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DEPRESSIVE DISORDERS AND FAMILY CONSTELLATION[1]

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The joint family forms an important and distinguishing characteristic of the Indian society. Desai (1964) says "Hindus understood only one type of family and that was the joint family. The normative patterns of their actions was characterised by the orientation to this group". Over the past two decades social scientists have expressed concern over the fate of the joint family when viewed in context of the rapid industrialization and urbanization that India is undergoing (Sethi and Manchanda, 1978). Some assert that this once-stable institution is undergoing fragmentation (Sethi, 1968; Sethi et al., 1974) whereas others opine that "although structurally the traditional family appears to break down, functionally it is not so," and go on to add that the joint family is not disintegrating in order to function as independent units (nuclear) but adopting to new patterns which have the same degree of jointness (Kaldate, 1962; Kapadia 1966; Desai. 1956, 1964). Needless to say this controversy has proved to be a fertile ground for investigative research whereby attempts are being made to determine an association between family type, a change in its pattern and a possible impact on individuals in terms of psychiatric disorders.

A brief review of such investigations from the Indian subcontinent reveals that in two epidemiological surveys of urban areas (Sethi et al., 1967; 1974) and one survey of rural areas (Sethi and Sinha, 1977) a higher percentage of psychiatric disorders were noticed in nuclear families as compared to joint ones. Depression (Lal, 1971; Sethi and Sinha, 1977; Bagadia et al., 1973); Delinquency (Sethi et al., 1976) and attempted suicide (Venkoba Rao, 1965; Lal and Sethi, 1975; Sethi et al., 1977) show similar trends.

Neuroses in particular, shows a fairly strong correlation with family type. Verghese and Beig (1974) in a survey of neuroses in Vellore township found a significantly higher occurrence in nuclear families as compared to joint ones (Ratio 3: 1 respectively). Veeraraghavan (1978) has also reported higher frequencies of neurotic patients in unitary families. Menon (1975) and Agarwal et al. (1978) found emotionally disturbed women belonged more often to nuclear families. In an attempt to find out a correlation of any particular type of neuroses with family jointness, Sethi et al. (1979a) studied 383 neurotics (Depressive Neurosis. Anxiety neurosis, Hysterical Neurosis) and did not discover any significant association. However, it was pointed out that the overall trend in all three types of neuroses was away from Category I and II (Joint family =96) through category III and IV (Extended variety =107) and towards category V (Not at all joint =180) as measured on Khatri Scale (1970) of family jointness

Dube (1970, 1971); Thacore et al. (1971) and Thacore (1973, 1975) reported a greater prevalence of psychiatric morbidity in joint families, especially of hysteria (Dube, 1970). Vyas and Bhardwaj (1977) also found a preponderance of joint families

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in a sample of 304 hysterical patients. Carstairs and Kapur (1976) did not find any significant correlation between family structure and psychiatric illness.

A few studies indicate that the family structure may have a more meaningful relationship with depressive illness (Lal, 1971; Sethi and Sinha, 1977; Bagadia et al., 1973). Venkoba Rao (1970) while referring to parental loss and depression mentioned that the joint family system as far as it still exists in India may counteract, the pathogenic effects of bereavement, but with the replacement of the joint family by the nuclear family late effects of early parental loss are to be expected. Lal (1971) studied 196 depressives and noted that majority of these patients belonged to a nuclear family. Venkoba Rao (1973) categories 60 depressed patients as Recurrent depressives, First-Attack Depressives, and Manic-Depressives and observed significantly more "jointness (Khatri's Scale, 1970) of family in the Recurrent-Depressives than in the First-Attack-Depressives group, while the Manic Depressive group occupied an intermediate position. In an earlier study by us (Sethi et al., 1979 b) involving 40 primary depressives and 60 secondary depressives we studied the family jointness by using Khatri's Scale, but did not find any significant difference in the two groups. However, in both the depressed categories a trend of patients showing aggregation towards nuclear family and away from a completely joint one was noted. No definite conclusions could be put forward as the sample size was rather small for this purpose.

From a careful scrutiny of the foregoing review two points of particular relevance to the present study emerge. One being that the definition of nuclear family and joint family in particular has been rather fluid with different authors defining them in various ways. Therefore it would be erroneous to draw any firm conclusions with regard to nuclearity or jointness of families and its association with psychiatric illnesses when no uniformity of definition or criteria exist. However, few workers (Venkoba Rao, 1973; Sethi and Manchanda, 1978; Sethi et al., 1979) have used a uniform measure of family jointness by adopting a scale devised by Khatri (1970) to measure jointness of families in India. But again, as yet such studies are few and further research is required to guide us to draw definitive conclusions. The other point of significance is with regard to depressive disorders and the perennial problem of their classification (Kendell, 1976; Klerman, 1975). This makes the task of interpreting the association of depressive illnesses with family structure more complex. The concept of Primary and Secondary depression as advocated by Feighner et al. (1972) seems to do away with the endless controversy of Endogenous-Reactive, Neurotic-Psychotic and other such divisions. As operational criteria are provided for these two categories, they provide us with some uniformity for research purposes.

