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Abstract

This paper addresses the relevant of institution of family that had come under considerable strain with the changing present scenario. The aim of this paper is to help middle class family to resolve frequent conflicts that threaten interpersonal relationship and to explore best alternative possible solutions. Employing phenomenological approach, psycho social factors of immediate social environment was assessed using semi structured qualitative interview, telephonic conversations, and observations during therapy sessions over a period of seven months. Depression of the patient and family functions were assessed using Zung self-rating scale and McMaster family assessment device respectively. Results showed that family therapy had been effective to resolve psycho social problems and enhance psycho social functioning among family members. Family stated satisfactions in relationship, healthy communication pattern, decision making and affective involvement to each other. An ultimate result shows an egalitarian environment in the house which strengthens family relationship and reduced conflicts.

Keywords

Family Therapy, Psycho Social Factors, Immediate Social Environment, Sculpting, Behavior Exchange, Qualitative Research.

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Relevance of Family Therapy in the Resolution of Family Dispute among Couple: Indian Perspective

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This paper addresses the relevant of institution of family that had come under considerable strain with the changing present scenario. The aim of this paper is to help middle class family to resolve frequent conflicts that threaten interpersonal relationship and to explore best alternative possible solutions. Employing phenomenological approach, psycho social factors of immediate social environment was assessed using semi structured qualitative interview, telephonic conversations, and observations during therapy sessions over a period of seven months. Depression of the patient and family functions were assessed using Zung self-rating scale and McMaster family assessment device respectively. Results showed that family therapy had been effective to resolve psycho social problems and enhance psycho social functioning among family members. Family stated satisfactions in relationship, healthy communication pattern, decision making and affective involvement to each other. An ultimate result shows an egalitarian environment in the house which strengthens family relationship and reduced conflicts. Keywords: Family Therapy, Psycho Social Factors, Immediate Social Environment, Sculpting, Behavior Exchange, Qualitative Research.

Introduction

This article provides a comprehensive introduction to contemporary thinking about the family based interventions in mental health in India. Family based intervention has been the most significant contribution in psycho social management of psychiatric illness. In India, it has been the long tradition of involving family members for the treatment of psychiatric problems. The effectiveness of family therapy is determined in terms of its needs of the family and structured process of the therapy consistent with clients. It is utmost important that how we look in to the cultural aspects of a family, and identifying its basic needs for survival. It is a successful requirement for family interventions. It is utmost important for an individual to successfully commit to his or her partner that requires self-esteem, empathy, and identity. Effective communication act as an essential component for marital success (Robinson & Blanton, 1993). Gottman (1995) stated that communication may be productive or destructive to personal relationships as unhappy partners tend to look down other partner, criticize, disagree, and complain on a little bit issues. In contrary, couples with marital satisfaction were more likely to use effective listening skills (Noller & Fitzpatrick, 1991), and also possess courage, self-control, and accompany each other (Fowers, 1986). A successful marriage needs sharing of emotional expression, a desire to make marriage work, and a willingness to expend time and effort to sustain it (Mace, 1982). Sabatelli and Cecil-Pigo (1985) found that when both partners had equal participation and inter-dependence in their relationship, the couple was very committed. Thus, marital relationship became successful if commitment is mutually achieved (Surra, Arizzi, & Asmussen, 1988).

Commitment is one of the essential component to marital relationship sustain (Mace, 1989). Besides this, the relevance of verbal and physical affection in a couple relationships (Bell et. al.1987), the couple must talk and sort out their differences concerning affections and sexual activity (Ammons & Stinnett, 1980). Gottman, (1995) identified romance as the most important component in the relationship and could be sustained by open expression of feeling and spending time together. However, failure to meet the expectations of each other about intimacy in the relationship predicts marital dissatisfaction (Kelley & Burgoon, 1991). However, socialization process of childhood shape gender related attitudes and beliefs that in turn create marital behavior patterns that may contain variety of cultural aspects whether traditional or non-traditional (Duck, 1993; Otto, 1979; Thoits, 1992). Social mores perpetuate that, in the marriage, men must be a superior, hierarchical status such as more educated, older, and more sexually dominant, more income generating power, (Carter & McGoldrick, 1989).

The lack of review of literatures of family therapy in India did not provide an insight in to an understanding of family relationships among its members. However, there are numerous study focused on the psycho social problems of an Indian family faces. In India, family violence varies across regions. Acts of physical violence which includes sexual, threat of abuse, psychological is rooted in the socio cultural set up of the society. For example, violence is inflicted against a women by an individual intimately connected to her through marriage, family relation, or acquaintanceship is universal and has its root in the socio-cultural set up of the society. Various regional studies conducted by researcher such as Mahajan (1990), who studied Punjab; and Sinha (1989) carried out research at Bihar, stated that cultural justifications of domination impregnated in patriarchal society in India. It is alleged that daughter in law was usually having conflict with or disrespect to her parents-in law (Mahajan 1990; Mohan 1990) or disobeying the husband (Heise et al., 1994). Often, parents-in-law are involved in the process (Sinha 1989).

In Indian culture, a woman is said to be “Ardhangini” (half of the body) of the man. It is only restricted to the literature and usually barriers came to implement it. The barriers are the traditional culture of India. It is recognized as the significant barriers of the empowerment of women, with consequences of women’s health, their health-seeking behaviour and their adoption of small family norm. The perpetrators of violence have often been found to be the males and the victims, their sexual partners. It revealed that the overall prevalence of physical, psychological, sexual and any form of violence among women of Eastern India were 16%, 52%, 25% and 56% respectively. These rates reported by men were 22%, 59%, 17% and 59.5% respectively (Babu & Kar, 2009). Men reported higher prevalence of all forms of violence apart from sexual violence. Husbands were mostly responsible for violence in majority of cases and some women reported the involvement of husbands' parents. It is found that various acts of violence were continuing among majority of women who reported violence (Babu & Kar, 2009). The marital dissatisfaction is associated with significant psychiatric co morbidity. The US National Co morbidity Survey revealed rates of victimization using severe physical aggression of 6.5% against women and 5.5% against men (Kessler et al., 2001). A study conducted by Archer, 2000 found that more women than men reported physical aggression in their relationships. In addition to marital dysfunction, intimate partner violence is associated with individual psychopathology, with rates of 54-68% for major depressive disorders and 50-75% for posttraumatic stress disorder in female victims (Nixon et al., 2004).

Methodology

We reported a single case to make possible understanding and holistic inquiry of the complex patterns of family disputes and its resolution in India. Participants were involved in the phenomenological understanding on the general meaning of family dissatisfaction. The present study had employed Giorgi's (2009), existential phenomenological approach as involves several persons share their view on and experiences with one and the same phenomenon. The phenomenological method provides the lived context of the participants and does so focusing on his or her perspective without the use of deception (Giorgi, 2009). This method permits the researcher to sustain the "voice" of the participants in the study without abstracting their viewpoints throughout psycho social interventions.

Phenomenology is both a research method as well as a philosophy. As a research method, it is an in-depth analysis of reexamining 'the things themselves' (Husserl, 1962). As a philosophy, it a particular way of approaching the world and understand lived experience (Merleau Ponty, 1962) and made accessible to psychology as a scientific research method by Giorgi (2009). Phenomenological perspective of the mind recognizes consciousness as the ultimate life quality that coexists with the body and thus, a person is regarded as an embodied consciousness (Husserl, 1977; Merleau-Ponty, 1962). Phenomenological study provides an opportunity to the persons how they articulate their lived experiences in common (Creswell, 2013). The purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence (Van Manen, 1990). This description consists of 'what' they experienced and 'how' they experienced it (Moustakas, 1994).

The Existential Phenomenological approach claims to have a comprehensive understanding of experiences of the human being from the consciousness and standpoint of the human being who is having the experience (De Castro, 2003). It had been claimed that this approach tries to reveal the essential meaning of the phenomenon under study, instead of creating abstract theories about the same phenomenon. It is utmost necessary to take in account by doing this kind of research is that a researcher has to focus on grasping the whole meaning of the experiences, instead of dividing it into parts without understanding the basic meaning structure, which gives sense to the whole experience. It reveals the essential meaning of the phenomenon under study (De Castro, 2003). If a researcher divides a given experience into parts before having understood how the person articulates his or her experiences, it reflects abstract concept that do not have holistic approach for that person. Therefore, a social researcher cannot grasp a sense of the whole of a given experience by separating the parts from the general context in which every part is based. If a researcher did so, it reflects artificial explanations about experiences because he or she will be approaching them from own perspective, that would not provide real picture of the experiences a person held it. Sokolowski, (2000) stated that a whole is called *concretum,* which is something that exists as a specific individual. He also stated that a part known as *moments* cannot exist and present apart from the whole to which they belong. So, as a researcher, it must be taken in to account, that they should not separate a given experiences from the concrete meaning structure of the person, because it lose the meaning that the person adhere in his/ her daily life. The goal is to comprehend human experiences as it is actually lived in the daily life and not in an artificial environment. Moustakas (1994) delineated that transcendental or psychological phenomenology focused less on the interpretations of the researcher and more on a description of the experiences of participants. He also focused on one of the Husserl's (1962) concepts, *epoché* (or *bracketing*), in which researchers set aside their experiences, as much as possible, to take a fresh perspective toward the phenomenon under study. Hence transcendental means "everything must be perceived freshly, as if for the first time" (Moustakas, 1994).

