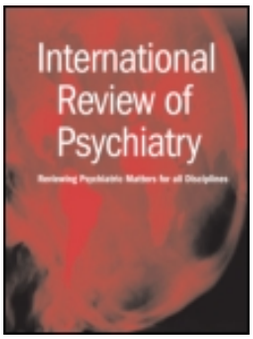

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Treating troubled families: Therapeutic scenario in India

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Abstract
India, a country of diverse cultures, languages, life styles, and ethnicities, is becoming a land of economic change, political stability, technological advancement, and changing traditional structures of relationships as well as health consciousness. Being known for its ancient traditions, rituals, religious orientation, spiritual outlook and folk beliefs, Indian families attempt to continue certain healthy and traditional elements such as warmth, strong bond, hierarchy, extended support, cultural orientation, shared values and time, tolerance, respect for the aged and inculcation of religious teachings and traditions in families. These factors, or practices, in fact have strong therapeutic value in supplementing the growth and development of individuals in the family system in spite of its transitional position. This paper deals with the review of family-based mental health services and focuses on the changing trends of those practices in India and the advancement of Indian families in their engaging ability with mentally ill members as well as with the treating team.

Introduction

Indian families are traditionally patriarchal and orthodox in their nature. Religious and family orientation, joint and interconnected systems and high interdependency among the members are a key part in the functioning of the family. A hierarchy of control and power is in place in Indian families which are based on age and gender – older age or male gender. Generally they have the control and the power, although this is beginning to change albeit at a very slow pace. Family is considered as a means through which society has been extending itself and ensuring its own survival and existence. Here the institution of marriage provides legitimacy and ensures the smooth functioning of a family. The Indian family plays an influential role as the primary social regulator of its members. Young Indian adults tend to remain with their families of origin long after they have completed their education and taken up employment, although this is beginning to change.

Older family members, both first degree and second degree relatives, have a large part to play in the approval of marriage partners and in the settlement of family disputes, be they minor spats between spouses or arguments related to property (Udaya Kumar et al., 2007). However, the advent of urbanization, industrialization and globalization phenomena has produced a shift from the joint family systems to nuclear families, increasing the chances of tensions between the old traditional and new individualistic values (Carson & Chowdhary, 2000; Natrajan & Thomas, 2002). Another potential consequence of this is the possibility of less extended support in the community and increasing stress in managing day-to-day family hassles.

Most Indians certainly in the rural areas used to grow up in extended families with members in interdependent family roles, engaged in the activities necessary to maintain the group as a cohesive and cooperating unit with the aim of ensuring the survival and collective welfare of family members and protecting them from the incursions of the outside world Nath & Craig (1999). The structures, organization of subsystems in Indian families are different in some parts of the country. One will see in India, the marital bond discouraged in extended families when marital bond is given most importance in nuclear systems.

Marriages are seen as occurring between families rather than between two individuals. The head of the family always had the authority to make the decision for choosing marriage partners for their children but this is becoming history in the current scenario. Traditionally there has also been a precedence of mother–son dyad over the marital dyad.

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In addition, family structures in parts of India have been matriarchal while the majority continue in patriarchal lineage. There is still practice of polygamy in many states in the Indian Union even though monogamy is commoner and the only legal form of marriage. There is a contrast in that there is an increasing divorce rate while the majority consider it as against tradition.

Culturally, parents maintain a child–parent relationship with their grown-up children while the ancient Sanskrit scripts teach *Varshe praptheshu shodashe Puthram mithravathachareth* (as the son grows up in age, he needs to be treated as a friend). Members in certain families function independently as well as jointly, but in rural joint families members are totally dependent on the head of the family. With the beginning of nuclearization, individualistic approaches to family life in city-based families have changed the existing whole-centred family approach which was the highlight of Indian families.

Irrespective of its loosening strings of family bonds, couples in many places of the country take much care for preserving family and couple relationships and preserve the ancient family values. The point here is that the family practices in rural and urban areas across the nation are diverse but even then one can find similarities. It is therefore not surprising that all these cultures offer distinctive solutions to universal human dilemmas and family issues.

