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Impact of Family Dysfunctions on Child and Adolescents Mental Health

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ABSTRACT

None of us live alone. Family is the primary unit where individuals find their self identity and desire to live. A rigid definition of family involves persons united by ties of marriage, blood, or adoption. The members of a family have a common habitat, share same roof and constitute a single house hold. They interact and communicate with each other in the performance of roles, as spouse, mother and father, son, daughter, etc. This unit has certain common characteristics in all societies although the relationship between the individuals, family, society, culture and civilization are variable and complex. The family provides for the child's biological needs and simultaneously directs its development towards becoming an integrated person capable of living in society and maintaining and transmitting culture. Specific to mental health, family plays a very significant role in development of positive mental health and making a person psychologically resourceful and socially organized.

Keywords: *Family, Child, Adolescents, Mental Health*

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None of us live alone. Family is the primary unit where individuals find their self identity and desire to live. A rigid definition of family involves persons united by ties of marriage, blood, or adoption. The members of a family have a common habitat, share same roof and constitute a single house hold. They interact and communicate with each other in the performance of roles, as spouse, mother and father, son, daughter, etc. This unit has certain common characteristics in all societies although the relationship between the individuals, family, society, culture and civilization are variable and complex. The family provides for the child's biological needs and simultaneously directs its development towards becoming an integrated person capable of living in society and maintaining and transmitting culture. Specific to mental health, family plays a very significant role in development of positive mental health and making a person psychologically resourceful and socially organized (David, 1978).

What is a dysfunctional family?

A dysfunctional family is a family, in which conflict, misbehavior and even abuse on the part of individual members of the family occur continually, leading other members to accommodate such actions. Children sometimes grow up in such families with the understanding that such an arrangement is normal. Dysfunctional families are most often a result of the alcoholism, substance abuse, or other addictions of parents, parents' untreated mental illnesses/defects or personality disorders, or the parents emulating their own dysfunctional parents and dysfunctional family experiences. Violence and verbal abuse are typical outcomes. Dysfunctional family members have common symptoms and behavior patterns as a result of their common experiences within the family structure. This tends to reinforce the dysfunctional behavior, either through enabling or perpetuation. The family unit can be affected by a variety of factors. Family dysfunction can be any condition that interferes with healthy family functioning. Most families have some periods of time where functioning is impaired by stressful circumstances (death in the family, a parent's serious

illness, etc.). Healthy families tend to return to normal functioning after the crisis passes. In dysfunctional families, however, problems tend to be chronic and children do not consistently get their needs met. Negative patterns of parental behavior tend to be dominant in their children's lives.

Sexual abuse happens to both boys and girls. It is committed by both men and women. In most cases, sexual abuse is part of an overall family pattern of dysfunction, disorganization, and inappropriate role boundaries. Responsibility for sexual abuse in all cases rests entirely with the adult. No child is responsible for being abused. Most sexually abused children are too frightened of the consequences for themselves and their families to risk telling another adult what is happening. As a result they grow into adulthood carrying feelings of self-loathing, shame, and worthlessness. They tend to be self-punishing and have considerable difficulties with relationships and with sexuality. Regardless of the kind of dysfunction or abuse, effects vary widely across individuals. Support from other healthy adults, success in other areas, or positive changes in the family can help prevent or minimize negative effects. The following questions may help you identify how you may have been or continue to be affected (Beavers, 1982; Ackerman, 1993).

Types of dysfunctional families:

1) According to Janet Kizziar identified four types of "troubled or dysfunctional family systems," in the context of describing the cardinal features of alcoholic families, such as:

- The Alcoholic or Chemically Dependent Family
- The Emotionally or Psychologically Disturbed Family
- The Physically or Sexually Abusing Family
- The Religious Fundamentalist or Rigidly Dogmatic Family

2) Kizziar (1989) mentioned that in all those families substance addiction or alcoholism tends to become more problematic as other non-dependent members of the family somehow promote or fuel the evil habit by becoming reluctant to them, or quietly accepting their addictive behaviour.

