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**FAMILY AND SCHIZOPHRENIA**

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Family has been an essential part of the mental health care programmes in India. The emphasis on the family as the single most important source of care is fairly unique for India and contrasts with the emphasis on the professionals and institu­tions in mental health care in the developed countries.(Shankar, 1998, Srinivasa Murthy, 1999, Srinivasa Murthy, 2000). The following aspects are considered in this review, namely, (i) role of family in mental health care in India, with special focus on schizophrenia, (ii) international developments in the area of family and schizophrenia, and (iii) future areas for work. The developments of the last 50 years in the area of family and schizophrenia can be seen as moving from need based response to understanding the family processes and in the more recent times making it an important part of the mental health care programmes of the country.

# Family and Mental Health care in India

The development of organised mental health care in India is of recent origin. Till about the time of independence and even during the first two decades of post Independence period, the focus of mental health care was on the provision of care through mental hospitals. The real beginnings for providing services outside mental hospitals can be traced to the setting of general hospital psychiatric units (GHPU) in the early 1960's.(Wig,1978). It is only in the last two decades, conscious efforts and measures are being taken to develop mental health care for the total population (Govindaswamy, 1948, DGHS, 1982, Reddy, 1992, Srinivasa Murthy, 1992a, 1992b, Srinivasa Murthy 1996).

As a result of the paucity of the organised care, families have been part of mental health care throughout the history of India. Whether this was by choice or due to lack of facilities is difficult to conclude, though there is some evidence to support that family involvement in care was and continues to be a preference of families (Kulhara and Wig, 1978; ICMR, 1988).However, some have even argued `if the families have always taken care of the mentally ill persons, why disturb the same, especially when it is a very good measure for care and improvement'. It is unfortunate that in this debate the `opinion' and `experience' of the families have not been adequately studied and the strengths of the families are not fully utilised in India. Such an approach is essential to place the role of family realisitically in the total mental health care programmes.

The first formal recognition of the importance of the family as part of organised mental health care can be traced to the work of Prof. Vidyasagar in the early period of post-independent India. In the mid fifties, (1950's) Dr. Vidyasagar took steps to change the public image in Amritsar Mental Hospital. He had observed that patients were brought for admission only when their mental illness was already long standing and when their relatives had despaired of their ever recovering. Relatives often made a long journey to bring patients to the hospital and were prepared to abandon them in the hospital at that stage of illness. Vidyasagar encouraged the relatives to stay with the patient during the treatment period. To accommodate the relatives of patients, he pitched tents within the hospital grounds for their stay. He also encouraged them to participate in the daily nursing care of the patients and by doing this, to learn about managing medica­tion and caring skills. In the evenings, Dr. Vidyasagar ad­dressed large meetings of patients and their relatives, wherein he outlined the principles of sound mental health and gave simple descriptions of mental illnesses and how they could be treated. His addresses were couched in the style of sermons of religious teachers with whom the audience were familiar. Eventually, his tents were replaced by simple stone houses, with sanitary and kitchen facilities. The rumour began to spread around the country-side that patients could be greatly helped, if not cured, and that in many cases they could return to live in their own villages. With this hope, families began to bring patients at a much earlier stage of their illness and the frequency of early discharge became correspondingly greater. Instead of being a place of dread, associated with life long incarceration, the hospital had become a renowned centre for active treatment and for public mental health education (Carstairs, 1974).

It is important to recognise that Vidyasagar's approach to involvement of families was total and integrated and not segmental. This is a theme that recurs in all of Indian experience in this area. This is in contrast to the approach of Western professionals who have viewed family members as a `support', `network', `buffer' (Wolin and Jacobs 1992).

The next major experiment was initiated at the Mental Health Centre, C.M.C., Vellore from 1957 (Kohmeyler and Fernandes, 1963; Chacko, 1967; Verghese, 1971). The beginnings of this venture as reported by Chacko illustrates the focus of the team at that point of time.

