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Dyadic relationships of people with schizophrenia

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Summary

Creating successful partnerships is important for the overall quality of life. People suffering from schizophrenia experience significant difficulties in entering and maintaining dyadic relationships due to psychotic symptoms, consequences of the disease and its treatment or social stigmatization. Difficulties in creating intimate relationships are noticed already during adolescence, constituting one of the elements of prepsychotic changes. Among people diagnosed with schizophrenia, women more often than men create dyadic relationships, which may be due to the later onset of the disease, better indicators of social functioning, and favorable socio-cultural patterns. Among coupled individuals, the quality of their relationships is important for the course of the disease and treatment. People with schizophrenia often prefer to bond with other patients because of the possibility of creating a balanced relationship providing acceptance and support. Healthy partners of people with schizophrenia, due to the burden arising from the specificity of the disease and commitment to care for a sick partner, also need professional support. Issues regarding dyadic relationships should be included in a holistic therapeutic approach to people diagnosed with schizophrenia.

Key words: schizophrenia, sexual health, social functioning

Introduction

Dyadic relationships (understood as close relationships formed on the basis of erotic feelings) of people suffering from schizophrenia (SCH) are poorly understood and often neglected in therapeutic process. The diagnosis of SCH often obscures individual characteristics and requirements of those affected and automatically qualifies them as incapable of controlling their sexuality or fulfilling partner and parental functions, while the expression of the relational and sexual needs of patients is sometimes considered as dysfunctional or health-threatening [1–3]. Meanwhile, this sphere requires careful study and routine consideration in clinical practice for at least two reasons. Firstly, the

possibility to conclude voluntary dyadic relationships by adult people, to maintain or dissolve them is widely recognized as one of the fundamental human rights listed in international declarations, including Article 16 of the *Universal Declaration of Human Rights* [4], Article 11 of the *Declaration of Human Sexual Rights* [5] or Article 23. of the *Convention on the Rights of Persons with Disabilities* [6]. Secondly, the realm of close relationships and sexuality reflects ability to form and maintain interpersonal relationships, achieve specific goals and meet one's needs. Therefore, it is a sensitive indicator of patients' overall functioning which is important for their quality of life [7].

This narrative review of the literature aims to describe relational needs, the ability to satisfy them and their importance for the health – and functional wellbeing of people suffering from SCH, as well as to indicate the need of taking into account the relational sphere in the treatment of SCH patients. In the discussion, the following assumptions will be verified: (1) SCH does not fundamentally change relational needs but poses a significant obstacle for affected individuals to meet them by creating and maintaining dyadic relationships; (2) creation and maintenance of dyadic relationships is differentiated by gender; (3) dyadic relationships of people with SCH are characterized by more difficulties in terms of intimacy and matchmaking, which makes them more vulnerable to break up; (4) being in a dyadic relationship is associated with favorable course of the illness and better functioning of patients; and (5) people with SCH tend to build dyadic relationships with people who also suffer from mental disorder, while relationships between people suffering from psychotic disorders do not constitute risk to their wellbeing. The manuscript ends with an attempt to formulate specific guidelines for clinicians on the inclusion of the issue of close relationships in the scope of treatment of people with SCH.

Relational and sexual needs of people suffering from SCH

In case of SCH, due to the wide scope and long range of changes in behavior, emotional reactions and mental processes, one should expect their significant impact on social and personal relations [7]. Harley et al. [8] showed that 56% of 137 people with SCH or schizoaffective disorder have never experienced an intimate relationship. Patients with SCH are less likely to experience sexual intercourse in comparison to patients suffering from other mental disorders [9].

This state of affairs is sometimes justified by social withdrawal and lack of interest of patients in intimate contacts or lasting relationships [3]. The study of Tsirigotis and Gruszczyński [10] involving 78 patients with SCH and 78 healthy controls showed that patients were less interested in contact with the opposite gender, less satisfied with such contacts and showed greater reserve, shyness and inhibition of spontaneous reactions, and they also attributed a lower rank to love. Rozya et al. [11] noted a significantly lower "ability to love" in the group of 40 people with SCH (in the *International Personality Item Pool – Values in Action*) compared to 40 healthy controls, and this weaker ability was associated with a decrease in life satisfaction. However, there is a significant difference between the lack of need for intimate relationships and the inability to form them.