The phenomenological research method required that a researcher must *suspend or bracket* theoretical, practical preconceptions and assumptions about the case under study (Merleau Ponty, 1962; Husserl, 1962). It aimed to explore the participant's life world and was motivated to fulfill this aim. In phenomenological study, reliable interview depend upon the interviewer's ability to ensure participant's confidentiality and realize comfortable to reveal sensitive information about them (Kvale & Brinkmann, 2009). However, in this case study we delineated and explained the phenomenon through one family's experiences of family distress. It intended to describe the structure of the psycho- social phenomenon so that it could be understood in a holistic and more comprehensive way.

Participants

The name of the participants had been changed to ensure the anonymity of the family. This case was studied a patient diagnosed with moderate level depression for last one year as per the International Statistical Classification of Diseases and Related Health Problems-10th Revision (World Health Organization, 1990). Although she was being treated for depression and complies with drugs adherence, there was no improvement. The participants in family therapy includes Mrs. G. (patient), 34 years old, Hindu female housewife; Mr. J. (Husband), male, thirty eight years old, teacher in a private school; and Mr. K. (Father in law), male, fifty years old, was teacher and now getting pension.

Data collection

A single case was designed to reflect the relevant of family therapy to resolve marital dissatisfaction in a couple in India. It is a single-case design that assessed depression and family functioning at baseline using Zung self-rating scale (Zung, 1965) and McMaster family assessment device (Epstein et al., 1983) and same scales was employed at the end of the psycho social intervention (post intervention). Apart of this, data was also collected using semi structured qualitative interviews, telephonic conversations, home assignment and observations during therapy sessions over a period of seven months.

Measures

In addition to structured interviews and telephone conversations, the patient was assessed at baseline with Zung Self-Rating Depression Scale (Zung, 1965) and McMaster Family Assessment Device (Epstein et al., 1983) by the therapist.

McMaster Family Assessment Device (FAD):

It is a 53-item self-report measure consists of seven subscales that are composed of separate items based on the McMaster Model of Family Functioning (MMFF) and describes the structural and organizational properties of the family group and pattern of transactions among family members (Epstein, Baldwin & Bishop, 1983). The seven subscales are: Problem Solving (ability to resolve problematic situations at the level that maintain family functioning); Communication (sending or receiving clear and direct verbal information); Roles (assesses whether the family has organized patterns of behavior for operating family functions that include division of responsibility for completing family tasks); Affective Responsiveness (assesses the degree to which family members express appropriate affect in the presence of a range of stimuli that is ability to respond with appropriate emotion); Affective Involvement (assesses the degree to which family members are interested in and

take value in other members' concerns), Behavior Control (manner used to express and maintain standards of behavior) and General Functioning (assesses overall functioning of family). It is 4-point Likert scale ranging from (1) strongly agree, (2) agree, (3) disagree, and (4) strongly disagree.

Scoring of FAD:

Once the assessment is filled out it is scored by summing the endorsed responses (1-4) for each subscale (negatively worded statements are reversed) and dividing by the number of items in each scale. The higher the score the worse the level of functioning is (Miller et al., 2000). The differing cut-off scores are as follows: general family functioning is 2.27; communication is 2.37; affective responsiveness is 2.36; problem solving is 2.32; roles are 2.37; behavior control is 2.14, and affective involvement is 2.32 (Epstein, Baldwin, & Bishop, 1983).

Zung Self-Rating Depression Scale:

It was designed by W. W Zung (Zung, 1965) to assess the level of depression for the patients diagnosed with depressive disorder. It is a short self-administered survey to quantify the depressed status of a patient. There are 20 items on the scale that rate the four common characteristics of depression: the pervasive effect, the physiological equivalents, other disturbances, and psychomotor activities.

There are ten positively worded and ten negatively worded questions. Each question is scored on a scale of 1-4 (a little of the time, some of the time, good part of the time, most of the time). For items 1, 3, 4, 7, 8, 9, 10, 13, 15, 19 the scoring is:

a) a little of the time=1;
b) some of the time=2;
c) good part of the time =3 and
d) most of the time (4).

For items 2, 5, 11, 12, 14, 16, 17, 18, 20, are reverse scored as follows:

a) a little of the time=4;
b) some of the time=3;
c) good part of the time =2 and
d) most of the time= 1.

The scores range from 25-100:

a) 25-49 Normal Range;
b) 50-59 Mildly Depressed;
c) 60-69 Moderately Depressed and
d) 70 and above Severely Depressed.

Interpretation of Raw Data

Table 1: Score on Zung Self-Rating Depression Scale (Zung, 1965)

Scale	*Cutoff score*	*Pre intervention Score*	*Post intervention score*
Zung Self-Rating Depression Scale	**50 or Above**	**64**	**38**

Table 2: Score on the McMaster Family Assessment Device (Epstein et. al., 1983)

Domains	*Non clinical (Mean)*	*Clinical (Mean)*	*Cutoff Score (Mean)*	*Pre intervention Score (Mean)*	*Post intervention Score (Mean)*
Problem solving	**2.20**	**2.38**	**2.32**	**3.16**	**1.33**
Communication	**2.15**	**2.37**	**2.37**	**3.33**	**1.77**
Roles	**2.22**	**2.47**	**2.37**	**3.27**	**1.54**
Affective Responsiveness	**2.23**	**2.42**	**2.36**	**2.50**	**1.66**
Affective Involvement	**2.05**	**2.23**	**2.32**	**2.57**	**1.28**
Behavior Control	**1.90**	**2.02**	**2.14**	**3.22**	**1.44**
General Functioning	**1.96**	**2.29**	**2.27**	**3.41**	**1.50**

The obtained score on Zung Self-Rating Depression Scale was 64 from their cutoff score 50 or above. This indicates that patient was moderately depressed. The same scale was also applied after seven month of intervention (post intervention), the obtained score was 38, that comes between the normal range 25-49 (**Table 1**). On McMaster Family Assessment Device, the obtained score on each domain was higher as compared to cutoff score at baseline. This means family shown dysfunction in the respective domains. Again this Family Assessment Device (FAD) was applied at the end of the intervention (Post intervention) the obtained score on each domain was lower as compared to cutoff score that means family performing their functions smoothly (**Table2**).

Procedure

The basic contents of this study were prepared by taking in to account the utmost need of a middle class joint Hindu family, consisted of six members' father in law, husband and wife (patient), and their three children. After assessment of the present case, content of the sessions was prepared with the help of family members. It was planned to keep in account the need of the middle class family and their culture. How culture influenced the ongoing process of the interventions, it is reflected in the sessions. Family interventions were carried out for seven months on interval of 15 days. Each session was conducted for one and half hours. Psycho social intervention was facilitated according to establish and prepared contents of the sessions.

The goal of the sessions was to involve the participants in such a way that they could help themselves. The contents of the family therapy sessions are depicted in the intervention packages (**Table 3**). In the 1st session of the family intervention, family members were to raise consciousness of the psycho social factors through psycho education. She (Mrs. G.) was also trained in the Jacobson progressive muscular relaxation training at end of first session. In the 2nd session, it was facilitated family to have a mutual responsive interaction that replaces negative cycle of criticizing, and blaming in to emotional support, security, and intimacy. In the 3rd session, it was facilitated to identify the triggering factors through self-

prepared five column chart. This technique was employed to identify problematic experiences that aggravate patient about the negative beliefs and thoughts. The self-prepared five column chart was used for recording of problematic situations that triggered a strong emotion. This exercise was designed to pinpoints patient's reactions more accurately for 7 days. In 4th session, the home assignment was reviewed and family members were facilitated to make effort to sit together in a way: father in law, daughter in law, and husband respectively. In sessions 5th & 6th, family members were tried to break emotional cut off through exchange of role. Members were assigned respective roles. In these sessions, family was tried to inculcate cultural aspects of Hindu marriage. In session 7th, family was taught the strategy of behavior change with acceptance using a technique of behavior exchange. For this both of the partners had signed a contract. During 8th session, it was emphasized upon family members to eat together at least one time in a day whether lunch or dinner. In 9th session, family members were tied at waist with a rope and instructed to move without disturbing to other members. This was exercised to achieve mutual understanding among family members to resolve any problematic situation. In 10th and 11th sessions, they were inculcated problem solving skills and communication skills respectively. In the 12th session, family members reviewed their communication pattern at home and how arrived at any decision. In addition to this, they were also inculcated stress management techniques, as deep breathe in and breathe out exercise and Jacobson progressive muscular relaxation (Jacobson, 1938). In the 13th& 14th, family was facilitated to review the all treatment sessions, and its pros and cons.

