

The Indian family and the diagnostician

by S Jithoo and J Landau

Summary

The article explores some of the pitfalls encountered by medical practitioners in therapeutic contact with the South African Indian Family.

Despite the vicissitudes of urban life (in particular, education, industrialization and Westernization), the nuclear household comprising the traditional Indian joint family segments, does not lose the tradi-

tional close-kin network and bonding.

Nevertheless, the anthropologist considers it vital for any medical practitioner administering therapy, to be aware of the socio-religio-cultural propensities of the patients, particularly when the society in question is exposed to acculturation.

Sabita (Jithoo): BA(Hons), MA (Natal) Head of Department & Senior Lecturer in the Department of Anthropology University of Durban-Westville.

Judith Landau: MB ChB DPM consulting Psychiatrist and Family Therapist (Ex Honorary Lecturer in the Department of Psychiatry at the Medical School) University of Natal.

The genealogical structure of the joint family is described by Shah as meaning "two or more elementary families joined together" (Shah, 1974, p109, and Shah, 1964).

The Indian joint family is generally patrilocal (or virilocal) and patrilineal, which means that the two elementary families are joined by patrilineal ties between the married males. They are also generally co-residential (that is "occupying the same dwelling") and frequently commensal (that is eating food "from the same kitchen") (Kolenda, 1968, p344), or "cooked at one hearth" (Shah, 1974, p113).

There are also often compacenary arrangements of proprietary and business which prescribe the implicit sharing of family property (usually among the males) until it is eventually partitioned.

Before presuming that a joint family is transitional it is vital for the therapist to examine the bonding and relationships of the family. It is erroneous to presume that an apparently nuclear family is necessarily functioning as such; the nuclear appearance may well be one of the

geography only and does not necessarily imply any deficiency in the relationship bonding or traditional functioning of the kutum.

In a study of the structure and developmental cycle of one hundred Indian joint families one of the authors (Jithoo) has found several causes of fission which do not necessarily imply severance of family ties and responsibilities.

These may be briefly listed as follows: problems of accommodation; family conflicts; transfer of professional people (especially teachers, lawyers, doctors) from the home; government and municipal legislation for slum clearance and subsequent provision of housing elsewhere; natural and political disaster, for example floods and riots. (See diagram A).

In these instances family ties are maintained, both by regular visits and by presumed assistance in times of stress, in addition to participation in the usual social and religious ritual

to page 10

The Indian family and the diagnostician

functions. It is therefore important to assess the bonding in the family prior to deciding that therapy is appropriate.

Intervention becomes appropriate when the family is transitional (that is with one or more members in transition towards nuclearization) and in fact, request for therapeutic intervention by a member of an extended family is diagnostic of transition (Landau & Griffiths, 1981).

The transitional extended family, whether co-residential or geographically divided into nuclear units, retains strong relationship ties in that its members remain available to each other in times of family celebration, severe stress or crisis.

It is therefore imperative to recognize the importance of regarding the composite parts of such a family as belonging to one family system for therapeutic purposes.

Where it is possible to institute combined family therapy, it is essential to do so, or co-operation and a great deal of critical information are lost.

Where this is impractical because of geography or marked transitional conflict between transitional and traditional members, transitional therapeutic techniques may be employed, for example: Link Therapy. It must not be forgotten that a person belongs to his own family, the family he creates and the family of his spouse, all of which must be included in the therapy if possible.

A major therapeutic pitfall to be avoided is the failure to discriminate between the geographically nuclear family with its strong bonding with the extended traditional unit, and the autonomous nuclear unit where the bonding is lost.

Failure to take cognisance of the essential relationship bonding in the former would inevitably lead to therapeutic failure.

Clinical examples of transitional conflict are very frequently seen amongst the South African Indian population. Transitional mapping of these families shows the majority to be in transition from the traditional joint family towards nuclearization.

