FAMILY PARTICIPATION IN MENTAL HEALTH CARE - THE VELLORE EXPERIMENT

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SUMMARY

This paper describes the experiment of family participation practised in Mental Health Centre, Christian Medical College, Vellore. An attitude study was conducted on a group of 94 relatives of patients. All the subjects showed a marked degree of change in their knowledge and attitudes on various aspects of mental health and illness.

Introduction

The whole concept of illness is in the process of changing. The social aspects of medical care are being recognised more and more. The need for the traditional hospital to lose its mantle as repairshop to become more community oriented is more and more realised. This becomes very important in psychiatry. Human behaviour cannot be completely understood in social isolation. One's behaviour influences and is influenced by the behaviour of others in the environment. One's immediate environment is the family and it is essential that the family must be actively involved in mental health care.

Mental illness in one member of the family is usually associated with the emotional disturbance of other members of the family. Although the orthodox family therapy concepts advocated by Ackerman (1967), and Howells (1962) are controversial there is no doubt that active involvement of members of the family in the treatment programme should be encouraged. Our present psychiatric care is by and large individual oriented and centres round large hospitals. The doors of the hospital close behind the patients and against the family causing progressive separation between patients and families. The relatives of the patients may be interviewed occasionally as part of individual psychotherapy. But it is doubtful whether any serious attempt is made to involve the whole family or as many members of the family as possible throughout the treatment programme. Cote et al. (1954) in Montreal have described their experiment of allowing selected relatives of patients to stay in the hospital. Though this step was taken because of financial stringency, this experiment was found to be of much educational and therapeutic value. Midelfort (1957) reported on his experiment of encouraging family participation in interview situations which was found useful for diagnostic and therapeutic purposes. In Asfouriyal hospital for mental and nervous diseases in Beruit, the relatives stay with the patients for the first few days and then make frequent visits (Bell 1969). Vidyasagar in Amritsar was the first one in India to encourage families to stay with patients during the treatment programme. The other two places where family members are actively involved in the treatment programme are Bangalore (Narayanan et al. 1972) and Vellore (Verghe 1971).

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The purpose of this paper is to describe the experiment of family participation which is being carried out at the Department of Psychiatry, Christian Medical College, Vellore, India, and to highlight on an investigation into the degree of change of attitudes on mental illness which relatives of patients undergo consequent to their stay in the hospital.

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We have been trying this experiment of family participation in mental health care at the Christian Medical College, Vellore, since 1957. Various aspects of this experiment have been reported by Kohlmeyer and Fernandes (1963); Chacko (1967); and Senseman (1970).

Recognition and appreciation of the theoretical principles underlying the involvement of family in mental health care, recognition of the importance of the traditional Indian family ties, and financial stringency, were the main reasons of undertaking this experiment. The traditional structure of the joint family though undergoing a change, still exists especially among the more conservative sections of the rural population. Sethi et al. (1967) reported that 25 per cent of the 300 urban families they studied belonged to the joint family system. We in Vellore, during the course of a mental health survey found that 12 per cent of the families in an urban area are joint families. In our department of psychiatry about 40 per cent of the first admissions are from joint families. Even where the joint family pattern has broken down, its ideological basis is preserved, which exerts its gravitational pull and this has to be taken note of in any treatment programme in psychiatry in India.

The Mental Health Centre is built on the campus of the Christian Medical College in a rural area, about 3 miles from the Vellore Town. The Department of Psychiatry has both outpatient facilities at the Mental Health Centre as well as outpatient facilities in the main hospital, which is situated in the town. At the Mental Health Centre, there are facilities to treat 68 inpatients. No particular school of psychiatry is adhered to and an eclectic type of psychotherapy is practised. There are about 4,000 new consultations every year. Of these, about 25 percent get admitted, 40 percent take treatment as outpatients and 35 percent come only for consultation. The most frequent diagnosis is schizophrenia (about 40 percent), which is followed by neurotic reactions (30 percent). The average length of stay as inpatient is about 7 weeks.

It is essential that one or two members of the family should stay with the patient throughout the treatment programme. There is no restraint or restriction. There are small self-contained living units where patients and their relatives can stay independently. The relatives are encouraged to take an active part in the treatment programme of the patients. They bring the patients for the Electroconvulsive treatment and supervise them throughout the recovery period. They bring the patients to occupational therapy section and participate in outdoor games. When the patients are disturbed they are of much assistance to the staff and they are often skilled in handling them. This system of utilising the relatives in the care of the patients has the advantage of relieving the staff from routine duties. The nursing staff supervise the physical treatments, observe the patients and advise and assist the relatives.

The relatives have group meetings, supervised by the occupational therapists, social workers and nurses when several
aspects of mental diseases are discussed. They thus get an insight into the treatment techniques and also a chance to dispel many wrong notions and attitudes about mental diseases which they have been entertaining. Through spread of this knowledge into wider circles of the public, a general education in matters of mental health and illness is affected. This is a useful way of improving public attitudes towards the mentally ill. The therapists interview the relatives regularly to know more about the family dynamics. If other relatives are found more significant in the dynamics they will be interviewed by appointment. In selected cases, several members of the family group are interviewed by the therapist. Thus an attempt is made to restore the family homeostasis. At the time of discharge, the relatives are instructed about the details of medication and follow up.

