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Influence of Family Factors in Causing Different Psychiatric Disorders: A Systematic Review

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Abstract:
Background: The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past decade. The concern of psychiatry with family has been important. It is indicated that family has a crucial role in the development of mental disorders. Mental disorders develop as a result of family pathology or faulty communication or interpersonal relationship. So this study was carried out to review the literature and to describe the family as a causative factor for facing to develop psychiatric Method: An electronic search of articles from Google was conducted for articles published. The purpose of this article was to present a review of the literature related family factors in causing different psychiatric disorders. There is a general agreement in the literature that a multitude of psychosocial and family factors affect the individual and it would result in causing psychiatric disorders. Therefore, this literature review examined the most frequently investigated variables such as family communication, expressed emotion, schizophrenic mother and psychological distress as they are related to family factors in causing psychiatric disorders. Results: A systematization of information revealed the existence of communication, expressed emotion, schizophrenic mother and psychological distress and various psychological strains. Conclusions: The findings of this study urge the mental health care professionals to actively work with the community to spread the awareness about the role of family in pathogenic causes of developing psychiatric disorder. And also it is important to work with those families who already have a person with psychiatric illness to educate them about healthy communication and healthy family environment and how it helps to recover from illness and also prevent further relapse.
Key words: *Family, Psychiatry, Disorder, mental illness*

Introduction:

Role of family is important for all aspect of human development. From family an individual gets emotional, financial, mental support and becomes able to solve his/her problems. Scientific observations on psychiatric disorders and psychiatric patients have indicated that family contributes significantly to the development of psychiatric disorders. The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past decade. The concern of psychiatry with family has been important. It is indicated that family has a crucial role in the development of mental disorders. Mental disorders develop as a result of family pathology or faulty communication or interpersonal relationship. Although the individual is affected, yet the whole family is sick because of inter or intrapsychic problems. Mental illness does not occur in a vacuum, it rises in a family set up, with family dynamics playing causative role (Kiran M., 2001). Studies have shown that pathogenic family structure for example, discordant, disturbed, disrupted, antisocial families have a significant role in causing mental

illness. Early conceptualization of the role of the family like focused exclusively on the mother-child relationship.

Statement of the Research Problem

It is presumed that there are some family factors which are causing mental illness. Literature review pertaining to influence of family factors causing mental illness reveals that there is dearth of research studies on this aspects in both foreign and in India. Hence, this research study would bring out the effect of above mentioned variables on influence of family factors causing mental illness

Materials and Methods

Aim: The aim of this study was to review the literature and to describe the influence of family factors causing mental illness

Research Questions

- What kind of family factors causing mental illness?
- How it has been affected their life?
- How they have been coping and how they handled the situation?
- What can be done to solve their problems?

Methods for inclusion/exclusion of studies for literature review

A systematic search from google was carried out for articles published. Key words included in the research were: family factors, communication, expressed emotion, social support, schizophrenic mother, psychosocial issues, burden, families, relatives, caregivers, carers impact, review, quality of life and a combination of them. Potential studies were included if they have considered family members and focused on family factors causing mental illness. Cross-sectional, longitudinal, reviews, qualitative and case reports studies were included. A total of 25 studies were retrieved. Titles and abstracts were reviewed independently and irrelevant articles were discarded. Finally, 20 studies were included in the review.

Results

Methodological aspect

To assess the family causes of psychiatric disorders, different methods and instruments were used; therefore, comparison among studies was difficult. The correlations between different variables and psychiatric disorder included in the discussion came mainly from quantitative descriptive studies. In order to summarize the results taking into account the heterogeneity and the quality of the studies, the authors agreed that an association between any family factor and psychiatric disorder was considered in the discussion and/or was present in at least 10% of the papers reviewed. This allowed us to discuss those associations that were significant form a statistical point of view and more frequently studied. The family members playing as a causative role in developing psychiatric disorders and it has been reviewed in great detail in different psychiatric disorders