Dealing with the issues pertaining to family structures or behaviours or complicated dynamics of relationships is not a new approach to the Indian healing traditions and cultures. There seems to be evidence of healing through extended family relatives, faith healers, priests, for the family-related issues irrespective of the multi-cultural, multi-lingual and multi-ethnic nature of the country (Davar, 1999; Mane, 1991; Mittal & Hardy, 2005; Mohan, 1972).

It is estimated that there are more than 20 million people in India who are in need of mental health services (Thara, 2002). Prevalence of mental illness is estimated to be 48.9 per 1000 for the rural population and 80.6 per 1000 for the urban population (Ganguli, 2000). The primary vehicles that help in dealing with the mental health needs of Indians include mental hospitals, general hospitals with psychiatric units, voluntary (non-governmental) mental health agencies, and private practitioners, some of whom still carry an individualistic orientation. There is considerable difference in numbers between service providers versus service seekers, the latter being drastically underserved (Kumar, 2002; Thara, 2002). With the changing socio-political environment in the country there is tremendous need for family-based approaches in the delivery of mental health services (Prabhu, 2003).

Family therapy

The evidence of systematic practices in family and marital therapy may be traced to the writings of few practitioners from India. Bhatti (1980a, 1985, 1996, 1998), and his colleagues (Bhatti & Channabasavanna, 1979; Bhatti & Varghese, 1995) concentrated on understanding family dynamics from a hospital-based population. Family and marital treatment-based studies were found in the writings of Geetha et al. (1980), Channabasavanna and Bhatti (1985), Prabhu et al. (1988), Raguram (1996), and Bhatti and Sobhana (2000). Marital conflicts and marital relationship studies were also reported by Shah et al. (2003), Shah and Isaac (2005), and Isaac and Shah (2004). The family factors leading to conduct disorder among adolescents were reported by Shalini and Raghuram (2005).

Indian family therapists also made contributions in developing tools for assessing family and marital issues. They are the Family Typology Scale (Bhatti, 1985), the Marital Quality Scale (Shah, 1995), and the Measurement of Family Violence Scale (Bhatti & George, 2001). There have also been efforts from practitioners in the development of intervention models. They are the Multiple Family Group Intervention by Bhatti (1980b), the Family Intervention and Support in Schizophrenia by Varghese et al. (2002), Group Intervention for Caregivers of Persons with Dementia by Henry et al. (2010), and Integrated Skills for Parenting Adolescents (Thomas & Parthasarathy, 2011).

The earlier studies during the period of 1970–2002 had a lot of psychiatric or clinical orientation in which family and couple conflict had been identified as a predisposing factor (Mane, 1991). The latest trends in research show more concentration on evidence-based practice models (Isaac, 2004; Kalra, 2006; Pothen, 2008), and a shift from remedial to preventive and promotive perspective (Henry, 2009; 2010; Thomas, 2011).

Training programmes in marriage and family interventions

In India, more than family therapy, the term 'marriage counselling' is popular among the educated and urban population. There are only a very few institutions that provide some formal training in the practice of marriage and family therapy, such as the National Institute of Mental Health and Neuro Sciences (NIMHANS) Bangalore, and the Schizophrenia Research Foundation (SCARF) in Chennai. However, there are universities and colleges such as the Indira Gandhi National Open University, New Delhi, Christ University and Sampurna Montfort College, Bangalore, the Tata Institute of

Social Sciences (TISS) Mumbai, and Total Response to Alcohol and Drug Abuse (TRADA) in Kerala, providing post-graduate programmes in social work, psychology and counselling, and training students in family and marriage counselling.

Institutes of mental health run by the central and state governments in different parts of India have received approval to initiate post-graduate programmes in psychiatric social work, clinical psychology and psychiatry. These institutes have potential for training mental health professionals in dealing with family and marriage issues through systematic approaches.

Training in family and marital counselling also happens through workshops and seminars for mental health professionals who do not have formal training in marriage and family therapy. These workshops are usually given for students of social work and psychology at their own institutes.

The Indian Association for Family Therapy (IAFT) is an association which periodically conducts training programmes and conferences on marriage and family therapy (Rastogi, 2005). Most of the practising family and marital interventionists have interdisciplinary training either in social work, or psychology or psychiatry.