Very few truly autonomous nuclear families are found, and instances of breakdown of the nuclear family in further transitional progress

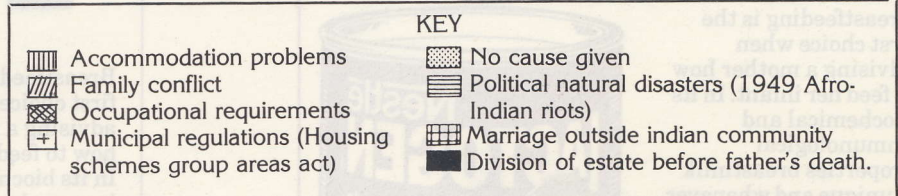
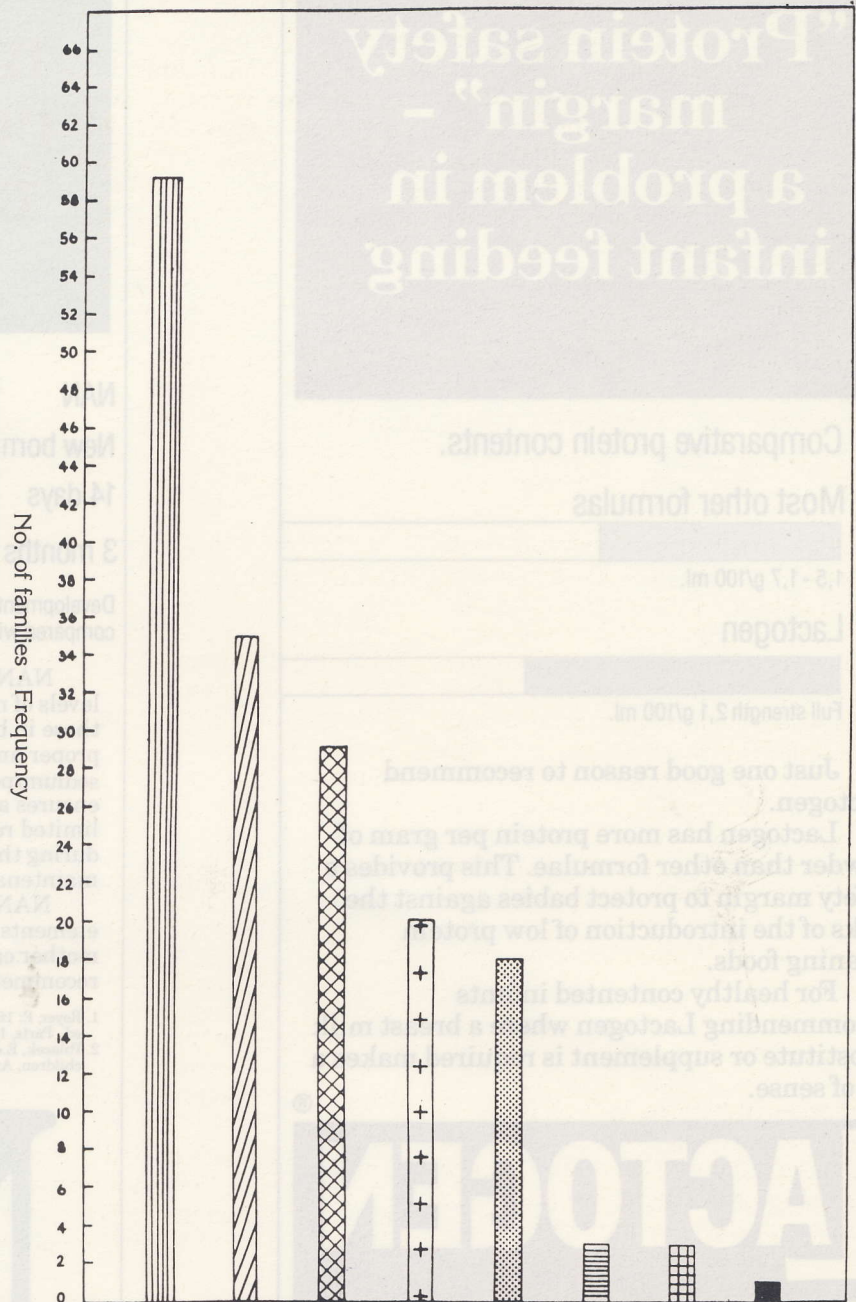


DIAGRAM A CAUSES OF SEGMENTATION IN 168 CASES IN THE EGO AND 1st DECENDING GENERATIONS OF HEADS OF THE FAMILIES STUDIED.

beyond the nuclear family are so rare as not to be worth mentioning. The conflict situations as is easily explained, tend for the most part, to be between the traditional and transitional members of the family.

Clinical example: The youngest of three sons of a tight traditional kutum, Mr H, who had been

automatically given a share of the family business, decided that he wished to go into the teaching profession.

His father, in addition to being distressed at what he regarded as the collapse of the family and all it stood

for, was unable to pay his son the necessary compensation. The oldest son explained to his brother that he would have to wait until the shop was sold (which they were all reluctant to do).

