This article is an illustration of Indian families as caregivers who are direct sufferers due to family members affected by mental illness such as schizophrenia, and other psychiatric disorders. Organised into a self-help group called AMEND, the article is based on the presentation made at the World Association for Psychosocial Rehabilitation Conference, held at Germany in May 1998. The practical aspects involved in the caregiving role of Indian families make them inevitable partners in care besides projecting a unique model to the other family support groups across the world. The discussion on barriers and gateways to the partnership role of family provides an insight into the cultural dynamics of care in a country like India.

Dr. Nirmala Srinivasan is an affected parent who started AMEND along with her late husband and son, who is under treatment. AMEND is the only self-help group started in India exclusively by the initiative of family members and it continues to be run by the families themselves.

INTRODUCTION

The pace is slow but steady. Barriers are many, but challenges are even more. We keep going forward, we may stumble and fall but we are determined to get up and stand because we love our family member who is suffering.

Across countries and cultures, mental health professionals acknowledge the positive correlation between family care and better outcomes among persons suffering from mental illness, especially schizophrenia. From the pschotogetic parent role in the fifties to the theories of schismatic/skewed marriages attributing the etiology of the ailment to the families, a major breakthrough came with the appreciation of the family's role as a coper and a sufferer experiencing the syndrome of living with a mentally ill member. The current perception is characterised by an even greater appreciation of a positive and proactive role...
that the families can and do play as carers and supporters of their disabled family members. The logical culmination of these changes is to acknowledge the positive role of families as partners in the ongoing treatment process. The paradigm shift is no doubt progressive and pragmatic, but certain conceptual and practical issues like defining care in a broader sense needs to be looked into.

Questions arise as to:

1. What does family care imply in terms of partnering care?
2. Partnership with whom and how?
3. What are the roles and boundaries defying partnership?
4. What are the roadblocks and gateways in developing partnership?
5. Is a universal model of partnership valid and applicable?

In the case of a country like India, where the families are an integral part of the treatment process, how does the caring concept work?

The above issues that constitute the central theme of the presentation are discussed with reference to the experiences of the Association for Mentally Disabled (AMEND), the self-help group for the families of the mentally ill started by a user and his parents way back in 1992. It is located in the city of Bangalore, the capital of the state of Karnataka in India. Today, there are on record about 55 families in the membership of AMEND in Bangalore and around 20 families in the country as a whole. Off records, there are many more well-wishers and beneficiaries of the group, who, for various reasons, are not enrolling themselves as formal members. Meetings of family members are organised once a month to discuss various issues of common interests, details of which are mentioned below. The main agenda of AMEND, as of now, is to focus on emotional support and psychosocial education for the affected families and the community at large. It is interesting to note that broadening the horizons of partnership was not a planned or a conscious effort. Spawned by circumstantial exigencies and practical problems, AMEND's case history is an excellent illustration of grassroots developments in the partnership model between the professional and natural caregivers, which, on most occasions, were responses to requests rather than pressure exercised by us on the system comprising mental health professionals, including rehabilitation workers, counsellors/therapists, and government officials engaged in the field of disability welfare. Another unique characteristic of AMEND's partnership is the absence of adversarial relations of the alliance at various levels and with different kinds of professionals. It does not
imply that there is widespread acceptance of families as partners — a relationship that is yet to become participative in the fullest sense of the term; nor do the families themselves feel a conscious sense of being partners in the caring process. It is a taken for granted family activity, though no family was ever prepared for assuming the new role thrust on them. This is where AMEND steps in.

It is evident from survey data that most of the users live with their families in India, largely due to financial constraints and absence of affordable alternative facilities. Therefore, for the families in India, care extends beyond the responsibility of visits to the psychiatrist. The families, in most cases, turn out to be companions besides being 'counsellors'. To be more precise, it involves the entire range of family responsibilities — manual and mental — that facilitates the users optimal levels of functionality besides ensuring the protection of their rights, dignity and safety. Before we proceed with AMEND's case analysis, it is necessary to have some background information on the existing mental health facilities in the city of Bangalore, where AMEND is located.