3) Steven Farmer (1989) identified following symptoms in dysfunctional families:

- Inconsistency and Unpredictability
- Role reversals ("parentifying" children)
- Closed family system" (a socially isolated family that discourages relationships with outsiders)
- Denial (i.e. a refusal to acknowledge the alcoholism of a family member; ignoring complaints of physical, emotional and sexual abuse)
- Lack of empathy toward family members
- Lack of clear boundaries (i.e. throwing away personal possessions that belong to others, inappropriate touching, etc.)
- Mixed Messages
- Extremes in conflict (either too much or too little fighting between family members)

4) Neurath (2002) also categorized dysfunctional family by identifying faulty parenting as:

- Dogmatic or chaotic parenting" (applying harsh and inflexible disciplines on children)
- Showing condition-based love and affection to children
- Socially isolated parents or parents with low social mixing skills
- Children are not expected to question parents or children not allowed to dissent or argument with parents
- Children are not allowed to develop their own value system by parents
- Parents are disrespectful to children's need, prestige and existence
- Signs of emotional intolerance from parents i.e., family members not allowed to express the "wrong" emotions

Examples of Faulty Parenting in Dysfunctional Families:

a) Deficient Parents:

Deficient parenting is characterized by having marked inadequacies in parents to provide children emotional and material care. These parents would likely to hurt their children more by omission than

by commission. Frequently, chronic mental illness or a disabling physical illness contributes to parental inadequacy. Children tend to take on adult responsibilities from a young age in these families. Parental emotional needs tend to take precedence, and children are often asked to be their parents' caretakers. Children are robbed of their own childhood, and they learn to ignore their own needs and feelings. Because these children are simply unable to play an adult role and take care of their parents, they often feel inadequate and guilty. These feelings continue into adulthood.

b) Controlling Parents:

Unlike the deficient parents, controlling parents fail to allow their children to assume responsibilities appropriate for their age. These parents generally show excessive dominating attitude to children and making decisions for their children well beyond the age at which this is necessary. Controlling parents are often driven by a fear of becoming unnecessary to their children. This fear leaves them feeling betrayed and abandoned when their children become independent. On the other hand, these children frequently feel resentful, inadequate, and powerless. Transitions into adult roles are quite difficult, as these adults frequently have difficulties making decisions independent from their parents. When they act independently these adults feel very guilty, as if growing up were a serious act of disloyalty.

c) Alcoholic Parents:

Alcoholic families tend to be chaotic and unpredictable. Rules those are applicable to one day may not be applicable in other days. Promises are neither kept nor remembered. Expectations vary from one day to the next. Parents may be strict at times and indifferent at others. In addition, emotional expression is frequently forbidden and discussion about the alcohol use or related family problems is usually nonexistent. Family members are usually expected to keep problems a secret, thus preventing anyone from seeking help. All of these factors leave children feeling insecure, frustrated, and angry. Children often feel there must be something wrong with them which make their parents behave this way. Mistrust of others, difficulty with emotional expression, and difficulties with intimate relationships carry over into adulthood. Children of

alcoholics are at much higher risk for developing alcoholism than are children of non-alcoholics.

d) Abusive Parents:

Abuse can be verbal, physical, or sexual.

1 Verbal abuse - such as frequent criticism, being critical to children's behaviour, frequently putting down children in front of others, comparing with other children regarding their academic, scholastic, behavioural, even physical appearances and showing less positive reinforcements - can have enduring effects, particularly when it comes from those entrusted with the child's care. Some verbal abusers are very direct, while others use subtle put-downs disguised as humor. Both types are equally damaging to children.

2 Definitions of physical abuse vary widely. Many parents, at one time or another, have felt the urge to strike their child. With physically abusive parents, however, the urge is frequent and little effort is made to control this impulse. The Federal Child Abuse Prevention and Treatment Act (U.S. Department of Health and Human Services, Administration for Children and Families) defines physical abuse as *"the infliction of physical injuries such as bruises, burns, welts, cuts, bone or skull fractures; these are caused by kicking, punching, biting, beating, knifing, strapping, paddling, etc."* Physically abusive parents can create an environment of terror for the child, particularly since violence is often random and unpredictable. Abused children often feel anger. Children of abusive parents have tremendous difficulties developing feelings of trust and safety even in their adult lives. While parents may justify or rationalize verbal or physical abuse as discipline aimed at somehow helping the child, there is no rationalization for sexual abuse.

