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R. M. ANULA RATHNAYAKE

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DOKTORSKA DISERTACIJA

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MENTORICA: IZR. PROF. DR. GABI ČAČINOVIČ VOGRINČIČ

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UNIVERSITY OF LJUBLJANA

FACULTY OF SOCIAL WORK

R. M. ANULA RATHNAYAKE

Mental Health and Family in Sri Lanka: Family Intervention and the Significance of Family Support for People with Mental Health Problems

DOCTORAL DISSERTATION

SUPERVISOR: SENIOR. PROF. DR. GABI ČAČINOVIČ VOGRINČIČ

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Dedication

This dissertation is dedicated to my loving parents and husband for their invaluable support and encouragement in my long journey of the academic performances.

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Povzetek doktorske disertacije

Cilj pričujoče študije je raziskati potrebe ljudi s težavami z duševnim zdravjem in njihovih družinskih članov ter oceniti, kakšna je osveščenost uporabnikov služb, njihovih družinskih članov in strokovnjakov ter kako vidijo posredovanje v družini in podporo družinam na področju oskrbe uporabnikov.

Terensko delo pričujoče študije smo opravljali dve leti (2011-2012) na Nacionalnem inštitutu za duševno zdravje v Šrilanki in na Univerzitetnem oddelku za psihološko medicino v Javni bolnišnici (NHSL) v Colombu v Šrilanki. Naša raziskava je opisna študija, ki ubira interpretativni pristop. Za zbiranje pretežno kvalitativnih podatkov, ki smo jih dopolnjevali s kvantitativnimi, smo uporabili kombinacijo kvantitativnih in kvalitativnih raziskovalnih tehnik.

Vprašalnik je izpolnil eden od dejavnih družinskih članov iz vsake družine uporabnika v vzorcu, ki je temeljil na poljubni metodi vzorčenja, v skupnem številu pa smo zbrali štiriinosemdeset (84) vprašalnikov. Izbrali smo petnajst ljudi iz vseh treh kategorij: dejavnih družinskih članov, uporabnikov služb in zaposlenih na oddelkih za duševno zdravje ter jih intervjuvali na podlagi vprašalnikov z obeh lokacij, z njimi pa smo opravili tudi poglobljene intervjuje na institucijah in njihovih domovih, v zasebnem in zaupnem okolju, na podlagi metode namernega vzorčenja. Uporabnike smo izbrali na oddelkih za psihiatrijo odraslih, na porodniškem psihiatričnem oddelku in na oddelku za mladostniško psihiatrijo in psihiatrijo mlajših odraslih na Nacionalnem inštitutu za duševno zdravje ter na Univerzitetnem oddelku za psihološko medicino javne bolnišnice v Colombu. Kategorijo zaposlenih na področju duševnega zdravja so sestavljali zdravniki in zdravnice, medicinske sestre, inštruktorji socialnega dela, socialni delavci in delavke s področja duševnega zdravja, delovni terapevti in terapevtke in pomočniki, po trije iz vsake poklicne kategorije. Vodnik za opravljanje intervjujev smo pripravili vnaprej. Da bi zbrali sekundarne podatke, smo uporabili tudi poročila z uporabnikovo evalvacijo, diagnozami in načrti zdravljenja, zloženke in zdravstveno dokumentacijo. Pri zbiranju

literature za našo raziskavo smo uporabili objavljene knjige, raziskovalna poročila, teoretske članke, arhivsko dokumentacijo, statistična poročila, ki so jih objavile domače in tuje vlade, etnografske zapiske o Šrilanki, objavljene in neobjavljene članke, časopisne članke in spletne strani institucij ter druge spletne strani. Teoretsko ozadje naše raziskave temelji na teoriji potreb, teoriji o družinskih sistemih in pristopu, imenovanem odpornost družine. Za analizo podatkov smo uporabili SPSS in tematsko analitični pristop.

Disertacija je razdeljena na dva dela in sicer: podatke iz pregleda literature in analitične dele. Ta dva dela obsegata šest poglavij. Prvo poglavje obsega opis ozadja raziskave in povzetek poglavij v disertaciji. V tem poglavju smo opredelili običajno in ključno vlogo družine kot osnovne in neformalne institucije socialne blaginje v družbenih situacijah. Prav tako v njem navajamo strnjen pogled na izvor socialnega dela, kot so filantropsko in dobrodelno delo, socialna gibanja in pomoč ljudem in njihovim družinam, ko se skušajo spoprijeti s težavami. V tem poglavju navajamo, da se socialno delo z družino ukvarja z družino na dva načina: ustvarja delovni odnos in pri tem črpa iz družinskih virov, da bi našli rešitve, socialni delavec in delavka pa se ukvarjata z družinsko dinamiko, stvarnostjo družine in njenimi notranjimi razmerji. Socialni delavec ali delavka ima ključno, izjemno pomembno vlogo pri oskrbi ljudi s težavami z duševnim zdravjem, saj z opazovanjem in pogovori ločeno oceni družinske člane in družino kot celoto, pri tem pa odkriva družinsko dinamiko, njene močne plati, šibke plati in težave. Čeprav se je socialno delo na področju psihiatrije začelo v začetku prejšnjega stoletja, se je razmahnilo šele po drugi svetovni vojni. V Šrilanki se je socialno delo kot poklic prvič oblikovalo v institucijah za duševno zdravje v času britanske vladavine v 30. letih prejšnjega stoletja.

V nadaljevanju poglavja raziskujemo slab učinek dejstva, da so bili azili vzpostavljeni daleč stran od družin uporabnikov, in predstavimo, kako so povzročili oslabitev družinskih vezi ljudi s težavami z duševnim zdravjem, vpliv spremembe v filozofiji obravnave v 50. letih prejšnjega stoletja in učinek na izboljšanje vključevanja družine, pomen družine in njenega vključevanja v deželah v razvoju, kamor na področju duševnega zdravja spada tudi Šrilanka. Sledijo kratka zgodovina oskrbe ljudi s težavami z duševnim zdrajem v Šrilanki in glavne ovire pri uveljavljanju socialnega dela v

Šrilanki, čeprav je na voljo veliko strokovno podkovanih in usposobljenih socialnih delavcev in delavk v skoraj vseh institucijah, ki javnosti omogočajo socialno oskrbo in socialne službe.

V drugem pogavju opisujemo zasnovo raziskave in metodologije ter obseg raziskovalnega problema, predstavimo raziskovalna vprašanja, metode, izbiro vzorcev in meril, raziskovalne lokacije, znanstveni prispevek k raziskavi, analizo podatkov, etične pomisleke in težave ter omejitve. Podajamo opis teoretičnih pristopov, podkrepljenih z razlago konceptov, ki so povezani z raziskovalnim problemom pričujoče raziskave. V sklopu razlage konceptov smo največjo pozornost namenili konceptom, kot so zdravje, duševno zdravje, težave z duševnim zdravjem, ljudje s težavami z duševnim zdravjem, družina, bližnji družinski člani, podpora družini in posredovanje v družini. V tovrstnih raziskavah je izjemnega pomena etični razmislek. Najprej smo predlog za raziskavo podali na Komisijo za etična vprašanja na Medicinski fakulteti Univerze v Colombu v Šrilanki in na Komisijo RS za medicinsko etiko v Sloveniji, da bi pridobili soglasje. V drugem koraku je vsak respondent pred intervjujem prejel obvestilo o tem, kdo smo in kakšen je namen raziskave. V tretjem koraku smo respondentom dali obvestilo, ki je bilo napisano v treh jezikih: sinhalščini, angleščini in tamilščini, saj so bili pri naši raziskavi navzoči respondenti, ki uporabljajo vse tri jezike. V četrtem koraku raziskave smo respondente seznanili z zaupnostjo podatkov, ki nam jih bodo posredovali, in fiktivnimi imeni, ki smo jih uporabili, da bi zavarovali njihovo identiteto. Nazadnje smo pridobili soglasje respondentov za izvedbo intervjuja, ki je bilo prav tako napisano v treh zgoraj omenjenih jezikih. Čeprav je bila raziskava povezana z ljudmi s težavami z duševnim zdravjem, z njihovimi družinami in zaposlenimi družinskimi člani, ki so včasih prihajali od daleč, ter z osebjem na psihiatričnih oddelkih, ki je na tesnem s časom, smo uspešno opravili skoraj vse raziskovalne dejavnosti.

V tretjem poglavju predstavimo kratek uvod v etiologijo težav z duševnim zdravjem, pogled nanje, evolucijo socialnega dela v zdravstvu v zahodnih in azijskih državah ter v Šrilanki, razpravljamo o družini in njeni strukturi, posredovanju v družini, podpori v duševnem zdravju in odpornosti družine. Poznavanje etiologije težav z duševnim

zdravjem je zelo pomembno, saj vpliva na obravnavanje ljudi s težavami z duševnim zdravjem. Obstaja več konceptualnih modelov težav z duševnim zdravjem, ki so vplivali na oblikovanje strokovne miselnosti s področja duševnega zdravja in na ljudi, prav tako pa tudi na vzorce obravnave in vire ljudi, ki imajo težave z duševnim zdravjem ter njihove družine. Med njimi so pomembni biološki model, model psihodinamične teorije, teoretski model družinskega sistema, socio-kulturno konceptualni model in model teorije stresa. Omenjeni pogledi na etiologijo težav z duševnim zdravjem so postopoma omogočili vključevanje družin in družinskih članov. Koncept čarovništva, duhov, kulturnih verovanj o zlu, ki se skriva v očeh, ustih in mislih (kot so *vaha, kata vaha* in *ho vaha*), verovanje o "demonih" (*yaksa disti*), vpliv slabih nebesnih teles in konstelacij planetov (zloveščih planetarnih vplivov) spadajo med razširjena verovanja o ljudeh s težavami z duševnim zdravjem, zlasti v številnih tradicionalnih, nezahodnjaških družbah. Čeprav so ljudje zelo negativno nastrojeni proti posameznikom, ki uporabljajo tovrstne vire pomoči, psihiatri, psihiatrične bolnišnice in druga pomoč ne navajajo nobenih dokazov o negativni nastrojenosti proti duhovnim vodjem ali ajurvedskim zdravnikom ali pa ljudem, ki se posvetujejo z obema viroma pomoči.

Socialno delo v zdravstvu se razvija že več kot 100 let kot odgovor na družbeno okolje zgodnjih 20. let prejšnjega stoletja; profesionalno socialno delo se je najprej začelo v zahodnih državah, kot so Anglija in ZDA. Vodja zdravnikov v Splošni bolnišnici Massachussetts v Bostonu, dr. Richard Cabot, je ustanovil prvi formalni oddelek socialnega dela, saj je bil prepričan, da je osveščenost zdravnikov glede socialnih in okoljskih vplivov na zdravstveno stanje in obravnavo pacientov izjemno pomembno, socialni delavci in delavke pa so bili pravi strokovnjaki, ki bi takšne podatke lahko zbirali. V razvoju socialnega dela so bili izjemnega pomena strokovnjaki Felix Biestek, Helen Harris Perlman, James K. Whittaker, Steven P. Schinke and Lewayne D. Gilchrist, ki so pripomogli k razvoju socialnega dela, saj so napisali knjige, povezane s socialnim delom. Kontinuiran razvoj socialnega dela v zdravstvu pa se je nadaljeval v zadnjih desetletjih 20. stoletja.

V južnoazijski regiji je bilo strokovno usposabljanje v socialnem delu uvedeno v 30. letih prejšnjega stoletja v okviru paradigme socialnega varstva. Pod tujim vplivom in okriljem so bile ustanovljene prve šole za socialno delo v Aziji. Ta vpliv se je širil zlasti na podlagi ameriške literature o socialnem delu. Na teh temeljih se je socialno delo v Južni Aziji razvijalo in začelo ukvarjati z raznolikostjo in kompleksnostjo v tej regiji. V Aziji sta opazna dva sklopa razvoja socialnega dela in socialnega varstva: ljudje tradicionalno uporabljajo obstoječe mreže in vire, pri tem pa se odzivajo na kulturne imperative in religiozna upoštevanja pri reševanju problemov ob hkratnem izpolnjevanju svojih potreb. Vključevanje vlade v dejavnosti socialnega varstva pa se je začelo s kolonialno administracijo v številnih državah, tudi Šrilanki. Profesionalno socialno delo v tej regiji se srečuje s številnimi problem in izzivi, kot so pomanjkanje priznanja s strani države in nizek ugled poklica socialnega delavca, pomanjkanje usposobljenih socialnih delavcev in delavk v institucijah, ki bi jih usposabljali za supervizijo na terenu, potreba po razvoju integriranega izobraževanja o socialnem delu in priložnosti za usposabljanje, pomen institucionalizacije profesionalnih standardov prakse socialnega dela in zaposlovanje socialnih delavcev in delavk v različnih upravnih vladnih službah, da bi dosegli najrevnejše prebivalstvo. Čeprav je v Šrilanki obstajala posebna potreba po uvedbi discipline socialnega dela v poznih 60.letih prejšnjega stoletja, ni mogoče opaziti nobenih poskusov, da bi uvedli socialno delo v univerzitetno izobraževanje. Na razvoj socialnega dela pa so vplivale tudi gospodarske, politične, filozofske in tehnološke spremembe, ki se občasno dogajajo v vsaki državi.

Družine so družbene enote, ki delujejo kot sistem z medsebojno povezanimi podpornimi deli, ki pomagajo pri ohranjanju, kontinuiranju in integriranju družbe. Družina deluje kot kraj, kjer se organizirajo načini, s katerimi se izpolnjujejo številne želje in potrebe posameznikov. Temeljna lastnost družine, ki dobro funkcionira, pa je sposobnost obvladovanja napetosti in frustracij, ki so posledica neizpolnjenih želja in potreb. Čeprav je družina odgovorna za marsikaj, kar zadeva oskrbo posameznikov s težavami z duševnim zdravjem, pa pogosto ne ve, kako ravnati s svojcem, ki ima tovrstne težave. Zato obstaja čedalje več pobud, da bi bila družina vključena v obravnavo svojcev s težavami z duševnim zdravjem. V tem poglavju raziščemo temeljne predpostavke

perspektive moči, ki jo je uvedel Dennis Saleeby. Razumevanje uporabnikovih potreb, interesov in močnih plati je pomembnejše kot diagnosticiranje in dajanje nalepk. Cilj pristopa, imenovanega odpornost družine, je opredeliti in okrepiti ključne interakcijske procese, ki naj bi po pričakovanjih družinam pomagali, da okreva po takšnih stresnih situacijah.

V četrtem poglavju pojasnimo ozadje našega raziskovalnega vzorca in družinskih struktur, skrb družinskih članov, družinsko dinamiko in komunikacijo ter sprejemanje odločitev, potrebe družin in uporabnikov, pričakovanja družin in uporabnikov, močne plati družine in duhovnost v duševnem zdravju. O posredovanju v družini, točkah posredovanja v družini, podpori družini, zadovoljstvu ob trenutni podpori in o vprašanju, kako družina in uporabniki služb vidijo posredovanje, ki ga izvajajo strokovnjaki s področja duševnega zdravja, razpravljamo v petem poglavju disertacije.

Sklepno poglavje posvečamo izsledkom raziskave. Pojasnimo pomen posredovanja socialnih delavcev in delavk v družinah, katerih člani imajo ljudje težave z duševnim zdravjem, in njihov vpliv na obravnavo in proces oskrbe ljudi s težavami z duševnim zdravjem. Prav tako v sklepnem poglavju razpravljamo o ovirah pri razvijanju duševnega zdravja v skupnosti v Šrilanki. Raziskovalka želi v tej raziskavi razpravljati tudi o nekaterih pomembnejših izsledkih. Večina uporabnikov je imela diagnozo shizofrenije, bipolarne motnje s psihotičnimi lastnostmi in depresije. Demografski podatki o uporabnikih služb vključujejo tako ženske kot moške, večino pa predstavljajo neporočeni in nezaposleni uporabniki v starostnem obdobju od 40-45 let, 20-26 let in 30-39 let, z dokončano nižjo ali višjo srednješolsko izobrazbo (stopnja 9 in 11). Večino uporabnikov je zastopala kategorija otrok, očetov, mater, ki so živeli bodisi s starši, sorojenci ali zakonci. Na koncu pa v poglavju pojasnimo predloge, ki so lahko koristni pri razvijanju duševnega zdravja v skupnosti v Šrilanki. Pomemben del raziskave so sestavljale nuklearne družine. V teh družinah so pogosti spori med zakoncema, družina ima težave z interakcijo, prav tako pa so pogosti spori glede odnosov in komunikacije. Družinski dohodek je nizek, saj večina nima redne zaposlitve, mnogi pa živijo pod isto streho s starši.

V razpravi o posredovanju in podpori v družini pomemben izsledek predstavljajo tudi visoka podpora družini, visoka izraženost čustev, kot sta kritiziranje in sovražnost, pomanjkanje razumevanja težav z duševnim zdravjem, simptomov, zdravljenja, spopadanje s težavami, visoka stopnja obiskovanja staršev, bratov in sester ter nizka stopnja obiskovanja ožjih družinskih članov, prijateljev in sovaščanov. Stigma in diskriminacija sta glavni razlog za visoko stopnjo obiskovanja starše, bratov in sester in nižjo stopnjo obiskovanja ožjih družinskih članov, prijateljev in sovaščanov zaradi prikrivanja težav z duševnim zdravjem in hospitalizacije. Kritika družinskih članov pogosto temelji na tem, da uporabnik slabo skrbi zase, ima slabšo delovno zmogljivost in potrebuje nadzor, porabi veliko časa in je počasen, ima nizko motivacijo in ne kaže navdušenja, kaže pomanjkanje osebne higiene, se razjezi, kadar ga priganjajo k delu, je vznemirjen, ne kuha in ne pospravlja. Večina uporabnikov ne sodeluje pri družinskem sprejemanju odločitev. Medtem ko je večina družinskih članov menila, da so odgovorni za skrb za uporabnike, pa v resnici prevladuje oskrba, ki jo nudijo ženske. Toda vloga uporabnikov služb in družinskih članov se spreminja, zato sta pogosta zanemarjanje težav z duševnim zdravjem in sprejem v bolnišnico.

Glede prepričanja družinskih članov o uporabnikih s težavami z duševnim zdravjem večina družinskih članov meni, da imajo njihovi družinski člani težave z duševnim zdravjem, duševno bolezen ali pa so nori (42,85%). Poleg tega so prepričani, da je razlog za težave z duševnim zdravjem treba iskati v stresnem življenju (22,61%), strahu (5,95%), slabem vplivu kodivine (črne magije) (7,14%) ali nevroloških težavah (4,76%). Uprabniki in družinski člani so bili preskrbljeni z osnovnimi potrebami, kot so hrana, pitna voda, bivališče, denar, varnost, ljubezen in občutek pripadnosti, in so znali ceniti sebe. Finančne potrebe so bile pomemben dejavnik za večino uporabnikov služb in njihovih družinskih članov. Poleg tega pa so bile druge potrebe družinskih članov tudi potreba po tem, da bi poznali težave z duševnim zdravjem, zdravila in nego, potreba po urejanju prihodnosti, oskrbe in varnosti svojih družinskih članov, potreba po podpori pri urejanju premoženjskih vprašanj in potreba po začasnem bivališču, kamor bi nastanili uporabnike. Uporabniki pa so imeli poleg osnovnih potreb tudi potrebo po sklenitvi zakonske zveze, zaposlitvi, nadaljevanju študija, podpori pri skrbi za otroke in

gospodinjstvu, ureditvi zakonskih težav in težav v spolnosti ter pri nadaljevanju zakonskega življenja. Glede pričakovanj pa si družinski člani želijo, da bi njihovi svojci okrevali, da bi se sami bolje seznanili z boleznijo, simptomi, zdravljenjem in prognozami, prav tako pričakujejo finančno podporo, da bi lahko prišli v bolnišnico, podporo pri tem, da bi svojca pripeljali v bolnišnico v primeru ponovitve, podporo pri nasvetih, iskanju zaposlitve za svojca s težavami z duševnim zdravjem, pričakujejo enako obravnavo, podporo pri obiskih na domu in zdravljenju zlasti z injekcijami, saj jih uporabniki težko sprejmejo, zdravila za druge družinske člane, saj njihovo vedenje vpliva na celo družino, podporo pri sprejemanju odločitev glede "nadaljnje oskrbe uporabnikov po smrti staršev" (če bratje in sestre niso pripravljeni prevzeti skrbi za uporabnika in ni na voljo nikogar, ki bi zanj(o) poskrbel). Družinski člani prav tako pričakujejo, da bo družina obveščena o bolezni svojca, potrebi po njihovi podpori in kako naj zmanjšajo spore, pričakujejo pa tudi podporo pri sprejemanju odločitev in reševanju lastninskih vprašanj. Uporabniki pa v glavnem pričakujejo od družinskih članov, da jih ne bodo kritizirali, da jih bodo imeli radi, da bodo do njih prijazni in sočutni, da bodo imeli denar za njihove osnovne potrebe. Uporabniki od strokovnjakov s področja duševnega zdravja pričakujejo, da bodo odpravili in pozdravili njihove težave z duševnim zdravjem, da jih bodo obvestili o težavah z duševnim zdravjem, naravi zdravljenja in prognozah, da bodo z njimi ravnali prijazno, ljubeznivo in sočutno, da bodo njihove družinske člane obveščali o težavah z duševnim zdravjem in jim pojasnili, kako naj komunicirajo z njimi ter da bodo varovali zaupnost. Družinski člani od uporabnikov pričakujejo, da se bodo potrudili pozdraviti, da bodo jemali zdravila, iskali službo, poskušali biti neodvisni, prevzemali odgovornost za gospodinjsko delo (ohranjanje čistoče doma, kuhanje in pranje itd.), se vedli mirno in tiho, poiskali podporo pri spolnih stikih (če so poročeni), in skrbeli za starše v prihodnosti. Vse tri raziskovalne kategorije so bile pozitivno naravnane do posredovanja in podpore v družini, skoraj vsi respondenti pa so poudarili, da uporabniki potrebujejo podporo družine, ki izpolnjuje osnovne potrebe za njihovo okrevanje, saj jim je najbližja in jih najbolje pozna ter ima izkušnje z njimi. Vse tri raziskovalne kategorije še vedno verjamejo, da je družina najpomembnejši podporni sistem za ljudi s težavami z duševnim zdravjem, strokovnjaki s področja duševnega zdravja pa menijo, da je to običajno v vseh

družbah po svetu. Večina strokovnjakov s področja duševnega zdravja je prepričana, da morajo biti družinski člani seznanjeni s težavami z duševnim zdravjem uporabnikov, z zdravljenjem in oskrbo, saj težave z duševnim zdravjem slabo razumejo, so frustrirani, nosijo veliko breme, so jezni, drži se jih stigma, prav tako pa so diskriminirani. Poleg tega strokovnjaki s področja duševnega zdravja verjamejo, da bi ljudi s težavami z duševnim zdravjem morali podpirati v akutni fazi, saj takrat ne morejo sprejemati odločitev zaradi zmedenih misli. Če jih ne podpremo v tej fazi, bi morali njihove težave z duševnim zdravjem videti kot druge nenalezljive bolezni. Toda družinski člani in uporabniki so prepričani, da uporabniki potrebujejo večjo podporo v vsakdanjem življenju, kar je v nasprotju z mnenjem strokovnjakov s področja duševnega zdravja. Žal pa strokovnjaki s področja duševnega zdravja ocenjujejo uporabnike služb bolj negativno kot običajni ljudje. Zato lahko opazimo manj institucionalnih posredovanj s kar najmanjšim upoštevanjem potreb družine in njenih stisk.

Naša raziskava je predstavila tri kategorije pogledov na potrebe in pričakovanja uporabnikov in njihovih družin. Najpomembnejši prispevek naše raziskave je navajanje literature in smernic za nadaljnje raziskovanje. Prav tako pa nam raziskava pomaga opredeliti praktične ovire, kot so pomanjaknje razumevanja težav z duševnim zdravjem, potreba po zdravljenju, oskrbi, okrevanju, visoka stopnja stigme in diskriminacije v okviru družin in sorodnikov, sosedov in prijateljev, delovnega mesta. Strokovnjaki s področja duševnega zdravja in družba pa kot praktične ovire navajajo pomanjkanje razumevanja težav z duševnim zdravjem, zdravila, visoko razširjenost čustvene preobremenjenosti, finančne težave in pomanjkanje izpolnjevanja osnovnih potreb uporabnikov in družin, pomanjkanje informacij o težavah z duševnim zdravjem, ki bi jih morali pridobiti strokovnjaki s področja duševnega zdravja, pomanjkljivo vladno in instutucionalno pozornost do težav z duševnim zdravjem in ljudi, ki imajo tovrstne težave. Strokovnjaki s področja duševnega zdravja lahko zlasti z opredeljevanjem potreb družine razvijajo podporne programe za družine, saj v Šrilanki službe duševnega zdravja skrb prenašajo na družino. Ob pomoči informacij in lastnih idej lahko opredelimo slabosti in hkrati tista področja, ki jih je potrebno razvijati in raziskovati v teh programih, prav

tako pa raziskovati v praksi socialnega dela na področju duševnega zdravja ter prepoznati pomen timskega dela, ki ga predstavlja vsak strokovnjak s področja duševnega zdravja, ki skrbi za ljudi s težavami z duševnim zdravjem. Naša raziskava podaja novo sporočilo in znanje, ki temeljita na praktičnih izsledkih, in je namenjena oblikovalcem politike in tistim, ki sprejemajo odločitve na področju duševnega zdravja v Šrilanki, saj zastopa uporabnike služb in družine z izkušnjami uporabnikov služb duševnega zdravja in njihove naravnanosti. Ob upoštevanju vseh omenjenih vidikov bi bilo koristno, če bi za družine, ki skrbijo za svojce s težavami z duševnim zdravjem, izboljšali programe posredovanja v družini in jih podprli tako, da bi se ukvarjali z njihovimi potrebami in s tem zmanjšali stisko spričo dejstva, da se skrb iz bolnišnic prenaša na skrb v skupnosti. To je v vsakem pogledu koristno, donosno in plodno, saj lahko zmanjšamo vložek, prav tako pa je dolgotrajno, saj je ta pristop socialen in kulturno občutljiv do države, kakršna je Šrilanka. Naša raziskava torej podaja pozitivno sporočilo različnim strokovnjakom in oblikovalcem politik na področju duševnega zdravja glede oskrbe ljudi s težavami z duševnim zdravjem v Šrilanki.

Pričakujemo, da bomo na podlagi empiričnih podatkov te raziskave pripravili priročnik o posredovanju v družini pri razvijanju duševnega zdravja v Šrilanki za socialne delavce na področju psihiatrije, in upamo, da bo koristen za vsakogar, ki dela na tem področju.

Summary

The objective of this study is to explore the needs of people with mental health problems and their family members and to examine the awareness and perception of people with mental health problems, their family members and professionals on family intervention (FI) and family support (FS) in the caring of people with mental health problems.

Field work in this study was carried out for two years (2011-2012) in the National Institute of Mental Health (NIMH) in Sri Lanka and the University Psychological Medicine Unit (UPMU) at the National Hospital Colombo, Sri Lanka (NHSL). This research is a descriptive study with an interpretative approach. A combination of quantitative and qualitative research techniques was applied to collect mainly qualitative data with supplementary quantitative data.

The questionnaire was administered to one of the active family members from each family of person with mental health problem in the sample based on random sampling method and total number of questionnaires was eighty four (84). Fifteen from each category of active family members, people with mental health problems and staff of mental health were selected for this purpose from both locations and were interviewed based on purposive sampling method at these institutes and their homes for privacy and confidentiality. People with mental health problems were selected from adult psychiatry units, perinatal psychiatry unit, and adolescent and young adult psychiatry unit in NIMH and UPMU and interviewed while they were in the wards excluding those in acute stage, who were not ready to sit in one place for interviews. Those interviewed from the category of mental health staff consisted of doctors, nurses, instructors in social work/ psychiatric social workers, occupational therapists and attendants. From these, three persons from each category were interviewed. Interview guide was developed in advance. To collect the secondary data, bed head reports (the reports with service users' assessment, diagnoses and treatment plans), brochures, and hospital documents were used. Published books, research reports, theory related papers, archival records, reports published by the local and foreign governments with some statics, ethnographic writings done based on Sri Lanka, published and unpublished articles, newspaper articles and

institutional and other websites were used for the collection of literature. This study was based on the needs theory, family systems theory and family resilience approach as its theoretical backgrounds. SPSS and thematic analysis approach were applied to analyze the data.

This dissertation has been divided into two sections based on the information on the literature review and the analysis parts, and these two parts consist of six chapters. First chapter consists of a description of the background of the study and a summary of the chapters in the dissertation. In this chapter the regular and vital role of family as a basic and informal social welfare institution in social situations are explained. And also, this chapter gives a brief picture about the origin of social work such as philanthropic and charitable work, social movements, and assistance to persons and family to cope with the problems in their situations. The chapter mentioned that family is addressed by family social work in two ways; creation of a working relationship mobilizing family resources for solutions and the social worker addressing the family dynamics, family reality, the internal dynamics of the family. Social worker plays key and very significant role in the care of people with mental health problems through the assessment of the families separately and as a whole through observation and interviewing and find family dynamics, strengths, weaknesses, and problems. Though psychiatric social work started from the early part of the century, it has expanded only after World War II. In Sri Lanka, social work as a profession was started in mental health institutions for the first time under the British government in 1930s. This chapter further explores the bad impact of establishment of asylums far away from their families and how it caused to worsen the family relationships with people with mental health problems, influence of the change of treatment philosophy in the 1950s and its impact to improve the family involvement, the importance of the family and its involvement in developing countries including Sri Lanka in the care of people with mental health problems, brief history of the caring of people with mental health problems in Sri Lanka, the main barriers to introduce the social work in Sri Lanka though there is a big dearth of professionally qualified social workers in almost all the institutions which provide social welfare and social services to the public.

Second chapter describes the research design and the methodology in this study and it includes the research problem, research questions, research methods, sample selection and its criteria, research locations, scientific contribution of the research, data analysis, ethical consideration and the problems and limitations. A description of the theoretical approaches with an explanation on the concepts related with the research problem in this study is also included. In this kind of study, the ethical consideration was very important. First of all, the research proposal was submitted to the Ethical Clearance Review Committee at the Faculty of Medicine, University of Colombo, Sri Lanka and the National Medical Ethics Committee (NMEC) in Slovenia to get the ethical clearance. In the second step, every respondent was given a self-introduction and the purpose of the study before the interviews. In the third step, respondents were given an information sheet and this form was in three languages: Sinhala, English and Tamil as there were respondents who used three languages in this study. Thereafter they were given an awareness of confidentiality of the information provided including the use of fictitious names to protect their identity. Finally, informants were given a consent form which was also in three languages as mentioned above. Though this research was related to the people with mental health problems, stressed and busy family members sometimes travelling from far and staff who were busy with tight schedules in their psychiatric wards, the study was able to successfully manage almost all the research activities.

A brief introduction on etiology of MHPs and mental health care in Sri Lanka, beliefs on MHPs, evolution of social work in health care in Western countries and Asian countries including Sri Lanka, family and its structure, family intervention, support in mental health care and family resilience are all discussed in the third chapter. There are several conceptual models on mental health problems and they have influenced in shaping the thinking patterns of the mental health professionals and the people, treatment patterns, and the resources for the mentally suffered persons and their families. Biological model, psychodynamic theory model, family system theory model, socio-cultural conceptual model, and stress theory model are significant among them. However, above views on etiology of MHPs gradually caused to change the involvement in the families with their family members with mental health problems. The concept of witchcraft, spirits, cultural

belief of evils in eye, mouth, and thought evil (*as vaha*, *kata vaha and ho vaha)*,), the belief on 'demons' (yaksa disti), the influence of bad planets and constellations (malefic planetary influences) are very famous among those beliefs on MHPs especially in many traditional and non-Western societies. Supernatural performances are very popular in the beliefs on treatment. Though people have strong negative attitudes toward individuals who use these help-sources and the psychiatrists, mental hospitals and other help, but no considerable evidence to tell that there are negative attitudes toward clergymen or physicians, or towards people consulting these two help-sources.

Social work has been developing for more than 100 years in health care field in response to the social milieu of the early twentieth century; professional social work first began in Western countries such as England and USA. However, it was Dr Richard Cabot in 1905 in Massachusetts General Hospital in Boston who established the first formal social work department because he believed that physicians' awareness of the social and environmental influences on their patients' medical condition and treatment is very important. And social workers were recognized as the proper professionals to gather this kind of information. In the evolution of social work, Felix Biestek, Helen Harris Perlman, James K. Whittaker, Steven P. Schinke and Lewayne D. Gilchrist are considered as very prominent professionals who contributed to this progress in writing social work related books. A continued development of social work in health care took place in the later decades of twentieth century.

Within a social welfare paradigm, a professional training in social work was initiated in 1930s in South Asia Region. Under the foreign influence and patronage, schools of social work in Asia were established. This influence came especially from the American social work literature. From that initiation, social work has been developing in South Asia addressing the diversity and complexity in this region. Two strands of development of social work and welfare in Asia can be seen: people using their existing networks, resources and responding to the imperatives of culture and religious observance to solve their problems and fulfill their needs, and the government's involvement in the social welfare activities beginning during the colonial administrations in many countries

including Sri Lanka. Professional social work in this region confronts several issues and challenges such as lack of state recognition and low image of social work profession, the need of the development of integrated social work education and training opportunities, lack of trained social workers in the institutions to train the social workers for training and field supervision, the significance of institutionalizing professional social work practice standards and employment of social workers in different government service delivery institutions to reach the poorest of the poor. Though there was a special need of introducing a social work discipline to Sri Lanka in the late 1960s, there has not been any attempt to introduce social work into university education. The development of social work also has been affected by economical, political, philosophical and technological changes which are happening from time to time in every country.

Families are social units which function as a system with interrelated supportive parts that perform functions to help with maintenance, continuation, and integration of society. Family functions as a locus for organizing the way to fulfill the many wants and needs of individuals. The ability to manage the tensions and frustrations of unmet wants and needs is the fundamental feature of a well-functioning family. Though the family is responsible for many things about the care of the individuals with mental health problems, it often does not know how to tackle their own members with mental health problems. Therefore, there are some growing evidence and opinion that family should be included in the treatment package of the people with mental health problems. This chapter explores the basic tenets of the strength perspective introduced by Dennis Saleeby. Understanding the clients' needs, interests, and strengths is more significant than diagnosing and labeling. The objective of the family resilience approach is to identify and strengthen the key interactional processes and it expects these families to rebound from such stressful situations.

Chapter four explains the background of the study sample, family structures and caring of the family members, family dynamics, family communication and decision making, needs of the family and service users, family and service user expectations, family strengths and spirituality in mental health. Family intervention and family support,

satisfaction on the current support, attitudes of people with mental health problems and their family members on mental health staff's intervention, family strengths and spirituality in mental health are examined in the chapter five.

In the concluding chapter, the researcher has paid her main attention on the important findings. It explains the significance of the social workers' intervention in the families where there are people with mental health problems and its impact on the treatment and the caring process. Finally, the chapter also explains the barriers caused to the development of community based mental health care in Sri Lanka. Among the people with mental health problems, the majority was medically diagnosed such as schizophrenia, bipolar affective disorder with psychotic features and depression. In the demographical information of people with mental health problems, a balanced participation from both male and female was sought with a, majority representation of unmarried and unemployed people with mental health problems who were at the age between 40-45, 20-26, 30-39, with an education level up to grade 9 and 11. Moreover, the majority of the service users were representative of children, fathers, and mothers living with parents, siblings or spouse. Nuclear families were prominent in the study as well. Frequent conflicts between spouses, problems with interactions, issues related to relationships and communications were common in families. Family income was very low as majority did not have stable employment and many of them lived in parents' houses.

In the discussion of the family intervention and family support, high family support, high expressed emotions such as criticism and hostility, lack of understanding on the MHP, its symptoms, treatment, and how to cope with the problems, high visiting rate of parents and siblings, less visiting rate of close relatives, friends and villagers were significant findings. Stigma and discrimination were the main reason for this high rate of parents and siblings visiting and less from other close relatives, friends and neighbours due to hiding of the MHP and subsequent hospitalization. Family members' criticism were often based on service user's poor self care, incomplete work and need to supervise, time consuming and slowness, poor motivation and no enthusiasm, lack of neatness, getting angry when

asked to do work, agitation and not cooking and cleaning. Majority of the people with mental health problems did not participate in family decision making. In addition the majority of the family members' attitude was it is their responsibility to look after people with mental health problems and female care giving in this aspect was prominent. Both people' with mental health problems and family members' roles change and the negligence by MHP and hospital admission is very common.

Among the beliefs of the family members on MHPs, the majority of the family members believe that their family members were having MHP, MI or madness (42.85%). Apart from that, they believe that it is a life stress (22.61%), fear (5.95%), bad influence of kodivina (7.14%), or neurological problem (4.76%). Both people with mental health problems and family members had the basic needs such as food to eat, water to drink, housing facility, money, safety, love and belonging, and self worth and self esteem. Financial needs were very significant for majority of the service users and family members. Apart from that, the need to know about the MHP, medication and caring, the need to arrange a future caring and safety of their members, support to solve property issues, and the temporary place to keep the people with mental health problems were significant factors. Also, person with mental health problem had other needs such as marriage, employment, continuation of studies, support to look after the children and house work, settlement of marital and sexual issues and continuation of the marriage life in addition to their basic needs. Among the expectations family members had, to cure the people with mental health problems, awareness on the MHP, symptoms, treatment and recovery, financial support to come to the hospital, support to bring the person with mental health problem to hospital in a relapse, good advices, support to find a job for the people with mental health problems, equal treatment, home visits and treatment (especially injection) as they are difficult to bring the individual with mental health problem, treatment supply to other family members as their behaviour effect on whole family, support them to take decisions with regard to future care of people with mental health problems after parents' demise (if siblings are not ready to take care of people with mental health problems or no one to care), awareness of the mental health problem, need to support and how to reduce conflicts, and support to take decisions/solve their property

issues were all important. Main expectations of people with mental health problems from families were not to criticize, be loved kind and compassion, money for their basic needs. People with mental health problems expected from mental health team to cure the MHP, to make them more aware of the MHP, nature of the treatment and prognosis, treat with kindness, love and compassion, awareness of their family members of their mental health problems and how to communicate with them, how to care them, and protection of their confidentiality. There were also expectations such as trying to be cured of the MHP, taking medicine, finding a job, be independent, to be responsible in domestic work (keep the home clean and neat, cook and wash etc), calm and quiet behaviour, support in the sexual contacts (if married), and looking after parents in the future. Three of the research categories had positive ideas on the family intervention and support and almost all the respondents emphasized that people with mental health problems need family support with fulfillment of basic needs for their recovery as they are the primary and close care takers with good knowledge and experience on them. Three of the research categories still believe that family is the major and significant support system for the people with mental health problems and mental health staff's attitudes was this is common for every society in the world. Majority of the mental health staff believed that family members need to be aware of their family members' mental health problems, treatment and caring as their poor understanding, frustration, huge burden, angry, and social stigma and discrimination. Mental health staff further believed that people with mental health problems should be supported especially in their acute stage as they cannot take decision at that stage due to their confusion. Except that, we should see their mental health problems like other non communicable diseases. But, family members and people with mental health problems believed that people with mental health problems need more support in their day-to-day living. Unfortunately, mental health staffs negatively label people with mental health problems than other ordinary people do. Less institutional intervention with minimum address of family needs and their distress can be observed.

This study represented three categories of views on needs and expectations of people with mental health problems and families. Therefore, the most important contribution of this study is supplying literature and directions for further research. Also, this study helps

to identify the practical barriers such as lack of family understanding on MHPs and its nature, need of medication, caring, recovery, high prevalence of stigma and discrimination among families and relatives, neighbours and friends, working place, among the mental health staff and society, lack of understanding of people with mental health problems on MHP, its nature, and medication, high prevalence of HEE, financial problems and lack of fulfillment of basic needs of people with mental health problems and families, lack of information from mental health staff on MHPs and its nature, lack of government and other institutional attention on MHPs and people with mental health problems. By identifying family needs especially, mental health staff can develop family support programmes where there are pushing forces from mental health services to family care in Sri Lanka. The information and their ideas help to identify weaknesses and areas to be developed or explored in these programmes and it helps further to explore the knowledge in practical social work in mental health field and identify the significance of the team work represented by every mental health professional related to the caring of people with mental health problems. This study provides new knowledge based on practical evidence to the policy makers and decision makers in the mental health field in the country because the study represents people with mental health problems and families with empirical experiences on the people's mental health problems and their behaviours.

Improving the current family intervention programmes, and further supporting the family to address their needs in order to reduce their distress where there are pushing forces from the care in the hospitals to care in the community is very useful, profitable and fruitful because of the insignificant investment and capital, long lasting results and social and cultural sensitive approach to country like Sri Lanka. Therefore, this study provides invaluable insights to the mental health professionals and policy makers with regard to the care of the people with mental health problems in Sri Lanka. Finally, based on the empirical data in this study, a handbook for psychiatric social workers on family intervention in the development of mental health in Sri Lanka is expected to be compiled with the hope that it will be useful for everyone in this field.

Abbreviations

DPM	Department of Psychological Medicine
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electro Convulsive Therapy
EE	Expressed Emotions
FI	Family Intervention
FS	Family Support
HEE	High Expressed Emotions
ICD	International Clarification of Diseases of World Health Organization
LFP	Labour Force Participation
LFPR	Labour Force Participation Rate
MD	Doctor of Medicine
MH	Ministry of Health
MHP	Mental Health Problem
MHPs	Mental Health Problems
MI	Mental Illness
NHSL	National Hospital Colombo, Sri Lanka
NIMH	National Institute of Mental Health
NISD	National Institute of Social Development
OPD	Out Patients' Door
SEARO	South East Asia Regional Organization
UPMU	University Psychological Medicine Unit
WHO	World Health Organization

Chapter One

Introduction

1.1. Background of the Study

In social situations, the family plays a regular but vital role and it becomes the initial system of social welfare. With the changing of the family, its role and functions and the patterns of coping, valuing, belonging, and relating also develop, bend, and change. While there are different views on the origin of social work such as philanthropic, charitable and missionary work, social movements, state boards of charity and settlement houses, the assistance to persons and family to cope with the problems in their situations could be seen from the beginning of social work (Constable & Lee 2004: 1-5, Leskošek 2009: 62, Osei-Hwedie & Rankopo 2012: 725). As Čačinovič Vogrinčič (2003) showed, family social work is broader than family therapy. Family social work has been defined as "*work with families as the solving of complex social problems together with the family, mobilizing their own resources, strength and power, its capacity for love, support and help*". Additionally, family is addressed by family social work in two ways; creating of a working relationship mobilizing family resources for solutions and the social worker addressing the family dynamics, the family reality, the inside of the family (Čačinovič Vogrinčič 2003:23-24). In the caring of the people with mental health problems, family social workers' intervention is very significant as they assess the family separately and as a whole through observation and interviewing and find family dynamics, strengths, weaknesses, and problems.

By 1903, social workers also worked in the Charity Organization Societies and they observed how family works as a system in the family organization like Family Welfare Association and Family Service Units (Manor 1984:7). While psychiatric social workers played a significant role from the early part of the century, in mental health care social work expanded after the World War II (Beder 2006: 1,152-153, Constable & Lee 2004: 237). Social workers in Sri Lanka began to work in mental health institutions for the first time under the British government in the 1930s. This was a significant factor in the

history of mental health care in Sri Lanka (Mapother 1938:3, 8-9). At present, considerable number of social workers is attached to mental health settings and they intervene in family as well as in the people with mental health problems. New recruitment of 37 psychiatric social workers[1] in December 2014 to the mental health hospitals, psychiatric units and general hospitals in Sri Lanka also was one of the significant contributions to the development of social work in mental health sector in Sri Lanka.

As pointed out by Reisser and Schorske (1994), family was the foundation of community life in pre-colonial and colonial America. The family had to be responsible for any troublesome behaviour of their members. Mental health problems were considered as an individual rather than a social problem during the 17th and 18th centuries (Lefley 1996: 11). Therefore, people with mental health problems in the 17th century were given less attention; their family members also did not bother much getting social support on behalf of their family members with such problems. This situation was somewhat different in the latter part of the 18th century with the establishment of the general hospitals and special institutions for people with mental health problems. New asylums built after the appearance of Dorothea L. Dix[2], also were located far away from their families. Some family members did not feel guilty putting their family members with such mental health problems in these asylums. But, most of them were not happy admitting their close

[1] In the recruitment procedure of psychiatric social workers, especially, those who have the special degrees in sociology and psychology are given the priority as there are no special degree programmes in social work in universities. Recently, some little changes happened in the recruitment because the National Institute of Social Development has introduced a degree programme in social work.

[2] Dorothea Lynde Dix was born in Hampden, Maine in 1802. But, she has moved to Boston in 1814 due to her parents' alcohol problems and lived with her wealthy grandmother. Later, she has become a school teacher. She has published a small book (*Conversations on Common Things: or, Guide to knowledge: With Questions*) including her belief that women should be educated to the same level as men. This book was very popular among the school teachers and it had been reprinted 60 times. Dorothea Dix has played a very significant role in the mental health field. Among her activities, the instrumental role in founding or expansion of more than 30 hospitals for the treatment of the people with mental health problems was very significant. There were national and international movements that challenged the idea that people with mental health problems could not be cured. Dix was a leading figure in those movements too (Parry 2006).

relatives into these located far away from their homes and tried to keep connections with them (Lefley 1996: 14, Hatfield 1987a: 3-6). However, these asylums caused many people with mental health problems feel isolated from their families. In Sri Lanka also, the establishment of main hospitals for people with mental health problems happened in locations far away from their family members' houses. For example, National Institute of Mental Health (NIMH)[3] was built 15 km away from Colombo (Carpenter 1988: 34-35). During this period, people with mental health problems from every area in Sri Lanka were admitted or transferred from other hospitals to this institute. But, this environmental background also was one of the reasons to keep them away from their families and family members also were discouraged to visit their family members with mental health problems due to the distance.

As a consequence of change of treatment philosophy, the movement towards the deinstitutionalization of people with mental health problems started in the 1950s with the apparent decrease of the hospital admissions. With this change, the development of family involvement in people with mental health problems also increased and the idea that family was a more suitable place for people with mental health problems than the community began to take shape. Therefore, most of the people in institutions, due to their mental health problems, were re-settled in the community by the 1950s (Hatfield 1987a: 3-6, Beder 2006: 153). The Italian Psychiatrist, Franco Basaglia's[4] and his colleagues' dedicated work in the asylum of Gorizia and later in the Trieste in the 1960s, Goffman's[5]

[3] NIMH was the foremost and largest psychiatric hospital built in 1926 under the British colonial period in Sri Lanka. Earlier it was named as 'Mental Hospital, Angoda'.

[4] "Italian Psychiatrist (1924-1980). He was the promoter of an important reform in the Italian mental health system, the "legge 180/78" (law number 180. Year 1978) that established the abolition of mental health facilities. He worked in Gorizia and Trieste and was leader of a movement of Democratic Psychiatrywhich was associated with anti-psychiatry and not wholly part of it" (Flaker et al 2007:73).

[5] "Erving Goffman (1922-1982) was a sociologist and writer. ..Goffman's greatest contribution to social theory is his study of symbolic interaction in the form of dramaturgical perspective and his account of the total institution (Asylums) from point of view of an inmate had atremendous impact on the criticism and subsequent deinstitutionalization" (Flaker et al 2007:75-76).

(1961), Cooper's[6] (1967) and Laing's[7] (1969b, 1985) ideological contribution to mental health field were also of great influence in the this process of deinstitutionalization. (Scheper-Hughes & Lovell 1987: xii-xxiv, 12-14, Goffman 1961, Cooper 1967: 96-116, Laing 1969, 1985). Goodwin (1977) pointed out several causes which influenced deinstitutionalization such as the introduction of new treatments, development of social psychiatry, emergence of anti psychiatry and civil rights' movement, poor conditions in old asylums, increased community tolerance, constitutional structures, funding systems, economic difficulty, and the change of nature of mental health problems (Lester & Glasby 2006: 28-29). At the beginning, to achieve the full expectations of the deinstitutionalization was impossible due to not having a proper alternate care plans in the community for the people discharged from hospitals; especially as nothing was done that focused on families with people with mental health problems (Hatfield 1987a: 7-9). The same issue prevailed in Sri Lanka in the programme of discharging people with mental health problems to the community due to the lack of connections with their family members maintained by mental health professionals while in the hospital.

Today 450 million people are considered as suffering from a mental health or behavioral difficulty and only a small minority of them seems to be receiving even the basic treatment. Most of the individuals suffering from severe mental health difficulties like dementia, depression, substance dependence, and schizophrenia in the developing countries do not receive treatment and cope with their burden privately. Unfortunately, mental health difficulties are still not given the equal attention as other physical health difficulties in many societies (The World Health Report 2001: Mental Health: New Understanding, New hope 2001:3). As pointed out by Deva (1999), in the developing countries in the Asia Pacific Region, mental health is still highly ignored and budgets for this field is also low compared with other health fields (1999: 59).

[6] "The term 'anti-psychiatry' was first used by David Cooper (1931-1986) in 1967. He is considered also as a leader in the anti-psychiatry movement, along with R.D.Laing, Thomas Szasz and Michel Foucault. ..Cooper believed that madness and psychosis were a product of society…" (Flaker et al 2007:73).

[7] Ronald David Laing (1927-1989) was a Scottish psychiatrist, influenced by existential philosophy (Flaker et al 2007:75).

As explained by Saxena et al (2006) in the following table, 30% of the countries do not have a specified budget for mental health care. Moreover, 25% of countries spend less than 1% of the total health budget on mental health. There are 1.84 million psychiatric beds through the world approximately. Apart from that, two-third of low -income countries and one-tenth of lower middle-income countries has less than one psychiatrist per 100000 populations. It seems that, attention of the majority of the low-income countries on mental health is very less.

Table 1.1. Policies, Services and Resources for Mental health in Different Countries by Income Groups (According to the World Bank).

Policies, Services and Resources	**Low**	**Lower-Middle**	**Upper-Middle**	**High**	**Total**
Policies and legislations:					
Mental health policy (N=195) (%)	50.8	69.1	65.7	70.5	63.1
Mental health legislation (N=173) (%)	74.0	69.2	81.3	92.7	78.3
Budget and financing:					
Specified budget for mental health (N=190) (%)	70.2	63.6	77.1	74.4	70.5
Mental health budget as percentage of health budget (N=101) (Median)	1.0	2.1	3.0	6.8	2.5
Community care and primary care:					
Community care for mental health (N=189) (%)	51.7	52.8	88.6	93.0	68.3
Mental health care in primary care (N=194) (%)	76.3	87.3	100	93.2	87.6

Facilities for management of severe mental disorders in primary care (N=192) (%)	55.2	45.5	71.4	79.5	60.9
Beds per 10,000 population:					
All psychiatric beds (N=190) (median)	0.2	1.6	7.5	7.0	1.7
Mental hospital beds (N=182) (median)	0.2	1.4[8]	4.8	4.3	1.0
General hospital beds (N=178) (median)	0.04	0.1	0.6	1.2	0.2
Mental health professionals per 100,000 population:					
Psychiatrists (N=187) (median)	0.1	1.0[9]	2.7	9.2	1.5
Psychiatric nurses (N=176) (median)	0.2	1.1	5.3	31.8	2.2
Psychologists (N=177) (median)	0.04	0.6	1.8	11.0	0.7
Social workers (N=168) (median)	0	0	2.0	18.0	0

Source: Saxena et al, 2006

[8] As an average there are 27 psychiatric beds per 100,000 individuals in Sri Lanka. Total number of beds in 2012 is 1453. This consists of 2% of beds available in government hospitals (Directory of Mental Health and Psychosocial service providers in Sri Lanka 2013).

[9] Sixty consultant psychiatrists work in Sri Lanka. The average number of psychiatrists is now 0.3 per 100,000for the country (Directory of Mental Health and Psychosocial service providers in Sri Lanka 2013).

As pointed out by Kala and Kala, families are very important in the caring of the people with mental health problems in the developing countries and they are a good resource for the family members with mental health problems. Most of the times, when people with mental health problems are admitted to the hospitals especially for a short period, their own family members are the bystanders[10] (Kala & Kala 2008:310). Schwartz and Gidron (2002), Yip (2004), Zauszniewski, Bekhet, and Suresky (2009) also have found that hospitalized people with mental health problems live with their own family members or it can be seen regular communication between them and their family members. According to the findings of Marsh and Johnson (1997), Solomon, Draine, Mannion, and Meisel (1996) and Sun and Cheng (1997), families of people with mental health problems play the key role of providing housing and financial aids for them; on the other hand, families are the invisible rehabilitation agencies in the journey of the recovery process of these people. But, Doornbos (2002), Yip (2003), and Mahliano et al (2005) have found that majority of the families are in a dilemma throughout the world because they are not capable of providing the care and support needed for their family members with mental health problems (Hsiao & Riper 2010: 69). It seems that the families where there are people with mental health problems are warning the mental health professionals that they need external support because their capacity for caring is deemed insufficient.

Sri Lankan cultural perception on the disabled is diverse. Perception on people with mental health problems among the disabled is somewhat negative. But, most families are prepared to look after their family members with mental health problems though families have great difficulties (Mendis 1986: 14,132). From the traditional times, Sri Lanka was a welfare society based on the family. There was a function of mutual support system taken over by the family and this has been derived from Buddhist ethics[11]. This shared aid system was a very significant required agent of the extended family in Sri Lanka. Because of this well established extended family support systems in the rural

[10] The person who stays with the patient in the hospital.

[11] In Buddhist ethics, it has been mentioned that helping the poor, people with multiple disabilities, patients, old people etc is merits gaining activities and they cause to have a good life in next birth.

communities, old people with mental health related geriatric problems did not present a problem to mental health services. As this aid was one of the major functions of the family, the social welfare policy is formed by the nature of the values in the society. The extension of the basic family values with the desires of maintenance of strong family structures, a good healthy environment for growing up and living, reintegration of the individuals into the family fold can be described as the Sri Lankan welfare state (Chandrasena 1979: 120, Chandrarathna 2008: 101). Though the establishment of institutions or hospitals for the people with mental health problems happened in British colonial period (Carpenter 1988: 1-8, Uragoda 1987:86-87), the most obvious factor was that no attention was given to establishment of a link with families of people with mental health problems in their treatment process. Also, there was no way to address the family members' distress created due to their family members' mental health problem. Instead, they built the asylums or hospitals away from their family members like in the Western countries and it was very difficult to come to these institutions though they wanted to visit their family members (Carpenter 1988: 23-26, 34-35, 48, Report of the Director, for the year 1886 1887: D 126). Because of this closed institution system, family also thought their responsibility is over after they put their members into the hospital.

With the beginning of deinstitutionalization in the Western countries, the introduction of new medicine was good news for the people with mental health problems and their family members in the late 1950s and early 1960s in Sri Lanka as well. It helped these suffering people to ease their condition and brought them to community due to the reduction of symptoms (Carpenter 1988: 49-52). The 'Voluntary Association for the Care of Psychiatric Patients'[12] addressed the people suffering from long term mental health problems, their family members, and employers and took an enormous effort to re-socialize these people (Kahawita 1958: B 56). With the establishment of the psychiatric units in general hospitals in each province between 1965 and 1975, gradually, most of the people preferred to go to these hospital units with their family members with mental

[12] Established in 1957 by several philanthropists with the collaboration of R.M.S. De Silva, a psychiatric social worker at NIMH.

health problems than into stigmatized mental hospitals located far away from their residence (Mendis 2003:101). By 1970s, with the beginning of community mental health care programmes, relocation to families of people with mental health problems and hospitalized for long period, started in 1986. By 1980s, the establishment of the private institutions such as Sahanaya and NEST[13] were a considerable effort to encourage community mental health (Mendis 2003:101, Carpenter 1988:63). Due to these community institutions and psychiatric units in general hospitals, participation of the family members in the treatment plan of their family members with mental health problems increased.

In Sri Lanka, state health sector consists of three levels: tertiary care, secondary care and the primary care. While specialized hospitals like mental hospitals, teaching hospitals and the general hospitals belong to the tertiary care, the secondary care includes the base hospitals and the district hospitals. Primary care can be divided into two parts: curative services which consist of peripheral units, rural hospitals, central dispensaries and the visiting clinics and the preventive services which include medical officers of health units. Until the group of medical officers was trained as medical officers, mental health and appointments were given to the secondary care institutions in 2000, mental health care in Sri Lanka was limited within the tertiary care level only. Through the Basic Needs'[14] model which consists of five components such as community mental health, capacity building, sustainable livelihood, research and policy and management and administration, it is expected to expand the mental health care to the primary level too (Fernando 2007:11). This attempt also most probably will be a good opportunity to strengthen the family relationships with the people with mental health problems and to improve their mental health care in Sri Lanka.

[13] Nongovernmental mental health institutions established in the community. Sahanaya (National Council for Mental Health) has a day centre and a home with residential facilities for the people with mental health problems. NEST was established based on Mulleriyawa Psychiatric hospital with the purpose of supporting the women stay for long time in this hospital because of their long term mental health problems. They have a day centre and vocational training facilities for the rehabilitation of these women.

[14] Basic Needs is also one of the nongovernmental institutions (UK based) worked in the community to support the people with mental health problems to rehabilitate and spend an independent life in the community.

In the consideration of the nature of the problem solving background in Sri Lanka, the majority of the people are happy to use the available resources which their family members used in their family networks. If those resources fail to support, they go for professional help. There are several reasons for not to go to professional support at first in a problematic situation. Among them, revealing the personal issues to outside is being taken as a weakness, damage to the personal pride, negative responses, troublesome to the client, breaking the trust and seeping into the gossip and rumours, lack of the existence and unaware of professional services are significant. With the gradual decline of solidarity of extended families, both government and private sector introduced advocacy, counseling and other mental health services which had been neglected in the traditional Sri Lankan society and today are popular among social work roles. On the other hand, majority of the social welfare related activities to be expected to fulfill by the social workers as their roles have been assigned by many of other officers attached to the different departments in Sri Lanka and this is one of the main barrier to introduce the social work though there is a big dearth of professionally qualified social workers in almost all the institutions which provide social welfare and social services to the public. Among the increasing problems in Sri Lanka, mental health problems may be the more prominent issue needed to be involved by professionally trained social workers in addition to other professionals such as psychiatrists, nurses and occupational therapists (Chandraratna 2008: 28-29, 115-117, 352).

Sri Lankan population is 20,359,439 and they are ethnically, religiously, linguistically and spatially diverse. Majority of the population (28.8%) is in the western province which is more urban (Census of Population and Housing 2011). Day by day, vulnerability groups created due to natural disasters such as tsunami, landslides, droughts and flood increase and their poverty further increases because of their exposure to these disasters. In addition, our aging population increases day by day and it has been estimated that the current rate of 11% would increase up to 29% by 2050. This makes a huge burden to the

country because of the declining of fertility rate and increasing the life expectancy[15] where majority are not covered by social security support. It has been found that there are 274,711 disabled individuals including hearing, seeing, speaking and other mental and physical disabilities in Sri Lanka (Sri Lanka Human Development Report 2012:8). By now, it has found that 3% out of the total Sri Lankan population, are suffering from any of the mental health problems (Mental Health Update 2008: 1). In the newly planned mental health policy report of Sri Lanka 2005-2015, it is expected to make the family involved in the caring of the people with mental health problems. Apart from that, it has been included the family services among the specialized services planned to be developed with regard to the mental health field in Sri Lanka (Mental Health Policy of Sri Lanka 2005-2015: 32-35). However, more research on the family and mental health care has been conducted in the western countries (Hsiao and Riper 2010: 68). Therefore, the time has come to discuss how social workers can contribute in this field to minimize the suffering of those people and their families and to strengthen and empower them to cope with their mental health problems. Identification of the needs, strengths, weaknesses of people with mental health problems and their family members and what they expect from professionals working in the service institutions in their recovery journey in their point of view is very significant. Family social workers can play a better role in this regard as they work in the context of the individual's total life situation and they ordinarily serves as link between the service agency and the family (A Resource Guide for Families Dealing with Mental Illness 2010: 20).

1.2. Structure of the Dissertation

This dissertation consists of six chapters. First chapter consists of a description of the background of the study and a summary of the chapters in the dissertation.

[15] Life expectancy in Sri Lanka for both male and female in 2015 is 75.6years. Female life expectancy is 78.16 years and male life expectancy is 71.97 years (World Population Prospects-global Demographic Estimates and Projections by the United Nations, 2015).

Second chapter describes research design and the methodology in this study. This included the research problem, research questions, research methods, sample selection and its criteria, research locations, scientific contribution of the research, theoretical background, data analysis, and ethical consideration and the problems and limitations. In the explanation of the concepts related to this study, it has been given main attention on the concepts such as health, mental health, mental health problems, people with mental health problems, family, close family members, family support and the family intervention.

In third chapter, the researcher has paid attention on a brief introduction on etiology of mental health problems and beliefs on mental health problems. Apart from that, researcher has discussed on mental health care in Sri Lanka and social work in health care and family. In the discussion of the social work in health care, researcher gives a brief introduction to the beginning of social work in Western countries, Asia and Sri Lanka and the challenges for the poor social work development in Asia including Sri Lanka.

Chapter four has divided into several parts such as a brief introduction on the study sample, structure of the family and caring for the family members, family dynamics, needs and expectations of families and people with mental health problems, family strengths and spirituality in mental health. In the first part of the chapter, it is explained about the nature of the study sample and then family structures where people with mental health problems live, and its changes with the mental health problems. And also, this describes on the communication and decision making patterns in the families where there people with mental health problems. Needs of family and people with mental health problems have been explored in the points of their view and the professionals' point of view. At the later part of this chapter, it has been paid attention in brief on the expectations of family members and people with mental health problems from each other and mental health professionals. Also, briefly, it has been discussed on future expectations of family and people with mental health problems. Finally, strengths with these families and spirituality have been discussed at the end of the chapter.

Information in the fifth chapter has been discussed under several sub headings. They are family intervention, Care planning, family support, and attitudes on the family intervention and support in the caring of the people with mental health problems. First, this gives a brief introduction on the significant of family intervention and support. The process of individual care planning and help seeking pattern of the family members has been discussed there. This chapter consists of the attitudes on the family intervention and family support in the caring of their family members with mental health problems in the point of view of people with mental health problems, their families and mental health professionals.

In the chapter on discussion and conclusion, first, a brief summary has been given on important findings. Then, there is a discussion on the findings with related to the theories used in this study. Not only the contribution of this thesis to the social work field but also the contribution to the research in this field has been discussed in this chapter. Apart from that, this chapter also has explored the social work and its importance as a profession in the development of mental health care of the people with mental health problems. Finally, chapter explains the barriers in the development of mental health, social work and family support system and suggestions which can be useful in the development of the mental health care, social work and family support system in Sri Lanka.

Chapter Two

Research Outline of the Study

2.1. Research Problem and Research Objectives

People with mental health problems need the care of their family members and family members need help to be able to support their members. And also, professionals need family members' support to make the recovery process a success. According to studies done by Rosenfield Wenzel (1997) on the social networks of the people with mental health problems, it has mentioned that family members are dominated among the people who are in their social networks. And also, Holmes-Eiber and Ringer (1990) have shown that pathology and the re-hospitalization are related with these networks. Leff and Vaughn (1985) in their studies on expressed emotions found that the family members' attitudes on the people with mental health problems, relatively effect on the relapse and the re-hospitalization. According to the studies on family burden (Hatfield 1997, Vaughn 1995), it seems that families care their members with mental health problems with lots of difficulties. Writers like Carling (1995) and Lefley (1993) have pointed out that only if there is a relationship with a significant family member, mental health professionals can give an effective support for the rehabilitation of a person with mental health problem. These information shows that the family plays a major role in the care of the people with mental health problems though they have many problems (Shankar and Collyer 2002: 15-28).

Most of the time, the clinician not only decides family views and their needs but also the outcome. As Hatfield (1979) discussed, family may have different kind of needs based on their family dynamics, we have to identify them in their point of view. Then, the outcome of the intervention activities also may be successful. Not giving enough information is the major complaint of the families. Therefore, family members have myths about MHPs, the behaviours of the people with mental health problems, and treatment. Providing education for the families on the above in a simple manner is very essential to dismiss their myths (Repper and Perkins 2003:126-127). Most of the mental health professionals

perceive family members as primary caretakers. As Varghese et al (2002) explained, they are the main caretakers of their family members with mental health problems (Varghese 2002:7).

People with mental health problems also have needs like other people. Most of the time, they get some short term and long term disabilities and they affect their employment, responsibilities, and emotions. Clark and Drake (1994) found in their research that family members are more helpful spending their money, time though some people with mental health problems live separately from their families (Lefley 1996:5). With time passing, the nature of their needs also changes. Family members' communication patterns are significant. Varghese et al (2002) explained family members may communicate with their family members with mental health problems in different ways. Family members also have different kinds of high levels of emotional tension and coping patterns with different problems. In the initial level of family member's mental health problem, families experience shock, surprise, anxiety, denial, and overoptimistic expectations. Their misunderstanding, frustration, irritation, criticism, hostility, emotional over-involvement, and warmth and positive remarks may create different kinds of expressed emotions. But, families, friends, neighbours, and professionals have a significant role to play in the recovery journey of people with mental health problems especially to maintain their relationships and to access new opportunities and social net works (Repper and Perkins 2003:125-129, Varghese et al 2002:64-65).

Creer and Wing (1974) pointed out that no one can apply community care work system without the cooperation of the families as family members are the most important persons having experience and knowledge on their close family members' mental health problems and their behaviours (Hatfield 1987b: 16-18). Varghese et al (2002) explained why mental health professionals should involve families in their care plan and have given several reasons for that; family members and close relatives are the main caretakers, they do not know what is wrong and they will have fears and anxieties, they want to know about medication, they may feel guilty, frustrated, and angry, burden, high expressed emotions, and avoid their social life due to stigma (Varghese et al 2002:8, 22). On the

other hand, professionals should give their priority to the families and friends as valuable resources because they are experts with knowledge and have a direct experience with their family members (Tew 2005b:217). As Hatfield (1987) pointed out, to what extent this will be successful may depend on the knowledge of the professionals on understanding the family experience and their needs from a family perspective (Hatfield 1987b: 27).

As pointed out by Steve et al (1998), over 95% of the people with mental health problems live in the families with their family members in the most of the developing countries. Around 80-90% people with mental health problems in Sri Lanka live in their families. Family support is one of the very significant factors in the process of the recovery, rehabilitation and the reintegration of the people those who suffering from mental health problems. It is very difficult to make this a success without the family support (Maduwage 2007: 43). According to the Expert Committee Meeting, SEARO 2000, in Sri Lanka, 5% to 10% of people are known suffer from MHPs that require clinical intervention. Psychosis, mood disorders, dementia, anxiety disorders, somatoform disorders, and adjustment difficulties are the most common conditions seen in clinical practice. Not only that, it is estimated that 70,000 people in Sri Lanka are suffering from mental health problem like schizophrenia and most common psychiatric practice is based on the biomedical approach (Working with Countries: Mental Health Policy and Service Development Projects 2002:34). It is estimated that 2% of the population is suffering from a serious mental health difficulty in Sri Lanka (The Mental Health Policy of Sri Lanka 2005-2015 2005: 30).

