CHAPTER I

INTRODUCTION
The mentally ill have always been with us. The words lunatic, insane, crazy, mad, all refer to the mentally ill. Literature since the time of ancient Greeks have portrayed pathetic lunatics and mad men. Mentally ill were laughed at, locked or chained, beaten, ill-treated and tortured. This was mainly due to the attitude of the society towards the mentally ill as opposed to the physically ill. Towards the physically ill there is generally a societal attitude of sympathy, perhaps because the features of physical illnesses can be seen, felt or objectively observed. On the other hand, mental disorders involve intangibles, such as feelings and ideas, which are often incomprehensible to other persons. Moreover, insanity was attributed to some evil spirits and attempts to drive the evil spirits led them to the ill-treatment of the mentally ill. Only when the society began to consider the mentally disturbed person as a sick person in the middle of the 19th Century, sympathetic consideration and treatment for the mentally ill for their recovery began. Even now for most people, it is frightening to think about mental illness and mentally ill. People act as though mental illness is a contagious sickness and try to avoid contacts with them as far as possible.

"A common image of the mentally disordered is that of a madman in a straight jacket, foaming at the mouth and struggling to free himself in order to attack any one who
happens to be nearby. Another is that of a dirty disheveled woman, babbling incoherently and engaging in random sexual relationships. But these images are misleading. Most mental disorders are neither bizarre nor dramatic, instead, they are the common experience of anxiety or depression with which we are all familiar" (Coleman and Cressey 1984; pp: 331-332).

MEANING AND DEFINITION OF MENTAL ILLNESS

Even after many years of research, there is no agreement on the meaning of the terms such as mentally ill, mentally disturbed and crazy. Though many Psychiatrists, Psychologists and Sociologists have attempted to define mental disorder precisely, none of these efforts has received widespread acceptance. Some experts see mental disorders as mental illness, others say that they reflect personal maladjustment and some others simply call them deviance (Coleman and Cressey 1984, p.332).

"Mental disorders or diseases are always defined by reference to an explicit or implicit formulation of personalities, which sets limits to the manifestations of human individuality. That which deviates from the norm thus created is regarded as aberrant and is considered genius or crime or mental disorder, depending upon a large number of secondary definitions, which fix the individuals relations with the group".
"Prenaturalistic views of human personality consider mental disorders as the results of manipulations of the victim by transcendental agencies, as for example, in the case of belief in demoniacal possession. Naturalistic interpretations may be classified into naive mechanistic doctrines, such as those which regard mental disorders as the results of medical diseases and attribute them to lesions in the nervous system, the endocrine glands or in other organs of the body. According to more sophisticated biological doctrines, mental disorders are more or less rigidly determined by the individual's genetic constitution or his environment or by a combination of both. Most psychological theories of mental disorder belong to these categories. Finally, anthropology views mental disorders as the result of unduly complicated interpersonal integrations arising from innately conditioned but culturally directed tendency system" (Sullivan 1963, pp. 313-314).

According to Elliott and Merrill (1961) mental illnesses are a response to the social order, which is unfavourable for effective functioning. A major characteristic of mental patients is their inability to function.

"From Durkheim's viewpoint and from Weber's social action emphasis, mental illness can be defined as the
inability of a person to perform institutionalized roles" (Schwab et al 1979, p.46).

Talcott Parsons states: "The primary criteria for mental illness must be defined with reference to the social role performance of the individual. Since it is at the level of role structure that the principal direct interpenetration of social systems and personalities come to focus, it is an incapacity to meet the expectations of social roles, that mental illness becomes a problem in social relationships and that criteria of its presence or absence should be formulated" (Parsons 1958).

Thus sociological concepts of disturbed behaviour are based primarily on societal norms and the capacity for institutionalized performance. Mental disorder is defined as any behaviour that is relatively uncommon -- therefore, abnormal -- according to a given society's generally accepted standard at a particular time.

The medical model or the clinical definition of mental illness is more popular in modern psychiatry, though other aspects are considered as useful.

MENTAL ILLNESS AS A SOCIAL PROBLEM

Mental illness is a serious social problem. Every year mental illness directly affects large numbers of people.
According to 1984 report of the World Health Organization, at least 40 million people in the world suffer from severe forms of mental disorders, such as Schizophrenia and dementia, no fewer than 30 millions suffer from epilepsy, which like other mental disorders, is left untreated in a majority of the cases, and a further 200 millions are incapacitated by less grave mental and neurological conditions. When these figures are augmented by the number of people affected by alcohol and drug related problems, and by mental disorders secondary to physical diseases, it becomes apparent that in terms of individual suffering the burden of families and the cost to communities, the health services are faced with the problems of gigantic magnitude (WHO, 1984).