In view of the points raised in the foregoing passages and also to improve on our earlier study (Sethi et al. 1979) by having a larger sample we were encouraged to study depression and its correlation, if any, with the nature of family constellation by utilizing Khatri's (1970) scale to measure jointness of families in India and Feighner et al.'s (1972) criteria of Primary and Secondary Depression.

AIM

To evaluate the degree of jointness of families of patients having Primary and Secondary depression.

MATERIAL AND METHOD

Two hundred depressed subjects (115 M, 85 F) whose ages ranged from 18 to 65 years comprised the sample for the present investigation. The sample was derived from patients attending the out-patient section of the Department of Psychiatry at

King George's Medical College, Lucknow. The diagnostic work-up of the cases was based on the research criteria as proposed by Feighner et al. (1972) with each case being assigned to the Primary or Secondary depressive, category.

Family-jointness was evaluated with Khatri's (1970) scale for primary as well as secondary depressives. The scale consists of a questionnaire covering the following family variables: residence, pooling of income and financial help; property and decision making. The results of scoring are arranged in five categories; completely joint (I); Very much joint (II); Somewhat joint (III); Slightly joint (IV); and not at all joint (V). The categories I and II fall approximately under the so-called joint family group and category V corresponds to the nuclear type; and categories III and IV to the extended variety (Venkoba Rao, 1974).

RESULTS

In the present study when the families of Primary depressives and secondary depressives were examined (See Table) according to various grades of family jointness (Categories I, II, III, IV and V of Khatri Scale, 1970) a marginally significant ($p < 0.05$) difference was noted. However, this difference was not consistent to all categories of jointness in either PD or SD and therefore no meaningful conclusions can be arrived at. When analysed according to categories of Joint family, Extended family and Nuclear family no significant difference was noted. Also when categories I to IV are grouped (All degree of Jointness) and compared to category V (Not at all joint) no significant difference results. But, when both the depressed groups were seen individually an overall trend for loading of patients towards a nuclear family setup and away from a completely joint system was noticed. Similar trends were noticed in our earlier study (Sethi et al., 1979) of Primary and Secondary depressives.

TABLE 1—*Family jointness (Khatri's scale, 1970)*

	Primary Depression (N=100)	Secondary Depression (N=100)
(*a*) *Degree of jointness :*		
I—Complete ..	6	10
II—Very much ..	13	6
III—Some what	11	21
IV—Slightly ..	25	14
V—Not at all ..	45	49
$X^2=9.98$, d.f.=4, $p<0.05$		
(*b*) I and II (Joint family)	19	16
III and IV (Extended family)	36	35
V (Nuclear family)	45	49
$X^2=0.44$, d.f.=2, N.S.		
(*c*) I—IV (All degrees of jointness)	55	51
V—(Not at all joint)	45	49
$X^2=0.32$, d.f.=1, N.S.		

COMMENTS

With increasing urbanization and industrialization in India there is undeniably a change in the family pattern from traditionally a joint one to a nuclear arrangement. Knowing the crucial role of family on the emotional lives of its members and that a change in family pattern involves a significant environmental change for its members we thought that it might show a difference between Primary Depression and Secondary Depression, as Secondary Depression is more of a reactive nature than Primary Depression. However, findings of the study show only a marginally significant difference between Primary Depression and Secondary Depression in terms of family jointness and therefore not sufficient to warrant firm conclusions. In an earlier study we did not find any difference amongst Primary and Secondary depression in terms of family jointness (Sethi et al., 1979b).

A search for explanations raises certain possibilities. One could be that the impression gained from the earlier studies correlating depression to a nuclear family (Lal, 1971; Bagadia, 1973; Sethi and Sinha, 1977) was not entirely correct and therefore replication is not achieved when examined by the use of relatively objective criteria for jointness or otherwise of family (Khatri's Scale, 1970) and depression (Feighner et al's criteria, 1972). Another possibility is that, as Khatri's Scale is only rating economic, residential, and decision making aspects of a family it ignores the affectional interaction amongst members which might be the important ingredient in the etiopathogenesis of depression. Furthermore it is our impression that a cross-sectional evaluation of a family does not really give a correct idea of the role of family in psychiatric disorders in general. For all we know patients who at any given point of time are found in a nuclear family may have lived a major part of their lives in a joint family where some factors responsible for subsequent depression may have operated. In our opinion these last two areas need careful research as they are most likely to prove fruitful.

In the end we have following suggestion for future line of research. They are (i) Earlier reports associating nuclearity of a family to depression should be interpreted with caution; (ii) A longitudinal perspective of a family should be taken into account; and (3) Familial interaction should also form an important component of subsequent research. We have already taken some steps in this direction and we intend to overcome these lacunae.

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