# Indian family systems, collectivistic society and psychotherapy

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## ABSTRACT

Indian society is collectivistic and promotes social cohesion and interdependence. The traditional Indian joint family, which follows the same principles of collectivism, has proved itself to be an excellent resource for the care of the mentally ill. However, the society is changing with one of the most significant alterations being the disintegration of the joint family and the rise of nuclear and extended family system. Although even in today's changed scenario, the family forms a resource for mental health that the country cannot neglect, yet utilization of family in management of mental disorders is minimal. Family focused psychotherapeutic interventions might be the right tool for greater involvement of families in management of their mentally ill and it may pave the path for a deeper community focused treatment in mental disorders. This paper elaborates the features of Indian family systems in the light of the Asian collectivistic culture that are pertinent in psychotherapy. Authors evaluate the scope and effectiveness of family focused psychotherapy for mental disorders in India, and debate the issues and concerns faced in the practice of family therapy in India.

**Key words:** Indian family systems, collectivistic society, psychotherapy

## INTRODUCTION

The term family is derived from the Latin word 'familia' denoting a household establishment and refers to a "group of individuals living together during important phases of their lifetime and bound to each other by biological and/or social and psychological relationship".[1] The group also includes persons engaged in an ongoing socially sanctioned apparently sexual relationship, sufficiently precise and enduring to provide for the procreation and upbringing of children.[1] Unlike the western society, which puts impetus on "individualism", the Indian society is "collectivistic" in that it promotes interdependence and co-operation, with the family forming the focal point of this social structure. The Indian and Asian families are therefore, far more involved in caring of its members, and also suffer greater illness burden than their western counterparts. Indian families are more intimate with the patient, and are capable of taking greater therapeutic participation than in the west.

In a situation where the mental health resource is a scarcity, families form a valuable support system, which could be helpful in management of various stressful situations. Yet, the resource is not adequately and appropriately utilized. Clinicians in India and the sub-continent do routinely take time to educate family members of a patient about the illness and the importance of medication, but apart from this information exchange, the utilization of family in treatment is minimal. Structured family oriented psychotherapy is not practiced in India at most places in India, except a few centers in South India. Research publications on family therapy from India are also few. Thereare some evidence from published "family intervention studies", but whether all non-pharmacological interventions with family members can be considered as "family therapy" is a matter of theoretical debate.

Sholevar[2] defines family therapy as any use of a family-focused intervention to bring out behavioral and/

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**Access this article online**

**Website:**

www.indianjpsychiatry.org

**Quick Response Code**

**DOI:**

10.4103/0019-5545.105555

or attitudinal changes in one or more family members" Although the "family" may be involved in many schools of psychotherapy, "family therapy" represents the most direct branch of psychotherapy that deals with the family system as a whole.

This paper discusses the features of Indian family systems in the light of the Asian collectivistic culture that are pertinent in psychotherapy and family therapy as used in India, and its further scope.

## UNDERSTANDING THE INDIAN FAMILY FROM A PSYCHOTHERAPEUTIC STANDPOINT

### Role of culture and collectivism in shaping the family

Families do not exist in isolation and family dynamics are often best interpreted in the context of their societal and cultural background. Culture has been shown to determine the family structure by shaping the family type, size, and form[3,4] and the family functioning by delineating boundaries, rules for interaction, communication patterns, acceptable practices, discipline and hierarchy in the family.[4-6] The roles of family members are determined largely by cultural factors (as well as stages of the family life cycle),[4,7] and finally, culture also explains families' ways of defining problems and solving them.[7]

Culture, however, is not an external passive influence on the families but families themselves serve as the primary agent for transferring these cultural values to their members.[8] Parents help children to learn, internalize, and develop understanding of culture through both covert and overt means.[9] Family members modify behaviors in themselves and others by principles of social learning. In this process, the general norms and beliefs may be modified to suit the needs of the family creating a set of "family values" – A subset of societal norms unique to the family.

It is imperative then, that therapists understand the impact of culture on family functioning as well as in conflict resolution and problem-solving skills of the family members.[10] One such important dimension of Asian and particularly Indian culture that affects family functioning is collectivism.[11-13] "Collectivism" refers to the philosophic, economic, or social outlook that emphasizes the interdependence amongst human beings. It is the basic cultural element for cohesion within social groups, which stresses on the priority of group goals over individual goals in contrast to "individualism", which emphasizes on what makes the individual distinct, and promotes engagement in competitive tasks. "Horizontal collectivism" refers to the system of collective decision-making by relatively equal individuals, for example, by the intra-generational family member; while "vertical collectivism" refers to hierarchical structures of power in a collectivistic family, for example, inter-generational relations in a three generation family.

