Family and Psychopathology: An Overview
Series-1: Children and Adults

Pradeep Kumar, S.C . Tiwari
Department of Geriatric Mental Health, CSM Medical University, Lucknow - 226 003.

Family

None of us live utterly alone. Family is the primary unit where individuals find their self identity and desire to live. A rigid definition of family involves persons united by ties of marriage, blood, or adoption. The members of a family have a common habitat, share same roof and constitute a single household. They interact and communicate with each other in the performance of roles, as spouse, mother and father, son, daughter, etc. This unit has certain common characteristics in all societies although the relationship between the individuals, family, society, culture and civilization are variable and complex. The family maintains a common culture, but may operationalize it differently. A rather loose definition of family connotes a group of individuals who live together during important phase of their lifetime and are bound to each other by biological or social or psychological relationship.

Psychopathology

Psychopathology refers to an abnormality, dysfunction, mental illness, or family psychopathology manifested in terms of behavioral, interpersonal, emotional, cognitive and psychophysiological functioning. Mental illness is a term that is largely synonymous with psychopathology, although it carries the implication that the unusual or aberrant patterns of functioning seen in these conditions reflect some form of disease or illness. Family psychopathology implies various risk situations (e.g. dysfunctional family structure, dysfunctional family functioning, faulty family relationship and communication patterns, etc) which have impact on mental health. In another words, it can be said that when the pathological life of the family creates problems in the equilibrium (balance) of the family environment, it is called as family pathology. Family psychopathology represents a particular risk in the immediate postpartum period, especially if family members suffer from bipolar affective disorder compared to other diagnostic groups.

Emergent Role of Families in Mental Disorder

Available evidence suggests that the prevalence of psychopathology among children in the family or foster care is higher than would be expected from normative data. Family is the main socializing agent for the child and is important in all aspects of a human development. From family, an individual gets emotional, financial, mental support and is able to cope with his/her problems with the help of the members of the family. Scientific observations on mental disorders and mental patients have indicated that family contributes significantly to the development of mental disorders. The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past decade. Clinical work and research on families, theories of family structure and dynamics had their beginning since 1940s with the work by Social scientist (Meyer and Sullivan). It is indicated that family has a crucial role in the development of mental disorders. Mental disorders develop as a result of family pathology or faulty communication or interpersonal relationship. Although the individual is affected, yet the whole family is sick.
because of inter or intrapsychic problems. The role of family in mental disorder/psychopathology has been classified into three broad categories such as:

1. Causative role of the family
2. Maintenance role of the family and
3. Therapeutic role of the family.

1. Causative Role of The Family

Mental disorders do not occur in a vacuum, they develop in a family setup with family dynamics playing causative role. In following areas family plays crucial role in the development of psychopathology:

(I) Faulty Parent Child Relationship:

Several types of specific parent child patterns appear with great regularity in children who show emotional disturbances. Some of these patterns are:

(a) Rejection: Rejection is manifested through physical neglect, denial of love and affection, lack of interest in the child’s activities and achievements, failure to spend time with the child and lack of respect for the child’s right and feeling as a person. In few cases, it also involves cruel and abusive treatment. It shows that parental rejection tends to foster low self-esteem, feeling of insecurity and inadequacy, retarded conscience and general intellectual development, increased aggression, lovelessness and inability to give and receive love. Cold and rejecting mothers report persistent bed-wetting, aggressiveness, slow conscience development in their children. Parental rejection is associated with diminished intelligence during the early school years, discouragement and general inhibiting and suppressing effect on child’s intellectual development and functioning. Parental rejection is a key factor amongst children suffering from excessive fear.

(b) Overprotection and Restrictiveness -

Maternal overprotection or “MOMISM” involves the smothering of the child’s growth. Overprotective mother may keep watch on the children constantly, protect them from the slightest risk, overly cloth and medicate them more than necessary and take decision on their behalf on slightest opportunity and make up their mind for them of the slightest opportunity. Such maternal reactions appear to represent a compensatory type of behaviour in which the mother attempts to gain satisfaction through her contact with the child. Such children are denied the much needed opportunity for reality testing and development of essential competencies. They became overanxious or have excessive fears. Rigid enforcement of roles and standards give the child little autonomy or freedom for growing his/her own way. It may foster well controlled, socialized behaviour, but it also tends to nurture fear, dependency, submission, repressed hostility and some dulling of intellectual striving. Over anxious youngsters are reported to have an over familiarizing overprotective mother.