Intervention Packages

Table 3: Description of family therapy Sessions and its Contents

Sessions	Contents
Session 1	The aim of this session is to raise the conscious of the family members by sharing of experiences; awareness regarding stages of behavior change, this session was initiated by asking participants to share their experiences of family problem. Patients were inculcated nature, course, and prognosis of depression and relevance of psycho social factors. Inculcation of Jacobson progressive muscular relaxation training at the end of the session.
Session 2	Inculcation of unity among family members using technique "softening."
Session 3	Records of problematic experiences through self-prepared Five-Column Chart; imagination; and home assignment.
Session 4	Evaluation of home assignment; develop competency among family members.
Session 5	Breaking of emotional cut off using role exchange technique.
Session 6	Role exchange by family members using technique sculpting; feedback and inculcation of Hindu cultural aspects.
Session 7	Behavior exchange with acceptance by signing a contract.
Session 8	Cultural aspects- lunch together.
Session 9	Inculcation of mutual understanding among family members using technique props.
Session 10	Problem solving skills; demonstration of problem solving skills through assigning respective roles; Homework assignment.
Session 11	Evaluation of homework assignment and feedback; inculcation of effective communication skills and pattern of transactions and home assignment.
Session 12	Evaluation of homework assignment and feedback; inculcation of relaxation training and breathing exercise and supportive counseling to family.
Session 13	Summarization of psycho social intervention and Inculcation of hope for further improvement.
Session 14	Review and termination. The participants were involved to review the overall sessions, its pros and cons, and discuss long term goals and follow up.

Ethical Considerations

The ethical principles of acceptance, individualization, confidentiality, and justice were considered. The work with the family members was done without taking account of caste, creed, sex, gender, social or economic status or any other factors. Each member was given opportunity to participate actively in the family therapy sessions without forcing them to accept the things provided in the sessions. Participants were guaranteed total confidentiality and they were informed they could withdraw from the family therapy session at any time. The purpose was to help the family members so that they could resolve their problematic situations themselves. This study was approved by the ethical committee of the Ranchi Institute of Neuro Psychiatry & Allied Sciences (RINPAS), Kanke, Ranchi, Jharkhand, India.

Case Introduction

Mrs. G., (name changed) 34 years old, Hindu female housewife. Level of education is graduation (Bachelor of Art) hailing from Dhanbad, urban area, from middle socio economic status and fluent in Hindi and English languages.

Presenting Complaints

She was apparently well one year before, brought to Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS) outpatient department by her husband (Mr. J.) in the months of June 2011 with following presenting complaints: disturbed sleep and appetite, loss of sexual interest, sometimes became irritable and restless, not concentrating upon works properly, loss of interest to do household works and pleasurable activities, low interaction with family members and others, remain sad and feeling of tiredness, hopeless about future, and headache for one year. She did not interact and communicate with husband as well as in laws. Due to frequent quarrels with husband and in laws, she felt stress and headache. She was hardly having sexual intercourse with husband since one year. She became hopeless about future and think about what would happen to my children. Patient's (Mrs. G.) verbatim stated that: "My husband used to beat and torture me mentally, and both husband and his father critically comment on me." "Although I do all household works, even then my husband and father-in-law used to say, she did not care and respect us." "I awoke at 5AM in the morning, prepare breakfast for my school going children and other family members and my husband awoke at 9AM., became fresh, take breakfast and went office." "He came in the afternoon, took lunch and again went office. He came home at 7PM, did dinner and went for sleep even without talking to me. He did not spend time with me."

Marital History

Mrs. G. got married at the age of twenty five years and her spouse (Mr. J.) was twenty seven years old in year 2000 through arrange marriage. In the early years of married life, she used to live in a village, Dihri, Bihar along with in laws and her husband used to live in Dhanbad, Jharkhand. After five years of marriage, she shifted along with her husband and father in law (Mr. K.) at Dhanbad, Jharkhand. At Dhanbad, she did not adjust with husband and in law. According to Mrs. G., her husband and father in law's attitude toward her were not adequate. They used to make false allegation that she had not been giving due respect to us, and did not provide meal at time. In addition to this, they also use abusive languages.

According to husband (Mr. J.) verbatim: “She did not do household work properly. I am working outside the home as a teacher in a high school at Dhanbad and when I returned home, she did not respond me.” “What was my expectation, she did not fulfill it. Even she did not prepare tea for me.” “She did not awake on time and did not prepare food on time.” “What a wife should do for her husband and in laws, she did not do so. That is why I did spend lot of time with my friends and colleagues instead of being with my family.” “Even we did not have sexual relationship for last one year. Whenever I approached, she denied.”

Past History

For the same complaints, she had been treated by faith healer but improvement was not noticed. Besides this, she was being treated by private psychiatrist at Ranchi, Jharkhand, 2010. She took medicines regularly but did not realize improvement. According to Mrs. G, “frequently conflicts with husband and father in law, critical comments about me and negligible support, aggravate my illness. I want peaceful environment in house.”

Family and Social History

The family resided at Dhanbad, Jharkhand. The immediate family members of the patient include husband, educated up to post graduate, thirty eight years old and teacher in a private school; fifty years old father in law, a retired teacher; elder daughter, eight years old and studying in class three; second offspring five years old son studying in nursery; and younger son three years old. The present family is in the stage III: The family with Young Children, (Carter & McGoldrick, 1980). They had been living in a rented house with four rooms along with toilet and bathroom. The surrounding environment was sanitized. They were living in peaceful area, daily cleaning of if any trash was identified, free from trash, as maintained by Municipal Corporation. Mr. J. is only earning member in the family. Due to illness, patient did not perform her role adequately. There are five subsystems present. The Mrs. G. – Mr. J. is the main sub system in the family. Boundaries are semi permeable. He is the leader of the family and makes decision without consent with the wife. Communication pattern between patient and husband is indirect. “We feeling” was not present in the family. Family adoptive pattern was inadequate. Expressed emotion is high in term of critical comments from husband and father in law. Primary support is inadequate, meant that she did not get social support from family members except children. Secondary and tertiary support systems were adequate in the sense that she gets support from neighbors, relatives and others.

The immediate family reported no history of psychiatric illness with the exception of patient’s diagnosis of Moderate Level of Depression according to International statistical Classification of Diseases and Related Health Problems (ICD-10). Mr. J. is a diabetic and used to smoke cigarettes occasionally. There is no history of suicidal or homicidal ideation or attempts in the past or present. G. Devi’s father is about 50 years old and farmer. Basically, he used to live in Dhanbad, approximately 20 km. from his daughter’s house. Whenever his daughter realized strain and stress, she called him for resolving disputes and even he stayed for 5-10 days there. Her father’s relationship with her husband and father in law was not adequate. Her mother is housewife.

Personal History

Psychosocial history reveals a rigid, shy, and withdrawn. Reactions to siblings include temper-tantrum and bed wetting in childhood. She tends to be impulsive without consideration of the consequences. Outburst of anger was found whenever she was criticized.

She did not easily mix with stranger. She got irritable and was rigid and remains withdrawn. She was slow- to -warm-up child. She denied past and current engagement in self-mutilating behavior. She revealed a history of psychological, physical and sexual abuse by her husband. As a result she expressed performance anxiety during sexual relationship with husband.

Case Conceptualization

The focus of treatment approach with Mrs. G. and her family uses much different intervention from a variety of Psychiatric Social Work Treatment Approaches and techniques. The focus of treatment was to restructure the family to resolve frequent quarrel among family members. The psycho social diagnosis of the present case study were: lack of insight about psycho social factors; problems in relationship with spouse; problem in relationship with in laws; inadequate family support; intimate partner violence; poor communication pattern among family members; stress and poor coping pattern.

The focus of the treatment in this case was to involve the family members in such a way that they could help themselves. The treatment includes: raise of consciousness about nature, course and prognosis of illness and psycho social factors associated with it; facilitating them to identify triggering factors through self-prepared five column chart; home assignment and its review; using technique sculpting (breaking emotional cut off through exchange of role); inculcation of cultural aspects of marriage; eat together at least one time a day; strategy of behavior change through signing a contract; using technique props (tying a rope at waste); inculcation of problem solving and communication skills; review of communication pattern at home; inculcation of stress management techniques and review of the all treatment sessions and its pros and cons.

Results

Psycho Social Treatment

Mrs. G. experienced a difficult relationship with husband and father in law. She was very disturbed, did not give proper attention on her daily activities and thought about her future. The irrational thought came in her mind that the life had been spoiled and future went in the dark as she did not realize any improvement in symptoms despite good compliance of medications prescribed to her. They tried to ignore psycho social factors the leads to maintenance of problematic situations. In the initial sessions of the intervention, family members realized little bit improvement up to 4^{th} sessions, but from 5^{th} to 7^{th} sessions, the problem situations were as it was earlier as family members did not gain improvement in their relationship. From 8^{th} sessions onwards, their understanding of psycho social factors and its related experiences increased (figure 2). It meant family members gained insight in comprehending the factors that leads whole family in a vicious cycle. At the end of the psycho social treatment, member's attitude toward each other became normal and they tried to comprehend each other's emotions. The effectiveness of intervention and its result can be understood through examining each session along with figure 2 and table 1 & 2.