Classically, the cultures of Western Europe and North America with their complex, stratified societies, where independence and differences are emphasized, are said to be individualistic, whereas in Asia, Africa, parts of Europe and Latin America where agreeing on social norms is important and jobs are interdependent, collectivism is thought to be preponderant.[14,15] Studies comparing Caucasians or Americans with people from Asian cultures, such as Vietnamese or Filipino[13,16] do show that individualistic societies value self-reliance, independence, autonomy and personal achievement,[16] and a definition of self apart from the group.[13] On the other hand, collectivistic societies value family cohesion, cooperation, solidarity, and conformity.[16]

Such cultural differences mean that people in different cultures have fundamentally different constructs of the self and others. For more collectivistic societies like ours, the self is defined relative to others, is concerned with belongingness, dependency, empathy, and reciprocity, and is focused on small, selective in-groups at the expense of out-groups. Relationships with others are emphasized, while personal autonomy, space and privacy are considered secondary.[17] Application of western psychotherapy, primarily focused on dynamic models, ego structure and individuals, therefore, becomes difficult in the Indian collectivistic context. The point has been well discussed by Indian psychiatrists in the past. As early as in 1982, Varma expressed limitations to the applicability of the Western type of psychotherapy in India,[18] and cited dependence/interdependence (a marker of collectivism) in Indian patients with other family members as foremost of the seven difficulties in carrying out dynamic and individual oriented psychotherapy. Surya and Jayaram have also pointed out that the Indian patients are more dependent than their western counterparts.[19] Neki, while discussing the concepts of confidentiality and privacy in the Indian context opined that these terms do not even exist in Indian socio-cultural setting, as the privacy can isolate people in interdependent society.[20] Neki recommended a middle ground with family therapy or at least couple of sessions with the family members along with dyadic therapy in order to help the progress of the psychotherapy.[21] Family, therefore, forms an important focus for change in collectivistic societies, and understanding the Indian family becomes an essential prerequisite for involving them in therapy.

### The traditional Indian family

Any generalizations about the Indian family suffer from oversimplification, given the pluralistic nature of the Indian culture. However, in most sociological studies, Asian and Indian families are considered classically as large, patriarchal, collectivistic, joint families, harboring three or more generations vertically and kith and kin horizontally. Such traditional families form the oldest social institution that has survived through ages and functions as a dominant influence in the life of its individual members. Indian joint

families are considered to be strong, stable, close, resilient and enduring with focus on family integrity, family loyalty, and family unity at expense of individuality, freedom of choice, privacy and personal space.[22]

Structurally, the Indian joint family includes three to four living generations, including grandparents, parents, uncles, aunts, nieces and nephews, all living together in the same household, utilizing a common kitchen and often spending from a common purse, contributed by all. Change in such family structure is slow, and loss of family units after the demise of elderly parents is counterbalanced by new members entering the family as children, and new members (wives) entering by matrimonial alliances, and their offsprings. The daughters of the family would leave following marriage. Functionally, majority of joint families adhere to a patriarchal ideology, follow the patrilineal rule of descent, and are patrilocal; although matrilocal and matriarchal families are quite prevalent in some southern parts of the country. The lines of hierarchy and authority are clearly drawn, with each hierarchical strata functioning within the principal of "collective responsibility". Rules of conduct are aimed at creating and maintaining family harmony and for greater readiness to cooperate with family members on decisions affecting almost all aspects of life, including career choice, mate selection, and marriage. While women are expected to accept a position subservient to males, and to subordinate their personal preferences to the needs of other, males are expected to accept responsibility for meeting the needs of others. The earning males are expected to support the old; take care of widows, never-married adults and the disabled; assist members during periods of unemployment and illness; and provide security to women and children.[1,23] Psychologically, family members feel an intense emotional interdependence, empathy, closeness, and loyalty to each other.

### The changing Indian family

The socio-cultural milieu of India is undergoing change at a tremendous pace, leaving fundamental alterations in family structure in its wake. The last decade has not only witnessed rapid and chaotic changes in social, economic, political, religious and occupational spheres; but also saw familial changes in power distribution, marital norms and role of women. A review of the national census data and the National Family Health Survey (NFHS) data suggests that,

gradually, nuclear families are becoming the predominant form of Indian family institution, at least in urban areas. The 1991 census, for the first time reported household growth to be higher than the population growth, suggesting household fragmentation; a trend that gathered further momentum in the 2001 and the 2010 census. A comparison of the three NFHS data [Table 1] also shows that over the years there has been a progressive increase in nuclear families, more in urban areas, with an associated progressive decrease in the number of household members.[24-26] Other important trends include a decrease in age of the house-head, reflecting change in power structure and an increase in households headed by females, suggesting a change in traditional gender roles.