3. Sexual abuse is the most blatant example of an adult abusing a child purely for that adult's own gratification. Sexual abuse can be any physical contact between an adult and child where that contact must be kept secret. Demonstrations of affection -- such as hugging, kissing, or stroking a child's hair -- that can be done openly are quite acceptable and even beneficial. When physical contact is shrouded in secrecy then it is most likely inappropriate. Sexual abuse happens to both boys and

girls. It is perpetrated by both men and women. It cuts across lines of race, socioeconomic level, education level, and religious affiliation. In most cases, sexual abuse is part of an overall family pattern of dysfunction, disorganization, and inappropriate role boundaries. Responsibility for sexual abuse in all cases rests entirely with the adult. No child is responsible for being abused. Most sexually abused children are too frightened of the consequences for themselves and their families to risk telling another adult what is happening. As a result they grow into adulthood carrying feelings of self-loathing, shame, and worthlessness. They tend to be self-punishing and have considerable difficulties with relationships and with sexuality.

Effects of faulty parenting on children:

Children growing up in a dysfunctional family may have to adopt following six basic roles, which are not healthy:

a) The Good Child – a child who takes over the parental role.
b) The Problem Child – the child who has been held responsible for most problems in his family, although he is found to be the most emotionally stable one in the family.
c) The Caretaker Child– the child who takes the maximum responsibility for the emotional well-being of the family.
d) The Lost Child – the inconspicuous, quiet one, whose needs are often ignored or hidden by family members.
e) The Mascot Child– the child who frequently uses humours or adopts the role of a comedian to divert attention away from the increasingly dysfunctional family system.
f) The Mastermind Child– the child who has opportunistic attitudes and who capitalizes on the other family members' faults in order to get whatever he/she wants.

Children of dysfunctional family system might as well develop following enduring problems in their later life:

a) Being distrustful to others or being suspicious to others' actions
b) Problem in either expressing or recognizing emotions or emotional needs of others
c) Low self-esteem and poor self-image

d) Less skillful in forming and maintaining healthy relationships with others

Parental & Familial factors

1. **Attachment /bonding: -** Mary Ainsworth et al (1978) first described patterns of mother infant interaction following brief episode of experimentally contrived separation denoted as 'strange situation'.

Three types of attachment were:

- Secure attachment
- Anxious attachment
- Resistant attachment

Lack of secure attachment predicts future psychological problem (Fonagy et al. 1994).

2. **Parental separation& loss**: Psychiatric morbidity has been found to be persistently higher in bereaved children than controls, at both short term & long term follow-up Depression & anxiety disorders occur most commonly but alcohol & drug use in males is particularly high (Kranzler et al, 1990). However, bereaved children may show resilience in presence of various protective factors. Risk factors in children are:-

- Young age (esp before 11 yrs)
- Female Sex
- No preparation for death
- Sudden or catastrophic death
- Witnessing the death
- Death of mother
- Prior ambivalent relationship
- Previous psychiatric disorder
- Previous & subsequent losses
- Poor social support
- Inability to mourn, no involvement in death rituals
- Lack of bereavement counseling.

3. **Parental Psychiatric/Medical Illness**: Besides contributing to genetic transmission, parental illness also adversely affects children

via environmental mechanisms like insecure attachment, chaotic family environment, marital disharmony & economic difficulties.

- Parental depression is associated with 3 fold increased risk of depression in offspring, as well as increased rates of phobias/panic disorder/ alcohol dependence & conduct disorder (Weissman et al, 1997).
- Parental substance use & personality disorders contribute to conduct disorders & substance abuse (Merikangas et al, 1998).
- Parental chronic physical illness like cancer/ AIDS/heart disease cause increased risk for anxiety/ low self esteem & poor social skills (Grant and Compas,1995)

4. **Parenting style**: 4 Types of parenting styles have been described with different developmental outcomes of the child ;-

- Authoritative style: is a protective factor with maximum benefit to child (Darling & Steinberg, 1993).
- Authoritarian style: results in shy/anxious child.
- Permissive style: results in poor impulse control
- Neglecting style: results in conduct problem.

5. **Parental marital status/relationship**:

- Parental divorce is associated with psychological/behavioral problems, specially in short term with boys, with particular risk for conduct problems & academic failure (Cherlin et al, 1991)
- More than the divorce itself, marital discord/ conflict preceding divorce especially increase risk of conduct problems. Single parent & step-parent / reconstituted families show higher mean levels of emotional problems & educational underachievement (Dunn et al, 1998).

