FAMILY JOINTNESS, SOCIAL INTERACTION AND NEUROSES : A RURAL URBAN COMPARISON[1]

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SUMMARY

The association between family patterns and neurotic illness has been reported variously in India. Previous work from our centre seems to suggest that a joint family provides better support and security to vulnerable individuals. The present work is a community based project conducted in a selected rural and an urban area. The door to door survey by the research team identified index subjects who were screened for presence of psychotic illness before being included. Non psychotic psychiatric disorders were identified using the Cornell Medical Index and Khatri's scale was used for typing the family pattern. The social interaction schedule was the major instrument to quantify the type and duration of interaction, and life events were scaled using the modified Life Events inventory.

Our results indicate that whereas the joint family system was prevalent in the rural areas, the major family constellation in the urban areas was nuclear. Though the primary group of the rural respondent was richer, the average member of the urban area spent more time in interaction and thus utilized the support system better. The results are discussed for their relevance to the understanding of the genesis of neurotic disorders.

Of late, mental health practitioners have become increasingly interested in the structural and functional aspects of the social organization, since evidence has accumulated on the detrimental effects of social disorganization. Researchers have attempted to discover what benefits or disadvantages accrue to individuals as a result of various patterns of social organizations and interrelationships; and more importantly, specific attempts are being made to define, describe, and isolate quantitative and qualitative characteristics of the social organization that appear to protect and support mental health.

In this context the work of Henderson and associates is particularly noteworthy for their attempts to investigate the role of social bonds through the study of social interaction between patients of non-psychotic disorders with members of their primary group* (Henderson, 1974; 1977; Henderson et al, 1978; 1980). Similarly Indian studies which attempt to correlate the structural and functional characteristics of the family to various psychiatric disorders assume significance for the simple reason that the family is the most basic unit of social organization with tremendous psychosocial influence on the life of an individual (Sethi et al., 1968; Sethi et al., 1977; Sethi and Manchanda 1978; Sethi and Sharma, 1981). Since several concepts related

to the social bond/social interaction studies and family research in India are common it permits a synthesis of ideas (Sethi and Sharma, 1980; Sethi et al., 1981; Sethi and Sharma, 1982) and thus a more comprehensive approach to the study of relationship between the family in India and neuroses. However the work in India in relation to family structure (Joint vs. unitary) suffers from several shortcomings (Sethi and Sharma, 1981) and these mainly relate to (i) lack of uniformity in the definition of terms such as joint or extended family, which makes comparisons between studies a difficult exercise; (ii) greater emphasis on structural aspects rather than on the interactional component; (iii) failure to consider other important sources of support (e.g. friends), which could be important from the therapeutic point of view, especially in cases of inadequate families; and (iv) non-availability of data on the pattern of family in the normal population. The present work is an attempt to overcome some of these shortcomings and is basically designed to gather information in respect to the last mentioned point. It is part of our ongoing community based family study which is being conducted with the following objectives in mind:

1. To obtain data on the degree of family jointness in rural and urban areas.

2. To study the pattern of social interaction of the healthy and neurotic individuals with members of their primary group.

3. To study the life events as experienced by the subjects.

4. To determine the frequency of occurrence of neuroses in rural and urban population being studied.

METHODOLOGY

The design of the study involves complete door to door survey of all families in a defined catchment area. The area of the study is covered by the Sarojini Nagar Primary Health Centre (located on the outskirts of Lucknow city) which is incidentally also a centre for our Community Psychiatry Programme. Although the majority of the area covered by the centre is rural, a significant proportion has become urbanized due to establishment of industries nearby. To begin with a village (Banthra) and an urban residential colony (Hydel Colony) were chosen for the door to door survey.

The team of investigators involved is lead by a psychiatrist and comprises a psychologist and 2 social workers (male & Female). The team visits each household, explains the purpose of research and seeks their cooperation. The household is then screened for inclusion criteria detailed as under :

(i) Age above 18 years.

(ii) Minimum education upto secondary school (Class VIII)

The age and educational criteria were specified because of the nature of evaluation instruments involved, particularly the Social Interaction Schedule (Henderson et al, 1978). In case more than one subject qualified as above, the eldest was selected. An interview with the subject was sought and undertaken in privacy at the time of first contact, if convenient, or at a mutually agreeable date later on. The interview involved recording of the identification and sociodemographic data on a semi-structured proforma and evaluation on the following instruments :

(a) *Khatri's Scale to Measure Jointness of Families in India (Khatri, 1970)*:

This consists of a questionnaire covering the following family variables: residence, pooling of income and financial help, property and decision making.

The results are scored and 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, category V corresponds to the nuclear type, and categories III and IV belong to the extended family (Venkoba Rao, 1973).