"The patients are located in open rooms and there is no restraint or restriction. They are provided with a room with adjacent bathroom unit similar to that which they are used to in their own home. It has been established as a firm policy at the centre that one or two members of them have to stay with the patient throughout his treatment. Rarely has there been any difficulty in finding family members to provide this service.... The close participation of the relatives in the treatment of the patient provides an opportunity to give them a better under­standing of the peculiarities of the individual case,. Through spread of this knowledge into wider circles of the public, a general  education  in the matters of  mental  health  is effected......the food habits of the people vary greatly. Therefore it would be impossible to provide for all of them from a central hospital kitchen.... The relatives take an active part in the treatment of the patient. For example they bring the patient to the treatment room for ECT and afterwards supervise him throughout the recovery period. They sit with the patient throughout the insulin treatment while the nurse is supervising the various stages. They provide the food after recovery. They learn about the treatments and are able to overcome their superstitious beliefs about illness and treatment. The relatives also are encouraged to take part in group therapy which is conducted every day. There they learn about the problems of other cases and about the psychological aspects of the illness of their own patients. They are given valuable suggestions for the handling of the cases, learn to observe the early symptoms of the breakdown as well as the appropriate steps to counteract them.... The responsibility for the patient is left with the family members who have been dealing with his disturbed behaviour prior to his admission and are often quite skillful. Other important factors that led to this type of inpatient care were the difficulty in getting enough number of experienced nurses and attendants as well as the cost of maintaining satisfactory twenty four hour care of the disturbed patients. The average stay of a patient at the Centre is about 7 weeks and this would cover the intensive treatment period and patients are encouraged to continue treatment as out-patients after this period..... Looking at this programme more critically, certain disadvantages are also obvi­ous. Although we accept two close and responsible relatives to stay with the patient, this is not always possible because of their family responsibilities. In some cases it may be servants who will attend to the patient, with family members only occa­sionally visiting the patient. Again in some cases, it will be difficult for a spouse to stay on and at the same time take care of children's education and his or her job and so on. In certain cases, the relative who is attending to the patient may not be the key person with whom the patient is having disturbing rela­tionship and in such instances family therapy is not possible. The long period of hospitalization - 6 to 8 weeks and the cost of hospitalization are other factors which discourage the relatives from participating in this programme. Another disadvantage in this type of treatment, is the lack of facilities for home visits during treatment period and for follow up purposes. It is proposed to study at least some of the inpatients, and their relatives and do a follow up over a five year period. This will help to evaluate the advantages of family participation, with regard to how regular they are about keeping in touch with the centre, following instructions for medication, the rate of relapses and possible causes, and also to assess how well the family is able to cope with the patient at home. It is essential for India and for other countries in which there are so few trained personnel that it be shown that a small mental health centre with a very limited number of trained staff can utilize ”family members to effectively treat and rehabilitate persons who are mentally ill. It is hoped that methods can be developed which will reduce the cost per patient and which can be duplicated in other centres in India and abroad". (Chacko, 1967).

The system of including a family member as an essential part of psychiatric in-patient care has been continuing for the last forty years. However, it is surprising that despite this period of experience at Vellore, there has been very limited research on the various aspects of family involvement in mental health. It could either mean an oversight of professionals to systematically study the experience or recognition of the positive feelings from families that is so evident that it did not seem to warrant systematic study.

Limited systematic efforts were made at Bangalore from 1968 (Narayanan & Reddy, 1968; Narayana et al, 1972; Narayanan, 1977; Geetha et al, 1980). The initial efforts were to compare routine treatment with that of family ward treatment as follows:

"Family ward in a mental hospital is a new concept, wherein the relatives stay with the patient and look after him.... Family ward was started in February 1968....The treatment in the family ward differs from treatment in the general ward. Since several families are grouped together in a ward for a common purpose gradually a type of consensus occurs, in which the relatives begin to participate, in the treatment, management and rehabilitation of not only their patient who is related, but also of other patients who are not related. The immediate and personal attention helped even the most unmanageable and excited patients to calm down, who started recovering by the third day..... In the evenings after attending to the routine necessities of the patients, the families gather together and have general group discussions. There is group singing of prayers again in the night. After this the psychiatrist spends sometime with all the members, in discussing problems relating to mental health and mental illness. Thus gradually but indirectly and hopefully mental health principles are imparted to the community at large." (Narayanan & Reddy, 1968).

