CHAPTER 2

REVIEW OF LITERATURE

2.1. INTRODUCTION

Health and mental health is identified today as a state, which is far beyond the general notion of the absence of disease or infirmity and believed to be covering all the areas of mental physical and social well being of the individual integrated with bodily, situational and environmental factors. Advancements in science and development of empiricism made tremendous transformations in the fields of the conceptualization, understanding and treatment of mental illness. This led to the gradual transformation of demonic version of causative theory to scientific, cause effect based interpretation of the phenomenon related with mental illness. The total outlook has changed of mental health and mental illness due to the advancement in understanding and mental illness is viewed today as a derailed state of functioning that affects cognitive, connative and affective areas of either particularly or fully of the individual performance that may lead the individual affected to a state of inability to secure job, earn a steady income, obtain self support and housing. The recognition of mental disorders and the facts about the society’s inability to compensate for this handicap, lead to the development of intervention strategies worldwide with an intention to assist/help the mentally ill who suffers social isolation, lack of daily living skill, unemployment, poverty and quiet often homelessness. The dominant personalities in the field of mental health worldwide started thinking of and coming up with intervention strategies to assist the cognitively impaired to place them back well in the environment they belong to. Schizophrenia, a mental illness that, cause most disabling impairments in all the areas of individual functioning, was a matter of concern over time, thus come under the purview of critical scanning of mental health experts. One after another they have been started identifying intervention strategies and tried them extensively. Pharmacological interventions along with well-planned environmental modification found better among them and much helpful with rehabilitating
schizophrenics. It is well documented that different models of interventions
aiming at environmental modifications tried in the schizophrenia treatment and
most of them found useful. A huge number of studies are available that speaks
about the involvement of family in the treatment process. So also the family
psycho education in mental health treatment process, thought to be helpful in
adding much to the prognoses, extensively studied and well documented. Many
tried to portray the different aspects of the significance of family involvement
in the treatment process of the individual affected with schizophrenia but none
stressed the impact of family psycho education and its involvement in the
treatment process of individuals affected with schizophrenia as such and
virtually no studies are available in this regard in Indian context. The literatures
available are reviewed here in this chapter.

2.2. MENTAL HEALTH

Mental health, a phenomenon that has always been a matter of concern for
thinkers’ overtime, is identified it today as a state, which is far beyond the
general notion of the absence of disease or infirmity and believed to be
covering all the areas of mental physical and social well being of the
individual. Ahuja (2004) in his attempt to define mental health concludes by
quoting World Health Organization ‘Mental health is a state of complete
physical, mental, and social well being and not merely absence of mental
disease or infirmity.’

The World Health Organization (1998) defines mental health as "a state of
well-being in which the individual realizes his or her own abilities, can cope
with the normal stresses of life, can work productively and fruitfully, and is
able to make a contribution to his or her community”. It was previously stated
that there was no one "official" definition of mental health. Cultural
differences, subjective assessments, and competing professional theories all
affect how "mental health" is defined.

Wyatt (1994) while speaking about ‘practical psychiatric practices’, explains
the concept of mental health as a term used to describe either a level of
cognitive or emotional wellbeing or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience.

Stuart and Lararia (2005) in ‘principles and practices of psychiatric nursing’ briefs ‘mental health is often spoken of as a state of well-being associated with happiness, contentment, satisfaction, achievement, optimism, or hope.

Tabers Cyclopedic Medical Dictionary (1959) defines mental health as ‘a state of being healthy in mind, body and spirit and the ability an individual possess to maintain healthy emotional and mental responses to the varying environmental stimuli.’

Saddock, et. al. (2003) quoted the report of the surgeon general of America to state about the health and mental health as, ‘it can be defined as, a successful performance of mental and physical function in terms of thoughts, physiology mood and behavior that results in productive activity, fulfilling relationship with others and the ability to adopt to change and to cope with adversity.

Dyer and Mc Guinness (1996) while speaking to nurses on ‘resilience: analysis of concepts’ summarizes the concept mental health as ‘an ability that an individual possess to handle successfully weathering each period of disruption and reintegration at life situations leaves the person disturbed but better able to deal with these situations systematically.

To give a precise and proper definition on mental health Offer and Subshin (1994) adopted the Methods of models. ‘Since mental health is difficult to define precisely, it should be well understood through placing it under different models of treatments namely the Medical Model, Statistical Model, Utopian Model, Subjective Model, Social Model, Process Model, and the Continuum Models which understands mental health as an integrated whole of wellness or being well in the respective fields of understanding.
Dianne and Robert (1995) describe mental health as the capacity to think rationally and logically, and to cope with the transitions, stresses, traumas, and losses that occur in all lives, in ways that allow emotional stability and growth. In general, mentally healthy individuals value themselves, perceive reality as it is, accept its limitations and possibilities, respond to its challenges, carry out their responsibilities, establish and maintain close relationships, deal reasonably with others, pursue work that suits their talent and training, and feel a sense of fulfillment that makes the efforts of daily living worthwhile.

Suggestive readings on mental health states much on the topic but ultimately all speaks about the same subject in different terms. Ultimately mental health is a positive state of mind engendering a sense of well being that enables a person to function effectively within society. Individuals who have good mental health are well-adjusted to society, are able to relate well to others, and basically feel satisfied with themselves and their role in the society. Mental health is a state of being healthy in mind, body and spirit and the ability an individual possess to maintain healthy emotional and mental responses to the varying environmental stimuli, as a state of well-being in which every individual realizes his or her own potential to cope with the normal stresses of life, to work productively and fruitfully, and thus make productive contributions life.

2.3. MENTAL ILLNESS

Mental health and mental illness are concepts often mistakenly treated and indistinctly understood. As Eisendrath and Lichtmacher (1999) observes mental health, refers to the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." On the other end of the continuum is mental illness, a term that "refers to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." This notion of a continuum sees mental health on
one end as 'successful mental functioning' compared to mental illness on the other end as 'impaired functioning.'

The American Heritage Dictionary of the English Language (2009) defines mental illness as any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or organic factors. Mental illness is also called emotional illness, mental disease, and mental disorder in American context.

Engel (1980) explains mental illness as a disorder of one or more functions of the mind results in the patient or others suffering. It does not include those conditions where the only problem is that the individual does not conform to the behavioral norms of society, nor does it include conditions of sub normality, where the individual has a general failure of normal intellectual development.

In Bromet’s (1998) opinion, it is reasonably clear that with mental illness there can be chronic mental malfunction, reduced or impaired capacities to respond to the world, to absorb process and remember information, respond with appropriate emotions, and the ability to form coherent plans will be impaired.

Jamison (1999) viewed Mental illness as a term that refers collectively to describe all diagnosable sub average mental functioning. Sub average mental functioning according to him are health conditions that are characterized by derailment and alterations in thinking, mood, or behavior (or some combination of all) associated with distress and/or impaired overall functioning of the affected individual.

Zastowny, et. al. (1992) observes mental, or psychiatric, illnesses are a major public health concern for developing nations. They adversely affect functioning, economic productivity, the capacity for healthy relationships and families, physical health, and the overall quality of life. They cut across racial, ethnic, and socioeconomic lines to affect a significant proportion of
communities worldwide. They tend to develop and manifest in the early adult years, often preventing individuals from leading full and productive lives.

Some thinkers are of the opinion that Mental illness is not only a disturbance in the function of a single organ like the brain. “It means the maladaptive and disordered psycho biological functioning” (Bhatia, (1997), Craig, (1998)). Scottowe (1995) an eminent English psychiatrist opined that “the hallmark of mental illness is that by reason of understanding of some change in the patient as a person whether that changes be due to physiological disturbances or to experiences of life, he is no longer able to adapt himself satisfactorily to his material, social or cultural environment. This state is intelligible as a disturbance of the relationship between the adaptive capacities of the individual on the one hand and his environmental load on the other.” Tabber’s medical dictionary defines (1959) mental illness as any disorder, which affects the mind or behaviour of the individual.

Offer and Sabshin (1984) describes mental illness is any disturbance of emotional equilibrium as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biological, psychological, or social and cultural factors that can cause impairment in overall functioning of the individual leading to social isolation, lack of daily living skill, unemployment and homelessness.

Ahuja (2004) gives a precise definition of the concept mental illness as ‘a mental illness is a clinically significant psychological or behavioural syndrome that causes significant distress (Subjective Symptamatology), disability (objective symptamatology) or loss of freedom and which is not merely a socially deviant behaviour or unexpected response to a stressful life event. Normally conflict between society and the individual are not treated as mental disorder. A mental illness should be a manifestation of behavioural, psychological and biological dysfunction in that person’.
2.4. SCHIZOPHRENIA

Mental illness has been recognized for thousands of years. At one point, all people who were considered "abnormal," whether due to mental illness, mental retardation, or physical deformities, were largely treated the same. Early theories supposed that mental disorders were caused by evil possession of the body, and the appropriate treatment was then exorcising these demons, through various means, ranging from innocuous treatments, such as exposing the patient to certain types of music, to dangerous and sometimes deadly means, such as releasing the evil spirits by drilling holes in the patient’s skull (Sadock et al. 2003). The advancements in science, technology and information with the emergence of empiricism changed the scenario and caused an overturn in the field of information and knowledge which generated information revolution in the field of mental health even. The result was conceptual clarity on then believed irresolvable problems of mental health and hence schizophrenia. The literature available on this respect is reviewed here.

Bailers Nurses Dictionary (2001) defined Schizophrenia as “a large group of mental disorders characterized by mental deterioration form a previous level of functioning and characteristic disturbances of multiple psychological process including delusions, loosening of association, poverty of content of speech, auditory hallucinations, inappropriate affect, disturbed sense of self and withdrawal from external world” Norquist and Regier (1996) in their attempt to speak about the epidemiology of psychiatric disorders says about Schizophrenia as ‘it is the descriptive term used for a group of psychotic disorders characterized by gross distortion of reality, withdrawal from social interactions and the disorganization and fragmentations of perception, thought and emotion.’

In search of the history of schizophrenia Sadock et al. (1995) reached at a conclusion that ‘One of the first to classify the mental disorders into different categories was the German physician, Emil Kraepelin. He used the term
"dementia praecox" for individuals who had symptoms that we now associate with schizophrenia.

Lilly (1996) while speaking on ‘schizophrenia and related disorders’ states that the Swiss psychiatrist, Eugen Bleuler, coined the term, "schizophrenia" for the first time in 1911. He coined the term by clubbing the words coming from the Greek root, schizo (split) and phrene (mind) to describe the fragmented thinking of people with the disorder. His term was not meant to convey the idea of split or multiple personality, a common misunderstanding by the public at large.