An enormous row ensued in which for the first time bad language and raised voices were heard in the presence of the senior members of the household. Two days later Mr H's mother had a massive cardiac infarct, and Mr H left home.

The problems in the culture of therapy in such a case are manifold. A therapist who grew up in the culture and therefore understands it, should have an obvious advantage over one who is inexperienced in the intricacies of the joint family system. However, a female therapist from this group, particularly if young, stands very little chance of being able to assume sufficient authority in the face of the patriarchal hierarchy.

In addition to this, if she is of the same group in a small closed community, she will prove an enormous threat to the standing and pride of the patriarch, whose name and reputation must remain uppermost.

An outsider may be regarded as an invader, but if able to earn the trust of the family, which is possible in transitional families though never in traditional ones, will be able to achieve far more than a junior female member of the same group. In the case of females therefore, an outsider may frequently be at an advantage.

There is little doubt that a male therapist will exert more authority, but the advantage provided by this may be outweighed by the threat imposed.

The therapist should be aware of the need to accept the boundaries initially imposed by the family and move very slowly towards a gradual sharing of the family secrets and skeletons, allowing for a maintenance of pride and face on the part of the head of the family and its other members.

An interesting finding in a survey done by van Zijl, (1980), of university student self-referrals for counselling, was that young Indian students, though they lived more frequently with their parents than students of

the other groups studied, were apparently less willing to consult their parents on intimate matters. This he explained in terms of the dominance and unapproachability of the parental figures.

Added to this he discussed the fact that the student is often the most highly educated, westernized, non-traditional and therefore transitional member of the family. It is in this light that the Indian student turns to his peers or the student counsellor for help in emotional matters.

Mysticism and attitudes to illness

The family is governed by powers which only priests, and certainly not therapists, may be able to control. The Hindu believes implicitly in his Karma, which is God's will and punishment for any sins committed in a previous life.

Any bad luck or misfortune in life is attributed to the rule of Karma. If he does good in this life then he will reap the rewards in his next life, until the individual merges in the Absolute in Moksha or final liberation.

A man is born into a caste or dharma because of his karma. The concept of dharma is expressed in doing good deeds that will achieve spiritual merit.

Both the individual and the group are responsible for performing the karma allotted to them. The dharma of the Hindu is not to eat pork or beef.

Illnesses are part of one's karma and are alleviated only by vows and propitiation ceremonies that must be directed either by the priests or by the traditional healers, Hakims in the case of the Muslims and Ayurvedic healers in the case of Hindus.

Amongst the traditional Hindus smallpox, measles, chicken pox and scarlet fever (the spotted sicknesses) are regarded as visitations by the Mother Goddess for which the family is extremely grateful.

The presence of a doctor, with his modern scientific ideas would defile the child in its state of grace, and would be regarded by the Goddess as an invasion. She would then punish the family most severely. There is often dreadful conflict between traditional and modern

generations in this type of situation as can be imagined.

If the younger generation take matters into their own hands and call in a doctor when the patient is in extremes, the older generations are convinced of the error of the youth and are more than ever determined to retain their beliefs. Another conflict occurs with regard to inoculation which is condemned by the conservative older patients, and many younger ones too, will arrive at last in the General Practitioner's consulting room wearing their amulets.

Before the patient considers seeing a conventional doctor he will always consult a traditional healer where one is available. In fact the last fully qualified Hakim in Natal (who was also a qualified doctor of medicine!) died recently and the traditional members of the community now have only recourse to their priests.

Amongst a few really traditional older members of the Muslim group are still some who regard their kismet (or future) as irrefutable and will look on serious physical illness in this light. There has been much written about the traditional Indian patient's attitude to severe illness in terms of his kismet (Muslim) or karma (Hindu).

It was said that a patient so afflicted would turn his face to the wall and refuse to make any effort to recover as this would be going against his fate. This situation is not seen in South Africa today, and it is wondered whether it was not a part of the hopeless situation of medicine in the India of old.

Patients with severe illness behave extremely well as a rule. They are not accurate in their description of the anatomy of their problems as these matters are generally a mystery to them and terminology tends to be quaint rather than precise.

It is not uncommon for a patient to complain of gallstones in his kidney or to refer to veins as nerves. A typical South African Indian complaint, not apparently found in India, is that of 'pulling veins' or 'poking pains', and many a young doctor has had great difficulty keeping a straight face while taking a medical history.

The patient does, however, refer

reasonably accurately to the area of pain, and when severely ill complains little and co-operates well with treatment.