To date, limited reports on the needs of dyadic relationships in SCH suggest that they remain largely preserved, despite significant changes in the experience and interpretation of reality or difficulties in interpersonal relationships. A review of literature made by de Jager and McCann [12] shows that in sexuality and intimate relationships, needs and desires do not differ fundamentally from the general population, but they usually remain unmet in people with psychosis. The study by Vucic Peitl et al. [13] regarding the sexual self-esteem of 200 people with SCH and 100 healthy controls matched by age and gender confirmed that people with SCH do not differ significantly from controls in terms of awareness of their own sexuality, readiness for sexual activity and desire for sexual adventurism. However, they reported significantly higher negative emotionality, sexual incompetence, and significantly lower sexual satisfaction regardless of the duration of the illness itself and antipsychotic treatment.

Impact of illness and treatment on relationships

SCH, due to a significant impairment of mental and social functions, as well as its treatment, are significant obstacles for long-term and stable dyadic relationships. Factors such as distrust, positive symptoms, uncontrolled behavior, as well as cognitive deficits, reduced motivation and interests, social withdrawal, reduced emotional expression or anhedonia significantly limit relational abilities. Additional complications are the side effects of antipsychotic drugs: sluggishness, muscle stiffness, decreased emotional expression and motor changes, or weight gain can deprive attractiveness and cause embarrassment, and thus reduce self-esteem and promote withdrawal [2, 14–16].

Studies suggest that the majority of people diagnosed with SCH experience gradual disruption of a normal psychosexual development beginning in adolescence in men and in early adulthood in women. Men show difficulties in finding sexual partner and worse sexual functioning even before the diagnosis. Women are often able to find a sexual partner, most of them marry, but later divorce rates increase. The disadvantage of this type of research is that a retrospective assessment of sexual functioning is not reliable and does not take many variables into account. Snyder and Whisman [17] argue that, taking into account patients' biological vulnerability, stressful events related to close relationships – or alternatively the lack of them – may be an important factor in the development of the illness. The authors add that understanding how relationships influence the course of the illness, both positively and negatively, may help in the rehabilitation process.

There are premises to assume that a deficient ability to form sexual relationships is a symptom of the illness long before the onset of more pronounced symptoms of psychosis [18, 19]. Raboch [20], based on a study of 51 women diagnosed with SCH and 101 gynecological patients, stated that sexual development of the respondents was "significantly delayed" in the SCH group, which meant that they significantly later established sexual contacts and formed close relationships. However, he did not find significant differences in terms of sexual interest, falling in love or the number of sexual partners. In adult life, women with SCH revealed much worse parameters of sexual functioning compared to the control group, although no differences were noted

for patients declaring being in satisfactory relationships.. The length of the illness, the number of episodes and hospitalizations, or the clinical picture of SCH were not significantly associated with the studied parameters of sexual functioning. Keefe et al. [21], in a study of 69 men chronically suffering from SCH or schizoaffective disorder (SZA), showed that poor premorbid socio-sexual functioning (lower level of social and sexual activity) was associated with a greater severity of negative symptoms, lower number of positive symptoms, greater overall severity of psychopathology, worse current social and professional functioning. Pre-morbid socio-sexual functioning was not significantly related to the age of the respondents, age at the onset of the illness, number and length of psychiatric hospitalizations, improvement of health when treated with haloperidol, duration of the illness, or education. In contrast, in a study of 280 outpatient with SCH or SZA, Joseph et al. [22] found that better cognitive performance was associated with a lower disturbance of functioning in romantic relationships. A strong and long-term relationship between SCH and loneliness was confirmed by the study of Agerbo et al. [23] involving 5,341 patients diagnosed with SCH at the first admission to a psychiatric institution in 1970–1999 and 53,410 matched controls. People with SCH were less likely to have a relationship long before their first admission to hospital. Patients clearly differed from the general population in relation to marital status, i.e., they were less likely to be married, even 15–20 years before, as well as 20–25 years after their first admission to a psychiatric hospital.