Marsh (1992) holds the view that Eugen Bleuler subdivided schizophrenia into categories, based on prominent symptoms and prognoses he came across with. Over the years, those who are working in this field have continued to attempt to classify types of schizophrenia. Five types were delineated in the DSM-III: disorganized, catatonic, paranoid, residual, and undifferentiated. The first three categories were originally proposed by Kraepelin. These classifications, while still employed in DSM-IV, have not shown to be helpful in predicting outcome of the disorder, and the types are not reliably diagnosed. According to him many researchers are using other systems to classify types of the disorder, based on the preponderance of "positive" v/s "negative" symptoms, the progression of the disorder in terms of type and severity of symptoms over time, and the co-occurrence of other mental disorders and syndromes. He believes that differentiating types of schizophrenia based on clinical symptoms will help to determine different aetiologies or causes of the disorder.

Eisendrath and Lichtmacher, (1999) Pointed out that, ‘since Bleuler's time, the definition of schizophrenia has continued to change, as scientists attempt to more accurately delineate the different types of mental diseases. Without knowing the exact causes of these diseases, scientists can only base their classifications on the observation that some symptoms tend to occur together.’

Collins and Drever (1995) say ‘it (Schizophrenia) impairs an individual in his cognitive, connative and affective areas of performance. Both the patients and
their families suffer from poor care and social ostracism because of widespread ignorance about the disorder. Hence of the entire major psychiatric syndrome Schizophrenia is found much the most difficult to define and describe.

According to Saddock, et.al (1995) “schizophrenia is a devasting mental illness of unknown causes and is probably the most distressing and disabling of severe mental disorders.”

Gelder, Michael et.al. (1996) quoted DSM IV (TR) of American Psychiatric Association to give a precise picture of this disorder. “Schizophrenia can be defined as (in terms of symptoms in acute phase and also in course). A mental disorder characterized by delusions, hallucinations, disorganized speech, or behaviour and negative symptoms, which have been present for one-month period unless successful treatment has occurred.

Lararia (2003) found that ‘there is no sex-related difference for the prevalence of schizophrenia among men and women. The average age of onset, however, differs slightly. For men, it is usually between 15 and 25, while women typically experience its onset between 25 and 35. Onset before age 15 and after age 50 is rare.’

Murphy and Farrell (1986) pointed out that a wide range of genetic studies strongly suggests a genetic component to the inheritance of schizophrenia.’

Brady, (1984) referred Dr. Amariah Brigham, one of the founders of American psychiatry, to authentically speak about schizophrenia and its organic base, that it “is now considered a physical disorder, a disease of the brain.”

Corcorann (2001) states and supports the organic theory of the origin of the schizophrenia on the grounds that ‘it was found in researches that individuals with schizophrenia, including those who have never been treated, have a reduced volume of gray matter in the brain, especially in the temporal and frontal lobes.’
Van Putten (2000) has found out that ‘Approximately 50 percent of individuals with schizophrenia, including those who have never been treated, have impaired awareness of their own illness (Poor Insight.)’

Awad et. al. (1995) believes that though the exact cause of schizophrenia remains unknown, experts agree on the fact that schizophrenia develops as a result of interplay between biological predisposition (for example, inheriting certain genes) and the kind of environment one is exposed to and pharmacology has much to do with the prognoses.

Marsh (2000) concludes that the cause of schizophrenia is not clear. Treatment to manage the symptoms of schizophrenia consists of medications, counseling, and a good support network. Schizophrenia is not the same condition as multiple personality disorder; it has its nature and features.

Wasow (1995) found it difficult to say what causes schizophrenia. He found several risk factors prefigure it, the most notable of which he found are the genetics and brain structure. And a combination of these also found influential. In addition to these, he found schizophrenia occurs with changes in brain chemistry, specifically, excessive levels of dopamine. Also, significant changes in the activation of the brain’s frontal and parietal lobes have been associated with schizophrenia.

Kesseler (1969) found that there is no known single cause of schizophrenia. Many diseases, such as heart disease, result from interplay of genetic, behavioural, and other factors; so also may be schizophrenia. He couldn’t find a point where scientists agree upon the factors necessary to cause schizophrenia, but all the tools of modern biomedical research are being used to search for genes, critical moments in brain development, and other factors that may direct the scientists to those elements in brain that may lead to the illness.

Liberman et. al. (1998) states that brain development disruption are likely the result of genetic and/or environmental stressors early in development (during pregnancy or early childhood), leading to subtle alterations in the brain.
Environmental factors later in development can either damage the brain further and further increase the risk of schizophrenia, by lessoning the expression of genetic or neurodevelopmental defects can decrease the risk of schizophrenia.

In Rockland (1989) opinion, Schizophrenia is a chronic, severe, and disabling brain disease. Approximately 1 percent of the population develops schizophrenia during their lifetime – more than 2 million Americans suffer from the illness in a given year. Although schizophrenia affects men and women with equal frequency in America, the disorder often appears earlier in men, usually in the late teens or early twenties, than in women, who are generally affected in the twenties to early thirties.

Corcorann (2001) believes that there is no prescribed amount of genetic or environmental input that will ensure someone will or will not develop schizophrenia. Moreover, causal situations may be different for different individuals - while one person may develop schizophrenia due to a strong family history of mental illness, someone else with much less genetic vulnerability may also develop the disease due to a significant pre-natal or environmental stressor during their lives.

Beck (1980) states with evidences of magnetic resonance imagery analysis of schizophrenics that abnormal brain structure is found consistently in people with schizophrenia. This includes enlarged ventricles and asymmetrical hemispheres. Computerized functional imaging of the brain has found decreased blood flow to the frontal lobes of people with schizophrenia. These types of brain abnormalities forecast certain symptoms, like loss of attention, difficulty with abstract thinking, and the inability to solve problems.

Klein (1979), it has become evident from genetics research that some people are genetically predisposed towards certain chronic diseases and schizophrenia has no exception. Evidences proved that some strong genetic factors that predispose some people to schizophrenia. The strong genetic role in schizophrenia is shown even in twin studies, for example, studies evidenced that if one identical twin has schizophrenia there is a 48% probability that the
second twin will also develop schizophrenia. Evidences in genetic studies proved that the more genes that a person shares with a person with schizophrenia - the higher the risk that they will also develop schizophrenia.

Sullivan (1963) reviews schizophrenia as ‘a (biological) disease (of the brain) that ebbs & flows. Acute periods are called "relapses” when patients experience sensations that are an addition to their usual repertoire of feelings. Because they are additions, they are referred to as "positive symptoms” but they are far from positive in the sense of being wanted. They are the hallucinations, delusions & thought confusions which return periodically, triggered, probably, by a variety of stresses. They respond, in general, to decreased stimuli, calm interactions, & antipsychotic medicine’.

Natahan (2002). Opined that heredity is the most well established risk for schizophrenia. People who have immediate family members with schizophrenia have a 10% chance of developing it, ten times that of the general population. Other personality disorders, including those with psychotic symptoms, also seem to be more prevalent in families with schizophrenia. Despite the chance for inheritance, the number of children born to parents with schizophrenia doubled in the first 50 years of the 20th century.

Lalitha(2000) Points out that it has long been known that schizophrenia runs in families. People who have a close relative with schizophrenia are more likely to develop the disorder than are people who have no relatives with the illness. For example, a monozzygotic (identical) twin of a person with schizophrenia has the highest risk – 40 to 50 percent – of developing the illness. A child whose parent has schizophrenia has about a 10 percent chance. By comparison, the risk of schizophrenia in the general population is about 1 percent.

Mruk (1999) extensively reviews all the recent studies that seem to support a genetic cause of schizophrenia and suggests that identical twins stand a 50% to 85% chance of sharing the disease. Furthermore, his study shows that this to be about three times that for fraternal twins. Still, most studies fail to identify the
exact mechanism and location of genetic transmission, though they do identify possible genes and chromosomes.

Gardner (1993) found Schizophrenia is a disorder which is found all over the world. The severity of the symptoms and long-lasting, chronic pattern of the illness often cause a high degree of disability. Medications and other treatments for schizophrenia, when used regularly and as prescribed, can help reduce and control the distressing symptoms of the illness but most often the affected are not greatly helped by available treatments or may prematurely discontinue treatment because of unpleasant side effects or other reasons. Even when treatment is effective, persisting consequences of the illness – lost opportunities, stigma, residual symptoms, and medication side effects – may be very troubling.

Flaskerud (2000) describes the first signs of schizophrenia often appear as confusing, or even shocking, changes in the behavior of the affected for the family members. Coping with the symptoms of schizophrenia will be difficult for family members who remember how involved or vivacious a person was before he/she became ill. The family and significant others find the symptoms, such as social isolation or withdrawal, or unusual speech, thinking, or behavior, may precede, be seen along with the illness embarrassing and distressing.

Seligman (1987) describes schizophrenia as a severe brain disease and psychiatric illness that, without treatment, interferes with the ability to think clearly, manage emotions, and interact with other people. It causes symptoms such as hallucinations, delusions, paranoia, and disorganized thinking.

Beck (1980) suggests with evidences that infants who experience birth trauma or complications while in the womb are at greater risk for schizophrenia. Maternal illness may play a part as well. A mother, who contracts a virus like the flu, especially during her second trimester, may increase the risk for her child to develop schizophrenia. It is not known, whether the virus itself or the immune response to it increases the risk. Whatever may be the cause, cognitive therapy, according to Beck, is a treatment of choice for schizophrenia.
Norquist and Regier (1996) while speaking on the epidemiology of psychiatric disorders states that winter birth may be associated with schizophrenia, especially during immune response and illness. Furthermore, viruses in the womb are more common during the winter months. This has led, according to him, some researchers to consider intrauterine viral infection during the winter as a risk factor. The same link, however, is found for major mood disorders, like bipolar disorder. Environmental factors and stress are thought to trigger the onset of schizophrenia. For example, moving, troubled relationships, problems at work, or substance abuse may aggravate the constellation of risk factors and lead to psychosis.

Fenton et. al.(1997) believes that schizophrenia is seldom curable; it requires chronic treatment to reduce suffering and to restore daily function. For them schizophrenia is a biological disease, it does not respond to changes in environment or to support therapy alone. Medication that influences brain activity is the cornerstone of treatment, and behavioural management therapy is used to support medication in most cases. Research has shown a 90% chance for recurrence in untreated schizophrenia within a year of the first episode. The chance for relapse drops to about 30% with treatment.

Lacro et.al.(2002) Points out that inpatient therapy have saved the lives of millions of people who suffer from schizophrenia. Primarily, inpatient therapy allows for emergency treatment and intervention in cases where people become suicidal, homicidal, or when diminished self-care endangers their well-being. This becomes especially important during psychotic episodes. They found that assessments of the disease and its prognosis are possible during an extended hospital stay. Furthermore, they believe that a plan may be established for management of the disease. Patients learn about their disorder, its treatment, and its prognosis in a safe, controlled environment.

Bellack (1984) suggests Partial hospitalization for the people with schizophrenia in the cases of relapse or possible doubts of relapse possibility and can be used as a follow-up to inpatient care. Other partial-care options
include living communities, like supervised housing, where medical professionals oversee daily routine and medication. Such situations allow the person to reclaim some autonomy while receiving support, maintenance, and care for their disease. Supported living situations of this type reduce the need for hospitalization and encourage recovery, as well as assimilation back into normal life after extended inpatient care.