Majority of the available research on family care giving of the people with mental health problems are based on the western countries (Hsiao & Riper 2010:68). And also, the available studies are not enough to explain the special contribution of the family to recovery and the rehabilitation (Shankar and Collyer 2002: 15-28). Then, it is very important to identify the needs of the people with mental health problems and their family members in the Sri Lankan socio-cultural context and to see the significance of the

family intervention and the support in the recovery of the people with mental health problems where the majority of them live with their family members.

Therefore, this research was conducted on research problem on 'What is the nature of Family Intervention (FI) and the Significance of the Family Support (FS) for People with Mental Health problems (MHPs) in Sri Lanka'. The following are the research objectives of this study;

1. To examine the needs of people with mental health problems**.**
2. To investigate the needs of the families with family members with mental health problems.
3. To examine the awareness and perception of people with mental health problems, their family members and mental health professionals on FI and FS in the caring of people with mental health problems.

2.2. Research Questions

Instead of hypotheses, this research aimed at investigating the following research questions:

- What do family members expect from their family members with mental health problems in their family activities?
- How do family members cope with their problems and what changes of the family needs to cope with their family members with mental health problems?
- What do family members expect from mental health professionals in the caring of their members with mental health problems?
- What do people with mental health problems expect from their families and mental health professionals in the recovery of his/her mental health problem?
- What are the future expectations of families and their members with mental health problems?

2.3. Research Locations

Field work was carried out in the National Institute of Mental Health (NIMH) which confers a high level of stigmatization on people who receive long term treatment for serious MHPs and the University Psychological Medicine Unit (UPMU) at the National Hospital Colombo, Sri Lanka (NHSL). NIMH has come a long way to become the largest tertiary care institution caring for the people with mental health problems in Sri Lanka. NIMH has spread over a spacious 15 hectares and located 15Km away from Colombo city. This is a teaching hospital and it has been upgraded to a national institute in October 2008. Since 2008, the administration of the Halfway Home in Mulleriyawa[16] and School of Nursing, Mulleriyawa are also under the NIMH. At present, there are more than 1000 inmates in this institute, but there are only 900 beds, and over 1000 full time staff members (See Annex IX). NIMH gets support from nongovernmental organizations such as the World Health Organization (WHO), BasicNeeds and NEST. In addition to the general adult psychiatry unit, there are 6 specialized units in this institution - psycho geriatric, general medical ward, perinatal psychiatry, learning disability, adolescent and young adult, and forensic. Perinatal psychiatry unit was established in 2006 with the purpose of providing a special care for the mothers who get MHPs after childbirth. These mothers are allowed to keep their newborn babies under the supervision of the nurses and their care-givers such as husbands or other close family members. Psycho geriatric unit has been started in 1999 to provide a special care for the elderly people with the diagnosis like dementia. The purpose of the starting the learning disability unit in 2008 was to support the rehabilitation of the people with mental health problems with the learning disabilities and train and educate their guardians. The general medical ward which is conducted under the supervision of a consultant physician, medical officer and trained

[16] This was another former psychiatric hospital built after the NIMH as a solution for the overcrowding in NIMH and situated 15km away from Colombo. By now, no one is admitted to this hospital and used as a halfway home by NIMH. Still, there are around seven hundred women with long term MHPs in this halfway home. Some of them still stay there because they do not have a place to go or their relatives cannot be found.

nursing staff was established in 2005 to give attention for physical care of the people with mental health problems and to prevent practical problems until they are transferred to the NHSL. To assess and treat the people with mental health problems who are referred from High Courts due to their forensic matters, the forensic psychiatric unit has been available in the hospital. Every two weeks, a magistrate conducts a special Court in the hospital premise itself and people with mental health problems those have minor offenses are produced before this magistrate. There are other units like occupational therapy, psychiatric social work, horticultural therapy, and research. Occupational therapy unit has been operating with the belief that if it is possible to engage the people with mental health problems in meaningful activities, they can improve their physical as well as mental well being. With the intention of assisting and supporting them to achieve their psychological, social, and economic welfare and creating a favourable environment for them in the community, psychiatric social work unit has been playing an active role in this hospital. Adult psychiatry unit has been divided into eight units similarly among male and female with acute, medium care, and long term care facilities. In addition, alcohol rehabilitation programme, outpatients' clinic, outreach clinics and Colombo outreach service are conducted on behalf of the people with mental health problems. With the aim of following the people with mental health problems in the community, NIMH conducts their outreach clinics and once a month they conduct these clinics with the supervision of a consultant psychiatrist. But their outpatients' clinics are conducted six days a week in the NHSL with the support of the whole team to on behalf of the people with mental health problems who are discharged from NIMH to minimize their transport difficulties and to mitigate stigma related issues. Colombo outreach service is also one of the most important and new services which NIMH has started very recently with the purpose of supporting the family members who cannot bring their members with mental health problems in their acute stage to this hospital. After informing the hospital staff (medical officer or community psychiatric nurse or psychiatric social worker) by the close family members with the recommendation of a consultant psychiatrist, the health team starts to

support these family members through this service[17] approved by the Ministry of Health (MH) (Field Data 2011-2012, Web Site of the NIMH).

In addition to the medical treatment with residential facilities, social and life skills trainings given by the occupational therapists, psychiatric social workers, development assistants to mental health[18], and volunteers[19] are significant in the NIMH. Admissions are based on self referral, by family or close relatives, referral from other health services, and judiciary services. Around thirty people with mental health problems are admitted on daily basis. Around 8000 people with mental health problems are admitted to this hospital annually and they are provided acute, intermediate and special care services while they are in the hospital. Nine visiting psychiatrists supervise these eight units and they have been divided under the geographical area and admissions are done for the psychiatrists according to this geographical division. The majority of the people with mental health problems stay two to four weeks in this institute for their treatment (Field Data 2011-2012, Web Site of the NIMH).

The UPMU is attached to the Department of Psychological Medicine (DPM) of the Faculty of Medicine of the University of Colombo. While the DPM was established in 1969, this was opened as a unit in 1970 and has functioned as the Psychiatric ward of the NHSL since then (Annual Reports, DPM 1968-1969, 1969-1970). Acute mental health problems are mainly cared in this unit. It consists of 25 beds and four types of people with mental health problems are treated at this unit:

- In-patients- people with mental health problems receiving treatment and other services with residential facilities.

[17]Family members have to pay Rs 2000/- (around €13) to the hospital and to sign a consent form before the health team start their service.

[18] These officers have been recruited under a graduate scheme conducted by the former government as a solution for the unemployment for the graduated persons. They have different degrees. After the recruitment of this batch (around 40) by the MH, they were given six months training on social work in mental health field by NIMH. By now, some of them have already left this post and gone for other jobs. While some of this group work in NIMH itself, others work in different hospitals with psychiatric facilities.

[19] The Volunteers are from the Volunteer Service Overseas VSO), an international nongovernmental organization and majority of them are from Asia and Africa.

- Day-patients- people come for treatment and other services while being in the community on appointment basis. Discharged people with mental health problems also follow in this category before they transfer to the clinic.
- Clinic patients- people with mental health problems followed at the clinics in room 43 at the OPD (Out Patients' Door) in NHSL. New comers as well as people referred from UPMU after discharge also follow in these clinics.
- Ward referrals – people with mental distress referred from other wards in NHSL or any other hospital (Secondary Data 2011-2012).

Two types of staff personnel work in this unit: staff from the DPM and the staff from the MH (See Annex VIII). Among the treatment and other facilities provided for the people with mental health problems coming to this unit, medication, Electro Convulsive Therapy (ECT), psychotherapy, family and individual counseling and awareness and education, psycho-social and economic support for the individual and families, cognitive behavioral therapy, skills training, integration with the outside institutions to gain socio-economical and legal support and support for the psycho-social rehabilitation are very significant. These services are given through the programmes conducted by this unit such as consultant psychiatrists' and other doctors' medical intervention, social workers' social work intervention with the people with mental health problems and their families, occupational therapists' therapeutic intervention, Psychiatric Patients' Welfare fund, rehabilitation programme, nursing officers' participation, and psychotherapy training programme. UPMU conducts three days clinics in week, one clinic in a week for alcohol and substance abused people and several community clinics per month targeting the people with mental health problems in the community. The treatment and support for a person with a mental health problem is provided as a team work in this unit and the team consists of the consultant psychiatrist, senior registrar/psychiatry, registrar/ psychiatry[20], instructor in social work[21]/psychiatric social workers, occupational therapist, ward

[20] All are medical doctors trained to be consultant psychiatrists.

sister/nurse. The treatment and support system in this unit has been divided into units with under the guidance of a consultant psychiatrist (Field Data 2011-2012).

Approximately, around one thousand people with mental health problems are supported annually at this unit as 'inpatients'. While around eight hundred people with mental health problems are supported annually as 'day patients', around three thousand people with mental health problems are supported as 'ward referrals' (Register of the Ward Admissions 2011, Register of the Day Unit 2011, Register of the Ward Referrals 2011). More than one thousand new people with mental health problems are supported annually at the clinic at the OPD of the NHSL (Register of the Clinic Unit 2011 -Room 43/OPD). In addition to the above activities, this unit also conducts teaching activities for the medical students, post graduate medical students and other mental health trainees. According to the above information, it is apparent that this UPMU is a place where multiple facilities are available for people with mental health problems as well as other trainees in the field of mental health.

2.4. Sample Selection and Criteria

As Cooper (1967) explains, it is important to clarify the criteria of selection of people with mental health problems for the interviews in this kind of study (1967:127). Therefore, for the questionnaires and in-depth interviews in this study, people with mental health problems were selected based on the following criteria.

- People who do not have any diagnosed problem in brain (people with problems in brain are excluded in the category of people with mental health problems in this study)
- People who do not have any I Q problem (same as above)
- People who do not have any organic problem like epilepsy, dementia (same as above)

[21] The post called 'Instructor in Social Work' is available only in the Faculty of Medicine, University of Colombo in Sri Lanka attached to social work by now. This also has been started as 'social worker' at the beginning and later it has been upgraded to this post.

- People who have at least one parent, sibling, spouse, child, child, grandparent, grandchild, uncle, aunt, nephew or niece (as family members are also one of the category of in this study)
- People who do not have a forensic history when he or she is admitted to the hospital (because they are not given permission to come out from their ward and they are kept locked until decision is given by the magistrate court).
- People who have been taking treatment from the NIMH/UPMU for more than one year.
- People staying more than two weeks in NIMH and more than one week in UPMU during the study period.

Field work was carried out for two years (2011/2012). The questionnaires were applied with one of the active family members from each family of people with mental health problems in the sample. At the beginning, it had been decided to administer one hundred questionnaires. But, this amount was reduced because of the repeated information was given by the family members. The total number of questionnaires was eighty four (84) and this number was selected randomly from both locations during the years. At first, fifteen active family members of above people with mental health problems from both locations were interviewed in depth intentionally at these institutes and their homes prefer in privacy and confidentiality. They were interviewed with the consent of people with mental health problems. In selecting the time for in-depth interviews with family members, the choice was given to them. Fifteen people with mental health problems were interviewed in depth from both locations based on purposive sampling method and they were selected out of the questionnaires. People with mental health problems were selected from adult psychiatry units, perinatal psychiatry unit, and adolescent and young adult psychiatry unit in NIMH and UPMU and interviewed while they were in the wards. Fifteen medical professionals and other health workers including doctors, nurses, instructors in social work/ psychiatric social workers (hereinafter all instructors in social work and psychiatric social workers are named as ‘social workers’ in this dissertation), occupational therapists and attendants (three professionals from each category) were

interviewed in depth and they were selected randomly. Approximately, there were such five categories intervened with the people with mental health problems in their recovery process except the psychologist and the researcher did not make the psychologist participated in this study sample as there was only one psychologist in both institutions (UPMU) in the time period of data collection.

2.5. Research Methods

This research is a descriptive study with an interpretative approach. As explained by Green and Thorogood (2004), the intention of the interpretative approach is to understand the world from the respondents' point of view in the research, rather than an explanation of the world (Green and Thorogood 2004: 13). In this study it was also expected to understand needs of people with mental health problems and their family members and the important of the family intervention and the family support from their point of view. A combination of quantitative and qualitative research techniques was applied to collect mainly qualitative data with supplementary quantitative data.

An interview guide was developed in advance and as Padgett (1998) explained, this has helped to enhance the credibility, implementation, and confidence in successfully completing this study (Padgett 1998:30). Accordingly, questionnaire and in-depth interview methods were applied. A simple questionnaire was used to collect only basic data of people with mental health problems and their family members. It helped to build up a rapport with both and give a self introduction for them. The questionnaire was applied with one of the active family members (family members living with people with mental health problems or live close-by with close connections) of each person with a mental health problem in the sample. In-depth interviews were the main data collection method in this study and this was applied with people with mental health problems, family members and mental health professionals. Every in-depth interview was recorded with respondents' consent.

To collect the secondary data, bed head tickets (the reports with the assessment, diagnoses and treatment plans of the people with mental health problems), brochures,

people's registers and hospital documents also were used. Specially, published books, research reports, theory related papers, archival records, reports published by the local and foreign governments with some statics, ethnographic writings done based on Sri Lanka, published and unpublished articles, newspaper articles and institutional and other websites were used for the collection of literature in this study.

2.6. Scientific Contribution of the Research

This study represented three categories'' views on FI and FS and the purpose was to identify the positive and negative aspects of FI and FS in people with mental health problems and the needs of people with mental health problems and their family members based on their points of view which are often neglected. Therefore, one of the most important contributions is this study gives literature and directions for further research. As mentioned in the above, where there is lack of literature which is collected based on the non Western countries and especially Sri Lankan socio-cultural context, this study findings would be significant contribution for further research. And also, this study helps to identify the practical barriers and areas to be developed in the enhancement of mental health of people with mental health problems and their families. By identifying family needs especially, mental health professionals can develop family support programme where there are pushing forces from mental health services to family care in Sri Lanka. The information and their ideas help to identify weaknesses and areas to be developed or explored in these programmes. It helps further to explore the knowledge in practical social work in mental health field and identify the significance of the team work represented by every mental health professional related to the caring of people with mental health problems. This study can give a new message and knowledge based on practical evidence to the policy makers and decision makers in the mental health field in the country because the study represents the people with mental health problems and their families with empirical experiences on the MHPs of the people. Finally, based on the empirical data in this study, a handbook for psychiatric social workers on family intervention in the development of mental health in Sri Lanka is expected to be compiled with the hope that it will be useful for everyone in this field.

2.7. Theoretical Background

This study was based on the needs theories, family systems theory and family resilience approach as its theoretical backgrounds. In the discussion of the needs theories, researcher has discussed about the ideas of different theorists' ideas in this study such as Doyal, Gough, Gasper, Illich, Maslow, Wasson, Dean, and Schutz. Every human being has some needs and they are similar to the other human beings' needs. But, this every need differs from one individual to another and from time to time. In the decision making with regard to the distribution of the resources, needs play an important role. Therefore, to clarify the needs is very essential in the health care setting too (Smart & Smart 1953:52). As Grebenc explains the usage of the term 'needs' is vary in the everyday language. Defining what needs is also is very vague in common sense. She further says that researching human needs is a collaborative activity and she considers need assessment in a community as permanent negotiations of meanings (Grebenc 2006:168). Stevens and Gabbay show that needs assessment is conceptually mixed-up, but technically difficult task. Also they say by now, a high priority has been given for the needs assessment (Stevens & Gabbay 1991:20). Stevens and Gillam have discussed on need assessment in health care. They point out that need assessment in health care is necessary to gather information on people's needs. This information is supportive to change of assistance to the health of population. This needs assessment takes place within the content of finite resources. But, this is not a universal acceptance. As a result of identification of the following factors, 'health gain' can be achieved by relocating theses resources;

- Non recipients of beneficial healthcare interventions (that is unmet needs)
- Recipients of ineffective healthcare (and releasing the resources for unmet needs)
- Recipients of inappropriate healthcare (for whom the outcomes could be improved) (Stevens & Gillam 1998).

But, Crown has claimed that needs assessment in health care has not yet improved. In the health care setting, needs assessment is significant because it is necessary to buy services

in health care to meet the needs of the population (Crown 1991:307). Gough has discussed about 'needs' and 'wants'. According to him, 'needs' mean (implicitly if not explicitly) 'a particular category of goals that are believed to be universalizable' and 'Wants' mean 'goals that derive from individual's particular preferences and cultural environments'. Also he says 'core values and needs are relative and local, while means and policies are global and universal' in this topsy- turvy world (Gough 2004: 292). Gough explains majority of the Marxists believe needs are historically relative to capitalism. But, some phenomenologists and some social researchers consider needs are socially constructed. Also, for various critics of cultural imperialism, needs are specific to members of groups or defined by gender, race etc. Post modernists critics and radical democrats think needs are not only discursive but also needs cannot exist independently of the consciousness of human agents (Gough 1994:27). As Wasson explain, as human beings we all have things such as needs and wants. On the other hand, definition and identification of needs and wants is a crucial stage. One of the significant requirements for a person to have both minimal health and well-being is addressing the different needs. The ultimate aim of this is to reach the human flourishing. Wasson has categorized human needs as basic needs versus non-basic needs. While the needs such as food, water, air and shelter which are more important for human survival and function are the basic needs, these are the universal physiological requirements of all people. The needs which contribute to our psychological, social and spiritual well-being are mentioned as non-basic needs by Wasson. Health professionals often pay their attention on basic human needs because they are very important and urgent for human beings (Wasson 2002). Doyal and Gough have examined about the needs in a broad way. They have talk about basic needs and intermediate needs. Physical health and autonomy have been identified as basic human needs by them. They further mention that these needs must be satisfied to some extent to participate effectively in life. Also, meeting basic needs helps to prevent the serious harm to people. What people must achieve is stipulated by basic human needs if they are to avoid sustained and serious harm. They further have explained that whatever people do or in whatever cultural context, every individual need physical health to do well in their everyday life. Poor physical health interferes their manual, mental and

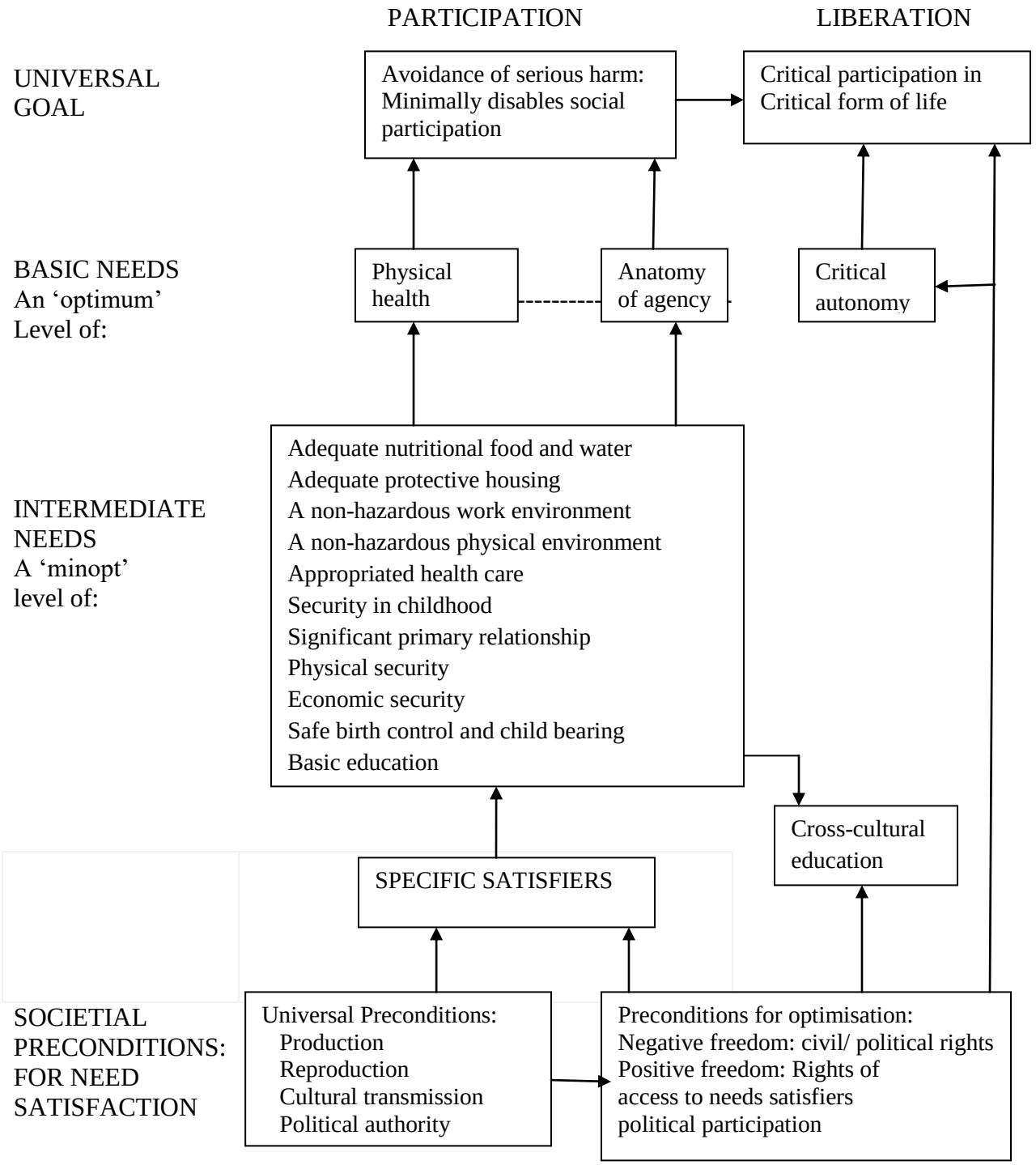
psychological abilities which they need to fulfill their daily tasks. In whatever culture, we live; physical health is significant for everyone. For instance, they have talked about three persons suffering from poverty and severe tuberculosis; 25 year without employment in Chicago, 40 year old casual labourer from Rio de Janiero and 12 year old child from Nirobi. Doyal and Gough said even though they come from different cultures, they are similar in three ways in this situation. First, three of them feel they are ill. Because of this systems and suffering three of they cannot effectively participate in their daily activities. Well referring to their illness by a variety of names and explanation of its origin and symptoms in various ways is the second similar thing for these three individuals with regard to this illness. Finally, the best technical understanding on tuberculosis says the most effective biological and environmental approaches to prevention and cure and provides the most complete account why they work for these three individuals. Sometimes physical health can be thought of transculturally in a negative way. But, if someone wishes to spend an active and successful life, his or her objective interest is to satisfy their basic need to optimize their life expectancy by avoiding the serious physical harm. Also, their illness is conceptualized in biomedical terms. Doyal and Gough say this is common for every individual in everywhere in the world. Under the autonomy, they explain three main important variables which affect the levels of autonomy. They are understanding (cognitive thinking skills), psychological capacity (mental health) and opportunities to engage in social participation. The availability and the quality of teachers influence the understanding of self and the culture. Even though, learning cognitive skills also vary from culture to culture, they are not totally variable according to Doyal and Gough. They say someone's psychological capacity means his or her mental health. This is an important component in all definitions in autonomy. They have taken into account the explanation on mental illness given by Edwards (1982, p 70) and Engelhardt (1982); 'the mental illness means only those undesirable mental/bahavioural deviations which involve primarily an extreme and prolonged inability to know and deal in a rational an autonomous way with oneself and one's social and physical environment. In other words, madness is extreme and prolonged practical irrationality and irresponsibility'. Doyal and Gough said mental health means 'practical rationality and responsibility'. According to

them, in a serious mental health problem, individual's absence of rationality can present in various ways such as visual and auditory illusions, delusions or gross inconsistencies in thought patterns (Clare,chs 2-3,1980). For instance, the person who suffers from a diagnosis such as psychotic depression, is totally loss from his or her sense of self and incapable of engaging in their everyday activities. In the consideration of the third variable in autonomy; opportunities, there are range of opportunities for new and significant action to the individual in their daily life. Significant actions mean socially significant categories such as parent, householder, worker or a citizen (Doyal & Gough 1991: 55-67). In addition to the above basic needs, they have identified eleven 'intermediate needs'. Doyal and Gough further point out that on the other hand they are the 'universal satisfier characteristics' which are essential for basic needs and enable autonomous needs to be satisfied. They are as follows;

- Adequate nutritional food and water
- Adequate protecting housing
- A non-hazardous work environment
- A non-hazardous physical environment
- Appropriate health care
- Security in childhood
- Significant primary relationships
- Physical security
- Economic security
- Safe birth control and child-bearing
- Basic education

In the following figure 2.1, Doyal and Gough has clearly explained about the needs categories what they have mentioned as researcher explained in the above. In addition to the basic human needs and intermediate needs, they have talked about the specific satisfiers and societal preconditions too. These preconditions have been discussed under two categories: universal preconditions and preconditions for optimization. Production, reproduction, cultural transmission and political authority are the universal preconditions according to them. Preconditions for optimization are negative freedom (civil/political rights) and positive freedom (rights to access to need satisfiers) and political participation (Doyal & Gough 1991: 169-170).

Figure 2.1 The Theory in Outline



Source: Doyal & Gough 1991:170

However, Miller (1976) explained that first it is important to identify individual's plan of life to decide what individual's needs are. After that, it is necessary respectively to establish the essential activities to that plan and investigation of the conditions supported to carry out these activities (Doyal and Gough 1991:50-51)

Illich also one of the very significant persons who talked about needs. He has explained basic needs are most insidious legacy left behind the concept of 'development'. He explains in the historical movement in the west, under the flag of evolution/progress/growth/development discovered and prescribed the needs. As a result of this process, man transited from bungling toilet to a needy addict (Illich 1990:2-3). Illich has explained the development as a rebellion. A simultaneous deconstruction of necessities and a construction of desires into needs are implied by development. But in the discourse of development, needs are neither desires nor necessities. He further says while necessities call for submission, needs for satisfaction (Illich 1990: 4). In the discussion of the different between needs and wants, he said 'needs are latter day-wants'. Illich noted that poverty has a relationship with needs. But, he says that welfare is not a cultural hammock. He further explores that this is an unprecedented medication of scare resources. He said while agents do not define what need is, where they exist, but they closely supervise the remedy for them with or without needy's approval (Illich 1990:13).

In the hierarchy of human needs explained by Abraham Maslow, physiological and safety needs can be mentioned as basic human needs. Maslow explained that the need for survival is the most and first need of people and for survival, people need food, water and shelter. After the satisfaction of the physiological needs, people work to meet the need for safety and security. The feeling that people do not have physical, mental or emotional harm can be defined simply as the safety. The feeling that people get low fear and anxiety can be defined as the security. While third and fourth categories respectively belongingness and love and self esteem can be taken as non-basic needs. The final level in the Maslow's hierarchy of human needs explains about individuals' wants and desires. A preference, desire or wish can be simply defined as a 'want' and sometimes these may overlap with or differ from needs. This level includes the need to know and understand,

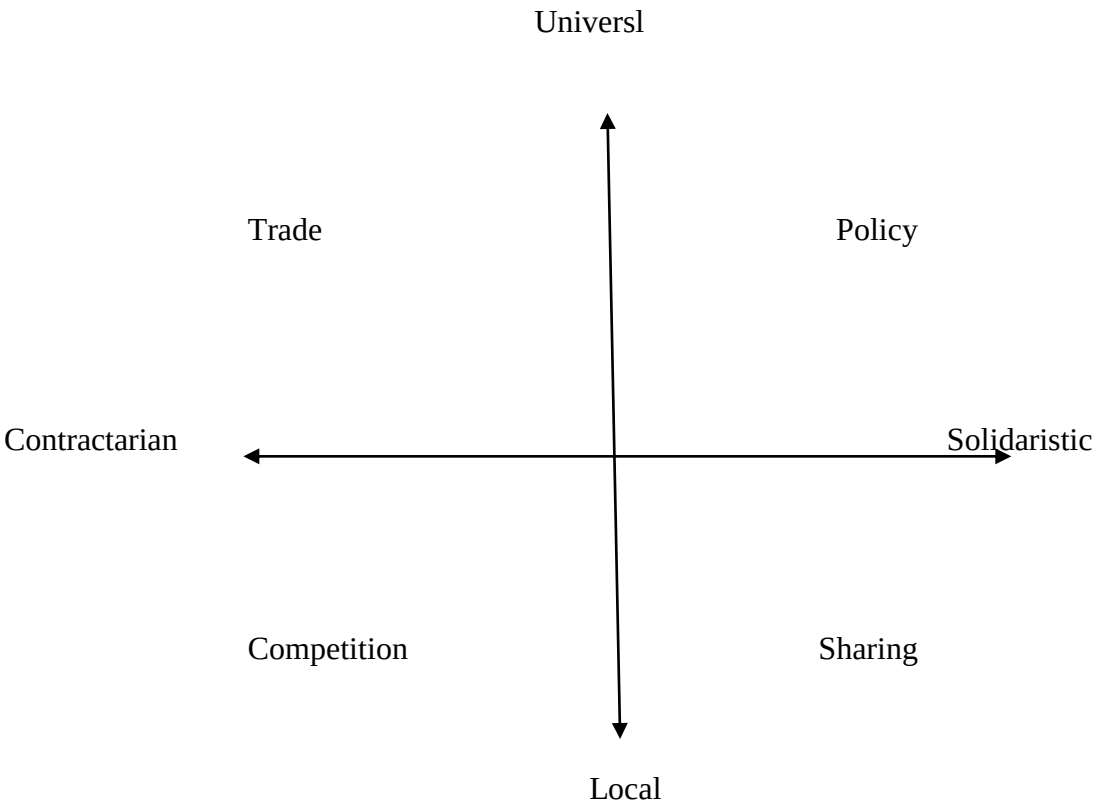
aesthetic need, and need for self actualization and these needs can never be satisfied completely (Martin & Joomis 2007:72-75). But, Gough (2014) criticizes this Maslow's theory. He says that it is a theory of motivation and drives of human action. Also, he says their theory (Gough and Doyal) is a theory of universal goals. His idea was that the pursuit of universal human needs will not necessarily be internally motivated (Gough 2014:11).

In addition, Dean and Schutz have discussed about needs. Schutz has talked about needs related to communication and his theory is called FIRO (Fundamental Interpersonal Relations orientation) theory of needs. He has mentioned three main needs such as inclusion, control and affection (Griffin 2008: 93). Among the ideas on needs presented by Dean, his supply of binary distinction between different kinds or levels of human need is important; for instance, absolute- relative, objective-subjective, basic-higher. He says many of these distinctions may overlap or coincide with each other. He has argued that human need represents a pivotally significant concept and this concept is the single most important organizing principle in social policy (Dean 2010). Dean says that that the human needs approach has been based on the idea that the possibility of establishing universal criteria for the satisfaction of human beings' most fundamental needs for health and autonomy. He further argue that this idea draws 'inter alia' upon Sen's (1984, 1985) important distinction between 'capabilities' (Dean 2003:7). Amartya Sen has defined functioning as 'an achievement of a person: what she or he manages to do or to be' (Sen 1985) (Gough 2003: 3). He explains capabilities are 'the range of possibilities that are substantively open within the lived experience of the situated human subject'. On one hand, they are 'commodities' such as goods, services and other resources and essential characteristics of these commodities. On the other hand, they are 'functions' such as productive, reproductive, caring and subjective end states such as happiness and sense of well-being. Because of this reason, his idea of capabilities is a representation of essential 'fulcrum' between primary resources and human achievements or else between welfare inputs and welfare outputs. Dean further says that human need approach is less individualistic in its orientation than Sen's capabilities approach. In the human need

approach (Doyal & Gough, 1991), the priority has been given to the emancipation and the societal conditions to optimize the need satisfaction (Dean 2003:7).

In his analysis of discursive repertoires, Dean has applied this to different modes of negotiations as mentioned below in the figure 2.2. He talks about 'thick' locally definable needs and 'thin' universally definable needs. 'Thick' needs means the needs which must be satisfied if people are truly to flourish and 'thin' needs means the needs which must be satisfied if people are merely to survive. Dean says that in the contractarian/solidaritic there is distinction between 'distributional' emphasis upon the processes and 'relational' emphasis. He says therefore, needs are interpreted relation to the distribution or the relations through which social functioning is secured. In this process, he has shown four ideal types of repertories for (modes of need negotiation). They are collective signification and sharing, individual struggle and competition, democratic debate and administrative policy making and private trade and enterprise (see the figure 2.2) (Dean 2003:8).

Figure 2.2 . Moods of Negotiation



Source: Dean 2003:8

Constable and Lee (2004) explained there are some basic and unique needs such as safety, belonging, communication, grow, interact, care, and love for people to survive in society and persons join families to understand these needs. When these needs are violated within the family, other professionals like social workers officially intervene in family in many ways such as changing the communication and meanings, reframing family's interpersonal narratives and stories of their experience, assisting families, changing the family's relational structure etc. (Constable & Lee 2004:18-19).

In the consideration of above information, it is obvious that there are different theoretical discussions on human beings' needs are available and this discourse is still going on with the contribution of various types of the academics, professionals and theorists.

Modern systems theory has emerged from the classical science. This was applied to the family by the psychiatry and the psychotherapy via clinical practice. While contacting the families of people with mental health problems in the theoretical assumptions in psychoanalysis was significant and it was very popular as a treatment method in the early 1950s (Bavelas and Segal 1982: 99-102).Later, systems theory has been widely applied in other disciplines including social work. System theory has been introduced to social work as a conceptual framework. A systems approach is a framework helping us to gather large amount of information about the world and make sense of it. It is not so much a formal theory though we name as a theory. This approach enables us to investigate the interactions and connections between people and their environment (Bavelas and Segal 1982: 99-102; Haynes & Holmes 1994:236-237). In the application systems theory in social work, a system is described as "a set of interrelated and interdependent parts that have common shared properties". First, a total individual can be seen as a whole system with physical, spiritual, intellectual, psychological and social components. Also, this individual is a production of different biological systems such as digestive, reproductive. Not only that, he is a part of other large systems such as family, neighbourhood and community. In systems theory, we use several significant terminologies such as focal or target system, subsystems, suprasystem, boundaries, homeostasis, and equifinality. Focal or target system means the system or unit which we focus at the moment for some intervention; for instance, in a children's protective services, social worker's focal or target system may be the children or the parents. In social work practice, individuals, families, groups and communities are the focal or target system. A subsystem means a part of a large system; for instance, in the family there are subsystems such as one or more parent, parents, grandparents, one or more children, uncles, aunts. This each subsystem again can be divided into subsystems too. Suprasystem means a larger one and it encompasses the whole, for instance, countries, cities, communities, households etc. A limit setter can be named as a boundary. If not, it a point that keeps other parts of a

system enclosed. The 'need for all systems to maintain a steady state of functioning' is called homeostasis in systems theory. But, there are no absolutely static systems and static systems cannot survive and die. Therefore, a system needs some energy flow or some movement to survive. The word 'equifinality' is more necessary and familiar with social work. This means 'there are many different ways to achieve the same goals, even we begin at different places (Haynes & Holmes 1994:237-240). For example, social worker can help the people with mental health problems to rehabilitate in different ways: supporting him to find a meaningful work, supporting him to use his or her strengths, supporting him to understand his problem and living with it, supporting him to take necessary medicine. Family is a system that has been assigned very specific functions by the society and it is a whole which consists of many interacting parts that form a closely integrated network of relations. As Bavelas and Segal (1982) explained "these relationships are established, maintained, and evidenced by the members communicating each other". These relationships and patterns create a family system. Therefore, any obvious or unobvious effect on one of its parts may cause serious problems to the other parts and to the whole due to their interrelatedness (Bavelas and Segal 1982: 102, Suppes and Wells 1996: 13-14). As the social workers such as Octavia Hill and Florence Hollis pointed out, disadvantaged people like people with mental health problems cannot separate from their environments. They have further mentioned that "*factors within the person interact with factors within the family*". Then these factors interact with the factors which are available in the neighbourhood. Not only that, these factors sequentially interacts with factors in the wider environment such as norms, attitudes, social expectations, economic conditions, and the local and national policies (Buchanan 2008:7).

World has been changing dramatically and our family lives also have been changing without our knowledge. During this change, some families are devastated by the crisis; other families have strengths and resources to cope with them. Family resilience is very significant concept in the mental health theory and research. The aim of this approach is to identify and strengthen most important procedures which make possible the families to resist and return from their troublemaking life challenges (Walsh 1998:3). Understanding

the strengths, needs, and interests of the people with mental health problems is very significant than the diagnosing and labeling in the strengths perspectives (Yip 2005: 453). A family resilience is a relational hardiness which we can use as a technique to support and strengthen the families with stressful situations. Walsh (1998) has defined resilience as *"the capacity to rebound from adversity strengthened and more resourceful. It is an active process of endurance, self-righting, and growth in response to crisis and challenge".* In this process, it can be seen continuing growth, and articulation of capacities, knowledge, insight, and virtues (Walsh 1998:4-14, Saleebey 2009:13).

Walsh (1998) has pointed out some several basic principles as the foundations for a family resilience approach and they have stranded in systems theory. They are as follows;

- Individual hardiness is best understood and fostered in the context of the family and larger social world, as mutual interaction of individual, family and environmental processes.
- Crisis events and persistent stresses affect the entire family and all its members, posing risks not only for individual dysfunction, but for relational conflict and family breakdown.
- Family processes mediate the impact of stress on all members and their relationships:

  - Protective processes foster resilience by buffering stress and promoting recovery.

  - Maladaptive responses heighten vulnerability and risks for individual and relationships distress.

- Family processes can influence the course of many crisis events.
- All families have the potential for resilience; we can maximize that potential by encouraging their best efforts and strengthening key processes (Walsh 1998:24).

Further Walsh (1998) has pointed out the keys to family resilience as follows;

- Family belief systems- making meaning of adversity, positive outlook, transcendence and spirituality.
- Organizational patterns- Flexibility, connectedness, social and economic resources.
- Communication processes- Clarity, open emotional expression, collaborative problem solving (Walsh 1998:24).

In strength approach, social worker looks at abilities as assets. Dennis Saleeby has first developed this approach in social work and most important factors identified in this approach are importance of empowerment, resilience, healing and wholeness in working with people. Two basic tenets of this approach are: (1) every individual, group, family, and community has strengths (2) every environment is full of resources (Johnson and Yanca 2011:8). As pointed out by Yip (2005), in this perspective, clients can be supported to recover in the community by using empathic understanding and normal interactions within a supportive social environment (Yip 2005:446-453).

In the passing of the last centuries, in the crisis and adversity within people's lives, spiritual beliefs and practices have promoted resilience and recovery from their loss and suffering. Today also many people practice this in the adverse events. Therefore, as a therapist or a human service professional we have to attend the spiritual beliefs and practices of our clients (Walsh 1999:3).

After identification of the needs and problems of the people with mental health problems and their family members, this family resilience approach to empower the people with mental health problems and their families can be applied.

2.8. Conceptual Clarification

Health, mental health, mental health problems, family members, family intervention, family support, and people with mental health problems are the most important concepts in this study.

Health and Mental Health

The World Health Organization has defined health as "*a state of complete physical, mental, and social well-being, and does not mean only the absence of disease and infirmity*" (Schaefer and Lamm 1998:480, Wasson 2002). This definition was applied in this study as 'health' because this definition itself emphasizes that some one's health cannot be measured only by physical factors and it should also include psychological and social factors. While general agreement is that mental health is more than the absence of clinically defined mental illness, according to World Health Organization (WHO) (2003), there is an ongoing debate on 'mental health', 'well-being', and 'flourishing'. To reach the both minimal health and well-being, addressing of different needs and wants is required for an individual. Then, the individual can reach the ultimate aim of human flourishing too. Therefore, identification of needs and wants are very important in this regard (Wasson 2002), Friedli 2009: 10). Especially the social workers working in the field mental health have to face with continuous new challenges and manage the responsibilities. Among the responsibilities, protection of the public, upholding human rights, working with families, addressing severe mental distress, incorporating the views of service users, operating within an evidence base, and making underfunded systems work are significant. In response to mental distress, different terms can be seen and need to be made clear. Good mental health is based on a number of interrelated aspects. Possession of a sense of self-worth, having self-confidence and self-esteem, being self-aware, having maturity of judgment, being able to form affectionate relationships, possessing the ability to generate and sustain supportive networks, being able to tackle life's tasks and deal with complex demands and, having the capacity to grow as a person are important (Fawcett 2012: 515-516). In the draft Mental Health Act-2007 in Sri Lanka, mental health has been defined as "a state of well-being whereby individuals recognize their abilities, are able to carry out activities for daily functioning, cope with normal stresses of life, adapt to change, be productive, have fulfilling relationships with other people, and participate in their communities in the context of their age, physical capacity, and social and physical environment" (Draft Mental Health Act-June 2007:42). However,

according to the social model, Bainbridge (1999) explains that "mental distress must be seen as situated within a continuum of everyday lived experience, and not constructed as some alien entity which separates out some people as fundamentally 'different' and starts to define their identities in terms of their 'pathology'". Also, in the discussion of mental distress in a social model approach, a commitment to a holistic approach, and a commitment to hear and take seriously what people may have to say about their mental distress are important. In this approach, it has been discussed two complementary ways in which mental distress may be viewed- the internalization or acting out of stressful social experiences and a coping or survival strategy. On the other hand, some people attached to the libertarian anti-psychiatry movement, such as Thomas Szasz (1961) has explained that mental distress as a 'unresolved conflict' or 'problem of living' (Tew 2005a:16-20). Once, Doyal and Gough has explained 'mental health' as *'practical rationality and responsibility'* in their discussion on human needs. They have explained the mental health like this based on the explanation on mental illness given by Edwards (1982,p70) and Engelhardt (1982); 'the mental illness means only those undesirable mental/bahavioural deviations which involve primarily an extreme and prolonged inability to know and deal in a rational an autonomous way with oneself and one's social and physical environment. In other words, madness is extreme and prolonged practical irrationality and irresponsibility' (1991:62). This definition has been used in this study as the 'mental health' because it very conceptually simple and related with the researcher's research topic.

Mental Health Problems and People with mental health problems

While mental health etiology is still a contested area, the existing definitions on MHPs vary according to different disciplines. Some people perceive the MHPs as malevolencies created by demons (Kapferer 1983:50). Most lay persons define MHPs as 'nervous breakdown' or 'nervousness' (Lefley 1996:29, Pilgrim and Rogers 1996:2). Psychiatrists and other medical professionals define MHPs based on International Clarification of Diseases of World Health Organization (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-III, DSM-IIIR, DSM-IV) (Double 2005:59-60; The ICD-10 Classification of Mental and Behavioural

Disorders: Diagnostic Criteria for Research, WHO, 1993). Each mental disorder has been conceptualized in DSM-IV as "*clinically significant behavioural or psychological syndrome or a pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom*" (Stein et al 2010:1759-1765). These different kinds of definitions have an impact on the perception, treatment, care giving, and available resources for MHPs (Lefley 1996:23-24). Mainly based on the information discussed in health and mental health part, "*a response to, and an implicit revolt against, experiences of injustice, enforced loss or abuse*" has been considered in this study as a 'mental health problem' (Tew 2005a: 25). The '*people those who have something wrong with their experience, behavior, and perceptions*' have been introduced as 'people with mental health problems' (Beresford 2005:35) in this study.

In mental health field, some of the words like 'mental illness', 'mental disorder' and 'psychopathology' are not often used and instead of them, some euphemistic terms such as 'mental health', 'mental health problems' and 'issues' are used. But, there is no any different of origins or meanings of them. Also, the legal base of these words is similar.

Family and Family Members (FMs)

The concept 'family' is very difficult to define and it has been a very complex concept. Based on different perspectives such as functionalist, conflict, and interactionist approaches, feminist theorists, and new right theorists, family has been viewed in different ways (Zanden 1993: 275, 280-284, Marcus and Ducklin 1998:119-128). Most people's idea of 'a normal household is a married couple with children' (Fulcher & Scott 2011:430). But, there is a problem that this definition how far is valid or corresponded because there are different types of categories of families in society. Among these family types, couple families, couple families with children, single parent families, same sex families, step families, blended families, reconstituted families, cohabitated families, grandparent carer families and non-resident parents families are available in society ("It's About Time: Women, Men, Work and Family"-Final Paper 2007:128, Zanden 1993:276

& Calhoun et al 1997: 295). As Giddens pointed out, though there are noticeably changes in characteristics of the family, family still exits and it plays a significant role in our lives. He has defined family as "*a group of persons directly linked by kin connections, adult members of which assume responsibility for caring for children*" (Giddens 2001:173). In traditional sociologists' view, "*family is a social group whose members are related by ancestry, marriage, or adoption and live together, cooperate economically, and care for the young* (Murdock, 1949).

Diana Gittins (1993) argued that instead of talking about 'the family', it is better to talk about 'families' and this may help to avoid some problems too. The defining of the family as a social unit has been rejected by the radical approach. Instead of connecting ourselves with 'what family is', David Morgan (1996,1999) has argued that it is useful to talk about 'family practices'[22] and 'what families do and what they consider to be family activities' (Fulcher & Scott 2011:431).

In the discussion of the family in the Sri Lankan context, Jayaraman (1975) has defined the family in Sri Lanka as "a group consisting of parents and their unmarried children" (Jayaraman 1975: 123). In Sri Lanka, the concept of 'household' is very important in the discussion on family because sometimes, researchers have used the word 'household' to explain the family. Ryan has explained nuclear family is the elemental unit of Sinhalese society. He further explains as an economic unit and primary group, the family centered about husband and wife and it is precisely defined and delimits the greater part of the closest and most intimate relationship of the individual (Ryan 1958: 35). Pieris (1956) explains 'family is the focus in which all the tender affections of a native are concentrated' (1956: 195).

[22] "Family practices' are those practice described as being in some measure about 'family' by one or more the following: individual actors; social and cultural institutions; the observer……they are also practices which matter to the persons concerned and which are seen in somebody is not simply to be able to identify, but also to invest that object of identification with a degree of emotionally significance. It should be stressed family matters, as many have noted, attraction and repulsion, approval and disapproval" (Morgan, 1999:19) (Fulcher & Sott 2011:432).

The family needs to be defined broadly and following definition also very important in the discussion of the concept 'family' related to the social work practice. It has been defined that family as " a social system comprised of individuals related to each other by virtue of strong reciprocal affect who share a permanent household or group of households that endure overtime" (Caroff & Mailick, 1985) (Dhooper 1997: 160).

Even though there are different definitions on families, at global level, UN definition of the family is important. UN has defined the family as "*any group of persons which cares for a child and is regarded as a family under the legislation and practice of a State*" (United Nations Committee on Civil and Political Rights 1993:3). Though this is not a perfect definition on family, this definition was used in this study as the family to mitigate controversial issues on the concept on 'family'. In this study, *parents, siblings, spouses or partners, children, grandparents, grandchildren, uncles, aunts, nephews and nieces* were named as 'family members'.

Family Intervention

As a profession, it can be seen three general types of levels of intervention in social work: micro, meso (mezzo), and macro intervention. In 'macro level', intervention in societies and communities is done as a whole. For instance, advocating for large-scale social policy change. While 'mezzo level' means 'middle' and this involves in the small scale groups such as neighborhoods, schools, or other local organizations. Intervention with individuals and the families is the third type of intervention and it is called 'Micro level'. This is the most common intervention in social work. For instance, helping individuals to find housing and social services. Sometimes this is called clinical social work (Haynes & Holmes 1994: 242-243; socialworklicensmap.com/macro-mezzo-and-micro-social-work/). As mentioned above, Constable and Lee (2004) explained when needs of the people are violated within the family, other professionals like social workers officially intervene in family in many ways such as changing the communication and meanings, reframing family's interpersonal narratives and stories of their experience, assisting families, changing the family's relational structure (Constable & Lee 2004:18-19). The concept of 'intervention' is a challengeable term (Davis 2008: 98). In this study

intervention means ‘working together with people’ and therefore, *“any working together with families to change or improve their individual, couple, child or whole family level relationships, interactions, communication patterns or reach their goals or to obtain services from other social institutions”* can be considered as a ‘family intervention’ in this study. Intervention can be directed in different ways such as individual parent, couples, the child, the whole family or groups (Walker 2012: 615).

Family Support

In the discussion of the family support, it seems that it has a long history. In the rapid change of the society, family always unavoidably caught up especially in these changes policies and politics (Walker 2012:613). Pinkerton (2005) emphasized that it is necessary to understand the changing nature of the state and welfare provision driven by economic and market forces and political practicality in the context of changes in family life. Therefore, he argues that family support should be located within this understanding. Also studies have found that some family members were unable to rely on the help when it was needed or sometimes they lost the help because of the intrafamilial changes in traditional patterns of kinship relationships and contact and support.

As Houston and Dolan (2008) explained, ‘*self-help or volunteer help with little statutory involvement, or it can mean a continuum of advice, support, and specialist help geared to provide early preventive intervention, parenting support, education, and marital therapy’* can be defined as family support (Walker 2012:615). Therefore, in this study, this definition has been used in the discussion on family support for the people with mental health problems.

2.9. Data Analysis

To analyze the gathered information, quantitative and qualitative data analysis methods were used. While the Statistical Package for Social Sciences (SPSS) was used to analyze the quantitative data in the questionnaires, the thematic analysis method was used to analyze the qualitative data in the in-depth interviews.

Boyatzis (1998) explained that "*thematic analysis is a method for identifying, analyzing and reporting patterns (themes) within data*". This is a fundamental method which researchers use to analyze qualitative data in their research. Holloway and Todres (2003) have identified that 'thematizing meanings' is a certain type of shared generic skill across qualitative analysis. Because of this generic skill, Boyatzis (1998) characterized thematic analysis is not as a specific but also as a tool which can be used across different methods. Because of this theoretical freedom, thematic analysis can be introduced as a flexible and useful research tool with the facility of providing rich and detailed data. Because of the advantage of flexibility of this method, there is no limitation and constraining of the data. It does not required detailed and technological knowledge of approach in thematic analysis like in grounded theory and discourse analysis. And also, this analytical method is an essentialist or realist method with multiple reports such as experiences, meanings, reality of participants and so on. Though thematic analysis is widely used to analyze qualitative data, there is no clear agreements on what method and how it should be done (see Attride-Stirling, 2001; Boyatzis, 1998; Tuckett, 2005 for other examples). But, there is a difference between thematic analysis and other analytic methods[23] which seek to describe patterns across qualitative data (Braun & Clarke 2006:78-87).

Steps in the Thematic Analysis

There are six phases in this analysis, (Braun & Clarke 2006:78-87) and data sets in the in depth interviews in this study also were analyzed based on these phases. While all these stages are not necessarily unique to the thematic analysis, some stages can be seen in other qualitative methods as well.

[23] Thematic discourse analysis, thematic decomposition analysis, interpretative phenomenological analysis and grounded theory.

Table.2.1. Steps in the Thematic Analysis Process

Phase	Descriptions of the processes
1. Familiarizing the data	Listened to the records, transcribed the verbal data, read the data and noted down the initial ideas.
2. Generating initial codes	Coded the interesting features of data and also collation was done.
3. Searching for themes	Collation of the codes into potential themes.
4. Reviewing themes	These thematic labels were summarized and divided into several parts based on the research questions. Some of the repetitions, commonalities as well as the contrasts were noticed in this summary. Checked whether the themes work in relation to the extracts, generated thematic map.
5. Defining and naming themes	Refined the specifics of each theme and generated the clear definitions and names for themes.
6. Producing the report	This was the final step for analyzing. Based on the research questions/ interview structure, it was expected to produce a scholarly report of the analysis.

Source: Braun & Clarke 2006:78-87

Familiarizing the data was the first step in these stages. At least once, going through the entire data set before the coding is very important because this step provides bedrock for

the next parts in the analysis (Braun & Clarke 2006:87). Researcher went several times through the entire data set since we should be familiar with all the aspects of our data. This was very time consuming work in this study because researcher had to read and re-read the data set to be familiar with important aspects of this research. This analysis often involved a constant moving back and forward between the entire data.

In the second step, the production of meaningful codes was done because coding is a useful way of analysing data (Huberman, 1994; Tuckett, 2005;) (Braun & Clarke 2006: 88). Important data extracts were taken out and put into a table. Then, it was used to build meaningful coding related to them in this step. While there were a bulk of coding tables in this study, researcher has presented the following table (based on one case study only) as an example for the readers (see Annex X for more samples of data coding tables).

Table 2.2. Generating Initial Codes

Data Extracts	Coded for
My parents did many things to my problem; tying thread, cutting limes, cutting ash pumpkin, putting a yantara (an amulet), keeping Bhodi puja (performance for the Bo tree) before we came here.	1. People have different beliefs. 2. Their beliefs are attached with their religion and culture.
This land is not our one. But, my father built the house. There is court case related to this land with relatives.	1. People have property issues and legal issues. 2. Family members and people with mental health problems have a hesitation on their ownership of the property in future.
No friends. No any relationship with relatives. Though we go, they do not come to visit us. They came only to participate in my father's funeral.	1. Relatives and friends do not want to keep close relationships with relative families with people with mental health problem. 2. Association of them is a hassle for them. 3.But, people with mental health problems and their families need contacts with them.
I wanted to do a job and get married. Still I feel to do a job and get marry. These days, there is no any enthusiasm to anything. Now, everything is done according to what	1.People with mental health problems have needs to have family life, needs to earn.

mother wants. I wear any garment which they give. Sometimes, I feel I do not have any responsibility and feel it is also good.	2.There are some distress time period which others to understand. 3.They need autonomy in what they want to do. 4.Removing responsibilities from them creates bad long term impact for their lives.
Doctors have not yet explained about my illness. But, I like to know about my illness. I think nurses cannot cure my illness.	1.People with mental health problems need to know about their MHP. 2.Making aware the people of their illnesses is not so important in medical professionals' treatment plans. 3. Patients think doctors are the only persons can support them in their illness.
Sometimes, I feel it is better not to gather with my family members because they quarrel with me as I do not have a bath, I do not do home work. If not, I am happy if they talk to me. Sometimes, I feel it is better to do a job and live alone because no one comes to me order to do this and that.	1.Sometimes, family creates issues. 2.People with mental health problems, need communication. 3.They need an independent life and autonomy.
My mother says my father died because of me. I am sorry and I do not know why they claim like that.	1.Family members cannot understand adversity effects well. 2.Family members think their members with mental distress bring misfortune to their family.
I have been fed up with being in the hospital. Beds are dilapidated, No food which I like.	1.People with mental health problems need to discharge from the hospitals/formal institutions. 2.They need a comfortable environment.
My family members did many things to cure my illness; Vowed, performed large-scale tovil (large-scale supernatural performance), western treatment.	1.Family members follow every type of treatment systems in mental health problems. 2.They expect the cure their family members.
From the beginning, there were problems in my marriage life. Only one month, I was with husband and his relatives. For few months, I was with relative sister, time to time I was with my mother. Now, I live with my	1.In family life, Problems are not new or strange. 2. Sometimes, distressful family background

husband and son.	precipitates mental health problems. 3.Support from close relatives were important in family issues.

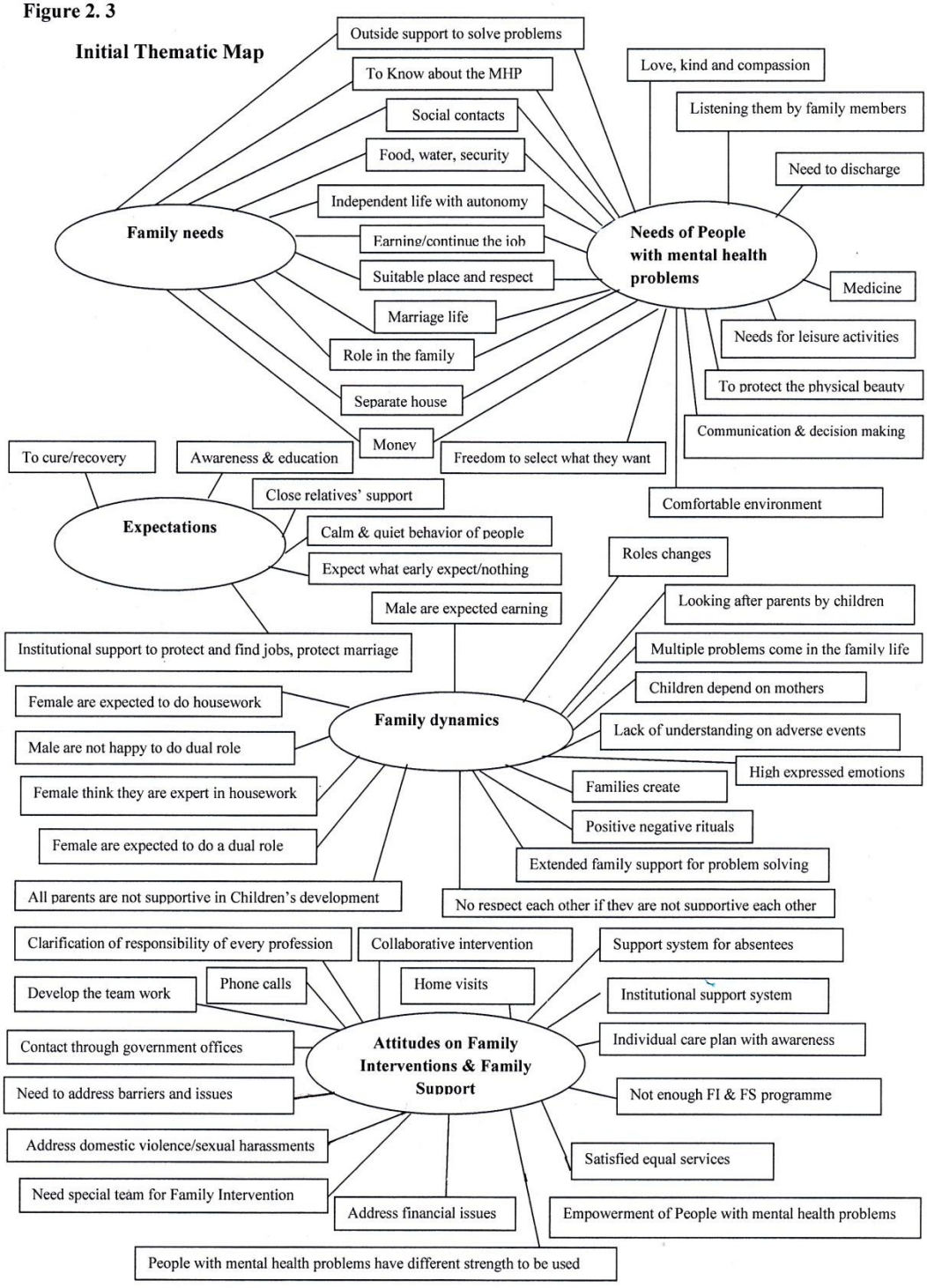
Source: Field Data 2011-2012

This data coding was done manually. Also, this coding process was based on the data in the research at the beginning. Later, they were based on some specific questions such as what are the needs of families and people with mental health problems, what are the expectations of them, what are the attitudes of families, people with mental health problems and mental health staff etc. As Braun & Clarke explain (2006), coding depends on whether it is aimed at the entire data set or look at the particular (and possibly limited) features of the data set (2006: 89). In this study, data coding was limited to the topics such as family dynamics, needs, expectations and attitudes of family intervention and support aiming at the research questions.

In the third step, the coded and collated data were organized into broader level of themes under the main themes of needs, family dynamics, expectations and attitudes on family intervention and family support. Again, these broader levels of themes were organized into theme-files. By using those theme-files, d a thematic map was designed (see the figure 2.3). This map enabled to see some combination among these themes too.

Figure 2. 3

Initial Thematic Map

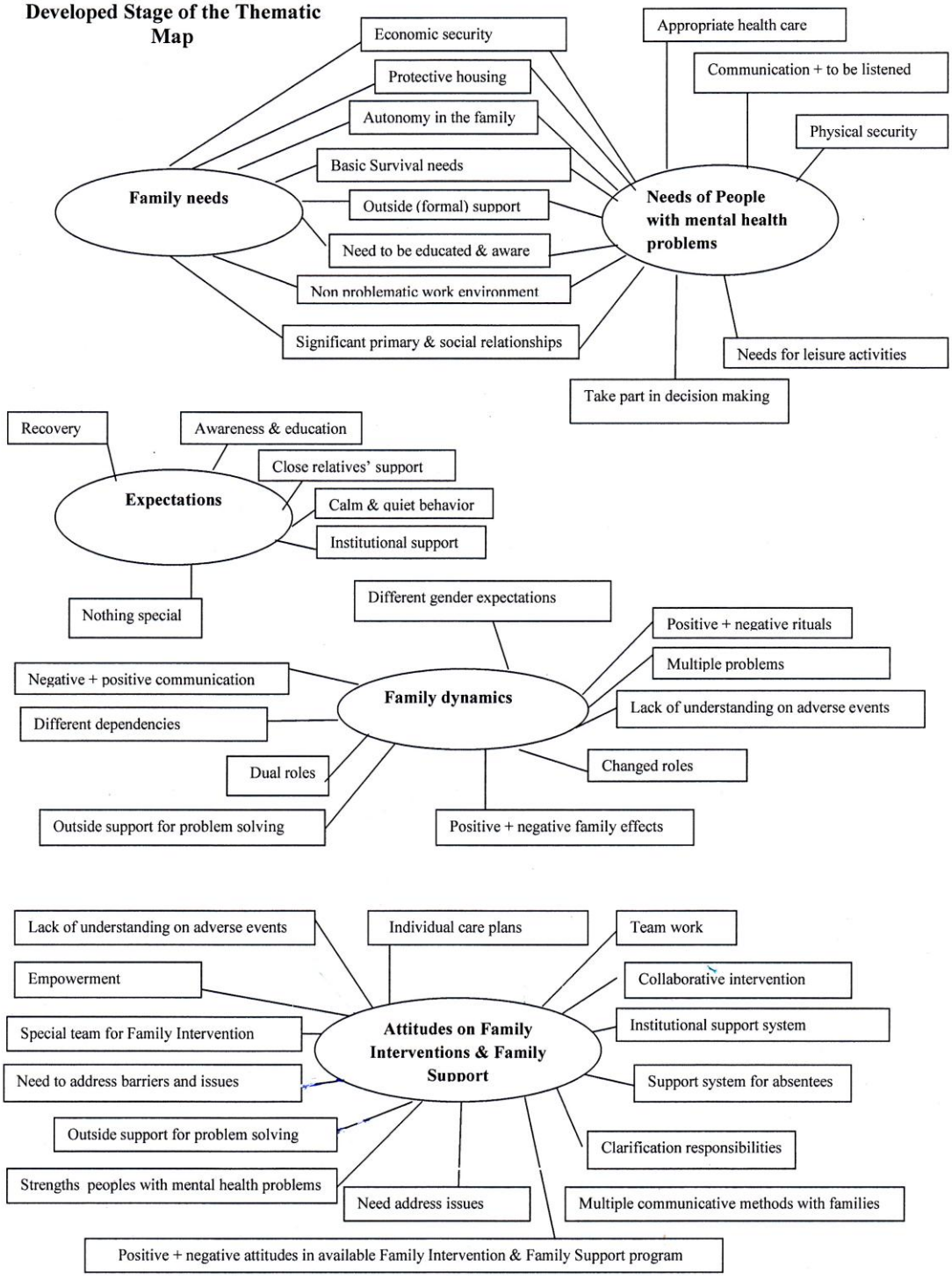


Source: Field data 2011- 2012

Reviewing and refinement of organized themes were done in the fourth stage in this analysis process. It was based on `two purposes: to ascertain whether themes worked related to the data set and to code the additional data which has missed in earlier coding. In this stage reviewing and refining was done at two levels. First, reviewing was done with the data extracts. Researcher read the all collated data extracts in each theme. In the second level, researcher was concerned to see whether there were coherent patterns to be formed (Braun & Clarke 2006: 92). In this stage, initial thematic map also was further developed (see figure 2.4).

Figure 2. 4

Developed Stage of the Thematic Map

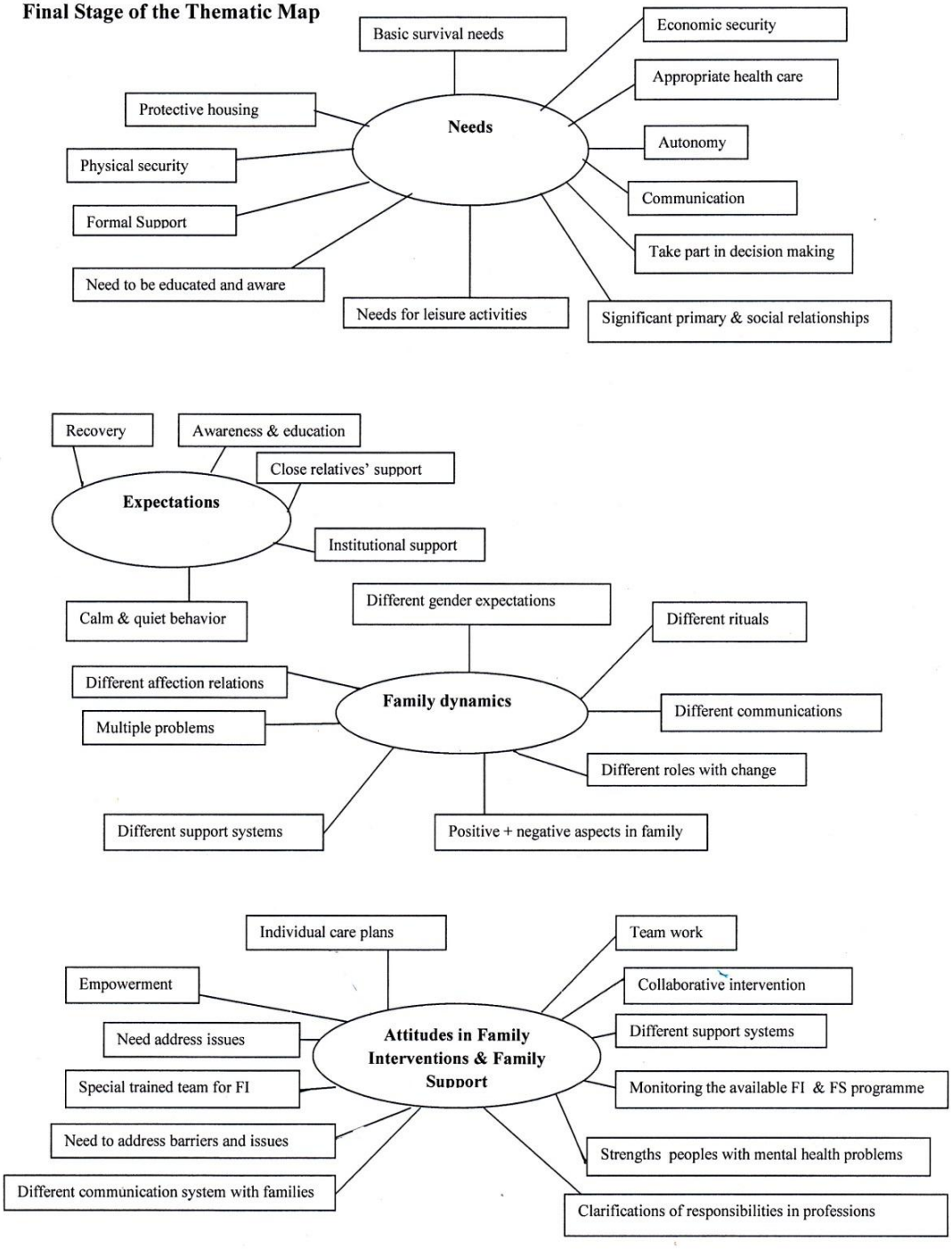


Source: Field data 2011- 2012

In the fifth phase, defining and refining was done and understood the essence of what each theme about and aspects of data which each theme has captured (Braun & Clarke 2006: 91-92). Final thematic was organized in this stage (see figure 2.5). It was able to see a clear picture behind this map and there was a story behind every theme in this map. Apart from that, there are sub themes behind the main themes in this map too.