6. **Dysfunctional/disorganized family environment**: Apart from above family related factors, increased risk for both externalizing/internalizing disorders in children are associated with :

- Inconsistent/unclear rules.
- Ineffective monitoring & supervision,
- Lack of intellectual stimulation.
- Overpunitive/harsh discipline
- Excessive use of corporal punishment

- Younger maternal ages (especially teenage mothers)
- Large family size.
- Abnormal parent child interactions like hostility /lacking of warmth/ disengagement/ overprotection/inadvertent reinforcement of undesirable behaviors.

7. **Child abuse and maltreatment**:

- Child abuse includes physical abuse/sexual abuse/emotional abuse & neglect.
- Physical abuse (non-accidental physical injury) results in 'battered child syndrome' & results in physical sequelae as well as behavioral problems like poor social skills, chronic oppositional & aggressive behavior & academic failure (Cichetti & Toth, 1995).
- Sexual abuse : This can lead to wide range of psychological sequelae : - (Kendall-Tackett et al, 1993)
  - Affective symptoms : phobia/PTSD/Depression.
  - Behavior problems: conduct disorder, hyperactivity, sexualized behaviour, self-destructiveness.
  - Cognitive functioning: Educational/language difficulties.

However, ultimate risk is tempered by effects of both quality of family environment & nature of subsequent life events.

- Neglect: (Physical, emotional, medical care & educational) results in failure to thrive (Psychosocial dwarfism), developmental delays, attachment disorders & conduct problems.

II. Peer related factors: Beyond family, relationships with peers provide unique & essential contribution to social, emotional & cognitive development. Increased risk may be caused by (Hawkins, 1992):

a. Rejection /isolation by peers: results in low self esteem & poor social skills.
b. Affiliation with behaviorally deviant peers: predispose to conduct problems.

III. School related factors: School life brings its own particular demands & challenges. Adverse influences include (Rutter, 1985):

a) Frequent change of school
b) Chaotic school environment

c) Absence of consistent discipline/rules
d) Corporal punishment
e) Bullying in school

IV. Community related factors:

a) Poverty & social disadvantage: Lower socioeconomic class & persistent financial difficulties are strongly associated with difficulties in cognitive skills & educational achievements (Carr, 1999).
b) Urban inner city residential areas; Risk of disorders were doubled in some studies (Rutter et al, 1975).
c) Increased community violence, criminality and unemployment
d) Lack of supportive community & social network
e) Increased prevalence of alcohol & substance use.

Protective Factors:

1. Biological factors: (Rutter, 1991)

- Good physical health
- Absence of genetic vulnerabilities
- No history of serious illness or injuries
- Uncomplicated birth
- Adequate nutrition
- Female gender before puberty & male gender thereafter

2. Psychological factors (Carr, 1999)

- Easy temperament
- High level of intellectual ability
- High self esteem
- Use of mature defenses & functional coping

3. Familial factors (Darling & Steinberg, 1993)

- Secure attachment
- Authoritative parenting style
- Parental marital harmony
- Involvement of father in child –rearing
- Explicit/consistent family rules
- Clear & direct communication

4. Educational Factors (Rutter, 1985)

- High quality day-care
- Preschool early intervention educational programme
- Favorable school environment with firm authoritative leadership
- Involvement with peer group

Emergent Role of Families in Mental Disorder

Available evidence suggests that the prevalence of psychopathology among children in the family or foster care is higher than would be expected from normative data3. Family is the main socializing agent for the child and is important in all aspects of a human development. From family, an individual gets emotional, financial, mental support and is able to cope with his/her problems with the help of the members of the family. Scientific observations on mental disorders and mental patients have indicated that family contributes significantly to the development of mental disorders. The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past decade. Clinical work and research on families, theories of family structure and dynamics had their beginning since 1940s with the work by Social scientist (Meyer and Sullivan). It is indicated that family has a crucial role in the development of mental disorders. Mental disorders develop as a result of family pathology or faulty communication or interpersonal relationship. Although the individual is affected, yet the whole family is sick because of inter or intrapsychic problems4. The role of family in mental disorder/psychopathology has been classified into three broad categories such as:-

