FAMILY STRUCTURE, DYNAMICS AND PSYCHIATRIC DISORDER IN INDIA

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SUMMARY

This paper briefly reviews the literature on family structure, dynamics and relationships between family-jointness and different psychiatric disorders in India. Many recent studies indicate that the nuclear families are more vulnerable and plea is made for maintaining the traditional joint family system, even in some modified forms, because of its "built-in-immunity" and supportive networks.

The family is a primary social unit of every culture, whether it be the society of the wandering Bushmen of the Kalahari-desert, the Cattle-herding of Fulani of Northern Nigeria, Industrial Britons, the Urban Australians or the peasants of India. Inspite of its universality, the structure and functions of a family vary from culture. In this paper, however, I will review the subject related only to India.

Every individual is a microcosm of the social macrocosm. Although, he is endowed with certain biological and mental capacities and potentialities, yet he is indebted to social influence for all that he is or hopes to be, because the fate of every individual is woven by the threads of society to which he belongs. Every society has a cultural heritage that influences its organisation and operation and every society acquires its major themes or characteristics from its cultural heritage. India's nearly 700 million inhabitants (80% of which live in rural areas) "show an enormous variety of distinct racial and ethnic characteristics with a wealth of different cultural patterns. The Indians are the descendents of many races which had migrated to India in the past and intermingled in the course of centuries" (Indian and Foreign Review, 1982).

According to Basham (1967), an authority on Indian History, the basic unit of Aryan society was the family. The ancient Indian family, described as a joint one, was staunchly patrilinear and patriarchal; including parents, children, grand-children, uncles and their descendants, and various collaterals on the male side. The husband was head of the house and administrator of the joint property and the wife, though she enjoyed respectable position, was definitely subordinate to her husband. The family, rather than the individual was considered as the unit of the social system. The bonds of family created blurring of the relationships within the group. There existed a deep sense of family solidarity which led to nepotism and various other abuses but it provided a measure of social security to its members, particularly in times of distress; in addition, incompetent and non-contributory members of the family were well accepted, protected and cared for.

The subject of joint family system in India has been a highly emotionally charged area where subjective reports outnumber objective studies (Mehta, 1977). It was accepted for long time that inspite of the historical, political and economical changes, the underlying family structure remained unscathed over the

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centuries, and the subtle changes, which occurred from time to time as the result of new developments didn't affect the stability of the institution of family jointness.

For the last couple of decades, different social scientists in India have been wondering about the fate of joint family system, particularly after the immense industrialisation and urbanisation in India since the independence of the country, (Sethi and Manchanda, 1978a). Migration has also been incriminated as an influencing factor (Bhaskaran et al, 1970; Sethi et al, 1972b). Some workers (Sethi, 1968; Sethi et al, 1974) have predicted fragmentation while others (Kapadia, 1966; Desai, 1966, 64) have claimed increasing strength in the system. In words of Kaldate (1962) "many recent studies have gone to assert that although structurally the traditional family appears to break down, functionally it is not so. They try to maintain that the joint family is not disintegrating in order to function as independent units (nuclear), but adopting to new patterns which have the same degrees of jointness".

As regards the actual incidence of joint and nuclear family types, figures vary considerably because there is no consensus of opinion regarding definitions, particularly of "jointness". However, the general feeling is that the joint family system is more prevalent, particularly in rural areas and the trend towards nuclear family system is more in urban population. In a number of studies referred to by Goode (1963), the reported incidence of nuclear families varies from 32% to 85%.

ROLE OF DIFFERENT FAMILY MEMBERS:

As described by Ramanujam (1967), "tradition has determined the role of the various members of the family. A son is expected to show proper deference to the opinion of his father, even when he is old enough to make independent decisions. The behaviour of a daughter-in-law towards parents-in-law and other members of the husband's household is more or less clearly indicated. The relationships between siblings—the special position of the eldest son, his obligations towards his younger siblings, the privileges of married daughters—are all determined by tradition. Perhaps, when this whole hierarchy of relationships was established, society also made provisions for the satisfaction of individual needs. There is no doubt that when there are rules and regulations governing the behaviour of one individual towards the other members of the family a sense of security is fostered among all".