Figure 2. 5

Final Stage of the Thematic Map



Source: Field data 2011- 2012

2.10. Ethical Consideration and the Problems and Limitations

Various professional groups have created codes of ethics. In general, research code of ethics address individual's right for dignity, privacy and confidentiality and avoidance of harm (Glesne and Peshkin 1992: 99). In this kind of study, ethical consideration was very important. First of all, the research proposal was submitted to the Ethical Clearance Review Committee at the Faculty of Medicine, University of Colombo, Sri Lanka and the National Medical Ethics Committee (NMEC) in Slovenia to get ethical clearance for this study. And also, this research proposal was submitted to the director of the NIMH for their permission to collect the data in their institute. The Head of the UPMU also was made aware of the data collection in UPMU and got his permission. In the second step, every respondent was given a self-introduction and the purpose of the study before the interviews. In the third step, respondents were given an information sheet and this form was in three languages: Sinhala, English and Tamil as there were respondents who used three languages in this study. The fourth step in this study, they were given an awareness of confidentiality of the information to be given by them and fictitious names were used for the informants to protect their identity. Finally, it was given a consent form and taken the respondent's consent for the interviews this form also was in three languages as mentioned above. As Kumar (1996) pointed out, if we want to ask sensitive questions from respondents, the respondent should be informed about the type of information we want to ask clearly and frankly and give them sufficient time to participate without any major inducement (Kumar 1996:193). Therefore, the respondents were often given the priority to decide the time when they preferred to talk and where. This helped to avoid bias and was an attempt to report correct and appropriate research methodology.

Though this research was related to the people with mental health problems, stressed and busy family members and the staff who were busy with their tight schedule in their psychiatric wards, it was able to successfully manage almost all the research activities. Though the researcher thought that the objections of family members to dedicate their time would be the main problem because some family members came from distant areas and they sometimes came just to visit their members, it was not a considerable problem in

this study. To prevent the problem of participating in the interviews for a long time and also to minimize their misery in recalling and answering about the condition of their close family members, the interviews were carried out according to their will, for instance in two stages. While interviews were going on, more time had to be spent to listen to their stories to minimize their stress as they had difficulties in concentrating on specific questions during the interviews. Especially, while the interviews were conducting at the family members' homes, they were very time consuming because interviews were conducted with some barriers in their family backgrounds. Sometimes, time to time, interviews had to be stopped on the way and listened and answered to some of the family members' questions. In addition, there were some events with high expressed emotions of family members towards the people with mental health problems. In such circumstances, the researcher had to spend time to address the family members, make them aware of the bad effects of such expression of emotions towards their family members with mental health problems and calm them down by using the working experience with such persons. Though it was a time consuming work, it was very useful to understand their family dynamics and relationships patterns. This situation prevailed throughout the interview process. But, it was able to manage this problem properly with researcher's previous experience in working with this type of service users and their family members in UPMU.

Even though there were data under different concepts in this study, in the coding of data researcher limited her coding to several topics based on the research questions such as needs of the people with mental health problems and their family members, expectations of them, family dynamics and attitudes of the people with mental health problems, their family members and mental health staff on family intervention and support to minimize the complexity. The lack of information in the social work practice in Sri Lanka was a limitation which the researcher experience in this study and the reason was that the poor and slow development of social work field in Sri Lanka. But, it was not a barrier to this study and able to manage with other literature gathered from other source collected by researchers in other countries. The researcher believed that this study would be another

contribution to the development of social work field in Sri Lanka with a multi socio cultural and multi ethnic society.

In the consideration of the above information, this study was based on the family intervention and family support and focused on the needs of people with mental health problems and their family members and the awareness and perception of people with mental health problems, their family members and mental health professionals on the family intervention in the mental health field. Questionnaire and in depth interview methods were used to collect the data in this study from the people with mental health problems, their family members and mental health professionals both in UPMU and NIMH in Sri Lanka. This study was based on needs theories, family system theory and family resilience approach and SPSS and thematic analysis approach were applied to analyze the data.

Chapter Three

Social Work and Family in Mental Health Care

In the first part of this chapter, researcher has discussed about the etiology of mental health problems and beliefs on the mental health problems. Family members' intervention and support for their family members with mental health problems also varies from their beliefs and attitudes. Then, researcher has paid her attention on mental health care in Sri Lanka, development of social work in health care including in Western countries, Asia and Sri Lanka. Apart from that, she has discussed about family and its functions, family in mental health care and family resilience in the later part of this chapter.

3.1. Etiology of the Mental Health Problems

Mental health problems has a rather dark history and it goes back to the early 'madhouses' and large Victorian asylums. These asylums were spread throughout the country and latter half of the twentieth century (Milner et al 2015:224). There are several conceptual models on mental health problems and they have influenced in shaping the thinking patterns of the mental health professionals and the people with mental health problems, treatment patterns, and the resources for the people with mental health problems and their families. Biomedical model is famous in the ancient era and it was lasted broadly in colonial and pre colonial America. As Rothman (1971) pointed out, it is very obvious according to the following statement written by Isaac Ray in one of his books;

> "Every general practitioner in the pre-Civil War era agreed that insanity was a disease of the brain and the examination of tissues in an autopsy would reveal organic lesions, clear evidence of physical damage, in every insane person"(Lefley 1996:34).

According to the biomedical model of disability, people with disabilities are put into wider social attitudes which constructed them as a 'tragedy'. This happened in both aspects such as their own self perception and how they were viewed by surrounding

people. After medical professionals failed to support to be 'normal', they ultimately blamed on their genetic or biophysical inadequacies (Tew 2005a: 18). In the biomedical model, mental health problems have been considered as brain diseases. Because of this reason, people were reluctant to go for biomedical base. The central concern of psychiatry also was this biological aspect of mental health problems (Double 2005:56-60).

As Oliver (1996) explained, social model of disability was started in this kind of background. After the social model was developed, the focus was shifted to what can be done for improving the quality of life of these people, as well as aspirations and opportunities for social inclusion. But, recognizing the impairment, medical interventions played a useful part to maximize some aspects' of individuals' potential. But disabled people were unable to gain full social and economic participation because of stigma, discrimination and prejudice. But, it has been found that many people with mental health problems have gained a greater capacity of living because of their finding meaningful employment in society (Tew 2005a: 18-19). Oliver (1983) points out that he has conceptualized the models of disability as binary distinctions. Also he further has shown two fundamental points on the individual models of disability. They are locating the problem of disability within the individual and the causes of this problem as stemming from the functional limitations or psychological losses (Oliver 1990: 2). But, Shakespeare and Watson (2002) have argued that the time has come to go beyond the social model of disability. They have done this criticism based on three points such as the issue of disability, the issue of impairment and impairment/disability dualism. They have done this argument mainly based on the British social model[24] of disability. For instance, they show that disability has been defined as a 'social oppression' within the British social model itself. Not only that, in the social model developed in North America also disable

[24] The British social model was developed in 1970s. This was developed by the activists in the Union of the Physically Impaired against (UPIAS). Later, academic credibility was given for this model by Vic Finkelstein (1980, 1981), Colin Barnes (1991) and especially Mike Oliver (1990, 1996). In Britain now, this social model has become the ideological litmus test of disability politics (Shakespeare and Watson 2002).

people have been defined as a ‘minority group’ according to their analysis. Therefore, they argue that this is a barrier for full social and economic participation of the disable people (Shakespeare & Watson 2002: 9-28).

Psychodynamic theory is also one of the conceptual models and was basically based on Freudian structural model on id, ego, and superego. According to Freud, psychopathology comes from after a conflict among the above three structures. From the 1950s onwards, there was a trend to treat people with mental health problems along with their family members by many psychodynamically trained therapists with the purpose of easily identifying the causes for the problems and getting support (Dallos and Boswell 1993: 103). But, later psychoanalysts did not agree with Freudian views and like McGlashan (1989) said while there is a lack of credibility of psychoanalytic theories of etiology, for clinical explanation, psychodynamic theories are useful (Hatfield 1987: 9-10, Lefley 1996:36-38).

Biopsychological model also has contributed to the identification of mental health problems. Wilson (1993) has listed the assumptions in the biopsychological model. According to this model, anyone can get a mental health problem, if he or she faces with a trauma. Therefore, the boundary between ‘normality’ and ‘insanity’ is fluid. According to this approach, a mixture of the harmful environment and the psychic conflict can be a cause for mental health problems. In addition, mental health problems are “conceived along a continuum of severity from neurosis through borderline conditions to psychosis” (Double 2005:57).

Basic idea of sociological models is that mental health problems have a relationship with the major domains like socioeconomic factors and social disintegration. Though there is insufficient evidence of learning theories to prove that there is a relationship between mental health problems and maladaptive behaviours in early childhood, it has develped a conceptual model in the explanation of etiology of mental health problems (Lefley 1996:40, 45). Within this, poverty and life stresses for MHPs have a significant place.

Chandrashekar, Reiff, Desjarlais et al explain the relationship between poverty and the origin of MHPs. According to Chandrashekar, if people are unable to fulfill their basic needs with the financial resources they possess, they become stressed and feel insecure. Because of the inability to maintain their mental equilibrium, they are more prone to MHPs (Chandrashekar 1998:25). In India, when the Community Mental Health Services Act was passed by the Indian Congress in 1963, facilities and funds were provided for people with mental health problems who are seriously ill among the poor because they were in a greatest risk of hospitalization. Most of the socially oriented mental health professionals also have proved that the poor are more prone to suffer from MHPs (Reiff 1974:14). Desjarlais et al show that MHPs associated with natural disasters, environmental scarcities, urbanization and physical illnesses are very high among the poor due to the lack of programmes and services to decrease their impact (1995:15). When these persons are unable to cope with their life stresses, many behavioral changes occur in them (Brow 1996:143). Patel and LIopis (2005) also have shown that the mental health of the populations living with poor socioeconomic circumstances is very poor (Prevention of Mental Disorders: Effective Interventions and Policy Options-Summary Report of the World Health Organization 2004:22).

In stress theories, the idea that expressed emotions cause mental health problems is established and these theorists add an idea of genetic predisposition with the above view. Brown, Birley, Wing (1972), and Vaughn and Leff (1981) are very important among the theorists who viewed mental health problems from this conceptual model. Brown and Harris (1978) have assessed the relationship between environmental stress factors and the formation of depression. They have identified a recent bereavement, separation, onset of unemployment, illness, crisis and disruptive changes such as unexpected pregnancy as provoking agents to get depression. And also if there are three or more young children at home, lack of an intimate relationship, poverty, unemployment and early loss of parents have all been identified as vulnerability factors for depression. As pointed out by Middleton and Shaw, working class people are more prone to get mental health problems than the middle class (Hatfield 1987: 14, Dallos and Boswell 1993: 94, Lefley 1996:4, Jordan and Jordan 2000:116).

In the cultural conceptual model, main focus is on the culture change and acculturation. According to clinical experience, Littlewood and Lipsedge (1989) have argued that "…*mental illness is rooted in biology and culture, in the individual and society* (Dallos and Boswell 1993:101).

Hereditary factor is one of those beliefs attached to the mental health problems. As pointed out by Desjarlais et al, there is a strong belief among the people that MHPs can be passed on through the generations within a family. As a result of that belief, some people neglect and isolate the people with mental health problems. The majority of the public consider the person with a mental health problem and his /her family as social outcasts and they have limited chances to get married. Sometimes, these people are kept separately in isolation (1995:39). According to the World Health Report 2000, hereditary cause was one of the perceived causes for MHPs (Weiss 2002: 51). But studies have shown that only about 10% of people with mental health problems have a family history of mental health problems. Scientists further say that only the 'weakness to develop a mental illness' is transmitted from the mentally ill parent to the child (Chandrashekar 1998:7). Sociological studies and theories of MHPs also do not ignore the possibility of a biological foundation to some of the major MHPs. But it does not mean that they should keep separately from the wider community (Giddens 1992:150-151). Ewen says that though genetic factors are more important in MHPs, the role played by environmental influences in the origins of MHPs also should be taken into account. Therefore, he further says that it is better to reduce the environmental stress because the inborn constitutional make-up is difficult to change (1947:15).

There were anti-psychiatry movements led by Ronald Laing (1961) in the UK and Thomas Szasz (1960) in the USA. They challenged the models and suggested that mental health problems are physical brain disorders. However, above views on etiology of MHPs gradually caused a change in the involvement of families with their family members with mental health problems. Thus with the development of 'biopsychosocial approach' it has become very important in the management of MHPs and caring of the people with mental health problems. Based on Engel's (1980) work, majority of the practitioners in medicine

and social work have identified later that MHPs are influenced by three factors: physical factors (disorders in the brain), psychological factors (unhelpful beliefs and perceptions) and social factors (such as isolation) (Milner et al 2015:224).

3.2. Beliefs on Mental Health Problems

Today most of the people suffer from mental health problems despite differences in gender, class, ethnicity, caste, religion, and family background. MHPs represent a huge burden throughout the world. But MHPs have not received enough attention in society. In the past three decades, MHPs have been given attention within psychiatry as a set of disorders (Desjarlais et al 1995:39). Desjarlais et al have further pointed out that severe MHPs like schizophrenia are devastating, not only because of the emotional turmoil , the confusion and fear suffered by the patient, but because of their social consequences for patient and family (1995:39). Attitudes towards MHPs especially related to the origin of MHPs, treatment and behaviour of the people with mental health problems are very important in the discussion of the intervention and support for these people to come out from their MHPs.

3.3.1. Causes for Mental Health Problems

People have different theories about the causes for MHPs from the past because there is a rich cultures in South Asia (Gambeera & Williams 2011: 17). The concept of witchcraft is one of the beliefs that people had related MHPs to and Szasz has pointed out that some persons believe that certain behavioral changes of people are seen as a result of witchcraft in the fifteenth century. By the twentieth century people believed that some behavioural changes could be seen due to the MHPs and these persons were named as insane at that time (Szasz 1971: 19-20). Marwick has pointed out that witchcraft created the people with mental health problems. Marwick's idea was that they were living in our world of dream (1970:11). According to Pritchard, generally witches have been identified as accomplices of destructive activities like crimes (Pritchard 1970:29-31). Most of the people with mental health problems in the rural areas also are believed to be the victims of such witchcraft. According to Obeyeesekere, Sinhalese have a precise classification of

misfortune. They explain misfortune with sorcery practiced by envious neighbours which is very common in urban Sri Lanka. It shows the mistrust and anomie that exist in the urban community. However, the person may not explain his bad luck by sorcery in Sri Lanka. He or she consults an oracle, or *sastra* and the oracle may say that he or she is badly affected by sorcery. After that, a person may select someone that he or she dislikes among his neighbours or other relatives and will consider him as a scapegoat for his illness (Obeyesekere 1981:107-108). Most of the time, this relative or neighbour may know nothing about it and it helps to create even more conflict among them.

Spirits is also another belief of people on MHPs and they believe that people can be haunted by evil spirits. In the ancient era, most people considered all kinds of events to be the deeds of spirits. Especially, the belief that the person with a mental health problem has been possessed by an evil spirit was very common in the ancient people (Morgan 1961:164). While Obeyesekere mentions that the ancestral spirits are culturally built concepts, Wijesekera explains that there is a relationship between the dead and the living and this may be a fearful, respective or benevolence existence. Spirits are supposed to look after the family because people believe that the spirits are reborn in the same family. There are maleficent spirits, who are born as ghosts and people believe that ghosts are dangerous. Not only Wirz, Wijesekera also mentions that ghosts can be seen in various guises and they may haunt houses, roads, places, fords, and cemeteries (1987:202). It seems that people's perception on spirits has been prevailing widely since the ancient era and they apply it to the behaviors of the people with mental health problems.

There is a cultural belief of Sinhalese in three evils[25] and they believe that people can suffer from mental health problems through these evils. Particularly, among the above evils, 'suniyam' is activated by thought evil (Kapferer 1983:52). As further explained by Kapferer, "*all kinds of malevolent human action (although huniyam/suniyam may also be used) can be named as kodivina".* Kapferer says that *anavina* is the most powerful action which is shaped by sound or verbal action (1997:37-38). Obeyesekere also has explained that sorcery activities as a technique of killing or harming someone particularly in many

[25] Eye, mouth, and thought evil (*as vaha, kata vaha and ho vaha)*

traditional and non-Western societies and they are believed to be very powerful than the lethal weapons or poison (Obeyesekere 1975:1). These ghosts, goblins, and the spirits of the departed, these classes of spirits can be seen in many societies. People believe that they severely influence our lives. Ghosts and spirits also present individualistically and they often attack a single person (Obeyesekere 1981:115).

According to Kapferer, in our society, there is a belief on 'demons'[26] and people believe that they can be captured in the demons' harmful eyesight or gaze (yaksa disti). Therefore, demonic victims experience emotional, mental and humoral imbalances. Certain extreme emotional states are the evidence of the mental imbalance and symptomatic of demonic illness. These unstable emotional states create a weakness in mental attitude and people with such weaknesses are more prone to get malevolence of malign supernatural. In such an occasion, exorcists question the time and place of unusual frightening, and the course of a patient's usual activity the beginning of demonic attack to trace the beginning of demonic attack (Kapferer 1983:50). According to Wirz, people believe that there are some particular places where these demons prefer to wait for the people at certain times of the day or night. Among such places, close to big old trees, streets, market places, or the coast where the fishermen work are more common in the our society (Wirz 1954:26).

Influence of Bad Stars and Planets (malefic planetary influences) is another belief on MHPs. Planets like *Saturn*, *Rahu* or *Kethu* are usually considered as bad ones. They become worst when located in certain places on the horoscope. As pointed out by Knox, astrologers are skilled in the knowledge of the Stars, and Planets and they forecast for all things associating these Stars and Planets (Knox 1981:277). As Wirz explains, various parts of the body and its organs are subjected to the influence of the nine planets.

[26] The importance of demonic agents like ghosts, spirits, and demons belongs to the inner domain of psychological forces. He says that demons are both subjective and objective realities. Demonomorphic representations of internal states and manipulated by individuals to express these states are subjective realities. On the other hand, they are also living in a specific group in our society and they are objective realities. In the case of ghosts, goblins, and the spirits of the departed, these classes of spirits can be seen in many societies. People believe that they severely influence our lives. Ghosts and spirits also present individualistically and they often attack a single person (Obeyesekere 1981:115).

According to Wirz, these planets influence the physical and mental well- being of mankind and all the capabilities and activities in their public and private life (Wirz 1954:113-115). However, these astrologers prescribe the rituals and pujas to get rid of the effect of these bad planets or constellations. Even though they cost much, family members follow these instructions spending large amounts of money with the intention of healing their family member suffering from the MHPs.

People believe that women are more vulnerable to develop MHPs. People perceive that exorcists gaze at women as a category. This is due to the cultural attitude towards women. There is a culturally very common attitude in the world that women are more impure than men. Sometimes people give this as a reason for the tendency of women to suffer demonic illness (Kapferer 1983:50). Pieris also explains that the girls at the (at their first instance of commencing the age puberty are always accompanied by a female relative) starting of the crisis of their puberty are protected by a female relative. There is a belief that these girls might be subjected to be possessed by evil spirits (*tanikama*) if they are isolated (Pieris 1956:226). As Wijesekera explains, the Buddhists have named the various stages of waxing and vaning of the moon within a month. So, to prevent them being affected by the evil influences of spirits, women are expected to refrain from consuming certain foods and avoid certain locations during particular periods of their lives. (1987:195). It seems that people have different attitudes on the causes for MHPs and most of the attitudes are culture related.

3.3.2. Behavior of the People with Mental Health Problems

There are so many beliefs built around the people with mental health problems and their behaviors. That people with mental health problems are strange and they are unable to understand the realities is a common belief prevailing among the people. People think that people with mental health problems possess an unusual power and they are dangerous. Field points out that the main elements of this stereotype appear to be conceptions of people with mental health problems as incurable, ‘dangerous’, and engaging in extreme forms of bizarre behavior. It may also be felt that people with mental health problems not only act differently but also look different (Field 1976:351).

Chandrashekar has said that people take unnecessary precautions and even ill-treat the people suffering from mental health problems due to the people's fear of them being dangerous. People throw stones and other harmful objects at the people with mental health problems. Sometimes people threaten and drive them away. Tying them with ropes and chains, beating, and locking the people with mental health problems in isolation in rooms are very common in our society as a result of the unnecessary fear of danger by them. But Chandrashekar further says that a small percentage of people with mental health problems can be dangerous only on certain occasions due to certain reasons (1998:35).

People have not only the above beliefs of the behavior of the people with mental health problems, but also think that people with mental health problems do not have modesty, do not feel pain as they are have unusual powers to tolerate pain and other uncomfortable feelings, hunger and thirst do not bother these people and also they often intentionally trouble others on the new-moon and full-moon days. The last belief mentioned above is a very common and popular belief, which is seen in many cultures. The word 'Lunatic' means a mad person. People believe that people with mental health problems cannot be controlled during the full moon days. Due to this misperception, unfortunately, most of the people with mental health problems are more vulnerable to be harassed during this period. But, it has been proved that there are no such behavioral changes of the people with mental health problems in psychiatric hospitals on these days. These people do not need extra medications during these days (Chandrashkar 1998:37-42).

3.3.3. Treatment

Among the Sinhalese patients in Sri Lanka there is a variety of practitioners to choose for seeking treatment. Among them, Ayurvedic[27] physicians, Western physicians, and ritual

[27] Ayurvedic medicine has come from India through Vedas, the earliest Brahmanic sacred verses dating from the second millennium B.C. This medical knowledge is highly respected in Sri Lanka. There is a State Ayurvedic hospital in Colombo and trains Ayurvedic physicians. Now is like Sri Lanka's own indigenous medicine. Ayurvedic medicine is primarily based on homeopathic and herbal treatments-whether these are

practitioners are significant (Amarasingham 2004: 71). Also there are different types of beliefs on the treatment for the people with mental health problems. People believe that healing is depends on only the time and fortune. Most of them practice ritualistic activities as the first treatment for the people with mental health problems with the belief that supernatural forces cause MHPs and they expect some miraculous cure by performing those activities. As Somasundaram, et al have pointed out, in villages, traditionally there are many kinds of help givers, such as Kurukkalas (Priests), Fathers, Moulavies, Siddha, Ayurvedic and native doctors; Astrologers, Shamans, Exorcists, Diviners, oracles (2000:28). In the discussion of the treatments for MHPs in Sri Lankan society, explanations of Kapferer, Brow, Wirz, and Pieris are significant.

Mapother also has explained that relatives of the people with mental health problems often wish to give a trial to magical and superstitious rites as an alternative to institutional treatment during early stages of illnesses in Sri Lanka. Among the alternative treatment, branding on the scalp to get rid of the spirits, applying oils, and the administration of drugs prescribed by Ayurvedic medicine are prominent (1938:6).

As Kapferer has explained, the performance of exorcism is concerned with the individual illness, in both its physical and mental expressions. Exorcists organize appropriate ritual treatment and people believe in the exorcism, counter black magic as a treatment for MHPs. The widespread belief in sorcery among the Sinhalese helps the exorcist to start the diagnostic practice. As Kapferer points out, *'Suniyam'*[28] is the harmful treatment for the people and it is practiced through the *black magic* [29]*(kodivina)*. Any household can

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drinking herbal concoctions and teas, applying herbal poultices, or rubbing various oils on the head or body (Baker 1998:67).

[28] People believed that some powerful evil are affected against their households by jealous people who do not want to see their family prosper. People believe that this can be done by burring an amulet with evil powers in the yard or doing some chanting of black magic over a food etc (Baker 1998:71).

[29] As Wijesekera points out, ancient people in Sri Lanka have used magic as a weapon of offence or defence. This magic is used in two ways to treat a subject and they are white magic and black magic. White magic is used for the beneficial purposes of the individual is called social magic. Bali and Tovil are the two elaborate systems of social magic. Black magic works to harm an individual in particular and it is called anti-social magic. Huniyam is practiced by the people under the black magic. According to this type of magic, people believe that the world is full of spirits, forces, and influences. Propitiation, offering, praise,

call exorcists at any time during the development of an illness. In the process of the ceremonies for demons, there are various ceremonies[30]. As Szasz points out, magician looks like a scientist and it is difficult to gather a religious out look in his method and his behaviour (1973:113). According to Wirz's explanation, in someone's illness, *ēdura* visits the patient and makes his diagnosis. He assumes what has happened to the patient and his or her house. Finally, he recommends the performance of a ceremony. It can be a class of the treatment. If it is a simple case, *ēdura* first recommends the *tēl-matrima* or a *nūl-bandhima.* For a more severe case, first he ties an *epa-nūla* to the patient to prevent the illness progressing. This is done to inform the *yakka* that a more wide-ranging offering ritual can be expected. After *ēdura* comes to visit the patient and he proposes a date for the ceremony (1954:13). As explained by Pieris, if someone afflicted by a planet, a Bali ceremony is performed in our culture (1956:226). However, this method of treatment costs a large amount of money or materials. There is a belief that if they do not perform the properly the prescribed ceremony, the evil spirits repeatedly will make the patient ill (Brow 1996:144). If young females suffering from MHPs, people believe that the most suitable and appropriate treatment is the marriage for them (Kapferer 1983:84-85).

As Gater et al explained, majority of the population live in rural areas in many of the developing countries. But many of the Western psychiatric services have been located in towns and cities. But, traditional healers are more often living and practicing in the villages. Therefore, family members bring their family members with mental health problems first to these healers. Therefore, in developing countries, these traditional and native healers play a significant role in mental health care. Easy accessible, locally available, and providing culturally sensitive care is main reasons for this popularity of the traditional and native healers (Shankar et al 2006: 221-222).

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and threat control the power of the above spirits, forces, and influences. Thus, it is guided by a chosen way to make sure peace, prosperity and happiness (1987:205-207).

[30] 'Pideni' is the small rites and the most complex major ceremony is the 'Yak tovil' (1983:50-53). 'Pideni' is the small rites and the most complex major ceremony is the 'Yak tovil' (Kapferer 1983:50-53).

It is apparent that people are having various beliefs on the treatment for the people with mental health problems and sometimes they cause other problems as well.

3.3.4. Places Where Treatment is Available

Recent studies (Dohrenwend, et al; Gurin, et al; Ramsey and Seipp; Woodward) have been concerned with the help-sources that people suggest using for MHPs, as well as the ones they actually have used. These studies indicate that people have strong negative attitudes toward individuals who use these help-sources. But no considerable evidence to tell that there are negative attitudes toward clergymen or physicians, or towards people consulting these two help-sources. People with emotional problems are more willing to consult clergymen and physicians than psychiatrists (Phillips 1968:215). As Chandrashekar pointed out people in India go to the traditional healers as possession states are considered as a syndrome and not as a psychosis. Few of them are taken to psychiatrists (Littlewood 2002:61).

There are some negative attitudes towards psychiatrists, psychiatric hospitals and other help sources. As Chandrashekar explains, people think that psychiatric hospitals are dangerous places and these patients should be located away from the living places (1998:68-71).

Chandrashekar has showed three main reasons for bringing people with mental health problems to psychiatrists by their family members. One is failing the all-traditional methods. They have said that they have gone to the best exorcist, best temple, best church, but possession is recurring so they have come to the psychiatrists. Atypical presentations are the next reason. In India, he has pointed out that if a person is possessed by an evil spirit, that's atypical. They have come to the psychiatrists because they cannot believe that this as a possession. Getting educated by others is the third reason. They bring their family members with mental health problems to the psychiatrists because they understand that the possession state can be a psychological phenomenon through reading a book or an article or being told by rationalists (Littlewood 2002:61).

It is obvious that people have different types of cultural beliefs in the origin of MHPs, behaviors of the people with mental health problems, treatments for them, and places where treatments are available.

3.3. Introduction on Mental Health Care in Sri Lanka

Health services in Sri Lanka have been organized similar to the British system. Funds come from the central government via the Ministry of Health to these services. Majority of the funds have been allocated to the Western medicine-based hospital and preventive services. About 8% from the total allocation is spent for mental health services. In addition to the system of Western medicine, system of Ayurveda medicine is also practiced by the Ayurveda medical graduates in a few governmental hospitals and many private clinics. There are folk healers and priests who use various charms, magic invocation of divine interaction, exorcism, and anti-witchcraft measures as the treatment methods. Majority of the people with mental health problems also visit these healers (Chandrasena 1979: 119).

With the sorcery of devil dance, the practice of Ayurveda medicine, and the ancient tradition of Buddhism, mental health care was started in Sri Lanka and its history goes back to several centuries. While the idea of 'mental illness' in Sri Lanka has been recognized as early as the mid 1700s, during his reign king Kittsirirajasingha (1747-1782), two kinds of diseases such as of the body and of the mind has been described and this proves that there had been a separate diagnosis for MHPs in ancient time (Carpenter 1988: 2).

A significant place goes to the system of Ayurveda medicine in the mental health care in Sri Lanka. Ayurvedic practices are one of the oldest systems of medicine in Sri Lanka. This system mainly based on the three fundamental concepts of Ayurveda[31] (Uragoda 1987:11-12).

[31] *Tridosha* (three humours), *vāta* (wind), *pitta* (bile), and *sleshma* (phlegm). According to the ayurveda, for a person to be in good health these humours should be in dynamic stability. It means that people are away from diseases (Uragoda 1987:11-12).

The whole field of medical science is divided into eight branches. There is enough literature to prove that MHPs also have been included in Ayurveda system. Third group was called *'kaya-jigisha'* (kaya= body; jigisha= emulation) and this group consisted of not only "the internal ailments, particularly infectious diseases but also those of the mind and the nervous system, insanity. Fourth category (bhuta-viya) included all kind of illnesses caused by influences of gods, planets and constellations, ghosts, demons, evil eye and evil talk. According to other better classifications (five groups) in Ayurveda, it has been mentioned about MHPs. According to another category of diseases in Ayurveda, it has been mentioned about MHPs such as *manasika-roga*, i.e. mental disorders (*manasika*=mind, thinking, reflections) and *Ummada-roga* (*Ummada*= frenzy, madness). The group '*Ummada-roga*' consisted of the disorders caused by demons, unfavourable influence of the planets and constellations, and the activity of an evil magic (*Kodivina*) (Wirz 1954: 2-9). Even in ancient era, there were some diagnosis and treatment for MHPs in Ayurveda and Ayurveda practitioners had a well defined classification including the mental health problems in their system.

As Carpenter, Uragoda and Senevirathna have showed, people maintain their beliefs in the Buddhist practices as form of treatment for MHPs since the ancient period in Sir Lanka. At the time of king Kittsirirajasingha (1747-1782), physicians were appointed to cure bodily illness and Buddhist doctrine was used to cure MHPs. Among the Buddhist practices, one of the most conspicuous is *pirith* and the purpose of performing this is to keep away all the malign influences by the demon or evil spirits. *Pirith* is an act of chanting of three *sutta*[32] (formulae) (Senevirathna 1978: 126, Carpenter 1988: 2-3, Uragoda 1987:10-11). *Pirith* is still an important treatment method which people use for MHPs in Sri Lanka.

There was an economic, political and cultural expansion of the West into Asia, Africa and Latin America since the late fifteenth century. This expansion caused a moving process of fundamental socioeconomic transformation in every field in the above regions,

[32] From the pali canon, the Maha mangala, Rathana, and Karaniya metta (Seneviratna 1978:126).

(Bandarage 1983:1). Changes in the socioeconomic structures as well as some other significant changes (especially during the British period) in the health sector occurred with this colonization process in Sri Lanka.

Portuguese and Dutch period

While the Portuguese were in Sri Lanka during the period of 1505-1656, the Dutch occupation took place during 1656-1796. In both periods nothing special happened to mental health care since their main attention was given to commercial activities in Sri Lanka (Carpenter 1988:1). Uragoda explained the Portuguese did not practice a totally western style; they gained some medical knowledge from the Moors of Spain. Some of their treatment methods were derived from India and Sri Lanka as well (1987: 45-46).

While above treatments were practiced, some miraculous cures and divine cures also could be seen even in Portuguese period. The Church of Our Lady of Miracles of Jaffna was well-known for such miraculous cures not only within Jaffna but also in other parts of the country. The Portuguese had to run with these divine practices because they believed religious rituals were against their evangelistic activities. They did their maximum to discourage these supernatural practices (Uragoda 1987: 49). Kapferer explained the attack on exorcism and other supernatural practices by Sinhalese was ideologically connected with the Sinhala Buddhist reformation and the resistance to colonial rule (1997:18).

Even though Portuguese's main intension was to provide medical care to their soldiers and sailors, their building hospitals was a substantial contribution to the health care in Sri Lanka. Apart from that, there was an institution called 'misericordia' run by the charity services in every leading town to look after the sick and the orphans (Uragoda 1987:50). However there is insufficient information regarding the direct contribution by the Portuguese to develop mental health care in Sri Lanka.

In the Dutch period also, they built hospitals in Colombo and other smaller institutions in Galle, Jaffna, Matara, Trincomalee, Mannar, Batticoloa and Kalpitiya with the purpose of

serving their military forces, shipping personnel and other Dutch nationals in the country (Uragoda 1987: 61). Building the Leprosy Asylum at Hendala was one significant contribution to the Sri Lankan mental health sector in Dutch period. There is a belief that this hospital is the property left by a philanthropic daughter of a Dutch governor. She has left this property to the government's trust to benefit the poor lepers of the colony after her death by leprosy and this was the first hospital built through the personal generosity of a colonial subject. People with mental health problems were admitted to this hospital for the first time and they were called 'lunatics' at this time (Carpenter 1988: 1). It is clear that the Portuguese or the Dutch had not contributed to develop the mental health in Sri Lanka at that time. A very minimum threat to Ayurveda from the Portuguese and the Dutch because of the reasons such as insufficient development in the field of Western medicine at this time, impression of both the Portuguese and the Dutch themselves on the knowledge of herbal medicine possessed by local physicians, no intention to serve the local population, and reigning in their own kingdoms providing royal patronage to Ayurveda by the Sinhala kings (Uragoda 1987:12).

Mental Health Care in the British Colonial Period

The history of modern psychiatry goes back to the Freudian times and modern Psychiatry in Sri Lanka began in the mid 1800s during the British Colonial period. In the early years of Sri Lankan colonization, those with mental health problems were incarcerated in jails with ordinary criminals (Carpenter 1988: 1-2, Gambeera & Williams 2011: 17). With the experience of handling people with mental health problems in their country and other Asian countries, a significant contribution has been done to the mental health care in Sri Lanka by the British. Among their contribution, building institutions/hospitals and introducing the treatment methods are significant.

The first general hospital for the poor civilians was proposed in 1817 and it was named as the Pettah hospital. Later the leprosy hospital at Hendala was maintained exclusively for the leprosy patients on the advice by Charles Farrell, MD, Deputy Inspector of Hospitals (1817) (Carpenter 1988: 1, Uragoda 1987: 86-87). Before opening the Borella asylum it seems that people with mental health problems were given the needed attention.

Wambeek explained it as follows and it gives a clear picture on how people perceived those with mental health problems in that period as well.

> "As a general rule, the new patients who are brought to the Asylum in a very wretched condition, ragged and emaciated, handcuff or tied, are immediately relieved of such restraints and washed and given clean clothes" (Carpenter 1988:9).

The Lunatic Asylum at Borella was first a hospital started in 1847 exclusively with the purpose of housing and caring for the mentally ill in Sri Lanka. Wambeek, Assistant Colonial Surgeon in change of the Borella asylum (1866), shows a considerable death rate[33] at the beginning of the asylum was recorded. Burden with diseases and problem of the land (swampy) of the hospital were the reasons for such high death rate. Therefore, during the early years of the asylum officials had to take a huge effort to prevent diseases and epidemics from spreading (Carpenter 1988: 4). This asylum was built with dormitories and single rooms and the majority of those with mental health problems were kept in the dormitories. Restless people with mental health problems were housed in the single rooms. Wambeek first prepared a programme to make people with mental health problems involved in various activities and the next he introduced recreation therapy because at the beginning of this asylum, people with mental health problems spent their time doing nothing. A fund also has been set up with the profit earned by the inmates doing several activities (Carpenter 1988: 4-8). There were three apparent and significant steps taken by the administrators on behalf of the people with mental health problems in Sri Lanka in the final years of the Borella asylum. Classification of the people with mental health problems in the asylum introduced by C.A. Kriekenbeek (Carpenter 1988: 21), attempting to improve the environment of the asylum by J.L. Vanderstraaten, introducing new skills and ideas by Plaxton were those steps (Ravenscroft et al 1882:135-138). Wambeek's contribution to the mental health care is excellent and he has taken a

[33] There were 9 deaths out of 73 patients treated during four months in 1847. It increased up to 21 deaths out of 99 patients in 1848 (Carpenter 1988: 4).

vast effort to develop the mental health care system in Sri Lanka. Based on Wambeek's dedication and reports written by him, in 1861 several British officials came to visit this asylum and appreciated the improvement of the asylum. W.D Bernard who visited this asylum recommended a permanent carpentry shop and mat making practice for the inmates and also to build verandahs as a place to bring all the people with mental health problems together. Officers had to struggle with the epidemics throughout this asylum period because epidemics came one after the other and death rate was high, the recovery rate[34] was low. The industrial fund introduced by 1907 and developed by Wambeek was earlier controlled by the Medical Superintendent of the asylum. But, later it was taken under the control of the government and it made the asylum's condition worse. With this the asylum gradually came to a close (Carpenter 1988: 29-33).

At the beginning of the Borella asylum, it was very difficult decide the type of treatment for the people with mental health problems. However, the medical officials' insight on the people with mental health problems began to change in this period and they felt that 'Lunacy' was a disease to be treated carefully with special care (Carpenter 1988: 5). Another hospital called 'Cinnamon Garden Hospital' was started in the early part of 1879. While the considerable numbers of people with mental health problems were treated at this hospital by the end of 1885, 322 individuals remained under treatment (Carpenter 1988: 23-26, Report of the Director, for the Year 1886 1887: D 126).

With the purpose of replacing the crowded Cinnamon Gardens Asylum, Mental hospital, Angoda was completed on the 31 of January in 1926 with 1728 beds. Eight years was taken to complete this hospital because of the poor funding support by the government at that time. Six three-story blocks including eighteen large wards were built for this asylum. This asylum was fully occupied in 1927 (Carpenter 1988: 34-35). As usual this hospital had the same familiar problems such as inadequate accommodation, overcrowded wards, lack of trained staff, lack of facilities and lack of funds. As a

[34] According to Spence's comparison of recovery rate in Ceylon with other asylums in countries such as England, Scotland, Jamaica, and Singapore, during the period from 1885 to 1894 the recovery rate in Ceylon asylum was about 17% above that of the asylums in England during the same time. While the death rate was high, the recovery rate was low. Therefore, this period probably was the worst in history of this asylum (Carpenter 1988: 29-33).

solution to the overcrowded wards, a separate ward was built in the asylum at Angoda in 1928 and it was called the 'noisy' block. But it also became crowded within a short time. Even although it was a mistake on the part of the Japanese, unfortunately, Angoda asylum also was damaged in the Second World War in 1942. Seventy people with mental health problems were injured and ten people with mental health problems were killed from this bombing. The most astounding incident of this bombing was that it destroyed the 'noisy' block which was already condemned to be demolished by Mapother in 1937. With this bombing the hospital was overflowing with people with mental health problems, and a small number of people with epilepsy, mental retardation and brain damage (Carpenter 1988: 35, 48). As a solution for the overcrowding, another branch of Angoda hospital was opened at Pelawatte, which was located near Kalutara, and 60 people with mental health problems were transferred in 1944 to this new branch. People with mental health problems in this center could engage themselves in agricultural work. This was a hospital to house people with mental health problems on their way to recovery and it seems that it was considered a rehabilitation center (Wickremesinghe 1949: C 49).

Through Mapother's comprehensive survey on Angoda asylum he identified main challenging areas made some important recommendations to the British government in 1937. This was a significant event in the history of mental health care in Sri Lanka. Among those recommendations were, treatment of the people with mental health problems with criminal issues in separate institutions under the control of the Ministry for Home Affairs, adaptation of Angoda asylum to accommodate the people with long term mental health problems, the creation of a special service of medical officers devoting themselves to psychiatry as a career, the institution for the service of well-trained mental health nurses, recruitment and training of social workers, and recruitment and training of occupational therapists. These were very important to the development of mental health care in our country (Mapother 1938:3, 8-9). He has identified the need of social workers and occupational therapists in his period itself. But, still majority of the nursing staff in the mental health unit are 'floating members' and psychiatric social workers are working in few mental health units (Chandrasena 1979: 119).

In this period also the attitudes on MHPs, people with mental health problems, psychiatric hospitals, and the treatment, were in a pathetic condition. The concepts used in this period were often associated with the notions of incurability, dirtiness, violence, inhumanness, uselessness, congestion, and inadequate treatment. This combination of negative circumstances might have been affected the stagnant state of the progress of mental health care in Sri Lanka. Once Dr Michelle Funk, the World Health Organization's mental health gap action programme co-coordinator explained the reasons for the underdevelopment of the mental health care in Sri Lanka as follows;

> "It is low extremely low for a couple of reasons. Part of the problem is the lack of awareness and knowledge about mental disorders. The lack of knowledge about the extent of the interventions-so that's one reason that explains the low priority given to mental disorders.
>
> Another very important reason and barrier is just what we were talking about in terms of the stigma associated with having mental illness and the misconceptions about the causes and the nature of mental health conditions. So all of the stigma, the beliefs that people are possessed by supernatural forces, that they're believed to be weak, that they are lazy or dangerous- all these prejudices and false beliefs lead to an under investment in mental health services and strategies as well as a number of different health rights violations." (The Guardian June 26 2013).

Although there were multiple problems in the mental health care in the twentieth century as well, some considerable developments in mental health care in Sri Lanka following Mapother's report also happened. For the first time, Sri Lankan doctors went to London for training in psychiatry in 1938. Opening a psychiatric outpatient unit in the General Hospital in Colombo in 1939, starting psychotherapy and follow up services at Colombo General Hospital in 1941 and opening a neuro-psychiatric clinic at Colombo General Hospital were other direct results of Mapother's recommendations (Carpenter 1988: 46).

According to Carpenter's explanation, the custodial care facility was dominant in the hospital at Angoda and there was nothing available in the form of chemotherapy except using sedatives till about 1940. While calm people with mental health problems were encouraged to participate in work and recreational activities, restless people with mental health problems were kept in the noisy block with the utmost restrictions. With the publication of Mapother's report treatment for people with mental health problems took a new turn. While new methods were introduced, widely practicing Insulin Shock Therapy and beginning of Electro Convulsive Therapy (ECT) existed by 1940. An Electrical Treatment Center was opened at Angoda during 1940s and an Electro-encephalograph was acquired in 1948. It is obvious that due to the lack of trained staff and facilities, lack of proper medication and a broken machine without spare parts etc, efforts taken to develop the mental health care in Sri Lanka often failed (1988: 48-49). By this period, a wide range of occupational programmes were conducted in Angoda psychiatric hospital. While the programmes were spread out to farming, cultivating, weaving, and domestic work, the profits gained from the above activities, were invested in developing the recreational activities such as volleyball, cricket, badminton, table tennis and cards (Wickremesinghe 1949:49).

Mental Health Care after the Independence

Many changes in the political, social and economic spheres have taken place in the country since independence from British rule in 1948. The traditional system of roles has eroded with the Western influences. It can be seen there is restratification of the communities into a small westernized elite and traditional village peasant population. Also a movement towards industrialization and urbanization is also one of the major change that occurred due to the western influence and may have a bearing on the mental health of the people (Chandrasena 1979: 119).

However, building mental health hospitals for the caring of people with mental health problems in Sri Lanka began after independence in 1948. Accordingly, Mulleriyawa psychiatric hospital was opened in 1957 as another solution for the continual problem of overcrowding of the people with mental health problems in Sri Lanka. Mulleriyawa

hospital has been built three miles away from Angoda due to the reasons of limited trained staff (Wickremesinghe 1949: C 49).

In Sri Lanka majority of the beds are available in the large hospitals built during the colonial period and remainder are available in the psychiatric units in general hospitals. The advent of the psychotropic medicines in 1950s changed the landscape of psychiatry. Even though Western psychiatry has taken this upper hand in Sri Lanka too, it is necessary to ensure whether this specialty meets needs of the population (Gambeera & Williams 2011: 17).

Even in the 1870s most of the people in Sri Lanka had kept their belief in supernatural influences as the cause as well as the remedy for mental health problems. According to William Gregory (1872-1877) who introduced the dispensary system in Sri Lanka,

> "Most liberal provision has been secured for the European stations and the medical institutions connected with them, but as regards the mass of the population in outlying stations, they are still at the mercy of ignorant quacks and devil dancers" (Uragoda 1987: 94-95).

Psychotherapy began by the psychiatrists with foreign qualifications from England as a new method of treatment for the people with mental health problems in the early 1950s. While a great deal of reorganization occurred in the mental health care, the problem of long term and overcrowding remained as usual in 1950 (Carpenter 1988: 49). With the publication of Mapother's report and the article titled "Angoda, Mental Hospital or Lunatic Asylum?" on 20th June 1954 based on the complaints regarding the ill-treatment faced by a former person with a mental health problem of this hospital, Wickremasinghe Commission[35], and returning of the foreign qualified mental health practitioners from England, mental health care system in Sri Lanka underwent remarkable changes after

[35] (R.H Wickremasinghe who was the head of the this Commission in 1955) (Carpenter 1988:49-52).

1948 (Carpenter 1988: 49-52). By 1957, a substantial changing of attitudes of the public towards MHPs was clearly visible. As Carpenter points out, this perceptional changing has been mentioned in the administrative report in 1957 as follows;

> "A great change has taken place in the attitude of the public in Ceylon towards mental diseases. These diseases have been brought out of the darkness. When mental and emotional problems are now freely discussed the stigma of mental sickness is slowly fading and patients are beginning to go for voluntary treatment" (1988: 52).

The contribution of the 'Voluntary Association for the Care of Psychiatric Patients' started in June 1957 by several philanthropists in the Colombo area with the collaboration of R.M.S. De Silva[36]. It was a very significant turning point in the change in attitudes. They addressed the problems of people with mental health problems, family members, and employers and took a huge effort to re-socialize people with mental health problems (Kahawita 1958: B 56).

With the introduction of new drugs for the MHPs, changes in caring for the people with mental health problems was evident and for that reason, their coming to the mental hospitals increased by 1965. The institutions also started to change with the changing of attitudes of the public towards the MHPs. Some sections at Angoda were modified with an intention to remove the prison look of the hospital. Restless people with mental health problems also were treated in open wards. Clinics were opened at Mulleriyawa, Angoda, and in the general hospital to encourage the outside treatment and care for people with mental health problems (in the community) (Carpenter 1988: 54). Here it can be seen a gradual perceptual change in the treatment and the places where the treatment was available

36 A psychiatric social worker who worked at Angoda.

After the Wickremasinghe committee[37] in 1966, mental health care system in Sri Lanka had a new approach. With the committee recommendations on recruiting and the training of the additional staff, establishment of community mental health system, establishment of the university departments of psychiatry[38] and the promotion of the psychiatric education helped the development of mental health care in Sri Lanka (Carpenter 1988: 56-61).

By 1970s, the community mental health care programmes played an important role. The community clinic began a as a part of an epidemiological research project in the suburban area of Kotte[39] by the university department in the mid 1970s and functioned from 1973 to 1976. After this programme, with the help of World Health Organization (WHO), an effort was made to relocate people with long term mental health problems to their homes in 1986. Through this, it was able to send back some of the patients to their homes and some of them were sent to their homes for extended visits. There were some problems identified in this project like the difficulty of finding the homes of the people with mental health problems due to giving false addresses by the family members at the time of admission, families shifting homes and not notifying the hospital and the hospital not maintaining the contacts with the family members. This project also was stopped mid way due to the lack of funding by WHO (Carpenter 1988:63). People's attitudes were apparent well in this period and they thought that the people with mental health problems were a burden to them and the society. It seemed that most probably the family members admitted those with mental health problems to these hospitals mainly with the purpose of avoiding the hassle of looking after them and not because of the getting proper treatment for them. The families giving false addresses to the hospitals obviously prove it.

[37] (headed by W.G. Wickremasinghe who was the medical superintendent of Angoda hospital)

[38] It was established in Colombo Medical College in 1968, Peradeniya Medical College in 1969 and Jaffna and Galle in 1982), (carpenter 1988: 56-61).

[39] Ancient capital in Sri Lanka situated in Colombo district in western province.

Some non-government organizations too contributed to the mental health care in Sri Lanka in 1980s through their community mental health programmes (Carpenter 1988:63). Main purpose of these programmes was to develop the skills of the people with mental health problems living with the community.

Many of the doctors who went for their overseas training in psychiatry had not returned (Mubbashar & Humayun, 1999) and still the psychiatrist per population ratio remained with a presence of 1:500,000 to 1,000,000. As a solution of this, one year training course on Diploma in Psychiatry was started by the Postgraduate Institute of Medicine with many objections of some mental health professionals to train the Medical Officers in Mental Health (Gambeera & Williams 2011: 18). Currently they are working in the peripheral hospitals and it was another positive opportunity for the people with mental health problems. In 1873, the prevailing mental health legislation in Sri Lanka was prepared (The Mental Health Policy for Sri Lanka 2005:4). This Act dealt with "lunatics and persons of unsound mind", was last amended in 1956 and the 'Mental Diseases (Amendment) Act' was publicized. This Act empowered the medical officers of the psychiatric hospitals in the Island to admit people as 'voluntary patient'. Not only that, this Act also provides for admission of temporary people with mental health problems on application made by relatives or guardians of the people with mental health problems. This procedure has thus been simplified so that the general practitioners and public health officers could refer people with mental health problems for treatment to the psychiatric hospitals (Abeywardena and Karunaratne 1964: 22). Giving approval by the government for the Mental Health Policy drafted by the Sri Lanka College of Psychiatrists is another land mark in the development of mental health care in Sri Lanka (Gambeera & Williams 2011: 18).

As explained by Sartorius et al (2010), introducing behavioral science streams in many medical faculties was another significant factor to reduce the stigma within the profession. These courses focus on the holistic care, imparting, and assessment of knowledge (Gambeera & Williams 2011: 18). According to above information, it is clear that the perception on the people with mental health problems and the treatment have been changing gradually but slowly from the ancient times in our country.

3.4. Social Work in Health Care

Working with the families is the roots of social work. “Social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilizing theories of human behavior and social systems, social work intervenes at the point where people interact with their environments. Principles of human rights and social justice are fundamental to social work. Social work is an interrelated system of values, theory and practice”. (Buchanan 2008:15). Today social work functions as a profession characterized by variety and diversity. It has ranged from working with children and families to different areas such as elderly people, disabled people, members of armed forces, prisoners, school children, ethnic minority groups, poor people, rural urban communities, new human settlements and people with mental health problems (Chitereka 2009:824).

3.4.1. Beginning of Social Work in Western Societies

In the health care field, social work has been developing for more than 100 years. As Hopps and Collins (1995) and Dworkin (1997) showed, professionally this is one of the largest sectors in health care in developed countries. In health sector, social work has been practiced specially in host organizations like hospitals and clinics. Social work has developed in the social climate of the day and the contemporary social welfare scene. As a response to the social milieu of the early twentieth century, professional social work has begun. As traced by many of the historians, beginning of professional social work in health care field to the work of the charity organization societies firstly was found in England and later in the USA. In 1891, Charles Loch of the London charity organization society has proposed to appoint social workers to the hospitals with the purpose of prevention of the abuse of medical charity. Those trained social workers were called as ‘almoners’. According to that, in 1894, the first social worker was seconded to London’s Royal Free Hospital. Later on, USA also volunteers and professional social workers were recruited to the similar situations (Auslander 2001: 202, Johnson and Yanca 2011: 10)

However, the chief of medicine called Dr Richard Cabot in 1905 in Massachusetts General Hospital in Boston established the first formal social work department. Dr Cabot believed that physicians' awareness of the social and environmental influences on their patients' medical condition and treatment is very important and social workers were the proper professionals to gather that kind of information. With the slowly replacement of the family as the pathway of the medical treatment in United States, physicians were able to realize that people's living condition and the personal problems also caused not only for their illnesses but also the recovery. According to that, to fill the first hospital social work position in United States, Dr Cabot appointed one of the nurses called Garnet I. Pelton. She was expected to report to doctors about people's domestic and social information, support patients to perform doctors' instructions, build a link between hospital and community agencies and organizations. Dr Cabot saw that social workers performed this duty well. As Volland (1996) showed these performances directed to the gradual development of social workers' involvement even in out of hospital-based clinics and dispensaries. Ida Cannon with years of nursing experience and knowledge of psychology and sociology in addition to her university training succeeded Mrs Pelton in 1906 and Cannon was very well in medical social work. The official recognition of social work in hospital wards was occurred by 1914 and Cannon was offered the post of 'chief of social services'. While Cannon's social work profession consisted of three essential ideas, they were keeping a central focus on individual person and his or her needs, continuous interpretation of social aspects of illness and good care of the people with illnesses and emphasizing the team of the professions. However, starting from one social worker in 1905 was increased up to 100 hospitals in 1913 (Auslander 2001: 202, Beder 2006:1-3). Not only that, these type of efforts were based on Mary Richmond's and similar thinkers' idea of social diagnostic model[40] of practice too. In this period, sociology was also highly influential on social work practice. Not only sociology, but also psychology and psychiatry influenced social casework stream of social work during the 1920s.

[40] Mary Richmond developed this social diagnostic model as an original framework for assessment of the people with mental health problems and she borrowed this term 'diagnosis' from medical terminology.

In the early 1930s a group of practitioners from different fields identified commonalities of practice; use of social history was one of the major commonalities among them. During this period itself social work related first group work course was introduced in the Western Reserve University attached to the School of Social Work. However, the National Association of Social Workers was formed consisting of seven social work organizations with related to the casework, group work and community organizations in 1955. While significant changes happened in the social work practice during the 1960s, reducing the dominated psychoanalytical thinking, beginning of the new approaches such as crisis intervention, task-centered, and social behavioural etc, developing a system of working with families, increasing the attention to work with families and social workers' clinical participation in the psychiatry and identifying multiple approaches to practice like casework, group work and community organization were very important among those changes. Another major events happened in the social work practice was introduction of social systems theory into social work and commonalities of practice theory and it was introduced as integrative practice which is currently introduced as 'generalist social work practice'. While starting of) BSW programmes (Bachelor of Social Work) in the early 1970s, moving into ecological paradigm in 1986 was also other important milestones in social work field. This ecological paradigm was based on "improving social supports through various forms of environmental helping and on improving personal competencies through teaching life skills". In the above mentioned social work developmental process, Felix Biestek, Helen Harris Perlman, James K. Whittaker, Steven P. Schinke and Lewayne D. Gilchrist are very prominent professionals who contributed to this progress in writing social work related books. By now, the concept of 'best practice' has emerged and a base for the Johnson – Yanca ecological/strengths approach to generalist social work practice also was formed. Following five concepts were developed over time; assessment, person in the environment, relationship, process and intervention. However, social worker's concern and need focus not only the social functioning of the individuals but also the social systems including family, small groups and communities (Auslander 2001: 202, Johnson and Yanca 2011: 10-13).

A continued development of social work in health care was occurred in the later decades of twentieth century. It seemed that social work field was very successful in the Western countries such as United States, more than one quarter of the 477,000 social workers worked by 2002. And also, hospital social worker's approach was 'biopsychsocial approach' which was given balanced and holistic view about the person with a health problem.

However, the development of social work have been affected by economical, political, philosophical and technological changes which were happening from time to time in every country (Auslander 2001: 201, Beder 2006: 4, Nikku 2011). As Aviram (2002) pointed out, "*social workers have been playing a role in the mental health service system since the early days of the profession……. During the early part of the century, psychiatric social workers were mainly involved in after-care of discharged mentally ill patients*". Psychiatric social workers work in the hospitals and involved in many activities of the soldiers affected in both world wars. But, after the World War II, social work in mental health expanded very much (Beder 2006:152). Among the psychiatric social workers' interventions in mental health unit, helping individuals to cope with their problems, therapeutic interventions and education of the people with mental health problems and their family members on medication compliance, taking efforts to reassure the people with mental health problems, developing the discharge plan, using the philosophy of psychiatric rehabilitation, empowerment of the people with mental health problems to manage their psychiatric symptoms, to develop a positive sense of self, and helping them to build on their existing strengths and skills are very important (Beder 2006:158).

3.4.2. Social Work Development in Asia

Without any formal requirements and professional interventions, informal care and welfare systems of communities were together with individuals, families and communities. They solved their issues in a self-reliant and sustainable manner. These systems with a set pattern and with or without mutual expectations and support on an ongoing basis, appeared spontaneously. As Pawar (2000) and Pawar and Cox (2004)

explained, these systems were mostly based on trust, human relationships, self-help group ideology, and an element of selflessness. Essentially, within a community and culture, community informal care and welfare systems emerged (Pawar 2000:439). There are some limitations and gaps though the available literature gave a significant insight of community informal care and welfare systems in Asia due to the following reasons. They are literature mostly developed in western countries, narrowly focusing on some of the areas in these studies, no way explained how we can involve in social work educators and practitioners nationally and internationally to understand and promote the community informal care and welfare system with very limited involvement of professionals, and doing very little international work on community informal care and welfare system in developing countries (Pawar 2000:440).

Within a social welfare paradigm, a professional training in social work was initiated in the 1930s in South Asia Region. Under the foreign influence and patronage, schools of social work in Asia were commenced. This influence specially came from the American social work literature. From that initiation, social work has been developing in South Asia addressing the diversity and complexity in this region. A settlement house called Nagpada Neighbourhood House in a slum area in Bombay, India was founded in 1926 by Dr Clifford Manshardt, an American missionary. But, at the beginning of his work, Dr Manshardt was rejected by the Church because of the religious influences. But later, Church understood that there is very little harm and very likely good for the people. Later he was appointed to a social work post in Bombay. Sir Dorabji Tata Graduate School of Social Work in Bombay established in 1936 was such a foreign transplant. In China also first social work service has been introduced by American social worker called Ida Pruitt in 1921. It was started as medical social work in a hospital social work department in Beijing (Healey 2008: 70). In 1922, with the assistance of Princeton University, social work training was started in a sociology department at Yanjing university in Beijing (Healey 2008b: 64). United Nations Relief and Rehabilitation Administration (UNRRA) programmes established for social work education sent the educational consultants to overwhelmed countries and funded for scholars to study in United States and elsewhere. Through this UN became the largest contributor in spreading social work throughout the

world. Especially they took the responsibility to start the social work in developing countries (Young Husband 1963) (Healey 2008a:80-81). Due to based on this foreign influences, it can be seen a comparative neglect of the study of the history of regional social reform movement and this negligence caused to the lack of development of the curriculum based on the Asian cultural, social, economic and political conditions. But in the countries like Hong Kong and Singapore, his foreign influence was less and social work education was started in 1950. There were social work departments in both universities in Singapore and Hong Kong. It was started the courses leading to a professional participation in social work (Hodge 1980: 68, Nikku 2011).

There are two strands of development of social work and welfare in Asia. On the one hand, people traditionally use their existing networks, resources and responding to the imperatives of the culture and religious observance to solve their problems and fulfill their needs. In the consideration of the histories of the voluntary organizations in all the countries in Asia, it seems that they have a common origin in a motivation of humanitarian feeling towards their neighbours as they were taught by their religions. We can see that first social services were done by the temples and churches and it was thought that it is necessary for their salvation of their souls. Then, schools, hospitals, other institutions established on behalf of the vulnerable groups such as children, aged persons and women started the social services. These organizations were established as there was no enough government facilities to fulfill these people's such needs. In the second strand, we can see the government's involvement in the social welfare activities began with the colonial administrations in many countries including Sri Lanka. Specifically this happened after the end of the Second World War when the British were involved in social welfare activities in their colonial countries.

Professional social work in this region confronts several issues and challenges. They are lack of state recognition and low image of social work profession, the need of the development of integrated social work education and training opportunities, the significance of institutionalizing professional social work practice standards and

employment of social workers in different government service delivery institutions to reach the poorest of the poor.

3.4.3. Social Work Development in Sri Lanka

Under the European colonialization, women's position and kinship relation which was given degree of security was reduced and became problematic. During the 19th century, society was transformed from feudal customs to highly stratified society. Not only that under the British rule, there were changes on gender and it impacted on the marriage, divorce, adoption and rights of the widow as well as human relations were transformed by the state and the economy (Risseeuw 1992:43-44).

In the interventions of social welfare activities began by the colonial governments, the Social Service Department which they established as a new technical department to solve the social and labour policy related issues in their colonial countries was very important. For last 50 years, the welfare sector including the health was improved in Sri Lanka (Hodge 1980:95-97, Chandraratna 2008:64).

Chandraratna (2008) also has mentioned some reasons for low attitudinal aspect with low prestigious on social work profession in Sri Lanka and he believes that this is true with other countries in Asia. Connotation of the word 'worker'[41] an activity of low intellectual application, not having an university degree offering, and not having special category in serving to man attached to the social service ministry as social worker and feeling that welfare activities can be done by graduates are the reasons for not taking social work as an occupational career in Sri Lanka. By now, there are 21 welfare related jobs categories[42] and there are more than 30000 such welfare officers in Sri Lanka (Nikku 2011, Chandraratna 2008:28). Therefore, there was a special need of introducing a social

[41] Generally, people think that the word 'worker' means someone's servant, no any power to take decision alone, always under someone's authority or supervision etc.

[42] For instance: Social service officer, probation and child care service officer, child rights promotion officer, social development officer, officer for women affairs, officer for elderly people, counseling assistant to mental health, early childhood programme officer, officer for youth affairs, etc. Majority work attached to the Divisional Secretariat Office (administrative office based on areas).

work discipline to Sri Lanka. In 1952, the National Institute of Social Development was established in Sri Lanka[43] and this was the first formal attempt in establishing a tradition of social work. Until late 1960s, it cannot be seen any attempt of introducing social work into university education. By now, four universities[44] have introduced social work into the sociology special degree course (Herath 2010: 4, Ranaweera 2011).

In the consideration of the above information, social work in Sri Lanka is still in its infancy and need to take some steps to developed further where there are variety of social problems in society with huge impact to the Sri Lankan family in which social workers can intervene to minimize the bad influence of them on the individual family, community and the society. Among the main challenges which Mapother identified through his comprehensive survey on Angoda asylum, he has given his attention on the recruitment and training of social workers to the mental health hospitals (Mapother 1938:3, 8-9). In the newly drafted mental Health Policy in Sri Lanka, it has given an attention to psychiatric social workers in the training of the allied specialists to develop the mental health care in Sri Lanka. That psychiatric social workers can play a crucial role in the development of mental health has already been accepted by other medical professionals (Who, 2007). Farooq & Minhas (2001) show that majority of the people with mental health problems are in the community with their families. Therefore, there is a need to strengthen the families to care for them with minimum burden (Gambeera & Williams 2011:19).

These all information emphasis that there is huge need of developing social work giving the priority to the Sri Lankan social, economical and cultural setting.

[43] Former School of Social Work. Higher Education Institute attached with the Social Service Ministry.

[44] There are 15 universities in Sri Lanka (2014) and 18 other Higher Education Institutions (2014) (Annual Report, Central Bank 2014:78).

3.5. Family Process

Understanding the concept of 'family' has become very difficult because family patterns have changed drastically. The composition and the organization of families and households have been diverse even throughout the human history.

Forms of the family also vary according to their composition, descent, residence and authority. Based on the composition, sociologists have talked about family of orientation and family of procreation and nuclear and extended family and they are similar to each other in some point. While family of orientation consists of parents and siblings, a unit reestablishing with one's spouse and children is called family of procreation (Zanden 1993:276 & Calhoun et al 1997: 295). "A domestic unit composed of a man and woman in a stable marital relationship, with their dependent children" is a nuclear family and "a unit where more than one generation of husbands and wives cohabit with their offspring" can be defined as an extended family. Social parenthood in extended families is more often a collective affair which we cannot see in the nuclear families (Bilton et al 1987: 253). Patrilineal, matrilineal and bilineal arrangement of families are based on the descent. In patrilineal arrangement, 'a people reckon descent and transmit property through the line of the father'. Descent and inheritance is taken place through mother's side in matrilineal arrangement. Based on the residence, patrilocal, matrilocal and neolocal families have been organized. In patrilocal residence, bride and groom live with husband's or partner's family. But in matrilocal residence, husband or partner goes to live with his groom's family. If the couple resides in an independent place, it is called neo-local residence. Sociologist talk about patriarchal, matriarchal and egalitarian based on the authority. In a patriarchal family father/ husband/partner or adult male takes the authority. The opposite pattern happens in matriarchal family and similar authority prevails in egalitarian family (Zanden 1993:277-278).

Also Baker (1998) introduced that the nuclear family functions as an economic unit in Sri Lanka and she explains as follows how it functions;

> "The forces of economic necessity that govern a nuclear family unit of husband and wife with children are considered more important than any moral indignation suffered. It is easier to carry on with a subsistence way of life when there is division of labour: husband and wife working as a team. This matter of practicality helps hold marriages together and may help smooth over infidelities" (Baker 1998: 87).

Ryan (1958) also emphasized this idea of economic unit in his writings on Sri Lanka (1958: 35). Though majority preferred to have a nuclear family to make easy their subsistence way of life, Baker notices that extended family relatives especially parents stay at their nuclear family or majority of the nuclear families have situated in the same land with extended families especially in villages (Baker 1998: 88). Because of this, the labour exchange between old parents and their married children can be often seen. This is good for the welfare of both parties. There are some changes of family elements in Sri Lanka. Chandratatna argues an extended family system can still be seen in Sri Lanka though all family members do not live together (2008:72-73).

In every human society, there are some forms of marriage. Family and marriage is interrelated. Again defining on marriage also gives some indication of the kind of complexity. There is one of the famous definitions on marriage given by Goodenough (1970) and it is as follows;

> "Marriage is a transaction and resulting contract in which a person (male or female, corporate or individual, in person or by proxy) establishes a continuing claim to the right of sexual access to a woman- the right having priority over rights of sexual access others currently have, or many

> subsequently acquire, in relation to her (except in a similar transaction) until the contract resulting from the transaction is terminated, and in which the woman involved is eligible to bear children" (p 12-13) (Edholm 1993:5).

Generally, a household is typically limited to the husband and wife and their children established in marriage. Ryan explains marriage as follows;

> "Marriage is a sacrament of kin, but the marital household is the principal functioning unit within the kinship web" (Ryan 1958: 35).

Ellawala (1969) mentioned that 'the real family life of an individual begins with his marriage' (1969:73). In the discussion of the marriage also, definitions have to be understood in relation to the kinds of social arrangements. Today, some groups live together, some of them corporate to produce its subsistence, there are other groups they cares for children. But, they are not always consisting of people tied by blood or marriage (Fox & Luxton 1993:21). According to the above information it is clear that it is necessary to talk and look at the family in different point of views.

