EDITORIAL

NEED FOR FAMILY INTERVENTIONS IN SCHIZOPHRENIA

In the last five decades the relationship between the family and schizophrenia has been an area of intense research. Initially the family was supposed to be having a causal role, but later due to the poor empirical evidence supporting this hypothesis the thinking changed. Research on expressed emotions (EE) showed with considerable empirical data, the role of family attitudes & interactions upon the course of schizophrenia rather than its onset. Family dynamics is seen more now in the framework of stress-vulnerability model. In the last two decades variety of family intervention strategies, mostly psycho educational have been derived from the studies on expressed emotions. Family intervention are proposed as adjuncts rather than alternatives to the drug treatments. The main purpose of these is to decrease the stress within the family and also the rate of relapse. These interventions have assumed greater importance as a result of the shift of chronic patients from hospitals to community.

Unlike in the west where in many cases the expensive network of professionals act as a surrogate family, in our country family remains the single most important source of care for the patients with chronic mental illnesses (Murthy, 1999). It is both by choice and compulsion due to the lack of facilities.

Several studies done on the families focussed upon the needs of families and the impact of interventions at the community level (Suman et al, 1980; Anand , 1980; Gujral, 1982). The author studied the attitudes of key relatives towards the patients on the course of schizophrenia (Trivedi et al., 1983).

Data from ICMR study "Factors associated with the course and outcome of schizophrenia (ICMR, 1988) indicated that over a five year follow up the overall attitude of families is positive and home treatment is preferred by majority of the families. Kulhara & Wig (1978) have earlier reported similar findings. As per of the WHO collaborative study on "Determinants of outcome of severe mental disorders, a sub-study focussed on the specific cross-cultural aspects of expressed emotions (Wig et al., 1987). The better outcome of Indian cohort of schizophrenic patients compared with sample from the west is partly attributable to the tolerance and acceptance by the Indian family members. A positive result of the focus on family has led to the development of variety of family interventions in last two decades.

The aim of family intervention is to offer a team approach for the patient and family towards support and understanding of the illness. They give the family proper knowledge about the early warning symptoms of an acute relapse so that the medication can be adjusted and the relapse may be prevented . These interventions also enhance the coping skills of the family with chronically ill psychiatric patient and reduces the burden on them . Through these interventions the relative’s ability to anticipate and solve problem is enhanced . This reduces anger expressions and guilt by the family. Maintenance of reasonable expectations for patient's performance, encouragement of relatives to set and keep appropriate limit while maintaining some degree of separation when needed and attainment of desirable change in family member’s behaviour and belief system are the other goals. Reducing
hostility and criticism in the family is one of the prime objective of these interventions.

In their meta-analysis about family interventions in schizophrenia and related disorders, Barbato and D'Avanzo (2000) reviewed 25 studies meeting the criteria set by them, they concluded that:
1. The addition of family interventions to standard treatment of schizophrenia has a positive impact on outcome to a moderate extent.
2. These interventions reduce the short term risk of clinical relapse after remission from an acute episode, the evidence of effect on patient's mental state and social functioning however is less.
3. The common factors for most effective interventions are: inclusion of patients in some phases of treatments, long duration and information and education about the illness provided within a supportive framework.
4. The evidence however is only in favour for chronic, male, patients living with high expressed emotion parents.

Which elements of family interventions programme are necessary is not clear largely because the studies so far have failed to demonstrate any significant differences between the models. Barbato & D'Avanzo (2000) have also suggested some points which may be included in the future research in this important area.

The major challenge however is to convert research findings to the clinics (Schooler & Fenton, 2000). The methods of transferring the technology has to be evolved. Further studies which are able to address such issues will contribute significantly to the better care of patients with schizophrenia.

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