**MENTAL HEALTH PROFILE IN INDIA WITH SPECIAL REFERENCE TO BANGALORE**

India is the second largest populated country in the world with the population having just crossed the 1 billion mark. The prevalence of schizophrenia is reported to be 2 per 1000 population with the incidence rates between 3 to 4 per 10,000 population. Of the 2 to 3 million patients at any point in time, only 5-10 per cent reach a psychiatrist because nearly 75 per cent of the total population live in villages with no medical facilities of the kind available in urban areas. Irrespective of location and literacy factors, there are still large number of people who believe in traditional healing practices such as visit to pilgrimage centres, exorcism, black magic, and so on (Chandrasekhar, 1998). Families are the mainstay of the disabled in India. Nearly 80 per cent and above stay with their families as compared to 90 per cent in China, 60 per cent in Britain and 40 per cent in the United States of America (Wolin and Jacobs, 1992). For the country as a whole, there are 42 mental hospitals with 21,000 beds, 2500 psychiatrists, 600 clinical psychologists, 400 psychiatric social workers and 600 nurses (Chandrasekhar, 1998). Almost all these are urban-based leaving the large numbers of the mentally ill in rural areas outside the scope of modern treatment practices.
Bangalore is rated as the fifth largest city in India with a population of 40,86,548 as per the 1991 Census (India, 1991) that is estimated to touch nearly 5.5-6 million in the year 2001. Acknowledged as the 'Silicon Valley' of India, Bangalore offers a typical example of a globalising Indian city — the urban prototype of the twenty-first century India, where the old is giving way to new institutions and systems that are more often ambiguous and uncertain if not non-existent. The demographic profile shows that the bulk of the population is youthful, about nearly 33 per cent fall in the 15-45 age group and nearly 35 per cent are below 15 years in age. Though the literacy levels are 69 per cent, well above the national figure of 36 per cent, the living facilities indicate that 45 per cent of the people live in single room shelters (Srinivasa Murthy, 1997). Going by the national distribution of the chronic mentally ill population to the total, we can put the Bangalore figure of the mentally ill at a rough estimate of 8000 to 9000 (Srinivasa Murthy, 1997).

Bangalore is believed to be the 'Mental Health Capital' of India on account of the presence of National Institute of Mental Health and Neuro Sciences (NIMHANS). Besides, the largest number of half way homes, long term homes and other counseling services are available in greater numbers in Bangalore, than in any other city in India. In fact, many affected families have sold their properties elsewhere to settle down in Bangalore for purpose of treatment, especially in the NIMHANS. There are also a large number of private practitioners in the city. For many families, it is still a matter of stigma to be seen in the mental hospital at NIMHANS and, hence, prefer to go to the private psychiatrists.

There is nothing such as a National Health Care programme in India leaving the choice of doctors to the families. There are no community based health services in urban areas nor do the mentally ill receive any social security, as in many developed countries. This is partially responsible for the widespread phenomenon of the disabled living with their families. The recent enactment of the Persons with Disability Act of 1995, officially recognises mental illness as a disability putting this category on par with other disabilities. As such, the mentally ill are entitled to a monthly benefit of about Rs. 165/- (US$ 3.75 approximately) depending on the family's income levels.

Family care/support entails total involvement with the service seekers on a day to day basis. Viewed thus, there is no doubt at all that Indian families top the list, though much is to be desired on the quality
of care itself. The co-residence of users with their families is necessitated by economic conditions familiar to developing countries such as India with nearly 40 per cent living below the poverty line. Absence of community based rehabilitation facilities and state supported services for the mentally ill, together with the fact that there is no social security or insurance of any sort, accounts for making families the sole caregivers of the disabled. Economic compulsions are overlooked in favour of bygone intellectual traditions that glorify Indian family values and virtues. There are several cases of mentally ill persons being thrown out on the streets due to the family’s inability to continue its caregiving role. These changes need to focussed more in any partnership efforts among the carers.