The patterns of relating, or interactions between family members are called family dynamics. Though there are some common patterns, each family system and its dynamics are unique. Every family has supportive as well as unsupportive family dynamics (Retrieved from www.strongbonds.Jss.org.an/workers/families/dynamics.html). Among the family dynamics, family norms, values, rules, roles, beliefs, rituals, and family communication are very important. Individuals and the system which he belongs cannot be separated. To understand the family, we need the individual and to understand the individual, we need to look at the family dynamics. Therefore, family plays a key role in the emotional and mental health of its members (Wise 2005:30).

3.5.1. Family Functions

The family is considered as very significant social institution as this response to some of the most important individual and collective fundamental human needs. As explained in the critical theories, there may be some unhappy, dark, and dysfunctional side in the families too. R.D Laing and David Cooper have explained the family with a radical psychoanalytical approach (Calhoun et al 1997: 295, Marcus and Ducklin 1998:119-122). According to the above information, it is obvious even though the concept 'family' is varied in its meaning, families are social units which function as a system with interrelated supportive parts which perform functions to help the maintenance, continuation, and integration of the society. Family functions as a locus for organizing the way to fulfill of the many wants and needs of individuals. The ability to manage the tensions and frustrations of unmet wants and needs is the fundamental feature of a well-functioning family. Some families handle this effectively and some families do not. The members of families who do not function effectively are more prone to get negative mental health outcomes. The basic principle of underlying most applications of family problem solving is that improving a family's ability to manage unmet needs and reduce the risk of negative outcomes (Marcus and Ducklin 1998:119-122, Vuchinich 1999:152).

There are very significant social functions which the family fulfills as a universal and major social institution. They are;

- The need for love and emotional security- warmth, loyalty, concern, willingness to sacrifice for the good of others, and unconditional love are offered by the family.
- The need to regulate sexual behavior- in every society has limitations on the sexual behavior with who can have sexual relations with whom and incest taboo is a universal restriction.
- The need to produce new generations- with this producing 'raw recruits' to the society, socialization process of the children also is done by the family through teaching the elements of culture.

- The need to protect the young and the disabled- every human being in the infancy and early childhood is dependent on their parents for food, clothing, shelter and basic care.
- The need to 'place' people in the social order- social structure consists of very complicated web of social roles and statuses and family motivates people to keep them in such statuses and play the roles (Calhoun et al 1997: 295).

People join with the families to meet their above mentioned needs (Constable & Lee 2004).

Instead of identification of the characteristics of a dysfunctional family, recent studies have been focused on the identification of the characteristics of a healthy and happy family. In the real situation, it cannot be seen these types of families in society. But, the purpose of this is to encourage and strengthen the family to move to enhance their family life by using these characteristics. As shown by Stinnett (1985), there are six characteristics of a healthy family;

- Commitment- family is functioning like an organism and all parts are interdependent on each other. It is necessary to work, coordinate, and be supportive of each other by these interdependent parts to build a family.
- Togetherness- a healthy family learns how to control the time and does not allow time to control the family. They arrange family together properly. Not only that, emotional support, the sense of security provided by the family. As Covy (1992) explained, this "security represents a sense of worth, identity, emotional anchorage, self esteem, and personal strength". Individuals' loneliness is reduced by being together with the family. On the other hand, family –time make a good opportunity to observe family dynamics too.
- Appreciation- every human being expects others to admire and appreciate his or her and this is a basic human need.
- Good communication- a sense of belonging, reducing frustration, and enhancing marital relations are created by the good communication. On the other hand, family members should be the good listeners too.

- The division of labour- it can be seen an equal division of labour and decision making in a healthy family.
- Spiritual well-being- Some studies have shown that high religiosity and happiness in the family is interrelated. But, it does not mean that high religiosity is that actively participating in attending church or temple service. It means the spiritual aspect of family life-style. Similar life goals, mission and meaning are provided by the spiritual well-being in a family (Lin 1994: 9-18).

In the consideration of the 'healthy' family, it is not limited to a medical definition and it encompasses a much wider meaning. In this family, individual and the family's needs can be met. Problems can be seen in every family including the healthy family and healthy family can cope with them and adjust well with their daily life. As long as family can meet their needs and mange the stresses through positive mechanisms, even a single parent family is also can be identified as a 'healthy' family (Lin 1994:9-20). When family face the stressful circumstances such as new arrival, a tragic accident, life threatening illness, loss of a job, family members attempt to maintain the equilibrium for peace, stability and survival. The efficient and effective functioning of a family system is based on following three factors;

- Each family must have an awareness of his or her worth and importance to the family.
- The rules of their living together must support each family member's self-worth respectfully in a human manner.
- Each family member must communicate congruently, that is, honestly with himself or herself and with others (Wegscheider 1979: 1).

Though the concept of family vary, marital relations and household compositions are different, relationships are different, it seems that as a social institution which fulfill human needs, family is still significant throughout the world because no such an institution has yet emerged to fulfill needs of the human being.

3.5.2. Family Support in Mental Health Care

Always every family member looks at the family crisis from his or her own vantage point. On the other hand, if the family member thinks or sees that their crisis threatens the family life, person with problem feels anxiety. Not only that, if family members think their crisis brings a big loss to the family, people with problems are more prone to get depression. But, if the family member takes this crisis as a challenge to their family, individual with the problem also may respond it with hope and positive motivation (Wegscheider 1979:34).

If the persons who have mental health problems lose the connections with families before or after the onset of the mental health problem, it causes to create another different problem such as isolation which causes to reflect a fragmentation of personality due to the loss of care identity. While some of the people with mental health problems with persecutory voices or fears go away from homes, working places and so on, there are other persons who seek their palliation through the alcohol which adds another burden. However, losing the contact with family and the community causes to the person adrift (Hollander 1991: 16). In many countries, the responsibility for the care of the people with mental health problems looks like a seesaw between the family and the state. Among the crucial mechanisms of maintaining the persons with mental health problems in the family is recognition, support, encouragement and an exchange of mental health support skills with the families of the people with mental health problems (Hollander 1991: 17).

People with mental health problems are considered as a vulnerable group and those who are living in rural areas are at higher disadvantage because they have limited access to health, lack of resources and traditional cultural beliefs system. It has been found that we can make direct effect on the welfare of the people with mental health problems and their families through social support (Letvak 2002:249-261).

Psychoanalytically trained professionals assume that family influence in serious MHPs was an etiological factor than a key factor in the journey of recovery. Due to this reason, once a special unit was opened at National Institute of Mental Health in Bethesda as

whole family of the people with mental health problems lived there for two years. There were regular meetings to observe their communication pattern in their day to day problems. Family members were encouraged to openly discuss their stress and how to cope with problems (Falloon 2003:20-28).

Most of the time, providing care for the individual is occurred separating from their families. If professionals do not make family participation in the treatment and care of the individual, this process may be a useless opportunity for both individual and the family. Family is responsible for many things of the care of the individuals with mental health problems. But, family often does not know how to tackle their family members with mental health problems. Therefore, there are some growing evidence and opinion that family should be included in the treatment package of the people with mental health problems (Repper and Cooney 1994:433).

In the consideration of the above information, there are different cultural and social beliefs on MHPs, their beaviours, treatment, and the places where there is treatment. In the history of mental health care in colonial period, it has been given considerable attention to the mental health care especially in British period and overcrowding was the main ongoing problem in the care of people with mental health problems in the hospitals. While beliefs are there and social work intervention also was included in the intervention of the care of the people with mental health problems they increased after the World War II. In Asia, social work began with the welfare system of those countries and most probably western social work tradition was influence with the colonization. In the social work intervention with the people with mental health problems, family intervention is very important in the care of the people with mental health problems in almost all the country and social workers have been doing a big contribution in this regard. They intervene in every aspects of the family members' life and try to identify their family, marital, social, economical, psychological, and legal problems, try to build a social network with social institutions to meet these family members' needs and expectations.

Chapter Four

Caring for People with Mental Health Problems: Family Dynamics, Needs, Expectations and Strengths

The findings of this study are presented in this chapter. Before the discussion on the findings, the background of the sample population is explained since people's thinking patterns, beliefs, attitudes, needs and expectations are based on their socio-cultural and educational background. In the later part of this chapter, the family structure and family dynamics, needs and expectations of people with mental health problems and their families, family strengths and spirituality in mental health are discussed in detail.

4.1. Background of the sample

This population in this study consists of eighty- four people with mental health problems representing both research locations. One family member from each family where people with mental health problems lived was interviewed to fill the questionnaire as the first step. Questionnaires were administered by the researcher and did not ask the respondents to fill. In the second phase, fifteen from each category of people with mental health problems, family and mental health staff were selected for in-depth interviews. These categories were selected from National Institute of Mental Health (NIMH) and University Psychological Medicine Unit (UPMU).

4.1.1. Background of the People with Mental Health Problems

Following table gives a picture of the mental health problems of the study sample of people with mental health problem in this study. This categorization has been taken from documents (bed head tickets)[45] of the people with mental health problems. The majority

[45] There is a separate file for every person who takes the treatment from the hospital and it consists of the medical assessment, diagnosis and treatment plan of the person with mental health problem. Apart from that, notes of the nurses, social workers, and occupational therapists are included in this file.

of the people with mental health problems have got medical diagnosis such as schizophrenia[46] (55.95%), bipolar affective disorder[47] with psychotic features (19.04%) and depression[48] (8.33%).

Table 4.1. Nature of the Mental Health Problem (According to the medical diagnosis on the bed head ticket)

Mental health problem	Number	Percentage
Alcohol dependency and delusions of jealousy late onset	1	1.19
Schizophrenia	47	55.95
Psychiatric illness	4	4.76
Schizophrenia with depressive episode	2	2.38
Bipolar affective disorder with psychotic feature	16	19.04
Mania	1	1.19
Depression	7	8.33
OCD	1	1.19
Psychiatric illness and Alcohol dependency	2	2.38
Learning disability and personality changes	1	1.19
Post Partum depression	1	1.19
Not mentioned	1	1.19
Total	84	100.00

Source: Field Data: 2011-2012

[46] A severe MHP characterized by odd beliefs such as delusions and hallucinations with marked changes in behavior.

[47] A MHP created severe mood swings and comes under severe MHPs.

[48] Depression comes under common MHPs (Integrating Poverty and Gender into Health Programmes 2005:6).

In the consideration of the background of the people with mental health problems, while female percentage was 51%, male percentage was 49% from total population. Majority of the people with mental health problems are from the age category respectively between 40-55, 20-26 and 30-39. It is very obvious that all of them are in most influential, capable and significant age categories in their lives. Majority has studied up to grade 9-10 and it was 46% out from the total population. In addition, 20% has studied up to Grade 12, but they have not been able to sit for the Advanced Level examination. Due to the influence of mental health problem which they got at their young age, most of them have been unable to sit for Ordinary Level examination or Advanced Level examination (Field Data, 2011-2012). Specifically, the educational and employment spheres of majority of the people with the medical diagnosis such as schizophrenia in this sample were badly affected because they have got that mental distress at their young age.

Many of the people with mental health problems were Sinhala Buddhist and this percentage was 79%[49]. In the consideration of the relationship of people with mental health problems with their household head, majority are young children (43%), Wives (13%), house hold head (13%) and fathers (9.5%). All of them however were directly involved with family functions. Therefore, this unhealthy situation of the family members in their family, get badly affected not only to the individual but also to the whole family. On the other hand, majority of the sample of the people with mental health problems are never married and it is 45.2%[50]. Married population is 36% and both males and females are in distress due to their mental health problems. Majority of them were in difficulty with taking responsibilities in their roles and incapable of getting married even though they are in marriageable age (Field Data, 2011-2012). According to Dr Michelle Funk,

[49] In Sri Lanka, total population is 20.359,439. Ethnic categories: 74.9% -Sinhala (three fourth of total population), 11.25-Sri Lanka Tamil, 9.3%-Sri Lanka Moors, 4.1%-Indian Tamils, and 0.5%-Other. Religious categories: 70% is Buddhist, 9.7% is Islam, 6.2% is Roman Catholic, 12.6% is Hindu and 1.4% is Other Christian (Census of the Population and Housing, 2011).

[50] Among the males, 15 years and above-30% is never married and this is 22% with females. 68% male is currently married and this figure is similar with female. 2.7% male is married by customary method and this is similar with female. 1% population is divorced or separated and divorce rate is increasing in Sri Lanka (Census of Population and Housing 2011).

WHO's Mental Health Gap Action Programme Co-coordinator, very clearly these individuals' mental health problems are badly impacted not only the individual but also the whole society as well:

> "We are talking about a combined measure of mortality and disability. It means that people are going to die younger or they are going to be suffering from some very disabling consequences of their illness. It means most definitely that productivity is going to be lowered and is going to also lead to higher levels of poverty for those people who are affected. And let me just give you a more concrete example that might happen it terms of someone who develops mental illness: they may not be able to work, for example, because of the illness directly, or because of the significant discrimination associated with having a mental illness.
>
> And then there is also another significant factor and that is that not only are there direct consequences in terms of productivity for the individuals, but they extend then to the family, because people who have a mental illness are often going to have to rely on financial support from family members just to meet the very basic living needs, and also to cover the cost of any treatment that they may require. So there are direct impacts at an individual level, at family level, at the community level which all contribute to lost and reduced productivity for the country as a whole" (The guardian, 26 June 2013).

In the function level also it is very apparent in this sample of the people with mental health problems and majority of the people with mental health problems are not employed (45.2%). On the other hand, 17% are domestic (unpaid) family workers and both categories do not financially contribute to their families. Therefore, this data shows that monthly income of 46.4% from the sample is nothing and this causes financial issues in their families (Field Data, 2011-2012).

4.1.2. Background of the Family Members

Majority of the respondent were female family members because majority of the visitors are female persons. It was 68% from the total sample and among them also, majority were mothers and siblings. In the consideration of the siblings, many siblings were female. Most of the time, unmarried siblings are with their married sisters if unmarried siblings do not have a parental home (*mahagedera*) to stay. Many respondents (family members) were in the age group of 56-65. This is because many of the people with mental health problems were young children (43%). Majority respondents were Buddhists and it was 77% from the total sample (Field Data, 2011-2012).

In the consideration of these family members economical situation, many of them do not have a stable monthly income as they do not have a job. On the other hand, as they are not employed, they are able to visit their family members with mental health problems. But, majority of the family members are not able to come often due to their poor financial situation. Monthly income level of the majority was Rs 7501-10000[51] (Field Data, 2011-2012). If family members were employed as daily paid[52] or temporary labourers, most probably they might have lost their job because of poor attendance. Sometimes, they would not have enough salary to take at the end of the month as most of them request money for bus fare from their working places as a loan to be paid off from their salary. This therefore creates another financial issue in the family and affects the whole family. Generally in Sri Lanka, a very small proportion is engaged in permanent employment and the majority is highly dependent on their families. Thus, many of them require better social protection (Sri Lanka Human Development Report 2012: 8). Following table (Table 4.2) shows the current situation of Labour Force Participation (LFP) in Sri Lanka.

[51] Monthly minimum basic salary of the Primary level unskilled labour in government sector Rs 11730 (€ 78.2), Maximum basic salary is Rs 17600 (€ 117.3). In addition to the basic salary, by now every person who work in government sector, get 5% allowance & 15% from their salary plus Rs 7800 cost of living & Rs 10000 interim allowance monthly (Public Administration Circular No. 06/2006(IV) 2007).

[52] Informal private sector daily wages: Agriculture:Male- around Rs 900 (€6), female- around Rs 700 (€ 4.7), construction field: Male -around Rs 1400 (€9.3) and female involvement is very minimal in this field (Annual Report, Central Bank 2014).

The number of the unemployed persons has decreased in 2014 compared to 2013 in Sri Lanka. Also, the number of the employed persons has increased in 2014 compared to 2013. But, female Labour Force Participation Rate (LFPR) has clearly declined in 2014 compared to 2013. One of the main reasons for the high number of female visitors is this low female LFPR in Sri Lanka. As World Bank statistics show, globally, Sri Lanka reports the 28th largest gender gap in LFP (Annual Report, Central Bank 2014:95).

Table 4.2.Household Population, Labour Force and Labour Force Participation(a)[53]

Item	2013	2014 (b)[54] (Annual)
Household Population'000 persons	16,360	16,532
Labour Force 1000 persons	8,802	8,805
Employed	8,418	8,424
Unemployed	384	381
Labour Force Participation Rate (c)[55]	53.8	53.3
Male	74.9	74.6
Female	35.6	34.8

Source: Annual Report Central Bank 2014:94

[53] (a)Household population aged 15 years and above and data carers all districts

[54] (b) Provincial

[55] (c) Labour Force as a percentage of household population

However, it is understandable that even though majority of them have a long term mental health problem which is a burden to their families, still they are looked after by their own family members. In this chapter and the next chapter, this situation is discussed in more detail.

4.1.3. Background of the Mental Health Staff

Among the medical professionals and other health workers who participated in this study were consultant psychiatrists, social workers, occupational therapists, nursing officers and attendants[56]. While majority of them have been working in these institutions for more than 13 years, some of them have had more than 30 years service in mental health sector. In total at both institutions, majority of the family intervention activities such as family contacts, gathering family information relate to their problems, commence of family meeting, family visits and family education and awareness are done primarily by the social workers. In addition, occupational therapists and doctors also participate in family visits when and where necessary. Occupational therapists talk to the family members when they need more information regarding the functioning level of the people with mental health problems. The main purpose of doctors' talking to family members is to gather information that supports their medical diagnosis of the individuals' mental health problem. Apart from that, they also address family issues and do some awareness regarding their issues. In the process of caring for people with mental health problems, nurses also talk to the family members to gather information with regard to the mental health problem and issues of the people with mental health problems. Every category of the mental health staff has different academic and professional qualifications and trainings which are useful in the helping process of the people with mental health problems. But, it seems that the responsibilities of the majority of professions have been overlapped with each other's responsibility. However, the medical doctors play a major and dominant role in the identification and confirmation of the mental health problems in

[56] The staff who assist the patients in the hospital in their day-to-day activities and nurses in their administrative activities and caring the patients in the hospital.

both institutions. On the other hand, medical model is dominated in the care of people with mental health problems in both institutions.

While medical intervention including medical assessment and the medical management of people with mental health problems (except giving medicine) were supervised by these psychiatrists, the medical assessment was done by these consultant psychiatrists and senior registrars or registrars in psychiatry[57] or medical officer (after this the researcher uses the word 'doctors' for all in this dissertation except in special mentioning) in both institutions. In addition, consultants psychiatrists participate in teaching (psychiatrists in UPMU) and training activities of the medical students and post graduate students (psychiatric training and related) and examination activities in the medical faculties in the universities. Apart from that, they contribute in the healing activities of the people with mental health problems, administration activities, policy making activities, awareness and educational activities in the nongovernmental and public sector. Almost all these psychiatrists in both institutions have overseas training (Western) in psychiatry after their MD (Psychiatry) Examination in Sri Lanka. In Sri Lanka, doctor must have completed one year of internship and another one year of post-internship to be eligible to sit for the selection Examination in MD (Psychiatry). After completion of a minimum of three years practical training as a registrar in psychiatry including general adult psychiatry, child psychiatry, forensic psychiatry, and other specialties such as addiction psychiatry, community and rehabilitation psychiatry, liaison psychiatry, psychotherapy and neurology, doctors are eligible to sit for their MD (Psychiatry) Examination. Their training should be in NIMH, general hospital/UPMH in NHSL, child psychiatry unit, and forensic psychiatry unit. The doctors who pass their MD (Psychiatry) Examination are eligible to receive their MD (Psychiatry) Degree. But they have to continue the two year training as a senior registrar in psychiatry and to submit a research dissertation to receive Board Certification to start their work as a specialist in psychiatry. In their two year training in senior registrar in psychiatry, they can do it as one year training in general

[57] Doctors who did not sit for their Examination in MD (Psychiatry) are named as Registrar in Psychiatry and doctors who got through the Examination in MD (Psychiatry) are named as Senior Registrar in Psychiatry.

adult psychiatry in Sri Lanka and one year training in general adult psychiatry overseas or two years itself in Sri Lanka (Prospectus: Doctor of Medicine (MD) in Psychiatry 2013: 5-10). But, still the majority prefers to do their MD (Psychiatry) training in Western countries (Field Data 2011-2012). On one hand, if they do their training in Sri Lanka, it may be a good thing for the people with mental health problems in Sri Lanka.

Social workers in both institutions also have been doing active participation in the care of people with mental health problems. Mainly they are involved in doing the individual care planning including an identification of family and social problems, needs and strengths of the people with mental health problems and their families. In addition, social workers are involved in the following activities;

- Attending to the 'ward rounds' in hospital and out clinics of the people with mental health problems at NHSL and in the community,
- Case work (working with individuals),
- Group work (family support groups, alcohol and drug dependency group),
- Working with special group of people (people with forensic histories-only in NIMH),
- Community work (promoting social integration of people with mental health problems),
- Counseling and healing activities, awareness and educational activities for people with mental health problems and their families,
- Playing advocacy role in the issues of people with mental health problems,
- Building a road between the people with mental health problems and the social service institutions which are available in the community to meet their needs,
- Home visits and institutional visits for more information and awareness,
- Support in the rehabilitation of the people with mental health problems,

- Preparing psychosocial reports to the institutions and helping people with mental health problems in their legal issues,
- Arrangement of discharge the people with mental health problems, and monitoring their follow up,
- Training the students those who come for psychosocial and counseling training activities from different outside institutions to these institutions (Field Data 2011-2012 & Web site, NIMH).

These social workers are graduates with a special degree in sociology and one of them in the sample has obtained foreign (Nonwestern) diploma but, not directly related in social work. While social workers who have been working in NIMH have been recruited under Ministry of Health and others in UPMU have been recruited by the UPMU in the Faculty of Medicine, University of Colombo as a separate category[58]. Due to the unavailability of degree courses in social work awarded by universities, recruitment criteria of social workers in Sri Lanka has not yet been changed and they have been recruited mainly among the graduates with a special degree in sociology (Field Data: 2011-2012). But, it is happy to tell that by now Department of Sociology in University of Colombo has introduced a social work stream attached to the Special Degree in Sociology with the support and collaboration of the Faculty of Social Work, University of Ljubljana, Slovenia. Already two batches that followed this course have passed out and work in many places in Sri Lanka. But, majority of the graduates and intellectuals think that those who have special degrees in sociology can find a better job than the post of social worker. However, it seemed that in both institutions social workers play a major and important role with people with mental health problems. They have a very close relationship with

[58] Social workers in the UPMU have been recruited as 'Instructor in Social work'. This post is available in the Faculty of Medicine, University of Colombo only at the moment. Many years ago, they have been recruited by the UPMU as 'social worker' and later this name has been changed to 'instructor in social work' due to the connotation issue related with the stigma and discrimination in the society. Majority people perceive that the word 'social worker' means a servant who works often under someone's authority. At the beginning, many of the graduates with a special degree in sociology were not happy to come to this 'social worker' post due to that problem and even intellectuals' attitudes on this post also very condemned and discriminative (Field Data: 2011-2012).

people with mental health problems and in turn they are also not reluctant to reveal their problems to social workers.

Occupational therapists also were a very significant group in these institutions in the care of people with mental health problems and their rehabilitation. They are the professionals who did the functional care plan of people with mental health problems and support to improve their lack of functioning in both institutions. In addition, they also talk to the families when and where necessary as mentioned above. In addition to their support in the rehabilitation of people with mental health problems, they make family members aware of the need to support the family members with mental health problems and to get them involved in household or their usual employments. There are occupational therapy units in both institutions and people with mental health problems with less distress are referred to these occupational therapy units by the doctors from the ward/wards. This is to make them involved in activities to improve their functional level. It is expected that they regain their previous skills lost due to the MHP or to improve new skills helpful to their future function from occupational therapy. Among the occupational therapy activities in both institutions;

- Exercises, reading and listening activities
- Sports to improve psychological well being (carom playing)
- Support to improve the skills needed to meet the future challenges and personality building (how to face an interview)
- Training the people with mental health problems for different type of self employment activities such as coir work (rugs and brooms), carpentry, textile weaving, candle making, making paper bags, production of exercise books, computer and printing
- Kitchen activities/cookery
- Drawing and painting, sewing and needle activities

- Handicrafts trainings such as flower making, jewelry, paper work, producing carpets, clay work, and soft toys

- Agriculture activities

There are separate horticultural centers in both institutions for the day structure and training activities of people with mental health problems (Field Data 2011-2012 & Web site NIMH).

In the history of mental health development in Sri Lanka, it can be seen when the psychiatric hospital at Borella was established, people with mental health problems spent their time idling. But, with the arrival of Wambeek (during the British colonial period) to this hospital, he has attempted for the first time to change this situation. He created an environment for people with mental health problems to spend their time in an active manner indulging in activities with the encouragement of Charsley. This development was a significant step for the welfare of the people with mental health problems and today this is called 'occupational therapy' (Carpenter 1988: 6). Wambeek has expounded his experimental effort in labour for people with mental health problems as follows and it seems that people with mental health problems have been given a certain value through this programme.

> "Such of those as are engaged in the Kitchen garden, the Arrow-root Plantation, keeping the ground and walks in good order, and who are thus necessarily exposed to the sun, are allowed to work only till about 10 o'clock A.M., when they are brought in and are again employed from half past 3 o'clock, to half past 5 o'clock P.M. Of indoor occupations, I may mention the preparation of Coir yarn, Coir matting, Rugs, articles of clothing for the Government Civil Hospitals, preparation of Arrow-root, and Cassava flour, etc. several of the men and women are employed as assistants to the Ward attendants, as also in the Kitchen, etc. There is also a workshop for carpenters. The women are engaged in weeding the grounds of the Asylum, several of them are also employed in pounding

> flour and coffee for the inmates of the Asylum, cutting vegetables, and helping in the Kitchen; and the more industries and intelligent of the women are employed in needle work and making Coir yarn" (Carpenter 1988: 7).

Currently, occupational therapists in both institutions have been recruited under the Ministry of Health and they have two year occupational therapy training in the Training School conducted under the Ministry of Health attached to the NHSL. People with mental health problems are also close to the occupational therapists and share their personal details and experience.

Among the mental health professionals who work as a team a very prominent place goes to nursing officers in both these institutions. In general, people with mental health problems and the family members perceive the nurses as kind hearted and are supportive to them. However, nurses primarily assist the doctors in both institutions and do the administrative activities in the wards. Additionally, they implement the treatment regimes prescribed by the doctors, are concerned about self care and food care and keep the people with mental health problems under their observation and report any changes of their condition to the doctors, discuss with the families and do some awareness activities, as well as participate in home visits and community care treatment. People with mental health problems and their family members often meet the nursing officers to make some clarifications which they should do from doctors without going to meet them. Several reasons such as distance between people with mental health problems and doctors, nature of their availability in the wards, fear of talking to doctors and the background of the people with mental health problems and family members are causes of this. While all nursing officers have a three year nursing training in the government Nursing Schools, there were some nursing officers with special training (psychiatric nursing) in this sample.

Though socially and intellectually, attendants' social status was far inferior in comparison with other medical staff, they were highly influential to the people's lives with mental

health problems because of their closeness with them. Mainly, they concern on physical care of the people with mental health problems and support them in bathing and feeding when and where necessary they need support. Apart from that, they support in the ward management, assist other staff specially nurses and doctors to control the restless people with mental health problems in both places.

During the 1850s and 1860s, attendants were not given training in the majority of asylums and they did not have any career structure. In a few asylums, attendants were given training by the superintendents and the quality of the training was depended on the knowledge and the enthusiasm of them. Generally, in the mid nineteenth century, attendants and nurses were not talented in doing work assigned to them. Majority of the attendants employed in these asylums were the persons who were unable to go to any other job because of the old age, laziness' and alcoholism etc. Mostly, the male attendants were considered as the unemployed Majority of the female attendants who worked in these asylums had worked early as domestic workers (Nolan 1993:47-48). In the beginning of the asylums, they were considered as simply intermediaries between doctors and people with mental health problems. And also, their role in the asylum had not been defined precisely. But, following duties were assigned to them;

- The attendants as rule keeper and enforcer
- The attendants as servants to the people with mental health problems
- The attendants as spiritual guide
- The attendants as intermediary between doctor and person with mental health problem

Since the beginning of the eighteenth century, there were well-managed private mental health institutions[59] owned by the male clergy, and doctors. They were mainly in demand by the wealthy people with mental health problems. Not only those owners wanted to keep them more comfortably and attendants were expected to minister to the people's every need (Nolan 1993: 53-54). In the past, one of the duties of the guard (currently they are called attendants) was to control the communication of person with mental

[59] In the beginning of eighteen century, these institutions were named as 'mad houses'.

health problem to higher staff level (Goffman 1961: 8). Today also this control is done by them, but not in such a rude level; for instance, when people with mental health problems come to disturb the doctors while they are talking to other people with mental health problems, attendants accompany them out. Attendants still do not participate in the mental health group and decision making though they have many experiences. They themselves also think that it is not their responsibility.

In the early period of the NIMH, there were labourers called 'Ralahami' (male) and 'Haminela' (female) and they worked as watchers (Field Data 2011-2012). According to this study, it seems that the educational level of the attendants working in the mental health institutions in Sri Lanka also is not high and their social and intellectual level is also low compared to other medical staff. But, people with mental health problems prefer to keep a close relationship with them and they share even their personal information with them. Therefore, sometimes, attendants were more aware of family information, problems and needs of people with mental health problems than other medical staff.

In the consideration of the above information, it is obvious that the majority of the people with mental health problems in this study sample are with long term mental health problems which impact on the individual as well as the whole family socially, psychologically and economically. Also, majority are in their young age and unemployed and unmarried due the MHP. While many of the people with mental health problems are young children, fathers or mothers, the number of the female visitors is higher than the male visitors. Monthly income of the families where there are people with mental health problems is very low due to the high rate of unemployment of both people with mental health problems and their family members.

In UPMU and NIMH, the caring of the people with mental health problems is performed as a team work and this team primarily consists of psychiatrists, senior registrars, registrars, medical officers, social workers, occupational therapists and nursing officers. In both institutions, the responsibility of the medical care plan and the medical diagnosis goes to the doctors and psychosocial care plan is mainly done by the social workers. Most of the time, social workers take decisions with regard to social care plan of people with

mental health problems. Improvement of the functional level and skills development are considered as the responsibility of the occupational therapists. They also are influential in the occupational therapy activities of the people with mental health problems. Main role of the nursing officers is to caring and of the people with mental health problems and giving them medicine properly. Nurses are more powerful than the attendants and sometimes, they contribute in decision making within the team. Attendants are supporting the people with mental health problems in their physical caring supporting the nursing and medical staff in their administrative and patients' management activities. But, some of the roles are overlapping except the medical care plan and medical diagnosis among doctors, social workers, occupational therapists and nursing staff. However, ultimate decision making with regard to medical diagnosis and medical management of the people with mental health problems and final responsibility of the team goes to the psychiatrist in every team. There are several such teams under the leadership of psychiatrists in both institutions.

4.2. Family Structure and Family Dynamics

Throughout the history of human socialization, family usually formed the basic unit of the society. Therefore, family plays a significant role in the social structure in every country in the world (Ellawala 1969: 73). As human beings, we are born into families, develop, grow and hopefully die in the context of our families. But it was clear that there are different ideas and attitudes on the concept of family according to the information given in the second chapter in this study. Further on, anthropologists such as Collier, Rosaldo, and Yanagisako have argued that 'family is an idea situated in the development of complex societies with distinct private and public spheres' (1993:9). As reactions to the inadequacies of old definitions and surveying the various kinds of family patterns excluded in household definitions, today, majority of the sociologists say that there is no such thing as 'family'. Also, they say that people's experience of family life and types of families have been markedly changed (Fox & Luxton 1993:22). Constable & Lee have defined family structure as "*A network of agreements that, once made, become essential for family operations*" (2004:83). There are different variations of forms of the family as

it was discussed early. Among them, two types of families are important in the discussion of family structure in this study; nuclear family and extended family. In Sinhalese society, family ties are extremely strong and most often members of the extended family live in one household especially in villages. On one hand this was useful for mutual care and assistance. Labour was exchanged among the children and their parents in the farms and caring of the children (Baker 1998: 88).

In considering the nature of the families where people with mental health problems in this study lived, following table shows that the majority (26.19%) lived with both parent families; that means many people with mental health problems live in their nuclear families.

Table 4.3. Nature of Living of People with Mental Health Problems

Nature of the household	**Number**	**Percentage**
Both parents based family	22	26.19
Single parent family	19	22.61
Spouse based families	19	22.61
Sibling based families	15	17.85
Children[60] based families	7	8.33
Close relatives based families	2	2.38
Total	84	100.00

Source: Field Data: 2011-2012

They have their homes which belong to their parents (79%) and attitudes of people with mental health problems were that they are their own homes as both or one parent is still living in these homes. As mentioned earlier, majority of the people with mental health

[60] Married children of people with mental health problems.

problems were unmarried and unemployed. Even though they are adults, they stay with their parents as dependents due to their mental health problem. Normally, whether adult individuals have a disability or long term illness or not, if they are unmarried they live with their parents at parental home though these homes do not belong to them. This is a very common characteristic of the Sri Lankan family. After both parents die, most of the time, siblings of people with mental health problems decide their residence. In the Sri Lankan context, the youngest male sibling is given the parental home. If there are no sons, youngest daughter is given this home. The decision whether a person with mental health goes for long term residence after parents' death is decided by this factor too. In this study, many of people with mental health problems were allowed to live in parental house especially with the consent of parents due to their long term MHP. They have not been given the house by a written due to on one hand the inability to take decision because of the MHP and on the other hand parents believed that any one among the siblings may look after the one with mental health problem due to the property. Some of them stayed with their siblings at parental home. On the other hand, there were some families where there were male siblings who influence their sisters with mental health problems to go out when they get marry.

Single parent family is one of the variations of the family and this type of family can be formed through divorce, separation, death of a spouse or by having children while mother was single (Calhoun 1997: 295). But, in Sri Lankan context single parent family concept is formed through divorce, separation or a death of a spouse than by having children while unmarried. In this study single parent family means families where one of the spouses was dead or separated. And also, another 22.61% are living within spouse based family because 36% of people with mental health problems are married in this sample. This proves that many of the married people with mental health problems live in their nuclear families though they have multiple conflicts. Very little number of people with mental health problems lives with their close relatives and it was 2.38% out of the total sample (Field Data 2011-2012). In 1980s, it has been found that the majority of the people with mental health problems in Sri Lanka lived with their families (Mendis 1986:

132). Further this study emphasizes that the majority of people with mental health problems in Sri Lanka still live with their own family members.

Among the visitors to the hospital, the majority of people are parents (25%) and siblings (16.66%) (see Table 4.3). On the other hand, they are from their nuclear families. Sexual activity, child-bearing, maintenance, and support of children, and socialization are first focused upon this nuclear family and as it was discussed in above, this consisted of a man and a woman in a stable marital relationship, with their dependent children (Bilton, et al 1987:253).

Families are organic units with some shifting compositions such as birth, marriage, divorce, remarriage and death. In the discussion of the family dynamics of the families with people with mental health problems, family rules, roles, routines, rituals, values, beliefs and communication and decision making are very important. First, researcher wants the readers to go through following case studies before she starts the discussion on the nature of the dynamics of the families where people with mental health problems live.

Case Study 4.1. Kanchana

Kanchana is 39 years old married unemployed woman with a mental health problem. She does not have children and lives with her husband of ten years. This was an arranged marriage organized by her father's friend. Her husband is forty-five years old. Kanchana has studied up to O/L. But, her husband cannot write or read. He works as a labourer in a private place and he uses alcohol. Kanchana had an adverse childhood. By birth she was a Buddhist. 20 years back she has changed her religion to Catholicism while she was staying in a boarding house when she worked in a garment factory as a helper for five years. Again she has converted as a Christian at the age of twenty-six. She had been a Christian for three years. But, with her marriage, she again became a Buddhist as her husband is a Buddhist. Her father was a Buddhist and mother was a Catholic. Always there were conflicts between mother and father due to the religious difference. But,

Kanchana does not often go to temple and is not religious from the beginning. But, her husband is religious. He is used to light the coconut oil lamp in front of the Buddha statue inside the house every day in the evening. He expected Kanchana to do it whereas he was not at home or on the days when he gets late to come home. But she was not so enthusiastic to do it every day and her husband was worried on that too.

Kanchana's mother had gone abroad at her age of ten after having a quarrel with her father due to his alcoholism. Kanchana has one younger brother and twin younger sisters. All they are married. With the mother's leaving, Kanchana's aunt (father's younger sister) had looked after Kanchana and her younger siblings until she got married. Her father had employed and away from home. With Kanchana's aunt's marriage, Kanchana and her sisters were boarded in separate places for two years and their brother was with their aunt. After their education was finished, they came home, but brother did not returned home and stayed with aunt. Mother had not returned to Sri Lanka for eighteen years, but father had not got married to another woman and was with children. Father died nine years back from alcoholism and mother has another family with three children. Mother has returned to Sri Lanka in 2010, but Kanchana did not have a good relationship with her. Even though Kanchana had not kept a good relationship with her brother from the separation, she has been keeping a relationship with one of her sisters from childhood.

Kanchana had lived in a rented house for one year with her husband after their marriage. After father's death, she has returned home where she now lives. This house still belongs to her mother. Mother wants to give this house to her son and Kanchana has been given a piece of land by her mother. Kanchana and her husband have started to build a house there, but it has not yet completed. But, younger brother often claims he needs this

house. Kanchana is happy to be in this house as she or her husband is not financially capable to complete their house soon.

From the age of twenty-four, Kanchana has been on treatment for schizophrenia. She has stopped her job in the garment due to her MHP. Her mother and one of the sisters also had suffered from MHPs. This sister has eloped with a man at the age of twenty-three and there is no more connections with Kanchana. Kanchana has gone abroad at the age of twenty-six and returned after two years due the relapse of her MHP. Later, she has never done a job. From her childhood, Kanchana was not active and not having special hobbies. She comes alone for medication and her medical compliant is very poor due to the husband's lack of supervision. She is not happy about husband's poor participation in her hospital visiting and her care. She said her MHP changed her everything; job, family life and social life. She explained her role changing and its impact on her family as follows;

"My husband did not want me to do a job. He is employed and earns Rs. 20000/- per month. He does the shopping and managing money. He always expects me to do household activities and keep the home properly. But, these days I do not feel like doing anything at home. So my husband has been cooking for two weeks. But, he has been very disappointed and angry with me because he has had to cook. Therefore, he often claims that he was trapped by getting married me. He works according to his will and if I talk a lot with regard to something, he even assaults me. My husband often forces me to stay inside the house. He has a fear that I would quarrel with neighbours. When he goes out, he put me into the house and locks the door. My husband often claims that I destroyed not only his business but also his whole life. He often makes me angry. My sister's husband also makes me scared that they will leave me somewhere else if I create problems. We do not have a good sexual life and this is just an empty marriage only. I never had sexual desires and motivation from the

beginning. But, my husband cannot understand it and he assaults me if I reject the relationship. Sometimes, I am disappointed with the whole marriage life. I do not go for weddings or other functions. I participated in one of my sister's and brother's wedding with my husband as I was unable to avoid. Most of the time I eat for hunger and sleep on the mat even in day time".

Kanchana also has the basic needs such as food and logging, garments and sleeping. She mentioned medicine as a basic need which she had early. Her early needs were fulfilled by the father and current needs are fulfilled by the husband and her sister. She does not do shopping and husband does it as he wishes. She is satisfied with their need fulfillment in the hospital. She expects her husband and close relatives to give more support in the house work and to keep her with them for few days. She wants the staff to make her relatives aware of her MHP and treatment and involve in their marital issues. To be cured the MHP and be with husband without conflicts is her only future expectation.

Case Study 4.2. Silva

Mr. Silva is a 64 years old married individual with a mental health problem. He lives with his wife in a house that belongs to his daughter who lives abroad. Silva has studied up to Ordinary Level Examination and stopped schooling due to his mother leaving him when he was fifteen. His mother has left them because of the conflicts with the father based on her gambling with her younger brother. But, she did not marry again and is now dead. The father also died at the age of fifty-five due to a heart attack. There were eleven siblings in Silva's family and he was the third. After the mother's separation, Silva and his younger siblings were looked after by the elder siblings.

Silva has done several jobs including government employment. But, he has from time to time changed jobs because he wanted to earn a lot at once. But, he does not have a pension though he worked in the government sector as he worked only for two years.

Silva has got married to his wife in 1967 after a love affair. He has four grown up children. His wife is sixty-eight years old house-wife and sewing at home as a leisure activity. His eldest son is not married and involved in politics while doing small business. But his other two sons are married and employed and third son is abroad. As mentioned above, daughter is married to a foreigner and lives in Australia. Silva has a good family and financial support as his wife is at home and all the children are employed. He has been suffering from bipolar affective disorder for thirty years according to medical diagnosis. This is the forth admission to the hospital. He was admitted to the hospital this time with the support of the police as he did not listen to anyone in the family at this acute stage.

Silva has used alcohol and cigarettes fifteen years back and he has stopped due to his physical illness such as diabetes. He has wasted a lot of money in the past and now has to ask money from his wife for everything. His children send money to his wife and she manages them. She takes decisions after discussing with the children. But, Silva has done the money management in the past and now he is worried about the changes of his statues with the MHP and reactions from the family members. He explained it as follows;

“In the past, I was the head of our home. I earned money and spent very freely. No wife or children did any influence on my expenditure. But, now, my wife is doing financial management and I have to ask money whenever I need. . But, she does not give extra money as I spend more. She always scolds me if I go out. Now I have to listen to her. I worry about it. I have to wait until my children accompany me for a film”.

Silva said he has everything which he needs. Only thing he needs now is that he wants to go home soon. He expects the doctors to send him home soon. He expects his family members to allow him to be home to do his own business. His only future expectation is to be independent and do meditation and listening to 'bana' (Buddha's preaching).

He was very keen about the staff in his ward too. He said he notices that junior staff of the ward is active while the psychiatrist is in the ward. If not, they do their own business too.

Case Study 4.3. Amila

Thirty-six years old Amila is unmarried, Sinhala Buddhist living with her mother and third elder brother at their own home. She is the youngest in her family with three elder brothers. She is not yet married. Her father has left home four years ago and no one knows where he is. Still family members are searching for him and doing supernatural performances/ magic on behalf of him. Father was 76 years old and a severe alcohol user who worked in a private company many years ago. Amila's mother is 67 year old house wife and brothers are forty, thirty-nine and thirty-eight years old respectively . While the older two brothers are married and living separately, the third brother is unmarried and employed in a private firm.

From childhood, Amila was not good in her studies and she was the last in her class at the school. Amila has studied up to O/L, but she has failed all the subjects. Her work performance at home also was not satisfactory and most of the time she listens to the radio and watches television as a hobby. She has nothing else to do. Their house was built by the father and some of the finishing work is to be completed. Amila is satisfied with the facilities at the house, but worried about the ownership as the younger brother is to be given this house being the youngest male sibling in the family. However, Amila has not yet been to other places after she got her mental

health problem. She has been living in this house as mother is still alive and there is nowhere else to go.

Since 1991, she has been on treatment for schizophrenia. From the age of sixteen, her performance was not well and deteriorating gradually. She has started to do several employments, but was unable to continue due to the symptoms of the MHP such as hearing voices, muttering to self, fearfulness and suspicion with often somatic complaints such as abdominal pain and neck pain. Because of her above symptoms, she has been having arguments with her brother and mother. Amila says "my elder brother always scolds me and criticizes me for slow working, repeating work, inability to prepare delicious curries and muttering to self while working. I am also not happy with them, but what should I do with that. I was fine before the illness and all the problems began after the illness. But, I do not think I have illness actually, only problem I have is hearing voices with obscene words and feeling to talk. He told me to go away when he gets married as I cannot live together with his future wife. This house belongs to him. That is why he always rejects me. I am very worried about my parents not giving this home to me though I am ill. But, there is no other place to go. My mother is also not listening much to me and my demands, nothing happens in our home according to my will. Everything happens to my brother's will. They take every decision on behalf of me. This situation makes me disappointed even to be at home. I feel I am alone. Not even a friend to talk to". The mother always has to keep quiet during Amila's complaint as she is helpless since he is the current bread winner in this family.

Amila had basic as well as some specific needs such as food, drinks, clothes, visiting relatives, going to temple, family support to wash clothes (currently done by mother), money, and a marriage for survival. After father' departure, Amila's mother's sister and her husband visit her and financially support as they do not have children. The mother and brother

also visit her. Amila's main expectation from the mental health professionals was curing the MHP. In addition, she expects them to educate the mother and brother on her MHP, her unhappiness on HEE of them. She mainly expects from the family not to blame her and criticizes her.

Case Study 4.4. Surani

Since 2009, Surani has been taking medicine for her medical diagnosis, schizophrenia. She is 18 year old. She has only studied up to Ordinary Level Examination. But, she has not gone to see her results even because of her MHP. She is the eldest child in a family with three children living with parents and grandmother. Surani has not yet decided to get married and she said she has time to think about it.

Surani's both parents are labourers with enormous financial issues. Therefore, she did not have high future expectations after her studies. Her only expectation was to do a job soon and minimize financial burden in their family. But, her MHP destroyed her hopes. She is worried about her father's alcoholism which makes their problems worse. Also, she is disappointed with his lack of understanding on her MHP and the treatment. She came out with her disappointment like this;

"Our father blames me when I cry. He says that neighbours also hear my crying. So, he sometimes, threatens me that he would hit me if I cry. But, father comes in the night after consuming alcohol and scolds us. Sometimes, he uses obscene words which neighbours may hear too. But, we do not criticize or blame him as he gets angry.

He says that I do not have any 'illness' and therefore, he tells me not to take medicine. He does not have any understanding of my 'illness'. Sometimes, I feel that he does not love me. He says that I by myself made ill. When he claims that I also feel that neighbours who run a 'devala'

(shrine) with soothsaying practice have done some 'kodivina' (malevolent act) on me".

Surani has started a job as helper in a garment factory at the beginning of her MHP. While she was on medication itself, she went to this employment due to the burning financial problems in the family. But, she was able to go to that job only one day and stopped due to the refusal by the officers due to her MHP. She explained the stigma and discrimination which she met in the family, work place and the society as follows;

"I went to my first job only one day. When I went there I was wearing a thread around my neck. The officers noticed it as well as my stammering due to lack of talking and shivering hands due to medication. They observed me as abnormal one from other workers. They asked why I was wearing a thread and I said nothing special. But they said you may be having a 'mental illness' because you are different from others. Unfortunately, they said I may fall into machines and they cannot be responsible for me and refused my coming to work there. I felt shame and stopped going there. From that day I did not go to any job and I am having a fear with shame everyone notices my inappropriate behavior. But, being at home was also a headache for me. Everyone in the village asked why I was not going to work and my mother was sent to work because she suffered a lot in her laboring job under the hot sun. So, again I thought I should go to work after two years of my medication. Doctors said that I have to continue medicine regularly for two years and then I would be able to come to normal life. But, after one and half years, I started to hear voices. I came to my aunt's house because I wanted to avoid villagers' different talks and rumors. Many of the close relatives supported us at the beginning. Later they themselves spread gossips among other relatives and villagers that I am mad. Again I came home. But, my brothers also blame me when I am crying because often I feel worry about my life. They laugh at me showing my medicine cards that I have been given good character

certificate by the doctors. My brothers criticize my walking style and my way of looking and often say that I continue the 'paule lede' (family illness) (there are several relatives with mental health problems in her paternal side). My grandmother is not happy with their criticizing me".
Surani's performances in house work and leisure activities could be fairly ok before her MHP. But, her performances were gradually deteriorating and she came out with her deterioration like this;

"Before I was ill, I played carom with brothers, listened to song, watched television. I kept cooking when my mother comes home. By now, I do not feel to do anything. Though I just feel to go to visit friends, my mother does not allow me go there alone".

Surani also wishes to do a job and she knows that her MHP further increased financial problems in their family. She further has hopes to spend a good life with enough money for the needs, such as food, house, medicine, clothes, and brothers' education. They did not have their own house and the house where they live belongs to her grandmother. Surani or her family does not know whether she will give it to them or not because there are other children of this grandmother and they are younger to her father.

Surani has some future expectation on her marriage life, but she said she has time to think about it and sometimes she feels that no one will be happy to get her married due to MHP.

She expects to make her family aware of her illness as many of them do not have enough understanding on that except mother and aunt who comes with her to the hospital though there were many relatives with this MHP. Surani wants to know about her illness and symptoms of it because she has not yet been made aware on that.

Case Study 4.5. Parameshwari

Parameshwari is a 39 years old married lady with four children. Her 20 years old daughter is having a MHP.

Parameshwari and her children live with her husband's relatives in husband's ancestral house. She works as a domestic servant in several houses. But she does not get work daily and sometimes only for few hours with low payments. Parameshwari's two sons (16 and 14 years old) are schooling and younger daughter (5yrs old) daughter is going to a nursery. Her Elder daughter is still on treatment for her mental health problem.

Parameshwari's husband (44years old) is addicted to heroin and alcohol and does not contribute anything for the family. He has been frequently stealing household items, including schoolbags, clothes of the children, gas cooker etc which causes severe distress to the family. He abuses the children and his wife physically and psychologically leading to lot of emotional problems in the family members. It can be believed that his problematic behaviour was one of the precipitating factors for his elder daughter's mental health problem.

The house where this family lives consists of four rooms, one kitchen, and a visiting room where more than four families reside including more than twenty family members (including children). The situation was made worse recently due to the problems created by the other in- laws of the house. They do not have any other place to go and live to get rid of this complicated and problematic environment.

While this situation was going on the elder daughter found an unskilled job in a religious place for a low salary due to the social worker's encouragements and supports. But, she lost her job after few months due to father's problematic behaviour (in front of the working place, father

scolded her using obscene words forcing to give her salary). Now she is again unemployed. Under these circumstances, their financial situation has gone down further and most of the days, they are in hunger.

In addition, Parameshwari's younger son developed emotional and behavioural problems (with school refusals, leaving home, threats of committing suicide) secondary to the above mentioned problems. There is also a high risk of relapse of the elder daughter's mental health problem under this traumatized environment.

It is Important to mention that despite of all these problems this mother courageously supports the children working actively and the elder son continues his education with satisfactory grades.

According to the social worker's observations and care plan, this mother was very keen on children and their education. She was a courageous lady who can continue her life with children if she has a good social and financial support.

Mental health team has attempted to support to rehabilitate this father with the help of the Police, National Dangerous Drug Control Board, and National Child Protection Authority. He was admitted to the hospital several times to help him to stop drugs and alcohol, but he escaped every time after few days of the admission. All the attempts taken to support his rehabilitation were failed.

Considering social and mental well being of the this family, the behavioural changes of the children and the risk to the elder daughter's mental health, mental health team finally came to the conclusion that the best solution for this family was to leave this house with difficult environment as soon as possible and live in a separate place (specially for the best interest of the children). But, they are unable to do it alone because of their very poor financial situation.

Case Study 4.6. Kasun

Twenty-eight years old Kasun is on medication for medical diagnosis, schizophrenia for 8 years. He is unemployed these days and he has not yet married. He lives with his mother and 16 year old younger brother in their own house. His education was up to Ordinary Level Examination. He has done several employments before and after the MHP. He had been unemployed for four years due to the difficulty in coping with the symptoms of his MHP. After he joined the rehabilitation programme conducted by the UPMU, again he has started to try to find an employment. He found some jobs, went for two three weeks and stopped due to lack of motivation and criticism on his slowness. His younger brother and mother often criticize his unemployment, not regular attending the job, and the dependency on mother.

He emotionally came out with his family members' reaction towards his as follows;

"In our house my mother decides everything. Sometimes she discusses important things with my younger brother and sometimes even with a relative. I am angry and worried about that. Even though I am the elder brother in our family where there is no trace of my father, no one cares for me. Sometimes mother claims that no use from me though I am a male at home".

Case Study 4.7. Thilaka

Thilaka is a fifty-three years old mother of a young woman with a mental health problem. Thilaka works as a labourer and her husband is also fifty-five years old. He is a daily paid labourer. Both are bread winners in their

home. They have three children including their daughter with mental health problem and all are dependants. While younger son is schooling, elder son is at home after sitting for the Ordinary Level Examination. In addition, Thilaka's eighty-five year old mother has been living with them and she is completely blind and needs someone's support to fulfill her day-to-day needs. Thilaka and her husband do not have stable income and the husband's heavy alcohol addiction makes the economical situation in their family further worse.

Since 2009, Thilaka's daughter has been on medication for her mental health problem and while she was in the hospital, most of the time Thilaka was the bystander. Therefore, she was unable to continue her job and she had to get a loan from her working place for bus fare and other expenses. In addition, she was supported by her and her husband's extended family members (brothers and sisters). But, Thilaka says she cannot ask money from them for every need and she has to accept whatever they give because they are also not so rich. She is satisfied with their relatives' current support because she was unable to manage financially without their support. Thilaka explains their family dynamics and attitudes of their family members as follows;

"In our home, shopping is done by my husband and cooking is done by me. If I am ill, my husband cooks. Sometimes, if he does not have work, he helps my daughter with cleaning. On Saturdays and Sundays, the sons are doing the cleaning. But, they are not so happy with that as my daughter does not involve much in household activities. But, my husband never comes to the hospital with my daughter to take medicine or he does not give money even. He says he cannot do dual duty at home; earning and doing shopping and accompanying children for medication. So I go to work and earn some amount of money and go to hospital with daughter. But, I am worried about my sons as loku putha (elder son) also has to cook as I am in the hospital and podi putha (younger son) is unhappy to be at

home without me. He does not talk about his needs with his thaththa (father). Without a mother, boys cannot cook properly".

They are not respecting each other as husband and wife and they have frequent conflicts. They are not used to having their meals together. At different times the family members have their meals. No communication amongst them when they have family issues and children often depended on the mother. Whatever they need, they request them from the mother and not from the father.

Thilaka on one hand believes that her daughter might get this MHP due to one of the young boys' proposal for her and she believes that the daughter got the MHP which her father's siblings have. Daughter's one of the aunts (father's sister) is having a MHP, but she is married and having children. Her two children are also having MHPs and aunt's husband and mother in law do house work in that family as aunt does not do anything at home. There is another unmarried aunt with mental health problem and currently she is looked after by her younger brothers and their children. Therefore, Thilaka sometimes has pessimistic thoughts on the recovery of her daughter's mental health problem. She has gone to an astrologer at the beginning of her daughter's mental health problem. He also has proved that she has their 'family illness' (paule lede). Therefore, Thilaka do not have any hesitation to continue the Western medicine as the astrologer also told the truth.

While Thilaka has many needs such as food and drinking, money to give alms giving ceremony and the temple, money for mother's caring and daughter's caring and medicine and children's education are prominent among them. Her main future expectation for her daughter is to be cured soon and send her back to a job to earn money to make lessen their economical difficulties. Thilaka's previous expectation on her daughter was to put her to a job and earn money to make her jewelries for future.

Thilaka is satisfied with the current support given by the mental health staff. She believes that family involvement and family support is very significant for the families with people with mental health problems as they have different needs and problems in addition to the MHP. Thilaka says they have trapped in a chain of problems and she needs to minimize them to some extent to come out from her daughter's mental health problem.

4.2.1. Family Roles and Family Rules

In the discussion of the family roles such as mother, father, son, daughter, sister, brother, aunt, uncle, grandmother, and grandfather, they tell us both gender and generational location of family members. On the other hand, gender indicates what we expect from each other, our statues and power in the family. The influence of gender on family life can be understood in different level such as personal, relational, and societal levels. How we should feel and behave in the family, how we should look, and what we want and value are the personal level gender based expectations. Organizing the social process of everyday life mainly our family or intimate relationships are the relational level gender activities. As an example, in most families with heterosexual couples, while men are considered as the main bread winner, even though women are employed, they are expected to do most of the household activities and caring of the children (Haddock et al 2003: 304-305). In this study also gender based roles are very prominent.

In this study, majority think that caring of a family member with a health problem is significant and essential responsibility of their family. Very significant factor was majority of the caregivers are female. Among the parents and siblings also, many of them are female. This gives us a picture that in the caring of people with mental health problems in Sri Lanka, female family members play a key role. On the other hand, their unemployment is also one reason for this. Not only that, it can be seen that after marriage of the adult female siblings also, they are more concerned about their young, unmarried and disable siblings' welfare. But, there are very few families where there are family members with mental health problems who is looked after by male family members

where there are no female family members in the family to look after their members. Sometimes, there are female family members, who are not ready to take care of their close family members as there are unmarried male siblings at home or property issue. Guberman et al have identified fourteen factors from an analysis of informants' responses for why females were primary care givers. Love, guilt and duty, women's social identity built around caring, absence of appropriate public or private care alternatives, and women's socio economic dependency are more prominent among them. In addition, sexual division of labour, its reinforcement through social policy and how women internalize ideas and norms regarding appropriate gender-role behavior are also to be considered in the women's caring (1992: 607).

However, in Sri Lanka, the main reason for high number of female care givers is very low female Labour Force Participation Rate (LFPR) (35%) and high male LFPR (75%) (see above Table 4.2). According to the World Bank statistics, globally, Sri Lanka reports the 28th largest gender gap in LFPR. There are about 65% of inactive female in Sri Lanka. Majority of female has taken up the household responsibilities in their homes (see Table 4.4).

Table 4.4. Reasons for Being Economically Inactive by Gender (2011-2013)

Reason	Total			Male			Female		
	2011	**2012**	**2013**	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
Engaged in house work	39.3	41.6	48.0	4.4	4.8	5.9	54.7	57.1	62.1
Engaged in studies	35.9	35.3	20.5	57.7	59.2	37.5	26.4	25.2	14.7
Retired/old age	16.4	15.5	20.7	23.5	23.0	34.8	13.2	12.4	15.9
Physical illness/disabled	5.1	4.5	6.1	9.1	8.2	12.9	3.4	3.0	3.8
Other	3.3	3.1	4.7	5.3	4.8	8.5	2.4	2.3	3.4
All	100	100	100	100	100	100	100	100	100

Source: Annual Report, Central Bank 2014:96

With the social transition of the families being nuclear, the trend of the females leaving employment to take up household responsibilities has been increasing for the last few years in Sri Lanka[61]. In the extended family background, there were several family members who can take the responsibilities in their home and they were not employed outside the family. Therefore, these family members shared their household activities among several adults. Especially, there was a higher mutual support from the elderly people in extended families (Annual Report, Central Bank 2014:94-96). In this study also, females did many of the household activities and majority of males expected them to do home activities. If a male has to do, majority of them were not happy. But, there were some of the male who supported in the household activities while mother or wife was not well or not at home. In Thilaka's family, when she is not at home, her husband or son cooks though she does mainly cooking in her home. But, some of the females perceived that they are expert in household responsibilities than the male in their home. Thilaka is worried about her son's involvement in cooking while she is in the hospital with her daughter. She believes male children are not able to play female children's role especially such as cooking.

In the ancient society in Sri Lanka also, women were expected to do household work and men were expected to supply household things and other amenities. As Stirrat explains father- husband dominated and authoritative in the family in Sri Lanka. Following extract explores it well;

> "The male particularly the father-husband is associated with dominance and authority in the family, and the wife with subservience and submissiveness. Division of labour is consonant with these ideally patterns. Women are

[61] There several key reasons for female's choosing to leave Labour Force Participation: Involvement in household responsibilities particularly in childcare, unavailability of safe accommodation and transportation facilities to and from work, difficulties in adhering to work time slots and inability to find employment after a break. In addition, the social norm in the country that women are to take up household responsibilities and men are engaged in earning also influences this (Annual Report, Central Bank 2014:96).

> considered physically and mentally weak (though actual facts belie these prejudices), and are supposed to engage in domestic activity, cook, draw water, bring firewood, look after the welfare of the children and husband, while the husband-father is the provider, one who supplies the household with food, and other amenities by his superior physical and mental abilities (Obeysekere 1963) (Stirrat 1988:89).

But, there were many women who took the responsibility of earning and caring the family in this study. Thilaka and Parameshwari are good examples of this. Parameshwari cared for the whole family. Neither her husband nor her children support her. Her husband spends everything what he earns for his alcohol and drugs (heroin). Parameshwari had fed the husband even. Only thing her husband did was creation of problems in the family.

In the Sri Lankan history, it has been mentioned that women even in high class families have been given a special training in cookery apart from religious and general education because this was considered as an essential attainment of a woman. It has been mentioned in the history, one of the chief minister's (Kakavanna Tissa of Rohana) daughters has been given a special training of cookery (Supasattha)[62] including both theoretical and practical knowledge. Not only that, they have been trained in entire household management (Ellawala 1969: 88). From the socialization process of children in Sri Lanka, female children are given an image that among their household responsibilities, cooking is a major role in their families whatever employment they do.

In the Sri Lankan society the father has a wide power over his family members in the family as the head of the family. After the advent of Mahinda[63], Buddhist household in

[62] Rasavahini, II, P45.

[63] There was a Golden Aged of Buddhism in India under the Emperor Asoka and they launched a programme to spread the Buddhism in countries outside India. As a result of this programme, Mahinda Thera, son of Emperor Asoka and other nine delegations arrived in 236 B.C. in Sri Lanka for the

Sri Lanka was regulated according to the code of social ethics laid down by the Buddha. According to a *sutta* called *Singalovada*, it can be found how to treat the children by a father in a family;

> "Restraining them from vice, exhorting them to virtue, training them to profession, contracting suitable marriages for them and in due time handing over their inheritance" (Ellawala 1969: 89-90).

But, there are some examples from the Sri Lankan history to prove that fathers have used their power on children in bad way too. Sometimes, they did not hesitate to sell, mortgage, discard or even kill their children. Some of the fathers have put their children into insecure or dangerous positions too. Kakavanna Thissa, one of the chief ministers has abandoned his beautiful daughter on the highway on behalf of his life (Ellawala 1969:90).[64] In this study also, researcher was able to find some fathers who did not support in their children's welfare. In Surani's case study, her father did not have any idea or attempt to find out how he can support her life or to make her life sensible. When he criticized her or scolded on her, she often felt that he did not love her. Therefore, she did not want to respect him. He refused to accompany Surani to the hospital and he claimed that it is not his responsibility. Parameshwari's husband also did not consider anything which he could do on behalf his children and their mental health. Instead, he creates many issues in their lives. There were some husband in this study; they used their power and authority on their wives to harass them physically and emotionally. Not only that, they sexually influenced their wives. Kanchan's husband assaulted her in her expression of the lack of sexual desires. She had a marriage life with no sexual desires. But, husband did not listen to her in this regard. This information tells us that on one way

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establishment of Buddhism in Sri Lanka on Full Moon Poson Poyaday (during the crowned king's Devanampiyatissa's kingdom). The Buddhism introduced by Mahinda Thera has been stll lasting in Sri Lanka for over 2500 years.

[64] Rasavahini, II, p.46

family support in their family members' welfare, on the other way family creates issues because of the ignorance of each other's role well.

Normally, majority of the families where there are no fathers, if there are adult males, they take the power including decision making and the responsibility. In Amila's family also this situation has gradually developed with the father's absence. After Amila's father went missing the power of the brother seems to have increased. Though her brother criticizes her, blames her, he visits her and support whenever he can. He also may be in distress which he has not discussed or cannot discuss with any one because the entire burden of the family is on his shoulder. He may be worry about the father's missing, other two brothers' away from home and negligence on the family and his suffering on his delay to get marry. In addition, Amila is in a very inferior position as a woman and as a family member with a mental health diagnosis in this family. She has no any voice at home. Amila is completely dependent on good will of her brother. She has a lack of knowledge and superstition on her mental health problem. Her family members have a lack of understanding on her mental health problem they do not tolerate her symptoms which make her bit slow. No one believes in her that she can gain something which would make sense to her life. Family members do not have any idea how to involve her in a way that she can be helpful to others. That is why they need extra professional support system to address their burden which they are reluctant to communicate with their close relatives or friends.

Due to the mental health problems, not only majority of the individuals' but also family care givers' roles have been neglected completely or partially. Sometimes their roles change. Most of the time, this happens with the knowledge or without the knowledge of family member with mental health problem. Sometimes, they want to involve in the household activities. But due to their psychological and functional deterioration and not having an invitation from the family members they do not have a motivation to do. But, in the families where mothers are employed, they had to play the dual role at home. In the researcher's observations while she was visiting houses of the people with mental health problems, she observed that majority of the family members were not involving their

family members with mental health problems in their household activities. One of the significant factors in this study is some of the male were not happy with losing their once dominant roles which they played before they get MHP by their wives or other family members. In the case study of Silva, this explores. Silva was the dominant character in his family before he got his mental health problem especially in money management. Later, his wife took it into her dominance. With this role change, Silva was very disappointed. Also, he went anywhere he wanted, did what he wanted, enjoyed in watching films according to his will in the past. But, with his mental health problem, how his family members controlled him, he had to wait go for a film until children came. But, he wanted the freedom to move here and there. That is human nature thought they have a MHP or not. But, his family did not understand it.

Family is a holding place and it provides comfort, nurturance, and a secure base for the development of individual's autonomy. Some families unexpectedly met changes such as a sudden death of a family member, diagnosis of a long term health problem and these unanticipated situations are the challenges not only to the individual but also the whole family system (Fiese 2006: 3-5). Kanchana's and Silva's case studies emphasize this very well in this study. They had to meet many unpleasant experiences in their child-hood because of their mother's sudden separation from their families. Silva had to stop his schooling on the way. Kanchana also had to leave the house and stay at a boarding house for her education. Later, she had to take some responsibilities of her mother's role whereas her mother's unavailability in their family.

Some of the family members considered family rules are important in their families. Family creates rules as stability force for behavior in the family. These rules tell the family members what are the acceptable behavior in the group. In this study also it is clear still family rules are considered as an essential family dynamics. Though their family members suffer from mental health problems, other family members expect them to behave according to their accepted rules. These rules and gender are interrelated. Female family members are expected to live calm and quietly. Father or husband does not want his daughter or wife to talk even loudly and make quarrel with neighbours. They feel that this is not pleasant for females. In this discussion it is important to identify the

differentiation between terms sex and gender. While sex refers to 'the binary categories of male and female', gender refers to 'the psychosocial implications of being male or female' (Archer & LIoyed, 2002; Caplan & Caplan, 2009; Korabik, 1999). Traditional beliefs are significant in this gender role division because these consist of what role behaviors are appropriate for male and female (Deaux & Lafrance, 1998). Accordingly, women's proper place has been decided as in the home and men's in the workplace. Also, gender stereotypes consisted of traditional beliefs. They have shown the characteristics of each gender (Kite, Deaux, & Haines, 2008) and what behaviuros we expect from both gender separately. While women are expected to show 'femine' traits such as nurturance, compassion, and sensitivity to the needs of others, men are expected to exhibit 'masculine' traits such as aggressiveness, independence and decisiveness (Powell & Greenhans 2010: 1011-1039). In Kanchana's case study, her husband wanted to keep her inside the house and not to come out or talk loudly. If she talks loudly, he assaults her without considering even her mental health problem. Kanchana did not have right to expressed her emotions, ideas at home or talk with people. How he controlled his wife is he has kept her inside the house when he went to his job. In Surani's case study also it has emphasized well. Surani's father did not want her to cry though she had distressful feeling in her mind. But, her father's behavior was a problem not only his family members but also neighbours. Her brothers also criticize her crying and no one of them is ready to listen to her and ask why. Social workers' intervention in this regard is very useful because they take part in the fundamental work with the family and use the system theory with family to address their needs (Corcoran 2012: 161). In this system approach, they can go into sub systems within the main system of family. They can meet the members in these subsystems, address their attitudes, beliefs, and make them aware together and come to some concrete decisions with regard to support.