According to Abramowitz and Coursey (1989) schizophrenia is disorder that found all over the world. The severity of the symptoms of the disorder is long-lasting, chronic pattern of schizophrenia often cause a high degree of disability. Medications and other treatments for schizophrenia, when used regularly and as prescribed, can help reduce and control the distressing symptoms of the illness. But social skills training, on an outpatient basis, if provided may give people with schizophrenia the resources they need to return to work, school, family, and self-care.

Tucker (1988) compiled all the available scientific studies of the decade that studied the genetic factors in schizophrenia. He found that scientific evidences are there on matters concerning complex genetic elements and their involvement in generating schizophrenia. He could compile the studies proving the facts like multiple genes and their involvement in creating the predisposition to develop schizophrenia. In addition, he found out in those studies the factors such as prenatal difficulties like intrauterine starvation or viral infections, perinatal complications, and various nonspecific stressors, seem to influence the development of schizophrenia. However, the scientists could not yet identify how the genetic predisposition is transmitted, and it cannot yet be accurately predicted whether a given person will or will not develop the disorder.

Shepperd (2004) Reviewed that several regions of the human genome are being investigated to identify genes that may confer susceptibility for schizophrenia. He states ‘the strongest evidence to date leads to chromosomes 13 and 6 but remains unconfirmed’. He strongly believes that identification of specific genes
involved in the development of schizophrenia will be providing important clues into what goes wrong in the brain to produce and sustain the illness and will guide the development of new and better treatments. He believes the initiative of National Institute of Mental Health, America, to learn more about the genetic basis for schizophrenia, may find the result soon and their efforts to gear up genetic Initiative to gather data from a large number of families of people with the illness will definitely unfold the secrets of the illness.

Basic knowledge about brain chemistry and its link to schizophrenia is studied by Seligman (1987) and concluded that neurotransmitters, substances that allow communication between nerve cells, have long been thought to be solely involved in the development of schizophrenia. It is likely, although not yet certain, but the disorder is associated more with some imbalance of the complex, interrelated chemical systems of the brain, perhaps involving the neurotransmitters dopamine and glutamate. This area of research is promising.

Linehan (1991) states that antipsychotic medications reduce the risk of future psychotic episodes in patients who have recovered from an acute episode of schizophrenia. Even with continued drug treatment, some people who have recovered will suffer relapses. Far higher relapse rates are seen when medication is discontinued. According to him in most cases, it would not be accurate to say that continued drug treatment "prevents" relapses; rather, it reduces their intensity and frequency. The treatment of severe psychotic symptoms generally requires higher dosages than those used for maintenance treatment. If symptoms reappear on a lower dosage, a temporary increase in dosage may prevent a full-blown relapse.

According to Masterson (1985) Schizophrenia usually first appears in a person during their late teens or throughout their twenties. It affects more men than women, and is considered a life-long condition which rarely is "cured," but rather treated. The primary treatment for schizophrenia and similar thought disorders is medication. Unfortunately, compliance with a medication regimen is often one of the largest problems associated with the ongoing treatment of
schizophrenia. Because people who live with this disorder often go off of their medication during periods throughout their lives, the repercussions of this loss of treatment are acutely felt not only by the individual, but by their family and friends as well.

Kreyenbuhl (2003) believes that achieving treatment adherence in schizophrenia is a great challenge. The reasons for lack of treatment adherence are complex, vary considerably from patient to patient, and can be categorized as follows: patient-related factors (e.g., persecutory delusions, lack of insight, health care beliefs), medication-related factors (e.g., lack of efficacy, distressing side effects), environmental factors (e.g., lack of caregiver support, ignorance) and clinician-related factors (e.g., therapeutic rigidity).

La Torre (2001) studied schizophrenia extensively and found that the level of denial of illness (the insight) among people suffering from schizophrenia is quite high. Researches he reviewed states the multiple reasons why patients with schizophrenia do not take their medication. He has indicated that patients with grandiose delusions are most likely to reject medication so as to avoid confrontation with a reality that is not so appealing for them. For example, it is much better to be lost in the delusion of being Jesus than to confront suboptimal living circumstances, such as a mental health centre. He quoted late Theodore Van Putten, M.D (Van Putten, 1974) and his colleagues to state his points, who realized that patients who had a negative initial impression of medication would be likely to discontinue medication in the future.

Francis (2004) reviewed facts and figures of schizophrenia and found stating that “it is estimated that approximately 50% of patients with schizophrenia do not take their prescribed medications as directed.” Lacro, et.al (2002) says many of the patients of schizophrenia if say particular, 65% to 75%, will relapse within one year of discontinuation. Lack of medication adherence translates into a huge economic burden of relapse and re hospitalizations (Norquist and Regier,1996). Dolder and colleagues (2002) demonstrated rates
of compliant refills of conventional antipsychotic medications to be 50.1%, compared to 54.9% for the second-generation medications.

A recent study conducted at the U.S. Department of Veterans Affairs (Valenstein et al, 2002), on the Medication Possession Ratio (MPR), a ratio of the number of days' supply of antipsychotic medication each veteran had received by the number of days' supply they needed to receive to take their antipsychotic continuously, and found that 49,003 patients with schizophrenia with poor adherence (MPR<0.8) were 2.4 times more likely to be admitted to the hospital than patients with high MPRs.

Heggarty, et.al.(1994) pointed out that the outlook for treatment of individuals with schizophrenia has changed drastically over the years due to the advancements in research, diagnoses and treatment criteria.

Kapoor (2004) while speaking about the management of schizophrenia states that advanced research advocates propagates a wide array of intervention strategies to deal with schizophrenia. Hospitalisation and psycho social treatments are extensively used and found best suitable as far as schizophrenia is concerned.

Ahuja (2004) on managing schizophrenia states that anti-psychotic medication introduced in early 1950\textsuperscript{s} have changed the entire concept and treatment procedures of mental illness especially schizophrenia. The antipsychotic drugs are mainly used to treat the disorder on symptom wise.

Horen and Toran (1995) studied schizophrenia and found clinical management is the primary choice of preference in the case of managing Schizophrenia. The clinical management vary from patient to patient covering multimode of treatments choices including hospitalisation, anti-psychotic medication as well as psychosocial treatments such as behavioural, family, group, individual and social skills and rehabilitation therapies.

Sadock et.al (2003) found that electro convulsive therapy (E.C.T) is used effectively in small percentage of schizophrenic patients particularly those
with acute catatonic type. They stated quoting researches and proved that patients in whom the illness has lasted less than one year, and in whom pharmacological treatment found non responsive are most responsive with E.C.T.

Bauman and Martin (1981) supports the view that drug therapy occupies the crucial role in reducing the psychotic symptoms like hallucinations, delusions and incoherence etc – but are not found to be consistent in reducing the behaviour symptoms of the disorder.

Liberman (1987) viewed that even when patients with schizophrenia are relatively free from psychotic symptoms through drug therapy many may be having extra ordinary difficulty with communication, motivation, self-care and establishing and maintaining relationship with others. He states “More over, because patients with schizophrenia become ill during the critical career forming years of life, they are less likely to complete the training required for skilled work and life.” as a result he believes that many with schizophrenia not only suffer thinking and emotional difficulties but lack of social, work skill as well as experience. According to him, such state of psychological, social and occupational problem anti psychotic medication alone is not as effective but drugs are coupled with psychosocial interventions can help the patients.

Smith and Birchwood (1987) stated that there are psycho-social interventions with most focus on improving the patients over all especially the increase social abilities, self-sufficiency, practical skills and skills in interpersonal communication are now available for people affected with schizophrenia. These interventions may enable the individuals who are severely ill with schizophrenia to develop social and vocational skills for independent living. These interventions are such that it can be carried out at any feasible environment effortlessly. But normally these are carried out at environmental settings such as hospitals, outpatient clinics mental health centres, day hospitals, and homes or social clubs.
These studies and reviews above indicate that medication has significant role in the schizophrenia management but other interventions also necessary to enhance the status of the people with severe mental illness, especially schizophrenia.

The reviews on Schizophrenia thus details that schizophrenia is a descriptive term used for a group of psychotic disorders characterized by gross distortion of reality, withdrawal from social interactions and the disorganization and fragmentations of perception, thought and emotion. The review presents the clinical picture of the disorder as it may vary but global impairment and the disorganization of the cognitive, connative affective faculties typifies schizophrenia. Scholars and experts in the field treats schizophrenia as a devasting mental illness of unknown causes and is probably treated among the most distressing and disabling of severe mental disorders. Since the disorder is capable enough in impairing an individual in his cognitive, connative and affective areas of performance, the significant others, both the patients and their families, suffer from poor care and social ostracism because of widespread ignorance about the disorder. Some holds the view that schizophrenia is found much the most difficult to define and describe because of its nature that it comprises a group of disorders with heterogeneous aetiologies and it includes patients whose clinical presentations, treatment responses and the causes of illness vary. Still DSM IV (TR) of American Psychiatric Association tried to give a precise picture of this disorder that it is a mental disorder characterized by delusions, hallucinations, disorganized speech, or behaviour and negative symptoms, which have been present for one-month period unless successful treatment has occurred.

Thus Schizophrenia is understood as a disorder that interferes severely with an individual’s ability to think, feel and to receive and understand sensory information. An individual’s behaviour also may be totally disturbed by the dominant symptoms like hallucinations, delusions, thought disorders and behaviour considered unusual for persons. In short Schizophrenia is such a
disabling illness that exhibits symptoms which influences a person in multiple
and complex ways of individual functioning like emotions, thoughts,
perception, memory, experience of self, movements and behaviour. The
reviews on the management found suggestive that pharmacotherapy is much
effective in reducing the manifested symptoms of schizophrenia but for the
management of behaviour disability caused due to illness and the lack of social
as well as work skill psychosocial treatments and rehabilitation are presented
suggestive and helpful.

2.5. SCHIZOPHRENIA AND REHABILITATION.

Schizophrenia is considered as most disabling among mental illnesses. It is
such a disorder that can cause ailments that can cause impairments in
psychological, social, occupational functioning of the affected. Though the
first choice of preference is anti-psychotic medication as far as schizophrenia
treatment is concerned which alone is not enough to deal with the multiple
impairments associated with schizophrenia. Many psycho-social interventions
are designed and are available for people affected with schizophrenia, with
most focus on improving the patients over all especially social functioning.
The psychosocial therapies include a variety of methods to increase social
abilities, self-sufficiency, practical skills and skills in interpersonal
communication. The main intentions of these interventions are to enable
individuals who are severely ill to develop social and vocational skills for
independent living. Normally these treatments are carried out at modified
environmental settings like rehabilitation centres. Much is spoken about the
environmental modifications and social skill up gradation and the extensive
literature on the concept is reviewed here.