CHANGES IN INDIAN FAMILIES

In a global study conducted by World Health Organisation in 1973 on patient outcomes, the findings pointed out that the Indian patients do well on account of tremendous support from the families. The time has, however, come to ask at what costs do the families cope up? Current sociological and demographic changes taking place in the Indian society have a direct bearing on family needs and hence treatment policies and processes. This insight is important to understand the existent and emergent role of family support in India which is acclaimed the world over for its total involvement in the treatment, right from the stage of consultation to rehabilitation phases. The family system in terms of structure, pattern, role relationships, obligations, values and norms varies according to diverse factors rendering it a highly differentiated and heterogeneous social entity. Accordingly, the impact of the wider society is also not uniform across all family types. Furthermore, some professionals tend to judge family support based on the criteria of joint versus nuclear structure to the exclusion of quality of life for the wards under these systems, that is are they treated with respect and dignity or contempt and disgrace. These are equally important treatment variables that are in urgent need for sociological demystification for proper care of the mentally ill. The official emphasis on small family norm has reduced the family size especially among the urban educated middle class, and perhaps some rural families with urban exposure. In fact, the debate over what is rural and urban itself is still unresolved by the intellectuals. The increasing influx of women into the organised employment sector has also added to the reduction of family size resulting in depletion of in house humanpower resources.
The shrinking size of family, combined with migratory movements among the younger generation, has left the family bereft of a second generation of care givers. Rise of individualism has been accompanied by gradual erosion of joint family obligations. As a result, either the families do not have sufficient care givers, or even if they have they are not caring enough. Be it an urban or a rural family, the shrinking size of the Indian families is becoming increasingly clear: not sufficient numbers are available to give care to the persons with disability. The paucity of existing mental health care facilities results in thrusting families to the forefront of caregiving services.

Is the picture of rural India different from urban India? The problem is likely to affect rural families as well, due to migratory compulsions, factional politics within families, poverty or land disputes, increasing political consciousness among rural women, and, finally an unmistakable tendency to imitate urban lifestyles. In general, most siblings or even relatives do not mind long distance care and even financial support as the question of extending home based care in one's own household has become a difficult proposition as a result of the rise in employment of women. The absence of the traditional nurturers in the family worsens the situation for the disabled. We know of enough cases where the service seekers are made to circulate between the various half way homes, one year at a time, as a substitute for family care. This sounds like a paradox that merits the attention of a full fledged research — a country that-boasts of glorious family legacies is not able to provide shelter for their schizophrenic members. The problem is already assuming serious proportion as is evidenced by the mushrooming growth of long term/life long term homes, especially in urban areas. One wonders whether the schizophrenics are victims of India's economic modernisation and global growth.

The elaborate account of the changes in the structure and function of the Indian family mentioned above is essential for us to appreciate the extent to which families discharge their caring obligations effectively. The burden of care already involves coping with the day to day needs of the patient besides managing crisis situations; worse still, the anxieties associated with the future care of the wards when the natural caregivers are no more. By and large, most patients stay with the families, and in many cases, due to financial and other family issues, the service seekers do not go through any formal rehabilitation programme, except what is practically available everyday wisdom in the community. Probably, in some ways, this proves as effective if not
more than formal rehabilitation inputs. These comparisons are informally discussed as matters of top priority in AMEND during its meetings but many families, if given a choice, seem to be comfortable passing on the burden of care to rehabilitation professionals.

In AMEND, care is practised at two levels; namely, day to day involvement with one’s own family member(s) suffering from mental illness that involves visits to the psychiatrist, administering medicines, developing a structure for the patient as part of home based rehabilitation, monitoring the patient’s schedule, supervising personal hygiene, engaging in recreational indoor/outdoor activities with the patient. In certain cases, some of the families accompany the wards to their schools or offices as the case be. In the event of hospitalisation, the patients are never left alone in the hospital, except under exceptional circumstances. This is true in the case of almost all the families, whether they are AMEND members or not. Most of them have the privilege of eating food prepared at home and brought to the hospital. Families also take care of patient hygiene and occupational therapy, if advised by the doctor. There are instances of the member families helping each other for hospital visits, and so on. At the group level, care becomes an advocacy issue that involves information dissemination about the nature and types of mental illness, other legal aspects such as the rights, dignity and safety of the mentally affected individuals. In this respect, care constitutes the core of AMEND’s activities with various sections of the community. The four major principles guiding our partnership strategies are educate, enrich, empower and enable.

LEVELS OF CARE

Partnership with Families outside AMEND

This is done purely on a voluntary and informal basis because, as of now, we do not have any organised forum with the service seekers or families who are not AMEND members. Starting from simple telephone calls to home visits, quite a few families are involved in engaging themselves with the patients in other families. The topics of concern, at times, shifts to informal and friendly guidance to cope with the ailment, drug compliance, adjustment with family members, maintaining a schedule, and so on. The most important message sent across to the families is love and respect for the mentally affected. The AMEND Annual Day is an important occasion for all the families and
the service seekers to meet each other, participate in sports and other activities of recreational interest. As a matter of principle, families are strictly forbidden from discussions on medicines and doctors during the celebration. Recently, a few patients (or users as we call them) have been included as part of the task force to work on the new disability legislation. Also, networking among the patients, especially for recreational activities, is gradually becoming a routine weekend activity.