Mrs. G.'s family treatment started on 5^{th} June 2011. Initially, patient was prescribed antidepressants for one month along with counseling about marital problem that lead to stress and resulting psychiatric illness. Besides this, family entered a seven-month (June 2011-December 2011) psycho social therapeutic program that encompasses cognitive restructuring through various techniques of family therapy.

In the *first session*, family expressed their anger and tried to complain each other. In their tone of speech, it also glimpsed that they are very sensitive to criticism. Sometimes it

appeared to have they would hurt each other during ventilation of emotion. Although patient ventilated feeling, she felt tense. So it was given relaxation training at the end of the session and instructed to practice regularly. Psycho social treatment started with providing psycho education to the couple. In the first session, couple was made aware about the fact of psychiatric illness and told about nature, course and prognosis of illness. It was also discussed about psycho social factors that may lead to relapses and also given opportunity to ventilate their feeling toward each other. Husband used to say she was alone responsible for her illness. Family was encouraged to take active role in the management of her illness. During session husband expressed that "she is responsible for her illness."

> **Therapist:** Mr. J., you told few minutes before that your wife is responsible for her problem.
> **Husband (Mr. J.):** She did not follow "rules" of the family. Since marriage, she is not mentally attached to my family, even with me. She did emotionally attach with her native family.
> **Therapist:** Mrs. G., Why did you not responding in-laws family?
> **Wife (Mrs. G.):** Since day one husband including in laws started commenting that she did not bring enough dowries. Whatever was promised before marriage, my father had given at the time of marriage. The allegation was baseless. He was telling lie.
> **Therapist:** Mr. J., How could you respond?
> **Husband (Mr. J.):** She is mental. She did not respond and look down in law's family.
> **Therapist:** Mr. J., when did you realize that she is mental?
> **Husband (Mr. J.):** She became depressed one year back. Since then, she had been taking medicine but no improvement was noticed. Sometimes, her behavior is normal but mostly she became sad.
> **Therapist:** When she became sad and did not interact with other family members?
> **Husband (Mr. J.):** Whenever became upset, she did not interact to me. But, I had seen, she interacted to children. I did not know when she became upset.
> **Wife (Mrs. G.):** He always tried to criticize me. Besides this, he tortured me mentally and physically. Frequent conflicts, blaming, abusing and hitting against me, usually happened in the house.
> **Therapist:** It was inculcated to the family members that psycho social factors as explained by the family member shall influence the psycho social functioning of the individuals and it lead to relapses even took medicine regularly.

It was observed both husband and wife were complaining each other. Sometimes it seems to be they got stand to hurt each other but after therapist intervention, became calm. Facial expression showed couple became irritate during expression of feeling. In this session, it was seen resistance from husband side "denying reality" of what happened among family members in day to day life. Most of the problems arise due to poor communication pattern among family members. During session "family dance" - unique personalities of the couple both in verbal and non-verbal manners were observed. They cross-complained each other's and frequently stood up for conflict. To overcome the resistance, it was told that interpret the situations positively. It is the ways through which family can cope and protect them. For example, it was explained to think positively on what happened in past and tried to look future bright.

Patient was also trained in the *Jacobson progressive muscular relaxation training* (Jacobson, 1938) at end of first session. The relaxation training was given in the subsequent sessions started from head; eyes areas; lips; jaw; neck; arms; shoulders; chest; abdomen; legs; and imagination.

Therapist: Mrs. G., How did you feel after relaxation?
Wife (Mrs. G.): I realized very comfortable. Initially, I was being realized headache but now I am feeling relax. Body seems to be light and feeling peace and relax.
Therapist: You have to repeat same things at home in a same sequence from head to toes. And do it regularly as a routine habit.

In the *second session*, feedback of the family was taken. It was observed that when family members enter in a therapy room, Mrs. G. seems to be tensed. According to her, "there was little bit improvement noticed, and still there are some discrepancies in my family." There is "no place of happiness" at the home. She was very critical to her family. She was inculcated deep breathing exercise to reduce immediate strains. It was demonstrated to be straight on the chair, close her eyes, concentrating on inhale gently into your abdomen, through your nose, slowly and deeply; then pause for just a moment and then exhale gently through nose for 20 minutes. Feedback was taken.

Therapist: Whether you realized tense or relax?
Mrs. G.: Now, I am feeling relax.
Therapist: It would reduce the immediate impulses of stress and provide soothing relax to mind.

In this session, family members were involved to look in to issues of maintenance of problematic situations in their immediate environment and its effects upon Mrs. G.'s illness.

Therapist: What did you feel, Mr. J.?
Mr. J.: I felt, there was no improvement.
Therapist: Could you explain why improvement was not?
Mr. J.: Some misunderstandings are there.
Therapist: It is most necessary to understand the psycho social factors such as commenting, blaming, frequent conflicts, criticizing, hitting etc. of the immediate environment that combines with the individual's brain called ***"Psycho-Social-Brain"*** affects the overall psycho social functioning of an individual. It is psycho-social brain because, it had an interlinked among emotion, cognition, and conation of an individual that reflects the feeling, thinking processes and finally behavior of the person concerned, respectively. The experiences realized in the immediate social environment directly affect the thinking process of the individual concerned that leads to either positive or negative behavior. So, it is mandatory to review the importance of immediate family milieu in the management of psycho social problems among family members.
Mr. K. (Father in law): Yes, it all happened in my house; blaming to each other, hitting and abusive to others, even on a little bit differences.

From the above, it revealed that family was facing frequent quarrel, because of this they did not express their feeling each other. Neither spouse felt secure in the relationship as

they misinterpreted each other's behavior and would often allow their frustrations and hurt to escalate to a point of anger, fighting, and withdrawal that lead to what we termed ***"Suffocating Life."***

Therapist: What are the stressors for the family members?
Mrs. G.: Frequent quarrels on a pitiable things; it leads to blaming, and denials.
Mr. J.: She misunderstands and misinterprets the information.
Father in law (Mr. K.): She tried to avoid our family member. Sometimes she also abused us.
Therapist: How could we get relief from that problem so that happiness would again come at the home?
Mr. J.: No response.
Mrs. G.: "I want happiness."
Father in law (Mr. K.): I would try to resolve the situation.

The technique so called "Softening" was inculcated to the family; in which mutual responsive interaction facilitate to replace the negative cycle of blaming, defensiveness, and withdrawal with a pattern characterized by emotional support, security, and intimacy. The vocal quality had changed over sessions. During the first 2 sessions, the tone of the voice was harsher and loud by Mrs. G. and weaker and more hesitant by the husband.

In the *third session*, Mr. G. was facilitated to identify the triggering factors that disturbed her and how she proceeded to resolve the problematic experiences. She was facilitated to identify an event or situation that triggered a strong feeling within her in a prescribed format (**Table. 4**) containing day of the week, problematic experiences, feeling related to experiences, rating of problematic experiences, and resolution of problematic experiences. It was done to minimize negative expectations and maximizing the positive feeling. To handle unpleasant feeling, she was rehearsed the distraction techniques such as listening radio, seeing television program that give soothing and relax, go to park and imagine there and recall pleasant experiences of past.

Table: 4 Shows format of recording problematic situations through Five-Column Chart (Self-prepared)

Days/ Date	***Problematic Experiences***	***Feeling related to Experiences***	***Rating of Problematic Experiences (0 Nil; 1 Mild; 2 Moderate; 3 Severe; 4 Extreme)***	***Resolution of Problematic Experiences***

Patient was taught about to imagine some pleasurable things that happened in the past while closing her eyes. The imagination training was given to the patient in the hospital set up. Patient was instructed to lying down on the bed with comfortable, close eyes and took deep breathe in and deep breathe out. Patient was facilitated to imagine different scenes with sufficient paused between sentences like *"I am in a beautiful park that was full blown of different colors of flower----"* She was given instruction *"to enter in a park with your children, observe different colors of flower. Think some colorful that happened in your life. The kids are also playing there." "You are also entertaining them. It gives much relax and mentally soothing you. You are interacting with other family members." "Look at in each*

colorful flower, a positive aspect and realized that some positive things would happened in my life. Share these experiences to your loved one."

> **Therapist:** How were you realizing the imagination?
> **Mrs. G.:** It seems to be very relaxed. According to instruction provided me, I had realized the things minutely. I was seeing how, each flower was growing, and realized soothing relaxed.
> **Therapist:** How would you realize the things, it depend upon your thinking pattern. When you think positive, it would give positive result and negative thinking will provide negative result.
> **Mrs. G.:** I will try at my level best to think positive.
> **Therapist:** You can do it; you have the patience and confidence to overcome the problematic situation.

Patient was given home assignment so that she may practice imagination at home. The scenes were *"I am with my husband and children enjoying picnic there-----""Imagine I am in Himalayan region having various type of plants and birds, snow, and temples----"* and also *"imagine pleasant experiences happened in the past."*After imagination, note down the experiences that you had got and repeat it during distress conditions.