Schizophrenia

Schizophrenia is a severe form of mental illness that results in serious impairment in day-to-day functioning of the affected person. Studies on the aetiology of schizophrenia had shown the biological underpinnings. Genetic factors and abnormalities in neurochemistry and neuroanatomy have been identified by many researchers in recent days as having role in schizophrenia. Despite this finding role of socio-environmental as well as family factors also plays a substantial role in this regard. Most mental health researchers have put forward the role of dynamic interplay among biological, socio-cultural and family factors in the causation of schizophrenia. One such hypothesis, i.e., diathesis-stress (or vulnerability-stress) model (Zubin & Spring, 1977) came up with some valuable notes regarding some persons' vulnerability to schizophrenia. The diathesis-stress model incorporates both biological and environmental factors into an integrated explanatory framework and is now the dominant heuristic for understanding psychopathology. By virtue of their placement on the vulnerability continuum, individuals are considered to be at greater or lesser risk of developing psychopathology when they are exposed to environmental stressors. Researchers investigated and identified some family-based demographic variables that are associated with elevated risk for the disorder. Belonging to low social class is one such example. In many landmark epidemiological studies it had been come up that people with schizophrenia are over-represented in more

disadvantaged socio-economic groups - a fact that could be explained by the downward social drift caused by having a disorder that makes it very difficult to work (Faris & Dunham, 1939). Nevertheless, it is also observed that being born into a lower social class (rather than drifting there due to illness) might as well cause elevate risk for the development of schizophrenia (Goldberg & Morrison, 1963). One reasonable explanation for this phenomenon is that poverty increases exposure to life stress.

Factor like father's age has also been held as some relationship with the onset of schizophrenia. There is evidence that having an older father may increase a child's risk of developing schizophrenia. Byrne et al (2003) identified an association between increased risk of schizophrenia and advanced paternal age, particularly for females whose fathers were over 50 years at the time of their birth. A similar pattern was revealed for males whose fathers were between 50 and 54 years old. But why these two have relationship each other has not been identified by the researchers so far. However, one possibility is that advanced parental age increases risk for genetic mutations.

Family related factor like 'communication' among family members has also been researched extensively to explore the role of family in causing schizophrenia. In the decade of 1960s Wynne and Singer (1963) explored that schizophrenia patients' families generally have faulty and inadequate communication. To establish their hypothesis they developed the construct of communication deviance (CD). These authors categorized a pattern of unclear, fragmented, disruptive, or amorphous communication that they observed in relatives of patients with schizophrenia. Later studies identified greater levels of CD in the parents of patients with schizophrenia compared with either the parents of healthy control children or the parents of children with non-psychotic disorders (Miklowitz et al., 1991; Hooley & Hiller, 2001). This suggests that these parents have difficulty in establishing and maintaining a common focus of attention. However, it is still unclear that whether the unusual patterns of communication found in the parents of those with schizophrenia contribute to the development of schizophrenia, or whether such communication deficits simply represent a reaction to the child's developing disorder. Goldstein (1987) endeavoured a study to examine how parental CD is related to schizophrenia or schizophrenia spectrum disorders in adolescents. They concluded that disturbed patterns of communication have some causal role in the development of schizophrenia. Later Wahlberg et al (2000) stated that communication deviance on the part of family members, especially parents might interact with genetic risk to trigger the development of schizophrenia in vulnerable individuals.

Apart from aetiological or triggering role of family factors there are some studies which have pointed out the role of family factors in the course of schizophrenia. Family variables like expressed emotion (EE) and affective style (AS) are well-studied in this regard. The concept of expressed emotion confers the family's attitude and behavioural expression to the patient. Categorically expressed emotion means how the relative speaks about the patient and is composed of three principal elements: Criticism, Hostility and Emotional Over-involvement (Vaughn & Leff, 1976). In many researches one consistent finding has been noted, i.e., patients suffering from schizophrenia who return to homes containing high-EE relatives have relapse rates that are more than double those found in patients returning to families who are low in EE (Butzlaff & Hooley, 1998). It is worthy to note that EE is not a relapse risk indicator that is specific only to schizophrenia. EE has also been found to predict relapse in unipolar depression (Vaughn & Leff, 1976; Hooley & Teasdale, 1989), bipolar disorder (Miklowitz et al., 1988), and other disorders such as alcohol abuse (O'Farrell et al., 1998). The Affective Style (Doane et al., 1985) is a construct developed to assess, in a more direct fashion, how the attitudes of relatives are expressed during these interactions with patients. Affective Style measures the level of *both* positive (supportive) and negative (critical, intrusive) verbal behaviours between patients and relatives during a certain point of time after the discharge of patients from psychiatric hospital. Doane et al. (1985) found that levels of negative Affective Style in relatives predicted the relapse of patients. Subsequently Rosenfarb et al (2000) found that levels of interpersonal criticism in family members interacted with deficits in working memory to predict the presence of unusual thinking in patients with schizophrenia. The affective quality

of family interactions may exacerbate cognitive deficits to contribute to the presence – or re-emergence - of symptoms in patients with schizophrenia.