(c) Over Permissiveness and Over Indulgence - Sometimes one or both parents cater to the child’s slightest whims and in doing so fail to teach and reward desirable standards of behaviour. Children of overly indulgent parents are characteristically spoiled, selfish, inconsiderate and demanding. High permissiveness and low punishment at home correlates positively with antisocial and aggressive behaviour. These children readily enter into relationship but exploit people for their own purpose. Such children are often rebellious.

(d) Unrealistic Demands -

Some parents place excessive pressures on their children to live up to unrealistically high standards. Under such sustained pressure, there is little room left for spontaneity or development as an independent person. No matter how hard the child tries, he seems to fail in the eyes of his/her parents and ultimately in his/her own eyes. It leads to pain, frustration and self-devaluation. Often parents don’t take into consideration the capabilities and temperament of their children. In some instances, parental demands are unrealistically low and parents don’t care what the child does as long he/she stays out of trouble. The children of such parents are
significantly lower in both achievements and self esteem. Thus, it is evident that unrealistic demands, too high, too low or distorted and rigid can be important cause of faulty development and maladjustment.

(e) Faulty Discipline – Parents are some times confused about appropriate forms of discipline. Inconsistent discipline makes it difficult for the child to establish stable values for guiding their behaviour. They often become more resistant to punishment and to extinction of their aggressive behaviour. There is high correlation between inconsistent discipline and later delinquent and criminal behavior. At present discipline is thought of more positively as providing needed structure and guidance for promoting healthy growth on the part of the child.

(f) Undesirable Parental Models – Since children tend to observe and imitate the behavior of their parents, it is apparent that parental behavior can have a highly beneficial or detrimental effect on the way a youngster learns to perceive, think, feel or act. Parents become undesirable models if they have faulty reality and value assumption. A parent who is emotionally disturbed or addicted to drugs or otherwise maladjusted may also serves as an undesirable model. Neurotic behaviour in the mother might lead to over anxious neurotic child. Undesirable parental model is an important reason why mental disorder, delinquency, crime and other forms of maladaptive behavior tend to run in families.

(II) Maladaptive Family Structure:

Current research on families has revealed that the general family environment as well as the child relationships may foster maladaptive behaviour on the part of the child with one or both parents. There is no model of the ideal family. However a few types of families that clearly have a detrimental influence on the child developments are:

(a) The Inadequate Family – This type of the family is characterized by inability to cope with the ordinary problems of the daily living. It lacks the resources, physical and psychological for meeting demands. Incompetence of such families can’t give its children the feeling of safety and security or adequately guide them in the development of essential competencies.

(b) The Disturbed Family or Home: Disturbed family may have certain characteristics like (1) the presence of parents who are fighting to maintain their own equilibrium and who are unable to give the child the needed love and guidance (2) Exposure of the child to emotional and faulty parental models and (3) almost inevitably, the inclusion of the child in the emotional conflicts of the parents. Disturbed homes have been associated with high incidence of psychological disturbances among children. It represents a threat to his/her “base of operation” and the only security he knows.

(c) The Antisocial Family: Here the family espouses values not accepted by the wider community. The parents are overtly or covertly engaged in behavior that violates the standards and interests of the society at large. They provide undesirable models to the child. Children in such families may be encouraged in dishonesty, deceit and other undesirable behaviour patterns and imitate the behaviour and attitudes of their parents. Their social interactions are shallow and manipulative. It has found that poor mental health in a congested urban area, with a higher mental risk for children who disapproved of their parents character.

(d) The Disrupted Family- Disrupted families are incomplete, whether as a result of death, divorce, separation or some other condition. A number of studies have shown traumatic effects of divorce on a child. Feelings of insecurity and rejection may be aggravated by conflicting loyalties. Delinquency and other maladaptive behaviours are much higher among children and adolescents coming from disrupted homes.

(e) The Discordant Family: Here one or both the parents are not getting satisfaction and
may express feelings of frustration and disillusionment in hostile ways such as nagging, belting and doing things purposely to annoy the other person. Serious discordant relationships are likely to be frustrating, hurtful and generally pathogenic in their effects on both the adult and the children.

(III) Family Factors In The Etiology of Schizophrenia

(a) Double bind (Bateson, Haley and Weakland) – It emphasises on giving the child incomplete messages (e.g. strictly avoiding a physical embrace, while saying why don’t you show me more affection?). This theory hypothesized that repeated exposure to such a dilemma generates or aggravates the schizophrenic state.