Issues seen in Indian families

From clinical observations, families with mental illnesses present issues pertaining to the management of the mentally ill member. Often, families share misconceptions on illnesses, and vague ideas on aftercare needs of the patient, report financial constraints in managing hospital expenses, show inadequate coping skills, exhibit burden and expressed emotions, and find helpless in managing emergencies and relapses in a poor community support system. The families who have a mentally ill member of marriageable age is in still more trouble because of their expectation for getting the ill family member married, and pressure from relatives and neighbours in getting the ill member married, ambiguity in informing in-laws about the illness along with entitlement of property and divorce with a background of mental illness.

Among the sub-clinical population, families show high academic expectations of children as well as of achieving things in life which parents could not. Usually children are brought for therapy on issues of disobedience and poor academic performance. The underlying issues are seen in parents in the form of high expectations from children, rigid beliefs on what is best for the child, and inconsistent parenting practices.

Among conflicting couples, lack of consensus in parental decisions and manipulation of parental conflicts by children are also observed. There has also been a complaint from mothers of under-involvement of husbands in household activities, especially in dual income families, as well as in parenting roles. Increasing involvement of fathers in child rearing in an expressive role is a change in the current social and economic scenario (Thomas & Parthasarathy, 2010).

Couple-orientated issues observed in the initial phase of marriage involve issues with boundaries of family of origin and in-laws, lack of trust in couples, high expectations from each other, difficulties in adjusting work and family, adjustment to a physical relationship, power struggle, as well as adjusting to in-laws. In recent years couples also report issues such as wife battering, alcoholism, fidelity concerns, increased work pressure leading to conflicts and child management-related issues. Moreover, parents require more confidence in their role as parents (Thomas, 2009).

Youngsters report undue parental involvement in deciding relationships and rigid beliefs on marriages for them. Youths also approach for therapy to deal with issues connected with breaking up of relationships, live-in relationships, and same-sex partnerships, which are rarely shared with parents. Guidance is also sought for dealing with same-sex issues in heterosexual marital relationships. Even though arranged marriages in Indian families are vanishing, there still remain youngsters waiting for parents to take decisions because of anxiety in intimate relationships. Parents also seek help for youngsters who refuse to get married or who postpone marriages.

Family interventions practised in India

The major observation to make from Indian rural communities is that many families believe solving problems is the responsibility of families, with their strong values, and the awareness of the solutions to their problems. It is interesting to not that most issues that are seen in families are issues concerning all families. However, some of the problems are not considered as a problem in many of the traditional families.

Couples/marital therapy

The term couples therapy is often interchangeably used with marital therapy in India. Usually an eclectic frame work is used in marital therapy because of the interconnected issues in marriage and couples' families. Usually couples therapy focuses on individuation from families of origin, creating healthy boundaries with families of origin, separation of spousal and parental roles, identifying common life goals, effective communication skills, coping skills, sharing responsibilities, financial management conflict resolution, amicable separation in cases of

divorce, and dealing with sexual, emotional, verbal and physical violence. Partner-orientated work on live-in and same-sex relationships is also gaining momentum in Indian cities. There are also partners who are in courtship meeting therapists for assurance of their decisions, indecisiveness, forgetting the past as well as fear of intimate relationships.

Sex therapy

Sexual difficulties in Indian couples are seen as a part of wider marital problems or pre-existing sexual problems or lack of knowledge and high expectations about sexual performances. Sex therapy is practised by marital and family interventionists in India on issues such as non-consummation, premature ejaculation or erectile dysfunction, problems commonly caused by stress, tiredness and other environmental and relationship factors. Adolescents are also found to be reporting for intervention to deal with guilt over sexual acts and guidance for remaining sexually safe while active.

Psycho-education

Even with improved medication treatment in recent years, we have seen families requiring more abilities to deal with positive (psychotic) and negative (functional and cognitive deficits) symptoms, functional disabilities, and the frustrations of living with a mentally ill family member. Family psycho-education has emerged as a treatment of choice for schizophrenia, bipolar disorder, major depression, and obsessive–compulsive disorder. But these days every family is educated about their ward's illnesses. Psychoeducation is given to individuals, caregivers, and significant family members either individually or in groups focusing on the individual's medical, psychological, family, social, employment needs as well as long-term care needs, risks, issues, and impacts, along with providing skills in handling own emotions, emergencies, relapses, addressing caregiver burden, reducing high expressed emotions and managing marital discord and empowering families to fight against stigma and ensure welfare benefits. This particular therapeutic programme is seen as very effective because the majority of families lack proper awareness but have many misconceptions (Udaya Kumar et al., 2007). Through this therapeutic service, families are empowered and found capable of engaging their mentally ill family member as well as finding space for themselves. It is interesting to note that this therapeutic process comes up with newer ways of dealing with older issues or newer issues themselves challenging therapists to think about them.

