1 **Family Therapy in Mental Health Care: A Narrative Review with Indian Contextual and**
2 **Psychiatric Social Work Perspectives**

3 **Abstract**

4 Family-based interventions have broadened from early systemic work in psychosis to encompass
5 a range of approaches for mood disorders, developmental and behavioral conditions, and
6 substance-related problems. This review integrates core theoretical models (e.g. systems theory,
7 communication patterns) and clinical schools of family therapy (structural, strategic, Bowenian,
8 experiential, cognitive-behavioral, and family-focused therapies) with an emphasis on evidence
9 and relevance in contemporary practice. We highlight key therapeutic mechanisms such as
10 lowering expressed emotion, enhancing communication and problem-solving skills, and
11 bolstering family support of treatment adherence. Sociocultural and resource factors that shape
12 family involvement in settings like India are examined, and the critical role of psychiatric social
13 workers in assessment, education, intervention delivery, and advocacy is discussed. Challenges
14 related to limited specialized training, engagement and ethical complexities are reviewed.
15 Emerging directions, including culturally adapted practice and telehealth-enabled family work,
16 are described. Overall, this narrative review argues that family therapy is an essential component
17 of person-centered, recovery-oriented mental health care, especially in contexts where families
18 remain primary caregivers and supports.

19 **Keywords:** Family Therapy, Family-based Interventions, Systemic Therapy, Indian Mental
20 Health, Psychiatric Social Work

21 **Introduction**

22 Family systems theory highlights that mental health problems are often intertwined with the
23 family context rather than arising purely from individual pathology (Watson, 2012). From this
24 perspective, a change in one family member unavoidably affects others, and the family is seen as
25 a dynamic emotional unit with interdependent parts (McGinnis & Wright, 2023).
26 Psychopathology can thus be viewed as emerging from transactional patterns (repeated stress
27 responses, entrenched communication cycles, role assignments) that involve feedback loops and
28 circular causality (McGinnis & Wright, 2023). By addressing these interactional patterns, family
29 therapy (FT) seeks to shift the focus from a single "identified patient" to the entire relational
30 network sustaining distress. This systemic view aligns closely with practice realities in low- and
31 middle-income countries like India, where multigenerational households and collective
32 caregiving are common, and families often bear primary responsibility for supporting individuals
33 with illness (Hahlweg & Baucom,2023). In such settings, strengthening family support,
34 improving coping and communication, and reducing family-based stress (e.g. expressed
35 criticism) can substantially influence illness course, relapse risk, and long-term recovery.

36 **Method and Scope of This Narrative Review**

37 This narrative review uses an integrative, conceptually driven approach. Sources were identified
38 through targeted searches in databases (PubMed, Scopus, Google Scholar) and relevant
39 textbooks/handbooks, focusing on both foundational theory and recent empirical work. We
40 included seminal publications as well as current review articles and randomized trials across
41 major psychiatric diagnoses, with attention to work from low-resource contexts and Indian
42 mental health practice. Unlike a systematic review, we did not follow strict inclusion criteria or
43 PRISMA guidelines; instead, we prioritized conceptual relevance and clinical significance. The
44 goal is to synthesize existing knowledge about family therapy principles, models, and evidence
45 and to interpret this knowledge through the lens of Indian cultural and service contexts. The
46 review emphasizes contextual factors that influence how family therapy is delivered and adapted,
47 and it highlights the role of psychiatric social work in implementing family-based care.

48 **Conceptual Foundations: Why Families Matter in Mental Health**

49 **Family systems and circular causality:** Modern family systems theory conceptualizes the
50 family as a social system in which members' behaviors and emotions are mutually
51 interdependent. It posits that individual symptoms or problems often develop in response to
52 family-level processes rather than existing in isolation. For example, a child's anxiety may be
53 both influenced by and contribute to parental worries, in a bidirectional cycle. Such transactional
54 models emphasize circular causality: an event (e.g. conflict escalation) triggers reactions that
55 feed back to the original cause, maintaining or amplifying distress. Under this view, mental
56 health difficulties are seen as emergent properties of ongoing family interactions, such as chronic
57 conflict cycles, dysfunctional communication patterns, and rigid role assignments, rather than the
58 product of a single linear cause (McGinnis & Wright, 2023). This helps explain why, for instance,
59 treating only one family member without addressing the family context often yields limited
60 results. By contrast, interventions that alter communication and relationships can disrupt the
61 vicious cycles that sustain symptoms.