Symptoms of SCH, side effects of antipsychotic drugs, as well as increased rates of somatic diseases (e.g., cardiovascular and hormonal ones), obesity and harmful habits (e.g., smoking) are responsible for the frequent occurrence of sexual dysfunction among patients. In the case of people in relationships, dysfunctions reduce couple's sexual satisfaction and are associated with deterioration in the functioning of the relationship in other areas. Among lonely people they result in fear of compromise, failure to meet the needs of the other person and abandonment, which favors withdrawal from attempts to initiate closer acquaintances. Patients who are sexually active before the onset of the illness may maintain the need for sexual contact, regardless of psychopathology. Its implementation, however, does not necessarily take place in a constant and monogamous relationship but takes the form of accidental sexual contact resulting from the availability of a partner or weakened behavioral control. These types of relationships are not only less satisfying and intimate but also expose patients to diseases transmitted during sexual contact [3, 18, 19, 24–26].

Living conditions of patients, including stays in psychiatric wards, limit the possibility of meeting intimate needs. For people in relationships, separation related to hospitalization is a big challenge. For lonely people, staying in a ward clearly narrows the possibilities of establishing and maintaining interaction outside of it, but it enables contacts with other patients, which are characterized by a greater level of understanding and comfort. Deepening the relationship is problematic in the context of the rules of the psychiatric institution [3, 24, 27].

Sex differences and dyadic relationships of patients

People with SCH are less likely to engage in relationships, marry and maintain partnered sexual activity in relation to the general population. However, research unanimously shows that women have better rates in these areas, which corresponds to reports of generally better social functioning of women with SCH both before and after the onset of the illness [28–31]. Due to the later onset of the illness, women are more likely to acquire social skills and create relationships before the changes caused by an active illness process occurrence [24, 32].

Gender differentiates the relationship between a close relationship and the course of the illness. In a study of 882 patients with SCH, Walker et al. [32] discovered an interactive effect of gender and marital status. The lowest results in terms of psychopathological symptoms were recorded for married men, while the most symptoms were presented by married women. It may be caused by a different influence of marriage on the course of the illness depending on sex, i.e., intensification of symptoms in women and their alleviation in men. On the other hand, the reason may be a greater tendency to remain married in more symptomatic women and less symptomatic men. Another important factor is the characteristic of the spouse, his/her mental stability and ability to provide support, which can have a positive effect on the course of the illness regardless of gender. Finnish studies on large psychiatric patient populations [33, 34] indicated that among people with SCH women were more likely to be in a stable relationship and live with partner or alone than men who lived more often with parents. The quality of life was rated as the lowest for single men compared to men in relationships and women. In contrast, women's quality of life was rated higher overall, regardless of being in a relationship.

Specificity of relationships in people with SCH

Psychotic symptoms can alter the way patients perceive their partners and relationships.. Positive symptoms may include delusional beliefs about experiencing sexual violence committed by the partner, infidelity, replacement of a loved one with a doppelganger (Capgras syndrome) or being the object of feelings of other people (de Clerambault's syndrome) [18]. Negative symptoms, e.g., apathy or neglect, are also likely to reduce the quality of a relationship. The quality of relationship has a huge impact on the course of the illness. High rates of expressed emotions (EE), i.e., a high level of hostility, criticism and overprotection with a lack of emotional warmth, are an important predictor of relapse. Although research on EE primarily concerns generational families, an analogous pattern can be assumed among partners [18].