The role of family in the pathogenesis cause of schizophrenia

Schizophrenia is a serious mental disorder, which typically begins during later puberty or at the first years of adultness. It is characterized by structural deformities of thought and perception and by unapt feelings. The disorder affects the very basic functions which attribute the sense of individuality, uniqueness and self-determination to the person. The behaviour can be seriously disturbed during certain phases of the disorder and thus have unfavourable social consequences. The course of schizophrenia varies from individual to individual, and complete recovery can be achieved at the one third of the cases. It can, however, follow a chronic and relapsing course with residual symptoms and insufficient social settling down. Many views have been stated concerning the pathogenic role of family in the pathogenesis cause of schizophrenia that are not widely acceptable today. On the contrary, the positive role of families in the programs of care mental suffering was recently recognized (WHO 2001). Many theories concerning the role of family in the development of schizophrenia have been formulated. Although Freud considered schizophrenia as an "organic disorder", since the beginning of 1930, the psychoanalysts have incriminated the relation of mother with her children as a factor for explaining the illness (Hartwell, 1996). For example, Sullivan (1931) considered that schizophrenia was the result of continuous stress and was caused by adaptation difficulties. In particular, he believed that schizophrenia was an emanation of precocious painful experiences with the mother. Linds and Linds (1949) were among the first who studied the characteristics of schizophrenics' mothers. More specifically, they investigated 50 cases and they found that in general the patients came from unstable families with frequent absence of one or even both parents due to death, divorce or separation. These researchers discovered serious insufficiencies and psychological disorders in the mother-child relation and father - child relation.

In 1948, Fromm-Reichmann established the term "schizophrenic mother" and attributed the "great interpersonal sensitivity" of the individual with schizophrenia to "early rejection" from a parent, usually the mother. In a widely known article of the time, the distinguished psychoanalyst, known for her work with schizophrenics, describes the "schizophrenic mother" as a totalitarian, cold, rejective, possessive individual who creates guilt's, and in conjunction with a passive, remote and ineffective father, causes confusion and a feeling of insufficiency to her son and finally leads him to schizophrenia. The appearance of family treatment in 1950, instead of discriminating parents, continued considering that the family constitutes the main problem for schizophrenia. Bateson et al introduced the concept of "double message" for interpreting and development of schizophrenia to a family member, stressing that schizophrenia is the result of failure of the family communication system. According to those researchers, a condition of double bond derives when an individual (often a child) receives repeated contradictory messages from the same individual (for example an adult) with whom the child has an important developing relation. The result of a repeated and extended exposition to this condition is that the child reacts with equally incoherent messages in order to protect himself and learns to face all relations with a deformed way. He finally loses the ability of understanding the real importance of his own communication or others' communication. In this point, the child starts expressing a schizophrenic behaviour.

Lidz et al (1957) have elaborated the role of the "matrimonial schism" and "matrimonial deviation" in pathogenesis cause of schizophrenia. The matrimonial schism refers to a condition during which every parent, preoccupied with his/her problems, does not accomplish to create a satisfactory role within the family that is compatible and mutual with the other spouse's role. At the same time, each parent has the tendency to undermine the other's value, specifically in front of the children and compete his/her spouse as it concerns their children's devotion, affection, compassion and support. In the form of matrimonial deviation, the continuity of marriage is not under threat, but there can be observed mutual destructive forms. In this type of families, one of the two parents suffers from serious mental disorder. The other parent who is often is depended and weak, concedes to the

situation and reaches up to the point of letting the children realise that this family situation is natural. This refusal of what is being lived may lead the children into further refusals and distortions of reality. Linds and his collaborators concluded that matrimonial deviation often precedes a schizophrenic son, while the matrimonial schism precedes a schizophrenic daughter.