As compared to the West, the basic philosophy of the joint-family system in India, is that the family interests take priority to individual ambitions. Problems may arise when individual needs are given more importance.

FAMILY DYNAMICS AND DEVELOPMENT OF PERSONALITY

(a) Ego Structure: Neki (1979) describes that "psychodynamics are nothing but ethnodynamics lived at an individual level". Neki refers to Surya (1966a), who "in his remarkable paper on the Ego-Structure in the Hindu joint Family delves deeply into the ethnodynamics and sociodynamics and that determine the structure of the Indian ego, its relatively weak outer boundaries, the degree of responsibility it accepts and the kind of dependency relationship in which it is enveloped". Surya states that the concepts of "mine-not mine" is poorly developed in the Hindu individual and it applies not only to material possessions but also to thoughts, emotions and time.

According to the religious philosophy of Advaitism, i.e., philosophy of non-dualism, which is followed by most of the
Hindus, man is composed of four entities—body, mind, intellect and higher self or consciousness called “Atman”. The higher self (“Atman”) is a part of the Supreme Self or Consciousness called “Brahman” and the self (“Atman”) is one and the same in all human beings irrespective of their colour, caste or creed (Chinmaya Lessons). This philosophy inculcates the message of “oneness” and encourages everybody to rise above one’s limited ego-centric view of life and expand awareness towards totality.

Bhatti et al (1980b) describe that “the families and neighbourhood communities in India are highly cohesive, bound by strong group loyalties and close kinship ties. The line of demarcation between the individual and the small group to which he belongs is hazy and freely admits of group intervention in several areas of the individual life. Living a shared life and subordinating individual autonomy to group cohesiveness come naturally and effortlessly to Indian, especially the rural folk”.

(b) Dependency Relationships: The area dependency relationships in India is quite often misunderstood, particularly in the West. Neki (1976,77) has critically examined “the cultural relativism of dependence as a dynamic of social and therapeutic relationships”. As compared to the Western concept where dependency is considered a sign of morbidity, in India it enjoys respectability because of its dynamic and constructive approach. “As children grow up, the permitted dependency, and fostered dependability together weave a pattern of interdependence...... This is something quite different from the subordination of the individual to the group”. Neki says, “Social dependency has never come to be regarded as despicable and parents do not encourage independence in their children, but seem rather to foster dependency, while themselves modeling dependability, a concept which, to my mind, represents the goal of personal development in the Indian Culture. It is because of this, that during the second phase of biological dependence, namely, old age, in India, people have their children to depend upon”. In the Indian environment, the ideal of maturity in the words of Surya (1966b) is a “satisfying and continuous dependency relation”.

The dynamic and constructive philosophy of dependency relationship is based on the traditional Guru-Chela (teacher-disciple) relationship which has been suggested as a therapeutic paradigm by many thinkers, including Dhairyam (1961), Carstairs (1965) and Neki (1973/4). Neki (1973) says, “the guru, by virtue of his role, fosters dependency; the beginning of the guru-chela relationship is nothing but a dependency relationship. The guru, however, through this relationship works on the disciple’s life pattern, awakens in him a self-value and questioning spirit and leads him through a spiritual independence to confident dependability. The guru, unlike the therapist, does not become anxious about the disciple’s dependence on him. On the contrary, by his prestige and power of suggestion he reinforces it, and continues to do so until he has relieved the disciple of all his anxiety. Then he begins to work for his restitution, layer by layer, removing the disciple’s ignorance, from which ultimately all anxiety and anguish stem. By providing true knowledge about the self, the guru makes his disciple fearless—a state of true spiritual independence, a state of dependability that ultimately inspires faith and courage in others”.

FAMILY PATTERNS:

Insufficient well planned research work has been done in this area as yet. Mahal (1975), on the basis of his clinical experi-
ence, has described the following patterns seen in Indian families.

1. Leaderless families: Mostly poor families with no long term goals and motives, concerned mainly with day to day living; elders providing poor leadership. Such families, because of lack of loyalty to each other, are liable to and are often exploited by others.