62 **Interaction patterns, boundaries, and hierarchies:** A central idea across many systemic
63 models is that dysfunctional family organization contributes to problems. Structural family
64 therapy, for example, focuses on family boundaries, the rules governing who is involved in
65 which interactions and hierarchies, the power or authority structure among family subsystems.
66 Healthy families tend to have clear but flexible boundaries, allowing each member personal
67 autonomy while still offering mutual support. In cohesive families, boundaries around parent–
68 child and spousal relationships are neither too rigid (isolating members) nor too diffuse (leading
69 to over-involvement). Dysfunction can arise when boundaries are unbalanced: enmeshment
70 (over-diffuse boundaries) produces emotional fusion and dependency, whereas disengagement
71 (over-rigid boundaries) isolates family members. Highly enmeshed families are characterized by
72 pervasive involvement: family members are overly entangled in each other's activities and
73 emotions, with limited personal space (Coe et al., 2018). In such systems, children may be drawn
74 into adult problems or spouses may skip over one partner to involve a third (forming coalitions).
75 These patterns can misalign authority (for example, a child assuming a parental role) and prevent

76 individuals from functioning independently(Coe et al., 2018). By mapping these patterns and
77 altering them (e.g. strengthening spousal boundaries, realigning parental leadership), structural
78 approaches aim to reorganize the family so that symptoms no longer serve a family function.

79 **Expressed emotion and relapse:** Decades of research have established expressed emotion (EE)
80 as a powerful predictor of outcomes in severe mental illness. EE captures critical, hostile, and
81 overinvolved attitudes that relatives may express toward a patient. Notably, patients returning to
82 families rated "high-EE" (with frequent criticism or intrusive care) face much higher relapse
83 rates than those returning to low-EE households (Hahlweg & Baucom,2023). For instance, one
84 classic finding is that patients discharged to high-EE families were about 2.5 times more likely to
85 relapse than those in low-EE settings (Hahlweg & Baucom,2023). Family therapy often explicitly
86 targets EE by helping relatives reduce criticism and learn supportive communication.
87 Interventions that successfully lower EE, through education about the illness, cognitive
88 reframing of patient behaviors, and improved coping have been associated with significantly
89 better outcomes in schizophrenia and other conditions (Rodolico et al., 2022; Hahlweg &
90 Baucom,2023). In fact, a recent network meta-analysis concluded that most structured family
91 intervention programs, even if differing in specifics, significantly reduce relapse rates in
92 schizophrenia compared to standard care (Rodolico et al., 2022). By addressing the emotional
93 climate (criticism, blame, overprotection) within which patients live, family therapy breaks one
94 of the key psychological stressors that precipitate symptom recurrence.

95 **Development of Family Therapy: From Classic Schools to Evidence-Based Practice**

96 Family therapy emerged in the mid-20th century as clinicians recognized that traditional
97 individual-focused psychiatry was not fully addressing chronic mental illness. Early pioneers
98 influenced by systemic thinking and communication theories, proposed that problems like
99 schizophrenia might be maintained by family interaction patterns (such as the "double bind"
100 hypothesis). However, these early theoretical formulations often stigmatized families and yielded
101 limited direct benefit. With the advent of antipsychotic medications in the 1950s, patients were
102 discharged sooner and families faced higher caregiving burdens. This shift spurred the
103 development of psychoeducational family programs: by the 1970s and 1980s, numerous
104 randomized trials showed that such programs could dramatically cut relapse rates (for example,
105 lowering 1-year relapse from roughly 50% to 13% in some studies) (Hahlweg & Baucom,2023).
106 From that point on, multiple schools of family therapy flourished. Structural (Minuchin) and
107 strategic (Haley) models focused on reorganizing family subsystems and hierarchies, while
108 Bowenian therapy emphasized individual differentiation within the family system. Experiential
109 therapies (Satir, Whitaker) highlighted emotional expression and growth. By the 1990s,
110 cognitive-behavioral and problem-solving models were adapted for families, and disorder-
111 specific packages like Family-Focused Therapy (for bipolar disorder) were developed and
112 empirically validated (Hahlweg & Baucom,2023; Berry et al., 2023).