(b) Schism and skew (Ruth Lide and Weakland)- They systematically studied the characteristics of schizophrenic families using a psychoanalytic oriented psychodynamic perspective. Their main emphasis was on the triadic and dyadic relationship in the families. In one type of family, there is a prominent power struggle between the parents and one parent gets overly close to a child of the opposite sex. In other types of family, skewed relationship with one parent involves a power struggle between the parents and the resulting dominance of one parent.

(c) Pseudo-mutuality and pseudo-hostility (Lyman Wynne and Margaret Singer) - They described families in which emotional expression is suppressed by the consistent use of pseudo mutual or pseudo hostile verbal communications. This suppression results in the development of verbal communication that is unique to that family and not necessarily comprehensible to anyone outside the family. Problems arise when the child leaves home and has to relate to other people.

(d) Family interaction pattern - Environmental studies on the etiology of schizophrenia have stated that pattern of communication relating to family systems are thought to contribute to a member becoming schizophrenic. It has been seen that schizophrenic families communicate with less clarity and accuracy than do normal families. Deviances in family interactions may get manifested in a variety of ways like:

- Communication deviance – It is a measure that reflects the inability of the parent to establish and maintains a shared focus of attention during transaction with the child. It has found that Communication deviance to be characteristics of parents of schizophrenics.

- Affective climate – In schizophrenic families, the climate and emotional interchange at the surface represents a sharp contrast with what goes on emotionally in depth in the families with bipolar disorder.

- “Schizophrenic”- Schizophrenic mothers have been characterized as rejecting, dominating, cold, over protective and impervious to the feelings and needs of others. The child is deprived of a clear cut sense of his own identity, distorting his views of himself and his world and causing him to suffer from pervasive feelings of inadequacy and helplessness. The “schizophrenic” father has been described as a somewhat inadequate, indifferent, or passive father who appears detached and humorless; a man who rivals the spouse in his insensitivity to other’s feelings and needs. Often he appears to be rejecting towards his son and seductive towards his daughter. The daughter often develops severe inner conflict as she feels an incestuous attachment to her father.

(IV) Family Factors Contributing To The Etiology of Various Psychiatric Disorders/Pathogenic Behaviors

Psychoanalysis has suggested that childhood deprivation of maternal affection through separation or loss predisposes to depressive disorders in adult life. Increased affective morbidity in adult life whereas children...
separated from their parents as a result of marital problems or divorces do subsequently have increased rates of depression. Patients with severe depressive disorders and mild depressive disorders remember their parents have been less caring. Loss of parents early in life are associated not with overt mood disorders but with immaturity, hostile dependency, manipulativeness, impulsiveness and low threshold for alcohol and drug abuse in adulthood without directly affecting the life time risk of depression. These characteristics may precipitate life events which may trigger depression earlier in life and result in more frequent episodes of depression. Similarly, 40% of depressed patients who have personality disorder experience more stress, an earlier onset of depression and poorer recovery than those without such disorders. Family dysfunction is one among many causal factors on the generation of drugs misused and related social and behavior disorder among adolescent and young adults. Parental substance use tends to put children and adolescent in such families of a heightened risk of a variety of stressful life event, behavioral and emotional difficulties, and weakened ties drug used in adolescence. Violence, sexual abuse and victimization appear to be a strong risk factor for life time mental health problem in the family. A set of six variables reflecting chronic familial adversities that cumulatively proved to be significantly associated with psychiatric disorder in the offering. — (1) Severe mental disorder. (2) Low social status. (3) Over-crowding and large family size. (4) Paternal criminality (5) Maternal psychiatric disorder and (6) Placement of the child in foster care. Presence of even two risk factors increased the probabilities of disorder four folds.