1. Causative role of the family
2. Maintenance role of the family and
3. Therapeutic role of the family.

Therapeutic Role of the Family

It is universally recognized that family plays a crucial role in the raising of children to become reasonably well adjusted member of the

society. The positive role of the family's mental health care programmes has been recognized relatively recently.29 Substantial evidence demonstrates the benefit of involving families in the treatment and management of schizophrenia, mental retardation, alcohol dependence and childhood behavior disorder. These are indications that the outcomes for patients living with their families are better than for those in institutions. It has been seen that by changing the emotional atmosphere in the home, the relapse can be reduced.30 In contact to epilepsy related factors, family factors especially those related to quality of the parent child relationship appeared to be strong predictors of psychopathology. In treating children with epilepsy, clinician should be aware of the importance of the parent-child relationship quality. Strengthening the relationship quality may prevent or reduce psychopathology.31 The family commonly provides useful information about the patients and other illness. This facilitates a treatment plan, in which the family can play a prominent role in helping to supervise medication, encouraging participation in rehabilitation programmes generally providing an environment conductive to promoting recovery or reducing disability. The family support provides an opportunity to patient to ventilate their anxiety freely, to arise at a shared understanding of the disease and to explore various alternative coping strategies.32 Family can offer an important reinforcement in the psychiatric therapeutic management. There are some basic steps in the family treatment to include family to participate in the management.

These are –

- *Improving problem solving ability of the families*
- *Educating the family regarding the illness.*
- *Modification of the family communication patterns*
- *Family guidance.*
- *Lowering the expressed emotion of the family members towards the patients.*
- *Manipulation of the power alliance within the family.*
- *Expanding social network.*
- *Enhancing social support.*
- *Crisis intervention.*

The therapy for marital discord is the core approach to family change.16 Several family intervention approaches for schizophrenia have been developed based on the general assumption that maladaptive interaction pattern within the family produce high level of stress for the patient and tend to relapse.33 These intervention have attempted to reduce the risk of relapse either by altering communication and problem solving in the home or by the modifying family attitudes about the patient through education about the illness. Home visit and focused communication training has been shown to be effective in studies.33 Reduction of expressed emotion is associated with good treatment outcome, especially in the families with high level of face to face contact with the patient. Superior patient outcome with two variations of behavioral approach compare to family education and routine treatment.34 Intensive behavioral intervention may not be cost effective and that change in the family communication pattern may only be important for a subset of families.

CONCLUSION

The family unit is the single most important variable in the onset, progression, treatment and outcome of psychiatric illness or mental disorders. Various researchers as well as theoretical formulations have been explored to understand the role of family pathology in the causation (genesis) and maintenance of mental disorders. However, most of the families studied have been carried out in relation with schizophrenia and some with affective disorders, particularly depression. Some of the clinical studies clearly mentioned, especially in early childhood experiences, familial stress factors such as parental death, parental separation, parental rejection, marital discord, violence at home, faulty family communication, etc. which have lifelong effects on mental health. However, the etiological aspects of various mental disorders require more exploration in the context of family life and its dynamics. Falling sick is a family event. It affects the well being of not only the patient but also that of the whole family by disrupting the normal day to day routine. The family is required to mobilize its internal and external resources to cope with the impending

crisis. For any meaningful intervention, it is important to identify families, which are more vulnerable and need support. The family as a unit is still the best bet for health care intervention. Situation can improve by helping the patient and family members to develop realistic expectation about the problem and its ramification.

REFERENCES

Ackerman, R.J. (1993). *Silent Sons.* Simon & Schuster.

Bateson G. Steps to an ecology of the mind. New York: Ballantine, 1972. *As cited in*: Mattejat F. Family therapy. In: Remschmidt Helmut ed Psychotherapy with children and adolescents. Cambridge: Cambridge Univ Press, 2001: 179-210.

Beavers, W.R. (1982). Healthy, midrange and severely dysfunctional families. In F. Walsh (Ed.), *Normal Family Process*. New York: Guilford Press, pp.45-66. Excerpts taken from Books Google on 04/07/2010.

Bellack AS, Haas GL, Scholer NR, Flory JD. Effect of behavioral family management on family communication and patient outcomes in a schizophrenia. Br J Psychiatry 2000; 177 : 434-439.