In addition to the sufferings of the mentally ill, untold number of spouses, children, parents, friends, fellow workers and others, suffer in some way or other as a result of another's mental disorder. Mental illness also places a burden on the economy. The cost on account of mental illness includes both the cost of treatment and the cost of lost productive capacities. The highest cost of mental illness, however, are tallied in human suffering and unhappiness. Mental illness may contribute to various other social problems. Mental disorders are considered as important contributing factors for high rates of crime, delinquency and family problems (Poplin 1978).
PREVALENCE OF MENTAL ILLNESS

There are no accurate reliable complete data available regarding the prevalence of mental disorders, though rough estimates are available in plenty. According to most of the prevalent studies, about 10 to 20 per thousand of population are affected by a serious mental disorder at any given time. This would constitute about 10 million citizens of India. The figure for neuroses and psychosomatic disorders are about 2 - 3 times higher, thus indicating that 20 to 30 million people may require professional attention. Mental retardation is estimated at 0.5 per cent to 1.0 per cent of all children, while alcohol and drug dependence rates, though still low as compared to the world scene reveal a disturbing rising trend (Bisht, 1982).

The number of new cases of serious mental disorders which become manifest each year is estimated to be roughly 35 per 100,000 or about 2,50,000 in the country (Bisht, 1982).

TYPES OF MENTAL DISORDERS

Conventionally, mental disorder has been classified by Psychiatrists as neuroses and psychoses. Neuroses are considered to be mildest and the most common type. Thoughts, feelings, expressions, beliefs and actions deviate more markedly from approved norms in psychotics.
Loss of contact with the reality is a characteristic of the psychotic behaviour. The psychotic's ability to communicate intelligently with others may be partially or completely interrupted. The essential features of the neuroses is that they involve behaviours, which deviate less markedly from social norms compared to the psychotics (Clinard, 1968).

There are two types of mental disorders according to the conventional classification of psychiatrists. They are organic psychoses, those having an organic basis and nonorganic or functional. Organic types of mental disorders are usually linked to some germ, to brain injury, to other physiological disorders, possibly to some hereditary factors. According to many psychiatrists, the functional or non-organic mental disorders "function" to adjust the individual to his particular difficulties, hence, the term functional. The idea that such mental disorders are necessarily an adaptation to stress is difficult to prove, although in many cases this adaptation may play an important part. Functional psychoses are generally divided into three main types, schizophrenia, the manic depressive psychosis and paranoia (Clinard, 1968).

**SCHIZOPHRENIA DEFINED**

According to encyclopedia of psychiatry "Schizophrenia" is the term used for a group of illnesses, whose aetiology is unknown, having characteristic mental
symptoms leading to fragmentation of personality. The patient undergoes experiences, which are unfamiliar and cannot be understood as exaggerations or prolongations of familiar sensations. Thought, emotion, drive and movement may be disordered.

"The illness often recurs, each recurrence increasing a chronic disability until a plateau is reached. The final result, oddity, social incapacity or chronic invalidism requiring prolonged hospitalization may be modified by professional guidance. Early adult life is the most frequent period of onset but the illness begins often in adolescence and sometimes at later periods of life. A characteristic insidious onset is often preceded by introversion, subdued behaviour or suspicious secretiveness (Schizoid personality). Males are a little more frequently affected than females and single subjects more than married. First admission rates for schizophrenics are about 15 per 100,000 of the white population in Britain. About 80% of the patients under 65 who have been continuously in hospital for two years or more are Schizophrenics" (Leigh et al P.321, 1982).

According to the Diagnostic and Statistical Manual of Mental Disorders, at some time during the illness, Schizophrenic disorder always involved at least one of the following: delusions, hallucinations or certain
characteristics in the form of thought. No single clinical picture is unique to Schizophrenia or evident in every case or at every phase of illness (A. P. A., 1980).