Further on, they conclude,

"Our experience of treating patients in the Family Ward has been very gratifying. Treatment of the patient in the family unit prevents the separation of patient from his family during therapy, prevents chronicity, lessens the length of stay of the patient in the hospital, and also helps in lessening the stigma attached to mental illness. The family situation could be understood better which helps in instituting effective and long lasting therapy. The problems of rehabilitation and readjustment with family and community is facilitated. This is one of the most effective way of spreading the knowledge of mental health in the community at large"“ (Narayanan and Reddy, 1968).

Subsequent efforts at the Family Psychiatry ward were to understand the family and group processes (Bhatti, 1980; Bhatti et al., 1980, Verhese,1991,Bhatti and Verghese,1995). A more recent shift has been the development of treatment packages for the families of the mentally ill persons. Most of this work at the Bangalore centre has been in the institutional setting.

During the latter part of the 1970s three important studies focussed on the needs of families and impact of the family level intervention at the community level.

The first of these studies were initiated at Chandigarh, under the leadership of Professor Wig (Suman et al, 1980). The emphasis was on non-institutional care and focussed on the need fulfilment. This study focussed on "attempts to meet the needs of a group of chronic schizophren­ics in the community." The setting was the Modecate Clinic and the team consisted of a psychiatric nurse, one psychiatric social worker, and two psychiatrists. In this study 30 of the persons suffering from chronic schizophrenia attending the special clinic were evaluated in detail for their symptoms, social functioning. Further efforts were made to provide required help to the ill individuals and the families. Information was obtained through non-structured interviews and observations of the patient, family members, and significant others, both in the clinic and in their homes.

The psychosocial problems of the families could be categorised under (a) high level of expectation, b) emotional over involvement, c) problems related to the long-term treatment, d) lack of understanding of patient's residual symptoms, e) problems related to marriage, and f) rehabilitation. In the group nearly half of the families had high expectations from the patient and the treatment in spite of long duration of illness. Nearly 40% of the families were either overprotective or critical of the patient. Some of the families had difficulties to continue the treatment for reasons of patients refusal to take the medicines, lack of understanding of the illness, fear of social stigma resulting in irregular treatment contact, hopes of marriage curing the illness and physical distance between the place of residence and the treatment centre. Relatives had significant difficulty to understand and accept the residual symptoms especially the negative symptoms of the illness. About half of the patients had difficulties in their marriage in one or other form. Ten percent of the subjects were divorced or separated. About 40% were single due to the illness. Unemployment was also a source of concern to the families. Half of the patients needed specific help for rehabilitation in the form of day care facility or employment.

Interventions consisted of regular home visits, family counselling, marital counselling, contact with social welfare agencies and providing an understanding about the illness. All the families were visited at home periodically .These home visits became a source of support to the family. The visits were utilised to share the caring skills with the family members.

The study concluded, "Family members have multiple needs when living with a chronic schizophrenic; the needs should be specifically examined and met to enhance the level of functioning of the patient as well as to decrease emotional problems of family members; the utilisation of multi-disciplinary team to reach out to the community is helpful to meet some of the complex needs and paraprofessionals can play a major role in the care of the patients in the community" (Suman et al, 1980).

Following this experience, in an another initiative from Chandigarh by Anand (1980), and Gujral (1982) specific nursing interventions to meet the needs of the families were developed and evaluated in both rural and urban areas.

Trivedi et al (1983) studied the role of attitudes of key relatives towards the patient on the course of the schizophrenic illness, involving 45 patients and 45 key relatives. The follow-up period was 6 months. The outcome measures were clinical course and social functioning. The frequency of critical comments, hostility, dissatisfaction, warmth and emotional over involvement was more in the "relapsed or continuously ill patients". Though the differences were not statistically significant, there is a trend towards negative attitudes of key relatives and chronicity.

Another very important study of this period was initiated at NIMHANS, Bangalore by Shaila Pai and Kapur (Pai and Kapur,1983). In this study, two similar groups of schizophrenic patients(27 each), undergoing two treatment modalities, namely hospital admission and home treatment through a nurse were compared for the outcome in terms of symptoms, social dysfunction, burden on the family (Pai and Kapur,1981), cost of treatment and outcome at the end of 6 months. The hospital group patients were admitted to the psychiatric wards and treated in a routine manner.(average hospital stay was 6 weeks).The home care group remained in their homes. A nurse trained in patient follow-up and counselling visited the home regularly for the purpose of patient assessment and treatment. The frequency of the visits were determined by the severity of the illness and the level of anxiety expressed by the family (Pai and Nagarajiah,1982).