**Partnership within AMEND**

Emotional support, learning through sharing, caring for the well-being of the family members constitute the core of AMEND's genesis and growth as a self-help group. Soon after its formation, it was found that in order to extend support to the consumers it was necessary for us to establish our group beyond interpersonal family concerns to emerge as a change agent in the mental health scenario in Bangalore. To facilitate such a role meant taking up more and more of advocacy issues involving medical, legal and various aspects related to the well-being of our consumers. However, advocacy was not possible without the internal core of emotional support and care within the group. In other words, to evolve as a like minded team from a loosely knit group characterised by grief, confusion and guilt is a constant challenge that we face as part of our growth process. The older members of AMEND have taken it upon themselves to ensure that the process is kept alive by holding regular meetings with family agenda topping the list. The following measures are adopted by us as part of broadening the base of partnership of care.

1. Identify needs of affected families and respond to the same by providing emotional support, problem solving and coping skills and practical help wherever possible.
2. Social visits among families.
3. Formal ventilation sessions that encourage families to share experiences/hold grief sessions if possible and seek help from other members through sharing and learning.
4. Informal/friendly guidance and advice to family members in trouble; supplemented with help to get additional professional help.
5. Share and provide updated information from various sources including personal experiences on medicines, side effects of drugs, and so on.
6. Provide guidance on rehabilitation services/cost/quality of care, and so on. AMEND has made a pioneering contribution to the empowerment of families and patients by launching training programmes that suit the respective needs of each. These packages are mainly skill based inputs designed to suit the felt needs of both.

**Partnership with Professionals**

Though AMEND was started in 1992, it took nearly three to four years to be identified as a movement that was making the difference in the mental health map of the city. The most fortunate aspect of its formative years was the immense help received especially from the professionals of NIMHANS. In fact, when news of the AMEND inauguration day was announced in the local news dailies, psychiatrists, psychiatric social workers and psychologists from NIMHANS attended the function without any prior invitation. Subsequent interactions developed into an excellent collaborative model of functioning between the families and the professionals. Today, AMEND is given its due recognition in all the academic forums. There are three levels of interaction between AMEND and the professionals.

**Information Exchange**

Professional help comes in a big way with information on the latest drugs that are locally made available, legislative enactments about mental illness, and so on. We, as families, offer information on our day to day experiences on various issues including stigma, coping styles in crisis, managing care, family needs and problems related to patient management, and so on. There are no formal methods of communication such as newsletters. Hence, concerned professionals are invited to give a talk to our members and if the topic is of vital importance, the lectures are thrown open to the public.

**Action**

There is an implicit support from all professionals for the advocacy issues taken up by AMEND. For instance, when import of clozapine had become an agenda with the Drug Controller of India, psychiatrists who had experience with clozapine trials backed us by supporting our claims with documentary reports. Similarly, AMEND's participation in various national and international fora has been largely due to initiative from professionals in the field. Some professionals participated
shoulder to shoulder with the families and their wards in the freedom rally that was organised by the disability network of Bangalore.

Implementation

At this level, the interaction between families and professionals involves certain inputs that are perceived to be of direct help in the short and long term management of the service seekers. The training programmes mentioned above is a hallmark of partnership between AMEND and mental health professionals, especially from the NIMHANS. Recently, another major milestone in partnership has been the formation of the Karnataka Association for Psychiatric Disability at the instance of AMEND's initiative to form a mental health lobby in the country.

Partnering Care with the Community

As the only self-help group for families of the mentally ill, AMEND can not remain isolated from the existing community based institutions of rehabilitation. Compelled by the existing circumstances of patient management on one hand, and the cause as an issue by itself on the other, AMEND has spread its fragile wings far and wide into the community.