International classification of Diseases (I.C.D-9, 1980) defines Schizophrenia as a group of psychoses in which there is a fundamental disturbance of personality, of thinking, often a sense of being controlled by alien forces, delusions, which may be bizarre, disturbed perception, abnormal affect out of keeping with the real situation and autism. Nevertheless, clear consciousness and intellectual capacity are usually maintained. Characteristic features described are formal thought disorder, bizarre delusions and auditory hallucinations, which comment on the patient or address him, other hallucinations, over-inclusive thinking evident in the form of incomprehensible speech, shallow or incongruous mood, negativism or stupor and catatonia. It is warned that diagnosis "Schizophrenia" should not be made unless there is, has been evidence during the same illness, characteristic disturbance of thought, perception, mood, conduct or personality preferable in at least two of these areas. The diagnosis should not be restricted to conditions, deteriorating or chronic course.

CONCEPT OF SCHIZOPHRENIA

Schizophrenia was originally delimited as a mental illness in which severe irreversible personality changes
occurred. The historical development of the concept of Schizophrenia is well known. Morel (1852) reported a series of cases of severe intellectual deterioration starting in adolescence and he called this illness demence precoce. Hecker (1871) described hebephrenia an illness, which occurred in puberty and led to a silly deterioration. Kahlbaum (1874) drew attention to a mental illness in which stupor occurred in the absence of disease of the nervous system. He called this illness tension insanity or catatonia. Pick (1891) described a 'simplex syndrome' emphasized the simple deterioration accompanied by a minimum of other symptoms in his residual group. Kraepelin (1893) brought together the syndromes of demence praecoce, hebephrenia, catatonia and dementia paranoids and called this group of illnesses 'psychological degeneration processes'. He (1899) used the term dementia praecox to designate this group of illness because intellectual deterioration was a common feature and the illness usually occurred in young people. In 1913 he defined dementia praecox as follows: "Dementia Praecox consists of a series of clinical states which have as their common characteristic a peculiar destruction of the psychic personality with the most marked damage of the emotional life and of volition "contrary" to what is commonly believed. Kraepelin named group of paranoid mental deterioration as "Paraphrenia".
Eugen Bleuler (1911) introduced the term "Schizophrenia". He defined Schizophrenia on the basis of symptomatology and course. Other workers especially Kleist have adopted the viewpoint that Schizophrenia is an illness which always leads to a defect state (Hamilton, 1984).

Four modern Psychiatrists who theorized about Schizophrenia were Adolf Meyer, Harry Stack Sullivan, Gabriel Langfeldt and Kurt Schneider (Kaplan and Sadock, 1988).

AETIOLOGY OF SCHIZOPHRENIA

Schizophrenia is caused by multiple factors. The following are considered to be important causative factors of Schizophrenia:

(1) Genetic factors;
(2) Biochemical factors;
(3) Neurological abnormalities;
(4) Personality and physique;
(5) Physical factors;
(6) Psychological factors; and
(7) Social factors.

(1) Genetic factors

Studies of relatives, twins and adoption studies conclusively prove that hereditary factors play a role. The disorder may be due to a single mutant, inherited gene, or
may be due to two genes--most likely to be Polygenic (Michael et al., 1983).

(2) **Biochemical factors**

Several hypotheses have been suggested. Most of the major biochemical hypotheses suggest a disturbance of neurotransmitter function. The current theory postulates excessive dopamine activity. Other hypotheses are serotonin (5-HT) hypotheses, noradrenalin (NA) hypotheses and involvement of other neurotransmitter systems. Serotonin hypotheses-evidence exists for 5-HT overactivity and underactivity. Noradrenalin (NA) hypotheses-evidence exists for over and underactivity. Involvement of other neurotransmitters-evidence exists for involvement and for lack of involvement of Ach, GABA endorphins and prostaglandins (Jonathan and Glynn, 1987).

(3) **Neurological Abnormalities**

Researchers have often detected signs of minor neurological abnormality in Schizophrenic patients. It is possible that some of these signs resulted from coincidental neurological disease. In the past, investigation searched for gross pathological changes in the brains of Schizophrenics but found none. Recent research is concerned with four issues: non-localizing (soft), neurologic signs, possible abnormalities of the corpus callosum, evidence of ventricular enlargement and changes in E.E.G.
'Soft signs' (neurologic signs without localizing significance) have been reported in many studies. Thickening of the corpus callosum has been reported in brains from a small number of schizophrenic patients. There have also been reports of functional abnormalities suggesting impairment of interhemispheric transfer in schizophrenics.

Ventricular enlargement in Schizophrenia was first reported from studies using air encephalography. The introduction of C.T. Scanning has provided non-invasive method for investigating the brain size in schizophrenic patients.