Bowen (1960) supported the view that schizophrenia constitutes a process which extends at least into three generations before it is expressed into a family member's behaviour. He supported that one or even both parents of a schizophrenic are problematic, immature individuals who, having suffered a serious sentimental conflict with their own parents, they subject their own child into similar conflicting situations. Singer and Wynne (1966) described the "warp" parental couple and "pseudoreciprocity". The term pseudoreciprocity is used to describe the way with which the families give the impression of a reciprocal, open comprehension relation existing in reality. The parents avoid every disagreement, giving a false picture of harmony to the others, while in reality they hide a deeper distance between them. Pseudoreciprocity constitutes a common policy drawn to protect all members of family from the diffuse sentiments of an empty and meaningless life. An individual who grows up in such a family environment does not manage to develop a powerful sense of personal identity; neither does he make sense from a personal off family experience. The aforementioned theories have been blamed as being incriminating for the family. In one of his studies on the historical general frame of the significance of schizophrenicogenic mother, Hartwell disagrees with the opinion that the incrimination of mother for the causation of schizophrenia constituted part of a social opinion that women were becoming increasingly dynamic. However, right or wrong, the tendency to ascribe the responsibility for schizophrenia to the parents has continued for years (Hartwell, 1996). Since the 1970s and beyond, the study of family and its relation to schizophrenia continues, but this time for different reasons. Modern approaches concern mainly the study of emotional, inner family atmosphere as well as the quality of inner family communication, the study of emotional and physical burdening of the other family members, the reasons of family participation into a therapeutic process and the need for various therapeutic interventions in the level of family.

B. Affective Disorder:

Parental deprivation

Psychoanalysts have suggested that childhood deprivation of maternal affection through separation or loss predisposes to depressive disorders in adult life. There is more support for the proposal that depressive disorder in later life is associated with parental separation; the main factors here appear to be parental discord. For example, in the Second World War children separated from their parents by evacuation did not experience. Increased affective morbidity in adult life and children separated from their parents as a result of marital problems or divorces subsequently have increased rates of depression (Tennant 1988). Patients with severe depressive disorders, patients with mild depressive disorders (neurotic depression) remember their parents as having been less caring (Parker, 1979).

Predisposing of events and life difficulties

To estimate the importance of life events in each condition, Peykel (1978) applies a modified form of the epidemiological measure of relative risk. He found that the risk of developing depression increased six fold in the six months after experiencing markedly threatening life events. The comparable increase for schizophrenia was two to four folds and for attempted suicide it was sevenfold. These conclusions were similar to those of Brown et al., (1973) who used another estimate, 'The brought forward time. It is a common clinical impression that the events immediately preceding a depressive disorder act as a 'last straw' for a person who has been subjected to a long period of adverse circumstances such as an unhappy marriage, problems at work or unsatisfactory housing (Brown & Harris 1978). Overall there is good evidence that poor social support, measured as lack of intimacy or social integration, is associated with an increased risk of depression (Paykel & Cooper 1992). Persons who were maritally distressed but not clinically depressed at an initial interview exhibited a heightened risk for depression eight months later, suggesting that marital distress is a risk factor for depression (Lewinsohn et al 1988). Akiskal (1989) has found

that loss of parents early in life are associated not with overt mood disorders but with immaturity, hostile dependency, manipulativencess, impulsiveness, and low threshold for alcohol and drug abuse in adulthood without directly affecting the lifetime risk for depression, these characteristics may precipitate life events that then trigger depression earlier in life and result in more frequent episodes of depression. Similarly, the 40% of depressed patients who have personality disorder experience more life stress, an earlier onset of depression, and poorer recovery than those without such disorder (Black et al 1988; Phoft et al 1984).