2. Split families: Where there are factions within the family because two or more persons are competing for leadership. Common goals are poorly pursued in such families.

3. Authoritarian families: Male authoritarian leadership is a very common pattern in India, except in Kerala where the matriarchal system is more prevalent. Family functions smoothly provided the leader, inspite of his authoritarian approach, remains supportive and sensitive to the needs of the dependents but resentment and rebellion may result if the leader becomes selfish and insensitive.

4. Families with democratic leader: who remains sensitive, responsive and helpful toward the dependents and through the means of better communication encourages group interaction and group participation and thus enhances group belongingness. Such families are productive and enthusiastic working co-operatively for common long-term goals.

5. Families in Transition: such families go through phases of confusion of values and dual orientation while changing from one pattern to another, e.g., from shared group family life to individualism.

6. Families in Crisis, when a particular pattern is disrupted by different crisis-situation like the sudden death of the leader, particularly an authoritarian leader or entry of a new incompatible member into the family by marriage.

**RELATIONSHIP BETWEEN FAMILY STRUCTURE AND DIFFERENT PSYCHIATRIC DISORDERS**

Research in this area is a more recent development in India. One of the main criticisms about such studies done over the last 10-15 years is the lack of uniformity of definitions on criteria. Only new workers (Venkoba Rao, Sethi and Co-workers) have used the same scale (Khatri, 1970), to measure jointness of families (using the variables of residence, pooling of income and financial help, property, and decision making).

Two epidemiological surveys of urban areas (Sethi et al, 1967, 1974) and one survey of rural areas (Sethi et al, 1972a), show a higher percentage of psychiatric disorders in nuclear families as compared in joint ones, while studies of Dube (1970), and Thacore et al (1971, 1975), have reported a greater prevalence of psychiatric problems in joint families; on the other hand, Carstairs and Kapur (1976); did not find any significant correlation between family structure and psychiatric illness.

In spite of the earlier conflicting reports, some recent studies have revealed some interesting findings.

**NEUROTIC DISORDERS**

Neurotic Disorders in particular show a strong correlation with family type, majority of workers have reported higher occurrence of neurotic disorders in nuclear families (Verghese and Beig, 1974; Menon, 1975; Veeraraghavan, 1978; Agarwal et al, 1978). No significant association between type of neurotic disorder and family jointness has been shown; hysteria was thought to be more common in joint families as reported by (Dube, 1970; Vyas and Bharadwaj, 1977), but a recent study by Wig et al (1982) indicates higher incidence in nuclear families.

According to Sethi and Manchanda
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(1978b), (a) more neurotics are from urban areas as compared to rural areas; (b) there are more neurotic females (mostly married), than neurotic males; (c) among female neurotics, there is a higher preponderance from rural areas in joint families while more female neurotics are from nuclear families in urban areas.

Sethi and Manchanda (1978b) claim that “the joint family perpetuates greater emotional stability except in hysteria”, and they also suggest that “a strong built in resistance exists within the joint family set up which ensures a lesser vulnerability toward development of an illness”.

More recently, Sethi et al (1981) have examined social interaction in neurotics (using Henderson’s Social interaction schedule) and have found that neurotic patients do not have a deficient primary group, however, they appear less active in making contacts with members outside the household.

AFFECTIVE DISORDERS

(a) Depression: According to some studies there may be a meaningful relationship between the family structure and depressive illness (Lai, 1971; Sethi and Sinha, 1977; Bagadia et al, 1973), showing more prevalence in nuclear families, while Venkoba Rao (1973) reports more jointness of family in the Recurrent Depressives. In a more recent work, Sethi et al (1979) and Sethi & Sharma (1980) didn’t find any significant difference among primary and secondary depression in terms of family jointness, but some trend towards nuclear family was assessed; however, they have suggested that earlier reports showing association between nuclear family and depression should be interpreted with caution and importance should be given to the longitudinal perspective of a family and familial interaction.

(b) Manic Depression Psychosis: Not much work has been done in this area. In a study, based on the analysis of 100 hospital cases of Manic Depressive Psychosis from India, 38% cases remained static in their social mobility, maintaining their original positions or the status because of the joint families (Chopra, 1967).