4.2.2. Family Routines and Rituals

Family rituals are also very significant and they provide a good opportunity for us to observe and understand family dynamics. When family meets sudden and unexpected changes, they think about the reconsideration of their rituals. Families use these rituals to reduce their psychological distress created from these unexpected changes in the family.

Rituals show us this is 'who we are as a group' and provides the feeling of belonging. Rituals are related with their cultural and traditional beliefs. Family routines are always related with the instrumental communication and it conveys us what needs to be done. And also routines can be directly observed by the outsiders. When routines are disrupted, it create a hassle, disruption of the rituals threatens the cohesion of the family (Fiese 2006: 5-10).

Table 4.5. Definitions of Routines and Rituals

Characteristic	**Routines of Daily Living**	**Rituals of Family Life**
Communication	Instrumental: "this is what needs to be done"	Symbolic ;this is who we are"
Commitment	Perfunctory and momentary: Little conscious thought Given after the act.	Enduring and affective: "this is right". The experience may be Repeated in memory.
Continuity	Directly observable and detectably outsiders. Behaviour is repeated overtime.	Meaning extends across generations and is interpreted by insiders: "this is what we look forward to and who we will continue to be across generations".

Source: Fiese 2006:11

Among the family rituals, family celebrations, family traditions and patterned family interaction are very important. Family celebrations such as weddings, funerals and religious celebrations are widely practiced throughout the culture. But, family traditions are more closely with the unique characteristics of a family. Anniversary celebrations and birthday traditions are some example for these rituals. Least deliberately planned rituals

are patterned family interactions such as meal times, bed time prayer (Fiese 2006: 25-26). While meal time looks like 'wartime' with argument and attacking each other in some families, there is very peaceful environment with expressions of mutual affection and caring in the meal time in other families (Lin 1994:13). In some families in this study, this ritual was related with their culture. For instance, father and brothers are served first in some of the families. Most of the time, family members did not have meals together. In some families, due to father's /husband's employment in far away from home, they cannot have their meals together. First, male individuals were given meals and meals were served by mother or sister. Then, female individuals had their meals. There were very few families where family members had their meals together when all family members were at home. This was not observed in Thilaka's family environment due to not having a good relationship between husband and wife and children and father. There was a distance between Thilaks's family members and her husband because of this lack of relationship. They did not feel that they are all together. In Surani's experience, she did not get 'we' feeling with family members because of the lack of understanding and relationships. She did not want to participate in the family functions. Especially, this negatively impacted on her welfare. But, family routines and rituals are important in the individual development. Kanchana's husband wanted to light the coconut oil lamp in front of the Buddha statue every day evening and he considered it as a routine in his house. But, Kanchana with her lack of motivation to do household activities was unable to involve in this routinely act. When this was not happened, her husband was anxious. As Fiese (2006) pointed out above, the disruption of this routine created a hassle in Kanchana's house. On the other hand, mostly Kanchana did not participated in family rituals. For instance, she can remember she participated in her brother's and one of the sister's wedding only. That is also she did as she was unable to avoid it. Wedding is a family rituals and invitation for a wedding and participation in it shows the feeling that 'this is who we are'. But, nonparticipation is a disruption of the rituals and it threatens the family cohesion. Some of the family members purposely did not make their family members with mental health problems participated in the family rituals because of the social stigma. This helped these people remove from their family cohesion or the unity.

Some of the people with mental health problems did not get the invitations for the family rituals by their relative families because of their misunderstanding on the people with mental health problems that they may create odd things or may do some problematic things.

4.2.3. Family Values, Norms and Beliefs

Family's basic value system, norms and beliefs are also very important in the caring of people with mental health problems. Beliefs of the family members strongly affect the reduce the impact of mental health problem, treatment or other intervention, compliance and preference of the family members to participate in their family members' treatment and healing process (Rolland 2003: 480).

Different family values and norms were observed in this study. They sometimes negatively affected on the people with mental health problems. As an example, the common norm that female should be responsible for household work and male should earn influence on both male and female persons with mental health problems. In some families with both male and female family members with mental health problems, family members were more criticized the female than the male if they did not do household work. Male family members were more criticized than female if they were not employed. As Flaker et al (2007) explained, there are some gender specific needs in the families. Male's identity most of the time expected to perform. They further point out that men have less access for compensation and they have lack of organized group support (Flaker et al (2007: 112). In this study there were some male family members with mental health problems who could not perform well due to the MHP, medicine they used, social stigma, lack of invitation from the family and the society, rejection by the society, misunderstanding of the people in the families and society. For instance, Kasun faced such problems in his family due to his mental health problem. His mother and brother often put him down due to his poor performances in the family whereas there is no father in the family. He was very disappointed with their perception. The value that grown up children should be employed and look after them in their old age also related with above gender based value. These values sequentially interact with the wider environment.

Because of that, some of the neighbours criticized the young people with mental health problems whereas they were not employed and old parents were employed. This was another distress for them. Sometimes parents themselves blamed on their adult male children with mental health problems for their lack of motivation to find or do a job due to this family values and norms. Apart from that, because of these norms, if female family members wanted to do some meaningful thing outside from the family, family members did not allow them to go away from the family and it caused to deteriorate their functioning level further. On the other hand, this norm supported them to protect from abuse or misuse by the outsiders too. It was able to see high affection with mothers than father among children. Most of the time, children discussed their day-to-day issues with mothers, requested their needs form mothers.

Beliefs among the family members also were very significant in this study. Family members believed that it is not good to reveal their personal/family matters to outsiders as it causes to harm their dignity. According to Asian cultural beliefs that people are discouraged to seek external help because it would suggest that family is not adequate to look after their own and it brings the shame. People perceive that stigma associated with MHPs as social and moral errors of family members and this perception prevent people to seek external help (Kung 2005: 410). Therefore, some of the family members as well as people with mental health problems were not happy to contact their family and discuss their issues at the beginning. They thought that their problems may increase due to that. Some of the people with mental health problems and family members requested the mental health staff to be careful on following things in the meeting their family members.

- To protect the confidentiality of their given information in front of their family members
- Not to reveal that they are the informants who gave family information
- Be careful not to create further problems.

Therefore, it is very important to identify such family values and respect them because they are very significant in the individual care plan with family intervention. On the other hand, in the beginning of one of their family member's mental health problem, they

wonder ‘why me’. Due to the lack of knowledge on the mental health problem and treatment, they build different assumptions on the cause for the mental health problem and treatment. Therefore, it is very necessary to assess the individual beliefs separately. In this study it was very apparent that there were different beliefs on their family members’ mental health problems and the Table 4.6 the gives us a picture on that.

Table 4.6. Family members’ beliefs on their members’ mental health problems

Belief	**Number**	**Percentage**
Mental health problem/mental illness/ madness	36	42.85
Fear	5	5.95
Kodivina (black magic)	6	7.14
Life stress	19	22.61
Karma[65]	1	1.19
Hypnosis	1	1.19
Apalaya[66]	1	1.19
Nerves problem	4	4.76
Kalukumara dosaya (black prince’s gaze)	1	1.19
Anger	2	2.38
Effect of Devil souls	1	1.19
Suspicion	1	1.19
God’s punishment	1	1.19
Wedu gei sanniya (Post partum depression)	1	1.19
Not clear	4	4.76
Total	84	100.00

Source: Field Data: 2011-2012

65 ‘Karma’ means our actions. People believe that we get disabilities in the present life as a result of bad things what we did in our previous birth.

[66] Bad influence of planets and constellations.

Among the beliefs on MHPs of their family members, majority of the family members believed that their family members have a mental health problem, 'MI' and madness (42.85%). In addition, they believed life stress (22.61%), fear (5.95%), kodivina (7.14%), neurological problem (4.76%). It seemed that the majority attempted to avoid answering directly that their family members have a 'MI' and they were happy with the word 'MHP' because they felt little comfortability of using this word due to stigmatization and discrimination. In addition, some of the family members believed the life stresses, fear or influence of kodivina (malevolent act as causes for the MHP). Therefore, it is very necessary to inquire the level of agreement and tolerance for differences not only among family members' beliefs but also between the family and health care system (Rolland 2003:484). Clausen and Yarrow's studies (1955) emphasized the need to become acquainted with relatives' perception, culturally defining and dealing with MHPs. Additionally, they point out peoples' response towards deviant people, especially, the way of maintaining the morale and cohesiveness in the family, role structures and their changing are also significant to consider (Hatfield 1987b: 15).

Kapferer (1983) conducted a research in Sri Lanka especially on people's beliefs on suffering, misfortune, disease, and illness and found that people believe a positive relationship between demonic influences and its relations with health problems (Kapferer 1983: 1). Chiu et al (2006) found that the majority of caregivers consider their burden as a tragedy or misfortune in their level in the study on caregiver burden in Hong Kong and Taiwan (Chiu et al 2006: 143). Because of this misunderstanding and beliefs, some of the family members and people with mental health problems make some relationship issues among their close relatives, friends and neighbours. One of the extracts taken from a case study in this study explains this more.

> "Ape putha (our son) marked the eyes of the Buddha statue in his school Buddha shrine because he was clever at drawing pictures. With this incidence he changed. We believe that he got this MHP because of the *esvaha* (gaze of eye). Generally, we have seen that majority of the artists who mark the eyes of Buddha statues got MHPs" (Perera).

By now Perera has anger on the school principal in his son's school because of selecting his son for the above special task. Perera thinks they are jealous towards his son. Sometimes, this misunderstanding creates other problems without anyone's knowledge. Therefore, in this occasion, it is necessary an intervention of a social worker as mentioned early, social worker's intervention can minimize the increasing of the problem because she can make them aware on the beliefs. Through the awareness social worker can reduce the relationship issues to be newly created.

There are some macro factors such as urbanization, war and displacement, and racial discrimination caused to increase the level of 'psychiatric morbidity' (Musisi, Mollica & Weiss, 2005). Nadraja believes that his mother got this MHP as a bad result of the urbanization and development. Following extract of a case study in this study shows how people apply factors such as urbanization and development with their mental health problems.

> "After 2009, the development was high in our area and value of the lands also increased. Because of this, villagers also were happy to gather lands. Our house was situated on 60 perches of land. Additionally, we had another 30 perches of bare land donated by the government without a deed. Villagers wanted to capture this land with this development and increasing the value of lands. Mother was worried on it and there is an ongoing fight on that" (Nadaraja).

Nadarajah does not wish to go back to his village with his mother. He wishes to sell all the properties and settle down in Colombo with his mother separately after she comes back to her usual condition.

Among the life stressors which family members mentioned in their interviews, studying for examinations, wife's leaving for a job in Middle-East countries, father's death, adverse childhood experiences, disappointed with life, breaking love affair, difficulty in adjust with the society and hunger for long time were very prominent. Surani's father

does not believe that she has a MHP and he influences her to not to take medicine. With that belief father has never come to take medicine with Surani. Therefore, it is necessary to help these family members to minimize the problems related with their beliefs and perceptions and not to create new issues with regard to their reactions to their beliefs.

4.2.4. Family Communication and Decision Making:

Through the process of social interaction we act and react with the people surrounding us and individuals' everyday interactions are based on a subtle relationship between what we express in words and what we express through many forms of nonverbal communication. Non verbal communication means 'the exchange of information and meaning through facial expressions, gestures and movement of the body (Giddens 2001:84). Though good communication is very important for the family function and resilience, it may break down especially in the essential time period such as in disruptive transitions, times of crisis, or prolonged crisis. Transmission of beliefs, information exchange, emotional expressions, and problem solving are happening through the communication (Epstein et al., 2003). In every communication, following two characteristics can be seen;

- Content aspect- conveying facts, opinions, or feelings
- Relationships aspect- defining, affirming, or challenging the nature of relationships.

Speaking (speaking for oneself and not to others) and listening (empathy and attentive listening), self-disclosure (sharing information and feelings about oneself and relationship), clarity, continuity tracking, respect, and regard are considered as skills of good communication (Walsh 2006: 106-107). Creating the sense of belonging, reducing the frustration and enhancing the marital relations are done by the good communication (see the table 4.7 for more information with regard to the communication process).

Table 4.7. Communication Processes: Facilitating Family Functioning.

Clarity

- Clear, consistent messages (words and actions)
- Clarity ambiguous information, expectations
- Truth seeking/truth speaking

Open emotional sharing

- Sharing wide range of feelings (joy and pain; hopes and fears)
- Mutual empathy; tolerance for differences
- Responsibility for own feelings, behavior; avoiding blaming
- Pleasurable interactions; humor, respite

Collaborative problem solving

- Identifying problems, stressors, constraints, options
- Creative brainstorming; resourcefulness
- Shared decision making: negotiation, fairness, reciprocity
- Managing conflicts: repairing hurts, misunderstandings
- Focusing on goals; taking concrete steps
- Building on success; learning from failure, mistakes
- Taking a proactive stance: preventing problems; averting crises; preparing for future challenges
- Devising "plan B"

Source: Walsh 2006: 108

Communication is very important unit in family life education. Practicing good communication includes becoming a good listener. In a well functioning family, communication keeps the idling away. But, negative patterns of communication create bad effect on the family. In the Chinese community they use the statement 'playing piano to a cow' to explain about the negative pattern of communication (Lin 1994:15). John

Gottman (1999) identified four negative patterns of communication such as criticism, defensiveness, contempt and stonewalling ("the four horsemen of the Apocalypse"). Criticism means 'any statement that implies that there is something globally wrong with the other, something that is probably a lasting aspect of partner's character'. 'An attempt to defend oneself from a perceived attack' can be defined as defensiveness and Gottman contempt was considered as the 'sulphuric acid' of a marriage. 'Any statement of nonverbal behavior that puts oneself on a higher plane than one's partner' has been defined as the contempt by Gottman. In a communication, sometimes listener is withdrawn from the interaction, not talking or unwilling to interact with the partner. Stonewalling occurs in this situation (Constable & Lee 2004: 74).

In most of the families in this study, nature of the communication patterns and decision making is very prominent and significant in their family members' recovery of MHPs. There are some criticisms on current service models especially from the user movement. They see that medical model often involve in the log-term management of symptoms. Most of the time, they believe that medicine cannot deliver any 'cure' for the mental distress (Coleman, 1999). Hope and recovery do not appear in the medical model. Some longitudinal research has found that considerable proportion of people with mental health problems recover from their psychosis. The significant factor is majority of them is from Third World countries (World Health Organization, 1979). Using of the biomedical model in these countries is less compared to developed countries. But, cultural expectations are more socially wide-ranging. Also, people with mental health problems in these countries return to their meaningful activities and household activities soon after they get well. Researchers believe that these reasons may cause their recovery (Tew 2005a:26). Among the many, mental health researchers, workers and people with mental health problems, the word 'recovery' are very complicate, and misunderstanding. "The process by which people are able to live, work, learn, and participate fully in their communities" can be defined as recovery. There are some individuals who can live productively despite their disability, others can reduce the symptoms or complete remission of symptoms (New Freedom Commission on Mental health, 2003) (Scheyett &

McCarthy 2006:412). Therefore, understanding on communication and HEE are useful in this regard with people with mental health problems.

There were high expressed emotions (HEE) in their communication between the family members and the people with mental health problems. Criticism, hostility and emotional over involvement are the main elements of high expressed emotions. Criticism is very significant among the family members where there are people with mental health problems (Hooly & Gotlib 2004:202). 'A statement which, by the manner in which it is expressed, constitutes an infavourable comment upon the behavior or personality of the person to whom it refers' has been defined as a critical comment (Left & Vaughn 1985: 15). Criticisms can be evident in two ways such as;

a). the content of the comment alone, but they are principally evident in the pitch, speed, and inflection imported to the statement by the person making it

b). the vocal aspect of the speech (critical content and vocal aspects).

Relatives describe the characteristic of the family members with MHP in unfavourable manner such as 'he lies to us' or 'he worked only three days for last month'. This gives a picture that people with mental health problems cannot be believed, they are unusual, and their behavior is odd. Sometimes we express ourselves in highly individual ways. But there is no any particular vocal characteristic to define the statements made by family members to say as invariably critical (Left & Vaughn 1985: 38-39). Also, though hostility can be defined in many ways, the criteria such as generalization of criticism and rejecting remarks are very important. Some family members use statements to say that their family members with mental health problems are not right or they can do very little. For instance, the sentence 'he is not any benefit to himself or any benefit to society or any benefit to the family situation' gives an idea that they are not useful at all. This sentence makes them angry. Rejecting remarks is a more generalized negative feeling. The sentence 'I might do a pile of washing just to get away from him' gives that family members are not happy to be with their members with mental health problems.

Emotional over involvement is also significant in the discussion on HEE. This can be detected in two ways such as repeated behavior of the respondent and behavior of the respondent at the interview. In the repeated behavior, exaggerated emotions response,

self-sacrificing and devoted behavior and extremely over protective behavior can be observed. Statements of attitudes, emotional display and dramatization can be seen in the behavior in the interview. Some relatives use some sentences to show that there are impacts of the MHP on them such as 'I live in a vacuum'.

There are some displaying their emotional situation such as they are tearful when explaining their relatives' mental health problem and its impact on him or her and them. Some of the relatives display their over concern by dramatizing (Left & Vaughn 1985: 41-46).

In the communication and relations among the family members in this study, it was able to observe that there were high expressed emotions with the family members with mental health problems. Criticism, hostility towards them and over-involvement were significant in the families. Especially, there were no good relationships between married people with mental health problems and their spouse. Due to the misunderstanding on MHP and its nature, majority female persons with mental health problems had problems with their husbands in the sexual contacts. It has been found that majority of women especially in their marriage life do not have good relationships with the men (Walters, Avotri and Charles, 1999). High number of divorce is encouraged by women. Also, it has been found that there are a high number of depressive women among the married women. Abusiveness, betray, disrespectfulness, abandon by their partners or husbands, difficulty to believe in their own value are the reasons for this (Hurst, 1999) (Williams 2005:158). Some of the female family members with mental health problems explored the physical harassments by their husbands too. Caring for relative with a mental health problem is a difficult and demanding task, whether the relative lives at home or lives independent from the family. Kanchana's husband often says that "I was put into a trap by your father". He shows that he has been fed up with his marriage, but, he on the other hand, shows that he cannot escape from Kanchana. But, there are some problems in his part such as criticism on her, his lack of supportiveness to Kanchana, Lack of understanding on her mental health problem, emotions and her lack of sexual desires, and his sexual harassment to Kanchana. He was always hostile towards Kanchana.

Though people with mental health problems did some work at home, others in the family did not admire and criticized the negligence or poor performance in front of the researcher and the individual with mental health problem even. Among their criticisms, following were very significant.

- Psychotic symptoms (you continue the family illness)
- Side effects of the medicine (you are walking like in a march past)
- poor self care (though you bath, you bath partially)
- half performance and need to supervise (If you do something rarely, it is done partially, if not we have to supervise)
- Time consuming and slowness (he often refuses my support and says that I am very slow)
- Poor motivation and no enthusiasm (you want to do nothing)
- Lack of neat (though you do something, no neat)
- Gets angry when order to do work (she gets angry if we ask her to support my house work)
- Agitation (go here and there, none stop)
- Not cooking and cleaning and though cook, not delicious (she rarely cooks, but, no one eats them)

But, as a human being, they are also happy to take part in family work though their health problem and treatment make them inactive. Keeping the HEE often with their family members with MHPs is not healthy for each other. As Lopez et al (2004) explained, family expressed emotions increase the risk of relapses of a individual with a MHP. Our culture plays a major role how our expressed emotions are articulating (Lopez et al 2004: 428-439). Here, culture, implies,

> "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" (National Association of Social Workers,2006:61) (NASW Standards for Cultural Competence in Social Work Practice 2001: 9).

Following extracts taken from the case studies in this study explain how family members express their HEE on their family members with mental health problems.

> "I resigned from my job even. I wanted to look after my mother. I think she needs our support. She waits to eat until I come. I want to strengthen my mother psychologically" (Nadaraja).

> "I am the head of the house. Every one listens to me and ready to follow my advices and guidance. If I get angry, I do not talk for few days. My family members know that I am angry and unhappy with their work. After two three days, they understand the mistake which they did and agree with my decisions" (Perera).

> "Now I am an invalid coin in my home. No one talks anything important with me. They think that I am mad. Whatever I tell and whatever I do, they think that I am mad and not giving any value for them. …But, I had a good dignity and acceptance previously among my relatives even. …Everything is decided by husband. Nothing is asked from me" (Kumari).

Above mentioned Kasun's case study emphasis about how his long term mental health problem change this decision making. When the researcher visited their house it was possible to observe the interactions, communication, status in the family and nature of the high expressed emotion among Kasun's family. His mother often criticized Kasun's poor functioning level and his brother was avoiding Kasun and did not allow him to enter into his room or touch anything that belongs to him. Due to brother's behavior, Kasun wanted

to make his brother angry and he said that it is also enough for him where there are no any communication between him and brother.

Nadaraja shows us the emotional over-involvement with his mother. It is clear that resigning from a job long term is not a good and health solution even though it is a short term relief. Sharing decision making and managing conflicts are very important for these types of family members to solve their problems smoothly and this can be done easily by a social worker. Nadaraja had no anyone to negotiate his burning problems because his relationship with relatives were not good, even with sister did not have good relationship until he came to their house. In future also he does not wish to negotiate his problems with any relatives. Social worker's intervention with a collaborative problem solving is the most suitable for this family member to minimize his problems.

Perera and Kumari tell about the gender power relationship in decision making. Many of the people with mental health problems expressed their unhappiness and worry about not talking any important things at home with them by their family members. Kumari says that she feels that she is like an '*invalid coin*' in their home. Communication and the decision making are interrelated. Study shows a gender power relationship in the decision making in the family. In the majority of Sri Lankan families, decision making is done by fathers/husbands. Sometimes they discussed the important matters with wife too. But, MHP has caused to change this gender power relationship also. Kasun's case study is a good example for this.

Most of the families, there was no any open emotional sharing or collaborative problem solving between the family members and the people with mental health problems. People with mental health problems were not make participated in the family discussions, or decision making. Above examples give us enough information on the communication and the decision making in the families where there are people with mental health problems and its relationship with the gender power difference.

4.3. Do They Need Human Needs?

There is an inherent complexity of the concept of 'need'. Therefore, defining needs is very difficult. According to the discussions in the previous chapters, it was very obvious

that there were different approaches on needs[67]. However, the pragmatic view of Green and Kreuter is important in the discussion of needs. They considered need as "*whatever is required for health or comfort*". They explain this comfort covers every aspect such as personal, social and environmental conditions, including family planning in formation, smoke-free zones, seal belt rules and 'health hot lines' (Asadi-Lari et al 2003:2). This study has come out with different needs of people with mental health problems and their family members and researcher has discussed them in the next part of this chapter.

4.3.1. Do People with Mental Health Problems have Human Needs?

Needs of the people with mental health problems are very significant in the intervention and support for them to develop their mental health. In Doyal and Gough's need theory, they have identified physical health and autonomy as the basic human needs and other intermediate needs which support for the fulfillment of basic needs. Addition, in health care settings, personal and social care, healthcare, accommodation, finance, education, employment and leisure, and transport and access have been identified as human needs as well (Asadi-Lari et al 2003:1). People with mental distress in this study explored the following needs as their significant needs while in their families as well as in the mental health hospitals.

- Basic survival needs
- Autonomy in the family
- Physical security
- Economic security
- Protective housing
- Appropriate health care

[67] Social view, philosophical point of views, pragmatic views, economists' approach, a health service approach, macro and micro level approaches.

- Significant primary and social relationships
- Communication
- Take part in decision making
- Leisure activities.
- Need to be educated and aware
- Close relatives' support
- Formal support
- Spiritual need

Doyal and Gough (1991) explained if someone cannot meet his or her basic needs, he or she cannot satisfactorily participate in society. Majority of the families had to struggle to fulfill this need not only of them but also their family members with mental health problems. Some of the people with mental health problems need medicine to stay healthy in the society though it created other issues. Their poor financial situation makes it further worse. Majority of the people with mental health problems also wanted to involve in some meaningful activity due to on one hand their poor financial situation in their family, on the other hand, due to their financial dependency on the parents or siblings. But, due to the lack of motivation created by the MHP and the medicine, over involvement by the family and the rejection by the institutions because of the strong social stigma and the discrimination, they are unable to meet this need by themselves. Surani wanted to support her mother and brothers by doing a job in their financial difficulties. But, due to above mentioned barriers, she was unable to make it success. Kasun also wanted to start and continue an employment to get rid of the dependency on his mother. But, he was unable to continue his job due to the MHP and medication and rejection by the society.

Majority of the people with mental health problems expected some role with responsibility and respect in their families. Majority of the family members with mental

health problems played a very poor role in the decision making in their families because they were not invited for this. But, they wanted to know what is going on in the family. sometimes, they wanted their family members to listen to them, what they say related to their lack of motivation to work, why they have lack of sexual desires, lack of self care, why they are taking to self and why they cannot walk well. But, majority in the families did not want to give them time and listen to their stories in this study. Instead, family members perceived that it is a hassle for them.

Majority of the people with mental health problems needed to have social contacts with their family members, relatives and friends. Sometimes, family members did not allow them to go out and have a chat with neighbours, relatives and friends. Case studies of Silva, Kanchana and Surani are examples for this in this study. It was very significant that majority of the female people with mental health problems expressed that they want to have a marriage. The main purpose of getting married was economical, social and emotional safety. They had a fear that what will happen to them, who will care for them after their parents' demise. On the other hand, they wanted the marriage because of the stigma related need come from the society and future safety not because of their actual need. Once Agger has explained that needs are false as they have imposed from the outside (1992: 144). In this study also it seems that 'the need of getting married and having a boy friend' are some social needs that indirectly imposed from society and it has a relationship with stigma and future safety. On one hand, it seems that these young ladies are trying to refrain from the stigmatized belief of the people that ladies with mental health problems are not capable enough to get marry and have children.

But, majority of the family members perceived that their family members with mental health problems do not have rational thinking or taking any responsibility of taking decision or other work. Therefore, they did not want them to participate in their activities and important decision making in the family. Therefore, many of them felt that they do not have any freedom, value, place in their home though they are male, fathers or adult.

There were some people with mental health problems and their family members with hesitation with regard to their loss of housing or property and it caused to increase the

distress further. If not, they were not satisfied with the available facilities in the house, or they lived with many difficulties due to the crowd, conflicts among them. Case studies of Parameshwari, Surani and Kanchana are the good examples for this. Kanchana's brother often insists her to leave the house where they live. But, she and her husband do not have enough economical ability to finish the rest of their partially built house. Surani is having a fear that whether their extended relatives force them to go out from their current house because it does not belong her parents. If this happens, because of their financial situation, they cannot go anywhere. Parameshwari and her children struggle with chain of problems due to not having their own house to go. The current house is a cramped house with four families. As Brandon (1974) and Decleva & Razpotnik (2007) explained, housing distress may be vary: plain homelessness, sleeping rough, under bridge and cellars, sometimes living with friends and associates, many people in a cramped space, inappropriate conditions and few households in one flat (Flaker et al 2013/2014: 111-132). There were some people with mental health problems in this study who did not have permanent or their own house to go, no permanent address to contact after the leaving hospital, no place to keep their goods. Some of them lost their vote right for ten years because of not having the permanent address. Some of them lost their right or access to apply for the public relief or disability allowances because of this issue. As Flaker et al (2007) explained, every human being needs a permanent address to function of a "homo bureaucraticus". Not only that this creates a lots of inconvenience such as problem in the police, job etc (Flaker et al 2007:96).

Especially, some of the female persons with mental health problems faced physical harassment, assaults by their spouses due to the inability to fulfill household work and lack of contribution in sexual contacts. Therefore, they wanted their husband to make them understand their problems to prevent such harassment. Both the people with mental health problems and their family had a need to know about the MHP, it nature, medicine, side effects, and recovery.

Financial needs were very significant for majority of the service users too. Previous researches have shown that both men and women with the mental health problems such

as schizophrenia and bipolar disorder, have mentioned that loss of their personal identity with the labeling of 'mentally ill' is one of the most painful and dehumanizing aspects of living with their diagnosis (Dickerson, Sommerville, Origoni, Ringel & Parente, 2002; Golbert, 2001; Wahl, 1999). Also, it was found that majority of the persons with mental distress have financial needs, employment needs and lack of affordable housing and transportation facilities, support for mental distress when they no longer manage their mental health problem and the crisis, medicine, peer support, family psycho education, MHP and medical management, assertive community treatment and supported employment (Scheyett & McCarthy 2006: 407-411). Flaker et al (2007) explained people with long term mental health problems need some needs while they are in the community too. Different types of residential services[68], organized activities[69], services[70], accompanying functions, and organizations are very significant among the needs in community (Flaker et al 2007:78-89).

In the consideration of above mentioned needs of people with mental health problems, social workers' intervention is very essential to enable them to fulfill these needs and expectations. As a human being, fulfillment of basic needs is very significant for their survival and it is common for people with mental health problems too. This has proved in this study. At the level of acute and long term MHP, social worker focuses on the individual's physical, psychological environmental needs. Based on their needs and expectations Social worker can build a support system to meet their needs because they have knowledge with the respective social institutions and link with them.

[68] Groups homes, hostels, board and lodging, foster care, sharing flats, sheltered housing, independent community living (floating support), crisis centres, run-away houses and asylums, coping with crisis at home, crisis in another family, respite care.

[69] Leisure and employment, associations and help.

[70] Personal services:Home nursing, personal assistance, companionship and escorts, home help, support crisis, outreach work, individual planning, helplines and advocacy: professional advocacy, lay advocacy, self-advocacy and peer-advocacy, citizen advocacy, other advocacy (Flaker et al 2007:78-88 .

BasicNeeds Sri Lanka (Nongovernmental organization), found that there is a demand for practice on MHPs, mental health users' needs, and services enabling them to solve their problems within their local environment (Practice of Community Mental Health: Seeking Reliability and Quality assurance in Low and Middle Income Countries: case Study on Mental Health and Development Programme in Southern Province, Sri Lanka 2008: 22).

On the other hand according to the stress theoretical approach in MHPs, it can be argue that if individuals do not have enough physical needs their mental health may be deteriorated. In the point of mental health professionals' point of view, these individuals are also like other individuals with physical illness and they need not necessary to give special attention, or compassion. They have further mentioned that if we do so it is a certain type of labeling and discrimination. And also, mental health professionals further mentioned sometimes these individuals are disempowered and labeled by mental health professionals by themselves because of this unnecessary kindness, love, and compassion. Professionals further view that some people with mental health problems try to take medicine properly and start a job or continue the previous job and come out from the MHP soon.

4.3.2. Family Needs

Not only people with mental health problems, but also their family members had needs in the caring of their family members with mental health problems. Following needs came out from the family members in this study as their important needs and fulfillment of their needs helped them to make easy and improve their support for their family members with mental distress.

- Basic survival needs
- Autonomy in the family
- Physical security
- Economic security

- Protective housing
- Appropriate health care
- Significant primary and social relationships
- Need to be educated and aware
- Mutual support of close relatives
- Formal support
- Need ‘time-out to rest from the strains-respite’
- Spiritual need

Except the need ‘time-out to rest from the strains-respite’, other all the needs which people with mental health problems had were common with these family members as well. Family members also felt that they do not have any recognition or priority among their close relatives because of the strong stigma associated with the mental health problems. Sometimes, some of the close relatives, friends, neighbours did not want to keep a close relationship with these people with mental health problems and their family members. They indirectly rejected them and thought their contacts as a hassle or as an extra burden. Because of this, not only people with mental health problems, but also their family members wanted to avoid social gatherings among their relatives, friends and neighbours. They limited themselves to only very close family members such as siblings’ and children’s weddings. Because of this rejection, some of them wanted to discuss their financial and other issues genuinely, with the officers from formal support organizations and get support or ventilation.

Families with significant burdens in caring for their family members with MHPs have expressed that giving more information and concrete advice about their family members with mental distress was one of the main family needs. And also it has been reported important positive results in the programmes conducted based on the family education for the family members living with their relatives with long term mental health problems

(Hugen 1993: 137-154). The study also shows that almost all the family members needed to be aware and educated on their family members' mental health problem, treatment and recovery mainly. Additionally, they wanted to be knowledged on other services which they can follow to meet their needs.

Due to family's natural concerns and responsibilities, families need information and support. But, families and professionals see the needs of families quite different. The information provided for families must necessarily include reasons for MHP, knowledge of the hospital setting, and ideas how to prevent a relapse. Families also need open communication and effective conflict resolution when members differ on major health care/treatment decisions (Rolland 2003:484). In the process of family recovery, families needs information on the MHP, its nature/ symptoms, cause, treatment, recovery of the MHP, information on the managing problem, legal issues, relapses and information on the self help group are very important. Families needs these information as family members start their journey of caring from the shock, denial, and angry from the beginning of the diagnosis.

Family members came out with the need 'time-out to rest from the strains-respite' too. For instance, they explored that they are actually happy if there are possibilities of short-term placements with nursing and support to keep their family members with mental health problems as a rest for them as well as for consider about neglected but essential needs. Some of the family members needed the mutual support from their relatives because they had to go for their medicine, employment, and other activities of children or family members. This mutual support was useful for them as they had some spiritual needs such as participation in religious activities and social activities.

Based on the study on experiences and needs of careers of persons with enduring mental health problems, some of the researchers have found that the majority of the satisfied careers were male from higher socio-economic group and their relatives with MHPs lived outside their homes (Karalova-O'Doherty and Doherty 2009: 257).

Advocacy in communicating with professionals and others was identified as the most frequent need. Advocacy is “about empowerment, autonomy, citizenship and inclusion”. On the other hand, advocacy is “a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options” (Kelley 2005: 2-3). It has been reported that more contact with social worker or physician would help them to improve their relationships with people with mental health problems. Family members had some barriers with the transportation and the distance (Gasque-Carter & Curlee 1999: 520). Family members especially needed the advocacy and formal/professional support to solve their some problems such as property issues, legal issues, marital issues, child-caring issues, finding a home for their disable family members, future caring issues of the family members with mental health problems after their demise and public aids for their disable members in this study. Especially, old parents have a hesitation /uncertainty about their children’s future care. They often discussed this with social workers. Parents who have government pensions often are keen on to make future arrangement to convert their pension for their disabled children. Some of the parents try to save even little amount of money on behalf of the future of these children. If not, parents keep at least a piece of land for them to make their safety.

It is obvious that family members are responsible first for their own personal development and transformation. Therefore, we also have some responsibilities as mental health professionals to perform on behalf of the families with people with mental health problems. On the other hand, that causes to improve the individuals’ mental health. Among our responsibilities, to be active in advocacy in the community and governmental levels, to schedule the activities in special organizations dealing with family's problems, and to be educated and educate others through facilitation are very important.

4.4. What They Expect from You and Us?

In the discussion of the expectations of people with mental health problems and their family members, it can be certain overlap with family needs. In the interviews, some of the family members interpreted some expectations as their needs too. Therefore,

researcher had mentioned some of the expectations in their category of needs. But, in simply need is something basic. Expectation is a goal or a wish in everyday life. Also, to get the family members and people with mental health problems full valued, they need to fulfill their expectations. However, people with mental health problems and their family members had following expectations in this study;

- Recovery
- Close relatives' support
- Caring the parents
- Awareness and education
- Institutional support
- Calm and quite behavior

Recovery was the main expectation which almost all the people had in this study. People with mental health problems and their family members expected to mental health professionals to cure their family members' mental health problem. If their professionals can cure their daughter or son, brother or sister, family members can protect their social status and they can restart their social life. On the other hand, the word 'recover' has been defined as "a complex, individual and self-defined process concerned with regaining hope and independence" (Turner-Crowson and Wallcraft, 2002) (Scheyett & McCarthy 2006: 412, Wallcraft 2005:202). According to the opinions of the people with mental health problems, they have described the recovery in different ways such as recovering hope, taking control of one's own life, developing new meaning and purpose in life, repairing and developing new valued relationships and social roles and persevering in spite of reverses and ongoing problems. They did not mean recovery as 'being free of all symptoms (Wallcraft 2005:203). It is better to describe recovery as an ongoing journey or a process, rather it is described as a finite goal (Wallcraft 2005:203). In this study also, majority of the people with mental health problems and their family members wanted to

talk about the recovery from their mental health problem. But, majority of them had very limited opportunity to talk this with their mental health professionals.

Very significant thing is almost all the family members wanted to cure their family member. But, family members and people with mental health problems have never heard from medical professionals that MHPs can be cured. Therefore, they often are in a puzzle with regard to their recovery. Family members had a worry and disappointment with this. This poor clarification on recovery made some of the family members and people with mental health problems discouraged to continue their medicine as well as stop their contacts with mental health institutions. This study shows some of the family members have gone for other healing institutions or treatment places because of this lack of information and dissatisfaction of the recovery.

People with mental health problems expected formal support to solve their marital and financial issues and issues in their employment. Some of the female family members had a fear of losing their marriage life. They wanted mental health staff to intervene in their marital issues and protect their marriage. Kanchana has many marital issues with her husband and she wanted professional support to solve them. Parameshwari wanted professional support to solve her housing issue. She was unable to go ahead without solving this housing problem in her family. Family members also expected the institutional support to mitigate their burden and lessen the caring of their family members. Some of the family members wanted financial support from the institutions for the bus fare to the hospital, medicine prescribed from outside, etc. Family members as well as people with mental health problems expected their close relatives' support in their inability to solve some problems such as finance, emotional distress, prevent from stigmatization and discrimination, physical caring whereas parents need a rest or time for their essential and unavoidable need fulfillment such as hospital admission, pilgrimage, spiritual need. In Surani's case study, it was clear that they needed a lots of support from their extended families where as they were unable to solve their problems alone. But, there were some incidences which these interventions created some issues among the relatives as well.

It has been found out by other researchers the family expected from the professionals to assist in understanding the symptoms of the MHP. In addition their expectations were specific suggestions for coping with patient's behavior, opportunities to relate to persons with similar experiences, substitute care for family respite, and a different living situation for the people with mental health problems (Hatfield 1987b: 21).

Family members expected their family members with mental health problems to be economically independent, be calm and quit at home, and look after them (old parents) as well. Especially, male family members expected the participation of the female person with mental distress in their sexual activities. There were many family criticisms and conflicts with regard to the poor sexual performances of the married female people with mental distress. But, the complaint of the people with mental health problems was that their sexual desires became low after they had medicine. This is one of the major reasons to stop medicine abruptly before person with mental distress got well. Though family members expect them to find an employment and to be independent, majority of the family members over involve in the activities of people with mental health problems such as alone hospital visits, visit friends and relatives, shopping and money management. If the family member with mental distress is the youngest in the family or only child, some of the parents expected them to look after them at the end of their life. Most of the time, researcher was able to see very old parents care their children or grandchildren with mental health problems.

Previous researches show people with mental health problems expect courtesy, respectfulness, honesty, openness, friendliness, informality, empathy, nonjudgmental attitude, caring nature, reliability, punctuality, willingness to share information and decisions, and to give practical help and support from the health and social care workers (Lelliott et al 2001: 68). In the investigation of needs and expectations of people with mental health problems and their family members, it seems that majority can be supported through the communication; awareness on the MHP, it nature/symptoms, treatment, and recovery, awareness of the family on how to care their members. Once, social worker is a good listener and the therapist. Therefore, she or he can use her skill of

communication and listening skills to support these family and people with mental distress to meet their needs/to reach their expectations. In the communication process when it comes to the social worker, they also follow the procedure of communication processes which family can be facilitated to function well. Accordingly, clarity, open emotional sharing and collaborative problem solving are very significant. This can be followed as a joint process with the family and the person with mental distress. Also, listening, advocacy, individual care planning and implementation of the goals can be used to support above needs fulfillment. Listening can be defined as 'attending, interacting and responding with the other person. Listening is part of the process of trying to hear and grasp what the other person is saying from their perspective. It is a participatory activity that requires responding to try to understand-being genuinely curious, asking questions to learn more about what is said and not what you think should be said' (Walsh 2006:108, Anderson 2007a:36). There were some women in this study who needed social workers' support/help to solve their issues with husbands such as domestic violence. They need an ongoing support programme to be free from physical harassments. Once, Helfer (1991) has pointed out some of the important interventions[71] to minimize the domestic violence in the community. He believed that they may be available and ongoing in the society to support these people (Blau et al 1993:222). Social workers can provide complete and unbiased information in a supportive manner at all times. They can encourage and facilitate family –to –family support and networking (Dhooper 1997: 162).

Social work practice as a response to concern and need is one perspective of social work. While concern is derived from a feeling that all is not right, through the identification of any unmet needs in the situation, social workers respond to the concern. To identify and understand the human need, social workers use several other bases such as knowledge about human development, human diversity, social systems, ecosystems and strengths. In addition to identification of the unmet needs and strengths, social workers identify the needs and strengths of important individuals and systems in the environment. In this

[71] Services to meet families' basic needs, health care and the procurement of medical services, social and personal support services, access to support groups, family-oriented counseling, skills training programs, one-on-one therapy, training to community such as teachers, foster parents (Blau et al 1993:222).

regard, social functioning is also very significant, helping the client systems to cope and on the environmental factors impinging on social functioning is the focus of social work endeavor (Johnson & Yanca 2011:14-15).

4.5. Family Strengths

In the recovery process of individual's mental health problems, strengths of people with mental health problems and their families make a good support the people with mental health problems. Among the factors associated with success of individual's mental health problem, medication, community support service/case management, self-will and self monitoring, vocational activity (including school), spirituality, knowledge about the illness/acceptance of the illness and mutual group aid-supportive friends have been prominent. On the other hand, these factors show us a picture on the evolution of mental health services from institutional care to community-based services, and then efforts of normalization and integration (Saleebey 1997: 185).

Table 4.8. Factors associated with Success (N=46).

Medication	72%
Community support service/Case management	67%
Self-will, self-monitoring	63%
Vocational activity (including school)	46%
Spirituality	43%
Knowledge about the illness/acceptance of the illness	35%
Mutual aid groups-supportive friends	33%
Significant others	30%

Source: Sullivan 1997: 185

Every family has its own strengths and resources to cope with their day to day problems (Walsh 1998: 3). The investigators those who focused on the family emotional climate have shown the importance of warmth, affection, and emotional support. They have further emphasized where parents are impossible to create this above mentioned climate, other close relatives like older siblings, grandparents, and extended kin in the family can support to fulfill this function (Walsh 1998:11). In this study also this is very clear and among the factors given for the absence of some close family members like parents due to their physical illnesses and old age, older siblings of people with mental health problems came to visit them. If not, close relatives such as parents' siblings' children came to visit their extended kin.

Social worker can support to achieve family members' relational goals which they created to their survival and growth as a person. Especially in stressful situations, though resilient families are able to carry on, some other family members are very difficult to achieve these goals. Actually, resilience is of a process and it is not a matter of a particular family structure. Family has to go through certain crisis problems or adverse circumstances. In the middle of this type of problem, resilient families develop its meanings, interacts with difficulties, adapt and preserve their own values. In a process in family resilience, it can be seen belief systems such as make meaning of adversity, positive outlook, transcendence and spirituality, organizational patterns such as flexibility, connectedness, social and economic resources, and communication/problem solving such as clarity, open emotional expressions, collaborative problem solving (Constable & Lee 2004: 22-24).

Among the family members in the study also it was able to observe some strengths and resilience which they used to cope with their crisis situations. Among the strengths of people with mental health problems, family support, support from the extended families, emotional sense on the family, need to come out from the MHP, need to participate in household activities, need to start a job, previous proper work performance, closeness to the family, different vocational abilities such as sewing, drawing, painting, home keeping, performing responsibility to the family, gardening skills, teaching abilities,

cooking abilities, and musical playing were prominent. Majority of the families did not use these strengths in their activities. Some of them thought that they cannot do the earlier things because of the MHP. Apart from that, this perception was further emphasized by the lack of motivation and lack of functioning of the people with mental health problems. But, discerning those resources, respecting them and the potential whether they can reverse the misfortune, counting illness, easing pain, and reaching goals is the first and foremost in the strength perspective (Saleebey 2009: 15). Also, it was observed that using strengths of people with mental health problems depends on the family education, social background, marital status, place where she or he has in the family before the MHP, personality, and the responsibility which they performed to the family. Following extracts from case studies in the study explain this further.

> "My son was the first in his class. He drew very well. He played musical instruments. I want to take him back to previous condition"(Perera).

> "My husband always chased me away. He does not want me to cook and he criticizes my curries. But I cooked well before the illness. He says I am very slow. Therefore, he says for me to be in the house and do my own business" (Karuna).

> "Now, I stay with my parents and sisters. My husband stays with his sister. My sisters do everything for me. I do nothing at home. However, I did not do anything at home while I was with my parents and sisters before marriage. They know that and now also they do not force me to do household work" (Chathuri).

First two families are educated and had a good family environment. In the third family, the family members also do not encourage Chathuri to be active and they have let her to be there as she wishes. In this situation also social worker can support through the

strengths approach. Social worker first can do a strength assessment. This is a standard feature of the helping endeavors. After completion of this assessment it is necessary to have a conversation. This should be nonthreatening. After identification of the strengths, abilities, accomplishments, and possibilities, can arrange a roadmap their need (Sullivan 2012: 176-183). Therefore, identification of the strengths of people with mental health problems and support them and their family members to use them for their individual's and family wellbeing is very essential in the development of mental health of the individuals and their families.

4.6. Spirituality in Mental Health

Almost all the family members with mental health problems face problems in all the stages of adjustment. During these stages of adjustment, complete ignorance, knowing nothing about mental health problems, even not knowing what to ask from psychiatrists, as mentioned above, at the onset of the diagnosis, family members were shock, felt guilt, blamed each other, angry and was in a denial. As long as family members didn't acknowledge that they have to change themselves, they spend a very crucial situation in their families. Some of the families have started following a spiritual path. Their spiritual knowledge was very important for their transformation and to experience their own reality.

Spirituality can be defined simply as "*that which connects one to all there is*" (Griffith & Grffith 1999). On the other hand, 's*pirituality concerns an active investment in an internal set of values*' (Walsh 1999:29). Following the spiritual path doesn't mean to live somewhere isolated from the society. Spirituality means everyday life with all problems we face, and which come only for two reasons, to learn from them and to solve, and only purpose of spirituality is to transform ourselves. The purpose of spirituality is to eliminate our misperception which cause for human unhappiness.

Following extract from a case study explains how this aunt follows her spiritual path to cope with the problems raised due to the mental health problems of her dead brother's daughter. She has dedicated her whole life on behalf of this daughter and her family for

47 years like a mother. This daughter's mother also is in a half-way home due to her long term mental health problem. But she does not have an angry and she follows a middle path on that. Further on she wants to make this daughter's life secure after her demise too.

> "I am proud of how I have all grown trough experience living with this daughter with the problems in mental health for 47yrs. As a family I include her in all my activities without high expectations at the beginning though now it cannot be done. She is important to all of us in our family. Actually, she gave me a life lecture. Through our life with her, I have developed the best what is inside of me. Now I have dedicated all in my life to her including my marriage life. I do not blame her or criticize her as I know she has this behaviour because of her mental health problem" (Badra).

In the process of spiritual choices, identification of contributing factors, exploration of spiritual resources and strategies and living with choices are very significant (Lyren et al 2005:630). Therefore, in the development of mental health of people with mental health problems and their families, these three interrelated phases are very useful. They may support to mitigate the distress of the family members as well.

In the consideration of the above details, it is obvious that there are different views on mental health problems, people with mental health problems and their family members. In the families with the family members with mental health problems, it could be seen from different types of dynamics. In the communication patterns, HEE such as criticism hostility and over involvement was common. In the decision making, father/ husband was given the priority in the families. Majority did not make their family members with mental health problems participated in the decision making. There were different types of roles mainly based on gender. Majority of the family members expected women to do household activities and men were expected to arrangement of finance and other

amenities in their families. But, there were some families with the women who took care of the entire family burden onto their shoulders. Almost all the family members needed to be aware of their family members' mental health problem, causes, symptoms, treatment and recovery. People with mental health problems also were keen to know what happens to them and make their family aware of it. People with mental health problems and their families had the similar needs as others have. In general almost all the categories think that people with mental health problems are also human beings and they also have similar needs as other people. Through the strength perspective, social worker can support the people with mental health problems and their family members to build their disrupted relationships and heal the pain. A spiritual path creates its own way to cope with individual's or families' problems.

Chapter Five

Family Intervention and Support: Thoughts and Attitudes

In the first part of this chapter, researcher discusses on the FI and individual care and support planning in detail. Findings in this study on FS, attitudes of people with mental health problems, family members and mental health professionals on FS, social stigma and help seeking behavior, mental health staff and FI and how to improve the FI are discussed in the later part of this study in detail.

Mental health professionals in the West have started to give their attention to the family and its role in the treatment and rehabilitation process of people with mental health problems since 1970 (Kung 2005: 409-418). Social work began as a profession with the work of multi problem families. Families have had problems from the inception. Some of the families have been solving their problems easily and some of the problems have led to individual's or family's demise. From the twentieth century, family problem solving has been handled with a scientific understanding. It has been well documented that the prominence of family problems and conflicts in the early writings like in the Bible, personal histories, literature, drama, ethnographies and biographies. Therefore, it seems that family problem solving has a long history. By understanding the family problems, it is very easy to understand the meaning of family problem solving. According to that, "*family problems are conditions that block the attainment of individual or family goals. These conditions may include behaviours, rules, expectations, attitudes, relationships, social structures, action patterns, or circumstances to the family*". According to this definition, the concept of a 'goal' is very important in family problems. A goal is an unobtained objective that individual or group wants to attain. Goals may be short term, long term or emotionally intense or mundane. A family problem is created when the attainment of these goals is blocked. This failure of attaining a goal creates individuals and families frustrated and they become even more serious family problems. Therefore,

family problem solving can be defined as '*the removal of conditions that block the attainment of a family-based goal*' (Vuchinich 1999: 1-12).

In the promotion and maintenance of an individual's health, families are the major context. The contribution of the individual family member's health and his or her behavior impacts on the whole family. Also, some of the patterns of interactions and behaviours of family members influence badly on other family members' mental health. Therefore, understanding of the family interactions and their relationships are very significant in the assessment, planning and evaluations of the interventions to lessen the unpleasant health outcomes of the individual and whole family (Willgerodt & Killien 2004: 150).

5.1. Family Intervention

In discussing intervention, social situations are very important. The study of an intervention in social situation is the common ground between social workers and psychiatrists. Though all psychiatrists and social workers do not do this, this is something which we always do. In the adoption of psychiatrists' medial model of a social situation, psychiatrists have to be practical as they have a hectic job; their theoretical analysis is done in the middle of the activity or later. Social situations are very important for psychiatrists in their diagnoses and treatment (Laing 1972: 22-31). Situation contains the basic context of social work, and the boundaries for individual care plan and intervention. Not only that, personal, familial and institutional environments are brought together by the social situation. Situational assessment engages in different types of social systems and social institutions (Constable & Lee 2004:7).

The word 'intervention' is a contested term. On the one hand, this word raises the meaning 'doing to others', while on the other hand, 'imposing a level of expertise and it is exclusive rather than inclusive'. Therefore, intervention can be identified as "'*working together with people*' in a systematic and planned way in an identified situation to make difference" and intervention works best if it is engaged with people with problems. In the

development of a systematic approach to social work practice, the separation of care plan, intervention and review is important (Davis 2008: 98-101).

As a profession, three general types or levels of intervention in social work can be seen. The first is 'macro level' and this intervenes in societies and communities as a whole. While 'meso' (mezzo level) is the second type and this involves in the small scale groups such as agencies, small organizations, and other small groups. Intervention with individuals and the families is the third type of intervention and it is called 'micro level'. Intervention with family may be with individuals, couples, units (Haynes & Holmes 1994:242-244).

In social work, there are different types of interventions and these have been named as 'methods' in social works. Social case work, group work and community organizing and planning are the traditional social work intervention methods. In the past, case work was done at the micro level of intervention. While group work was done at the meso level, community organization and planning was done under macro level. The intension of the case work was to help the individual and this method was unique to the social work. In this method, social worker directly involved with the individual. Social case work was articulated by Mary Richmond (1917, 1922)[72] (Haynes & Holmes 1994:242-244). The belief that groups are an effective and efficient is the main base on group work. James Whittaker and Elizabeth Tracy (1989) have distinguished four features of social group work. They are;

1. The group as a whole and the development of individuals as group members
2. The development of mutual aid/support among and within the group
3. The power of group process over the life of the group
4. The development of an autonomous group

[72] She has defined Social case work as 'those processes which develop personality through adjustments consciously effected, individual by individual, between men and their social environment'.

Groups that do not involve professional leader or facilitator are named as self-help groups. Their purpose is to help each other. The history of the community organizing and planning goes to the charity organization societies and settlement house movement. There are three main specific strategies in this method such as locality development, social planning and social action (Haynes & Holmes 1994:249-254). Today, strengths-based care planning, individual care and support planning and implementation of goals are well-known among the social work methods in working with people and helping with their multiple problems. This research discusses in detail the individual care planning and strengths-based care planning in the next parts of this chapter.

5.1.1. Why Family Intervention?

In any society, family often has been the basic informal welfare system. Individuals take part in families to accomplish their basic as well as unique needs such as the need for safety, the need for belonging, the capacity for communication, the capacity to choose in an ethical and relational framework, and the capacity to grow, care and to love. But, some of the basic needs can be intensely violated within the family and then arise crisis in those families (Constable & Lee 2004: 18). While crisis becomes a stigma to the person, the burden is carried by the rest of the family. Following progression of feelings is experienced by anyone who go through any crisis;

- First stage- the initial response to the news on the crisis/problem is denial.

Usually they do not know what is wrong with them. In this study, most of the family members had fears and anxieties at the beginning of their family members' mental health problems.

- Second stage- feelings such as 'it is not fair. Why me' and anger.

Some of them may feel they should be responsible for the crisis, and then they get guilty feeling in the second stage. Also, they get frustrated and angry even because their family routines may change due to crisis.

- Third stage- bargaining; any last hope such as the possibility of medical discovery or miracle operation.

Family members may want to help in the treatment of people with mental distress or other problem, but they do not know how to do it.

- Fourth stage- if family members cannot cope with the crisis, they may be difficult to adjust with the crisis situation, and then they may be depressed even.

However the rest of the family tries to maintain the balance within the family and they chose their own survival roles for this maintaining the balance. If the family members feel that their resources are not enough to cope with the crisis or problem, they expect to get professionals' support for this (Wegscheider 1979: 31-32, 50). On the other hand, when they struggle with their problems, if they do not have clear understanding on the crisis, nature and reasons for the crisis, solutions and how to cope with it, not only the individual's but also the whole family's welfare might collapse without their knowledge. The case studies of Surani, Sheela, Kanchana, Kasun, Amila, and Parameshwari are good examples for how family members were difficult to cope with their unexpected crises with their family members. Different problems began due to their lack of understanding and lack of coping strategies with crises.

Therefore, in such situations, professional intervention is very important. Social worker/therapist can counsel a family on how they can shift intentionally its dynamics from dysfunctional to functional.

5.1.2. Individual Care and Support Planning

Individual care planning sometimes is named as 'person-centred planning' as well. There are different terms used in different settings for different conditions. For instance, the term 'person-centred' care planning is used in social care settings. Sometimes, it is used the term such as care and support planning as well. However, the aim of this method is similar and it includes the all aspects of the health, well-being and life (Personalised Care

and Support Planning Handbook: The Journey to Person-centred Care (part 1-3) 2015:12-14).

Individual care plan is on-going throughout the helping process. In this process, it is necessary to decide by the family members what they can and what they want to do. Whether family can do and willing to do something about the problem and care plan conjointly conditions and tasks a couple and family face are very significant in the care plan. On the other hand, social worker should be able to get an emergent general picture from the care planning on what needs to be fulfilled if the family is ready to regain and maintain its balance because family structure and family needs are diverse. However, family may decide ultimately what they do (Constable & Lee 2004: 99-100).

Individual care planning emerged as a result of 30 years dialogue and investigations. History of individual care planning goes back to the 1970s. As a result of the movement of 'normalization', long-stay institutions started to close down and ordinary living became popular. Brooker (2004) has pointed out that person-centred approach can be seen in Carl Roger's (1958) work and he approached the 'client-centred psychotherapy'. This method initially has been developed to help people with learning difficulties. Today, this method is used in many of the social care centres. Simply put, individual care planning is "*a way in which support for people who use social care services*" (Mansell and Brown 2004a). If not, it is "a way of enabling people to take a lead in planning all aspects of how the services they receive are delivered" (Dowling 2006:3). Individual care planning has been defined in different ways based on different approaches such as terminological, philosophical and practical. Terminologically in mental health individual care planning relies on notions of empowerment and user inclusion. Though there are different approaches on the implementation of individual care planning, personal empowerment of the person with problem is the common characteristic of each approach. This method encourages the non-professionals' (family and friends) involvement as well. Main focus of this method is choices, abilities and aspirations. Accordingly individual care planning has been defined as "*person-centred planning is grounded in a rights based approach incorporating principles of independence, choice and inclusion*" (Stalker and

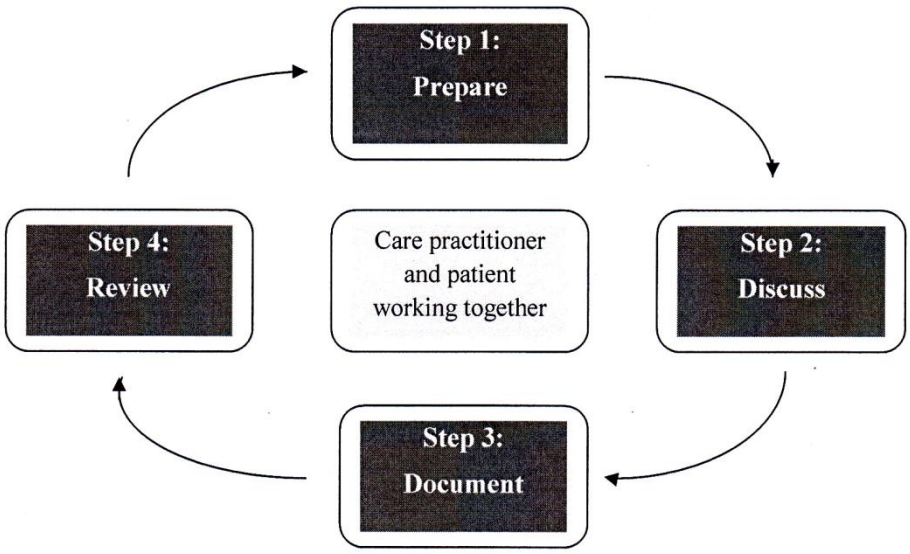
Campbell, 1998). But, philosophically, this method has been defined in other way: "*person-centred planning is a strong planning process that puts the person at the centre and deliberately shifts power towards them and can help reclaim some of the freedom which most of us take for granted*" (Parely, 2001). There are four tools developed to implement the individual care planning.[73] According to this practical approach, it has been defined as "*it is not a single technique but a, 'family' of approaches that, collectively, seek to give disabled people control over their own lives and ensure that they are respected and valued"* **(**Todd, 2002) (Dowling 2006:4-6). Person-centred care planning is a collaborative process. In this process, there are equals between people with mental health problems and care needs along with family members and they work together with social worker or other care practitioner (Personalised Care and Support Planning Handbook: The Journey to Person-centred Care (1-3) 2015:11).

Steps of Care and Support Planning

In arrangement of a care and support plan, there are four main steps to follow. They are preparation, discussion, documentation and review. In Figure 5.1, it can be seen very clearly how this four steps are interrelated in the delivery of a care and support plan for an individual in a long-term care service institution.

[73] (1) McGill Action Planning System (MAPS) (2) ELP (Essential Life Planning) (3) Personal Future Planning (4) PATHS (Planning Alternative Tomorrows and Hope) (see Sanderson et al, 1997) (Dowling et al 2006:6).

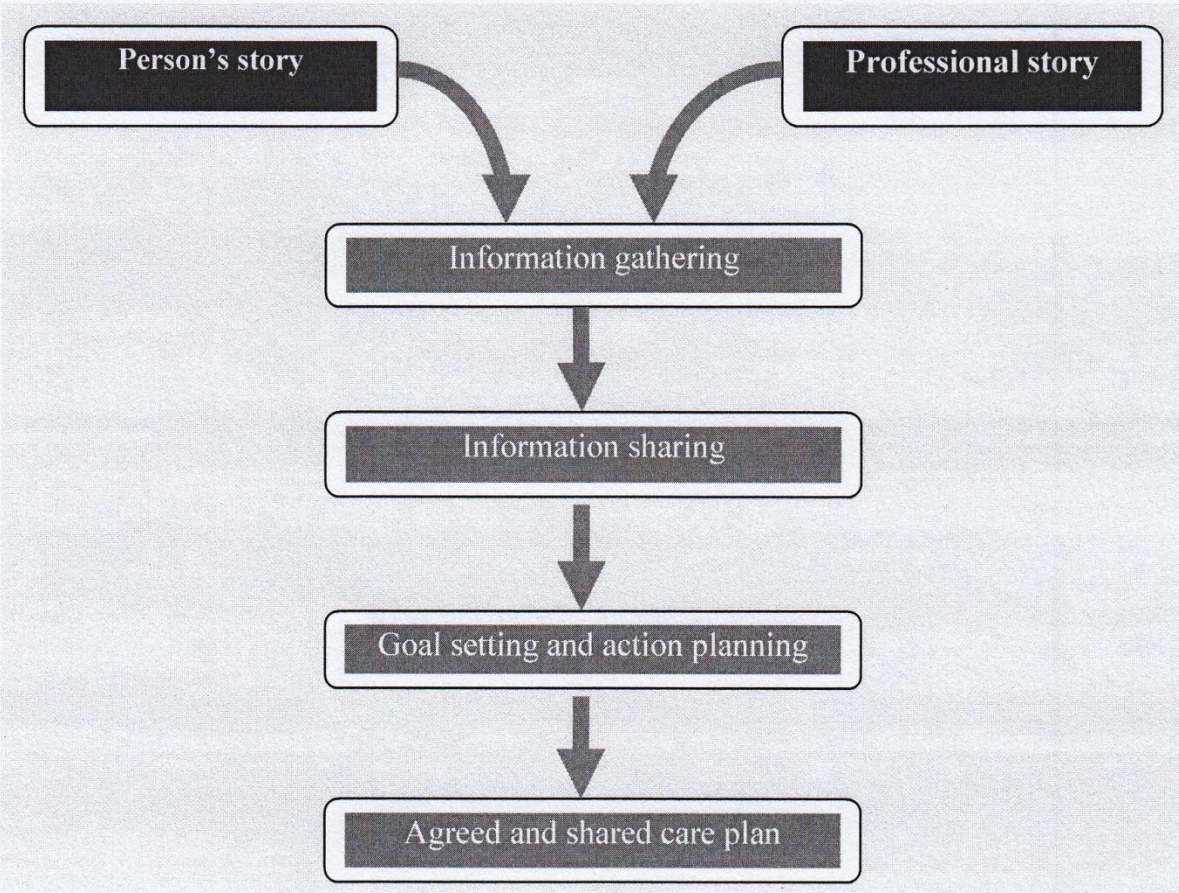
Figure 5 .1 Practical Steps and the Processes of Delivering Care and Support Planning



Source: Personalised care and support planning handbook: The journey to person-centred care 2015: 10

In the step of preparation, person with mental health problem or other problem need some support to gather information on his or her mental health problem, treatment, medicine, records, services etc. Sometimes, people with problems may talk to their families, friends, and care-givers to gather information. However, it is necessary to start from the point of view of the individual with the problem. Social worker also should contact the individuals with mental health problems; need to invite them to participate in the care planning. Apart from that, social worker should select what type of persons to be selected for the care and support planning. Next, it can build a time to reflect and consider options (Personalised Care and Support Planning Handbook: The Journey to Person-centred Care (Part 5) 2015: 6). As mentioned in Figure 5.2, social worker can arrange this time for the discussion.

Figure 5.2 The Process for the Care and Support Planning Discussion



Source: Personalised care and support planning handbook: The journey to person-centred care 2015: 10

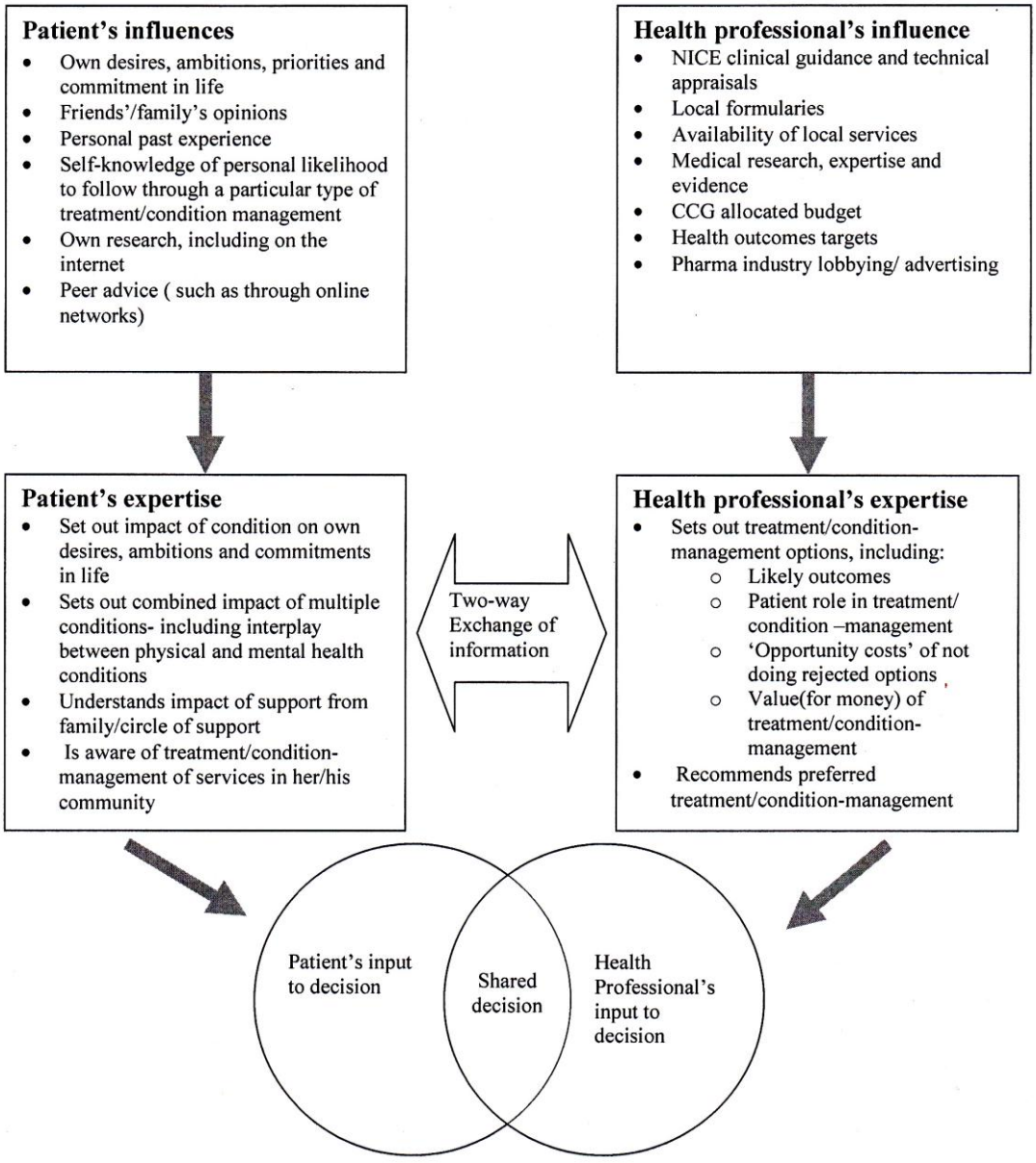
Social worker also has to be prepared before starting the next step. Social worker can prepare by gathering information on individual's health and care needs. In this process, social worker can contact other professionals who are involved in the individual's health care. Also, social worker can gather information from them with regard to possible options and support. Sometimes, social worker can invite other professionals to participate in the discussion (Personalised Care and Support Planning Handbook: The Journey to Person-centred Care (Part 5) 2015: 8). Collaboration and inter-professional practice is often important concept in social work. Inter-professional education can be

defined as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care”. Here there is a common learning (Freeth et al, 2005, p11) (Taylor 2012: 662).