1. Network with other disability groups in the city.
2. Network with other self-help groups in other cities like Aasha in Chennai and World Schizophrenic Fellowship in Canada. AMEND is taking a leading part in the formation of an apex body or a federation of mental health associations in India in response to the initiative taken by Aasha.
3. AMEND got the National Human Rights Commission (NHRC) in India to take up the cause of the mentally ill as a special subject following which, the NHRC has now set up a special mental health cell. It also took up the delay in implementation of the Disability Act based on the petition submitted by AMEND.
4. Enormous amount of liaison work is being done with the local and central governments in connection with the new Disability Act that officially recognises mental illness as a disability on par with others. The local state government has granted AMEND's request for representation of the mentally ill in the state level committee by nominating a professional of its choice. A seminar to promote awareness of mental illness among the state officials was also undertaken recently.
5. Part of AMEND'S awareness campaign is to educate teachers in schools and colleges on mental illness and all related matters.
6. Media contacts are also an important aspect of our involving the community in the area of the mentally ill, though it is yet to emerge as an organised effort.
7. Home visits by counselors from the Medico Pastoral Association's psychiatric counseling centre, has been arranged for AMEND families interested in availing of such a facility.

The elaborate account of efforts by Indian families as carers and supporters shows that it is unique as compared with developments in the West and other European countries. Consumers in India are an essential part of the family and social milieu in which the efforts are being made. Although consumer empowerment, as compared to the West, is much less, the Indian family provides the basic backbone of treatment, rehabilitation and subsequent integration into the community. India is a land of festivals with nine months in the year identified as festive seasons that offers a social landscape for the families to participate in the affairs of the community. However, unlike in the case of other disabilities, families of the mentally ill tend to isolate themselves for fear of ridicule, stigma and social ostracism. As a result, there is certain amount of discomfort in the community linkages which, in turn, affect a patient's well-being. Awareness of mental illness is still steeped in superstitious beliefs making the victims targets of public humour, ridicule and wrath. Paucity of community based rehabilitation facilities and total absence of state funded/alternate care institutions inevitably makes the family assume the major responsibility (which is fast turning out to be a burden) as a striking contrast to the Western models. There is a higher level of interaction between the families and the patients in India, though not necessarily a higher degree of quality of life for the patient because, the families' caretaking responsibilities are, at times, stretched beyond limits of human tolerance.

However, in order to discharge the responsibilities of care, the families have to work in tandem with the others, especially professionals, and rest of the community. Still more, the needs of the families have to be fulfilled in order to facilitate their inputs of support and care. Viewed thus, one finds certain major roadblocks that retards the pace of development.
BARRIERS TO PARTNERSHIP

Sociocultural Constraints

The attributes of the wider sociocultural environment has an inevitable impact on the success of the partnership model. Hierarchy is a salient feature of the Indian society characterising most of the interpersonal relations including those in the family. This, combined with respect for authority and professional wisdom (especially for the healing profession), makes the families believe in the superiority of professional knowledge as the only solution to the problems on hand. On the other hand, there are also instances when families feel that they are not able to communicate with the professionals for fear of disturbing the apple cart. On their side, the professionals also find it an equally strange experience to share the forum with families as they are comfortable writing down prescriptions. On most occasions, the relationship between the professionals and families are characterised by the tutor and the taught, instructional rather than participative approach. Many families, including users, feel that the doctor-patient or family bond is a power rather than partnership equation. Consciousness, as a category, is not as sharply crystallised as in the West to identify the power 'imbalances' characterising the relationship. As a result, very few families feel the need for empowerment to facilitate participative encounters. The formal and closed pattern of interaction, familiar to the sociocultural milieu of Indian society, results in the persistent presence of the old order. For a country with deep rooted primordial ties (based on caste, religion, language, and so on), secondary group affiliations based on acquired status factors (like membership in AMEND) are not familiar every day experiences. Worse still, is the case of groups like AMEND wherein the mobilisation of family power is around a cause that is charged with social stigma. There are many instances where individuals joined AMEND as volunteers to begin with, and subsequently acquired membership identity once they got comfortable in the group. The resultant implications for advocacy movement is clearly seen in the sense that the families in India are more family/user driven than cause/issue driven because of the relative openness required from the latter. While this is a major deterrent to the family movement, the increasing emotional and physical isolation experienced by many families from their kith and kin has made some members acknowledge AMEND as their adopted family. Crystalisation of a new identity in the offing cannot be identified on par with
the nature and degree of advocacy commitments among the family members in the West. At the same time, for a developing country with high levels of illiteracy and total absence of structured psychosocial family education, the involvement and role of the families, at least with their own respective wards, is not as bad as it could have been. In fact, the caring role of the family as a counselor, companion, caregiver, at times, goes to the extent of even becoming an employer.

