

Family interventions and empowerment as an approach to enhance mental health resources in developing countries

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In many developing countries, families have been partners in the care of persons with mental disorders for

over five decades. This was so even when the rest of the world looked at families as a cause of mental disorders (1-4).

One of the first community studies in a developing country was carried out at Chandigarh, India, under the

leadership of N. Wig (5). This study focussed on 'attempts to meet the needs of a group of chronic schizophrenics in the community'. The setting was the Moderate Clinic and the team consisted of a psychiatric nurse, one psychiatric social worker, and two psychiatrists. In this study, 30 of the persons suffering from chronic schizophrenia attending the special clinic were evaluated in detail for their symptoms and social functioning. Further efforts were made to provide required help to the ill individuals and the families. Interventions consisted of regular home visits, family counselling, marital counselling, contact with social welfare agencies and providing an understanding about the illness. All the families were visited at home periodically. These home visits became a source of support to the family. The visits were utilised to share the caring skills with the family members.

Another important study of this period was initiated at the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore by Pai and Kapur (6-10). In this study, two similar groups of schizophrenic patients (27 each), undergoing two treatment modalities, namely hospital admission and home treatment through a nurse, were compared for the outcome in terms of symptoms, social dysfunction, burden on the family, cost of treatment and outcome at the end of 6 months. The hospital group patients were admitted to the psychiatric wards and treated in a routine manner (average hospital stay was 6 weeks). The home care group remained in their homes. A nurse trained in patient follow-up and counselling visited the home regularly for the purpose of patient assessment and treatment. The frequency of the visits were determined by the severity of the illness and the level of anxiety expressed by the family. The two groups "were comparable and the differences in outcome could be safely attributed to the differences in the two systems of delivery of care". The home treatment through a visiting

nurse gave a better clinical outcome and social functioning of the patient and greatly reduced the burden on the families. This treatment modality was also more economical.

A follow-up study was made of this group of patients after two years. 37 of the 54 patients could be contacted. It was observed that the home care group of patients had maintained significantly better clinical status than the controls and had been admitted less often (9). However, in terms of social dysfunction and burden on the family, the benefits of initial home care disappeared.

In a subsequent study, the focus of family care by visiting nurses was patients with a diagnosis of chronic schizophrenia (11). Two groups received the routine out-patient care and home care respectively. Each group had 32 patients and the duration of follow-up was two years. The two-year follow-up assessment showed that the home care group maintained better clinical status, as well as a better level of social functioning, but the differences were not statistically significant. Only two of the home care group were admitted to hospital over two years in comparison to 8 patients in routine care. The authors concluded that a home care service seems to offer a viable alternative mode of follow-up care for the chronically mentally ill population. Moreover, it may be possible to prevent repeated hospitalisations for these patients and offer them a better chance of long-term community adjustment.

During the latter part of 1980s, as part of the World Health Organization (WHO) collaborative study on 'Determinants of outcome of severe mental disorders', a substudy focussed on the specific cross-cultural aspects of expressed emotions (EE). The Chandigarh centre was under the leadership of N. Wig. In this comparison, two samples of relatives of first-contact patients with schizophrenia from Aarhus (Denmark) and Chandigarh (India) were assessed for the EE and their relationship with outcome. The

training of the investigators from different cultures was satisfactory and it was found that the rating of critical comments could be transferred satisfactorily from English to Hindi (12,13). The Danish sample consisted of 28 patients, while the Indian sample consisted of 78 patients from the urban and rural areas.

56% of Chandigarh relatives made no critical comments at all, compared with 29% of Aarhus relatives and 28% of British relatives. While 16% of the British relatives scored 15 or more, no Chandigarh relative made more than 14 critical comments. The mean number of critical comments made by Indian urban relatives was 2.42, compared with only 0.58 for Indian rural relatives, and 8.4 for the British sample. In the Indian sample, warmth was likely to be associated with high criticism as well as low criticism, whereas in the English and Danish samples warmth was much more likely to accompany low criticism. The proportion of families categorised as high-EE was 54% in English and Danish samples as compared to 30% in the urban and 8% in the rural Indian samples. The author concluded: "The starting point for further studies could well be the major difference in distribution of EE components between the urban and rural relatives. The possible insights afforded by this line of enquiry could contribute to therapeutic endeavours to alter the emotional environment in high-EE homes".

In a subsequent report, Leff et al (14,15) followed up 86% of the above group of patients at the end of two years. In contrast to the one year findings, the global EE index at initial interview did not predict relapse of schizophrenia over the next two years. However, there was a significant association between initial hostility and subsequent relapse.

In view of the association of high EE and family attitude with the course and outcome of schizophrenia, and the known better outcome of schizophrenia in India (as well as other developing countries), the failure

to follow up the above leads is unfortunate. This is an area for urgent attention by professionals.

During the recent years a number of investigators have studied in more details the family life of the persons with schizophrenic illness and factors associated with family care. These studies offer new understanding as well as potential avenues for further work.

Sharma et al (16) compared 78 patients living in the community with a diagnosis of schizophrenia in Liverpool, UK and 60 patients from the rural areas near Bangalore, India. In Liverpool only 20% were ever married as compared to 90% in Bangalore sample. Less than half of the patients were living with the family in Liverpool, while all but one patient in Bangalore were living with the family. Very few patients in Liverpool were employed. Inpatient treatment was common in Liverpool while it was rare in Bangalore. Illicit drug use was seen in 22% of Liverpool patients as compared to 2% in Bangalore. The authors conclude that "Bangalore patients were more socially integrated than Liverpool patients, who appeared socially marginalised".

During the 1990s, the movement to develop programmes for family members has been initiated in India. These include family education, family intervention, formation of self-help groups and greater support to families to become partners in care (17).

The focus of family interventions, to date, has been to build a relationship with caregivers based on understanding and empathy, focussing on the strengths of caregivers and assisting them to identify community resources, interventions to promote medication compliance, interventions to promote early identification of relapse and swift resolution of the crises, guiding families to reduce social and personal disability, guiding families to reframe expectations and moderate the affect in the home environment, guiding families to improve vocational functioning of the patient, emotional support to caregivers and

development of self-help groups for mutual support and networking among families.

The need of the families to take up this important role is at three levels. Firstly, families need support from the professionals to acquire the skills of care, respite care and crisis support in emergencies, as well as emotional support to meet their own needs and to maintain the cohesion of the families. Secondly, the state should support families financially to offset the caring responsibility of the families and help them to form self-help groups. Thirdly, professionals have to change their attitudes and practices to develop a true partnership with the families and make the experiences of the family an essential part of the programme and policy development. Developing countries have a unique opportunity to build mental health programmes on the strengths of families.

The issues relating to the families empowerment are: growing urbanisation of India; breaking down of the traditional joint and extended families; increasing numbers of nuclear families; single parent families; families with working parents; families in distress due to economic deprivation, social marginalisation, alcohol dependence, chronic illnesses; growing numbers of elderly persons and families of mentally ill with elderly caregivers; increasing influence of mass media in shaping the aspirations of young people and family life.

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