(b) *Social Interaction Schedule (Henderson et al., 1978)* :

The schedule examines a person's interaction with members of his primary group and those outside it during past week. The schedule has been suitably modified, abbreviated and adapted for the Indian population by us (Sethi et al., 1981). It determines (i) numerical size and composition of the person's household, (ii) respondent's estimate of the number of persons he or she sees as good friends, and (iii) details of the respondent's interaction during the previous week with his immediate household, all others in his primary group, and persons outside the primary group.

The information pertaining to social interaction is obtained through enquiries on (i) minutes or hours spent with each member of the household, (ii) number and duration of contacts with persons in the primary group but outside the household, and (iii) the period of time spent with each person and what proportion was 'pleasant', 'neutral' or 'unpleasant'.

Subsequently the interview identified the respondents' principal and other attachment figures with whom the respondent had affectional ties. A series of questions then explored what comfort, help or support the respondent had obtained in the last one week from the principal attachment figure and from other attachments, including non-personal ones such as work hobbies or religion. They were next asked what, if anything they perceived as missing from their life at the moment and whether this was of an interpersonal, personal or extrapersonal nature.

(c) *Cornell Medical Index (CMI) (Sections M-R)* :

The CMI (Broadman et al, 1949) is a simple self-reporting questionnaire useful for screening purposes. It has been widely used as a screening tool to detect significant emotional disturbances by various investigators abroad as well as in India (Pershad et al, 1972; Wig et al, 1977) and there are fair evidences of its reliability and validity. "Medically significant emotional disturbance" is suspected when 10 or more 'yes' are reported in sections M-R.

In the present study, respondents scoring above the cut-off (more than 10 score) would be subjected to a detailed psychiatric evaluation for presence of any classifiable (ICD-9) disorder.

(d) *Life Event Inventory (Tenant and Andrews (1976) as modified by Venkoba Rao and Nammalvar (1976)*:

This comprehensive life event inventory was originally constructed by Tenant and Andrews (1976) with the view that what constitutes stress in some people may not be at all stressful to others. They utilized this questionnaire in Australian population to quantify the emotional response associated with life events. Venkoba Rao and Nammalvar (1976) modified it and used it in Indian population in their study of depressed patients. This inventory consists of 67 life events pertaining to nine areas namely (i)health (2) bereavement (3) family and social (4) friends and relatives, (5) education, (6) occupation, (7) moving house, (8) financial and legal, and (9) others.

RESULT AND DISCUSSION

The basic socio-demographic variables of the sample are depicted in Table-1. As regards age, the distribution was fairly equal in both the groups with the majority of respondents being below 30 years of age. The majority of rural respondents were engaged in agriculture whereas in the urban group the division was almost equal among the housewives and those in service. This last finding is explicable by the sampling time chosen, when most of the men were away to work and the housewives responded. The sex distribution again reflects the occupation in the urban group, whereas in the rural population there was no female respondent.

TABLE-I. *Sociodemographic Variables*

		Urban (N=50)	Rural (N=50)
1.	*Age:*		
	Upto 20	15	14
	21—30	31	28
	31—40	3	5
	41—50	1	3
2.	*Occupation:*		
	Agriculture	—	41
	Student	—	4
	Service	23	5
	Housewife	27	—
3.	*Sex:*		
	Male	23	50
	Female	27	—

Table-2 compares the extent of social support available to the subjects as measured on the social interaction schedule. The average number of household members was significantly

TABLE-II. *Social Support*

		Urban (N=50)	Rural (N=50)	
1.	Household members	4.2	11.7	$p < 0.001$
2.	Close relatives	4.8	0.34	$p < 0.001$
3.	Number of good friends	3.2	4.1	N. S.
4.	Primary group contacts (outside household)	7.1	6.8	N. S.
5.	Outside primary group	2.1	1.9	N. S.
6.	Total number of attachment figures	2.8	6.9	$p < 0.001$

more for the rural respondents as compared to the urban. This finding parallels the family jointness results (Table IV). Also the total number of attachment figures is more for the rural population vis-a-vis the urban. The difference is statistically significant at the 0.1% level. An explanation for this lies partly in the larger number of available household members in case of rural subjects. The number of friends and contacts outside household are not different in the two groups.

As shown in Table-III, the social interaction measured as the mean of

TABLE-III. *Mean Hours of Social Interaction*

		Urban (N=50)	Rural (N=50)	
1.	Household	34.5	97.4	$p < 0.001$
2.	Primary group (outside household)	11.4	7.9	$p < 0.05$
3.	Outside primary group	4.4	3.9	N. S.
4.	Principal attachment figure	10.9	21.6	$p < 0.001$

total number of hours over the past one week yields interesting findings. In the household a mean of 97.4 hours were spent by the rural subjects in social interaction whereas those from an urban setting were able to set apart only **34.5** hours-a highly significant difference statistically. The urban subjects however spend significantly more time than rural subjects in interacting with members of the primary group outside the household. This is perhaps explainable to some extent on the nature of work engaged in by the two groups. Most of the urban subjects were in service which required them to be away for quite some time, whereas in case of rural subjects the occupation was mainly agriculture in which case they were easily accessible to household members being close to home most of the time and not bound by time schedules of service conditions.