Electro-encephalographic abnormalities in schizophrenic patients have been reported including increased theta activity, fast activity and paroxysmal activity (Michael et al., 1983).

(4) Personality and physique

It has been claimed that the pre-morbid personality of Schizophrenics is usually schizoid in nature. The schizoid personality is a quiet shut-in person who shows little emotion, is usually unsociable, and indulges in excessive private fantasy. They may also show asthenic (lean and narrow) type of body build (Michael Gelder, 1983).
(5) **Physical factors**

Apart from direct damage to the brain, there are various physical factors which may provoke or modify mental illness. These are age, sex, endocrine changes, exhaustion, operation, climatic conditions and seasonal variations (Hamilton, 1984).

(6) **Psychological factors**

There are many psychological theories of mental illness which in general, reduce mental illness to some problems of maladaptive behaviour. Three main types of behaviours can be identified.

According to psychoanalytic theory, a crucial defect in schizophrenia is a disturbance in ego organization which affect the interpretation of reality and the control of inner drives (e.g. sex and aggression).

Theories of self such as Rogerian or Laingian which similarly attribute psychiatric disorder to inadequate concepts of 'self', though these may be derived from current as well as past interpersonal situations.

Behaviorists view psychiatric disease in terms of learned maladaptive behaviour.
These theories share in common the belief that psychiatric disorder is fundamentally a problem of the mind but each group of theories offers different and often conflicting views of how the mind came into this state. All theories tend to stress interpersonal relationship as contributory but how and when they do so is debated (David Armstrong, 1980).

(7) Social factors

The possible importance of social factors in the causation of mental illness has been recognized since long. During the past few decades both investigators and clinicians have given increasing attention to social factors related to psychiatric illness. The term social psychiatry has gained currency as a description of a number of related and overlapping disciplines and activities, whose ultimate aim is to identify the social factors that contribute to the causation of mental disorder and also to prevent psychiatric illness or reduce its prevalence.

As Odegaard (1962) pointed out, although the psychiatrist is more concerned with individual, he must be prepared to investigate groups and populations, if he is to arrive at knowledge that is reliable and objective.
Perhaps the best known attempt to describe the causation of a psychiatric phenomenon in wholly sociological terms was the classical study conducted by Durkheim (1897) on suicide. Durkheim considered that suicide rate reflected patterns of social relationship within communities.

Several social factors play a vital role in the understanding of mental illness. The following are some of the important social factors associated with mental illness.

(a) The role of family

Family has often been called the cradle of personality. During the formative years of the child's relationships with his parents (especially his mother) carry strong emotional overtones. The mother provides the satisfaction for many of his basic needs ranging from food to love. The extent to which these needs are supplied by the mother and the members of the family go far in determining the child's mental and emotional structure (Mangus, 1957).

The family probably has an even more direct impact upon mental health. The emotionally disturbed parent is clearly inadequate to carry out parental responsibilities. He or she is often extremely self-centred, aggressive, hostile or selfish. Such a parent is usually most concerned with satisfying his or her own emotional needs and may in fact, exploit the child as a means of satisfying them. The
parent thus may reject the child by punishment or extreme coldness or the parent may attempt to overcome guilt-feelings by showering the child with attention, presents or solicitude. In any case the child suffers (Herman, 1958).

Where the mother is neurotic or emotionally disturbed, she may become overattached to her son or daughter, especially if her own marriage is less successful than she had anticipated (Burchinel et al., 1957).

A major share of mental disorganization is the result of inability to adjust to the strains of modern life. Tensions in international relations, the struggle for material possessions, the problems of sexual maladjustment, the frustrations of the job, the aggressions, engendered by competition, the migration, which involves marked cultural adjustment, the pervasive attempt to rise in the social scale, the discrimination against minority groups and the hidden memories of unhappy family relationships -- these and many other factors combine to increase the difficulty of living in the age of the cold war and the international ballistic missile. In studying them, sociologists have contributed significantly to the new field of Social Psychiatry (Warren Dunham, 1948).

Much mental disorganization is partially caused by frustration and anxiety. The modern social structure is so organized that many persons are unable to receive the love,
recognition, prestige, acceptance and security, which they strongly desire. Such values are for the most part, derived from interpersonal relationships. An individual must be loved, recognized, and accepted by someone else -- whether it be husband, wife, parents, comrades, business associates, or friends. In other words, his mental organization depends upon successful communication with others, and their assurance that he is loved, admired and cherished. At the same time, he may become over-anxious either lest he be deprived of this assurance in the future or because he has been deprived of it in the past (Sullivan, 1953).