SCHIZOPHRENIA

Not many workers have looked into the relationship between family structure and schizophrenia. Sethi and Manchanda (1978b) claim that this relationship may not be so significant even though there is some trend toward nuclearity, while Bagadia et al (1979) report higher representation from joint families.

According to Rastogi (1970) parental functioning is more disturbed in the families of schizophrenics as compared to the families of neurotics. However, according to W.H.O. sponsored International Pilot Study of Schizophrenia (W.H.O., 1973), which includes Agra (India), progress of schizophrenia may be better in India and other developing countries than in Europe or the U.S.A. apparently because of better family support provided by the joint family system.

OTHER DISORDERS

(a) Trends toward nuclearity in attempted suicide (Venkoba Rao, 1965; Lal & Sethi, 1974; Sethi et al, 1977) and delinquency (Sethi et al, 1976) are reported.

(b) Psychogeriatrics: Ramachandran et al (1981) has reported that living conditions are significant factors affecting the mental health of the elderly patients; functional psychiatric disorders are high in those aged people who are living alone or in nuclear families.

ROLE OF FAMILY IN TREATMENT

The work of involvement of family members in the care and treatment of the mentally ill was pioneered by a saintly
The families lived with their sick relatives in the tents, provided complete care and were fully involved in the different group therapeutic programme and religious-cultural-recreational activities. In the words of Vidya Sagar (1971), "patients were not separated from the families, so that hostility on either side was avoided and there was no problem of reintegrating the family".

Following the noble traditions set by Vidya Sagar, many centres in India, particularly at Bangalore and Vellore, have started involving the families in the total treatment of psychiatric patients and are conducting studies in order to test the efficacy of such methods. Chacko (1969), from Vellore describes the usefulness of family-participation in treatment and rehabilitation of the mentally ill. Bhatti et al (1980b) from Bangalore claim that "insofar as disturbed family dynamics are an important factor in determining patient's psychopathology, any treatment plan has of necessity to include a study of the family as a social unit in terms of styles of communication, patterns of social control, roles and role relationships of the members, cultural sources of conflicts, generation gap and strains generated by transitions". They have described 'multiple family group interaction' as a method of family therapy based on their experience with non-psychotic problems and they have found that "advice" is the main ingredient of effective psychotherapy for Indian patients (Bhatti, 1980a).

CONCLUSION

The majority of recent studies from India show that nuclear families are more prone to psychological problems, apparently caused by a breakdown of traditional support systems. Some social scientists are of the opinion that all possible efforts should be made to maintain the traditional family-jointness because it is equipped with "built-in-immunity" against psychiatric morbidity and also provides well-knit supportive networks in the event "breakdowns". However, the system would need some modifications so that it could survive and function more effectively in this modern age.

REFERENCES

AGARWAL, A. K.; MEHTA, U. K. AND GUPTA, S. C. (1978): Joint Family and Neurosis (A study of wives of male neurotics). Indian J. Psychiat., 20, 232.

BAGADIA, V. N.; JESTE, D. V.; DAVE, K. P.; DOSHI, S. U. AND SHAH, L. P. (1973): Depression: Family and Psychodynamic study of 233 cases. Indian J. Psychiat., 15, 217.

BAGADIA, V. N.; MUNORA, V. K.; SHASTRI P. G.; DAVE, K. P.; MANKODI, R. AND SHAH, L. P. (1979): Schizophrenia: A study of the family and childhood environment in 495 cases from Bombay, India. Indian J. Psychiat., 21, 101.

BASHAM, A. L. (1967): The wonder that was India. New York, Collins.

BHASKARAN, K.; SETHI, R. C. AND YADAV, (1970): Migration and Mental Health in Industry. Indian J. Psychiat., 12, 102.

BHATTI R. S.; JANAKIRAMAN, N.; CHANNABASAVANNA, S. M. AND DEVI SRIKANTA I (1980b): Description and qualification of Multiple Family group interaction. Indian J. Psychiat., 22, 51.