This is a good description of the relationship in social work process. Through this relationship, individual’s and family member’s assets, skills, preferences and knowledge should be researched, identified. In the discussion step, conversations should emerge the reflections, decision making, open questions and negotiations (Personalised Care and Support Planning Handbook: The Journey to Person-centred Care (Part 5) 2015: 9). Čačinovič Vogrinčič (2015) claims, reflexive research of social work processes in and for practice are needed to produce new knowledge and build specific social work scientific knowledge. She introduced the concept of ‘co-creation’ as a process of help in a clearly defined working relationship where individual helping projects are co-creted (2015: 253). In this helping process also, it can be seen that often people are put first, their knowledge, skills, abilities and preferences are given the priority in the helping process. In the discussion all the voices should be heard, but the professionals have the responsibility to give priority to user’s voices, what individual need, what his preference is. In Figure 5.3, it has been very clearly explained how both parties can come to a shared decision by using both health professional’s and individual’s with mental health problem. This decision also is taken after a negotiation. In this process, individual with the problem uses his or her influence and friends’, family members’, carers’ influences and individual’s expertise. Medical professional also uses his or her influences and expertise to take this decision. But, it is shared. Apart from that, addressing the needs, goal setting and action planning, exploring options and choice, planning future, discussion and management of risk and consent and information governance are also very significant in this step. In addition to the medical needs, there may be lots of sensitive issues such as personal issues, relationship issues, employment and finance issues. But, they are not related with the medical issues. In the goal setting, individual’s goals should be given priority. Also, goals should be based on needs, not on services. Goals should not be limited to

medication and treatment (Personalised Care and Support Planning Handbook: The Journey to Person-centred Care (Part 5) 2015: 13-17).

Figure 5.3 A Model of How the Influences, Expertise and Roles of Health Professionals and Patients Should Inform Shared Decision Making



Source: Personalised care and support planning handbook: The journey to person-centred care 2015: 10

Third step is documentation and in this step, social worker has to write down what they discussed and what are the key points. Care plan discussion and written care plan should be short and information in the care plan must be meaningful and accessible. Individual's wishes and aspirations should be included in this plan. The agreement of the parties (professional, individual with problem and family member) also should be include in this plan. A copy of the care plans should be given to the individual with problems because he or she feels certain ownership of it and it is certain type of responsibility for them.

Review is the last stage. Support care planning is a long process. Therefore, it should be reviewed to see what is working and what is not. Sometimes, extra reviews may be needed due to some life changes such as bereavement, hospital discharge, new diagnosis, change the caring etc (Personalised Care and Support Planning Handbook: The Journey to Person-centred Care (Part 5) 2015:19, 24-25).

In the consideration of the above information on individual care planning, it is very clear that people with mental health or other problems and their family members have often been given the priority in this helping method. People are respected; abilities, skills and aspirations are related with the planning. Person's preferences come first in the decision making. The language is also different I this helping method. Language is based on empowerment. Always, people are given the power to control their lives and live their lives in this helping process.

5.1.3. Strengths-based Care Planning

A standard feature of most helping endeavours is completion of the care plan. This is often considered as 'a required activity, necessary for reimbursement, and as a tool used to zero in on a problem definition or diagnosis'. The care plan is considered as the step preceding the phase of actual helping. In most medical settings, care plan interview can be similar to standard intake procedure in the most benevolent situations. But, it is very

painful experience to the individual with problems because repeating their personal histories, recounting their personal failing does not make happy the individuals.

Therefore, strengths-based care planning is a good solution for this. This type of care planning is not just a precursor to the helping process and it is there as a significant intervention as well. Strength bases care planning with people with problems uncovers, reveals, and recognizes individual and family strengths as well as strengths in the world around them. This is one of the most important key tasks in processes of intervention, care, support. In the completion of an individual care plan, a conversation is required. This conversation should not be threatening one and it should include very simple open-ended questions. In the conversation, social worker can take individual's cues to explore some areas in depth. Saleebey (2006) has pointed out some of the important keys[74] of stimulating this type of conversation. The identification of strengths, capabilities, possibilities, abilities, and accomplishments is very important and this makes a roadmap to out of these people's current dilemmas. While the conversation is going on, social worker can move the conversation from problems to solution as well. Further on, Individual with problems may reveal past interests, activities, important people whom he or she wishes to reconnect. Then, social worker can ask about the current interests. If he or she acknowledges unmet needs, goals or aspirations, social worker can move the conversation to discuss about obstacles to be moved away to go ahead. Care planning and goal-setting are consanguineous and therefore, this can take as a topic to discuss in the conversation at the right time. One focus of the conversation is identification of the skills and abilities which individual needs to accomplish his or her stated goals. Other focus is the target of an intervention to increase the available opportunities in the surrounding world (Sullivan 2012:182-185).

[74] "First, it is incumbent on the practitioner to provide the words and images of strength, wholeness, and capacity where they may be lacking. Second, it is important for the practitioner to be an affirmative mirror, beaming back to the client a reflection of that person's positive attributes, accomplishments, skills, and talents. Last, it is wise to carefully lay out with an individual what may be possible in his or her life- big or small things, it doesn't matter. And all of this must ring true to the person and be grounded in the dailiness of life" (p. 89) (Sullivan 2012:183).

In the intervention, we have to be careful on the cultural differences between family members and their outside environment, and within the family as well because they are powerful determinants of the intervention (Constable & Lee 2004:98). Clausen and Yarrow emphasized the need to become acquainted with relatives' perception, culturally defining and dealing with MHPs, peoples' response towards deviant people, especially, the way of maintaining the morale and cohesiveness in the family, role structures and their changing (Hatfield 1987b: 15).

According to the above information it is clear that former assessment and the intervention was most of the time one way approach. But under the new approach on care planning, '*in the process of collaborative relationship and a dialogical conversation, client and the social worker become mutual participants trying to understand and respond to each other from within the conversation and the relationship*'. When the social worker is involved in this common and dynamic activity, both are shaped and reshaped; formed and reformed. Not only that social worker and the individual with a problem construct something new with the help of each other (Anderson 2007a:34, Anderson 2007b:51).

Many of the recent government guidance emphasizes this inter-agency collaboration because this type of mutual care planning, emphasizes people's competence and abilities to use for the better collaboration with service users and their families and giving more attention their expertise (Milner et al 2015: 12).

Care planning and intervention are different from one another. Assessment becomes a care plan and it includes the partnership, empowerment, multi-agency corporation and value of money. But the former (assessment) focuses on the identification of objectives and problems to be tackled. Later the concept of care planning was focused on the actual selection of suitable means to meet the needs. This new approach was mostly welcome by social workers. There are two major influences on care planning practice. One is social workers remove their high involvement from the practice theory because of this separation. On the other hand, this separation made social workers' value explicit (Milner et al 2015:11).

Dalrymple and Burle (2006) have proposed the following ethical framework for care planning for searching needs under the implications of anti-oppressive practice for care plans;

- Care planning should involve those being assessed
- Openness and honesty should permeate the process
- Care planning should involve the sharing of values and concerns
- There should be acknowledgement of the structural context of the process
- The process should be about questioning the basis of the reasons for proposed action, and all those involved should consider alternative courses of action
- Care planning should incorporate the different perspectives of the people involved (Milner et al 2015:27).

However, Payne (2010) has pointed out some barriers to delivery of care plans such as lack of time, inadequate information, lack of consensus among the professionals about who should initiate care plan, how they should do it and in which setting (2010:114).

5.2. Family Support

Almost all the families need support. This support may be natural or informal support. The support given by other families, friends and communities can be named as natural support. The formal support is given by organizations to meet the educational, health, housing, financial needs, recreational, and spiritual needs. Most of the time, natural support for the families with people with mental health problems reduces due to the social stigma (Gyamfi et al 2010:14). As explained in Chapter Two, family support can be defined '*as self-help or volunteer help with the little statutory involvement, or it can mean a continuum of advice, support, and specialist help geared to provide early prevention intervention, parenting support, education, and marital therapy*' (Houston & Dolan, 2008). Through a three-stage model, the place of preventive family support work can be conceptualized: primary level, secondary level and tertiary level, intensive work.

- The Primary level- offers universally available services to strengthen family functioning provided by a mix of state welfare providers and parent education services often organized by voluntary organizations.

- The secondary level- provides services targeted to families in early difficulties, such as relationships counseling for couples, visiting schemes by voluntary agencies to help families with young children.

- The tertiary level, intensive work- either by the statutory or voluntary sector to prevent family breakdown- can include those who are experiencing severe difficulties and who are on the threshold of care proceedings (Walker 2012: 615-616).

Thus multiple problems in the families were able to be seen. Among their problems, marital issues, lack of mutual understanding, unemployment, financial issues, fathers' alcohol misuse, property issues and lack of mutual support were prominent. This problematic background badly impacted on the people with mental health problems in these families. For instance, parents' unemployment negatively influenced these people's poor level of financial situation. Then, it becomes a special need for both families and people with mental health problems to be fulfilled by another group; institution or organization. Also it was able to find positive family support from the family members for the welfare of the family as well as negative contribution to create family issues within the family in this study.

Families are very important resources for the people with mental health problems in developing countries. In majority of the short term hospital admissions, family members stay with their ill members (Kala & Kala 2008: 310). It should be stated that extended family support is very significant especially for families with poor financial situation, and family with conflicts. Extended families can act as a source of social support (Fiese 2006: 74). In the ancient Sri Lankan society in the married or unmarried children' problems, their extended parents were supportive and they had some plans in advance. Following extract shows how fathers have arranged some plans in advance for family crises.

> "…a witness stated that one Wirasimha Mudaliar, at his death bed, calls his seven daughters before him and said, "I am not certain that you will all marry out, and it also may happen that some of you will return home from your husbands. Should that be the cased I have reserved one pala[75] of Koholvila-deniya[76] to be possessed by such daughters. Only three daughters survived, two of whom married and left the home. The youngest enjoyed the land, leaving it when she married. Her first husband was executed the King's orders and she returned to her father's house to resume possession of the pala of Koholvila-deniya; "she afterwards was called to wife by Valbavagedera, a man of Seven Koralas[77] who dying, and she having no maintenance, she returned to her father's house being big with child.."(Pieris 1956:196-197).

Studies have found that many people with mental health problems are accompanied by a family member for treatment and most (90%) of the people with mental health problems are discharged from hospital to the family in Asia (Snowden 2007: 390). Families are the most possible to voice the first signals of concern because generally it is considered that such care is the family's 'responsibility' or their 'obligation'. Sometimes, they call their friends, neighbours, even the police to assist them in such occasions. Especially, family needs this type of support in the occasions of their family members' acute stage and bringing them for treatment. In this type of occasion, it can be clearly observed the hidden culturally-shared assumptions that one of the duties of the family members is to care for each other. However, frequently family tries to bear the burden of the

[75] Method used to measure the lands of paddy fields in Sri Lanka. 'Pala' is similar to half acre.

[76] Name of a land of a paddy area. There are special names for some lands and paddy lands in Sri Lanka and they have been mentioned on the deeds even.

[77] Under the British colonial period, there were different administrative officers who ruled the areas. 'Korala' is such an administrative officer who ruled several villages under the British colonial period.

responsibility of the care of each other in the family. This happens not because of their guilty but because of their guilty is aggravated by others if family members do not shoulder the burden and seek outside support (Dallos & Boswell 1993:91). Therefore, family should be supported in their crisis period to minimize their distress and the burden and assisting the family means assisting the individual with mental health problem.

And also, 4.76% out of the total sample in this study are the category of close relatives (see Table 5.1). Many close relatives are kin relatives from their extended families of people with mental health problems. These relatives support much for the single parent families where especially father died or separated, or fathers with poor financial support due to their alcoholism.

Table 5.1. Common Hospital Visitors

Nature of the relationship	**Number**	**Percentage**
Parents	28	33.3
Spouse	17	20.2
Siblings	22	26.1
Children	12	14.2
Close relatives	4	4.76
None	1	1.19
Total	84	100.00

Source: Field Data: 2011-2012

Also, it is understandable that though married siblings were living separately, they have not forgotten to visit their siblings who suffered from mental health problems when and where necessary.

This chapter will now turn to several case studies before the discussion of what family and people with mental health problems think of family support for people with mental health problems.

Case Study 5.1. Gamini

Forty-five year- old Gamini has been medically diagnosed as having schizophrenia from his age of 24. He has studied up to Ordinary Level Examination and has been living with his parents and elder sister in the parental home. Gamini is single and unemployed. Mother was a house-wife and father was employed in the government sector. Elder sister was his only sibling and she was also employed and unmarried.

Gamini had been taking treatment from multiple psychiatrists from private sector and he has been treated at government hospital since 2000. His mother and father brought him for treatment at the beginning carefully. Unfortunately, his mother died few years back at the age of 70 years and his father (77years) had to take all the responsibility of Gamini. But, father also was not well due to his neurological problem and physical diseases. However, he brought his son for treatment with many difficulties. Gamini did not have any understanding of his mental health problem and medicine. He had issues with his physical care due to the bad impact of his mental health problem.

In the process of Gamini's hospital visiting and treatment, no one from the mental health staff has met his elder sister. She was a school teacher. She has never come to visit her younger brother or health professionals. Father also was very concerned about their social status. He was not happy to take his daughter to meet the mental health staff at all due to the social stigma associated with his son's mental health problem. With the gradual deterioration of Gamini's father's physical health and old age, mental health team understood that he was very difficult to bring Gamini for

treatments. Therefore, the father was requested to accompany his sister to make her aware of Gamini's mental health problem, its nature, importance of the regular treatment and future care as no other person is to look after this individual after father's demise. But, the father refused to accompany her and he got angry for that request.

One day, Gamini's sister came and met the mental health staff. She said that she also has been living separately for many years due to the problems of Gamini's mental health. She was angry about her parents' over-involvement only on her brother. The father also took all the responsibilities of his son until the last resort without revealing or criticizing his daughter's lack of support in his son's caring and medication.

Later, Gamini's father died. His sister had to take her brother's responsibility though she was not happy. She wanted to take the mental health staff's support to divert her father's pension to her brother as he cannot do a job and survive independently. Her ultimate purpose was to put her brother to a home for the people with mental health problems because he has his father's pension. She said that she would not be able to take the long term care of her brother with the problems in his behaviour and the poor recovery which she experienced up to now.

Case Study 5.2. Samanthi

Samanthi is s married lady with two children and suffered from a long term mental health problem since 2000. She is 42 years old. Samanthi was unemployed. She lives with her husband and two children in a rented room. She had lots of family, social and financial issues due to her mental health problem, husband's alcohol and substance abuse and his lack of support to her and children.

Samanthi eloped with her husband at the age of thirty two as her parents were against their love affair due to the high social status of Samanthi's

family, discrepancy between their jobs and age (husband is six years younger to her). Husband is a thirty six year old labourer. While Samanthi has studied up to Ordinary Level Examination, her husband was educated only up to grade four. Samanthi has worked as an account clerk before marriage. Soon after the marriage, she got her second episode of the MHP. She believes she got her second episode as she has stopped her medication and faced the unexpected family problems. Since then, she has been suffering a lot from her problems. Her problems have increased due to husband's poor understanding about her mental health. She had lots of side effects of her medicine. Samanthi has limited support from her extended family due to the stigma associated with her mental health problem. Her children show problems in their behaviours due to poor parenting. She or her husband did not have their own house and for ten years they have been changing their residence form place to place.

Her husband has never come to the hospital with Samanthi and criticizes her mental health problem and treatment. He often assaults her criticizing her poor functioning level. Therefore, in addition to the medication, social worker had done a home visit and met her husband to address his beliefs and awareness on Samanthi's mental health problem. First, social worker needed to take Samanthi's consent to meet him. It was very difficult to make her understand on the purpose of the meeting of her husband at the beginning. At that time, Samanthi expressed her ideas as follows; "sometimes, my husband may think that I reveal his fault and our private information. Therefore, I am having a fear of hospital staff's visit". However, she has given her consent to visit her house and meet the husband after making her aware of the purpose of visit and its good impacts on her and her family. Researcher observed that Samanthi did not talk anything in front of her husband though she had revealed many problems in her family to the mental health staff in the hospital. Though

the husband agreed to come to the hospital with Samanthi in the next follow up, he did not come.

In addition to Samanthi's mental health problem and husband's alcohol and substance abuse, the problems of her children's behaviour and husband's physical harassments caused to increase her mental distress. Especially, her son has been playing her husband's role at home when her husband is not at home. He thoroughly refuses to go to school. He is used to stealing money. He threatens and even assaults the mother when she influences him to go to school. Samanthi is afraid to tell anything to him because of his behaviour. Not only that he often criticizes his mother's mental health problem, treatment and her behavior by using the word 'pissi' (mad lady). Social worker has visited Samanthi's house again with the mental health team to meet the husband. But, the husband was not at home when they went there. Samanthi's landlord has informed her to leave their premises soon because of the delay in paying rent not keeping the room properly and clean and quarreling each other at night. Samanthi was helpless when the mental health team visited her house because she had no enough money to find another place to go with the children or even to buy something for the children to eat. Husband has not come home for few days. Though her husband had known that house owner requested their room back he has not taken the responsibility of finding another place to go. He has influenced Samanthi to go to her mother's home with children and ask for money to rent a new place or their additional house given on rent. But her mother does not want her to give their additional house. Also, she was not happy to keep them with her because of the stigma, Samanthi's husband's alcohol and substance use and his usual negligence of the responsibilities in their family and dependency on them. Though Samanthi used to go to her mother's house and bring things for their living, the mother has never visited Samanthi's place. When the social worker discussed this issue with her mother, she said, "we

supported her at the beginning well and kept her with children after her delivery of the daughter. But, husband cannot live with her well and he assaults daughter, wastes money for unnecessary things. Now I cannot take her back because I am living with my son and his family and my unmarried young daughter. I want to find a marriage partner for my daughter. If I take Samanthi back, I will not be able to find her a partner. My daughter- in -law also does not want Samanthi and her children to come to our home because of the shame".

Unfortunately, Samanthi did not have any welfare benefits as they did not have any permanent address. They did not have even their right to vote in the elections for ten years as they did not register in any Grama Sevaka[78] Division as they are homeless. Not only that, she has not obtained even her daughter's birth certificate though she was four year old now. Due to her husband's and close relatives' poor support and bad impact of her mental health problem on the care of the children, she was unable to take her daughter's birth certificate. Ultimately, the social worker with the help of mental health team was able to help her to obtain the birth certificate. Also the social worker has helped Samanthi to build a relationship network between Samanthi and government officers[79] who can support in Samanthi's multiple issues.

Case Study 5.3. Sheela

Sheela is a mother of an individual with mental health problem from a suburban area from Colombo. She is 56 years old and works in a private firm. She has retired from her government employment to care her three children with mental health problems. But, she has restarted her employment in the private sector recently due to financial difficulties. Her

[78] Grama Sevaka Division is the smallest village level administration office in Sri Lanka. Almost all the application for public aids should go through this office.

[79] School teachers, social service officers, child rights promotion officers, probation and child care service officers, Grama Sevaka.

husband also has retired from his job. He is at home looking after their children. Three of them are in their twenties (one daughter and two sons). All three children have been medically diagnosed as having schizophrenia and no one continues regular treatment for their medical diagnoses. Even though, all three children have studied up to Advanced Level Examination and have good results, no one is employed. No one has yet married. The daughter has from time to time worked in several institutions; she stops her employment because of the repeated relapses of her mental health problem.

The mother comes from a highly educated family. But, she has disconnected all contacts with them because of her relatives' rejection of their children visiting their houses. No one from her extended family also visit them. The father in this household plays a very passive role. No child listens to the mother or the father and they spend their lives according to their will. Both sons are very demanding at home. When parents do not give in totheir demands, they destroy household items. Though they need residential treatment, the mother is not happy to bring them to a hospital for treatment. She has channeled psychiatrists in the private sector. Most of the time, children were reluctant to visit the psychiatrists in mental health hospitals.

First, Sheela came to the UPMU to meet the doctors and nurses to get advice on her children's mental health problems because she had some connections with medical staff. Mental health staff has advised her to bring the children to the hospital. She agreed to bring her daughter first. She was taken to the UPMU. Doctors diagnosed her as having schizophrenia and started treatment. The mother was advised to bring gradually her other children as well. Sheela's daughter had taken medicine for one year. She suddenly stopped her medicine because she wanted to go for a job. The social worker visited this house with other mental health staff and met the sons and the father at the mother's request. When the

team visited their house, the younger son has neglected his personal care more and at the beginning he rejected to talk to the team. But, at the end, he agreed to come to the hospital. Few days later, he was accompanied by his parents to UPMU. But, he was not happy to stay a few days for residential treatment though it was needed. The elder son has been brought to a psychiatrist in the private sector and he has started medicine for him as well.

Sheeela's daughter stayed in a boarding house and did her job for five months. She stopped her employment due to her inability to cope with the symptoms of her mental health problem. Again, she was brought to the UPMU for treatment. This time, she participated in the rehabilitation programme conducted by this unit. Again, she became well and started a training course while she was on medication.

But, the sons did not continue their treatment and went back to their usual life Sheels came and requested home visits and give injection medication to her younger son as his personal care was deteriorating day by day very badly. The mental health team visited their house twice. The younger son was given injection medication after having a long chat with him to take his consent for injection.

Due to lack of resources, visiting this house every month was not practical. Sheela was advised by the psychiatrist to admit the sons in NIMH with the support of the police. But, she was not happy with that suggestion at all though the father agreed. In the decision making role, the mother was dominant in this house. Later the daughter also stopped her medicine and she did not listen to even the mother. Even though, the social worker encouraged the mother over the phone to bring her children for treatment and support for rehabilitation, it was not successful as she was unable to bring them.

Case Study 5.4. Nadaraja

Nadaraja is a son of a Tamil woman who takes treatment from UPMU for her depression since 2011 and they are from a village far away from Colombo. Nadaraja had been living with his mother in their own house before she got the current episode of depression. Soon after this episode, he has come to the UPMU and admitted her. Nadaraja has temporarily stayed at his elder sister's house in Colombo. Nadaraja started to work in his sister's shop because he felt that it was not good staying in the sister's house without supporting in their work. It is his brother-in-law's house. There was no good relationship with his sister and her husband based on property issue. He wanted to keep the peace in their family. Nadaraja could not afford another place because of his leaving the employment due to mother's caring. He comes to visit his mother in the lunch time.

No one comes from his village to visit the mother though she was very active among the villagers and catholic devotees who came to their Church before the MHP. Also, Nadaraja did not want anyone to know that mother is in the hospital and come to visit. He did not expect their support further for his mother and he explained the reason for that as follows;

"First, we had discussions with our relatives and tried to find solution for my mother's issues and property issues. But, we were unable to solve and the relatives increased the problems. So, we went to our Church and discussed with the priest. In the family problems, we do not deal anything further with our relatives or outsiders because we have some bad experiences in the past".

Nadarajah has already resigned from his employment. He further explained his mother's previous status and future hope on her recovery as;

> "I resigned from my job. I wanted to look after my mother. I think she needs our support. She waits to eat until I come. I want to strengthen my mother psychologically. She worked hard and enjoyed before she was ill. My mother performed all the activities in our home before her illness. She was very happy to keep the home neat and clean. See plucked the tea in our garden, cooked deliciously. She enjoyed by doing these everything. But now she was disappointed with everything. However, I think she would be able to restart these things after few weeks with her medication".

5.2.1. What Do Families Think?

In the exploration of the reasons for daily visiting their family members with mental health problems, it is obvious that majority of the family members have visited them as they are their own close family members and they think that it is their responsibility to look after them. People with mental health problems also think that if there are family members with such problems, their family should look after them. But Flaker et al (2011) have mentioned that family is obliged to look after all their family members and it is a moral principle which people often state. However, this cannot be seen in practice due to many reasons such as increasing employment of the family members and their overburden (2011: 201). On the other hand, family support and emotional support are very important for the people with mental health problems in the family members' point of view. Within the emotional support explained by the family members, it consisted of compassion, love, kindness and feeling of togetherness. Interpersonal relations are the dominant consequences in the Asian families and values are based on unity, harmony, and togetherness (Willgerodt and Killien 2004: 152-153).

Table 5.2. Reasons for Daily Visits

Reason	Number	Percentage
A close family member	17	20.23
Need family support in addition to medicine	10	11.90
Expectation of emotional support by visiting	10	11.90
Unhappiness to have hospital meals	1	1.19
Suicide risk	1	1.19
Not coming daily/do not apply	44	52.38
Not mentioned	1	1.19
Total	84	100.00

Source: Field Data: 2011-2012

According to the frequencies of the hospital visits of family members and reasons for visiting daily and not visiting daily, we can see the level of family support for family members with mental health problems. Any of the family members is used to come to hospital to visit family members with mental health problems and it was 34.52% out from the total sample. There were some family members (14.28%) who came twice a day to visit their family members. But, this nature of visiting was dependant on the distance too. Majority was 5-10km away and they were able to visit their family members twice a day.

Table. 5.3. Frequencies of Hospital Visits

Nature of the Frequency	Number	Percentage
More than two times in a day	12	14.28
Once a day	29	34.52
More than two times in a week	24	28.57
Once a week	9	10.71
Depend on income	2	2.38
Rarely	8	9.52
Total	84	100.00

Source: Field Data: 2011-2012

But family who lived 35-50km away from the hospital was difficult to come to the hospitals twice a day due to the distance. People with mental health problems are considered as a vulnerable group and those who are living in rural areas are at higher disadvantage because they have limited access to health, lack of resources and traditional cultural beliefs system. It has been found that a direct effect is needed on the welfare of these people with mental health problems and their families through social support (Letvak 2002:249-261). Another majority of family members came more than two days in a week and the distance and financial difficulties were the main reasons for this type of visits (Field data 2011-21012). There were some family members who were unable to come to visit their family members due to their employment though they wanted to visit them. In addition, there are families with dual career (Calhoun et al 1997: 298) and they find it difficult to come to visit their family members with mental health problems on week days and they come on weekends only. This number was 8.33% in this sample

(Field data 2011-21012). It seems that even though family members want to come to visit their family members with mental health problems, some of them cannot come due to some practical issues.

5.2.2. What Do People with Mental Health Problems Think?

It has been studied how family caregivers negotiate their involvement with their family members with mental health problems and found different kinds of assessing the obligations[80]. On the other hand, this explains the needs which people with mental health problems expect from their family in addition to the physical needs (Karp and Watts-Roy 1999: 469). Following extracts taken from case studies in this study also explains what types of support they expect from their families.

> "If family member has an illness, other family members in his or her family should look after him or her; they should bring them for medication and support to give medicine….Otherwise, who do this?" (Karuna).

> "From the beginning, there were problems in my marriage life. Only one month, I was with husband and his relatives. For few months, I was with relative sister, time to time I was with my mother. Now, I live with my husband and son" (Kumari).

In their family crises, people with mental health problems have taken support from their extended and close families. Sometimes, they have stayed with relatives until their crises settled down. Some of them have taken their relatives' involvement in the solving of their crises while they were with relatives. In this study, it can be taken some examples from the case studies of Kanchana, Amali, Samanthi, Kasun, Silva and Surani. Kanchana expected her close family members' support to reduce her distress. For instance she expected them to allow her to stay with them for few days. Amali also wished their

[80] Hoping, learning, revising, expectations, assessing responsibility and preserving oneself. (Karp and Watts-Roy 1999: 469)

mother's support in her daily activities. Some of the people with mental health problems needed family support in their daily living activities in their acute stage. Flaker et al (2007) explained that people with mental health problems need some money for their social and sports activities. Also they need some escorts and companions. For instance, they also need to go to cinema, city, picnic, or a trip. In this regard, they expect family support, sometimes money, sometimes accompanying them and bringing back home (2007:104). Silva expected money from his family to go for a film, expected to go out to talk to his previous friend. But his wife and children did not allow going him out. They have closed the gate even. He was very disappointed with them because of not giving their permission. He had to wait until children come to go for a film.

Kasun also expected his family to support him in various ways including being understanding. He especially expected his only brother's talking. Samanthi expected her mother's support in her housing crisis though she rejected it. She wanted a temporary place to stay at least with children until her husband finds a place to stay. She needed to keep her goods somewhere else. As Flaker et al (2007) explained personal items and belongings represent a significant basis to construct someone's identity throughout our civilization (2007:96). In Surani's story also, she expected her close relatives' support to stay for her to avoid the distress due to MHP. But, there were some examples to prove that on one hand, family support those with mental health problems to mitigate their extra problems, on the other hand, they themselves, caused to increase the social stigma as well.

However, it is clear that majority of the people with mental health problems in this study saw the family support as a positive factor to improve their mental health.

5.2.3. Social Stigma and Help Seeking Behaviours

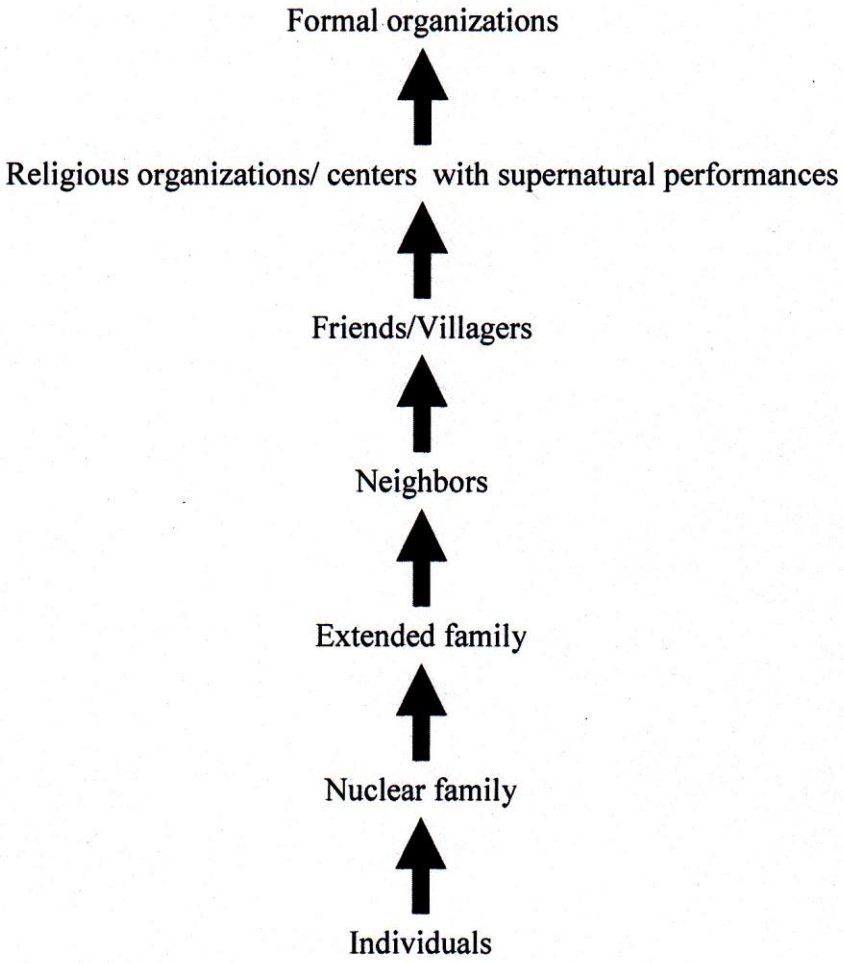
Help seeking among the human beings is not an isolated or rational action. This is a process started with the influences from individuals in one's social network; family members, friends and close associates. People with mental health problems also have people who are ready to come to support them in their problematic situations. Among

their support, emotional support, reminding them of appointments, offering transportation, and ensuring that they adhere to appropriate aftercare and son are significant. On the other hand, these members in this social network itself, might also transmit the stigma and negative messages about formal services as well (Lindsey et al 2009: 5).

In the family issues, nuclear families expected extended family support than other outsiders. Though there were some relationship issues among the close relatives, they supported their close family members financially, physically and emotionally in their adverse life events such as mental health problems. On the other hand, they were problem created factors too.

In this study, normal help seeking pathway among the family members can be explained as follows:

Figure 5 .4 Normal Help Seeking Pathways



Source: Field data: 2011-2012

This was first started from the individual and then it was spread up to formal organizations such as the Grama Sevaka[81] office and police. First, they try to solve their problems among the nuclear family members. If they are difficult, they expect the support from their extended family members. Sometimes, they have gone to their religious institutions to discuss their family problems and search for solutions without going to neighbours or friends as they believed that religious leaders might not reveal their private and confidential things to others and might not discriminate them. In Surani's case, she sometimes was sometimes unhappy with her close relatives. Even though they have at the beginning supported her well, later they spread stories that Surani has a MHP which is most probably transmitted from her father's family. Nadaraja too explained why he did not expect relatives' support in his mother's mental health problem. Due to his previous bad experience of sharing family matters with relatives, his former property issues further increased. Therefore, he had no idea to further share his mother's issue with them and he believed his priest in the Church is suitable to get some advice. Apart from that, Nadaraja is having a fear of moving with his relatives because of the land issue.

There are some sex differences in help seeking behavior. Accordingly, female persons are more prone to come for help seeking. Male persons are somewhat reluctant to reveal their information and say that they are having a mental health problem (Pilgrim & Rogers 1996: 29). Therefore, female individuals can be accompanied with less influence than male individuals for treatment. In this study also, it was clear that those who revealed more information on their mental health problem in the interviews were female. According to the information gathered from this study, pathway of seeking psychiatric treatment for MHPs is different from their usual help seeking pathway. Following table gives us a picture on that.

[81] 'Grama Sevaka' is the village level administration officer in Sri Lanka. There is a office called 'Grama Seva Office' in a village and sometimes, one "Grama Sevaka' covers two three villages. It is called 'Grama Seva Division". 'Grama Sevaka' is responsible for the 'Divisional Secretary' in the 'Divisional Secretariat Office'. There are more than three hundred 'Divisional Secretariat Offices' in Sri Lanka.

Table 5.4. How did you Resort to Western Psychiatric Treatment?

Pathway	**Number**	**Percentage**
Direct admission due the awareness	6	7.14
Directed by a known person	8	9.52
Directed by an ordinary medical personal	12	14.28
Advised in the private channeling	35	41.66
Sent by government hospital	18	21.42
Directed by outdoor patient's unit of NHSL	3	3.57
Cannot remember	1	1.19
By the police	1	1.19
Total	84	100.00

Source: Field Data: 2011-2012

In this study, many of the people with mental health problems (41.66%) have been accompanied by their family members to channel the doctors in the private sector first. Another 14.28% has been directed by ordinary medical personals such as nurses working in the psychiatry units, officers working in the hospital labs. Some of them have been directly admitted to these both psychiatric institutions because of their previous experience in the treatment for their other family members with mental health problems. On the other hand, it is obvious that they have not follow the usual help seeking procedure and stigma, labeling and the discrimination are the reasons for this. As possible as they can they have tried to take medicine from the private sector though all of them are not financially capable to continue this without going to the government psychiatric hospitals or units with the purpose of preventing the spreading of their mental health due

to stigma. Very rarely, family members have obtained the official support from the police to take their family members with mental health problems to the hospitals and this also shows that family involvement is very high and family members think that it is mainly their responsibility to accompany them for treatment. On the other hand, they were not happy to use the support of the police to mitigate the stigmatization and angry of people with mental health problems.

Table 5.5. Reasons for not visiting the hospital

Reason	**Number**	**Percentage**
Stigma	16	19.04
Distance	9	10.71
Lack of time due to employment	2	2.38
No relations with others	4	4.76
Other don't know about MHP or hospitalization	41	48.80
Rejected others arrival	3	3.57
Mental health problem	4	4.76
Old age (parents)	3	3.57
Bad human relations due MHP	2	2.38
Total	84	100.00

Source: Field Data: 2011-2012

In the discussion of reasons for not coming to visit the family members with mental health problems, it is apparent that around 49% out from the total sample does not come to visit family members because they have not been informed the family member's MHP and hospitalization. In addition, 19.04% does not come directly due to the stigma.

Distance is also one of the main reasons for not coming to visit the family member. People with mental health problems from throughout the country come for treatment in these hospitals and the majority is coming from between the distance categories of 5-10 and 31-50km. Not only that, the majority comes for treatment by public transport and it is 85% from total sample. Income level of the majority of the families was not enough to use the personal transport or hire the private vehicles. There were two main reasons for coming to these hospitals for treatment: hospital referral and avoidance the stigma (Field data: 2011-2012).

The majority of people with mental health problems expect negative reactions from their environment especially in their work (Angermeyer et al 2004: 153). The main obstacle in providing care for people with mental health problems is the stigma attached to MHPs. While stigma does not stop MHPs, it labels people with mental health problems, their families across generations, institutions providing treatment, drugs, and mental health professionals (Sartorius 2007:810). Therefore, effect of stigma, poverty, and victimization should be included in the individual care plan of the person with mental health problem because they are the barriers to recovery from MHPs (Perese 2007: 285).

When we look at the visitors who did not come to visit people with mental health problems in this study, majority of this category consists of close relatives (48.8%), villagers (14.2%) and friends (11.9%) (see the following table). One reason for this is family members think of that they are out from their family and they should not come to visit their family members with mental health problems. Other hand, they have not informed them about the MHP and hospitalization due to the stigma associated with MHPs. Stigma is "*something about a person that causes her or him to have a deeply compromised social standing, a mark of shame or discomfort*". Most of the people with mental health problems appear as different from other people due to the symptoms of their mental health problems or the side effects of the medication. Other people misunderstand this difference and act negatively towards them. There are some bad

effects[82] of the stigma as well (Advocacy for Mental health: Mental Health Policy and Service Guidance Package 2003:11). Brunton (1997), defined stigma as "*a societal reaction that singles out mental illness as an undesirable attribute, defines the possessing person according to the attributes and devalues the person who possesses it*". Majority experience that stigma as problematic not only for people with mental health problems but also for families (Muhlbauer 2002b: 77). Among the reasons why is MHP of concern to general health workers, MHP leads to stigma is one significant reason. Many of the people with mental health problems are reluctant to admitting the MHP and it is one of the most feared diseases. People with mental health problems are frequently discriminated by their families, communities and even not treated sympathically by health workers (Integrating Poverty and Gender into Health programmes: A Sourcebook for Health Professionals 2005:5). In this study, Surani's case in Chapter Four explains well about the stigma and discrimination associated with her mental health problem in the family, among the neighbours and relatives, work places and the society. Even though she wanted to do a job as a solution for their economic burden, work place and society did not make a room for her and did not encourage her. Instead, they put her down. As a human being, she felt shy and disappointed with the reactions and attitudes of the neighbours and people in the work place towards her. Ultimately, her hopes have faded away.

[82] Unwillingness of people with mental health problems to seek help, isolation and difficulty in making friends, damage to self esteem and self confidence, Denial of adequate housing, loans, health insurance and jobs because of the MHP, adverse effects on the evolution of MHP and disability, families are more socially isolated and have increased levels of stress, Fewer resources are provided for MH than other areas of health.

Table 5.6. Persons Who Never Come to the Hospital

Nature of the relationship	Number	Percentage
Father/ mother	8	9.52
Husband/wife	3	3.57
Siblings	6	7.14
Children	1	1.19
Close relatives	41	48.8
Friends	10	11.9
Villagers	12	14.2
Other don't know about illness or hospitalization	3	3.57
Total	84	100.00

Source: (Field Data: 2011-2012)

Stigmatization of people with mental health problems has been persisting throughout history in both low and high- income countries. Therefore, WHO points that mental health legislations are very significant for countries because they support the people with mental health problems to prevent from stigmatization. Discrimination not only impacts on the access of people with mental health problems for adequate treatment and other services but also their other areas of lives such as employment, education and shelter (World Health Organization Resource Book on Mental Health, Human Rights and Legislation 2005:1-3). Kasun's case in Chapter Four is another example for this. He was rejected form several employment stations due to his mental health problem. Most of the time, older people who have mental health problems are very difficult to enter to an

elderly home because of their mental health problems. Staff of the elderly homes is afraid with the nature of the old people's mental health problems and they do not have any understanding on them. Sheela in this study was very reluctant to bring her children to the psychiatric hospital mainly because of the social stigma coming from relatives, neighbours and society. Therefore, in the care planning of the people with mental health problems, social stigma and discrimination is very significant concept to be addressed by the social worker. Mental health staff experienced family members also on one hand cause to increase the social stigma. It seems that though family members need support from other relatives, they are reluctant to get them mainly due to the social stigma. However, this creates other issues such as social isolation, lack of seeking help, increasing the MHP, losing employment, and lack of getting public aids.

5.3. Mental Health Staff and Family Intervention

According to the study on attitudes of hospital staff toward major MHPs, Aydin et al (2003) found that there were negative attitudes especially among academicians, physicians, and nurses rather than among uneducated hospital staff (Aydin et al 2003: 17). Mental health staff who participated in this research experience that majority of the health staff has negative attitudes towards people with mental health problems and their family members. Some of the mental health staff members said that majority of people's common attitude on public hospitals is 'public hospitals are the places where people are scolded and blamed with tough words for different reasons'. Only very few of the people with mental health problems claimed about some influential activities of the attendants in this study such as controlling their behavior, influencing them to keep good self care, and tough talking with commands. On the other hand, people with mental health problems think that it is their official duties. This gives us certain message that attendants are more powerful and dominant in the care of people with mental health problems, their personal hygiene and behavior in the hospital. Even though they do not participate in the team meetings in both institutions, they use their power on the people with mental health problems.

The following extract explained this perception on attendants like this:

> "Sometimes, attendants pull us from the bed and bring to bath forcefully. But, I am not happy with that. But, I think those may be their official duties to be done" (Malani).

Majority of the ordinary people were interested in talking to the non medical people such as occupational therapists and social workers. They believed that they can share their ideas on every aspect with them and they listen to them. Also, they believed they can release their suffering after talking to them. In both institutions, there was a close relationship between individual with mental health problem and social workers. It is necessary to avoid blaming by the social worker and instead, try to identify competencies of individual with mental health problem and to affirm their experience. Then self confidence can grow. There is a criticism towards the social workers with regard to their failing to acknowledge the strengths and coping strategies of minority groups. It has been suggested on way as a solution to this criticizes in the anti-oppressive practice. When social worker talks with the individual with mental health problem, social worker respectively requests him or her to share their stories of struggle and survival, their families struggle and survival patterns, membership of their community group. In this study, researcher observed that majority of the social workers did not pay much their attention on the identification of the strengths, abilities and interests of the people with mental health problems. Instead, they often talk to them to identify their problems. Social workers are informed of the use of both methods in talking about their wounds and talking about their survival and struggle as well. Through this method, social worker can easily identify their strengths (Milner 2015:30). Researcher's another observation was most of the time social workers had to take decisions regarding people with mental health problems with the authority of the medical professionals. Almost all the medical professionals mainly were based on the medical model.

In general, people with mental health problems and their family members did not criticize much on doctors in public. Majority admired their kindness and treatment. The concept of 'power' can be related with this as well. Majority had a fear to criticize them. People

believed that doctors are the most powerful professionals in hospitals. Majority did not have enough understanding the difference between other professions such as social workers, occupational therapists and psychologists and doctors in mental health units. Most of the time, they thought social workers as 'social service officers'. Social service officers are more familiar with people with disabilities and their families than social workers in Sri Lanka. Generally, majority of the people do not criticize the professionals especially doctors who serve them though they had enough reasons to criticize them. But they believed that doctors are busy and do not have much time to talk or listen to one person with mental distress for long time. Therefore, they most often kept silence and waited specially in clinics until their turn comes.

5.3.1. Do They Want to Intervene?

According to the mental health staff's point of view, every individual with mental health problem has the same basic human needs as they are also human beings though they have MHPs. Mental health staff further views that people with mental health problems are not a special group. Every time they should not be cared. While they are having the acute changes such as suicidal thoughts, they should be supported.

> "Mentally ill people also have same needs which other people have. Only thing they need support in their acute stage to take decisions because they may lose job, marriage, no guardian etc" (Nimal).

According to the mental health professionals' such as psychiatrists' point of view, family is significant not only in Sri Lanka, but also in other countries. There is an enough family intervention for the people with mental health problems. They should be considered as other people with non communicable diseases. Almost all the staff members saw family intervention and support as very important concepts in the field of psychiatry. Majority believed that mental health staff should improve their interventional programmes further because majority of the family members have difficulties in coping with their economic,

marital, social, psychological problems. One of the staff member said that family suffers not because of caring for the individuals with mental health problems, but because of the thought that 'there is an individual with mental health problem in my family'. Therefore, professionals should try to make family members participate in every programmes related to their members with mental health problem.

Among the ideas on family intervention, staff members believed assessment and identification of their problems, talk to them, make them aware in MHP, medication, care, family meeting and home visits as the parts of their family intervention. They defined financial support, awareness, emotional support, keep a service user for few days in hospital because of family members' special needs/function (hospitalization, wedding) and social support, counseling and advices are as family support.

Family psycho educational interventions with people with the medical diagnoses of schizophrenia in different geographical sites and found family intervention helps to reduce relapse rate. Psycho educational interventions with families also have effected to good drug compliance with family intervention (Lefley 1996: 7, 141-142). A psycho education programme for Chinese family carers with their members with schizophrenia in Hong Kong, identified a significant improvement on family carers' perception of social support and burden of care (Cheng and Chan 2005: 583). Following table explores about the number of hospital admissions. Majority of the people with mental health problems has more than ten hospital admissions.

Table 5.7. Number of Previous Hospital Admissions.

No of Hospital Admissions	Number	Percentage
None	4	4.76
One	15	17.85
Two	12	14.28
Three	9	10.71
Four	8	9.52
Five	6	7.14
Five to ten	5	5.95
More than ten	23	27.38
Total	84	100.00

Source: Field Data: 2011-2012

Majority of the family members believed the similar reasons which caused to the relapses for this as well. This also explains that family awareness is less on their family members' mental health problems, nature of them and treatment. But, mental health professionals interviewed in this study have experiences on positive results of family awareness and education. They have noticed that after the family education on MHP, its nature, treatment, family members bring directly another persons with mental health problems for treatment though they came to these institution through another known person or from private channeling. Following extract of a case study of a mental health staff member makes this clear further on;

> "Majority family members bring their own family members with mental health problems with the help of hospital worker or due to

> private channeling. After we make them educate on MHPs, symptoms, and medication, next week they accompany another persons with mental health problems. That means our family education has been effective for them" (Mali).

In the improving of participants' psychosocial well-being and views of their relationships with people with mental health problems, family-led educational programmes are important (Pickett-Schenk et al 2006: 1043). Based on the experiment programmes on education on MHPs and awareness about communication and problem-solving skills, it has been found there was some improvement on expressed emotion, better social adjustment, and less family burden after their awareness programmes (Hatfield 1987:23).

Sheela definitely needs social worker's collaborative support to minimize her children's mental health issues because of children's issues whole family has collapsed. Sheela and her husband also worry that no one will care for their children after their demise. Unfortunately, three of them are not functioning. Extended families also do not have an interest in supporting them at all. Due to the distance, they were unable to get the support available in the institutions. Due to the stigma, they are not happy to go to the psychiatric clinic in hospital in home town. Lack of the resources caused to stop professionals' support on the way. Mainly, Sheela avoids some support due to the stigma and discrimination associated with the MHPs though she worked in a health sector.

Helping the families to live their own life is very significant because they have a right to live their own life. Here, social worker has to play a difficult role. The aim of helping is making them enable to choice. In three broad ways, professionals can support these families to live their lives; giving support, providing practical services and linking them to other source of support (Tilbury 1993:114-115). Social Worker also can support in these three ways to make their life more comfortable.

It has been identified as a negative relationship between fulfilling the needs of the children and parents with mental health problems. By now it has been an increasing problem in every society. The National Mental Health Strategy (2000) has emphasized that people with mental health problems should be treated in the community because they

need a good support to keep their children in their care. Minimum involvement of mental health professionals with the child protection systems and ineffective co-operation between child protection services and adult mental health are factors to bring the children to the children's court. It is a big challenge to take the decisions by the court. Therefore, it is necessary to have full information about mental health needs of those parents and expected outcomes with regard to their children because this type of parent's lack of ability causes the poor to respond to the child's needs (Sheehan & Levine 2005: 18). Samanthi's case emphasizes the need of extra support to look after her children. However, in her family, she is not supported by her husband and her extended family because of the stigma associated with the MHP. There are some family members who try to pretend that their family members with mental health problems are not their relatives or known persons because of the stigma. Samanthi's mother is worried that she would not be able to find a suitable partner for her younger daughter if she keeps a close relationship with her elder daughter who has a mental health problem.

It has been identified that there is a high risk of getting psychiatric problems by the children of the parents with mental health problems and substance abuse. For example, researchers have found that around 50% of risk of getting depression is possible for the children before age twenty (Beardslee et al, 1988). People living with poor socio economic circumstances are at risk of getting poor mental health, depression and poor wellbeing (Patel & Jane-LIopis, 2005) (Prevention of Mental Disorders: Effective Interventions and Policy options 2004: 22, 30). Samanthi's children already show some issues in their behaviours with poor mental health and well being. No one can trust her husband because throughout the marriage life he has been avoiding his responsibility of the children and family. He has not even come to the hospital to see Samanthi and her new born daughter according to social worker's past record. Therefore, Samanthi was unable to take the birth certificate for her daughter until 4 years passed. Generally, the father's appearance and participation is very important to obtain a birth certificate for the children in Sri Lanka. Here all the problems are interrelated with her and children's mental health. Therefore, this family needs social worker's further support. Families cannot effectively function without other institutions' support and concurrent interaction

such as work and welfare, law and justice, education, health care and religion. These institutions also cannot smoothly function without the collaboration with families. Where there is no this crucial link with other institutions, families would experience the stress and breakdown soon (Ryan, 1971). Social workers work on the outside as well as in side the families. They work with these all the social institutions (Constable & Lee 2004: 4). Also, Social work has intimate link with various national policies, legislation, and socio-cultural traditions trying to support families in some way or another (Walker 2012: 613). Therefore, they can easily build a good network through the collaboration of all the social institutions as social worker did in Samanthi's case study and minimize the risk of children and their family being vulnerable to get mental health problems. Mental health staff knew that these people need professional support to minimize their mental distress. Also they believe if there professionals cut their support off from these people with mental health problems, they are more vulnerable to get other issues including sexual and physical harassment. Most of the time, keeping a link with mental health services makes them empower to cope with their problems and reduce because her family and close neighbours know that they have professional connections to talk their unnecessary influences. But, mental health staff believes that every individual with mental health problem does not need to continue their intervention and support as well.

5.3.2. Do We Need Their Intervention?

Majority of the people with mental health problems and their family members needed the intervention of mental health staff in the care of people with mental health problems. For instance, most of the family members were happy with mental health staff to intervene in their problems because they believe that they can keep their problem without spreading among other relatives or neighbours or work place. Also, they think social stigma is less among health staff than among relatives, friends, neighbours and people in the work place. That is why Sheela often needed mental health staff's help that the help from her relatives. In Gamini's case study also, his sister first, expected mental health staff's intervention and support to solve his future care issue. In this problem, her main concern was the social stigma and discrimination. But, she knew that, if she has professional

support, she can easily get her father's pension to her brother. She wanted to keep some links with the mental health staff because she knew that she needs help from them in the caring of her brother in future as well. She had an idea to put her brother to a home as well.

Generally, a child with a disability including the long term mental health problems can get his or her parents' pension after their demise[83]. There are very few institutions with residential facilities for people with mental health problems in Sri Lanka and majority of them are also conducted by the non governmental agencies. Also, they charge money for their services and majority of the family members are difficult to afford these charges according to their monthly salaries. This situation make somewhat easy if individual with mental health problem has his or her own pension or parents' pension (if they are not alive). At least it is necessary to pay around RS. 20000-25000[84] minimum (more than €130) monthly to enter to a home for the people with mental health problems in Sri Lanka. On the other hand, homes for the elderly people in Sri Lanka are more reluctant to take people with mental health problems though they are old sometimes due the bad effects on MHP for other inmates. The majority of the people with mental health problems do not have a pension (this sample proves it) and this situation again make their economical situation worse. But, in Gamini's story, he is fortunate in this regard and his sister also attempted to take their father's pension to him because of this future advantage and the security. But, majority of the people's attitudes on putting someone to a home in Sri Lanka is negative and stigmatizes the whole family. But in this life story, on the one hand sister will also be helpless in future as she does not have any one to look after since she is unmarried and no other siblings in their family. Sometimes, she might have thought it and planned early to cope with the problems expected to be raised because they are the

[83] According to the current policies of the Department of Pension in Sri Lanka, disabled people are eligible to get this pension only if they have got their disability before the age of twenty six and they can prove the disability.

[84] Primary level government worker's basic salary is Rs. 11730 (€ 78.2) and maximum basic salary is Rs. 17600 (€ 117.3), Government school teacher's basic salary is Rs. 13120 (€87.4) and maximum basic salary is Rs. 34545 (€230) (Public Administration Circular No 06/2006 (IV)).

people who have good and long term experiences with regard to the difficulty in caring of the people with mental health problems. MHP of their family member is not just a crisis for a family and it a prolonged crisis for whole family (Tilbury 1993:99). Therefore, again this story gives a message to professionals that they need some professional support systems to minimize their stress and rejection.

Therefore, there were some of the family members who needed professional support to obtain their services easily. Samanthi's mother also wanted the mental health staff to support her and she did not intervene with her daughter's issue due to the stigma associated with her mental health problem. In the case study of Kanchana in Chapter Four, she needed professional support to solve her marital issues with her husband.

Lack of a permanent home or homelessness is one of the major problems faced by people with mental health problem. Homelessness makes it worse in Samanthi's and Children's mental health. In addition to Samanthi's case, Parameshwari is also a good example for this. Though Parameshwari has been recommended to leave their house where they currently live, because of her financial issues, Parameshwari has been unable to take any action with regard to this. Because of her husband's heroin addiction, and relatives' conflicts, they have been suffering a lot for a long time. In this regard, professional support makes them easy find some solutions for their problems. Samanthi and Parameshwari often visit the mental health staff and discuss their above main issues with them and expect some support from them.

Very few of the people with mental health problems, came out with some criticisms based on the discrimination from the mental health staff. But, researcher believes that they did not come out much with this topic. There were some people with mental health problems who were happy to be in these units where there are no physical resources at homes or no permanent place to stay. Once, McCarthy also has pointed out that people with mental health problems also expect to do something meaningful in their homes.

> "…. To be alone, without anything constructive to do, or anywhere to go, and little money, corrodes he will to fight.

> It is so much more comfortable, in hospital, or even in the police cells. So why bother ?" (McCarthy 1991: 31).

Some of the mental health staff members came out with information on how people with mental health problems and their family members perceive on the available services. They explained as follows;

> "We heard majority claims that considerable support is given by this unit. In their discharge, family members admire it. There are some of the family members disappointed of being in this unit because of the poor recovery of their family members. They compare with each other's recovery. Sometimes they count days and question why their service user do not cure?..... But, I feel that we should minimize wasting of family members' time in the hospital because some of them have to wait for long time to meet the doctor" (Sarath).

> "Sometimes mentally ill people and family members get worried about staff members' anger. I also heard that very few of the staff members talk to the mentally ill with little anger. I believe that is also not suitable" (Nipuni).

But, majority of the people with mental health problems and their family members did not comment much on their satisfaction and tried to respond in short and brief manner.. Researcher being a social worker who works in mental health sector may be one reason for them talking less on satisfaction with the available services. Power may be another reason for that. Power is very important element in every relationship and it is one of the main motivating factors. Social work power is legitimately used to make others empower. In anti-oppressive practice of social work, this is very common. Even social workers also feel lack of power in some occasions with regard to taking decision on behalf of the people with mental health problems. Social workers crucially use power to exclude the

marginalized. Thompson (2012) argues us to recognize the power of social workers as knowledge and expertise, access to resources, statutory powers and influence over the individuals and agencies' (Milner et al 2015: 22). In the consideration of the overall picture on attitudes of people with mental health problems and their families, researcher perceived that majority expected mental health staff's intervention and support to come out from not only their mental health problems but also other problems such as finance, marital and family.

5.3.3. How Can We Improve Family Intervention?

Even though there family support for the people with mental health problems, majority of the people with mental health problems, their family members and mental health staff members believed that FI activities are not enough in both institutions. They came out with the following ways which we can use to improve the FI. Majority of the ideas came from the mental health staff.

- Clarification of the responsibilities of every profession
- Monitoring and evaluation the available FI and FS related programs
- Development of team work
- Capacity building
- Collaborative intervention
- Special trained team for FI
- Address barriers issues for FI and FS
- Individual care planning
- Address the family members' issues separately
- Awareness and education programmes
- Development of different communication systems with families

- Development of different support systems for people with mental health problems and their families (including support system for absentees from mental health services)
- Empowerment (people with mental health problems and their family members)
- Address the strengths of people with mental health problems and support to get use them for individual and family welfare

Clarification of the responsibility in each profession was one of the important factors suggested by some of the mental health staff members in this study. They believe that there are some overlaps of responsibilities. For instance, family education is done by nurse, occupational therapists, social workers and doctors. Sometimes, there is no coordination, and essential family education activities are neglected.

Collaboration, team work and specially trained team for FI are other factors which mental health staff discussed regarding the improvement of FI. Even though already there is a team work, in both institutions, majority of the mental health staff members believe that team is not functioning well, especially in decision making with regard to people with mental health problems. Once, Repper and Cooney (1994) explained that multi-disciplinary team with different professionals is essential to a mental health service institute because people with different needs come to obtain services for those institutions. Also, team should work to maximize people's potentials for independent living. They further emphasized that this team is very significant in the communication and decision making as different qualities and opinions from different disciplines come. Further on they point out that the team should not be functioned as a group with hierarchy to be effective. They say that psychiatrists have played the powerful and leading role traditionally. But, they say that there should be a leadership in the team to make it function, for instance, to commence meetings. But, this may change the basis of clients (1994: 425-426). But, mental health staff in this study in both institutions had an idea that hierarchy can be observed in their teams and psychiatrist is often the team leader.

Headley and Moore (1994) also have shown some important ingredients[85] of a successful multi-disciplinary team (1994: 492-493).

Some of the mental health staff members explored with the barriers to increase the FI such as lack of resources, work load, lack of professional freedom and weaknesses of the available systems of sending messages to families. Following extract of a case study of a mental health staff explains it clearly;

> "In our institution, family intervention is less due to lack of resources, work load, no professional freedom etc. no proper system to send messages to families, we cannot keep our belief on available system. We do not have proper treatment plan and discharge plans. Therefore, some of them are neglected from our services or they do not get enough services from us" (Sarath).

They expected to monitor and evaluate the available FI and FS programmes as well. Capacity building programs also one of the way mental health staff (especially non medical) presented to improve the FI. They perceive that they have very limited opportunities to be trained in their field and there is no 'continued professional development' for them.

Both people with mental health problems and their family members and staff members kept their beliefs on the family awareness and education programs as a part of FI in the improvement of mental health. Above categories have different ideas and

[85] (1).the team members are constant and therefore able to identify with, and exhibit loyalty to the team rather than their own discipline. (2). Members within the team openly acknowledge and are confident of each other's individual skills. (3). Members of the team are also able to acknowledge that in some instance there is blurring and overlapping of roles. (4) The team is able to meet to discuss general management issues, their own group dynamics, as well as the cases with which they deal. (5) Whilst there is a clearly identified clinical leader of the team, each client is assigned a key worker who has prime responsibility for the day-to-day management of the case. Key workers will be allocated on the basis of their particular skills and the particular needs of the patient at that time (Headley and Moore 1994:492-493).

misunderstanding on their mental health problems, treatment and recovery. The following extract from a case study offers some clarification on this matter;

> "Majority family members try to change their doctors after two three weeks because of the poor improvement. They expect cure their family members with MI soon. Therefore, it is necessary to make them aware of the MI, Symptoms and recovery. Otherwise they do 'doctor shopping' because of their distress, but nothing happen good to patient" (Fernando).

Case studies of Samanthi, Amali, Surani and Sheela explain the significance of awareness programmes and the need for support from the staff to minimize their issues.

According to the following table, it is clear that majority of the people with mental health problems have relapsed many times. Many of the family members idea was that their family members' poor drug compliance and family issues caused the relapses. Though they supervised medication at the beginning, later they did not do as they functioned independently and believed that they might have taken the prescribed medicine. According to research done for several decades it has been shown that HEE is a highly reliable psychosocial predictor of psychiatric relapse. People with mental health problems who live in a family environment with criticism, hostility and emotionally over-involvement or intrusive attitudes, are more prone to elevate risk of early relapse in the comparison of the people with mental health problems those who do not live in such family environments. This is more related with people with mental health problems such as the diagnoses of schizophrenia and depression. On the other hand, family based interventions specially seeking to reduce HEE, have influenced to reduce the relapses. Through the family education on how to reduce the HEE, hospital admissions also have been reduced considerably. Not only that, these changes in HEE caused for effective family therapy as well (Dallos & Boswell 1993: 104, Hooly & Parker 2006:386). In the previous chapter, it was discussed the HEE among the family members towards their family members with mental health problems in this study.

Table 5.8. Number of the Episodes of Mental Health Problem

No of episodes	Number	Percentage
One	10	11.90
Two	12	14.3
Three	10	11.9
Four	6	7.14
Five	3	3.57
Five to seven	19	22.61
Seven to ten	1	1.19
More than ten	23	27.37
Total	84	100.00

Source: Field Data: 2011-2012

Majority of the family members did not have enough and clear understanding and insight on the mental health problem including its nature, symptoms, relapse, recovery and medication. Therefore, majority of the family members' main expectation/need was to make them aware of the MHP by the professionals. Almost all the family members' future expectation was to 'cure their family members with mental health problem'. But, Western psychiatrists say those MHPs such as schizophrenia and bipolar affective disorder cannot be cured and only can be controlled its symptoms. They inform majority of these people with mental health problems to take medicine lifelong. But, majority of the family members' hope is to finish everything within a short time period and cure them soon. Following extract of a case study explains clearly about this;

> "At a last resort, this daughter's father wrote to the newspaper and said that he would give a big amount of

> money, if someone could cure his daughter. But, no one answered it" (Badra)

Mental health professionals also know that family members' main expectation from them is to cure their family member. Some of the professionals are not happy with the statement that 'mental illness can be cured'. Because of this misunderstanding, family members expect their family member to be cured soon. If this drags long time, they get angry and increase their psychological distress. Not only that, family members experience the family burden and expressed emotion such as hostility, and criticism and burden and they are interrelated as discussed in chapter four. Family members believe that family member with mental health problem have the complete control over of his or her actions. They get angry on this and attribute that lack of functioning and lack of motivation of the family member with mental health problem is under his or her control. So, family members' irritation and criticism may increase. But, through the awareness activities, family members can be made aware of how they can cope with this. Gradually they start to understand them and acknowledge the small success, less expressed emotions (Repper & Perkins 2003: 125-126).

In addition to the above, factors, development of different support systems, separate discussions on family issues, development of communication systems, empowerment of families and people with mental health problems, individual care plan and use the strengths of the people with mental health problems also were presented by these three categories as ways of improving FI and FS in both institutions. Already mental health staff uses some methods to communicate family members such as telephone calls, letters, sending message through the Divisional Secretariat offices, and home visits. However, staff believed they are not enough, and sometimes, not supportive because of the lack of effective network with other service institutions and their lack of understanding on MHPs. Also, every family has their own different issues and they need to discuss with the staff privately. Separate discussions are very useful for the individual care planning too. Staff believes that individual care planning is in its infancy level. Instead of individual care planning, majority of the mental health staff including social workers use the

assessment method with the purpose of identification of the problems of the people with mental health problems. Further, they believed if there is separate individual care planning, it is useful for the decision making related to the discharge as well.

Majority of mental health staff believed the concept of 'empowerment' is a successful method to support the family and people with mental health problems. As Wise (2005) explains the word 'empowerment' is a concept as well as an action. Also, it is an ongoing and reciprocal process from conceptual understanding to visible action. Historically, systems theory and ecological perspective have been used to empower and strengthen the families. These theorists believed that family is not only a complex system but also a part of the natural and biological social order. Therefore, the process of helping the family is embedded within the above frame work (2005:20). While there are different definitions on the concept 'empowerment', "*the freedom to choose*" (Howie the Harp, in Carling 1995:xiv-xvi) and "*the ability to make things happen*" (Giddens 1994:15) are very significant definitions. Apart from that, it is very important to discuss about the language of empowerment. There is a vocabulary which used in the Competence-based practice (Maluccio 1981) and strengths perspective (Saleebey 1997) and still there are special words which we use in empowerment practice based on 'choice' and 'skills'. Among them, freedom to choice, capabilities, capacities, support, resources, voice, listen, strengths, competence, resilience, potential, integration, quality of life, enhance allies and independence/interdependence are choice based words. Among the 'skills' based words involvement, well-being, options, respect (mutual), access, mobilized, diversity, equalizing, cooperation, collaboration, opportunities, possibilities, sustain, create and consumers/citizens/participants are significant. In the discussion of levels of the empowerment, there are three levels such as personal, interpersonal, and social/community. *Self-esteem, self-respect, self-worth, and self-efficacy* are included in personal empowerment. Interpersonal empowerment has been defined as "*the motivation, freedom and capacity to act purposefully, with the mobilization of the energies, resources, strengths, or powers of each person through a mutual, relational process*" by surrey (1987). Society/community empowerment is a "*society built on strength, contribution, and opportunity*". To complete the empowerment practice, it is necessary to

listen to the family needs. Normally, after social worker helps to the family to access necessary resources in their community, their empowerment process will exist (Wise 2005:24, 28-29, 47-49). Wise further has discussed about the empowerment principles as well. They are as follows;

1. Build on strengths and resources; diminish oppressive factors
2. Multicultural respect
3. Recognizing needs at the three levels of empowerment (personal, interpersonal, community)
4. With sufficient resources, families can empower themselves
5. Support is needed from each other, from other families, and from the community
6. Establish and maintain a "power WITH" relationship
7. Using cooperative roles that support and assist family members (Wise 2005:68-85).

In the empowerment approach, it is important to use the concept 'put people first' and not to consider their characteristics.