Danica (1999) while speaking on psychiatric rehabilitation for schizophrenia
concludes that antipsychotic drugs are found effective for reducing the
psychotic symptoms of schizophrenia like hallucinations, delusions, and
incoherence, but are not effective in reducing the behavioural symptoms of the
disorder and the extraordinary difficulty found with the disorder for
communication, motivation, and self-care and to establish and maintain relationships with others. According to her the patients with schizophrenia normally become ill during the critical career-forming years of life (e.g., ages 18 to 35). As a result, many with schizophrenia not only suffer thinking and emotional difficulties, but also lack social and work skills and experience as well. She strongly suggests that with these psychological, social, and occupational problems the psychosocial treatments especially psychiatric rehabilitation is found the best alternative.

Deborah (2003) believes that psychosocial approaches are of high value for acutely psychotic patients especially schizophrenics (those who are out of touch with reality or have prominent hallucinations or delusions), since they have calibre for reducing the severe symptoms and lead the patients affected to a regulated and well monitored status.

Neuchterlein (2003) found that numerous forms of psychosocial interventions are available for people with schizophrenia, with focus on improving the patient's overall especially social functioning, and psychiatric rehabilitation is found extensively used among them. He came across with a facts that rehabilitative interventions are available everywhere but the forms of intervention varies greatly from place to place and need to need.

Rosen (1999) broadly defined psychiatric rehabilitation as, `rehabilitation includes a wide array of non-medical interventions for those with schizophrenia’ . He briefed the programs in rehabilitation that emphasize social and vocational training to help patients and former patients to overcome difficulties in these areas. Rehabilitation programmes may include vocational counselling, job training, problem-solving and money management skills, use of public transportation, and social skills training.

Donahoe and Driesenga (1988) find that the psychiatrically disabled persons can be helped to overcome their handicaps through rehabilitation interventions. Arieti, (1974) believes that psychiatric rehabilitation is the key element of social and instrumental role functioning to the fullest extent possible through
learning procedures and environmental support of the individual affected with schizophrenia.

Dennis et.al. (1994) Says schizophrenia rehabilitation to a certain extent depends upon how an individual affected trained under different circumstances to face a balance between over stimulating environment and under stimulating environment.

Kupers and Korten (2000) found the approaches practiced in psychiatric rehabilitation is effective and are important for the success of the community-centred treatment of schizophrenia, because they provide the patients and discharged patients the necessary skills needed to lead productive lives outside the hospital.

Emami et. al. (2001) agrees that psychiatric rehabilitation initiatives provide a broad array of activities for the discharged patients. The programs typically designed four to six hours per day, several days per week and lasts normally for months together covering activities including the activities of daily living, independent living, cooking, shopping, planning a menu and budget money. Frequently, the learning is both didactic and experiential, as participants are exposed to direct situations and show as well as make them to confront the situation.

Serrano and Sledge (2004) says that psychiatric rehabilitation initiative includes a great deal of activities including vocational training and activities including supervised work experiences, placement into volunteer jobs, or transitional employment placement to learn work skills. The Skills are taught in rehabilitation, as individuals with schizophrenia frequently found deficient in the social skills needed to make an effective living. But all these initiatives require effective environmental support and major portion of this environment falls with the family.

Cohen (1995) says social skill training is one among the major focus of rehabilitation activities of schizophrenia. The basic training in communication skills and interpersonal social skills are included in the rehabilitation programs
since the perceptual impairments and disordered thinking associated with the illness often interferes with the individuals “natural” learning of these skills and feedbacks. But the social skill training needs the back up of the original environment in which the affected person is an inherent part. Family and significant others comprises of this original environment.

Smith and Birchwood (1987.) strongly believes that the rehabilitation goals are achieved effectively only through educating the family about the illness, teaching families techniques that will help them cope with symptomatic behaviour, and reinforce the family strengths.

Horen and Toran (1995) opined that the primary objective of the inclusion of the family in rehabilitation is the promotion of mental health, Prevention of mental illness, provision of care and disability limitation of the affected family member with schizophrenia through providing effective education to the members of the family regarding the management of the affected.

Carson and Arnold (1998) feels that it is the responsibility of those charged with rehabilitation to educate the members of the family about those entitlements of schizophrenia and rehabilitation and to assist them through helping them to access them as fully as possible.

Zastowny et. al.(1992) points out that those psycho-educational programs for the families of the schizophrenics are designed primarily for the education and support in the rehabilitative intervention with better outcome. They are the result of the emergence of family self-help movement in psychiatric rehabilitation for the schizophrenics.

Halford and Hayes (1991) pointed out that in addition to providing psychological theory and drug treatment doctors and rehabilitation experts are increasingly recommending treatment programmes that may include family members.

Tarrier et.al. (1988) concludes that the family involvement in the controlled clinical studies with a believe that schizophrenia is a brain disorder responsive
to the social and familial environment have shown effects at the rehabilitation outcome for medicated, community based patients of as much as 60%.

Reviews above stated it clearly with evidence that psychiatric rehabilitation is an effective means used extensively to deal with sub average functioning of the person affected with schizophrenia in various walks of life. Psychiatric rehabilitation is widely welcomed among the experts in the field perceiving its quality and potential to reduce the behavioural symptoms of schizophrenia as well as an instrument to treat the derailed social skills of the person affected. Psychiatric rehabilitation for schizophrenia presupposes the environmental modification. (Serrano and Sledge, 2004). Psychiatric rehabilitation and associated interventions other than medication is possible only through the effective modification of the environment of the person affected. Family constitute the lion’s portion of the environment of an individual affected with schizophrenia. There is much said about the involvement of family in the rehabilitation process of individual with schizophrenia but practically no literature is available stating the significance or impact of educating the family or family members of the person undergoing rehabilitation process for schizophrenia. Extensive research is needed in this area to come up with suggestive statements and on matters concerning psycho education and its impact on schizophrenia rehabilitation extensive areas are there to be explored of still.

2.6. SCHIZOPHRENIA AND FAMILY

As schizophrenia and rehabilitation studies got popularity and acceptance, the significance of involving the family members in the treatment of person affected with schizophrenia got wider welcome and hence the matter is well studied and described even. So many investigations were conducted extensively on the issue and the results were propagated with much suggestive affirmation. The major advocates of the involvement of family in the treatment of schizophrenia comprises of a number of experts covering Tarrier (1988), Barrowclough (1988), Vaughn (1988), Liberman (1988), Bamrah (1988)
Porceddu (1988), Watts (1988), and Freeman (1988) etc. The suggestive statements on family and schizophrenia are reviewed here.

Ta-Hsu Syui (2003) studied and examined the relationships among contextual factors including dimensions of family, social and environmental support adaptations and psychiatric symptoms among mentally ill Taiwanese adults in a mental health hospital in southern Taiwan. The study tested the effect of the dimensions of family, social and environmental support adaptations as well as whether family, social and environmental support adaptations moderated the relationship between psychiatric symptoms and adaptation. The study came up with the conclusion that family, social and environmental support adaptations enhances an individual's ability to cope and adapt to daily life events and stressors and consequential reduction of relapse.

Mueser and Glynn (1995) conclude that family is the key stake holder in the treatment of the person affected with schizophrenia. The needs and preferences of adult family members of individuals with schizophrenia may be diverse and varied. So also the level of knowledge regarding the illness in them and interest in matters concerns the treatment of the patient or illness. The family has to be oriented well regarding the illness and the families may be benefited from ongoing provision of information and support tailored to meet the families' individual needs at the context of an ill relative at home as well as the patients' therapeutic needs. Continued efforts should be made to understand and address the patients and family needs, potential barriers to participation of family in rehabilitation or treatment services, and the relationship between stigma and family need.

Randolph (1994) et. al found in their effort to include families in the treatment of schizophrenia after the provision of primary orientation about the biological nature of the illness and the principles for treatment (especially medication compliance, attention to early warning signs, reducing stress, and providing a supportive environment). Gradually after the induction the family is treated as an ally by the treatment team and is discouraged from feeling guilty or to blame.
for the patient's illness or its course. The outcome with the patient found progressive and incidents of relapse found reducing considerably.

Amy and Tina (1999) conducted a study on Unmet Needs of Families of Adults with Mental Illness and Preferences Regarding Family Services with an objective to assess the information and educational needs of family members of adults with mental illness especially schizophrenia and their preferences regarding how to address those needs. On average, family members found with reporting a substantial number of unmet needs (mean±SD of 7.09±4.71 needs; possible number of needs ranges from 0 to 16), often despite prior receipt of information. Family members' experiences of stigma and having an ill relative with a more recently occurring condition (for example, a younger relative or a shorter length of illness) or with a disabling condition (for example, recent hospitalization) were significantly associated with a greater number of unmet needs. Family members preferred that a mental health provider (27%) or social worker (63%) address their needs on an as-needed basis (58%).

Shirley et. al (1999) studied The Potential Impact of the Recovery Movement on Family Interventions for Schizophrenia: Opportunities and Obstacles and concluded that Many types of family interventions have been found to be effective in reducing exacerbations in schizophrenia; some also improve patient social functioning and reduce family burden. Regardless of their origins, these interventions share a number of common features, such as showing empathy for all participants, providing knowledge about the illness, assuming a nonpathologizing stance, and teaching communication and problem-solving skills. Importantly, these family interventions have many characteristics that are consistent with the growing recovery movement in mental health in that they are community-based, emphasize achieving personally relevant goals, work on instilling hope, and focus on improving natural supports.

Susan and Allan (1995) in their study Research-based Family Interventions for the Treatment of Schizophrenia found that One of the most prominent advances in psychosocial treatment in the past 15 years has been in the area of family
interventions, with several well controlled long-term research studies reporting positive effects on the course of the illness when families provided with proper knowledge about the illness and are included in the treatment program.

A psycho educational workshop is conducted by Schooler and Keith (1997) for the members of the family of the persons affected with schizophrenia who are undergoing treatment. Regular meetings were held with the family, ranging from weekly to monthly. Support was provided by the treatment experts and multi disciplinary team. The intervention designed was of long-term, usually lasting 2 years. Families’ were assisted in knowing the disease, improving their coping methods to varying aspects of the illness and the symptoms as well as their communication with each other. The treatment and multi-disciplinary team members coordinate frequently with each other and outside agencies. Medication is followed closely, with rigorous attempts made to maximize compliance. The positive outcome was amazing and unbelievable.

Glick (1998) found that some elements of family intervention seem much beneficial for the patient with schizophrenia since that help the patient to get well along with the disease situation through proper environmental facilitation. They support the view that family intervention appears to be effective in treating the person affected with schizophrenia at home or at the clinic and experts from a variety of professional backgrounds should be utilized for facilitating families for involving in treatment procedures.

Henry (2000) conducted a study for understanding ‘role of family in the treatment of mental illness’ and formulated an ongoing monthly support group of the significant others of person with schizophrenia which meet for 90 minutes for every month and continue the theme of the study by carrying on with discussions. Families were provided with opportunities to know the disease, its features, signs and symptoms, and training to manage the patient through individual sessions focusing on individualized learning and provided opportunities for the families for practicing specific ways to communicate and solve problems in less stressful ways. The outcome found with commendable
changes with the family members and the attitudinal variation of the significant others affected with schizophrenia toward the patient and treatment.