The "two groups were comparable and the differences in outcome could be safely attributed to the differences in the two systems of delivery of care". The results found that the home treatment through a visiting nurse gives a better clinical outcome ,better social functioning of the patient and greatly reduces the burden on the patients` families. Further the treatment modality is also more economical (Pai and Kapur,1982, Pai and Kapur,1983).

A follow-up study was made of this group of patients after two years.37 of the 54 patients could be contacted. It was observed that the home care group of patients had maintained significantly better clinical status than the controls and this group had been admitted less often.(Pai and Roberts, 1983). However, in terms of social dysfunction and burden on the family, the benefits of initial home care disappeared.

In a subsequent study the focus of family care by visiting nurses was chronic patients with a diagnosis of chronic schizophrenia(Pai et al,1985). Two groups received the routine out-patient care and home care respectively. The mean duration of illness was 9 years. Each group had 32 patients and the duration of follow-up was two years. The two-year follow-up assessment showed that the home care group maintained better clinical status, as well as a better level of social functioning, but the differences were not statistically significant. It was found that the clinical improvement noted in the home care group was more marked in relation to the symptoms of sleeplessness, loss of appetite, depressive mood, emotional withdrawal, anxiety, grandiosity or suspiciousness, tension, hallucinatory behaviour and unusual thought content, possibly related to the more effective medication. Only two of the home care group were admitted to hospital over two years in comparison to 8 patients in routine care. Authors concluded that it is evident from the data presented here that a home care service seem to offer a viable alternative mode of follow-up care for the chronically mentally ill population. It also suggests that it may be possible to prevent repeated hospitalisations for these patients and offer them a better chance of long-term community adjustment.

However since the completion of these studies in 1985, family care in the community by nurses has not become routine in either of the centres or in the rest of the country.

Data about how the families view their ill family member is provided by the Indian Council of Medical Research (ICMR) study "Factors associated with the course and outcome of schizophrenia". This study was carried out in three centres namely Lucknow, Madras and Vellore (ICMR, 1988, Verghese et al, 1989). Results indicate that over a five year period of follow up, the overall attitude of the families is positive and keeping the ill member at home is preferred by majority of the families. Similar findings were reported earlier by Kulhara and Wig (1978) from Chandigarh.

This above ICMR study also found that based on the two and five year follow-up evaluations, there is a steady increase in the number of patients experiencing two or more episodes. At the two year follow-up only 3.8% had more than two relapses and this group was 18% at 5 year follow-up. The above data suggests a role for family interventions which have the potential to impact relapse rates (Shankar,1998).

Another set of studies related to the burden of mental illness on the families was conducted by Verghese (1982) wherein the problems faced by the families in three groups of patients of schizophrenia, mania and major depression were studied. Verghese(1982) concluded that manic patients had more severe and disruptive psychopathology and caused maximum burden on the families. Isaac et al (1989) studied family burden using Pai and Kapur(1981) scale and compared the burden in different types of care namely home care, day care, and inpatient care. They also studied the relationship of burden and disability and reported that they were positively correlated and they remained so over time. There was no significant difference in the 3 types of care. Ranga Rao (1989) studied family burden in chronic schizophrenic patients in rural and urban areas and reported lesser burden was experienced by the families in rural areas. The burden was less in terms of the disruption of routine family activities and disruption of family interaction. Muralidhar (1986) studied the reha­bilitative potentials in the families of schizophrenic patients. As part of a WHO study conducted in 4 developing countries of including India, Giel et al (1983) studied family burden and reported that burden was highest in the urban areas. They also reported that mental health care delivered at a distance from patient's home involved a heavy burden on the families and this could be reduced if a health worker delivered the care at home.

EXPRESSED EMOTION Study

During the latter part of 1980's, as part of the WHO collaborative study on `Determinants of outcome of severe mental disorders' a substudy focussed on the specific cross-cultural aspects of expressed emotions (EE).The Chandigarh centre was under the leadership of Prof.Wig.In this comparison two samples of relatives of first-contact patients of schizophrenia from Aarhus (Denmark) and Chandigarh (India) were **assessed for the expressed emotions and the relationship of EE with the outcome in the two centres.** The training of the investigators from different cultures was satisfactory and it was found that the rating of critical comments could be transferred satisfactorily from English to Hindi.(Wig et al,1987a).The Danish sample consisted of 28 patients, while the Indian sample consisted of 78 patients from the urban and rural areas.