Belief Systems

Prevailing attitudes and beliefs about disabilities as fate or *karma* beyond human control also acts as an impediment and erodes the self-confidence of family members in engineering treatment outcomes and patient management. The intensity of the belief is not so widespread now as it was in the past; yet, it accounts for certain amount of fatalism and apathy that come in the way of the family playing a proactive role on par with the professionals. In fact, many a times, even professional indifference or mishaps are overlooked through rationalisations as *karma*. At the same time, we must concede the fact that belief in *karma* helps in developing an empathetic and guilt free outlook for the affected persons by the family members (Shanker, 1998) Moreover, based on AMEND's experience, that is also corroborated with evidence from other research studies, it is clear that the family perceptions are dominated by the bio-medical model (Shanker, 1998). This, in turn, affects the family's self-image as a carer (or curer?).

Historical Legacies

Even after 50 years of India's independence from the British, one sees an unmistakable presence of the colonial mentality nurturing dependence as a national character of Indians. There is hardly any realisation among a large number of families that, as the major caregivers of the mentally ill, their contribution can bring about a decisive change in the quality of the services. The dependence mentality not only affects the family initiative, but also percolates down to even activities in self-help groups. Inadequacies in the mental health services, leading to unmet family needs, reinforces submissive and passive outlook. The absence of a civil rights discourse, backed up by the forces of bureaucratic hegemony of the state, in popular grassroots inertia unlike groups like NAMI in the United States or the WSF in Canada. Moreover, lobbying for the mentally ill as a disabled group is a recent phenomenon in India. While there is relatively greater exposure in Bangalore, and other
southern cities, by and large, the mentally ill have been a largely neglected segment of the society. As compared with the highly politicised and activist lobbies of other disabilities like the visually impaired, the cause of the mentally ill is not only recent, but suffers from social stigma as well. The combined effect is to delay the process of grassroots activism essential to the care of the disabled.

**Psychological Constraints**

India is traditionally a role and rule bound society, an attribute that was strengthened further by the influence of British bureaucracy. A doctor is expected to confine his/her services to treatment and prescription just as the patient is expected to follow that treatment. Hence, cure becomes the doctor's responsibility and care becomes the family's duty — a perception that was found in the Chennai study (Shankar, 1998). The cure-care dichotomy, as perceived by the families, poses a psychological barrier for the self-perception of families as partners in care over and above their traditional role as nurturers. The current expectation from families as caregivers demands more commitment and proactive involvement on an individual and collective basis contrary to the customary beliefs and practice. Once again, this transformation takes its own course due to cultural predispositions. The entire responsibility of treatment is perceived to be the domain of the doctor and families do not go to the extent of even referring or reading literature relevant to the well-being of their wards.

Yet another familiar experience in is the fact that there is no free expression of emotions, except within the context of role achievement and fulfillment. In other words, role clarity is an important precondition for emotional transactions especially in the hierarchical, authority based relations like parent-child. Praise is marked by achievement just as anger by failures. In the case of affected families where one or more members suffer from mental illness, role clarity is superseded by role fuzziness affecting normal emotional transactions customary to Indian culture and society. The families need tremendous amount of exposure to develop 'stroking' techniques that are essential to enrich feelings among the mentally affected persons.

**CONCLUSION**

It is interesting to note the pattern of care emerging from the Indian experience as portrayed by AMEND's case history. As an academic model, it throws new light on the question as to whether we can have
universal models of partnership or country and culture specific ones. In turn, this raises some pertinent questions for the family movement as a global endeavour. If schizophrenia is believed to be a leveling experience for the victims, it is equally so for the families across countries and cultures, hence not withstanding academic debates and models, families pursue the cause with their own homespun wisdom based on everyday experiences.

NOTE

The data given in this section is based on a paper written by me in 1997.

REFERENCES

Chandrasekhar, C.R. 1998  

Shankar, R. 1998  

Srinivasa Murthy, R. 1997  
The City of Bangalore, India. Paper Presented at the Mental Health in the City Conference, London: King's Institute of Psychiatry.

Srinivasan, N. 1998  

Wolin, S.J. and Jacobs, J. 1992  