Leff and Sturgeon (1985) compared their version of family intervention to routine outpatient care for patients who lived with or had frequent contact with relatives who measured high in Expressed Emotion (EE), as measured by the Camberwell Family Interview. The family intervention involved both individual sessions and multiple family support groups. It was aimed at providing education, training for the family to manage the patients on symptomatic status, reducing expressed emotion in the family and increasing the patient's independence from high expressed emotion relatives. During the first 9 months of treatment, half of the patients who received routine care relapsed, compared to 8% of patients whose families received intervention. After 2 years, there was a 50% relapse rate for the family intervention compared to 75% for the group receiving treatment as usual. However, if the data are analyzed looking only at patients who continued medication, relapse rates are 20% versus a significant difference in favor of family intervention.

Falloon, et.al. (1984) compared home-based Behavioral Family Therapy (BFT) to clinic-based individual psychotherapy. Patients were selected based on having high expressed emotion relatives. Behavioral family therapy provides education about the illness, its nature, symptoms and warning signs of relapse, communication skills training and problem-solving training to the whole family, including the patient. After nine months, there were several advantages for patients treated in the behavioral family therapy including fewer symptom exacerbations (6% versus 44%), increased remission of symptoms (56% versus 22%) and reduced number of hospitalizations (11% versus 50%). After 2 years there continued to be a positive effect for the behavioral family therapy group condition regarding symptoms, with 83% of the behavioral family therapy patients avoiding a major exacerbation compared to 17% of individually treated patients.
Hogarty et. al (1991) compared medication alone to medication and three psychosocial treatment approaches covering psycho education to the family members for patients who lived in high expressed emotion households (n=103). One group of patients received social skills training (SST), one group received family psycho education (clinic-based) and one group received both social skills training and family psycho education receiving customary care and the other receiving clinic-based Behavioral Family Therapy (BFT). This study included both low and high expressed emotion families. After 1 year, 14% of the patients in the family psycho education treatment condition experienced symptom exacerbation compared to 53% of patients in the customary care and psych therapy condition.

Xiong et.al (1994) conducted a study at China, randomly assigning 63 patients to receive standard care or standard care plus a family-based intervention. The family intervention included multiple family groups and individual sessions focusing on education, behavioral training, and problem-solving and crisis intervention. After 1 year, 33% of the patients who received family treatment relapsed, versus 61% of the control group, and 12% of the family group were rehospitalized, versus 36% of the control group.

With an intention to examine the effects of a behavioral family intervention and a family support program on communication, problem solving skills and in order to determine the impact of structured family involvement in treating the person with schizophrenia. Bisbee (1991) conducted a study and found that Family interventions that aimed at imparting proper knowledge about the nature and feature of the illness to the significant others of the patients with schizophrenia have proved to be highly effective in preventing relapse, but it is not clear how they work or how they should be structured.

Wong (2006) states in his ‘clinical case management for people with mental illness: a bio psychosocial vulnerability-stress model’ that there is sufficient scientific evidence to conclude that strategies that enhance the care giving capacity of family members and other people involved in the day to day care
for people with mental disorders have a clinically significant role on the course of major mental disorders and the evidence is strongest for schizophrenia and bipolar disorders.

Stanley and Platman (2000) of Maryland’s Department of Health and Mental Hygiene conducted a study on ‘Family Caretaking and Expressed Emotion: An Evaluation’ and found that ‘recently more and more families have assumed the role of primary caregiver for their schizophrenic relatives. The author enumerates the needs of care giving families and reviews the work of researchers involved in family therapy approaches to the treatment of schizophrenia. After discussing theories based on the concept of expressed emotion—that is, the amount of hostility, intrusiveness, or criticism expressed by family members toward the schizophrenic relative—the author examines the effects of contact with families exhibiting high expressed emotion on patient relapse. He suggests that high expressed emotion is not a characteristic unique to families of schizophrenic patients and calls for further standardized research among families who care for individuals with other mental disorders.

David and Terry (2003) conducted a study on ‘Using Family Consultation as Psychiatric Aftercare for Schizophrenic Patients’ and came across with the facts that the families of 14 schizophrenic patients who were discharged from hospital, i.e. the samples, were provided with periodic consultation at their homes from members of multi disciplinary team. The team members educated the families and the patients about community resources, consulted with them about interpersonal problems, and were available for crisis intervention following the last scheduled visit. Three months and one year after their discharge, the patients were compared on various measures of outcome with a control group of 22 similar patients whose families did not receive periodic consultation. At the three-month follow-up, patients whose families received consultation had spent significantly fewer days in the hospital that had the control patients.
In his work ‘Family Treatments of Schizophrenia: Background and State of the Art’, Christian (2002) observes that Schizophrenia, appears as an illness that cause failure to achieve maturity and independence, has always had distressing effects on a patient's family. He explains that scientific theories that propose the family itself as a contributing factor in the treatment and have eroded the alliance between professionals and family members. The initiative in designing family therapy for schizophrenia began among an early group of innovators who subscribed to strong family-theory ideologies. He found that today a more pragmatic group, trained in various research methodologies, has taken the lead. The authors discuss the historical development of family therapy for schizophrenia and review new programs including relatives' groups, psycho educational family therapy, and strategic and systemic approaches.

Reviews above states it clearly that experts in the fields of psychiatric treatment and management has been started recognising and considering family intervention as an effective means to involve family in the treatment process for the better treatment outcome of the person affected with schizophrenia. Recently family intervention is widely welcomed among the experts in the field perceiving its quality and potential to the family support for the treatment of schizophrenia. Family intervention in the treatment of schizophrenia facilitates the environmental modification that is necessary for better treatment outcome. (Serrano and Sledge, 2004). Family intervention facilitates the effective modification of the environment of the person affected with schizophrenia which constitutes the lion’s portion of the non medical intervention for the individual affected with schizophrenia. There is much said about the involvement of family in the treatment process of individual with schizophrenia but practically no literature is available stating the significance or impact of educating the family or family members of the person undergoing treatment for schizophrenia.
2.7. SCHIZOPHRENIA AND FAMILY PSYCHO EDUCATION

Psychiatric treatment and management has been started recognising and considering family intervention as an effective means to involve family in the treatment process for the better treatment outcome of the person affected with schizophrenia. Recently family intervention is widely welcomed among the experts in the field of schizophrenia treatment and management after perceiving its quality and potential to influence the treatment outcome and attempts were made to ensure the family support for the treatment of schizophrenia. Family intervention facilitates the effective modification of the environment of the person affected with schizophrenia well, which constitutes the lion’s portion of the non medical intervention for the management of individual affected with schizophrenia. In order to ensure the family support and facilitate family inclusion, the significant others of the person affected with schizophrenia has to be oriented and educated well and a single means to attain this initiation is through educating the family members in a proper manner. Many experts in the mental health field like Anderson (1983), Glick (1998), Hogarty (1994), Reiss (1980), Henry(2000), Hooley(1995), etc have recognised the fact and studied the matter extensively. The literature available is reviewed here.

Lefley et.al (2002) defines that family psycho education for schizophrenia is a method based on clinical findings for training families to work together with mental health professionals as part of an overall clinical treatment plan for their family members. Family psycho education has been shown to improve the knowledge of the family about the disease condition and the management that ultimately leads to better patient outcomes for persons with schizophrenia and other major mental illnesses.

The term "psycho education" in the field of schizophrenia treatment was first employed by Anderson et al (1983) and was used to describe a behavioural therapeutic concept consisting of 4 elements; briefing the patients about their illness, problem solving training, communication training, and self-
assertiveness training, whereby relatives were also included.

Family psycho education according to Daiuto and Stickle (1998), is an effective means to assist the significant others of the patients with severe mental illnesses to know the disease and accordingly intervene, and to promote their loved ones re-entry into their home communities, with particular regard for their social and occupational functioning. The family psycho education programs seek to provide families with the information about the various aspects of the illness and the coping skills that the family develops accordingly will help them to deal with their loved one's psychiatric disorder. The family psycho education, according to them, even will be capable enough in providing support for the patients' families of professional, emotional and social realm. Families experience many burdens (financial, social, and psychological) in serving as long-term caregivers for their loved ones. Although the primary focus of family psycho education groups is improved patient outcomes, an essential intermediate goal is to promote the well-being of the family.

Lowson and Barrowclough (1991) found that the term family psycho education was developed and used first by Anderson et al. (1980). It is a specific, empirically-based method of intervention that includes an intensive engagement effort with family and patients, extended education about the disease and its treatment, and guidelines for recovery based on research and best clinical practices. It pursues a careful, gradual intervention process that promotes a strong stable symptomatic recovery and relapse prevention, followed by an equally careful social and vocational rehabilitation effort, and problem solving based on the needs of both family and patient. Lowson and Barrowclough (1991), views that Anderson (1980) translated her long experience working with families of patients with schizophrenia into a standardized approach that emphasizes partnering with family members, extended joining effort, incorporating family and patient desires and ambitions as the core of the treatment plan, and empathic acceptance of the family's suffering, burdens, and frustrations in caretaking.
Cook and Laris (2000) has extensively studied about family psycho education for the persons affected with schizophrenia and found that the concept of educating the family is originated from several sources in the late 1970s. Perhaps the leading influence behind the generation of family psycho education was the growing realization that conventional family therapy, in which family dysfunction is assumed and becomes the target of intervention for the alleviation of symptoms, proved to be at least ineffective and perhaps damaging to patient and family well-being. As efforts to develop and apply family therapy to schizophrenia and other psychotic disorders waned, awareness grew, especially among family members themselves and their rapidly growing advocacy organizations, that living with an illness such as schizophrenia is difficult and confusing for patients and families alike. The aftermath is a much effective system, the family psycho education.

West and Snyder (1988) describes the term psycho education for schizophrenia to explain about the activities comprises of systemic, didactic-psychotherapeutic interventions, which are adequate for informing patients and their significant others about the illness, the symptoms, characteristics and its treatment, and facilitating both an understanding and personally responsible handling of the illness as well as supporting those afflicted in coping with the disorder. They found that the roots of psycho education are to be found in behavioural therapy, although current conceptions also include elements of client-centred therapy in various degrees. Within the framework of psychotherapy, psycho education refers to the components of treatment where active communication of information, exchange of information among those afflicted, and treatments of general aspects of the illness are prominent.

Henry and Holly (2001) during their presentation on ‘Building Collaborative Relationships with Families of the Mentally Ill’ during first Division of family psychotherapy training at Cambridge Hospital, 1493 Cambridge Street, Cambridge, stated that Studies of the expressed emotion construct have demonstrated that educational programs aimed at helping families deal with a
mentally ill member can reduce patient relapse rates and improve family coping. They described the clinical approach to family psycho education focused on building collaborative relationships with mental health professionals. The approach, according to them should be based on the assumption that family education will benefit the patient, but any implication that the family is to blame for the patient's illness is studiously avoided. They suggested that five tasks that must be addressed in beginning work with families of the mentally ill. They are ensuring that the family has a chance to be heard, imparting information, helping the family deal with the feelings engendered by the patient's illness, identifying the family's coping patterns, and helping the family face the ethical and existential conflict between their own needs and those of the patient.

