THE FAMILY AND SCHIZOPHRENIA
PRIORITY AREAS FOR INTERVENTION RESEARCH IN INDIA

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The aim of the paper is to encourage and give some directions for research activities which might help us to understand the patterns of interaction in the families of Indian schizophrenics, thus paving the way for suitable intervention strategies. The Western studies implicating the role of family are examined for relevance to Indian patients. The methodology of studying family interaction is critically evaluated. The factors believed to be responsible for a better prognosis of schizophrenia in Indian context are outlined with the hope of discovering those family characteristics which might be protective against schizophrenia. It is pointed out that the cooperation of the Indian family should not be automatically assumed; the patient can, in fact, be a stressful burden. Finally, arising out of observations made in the earlier sectors, the specific research directions are outlined.

The need for specific Indian studies, to discover appropriate strategies of family intervention arises in the context of the following major developments in the understanding of schizophrenia:

1. Family studies in the Western culture implicating deviant role relationships and disordered communication processes in the etiology of schizophrenia.

These studies have led to psycho-educational approaches designed to combat the deviance and the disordered communication process thus hoping to improve the prognosis. This raises several questions: What is the nature of 'deviance' and 'disordered communication' in the Indian family? Do these terms mean the same thing as they do in the West? If not, how appropriate for India are the Western instruments that elicit these pathologies? Further, how appropriate to the Indian families with schizophrenics, are the psycho-educational approaches generated by the Western studies of the family pathology? How does one establish norms of family interaction in Indian culture? Can one improve upon the methodologies developed in the West for studying pathological family interaction?

2. Cross cultural studies demonstrating better prognosis of schizophrenia in developing countries including India as compared to the Western industrialised nations.

One would like to know if there is something specifically healthy in the Indian family structure and interaction which protects against onset and chronicity of the illness. If so, is it possible to retain this healthy element against the onslaught of industrialisation, modernisation and westernisation.

3. Movements across the world to take patients out of the mental hospitals and into community.

Let us examine these issues in some greater detail before setting up priority areas for intervention research.

A. WESTERN FAMILY STUDIES ESTABLISHING PATHOLOGICAL FACTORS RELATED TO ONSET AND CHRONICITY OF SCHIZOPHRENIA:

The major theoretical perspectives linking family interactions of certain kind with the predisposition to schizophrenia were proposed almost three decades ago by Bateson et al. (1956), Lidz et al. (1958) and Wynne et al. (1958). These involved skewed relationship between parents, schizm in the way the parents relate to the children, erotocised parent-child relationships, double-bind, amorphous as well as fragmented nature of communication. Many studies were carried out to examine these hypotheses and these have been reviewed.
by Jacob (1975) and Goldstein and Rodnick (1975). The problem with these studies is that the design does not permit one to ascertain whether the family pathology was antecedent or responsive to schizophrenia in the index member. Subsequently, many other studies were carried out to deal with this question. Waxier (1974) examined artificial families combining healthy children with parents of schizophrenic children and vice versa. She discovered that the parents of schizophrenics did not affect the communication amongst healthy children while the parents of the healthy children, in fact, improved the communication amongst the disturbed children. Singer and Wynne (1966) discovered greater pathology in the parents of children at high risk of schizophrenia as compared to the parent of low risk children.

Reiss (1976) listed scientific requirements before some factors could be accepted as having aetiological relationship with schizophrenia. These are:

a) Hypothesised variables should be clearly defined and the measures should be reliable and objective;

b) The causal role of these factors must be assessed by demonstrating that these factors:

(i) were linked with schizophrenia but no other psychiatric condition;

(ii) had an impact on the individual before the onset of illness;

(iii) were not confounded by a covarying or concomitant variable that is the true aetiological variable.

None of the studies mentioned above fulfils the Reiss requirements fully. Brown et al. (1972), in an important study, decided to concentrate on the relationship between family pathology and relapse in schizophrenia rather than the onset of the illness. They used a standardised instrument, the Camberwell Family Interview (CFI) which assessed critical comments, hostility, over-involvement, warmth and positive remarks on part of a relative towards the patient. They found that high levels of Expressed Emotions (EE), which combine the first three factors, were related to a quicker relapse rate. Vaughn et al. (1984) confirmed this finding in a replication study carried out in California. Leff et al. (1982) demonstrated that psycho-educational programmes designed only did reduce the EE but also the relapse rate at the end of 9 months follow up.