During *fourth session*, the home assignment of problematic experiences through five column chart was evaluated. As five-column chart reflected that how Mrs. G. had tried to manage her problematic experiences. This home assignment had been effective in the sense that it inculcated confidence and motivation in Mrs. G. to acknowledge her potential and strength to resolve the problematic situations herself. Here the strength of Mrs. G. was *"not to expect from others"* and manage by engaging herself in different activities (**Table 5**).

Table: 5 Shows recording of problematic situations through Five-Column Chart by patient.

Day /Date	***Problematic Experiences***	***Feeling related to Experiences***	***Rating of Problematic Experiences (0 Nil; 1 Mild; 2 Moderate; 3 Severe; 4 Extreme)***	***Resolution of Problematic Experiences***
Thursday/ 21/7/11.	Critical comments by husband.	It seems to be very painful. Crying spells and thought about life.	Moderate.	Not interacted to anyone.
Friday/ 22/7/11.	Remembering of things happened in the past.	My life becomes ruined.	Moderate.	Remain silent on any issue.
Saturday/ 23/7/11.	Nobody care me at home.	Became sad and isolated from others.	Moderate.	Tried to avoid things.
Sunday/ 24/7/11.	Same problems as experienced earlier days.	Remain isolated but tried to engage myself.	Mild.	Tried to engage in home activities and also engage with children.
Monday/ 25/7/11.	Little bit quarreled with husband.	Husband tried to talk with me. Father in law had also interacted with me.	Mild.	Listening music and tried to talk with husband. He had cooperated.
Tuesday/ 26/7/11.	Past experiences and about children.	Family members cooperated but not sustained for a whole day.	Mild.	Tried to think positive and not expected more from others.
Wednesday/ 27/7/11	Problem experiences as usual.	It appeared to have that husband had been	Mild	I did not expect from others and tried to

		taking account of my problem.		engage myself with children, reading books, etc.

In this session, the sitting arrangement of the family members was made in that way: father in law, daughter in law, and husband respectively. It was observed that father in law was feeling anxious to sit next to daughter in law and felt embarrassment to interacts and maintain eye contact with her. It may be due to cultural context.

Therapist: Mr. K., why were you feeling embarrassment?
Father in law (Mr. K.): All this happened because of backbiting against daughter in law.
Therapist: Could we expect that situation would improve?
Mr. K.: I would try at my level best. I tried to protect my family from breaking down as far as possible.
Therapist: All of family members can do it. I had recognized the potential of the family members. The only need would be required that each member must understand the feeling of others. It is because, family would not get any happiness until each family member emotionally attached to each other.
Therapist: How could each family member contribute to protect the family?
Mr. J.: Situation may improve in near future. I would convey clear message so that any discrepancy would not be realized by family members.
Mr. K.: I would share each and every aspect of things with my son and daughter in law. We could solve problem together.
Mrs. G.: I want happiness and peace at my home.
Therapist: The aim of this session was to change the perception of everyone. It may increase the possibility for family members developing new competencies to deal with day to day problematic situations.

In the *session fifth*, family members were tried to break emotional cut off. Father in law and his son (husband) were in one side against the daughter in law. They were inside the triangle and daughter in law was outside the triangle (**Figure 1**). Each family member were assigned respective role that is husband performed the role of daughter in law, daughter in law as the role of husband and father in law his own role.

Therapist: Mr. J., Suppose you were daughter in law (Mrs. G.)?
Mr. J.: I would have been tortured like my wife and became depressed.
Therapist: What we will do to resolve the problematic situations?
Mr. J.: We will try to solve the problem as far as possible.
Therapist: Mrs. G., if you were husband, then what happened to you?
Mrs. G.: I could have tried to listens problem first, and then took decision. I never did any act on the basis of backbiting, as happening in my family.
Therapist: Mr. K., how could you resolve this problem?
Mr. K.: I would try to listens both daughters' in law and her husband's views on any problem and tried to resolve it impartially.
Therapist: The aim of this session was to break down triangle among father in law, his son and daughter in law and inculcate the importance of each individual in decision making, responsibility taking and maintain smooth relationship among family members.

In the later sessions (4th onwards) the vocal tone of the wife had been pursuing softer and more relaxed. This enables both wife and husband to make vulnerable requests for support and closeness and teaches the other partner to request in an emphatic way in a subsequent sessions.

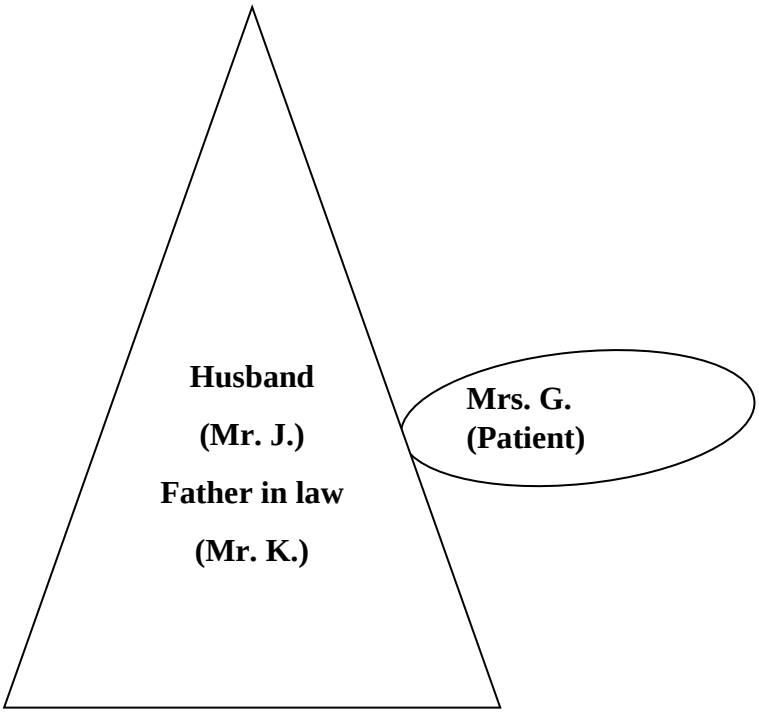

Figure 1: Diagrammatic representation showed that two members of a family inside the triangle and one outside this triangle.

In the *sixth session*, father in law, husband, and wife were instructed that they would exchange their role as of daughter in law, father in law and husband respectively. They acted according to assigned role respectively. This technique is referred as Sculpting. Sculpting is the technique whereby family members are molded during the therapy sessions into positions symbolizing their actual relationship, as seen by one or more members of the family (Sauber et al., 1985). The purpose of this technique is to expose outgrown family rules and to clarify misconceptions (Jones-Smith, 2012).

Therapist: Mr. K., how did you feel, taking up a role of daughter in law?
Mr. K.: I did feel embarrass.
Therapist: Why did you realize embarrass?
Mr. K.: There was something wrong happened with my daughter in law. I was responsible for that.
Therapist: What wrong had you done?
Mr. K.: I was gossiping against daughter in law. Because of this reason, my daughter in law was being mentally and physically tortured by her husband.
Therapist: How could we solve this problem?
Mr. K.: From now, I would try to solve the problem by conciliation between husband and wife.
Therapist: What can you do for improving the relationship between husband and wife?

Mr. K.: The quarrel between husband and wife was due to my fault, I will try at my level best to improve the situation.
Therapist: Mrs. G., how are you feeling now? If you were a father in law, what could have done?
Mrs. G.: I felt aloneness in the house. Nobody listen to me and my right was not recognized. The house was dominated by my father in law and husband. I want happiness in my life. This happiness would come, if backbiting would be stopped. What would be the benefit from breaking the relationship? This will not give happiness in the relationship.
Therapist: Mr. J, how did you feel from your role now?
Mr. J.: I did not take decision on the advice of other members. I would take own decision.
Therapist: Your father just told, I was gossiping to my son against daughter in law.
Mr. J.: Yes, I had to follow my father advice.
Therapist: Did you try to clarify father's advice?
Mr. J.: No, he is the leader of the family. It is my right to follow his advice.
Therapist: You must consider what was right or wrong going on in the family, what would be your opinion?
Mr. J.: Yes, it is right to clarify things before any action. Challenging the father's advice, would harm the relationship with father.
Therapist: What about relationship with wife? As you realized that the relationship with wife was not so good. As per Hindu cultural tradition of marriage, you had revolved seven times around Agni (Fire) and promised to live whole life with wife at the time of solemnization of marriage. Are you happy with that?
Mr. J.: No, I am not happy with that. I had been emotionally cut off from my wife.
Therapist: How could you resolve the problem?
Mr. J.: I will try to improve my relationship with my family. Now, I will clarify the situation before any action.
Therapist: Fulfillment of the emotional need is the basic to human survival and individual happiness.

During *seventh session*, family was taught the strategies for change with acceptance, *Behavior Exchange* to increase the frequency of desired behavior. In this session, family was advised to express their wishes and complaints specifically and behaviorally. They were also told to ask each partner to list things he or she would like the other to do more often. This will provide to learn new ways to influence each other through positive reinforcement. Both partners had signed a *contract* that takes the following form (**Appendix 1**).