Lorenza. et al. (2006) conducted a study on ‘Patient Functioning and Family Burden in a Controlled, Real-World Trial of Family Psycho education for Schizophrenia’. Through the study they explored the effectiveness of a psycho educational family intervention for schizophrenia on patients' personal and social functioning as well as on relatives' burden and perceived support covering thirty-four mental health professionals from 17 public mental health centres in Italy. They selected 71 families of patients with schizophrenia. Forty-two families were randomly assigned to a group that received the intervention for six months, and 29 families were assigned to a waiting list for six months. At baseline and six months later, validated tools were used to assess patients' clinical status, personal and social functioning, and social network as well as relatives' burden, social resources, and perception of professional support. And they came across with the result that in the intervention group the number of patients with poor or very poor global personal and social functioning decreased significantly, from 17 (47 percent) at baseline to nine (25 percent) at follow-up. A significant improvement was found for the intervention group in patients' social relationships, interests in obtaining a job, maintenance of social interests, and management of social conflicts. Twenty-seven patients (74 percent) reported that their social relationships had improved during the six-
month period. For both the intervention and control groups, family burden significantly improved. Relatives' social contacts and perception of professional support significantly increased only in the intervention group. And they reached at conclusions that a psycho educational family intervention may have a significant role in determining the functional outcomes of schizophrenia when provided to patients and caregivers in real-world settings.

Jeanie (2003) finds the family psycho education for schizophrenia can influence relapse rate, is cost effective. She finds that families can negatively react to a family member's symptoms of schizophrenia with confusion, anger, misunderstanding, hostility, criticism or even over-protectiveness, over concern, over alert and high sensitivity. These reactions from within a family is referred to as the families "high expressed emotions". A family with "low expressed emotions" is described as one wherein the family members are supportive to the treatment and this can be achieved through family psycho education. She believes and states with evidence that people with schizophrenia living in families with a high level of expressed emotion (EE) are at greater risk of relapse than those living in low EE households. "Family psycho education" is a process in which the whole family is taught about the patient’s psychiatric illness, and therefore lowers the level of EE in the household.

Mueser and Haas (1999) studied Family psycho education programs for the persons with schizophrenia and found that the subject have been studied extensively and refined by a number of researchers, including Drs. Ian Falloon(1984), Gerald Hogarty(1994), William McFarlane (1995), and Lisa Dixon(1995) and they could find that these eminent personalities have proposed different methods called ‘models of family psycho education’. Although these methods share common facts and elements, they includes single- and multiple-family groups as well as mixed groups that which comprises of family members and patients groups of varying duration of treatment. But according to Mueser& Haas among the entire methods, single family group excluding the patients found much consistent bringing the
positive outcome.

Researchers observe that family psycho education should not be neglected. If neglected that may be due to the mental health providers' under appreciation and lack of knowledge about the importance of family psycho education in relapse prevention and hopelessness of the significant others, in that, some family members may believe that nothing of this sort will help. Patients may experience some of the same hesitations as their family members about participating in family psycho education. In addition, they may worry about losing the confidential relationship with their treatment teams and about losing autonomy. (Dixon & Lehman, (2001); Solomon, (1996)).

Lisa et.al (2005) of University of Maryland School of Medicine reviewed in detail 15 new studies on family interventions for the patients with schizophrenia to consider issues around the implementation of family interventions in present day mental health practice. The data supporting the efficacy of family psycho education remain compelling. They propagate that such programs should remain as part of best practices guidelines and treatment recommendations especially for the treatment for schizophrenia. However, assessment of the appropriateness of family psycho education for a particular patient and family should consider the elements like the interest of the family and patient; the extent and quality of family and patient involvement; the presence of patient outcomes that clinicians, family members, and patients can identify as goals; and whether the patient and family would choose family psycho education instead of alternatives available in the agency to achieve outcomes identified.

Burland (1998) says that the family psycho education should be designed carefully and would not be unrealistic and contented with too many elements of communication training, problem solving, training of social competence, etc that may add to the burden of the family. According to him the contents of family psycho education were to be suitable even for integrated into short-term treatment programs. Significant improvements in the psycho education
Goldstein and Miklowitz (2000) concluded that family psycho education for people afflicted with schizophrenia was highly effective when compared to standard care or medication alone. Going beyond basic efficacy of family psycho education, they described a number of studies in progress or very recently published that addressed the question as to whether there were technical variants that were more or less effective and/or specific subpopulations of patients with schizophrenia for which family psycho education for people with schizophrenia was considered superior. They went on to note that in the U.S., where the bulk of the research had been done, there was little application in routine clinical practice. In the U.K., by contrast, there was at least one national and one major large urban initiative to implement the family psycho education. Finally, they noted that family psycho education had begun to be tested by experts on other psychotic disorders, beginning with bipolar disorder and the result was positive.

Susan et. al. (2008) conducted a study on family led education on family members of adults with schizophrenia who often experiences emotional distress and strained relationships. The major objectives of the study were to test the effectiveness of family-led educational interventions, the journey of hope, in improving participants' psychological well-being and relationships with their ill relatives. They applied a randomized controlled trial using a waiting list design was conducted in the community in 3 south-eastern Louisiana cities and a total of 462 family members of adults with mental illness participated in the study, with 231 randomly assigned to immediate receipt of the journey of hope course and 231 assigned to a 9-month course waiting list. The Journey of Hope intervention consisted of 8 modules of education on the aetiology and treatment
of mental illness, problem-solving and communication skills training, and family support. The Participants’ psychological well-being and relationships with their ill relatives were assessed at study enrolment, 3 months after enrolment (at course termination), and 8 months after enrolment (6 months after course termination). Mixed-effects random regression analysis was used to predict the likelihood of decreased depressive symptoms, increased vitality, and overall mental health, and improved relationship ratings. They come across with results that intervention group participants reported fewer depressive symptoms, greater emotional role functioning and vitality, and fewer negative views of their relationships with their ill relatives compared with control group participants. These improved outcomes were maintained over time and were significant (P<.05 for all) even when controlling for participant demographic and relative clinical characteristics. In the light of the study they concluded that the family-led educational interventions are effective in improving participants' psychological well-being and views of their relationships with ill relatives.

Weiden (2003) after assessing various treatment strategies suggests that multi-family groups, which bring together several patients and their families, can lead to better treatment outcomes than single-family psycho education groups.

Boise and Eskenazi (1996) reviewed the researches conducted over the last few decades as part of their research and has supported the view that the evidence-based practice guidelines for addressing family-members' needs for information, clinical guidance, and ongoing support is essential and facilitatory for positive prognoses. The researchers have demonstrated that meeting the needs of family members also dramatically improves the treatment outcomes. They came across with different viewpoints of family interventions that address schizophrenia through sensing the needs of family members and significant others of the person affected with the illness like, individual family consultation; professionally-led family psycho education (Anderson et al. 1980; Falloon et al. 1984), in single-family and multifamily group formats (McFarlane, 2002): various forms of more traditional family therapies (Marsh,
2001); and a range of professionally-led models of short-term family education-sometimes referred to as therapeutic education (Amenson, 1998; Marsh, 2001). They have also spoken of family-led information and support classes or groups such as those of the National Alliance for the Mentally Ill (Burland, 1998; Cook and Laris, 2000). They found that among these methods, family psychoeducation has a deep enough research and dissemination base to be considered an evidence-based practice. They feel that the description "psycho education" can be misleading; family psychoeducation for schizophrenia may include many cognitive, behavioural, and supportive therapeutic elements, often utilized as a consultative framework, and shares key characteristics with other types of family interventions.

Snyder and Mintz (1988) studied the family factors and the course of schizophrenia and bipolar affective disorder and found that the origins of multiple-family group therapy go back as far as 1960, when these groups were first assembled to solve ward-management problems in a psychiatric hospital. The programs provided their participants with information about mental illness, its symptoms and treatment; medication and its side effects; how to communicate with a person with mental illness; and techniques for crisis intervention and mutual problem-solving. Initially these family interventions were promoted with an intention to help the mental health professionals with the necessary family support for treatment facilitation. In due course of time it was perceived that family psychoeducation has much role to play with regard to the prognoses than mere assuring treatment facilitation.

Pekkala and Merinder (2002) stated that family psychoeducation has emerged as an intervention of choice for schizophrenia, bipolar disorder major depression, and other disorders in late seventies. More than 30 randomized clinical trials have demonstrated reduced relapse rates, improved recovery of patients, and improved family wellbeing among participants of family psychoeducation programs for the person affected with psychoses. Interventions common to effective family psychoeducation programs are activities including
empathic engagement, education, ongoing support, clinical resources during periods of crisis, social network enhancement, and problem-solving and communication skills.

Danica and Robert (1984) in their work ‘Involving Families in Rehabilitation Through Behavioural Family Management’ states that a wide variety of family psycho educational approaches for persons with serious and persistent mental illness like schizophrenia have been developed and used by mental health professionals since the introduction of such approaches. The types of interventions that have tried comprises of a series of educational sessions followed by training in communication and problem-solving skills. Behavioural learning principles were also even tried to promote the acquisition of knowledge, coping skills, and problem solving for families. Most of these approaches have in common an adherence to practical goals that are individualized for each family and an educational rather than a "therapeutic" slant. Most of the intervention strategies comprises of academic detailing, consensus building among all stakeholders, and the development of modules consisting of trainers' manuals, patients' workbooks, etc. The ultimate intentions of these initiations are to attain maximum positive output and the result is found with consecutive reduction in patient relapses and a raise in the families’ confidence in professional interventions for managing the illness.

Leff (1994) says after analysing the studies and experiments available that the application of family psycho education in routine settings is essential where patients admitted with severe complicated psychiatric disorders such as schizophrenia which required full family support for intervention. Through family and family advocacy organizations, clinician training, and ongoing technical consultation and supervision, the family psycho education has to be promoted in routine clinical settings since it has the power to influence the relapse and bring positive prognoses.

Dixon et. al. (2000) recently outlined the characteristics of successful family psycho education programs. That includes; the programs considering mental
illness an illness like any other, that are led by mental health professionals, that are part of a total treatment plan, that includes medication, families are treated as partners rather than patients, the programs focus primarily on patient outcomes, secondarily on family outcomes, the programs differ from traditional family therapy in that they do not treat families as part of the problem; they see them as part of the solution.

Ho(1996) is of the opinion that while planning post treatment interventions like family psycho education, formulation of realistic and coherent goals are of particular importance for all involved in the programme namely the patients, relatives, and professional auxiliaries in order to avoid adverse effects. Greatest care has to be taken while imparting psycho education to the significant others of person affected with schizophrenia since the limitations like narrow time frame in which the intervention is to be carried out; goals are set which are too high and indeed unattainable that can be potentially dangerous.