Relationships of people with a serious mental illness are characterized by less intimacy and commitment, as well as less well-matched fit and satisfaction than in the general population. In the Perry and Wright study [3], among 369 patients with affective and psychotic disorders, it was shown that they were mostly lonely, more often they established short-term relationships or long-term relationships that did not lead to serious commitments. They also more often maintained parallel relationships,

earlier engaged in sexual activity with new partners, and patients' partners were less integrated into their social networks. Patients reported less physical satisfaction with their partners and less frequent orgasm. Aggarwal et al. [35] compared 76 patients with SCH and 58 with depressive disorders, all of whom were married. Subjects with SCH revealed a weaker marriage fit and poor marriage quality. In addition, they rated sexual satisfaction lower, although they did not differ from depressive patients in terms of the prevalence of sexual disorders. The duration of marriage did not significantly affect marital and sexual adaptation.

Relationships of people with SCH are characterized by a poorer quality and are less lasting. Beach et al. [36] observed the marriages of 37 patients with depression, 38 with bipolar disorder and 21 with SCH compared to 49 marriages of healthy people. After 3 years, all clinical groups had significantly higher divorce rates than the control group. Among marriages where one of the partners suffered from SCH, there was a tendency to report the greatest marriage mismatch, however, the differences compared to other groups were not significant. 71% of respondents from this group indicated a negative course of their marriage within 3 years of observation. Thara and Srinivasan [37] examined changes in marital status of 76 patients treated for the first time for SCH over a 10-year period. The maintenance of marriage was related to its conclusion before the onset of the illness, having children, the shorter duration of the illness at the beginning of the examination, and the presence of hallucinations on admission to the ward. Unemployment and a decline in the socio-economic level, as well as reduced affection and self-neglect were not conducive to maintain marriage.

There is a lack of data on intrapsychic factors important for creating and maintaining relationships among people with SCH. The exception here is the study by Uznańska and Czabała [38], which highlighted that patients suffering from SCH who are in stable relationships ($n = 30$) differ from lonely patients ($n = 30$) in terms of greater desire and attempt to maintain stable relationships, greater openness to other people, their needs, feelings and views. Relationship subjects were also more likely to compromise and do something for others and were less afraid of change and expected their ideal partner to look after others and be ready to change.

Dyadic relationships and the course of the illness

Research to date suggests that staying in a positively perceived relationship helps to cope with the illness. By positively influencing the functioning of people suffering from SCH, it contributes to their fuller recovery. Research shows that married people diagnosed with SCH are less frequently hospitalized and more easily integrate into the community than divorced or single people. This is in line with an assumption that a basic and universal human need of being loved and needed is satisfied in a relationship [39 as cited in: 40].

Salokangas [34] in a five-year study of 227 patients with SCH proved that living together with a partner was the main factor responsible for the beneficial functioning and course of the illness. The best results in terms of clinical parameters and functioning were obtained by patients living with partners. They maintained the most intense rela-

tionships with family members and friends in the first years of the illness. This finding can be explained by the better premorbid functioning of patients in relationships, as well as the beneficial effect of the relationship on maintaining relationships with loved ones even in the first and most severe stages of the illness. The high level of social interaction was conducive to improving health in terms of psychotic and depressive symptoms – patients living with partners at the end of observation had a significantly lower level of these symptoms than other subjects, although at the beginning of the study they were at the same level in all groups. In general, patients living with partners required less hospital care and received lower doses of antipsychotic drugs.

Żmuda et al. [41] stated that although a close and satisfying relationship is not a complete protection against relapse, a sense of security and positive emotions activated in it can be a significant strengthening in all dimensions of functioning and a strong motivation in the recovery process. In turn, loneliness is one of the basic factors responsible for poor quality of life. A study by Cardoso et al. [42] on 123 outpatients with SCH revealed that not-married status clearly increased the chances of poor quality of life in general as well as in the professional, intrapsychic and interpersonal spheres. Nyer et al. [44] showed that in middle-aged and elderly people with SCH or SZA and depressive symptoms, marital status was significantly associated with quality of life and the presence of suicidal thoughts. The quality of life was significantly higher in the group of married people or those in informal relationships compared to single people, which may be mediated by an attachment (feeling of emotional closeness and security) as a factor positively affecting the quality of life of people with SCH or SZA [43]. Moreover, married people reported fewer suicidal thoughts than unmarried people, while people experiencing breakdown or loss of relationship are at a greater risk of committing suicide [44].