In the next session, couple came with lot of improvement by complying contract signed by both of them. According to wife, her husband came at home timely, spending time with children as well as with me. Wife also cooperated with husband. However, couple maintained relationship with minimal conflict of interest, it need to be sustained for longer time.

In the *eighth session*, family members were tried to facilitate to eat together at least one time in a day whether lunch or dinner. In Indian culture, daughter in law usually do not eat in front of father in law. It is considered culturally taboo in some communities. She used to eat last after providing meal to father in law, husband and children. She occasionally used to eat along with husband. After therapeutic intervention, she started eating along with

husband and children but not with father in law. As in the treatment session, was told to hold family lunch or dinner together and discuss issue that you seems to be problematic. Father in law, 60 years old, culturally accepted that my daughter in law will not eat along with me as she feels embarrassment because of social norms. Due to cultural aspect of India, Indian women did not have lunch or dinner along with father in law.

In the *ninth session*, family members were tied at waist with a rope; given instruction to stand in an order- father in law, husband, and wife respectively and told each one to move without disturbing to other. Each one tried to move and affected other members during walk. This technique is called Props. Props are materials used to demonstrate the impact of family's action. In this technique, a rope is tied around each family member's waist and then asks to move (Satir & Baldwin, 1983). Ropes are used to indicate how many family members were connected to each other.

> **Therapist:** How each family member understood this activity?
> **Mr. K.:** It was very difficult to move.
> **Therapist:** What difficulties did you face?
> **Mr. K.:** I was tied, that is why not able to move. When I started moving, other members were affected.
> **Therapist:** What problem did Mrs. G. face?
> **Mrs. G.:** It was very difficult to move individually because we were tied together.
> **Therapist:** Mr. J., what problem did you realize?
> **Mr. J.:** The same problem I had faced.
> **Therapist:** What could we understand from this activity?
> **Mr. K.:** Togetherness of the family members.
> **Mr. J.:** One must work and comprehend each family member mutually to arrive at decision.
> **Mrs. G.:** As a family member, one must consider the things first, and then work on it.
> **Therapist:** The aim of this activity was to inculcate and achieve mutual understanding among family members to resolve any problematic situation.

In the *tenth session*, family was taught how to solve problem if they face in their daily life. There are following steps were discussed with the family. Firstly, both husband and wife were told to understand the problem in a specific situation, and then think over it with plenty of possible solutions, evaluate the pros and cons of the each solution, tried to choose one of the best possible solutions and implement it. The couple was facilitated to practice exercise in the session, in which one partner was the speaker and the other listener. Here the speaker (husband) was given 5 minutes to share feeling about his wife. After that, the listener (wife) was given a chance to respond with an empathic statement. The speaker provided feedback to the listener regarding accuracy of the statement. After the completion of one role, the role was exchanged with wife as speaker and husband as listener. This was practiced during the session and also told the family to practice at home.

The problem solving skills are inculcated through assigning task to the husband and wife during the subsequent session.

> *"You and your husband were travelling in a train and in the same compartment husband's lady colleague present. When she seen, approached your husband to talk a few things. While seeing that scene, you would become upset and became irritated and after that you did not talk to your husband."*

Mrs. G.: Who was this lady (Husband's lady colleague)?
Mr. J.: She was my class mate, during graduation.
Mrs. G.: What she was talking?
Mr. J.: She was asking that what you were doing?
Mr. G.: Then what did you say?
Mr. J.: I told, am teacher.
Mrs. G.: I saw, she was approaching you.
Mr. J.: Just, she came and sits. She was not approaching me. She was just talking like a friend, nothing else.
Mrs. G.: I became upset to see this.
Mr. J.: No darling, do not fear. I love you.
Mrs. G.: Okay.

The second scene was given to carry out at home.

> *"You and your husband went a party and husband started taking drink (alcohol) there, leaving you alone. You realized that I should not come to the party along with him. It had been better that I would have been at home."*

During the *eleventh session* feedback was taken, and after that family was inculcated effective communication taught to be specific, request in positive terms, respond directly to criticism instead of cross-complaining, talk about the present and future rather than past, listen without interruption, and say something in a soft manner. It was taught to describe their spouse's specific behavior rather than apply as lazy, aloof, or frigid and provide positive feedback.

The steps to effective communication were discussed with the family members like *explain the behaviors of a person concerned*- tell the person (to whom interaction taking place) about your views of what he or she is doing. You must aware that you were explaining behavior of other, not accusing to him or her, *rational explanation of your feelings about behavior concerned or how you reacted to a particular situation* –rationally explain the person how you are realizing about the particular behavior or whether it affect you, and *explain positively what you expected to be happened*- explain the person what you would like to expect from him or her to do a particular behavior. Be sure to use specific terms that focus on the behavior rather than looking down the other person. It would reflect positive interactions among persons concerned.

One must make eye contact whenever communication is going on. It revealed emotional state and sensitivity to and understanding of the immediate situation. Making eye contact indicates openness and a willingness to engage in communication. Gesture of greeting must be used to boost up relationship as taking account of one's culture. Each family member must talk assertively to each other. Family members must start sentences with the word "I" instead of "You." When we begin a statement with "You," it often places blame on the other person and blocks the communication; starting with "I" helps us take responsibility for our behavior, thought, and feelings. It make possible to send a clear and direct message.
Mrs. G. was given home assignment to be carried out at home.

(i) *"You and your husband went to attend a marriage ceremony and your husband started dance with other lady. While seeing this scene, you leave the marriage party and come at home."*

(ii) *"You and your children want to go market to purchase clothes. Just your husband came and say darling, today we will go to see a movie."*

In the *twelfth session,* family evaluated their communication pattern at home and how they arrived at any decision.

Therapist: Did you complete your home assignment?
Mrs. G.: Yes, we are very happy. Besides, home assignment, we had taken various decisions jointly. My father in law was also involved in decision making; he helped much to arrive at a final decision. For instance, it was problem where to take admission of my son. We sat together and jointly arrived at a decision taking account of financial capacity.
Therapist: I hope family would achieve happiness at home in near future.

In this session, couple was taught two stress management techniques. It was demonstrated upon patient, the deep breathing exercise for the 20 minutes. Besides this, it was also inculcated Jacobson progressive muscular relaxation (JPMR) from head to toes so that patient could realize comfortable during stress and feel better. Couple was advised that they must practice relaxation training and breathing exercise daily as a routine habit.

In the *thirteenth session*, family was summarized the overall psycho social treatment. Family was developed hope that the situation would improve further, if they would cooperate themselves.

Therapist: Now, can I consider that approximately 75-80% of the problem had been resolved?
Mr. K.: Yes, now I along with my other family member was trying to improve the further relationship.
Mrs. G.: Problem was resolved but few are there, I expect we will resolve the situation mutually.
Mr. J.: I would also try to solve the problematic situation, if any.
Therapist: Well, it depends on the self of the individual, how you people would take and understand each problem and try to resolve it.

In the *fourteenth session*, family came at follow up. The couple gained improvement gradually. They tried to resolve the problematic issues and became successful in resolving it. However, occasionally they did not resolve some critical problem but maintain balance in their relationship. It is important to have "*some ups and down in the relationship for long term sustaining."* The family has learned how to openly communicate with one another in noncritical ways. Their relationships have been strengthened, and they recognize that their support of one another has led to their success in improving family environment (**Figure 2**).