The presence of the relatives with the patient is a comforting experience to the patients, especially to those who are leaving their homes for the first time. This minimises the apprehensions of hospitalisation. They participate in the treatment programme without much reluctance because their people are with them always. At the time of discharge, an abrupt change in his relationship to the environment is avoided and the same persons are with them during rehabilitation in their own homes. All patients and relatives are encouraged to keep in touch with therapists. Those in distant places write; those nearby come for periodical evaluation. During their stay in the hospital, the relatives become aware of the early symptoms of a relapse and we find that they are as a rule quite prompt to bring the patients for treatment at the very early stages of relapse.

Thus the relatives of patients are actively involved in the treatment programme. This is more in the case of relatives of neurotic patients, whose presence is essential in the understanding of the dynamics and the manipulation of environmental factors which have produced the neuroses. In the case of children, the psychotherapy is mainly for the parents. In the case of psychotic patients, the relatives learn about the early symptoms and realise the importance of early treatment, continuation of drugs and the periodical check up. They get more insight into the rehabilitation of the patients. During their stay in the hospital, the relatives of all the patients get more awareness into the various aspects of mental diseases, which knowledge permeates into the society.

**Evaluation of the programme: an attitude study**

One of the assumptions of our experiment is that the relatives during their stay in the hospital get more information and develop more positive attitudes about mental health and illness. We made an attempt to evaluate this by conducting an attitude study.

**Material and Methods**

One hundred first degree relatives (parents, children, sibs and spouse) of patients who agreed to stay in the hospital for at least 4 weeks continuously were selected for the study. This selection was done on a consecutive basis.

Nine vignettes developed and standardised by Malhotra and Wig (1975) were used. These vignettes were on catatonic schizophrenia, paranoid schizophrenia, hysteria, obsessive compulsive neurosis, depressive illness, manic excitement, anxiety state, alcoholism and dementia. After each vignette was read out, the subject's knowledge of the attitudes to various aspects (perception of illness, etiology,
treatment, and rehabilitation) were assessed using an attitude questionnaire (Appendix). After this initial assessment, the relatives were actively involved in the treatment programmes as described earlier. After one month, the attitude assessment was repeated.

The responses were scored in relation to a standard response scoring sheet which was prepared by discussing with 5 qualified psychiatrists. These specialists were asked to score, judging by their experience, the correctness or otherwise and positiveness or otherwise of the various possible responses. Using this scoring sheet, the responses of each subject for all the nine vignettes were scored at the time of admission and after 4 weeks of stay in the hospital. The magnitude of change was calculated as follows:

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\text{% change} = \frac{\text{Final score} - \text{Initial score}}{\text{Initial score}} \times 100
\]

Higher the score, more positive would be the change. The percentage changes in the perception of illness, etiology, treatment, and rehabilitation for the total group of subjects were calculated. An analysis of the influence of parameters such as sex, age, education, and habitat (rural or urban) on the % change in knowledge and attitudes was also made.

## Results

Out of the subjects, 6 did not repeat the attitude questionnaire after one month. Hence only 94 subjects were included in the analysis. Of these, 34 were males and 60 were females. Fifty were less than 40 years old and forty-four were 40 years and more. Fifty-four were from urban areas and forty were from a rural background. Seventeen studied up to 5th standard; eighteen studied between 6-10 standards; and fifty studied 10th standard and above.

The initial score, final score and % change in the various areas (perception of illness, etiology, treatment and rehabilitation) are shown in Table 1. There is a very high degree of change towards positive in all the above areas. It was found that parameters such as sex, age, education, and habitat had no differential influence on the rate of change in knowledge and attitudes.

| Parameter            | Initial score | Final score | % change | Significance |
|----------------------|---------------|-------------|----------|--------------|
| Perception of illness| 127           | 1137        | 995      | P<0.001      |
| Etiology             | 395           | 1285        | 228      | P<0.01       |
| Treatment            | 1193          | 3548        | 197      | P<0.01       |
| Rehabilitation       | 1689          | 2674        | 58       | P<0.05       |

## Discussion

The above results conclusively show that the subjects, as a result of the family participation programmes for about a month in the hospital have shown a marked change for the better in their attitudes about various aspects of mental health and illness. This is important because these people when they go back to their places will influence others also to change their attitudes. We find that more patients are brought to our hospital from places where another patient had been treated in the past. Hence the relatives who spend some time in the hospital become agents of social education in mental health and illness.

We are in the process of repeating this study on the same group of subjects after a period of 3 years to see whether the change in attitudes which they develop during the hospitalisation are sustained.
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APPENDIX

Attitude Questionnaire

Name: Sex: Age: Monthly Income: Marital status: Education: Occupation:

(Answers to be filled for each vignette separately)

PERCEPTION OF ILLNESS:
1. What do you think about this person?
   (a) Nothing wrong
   (b) he has some illness
   If the response if (b) What is the type of illness? Physical; Mental; Both; Don’t know.

ETIOLOGY:
2. What is the cause?
   Evil spirits; Heredity; God’s punishment; Excessive sexual indulgence; Physical affliction; Emotional problem. Any other?

TREATMENT:
3. What should be done for him?
   i. No need for any treatment.
   ii. Doctor/General practitioner.
   iii. General hospital.
   iv. Mental hospital.
   v. Faith healer.
   vi. Ayurvedic doctor.
   vii. Diet.
   viii. Do you think that marriage will cure the illness?
    x. Any other?

4. What will happen to this person? With treatment/Without treatment
   Better in a few weeks
   Better in 6 months/1 year
   No change
   Do not know
   Any other?

REHABILITATION:
5. After treatment can such a person
   i. stay with the family?
   ii. continue studies?
   iii. go back to work?
   iv. can marry?