Tienari et al (2004) described various forms of family dysfunction that were associated with affective psychosis. Earlier Alnaes and Torgersen (1993) had reported that marital discord between an individual's parents can increase that individual's risk for developing bipolar disorder. Though this finding is not free from criticism as bipolar disorder tends to run in families or having genetic predisposition, so it is not clear if marital discord between the parents is linked to mood lability in the parents themselves or whether it is an independent risk factor. Certainly, the possibility that marital problems in the parents arise from the stress of dealing with a temperamentally challenging child who is in the early stages of susceptibility to mood instability also warrants consideration. Dysfunctional relationships with parents since early age have been associated with increased risk of developing bipolar disorder in some studies (Alnaes & Torgersen, 1993; Rosenfarb et al., 1994). Though, high elevation of the level communication deviance was noted in parents of patients with bipolar disorder. However, the potential role of communication deviance in the development or course of this disorder remains unexplored. But it has been seen that parents of manic patients seem to be more likely than those of schizophrenia patients to exhibit "contorted, peculiar language". This includes odd word order, leaving words out, or inclusion of many unnecessary words or details. Parents of manic patients also appear to be more likely to make tangential, inappropriate remarks than do parents of schizophrenia patients. During the interactions used to assess communication deviance, manic patients, as well as their parents, demonstrated odd word usage and unusually constructed sentences more frequently than schizophrenia patients (Miklowitz et al., 1991). In case of expressed emotion bipolar patients who return to live with high-EE families relapse at almost twice the rate (90% vs. 54%) of those living in low-EE family environments (Miklowitz et al., 1988). Major difference regarding the link between EE and relapse in bipolar disorder and in schizophrenia is that, even when they live with low-EE families, bipolar patients are still at higher risk of relapse than schizophrenia patients (Miklowitz et al., 1987). This suggests that although EE is an important variable with regard to predicting the clinical outcome of bipolar patients, other factors also warrant consideration. Perhaps because patients with bipolar disorder are especially stress sensitive, they are liable to break down in the face of stress from a greater variety of sources. In affective disorder presence of factors like family conflict and negative life events have some association with frequent relapses among bipolar patients (Christensen et al., 2003). In case of depression factors under the ambit of family environment like parental psychopathology (particularly mood disorders), attachment, childrearing practices, and communication and interaction patterns among family members have some association with the onset and/or maintenance of depression. Exposure to adverse family environments characterized by the absence of supportive and facilitative interactions among family members and, elevated levels of conflict, frequent criticism by family elders and/or angry interactions are associated with depression in children and adolescents. In previously done community/clinical/at risk samples studies it was observed that depression is inversely related to factors like level of family support, attachment, and approval from family members.

C. Substance Addiction:

The risk of drug abuse is greater in societies/families, which condone drug – taking of one sort or another within the immediate group. There may be social pressures for a young person to take drugs to achieve status. There is evidence that drug use by Individuals can be predicted by the substance use of their peers (Swadi 1992). There are also links between drug abuse and indices of social deprivation such as unemployment and homelessness (Hammer 1992; Medina-Mora 1992). The sons of alcoholics are at

increased risk of developing alcohol dependence, and a number of studies have attempted to find biological abnormalities that may antedate and predict the development of alcohol dependence in these subjects (Berman Noble 1993). It has been reported that children tend to follow their parents drinking patterns (Hawker 1978), and that from an early age boys tend to be encouraged to drink more than girls (Jahoda & Cramond 1972). Non-genetic familial factors appear to be important in determining levels of alcohol use (Clifford et al., 1984). It has already been proved that family has a major role in the etiology of substance abuse, which is confirmed by research findings, although these are important interaction with peer influences is also present. Research has commonly focused on various aspects of family dysfunction as risk associated with substance abuse (Hawking et al., 1992), or in other words family dysfunction is one among many causal factors in the generations of drug misuse and related social and behavioral disorders among adolescent and young adults. In particular research continues to indicate that parental substance use tends to put children and adolescent in such families of a heightened risk of a variety of stressful life events. Behavioral and emotional difficulties, weakened ties drug use in adolescence. Several researches have revealed that the aetiology of substance addiction comprises a complex network of interactive social, cultural, biological, and genetic factors. And the family is the primary source of transmission of these factors. Family factor like positive family history of substance addiction (i.e. presence of a disorder in *any* first-degree relative: parents, siblings, or offspring) is a consistent and robust risk factor for substance. Parental alcoholism has been shown to be the most consistent risk factor for the development of substance-related problems in vulnerable youth. Other family factors like parenting style, parental psychopathology (e.g., Parental depression, anxiety, and antisocial personality disorder) are associated with offspring substance use), neglect and abuse, negative patterns of family interaction, laxity in monitoring children, and inconsistent discipline and displays of affection have been found to have some association with substance addiction to adolescents and young adults.