56% of Chandigarh relatives made no critical comments at all, compared with 29% of Aarhus relatives and 28% of British relatives. While 16% of the British relatives scored 15 or more, no Chandigarh relative made more than 14 critical comments. The mean number of critical comments made by urban relatives was 2.42 compared with only 0.58 for rural relatives, as compared to 8.4 for British sample. In the Indian sample warmth is likely to be associated with high criticism as with low criticism, whereas in the English and Danish samples warmth is much more likely to accompany low criticism. The proportion of families categorised as high-EE was 54% in English and Danish samples as compared to 30% in urban and 8% in the rural samples (Wig et al, 1987b).

During the one year follow-up of the above group of patients at Chandigarh, only 14% had a relapse, as compared to 29% in the British sample. The same association between the individual components of EE and relapse in previous Anglo-American studies was found in Chandigarh, but only the association between hostility and relapse was statistically significant.(Leff et al,1987). The overall findings of this set of cross-cultural comparison of EE studies are that (i) there were far fewer critical comments made by Indian families than by British relatives and within the **Indian families rural relatives were significantly less critical than urban relatives, (ii) Over involvement was virtually absent in the Indian sample, (iii) city dwellers show a shift towards western patterns of EE, (iv) in the west hostility is closely linked with critical comments, but in Chandigarh, relatives expressed hostility at relatively low levels of criticism; and (v) the relationship between critical comments and warmth was different in the Indian sample. Western relatives are unlikely to express warmth if they are highly critical while in Chandigarh relatives can often be warm and critical at the same time.**

Authors of this set of studies conclude:

**"the starting point for further studies could well be the major difference in distribution of EE components between the urban and rural relatives. The possible insights afforded by this line of enquiry could contribute to therapeutic endeavours to alter the emotional environment in high-EE homes".**

In a subsequent report Leff et al(1990) followed up 86% of the above group of patients at the end of two years. In contrast to the one year findings, the global EE index at initial interview did not predict relapse of schizophrenia over the next two years. However, there was a significant association between initial hostility and subsequent relapse. **The better outcome of this cohort of schizophrenic patients compared with samples from the West is partly attributable to tolerance and acceptance by family members.**

**In view of the association of high EE and family attitude to the course and outcome of schizophrenia, and the known better outcome of schizophrenia in India (as well as other developing countries) the failure to follow-up the above leads is unfortunate. This is an area for urgent attention by professionals.**

During the recent years a number of investigators have studied in more details the family life of the persons with schizophrenic illness and factors associated with family care. These studies offer new understanding as well as potential avenues for further work.

Sharma et al (1998) compared 78 patients living in the community with a diagnosis of schizophrenia in Liverpool, U.K. and 60 patients from the rural areas near Bangalore, India. In Liverpool only 20% were ever married as compared to 90% in Bangalore sample. Less than half of the patients were living with the family in Liverpool, while all but one patient in Bangalore was living with the family. Very few patients in Liverpool were employed. In-patient treatment was common in Liverpool while it was rare in Bangalore. Illicit drug use was seen in 22% of Liverpool patients as compared to 2% in Bangalore. Authors conclude "Bangalore patients were more socially integrated than Liverpool patients who appeared socially marginalised".

Three recent studies have focussed on the family role in the help seeking behaviour in the different environment. Naik et al(1996)studied as part of the District Mental Health Programme in the Bellary District,132 patients diagnosed as suffering from schizophrenia to understand the family climate and its relationship with treatment adherence. The majority of patients compliant to treatment had better income, better level of education as compared to the non-adherents to treatment. The families of compliant patients scored significantly higher in respect of intellectual, recreational, moral/ religious and organisational dimensions of the family environment scale.