Modern society exacts an unequal toll on its members. Some persons are more exposed than others to the stresses that produce or intensify mental disorganization. The stresses give rise to anxiety, which in turn interferes with communication. Members of the submerged classes often resent their lot. So, too, do minority groups or those who are continuously transferring from one community to another. All these conditions produce strain on personality organization. When there is great disorganization such as warfare, many persons are upset and cannot lead a satisfactory life (Elliott & Merrill, 1961).

In short, we can say that disturbances in family relationships, over-protection or rejection, disturbances in communication and interpersonal relationships in the family may provoke the onset of schizophrenia.
(b) The influence of community

The pioneer study of Faris and Dunham on the ecological aspects of mental illness pointed out to the differential impact of urban neighbourhoods on mental illness. They studied the distribution of mental disease in various parts of Chicago and found that Schizophrenic cases were concentrated in the cheap rooming--house districts, where homeless men lived. In the central business district and in the deteriorated Negro communities, there was also a higher than average rate. Social isolation was the most characteristic aspect of these areas, whether on the basis of sex, ethnic or immigrant isolation or racial isolation in the case of Negroes (Faris and Dunham, 1939).

There is a lack of agreement as to why this ecological distribution of mental illness occurs. Some psychiatrists maintain that actual or potential schizophrenics "naturally" find their way to depressed urban areas and thus swell the rates in such sections. Others hold that the social isolation of the individuals living in high mobility neighbourhoods makes it difficult for them to maintain communication, which in turn results in schizophrenic symptoms. Still others believe that social isolation is an important factor in schizophrenia but are perplexed as to why some persons become mentally ill and others do not (Clausen and Kohn, 1954). Anyway it appears
that the stronger the life organization of the individual, the less likely he is to become mentally ill.

(c) Occupation

A person's work is often a source of strain both because of the competition and because of the frustration of individual goals. Failure to achieve better pay or more desirable job may produce mental illness. Many of the most important and difficult life adjustments are those "on the job" (Dubin, 1958).

Work is the source of other mental strains, one of which is job insecurity especially for the industrially employed. Unemployment is a threat to one's self-esteem. Hollingshead and Redlich found a sense of frustration and despair common among the lower class in New Haven (Hollingshead and Redlich, 1954).

For the average person work is also the most conspicuous aspect of personal success or failure. 'Competition is the basis of work and money is the most tangible form of reward. Psychiatrists report that the difficulties of many of their mental patients centre around money (Stanley and Lawrence, 1956).

Schizophrenics were not "status achievers" and this fact may have a definite bearing upon their problems. Whether they have been unable to achieve status because of
their Schizophrenic tendencies or whether the latter resulted from their failure to move upward is not clear. In any case, persons who become schizophrenics are apparently found to a disproportionate degree among the "failures" in the world (Mary Lystad, 1957).

(d) Social class

One of the oldest and the most firmly established associations in psychiatric epidemiology is the one between social class and mental illness. Social class is a broad and inclusive concept, which includes not merely the position of the individual in the social structure but such factors as occupation, cultural values, family background, ethnic status, religious denomination, expectation of mobility and self identification (Goldschmidt, 1950).

Hollingshead and Redlich's study (1958) was concerned with mental health of the various social classes in New Heaven and they found a significant inverse relationship between social class and mental illness. That is the lowest overall mental illness rates were in the upper classes and the highest rates were in the lower classes. The Hollingshead and Redlich study thus indicates conclusively that position in the social structure tends to affect mental health.

Economic stress, physical illness, family disorganization and psychological frustration increases as
one descends the social scale. The hazards to mental health are greater in the lower class, the schizophrenia is especially prevalent in this group (Jerome and Schaffer, 1954).

Midtown Manhattan study by Srole and co-workers corroborated the findings of the earlier study. They also stated that stress was found to be an important component in mental disorders (Leo Srole et al., 1962).

The Stirling country study of Leighton and colleagues found that mental disorder was most common among the lowest socio-economic group (Leighton et al., 1963).