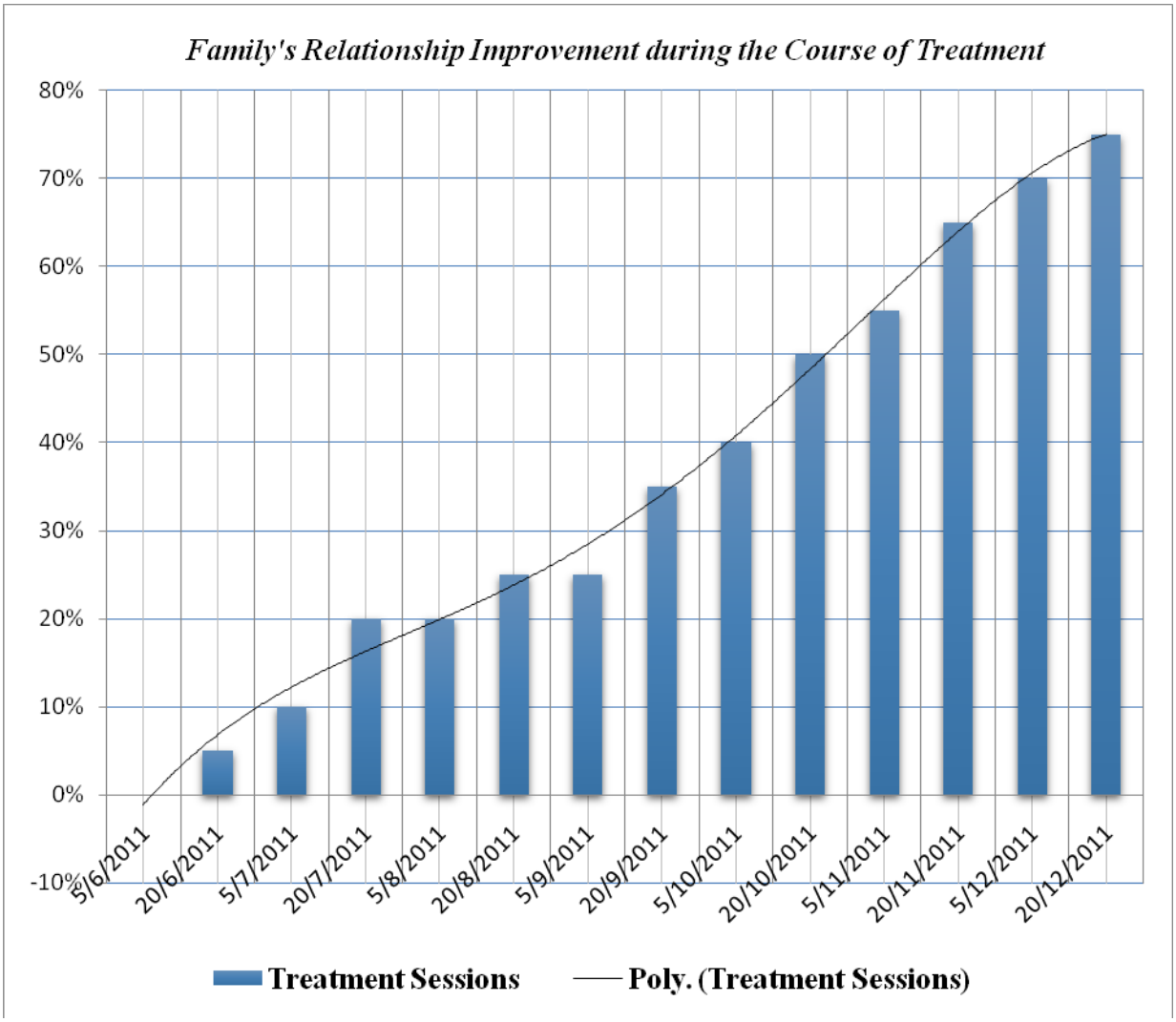

Figure 2: **Family's relationship improvement in each session during the course of psycho social treatment.**

Discussion

The current case illustrated how different family therapy techniques can be applied to resolve the problematic situations among the family. Result supports the notion that the different techniques used with the present case, had been effective at strengthening and sustaining the relationship among family members in India. This suggests that content that is tailored to meet the need of the family may be effective at enhancing family relationships. Such effective efforts may contribute to strengthening of family's relationships which in turn led to better health and well-being in their family.

Initially, family members did not meet the emotional requirement of each other. They live rather like stranger in a boarding house in their own house. They are frequently alienated and unfulfilled. For the first 2 sessions, family was uncooperative to each other; the tone of the voice was harsher and loud. It was observed 4th onwards that vocal tone of the wife became softer and more relaxed and tried to provide emotional support. Although initially very slow changes in the family, they responded better in later stages of family intervention. Therefore, result suggests that family was more satisfied with mutual understanding after

seven month psycho social intervention. This suggests that intervention effects on relationship commitment, which in turn, lead to sustain satisfaction over a period of time (Snyder, Castellani & Whisman, 2006). The family members who were separated emotionally each other were made effort to unite so that they could share their feeling each other. Participation of family during sessions led to greater use of healthy relationship skills, including enhancing emotional intimacy. So it can be important to provide troubled family ample of opportunities to engage them in skills training that focused on the relevant issues that they are facing in their relationships. A relationship with dedicated partner had been shown to promote better health in couples and their offspring (Whisman et al., 2010), enhancing intimate relationship must be impregnated within the sound home environment (Gottman, 1994)

The family therapy technique such as sculpting and props were exercised in the sessions 6^{th} and 9^{th} respectively. In technique sculpting, family members were involved by exchanging their roles so that they could understand the reality of the relationship. Besides this, family members were tied in a rope, using technique props, at waist and instructed to move without disturbing to other. This activity had given much insight among family members and made them feeling of emotional tied. This inculcated the relative empowerment of each member in a family. Family in a healthy and committed relationship may enhance their mental and physical health (Cleary Bradley, Friend, & Gottman, 2011; Braithwaite, Delevi, & Fincham, 2010), couple gets social support from committed relationship and made them enable to cope up with stressful situations (Coan, Schaefer, & Davidson, 2006) and children also benefit from such a healthy relationship throughout life (Harold, Aitken, & Shelton, 2007). So it is utmost important to provide family ample of opportunities that enable them to sustain healthy relationship. Although administrative efforts of the Indian Government had taken impressive steps to protect the family, but there is some lacuna. Indian Government must take effective initiatives as United States of America had highlighted the importance of providing Couple and Relationship Education (CRE) to those who are most in need and at risk of adverse associated with their relationship (Halford, Markman, & Stanley, 2008).

Family members were inculcated the pros and cons of psychosocial factors through psycho education. The relevant psychosocial factors in this case were commenting, using abusive languages, blaming, criticizing, frequent conflicts, hitting etc. of the immediate environment that ultimately affect individual's thinking process. The psycho education provided to family members about psycho social factors had given insight among them that their environment is the most immediate psycho social milieu. Family members had understood the relevant of psycho social factors during treatment process. So it suggests that family may play an important role in the management of psychiatric illness. As Gardner (2005) stated that how immediate environment affects individual's thinking process through the concept of social brain. As Psychiatry recognized that social interaction influences mental symptoms (Verhulst, 2005). Psycho educations given through structured psychotherapy affects social brain through verbal engagement or alter input from family or other social networks. This change occurs how the patients perceives social reality and acts in it (Verhulst, 2005). Incorporating close family members in psycho social treatment may have positive impact on patient health behavior's emotional wellbeing and symptomatology as a result of increased empathy and supportiveness of the family member (Martire & Schulz, 2007).

The psycho social treatment of the family must also be taken in to consideration about the cultural aspect of the treated family. As history revealed that the house of the present family was dominated by male. The cultural aspect taken up in this case encompass eat together at least one time in a day, sitting arrangement of the participants (father in law,

daughter in law and her husband respectively), and Hindu cultural tradition of marriage (revolved seven times around Agni (Fire) and promised to live whole life with partner during solemnization of marriage). The inculcation of these cultural aspects among family members gets awareness about the feeling of its member and it also acts as a seeds of optimum emotional climate within a care environment. Emotional climate acts as a meaningful predictor of relapse within a care environment (Butzlaff & Hooley, 1998). This was clarified during session subordinate status of women combined with socio cultural norms that are inclined towards patriarchy and masculinity, can be considered as an important factor determining the domestic violence, which in turn leads to relapses. So successful family intervention reduces rates of relapse and improves quality of life for patients with depression (Miller et al., 2005). Patients receiving family therapy had shown significant improvement and reductions in interviewer-rated depression and suicidal ideation than patients who were treated without family therapy (Miller et al., 2005). A study done in India by Sethi (1989) enumerated that family must fulfill the physical, spiritual and emotional needs of its members and it was possible through effective communication, provide social support, security and encouragement; maintain and create constructive and responsible relationships; have mutual respect for the individuality of family members.

In addition, family oriented interventions had also targeted problem solving skills among couple which was facilitated by providing exercises in the session, and they became able to take decision jointly along with father in law. Researches stated that open and effective communication is essential for human growth and development (Morries, 1999), effective communication skills and conflicts resolution skills were utmost important for couple to cope with marital stress (Mace, 1989; Olson et al., 1989), reduction in stress and improvement in family communication (Campbell, 2004) and creating healthy relationship program among couples also reduced conflicts, increased relationship satisfaction, and use of healthy relationship skills for low income couples in distress (Cleary Bradley et al., 2011).

It is normal that couples have some areas of difference and disagreement. However, when couples respond to their differences and disagreements in a destructive ways, relationship distress may result (Dimidjian, Martell, & Christensen, 2008). These destructive ways of handling conflicts over differences are characterized by coercion and polarization. To alleviate unexpected differences, here couple was also facilitated to increase the frequency of desired behaviors through technique called *behavior exchange* (Something for Something).For this couple had signed a contract to encourage acceptance through the partner's mutual empathy and tolerance building around the problems. This technique had shown better understanding among couple. It has increased one's tolerance to give up the struggle to change the partner and accept the behavior. However, couple sustained their relationship with minimal conflict which is necessary for maintaining equilibrium in the relationship.

In conclusion, marital disputes resolution effort must acknowledge the intricate interaction among various levels of intra psychic conflict (guilt, trauma, or shame), interpersonal couple conflict (distrust, marital discord, betrayal, abandonment), and anxiety (pressure to please, fear of failure, worrying about whether one partner will be able to please another partner). The comprehensive holistic approach had yielded better result to resolve marital disputes among couple during the course of psycho social treatment.

References

Ammons, P., & Stinnett, N. (1980). The vital marriage: A closer look. *Family Relations, 29,* 37-42.