These studies have produced great excitement across the world because not only do they prove the impact of family pathology on prognosis of schizophrenia but also the success of intervention. There are however some problems with an unequivocal acceptance of these conclusions: At least four other studies: Mcmillan et al. (1986), Dulz et al. (1986), Parker et al. (1988) and Hogarty et al. (1988) do not confirm the relationship between high EE and relapse. Parker et al. (1988) in fact, question the methodology of the studies which do show the relationship. They also suggest that the lowering of EE in experimental group may be related to improvement in the patient due to other factors rather than success of the intervention programme.

Inspite of the reservations mentioned above, one can still say that there is some evidence of a relationship of family pathology with the onset and relapse of schizophrenia in the West as well as the usefulness of psycho-educational programmes based on these findings. What is not at all convincing is the applicability of these findings and of instruments like CFI to studies in non-western cultures. One would say this inspite of the claim made by Wig et al. (1987) that high EE is predictive of relapse in India also.

While Wig et al. have gone to a considerable effort in establishing the reliability of CFI across cultures and across languages, they have paid insufficient attention to its validity. Emotion in India is expressed through posture, gait, facial movements and acts like offering food and gifts (Kleinman, 1989). Evaluation of EE through verbal channels only is done with CFI will underestimate the extent as well as distort the interpretation of EE in India.

It is a common practice in cross-cultural psychiatric studies to select an instrument of inquiry developed in - let us say - culture I, translate it for use in culture II and then train the researchers in culture II to use the instrument in the same fashion as used by researchers in culture I. Sometimes this similarity is ensured through glossaries which not only define the terms but also guide the interpretation of responses. At other times, as was done in the study quoted above, the researchers from the second culture are actually brought in to work along the researchers in culture I so that they could learn how to interpret the responses in the same manner as the researchers of culture I.

In this obsession with reliability one tends to forget that what one is looking for may be expressed quite differently in the two cultures, thus rendering the instrument developed one in culture, unsuitable for use in another. What does one do in such a case? Should
one forgo the pursuance of reliability? Should one accept that no cross-cultural comparisons are possible?

It is author's conviction that there is a method of conducting cross-cultural studies which makes the comparisons richer and more meaningful without transgressing the principle of reliability. The way is to ensure similarity in the categories being investigated in the two cultures (e.g. Hostility, Over-involvement, Warmth, etc. in the above mentioned example) encourage empathy in the understanding of these concepts through mutual discussions and case illustrations but leave the formulation of relevant questions and other observational techniques to the judgement of the researchers from different cultures. The reliability is therefore ensured at a conceptual level and that is what is really important.

B. METHODOLOGY OF STUDYING FAMILY INTERACTION:

The instruments for studying family interaction involve microanalytic methodology with stress on categorisation of behaviour, precise operational definitions and quantification of the variables. These also attempt to do away with the role of the observer. This goes against the grain of clinical evaluation which is carried out by the clinician making an overall judgement keeping in mind the context in which the observations are made. Separation of the observer from the observations is an untenable goal even in natural sciences! There is a need to develop instruments which keep the total context in mind and which take into consideration the sensitivity of the observer (Eisler et al., 1988).

C. PROGNOSIS OF SCHIZOPHRENIA ACROSS CULTURES:

The renowned International Study of Schizophrenia WHO (1973) and WHO (1979) discovered that after 2 years of follow-up the prognosis in terms of remission as well as number of symptoms was better in developing countries as compared to those which are industrially developed. This was not a new finding: Lambo (1955), Rin and Lin (1962), Murphy and Raman (1971) and Waker (1979) had earlier found similar results. A variety of factors have been claimed to be responsible for these important findings (Murphy, 1982; Cooper and Sartorious, 1977 and Waker, 1979). It has been hypothesised that in the pre-industrial societies:

(1) the communities being small are more able to tolerate deviance and hence are less rejecting of the schizophrenic

(2) a majority of those who are likely to develop serious illness with greater chronicity die before reaching the age when schizophrenic symptoms becomes evident;

(3) there are fewer expectations from schizophrenics regarding the work and social roles and this reduces the pressure on the patients;

(4) there is a greater and better supportive network because of extended relationships;

(5) the magico-religious beliefs about causation of madness allow the patients in pre-industrial societies to accept the delusions and hallucinations with lesser sense of anxiety;

(6) there is a more spontaneous acceptance of external causation of illness; the personality and the past of the patient are not implicated and hence the patient as well as the family have lesser guilt about having the illness; and

(7) the illness is expected to run a short course while opposite is the case for the industrialised societies. The chronicity of schizophrenia in the West is the result of the labelling process.