BHATTI, R. S.; JANAKIRAMAN N. AND CHANNABASAVANNA, S. M. (1980a): Family Psychiatric Ward. Treatment in India. Family Process, 19, 193.

CARSTAIRS, G. M. (1965): Cultural element in response to treatment. In DeRenck, A. & Porter, P (Eds.) Cibor Foundation Symposium on Transcultural Psychiatry. London: J. & A. Churchill, Ltd.

CARSTAIRS, G. M. AND KAPUR R. L. (1976): The great Universe of Kota. Stress, change, and mental disorder in an Indian village. London: The Hogarth Press.

CHACKO ROSE (1967): Family participation in the treatment and rehabilitation of the mentally ill. Indian J. Psychiat 9, 3-8.

CHINMAYA LESSONS, Central Chinmaya Mission Trust, Bombay, India.
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CHOPRA, H. D. (1967): A study of Biological Psychological and Socioeconomic factor in the causation of Manic Depressive Psychosis M. D. Thesis. Bihar University (Unpublished).

DESAI, I. P. (1964): Some aspects of Family in Mahura, Bombay. Asia Publishing House.

DIHAPRAM, D. (1961): Research need for development of Psychotherapy. Menon T. K. (Ed.). Recent trends on Psychology. Bombay, Calcutta Madras and New Delhi: Orient Longmans.

DUBE, K. C. (1970): A study of prevalence and biosocial variables in mental illness in a rural and an urban Community in Uttar Pradesh.

GOODE, W. J. (1963): World revolution and family patterns: Free Press, New York.

INDIAN AND FOREIGN REVIEW (1962): *The people of India*, 19, 4.

KALDATE, S. (1962): Urbanisation and disintegration of rural joint family, Sociological Bull., 11.

KAPADIA, K. M. (1966): Marriage and Family in India. Bombay: Oxford University Press.

KHAIRI, A. A. (1970): Manual of the scale to measure jointness of families in India. Ahmedabad, India B. M. Institute.

LAL, N. (1971): Pattern and distribution of depressive disorders. Thesis for M.D. Psychiatry. University of Lucknow (Unpublished).

MAHAL, A. S. (1970): Psychiatry in India. Indian J. Psychiat., 17, 77.

MEHTA, U. K. (1977): Investigation of Psychosocial factors associated with Psychiatric Morbidity in the wives of male Neurotics. Thesis for M.D. (Psychiatry). University of Lucknow (Unpublished).

NEKI, J. S. (1973): Guru-Chela Relationship. The possibility of a therapeutic paradigm: Amer. J. Orthopsychiatry, 43, 755.

NEKI, J. S. (1974): A reappraisal of Guru Chela relationship as a therapeutic paradigm. Int. Ment. Health Res News Letter, 16, 2.

NEKI, J. S. (1970): An examination of the cultural relationship of dependence as a dynamic of social and therapeutic relationships-I: Sociodevelopment. Brit J. Med. Psychol., 49, 1.

NEKI, J. S. (1975): An examination of the cultural relationship of dependence as a dynamic of social therapeutic relationships—II: Therapeutic. Brit J. Med Psychol., 49, 11.

NEKI, J. S. (1977): Dependence: cross-cultural consideration of dynamics. Arieti, S. and Ghazzanedi, G. (Eds.).—New Dimensions in Psychiatry, Vol. 2: New York: John Wiley & Son.

NEKI, J. S. (1979): Psychotherapy in India. Chapter in the book: Psychotherapeutic processes; (Eds.) Kapoor et al., Bangalore, India.

RAMACHANDRAN, V.; SHAHRA MENON, M. AND RAMAMURTHY, B. (1961): Family structure and mental illness in old age. Indian J. Psychiat., 23, 21.

RANJANJAM, B. K. (1967): Some thoughts on psychological problems of families in India. Indian J. Psychiat., 9, 9.

RASTOGI, D. S. (1970): Changing patterns of culture and Psychiatry in India. Amer. J. Psychol., 22, 46.

SETHI, B. B.; GUPTA, S. C. AND KUMAR, R. (1967): Three hundred Urban families—a psychiatric study; Indian J. Psychiat., 9, 280.

