so-called burnout syndrome [13]. An estimated 12–18% of people who care for patients with schizophrenia are at risk of developing depression. Factors which increase this risk are young age of the patient, caregiver's low level of education and severity of symptoms of the illness [11]. Further substantial burden is the anxiety associated with encouraging the patient to carry out the tasks of daily life. It should be noted that due to the burden of caring for a person suffering

from schizophrenia, nearly 25% of the research subjects used the help of a psychologist or psychiatrist, in order to better cope with gradually increasing difficulties and problems. Factors that were considered the most burdening were: life destabilization caused by relapse, financial burden and lack of free time for themselves [12].

With reference to the above considerations, our aim was to determine the relationship between the use (or lack thereof) of psychological assistance by family members of schizophrenia patients and their assertive behaviors displayed towards their relatives suffering from the illness.

Material and methods

The study group consisted of 34 people whose loved ones were people suffering from schizophrenia. All respondents expressed their voluntary consent to participate in the study. All data were confidential, and the survey was anonymous. The study was conducted on psychiatric wards and in associations gathering family and friends of patients suffering from mental disorders. Caretakers who did not live with patients were not qualified for the study.

In order to verify our hypotheses, we used the Social Competence Questionnaire (KKS) by Matczak [14], and the Coping Inventory for Stressful Situations (CISS) in the Polish adaptation by Wrześniewski et al. [15]. Socio-demographic data were collected using a self-designed survey. The data obtained in the KKS described the subjects' assertive behavior. In this work precisely this factor was of particular value.

In the study we also evaluated the relationship between coping styles and, among others, social competence, which has been the subject of our clinical interest.

Results

Firstly, we present the characteristics of the subjects, including the percentage distribution of the analyzed variables (Table 1).

Table 1. **Characteristics of the study group**

Age	early adulthood 15%
	middle adulthood 53%
	late adulthood 32%
Sex	women 79%
	men 21%
Degree of kinship with schizophrenia patient	mother 46%
	father 13%
	sister/daughter 10%
	wive 9%
	brother/husband/male grandchildren 3%

table continued on the next page

Education	Primary 9%
	Vocational 32%
	Secondary 47%
	Higher 12%
Illness duration (years)	1–5 years 29%
	6–10 years 13%
	11–15 years 29%
	16–20 years 29%
Experienced stress level associated with schizophrenia of a loved one	I definitely do not experience stress 3%
	I rather do not experience stress 3%
	Neutral 6%
	I rather experience stress 24%
	I definitely experience stress 64%
Psychological assistance	Present 47%
	Absent 53%

The data show the predominance of women (79%) in the study group. 46% of these women were schizophrenia patients' mothers. The highest percentage of respondents, as many as 53%, were in their middle adulthood and completed secondary school – 47%. 29% of schizophrenia patients suffered from the illness up to 5 years and longer than 11 years. Importantly, 64% of respondents definitely experienced stress associated with the illness of their relative. The study group was divided into those using and not using psychological help. The difference in percentage points was not significant and was 6%.

The analyzes allowed to assess assertive behaviors displayed by the subjects (Table 2).

Table 2. **Distribution of assertive behaviors among members of the families of schizophrenia patients**

Assertive behaviors	N	Minimum	Maximum	Mean	Standard deviation	Skewness	Kurtosis
KKS – raw score	34	33.00	62.00	46.735	8.08	-0.162	-0.903

The surveyed family members obtained an average of 47 raw points (with SD = 8.08 point) on the scale of assertive behaviors (KKS), which translated as the standardized sten score of 5, indicating average intensity of assertiveness in the study group. None of the respondents reached extreme results, and skewness and kurtosis values close to 0 could be interpreted as indicative of symmetry of the distribution and concentration of results around the mean – as it happens in a normal distribution.

Moreover, comparisons of assertiveness were made in subgroups of subjects using or not using psychological help (Table 3).

Table 3. **Assertive behaviors among caregivers using and not using psychological help**

Variables	Psychological help	N	Minimum	Maximum	Mean	Standard deviation	Student's t-test		
							T	df	p
KKS – raw score	Yes	16	33.00	59.00	44.650	8.911	-1.368	32	0.181
	No	18	34.00	62.00	48.500	7.057			

Our data showed no significant differences in the level of assertiveness among those who benefited from psychological support and those who did not use it. In the first subgroup, the mean score raw was 45 points, while the other subgroup subjects obtained an average score of 4 raw points higher. In the entire group these differences turned out not to be statistically significant, and the results indicated the average level of assertiveness both in caregivers using and not using psychological help.

In view of our hypotheses, we analyzed the correlation of the data obtained from the KKS and CISS questionnaires (Table 4.)