However, though traditional joint families have been significantly replaced by urban "new order" nuclear families, it would be wrong to look at present Indian families in such simple bimodal groups. The family systems presently have become highly differentiated and heterogeneous social entities in terms of structure, pattern, role relationships, obligations and values. Joint families that stay under same roof, but with separate kitchen, separate purse and with considerable autonomy and reduced responsibility for extended family members are common and represent "transitional families".[27] Others may stay in separate households but cluster around in the same community. Such transitional families though structurally nuclear, may still continue to function as joint families. Sethi, back in 1989 pointed out the strong networks of kinship ties in Indian "extended families", and observed that even when relatives cannot actually live in close proximity, they typically maintain strong bonds and attempt to provide each other with economic help and emotional support.[1]

### *Effects of societal and familial change on mental health*

Social and cultural changes have altered entire lifestyles, interpersonal relationship patterns, power structures and familial relationship arrangements in current times. These changes, which include a shift from joint/extended to nuclear family, along with problems of urbanization, changes of role, status and power with increased employment of women, migratory movements among the younger generation, and loss of the experience advantage of elderly members in the family, have increased the stress and pressure on such families, leading to an increased vulnerability to emotional

### Table 1: Summary data from the National Family Health Survey

| Nuclear | | Household type (in %) | | Sex of household head (males,%) | Median age of household head | Mean size of household |
|---|---|---|---|---|---|---|
| | | Nuclear | Non-nuclear | | | |
| NFHS-1, 1992 | Urban | - | - | 90.4 | 44.2 | 5.4 |
| | Rural | - | - | 90.9 | 45.1 | 5.7 |
| NFHS-2, 1998 | Urban | 59.3 | 40.7 | 88.9 | 45.2 | 5.2 |
| | Rural | 55.6 | 44.3 | 90.0 | 45.1 | 5.5 |
| NFHS-3, 2005 | Urban | 63.0 | 37.0 | 86.8 | - | 4.6 |
| | Rural | 59.3 | 40.7 | 85.1 | - | 4.9 |

problems and disorders. The families are frequently subject to these pressures.

Countries within the developing world are impatient and intend to achieve within a generation, what countries in the developed world took centuries. Hence societal changes here are not step by step or gradual, but rapid, the process inevitably involving "temporal compression". Additionally, the sequences of these societal changes are haphazard or "Cacophonic",[28] producing a condition that is highly unsettling and stressful. For example, in a household where a woman is the chief breadwinner but has minimal standing in decision making, the situation leads to role resentment and disorganized power structure in the family. Indeed, studies do show that nuclear family structure is more prone to mental disorders than joint families.[29] Fewer patients with mental illness from rural families have been reported to be hospitalized when compared to urban families because of the existing joint family structure, which apparently provides additional support.[30] Children from large families have been found to report significantly lower behavioral problems like eating and sleeping disorders, aggressiveness, dissocial behavior and delinquency than those from nuclear families.[31] Even the large scale international collaborative studies conducted by WHO – the International Pilot Study on Schizophrenia, the Determinants of Outcome of Severe Mental Disorders and the International Study of Schizophrenia – reported that persons with schizophrenia did better in India and other developing countries, when compared to their Western counterparts largely due to the increased family support and integration they received in the developing world.[32]

Although a bulk of Indian studies indicates that the traditional family is a better source for psychological support and is more resilient to stress, one should not, however, universalize. The "unchanging, nurturant and benevolent" family core is often a sentimentalization of an altruistic society.[33] In reality, arrangements in large traditional families are frequently unjust in its distribution of income and allocation of resources to different members. Exploitation of family resources by a coterie of members close to the "*Karta*" (the head of family) and subjugation of women are the common malaise of traditional Indian family. Indian ethos of maintaining "family harmony" and absolute "obedience to elderly" are often used to suppress the younger members. The resentment, however, passive and silent it may be, simmers, and in the absence of harmonious resolution often manifests as psychiatric disorders. Somatoform and dissociative disorders, which show a definite increased prevalence in our society compared to the west, may be viewed as manifestations of such unexpressed stress.

Therefore, rather than lamenting on the change in societal structure and loss of the joint family, the therapist should be aware of the unique dynamics of each family he treats, and should endeavor to find and utilize the strengths therein, while providing ways to cope with stress within the limits of the available resources.