Relationships between mentally ill persons

The specificity of life of people suffering from SCH (reduction of social networks, hospitalizations) increases the chance of establishing relationships with a mentally ill person. Thomsen et al. [45] examined cohabitation patterns between persons of the opposite gender in the Danish population over a period of 13 years. The study indicates that people with SCH have a clear tendency to cohabit with people with severe mental disorders, especially SCH. Among those who lived with a person suffering from SCH there was a clearly increased frequency of diagnosing an episode of depression and an even greater frequency of diagnosing SCH. Women living with a man with SCH were up to twelve times more likely to have a diagnosis of SCH compared to women living with men who are not mentally ill.

The prospect of a relationship with someone who is also ill can be assessed as favorable because of the chance to create a balanced relationship providing acceptance and support [27, 46]. Shanks and Atkins [47] examined 22 marriages in which both partners had psychiatric diagnoses (13 men and 8 women were diagnosed with SCH; in 5 marriages both partners had SCH). After wedding, the number of outpatient visits did not change significantly, however, the time spent in the hospital was significantly

shorter. The study did not confirm the harmful effects of the relationship on mental health, but rather demonstrated the ability to build stable and satisfactory relationships between mentally ill people.

Dyadic relationships in the context of diagnosis and treatment of schizophrenia – guidelines for clinicians

Recognizing that a goal of a comprehensive care of a patient is not only to reduce psychotic symptoms, but also to build abilities to lead a satisfactory and productive life, the aspect of emotional and sexual relationships cannot be ignored. Unfortunately, in the literature on the subject, there are few hints on the ways or scenarios for conducting conversations with mentally ill people and their partners about sexual relationships. There is also a lack of tools for determining their needs or difficulties, which are inextricably linked with the experience of the illness, and therefore are not universal for the general population. Similarly neglected is the issue of providing professional help focused on dyadic relationships of ill people. Most authors, however, emphasize the usefulness of communication skills training, and couple or sexual therapy, if it takes into account the specificity of the patients, may turn out to be sufficient in overcoming their problems. Below, seven basic principles are presented with a rationale for relational issues that should be taken into account in a holistically conducted assessment and treatment of people with SCH.

I. Patients have the same relational needs as everyone else, and close relationship issues should be considered as a routine part of the assessment and treatment. A common assumption that people suffering from SCH do not have needs for close emotional or sexual relationships results in ignoring them in the treatment process [3, 8]. This is escalated by a fear that raising particularly intimate topics will trigger strong emotions favoring patient's decompensation, making treatment process difficult, or will be treated as an incentive for uncontrolled sexual behavior. One study found that nurses were reluctant to talk with patients about their sexuality because they did not consider it as part of their job, pointed to their own deficiencies in sexual education, and considered patients as "devoid of sexuality" and "too sick" to undertake such topics [48]. Similarly, psychiatrists may perceive people with SCH as "asexual" or too socially isolated to engage in sexual activity [49]. Meanwhile, patients are often ready to talk about relationships and sexuality, able to express their experiences and desires as well as to receive information. Conversation with a specialist on intimate topics should be conducted with respect for privacy and in an atmosphere of trust [2, 20, 23, 25, 50].

II. Relational needs should be identified for each patient, and it is up to the clinician to initiate a proper conversation.
Patients' needs and related goals of the therapy generally focus on helping to increase the ability to establish intimate relationships, as well as to fulfill various roles in the relationship, despite the limitations that may be imposed by the symptoms. In the study by Östman and Björkman [51], both patients and their

partners indicated that they tried to raise the problem of sexuality during regular therapeutic sessions, but this was without any response from their doctors. In inpatient psychiatric wards, issues related to sexuality were also avoided. At the same time, they expressed a desire of access to such treatment, both in inpatient and outpatient psychiatric care, in which doctors would openly talk with them about their sexuality, not limiting themselves to diagnosing a dysfunction. The partners emphasized that they would be happy to welcome an initiative involving them in the therapeutic and healing process because their lives are already related, one way or another they both live with the illness [51].