Table 4. **Verification of significance, direction and strength of the relationship between assertive behavior and styles of coping with stress**

Variable/Styles of coping with stress		N	T-O	E-O	A-O	DO	SD
Assertive behavior	Pearson's r	34	0.189	0.038	0.486**	0.354*	0.431*
	Significance (two-tailed)		0.284	0.831	0.004	0.040	0.011

* $p < 0.05$; ** $p < 0.01$

T-O – task-oriented coping style; E-O – emotion-oriented coping style; A-O – avoidance-oriented coping style; DO – distracting oneself with other tasks or situations; SD – social diversion

Our results show that there are three major relationships which concern avoidance-oriented coping style. Very significant moderate positive correlation occurred between this variable and general tendency to avoid action in a stressful situation as well as one of the factors of this scale – the tendency to seek social diversion in order to cope with stress. There was also a weak positive correlation between assertive behavior and a tendency to distract oneself with other tasks or situations. This meant that a greater willingness to manifest assertive behavior was present in people who have a greater tendency to avoid thinking about the problem or looking for measures for its solutions in a stressful situation.

Discussion

Caring for psychotic patients increases emotional tension in the caretakers, especially the level of guilt and shame [16]. In their research, de Mamani and Suro [16] pointed out that maintaining good quality of life and living according to one's values helped family members of persons with experience of psychosis in dealing with their emotions and stress associated with the illness of their loved ones and the necessity to care for them.

In this study, caregivers of schizophrenia patients who either used or did not use psychological support were characterized by an average level of assertiveness in

relation to the patient. In the second place in terms of number of people, there was the group with low levels of assertiveness. Subjects with high levels of assertiveness constituted a sparse part of the study sample. It could be assumed that when it comes to the described phenomenon, the underlying factor is anxiety triggered by contact with a chronic illness that is schizophrenia. Families trying to care for the patient take over most of their duties. Most probably, in this way caregivers tried to emphasize their attitude of concern and compassion.

There are also studies indicating that not expressing all the emotions is associated with states of emotional tension in the caregivers. One of such studies was carried out by Lerner et al. [17], who focused on the evaluation of the level of stress among caregivers of schizophrenia patients. They demonstrated that stress experienced by caregivers in the study sample was significantly higher than in the general population. According to the authors, the factors affecting the level of stress, were, among others, care for relatives suffering from schizophrenia, monitoring their taking of medication, lack of social support, and negative assessment of health care system [17].

In the present study we did not carry out a detailed analysis of the health and well-being of our subjects. 64% of the group admitted that they definitely experienced stress associated with their relative's illness. Hence the assumption that it is precisely this factor that could lead to the caregiver's emotional anxiety or depressive disorders, and consequently, to lower manifested assertiveness. Furthermore, the two main styles of behavior deviating from the assertive one are those aimed at expressing aggression or submission. These features were not included as variables in our study, since one of our main objectives was to determine the level of assertiveness, without references to the above extreme behavior. It would be, however, worthwhile to conduct careful analysis taking them into account.

The number of subjects who benefited from psychological help was similar to the number of those who did not seek professional support. The importance of psychological support for families of patients with schizophrenia was described by Giron et al. [18]. They noticed that psychological help was associated with a decrease in their level of guilt and an increase in empathy towards their ill loved ones. The authors pointed out that the reduction of guilt and empathy increase in caregivers were the mediators of the beneficial impact of psychosocial interventions on the outcome of treatment of schizophrenia patients [18].

In another study on the care of relatives diagnosed with schizophrenia [12], the distribution of results differed from that presented in this study. Those authors reported only 25% of respondents seeking such help, while in the presented study it was as many as 47%. This may be related to the selection of the study sample, as our subjects were recruited during their visits on psychiatric wards or in associations gathering family and friends of the mentally ill. Therefore, it could be speculated that they displayed high levels of motivation for contact with other people who also shared interest in mental illness. The need for this kind of support could cause the desire to initiate or maintain relationships with mental health professionals, or other people experiencing similar problems. For this reason, it would be useful to replicate the study on a ran-

domly selected group of caregivers, and not recruited in the places associated with the illness of their close ones.

McFarlene [19] carried out a meta-analysis of research on the importance of family and its impact on the outcomes of treatment of schizophrenia patients. He emphasized the role of psychoeducation for family and caregivers of persons with schizophrenia. He pointed out that it is important in reducing emotional stress and is a means of preventing the recurrence of the illness through proper care. He also demonstrated that lack of psychological support and family psychoeducation worsens prognosis and increases recurrence of psychosis [19].

Our study results indicated that assertive behavior co-occurs with the so-called avoidance-oriented coping strategy. Such finding suggests that subjects who try to cut themselves off from the source of the problem in a stressful situation, mostly by seeking relief in social diversion or alternative activities like eating, sleeping, shopping etc., are characterized by greater assertiveness. Interestingly, younger people displayed higher levels of assertiveness than the older subjects. It could be, therefore, assumed that it is this age group that is characterized by a greater tendency to exhibit assertive behavior towards an ill family member, and that it decreases with age. Additionally, statistical analyses suggest that variables such as gender, caretaker's education, place of residence and type of relationship with schizophrenia patient, do not differentiate our subjects in terms of assertive behavior. Among the investigated psychological variables, only avoidant coping style turned out to be correlated with assertive behavior.