## UNDERSTANDING PSYCHOTHERAPY FROM THE FAMILY PERSPECTIVE

### Family oriented psychotherapy: History and scope in India

Social interventions with families to help them cope with problems have always been a part of all cultures in form of a variety of rituals, for example, the rituals surrounding death of family members. The roots of the formal development of family therapy, however, dates back to the early 1940s, when pioneers like John Bowlby in the United States; John Elderkin Bell, Nathan Ackerman, Theodore Lidz, Lyman Wynne, Murray Bowen and Carl Whitaker in United Kingdom; and D.L.P. Liebermann in Hungary began seeing and observing family members in therapy sessions.[34] The initial strong influence from psychoanalysis soon gave way to concepts from social psychiatry, learning theory and behavior therapy, and the early concepts of theoretical framework for family therapy were formed.[2] In the mid-1950s, Gregory Bateson and colleagues at Palo Alto in the United States, introduced ideas from cybernetics and general systems theory in psychotherapy.[35] The systems approach did not focus on the linear causation model of individual psychology, and instead emphasized on feedback and homeostatic mechanisms that operate in family systems. The famous "circular causation and process" model was forwarded and here-and-now interactions between family members started being viewed as a major factor in maintaining or exacerbating problems, whatever be the original cause.[36] Simultaneously, Murray Bowen at the National Institute of Mental Health, worked on his hypothesis on family systems, based on his observations on the father-mother-child triad. Bowen's observations on triadic relationship, fusion and distancing, nuclear family emotional process, multi-generational transmission processes and family constellation forms the basis of the family systems theory, which later came to be known as the Bowen's theory.

By the mid-1960s, a large number of distinct schools of family therapy had emerged, some of which included brief therapy, strategic therapy, structural family therapy, and the Milan systems model. Concurrently and somewhat interdependently with the systems theory, intergenerational therapies emerged, which theorized the intergenerational transmission of health and dysfunction and usually dealt with at least three generations of a family. After the late-1970s, the field of family therapy saw many practical modifications of the earlier rigid theoretical frameworks, especially in the light of accumulated clinical experience in treatment of serious mental disorders. In the past few decades, there has been a general move towards integration and eclecticism, with practitioners using techniques from several areas, depending upon their own inclinations and/or the needs of the clients.

In India, work in family therapy started in the late 1950s, coinciding with the period of increased interest in psychotherapy in India. Vidya Sagar, who worked with families at the Amritsar Mental Hospital in the 1950s, is credited as the father of family therapy in India. His own writings on the topic are sparse, but he was able to involve families of patients in understanding and taking care of their patients with psychiatric illness, and to support each other through group participation.[37] Vidya Sagar found that involving the family significantly reduced the hospital stay, increased acceptance of the patient by the family, and enhanced family coping skills.[38] In a similar attempt about the same time, the Mental Health Center at Vellore[39] started admitting all psychiatric patients along with their families to unit family rooms. Mental Health Center, Vellore tried to focus on family education and family counseling on how to deal with the index patient and showed promising results of the family interventions. 1960s was also the time of beginning of the general hospital psychiatric units (GHPUs) with inpatient facilities, where patients were admitted mandatorily with a family member with focus on family education and counseling. The similar practice has been followed at all the GHPUs, which have been established in India over the last 5 decades. These units, though may not be conducing family therapy, are working with family involvement in treatment of the persons with mental illness.

Another major boost to family therapy in India occurred in the late 1970s and early 1980s, when the National Institute of Mental Health and Neuro-Sciences (NIMHANS), Bangalore started working actively on family members of patients with psychiatric disorders, which ultimately resulted in the formation of a formal Family Psychiatry Center in 1977. Early work from the center showed that families could be taught to cope with their burden through education, counseling and group support in an effective manner.[40] Subsequent work by researchers[41-43] showed the usefulness of involving families in the management of a variety of psychiatric disorders including marital discord, hysteria and psychosis. In the late 1980s, the center developed Indian tools for working in the field of family therapy, notable amongst which are the Family Interaction Pattern Scale, the Family Topology Scale[44,45] and the Marital Quality Scale.[46] In the late 1980s and 1990s the center started training post graduates in psychiatry in concepts and schools of family therapy and started orienting itself to structured rather than generic family therapy. At the turn of this century, it became the only center in India to offer formal training and diploma course in family therapy.[47] Though the center in past had practiced various dynamic and behavioral models, currently it follows primarily a systemic model of family therapy.[48]

In the non-government sector, though there are family therapy practitioners, particularly in the cities of Delhi, Mumbai and Bangalore, they are mostly scattered and often suffer from the lack of training and resource facilities.

The Schizophrenia Research Foundation at Chennai, which works with long-term care and rehabilitation of the chronically mentally ill patients, conducts a family intervention program, focused on education and coping of family members with the illness of the index patient. The Indian Association for Family Therapy, founded since 1991, has also been working in the field to provide a platform for private therapists.

## Effectiveness of family oriented psychotherapy in India

Although a significant number of therapists practice family therapy in India in government and private settings, the published literature on the subject is surprisingly sparse. Most publications are issue based experiential accounts of the practitioners, rather than evidence based merits of particular therapy modalities. Even then, most intervention studies report significant benefits whenever family have been involved in management of psychiatric disorders. Table 2 summarizes the findings of major family intervention studies from India.