The *Camberwell Assessment of Need* (CAN) [52] is a tool designed to assess the complex clinical and social needs of people with mental illness. The questionnaire includes 22 items to assess problems, including those relating to intimate relationships and sexual expression, both by staff and patients. One study revealed significant differences between staff and patient perceptions of needs – nearly all patients (90%) identified a need for sexual expression, while the staff gave a very low priority to this issue. This discrepancy may highlight concerns about staff attitudes towards sexual needs of patients and the potential to discuss them [53, 54]. Therefore, it is worth to encourage medical personnel to self-reflect and consider their own prejudices regarding these couples in order to provide them with more effective support [55].

III. Actions to provide assistance in the field of sexual relationships must take into account the safety and well-being of a patient.

As people with SCH have an increased risk of experiencing various forms of violence, professionals should be vigilant about its symptoms also in the area of patient relationships. Sexually transmitted disease prevention and family planning should be treated as routine elements in discussing patient relational and sexual functioning. Interventions aimed at improving the ability to establish and maintain close relationship require earlier reduction of psychotic symptoms and obtaining criticism by a patient [2, 3, 39, 50, 56]. An important aspect is determining the patients' ability to voluntarily and consciously engage in sexual relations. Disturbances in thinking and perception, mood swings, impulsiveness and suggestibility, etc. significantly impede the patients' ability to adequately discern the situation and give consent, which makes them particularly vulnerable to all forms of sexual violence and undesirable consequences of sexual activity, such as sexually transmitted diseases and unwanted pregnancies. For these reasons, Mandarelli et al. [50] developed a partially structured interview for clinicians – the *Sexual Consent Assessment Scale* (SCAS) and it's shortened version (SCAS-10). The use of this tool among patients in a stable mental state (at the end of hospitalization) showed that people with SCH spectrum disorders (n = 31) were less able to consent to sexual contact than patients with bipolar disorder (n = 54) as well as had significant gaps in a basic knowledge on sexuality.

Many people may need help to neutralize the stress resulting from the stigma caused by the illness, but also the specificity of a person's sexuality, if it is

not perceived as normative by the general public. It may be useful to address issues related to sexual identity and experiencing discrimination and violence in communities and care settings while planning treatment for people with mental illnesses [57].

IV. Treatment process should include patient's functioning in dyadic relationships. Including the topic of patients' relationships in the treatment process is of a great importance for its effectiveness. Strategies focused on minimizing conflicts and adapting to illness-induced changes are an important element in reducing the risk of relapse. In many cases (e.g., relationship crisis, sexual dysfunction) it is necessary to implement partner and sexual therapy. It can be helpful to have a discussion about the challenges of sexual intimacy in a marriage. Therapy and sexual education usually lead to an increased satisfaction and intimacy in the relationship [58]. Special care is needed for patients experiencing relationship breakdown being a highly stressful situation with a high risk for their mental well-being.

V. Helping people suffering from schizophrenia with regard to dyadic relationships should address the needs or problems specific for this group.
Establishing an intimate relationship puts people with SCH in front of the dilemma of revealing their diagnosis to their partners. Feelings of shame, fear of rejection or the real experience of losing an important relationship because of an illness are usually highly stressful and potentially harmful to mental health. Seeman [16] points out that although a person's identity cannot be reduced to a psychiatric diagnosis, potential partners have the right to information on this subject because of the consequences of SCH for their life together. Due to the significant stigmatization of people with SCH, disclosing the diagnosis may be a gradual process and, if necessary, supported by the help of a specialist.
The dilemma of having children is related to concerns about the inheritance of the illness by an offspring, the influence of pregnancy and childbirth on the mental state of patients, as well as a possibility of raising children and ensuring stable living conditions for them. The functioning of patients in the future raises doubts, i.e., whether at all and how long a healthy partner will be able to look after another elderly person, or when he/she starts experiencing health problems himself/herself [16, 59].