In the development of different support systems to improve the FS and mental health of people with mental distress, mental health staff's main attention was given to the family members' financial issues and absentees from the mental health services. Their idea was to develop a special support system for support such families. Sometimes, family members request from the mental health staff to support their family members with mental health problem because they are reluctant to come for the services. For instance, Sheela's children are not happy to come to the hospitals for treatment, but they need support from the mental health services. Mental health staff as well as family members expected to have some community health service programme to support them. Already,

NIMH has conducted a programme[86] to support the family members to accompany their family members with mental health problems to the hospital in their acute stage. Already a fund[87] has been available in UPMU to financially support the family members and people with mental health problems. But, this is not enough at all to support people's financial needs. Some of the family members do not reveal their financial issues though they have because of the human dignity.

Encouragement to use the strengths of the people with mental health problems and their family members is less in both institutions. Therefore, mental health staff perceived this to be used to support the people with mental health problems to come out from their long-term health problems, and this is good way to develop their families' welfare as well. Once, Underhill claimed that majority of the people with mental health problems has a clear understanding of the only way to get the family and community acceptance is being productive (Underhill 2002: 8). In this study also many of the people with mental health problems had an insight that majority of their family members put them down, discriminate, criticize because of their lack of economical support/zero support to their families. The case studies of Kasun, Surani, Amali, are good examples for this in this study.

Above information gives an obvious picture that people with mental health problems, their family members and mental health staff members expect the family intervention and support to be improved. They believe that this help to develop the mental health of not only the people with mental health problems but also their family members. Yet, very few mental health staff members had an idea that there is no need to intervene with the family further as people with mental health problems have enough family support.

[86] Colombo outreach service: the purpose of this programme is to support to family members who cannot bring their family members with mental health problems in their acute stage. The ambulance is sent only if the person with mental health problem is living within 50km radius.

[87] This fund has been named as 'Psychiatric Patients' Welfare Fund' and it functions under the control of the University of Colombo, Sri Lanka. This has been running for more than ten years with the kind support of the outside donors.

However, in the consideration of the above information, it is clear that family intervention is a communication act and an attempt to encourage or discourage the changes. In the family intervention, communication is very important and we are doing this through verbally or in writing,. In addition, family as a system, there are some major characteristics such as goals, interdependence, casualty, connectedness, and subsystems. But, family relationships are very important in the system of family and they are irreplaceable. Therefore, if someone gets a health problem or die, no one can be replaced in that place. Though someone can be replaced physically, that person cannot fulfill the personal and emotional aspects (McGoldrick & Carter 2003: 376). And also, it is clear that, if one individual has a crisis, the whole family dynamics get affected. Then, interactions and relationships also change. As a system, family consists of sub systems and they also play a major role in crisis situations in the main system.

Even though there is enough family support in the society for people with mental health problems, family members' relationship issues are more prominent in the majority of the families. High expressed emotions are very significant in the families where there are people with mental health problems. Therefore, relapses and hospital admissions are very high. One of the important points given in this information is that families need extra institutional or professional support in the caring of their family members with mental health problems. It is necessary on behalf of not only the individual with mental health problem with mental health problem but also the whole family.

Mental health professionals' and especially social workers' family intervention is very essential for these families as they can easily involve in the individuals and families to solve or mitigate their problems. According to the respondents in this study, family education and awareness is most important in this regard. From these interventions relapses and hospital admissions can be reduced and this is a good thing for the individual as well as the family economically. Institution-wise- also this has a good impact. In this study, it was shown that institutional and family links are very poor and it is necessary to strengthen them. Vital institutional link with family is very important; if there is no such link, family will suffer from institutional failure. Family has been rooted

with social institutions and social guidance systems and families always interact and mediate these social institutions. To gain success in any social institution, collaboration of the family is very essential (Constable & Lee 2004: 4). If mental health institutions can support the families when and where necessary in the caring of family members with mental health problems, this may reduce the burden on the hospitals, stigma in society, and expenditure while there is a push model from hospital to community.

Family support can also be identified under three levels such as primary, secondary and tertiary level. Just after the identification of a MHP of a family member they react in different ways, such as denial, guilt, anger, frustration. The intervention method of assessment was based on one side and individual care planning is a mutual and collaborative approach based on dialogue.

Social workers can practice the method of individual care planning as an effective intervention method with individuals and their families because this method puts ‘people first’ and give them power to control their lives by themselves making use of their abilities, skills and strengths.

Chapter Six

Discussion and Conclusion

Assistance to persons and families to cope with the problems in their situations was one of the significant starting points of social work. Psychiatric social workers' role in mental health field expanded after the Word War II (Beder 2006) and social workers in Sri Lanka began to work in mental health care institutions (Western) under the British colonial period in the 1930s (Mapother 1938).

Family has been playing a very significant role in the caring of people with mental health problems from the past. With the introduction of new drugs and deinstitutionalization, family involvement in caring for people with mental health problems increased (Hatfield 1987a & Beder (2006). Family social work intervenes in the family in creating a working relationship mobilizing family resources for solutions and addressing family dynamics, family reality, and internal workings of the family (Vogrinčič 2003). Most people with mental health problems live with their families in Sri Lanka (Mendis 1986) and this has been proved in this study as well. However, throughout the mental health care system in Sri Lanka, this fact has not been given sufficient attention especially on the development of the family support system or system to keep the link between family and the mental health institutions. However, with the emergence of the nongovernmental community mental health care institutions in the 1980s, certain amount of attention has been given to the community mental health care (Carpenter 1988, Mendis 2003) and this has resulted to some extent in building and strengthening the relationship between people with mental health problems and their families. The caring for people with mental health problems has been shifting from one or more family members to others in the family over their lifespan. This dyadic relationship started from mother to child initially and then, the care giving responsibility is shifted directly or indirectly to other family members (Grant & Whittell 2001:112).

Identification of needs and expectations of people with mental health problems and their family members was a very crucial and significant finding in this study. The study found that both people with mental health problems and their family members have similar needs except very few special needs created due to their mental health problems. Basic survival needs, autonomy in the family, physical security, economic security, protective housing, appropriate health care, significant primary and social relationships, education and awareness, close relatives' support, formal support as well as spiritual needs were all very significant for both groups. Apart from that, family members had the need to have 'time-out to rest from the strains-respite'. Also, people with mental health problems had several needs such as communication (among family members who would listen to them), take part in decision making and the need for leisure activities. While majority of the family members with mental health problems played a very poor role in decision making within their families, there was a lack of invitation for other family members. Even though, family members and mental health staff believed that there is good family support for people with mental health problems in Sri Lanka, very high expressed emotions such as criticism, hostility and over-involvement were very common in the families with mental health problems. This happened due to the lack of understanding of mental health problems, their nature, lack of coping skills and financial difficulties. Specifically, there were many relationship issues between married people with mental health problems and their spouses. Some of the female family members with mental health problems explained the physical harassments by their spouses mainly for their lack of sexual desires. As pointed out by Oliver (1990a), most of the time, people believe that disabled women are inadequate for economically productive roles. But, disabled men can seek to fill the socially powerful male roles. Also, they are obliged to fight with the social stigma associated with disability (Oliver 1990a: 71). In this study, majority of the female persons with mental health problems were harassed by their spouses than the male persons with mental health problems. The study therefore sees a gender discrimination issue with mental health problems as well. The family and social norms that females should be responsible for household work and male should be responsible for earning and supplying household requirements was negatively impacted on female persons with

mental health problems compared to the male counterparts. Failure and disarray in household activities was another reason for the emotional and physical harassments of female persons with mental health problems by their family members.

Out of the research findings, it was obvious that the majority of the caregivers were female. But, as researcher has discussed in Chapter Four, the main reason for this is women's low Labour Force Participation. However, researcher found that majority of female family members such as mothers and sisters were exhausted in caring for their family members with mental health problems. Apart from that, increasing elderly population[88] in Sri Lanka is also a burden for them. In this regard, the study sees female carers as psychologically distressed than male carers. In addition, the study also points out that we have to think of this issue seriously because of two reasons. One is how far can they do this activity and cope with it. If the women get distressed, it affects the whole family and then creates family issues. As mentioned in the system theory, factors within the person interact with the factors within the family (Buchanan 2008). The second point is lack of female Labour Force Participation and its impact on the country's development. In Sri Lanka, both male and female have a good education level compared to other developing countries.[89] With the development and social transition, people migrate to urban areas as nuclear families. They migrate for different purposes such as employment, education and living with better facilities. With migration, new needs emerge such as security of the children, old parents and disable people. These needs have emerged as a result of social and economic development. Illich (1990) in his discussion on human needs has shown that people have different needs as a result of development. But, when people meet some of their needs, they have to dedicate their abilities, talents, skills and

[88] Percentage of elderly population (60 or above) in 2012 is 12.4 and it was 6.6 in 1981. This has been projected to double again from the current level in 2041 and the level of 24.8% (Census of Population and Housing 2011).

[89] Literacy rate in the age group 15-24 is 95.7% in 2012. Male literacy rate in 96.9%, Female literacy rate is 94.6% in 2011. Urban literacy rate is 97.7% and rural literacy rate is 95.7% in 2011 (Census of Population and Housing 2011).

professional qualifications to meet their emerging needs. Thus researcher see a relationship between needs satisfaction and emerging new needs.

Illich (1990) further argued that development has implied a simultaneous deconstruction of necessities and a construction of desires into needs. But, needs are neither desires nor necessities in the discourse of development. While relevant agencies or institutions do not define needs and where they exist, they closely supervise the remedies. In Sri Lanka, there are different programmes for poor people, disabled people, elderly people, and children under the social protection systems. However, in the practical setting, it can be seen that a low coverage of eligible persons (Tilakaratna 2014: 1-4). Hence this researcher sees there is no proper needs assessment of the disable, elderly or poor people. The institutions pay their attention only for remedies such as giving money, food subsidy, housing and sometimes construction materials. Therefore, finding long-term solutions for their social issues are still very far away.

On the other hand, these should be noted as a priority for people with mental health problems in health care. As Doyal and Gough (1991) have pointed out, mental health can be considered as a basic human need because they have identified physical health and autonomy as basic human needs. Under autonomy, they have considered mental health as a basic need and someone needs to fulfill this need to work rationally and responsibly in day-to-day life. Almost all the people with mental health problems know that they should be productive to receive the respect or acceptance from their families. But, we cannot expect them to be productive without helping them to come out from the mental distress because they are psychologically incapable of fulfilling their daily tasks. Therefore, there is a relationship between basic needs and intermediate needs as further explained by Doyal and Gough (1991). People with mental health problems and their families need to fulfill their needs such as physical security, economic security, social relationships, communication, non-hazardous housing and non-hazardous working place etc to fulfill their basic human needs. But, this researcher was able to find that there were people with mental distress in this study with physical harassments, stigmatization and discrimination in the work places, and unsatisfactory housing facilities. Apart from that, basic human

needs and intermediate needs impinge on each other. But, some studies have shown that the use of medication is a universally noted factor of success among other factors (Saleebey 1997:185). Hence this study argues that for some of the people's with mental health problems, medication is not their only basic need. Their basic needs are housing facilities, free domestic/ home environment, non-discriminated work environment, and meaningful work. If we can fulfill these needs, most probably they may get on with their mental distress and start their usual life as well. Majority of the people with mental distress and their families fulfill their 'thin' needs than 'thick' needs (Dean 2003). Therefore, majority of them cannot flourish and instead, have to merely survive.

Majority of those with mental health problems and their families have had many expectations from mental health professionals. Recovery was their main expectation. It is better to describe recovery as an ongoing journey or process, rather than as a finite goal (Wallcraft 2005). In this study also, majority of the people with mental health problems and their family members wanted to talk about the recovery from their mental health problems. But, most of them had very limited opportunity to talk about this with their mental health professionals. Social worker can use the social model to support the individual with mental health problem because this model focuses on the 'recovery'. According to this model, social worker considers the disabled person as 'contributing member of society as both workers and valued customers or users' or 'as active citizens with all that implies in terms of rights and responsibilities' (Oliver 2004) (Oliver et al 2012:24). However, there is a need to rediscover whether majority of social workers in mental health care institutions in Sri Lanka use this social model. Almost all the social workers[90] in mental health institutions in Sri Lanka work under psychiatrists. Therefore, most of them are socialized in a medical model. Also, most social work students train in the mental health institutions where there are medical models in operation. It was obvious that traditional assessment outline was anchored in the medical model (Madsen 2003). But, findings of this study illustrate the significance of using social model to help the people with mental health problems by social workers.

[90] There are around 50 psychiatric social workers working in government psychiatric units and mental health hospitals in Sri Lanka (except the social workers working in University Psychiatric units).

Social worker has an essential role to play in the above context. In a family background with violation of needs fulfillment, social workers can intervene officially (Constable & Lee 2004). In this intervention, they can use the intervention methods discussed in Chapter Five in this thesis. Counseling, advocacy, individual care planning or strength-based care planning can be used. Advocacy can be used more in people with domestic violence because they need special empowerment with legal support. Yet, getting to know about the individual's diagnosis by social workers is not compulsory. Diagnosis is significant for social workers to know how the person lives with the diagnosis, how diagnosis changes his or her world and how medication influences their everyday life. Social worker's 'visible' role is very important. Therefore, social workers should not limit their attention to pathology in their assessment. Instead of that, planning of social intervention is advisable because it is based on an operational definition (Kvaternik & Grebenc 2009:518). Working collaboratively and properly planned intervention strategy is not considered as a luxury. But, this is now accepted and required helping process in social work (Oliver et al 2012:25). Social worker can use the working definition of Minahan (1981; p6); "the purpose of social work is to promote or restore a mutually beneficial interaction between individuals and society in order to improve the quality of life for everyone" (Haynes & Holmes 1994). In the individual care planning, social workers are possible to know about individual's situation of economic, housing, and employment, their wishes, needs and interests. They are very significant for the social worker in the helping process. Social worker can work together with the individuals and their families to identify their beliefs, organizational patterns and communication process in the preparation of the individual care plan. Social worker can help the families to resist and return their trouble making challenges by using their strengths, needs and interests. Then, social worker can work with the families to change or improve their individual, couple or family interactions, relationships, communications and reach their goals. Not only that social worker can work together with them to obtain their services from different institutions too. Through this approach in social work, it can be built a mutual understanding between the person with mental health problems and social worker. This approach emphasizes the inter agency collaboration and assuming the people's

competence, expertise and ability. Therefore, to work with the families with people with mental health problems, this mutual helping process is very useful. Ultimately, based on the individual care plan and his or her agreement with key members of the family, the social worker can be a catalyst for the development of family structure for the benefits of its members, searching for the goods of a secure base: safety, belonging, communication, capacity to choose, and the capacity to grow, to interact, and to care for one's self and others (Constable & Lee 2004).

In the method of 'working with people' all social work principles are amply reflected. Conversation in the individual care planning emerges the reflections, decision making, open questioning and negotiations. Based on this information, Vogrinčič (2015) introduced the concept of 'co-creation' as a process of helping a clearly working relationship where individuals helping projects are co-created. 'Working with families' is very useful in resilience approach rather than acting on them being on the outside (Madsen 2003). This study explored the basic tenets of the strength perspective introduced by Dennis Saleeby (1997). Saleebey claimed every individual has strengths and every community is full of resources. Therefore, social workers' understanding the clients' strengths is more significant than diagnosing and labeling them. The objective of the family resilience approach is to identify and strengthen the key interactional processes and is expected to rebound these families from such stressful situations. However, there is no definite agreement that this method should only be used to help the family and individuals in social work. Therefore, social workers can use the 'eqifinality' which often use in systems theory in social work. From different places, social worker can use different methods to achieve the same goals of the individual and families.

Out of the results of this study, it is apparent that there are different and significant needs, expectations of people with mental health problems and their families and attitudes of people with mental health problems, their families and mental health staff. Therefore, the most significant contribution of this study to the field of social work, mental health and family is the collection of literature. This research was based mainly on three aspects of social work: mental health, family and human needs. Many literature is available based

on Western society and culture. Compared to Western literature on especially evolution of family and human needs, much of them are from Western societies.

Direction for further research is another contribution to the field of social work, mental health and family. Based on this research, other researchers can identify many topics of interest. Also, this study helps to identify the practical barriers in the development of mental health such as;

- Lack of understanding of people with mental health problems and their family members on MHPs, its nature, medicine and other services and recovery.
- High prevalence of social stigma and discrimination among families, relatives, neighbours, friends, work place, mental health staff and society
- Lack of identification of strengths of people with mental health problems
- High prevalence of high expressed emotions in the families
- Lack of fulfillment of basic needs of people with mental health problems and their families including financial need.
- Lack of information from mental health professionals on MHPs and its nature
- Lack of collaboration among the different professions and service agencies.
- Lack of capacity building programmes
- Lack of government and other institutional attention on MHPs and people with mental health problems.

Also, the findings of this study can be used for initiation of future support programmes attached to mental health development, for people with mental health problems and their families. The researcher has used thematic analysis method to analyze the qualitative data in this study. Mostly, this qualitative analysis method is used in psychology. But, researcher has proved that this method is very useful to analyze the qualitative data in social work as well. Apart from that, based on the empirical data in this study, a

handbook for psychiatric social workers on family intervention in the development of mental health in Sri Lanka is expected to be compiled with the hope that it will be useful for everyone in this field.

Social worker can initiate family support programmes with the collaboration of the mental health team where there are pushing forces from mental health services to family care in Sri Lanka. The information and their ideas help to identify areas to be developed or explored in these programmes and help to further explore knowledge in practical social work in the mental health field. The contribution of academics, politicians, governmental and nongovernmental organizations, is very essential to develop mental health and social work. The researcher believes that mental health and social work in Sri Lanka should be developed first with the contribution of the above mentioned persons as social work has not yet developed adequately. While both these fields are being developed, it is necessary to improve the family intervention and support system programmes to help the individuals and their families to cope with mental health problems. All these three areas are interrelated and impinge on each other. Accordingly, the researcher proposes the following suggestions to improve mental health, social work and the family support systems:

To develop social work field in Sri Lanka:

- Professional and governmental recognition of social work.
- Establishment of a degree programme in the universities.
- Development of appropriate literature in social work.
- Development of research activities and supply of funds by the government towards research.
- Links between local and foreign universities (Western and Nonwestern) in the development of social work in Sri Lanka.

- Adoption of social work programmes which have already been developed in developing countries.
- Appointment of social workers in each hospital in secondary care and primary care hospitals in addition to the tertiary care hospitals.

To improve mental health in Sri Lanka:

- Education and awareness programmes on mental health problems during the clinic hours in hospitals.
- Education and awareness programme on mental health problems for the officers in other services (social services such as elderly, child, pension, disable etc).
- Integration of the psychiatric service to the primary health care services.
- Integration of mental health services with other social services agencies.
- Improve the short term training programmes for primary health care workers to identify the needs of people with mental health problems.
- Drugs (medicine) availability at least in every secondary care hospitals in addition to the tertiary care hospitals.

To develop family support system:

- Develop team work in mental health institutions (with the collaboration of psychiatrists, other doctors, social workers, occupational therapists, and nurses in the institutions).
- Clarification on the professional responsibilities
- Capacity building programmes
- Family education and awareness programmes

- Develop the different family support systems (to support for absentees, financial issues, family problems) with the participation of the above mentioned mental health professionals.
- Develop a programme for using the strengths of the people with mental health problems for the family welfare.
- Strengthen the family support system by providing incentives to those caring for people with mental health problems
- Separate legal support system for people with mental health problems and their family members.
- Separate government financial support system for people with mental health problems (with the recommendation of the doctors and social workers).
- Government based support system to care for service users (short-term placements, people who take over nursing and support, people with mental health problems and those who do not have any caregiver with or without property).
- Institutional link with every family that has people with mental health problems through social workers while they are in the hospital.
- Develop the mutual support group systems in the community.
- Resource allocation for the development of family support systems.

Development of above programmes would be useful, profitable and fruitful to lessen the burden on the family of people with mental health problems since the majority of people with mental health problems live with their families in Sri Lanka. However it is necessary to conduct further research in the areas such as: awareness of people with mental health problems and their family members, the recovery from MHPs and how people with mental health problems perceive it, relationship between people with mental health problems and domestic violence, need satisfaction of people with mental health problems and their family members, homelessness of the people with mental health problems and

its relationship with MHP, Socio-economic situations of families with people with mental health problems, Sri Lankan family and its changes, institutions or persons with other mental health treatment methods and people's participation in these and social workers' role in mental health care in Sri Lanka.

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Appendices

Annex I

Glossary

Anavina	All kinds of malevolent sound or verbal action
Apalaya	Bad Influence of planets and constellations
Asvaha, katavaha, hovaha	Eye, mouth and thought evil
Ayurveda	One of the oldest system of medicine introduced from North India
Bana-	Buddhist preaching
Budu Pahana	The oil lamp which Buddhist people light for Buddha statue in their homes
Edura	The person who performs the supernatural performances
Epa-nula	Thread tying before starting the class of performances for the demons
Grama Seveka	Village level administrative officer
Haminela	Female attendants
Kalukumara dosaya	Black prince's gaze
Kodivina	All kinds of malevolent human action (although huniyam/suniyam may be also used)(black magic)
Kurukkala	Hindu priest in Hindu kovils
Loku putha	Elder son in a family

Mahagedera	Parental house
Moulavies-	Islam priest in mosques
Nul bandhima-	Tying thread
Paule lede	Family illness
Pavula potak-	Family book maintained by the Church and births, marriages, and deaths, mass attendance, and the payment of Church dues were entered into this book
Pideni	Offerings to the demons
Pissi	Mad woman/ woman with a mental health problem
Pujas	Offerings to the God or Buddha
Ralahamila	Male attendants
Sastra	Soothsaying
Tanikama	Isolation and related with female individuals
Thaththa	Father in the family
Tel-matrima	Chanting oil
Vaku cholluthal	Oracles
Yakka	Demon
Yak Tovil	Performances for demons
Yaksa disti	Demon's harmful eyesight or gaze

Annex II

Information Sheet

I am Ms. R.M. Anula Rathnayake and working at the Department of Psychological Medicine, Faculty of Medicine, University of Colombo as an Instructor in Social Work. My research is on 'Mental Health and Family in Sri Lanka: Family Intervention (FI) and the Significance of Family Support (FS) for People with Mental Health Problems'.

This is going to be carried out in the National Institute of Mental Health, Angoda and the University Psychological Medicine Unit, National Hospital Colombo, Sri Lanka. I would like to invite you to participate in this study as an informant.

1. To investigate the needs of the families with family members with mental health problems, the needs of people with mental health problems, and examine the perception of family members and people with mental health problems on mental health professionals' FI in the caring of people with mental health problems and the existing programmes attached to FI are the objectives of this study.

2. Your participation in this research is not a compulsory thing. Although you give your consent to participate in this study, you can withdraw from the research at any time. If you feel to withdraw from the study, please be kind enough to inform the investigator as soon as possible. No any harm to your medical or other service or treatment facilities.

3. Your participation would be more benifited to the future programms on family and service users.

4. All of your information will be kept confidentially and will be used anonymous names for every service users. In the thesis and preserntations, your data will never be used in a way that you could be identified.

5. If you have any questions about the study, its purposes, and its benefits, and so on, please do not hesitate to ask the investigator at any time. You can directly meet the investigator in the institute or can call the investigator over the phone to

clarify your questions or doubts (Please use this TP number to contact the investigator, Ms Anula Rathnayake- 077-3653687).

Ms. AnulaRathnayake/Principal Investigator

Annex III

Consent Form

Ms. R.M. Anula Rathnayake (Principal investigator) made me aware of this study (purpose, participation, benefits, confidentiality of the information, withdrawing from the research, and so on). Therefore, I can be satisfied with the information given by her and I would like to participate in this research.

Participant's
Name:……..

Date:……

Signature:……

I expalined about the study to the above mentioned participant and he/she has given his/her consent to participate in this study.

Investigator's Name:
……

Date: ……

Signature: ……

Annex IV

Questionnaire for the Family Members of the people with mental health problems

Mental Health and Family in Sri Lanka

Sample No:……

Date Interviewed:……..

Date Admitted:…….

No of days in the hospital (by the time of the interview): …….

Date Discharged:……

Informant (name):…….

His or her relationship with the person with mental health problem.. …….

1. Address:…….
   ……
2. Telephone No:……

3. Closest Town:……

4. District:……..

5. Province:……

Part I: Information of the Family person with the mental health problem

6. **(Highlight the informant and the person with mental health problem)**

Relationship to the house hold head	**Sex**	**Age at last birth day**	**Ethnicity**	**Religion**	**Education**	**Marital status**	**General activity**	**Monthly income**

7. Nature of the family structure

Nature of the family structure	**Code**
Both-parent family	
Single- parent family	
Only siblings	
Siblings + close relatives	
Other (mention)……..	

PART II: Information of the Housing Facilities of the Family of the person with mental health problem

8. Your family live in …..

Ownership of the house	**Code No**
Own house	
Parents' house	
Grandparents' house	
Close relative's house	
Friend's house	
Government's house	
Rented House	
Other (mention)……...	

8.1. Transport to the hospital

Source	**Code**
Own vehicle	
Neighbour's vehicle	
Friend's vehicle	
Office vehicle	
Public transport	
Other (mention)…….	

8.2. Distance from home to hospital

Distance (Km)	**Code**
Less than 5	
5-10	
11-15	
16-20	
21-25	
26-30	
Other (mention)……..	

PART III: Information of the Family Relationship of the person with mental health problem

9. With whom does the person with mental health problem live?

Relationship to the patient	**Code No**
Father	
Mother	
Husband	
Wife	
Siblings	

Children	
Close relatives	
Neighbors/ villagers	
Friends	
Other (mention)	

10. Who comes more often to the hospital to visit the person with mental health problem?

Relationship to the patient	**Code No**
Father	
Mother	
Husband	
Wife	
Siblings	
Children	
Close relatives	
Neighbours/ villagers	
Friends	
Other (mention)	

10.1. Who do not come at all to the hospital to visit the person with mental health problem?

Relationship to the patient	**Code No**
Father	
Mother	
Husband	
Wife	
Siblings	
Children	
Close relatives	
Neighbours/ villagers	
Friends	
Other (mention)	

10.2. If someone does not come at all, what are the reasons for that?

……

……..

11. How often do you visit the person with mental health problem?

Time period	**Code No**
Morning +Noon+ Evening	

Noon+ Evening	
Daily	
Every other day	
Few days in the week	
Once a week	
Depend on the income	
Rarely	
Other (mention)	

11.1. If you come daily, what are the reasons for that?

……
……
……

11.2. If you do not come daily, explain the reasons?

……
……
……

Part IV: Information of the Mental Health Problem

12. When did the mental health problem start?

Time duration	**Code no**

Less than one year	
One year back	
Two years back	
Three years back	
Four years back	
Five years back	
Not clear	
Other (mention)	

13. How many recurrent episodes of the mental health problem? (Except this episode).

No of bouts/episodes	**Code No**
One	
Two	
Three	
Four	
Five	
Not clear	
Other (mention)	

13.1. This episode is…….. (put the turn of the episode. Ex 1st,2nd ….)

13.2 Do you believe some reasons/precipitating factors caused to recurrent episodes?

1st episode:…….

2nd episode:……

3rd episode:……

4th episode:……..

5th episode:……..

Other:…….

14. At what age, person with mental health problem got his or her first mental health crisis?

Age category (years)	**Code No**
Less than 1	
1-5	
6-10	
11-16	
17-19	
20-26	
27-29	

30-39	
40-55	
56-65	
66-75	
More than 75	

15. No of previous hospital admissions (except the current admission):

No of admissions	**Code No**
One	
Two	
Three	
Four	
Five	
Not clear	
Other (mention)	

16. How do family members manifest their member's mental health problem?

……

……

……

16.1. What mental health problem does person have? (According to the medical diagnosis).

……..

PART V: Information of the Treatment of the Person with Mental Health Problem

17. How did you resort to western treatment?

……
……
……

18. How long did it take you to seek western treatment since the signs of the mental health problem appeared for the first time?

Time	**Code No**
Within one week	
Within two weeks	
Within one month	
Within three months	
Within six months	
Within nine months	
Within one year	
Within two years	
More than two years	

19. What was the treatment for your family member with mental health problem?

1st episode:…….

2nd episode:……

3rd episode:……

4th episode:……..

5th episode:……..

Other:…….

Part VI: Family History of Person with Mental Health Problem

Questions	Mother	Father
20. Do parents have any long-term health problem?	Y N	Y N
20.1. If yes, Mention the health problem & the type of treatment		
21. Do siblings have any long-term health problem?	Y N	Y N
21.1. If yes, Mention the health problem & the type		

of treatment		
22. Do parents' siblings & grand parents have any long-term health problem?	Y N	Y N
22.1. If yes, Mention the health problem & the type of treatment		
23. Do children of the person with mental health problem have any long-term health problem?		
23.1. If yes, Mention the health problem & the type of treatment.		

Observation

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Annex V

Interview Guide Line with the Person with Mental Health Problem

Mental Health and Family in Sri Lanka

Sample No:……

Date Interviewed:……..

Name of the Interviewed Person with mental health problem……

6. Address:…….
   ……
   ……
7. Telephone No:……

8. Closest Town:……

9. District:……..

10. Province:……

PART I: Information of the personal background of the person with mental health problem

11. Age
12. Education-
    - If person with mental health problem unexpectedly stopped studies, reasons for that
    - Expectations in the studies
13. Employment-
    - current employment/early employments
    - If changed, reasons; if not employed, reasons
    - Time duration for the employed life,
    - Continuation of the jobs; if not, reasons and so on
14. Religious life-
15. Leisure activities-
    - Before and after the mental health problem
    - If not go for leisure activities, explain the reasons

PART II: Information of the Residence of the Person with Mental Health Problem

16. Living-
    - With whom live
    - Changes of the living situation before and after the mental health problem and reasons for changes
    - Willingness to live with family members and willingness to keep the person with mental health problem with his/her family members
17. Ownership of the house; type of the house (rented, own etc..)
    - If a rented house, who does the payment; can afford
    - If it is an own house, who built/bought

18. Satisfaction with the facilities in the house
19. Ownership of the land, who bought/gave
20. Residence/house changing and reasons for changes

PART III: Information of the family life of the person with mental health problem

21. Marriage life:
    - If married, when got married, how (from a love affair or proposal….)
    - Spouse and employment, age, education, social status and so on
    - Satisfaction of the marriage life
    - Conflicts and reasons, how long and so on
    - Children

22. Position in the family
    - Same as before the mental health problem
    - Changed (Increase/decrease) the value of the position in the family
    - Family members' perception on person with mental health problem (do they respect as in the past or not….)
    - What is your perception on the role changes in the family?
    - What is the family perception on the role changes in the family?
    - What is your point of view on the perception on the family perception on the role changes in the family?

18. Relationship with spouse:
    - Condition of the relationship (negative/positive)
    - If changed, reasons
    - Solutions taken for conflicts or changes
    - Current relationship

19. Relationship with children:

- Condition of the relationship before and after the mental health problem
- If changed, reasons
- Solutions for the conflicts
- Current relationship
- Influences for the bad relationships/good relationships

20. Relationships with parents or siblings:

- Condition of the relationship (negative/positive)
- If changed, reasons
- Solutions for the conflicts
- Current relationship
- Influences for the bad relationships/good relationships

21. Family communication

- Communication patterns (equal with every family member/ unequal)
- Listening
- Paying attention
- Direct/indirect communication (for needs of the person with mental health problem/ children….)
- Critical communication
- Hostile comments
- Family gathering

PART IV: Needs of the person with mental health problem

22. In general, what were your needs (before the mental health problem)

- Physical, Social, Emotional, Spiritual (explain what kind of needs you had)
- How were they fulfilled

- Are you satisfied with fulfillment of your needs?
- Did you have any problems in the fulfillment of them
- Who supported to fulfill your needs

23. Changes of the needs
    - Changed needs (comparison with general needs which had early)
    - Reasons for the changes
    - Relationship between the mental health problem of the person and changed needs
    - Feelings on it
    - Support system for the fulfillment of these needs
    - Can you satisfy with your fulfillment of current needs?

PART V: Expectations of the person with mental health problem in the recovery from the mental health problem

24. Expectations from the other family members
    - In the household chores
    - In the caring of the person with mental health problem
    - In the decision making
    - In the caring of the others in the family
    - In the meeting of the professionals for the person with mental health problem

25. What person with mental health problem expect from the close relatives?
    - Do they expect their support
    - If yes, in what
    - If yes, are close relatives ready to help
    - If yes, in what ways
    - If they are not ready, why?

26. What does person with mental health problem expect from the professionals?
    - Do family members expect support from the professional?
    - If yes, what type of support (awareness, treatment, caring, to build the relationship with family, to obtain the community services)
    - If not, why?

PART VI: Satisfaction of the support (given by family, close relatives, and professionals) in the recovery of the mental health problem

27. Support from the family
    - In the household chores
    - In the caring of the person with mental health problem
    - In the decision making
    - In the caring of the others in the family
    - In the meeting of the professionals for the person with mental health problem
28. Support from the close relatives
    - Support for the household chores
    - Support for the caring of the person with mental health problem
    - Barriers to get the support

29. Support from the professionals
    - In the making knowledgeable
    - In the treatment
    - In the obtaining the community services
    - In the management of the family relations
    - In the skills training and so on
    - Barriers to get the support
30. Perception on the family members' contribution on behalf of the person with mental health problem

- What is your perception on the family members' contribution on behalf of you?
- What is your family members' perception on their contribution for you?

PART VII: Perception on the interventions in service centre

31. Staff (psychiatrists, other doctors, nursing staff, psychiatric social workers, development assistant to mental health, attendants, labourers.)

32. Perception on the family involvement
    - Family engagement in the assessment of the person with mental health problem
    - What do you think on making the family involved in the caring of the people with mental health problems(negative effect/positive effect on the recovery)
    - Are people with mental health problems happy with the making their family involved in the assessment and treatment process by the professionals?
    - If yes, why and how can improve the family involvement

PART VIII: past and Future of the person with mental health problem

33. Expectations of the person with mental health problem which they had before the mental health problem
34. Expectations person with mental health problem in the future

Observation

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Annex VI

Interview Guide Line with the Family Members of the Person with Mental Health Problem

Mental Health and Family in Sri Lanka

Sample No:……

Date Interviewed:……..

Name of the Interviewed person: ……..

His/her relationship with the person with mental health problem……..

23. Address:…….
……
24. Telephone No:……

25. Closest Town:……

26. District:……..

27. Province:……

PART I: Family structure

6. Roles of the each family nmember
    - Breadwinners, dependants, and so on
    - Support systems of the household chores
    - When a family member is not well, how to continue the family chores
    - When someone has a problem, do the approach to discuss
    - Who is responsible for maintaining the family rules/decision making
    - In the fulfillment of the family roles, do they meet the expectations of other family members

7. Status in the family
    - Status in each family member
    - Hierarchy of the statues
    - Do they respect each other
    - Problematic Statues/ conflicts/ reasons for conflicts

8. Family cohesiveness
    - Family attachment and detachment
    - Are they healthy or unhealthy
    - Emotional involvement/over involvement
    - Family rituals (eating together…..)
    - Over protectiveness of the family

9. Family communication
    - Communication patterns (equal with every family member/ unequal)
    - Listening
    - Paying attention
    - Direct/indirect communication (do children talk to mother/father directly for their needs….)

- Critical communication
- Hostile comments

10. Family coping strategies
    - Experiences on the household crises in the past
    - The way they were handled
    - Family members' contribution in the problem solving
    - Level of the ability of the solving them (confused/were they able to cope…)
    - Do they need the relatives' support in their problem solving
    - If yes, what kind of support

PART II: Changes in the family structure after the mental health problem of the family member

11. Roles of the each family members
    - Role changes in the role of the family/ person with mental health problem in the family (Breadwinners, dependants)
    - Support systems of the household chores
    - When person with mental health problem is not well, how to continue the family chores
    - When person with mental health problem has a problem, do the approach to discuss
    - Who is responsible for maintaining the family rules/decision making
    - In the fulfillment of the family roles, do they meet the expectations of other family members
    - What is your perception on role changes in the family after getting the mental health problem of the person with mental health problem?
    - What is family perception on role changes in the family after getting the mental health problem of the person with mental health problem?

- What is the perception of the person with mental health problem on role changes in the family after getting the mental health problem of the person with the mental health problem?

12. Status in the family
    - Changing the Statues in the family
    - Changes in the hierarchy of the statues
    - Do they respect each other/ person with the mental health problem
    - Problematic Statues/ conflicts/ reasons for conflicts

13. Family cohesiveness
    - Family attachment and detachment
    - Are they healthy or unhealthy
    - Emotional involvement/over involvement
    - Family rituals/ changes of the rituals (eating together…..)
    - Over protectiveness of the family and its effect on the person with the mental health problem

14. Family communication
    - Communication patterns (equal with every family members/ unequal)
    - Listening
    - Paying attention
    - Direct/indirect communication (for needs of the person with the mental health problem / children….)
    - Critical communication
    - Hostile comments

15. Family coping strategies

- Experiences on the household crises in the past (mental health problem of the person)
- The way they were handled
- Familynmembers' contribution in the problem solving
- Level of the ability of the solving them (confused/were they able to cope…)
- Did/do they need the relatives' support in their problem solving
- If yes, what kind of support

PART III: Perception on the mental health problem

16. Family responses to the mental health problem of the oerson
    - Denial, angry…….etc (toward the person with the mental health problem /family members)

17. Family members' feelings (positive/negative) on the person with the mental health problem
18. Family members' feelings on the welfare of the person with the mental health problem (anxious/worry…..)

PART IV: Family members' contribution on the mental health problem

19. Parents' contribution
    - Contributed your (parents') needs on behalf of the person with the mental health problem (ex: giving up job……)
    - Your (parents') point of view on parents' attitudes on such contributions
    - Other family members' attitudes on such contribution on behalf of the person with the mental health problem
    - Usefulness of parents' contributions

20. Siblings' contributions
    - Your point of view on your contribution
    - Your point of view on other siblings' contribution
    - Usefulness of the contribution

21. Children's contribution
- Your point of view on the children's contribution
- Usefulness of the contribution

22. Effect of the mental health problem on the family lives (health problems, physical harassment, poor relationship with the person with the mental health problem, feelings to committee suicide, lacking social relations)

PART V: Family needs

23. In general, what are your needs
    - Physical, Social, Emotional, Spiritual (please explain)
    - How were they fulfilled
    - Are you satisfied with the fulfillment of your needs?
    - Did you have any problems in the fulfillment of them
    - Who supported to fulfill your needs

24. Changes of the needs
    - Changed needs (comparison with general needs which had early)
    - Reasons for the changes
    - Relationship between the mental health problem of the person and changed needs
    - Feelings on it

- Support system for the fulfillment of these needs
- Do you satisfy with the fulfillment of current needs?

PART VI: Family expectations in the caring of the person with mental health problem

25. Expectations from the person with the mental health problem
    - In the family roles and statues
    - In the welfare of the family
    - In the decision making in the family
    - In the household chores

26. Expectations from the other family members
    - In the household chores
    - In the caring of the person with the mental health problem
    - In the decision making
    - In the caring of the others in the family
    - In the meeting of the professionals for the person with the mental health problem

27. What family members expect from the close relatives?
    - Do they expect their support
    - If yes, in what
    - If yes, are close relatives ready to help
    - If yes, in what ways, if not why?

28. What do family members expect from the professionals?
    - Do family members expect support from the professional?
    - If yes, what type of support (awareness, treatment, caring, to obtain the community services, to manage the crises)

- If not, why?

PART VII: Satisfaction of the support (given by the person with the mental health problem, family, close relatives and professionals) in the caring of the person with the mental health problem

29. Support from the person with the mental health problem
    - In the caring of him/her, taking treatment
    - In the household coheres
    - In the decision making

30. Support from the family
    - In the household chores
    - In the caring of the person with the mental health problem
    - In the decision making
    - In the caring of the others in the family
    - In the meeting of the professionals for the person with the mental health problem

31. Support from the close relatives
    - Support for the household chores
    - Support for the caring of the person with the mental health problem
    - If you did not get support, why?
    - If they didn't give support, why

32. Support from the professionals
    - In the making knowledgeable
    - In the treatment
    - In the obtaining the community services

- In the management of the crises
- In the skills training and so on
- Barriers

PART VIII: Perception on the intervention in the service centre

33. Staff (psychiatrists, other doctors, nursing staff, psychiatric social workers, development assistant to mental health, attendants, labours.)
34. Perception on the family involvement
    - Family engagement in the assessment of the person with the mental health problem
    - What do you think on making the family involved in the caring of the people with mental health problems(negative effect/positive effect on the recovery)
    - How can improve the family involvement

PART X: Future of the of the person with mental health problem

35. Family expectations which they had in the past on the person with the mental health problem
36. Family members expectations in the future on the person with the mental health problem

Observation

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Annex VII

Interview Guide Line with the Mental Health Staff

Mental Health and Family in Sri Lanka

Sample No:……

Date Interviewed:……..

Name of the Interviewed person: ……..

His/her Profession:……..

PART I: Nature of the Profession

1. Profession
    - Name of the profession
    - How long have you been working in the medical profession
    - How long have you been working in the mental health field
    - How long have you been working in this institute
    - Educational and professional qualifications of the professionals

2. Contribution to the institution and the mental health service
    - Representative group (medical, non medical, and so on)
    - Nature of the work (individual, team work, what kind of service given to the people.)
    - Contribution to the decision making in the group and the institute

3. Communication
    - Communication patterns with the service users and the family members while the people with mental health problems are in the hospital
    - Communication patterns with the service users and the family members after the people with mental health problems are discharged
    - What do you do if the people with mental health problems do not follow up at the institute according to your appointment?
    - What do you do if you need to meet the family members of the people with mental health problems (specially Family members those who do not visit their relatives in the hospital).
    - What is the message which you give to the service users and family members?.
    - How do you tell them what should do and do not?.

PART II: Perception on the mental health problem

4. Your perception on the people with mental health problems
5. Perception on Family responses to the people's mental health problem
6. Perception on responses of the people with mental health problems to their mental health problem
7. Your perception on the people's strengths to cope with the problem

PART III: Perception on family members' contribution on the mental health problem

8. What do FMs see as a contribution?
    - Your point of view on parents' attitudes on such contributions
    - Other family members' attitudes on such contribution on behalf of the person with mental health problem
    - Usefulness of parents' contributions
    - What do you mean by 'usefulness' and 'not usefulness' of the contribution?

9. Siblings' contributions
    - Your point of view on the siblings' contribution
    - Usefulness of the contribution

10. Children's contribution
    - Your point of view on the children's contribution
    - Usefulness of the contribution

PART IV: Family needs

11. Perception on family needs and service users' needs

12. Changes of the needs
    - Changed needs (comparison with general needs which had early)
    - Reasons for the changes
    - Relationship between the person's mental health problem and changed needs

- Feelings on it
- Support system for the fulfillment of these needs

PART V: Perception on family expectations in the caring of the person with the mental health problem

13. Expectations from the person with mental health problem
    - In the family roles and statues
    - In the welfare of the family
    - In the decision making in the family
    - In the household chores

14. Expectations from the other family members
    - In the household chores
    - In the caring of the people with mental health problems
    - In the decision making
    - In the caring of the others in the family
    - In the meeting of the professionals for the people with mental health problems

15. What family members expect from the close relatives?
    - Do they expect their support
    - If yes, in what
    - If yes, are close relatives ready to help
    - If yes, in what ways, if not why?

16. What do family members expect from the professionals?
    - Do family members expect support from the professional?
    - If yes, what type of support (awareness, treatment, caring, violent control, to obtain the community services, to manage the crises …..)

- If not, why?

17. What does the staff know on family expectations?

PART VI: Perception on satisfaction of the support (given by the person with mental health problem, family, close relatives and professionals) in the caring of the person with the mental health problem

18. Support from the person with mental health problem
    - In the caring of him/her, taking treatment
    - In the household coheres
    - In the decision making

19. Support from the family
    - In the household chores
    - In the caring of the person with mental health problem
    - In the decision making
    - In the caring of the others in the family
    - In the meeting of the professionals for the person with mental health problem

20. Support from the close relatives
    - Support for the household chores
    - Support for the caring of the person with mental health problem
    - If you did not get support, why?
    - If they didn't give support, why

21. Support from the professionals
    - In the making knowledgeable
    - In the treatment
    - In the obtaining the community services
    - In the management of the crises
    - In the skills training and so on
    - Barriers

PART VII: Perception on the services available in the service centre

22. Perception on the family involvement/intervention
    - Family engagement in the assessment of the person with mental health problem
    - What do you think on making the family involved in the caring of the people with mental health problems(negative effect/positive effect on the recovery)
    - How can improve the family involvement/intervention

PART VIII: Future of the of the person with mental health problem

23. Family expectations which they had in the past on the person with mental health problem (in the point of your view)
24. Family members expectations in the future on the person with mental health problem (in the point of your view)

Observation

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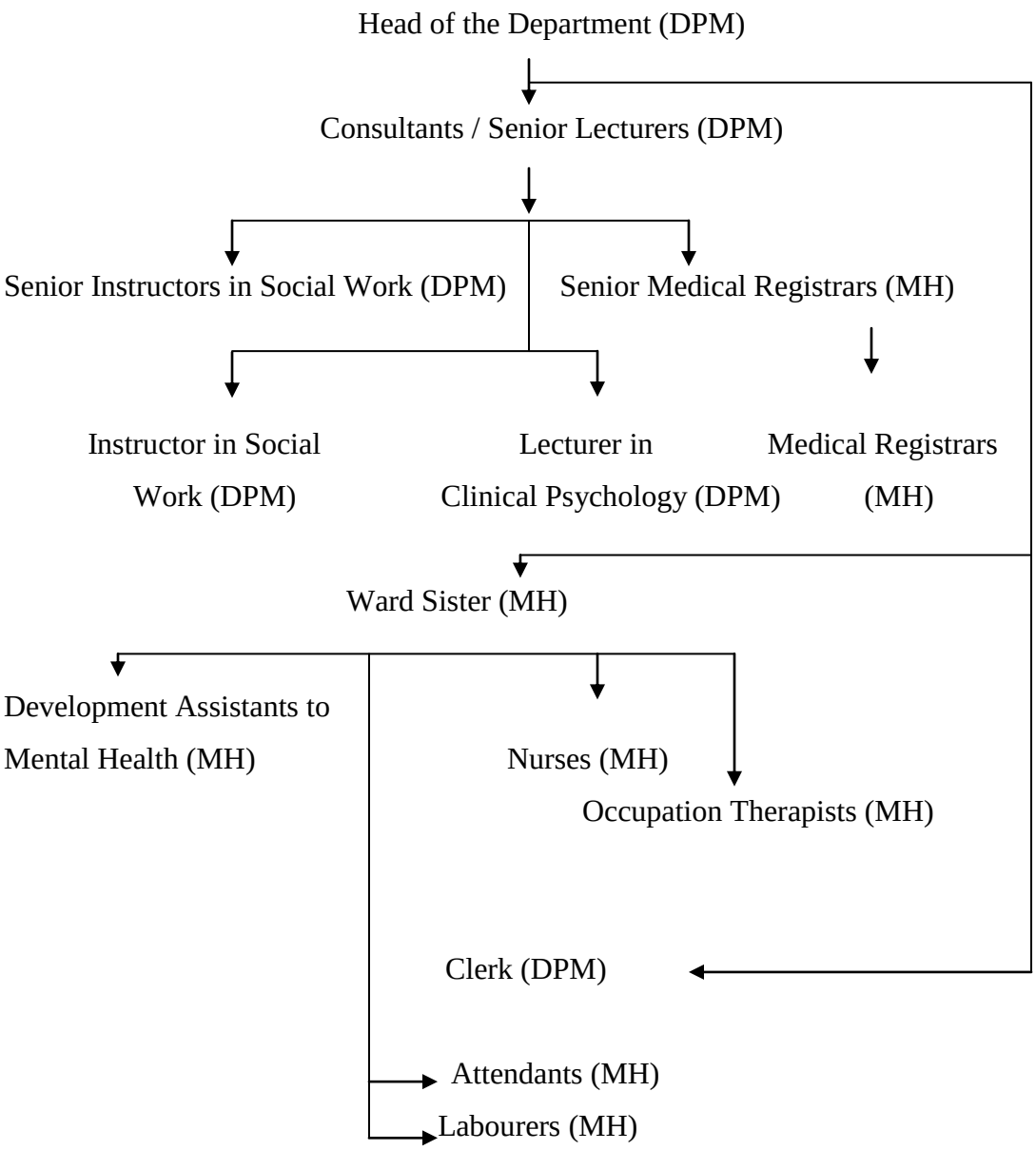
Annex VIII

The Structure of the University Psychiatric Unit



Source: Field Data: 2011-2012

Annex IX

Table of the Staff in National Institute of Mental Health

Category	**No**	**Category**	
Director	01	Radiographer	02
Deputy Director	01	Medical Record Assistant	01
Consultants	10	Pharmasist	06
Medical Officers	41	Dispensers	01
Dental Surgeon	01	ICT Assistant	01
Accountants	01	Telephone Operator	01
Administration Officer	01	Ward Clerk	12
Matron	06	Lab Orderly	02
Nurses	343	Diet Stewards	03
Ward Sisters	08	House Warden	04
Technical Officer	01	Drivers	11
Paramedical Officers	04	Cooks	12
Public Management Assistant	30	PHI (Public Health Inspector)	01
Psychiatric Social Workers	09	Overseers	05
Development Assistants *	11	Seamstress	02
Occupational Therapists	07	Attendants	130
Physiotherapists	02	Supportive Staff	363

*. This category has been recruited under a graduate scheme which conducted to give employment for the gradates and they also work in the social work section. But, they have different degrees.

Source: Field Data 2011-2012 & www.nimh.health.gov.lk

Annex X

Data Coding Tables

Interviews with People with Mental Health Problems

Data Extract	Coded for
I have four sisters and three brothers. My two brothers and one sister have mental illnesses. One brother is in a rehabilitation home. Only one brother and one sister are married. Except one sister and married brother, other all are unemployed.	1.Family members have beliefs about genetical relationship with mental health problems. 2.Family sometimes cannot cope with their distress events and need outside support.
Now I am an invalid coin in my home. No one talks anything important with me. They think that I am mad. Whatever I tell and whatever I do, they think that I am mad and not giving any value for them. …But, I had a good dignity and acceptance previously among my relatives even. …Everything is decided by husband. Nothing is asked from me. Before my illness, I grew vegetables, flower plants, cooked, and sewed, gradually, all these deteriorated because of the illness and medicine.	1.People with mental health needs to participate in family discussions, take part in important decisions in the family. 2. They need self worth and dignity. 3.They have also strengths to be used for family welfare. 4. Not only MHP but also the medicine creates issues.
My family members did many things to cure my illness; Vowed, performed large-scale tovil (large-scale supernatural performance), western treatment.	1.Family members follow every type of treatment systems in mental health problems. 2.They expect the cure their family members.
I do not have money to spend for my needs; I want to fill my two teeth, I asked my husband, but he did not give. But, he has enough income. ……..I expect my husband's kindness, love, compassion and support. I need close relatives' support. It is a big strength for me. I like to start my previous hobbies; to grow	1.People with mental health problems need money. 2.They need to protect their physical beauty. 3.They need love, kind, compassion and

flower plants, vegetables. I am happy if others support me. But, I used to be alone now. Sometimes husband support in cooking, but he does not give what I want.	support. 4.They have need to select or decide what they want. 5. They have strengths to be brushed up and they can support the family.
From the beginning, there were problems in my marriage life. Only one month, I was with husband and his relatives. For few months, I was with relative sister, time to time I was with my mother. Now, I live with my husband and son.	1.In family life, Problems are not new or strange. 2. Sometimes, distressful family background precipitates mental health problems. 3. Support from close relatives were important in family issues.

Data Extracts	**Coded for**
Our father blames me when I cry. He says that neighbours also hear my crying. So, he sometimes, threatens me that he would hit me if I further cry. But, father comes night using alcohol and scolds on us. Sometimes he uses obscene words neighbours may hear too. But, we do not criticize or blame. He says that I do not have an illness and therefore, he influences me not to take medicine. He does not have any understanding on my illness. Sometimes, I feel that he does not love me. He says that I by myself made ill. When he claims that I also feel that neighbours who run a 'devala' (shrine) with soothsaying practice have done some malevolent act for me.	1.There are rules at home about how we should behave. 2.Family expects a calm and quit behavior from their family members. 3. Beliefs about what psychological traits are characteristic of members of each sex. 4. Family beliefs on Mental health problems. 5.HEE at home.
I went to my first job only one day. When I went there I had wearing a thread around my neck. The	1.Different treatment methods are followed by family members to cure the

officers noticed it and my stammering with lack of talking, shivering my hands raised because of the medication. They observed it as unusual from other workers. They asked why I was wearing a thread and I said nothing special. But they said you may be having a mental illness because you are different from others. Unfortunately, they said you may fell into machines and we cannot be responsible for you and refused my coming to work there. I felt shame and stopped going there. From that day I did not go to any job and I am having a fear with shame everyone notices my inappropriate behavior.	MHPs. 2.People with MHPs are stigmatized and discriminated in their work places. 3. Stigmatization and discrimination are reasons to people with mental health problems prevented from doing meaningful work. 4.Side effects of Medicine creates another issues for them and prevent them going to the society.
But, being at home was also a headache for me because everyone in the village asked why I was not going to work and my mother is sent to work because she suffered lot in her laboring job under the hot sun. So, again I thought I should go to work after two years of my medication because doctors said that I have to continue medicine regularly for two years and then I would be able to come to normal life. But, after one and half years, it was started to hear voices.	1.Doing a job by grown up children and looking after their parents is a social value in society. 2.Female do a double role; job in outside and homework. 3.people with mental health problems are in a puzzle due to the lack of information by medical professionals.
I came to my aunt's house because I wanted to avoid villagers' different talks and rumors. Many of the close relatives supported us at the beginning. Later they themselves are spreading among other relatives and the villagers that I am mad. Again I came home. But, my brothers also blame me when I am crying because often I feel worry about my life. They laugh at me showing my medicine cards that I have been given good character certificate by the doctors. Brothers criticize my walking style and my way of looking and often says that I continue the 'paule lede' (family illness) (there is a strong family history of MHPs in her paternal side). My grandmother is	1.Sigmatization and discrimination make confused the life of people with mental health problems. 2.Close relatives once support in family crisis, other hand, create issues. 3.People with mental health problems are stigmatized by family members. 4. HEE at. home (criticism)

not happy with their criticizing me".	
Though I just feel to go to visit friends, my mother does not allow me go there alone.	1.Overinvolvement by family members with their family members with MHPs.

Interviews with Family Members

Data Extract	Coded for
Most of the time Thilaka was the bystander. Therefore, she was unable to continue her job and she had to get a loan from her working place for bus fare and other expenses. In addition, she was supported by her and her husband's extended family members (brothers and sisters).	1.Mental health problems cause to financial difficulties. 2.Extended family members are supportive.
Thilaka said she cannot ask money from them for every needs and she has to accept whatever they give because they are also not so rich. She is satisfied with their relatives' current support because she was unable to manage financial things up to this level if they did not support her.	1.Extended family support is important. 2. Family members also expect to be independent.
Husband never comes to the hospital with my daughter to take medicine or does not give money even. He says he cannot do dual duty at home; earning and doing shopping and accompanying children for medicine. So I go to work and earn some amount of money and go to hospital with daughter. But, I am worried about my sons as loku putha (elder son) also has to cook as I am in the hospital and podi putha (younger son) is unhappy to be at home without me and he does not talk about his needs with his thaththa (father). Without a mother, boys cannot cook properly.	1.Male do not expect to do a dual role at home. 2.Female also are worried about male children's participation in homework. 3.Female think they are experts in home work. 4. More children depend on their mothers for their needs including emotional needs.
They were not respecting each other as husband and wife and they had frequent conflicts. They were not used to	1.Family members do not respect each other

have their meals together and time to time family members had their meals. No communication together when they have family issues and children often depended on mother. Whatever they need, they request them from mother and not from father.	when they are not supportive each other. 2.Family rituals are not positive. 3.No communication to solve family problems. 4.Some children are depend on mother for their needs.
Other hand, she believed that her daughter got the mental illness which her father's siblings have. Daughter's one of the aunties (father's sister) is having MHP, but she is married and having children. Her two children are also having MHPs and aunt's husband and mother in law do house work in that family as aunty does not do anything at home. There is another unmarried aunty with MHP and currently she is looked after by her younger brothers and their children. Therefore, Thilaka sometimes is having pessimistic thoughts on the recovery of her daughter's MHP. She has gone to an astrologer at the beginning of daughter's MHP and he also has proved that she has their 'family illness' (paule lede) and therefore, Thilaka do not have any hesitation to continue the Western medicine as the astrologer also told the truth.	1.family members think about genetic relationship with Mental health problems. 2.This creates pessimistic thoughts on recovery. 3.People go to healers to confirm their family members' health problem..

Data Extract	**Code for**
Husband (44yr) is addicted to heroin and does not contribute anything for the family. He has been frequently stealing household items, including the schoolbags, clothes of the children, gas cooker and it causes severe distress to the family. He abuses the	1.Due to the problematic family background, family members get mental health problems. 2. All parents are not supportive in

children and his wife physically and psychologically leading to lot of emotional problems in the family members. It can be believed that his behaviour was one of the precipitating factors for his elder daughter's mental health problem.	children's development.
The house where this family lives consists of four rooms, one kitchen, and a visiting room where more than four families reside including more than twenty family members (including children). The situation is worsened recently due to the problems created by the other in laws of the house. They do not have any other place to go and live to get rid of this complicated and problematic environment.	1.Housing problems creates MHPs or MHPs create housing problems?. 2.Sometimes separate house is good for some people with mental health problems. 3.Some people cannot afford for housing.
Elder daughter found an unskilled job in a religious place for a low salary due to the social worker's encouragements and influences. But, she lost her job after few months due to father's behaviour (in front of the working place, father scolded her using obscene words forcing to give her salary).	1.There are parents create problems for children. 2. Parents' substance use creates risks to the children's psychological situation.
Parameshwari's younger son developed emotional problems in his behaviour (with school refusals, leaving home, threats of committing suicide) secondary to the above mentioned problems. There is also a high risk of relapse of the elder daughter's mental health problem under this traumatized environment.	1.Social and economical factors support for mental health problems.
Finally mental health team came to a conclusion that the best solution for this family was to leave this house with difficult environment as soon as possible and live in a separate place. (specially for the best interest of the children). But, they are unable to do it alone without social and financial support. They have	1.Seperate house is a basic need of all. 2.Supporting people with mental health problems and their families should be a collaborative work.

already applied for the Ministry of Construction Engineering Services, Housing and Common Amenities and requested to support them.	

Interviews with Mental Health Staff

Data Extract	Code for
I think it is necessary to clarify the main responsibility of every profession in the team. Otherwise, all responsibilities are overlap and not performing well. Team work should be developed further. Also, we want to build up a mechanism/network with other services to support the people who vanished from the follow up system.	1.Responsibility in each profession is important in supporting people with mental health problems. 2.Team work is important. 3.It is necessary to support for the people who do not come to the hospital.
We sometimes contact families of the people with MI over the telephone, if not, through the grama seveka or divisional secretariat office. If not, we do home visit most probably as a team. But, This is not in a satisfied level and we need to improve.	1.Family intervention can be done through the phone. 2. We need other institutions' support in helping these people. 3. Home visit are also good to develop family intervention and support them.
In our institution, family intervention is less due to lack of resources, work load, no professional freedom etc. no proper system to send messages to families, we cannot keep our belief on available system. We do not have proper treatment plan and discharge plans. Therefore, some of them are neglected from our services or they do not get enough services from us.	1.There are some reasons for lack of family intervention; lack of resources, overburden of work, lack of professional freedom. 2.Individual care plan is important for everyone.
If we think of some mental illnesses such as depression and schizophrenia, about 13%-15% get cured, half of them needs to take medicine lifetime,	1.Staff members believe that all mental health problems cannot be cured. 2. They believe that medicine is essential

about 40% of them may be chronic in the illness.	for majority of the people with mental health problems.
But, I have experience in my profession; we can improve their recovery than this if we educate people with mental health problems and their family. They have some misunderstanding on MI cause as barriers for the recovery.	1.Awareness and education on mental problems and recovery are interrelated. 2.Misunderstanding on MHPs is a barrier for recovery.
Stigma is still associated with MI and people with MHPs. It is in people's mind. On one hand, we need people's (with MI) support to reduce the stigma. If they get support us and come for the treatment they can be among other people, If they get worse their problems, it helps to develop the stigma.	1.Stigma is related with people's thinking patterns. 2.People with mental health problems also contribute to increase the stigma.
Majority in the past thought that 'the mad' are dangerous. But, I know with my experience, not all are dangerous.	1.People believe that people with mental health problems are dangerous. 2. Truth is all are not dangerous.
Majority family members try to change their doctors after two three weeks because of the poor improvement. They expect cure their family members with MI soon. Therefore, it is necessary to make them aware of the MI, Symptoms and recovery. Otherwise they do 'doctor shopping' because of their distress, but nothing happen good to patient.	1.In the care plan, awareness on MHP, its nature and recovery is important. 2. Awareness can reduce money wasting, time wasting, harm to the person with mental health problem.
Mentally ill people think that their illness cannot be cured, they have to take medicine lifetime etc. But I am not happy the professionals to cheat the people saying that their 'illness can be cured'. In psychiatry, there is no method to measure the improvement. Most of the time, only thing they do increasing medicine.	1.People with mental health problems believe that their MHP cannot be cured. 2. Mental health professionals also believe that MHPs cannot be cured. 3.We need a to have a way/method to measure people's recovery.
People with mentally illnesses have strengths. But,	1.People with mental health problems

they are different from one another. We can use them to develop their recovery.	also have different strengths. 2. Their strengths are useful their recovery.
Mentally ill people and their families have same basic needs such as food, house, love. Security, money, activities etc. Sometimes, needs of mentally ill people change; for instance, some of them have to control food, some of them need more food due to medicine, extra guardian etc. In addition, we should support them to improve interpersonal relations. In addition, medicine, socialization, social need such as suitable place in the society, caring, continuation of the job are other basic needs. If they are difficult to continue the job with same duties, there should be new arrangement in the system; for instance, jobs with light duties. Not only that, they also need leisure activities such as films, music etc. In the past, we had some programmes to go on trips to park, beach etc. But, now there is no one to take those responsibilities.	1.People with mental health problems and families have same human needs. 2.Sometimes, needs change due to special reasons. 3.People with mental health problems need interpersonal relations, leisure activities, caring, continuation of the job, suitable status in the society.
Majority mentally ill people know that they should take medicine. Majority of the family members also support our patients; they come and ask medicine needed to buy from outside, they try to fulfill the basic needs, majority of them come to take the patient after the discharge. Majority them are parents, husband or wives, or children of the clients.	1.Medicine is a need of people with mental health problems. 2. Majority families support to fulfill basic needs. 3. Majority visitors are parents, spouse or children.
People with mental health also has some fears and anxieties such as whether I will be able to get cure form my illness, whether my job will be lost etc.	1.People with mental health problems have anxieties to be addressed related to their basic needs and problem.
We should support families to share their distress; they have losses happened due to patient's illness, stigma etc. They need our support to be aware of	1.Families have expectations such as sharing the distress, awareness on reducing stigma, medicine, caring,

how to mitigate stigma, how to care them, how to give medicine, how to reduce forensic issues, how to reduce sexual harassments and crimes etc.	reduction of forensic issues, sexual harassments and crimes etc.
The government also need to improve welfare facilities for the mentally ill people. They need to support the people those who cannot continue their jobs, those who cannot rehabilitate.	1.In a country government also has some responsibility to support the people with mental health problems. 2. There is one category of people who cannot come to a satisfied functioning level due to MHP.
No any argument, it is very essential the family intervention. By now, FI is not in a satisfied level, our current treatment concept is patient-based one, But it should be family-based one.	1.Family intervention is very important. 2.Some of the MH staff believe that treatment plan should be a 'family-based ' one.
We need to have family meetings, discussions, etc with the team. We need should have some conversations and discussions on patients, coordination and monitoring on what team do.	1.Team work is important. 2.Co-ordination and monitoring on what we do related with the persons with mental health problems are necessary.
Majority of the parents expect their children to get marry, to pass the exams, to go abroad, to go to the job etc. Finally, there are some family members to get rid of the patient too.	1.Family expectations are marriage, job, sending abroad, passing exams and get rid of the family member with mental health problem.

Data Extract	**Code for**
Every time, we should give the responsibility to the family about the patient without disempowering the patient. We have to make them aware of the mental illness in a relevant way, need to encourage them to	1.Family is fist in the caring of the people with mental health problems. 2.Family awareness is important 3. Empower the people with mental

take decisions, explain our services etc.	health problems is necessary.
Mental illness is also one of noncommunicable diseases. There are limited number of long-term or chronic patients, Sometimes, may be because of the illness. Sometimes, mental health team dis-empowers the patients. I think mental illness is 'a set of science of symptoms'.	1.Mental health problem is a scientific thing. 2.Mental health staff also dis-empower the people with mental health problems.
Some people in society think mentally ill are foolish, disorderly, wild, and disobedient people. Sometimes, family members increase the stigma because they are also in this society among those people with such perception. Unfortunately, some of the mental health staff also has these attitudes. Mentally ill people also are in this idea. So, stigma can see as a cycle. On the other hand, if we more and more talk about MHP, stigma is increased.	1.People believe that people with mental health problems are foolish, wild, disorderly and disobedient. 2.Fammilies and mental health staff also contribute to increase the stigma. 3.No need unnecessary talk on MHPs.
We cannot say mentally ill people cannot take any decision because illness may not last long time, sometimes for a short period. Therefore, mentally ill should not be given special attention. But, in their acute stage, they need support for instance, pt with depression with suicidal thoughts. We should expect from them what we expected early, nothing special.	1.People with mental health problems also can take decision except in their acute stage. 2. They need others' support only in special occasions, for instance, acute stage with suicidal thoughts. 3. No special expectations from them.
Always, as a mental health staff, we should work to increase their power, if not we should not contribute to increase the social attitude that mentally ill are foolish. I think media also on one hand increase the stigma.	1.Mental health staff's responsibility is to make the people with mental health problems empowered. 2. Media on one hand increase the stigma.
Mentally ill people also have same needs which other people have. Only thing they need support in their acute stage to take decisions because they may	1.People with mental health problems also have similar needs. 2. Sometimes, for some people need

lose job, marriage, no guardian etc.	professional support to protect their job, marriage ate.
Mentally ill people lose their job not because of the illness but because of the misperception of the working place. In acute stage, some people lose their job.	1.Mental health problem is not a factor to lose the job.
Support for the mentally ill people and their family members should be done by a specialized team. But, generic advice set are not good for them.	1.Family support/intervention should be done by a specially trained team.
I think family members are always try to find witness to prove that he or she is doing this and that because of his 'madness'. Patients also try to wait until others do everything, for instance, though they used public transport early, now they try to hire private vehicle. Majority family members try to make us to prove that their members are foolish, inability to take decision, need support etc.	1.Family members on one hand, increase the stigma and dis-empower their family members with mental health problems.
Family members expectations also change unexpectedly, some family members believe getting a MI is a very unfortunate and unlucky thing. Therefore, they blame the patient. Some of the patients also try to take their parents' pension and be without trying to do any meaningful thing.	1.Family members also cannot cope with or understand adverse event in their family.
I think majority are satisfied with our services and equal treatment etc.	1.Equal treatment. 2.Majority are satisfied with current services.