A large body of published work in family therapy in India comes from the Family Therapy Center, at NIMHANS.[49] In one of the earliest studies from the center, it was found that staying with a preferred family member reduced duration of hospital stay in psychiatric inpatients.[42] In another definitive study on the effectiveness of family therapy in Indian setting, Prabhu et al. in 1988 followed-up 60 families over 2 years, who had received brief integrative inpatient family therapy. Two third of the group did very well or moderately well.[50] Later studies have reported improvement with family therapy in patients with a wide range of psychiatric problems, including schizophrenia,[51] alcohol dependence,[52] eating disorders,[53] epileptic psychosis,[54] adolescent conduct disorder,[55] marital problems,[56-59] family violence[60,61] and in families coping with people living with HIV AIDS.[62]

In addition to the interventional studies, experiential accounts and reflective writings by therapists working with families in India help us to understand issues, practical difficulties and unique advantages of the Indian setting. Table 3 summarizes the major points of various published studies on family therapy by Indian practitioners in last 15 years, that throw light on the process issues rather than the outcome.

## Family oriented psychotherapy: Process and issues in practice

Ideally, any psychotherapy would include intake process, therapy proper and a termination phase. In family therapy, aim of the intake phase is to understand the families' perception of the problem, their motivation to undergo therapy, and the therapist's assessment of the suitability and type of family therapy to be applied. Assessment of the family forms an important part of the intake phase

### Table 2: Summary of the findings of family intervention studies from India

| Study | Sample | Intervention | Outcome |
|---|---|---|---|
| Chacko et al., 1967[63] | Mixed group; mainly with schizophrenia | Descriptive study of treatment in family ward | Benefits from treatment |
| Narayanan et al., 1972[64] | Mixed group; mainly with schizophrenia | Descriptive study of treatment in family ward | "Gratifying results" with treatment |
| Narayanan, 1977[40] | Various patient and family groups | Experiences with group and family therapy. | Patients receiving group or family therapy showed significant improvement compared to controls |
| Bhatti, 1980[42] | Inpatients and family members | Family therapy during ward stay | Staying with a preferred relative shortened duration of hospital-stay |
| Pai and Kapur, 1982;1983[65,66] | Patients with ICD-9 diagnosis of 1st episode schizophrenia | Home treatment by trained nurse versus hospital treatment | At 6 months follow up (F/U), the home treatment group significantly better |
| Pai and Roberts, 1983[67] | Patients with ICD-9 diagnosis of 1st episode schizophrenia | Home treatment by trained nurse versus hospital treatment | At 2 years F/U home treatment group significantly improved on symptoms and had less hospitalizations |
| Pai et al., 1985[68] | Patients with chronic schizophrenia, psychosis and epilepsy with>2 years illness | Home treatment by trained nurse versus hospital treatment | At 2 years F/U, home treatment group less hospitalized. Symptoms, functioning, family burden similar in both groups |
| Varghese et al., 1988[69] | Caregivers attending a family participation program | Assessment of knowledge and attitudes of caregivers | Positive change in knowledge and attitudes |
| Narayanan et al., 1988[70] | Parents of children diagnosed with mental retardation | Brief inpatient family intervention | Most parents experienced a favorable change in motivation to train their children; most children had small gains in their skills |
| Mehta, 1990[71] | Patients diagnosed as obsessive-compulsive disorder | Family member as a co-therapist versus no co-therapist as an adjunct to usual psychotherapy for OCD | Family-based approach showed significant reduction in psychopathology and improvement in social and personal adjustment |
| Shankar and Menon,1993[72] | Case reports | Description of a family intervention module | Intervention useful |
| Sovani, 1993[73] | Caregivers | Descriptive study of a 1-day family-psycho education program | Caregivers expressed need for such programs |
| Russell et al., 1995[74] | Parents of children diagnosed with mental retardation | Randomized control trial to assess efficacy of interactive group psychoeducation (PE) versus treatment as usual | PE significantly improved parental attitude orientation towards child-rearing knowledge and attitude towards management of intellectual disability |
| Gopinath and Shihabuddeen, 2005[75] | Caregivers of patients with schizophrenia and bipolar disorder | Group meetings conducted for 45 min once a month for 17 months | Reduction in the subjective family burden and family distress, development of adequate coping skills and good compliance with treatment programs |
| Thara et al., 2005[76] | Families of persons with schizophrenia | Structured family education utilizing standard evaluation instruments versus flexible intervention tailored to the needs of the family members | Preference for second program. Informal educational sessions with periodic 'across-the-table' reinforcers may be more effective and practical in the Indian setting |
| Das et al., 2006[77] | Relatives of patients with schizophrenia; reassessed at 2-weeks | Randomized control trial to assess effect of structured educational programme (EP) on explanatory models of illness | EP significantly enhanced understanding of non-biomedical causal explanatory models; but no difference in understanding treatment explanatory models |
| Kumar and Thomas, 2007[78] | Patients of alcohol dependence syndrome (DSM-IV) and matched control | Family intervention therapy versus brief supportive psychotherapy as an adjuvant to pharmacotherapy | At 1 year F/U family intervention significantly reduced the severity of alcohol intake, improved the motivation to stop alcohol and changed the locus of control from external to internal. |