Banerjee and Roy(1998) studied the help seeking behaviour of 83 families of schizophrenic patients seeking help in a medical college department of psychiatry. The time lag in seeking treatment was more than 5 years in 25% of the patients. Believers in the supernatural causation of mental illness consulted indigenous healers in about 85% of cases, while all those who believed it to be a medical problem consulted practitioners of modern medicine as their first contact for treatment. 83% of the families who believed schizophrenia to be a medical problem acted on family decision, while of those who believed in supernatural causation acted on family decision in 27% of cases and on the decision of the social network in 73% of cases. When the belief system is supernatural 79% consulted a traditional healer while none of the families who considered it a medical problem did so. The majority of the rural families(62%) preferred the indigenous healers. The imporantance of these findings are related to the delay in seeking treatment and its contribution to chronicity.

Padmavathi et al (1998) in their study of urban patients with schizophrenic illness, identified as part of a prevalence study found that out of 261 patients, about one third were found to have not received any treatment, in spite of being ill for long periods of time(Mean period 11.64 years). Half of the patients were living in nuclear family setting and the rest in extended/ joint family. None of the patients was living alone.61% were married and 40% of them were divorced or seperated.45% were employed.28.7% had never received any psychiatric treatment in spite of living within 10 kilometres of psychiatric facilities. The untreated group was older in age, ill for a longer period, were more symptomatic and severely disabled. They also were more often uneducated and divorced and lived in large extended families. It was noted that the family members living with them were less aware of the psychiatric nature of the illness. Authors emphasise the need to involve the family in treatment.

The above three studies are important as they to indicate the role of public education, involvement of families as essential part of treatment and the need for special programmes to reach the rural, less educated and less well off families to make treatment programmes more effective.

During the 1990's, the movement to develop **programmes for family members** and professional involvement have been initiated. These are (i) family education (Viswanath and Padmavathi, 1992), (ii) family intervention, (Shankar, 1994, Nagarajiah, 1994, Bhatti and Verghese, 1995, Shankar, 1998), (iii) formation of self-help groups and greater support to families to become partners in care. (Shankar and Menon,1991, Srinivasan, 1998,Srinivasa Murthy, 1999).

The focus of family interventions, to date, has been to build a relationship with caregivers based on understanding and empathy, focussing on the strengths of caregivers and assisting them to identify community resources, interventions to promote medication compliance, interventions to promote early identification of relapse and swift resolution of the crises, guiding families to reduce social and personal disability, guiding families to reframe expectations and moderate the affect in the home environment, guiding families to improve vocational functioning of the patient, emotional support to caregivers and development of self-help groups for mutual support and networking among families.(Shankar,1998,Nagarajiah,1998).

# Changing families in India

The issues relating to the families are i) growing urbanisation of India, (ii) breaking down of the traditional joint and extended families, (iii) increasing numbers of nuclear families, (iv) single parent families, (v) families with working parents, (vi) families in distress due to economic deprivation, social marginalisation, alcohol dependence, chronic illnesses, (vii) growing numbers of elderly persons and families of mentally ill with elderly caregivers, (viii) increasing influence of mass media in shaping the aspirations of young people and family life.

All of these changes have mental health implications in the following ways. There will be relative increase in some of the mental health problems (suicide, drug dependence, stress related disorders, child mental health problems) which will need professional interventions. There will be lesser availability of the family level care and caregivers, necessitating the organisation of alternative care provisions. An indication of this need is the gradual increase of half-way homes and long-stay homes in different parts of the country. Those families who continue to care for the ill persons will require organised support in the form of visiting help and networking of the families. Families will require financial and other supports (insurance, aid, preferential housing etc). In future, professionals have to work actively with families as partners.

# International Developments

All over the world there has been dramatic changes in the organisation of mental health care and the role of families in this changing scenario (Srinivasa Murthy, 1999). The following observations of the changing role of families as presented by Wolin and Jacobs (1992) and Leff (1996) illustrate this issue.

Wolin and Jacobs (1992) describe the shift in the role of the family in mental disorders as follows:

"Our concept of the family's role in chronic mental illness has undergone a dramatic shift over the past thirty years. Over this period there have been three phases in thinking about the family and its relationship to a psychotic or characterologically disturbed member, each with major consequences for clinical care.

In the first phase, which can loosely be termed the `psychotogenic parent' period, the etiology for schizophrenia in a child, as well as other psychiatric disorders, was seen as a direct result of disturbed parenting. Fromm Reichmann first labelled certain mothers as `schizophrenic; if they were lacking in affection towards their infant. Dependent and emotionally immature mothers were accused of being `addictogenic' in their ability to produce alcoholic and drug-abusing children. The pattern of passive, distant, unavailable fathers and aggressive, overly seductive mothers was seen as capable of producing homo­sexual sons. Although these theories of parental responsibility for the serious mental illness of their offspring received little to no support from empirical research, this early model has greatly influenced the practice of generations of clinicians.