McDaniel and Weber (1988) studied family psycho education and found that a large body of evidence supports the use of family psycho education for schizophrenia as a "best practice" for young adults and their families. Because of this compelling evidence, researchers at the University of Maryland, as part of the Schizophrenia patient outcomes research team (PORT), identified family psycho education as an evidence-based practice that should be offered to all families. This and other research studies have shown considerable influence of family psycho education on relapse and rates of rehospitalization among patients and families participated in the programme. Other outcome includes increased rates of patient participation in rehabilitation and other programs and employment; decreased costs of care; and improved well-being of family members.

Pearson (1995) in his work ‘Mental health care: professional services and family responsibilities’ conducted a meta-analysis of 16 individual studies of family psycho education have been conducted outside the United States of America and found that family interventions of fewer than 10 sessions have
reduced effect on the reduction of family burden of the persons affected with schizophrenia.

Hatfield & Lefley (1987) came across with a multitude of studies that have demonstrated clear superiority of psycho educational family interventions as compared with standard treatments. They states that the super ordinate goal of family psycho education can be seen in patients and their relatives acquiring basic competency in order that they may reach well-informed and self-competent decisions as to which of the modern therapeutic options—medical, psycho therapeutic, psycho social —are recommendable and suitable in the case of their significant other.

Horvath and Luborsky (2004) says the family psycho education provides training for the members’ of the families of the person affected with schizophrenia to assist in creating an optimal psychosocial environment for recovery, especially one that is somewhat quieter, less intense, less complex, and moves a bit slower than the world in general.

Mueser and Glynn (1999) Family psycho education sessions are quiet often neglected, though which should not be done for the good of the illness, since such programs are normally scheduled when facilitators are available, but doing so may not mesh with potential participants' needs. Family members report significant burdens that may pose barriers to attendance though attendance may lighten these burdens.

Kuipers (1980) assessed the psycho educational procedure within the framework of a multicenter study. A total of 236 patients suffering from a psychosis from the group of schizophrenic disorders (DSM IV-R/ICD-9) and their relatives were included in the study; 125 patients took part in psycho educational intervention groups and 111 patients together with their relatives were assigned to the control group. Assignment was carried out randomly. Patients and relatives each received 8 independent psycho educational group sessions starting during the stay of the patient in a medical institution. The result was alarming; rehospitalisation rates and days in hospital after 2 years
were reduced considerably in the intervention group. It was thus possible to show that a short-term psycho educational intervention including patients and their closest relatives can have an effect on rehospitalisation rates and the number of days spent in hospital.

Linszen (1993) states that a key feature with the family psycho education is that its strong commitment to help the family members or the significant others of the person affected with schizophrenia to come up to the level even to solve problems raised by the persons affected with schizophrenia, that are properly the area of the mental health professionals. Much of the intervention strategies were derived and taken from structural family therapy but with a difference in application.

McFarlane et al, (1995) found with explaining that the basic psycho education session provided to the family together with expedient relapse prevention techniques may be adequate in providing stability in the prognoses and the significant reduction in the status maintained for the patients suffering from a less severe schizophrenic clinical course. But in the case of more seriously impaired patients, well planned systematic involvement with long term objectives and more differential therapeutic options are required bring notable result in the status maintained.

Rodnick(1992) affirms that psycho education is by no means a challenge or substitute to cognitive behavioural therapy or other forms of psychotherapy in general. On the contrary, psycho education, for him is to be seen as a precursor and catalyst for subsequent complementary psychotherapeutic and psychosocial treatment strategies, such that patients and their relatives are in a position to discover the form of treatment which is optimal for their respective phase of illness.

Solomon et. al (2002) finds that there is some evidence that individualized family psycho education have more benefit (than group psycho education) for families who already have ample natural supports or are part of a support group (Solomon, 1996; Draine, & Mannion, 1996). But McFarlane (2002) believes in
Multifamily groups are specifically more effective than single-family format for patients who respond only partially to medication, families with high expressed emotion, and first episode cases.

Paz and Leong (1994) found that there are also several controlled studies that support the effectiveness of single-and multiple-family interventions for bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa, and borderline personality disorders. They found that unfortunately, putting family psycho education into effect in clinical settings has not kept pace with researches. They could find only 31% of families who have reported that they received information about their illness. One recent strategy to expand these programs includes integrating family psycho education into assertive community treatment programs.

Boyd, & McGill (1984) observes that the very strength of family psycho education lies in the deliberate focus upon patients and their significant others attaining basic competence in the area of managing mental illness especially schizophrenia. In light of the feelings of helplessness and overload with which many patients and their families are confronted, especially at the onset of the illness, family psycho education is in no way of secondary importance. On the contrary, it is only when the family psycho education and the requisite therapeutic measures have been established that more continual and specific results can be achieved. Also, the family will be helped to handle the situations on exacerbations.

Mueser & Glynn (1999) finds that on the individual family member and patient level, effective family psycho education models include strategies for overcoming barriers to participation such as the family's sense of hopelessness and stigma.

According to Eberlein and Sturgeon (1982) psycho education is ascribed as a basal psychotherapeutic function, setting the general course for successful long-term coping in the case of first episode patients of schizophrenia and adjusting the course once again for relapsed patients of schizophrenia. Through the
employment of well-established elements from supportive and cognitive behavioural therapy, it is possible to draw up a pragmatic therapy concept which accommodates the specific needs of the afflicted patients at the same time as incorporating their unquestionably retained resources.

May, & Steinberg (1998) states on the basis of a successful psycho educational program they have conducted that psycho education programme including sufficient pharmaco therapeutic intervention can facilitate the relapse prevention. They hold the view that numerous continuative treatment methods can be built up in the sense of a family psycho education and interventions such as supportive therapy, cognitive behavioural therapy, psychosocial support, etc.

World schizophrenia fellowship observes (1998) that if family members perceive that "training" through family psycho education includes expectations they will take on yet more care-giving responsibilities, they may stay away from family psycho education programmes.

Reiss (1980) finds that even with the conceptual changes and advancements in treatment strategy, it took long years for interest and effort in involving families in the treatment of persons with severe mental illness especially schizophrenia. Though it emerged with an entirely different ideology investigators began to recognize the crucial role families played in outcome after an acute episode of schizophrenia had occurred and endeavoured to engage families collaboratively, sharing illness information, suggesting behaviours that promote recuperation, and teaching coping strategies that reduce the families' sense of burden.

Marsh & Johnson (1997) finds that psycho education occupies a very significant role as far as the treatment of schizophrenia is concerned and is indeed a method easily accessible for all patients with mental illness especially the patients with schizophrenics and their significant others. Psycho education should ensure a comprehensive introduction into the realm of psychoses for patients and the families with a first episode of schizophrenia and train the recurrent patients and the significant others with the relapse sings and of the
latest developments in terms of treatment options. It will help the patients and
the families with the alarming signs of relapse and it can be effectively
addressed.

Pickett. et al. (2000)views that the family psycho education programs should be
professionally created and led, offered as part of a treatment plan for the patient
affected with schizophrenia and their significant others, and should be usually
diagnosis-specific. The type of intervention (multiple-family, single-family,
relatives only, combined), structure (involvement or exclusion of patient),
duration and intensity of treatment, and setting (hospital or clinic, home) may
vary. If provided effectively the family psycho education provides variable
emphasis on didactic, emotional, cognitive behavioural, clinical, rehabilitative,
and systemic techniques. Most have focused first on patient outcomes, although
family understanding and well-being are assumed necessary to achieve those
outcomes.

Adamec (1996) views that a well-functioning family who have a person with
mental illness especially schizophrenia must have to possess the available
knowledge about the mental illness itself and coping skills specific and
particular to the disorder that may influence the treatment outcome. A most
adaptive family was increasingly seen to be the one that has access to correct
information, with the implication that the treatment system is a significant
source of that information. Family psycho education also adds to it and
ultimately the treatment outcome is influenced.

Schooler et al (1997) found no significant difference in relapse rates between
families receiving the more intensive program that consisted of a simplified
version of cognitive behavioural family intervention plus a multiple family
group and those receiving a less intensive psycho educational (supportive)
multifamily group program. They also found that though the World
Schizophrenia Fellowship and others have delineated the core components of a
successful family intervention like psycho education, the minimal ingredients
are still uncertain.
Cochrane and Rogers (1997) found that family psycho education helps the families to develop coping skills, sometimes many families develop methods of dealing with positive (psychotic) and negative (functional and cognitive deficits, such as flattened affect, loss of energy and apathy) symptoms, functional disabilities, and the desperation of their ill relatives through painful trial and error. They also found that those families who have access to each other to learn of other families' successes and failures, and to establish a repertoire of coping strategies that are closely tailored to the disorder that affected their significant other has vital significance with regard to the coping pattern. Further, family members and significant others involved in the lives and care of adults with serious mental illnesses especially schizophrenia often share emotional and instrumental support, and case management functions if provided opportunity.

Falloon et al. (1999) states that the family psycho education for schizophrenia presupposes the notion that schizophrenia is a brain disorder that can only be partially remediable by medication, and that families can have a significant effect on their relative's recovery. Thus, the family psycho education shifted away from keeping families away from treatment to get the families involved through changing their attitude towards the patient through education and persuasion that can facilitate or impede recovery of the patient by compensating for deficits and sensitivities specific to schizophrenia.

Marchal and Crilly (1995) found that family psycho education can facilitate the expansion of the families' networks with other families who have similar problems that occur through mutual problem solving, direct emotional support, and out-of-group socializing. In two different studies at seven simultaneously replicating sites, they found, multifamily groups were shown to be more effective in handling the patients and expressed emotions than a single-family, in a combination of family psycho educational and behavioural family interventions.

Cuijpers (1999) believes that delivery of the appropriate components of family
psycho education to patients and families appears important in determining outcomes of families and patients. Several studies (Greenberg 1997, Greenley and Kim, 1995) have demonstrated that programs fail to reduce relapse rates if they present information without also providing family members with skills training, ongoing guidance regarding illness management, and emotional support. Information-only interventions also tend to be quite brief; a metaanalysis of 16 studies found that family interventions of fewer than 10 sessions had no important effects on relatives' burden.

Barland (1998) et al. (1998) have conducted a large number of controlled and comparative clinical trials and have demonstrated a markedly decreased relapse and rehospitalisation rates among patients with schizophrenia whose families received psycho education compared to those who received standard individual services. They have presented their findings with eight reviews in the past decade, and all supported their findings with a large and significant effect of family psycho education upon the prognoses of the person affected with schizophrenia (Barland. et.al 1997; Dixon and Lucksted, 1995; Dixon and Lehman, 1995; Dixon, McFarlane, et al.1996; Falloon, et.al. 1997; Goldstein and Miklowitz, 1995; Lam, 1991; McFarlane and Lukens, 1998; Penn and Mueser, 1996;). They added that since 1978, with the publication of Goldstein et al.'s study showing dramatic short-term effects of educational and coping skills training intervention, there has been a steady stream of rigorous validations of the positive effects of family psycho education on relapse in schizophrenic disorders. Overall, the relapse rate for patients provided with family psycho education has hovered around 15% per year, compared to a consistent 30% to 40% for individual therapy and medication or medication alone.