Bellack AS, Musser KM. Psychosocial treatment of schizophrenia. Schizophrenia Bull 1993; 19 : 317-336.

Carr, A. (1999). The Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach. London,

Brunner-Routledge.

Cherlin, A.J., Furstenberg, F.F., Chase-Lansdale, P.L. et al. (1991). Longitudinal studies of effects of divorce on children in Great Britain and United States. Science, 252, 1386-89.

Cicchetti, D., Toth, S. (1995). A development psychopathology perspective of child abuse and neglect. J Am Academy of Child and Adolescent Psychiatry, 34, 451-565.

Darling, N., Steinberg, L. (1993). Parenting styles and context: An integrative model. Psychological Bulletin, 113, 487-496.

David, H.P. (1978). Healthy family functioning: A cross-cultural appraisal. *Bulletin of the World Health Organization,* 56(3), 327-342.

Dunn, J., Deater, D.K., Pickering, K. et al. (1998). Children's adjustment and prosocial behaviour in step, single- parent and non step family settings: findings from a community study. Journal of Child Psychology and Psychiatry, 39, 1083-1095.

Epstein, N., Bishop, D.S., Levin, S. (1978). The McMaster model of family functioning. *Journal of Marriage and Family Counselling,* 4, 19-31. (Abstract)

Fonagy, P., Steele, M., Steele, H. et al. (1994). The Emmanuel Miller Memorial Lecture, 1992: The theory and practice of resilience. Journal of Child Psychology and Psychiatry, 35, 231-257.

Grant, K.E., Compas, B.E. (1995). Stress and anxious depressed symptoms among adolescents: searching for mechanisms of risk. Journal of Consulting & Clinical Psychology, 63, 1015-1021.

Gurman AS, Kniskern DP. Family therapy outcome research: knowns and unknowns. In: Gurman AS, Kniskern DP eds Handbook of family therapy. New York: Brunner/Mazel 1981. As cited in: Barnes GG. Family therapy. In: Rutter M, Taylor E, Hersov L. eds. Child and adolescent psychiatry: modern approaches 3rd ed.Oxford: Blackwell Science 2000: 946-967.

Hawkins, J., Catalano, R., Miller, J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood. Implications for substance use prevention. Psychological Bulletin, 112, 64-105.

Kizziar, J. (1989). Excepts taken from the website: http://www.mudrashram.com/dysfunctionalfamily on 10/07/2010.

Leff J, Gamble C. Training of community psychiatric nurse in family work for schizophrenia. Int J Med Health 1996; 24 : 75- 88.

National Network for Family Resiliency (1993). Taken from http://www.nnfr.org/

Neuharth, D. (2002). If You Had Controlling Parents: How to Make Peace With Your Past and Take Your Place In the World, (p. 4-5), Quill Books.

Rodenburg, Marie Meijer. Family predictors of psychopathology in children with epilepsy. Epilepsia 2006; 47 (3) : 601-614.

Rutter, M. (1985). Family and school influences on behavioural development. Journal of Child Psychology and Psychiatry, 26, 349-368.

Rutter, M. (1991). Nature, nurture & psychopathology: A new look at on old topic. Development and Psychopathology, 3, 125-136.

Rutter, M., Gould, M. (1985). Classification. In: Rutter, M. Hersov, L. (eds): Child and Adolescent Psychiatry: Modern Approaches 2nd edn, Oxford, Blackwell Scientific, 304-321. Cited in: Volkman, F.R., Schwab-Stone, M., First, M. (2004). Nosology and Psychiatry, Philadelphia, Lippincott Williams & Wilkins.

Rutter, M., Shaffer, D., Shepherd, M. (1975). A multiaxial classification of child psychiatric disorders. Geneva, World Health Organization.

Tarrier N, Barowclough C, Vaughn CE, Bamrah JS, Porceddue K, Watts S, Freeman H. Community management of schizophrenia: A Controlled trial of a behavioural intervention with families to reduce relapse. Br J Psychiatry 1988; 153 : 532-542.

Taylor, S. Health Psychology, New York, Random House, 1986.

Weissman, M.M., Warner, V., Wickramaratne, P. et al. (1997). Offspring of depressed parents. 10 years later. Archives of General Psychiatry, 54, 932-940.