D. Depression and Family

According to Sethi et al (1985) mental illness is a product of sick family i.e parental pathology or pathological pattern of interpersonal relationship in the family. Problems are usually the symptomatic manifestation of a disturbed family unit. According to them depression is a more common in the nuclear family set up. Depression reaction appears to be related to the social changes in the family structure. For generations life in india has centered in the joint family, which provided a form of social insurance in one the docile. Urbanization and industrialization, employment of women, these factors are responsible for this change. This new pattern of individual family unit seems to have caused more depression and suicidal in our generation, primarily because such breaking away leads to emotional inadequacy in vulnerable individuals and also produces a marked sense of guilt. Whereas a joint family was an useful social agency providing protection and security.

Limitations:

This current study has certain limitation. Due to the language criteria, relevant information published in languages other than English may have been missed. The literature search terms were selected to be as inclusive as possible, but some articles could have been omitted, including studies that did not mention key words. This review is considered a contribution to the literature, presenting the most frequent family factors related to psychiatric illness. The relationship of these factors with the different theories (expressed emotion, social support and double bind communication) provides guidelines for future interventions, in the sense of knowing what, with whom and when to deal. It is necessary to include the prevention of the family factor instead of the intervention of psychiatric illness. Future research is suggested to consider this point.

Recommendation from the study

This literature from various studies indicates that family plays as a causative role for their loved ones development of mental illness in their family. They need to be given proper attention and psychosocial intervention to make them realize that how the family has contributed for the development of their loved ones illness. However, implication pertaining to reducing the family's causative thing it is also important to establish

government policies of investment aimed at providing a public awareness.

Conclusion:

The findings of this study urge the mental health care professionals to actively work with the community to spread the awareness about the role of family in pathogenic causes of developing psychiatric disorder. And also it is important to work with those families who already have a person with psychiatric illness to educate them about healthy communication and healthy family environment and how it helps to recover from illness and also prevent further relapse.

References:

1. Bateson G, Jackson DD, Haley J & Weakland J. Towards a theory of schizophrenia. Behavioral Science 1956, 1: 251-264
2. Berman S. M. Noble, E. P. (1993) Childhood antecedents of substance misuse. Current opinion in Psychiatry 6, 382-87.
3. Bowen M. A family concept of schizophrenia. In D. Jackson (Ed), The aetiology of schizophrenia. New York, Basic Books, 1960 : 346-372.
4. Brown and Harris (1978) Social origins of depression. Tavistock (London).
5. Brown et al. (1973a) life events and psychiatric disorders: the nature of the causal link. Psychological Medicine, 3: 159-76.
6. Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. *Archives of General Psychiatry, 55,* 547-552.
7. Byrne, M., Agerbo, E., Ewald, H., Eaton, W. W., Mortenson, P. B. (2003). Parentel age and risk of schizophrenia: A case-control study. *Archives of General Psychiatry,* 60, 673-678. (Abstract)
8. Clifford et al., (1984) A genetic and environmental analysis of a twin family study of alcohol use, anxiety and depression. Genetic and epidemiology 1, 63-79.
9. Doane, J.A., Falloon, I. R. H., Goldstein, M. J., Mintz, J. (1985). Parental affective style and the treatment of schizophrenia. *Archives of General Psychiatry,* 42, 34-42.
10. Faris, R.E.L. & Dunham, H. W. (1939). *Mental disorders in urban areas.* Chicago: University of Chicago Press.
11. Fromm-Reichmann F. Notes on the development and treatment of schizophrenia by psychoanalytic psychotherapy. Psychiatry 1948, 11: 263-273
12. Goldberg, E.M. & Morrison, S.L. (1963). Schizophrenia and social class. *British Journal of Psychiatry, 109,* 785-802.
13. Goldstein, M.J. (1987). The UCLA high-risk project. *Schizophrenia Bulletin,* 13(3), 505-514.
14. Hammer, T. (1992) Unemployment and use of drug and alcohol among young people: a longitudinal study in the general population. *British Journal of addiction,* 87, 1571-81.
15. Hartwell CE. The schizophrogenic mother concept in American psychiatry. Psychiatry 1996, 59: 274-279
16. Hawker A., (1978) Adolescents and Alcohol Edsall, London.
17. Hooley, J.M. & Hiller, J.B. (2001). Family relationships and major mental disorder: Risk factors and preventive strategies. In: B. Sarason & S. Duck (Eds), *Personal relationships: Implications for clinical and community psychology* (pp. 61-87). New York: Wiley.
18. Jahoda.G. Cramond J. (1972) Children and alcohol. A developmental study in Glasgow, Vol. 1 HMSO, London.
19. Kiran, M. (2001). Family role in psychiatry. Indian Psychiatric Society – Jharkhand state branch, Newsletter, Sept-Nov, P 5.
20. Lidz T, Cornelison AR, Fleck S, Terry D. The intrafamilial environment of the schizophrenic patients. II. Marital schism and marital skew. Am J Psychiatry 1957 , 114:241-248.
21. Linds RW & Linds T. The family environment of schizophrenic patients. American Journal of Psychiatry 1949, 106: 332-345.
22. Medina Mora, M. E. (1992) Epidemiology of substance misuse. Current opinion in psychiatry 5, 403-07.