Parent management training

Parents are taught to increase positive interactions with children, to reduce coercive parenting practices, to reduce inconsistent parenting practices, to increase consensus in parenting practices, to follow age-appropriate parenting practices and manage specific psychological issues of children. Many children with early onset conduct problems are found to have parents with significant personal problems including low income, single parenthood status, marital conflict, parental mood disturbance, and high level stressful life events. These kinds of families are benefited through marital and family interventions while simultaneously learning how to manage their child's behavioural problems. Families of children with autism, mental retardation, ADHD or learning disability have separate parenting programmes which are educational and therapeutic in nature.

Supportive therapy

Supportive work with families and couples is another therapeutic programme for the management and resolution of current difficulties, taking life decisions using the family's strengths and available resources, ventilation, reassurance, enhancement of the affected family's social support network as well as maximizing adaptive coping strategies of the family members (Udaya Kumar et al., 2007). Often we find that supportive work helps a single family member approaching for interventions for family problems in the absence of other significant family members who may be non-cooperative.

Grief counselling

Families surviving traumatic life experiences are seen in family session to grieve for a terminally ill, chronically ill, psychologically disintegrating or dead family member.

Psychosocial rehabilitation

Family members are treated as partners in the rehabilitative process as they are the primary caregivers of the patient. The psychosocial rehabilitation process begins with a baseline assessment of the family and the patient's abilities, resources and social support networks. After this the family may be encouraged to support the patient to undergo vocational retraining, cognitive retraining and placement. Discussions may also be held with the family with regard to residential and non-residential care options in order to provide respite to family members

or to decrease the degree of expressed emotions. Residential options may include half-way homes, long-stay homes or respite care homes (Udaya Kumar et al., 2007).

Geriatric group services

Geriatric group services are offered to the caregivers of patients who attend the geriatric clinic at NIMHANS, Bangalore. These groups are managed by psychiatric social workers, and the programme consists of three sessions spread over three months on three dimensions such as psycho-education on health problems related to old age, psychosocial management of the aged person, and welfare measures available for the aged in India (Henry et al., 2010).

Preventive and health promotion services

Family life education

Relationship focused programmes under the banner of family life education are very recent in India, where mental health professionals are educating children, adolescents, young adults, young couples, young parents and the aged about enhancing the quality of their family life and relationship as against earlier topics such as sexually transmitted diseases, nutrition and reproductive health alone.

Premarital counselling programmes

The pre-marriage course in India is an educational programme youths should undergo before their marriage. This programme has become mandatory for Christian youths. Such programmes are largely organized by Catholic church in India. It is also known that some Hindu religious groups have also made it mandatory to prepare young adults for marriage and equip them with confidence before they get married. However, the quality and efficacy of such programmes are not systematically ensured and measured, because of lack of needs-based educational inputs and the heterogeneous nature of participants. However, pre-marriage courses have become popular in India. The professional group which conducts pre-marriage programmes incorporates sessions on common sources of stress, reproductive health education, sexually transmitted diseases, marriage as an institution, types and functions of families, gender and power structure, communication skills, coping skills, interpersonal skills, decision-making skills, preparation for parenthood, financial management, time management, sleep and food hygiene and positive health. Young adults in cities also seek help from private consulting family therapists on issues related to sexuality, and in dealing with past relationships before the marriage.

Parent training programmes

Parenting skills programmes are found to be in high demand in India because of the huge amount of exposure they are getting. Parenting is found to be a challenge for new parents and those who have not had healthy role models to learn from. Such programmes are largely attended by mothers who have children or teenagers with sub-clinical difficulties. There are colleges, non-governmental organizations (NGOs) and hospitals organizing 'effective parenting' workshops to help couples become good parents. Integrated Skills for Parenting Adolescents (ISPA) (Thomas, 2011), a culturally tailored parenting skills development model, helps parents to strengthen the parent–adolescent bond. These programmes are given as workshops, as group work, as individually administered face-to-face programmes, and through telephone-assisted programmes. This programme also involves helping young couples make the transition from being just spouses to taking on the additional role of parenthood. Parenting programmes are also delivered in Parent Teacher Association (PTA) meetings in schools.