The second phase - family system thinking - marked an important shift away from blaming the individual parent for the mental illness of the child. This theoretical approach directs responsibility instead to interaction patterns either at the marital level or across the family as a whole. Theories of `double-binding' parents, `schizmatic or skewed'  marriages, `undifferentiated' multigenerational family systems, `pseudomutual' patterns of communications and others, have contributed various hypotheses regarding the family's responsibility in causing the disturbance of their sick member. As in the earlier, individually oriented phase, these family-based models of psychopathology provided little empirical research evidence to substantiate them.

Recently, a third phase in thinking about families has focussed not on the family's hypothetical role in causation, but rather on its response to the inevitable trauma of living with a chronically mentally ill member. In this more pragmatic, and perhaps less accusatory perspective, serious mental illness is conceptualized as a disease with biomedical, often genetic, origins. Over the past decade an important genetic contribution has been claimed for schizophrenia, affective disorders, alcoholism and other addictions and serious character disorders. In this more recent model the illness in one member is seen as a crisis for the whole family. Accordingly, the family's ability to cope with the manifestations of this illness may explain many behaviours, but not the underlying etiology of the disease".

The shift in thinking about the family's role, from etiologic agent to "coper" and responder, has been the result of several promising research and clinical experiences. In each of these models the family is conceptualised as more or less able to handle the crisis of a mentally ill relative. The family's response is a result of its level of competence, its adaptive skills. Some families, with one quality or another, are seen as more resistant and adaptive, while others are relatively less stress-resistant.

Leff (1996) comments on the problems of providing care when there are no families as follows:

"Our problem in the West is, that somehow or other we have to make up for the families (emphasis added) who have disappeared and create a supportive structure - not for the patients but for the single relatives who are often desperately trying to cope with schizophrenia. It is, of course, very expensive to create a network of professionals who act as a SURROGATE FAMILY (emphasis added), but we have to provide that form of support, because it is even more expensive to keep hospitalising patients."

A positive outcome of the focus on the family potential, essentially a result of the shift of chronic patients from hospitals to the community, has been the variety of family interventions during the last two decades. A recent review (Dixon et al,2000) of 15 new studies on family interventions concluded "data supporting the efficacy of family psychoeducation is compelling, such programmes should remain as part of best practices guidelines and treatment recommendations".

The challenge is translating these research observations into clinical practice as noted by Schooler and Fenton(2000)"at this juncture we appear to know more about what constitutes effective psychosocial treatment than how to effectively transfer what we do know to the clinic. An investment in research aimed at defining and evaluating methods of technology transfer is required to teach us how to adapt what has been learned to environments often characterised by harsh exigencies and scarce resources for clinicians, patients, and families on the front line".

With the availability of newer treatments, recognition of the rights of the ill persons and growing awareness of the psychosocial factors that contribute to the course of illness, there is real re-examination of the role of families in the care programmes in the west.

# Future Directions

We would like to identify the following specific areas for research and intervention work in the area of families and schizophrenia.

1. There is a need to study and understand `in a holistic manner' the functioning of the family in India. This would include both the normal situations as well as when there is an illness like schizophrenia. This study should be not only on the structure of the family but also on family functioning. In quite a number of families the situation of an ill person or a dependent person is seen in positive terms and not as a burden. It is also important that we understand the family functioning across the different religious groups, social class groups, caste groups, rural-urban areas, as the functioning of the family is influenced by these variables.

2. Understanding of the current approaches of the families to provide care for mentally ill persons should be the next starting point. As has been seen with problems of mental handicap, alcoholism, and old age, there is likely to be a large amount of wisdom in regard to care available within the families. We should have the humility to learn from the families rather than assume that we have all the answers. We foresee that if we work with the families in this manner, then we would be richer and the next set of interventions would be more in harmony with the needs of the families. Specifically, research should focus on the advantages and disadvantages of the Indian families for the care of the mentally ill persons.