23. Miklowitz, D. J., Goldstein, M. J., Nuechterlein, K. H., Snyder, K. S., & Mintz, J. (1988). Family factors and the course of bipolar affective disorder. *Archives of General Psychiatry*, 45, 225-231.
24. Miklowitz, D. J., Velligan, D. I., Goldstein, M. J., Nuechterlein, K. H., Gitlin, M. J., Ranlett, G., & Doane, J. A. (1991). Communication deviance in families of schizophrenic and manic patients. *Journal of Abnormal Psychology*, 100(2), 161-173.
25. O'Farrell, T., Hooley, J. M., Fals-Stewart, W., Cutter, H.S.G. (1998). Expressed emotion and relapse in alcoholic patients. *Journal of Consulting and Clinical Psychology*, 66, 744-752.
26. Parker G. (1979) Parental characteristics in relation to depressive disorders. British Journal of Psychiatry, 134: 138-47.
27. Paykel E. S. & Cooper Z. (1992) Life events and social stress. In Handbook of affective disorders (ed. E.S Paykel): 149-70. Churchill living stone, Edinburgh.
28. Paykel E.S (1978) Contribution of life events to causation of psychiatric illness. Psychological Medicine, 8: 245-53.
29. Rosenfarb, I. S., Nuechterlein, K. H., Goldstein, M. J., Subotnik, K. L. (2000). Neurocognitive vulnerability, interpersonal criticism, and the emergence of unusual thinking by schizophrenic patients during family transactions. *Archives of General Psychiatry*, 57(12), 1174-1179.
30. Sethi,B.B, Chaturvedi,P.K, Trivedi,J.K, Saxena,N.K (1985). Attitude of family and outcome in schizophrenia. Indian Journal of Psychiatry, 1,186-193.
31. Singer MT, Wynne LC. Communication styles in parents of normal, neurotics and schizophrenics. Psychiatry Res Rep 1966, 20: 25-38.
32. Sullivan HS. Environmental factors in the etiology and course under treatment of schizophrenia. Medical Journal and Record 1931, 133: 19-22.
33. Swadi H (1992 b) Relative risk factors in detecting adolescent drug abuse. Drug and Alcohol dependence 29, 253-54.
34. Tennant C. (1988) Parental loss in childhood: its effect in adult life. Archives of General Psychiatry, 45: 1045-50.
35. Vaughn, C., & Leff, J. (1976). The measurement of expressed emotion in the families of psychiatric patients. *The British Journal of Social and Clinical Psychology, 15*, 157-165. (Abstract)
36. Wahlberg, K. E., Wynne, L. C., Oja, H., Keskitalo, P., Anais-Tanner, H., Koistinen, P., Tarvainen, T., Hakko, H., Lahti, I., Moring, J., Naarala, M., Sorri, A,, & Tienari, P. (2000). Thought disorder index of Finnish adoptees and communication deviance of their adoptive parents. *Psychological Medicine*, 30(1), 127-136.
37. World Health Organization (2001) . World Health Report 2001. Mental Health – New Understanding, New Hope.
38. Wynne, L.C. & Singer, M. T. (1963). Thought disorder and family relations of schizophrenics: I. A research strategy. *Archives of General Psychiatry*, 9, 191-198.
39. Zubin, J., spring, B. J. (1977) Vulnerability: a new view of schizophrenia. J. Abnormal. Psychol. 86:103-26.