Findings of Ruggeri et al. [20] confirmed the importance of the role of the family in the treatment outcomes of patients with schizophrenia. They acknowledged that cooperation and family interventions are an integral element in the treatment of psychosis. The study concerned assessment of the "burden" associated with the care for mentally ill relatives and related stress. Study sample consisted of relatives of patients with the first episode of psychosis in a 9-month follow-up. It was noted that psychological help, psychoeducation and support lead to significantly lower levels of emotional tension and stress in caregivers of schizophrenia patients, better compliance with medical recommendations and a more favorable prognosis [20].

Likewise, Caqueo-Urízar et al. [21] indicated that the family is the primary caretaker of patients with schizophrenia. In their study they observed and evaluated changes in the functioning of the family and consequences of the chronic nature of the illness. They emphasized that psychological support significantly improves functioning of families of patients. According to their research, the process of positive changes regarding the quality of life of patients and their families is slow and requires involvement of healthcare as well as local authorities and an increase in the funding of therapeutic activities concerning families of patients with schizophrenia [21].

Among the demographic variables, only age of the schizophrenia patient's family members differentiated the level of assertive behavior. Summing up, we may conclude that a greater propensity for assertive behavior is exhibited by people who are younger and those who are more likely to cope with stressful situations by resorting to use of avoidant strategies. This may, therefore, mean that search for company or distrac-

tion with other activities allows to alleviate emotional tension, which in turn leads to greater display of assertive behavior. It could, then, be hypothesized that younger people, who were brought up in the days of promoting self-realization, fulfillment of their own needs and healthy selfishness, have learned to refuse others or assertively express their opinion. The opposite could be said of the group growing up in a more collective model of the family, which popularized multigenerational households [22]. In such, often large, families, it was natural that their members looked after one another, especially after those who were ill, elderly, or children. It was also associated with little display of any type of assertive behavior.

Another hypothesis could be linked to one's individual development [23]. The subjects in their early adulthood probably focused on other developmental tasks, typical of that stage of life. Education, career, starting their own family were thus some of their main areas of interest. Conversely, older people, who have already fulfilled their plans and achieved their goals, could begin to focus their attention on the family and become more caring [23]. What followed was that they tended to exhibit assertive behavior to a lesser extent.

Our data analyses lead to a reflection on the limitations of the study. One of them was the selection and size of the investigated sample. A considerable number of people, despite their initial expression of interest in the study, refused to participate after getting acquainted with the procedure. Those persons excused themselves with chronic lack of free time or their own prejudices against contact with a psychologist/psychiatrist. Interviews with relatives of schizophrenia patients often showed that they had a negative attitude concerning cooperation with the aforementioned specialists. This could indicate poor knowledge of this group on the part of mental health professionals, a greater interest of doctors and psychologists in contact with the patient, and not their family or it could simply be related to the characteristics of the study sample. It is possible that because of numerous burdens, they were particularly sensitive to certain aspects of that relationship. However, these are only hypotheses, which would require further verification.

What is worth noting, research by Gurak and de Mamani [24] indicates that family can constitute both a protective and harmful factor in the treatment of schizophrenia patients. They pointed out that high criticism of the caregivers, their little empathy and weak family cohesion led to worsening of psychotic symptoms. In contrast, according to their research, the most important factor reinforcing effectiveness of treatment was family cohesion [24].

To summarize the above analyses and theoretical considerations about the image of caregivers of individuals with schizophrenia, we can formulate some guidelines that would allow for a better understanding of the presented study group. The first one would refer to the data concerning their desire to maintain contact with people offering help in the form of emotional and instrumental support or information. As long as caregivers do not have a sense of understanding and security, their contacts and relationships with mental health professionals are bound to be superficial, reticent or aloof. This means that the therapeutic team should pay particular attention to the problems of their patients' caregivers. Another important aspect is the average or low

level of expression of assertive behaviors among the caregivers towards their relatives suffering from schizophrenia. Given the importance of assertiveness in everyday life, it might be beneficial to consider creating assertiveness training groups. Such groups would create an atmosphere of kindness and focus on mutual assistance during training. This would allow for the introduction of specific changes in the life of the caretaker, and thus also the patient.

It could also certainly be said that the subjects displayed high levels of stress, which was associated with the care for a chronically ill person. In the study we observed a relationship between avoidance-oriented coping strategy and exhibited assertiveness. Allowing caregivers to cope with stress by not focusing exclusively on their experienced emotions or specific tasks, but rather by giving them the choice of substitute methods could improve their mental and social functioning.

The role of mental health professionals should be to offer psychoeducation also to caregivers of individuals suffering from schizophrenia, which would make them aware that taking care of their own life does not mean lack of loyalty to their ill relative. Caregivers should be allowed to experience emotions in their own way, take care of themselves, and set certain boundaries so that they are able to care for their loved ones in good health.

Conclusions

Our study did not confirm the link between the use of psychological assistance by the relatives of schizophrenia patients and their expression of assertive behavior in relation to the patient. However, it proved important that younger people who coped with stress by means of avoidance-oriented strategies manifested a greater propensity for assertive behavior.

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Address: Agnieszka Samochowiec
Department of Clinical Psychology and Psychoprophylaxis
Institute of Psychology, University of Szczecin
71-017 Szczecin, Krakowska Street 69
email: agnieszkasamochowiec@gmail.com