Hardly any study is available which tests out the above hypothesis.

D. TREATMENT OF SCHIZOPHRENICS OUTSIDE PSYCHIATRIC HOSPITALS:

Work done at Bangalore (Kapur, 1975, 1979; Chandrasekhar et al., 1981) and subsequently at many other centres in India has proved that not only can the schizophrenia be treated outside the psychiatric hospital but also that it can be treated by family practitioners and para-professionals. Pai and Kapur (1982, 1983) have shown that the family in fact perceived much less of the burden when a schizophrenic was treated in the family with regular visits of a trained nurse as compared to visits to the out-patients department of a psychiatric hospital. One wonders, however, whether the Indian family would continue to tolerate the schizophrenic in its midst as the industrialisation advances and the work roles get sharply delineated. One worries that in times to come Indian schizophrenics will also roam the streets as they do in the West where the patients have been taken out of the hospital without, at the same time,

providing for suitable and sufficient outreach programmes. What kind of outreach programmes are suitable for India and in what way and to what extent can the
family be involved in these? Taking into account the social changes which are going on, this has to be considered very carefully. Pious statements about the wonderful Indian family will just not do. One needs to examine the impact of social change on the Indian family.

E. PRIORITIES FOR INTERVENTION RESEARCH IN INDIAN SETTING:

If the issues raised above are kept in mind, the priority areas for research become self-evident. These are described here with suggestions regarding methodology:

(1) There is a considerable amount of ethnographic literature on Indian families but it hardly touches those aspects which are of interest to a mental health professional. On the other hand, there is an excellent intuitive clinical literature on interpersonal relationships, role boundaries, development of self and ego (Surya, 1966; Neki, 1976), but the insights which these studies reveal have not been examined through properly designed field research. The need is to carry out ethnographic studies touching upon these issues and to collect normative data on these parameters. For example, one would like to see normative ethnographic data on the relative role of father and mother in providing security needs of children, on the factors related to maturational process, on the manner in which affection and hostility get conveyed in Indian families. One would also like to examine how Indian family is changing under programmes of industrialisation and modernisation. This kind of work will best be carried out through collaboration between anthropologists and mental health researchers.

(2) Research is required to develop instruments for measurement of family interaction which are meaningful in the Indian context. The issues raised in sections A and B should be kept in mind when developing the methodology. These instruments will allow overall judgements using both verbal and non-verbal cues rather than depend on numerical scores. Further, one would advocate a methodology which aims at collecting the observations of experienced researchers through a consensus approach rather than set one against the other.

(3) Research is required for preparing psycho-educational material suitable to Indian ethos. One cannot just transplant the Western psycho-educational material. For example, the material prepared by Leff et al. (1982), which advocates reduction in face to face contact between the patient and the relatives, will be impractical and meaningless in the Indian setting. Indian houses do not have enough space to prevent face-to-face contact. Further, a lot of intense emotional interaction goes on in Indian families without face-to-face contact; just consider the daughter-in-law of the house who wears a veil or think of lovers who have never met!

(4) There is need for ethnographic literature regarding popular perception of mental illness as well as views about its causation and prognosis. The majority of attitude literature in India, stressing as it does and questionnaires, reliability, factor analysis and so on, ends up giving a quite trivial information. Instruments like EMIC (Explanatory Model Interview for Classification) seems promising but need further examination (Weiss: Personal Communication).

(5) Several natural field studies could be started to test the hypotheses raised in connection with the better prognosis of schizophrenia in developing countries. For example, the ability of smaller village community for tolerating deviance and for providing flexible roles could be tested by comparing the schizophrenics in village communities to those in city slums. The role of expectations, magico-religious beliefs, labelling process and guilt induced by stressing the invoking vs. external causation could be tested through open-ended interview schedules or instruments like EMIC. Those factors found to favour better prognosis could then be incorporated in the psycho-educational material and this could further be examined through studies which control for one factor at a time.

(6) Studies of burden on the family need to be carried out and it should be examined if the burden is felt differently in families of different socio-economic as well as educational background.

(7) Operational studies examining the relative value of different explanatory models, impact of marriage on the prognosis of schizophrenia, role of family intervention in acute psychosis vs. chronic illness could all be useful.

In the end, one would like to stress most strongly that in the treatment of such a complicated phenomenon like schizophrenia, the research endeavour requires a lot of intuitive wisdom; mere precision and objectivity are not enough.

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