The behaviour of the patient with minor illness is, however, very different. An enormous fuss is made both by the patient and his relatives in an effort to ensure that the doctor does not underestimate the gravity of the ailment.

Where the Indian patient is silent about emotional pain, he complains vociferously about minor physical pain. He is also hopelessly inaccurate in its description.

One of the difficulties in this area is that physical illness is far more acceptable to the Indian patient than emotional affliction. A label of neurosis, however frequently accurate, is one of the worst insults that can be given and would result in the patient refusing to visit that particular doctor again. This leaves the Indian patient wide open to surgical abuse. Compounding this problem is the natural corollary that psychosomatic conversion reactions are extremely common and their emotional basis fervently denied. Gross conversion and hysterical phenomena are not infrequently seen in an outpatient department.

Hysterical phenomena

Clinical example. Mr B aged 57, a frail gentleman accompanied by his wife, four sons and their wives, and those young children of the family who were not at the time yet in school, was seen in the casualty department of a large general hospital. He had been 'paralysed' and totally bedridden for seven and a half years.

The physician who examined him called in the psychiatry registrar on duty who confirmed his suspicion of the diagnosis. A very dramatic hypnosis session ensued during which, to the family's amazement, Mr. B was able to walk!

Among the most common psychosomatic illnesses seen in the Indian population, are asthma, peptic ulceration and the female dysuria-frequency syndrome.

Women commonly convert emotional and sexual problems to

gynaecological complaints, unfortunately often followed by numerous unnecessary operations. It would appear that there is a higher incidence of these amongst this group than any other in South Africa.

In addition to these, a desperate situation exists in the treatment of male and female infertility. In the case of the latter, a tragic situation may arise, in that the family may decide that it is advisable for the man to return his barren wife to her family of origin, if treatment fails to produce progeny. When a wife is returned to her family of origin for this reason, or because of conflict with her mother-in-law, she will never again have the opportunity of marriage.

We have mentioned earlier the importance of sons to the family, so it will not be surprising that any measure will be considered to achieve this goal. If male infertility is diagnosed the whole family will consult every doctor in town and refuse to accept the verdict of any laboratory tests.

In the case of the wealthy, years of futile travel to other centres, and often other countries, will follow the diagnosis.

The involvement of the whole family in all matters is often a great irritant to the doctor or therapist who fails to understand the structure and function of the kutum. In an effort to express solidarity and concern for the patient any number of relatives will call the doctor, or the hospital staff, on a daily basis, and be desperately offended if their enquiries and requests are not met with patient and tolerant understanding.

A psychotherapist trained to interpret numerous telephone calls and requests for interviews in terms of family pathology, may make many grave errors in this regard unless he takes cognisance of the normal customs of the kutum.

Superstition

In addition to karma, other forms of mysticism have great influence on the daily life of the believing Indian. A busy surgeon was astounded to find that he experienced great difficulty in filling his operating slate on a Tuesday. His confusion was only resolved when his secretary informed

him that patients were pleading with her to book them into hospital on any other day to ensure their survival as Tuesday was a very inauspicious day.

The priests of religion are consulted about auspicious days prior to any major move being taken, from the purchase of a necessity to the removal of a household or a doctor's appointment. Before the patient can be held responsible for missing an appointment it is wise to investigate the background.

The priests will often provide mystical reasons for illness or emotional and interpersonal difficulties. A couple may well be told by their priest that a move of house will resolve their sexual difficulties, or their son's epilepsy. The therapist will immediately lose credibility unless he manages to incorporate the mystical beliefs in his therapy of the situation.

Unfortunately the priests are not all good priests; bad priests are those who deal in black magic which can have catastrophic results.

Clinical example. Mr. S, aged twenty-seven was arrested for the murder of his grandmother-in-law, who had been brutally killed. He had no history of previous mental illness, was a happily married man with two small children of five and three years of age.

The young couple had, for the past year, been living with the grandmother and life had proceeded well until an elderly aunt had started taking the old lady to the temple on a regular basis.

It was at that stage, the young couple firmly believed, that the grandmother commenced the practice of black magic. They were both convinced that magic smoke was being burnt that was steadily making them lose their minds, making them anxious and confused. They both felt that if they allowed the situation to continue their marriage would be destroyed and they would both become insane.

They resolved that murder was their only option.

Many Hindu groups and some Muslim groups regard the fulfilment of vows as an integral part of life. Vows are taken in times of illness, when there are ambitions to be realized, before commencing a journey and when children are born, to mention but a few instances. Unless the household deity is propitiated, life