Subject Index

Author Index

Povzetek doktorske disertacije

Pričujočo raziskavo smo izvedli na podlagi raziskovalnega vprašanja »Kakšne so značilnosti posredovanja v družini in kakšen je pomen podpore družini oseb s težavami z duševnim zdravjem v Šrilanki?«. Cilj raziskave je raziskati potrebe ljudi s težavami z duševnim zdravjem in njihovih družinskih članov ter oceniti, kakšna je osveščenost uporabnikov služb, njihovih družinskih članov in strokovnjakov ter kako vidijo posredovanje v družini in podporo družinam na področju oskrbe uporabnikov.

Pričujoča raziskava ne zastavlja hipotez, temveč raziskuje naslednja raziskovalna vprašanja:

- Kaj družinski člani pričakujejo od svojcev s težavami z duševnim zdravjem v družinskih dejavnostih?
- Kako se družinski člani spopadajo s svojimi težavami in kakšne spremembe potrebujejo, da bi lahko poskrbeli za družinske člane s težavami v duševnem zdravju?
- Kaj družinski člani pričakujejo od strokovnjakov s področja duševnega zdravja pri skrbi za svojce s težavami z duševnim zdravjem?
- Kaj ljudje s težavami z duševnim zdravjem pri okrevanju pričakujejo od svojih družin in strokovnjakov s področja duševnega zdravja?
- Kaj v prihodnosti pričakujejo ljudje s težavami z duševnim zdravjem in njihovi družinski člani?

Terensko delo pričujoče raziskave smo opravljali dve leti (2011-2012) na Nacionalnem inštitutu za duševno zdravje v Šrilanki in na Univerzitetnem oddelku za psihološko medicino v javni bolnišnici (NHSL) v Colombu v Šrilanki. Nacionalni inštitut za duševno zdravje je največja terciarna skrbstvena ustanova, ki obravnava ljudi s težavami z duševnim zdravjem v Šrilanki. Trenutno je v njej več kot 1000 oskrbovancev, čeprav je

na voljo le 900 postelj, redno zaposlenih pa je več kot 1000 članov osebja. V tej ustanovi je glede na ljudi, ki prihajajo po pomoč služb in glede na njihove težave, osem oddelkov, in sicer: dva splošna oddelka za psihiatrijo odraslih, oddelek za psihiatrično geriatrijo, oddelek splošne medicine, porodniški psihiatrični oddelek, oddelek za ljudi z učnimi težavami, oddelek za mladostnike in mlajše odrasle in oddelek za forenzično psihiatrijo. Vseh osem oddelkov spremlja osem zunanjih psihiatrov. Poleg omenjenih oddelkov so v ustanovi tudi oddelek za delovno terapijo, psihiatrično socialno delo, hortikulturno terapijo in raziskovalni oddelek. Izjemno dejavno vlogo v bolnišnici ima oddelek za psihiatrično socialno delo, ki pomaga ljudem s težavami z duševnim zdravjem in jih podpira pri doseganju psihološke, družbene in ekonomske blaginje ter zanje v skupnosti ustvarja naklonjeno okolje. Sprejem v bolnišnico je mogoč na lastno pobudo, na pobudo družinskih članov ali bližnjih sorodnikov ali pa priporočil drugih zdravstvenih služb in sodstva. Letno je v bolnišnico sprejetih približno 8000 ljudi s težavami z duševnim zdravjem. Večina jih ostane na zdravljenju v bolnišnici od dva do štiri tedne (terenski podatki 2011-2012, spletna stran Nacionalnega inštituta za duševno zdravje). Univerzitetni oddelek za psihološko medicino je del Oddelka za psihološko medicino Medicinske fakultete Univerze v Colombu v Šrilanki. V tej enoti se zdravijo večinoma ljudje z akutnimi težavami z duševnim zdravjem in na voljo so bivalne enote za 25 ljudi s težavami z duševnim zdravjem (terenski podatki, 2011-2012). V tej enoti delata dve vrsti osebja: osebje z Oddelka za psihološko medicino in osebje z Ministrstva za zdravje. Poleg zdravljenja in drugih zmogljivosti, namenjenih ljudem s težavami z duševnim zdravjem, je na voljo tudi zdravljenje z zdravili, elektrokonvulzivna terapija (EKT), psihoterapija, družinsko in individualno svetovanje, ozaveščanje in izobraževanje, psihosocialna in ekonomska podpora za posameznike in družine, kognitivna vedenjska terapija, usposabljanje, sodelovanje z zunanjimi ustanovami, da bi ljudje s težavami z duševnim zdravjem pridobili socialno-ekonomsko in pravno podporo ter psihosocialna rehabilitacija. V tej enoti letno prejme pomoč približno tisoč ljudi s težavami z duševnim zdravjem (Register sprejemov, 2011). Obravnavo v povezavi z drugimi službami pa omogoča timsko delo obeh institucij, ki ga sestavljajo specialist psihiatrije kot svetovalec, specializant psihiatrije (zdravnik, ki se usposablja za specialista psihiatrije), inštruktor na

področju socialnega dela/socialni delavec na področju psihiatrije, delovni terapevt, višja medicinska sestra/medicinska sestra (terenski podatki 2011-2012).

Naša raziskava je opisna študija, ki ubira interpretativni pristop. Za zbiranje pretežno kvalitativnih podatkov, ki smo jih dopolnjevali s kvantitativnimi, smo uporabili kombinacijo kvantitativnih in kvalitativnih raziskovalnih tehnik. Uporabili smo vprašalnik in opravili poglobljene intervjuje. Vprašalnik je izpolnil eden od dejavnih družinskih članov iz vsake družine uporabnika v vzorcu, ki je temelji na poljubni metodi vzorčenja, v skupnem številu pa smo zbrali štiriinosemdeset (84) vprašalnikov. Poglobljene intervjuje smo opravili z ljudmi s težavami z duševnim zdravjem, njihovimi družinskimi člani in zaposlenimi na področju duševnega zdravja. Intervjuvali smo petnajst ljudi iz vsake kategorije in z obeh lokacij. Ljudi s težavami z duševnim zdravjem in njihove družinske člane smo izbrali na podlagi vprašalnikov z obeh lokacij na podlagi ciljne metode vzorčenja. Družinske člane smo intervjuvali pri njih doma ali v ustanovah. Ljudi s težavami z duševnim zdravjem nismo izbirali na oddelkih za psihiatrično geriatrijo, za ljudi z učnimi težavami in forenzično psihiatrijo, saj je dostop do teh oddelkov omejen, prav tako pa je težje opraviti pogovore. Kategorijo osebja, zaposlenega na področju duševnega zdravja, so sestavljali zdravniki, medicinske sestre, inštruktorji na področju socialnega dela/socialni delavci na področju psihiatrije, delovni terapevti in spremljevalci. Intervjuvali smo po tri osebe iz vsake omenjene kategorije. Vodnik za opravljanje intervjujev smo pripravili vnaprej. Da bi zbrali sekundarne podatke, smo uporabili tudi poročila z uporabnikovo evalvacijo, diagnozami in načrti zdravljenja, zloženke in zdravstveno dokumentacijo. Pri zbiranju literature za našo raziskavo smo uporabili objavljene knjige, raziskovalna poročila, teoretske članke, arhivsko dokumentacijo, statistična poročila, ki so jih objavile domače in tuje vlade, etnografske zapiske o Šrilanki, objavljene in neobjavljene članke, časopisne članke in spletne strani institucij ter druge spletne strani.

Za analizo podatkov smo uporabili SPSS in tematsko analitični pristop. Tematska analiza je osnovna metoda, ki jo raziskovalci uporabljajo, da bi pri raziskovanju analizirali podatke. Metodo lahko opredelimo kot »*metodo za opredeljevanje, analiziranje in*

poročanje o vzorcih (temah) v okviru danih podatkov« (Boyatzis, 1998). Holloway and Todres (2003) sta določila, da je »tematiziranje pomenov« določena vrsta skupnih generičnih spretnosti celotne kvalitativne analize. Zaradi generične spretnosti je Boyatzis (1998) tematsko analizo opredelil ne le kot specifičnost, ampak tudi kot orodje, ki ga lahko uporabimo v različnih metodah. Spričo takšne teoretične prostosti lahko tematsko analizo uvedemo kot prožno in koristno raziskovalno orodje, ki nam omogoča bogate in podrobne podatke. Zaradi prožnosti metode podatki niso omejeni in omejujoči. Ta metoda tudi ne zahteva podrobnega tehnološkega znanja pristopov k tematski analizi, kot to velja za utemeljeno teorijo in diskurzivno analizo. Ta analitična metoda je tudi bistvena ali realistična metoda z mnogoterimi poročili, kot so izkušnje, pomeni, stvarnost, kakor jo vidijo sodelujoči. (Braun in Clarke 2006:78-87).

Našo raziskavo, torej tematsko analizo smo opravili v več korakih:

1. Seznanjanje s podatki – poslušali smo poročila, zapisovali verbalne podatke, jih prebrali in izpisali glavne zamisli.

2. Generiranje začetnih kod – zanimive značilnosti podatkov smo kodirali in opravili primerjavo.

3. Iskanje tem - urejanje kod v morebitne teme.

4. Pregled tem- tematske oznake smo povzeli in razdelili na več delov, glede na strukturo intervjuja. Nekatera ponavljanja, skupne opredelitve ter nasprotja smo zapisali v povzetek. Preverili smo ali se teme ujemajo z odlomki in splošnim tematskih zemljevidom.

5. Opredeljevanje in imenovanje tem – podrobneje smo opredelili posebnosti vsake posamezne teme in pripravili jasne opredelitve in naslove tem.

6. Priprava poročila – to je bil končni korak analiziranja. Na podlagi raziskovalnih vprašanj /strukture intervjujev smo pripravili akademsko poročilo o analizi (Braun in Clarke 2006:78-87).

V prvem koraku je raziskovalka večkrat pregledala celoten nabor podatkov. S tem je postavila temelje za nadaljnji postopek analiziranja podatkov (Braun in Clarke 2006:87). Ta del je bil časovno zamuden, vendar se je bilo potrebno seznaniti z vsemi vidiki podatkov. Analiza je torej pogosto obsegala nenehno premikanje naprej in nazaj med podatki. V drugem koraku smo opredelili smiselne kode, saj je kodiranje koristen načina analiziranja podatkov (Huberman, 1994; Tuckett, 2005) (Braun in Clarke 2006: 88). Pri tem smo izbrali pomembne podatkovne izseke in jih vstavili v tabelo. Nato smo izdelali pomensko povezano kodiranje. V tem koraku je raziskovalka prejela dobršen del kodirnih tabel. To kodiranje podatkov je potekalo ročno. Prav tako je ta postopek kodiranja temeljil na podatkih, pridobljenih na začetku raziskave. Pozneje pa na specifičnih vprašanjih. Kodiranje podatkov je bilo omejeno na teme, kot so družinska dinamika, pričakovanja in naravnanost posredovanja v družini ter podpora, ki je bilo usmerjeno k raziskovalnim vprašanjem.

V tretjem koraku smo kodirane in urejene podatke razvrstili v širše teme pod glavnimi temami: potrebe, družinska dinamika, pričakovanja in naravnanost do posredovanja v družini ter podpora družini. Širše teme smo ponovno uredili v tematske datoteke. Z njimi smo oblikovali tematski zemljevid. Ta nam je omogočil, da smo med temami opazili tiste, ki se medsebojno povezujejo. V četrtem koraku analize smo opravili pregled in podrobneje uredili teme. To smo storili iz dveh razlogov: da bi ugotovili, ali obdelane teme ustrezajo nizu podatkov, in da bi kodirali dodatne podatke, ki smo jih spregledali pri prejšnjem kodiranju. Pri tem koraku smo izpopolnjevali začetni tematski zemljevid. V petem koraku smo podrobneje opredelili bistvo vsake teme in vidike podatkov, ki jih vsaka posamezna tema zajema (Braun in Clarke 2006: 91-92). V zadnjem koraku pa je raziskovalka začela pisati analitična poglavja svoje disertacije na podlagi zgoraj omenjenih tematskih zemljevidov in tabel.

V naši raziskavi smo uporabili tri teoretske pristope, kot so: teorija potreb, teorija o družinskih sistemih in pristop, imenovan odpornost družine. V razpravi o teoriji potreb smo predstavili zamisli različnih teoretikov, kot so Doyal, Gough, Gasper, Illich, Maslow, Wasson, Dean in Schultz. Kot pojasnjuje Vera Grebenc je uporaba izraza

»potrebe« v vsakdanjem življenju zelo raznolika. Opredelitev potreb je precej ohlapna tudi na splošno. Pravi tudi, da je raziskovanje človekovih potreb skupna dejavnost, medtem ko je ocena potreb v skupnosti nenehno pogajanje / dogovarjanje o pomenih (Grebenc 2006:168). Gough razpravlja o »potrebah« in »željah«. Po Goughu »potrebe« pomenijo (implicitno, če ne že eksplicitno) »posebno kategorijo ciljev, ki naj bi veljali za univerzalne«, in »želje« pomenijo »cilje, ki izhajajo iz posameznikovih posebnih preferenc in kulturnega okolja«. Prav tako pravi, da so »ključne vrednote in potrebe relativne in lokalne, medtem ko so sredstva in politike globalne in univerzalne« v svetu, kjer je marsikaj narobe (Gough 2004: 292). Gough razlaga, da je večina marksistov prepričanih, da so potrebe zgodovinsko povezane s kapitalizmom. Nekateri fenomenologi in družboslovni raziskovalci menijo, da so potrebe družbeno konstruirane. Zaradi različnih kritik kulturnega imperializma so potrebe tudi specifične za pripadnike skupin ali pa jih opredeljuje spol, rasa itd. Postmodernistični kritiki in radikalni demokrati menijo, da potrebe niso samo diskurzivne, temveč ne obstajajo neodvisno od človekove zavesti (Gough 1994:27). Wasson pa razlaga, da imamo vsi ljudje nekaj, kar imenujemo potrebe in želje. Po drugi strani pa je opredelitev in prepoznavanje potreb in želja izjemno pomembno. Eden pomembnejših pogojev, ki človeku zagotavljajo minimalno zdravje in dobro počutje, je zadovoljevanje potreb. Končni cilj tega pa je človekovo blagostanje. Wasson je človekove potrebe razdelil v dve kategoriji, in sicer: osnovne potrebe in neosnovne potrebe (Wasson 2002). Doyal in Gough sta širše razmišljala o potrebah. Govorita o osnovnih in vmesnih potrebah. Telesno zdravje in avtonomijo sta opredelila kot osnovni človekovi potrebi. Nato dodajata, da je treba ti dve potrebi zadovoljiti do neke mere, da bi lahko učinkovito sodelovali v življenju. Izpolnjevanje osnovnih potreb prav tako ljudem onemogoča, da bi utrpeli resno škodo. Tisto, kar naj ljudje dosežejo, opredeljujejo človekove potrebe, če se želimo izogniti trajni in resni škodi. Pod avtonomijo omenjata tri glavne spremenljivke, ki vplivajo na stopnjo avtonomije. Te pa so razumevanje (spretnosti kognitivnega mišljenja), psihološke zmožnosti (duševno zdravje) in priložnosti za vključevanje v družbeno participacijo (Doyal in Gough 1991: 55-67). Poleg zgoraj omenjenih osnovnih potreb sta opredelila tudi enajst »vmesnih potreb«. Prav tako sta opozorila, da so po drugi strani to

»univerzalne značilnosti zadovoljevanja«, ki so bistvene za osnovne potrebe in omogočajo zadovoljevanje potreb po avtonomiji. Te pa so:

- ustrezna hranljiva hrana in voda
- ustrezno varno bivališče
- varno delovno okolje
- varno fizično okolje
- ustrezno zdravstveno skrbstvo
- varnost v otroštvu / zaščitenost
- pomembni primarni odnosi
- fizična varnost
- ekonomska varnost
- varno odločanje o rojstvu otrok in vzgajanju otrok
- Temeljno izobraževanje

(Doyal in Gough 1991: 169-170).

Tudi Illich je pomemben teoretik, ki je razpravljal o potrebah. Pojasnil je, da so osnovne potrebe najbolj zahrbtna zapuščina koncepta »razvoja«. Na podlagi zgodovinskega gibanja na zahodu pojasnjuje, da so se pod okriljem evolucije/napredka/rasti/razvoja razkrile in predpisovale potrebe. Posledica tega procesa pa je, da je človek prešel od stranišča, ki vse požre, do zasvojenca s potrebami (Illich 1990: 2.3). Illich je razvoj pojasnil na podlagi upora. Razvoj namreč obsega sočasno dekonstrukcijo nuj in konstrukcijo želja v potrebe. Toda diskurz razvoja kaže, da potrebe niso ne želje ne nuje. Illich nadaljuje, da nuje zahtevajo podrejanje, potrebe pa zadovoljevanje (Illich 1990: 4). V razpravi o razliki med potrebami in željami pa pravi, da so »potrebe sodobne želje«. Illich tudi opaža, da je revščina povezana s potrebami. Toda agencije socialnega

varstva/socialne službe iščejo načine, kako pomagati, namesto, da bi opredeljevale potrebe, kjer se pojavijo (Illich 1990: 13). Zato pride do težav pri selekciji prikrajšanih ljudi kot ustreznih za službe socialnega varstva, prav tako tudi pri razdelitvi sredstev.

Abraham Maslow je pojasnil hierarhijo potreb, kot so fiziološke potrebe, potrebe po varnosti in zaščiti, potrebe po pripadanju in ljubezni, potrebe po ugledu, spoštovanju, potrebe po znanju, razumevanju, estetske potrebe in potrebe po samouresničevanju. Prvi dve kategoriji obsegata osnovne človekove potrebe. Maslow pojasnjuje, da je potreba po preživetju najpomembnejša in prva človekova potreba. Ljudje za preživetje potrebujejo hrano, vodo in zavetje. Po tem, ko so fiziološke potrebe zadovoljene, si ljudje želijo izpolniti potrebo po varnosti in zaščiti. Občutek, da so ljudje varni pred fizično, duševno ali čustveno škodo lahko preprosto opredelimo kot varnost. Občutek, da ljudi ni strah in niso tesnobni lahko opredelimo kot zaščito. Tretja in četrta kategorija potreb veljata za neosnovne potrebe. Najvišja kategorija človekovih potreb po Maslowovi hierarhiji potreb govori o posameznikovih hotenjih in željah. Teh potreb nikoli ne moremo popolnoma zadovoljiti (Maslow 2007:72-75). Toda Gough je teorijo potreb po Maslowu ocenil kritično. Meni, da je ta teorija teorija motivacije in gonov človekovega delovanja. Pri tem pa je Goughova in Doyalova teorija teorija o univerzalnih ciljh. Teoretika namreč menita, da iskanje univerzalnih človekovih potreb ni nujno ciljno motivirano (Gough 2014:11).

Poleg zgoraj omenjenih teoretikov so o potrebah razpravljali tudi Dean, Stevens in Schutz. Shutz omenja potrebe, povezane s komunikacije, njegova teorija pa se imenuje teorija temeljnih medosebnih orientacij. Omenja tri glavne potrebe, kot so vključenost, nadzor in naklonjenost (Griffin 2008: 93). Dean omenja binarno razlikovanje med različnimi ravnmi človeških potreb, denimo, absolutno/relativno, objektivno/subjektivno, osnovno/višje. Meni, da se mnoga razlikovanja prekrivajo in dopolnjujejo. Človekove potrebe namreč predstavljajo koncept osrednjega pomena. To je edino najpomembnejše načelo organiziranja v socialni politiki (Dean 2010). Stevens in Gillam razpravljata o oceni potreb v zdravstveni oskrbi. Menita, da je ocena potreb v zdravstveni oskrbi nujna za zbiranje podatkov o človekovih potrebah. Ti podatki pa omogočajo spreminjanje dajanja pomoči v zdravstveni oskrbi prebivalstva (Stevens in Gillam 1998).

Sistemska teorija je bila uvedena v socialno delo kot konceptualni okvir. Moderna sistemska teorija je izšla iz klasične znanosti. Psihiatrija jo je začela uporabljati na družini, izšla pa je iz klinične prakse. Pozneje so sistemsko teorijo širše uporabljali tudi v drugih disciplinah, med njimi tudi v socialnem delu. Sistemski pristop je okvir, ki nam pomaga zbrati veliko količino podatkov o svetu in si jih pojasniti. Ne gre toliko za formalno teorijo, čeprav spada med teorije. Ta pristop nam omogoča raziskati interakcije in povezave med ljudmi in njihovim okoljem (Bavelas in Segal 1982: 99-102; Haynes in Holmes 1994:236-237). Pri uporabi sistemske teorije v socialnem delu, opisujemo sistem kot »niz medsebojno povezanih in soodvisnih delov, ki imajo skupne značilnosti«. Prvič, posameznik je celoten sistem s fizičnimi, duhovnimi, intelektualnimi, psihološkimi in družbenimi komponentami. Prav tako je posameznik rezultat različnih bioloških sistemov, kot so prebavni in reproduktivni. Ne le, da je del drugih večjih sistemov, kot so družina, soseska in skupnost, v sistemski teoriji uporabljamo več pomembnih izrazov, kot so ciljni sistem, podsistemi, nadsistemi, meje, homeostaze in ekvifinalnost (Haynes & Holmes 1994:237-240). Družina je sistem, ki mu družba pripisuje zelo specifične funkcije in je celota, ki jo sestavljajo mnogi medsebojno delujočimi deli, ki tvorijo tesno povezano mrežo odnosov. Bavelas in Segal (1982) pojasnjujeta, da »se ti odnosi vzpostavljajo, ohranjajo in beležijo/dokazujejo prek članov, ki komunicirajo drug z drugim«. Ti odnosi in vzorci ustvarjajo družinski sistem. Zato očiten ali manj očiten učinek na enega od mnogih delov lahko povzroči resne težave drugim delom in celoti zaradi medsebojne povezanosti (Bavelas in Segal 1982: 102, Suppes in Wells 1996: 13-14). Octavia Hill and Florence Hollis poudarjata, da ljudje, ki so prikrajšani, denimo, ljudje s težavami z duševnim zdravjem, ne smejo biti ločeni od svojega okolja. Prav tako omenjata, da »*dejavniki znotraj človeka delujejo vzajemno z dejavniki znotraj družine*«. Ti dejavniki pa delujejo vzajemno z dejavniki v okolju. Poleg tega ti dejavniki posledično delujejo vzajemno z dejavniki v širšem okolju, kot so norme, naravnanosti, družbena pričakovanja, gospodarske razmere in lokalne ter nacionalne politike (Buchanan 2008:7).

Odpornost družine je zelo pomemben koncept v teoriji in raziskovanju duševnega zdravja. Cilj tega pristopa je opredelitev in krepitev najpomembnejših postopkov, ki družini omogočajo, da vzdrži in si opomore po težavnih življenjskih izzivih (Walsh

1998:3). Razumevanje močnih plati, potreb in interesov ljudi s težavami z duševnim zdravjem je z vidika krepitve močnih plati pomembnejše od dajanja diagnoz in nalepk (Yip 2005:453). Odpornost družine je relacijska vzdržljivost, ki jo lahko uporabimo kot tehniko, da bi podpirali in krepili družine v stresnih situacijah. Walsh (1998) opredeljuje odpornost kot »*zmožnost, da družina po preživeti stiski postane okrepljena in iznajdljiva. To je dejaven proces vzdržljivosti, iskanja ravnovesja in rasti kot odziv na stisko ali izziv*«. V tem procesu lahko opazimo nenehno rast in opredeljevanje zmožnosti, znanja, vpogleda v situacijo in vrlin (Walsh 1998:4-14, Saleebey 2009:13). Sisteme družinskih prepričanj, organizacijskih vzorcev in proces komunikacije je Walsh opredelil kot ključne za odpornost družine (Walsh 1998:24). Po tem, ko smo opredelili potrebe in težave ljudi s težavami z duševnim zdravjem ter njihovih družinskih članov, lahko pristop odpornosti družine uporabimo, da bi okrepili njih in njihove družinske člane.

Disertacija je sestavljena iz šestih poglavij. Prvo poglavje obsega opis ozadja raziskave in povzetek poglavij v disertaciji. V drugem poglavju opisujemo zasnovo raziskave in metodologije. Predstavimo raziskovalni problem, raziskovalna vprašanja, metode, izbiro vzorcev in meril, raziskovalne lokacije, znanstveni prispevek k raziskavi, teoretične pristope, analizo podatkov, etične pomisleke in težave ter omejitve. Podajamo opis konceptov, ki so povezani z raziskovalnim problemom pričujoče raziskave. V tretjem poglavju namenjamo pozornost kratkemu uvodu v etiologijo težav z duševnim zdravjem in prepričanj o težavah z duševnim zdravjem. Poleg tega razpravljamo o oskrbi v duševnem zdravju v Šrilanki, razvoju socialnega dela v zdravstvu in družini ter o odpornosti družine. Četrto poglavje je razdeljeno v več delov, ki jih sestavljajo kratka predstavitev raziskovalnega vzorca, struktura družin in oskrbe družinskih članov, družinska dinamike, potrebe in pričakovanja družine in ljudi s težavami z duševnim zdravjem, močne plati družine in duhovnost v duševnem zdravju. O vsebini petega poglavja razpravljamo v več podnaslovih. To so posredovanje v družini, podpora družini, naravnanost pri posredovanju v družini in podpora v duševnem zdravju. V tem poglavju in v zaključku podajamo kratek povzetek pomembnih izsledkov. Sledi razprava o izsledkih, ki smo jih v raziskavi povezali z uporabljenimi teorijami. Poleg tega sledi še razprava o prispevku naše raziskave na področju socialnega dela in raziskovanja. Na

koncu pa pojasnimo ovire v razvoju duševnega zdravja, socialnega dela in sistema podpore v družini v Šrilanki.

Pri razlagi konceptov smo največ pozornosti namenili konceptom, kot so zdravje, duševno zdravje, težave z duševnim zdravjem, ljudje s težavami z duševnim zdravjem, družina, bližnji družinski člani, podpora v družini in posredovanje v družini.

Opredelitev zdravja, ki ga je podala Svetovna zdravstvena organizacija (WHO), je v naši raziskavi uporabljena kot "zdravje". Ta opredelitev poudarja, da posameznikovega zdravja ne moremo meriti zgolj s telesnimi dejavniki, temveč moramo upoštevati tudi psihološke in socialne dejavnike. Svetovna zdravstvena organizacija opredeljuje zdravje kot »stanje popolnega fizičnega, duševnega in socialnega blagostanja in ne le odsotnost bolezni in invalidnosti« (Schaefer in Lamm 1998: 480, Wasson 2002). Na splošno sicer velja, da duševno zdravje ni samo odsotnost klinično opredeljene duševne bolezni, Svetovna zdravstvena organizacija (2003) pa meni, da je treba nadaljevati razpravo o »duševnem zdravju«, »dobrem počutju« in »uspehu«. Da bi posameznik to dosegel, torej minimalno zdravje in dobro počutje, mora zadovoljiti različne potrebe in želje. Šele potem lahko posameznik doseže končni cilj uspeha. V tem pogledu je torej opredelitev potreb in želja zelo pomembna (Wasson 2002, Friedli 2009: 10). Posebno socialni delavci in delavke na področju duševnega zdravja se ves čas spopadajo z nenehnimi novimi izzivi in odgovornostjo. Med njihove odgovornosti spadajo varovanje javnosti, podpiranje človekovih pravic, delo z družinami, ukrepanje v času hujših duševnih stisk, upoštevanje vidikov uporabnikov in uporabnic in vzpostavljanje delovanja finančno slabše podprtih sistemov. Na področju duševnih stisk je treba upoštevati različne potrebe. Dobro duševno zdravje temelji na številnih medsebojno povezanih vidikih. Pomembni so občutek za lastno vrednost, samozavest in cenjenje samega sebe, zavedanje sebe, zrelo presojanje, sposobnost tvorjenja naklonjenih razmerij, sposobnost vzpostavljanja in ohranjanja podpornih mrež, sposobnost spoprijemanja z življenjskimi nalogami in ukvarjanje s kompleksnimi zahtevami ter sposobnost osebnostne rasti (Fawcett 2012: 515-516). Glede na socialni model Bainbridge (1999) pojasnjuje, da »je potrebno duševno stisko videti kot kontinuum vsakdanje življenjske izkušnje in ne kot konstrukt

neke tuje entitete, ki nekatere ljudi ločuje kot temeljno »drugačne« in jih opredeljuje z izrazi njihove »patologije«. V razpravi o duševni stiski z vidika socialnega modela je pomembna zaveza k holističnemu pristopu in zaveza, da bomo prisluhnili ljudem, ki govorijo o svoji duševni stiski, in jih vzeli resno. Po tem pristopu se razpravlja o dveh dopolnjujočih se načinih, po katerih lahko duševno stisko vidimo kot ponotranjenje ali izraz stresnih družbenih izkušenj in spopadanje z njimi oz. strategija preživetja. Po drugi strani pa nekateri ljudje, ki se navezujejo na libertarno antipsihiatrično gibanje, denimo Thomas Szasz (1961) menijo, da je duševna stiska »nerešen konflikt« ali »težava v življenju« (Tew 2005a: 16-20). Doyal in Gough v razpravi o človekovih potrebah (1991:62) razlagata, da je »duševno zdravje« »praktična racionalnost in odgovornost«, to opredelitev pa uporabljamo tudi v pričujoči raziskavi kot »duševno zdravje«. Glede na zgoraj povedano pa v naši raziskavi kot »težavo v duševnem zdravju« upoštevamo »odziv na in impliciten upor proti izkušnjam nepravičnosti, vsiljene izgube in zlorabe« (Tew 2005a: 25). V naši raziskavi so ljudje, pri katerih je nekaj narobe z izkušnjami, vedenjem in zaznavanjem, »ljudje s težavami z duševnim zdravjem« (Beresford 2005: 35).

Za večino ljudi je »normalno gospodinjstvo tisto, v katerem živi poročen par z otroki« (Fulcher in Scott 2011: 430). Vprašanje pa je, v kakšni meri je ta opredelitev resnična oziroma ustrezna, saj obstajajo različne kategorije družin v družbi. Mednje spadajo družine, ki jih sestavlja par, družine s parom in otroki, enostarševske družine, istospolne družine, sestavljene družine, ponovno vzpostavljene družine, družine s starimi starši kot skrbniki in razseljene družine (“It’s About Time: Women, Men, Work and Family”, Final Paper 2007: 128, Zanden 1993: 276 & Calhoun et al 1997: 295). Oblike družin se razlikujejo tudi glede na sestavo, poreklo, bivališče in avtoriteto. Glede na sestavo sociologi omenjajo dve glavni obliki družin in sicer jedrno in razširjeno družino. Patrilinearno, matrilinearno in bilinearno urejene družine temeljijo na poreklu. Glede na bivališče ločimo patrilokalne, matrilokalne in neolokalne družine. Sociologi govorijo tudi o patriarhalnih, matriarhalnih in egalitarnih družinah glede na avtoriteto (Zanden 1993:277-278). Čeprav obstajajo različne opredelitve družin na globalni ravni, je pomembna tudi opredelitev družine, ki jo je podala Organizacija Združenih narodov.

OZN opredeljuje družino kot »skupino ljudi, ki skrbi za otroka in je kot taka prepoznana v zakonodaji« (Odbor OZN za civilne in politične pravice 1993:3). Ta opredelitev sicer ni popolna opredelitev družine, vendar jo uporabljamo v pričujoči raziskavi, da bi omilili vprašanja glede koncepta »družine«. V naši raziskavi smo starše, brate in sestre, zakonce in izvenzakonske partnerje, otroke, stare starše, vnuke in vnukinje, strice, tete, nečake in nečakinje poimenovali z izrazom »družinski člani«.

V naši raziskavi posredovanje pomeni »sodelovanje z ljudmi«. To vključuje »kakršno koli sodelovanje z družinami, da bi spremenili ali izboljšali njihove individualne odnose, odnose med parom, otroki ali vso družino, njihove interakcije, vzorce komunikacije ali pa dosegli njihove cilje in pridobili službe od drugih socialnih ustanov«. Posredovanje je lahko usmerjeno v različne načine, bodisi kot posamezen starš, par, otrok, cela družina ali skupina (Walker 2012: 615). Houston in Dolan (2008) opredeljujeta podporo v družini kot »samopomoč ali prostovoljno pomoč z majhnim zakonskim vključevanjem ali pa to lahko pomeni kontinuirano svetovanje, podporo in specialistično pomoč, s katero lahko priskrbimo zgodnje preventivno posredovanje, podporo pri starševstvu, izobraževanju in zakonsko terapijo« (Walker 2012: 615). V naši raziskavi uporabljamo to opredelitev v razpravi o podpori družini za ljudi s težavami z duševnim zdravjem.

V raziskavi smo pozornost namenili tudi etičnemu razmisleku. Etične kodekse pripravljajo različne strokovne skupine. Na splošno pa etični kodeks za raziskovalce upošteva posameznikovo pravico do dostojanstva, zasebnosti, zaupnosti in izogibanja škodi (Glesne in Peshkin 1992: 99). Da bi zagotovili etični vidik raziskave, smo sledili več metodam. Prvič, predlog za raziskavo smo podali na Komisijo za etična vprašanja na Medicinski fakulteti Univerze v Colombu v Šrilanki in na Komisijo RS za medicinsko etiko v Sloveniji, da bi pridobili soglasje za izvedbo raziskave. Predlog za raziskavo smo podali tudi direktorju Nacionalnega inštituta za duševno zdravje in pridobili dovoljenje za zbiranje podatkov na inštitutu. O zbiranju podatkov smo obvestili tudi predstojnika Univerzitetnega oddelka za psihološko medicino in pridobili njegovo dovoljenje. V drugem koraku je vsak respondent pred intervjujem prejel obvestilo o tem, kdo smo in kakšen je namen raziskave. V tretjem koraku smo respondentom dali obvestilo, ki je bilo

napisano v treh jezikih. V četrtem koraku raziskave smo respondente seznanili z zaupnostjo podatkov, ki nam jih bodo posredovali, in fiktivnimi imeni, ki smo jih uporabili, da bi zavarovali njihovo identiteto. Nazadnje so respondenti podpisali soglasje za izvedbo intervjuja, ki je bilo prav tako napisano v treh zgoraj omenjenih jezikih. Respondenti so dobili možnost, da sami določijo čas in kraj izvedbe intervjuja. S tem smo se izognili pristranosti in pridobili možnost, da poročamo ustrezno in pri tem uporabimo ustrezno raziskovalno metodologijo. Da bi preprečili predolgo izvajanje intervjuja in čim bolj zmanjšali nesrečo, ki jo izzove spomin na neprijetne dogodke, in pridobili podatke o okoliščinah družinskih članov, smo intervjuje opravili v dveh korakih. Med intervjuji smo morali veliko časa posvetiti tudi osebnim zgodbam ljudi, da bi čim bolj zmanjšali njihovo stisko, saj so se težko osredotočili na specifična vprašanja. To se je zgodilo zlasti takrat, ko smo intervju izvajali na domu družinskih članov. Ti intervjuji so bili časovno zamudni, saj smo naleteli na številne ovire iz družinske preteklosti. Občasno smo morali intervju prekiniti, prisluhniti družinskim članom in odgovarjati na njihova vprašanja. V nekaterih pogledih so družinski člani izražali močna čustva glede ljudi s težavami z duševnim zdravjem. V takšnih okoliščinah je morala raziskovalka posvetiti svoj čas družinskim članom, jim predstaviti slabe učinke takšnega izražanja čustev proti ljudem s težavami z duševnim zdravjem in jih pomiriti z lastnimi izkušnjami dela s takšnimi ljudmi. Tovrstno delo je bilo časovno zamudno, vendar je bilo koristno, saj smo tako razumeli družinsko dinamiko in vzorce odnosov. Takšne situacije so vznikale v celotnem procesu intervjuvanja. Toda s to težavo se je raziskovalka zaradi prejšnjih delovnih izkušenj uspešno spopadla, saj je že delala s takšnimi uporabniki služb in njihovimi družinskimi člani na Univerzitetnem oddelku za psihološko medicino.

Sledi razprava o pomembnih izsledkih raziskave. V naši raziskavi obravnavamo ljudi s težavami z duševnim zdravjem. Večino zdravimo zaradi naslednjih diagnoz: shizofrenije, bipolarne motnje s psihotičnimi značilnostmi in depresijo. Sodelovanje moških (49%) in žensk (51%) s težavami z duševnim zdravjem je bilo uravnoteženo. Odstotka neporočenih (45,2 %) in nezaposlenih (45,2 %) sta v naši raziskavi visoka. Prav tako je v raziskavi sodeloval precejšen odstotek neplačanih delavk v gospodinjstvu (17 %), ki

domača opravila opravljajo na svojih domovih ali na domovih svojih sorodnikov ali pa tovrstne dejavnosti opravljajo občasno. Družinski člani so seznanjeni tudi z vprašanjem, ali so ljudje s težavami z duševnim zdravjem vključeni v koristne dejavnosti, pri katerih se jim ni treba ukvarjati z višino plačila. Nekateri ljudje s težavami z duševnim zdravjem so za svoje delo prejemali samo hrano in avtobusno vozovnico. Nekateri delodajalci, pri katerih delajo ljudje s težavami z duševnim zdravjem, so svojim zaposlenim s težavami z duševnim zdravjem povedali, da jim težko plačujejo redno plačilo za delo, saj ljudje s težavami z duševnim zdravjem ne morejo redno prihajati na delo. Večina ljudi s težavami z duševnim zdravjem je mladih. Mnogi imajo končano nižjo ali višjo srednješolsko izobrazbo.

Mnogi ljudje s težavami z duševnim zdravjem so otroci, vodja gospodinjstva ali pa mati ali oče. To v veliki meri vpliva na ekonomske razmere v družini. Zaradi nizkih dohodkov ima družina precejšnje finančne težave. Večina družinskih članov (46,4 %) ne prejema nobenega dohodka. Mnogi ljudje s težavami z duševnim zdravjem živijo v domovih svojih staršev. Visok odstotek ljudi s težavami z duševnim zdravjem živi s svojimi starši, brati in sestrami ali zakonskimi partnerji.

V sklopu družinske dinamike smo opazili različna pričakovanja glede spola. Izjemno pomemben dejavnik je dejstvo, da je bilo večina skrbnikov ženskega spola. V Šrilanki je to razlog za nizko udeležbo žensk na trgu delovne sile (35 %) in visoko udeležbo moških na trgu delovne sile (75 %). Po statističnih podatkih Svetovne banke zaseda Šrilanka 28. mesto glede razkoraka med zaposlenimi moškimi in ženskami. V Šrilanki je približno 65 % žensk, ki niso aktivne na trgu delovne sile. Večina ostaja doma in prevzema odgovornost za vodenje gospodinjstva. V jedrnih družinah se je v zadnjih nekaj letih v Šrilanki povečal delež žensk, ki zapuščajo delovno mesto, da bi prevzele odgovornost za svoje gospodinjstvo. V razširjenih družinah si družinski člani delijo gospodinjska opravila. V tej kategoriji družin je zlasti visoka udeležba starejših ljudi, ki vzajemno pomagajo pri gospodinjskih opravilih. Po drugi strani pa v državi velja družbena norma, po kateri ženske prevzemajo breme gospodinjstva, moški pa služijo denar, kar povzroča nizko udeležbo žensk na trgu delovne sile (Letno poročilo, Centralna banka 2014: 94-96).

V naši raziskavi so ženske opravljale večino gospodinjskega dela, prav tako so to od njih pričakovali tudi moški. Če morajo moški opravljati gospodinjska opravila, so nezadovoljni. Illich je pojasnil, da je posledica razvoja tudi dejstvo, da ljudje potrebujejo različne potrebe. Večina družin se je preselila v mesto in začela delati zaradi urbanizacije. Urbanizacija je namreč ena od posledic razvoja. Vzajemni podporni sistemi so se ohranili po koncu razširjenih družin in namesto njih so člani jedrne družine morali poiskati druge rešitve za svoje potrebe, kot so skrb za otroke, starejše starše in ljudi z oviranostjo. Zaradi težav z duševnim zdravjem in dolgotrajno hospitalizacijo pa so vloge ljudi s težavami z duševnim zdravjem in družinskih članov zanemarili. Opazili smo številne težave v družinah. Mednje spadajo zakonske težave, pomanjkanje vzajemnega razumevanja, finančne težave, očetova zloraba alkohola, težave z nepremičninami in pomanjkanje vzajemne podpore. Težavno ozadje je slabo vplivalo na ljudi s težavami z duševnim zdravjem v teh družinah. Denimo, nezaposlenost staršev je slabo vplivala na finančen položaj teh ljudi. Takrat se pojavi potreba po tem, da tako družina kot ljudje s težavami z duševnim zdravjem potrebujejo pomoč druge skupine, ustanove ali organizacije. V naši raziskavi smo razbrali tako pozitivno podporo družinskih članov, kot tudi negativno naravnanost, ki povzroča težave v družini. Denimo, očetova zloraba alkohola v nekaterih družinah povzroča psihično stisko družinskih članov. To lahko slabo vpliva na razvoj otrok. Po teoriji o družini kot sistemu deluje prispevek družinskih članov kot varovalni dejavnik, po drugi strani ustvarja težavne dejavnike v družini sami. Octavia Hill in Florence Hollis sta pojasnili, da se ljudje, ki so prikrajšani, kot to velja za ljudi s težavami z duševnim zdravjem, ne morejo umakniti iz težavnega okolja. Nekateri družinski člani menijo, da so družinska pravila v njihovih družinah pomembna. Obredi in praznovanja so povezani z njihovimi kulturnimi in tradicionalnimi prepričanji. V nekaterih družinah, na primer, najprej postrežejo očetu in bratom. Večino časa pa družinski člani ne obedujejo skupaj. V nekaterih družinah tudi ne morejo skupaj jesti, ker je oče / soprog zaposlen daleč stran od doma. Družinski člani so prepričani, da ni dobro razkrivati družinskih / osebnih zadev drugim ljudem, saj to škodi njihovemu dostojanstvu. Med prepričanja družinskih članov o težavah z duševnim zdravjem je večina družinskih članov menila, da imajo njihovi svojci težave z duševnim zdravjem, duševno bolezen, norost (42, 8 %),

doživljajo stres v življenju (22.61%), strah (5.95%), trpijo za posledicami kodivine (7.14%) in imajo nevrološke težave (4.76%). V naši raziskavi smo opazili tudi različne družinske vrednote in norme, ki včasih negativno vplivajo na ljudi s težavami z duševnim zdravjem. Za primer navedimo splošno normo, po kateri naj bi bile ženske odgovorne za gospodinjstvo, moški pa naj bi si pridobili vpliv nad moškimi in ženskami s težavami z duševnim zdravjem. V nekaterih družinah, kjer so tako moški kot ženske s težavami z duševnim zdravjem, so družinski člani bolj kritizirali žensko kot moškega, če ni opravljala gospodinjskih opravil. Moške družinske člane pa so v primerjavi z ženskimi družinskimi člani bolj kritizirali, če so bili nezaposleni. Nekateri starši verjamejo, da bi morali njihovi odrasli otroci biti zaposleni in skrbeti zanje, ko bodo stari. Te vrednote posledično zadevajo ob širše okolje. Zato so nekateri sosedje kritizirali mlade ljudi s težavami z duševnim zdravjem, ker niso bili zaposleni, njihovi starejši starši pa so bili. To jim je povzročajo dodatno stisko. Včasih so starši krivili svoje odrasle sinove s težavami z duševnim zdravjem, češ da niso dovolj motivirani, da bi našli ali ohranili zaposlitev, ker je takšen sistem vrednot in norm te družine. Pri tem pa ženskim članicam družine, ki bi si želele opraviti kaj koristnega izven družine, ne dovolijo, da bi se oddaljile od družine, kar še bolj poslabša njihovo stanje. Po drugi strani pa jih ta norma varuje pred zlorabo, ki bi jim jo lahko prizadejali drugi ljudje. Nekatere gospodinje menijo, da so uspešne pri gospodinjskem delu in da ne bi bilo dobro, če bi ta dela prepustile moškim. Zaradi tega občutka jih je skrbelo, kako bodo moški poskrbeli za otroke v njihovih domovih v času, ko se spopadajo z duševnimi stiskami in so hospitalizirane zaradi težav z duševnim zdravjem. Opazili smo, da ženske kot matere izražajo večjo naklonjenost do svojih otrok kot očetje. Večino časa otroci razpravljajo o vsakdanjih dogodkih z materami in matere izpolnjujejo njihove potrebe. Na področju komunikacije in odnosov med družinskimi člani smo v naši raziskavi opazili, da imajo družinski člani burna čustva do družinskih članov s težavami z duševnim zdravjem. Kritiziranje in sovražna nastrojenost sta bili pomemben dejavnik v družinah naše raziskave. Opazili smo zlasti to, da poročeni ljudje s težavami z duševnim zdravjem nimajo dobrih odnosov s svojimi zakonskimi partnerji. Zaradi nerazumevanja težav z duševnim zdravjem in njihovimi značilnostmi je večina žensk s težavami z duševnim

zdravjem imela težave s soprogi pri spolnih stikih. Nekatere ženske s težavami z duševnim zdravjem so imele tudi izkušnjo spolnega nadlegovanja s strani svojih soprogov. Glede družinskih vprašanj so jedrne družine pričakovale večjo podporo s strani razširjene družine kot od neznancev. Kljub temu, da se pojavljajo težave v odnosih med bližnjimi sorodniki, so ti vendarle podpirali bližnje družinske člane v finančnem smislu, fizičnem in emocionalnem v času stisk zaradi težav z duševnim zdravjem. Z našo raziskavo o družinski dinamiki smo odkrili tudi to, da vsak dejavnik v človeku deluje znotraj družine. Sistem družine, njenih interakcij in odnosov so bili varovalni dejavniki v času stisk družinskih članov, po drugi strani pa so ti isti dejavniki sprožali tudi težavne dejavnike.

Pomemben izsledek naše raziskave je obsegal tudi potrebe ljudi s težavami z duševnim zdravjem in njihovih družinskih članov. Ugotovili smo, da imajo oboji, torej ljudje s težavami z duševnim zdravjem in njihovi družinski člani naslednje potrebe:

- Osnovne potrebe po preživetju (kot so voda, hrana itd.)
- Avtonomija v družini
- Telesna varnost
- Ekonomska varnost
- Varno bivališče
- Ustrezna zdravstvena oskrba
- Pomembni primarni in družbeni odnosi
- Potreba po izobraževanju in ozaveščanju
- Podpora bližnjih sorodnikov
- Formalna podpora
- Duhovne potrebe

Poleg zgoraj omenjenih potreb potrebujejo družinski člani tudi »odmor, da se lahko odpočijejo pred stresnimi dejavniki«. Družinski člani in ljudje s težavami z duševnim zdravjem ugotavljajo, da so zadovoljni spričo možnosti za kratkotrajno namestitev z nego in podporo, saj se njihovi sorodniki s težavami z duševnim zdravjem lahko odpočijejo, sami pa lahko razmislijo o nujnih, vendar pogosto zapostavljenih potrebah. Poleg tega so ljudje s težavami z duševnim zdravjem tudi povedali, da imajo številne potrebe, ki so zanje pomembne. To so: komunikacija (da bi jim družinski člani prisluhnili), da bi sodelovali pri odločanju in da bi imeli prostočasne dejavnosti. Večina družinskih članov s težavami z duševnim zdravjem je bila slabo udeležena v procesih odločanja v svojih družinah, saj k temu dejanju niso bili povabljeni. Želeli pa so vedeti, kaj se dogaja v družini. Prav tako si želijo, da bi jim družinski člani prisluhnili in bi jim lahko zaupali, da so slabo motivirani pri delu, pri spolnosti, pri skrbi zase, zakaj se pogovarjajo sami s seboj in zakaj težko hodijo. Toda večina družinskih članom jim ni naklonila časa in ni prisluhnila njihovim zgodbam. Namesto tega so vztrajali, da je to zanje moteče.

Doyal in Gough (1991) sta v svoji teoriji o potrebah pojasnila, da je telesno zdravje temeljna zahteva za življenje v družbi. Če kdo ne more izpolniti te potrebe, ne more zadovoljivo sodelovati v družbi. Večina družin se je morala potruditi, da bi izpolnila to potrebo, ne le zase, temveč tudi za družinske člane s težavami z duševnim zdravjem. Toda njihov slab finančni položaj, jim ta položaj poslabša. Večina ljudi s težavami z duševnim zdravjem se je želela tudi vključiti v smiselne dejavnosti, po eni strani zaradi slabega finančnega stanja svoje družine, po drugi strani pa tudi zato, ker so finančno odvisni od staršev in bratov in sester. Zaradi pomanjkanja motivacije, ki je posledica težav z duševnim zdravjem, in jemanja zdravil, pretiranega vključevanja svojih družin in zavračanja s strani ustanov zaradi velike družbene stigme in diskriminacije, pa te potrebe ne morejo izpolniti. Zelo povedno je tudi dejstvo, da je večina uporabnic služb izrazila željo po zakonski zvezi. Glavni namen zakonske zveze pa so ekonomska, socialna in čustvena varnost. Bojijo se, kaj se bo zgodilo z njimi, kdo bo skrbel zanje po smrti staršev. Avtonomija je osnovna potreba, ki sta jo v kategoriji potreb predstavila Doyal in Gough. Pod avtonomijo navajata tri postavke, kot so duševno zdravje, spretnosti kognitivnega mišljenja in priložnosti za družbeno participacijo (1991: 60). V naši

raziskavi se je pokazalo, da oboji, torej družinski člani in njihovi svojci s težavami z duševnim zdravjem želijo zadovoljiti to potrebo. Toda večina družinskih članov je menila, da njihovi svojci s težavami z duševnim zdravjem ne znajo racionalno razmišljati in sprejemati odgovornosti za odločitve ali druge stvari. Zato niso želeli, da sodelujejo v različnih družinskih dejavnostih in pri sprejemanju odločitev v družini. Zato mnogi ljudje s težavami z duševnim zdravjem menijo, da niso prosti, da niso dragoceni, da nimajo svojega mesta v svojem domu, tudi če so moški, očetje ali odrasli. Poleg tega so družinski člani tudi menili, da niso priznani, da niso cenjeni med bližnjimi sorodniki, predvsem zaradi močne stigme, ki jo prinašajo težave z duševnim zdravjem. Poročali so tudi o tem, da nekateri bližnji sorodniki, prijatelji, sosedje niso hoteli ohranjati bližnjega odnosa tako z družinskimi člani, kot s svojci s težavami z duševnim zdravjem. Zavračajo jih in stike vidijo kot breme. Zato se družinski člani in njihovi svojci s težavami z duševnim zdravjem izogibajo druženju s sorodniki, prijatelji in sosedi. Njihovi stiki so omejeni na najbližje sorodnike, kot so bratje in sestre. Zaradi zavračanja so nekateri ljudje s težavami z duševnim zdravjem v naši raziskavi želeli urediti finančne zadeve in druga vprašanja z uradniki iz formalnih podpornih skupin, da bi pridobili podporo. Nekateri ljudje s težavami z duševnim zdravjem in njihovi družinski člani so oklevali in niso ukrepali, ko so izgubili bivališče ali svojo nepremičnino, zato so se znašli v še hujši stiski. Nekateri niso zadovoljni z opremo hiše ali pa živijo s številnimi težavami zaradi tega, ker jih je veliko in so med njimi nesoglasja. Brandon (1974), Dekleva in Razpotnik (2007) so pojasnili, da so stiske zaradi stanovanja zelo različne: brezdomstvo, spanje na prostem, pod mostovi, v kleteh, včasih življenje pri prijateljih in znancih, po več ljudi v enem prostoru, neprimerne razmere in več gospodinjstev v enem samem stanovanju (Flaker et al. 2013/2014: 111-132). V naši raziskavi je bilo nekaj ljudi s težavami z duševnim zdravjem, ki niso imeli stalnega bivališča ali svoje hiše, niso imeli stalnega naslova, kjer bi bili dosegljivi po odpustu iz bolnišnice, prav tako niso imeli prostora, kjer bi lahko shranili svoje stvari. Nekateri od njih so izgubili volilno pravico za deset let, ker niso imeli naslova stalnega bivališča. Nekateri so izgubili pravico do vložitve prošnje za socialno podporo ali invalidnino. Flaker et al. pojasnjuje, da vsak človek potrebuje stalen naslov, da bi lahko ugodil zahtevam »homo bureaucraticusa«. To ne povzroča samo

težav, kot so problemi s policijo, zaposlitvijo itd. (Flaker et al. 2007: 96). V naši raziskavi so nekatere ženske s težavami z duševnim zdravjem doživele tudi telesno nadlegovanje, napade svojih soprogov zaradi nezmožnosti opravljanja gospodinjskega dela in pomanjkljivega udejstvovanja v spolnem življenju. Želele so si, da bi jih njihovi soprogi razumeli, da bi razumeli njihove težave in preprečili tovrstno nadlegovanje. Tako ljudje s težavami z duševnim zdravjem kot njihovi družinski člani pa so izrazili potrebo po tem, da bi se seznanili s težavami z duševnim zdravjem, značilnostmi teh težav, z zdravili, stranskimi učinki in okrevanjem.

Jasno pa je, da imajo ljudje s težavami z duševnim zdravjem tudi človeške potrebe in vpogled v lastne potrebe. Illich pojasnjuje, da po eni strani revščina vpliva na izpolnjevanje človekovih potreb. Po drugi strani pa so nekatere želje postale človekove potrebe kot posledica razvoja.

Okrevanje/zdravljenje, podpora bližnjih družinskih članov, ozaveščanje in izobraževanje, institucionalna podpora so pričakovanja ljudi s težavami z duševnim zdravjem in njihovih družinskih članov. Poleg tega družinski člani pričakujejo, da se bodo njihovi svojci s težavami z duševnim zdravjem vedli umirjeno in tiho in da bodo zanje skrbeli tudi v prihodnje. Okrevanje je eno glavnih pričakovanj obeh skupin. Turner-Crowson in Wallcraft (2002) pojasnjujeta, da koncept »okrevanja« na splošno opisan kot »kompleksen, individualen in samoopredeljujoč proces zadeva pridobitev upanja in neodvisnosti«. Toda tako ljudje s težavami z duševnim zdravjem kot njihovi družinski člani so okrevanje opisali drugače. Zanje je pomembno ponovno pridobiti občutek za upanje, razvijati občutek za preteklost, da bi se lahko premaknili naprej, prevzemanje nadzora nad lastnim življenjem, popraviti in razvijati nove dragocene odnose in družbene vloge, razvijanje novega smisla in ciljev v življenju, vztrajanje kljub oviram in nenehnim težavam. Okrevanje je torej bolje predstaviti kot neprestano potovanje ali proces in ne kot končni cilj (Wallcraft 2005: 203). V naši raziskavi je večina ljudi s težavami z duševnim zdravjem želela govoriti o okrevanju z vidika težav z duševnim zdravjem. Toda večina je imela zgolj omejene možnosti pogovora o tem s strokovnjaki s področja duševnega zdravja. Ljudje s težavami z duševnim zdravjem pričakujejo formalno podporo, da bi

razrešili svoje zakonske in finančne težave ter težave pri zaposlovanju. Nekatere ženske s težavami z duševnim zdravjem so se bale, da jim bo razpadel zakon. Želele so si, da bi strokovnjaki s področja duševnega zdravja posredovali pri zakonskih zadevah in zavarovali njihov zakon. Družinski člani so pričakovali tudi institucionalno podporo, da bi ublažili breme družine in zmanjšali skrb za svoje družinske člane s težavami z duševnim zdravjem. Nekateri družinski člani so si želeli finančno podporo institucij za avtobusne vozovnice v bolnišnico, zdravila, ki jih je predpisal nekdo od zunaj. Družinski člani in ljudje s težavami z duševnim zdravjem pričakujejo podporo bližnjih družinskih članov, saj sami niso sposobni reševati nekaterih težav, povezanih s finančnim položajem, emocionalno stisko, preprečevanjem stigme in diskriminacije in fizične skrbi zanje, medtem ko starši potrebujejo počitek ali čas, da bi zadovoljili potrebe, ki se jim ne morejo izogniti, kot so sprejem v bolnišnico, romanje, duhovna oskrba (obisk templjev).

Pozornost namenjamo tudi izsledkom glede naravnanosti ljudi s težavami z duševnim zdravjem, njihovih družin in strokovnjakov s področja duševnega zdravja do posredovanja v družini in podpore. Večina iz vseh treh kategorij meni, da sta posredovanje v družini in podpora bistven dejavnik pri izboljšanju duševnega zdravja ljudi s težavami z duševnim zdravjem in njihovih družinskih članov, ki zanje skrbijo. Imeli pa so različna mnenja glede razpoložljivega posredovanja v družini in podpornih programov ter njunem razvijanju. Nekateri iz vseh treh kategorij niso bili zadovoljni s programi, ki so na voljo, in so povezani s posredovanjem v družini in podporo. Nekateri strokovnjaki s področja duševnega zdravja menijo, da so sedanji programi slabi predvsem zato, ker na voljo ni dovolj sredstev, dela je preveč, prav tako pa ne omogočajo zadostne strokovne svobode. Strokovnjaki s področja duševnega zdravja uporabljajo različne sisteme komuniciranja, da bi vzpostavili stik z družinskimi člani v imeni njihovih svojcev s težavami z duševnim zdravjem, kot so telefonski klici, podpora uradnikov iz tajništva bolnišnice, obiski na domu itd. Strokovnjaki s področja duševnega zdravja imajo nekaj pomembnih zamisli/predlogov glede izboljšanja posredovanja v družini in podpore. Nekatere od njih so: jasna določitev strokovne odgovornosti, individualni načrt oskrbe, razvijanje timskega dela, skupno posredovanje, ukvarjanje z vprašanji in ovirami, povezanimi z duševnim zdravjem, spremljanje razpoložljivih programov, razvijanje

različnih podpornih sistemov, razvijanje sodobnih sistemov komunikacije, krepitev moči družine in njenih družinskih članov s težavami z duševnim zdravjem in posebno usposobljen tim za posredovanje v družini. Žal pa večina strokovnjakov s področja duševnega zdravja ne krepi moči ljudi s težavami z duševnim zdravjem. Menijo namreč, da bi morali odločitve glede težav z duševnim zdravjem in zdravili prepustiti družini. Pomembno pa se jim zdi, da družino ustrezno seznanijo s težavami z duševnim zdravjem in zdravljenjem in da ljudje s težavami z duševnim zdravjem potrebujejo podporo strokovnjakov, zlasti v akutni fazi, če imajo diagnozo depresije s suicidalnimi mislimi, saj s tem zavarujejo njihovo zaposlitev in zakon itd. Poleg tega je potrebno reševati probleme in ovire, ki so povezani s težavami z duševnim zdravjem, kot so družbena stigma in diskriminacija ter različna prepričanja, ki slabo vplivajo na ljudi, ki bi se želeli obrniti po pomoč na službe. Večina strokovnjakov s področja duševnega zdravja je žal prepričanih, da ravno oni, ljudje s težavami z duševnim zdravjem in njihovi družinski člani ustvarjajo družbeno stigmo in jo celo povečujejo.

Če upoštevamo vse, kar smo omenili zgoraj, je očitno, da smo v raziskavi opredelili različne, vendar pomembne potrebe, pričakovanja in naravnanosti vseh treh kategorij. To pomeni, da je najpomembnejši prispevek naše raziskave prav nabor literature in priprava smernic za nadaljnje raziskovanje. V raziskavi smo tudi opredelili praktične ovire v razvoju duševnega zdravja. To so:

- Pomanjkanje razumevanja do ljudi s težavami z duševnim zdravjem in njihovih družinskih članov o težavah z duševnim zdravjem, njihovih značilnostih, zdravljenju in drugih storitvah ter okrevanju.

- Visoka prevalenca stigme in diskriminacije med družinskimi člani in sorodniki, sosedi in prijatelji, na delovnem mestu, med strokovnjaki s področja duševnega zdravja in družbo kot celoto.

- Pomanjkanje programov, ki bi omogočali krepitev zmogljivosti

- Pomanjkanje prepoznavanja močnih plati ljudi s težavami z duševnim zdravjem.

- Visoka prevalenca močnih, burnih čustev družinskih članov do svojcev s težavami z duševnim zdravjem.
- Pomanjkanje izpolnjevanja osnovnih potreb ljudi s težavami z duševnim zdravjem in njihovih družin, vključno s potrebo po finančni podpori.
- Pomanjkanje informacij o značilnostih težav z duševnim zdravjem, ki bi jih širili strokovnjaki s področja duševnega zdravja.
- Pomanjkanje sodelovanja med različnimi poklici in službami.
- Pomanjkanje pozornosti vlade in drugih institucij do težav z duševnim zdravjem in ljudi s težavami z duševnim zdravjem.

Z opredelitvijo potreb ljudi s težavami z duševnim zdravjem in potreb njihovih družinskih članov lahko socialni delavec ali delavka uporabi pristop opiranja nase in jim pomaga v procesu okrevanja. Socialni delavci in delavke lahko posredujejo na mikro, mezo in makro ravneh, da bi podpirali ljudi. Pri posredovanju na mikro ravni lahko socialni delavec ali delavka soustvarja z osrednjimi sistemi, kot so posamezniki, manjše skupine in družine. Ta vidik lahko uporabimo, kadar podpiramo ljudi s težavami z duševnim zdravjem in njihove družine. Pri tem lahko socialni delavec ali delavka uporabi delovno opredelitev Minahana (1981: 6): »namen socialnega dela je spodbujati ali ponovno vzpostaviti vzajemno dobrodejno interakcijo med posamezniki in družbo, da bi izboljšali kakovost življenja za vsakogar« (Haynes in Holmes 1994: 243). Socialni delavec ali delavka lahko družini pomaga pri upiranju in njihove težavne izzive obrne njim v prid z uporabo njihovih močnih plati, potreb in zanimanj. Socialni delavec ali delavka lahko sodeluje s posamezniki in njihovimi družinami, da bi opredelil njihova prepričanja, organizacijske vzorce in procese komunikacije, pri tem pa pripravlja individualni načrt oskrbe. Poleg tega lahko socialni delavec dela z družino, da bi spremenil ali izboljšal njihove individualne, zakonske ali družinske interakcije, odnose, komunikacijo ter pri tem dosegel njihove cilje. Socialni delavec ali delavka ne dela z njimi le zato, da bi lahko pridobili službe in storitve različnih institucij. Socialni delavec ali delavka lahko sledi nerepresivnemu pristopu v praksi, da bi pomagal družinam in

posameznikom. S tem pristopom v socialnem delu lahko vzpostavi vzajemno razumevanje med človekom s težavami z duševnim zdravjem in socialnim delavcem. Ta pristop poudarja medgeneracijsko sodelovanje in sprejemanje sposobnosti ljudi, njihovega znanja in zmožnosti. Praksa, ki temelji na dokazih in spremenljivost sta koristna naravnanost pri tem pristopu socialnega dela. Torej, za delo z družinami, ki imajo družinske člane s težavami z duševnim zdravjem, je ta postopek, ki temelji na vzajemni pomoči, zelo koristen.

Socialni delavec ali delavka lahko spodbudi podporne programe za družine s sodelovanjem z zdravstvenim osebjem s področja duševnega zdravja, ki v Šrilanki prelagajo storitve duševnega zdravja na oskrbo v družini. Njihove informacije in zamisli nam pomagajo opredeliti področja, ki jih je potrebno razvijati ali raziskovati v sklopu teh programov in nadalje razvijati znanje v praktičnem socialnem delu na področju duševnega zdravja. Pri tem je ključen prispevek vseh udeležencev, kot so akademiki, politiki, vladne in nevladne organizacije, saj bomo tako lahko razvijali duševno zdravje in socialno delo. Raziskovalka meni, da je treba razvijati duševno zdravje in socialno delo v Šrilanki najprej v sodelovanju z zgoraj omenjenimi udeleženci. S sočasnim razvojem obeh področij je potrebno izboljšati tudi posredovanje v družini in programe podpornih sistemov, da bi posameznikom in njihovim družinam pomagali reševati težave z duševnim zdravjem. Vsa omenjena področja so povezana in vplivajo drugo na drugo. Posledično raziskovalka predlaga naslednje izboljšave na področju duševnega zdravja, socialnega dela in podpornih sistemov za družine:

Da bi razvijali socialno delo v Šrilanki je potrebno:

- Vzpostaviti strokovno in vladno priznavanje socialnega dela.
- Uvesti diplomske programe na univerzah.
- Razvijati primerno literature na področju socialnega dela.
- Razvijati raziskovalne dejavnosti in pridobiti vladna sredstva za raziskovanje.

- Povezovati lokalne in tuje univerze (zahodne in nezahodne) pri razvoju socialnega dela v Šrilanki.

- Pregledati programe socialnega dela, ki so jih že razvili v državah v razvoju.

Duševno zdravje v Šrilanki:

- Vključevati psihiatrične službe v primarno zdravstveno službo.

- Izboljšati kratkotrajne programe usposabljanja zdravstvenih delavcev v primarnem zdravstvu, da bi opredelili potrebe ljudi s težavami z duševnim zdravjem.

Podporni sistemi za družino:

- Razvijati timsko delo v sodelovanju s psihiatrom, drugimi zdravniki, socialnimi delavci, delovnimi terapevti in medicinskimi sestrami v ustanovah.

- Razvijati različne sisteme podpore v družini (z ozaveščanjem, podpiranjem pri sprejemanju odločitev, krepitvi moči) s sodelovanjem zgoraj omenjenih strokovnjakov s področja duševnega zdravja.

- Razvijati program, ki bi za dobrobit družine uporabil močne plati ljudi s težavami z duševnim zdravjem.

- Ločen pravni podporni sistem za ljudi s težavami z duševnim zdravjem in njihove družinske člane.

- Ločen podporni sistem financiranja družine in ljudi s težavami z duševnim zdravjem (na priporočilo zdravnikov in socialnih delavcev).

- Sistem, ki bi temeljil na vladi in bi bil namenjen oskrbi uporabnikov služb (možnosti kratkotrajne namestitve, ljudje, ki omogočajo oskrbo in podporo).

- Vzpostaviti vladni podporni sistem za oskrbo ljudi s težavami z duševnim zdravjem, zlasti za tiste, ki nimajo skrbnikov z nepremičninami ali brez njih.

- Povezati vsako družino s svojci s težavami z duševnim zdravjem preko socialnih delavcev in delavk z ustanovami.
- Razvijati sisteme vzajemne pomoči v skupinah v skupnosti.
- Odmeriti sredstva za razvijanje podpornih sistemov za družine.

Razvijanje zgoraj omenjenih programov je zelo koristno, donosno in plodno pri zmanjševanju bremena družine, ki skrbi za ljudi s težavami z duševnim zdravjem, saj jih v Šrilanki večina živi z družinami. Pomembno pa je opraviti tudi nadaljnje raziskave na področju ozaveščanja družin glede težav z duševnim zdravjem in okrevanja, odnosa med ljudmi s težavami z duševnim zdravjem in njihovimi zakonskimi partnerji ter nadlegovanja v družini, prepoznavanja potreb, zadovoljevanja potreb, brezdomnosti ljudi s težavami z duševnim zdravjem in naravnanosti zdravstvenega osebja do težav z duševnim zdravjem in ljudi s težavami z duševnim zdravjem.