3. A specific focus of research will be to understand the needs of the schizophrenics and their families. So far the efforts in this area have been in terms of disability, burden etc. There is need to enlarge the scope to cover the totality of functioning of the family as a unit rather than focussing on the ill person only. Another aspect that needs to be better understood is the need for changing requirement as the illness progresses, recovers, or stabilises over time. Understanding of the differential needs of the different socio-economic classes, caste groups, or regional groups should also receive attention. In this context the likely differences between ill persons of the two sexes, the rural-urban , the families with elderly parents, call for special attention. The family perceptions about the early features of mental illnesses, the need for treatment, the sources of difficulties, type of help that is needed, are to be studied in different social groups. This knowledge should become an important knowledge base for mental health professionals in their training and work.

4. Another aspect would be to develop specific interventions to meet the needs of the families. Here again the emphasis should be on the totality of the needs fulfilment rather than segmental activities like education, decrease in expressed emotion, day care etc. There is an urgent need to provide family care from the beginning of the illness and on a longitudinal basis rather than thinking of family only when there is chronicity. Such studies should focus on the psychopathology of the ill person, disability associated with the illness, burden on the family and the cost of the illness and family care. Further cost-effective interventions should be developed and evaluated in the routine care giving settings. Such demonstration projects carried out in different parts of the country can result in a national level initiatives to support families with a patient of schizophrenic illness.

5. The role of non-medical mental health professionals and welfare services need to be recognised. These relate particularly to the non-medical interventions such as economic, educational, rehabilitative and supportive help. In order to be effective in this area, professionals at the national level should take a conscious decision to develop co-ordinated ways of working among psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, occupational therapists and personnel from voluntary organisations. This development has to be supported not only by professionals but by policy makers as well. It is important to recall that in USA, the transformation of psychiatric care occurred against the background of expanding welfare services in the 1960's and the most important of them were not directed at mental patients. So, working towards an enlarging base of welfare services and welfare personnel is an urgent need. The progress in mental health manpower development in India, especially with regard to non-medical group, is far from satisfactory. Specific plans have to be made to fulfil this need.

6. The current training programmes of mental health professionals emphasise very strongly the western bias towards the aetiological role of the family. This needs to be shifted in terms of changing the history taking pattern and emphasising the place of family in the totality of the care from the beginning rather than considering them only as accessories to therapy. This requires a major modification in the postgraduate training of mental health professionals to give them skills to understand families and work with them as partners.

7. Macro-level changes in the society also bring about change in the structure of the family. For example, we have, in the urban areas, an increasing number of nuclear families, single parent families and migrant families. The needs of changing families when there is a mentally ill person in the family should be studied and appropriate interventions developed.

8. There is a need to learn from and benefit from the initiatives of human development professionals in working with families in distress and adapt the successful methods to the care of mentally ill. The need for inter-disciplinary collaboration and cooperation is vital in this area of work. Prof. Saraswathi has emphasised this need in her contribution to the book (Chapter 18).

9. The practical challenge for all professionals is the identification of the currently available mental health information and develop mechanisms to reach the relevant information about mental health and mental illness to all rural and urban Indian families. In all our efforts to work with the families, the focus should be on the quality of family life rather than only on the needs of the mentally ill persons and their caregivers (Wig and Srinivasa Murthy, 1994).

In conclusion, we would like to say that the place of family in mental health care, especially schizophrenia, has come a full circle from family care to institutionalisation to family care. Indian initiatives relating to families and mental health care have depended on the family support for the mentally ill persons. Since 1960s families have been formally included to supplement and support the psychiatric care by professionals. During the 1970s and 1980s,efforts were made to understand the functioning of families with an ill person in the family and their needs. Along with this there was study of factors contributing positively/negatively to the course and outcome of schizophrenia. During the last 10 years, a more active role for families is emerging in the form of formation of self-help groups and professionals accepting to work with families in partnership. However, many of the leads provided by pilot studies and successes of family care programmes have not received the support of professionals and planners to the extent it could become a routine part of psychiatric care. The larger community of persons with schizophrenic illness and their families continue to not benefit from these developments. As we enter the 21st Century, India has the opportunity to benefit from the experiences of the West and build upon the strength of the Indian family system. The emphasis now must be on strengthening the family in providing care to the ill individual. This would be India`s contribution to the rest of the world.

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