Family intervention workshops

This involves training other professionals such as school teachers, lay counsellors, NGO staff, personnel officers in the industry and medical officers. Basic skills in family assessment and counselling and life skills education are taught to these lay people for the purpose of early detection and resolution/referral of familial problems. The workshop includes understanding of family and marriage dynamics, assessment of problems in marriage and family relationship throughout life cycles, approaches, techniques, skills training and ethical issues. These workshops are prepared according to the needs and levels of the people participating in them.

Relationship enrichment programmes

The Catholic Church in India has taken up initiatives in helping Christian couples to undergo prayer-based retreat programmes to enrich their relationships. Several priests and nuns organize these programmes. It is also observed that in rural areas priests are more often approached first to deal with problems. However, only very few of them have undergone proper training in dealing with marriage and family issues, but the techniques or advice from their life experience or others' experiences are valued

by the troubled families for bringing necessary changes. As long as the attitude people have about help-seeking only when they are in trouble exists, enhancing quality of family life in the absence of a real big problem is a challenge.

Practice settings of marriage and family interventions

Marriage and family interventions are carried out in India mostly in hospitals where mental health services are attached. General hospitals generally do not give family therapy services. However, medical social workers attached to these hospitals attend to the issues of care-giving and treatment expenses. The institutes and hospitals which have psychiatric services have trained family and marital therapists working on different areas of family life.

In addition to this, India has several non-governmental organizations which offer family and marriage support services. The government of India has established family counselling centres in every state for the support of troubled families. The poor functioning of these agencies, lack of training and experience of the counsellors in these centres have led to minimal utilization of services by couples and families.

Many marriage counsellors and family therapists are in private practices in major cities such as Banglaore, Mumbai, Chennai and Delhi. All these practitioners may be running their own clinics or may be affiliated to employee assistance programmes (EAP) of corporate companies or any other universities or NGOs. Private practitioners are challenged to have minimal sessions and fast improvement in family and marital adjustments. Since help-seeking for family and marriage-related issues carries stigma in society, families do not come directly for family interventions but find some other reason for appearing before the therapists. These families are largely helped in private consultations.

Challenges of family therapy in India

Family therapists and researchers in India need to address a multitude of aspects in family therapy because of India's multicultural and multi-dynamic context. Previous studies by Desai (1991), Nath & Craig (1999), Carson & Chowdhary (2000), and Shah et al. (2000), reflect several challenges which need thinking and rethinking by practitioners and researchers on issues such as rural and urban differences, linguistic diversity, variations in family interactions across cultures, dealing with the boundaries of extended families, pathological nature of hierarchical relationships, importance of family of origin, notion to preserve relationships despite constraints, socioeconomic and ethnic background, family power structure, stages of family life cycle, members included in the marital sub-system, and developmental tasks.

At a macro level, lack of licence for family practitioners, poor publicity about the availability of such services, lack of acceptance of family therapy as one of the primary methods of treatment, non-existent uniform sets of practice and unified training programmes in family therapy, lack of networking among family therapists and dearth of evidence-based research and publications could be perceived as challenges. The processes of globalization and liberalization are affecting families in India in their transition, which challenge the professionals to improve on the strategies adopting for interventions from time to time.

Conclusion

Family plays a major role in everyone's lives, as a ground for upbringing children, a support during crisis, members to rely on, and a place to go back at the end of a day. Family is given priority in everyone's life. But opportunities for dealing with the troubled situations in proportion with the contribution that every family makes in people's life are yet to be created. Even in the light of existing services, the number of professionals with proper knowledge, and skills to understand and engage an individual in the context of family is low. As long as the concept of 'the individual is the problem' remains, negative attitude in seeking help for issues pertaining to relationships is unchanged, stigma prevails, and evidence-based results are published in India, dealing with issues of family remain a challenge for professionals, and a continuing process for elders in the family or influential members close to these troubled families.

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