(e) Migration

A number of studies show that migration is conducive to mental illness. Migration involves the physical departure of an individual from his cultural surroundings and the consequent necessity of adjusting to a new set of interpersonal relationships (William Peterson; 1958). The immigrant who leaves the Old World and comes to the New World is the most obvious example of migration. But the individual who leaves the country and comes to the metropolis is also migrating. In each case, the person quite literally breaks his former relationships and is forced to form new ones in a strange setting. Failure to make these adjustments satisfactorily may result in mental illness (Elliott and Merrill, 1961).
SOCILOGICAL STUDIES ON SCHIZOPHRENIA

(1) Studies on family interaction and family environment

Some studies were conducted on patient's family environment. Fromm (1948) described about 'Schizophrenogenic' mother. Alanen (1958, 1970) found that the mothers of Schizophrenics showed an excess of psychological abnormalities. He suggested that these abnormalities might be an important cause of the child's schizophrenia. The investigations by Lidz and his colleagues (1949, 1956, 1957) at Yale have been amongst the most careful of these studies. They reported initially on a group of 50 young Schizophrenics. Only 5 of these patients were considered to have been raised in homes which seemed reasonable, favourable and which contained two stable and compatible parents until the patient was 18 years of age. Broken homes, unstable parents and an unusual pattern of child rearing appeared to be almost the rule. Later, investigating more intensively in 16 middle class families, the intrafamiliar environment in which schizophrenia developed, Lidz and colleagues reached the conclusion that serious pathology of the family environment is the most consistent finding pertaining to the aetiology of schizophrenia. The marital relationship of the parents is reported to be seriously disturbed, in one of the two ways, either there is a chronic disequilibrium, with
derogation and undercutting of the martial partner and threats of separation ("marital discord") or one spouse is dominant and imposes his or her psychopathology on the masochistic partner, who achieves some marital peace by submission ("marital skew"), in which one parent yielded to the other's (usually the mother's) eccentricities, which dominated the family. The schizophrenic's father, they report, tends either to be a passive non-entity or to sabotage his wife in her role as a mother, being himself motivated by jealousy of a son or by a wish to mould a daughter after his own arbitrary fashion.

There can be disturbance in the style of communication. Research on disordered communication in families originated from the idea of "double bind" (Bateson et al., 1956). A double bind occurs when an instruction is given overtly, but contradicted by a second, more covert instruction -- like overtly telling the child to come, whilst conveying by manner and tone of voice rejecting him. A further element is that there is no escape from the situation in which contradictory injections are received. According to Bateson, double binds leave the child able to make only ambiguous or meaningless responses. Bateson further supposes that schizophrenia develops, when this process persists. Wynne and his colleagues suggested that different patterns of disordered communication occurred among the parents of schizophrenics (Wynne et al., 1958). These investigators
first gave protective tests to such parents and identified 'amorphous communications' (vague indefinite and loose') and 'fragmented communications' ('easily disrupted, poorly integrated, and lacking closure').

(2) Studies on family stress and burden

Some studies have concentrated on a very important area viz, the burden or stress felt by or exerted on the family of mental patient, when the patient continues to stay in his own home rather than in a mental hospital. Various researchers from the field of community mental health and other allied fields have attempted to assess this burden in the west as well as in India. Earlier workers who had studied the discharged chronic long stay patients living in the home attempted to assess the social burden as measured by the readmission of the patient or relapse of his illness.

These studies were conducted, as it was assumed that a patient staying in the family would get relapse and had to be readmitted to the hospital because the patient was causing stress or burden to the family during his stay as a patient in the family.

In this regard Mandelbrote and Folkard (1961) followed up patients managed largely in the community with emphasis on avoidance of long stay hospitalization. They studied them for four years. As a result, they found that patient's families experienced stress when the patient's
bizarre behaviour came in the way of normal family functioning and restricted their normal activities. In their study no standardized parameter was used to assess the severity of burden experienced by the family. During 1963, Grad and Sainsbury made a remarkable headway in assessing this phenomenon -- on a three point scale. They rated the effects of parent's illness on family income, employment, social and leisure time activities, domestic routine children in the home, health of others in the family, relationship with neighbours etc. They also tested the scale for its reliability and found it to provide 75 per cent of agreement between three interviewers.

As a result, the authors identified the types of behaviour of the patient that exerted more stress on the family viz.,

(1) Constant bodily complaints from the patient;
(2) Possibility of the patient harming himself; and
(3) Excessive demand of the patient on the family.