2. Maintenance Role of The Family In Mental Disorders:

In the last few decades there has been an increasing trend towards treating psychiatric patients in the family setting rather than in mental hospital. Most people with schizophrenia who live their life with their families remain significantly disordered by their illness, while their careers suffer ongoing distress. Only a quarter of patients make a good recover from the first episode of schizophrenia despite the availability of effective treatments. Most sufferers now live outside hospital, about half with their family. Some are well but for others family care continues at the cost of hardship and distress to careers. Majority of relatives of patients with bipolar disorder experience subjective distress in relation to the patient’s symptoms, role dysfunction and the adverse effect of the patient’s illness on the relatives own work and leisure time. The degree of burden experienced will be greatest in relatives who believe that the patient is able to control over the patient illness- related behavior and in those relatives who are fully aware of the seriousness and prognosis of the illness. Caring for family member with a chronic illness could be both rewarding and challenging experience for the care givers. In an overview of family burden of psychiatric patients, it was noted that, the Indian family often tolerates considerable burden without complain. However, due to the rapid industrialization and urbanization and subsequent changes in the family structure and role, care for psychiatric patients impose a significant burden in the families in developing countries like India. It has found that perceiving the patient’s illness symptoms under his or her control has been associated with higher level of expressed emotion –critical comments, perceiving as helplessness or rage, contributing to the experience of the burden. It has also been seen that people with poor quality of marital relationship are heavier drinker. Husband undermining behaviours negatively affected the mental health and functioning of their wives. Work place support enhances well being of the family. Supportive supervisors were linked to decrease in health problems in married men. Studies show that both mothers and fathers are assigned to the low care and high protection quadrant by patient with depressive neurosis, social phobias, anxiety neurosis and agrophobia. Social status has always been associated with social attitude and there is no difference for attitude toward mental illness. Research finding indicated that people of lower social class almost never actively sought psychiatric help for themselves or for their relatives. Relatives of many mentally ill
people in high socioeconomic class express feeling of shame and guilt, whereas relative of low social status showed fear and resentment.

It is estimated that one in four families have at least one member currently suffering from a mental or behavioral disorder. Families in which one member is suffering from mental disorder make a number of adjustments and compromises that prevalent other members of the family from achieving their full potential in work, social relationships and in leisure’s. Family often has to set aside a major part of their time to look after the mentally ill relatives and suffer economic & social deprivation because he or she is not fully productive. There is also a constant fear that the recurrence of illness may cause sudden and unexpected disruption in the lives of the family members.

3. Therapeutic Role of The Family

It is universally recognized that family plays a crucial role in the raising of children to become reasonably well adjusted member of the society. The positive role of the family’s mental health care programmes has been recognized relatively recently. Substantial evidence demonstrates the benefit of involving families in the treatment and management of schizophrenia, mental retardation, alcohol dependence and childhood behaviour disorder. These are indications that the outcomes for patients living with their families are better than for those in institutions. It has been seen that by changing the emotional atmosphere in the home, the relapse can be reduced. In contact to epilepsy related factors, family factors especially those related to quality of the parent child relationship appeared to be strong predictors of psychopathology. In treating children with epilepsy, clinician should be aware of the importance of the parent-child relationship quality. Strengthening the relationship quality may prevent or reduce psychopathology.

The family commonly provides useful information about the patients and other illness. This facilitates a treatment plan, in which the family can play a prominent role in helping to supervise medication, encouraging participation in rehabilitation programmes generally providing an environment conductive to promoting recovery or reducing disability. The family support provides an opportunity to patient to ventilate their anxiety freely, to arise at a shared understanding of the disease and to explore various alternative coping strategies.

Family can offer an important reinforcement in the psychiatric therapeutic management. There are some basic steps in the family treatment to include family to participate in the management. These are –

- Improving problem solving ability of the families
- Educating the family regarding the illness.
- Modification of the family communication patterns
- Family guidance.
- Lowering the expressed emotion of the family members towards the patients.
- Manipulation of the power alliance within the family.
- Expanding social network.
- Enhancing social support.
- Crisis intervention.

The therapy for marital discord is the core approach to family change. Several family intervention approaches for schizophrenia have been developed based on the general assumption that maladaptive interaction pattern within the family produce high level of stress for the patient and tend to relapse. These intervention have attempted to reduce the risk of relapse either by altering communication and problem solving in the home or by the modifying family attitudes about the patient through education about the illness. Home visit and focused communication training has been shown to be effective in studies. Reduction of expressed emotion is associated with good treatment outcome, especially in the families with high level of face to face contact with the patient. Superior patient outcome with two variations of behavioral approach compare to family education and routine treatment. Intensive behavioral intervention may not be cost effective and that change in the family communication pattern may only be important for a subset of families.
family not in the causation of mental disorder, but the amelioration or deterioration of patient’s illness is largely dependent on the families’ notion of the attitude towards the illness. In this context, it is noteworthy to mention that to reduce the grievance of faulty care and attitudinal problems originated from family members out look towards the patient family centered therapeutics services has now become an indispensable process of management of the patients with mental disorder.

Assessment of family and psychopathology—there are four principle areas to be investigated in carrying out a family assessment.

(a) **The problem** - A clear understanding of the nature of the problems is essential in deciding how to deal with it.