Archer, J. (2000). Sex differences in aggression between heterosexual partners. A Meta analytic review. *Psychological Bulletin, 126,* 651–680.

Babu, B. V., & Kar, S. K. (2009). Domestic violence against women in eastern India: A population-based study on prevalence and related issues. *BMC Public Health, 9*(129), doi:10.1186/1471-2458-9-129

Bell, R. R., Daly, J. A., & Gonzalez, M. C. (1987). Affinity-maintenance in marriage and its relationship to women's marital satisfaction. *Journal of Marriage and the Family, 49,* 445-454.

Braithwaite, S., Delevi, R., & Fincham, F. (2010). Romantic relationships and the physical and mental health of college students. *Personal Relationships, 17*(1), 1–12.

Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse: A Meta-analysis. *Archives of General Psychiatry, 55,* 547–552.

Campbell, A. S. (2004). How was it for you? Families' experiences of receiving Behavioral Family Therapy. *Journal of Psychiatric and Mental Health Nursing, 11,* 261–267.

Carter, B., & McGoldrick, M. (1980). *The expanded family life cycle* (3rd ed.). Boston, MA: Allyn & Bacon.

Carter, B., & McGoldrick, M. (1989). *The changing family life cycle: A framework for family therapy* (2nd ed.). Boston, MA: Allyn and Bacon.

Cleary Bradley, R. P., Friend, D. J., & Gottman, J. M., (2011). Supporting healthy relationships in low-income, violent couples: Reducing conflict and strengthening relationship skills and satisfaction. *Journal of Couple & Relationship Therapy, 10,* 97–116.

Coan, J., Schaefer, H., & Davidson, R. (2006). Lending a hand: Social regulation of the neural response to threat. *Psychological Science, 17*(12), 1032–1039.

Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publication, Inc.

Dimidjian, S., Martell, C. R., & Christensen, A. (2008). Integrative behavioral couple therapy. In A. S. Gurman (Ed.), *Clinical hand book of couple therapy* (4th ed., pp. 73–103). New York, NY: Guildford Press.

Duck, S. (1993). *Learning about relationships*. Thousand Oaks, CA: Sage.

Epstein, N., Baldwin, L., & Bishop, D. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy, 9,* 19-31.

Fowers, B. J., & Olson, D. H. (1986). Predicting marital success with PREPARE: A predictive validity study. *Journal of Marital and Family Therapy, 12,* 403-413.

Gardner, R. (2005). The social brain. *Psychiatric Annals, 35,* 778–86.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh, PA: Duquesne University Press.

Gottman, J. M. (1994). *What predicts divorce? The relationship between marital processes and marital outcomes*. Hillsdale, NJ: Erlbaum.

Gottman, J. M. (1995). *Why marriages succeed or fail: And how you can make yours last*. New York, NY: Simon & Schuster.

Halford, W., Markman, H., & Stanley, S. (2008). Strengthening couples' relationships with education. *Journal of Family Psychology, 22*(4), 497–505.

Harold, J. T., Aitken, J. J., & Shelton, K. H. (2007). Inter-parental conflict and children's academic attainment. *Journal of Child Psychology and Psychiatry, 48*(12), 1223–1232.

Heise, L. L., Pitanguy, J., & Germain, A. (1994). *Violence against women: The hidden health burden*. World Bank discussion papers. Washington, DC: World Bank.

Husserl, E. (1962). *Ideas: General introduction to pure phenomenology*. New York, NY: Collier Books.

Husserl, E. (1977). *Phenomenological psychology* (J. Scanlon, Trans.). The Hague, Netherland: Martinus Nijhoff.

Jacobson, E. (1938). *Progressive relaxation*. Chicago, IL: University of Chicago Press.

Jones-Smith, E. (2012). *Theories of counseling and psychotherapy: An integrative approach*. Thousand Oaks, CA: SAGE.

Kelley, D. L., & Burgoon, J. K. (1991). Understanding marital satisfaction and couple type as functions of relational expectations. *Human Communication Research, 18,* 40-69.

Kessler, R. C., Molnar, B. E., Feurer, I. D., & Appelbaum, M. (2001). Patterns and mental health predictors of domestic violence in the United States. Results from the national co morbidity society. *International Journal of Law and Psychiatry, 24*(4-5), 487–508.

Kvale, S., & Brinkmann, S. (2009). *Interviews. Learning the craft of qualitative research interviewing.* Los Angeles, CA: Sage.

Mace, D. (1982). *Close companions: The marriage enrichment handbook*. New York, NY: Continuum.

Mace, D. (1989). Three ways of helping married couples. *Journal of Marriage and Family Therapy, 13,* 179-185.

Mahajan, A. (1990). Instigators of wife battering. In S. Sood (Ed.), *Violence against women* (pp. 1-10). Jaipur, India: Arihanti Publisher.

Martire, L. M., & Schulz, R. (2007). Involving family in psychosocial interventions for chronic illness. *Current Directions in Psychological Science, 16*(2), 90-94

Merleau-Ponty, M. (1962). *The phenomenology of perception*. London, UK: Routledge & Kegan Paul.

Miller, I. W., Keitner, G. I., Ryan, C. E., Solomon, D. A., Cardemil, E. V., & Beevers, C. G. (2005). Treatment matching in the post hospital care of depressed inpatients. *American Journal of Psychiatry, 162,* 2131–2138.

Miller, I. W., Ryan, C., Keitner, G., Bishop, D., & Epstein, N. (2000). The McMaster approach to families: Theory, assessment, treatment and research. *Journal of Family Therapy, 22,* 168-189.

Mohan, V. (1990). Is there hope for battered wives? In S. Sood (Ed.), *Violence against women* (pp. 11-22). Jaipur, India: Arihant Publishers.

Morries, L. M. (1999). Transition to marriage: A literature review. *Journal of Family and Consumer Sciences Education, 17*(1), 1-21.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Nixon, R. D., Resick, P. A., & Nishith, P. (2004). An exploration of co morbid depression among female victims of intimate partner violence with posttraumatic stress disorder. *Journalof Affective Disorders, 82,* 315–320.

Noller, P., & Fitzpatrick, M.A. (1991). Marital communication in the eighties. In A. Booth (Ed.), *Contemporary families: Looking forward, looking back* (pp. 42–53). Minneapolis, MN: National Council on Family Relations.

Olson, D. H., McCubbin, H. I., Barnes, H., Larsen, A., Muxen, M., & Wilson, M. (1989). *Families: What makes them work* (2nd ed.). Los Angeles, CA: Sage.

Otto, L. (1979). *Contemporary theories about the family.* New York, NY: The Free Press.

Robinson, L.C., & Blanton, P.W. (1993). Marital strengths in enduring marriages. *Family Relations, 42,* 38-45.

Sabatelli, R. M., & Cecil-Pigo, E. F. (1985). Relational interdependence and commitment in marriage. *Journal of Marriage and the Family, 47,* 931-937.

Satir, V. M., & Baldwin, M. (1983). *Satir step by step*. Palo Alto, CA: Science and Behavior.
Sauber, S. R., L'Abate, L., & Weeks, G. R. (1985). *Family therapy: Basic concepts and terms*. Rockville, MD:Aspen.
Sethi, B. B. (1989). Family as a potent therapeutic force. *Indian Journal of Psychiatry, 31,* 22–30.
Sinha, N. (1989). *Women and violence*. New Delhi, India: Vikas Publishing House.
Snyder, D., Casterllani, A., & Whisan, M. (2006). Current status and future directions in couple therapy. *Annual Review of Psychology, 57*, 317–344.
Sokolowski, R. (2000). *Introduction to phenomenology.* New York, NY: Cambridge University Press.
Surra, C. A., Arizzi, P., & Asmussen, L. L. (1988). The association between reasons for commitment and the development and outcome of marital relationships. *Journal of Social and Personal Relationships, 5*, 47-63.
Thoits, P. A. (1992). Identity structures and psychological well-being: Gender and marital status comparisons. *Social Psychology Quarterly, 55*, 236-256.
Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* Albany, NY: State University of New York Press.
Verhulst, J., Gardner, R., Sutton, B., Beahrs, J., Kerbeshian, J., Looney, J., . . . Wamboldt, F. (2005). The social brain in clinical practice. *Psychiatric Annals, 35*(10), 803-811.
Whisman, M., Uebelacker, L., & Settles, T. (2010). Marital distress and the metabolic syndrome: Linking social functioning with physical health. *Journal of FamilyPsychology*, *24*(3), 367–370.
World Health Organization. (1990). *International Statistical Classification of Diseases and Related Health Problems—Tenth Revision*. Genèva.
Zung, W. W. K. (1965). A self-rating depression scale. *Archives of General Psychiatry, 12,* 63-70.

Appendix 1: Illustration Shows the Form of Contract Signed by the Couple

This month I agree to……

1. Come home from office by 5 PM.
2. Teach the children 1 hour daily.
3. Spent most of the time at home with wife and children.

Husband's signature.……
Mr. J.

If above changes were made, I agree to……

1. Provide meal at time.
2. Cooperate with my husband.
3. Do what my husband would want.

Wife's signature.……
Mrs.G.

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