VI. In helping people suffering from schizophrenia in establishing and maintaining dyadic relationships, the same methods as in other groups of patients are used .
Clinicians can work with people with SCH to improve their general social competences by training skills to improve conversational skills, interactive behavior, social intelligence/perception, assertiveness, and dating/relationship building skills [60]. The therapy enables individuals to practice scenarios such as: starting and maintaining a conversation, inviting someone on a date, expressing positive feelings, and asking their partner to use protection against pregnancy and sexually transmitted diseases. Practicing such scenarios increases the likelihood that social skills related to sexuality will be learned and effectively implemented in the real-life situations.

Among communication skills in relationships, none is specifically designed for couples in which one or both partners suffer from a mental illness. Some authors have proposed using the *Couple Communication* (CC) program designed by Miller, Wackman and Nunnally (1992) for couples in which one person has SCH. The program is easy to learn for both instructors and clients, has a clear format with an instruction manual; uses visual cues helpful in learning and a group format that provides participants with a sense of connection with others in similar life situations [61]. It uses elements of instruction, modeling, session role-play and "homework". The process of teaching communication skills is divided into four main sections (taking care of yourself, taking care of your partner, resolving conflicts, choosing communication styles). By teaching expressive and receptive verbal skills as well as problem solving, communication between partners should become more clear [61]. One of the forms of psychoeducation to be used in working with relatives of people suffering from SCH is an online guide prepared by the experts in the field of mental and sexual health, such as *A Guide for Spouses of Partners with Serious Mental Illness* (https://www.bcss.org/support/guide-spouses-partners-serious-mental-illness/).

VII. In the case of patients who are in a relationship, their partners should be involved as much as possible in the evaluation and treatment process.

Interview collected from partners often provides important information about the mental state of patients, especially if their criticism is limited. The spouses make decisions in critical moments about treatment and life situation of the people with SCH if their condition does not allow them to express their will. In such a situation, spouses are expected to act in the best interests of patients, relying on insightful knowledge of their preferences or predictions of their decisions based on a close relationship [62]. The involvement of partners is of great importance, as they are usually responsible, at least periodically, to care for and control the treatment of patients. However, effective fulfillment of this function requires careful education [63, 64]. Encouraging continuous support from spouses is a key element. The empathy shown by the medical staff will help the couple feel understood and less lonely. A focus on empathy in counseling couples can increase marital satisfaction [65]. Support is provided by programs addressed to loved ones, especially in overcoming social isolation and normalizing the experience of a loved one's mental illness. Direct intervention of specialists is required in situations in which patients' partners are exposed to mental and physical damage, e.g., when they have become objects of delusional jealousy [18, 56, 59]. It is good practice to provide education to help partners manage the person diagnosed with SCH. This will enable the couple to acquire knowledge and skills that increase the chance of establishing a healthy and stable relationship [66].

Recapitulation

Dyadic relationships should be treated as a significant value for the optimal functioning and quality of human life, regardless of their mental health. The desire for a close relationship of people with SCH may be an important element in striving to improve health and achieve a common lifestyle of healthy people [23, 27, 46]. The fulfillment of relational needs by people affected by SCH encounters difficulties which are not only a direct consequence of the illness and its symptoms but also other factors (social stigma, living conditions, etc.). The creation and maintenance of relationships by SCH individuals is differentiated by gender, in favor of women who have more chance of acquiring social skills and creating relationships, having children, being married or living with a partner. Cognitive deficits identified with SCH make it difficult to create and maintain a relationship, in the case of such couples, the separation and divorce rate is high. Difficulties in coping together and understanding the emotional expression of the partner are significant factors influencing relationships, and lack of motivation to communicate and the desire to withdraw from the relationship were often observed [38]. The life situation of individuals suffering from SCH, including marital status, is one of the main factors influencing clinical and functional remission. It is possible that close and trusting relationship with partner helps patients to keep family interactions at a fairly high level. A successful relationship is a source of support and motivation to continue therapy, so helping patients in this area should be an integral part of SCH treatment [3, 41].

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