According to Bergmark (2004) a significant consensus about critical ingredients in the family psycho education for the people affected with schizophrenia was thought in 1999, under the encouragement of the leaders of the World Schizophrenia Fellowship Leff, Falloon, and McFarlane (1998),
developed and encouraged the concept which was then refined and ratified by many recognized clinical researchers working in this field.

Gallagher and Mechanic (1996) are of the opinion that the goals for working with families of persons with mental illness especially schizophrenia is to achieve the best possible outcome for the treatment imparted and to alleviate suffering among the members of the family by supporting them in their efforts to foster their loved one's recovery.

Pinsof and Wynne (2000) feels that normally family members do not hesitate to participate in psycho education programmes if they understand that it has something to do with the condition maintained by their significant other. But in rare cases some family members may not want to be identified with psychiatric problems. They may feel uncomfortable revealing to others the psychiatric illness in their families and airing their family problems in a public setting. This for long found to be a major setback for involving the family members in the psycho education programmes and consequently that may lead to relapse and rehospitalisation.

Moltz (1993) is greatly influenced by Hogarty and Ulrich's (1977) findings and commented that relapse is a major impediment to longer-term clinical and functional improvements, but that after roughly a year of the provision of family psycho education, most patients can make significant functional gains, are more resistant to stress, and can tolerate increasing mental and physical demands.

Wright et.al. (1995) are of the opinion that the family psycho education attempts to reflect contemporary understanding of schizophrenia and other severe mental illnesses from a biological, psychological, and social perspective. Family psycho education for schizophrenia can be even treated as a second-generation intervention model that incorporates the advantages of its own, diminishes its negative features, and leads to a number of synergistic effects that appear to enhance efficacy of the treatment imparted and consequently the prognoses.
Lucksted, (2000) found that unlike the recent origins of psycho education, however, family intervention arose nearly 3 decades ago in attempts by Laqueur, LaBurt, and Morong (1964), and Detre, Sayer, Norton, and Lewis (1961) and others to develop psychosocial treatments for hospitalized patients. The emphasis was more pragmatic than theoretical and aim was to help the family and the person affected.

There are instances where clinicians and administrators may not appreciate the impact of mental illness on families, or may not know about the effectiveness of family psycho education. They may focus on medication over psychosocial interventions, and the individualistic orientation of medicine may make family involvement seem superfluous. Additionally, some may still follow theories that blame family dynamics for causing schizophrenia. (Dixon, et. al 1999; Mc. Farlane, et. al. 1993)

Laqueur (2000) noted improved ward social functioning of inpatients who are provided with opportunity to visit relatives who are well oriented and trained with sufficient family psycho education.

Detre (1999) found that family psycho education is efficient in enriching the cooperation of the family with resident psychiatrists, social workers and other mental health professionals on the provision of acute inpatient service, which is very much essential and contributory for the treatment outcome.

Short and Hendryx (2000) says that research on technology transfer has identified four fundamental conditions that must be met while implementing family psycho education, a key element that can potentially influence the course of the illness, for the family members of the persons affected with schizophrenia namely, dissemination of knowledge; evaluation of programmatic impact; availability of resources; efforts to address the human dynamics of resisting change.

Amenson (1998) have observed that the psycho education provided to the family or significant others of the person affected with schizophrenia have remarkable effects on a number of social and clinical management problems
commonly found with schizophrenia and other severe mental illnesses.

Hooley and Richters (1995) states with evidences quoting studies that those families attempting to cope with schizophrenia inevitably will experience a variety of stresses that secondarily put them at risk of manifesting exasperation and discouragement as natural reactions. These responses often take the form of high expressed emotion, in which relatives are highly critical or over involved, a factor empirically shown to predict and, most likely, cause relapse. Psycho education provided if timely, can keep high expressed emotion under check and consequently the relapse chances can be averted.

Barrowclough and Haddock (2001) found that Psycho education provided to the family members of the person affected with schizophrenia as part of treatment program is effective in addressing the problems related with the illness like social isolation, stigmatization, and increased financial and psychological burden associated with the illness directly. The family psycho education provided to the family members of the person affected with schizophrenia facilitates the family to connect the family to other families like themselves, providing a forum for mutual aid, providing an opportunity to hear the experiences of others who have had similar experiences and have found workable solutions, and building hope through mutual example and experience.

Goldstein and Miklowitz (1995) reviewed Leff (1985) and his colleagues and found that they have eventually devised two different studies to assess the effectiveness of family psycho education. In the first study of Leff and his colleagues, Goldstein and Miklowitz (1995) could find that they compared patients receiving standard treatment, which involved little or no family intervention, with a family program that combined educational sessions, a relatives group, and family sessions in the home including the patient (Leff et al., 1985). In the second study they found that Leff and his colleagues, (Leff et al. 1990) tested the components of the first intervention, so families were invited to attend either ongoing relatives group, excluding the patient, or individual family sessions at home. When the data from the first and second
studies were combined, they could find that the relapse rate at 2 years was 75% for those patients who received standard treatment as compared to 40% for those whose families received any form of intervention, providing strong endorsement for the value of a family support model regardless of format.

Coursey & Marsh (2000a), (2000b) found that a great number of studies supported the notion of family psycho education for schizophrenia and its positive effects on the treatment outcome. They found Dixon et al., (2001) stating that the schizophrenia patient outcomes research team (PORT) project included family psycho education in its set of treatment recommendations. The patient outcome research team recommended that all families in contact with their relative who has mental illness should be offered a family psychosocial intervention spanning at least 9 months and including education about mental illness, family support, crisis intervention, and problem-solving skills training and the result was found very much positive that almost all the participants reported with changes in the maintained symptom status or relapse rate. They also found The American Psychiatric Association, (1997); Frances, et. al. (1987); Frances and Kahn (1996); have also recommending the families to undergo psycho education and support programs.

Amenson and Liberman (2001) found that many patients and their family members are more concerned about the functional aspects of the illness schizophrenia, especially housing, employment, social relationships, dating and marriage, and general morale than about remission, which tends to be somewhat abstract as a goal due to the lack of proper awareness. Several interventions especially the family psycho education, particularly the American versions-those of Falloon et al. (1984), Anderson et al. (1986), have used, found to be useful in reducing the remissions (the absence of relapse).

The studies of Kottgen et.al. (1984); Linszen et al., (1996;) extensively states that in patients living with family, personal therapy had lower relapse rates than family or supportive therapy, but personal adjustments, reduced relapse, reduced symptoms were found typical result of family psycho education.
The Linszen et al. (1996) study illustrates a key finding that, the family psycho education programs lasting longer than 3 months had more robust effects. In fact, consistent efficacy has been demonstrated only in those studies in which intervention was provided on an ongoing basis, lasted at least 6 months, and incorporated problem solving, coping skills training, expanded social support, and communication skills training. As will be explored further in the section on differences in models, it has become clear that education alone has at least short-term salutary effects for family members.

Solomon (1996) believes that most often implementation of family psycho education programs which is an inherent element in the relapse lessening is hindered by realities in the lives of potential participants. Practical issues like transportation, time commitment, and competing demands for time and energy are common.

Borland (1998) found that even the shorter-term positive effects for family members of the person affected with schizophrenia that they will be benefited from the family psycho education since it has the potential to influence the persisting deficits, symptoms, and burdens. Thus, the critical elements of the family psycho education include those that involve changes in behaviour and ongoing training in diagnosis-specific and clinically oriented coping skills training. He also found that the focus of intervention has to be shifted to functional aspects, especially employment; the patient has been included in these skills training and behavioural interventions. He finds the recent reports that have only added to the strong validation of the effects on relapse, particularly because these later studies have been conducted in a variety of studies.

Wiedemann et al. (2001) are of the opinion that the effects of family psycho education are additive to, but not substitutive for; antipsychotic medication.

Bae & Kung, (2000) found that behavioural family management did not compensate for the increased risk of relapse posed by targeted drug treatment, in which the patient did not use medication unless experiencing prodromal
signs or symptoms of relapse.

Bergmark (2004) pointed out that family psycho education has established its efficacy and effectiveness as an evidenced-based practice that has the potential to improve the status of the patients. Nearly all practitioners, of many disciplines, who use the approach reported marked increases in their sense of professional satisfaction, gratification, and enjoyment of their work, and gratitude and appreciation from families and patients, often rarities in work with severe mental illness.

2.8 CONCLUSION

The foregoing review of literature highlights the multidimensional approach followed by the scholars of different discipline and which reveals that schizophrenia is a disorder of multifactor aetiology and it creates impairments in the overall functioning especially in the areas of cognition, connotation and affect of the individual affected. It was well documented that pharmacological treatments can do a great deal with regard to the reduction of manifested symptomatic behaviour of the individual affected but absolute remediation of the illness and the disabilities caused is beyond the purview of pharmacology due to the handicaps occurs in the areas of the overall functioning especially in the expected level of occupational as well as social functioning of the individual affected since the onset of the disorder that may lead to social isolation, lack of daily living skill, unemployment and sometimes homelessness even. The thoughts on the possibilities of remediating the handicaps of the illness other than organic reached at psychiatric rehabilitation. The reviews on psychiatric rehabilitation affirm with evidences that a well planned psychiatric rehabilitation programme can remediate, to a considerable extent, the handicaps other than organic caused by schizophrenia. The experts are of the opinion that since psychiatric rehabilitation is a process that offers opportunity for individual who are impaired or handicapped with mental illness to reach their optimal level of independent functioning in the community, the stress has to be given in the empowerment of individuals social competence and creation
of long term systems of social and environmental support. This social and environmental support can be achieved through the environmental modification and the environmental modification very well covers the family where the affected individual is a part. As stated in the reviews above, the advanced studies and researches in the area testified the role of family support and attitude in the environmental modification and consequently on the treatment outcome of the person affected with schizophrenia.

All the primary studies available on family intervention on schizophrenia treatment are retrieved in the present study. It was found with the published reviews that the experts in the field hold multidimensional approaches on family interventions especially of family psycho education and scholars of different disciplines uses different strategies with varying philosophical milieu and hence ambiguity pertains at various realm. Practically no studies have conducted on family interventions especially of family psycho education for person with schizophrenia at a social work milieu. The studies on family psycho education suggests that it play a key role in the treatment of mentally ill especially schizophrenics and many studies agrees upon the fact that family psycho education is one among the best practices for those who are undergoing treatment for schizophrenia since it has the potential for influencing patient relapse and improving family well being. Most of the researches and interventions in the treatment of schizophrenia found cross sectional in nature and almost all the studies on family intervention, especially of family psycho education for schizophrenia have conducted at western clinical contexts. Critically not much research in this regard has conducted in India and practically no research on the impact of family psycho education in the treatment of individual with schizophrenia has conducted at a social work environment. In the present study an attempt is made by the researcher to investigate thoroughly ‘the impact of family psycho education in the treatment of individual with schizophrenia with specific reference mental health centres in Kolhapur’, Maharashtra.