SETHI, B. B. (1968): Changing patterns of culture and Psychiatry in India. Amer. J. Psychol., 22, 46.

SETHI, B. B.; GUPTA, S. C.; MAHENDRU, R. K. AND KUMAR, P. (1972a): A Psychiatric survey of 500 rural families. Indian J. Psychiat., 14, 143.

SETHI, B. B.; GUPTA, S. C.; MAHENDRU, R. K. AND KUMAR, P. (1972b): Migration and mental health. Indian J. Psychiat., 14, 115.

SETHI, B. B.; GUPTA, S. C; MAHENDRU, R. K. AND KUMARI, P. (1974): Mental Health and Urban life—study of 850 families. Brit. J. Psychiat., 124, 213.

SETHI, B. B.; GUPTA, S. C.; AGARWAL, S. S. AND SINGH, P. K. (1979): A psychosocial study of delinquency with special reference to aggression. Indian J. Psychiat., 18, 157.

SETHI, B. B. AND SINGH, P. K. (1977): Pattern of depressive disorders in Northern India. Paper presented at VIth World Congress of Psychiatry, Honolulu, 1977.

SETHI, B. B. AND MANCHANDA, R. (1979): Socioeconomic, demographic and cultural correlates of psychiatric disorders with special reference to India. Indian J. Psychiat., 20, 199.

SETHI, B. B.; MANCHANDA, R. (1978b): Family structure and Psychiatric Disorders. Indian J. Psychiat., 20, 283.

SETHI, B. B.; PRakash, R.; AHUJA, V.; TRIVEDI, J. K. AND SHARMA, M. (1979): A sociodynamic study of Depression. Paper presented at Symposium on Depression, Madurai, 1979.
Sethi, B. B. and Sharda, M. (1980): Depressive disorder and family constellation; Indian J. Psychiat., 22, 69.

Sethi, B. B.; Sharm, Mukal and Srivastava, A. (1981): Social interaction and neuroses (The family and primary group). A Pilot study, Indian J. Psychiat., 23, 33.

Shardamanon, M. (1975): Psychiatric Disorders in woman. Kerala J. Psychiat 3 (8), 48.

Surya, N. G. (1966a): The ego-structure in the Hindu-Joint Family. Paper read at the Conference on Mental Health in Asia and the Pacific, Honolulu.

Surya, N. G. (1966b): Some observations in the field of transcultural psychiatry. Paper read at the Conference on Mental Health in Asia and the Pacific, Honolulu.

Thacore, V. R.; Gupta, S. C. and Suraiya, M. (1971): Psychiatric clinic at the Urban Health Centre, Alambagou, Lucknow. Indian J. Psychiat., 13, 233.

Thacore, V. R.; Gupta, S. C. and Suraiya, M. (1975): Psychiatric Morbidity in a North Indian Community. Brit. J. Psychiat., 126, 364.

Veeragavan, V. (1978): A comparative study of difference types of neuroses in relation to certain aetiological and demographic variables. Indian J. Psychiat., 20, 61.

Venkoba Rao, A. (1963): Attempted suicide. An analysis of 114 medical admissions into Erskine Hospital, Madurai. Indian J. Psychiat., 7, 253.

Venkoba Rao, A. (1973): Affected illness in first degree relative, parental loss and family jointness in Depressive Disorders. Brit. J. Psychiat., 12, 601.

Vergehe. A. and Elio, A. (1974): Neuroses in Vellore Town—an epidemiological study. Indian J. Psychiat., 16, 1.

Vidyasagar (1971): Some innovations in psychiatric treatment at Amritsar Mental Hospital: In report on seminar on the organisation and future needs of Mental Health Services, New Delhi, W. H. O. SD/MENT.19, 1971.

Vyas, J. N. and Bharadwaj, P. K. (1977): A study of hysteria. An analysis of 304 patients. Indian J. Psychiat., 19, 71.

W. H. O. (1974): The International Pilot study of Schizophrenia. Geneva

Wig, N. N.; Mangalwedhe, K.; Berti Harinder and Multhy, R. Srinivas (1992): A follow-up study of hysteria. Indian J. Psychiat., 24, 120.