*(Contd...)*

| Study | Sample | Intervention | Outcome |
|---|---|---|---|
| Kulhara *et al.*, 2009[79] | Patients with schizophrenia (DSM-IV) and their caregivers | Psycho education (PE) versus with standard outpatient treatment | Structured PE significantly better in reducing psychopathology, disability, and enhancing caregiver-support and satisfaction |
| Chow *et al.*, 2010[80] | Patients suffering from mental illness and their family members | Evaluation of Multi-Family Psycho-education Group (MFPG) by an Assertive Community Treatment Team; developed to serve culturally diverse clients (Chinese and Tamil) | MFPG increased family members' acceptance, and understanding of mental illness; it also decreased perceived family burden, stress and negative feelings towards the patient |
| Nattala *et al.*, 2010[81] | In-patients diagnosed with alcohol dependence syndrome | Patients randomly assigned to individual relapse prevention (IRP), dyadic relapse prevention (DRP), and treatment as usual (TAU) | At 6 month F/U DRP consistently performed better than TAU and IRP on all of the outcomes (reduction in quantity of alcohol, drinking days, and number of days with dysfunction in family). Findings provide evidence for the effectiveness of Western-based family-oriented intervention for alcohol-dependent patients in India |
| Devaramane *et al.*, 2011[82] | Patients diagnosed with schizophrenia and their primary caregivers | 3, one-hour brief intervention sessions (psycho-education, communication and problem-solving skills, expression of emotions) | At 3 month F/U, significant improvement on measures of psychopathology as well as family functioning |
| Jones *et al.*, 2012[83] | High risk couple drawn from infectious disease and family planning clinics. | 1 month of 3 weekly gender-concordant behavioral intervention groups (sexual barrier use, self-efficacy, knowledge, conflict resolution, and coping) among high-risk | Improvement in all parameters at F/U-consistent condom use, decreased verbal aggression, increased self-efficacy, and increased HIV-related knowledge, and increased positive coping tactics |

and different therapists employ different techniques for the purpose like the three generation genogram; life cycle chart, structural map or the circular hypothesis. The three generation genogram diagrammatically lists out the patient's generation and two more related generations and helps to understand trans-generational patterns of interaction. The life cycle chart explores the functions of the family and roles of different family members. A structural map shows the different subsystems in the family, the power structure and the relations between the family members. This can show if relations are normal, overinvolved, conflictual or distant. The circular hypothesis generally used in systemic therapy helps to understand the meaning of the symptoms for the patient and the role of the family members in maintaining them.

As most of these assessment tools were originally developed in the west, they need to be suitably modified for use in the eastern culture. In the last few decades attempts have been to develop culturally sensitive tools to assess Indian family in treatment. The Family Topology Scale[52] is a 28 item scale that measures family types, and groups them into the five subtypes of normal, cohesive, egoistic, altruistic and anoxic. Another tool, the Family Interaction Pattern scale,[44] looks into the developmental phases of the family. The scale

has six subscales looking into leadership, communication, role, reinforcement, cohesiveness and social support. For assessing marital problems in Indian couples two tools are available: Marital Adjustment Questionnaire[92] and Marital Quality Scale.[46] Marital Adjustment Questionnaire[92] attempts to assess marital adjustment in Indian couples, and measures seven aspects of family functioning, including personality, emotional factors, sexual satisfaction, marital role and responsibility, relationship to in laws, attitudes to children and family planning, and interpersonal relationships. Marital Quality Scale[46] is a more comprehensive instrument for assessing marital problems and looks into 12 dimensions of understanding, rejection, satisfaction, affection, despair, decision making, discontent, dissolution potential, dominance, disclosure, trust and role functioning. Such emic assessment tools are invaluable in understanding the unique problems of the family in our culture.

The therapy proper is the phase, where major work on the family is carried out. The school of therapy used depends on various factors. For example, the degree of psychological sophistication in the family will determine if psychodynamic techniques can be used. The nature of the disorder will also determine the therapy, like the use of behavioral