The degree of family jointness is displayed in Table-VI. The differences by X^2 test are highly significant, with more in rural sample belonging to the completely joint-family and more in urban sample belonging to the 'Not at all Joint' category.

TABLE-IV. *Degree of Jointness*

		Urban (N=50)	Rural (N=50)
1.	Completely joint	3	38
2.	Very much joint	2	7
3.	Somewhat joint	8	2
4.	Slightly joint	6	1
5.	Not at all	31	2

p<0.001

As shown in Table-V the number of life events experienced by the subjects during the past 3 months as well as the CMI score were similar in both the

TABLE-V. *Comparison on Life Events and CMI Score*

	Urban (N=50)	Rural (N=50)	
Number of life events (past 3 months)	2.4	2.1	N. S.
CMI score (section M to R)	2.4	2.8	N. S.

groups. The mean CMI score (section M-R) was 2.4 and 2.8 in the urban and rural respondents respectively. No subject scored above the cut-off which is 10 for these sections. We therefore had no subject who could be suspected of having a 'medically significant emotional disturbance' and who on detailed evaluation could possibly be having neuroses as per ICD-9 criteria. The incidence of neurotic disorders has been variously reported by different workers, our own urban survey done earlier giving a figure of 27/1000. The absence of neuroses in the present sample of 100 is not surprising, particularly in view of the fact that the design of the present study was only to identify such disorders in the respondents and not in the family and that the respondents were not random but highly selective-being chosen on basis of inclusion criteria (e.g. education and seniority in the family).

The findings of the present paper pertain to only a part of our work which is still ongoing; involving a small sample and hence preliminary and tentative in nature. Nonetheless, their value lies in the fact that, for the first time, we have some idea as to the patterns of family and social interaction, as it exists in the general (and healthy) population (rural and urban). A follow-up of these subjects is planned and which should be useful in determining the correlation

these factors have with neuroses, should it develop in them during follow-up. Similar information may also be yeilded by spontaneous cases of neuroses which may be found in the much larger sample collected for the complete study.

The information on social interaction, the family and the primary group obtained jointly is especially important because within the entire social network the most important component to an individual is his primary group and within the primary group his family. The family provides for an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time. An individual's interaction with family members (or in a wider context with his primary group) provides the basis for formation of social bonds*, which according to some evidence (Henderson 1980) is an evolved and valuable component of human behavioural repertoire and now considered necessary for persons to maintain a reasonable degree of affective comfort and to operate effectively in the face of adversity. While social relationships almost certainly carry multiple functions, as described by Weiss (1974), one category which is assumed to be of special significance to psychiatry is the provision of 'support'. This is precisely the commodity with which we are concerned in our consideration of the joint and nuclear family.

Central to our thesis that favours the joint family over the nuclear one is the concept that a large and closely knit kinship system, as represented by a joint family, allows for formation of strong bonds of emotional attachment with a large number of persons, group support and considerable social and economic support, all of which either have a positive influence on mental health, or protect vulnerable individuals from decompensating in adverse circumstances. Compared to a nuclear family, a joint family is better source of support by virtue of it providing for a large number of attachment figures. The size of a person's family may be of significance in relation to neurotic illness. In general populations the primary network usually consists of about 25-40 people (Hammer, Makiesky-Barrow and Gutwirth, 1978) and the degree of interconnectedness of network ties appears to be directly related to the duration of ties, that is, in networks where members are highly interconnected, ties tend to be long term. This has obvious relevance to our supposition with regard to joint and nuclear family. In comparison to normative sample Pattison et al (1975) found that primary networks of neurotics were smaller in size (about 10-12 persons), often including significant persons who were no longer living or live far away and the density or interconnectedness of neurotics network tended to be low in comparison to the normative sample.

It should now be clear as to why we consider the size of the family to be important. In India we are probably facing a situation where, due to the reasons mentioned in earlier part of the paper, an effective, spontaneous and a rich support system (represented by a joint family) is being replaced by a weaker substitute (represented by nuclear family). The consequent weakening and

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*Social bonds : The sociological and anthropological term social bonds refers to that range of relationships which connect an individual to those who make up his primary group. The bond may be primarily affectional, as with a spouse, a special friend, or close kin. It would be less affectional and more instrumental as one moves towards the periphery of the primary group (Henderson, 1980).

concommitantly 'support' may be affecting the mental health of individuals.

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