They also found that certain factors such as parent's age, clinical status, chronicity of his illness, composition of the family and closeness of the patient to a responsible relative of the family were the significant relative aspects with the amount of burden felt by the families.
Hoenig and Hamilton (1966) added another dimension to this assessment of burden on the patients' families. They attempted to differentiate the objective from the subjective burden felt by the family members.

Objective burden according to them consisted of the following areas: (1) financial, (2) health, (3) effects on children (4) effects on family routine, (5) any type of abnormal behaviour in the patient, which was likely to be disturbing to others.

Subjective burden was assessed by asking the family members whether as a result of the patient's illness, they thought the household had suffered a sense of burden. This was an enquiry more into the attitudes of the family members.

Their findings revealed that the highest percentage of households were affected on the area of family disturbance. Next, in frequency came the financial loss because of the patient's presence in the family.

Clinical factors such as diagnostic groupings did not seem to show significant differences in burden and non-burden groups. However, duration of illness was significantly related to burden on the family.

In the areas of subjective burden, the authors noted that the subjective attitudes by no means corresponded
to with what one might have expected from the assessment of objective burden. Subjective burden showed more relationship with factors such as age of the patient, marital status of the patient, relationship of those with whom the patient lived and the social class of the family than to the objective burden.

Washburn et al., (1976) used yet another method to assess the burden on the patient's family. Their burden evaluation line was a graphic rating scale with two end points -- 'severe burden' and 'no burden' and the informant was asked to rate the current overall level of burden experienced by the family. Although, the assessment tool was different, it corresponded to the subjective burden assessment mentioned in the earlier studies.

Doll (1976) studied 125 families, who had their mentally ill relatives living with them. He used interviews and attitude tests to collect information and reported that patient's presence especially when severe psychotic symptoms persisted often had put heavy emotional and social strains on the families. He also warned that though the families accept the physical presence of the patient, the accompanying social rejection, could have serious consequences for the community mental health involvement.
(3) Studies on the attitude towards mentally ill and mental illness.

It is pertinent to know about the attitude of the family members towards mentally ill and mental illness, when we study about the social aspects of mental illness.

Crocetti (1971) has rightly put it that the success of family based on mental health programme as an alternative to hospitalization for persons suffering from mental illness depends on a large measure on the favourable climate and opinion in the family situation. In one of the earlier works, Cumming and Cumming (1957) in their study on attitude towards mental illness concluded that denial, isolation and insultation of mental illness are common in almost all moderate families and concluded that the family tolerates these deplorable conditions in mental hospitals because of these attitudes.

In this regard Nunnaly (1961) had reported on what the public knows and thinks about mental illness. Nunnaly measured the attitudes of 350 people on a seven point Likert type of scale. After analysing the results, he interpreted his findings to show that public information about mental illness was not highly structured or crystalized and that the public was informed rather than uninformed.

It is only during the last decade studies on attitude towards mental illness have shown that there is a
change in the negative and positive aspect among the people about mental illness. Van Weerdan and his associated (1972) found the attitudes in a Netherlands' sample to be ambiguous rather than either positive or negative. They also did not find any direct relationship between favourable attitudes and real contact with the mentally ill.

Earlier, Freeman (1961) had found that better educated relatives of the mentally ill tended to hold more enlightened attitude. He also reported that relatives' attitude was not influenced by the duration of mental illness or the number of hospitalization of the patient. However, the recovery of the patient and the behaviour after release from the hospital influence the attitude of the families. He did not find any attitudinal difference by social class of the relatives. This finding of Freeman was contrary to the findings of Hollingshead and Redlich (1958) who had brought out striking social class differences in the attitude of relatives. Rodrigues and Kaneth (1971) in their investigation studied the differences in attitudes among people, who had their relatives in mental hospital and those who did not have. Their findings revealed no significant differences. Wylan and his associates (1976) found ethnic differences to be related with attitudinal differences among patients families.
INDIAN STUDIES

In India sociodemographic studies of schizophrenia have been subject of many enquiries in the recent past. Studies regarding parental deprivation at an early age (Bagadia et al., 1979); occurrence of life events and other related aspects have been subject of many reports (Abraham, 1973; Marfatia, 1973; Mohan, 1970; Mohan, 1975). Perhaps the most significant contribution regarding schizophrenia is the now well-known WHO pilot study of schizophrenia (1973).