(b) **The family is a social system** – The family generally perceived by society as the unit responsible for children with environment that serves their physical and emotional needs. It is accepted practice today to view the family as a system organized around the support, regularity, nurturance and socialization of its members.

(c) **The family and its environment** – It is important to have clear understandings of the overall scope of the families environment and recognize that it consist not only of create realities such as food, cloth, shelter, medical care, employment. Physical safety, education, recreation etc. but also includes social realities in terms of interpersonal relationship.

(d) **The family life cycle** – Discussed the importance of family life cycle into six stages of family development which are (i) the unattached young adult (ii) the new couple (iii) the family with younger children (iv) the family with adolescents (v) the family which is launching children.(vi ) the family in later life. In each of the stages, there are specific tasks that create stresses in the individual as well the family and sometimes help is required to deal with the problems that result.

**Assessment Models of The Families**

*Mc Master Model of the family functioning* is a useful way of looking families and is based on system approach. It considers six aspects of family functioning viz. problem solving, communication, roles, affective responsiveness, affective involvement and behaviour control. This model deals with the current functioning of the family rather than its past development or present development stage. The *process model of family functioning* derives from the family categories schema. It considers family functioning along six dimensions—problem solving, role performance, communication, affective involvement, control, value and norms.

**The Structural Model for Assessing Families**

The model outlines six aspects of family functioning: family structure flexibility, resonance, life context, development stage and the relationship of the identified patient symptom to the family transactional patterns.

**The Circumflex Model**

It identified two aspects of family behavior: cohesion and adaptability. Cohesion measures the emotional bonding that family members have toward one another. Family adaptability is the measure of how far the family permit changes (Morphogenesis) and how for it is characterized by stability (Morphostasis).

**The Beavers Model**

It has two axes one is concerned with the stylistic quality of family interaction, which is classified as either centripetal, mixed or centrifugal. The other is concerned with structure, available information and adaptive flexibility of the system. *Triaxial classification* identified three classes of family with problem:- Family Development dysfunction, Family system dysfunction, and Family group dysfunction.

**The Global Assessment of Relational Functioning**

It is a simple rating scale on which any relational unit (i.e. family, couple or other grouping) can be rated for its functionality on a 100 points scale. The family system test as an innovative technique that utilizes the generation of figure by family member to represent emotional bonds and hierarchical structure. The family environment scale contains ninety true/false questions assessing
three domains: relationship, personal growth and system maintenance. Family Interaction Pattern Scale measure the quality of family functioning, the scale has one hundred six items under six domains:- reinforcement, social support system, role, communication, cohesions and leadership on a 4 points Likert scale. There are some scales to administer family interaction factors like expressed emotion, burden in the family life, attitude questionnaire by Sethi et al, social support questionnaire by Nehra and Kulahra, family burden Inventory schedule by Pai and Kapoor etc.

In the last few decades, a global need is being felt for a staff in mental health care from psychiatric institution to community based services. Family has an important role in the planning as well as implementation of deinstitutionalization and community mental health programme, which is needed and recommended by WHO in World Health Report 2001. Family should not only be involved in the treatment process but also in the decision making of policies, programs and services.

Conclusion

The family unit is the single most important variable in the onset, progression, treatment and outcome of psychiatric illness or mental disorders. Various researchers as well as theoretical formulations have been explored to understand the role of family pathology in the causation (genesis) and maintenance of mental disorders. However, most of the families studied have been carried out in relation with schizophrenia and some with affective disorders, particularly depression. Some of the clinical studies clearly mentioned, especially in early childhood experiences, familial stress factors such as parental death, parental separation, parental rejection, marital discord, violence at home, faulty family communication, etc. which have long effects on mental health. However, the etiological aspects of various mental disorders require more exploration in the context of family life and its dynamics. Falling sick is a family event. It affects the well being of not only the patient but also that of the whole family by disrupting the normal day to day routine. The family is required to mobilize its internal and external resources to cope with the impending crisis. For any meaningful intervention, it is important to identify families, which are more vulnerable and need support. The family as a unit is still the best bet for health care intervention. Situation can improve by helping the patient and family members to develop realistic expectation about the problem and its ramifications.

References


27. Mukharjee P. Stigma – Caregiver attitude toward mental illness M. Phil (M&SP) dissertation, submitted to the ranchi University, under the guidance of Dr. S. Haque Nizamie, 2002.


46. Gehring TM. The family system test, Seattle, WA, Horgrefe and Huber Publisher, 1998.