**Table 3: Summary of experiential and reflective journal articles on family therapy in India**

| Author(s) and year | Name of the study | Summary |
| --- | --- | --- |
| Nath and Craig, 1999[84] | Practicing family therapy in India: how many people are there in a marital subsystem? | Article attempts to describe personal and professional problems experienced by the Indian family therapist working with Western constructs of family organization. Systemic therapy appears to be a viable form of treatment Indian context. The author suggests that Indian family therapists should seek to work in culturally appropriate ways and tolerate their own internalized conflicts regarding differing cultural norms |
| Shah *et al.*, 2000[85] | Brief family therapy training in india | The author looked into the feasibility of formal training in family therapy in India and presented findings from a preliminary evaluation of 1-month long, brief family therapy training program held at NIMHANS. Findings indicated improvement in basic family therapy skills as well as in conceptual skills for trainees and importance of such training |
| Carson and Chowdhary, 2000[86] | Family therapy in India: A new profession in an ancient land? | The article examines the evolution and need for family therapy in India and its development as an integrated academic discipline. Authors discuss targets, settings and potential benefits of family therapy in today's rapidly changing society |
| Natarajan and Thomas, 2002[87] | Need for family therapy services for middle-class families in India | Authors explore the need for family therapy in middle-class families, using qualitative methodologies. Using focus group discussions, participants were introduced to the concept and practice of family therapy. Findings revealed that middle-class couples with marital problems are seeking outside help, but there is need to develop indigenous theory of relationships to culturally suit couple therapy |
| Shah, 2002[61] | Violence and abuse in therapy with couples: Guidelines and concerns of a therapist-cum-trainer | Sensitively broaches the complex issues related to therapy in couples with abuse and violence. The author shares her concern as a therapist and using a case provides some guidelines as to how to proceed in such cases |
| Isaac and Shah, 2004[58] | Sex roles and marital adjustment in Indian couples. | The study looked into the effect of sex role differences on close relationships in 20 distressed and 20 non-distressed Indian couples and showed a trend for present day couples to move towards more gender-neutral constructions of marriage |
| Krishna *et al.*, 2005[62] | Unheard voices: Experiences of families living with HIV/AIDS in India | The study tried understanding the impact of HIV on the family system in the Indian context and looked into issues of stigma and discrimination; disclosure; changes in family functioning; financial difficulties; fears of the family; and helplessness in Indian families |
| Rastogi *et al.*, 2005[88] | On Becoming a Profession: The Growth of Marriage and Family Therapy in India | The article highlights the history of couple and family therapy practices in India and includes experiential experiences of the authors as family therapists. Article also documents the needs of providers in the area of training in systems-based therapy |
| Mittal and Hardy, 2005[89] | A re-examination of the current status and future of family therapy in India | The authors present an overview of the present needs and current status of marriage and family therapy in India. The authors also prognosticate the future of the profession of family therapy in India by proposing a number of salient issues and outlines pathways for development of the subject |
| Shalini and Raghuram, 2005[55] | Marital conflict among parents: Implications for family therapy with adolescent conduct disorder | The paper highlights the role of parents' marital conflict in the emergence and maintenance of adolescent conduct problems. The importance of family therapy in managing adolescent conduct disorder is discussed through case examples from India |
| Carson *et al.*, 2009[90] | Counseling and family therapy in India: evolving professions in a rapidly developing nation | This article also provides an overview of the need for, current status and future of counseling and family therapy in India, including examples of training programs. It discusses cultural issues to be considered by Indian family therapist, potential barriers to counseling and ways of overcoming them are also discussed |
| Thomas, 2012[91] | Treating troubled families: therapeutic scenario in India | Paper reviews the family-based mental health services and focuses on the changing trends of those practices in India. Highlights the advantage of Indian families in their engaging ability with mentally ill members as well as with the treating team. Discusses the protective factors imposed by the Indian family despite its transitional position |

techniques in chronic psychotic illness. Therapist's comfort and training, and the time the family can spare for therapy are other determining factors. Dynamic approaches generally take months to years, where as focused strategic techniques can bring benefits over a few sessions.

Endo-cultural issues may crop up at the initial phases, which threaten to jeopardize the therapy outcome. The therapist needs to be aware of them and be sensitive and considerate. Although Indian families are more encouraging and supporting of their mentally ill member, the rigid

hierarchical structure of Indian families often hinders free communication of thoughts and feelings. Therefore, the therapist may encounter difficulties in improving family communication pattern. The "karta" (head) of the family may resist attempts of family members to usurp his authority and so may not allow other family members to express feelings. The therapist may come to an impasse, if he attempts to challenge the authority of the father or sides with the wife rather than with the husband in couple's therapy. Additionally, given the diverse cultural and social background, the therapy needs to be tailored to the needs of individual family, keeping factors such as socio-economic status, educational level and family structure (nuclear, transitional, joint, traditional) into account. Directive approaches may be more suitable for traditional families, as the therapist is often looked upon as charismatic, authoritarian and in control of the session.[93]

New and unexpected problems arising out of the rapid changing social scenario also need to be addressed. Family and couple's conflict arising out of factors such as conflicts in families over dowry, or related to inter-caste marriage; sexual problems arising out of physical separation of couples due to job timing or placement; disagreement about child rearing practices (both within couples and intergenerational); conflicts related to husband's role in sharing in domestic chores for working couples; problems with unsupervised children, and loss or displacement of role or function of the elderly are only a few of the problems unique to modern Indian families.[90] In family therapy focusing on adolescent and children, substance abuse, juvenile delinquency, school dropout or low school attendance are common amongst the lower socioeconomic classes. Parent-child conflict from increased autonomy and individuation of the child are common in nuclear families. In recent times, increased demands on children or adolescents for academic achievements from parents, the culture clash with children going for night-outs, parties, raves and adolescent sexual experimentation have been reported by Indian therapists as common issues while dealing with adolescents.[86] Although most of these problems are the same that troubled the west in the 1960s and the 1970s, our cultural differences make the therapist look and treat these problems as new.