Some studies in India have focussed on the family environment and family interaction patterns. Rastogi and Mahal (1971) have compared a group of 12 families of schizophrenics and neurotics and found similarity in patterns of interactions 'harmonious and understanding parents seeking dependence from each other, aggressive dominant father, subdued mother and child, passive dependent father, competing with child for mother's favour, competitive families with each adult competing with the others'. Sathyavathi (1971) concluded that there was no single family (Schizophrenic group) operating at the adaptive level. Gomez (1976) and Gomez and Bhatti (1977) found statistically significant disturbance in the schizophrenic families compared with normal families as the following:
(1) family group patterns of interactions;
(2) interaction of wife and husband as marital partners;
(3) interaction of wife and husband as parents;
(4) parent-child interaction; and
(5) child-parent interaction.

Some studies were done on the burden experienced by the patient's family members. During 1981, the works of Pai and Kapur, Muralidhar, Pai and Shariff and Muralidhar and Shariff at NIMHANS, Bangalore, concluded that the families of psychotic patients forced to get the patients admitted to the mental hospitals as the patients become too burdensome to be looked after and cared. The families experienced severe burden in the areas of finance, inter-personal relationships and effect on physical and mental health on other family members, became significant.

During the same year Pai and Kapur developed a scale to measure the burden on the family of psychotic patients based on the earlier works of Mandelbrote and Folkard (1961), Grad and Sainsbury and Hoenig and Hamilton (1966).

WHO collaborative study (1972) on the assessment and reduction of psychiatric disability has pointed out that as chronicity results in burden and number of impairments,
there is need for programmes, aiming at prevention containment or reduction on high priority basis.

Krishna (1987) in his study of Post-hospital Adjustment of Chronic Psychotic Patients reported that family burden was statistically significant in the areas of finance, disruption of family interaction, effect on mental health of others and subjective burden, whereas in disruption of family routine activities, disruption of leisure time activities, effect on physical health of others, there was no significance.

Studies to find out about the attitude of the family members towards mentally ill and mental illness were also conducted by a few researchers.

Verghese and his associates (1974) in an epidemiological work in Vellore found that there was a change of attitude in the public, which was positive and favourable in respect of mental illness and its treatment.

In a study conducted by Kshama et al., (1974) in NIMHANS, Bangalore, it was deduced that the relatives of the hospitalized mental patients did not show positive attitude towards mental illness.

Though literature on social aspects of Schizophrenia is known for its variety and abundance, it has its own short-comings. Inspite of the advancement in
knowledge and professional realization about the vital role of families, no adequate efforts were focussed on exploring the different aspects of the families of schizophrenic patients. The focus on different aspects of the families like family interaction patterns, family environment, family burden, attitude of the family members towards mental illness, would provide adequate information which can be beneficial for improving the quality of family life, which in turn can lead to find better ways of prevention and rehabilitation of the Schizophrenic patients.

STATEMENT OF THE PROBLEM

Schizophrenia is the most frequently diagnosed mental illness in India as in other parts of the world. 85 per cent of the mental hospital population and 42 per cent of the patients attending the out-patient departments of the mental hospitals falls in this category. Though Schizophrenia is such a serious problem, only a few studies have tried to examine the social aspects of Schizophrenia. Reliance on the families for the purpose of treatment and rehabilitation being the only alternative in our country, all concerted efforts need to be focussed on this vital unit. Literature review of the above mentioned studies clearly show that there is hardly any scientific study regarding families of schizophrenic patients in Goa. Goa remained away from India for a very long time. The motivation for this study arose out of the realization that there is a need to study,
Goan schizophrenic families. So the study of social aspects of schizophrenia with emphasis on different aspects of families can offer valuable clues and points for strengthening knowledge base of social scientists and other professionals. It can also be of great help for planning and organizing important activities for the individuals, their families and to prevent the onset of schizophrenia to a certain extent by providing social support to the vulnerable sections of the society. It is to fill this gap in our knowledge and understanding relating to the various social aspects of schizophrenia that the present study was undertaken in Goa.

The present study is organized in the following manner. This introductory chapter constitutes the first chapter of the study. Second chapter deals with research methodology. Chapter three describes the socio-economic background and the clinical condition of the patients. Chapter four deals with the family interaction patterns of the schizophrenic patients. Chapter five describes the family environment of the patients. Burden experienced by the patients' family members is dealt with in Chapter six. Chapter seven explains the family members attitude towards mental illness and mental patients. Chapter eight is devoted to the general summary and conclusion of the study. In addition to these chapters, there are seven appendices and an exhaustive bibliography.