It might be beneficial for the therapist to understand that in India and other similar collectivistic societies, the concepts of self, attitudes, values and boundaries are defined differently from those of the western world. In collectivistic societies the self is largely defined through the collective identity with family identity forming a significant component of the self-identity.[94] Therefore, individuals from such societies, when they stand up for their individual rights are termed rebellious, disobedient, or disrespectful. In therapy, if the person resists the solutions proposed by family members, the person may often be accused of not respecting important members of the family and/or community.[15] Attitudinal differences in collectivistic societies hamper treatment seeking too. People from collectivist societies often tend to keep their personal problems to themselves, especially if their own opinions and experiences are inconsistent with the conventional wisdom and mores of the family. Typically, only in severe cases, the people seek support from outsiders, and even then at the cost of significant resistance from other family members, who may perceive help seeking from the therapist as a measure of failure of the family to solve the problem of their member.[95] Additionally, involvement of outside strangers in resolving personal problems may be perceived by members of the collective society as intruding in the family's private affairs, undermining the family's harmony, and/or as a potential threat to their reputation. Collectivist values make each member of the family responsible for the behavior and the life conditions of every other family member, even to the extent of denial of individual needs and aspirations. In therapy, this often leads to over involvement, lack of privacy and space for the client. Indeed, negative expressed emotions that might hamper therapy and positive expressed emotions that help, have both been found to be more significant predictors of outcome in our country compared to the west.[96]

Finally, the therapist should be aware of the psychotherapeutic concepts derived from Indian philosophy and religion, as they have been found to be effective and culturally more acceptable in certain cases. The concept of "Shivite" stemming from the Hindu mythology of God Shiva and representing a phallic symbol can be used in dynamic psychotherapy.[97] The legend of Savitri has been used as a framework for psychotherapy by Surya and Jayaram.[98] Wig has used the term Hanuman complex[99] for the mythological story of Lord Hanuman needing external help being reminded about his forgotten powers. The concept can be used to help patients understand the process of psychotherapy and identifying one's hidden strengths. Varma used principles from the communication of Buddha in psychotherapy, which he viewed as an 'interpersonal method of mitigating suffering'. He has also emphasized on the use of concepts of Karma and Dharma in psychotherapy.[18] Neki used the concept of "Sahaja" and the role of "nirvana" in psychotherapy. He also propounded on the directive interaction between the therapist and the patient using the "Guru-Chela" paradigm.[100] Although such concepts may not be universally applicable, particularly in the changed urban modern scenario, they can be effectively used particularly in traditional systems to make therapy more acceptable and effective.

The termination phase summarizes the original problem, reviews the beneficial changes and patterns of interaction that have emerged through therapy, and stresses on the need for sustaining the improvements achieved. The follow-up sessions may be continued over the next 6 months to a year

to ensure that the client therapist bond is not severed too quickly.

## CONCLUSION

Indian families are capable of fulfilling the physical, spiritual and emotional needs of its members; initiate and maintain growth, and be a source of support, security and encouragement to the patient. These fundamental characteristics of the Indian family remain valid even now despite the changes in the social scenario. In a country, where the deficit in mental health professionals amounts to greater than 90% in most parts of the country, the family is an invaluable resource in mental health treatment. From a psycho-therapeutic viewpoint, in collectivistic societies like ours, the family may be a source of the trouble as well as a support during trouble. It is therefore, plausible that the family might also provide solutions of the trouble and indeed, interventions focusing on the whole family rather that the individual often results in more gratifying and lasting outcome. Sadly, the progress made in the last few decades has been minimal and restricted to few centers only and family therapy has not found popularity amongst the mental health community. Lack of integration of psychotherapy in postgraduate curriculum, lack of training centers for clinical psychologists, and lack of a good model of family therapy that can be followed in the diverse Indian setting are the three cardinal reasons for the apathy. This does not absolve the mental health professionals from the responsibility of providing solutions for the problems of the family, which seems to have multiplied during the same time. The Indian family, which often feels bewildered in these times of changed values, changed roles, changed morality and changed expectations is in need of support and is ready for family therapy. If developed enthusiastically, family therapy might be the right tool to not only help the families in need but also to develop a huge resource in community-centered treatment of mental-health problems.

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