113   As the evidence base grew, family therapy became recognized in clinical guidelines for many
114   conditions. For example, the National Institute for Health and Care Excellence (NICE)
115   recommends offering family intervention to all patients with psychosis who are in close contact
116   with relatives (Hahlweg & Baucom,2023). Family therapy techniques have also been integrated
117   into youth services, substance use treatment, and child welfare programs. Thus, what began as
118   "systems-informed" clinical curiosity has evolved into a diverse set of evidence-based
119   approaches that target relational factors across diagnoses.

120   In India, structured family therapy has developed more recently, building on centuries-old
121   traditions of collective caregiving but with few early formal programs. Historically, Indian
122   families (often joint or extended) took primary responsibility for members' emotional problems,
123   using elders and community networks in lieu of formal mental health care. The first systematic
124   initiatives in family-based treatment are attributed to Dr. Vidyasagar and colleagues, who in the
125   1950s and 1960s introduced family interviews on psychiatric wards in Amritsar (Sovani, 2018).
126   NIMHANS in Bangalore and a few other institutions offered occasional family sessions and
127   informal training in the 1970s, but a dedicated academic discipline took time to emerge. The
128   Indian Association of Family Therapy (IAFT), founded in 1991, represents a milestone in
129   cultivating training and practice standards (Sovani, 2018). Nevertheless, specialized education in
130   family therapy (e.g. full-degree programs) remains limited, and many practitioners learn
131   systemic skills ad hoc. Despite these gaps, scholars note that basic family therapy principles
132   resonate well with Indian values of connectedness and shared responsibility. Structured family
133   interventions have been introduced in India primarily through Western models, which have often
134   been informally adapted to fit cultural norms and extended household arrangements. For
135   example, joint-family decision-making may shift therapy goals, and culturally sensitive
136   communication is essential when discussing issues like intergenerational conflict or stigma. In
137   recent years, research and clinical reports have begun to demonstrate the feasibility of family-
138   psychoeducation and problem-solving approaches in Indian settings, suggesting the potential for
139   wider uptake if challenges (e.g. stigma, workforce limits) can be overcome (Sovani, 2018; Raj et
140   al., 2025).

141   **Major Schools and Core Clinical Mechanisms**

142   Over the decades, multiple formal models of family therapy have been articulated. Although they
143   differ in techniques and theory, they share a systemic orientation. Below we summarize key
144   schools and their central strategies:

145   **Structural Family Therapy (SFT):** Developed by Salvador Minuchin, SFT conceptualizes
146   problems as by-products of dysfunctional organization within the family system. Therapists
147   assess family structure by observing interaction patterns (e.g. alliances, boundaries) and then
148   enact changes (through enactment techniques) to strengthen appropriate subsystems. For
149   instance, a therapist might intervene to realign a parent–child hierarchy or clarify boundary rules.
150   Techniques include mapping (genograms, family sculptures) and active engagement to

151 restructure family roles (Minuchin, 1974). The goal is to create clear, healthy boundaries and
152 hierarchies, for example, reinforcing parental authority over decision-making so that children are
153 not burdened with adult problems. In India, Minuchin's ideas of boundaries resonate culturally,
154 as discussed by Indian authors who note that joint family structures often blur generational lines
155 (Sovani, 2018). However, clinicians adapt SFT flexibly; for example, rather than directly
156 challenging elders, they may use extended family coalitions to support change.

157 **Strategic Family Therapy:** This approach (pioneered by Jay Haley and influenced by Erikson)
158 uses a problem-solving, directive style. The therapist deliberately prescribes tasks or paradoxical
159 interventions to disrupt maladaptive patterns(Haley, 1976). For example, a strategic therapist
160 might instruct a family member to continue a symptom or to exaggerate a conflict in session, in
161 order to produce insight or break repetitive cycles. Strategic therapy emphasizes power dynamics
162 and often uses brief, goal-oriented directives. It is generally pragmatic: therapists quickly
163 identify repetitive patterns that maintain the problem and assign homework to interrupt them. In
164 cross-cultural practice, elements of this model (pragmatic advice or role-playing) can fit well in
165 Indian contexts where families appreciate concrete guidance(Varghese et al., 2020). However,
166 therapists must be cautious of cultural norms: heavy-handed directives may be less acceptable in
167 hierarchical families, so local practice often blends strategic techniques with gentle
168 psychoeducation.

169 **Bowenian (Family Systems) Therapy:** Bowen's model centers on individual differentiation
170 within the family emotional system. It posits that anxiety and reactivity can cycle through
171 generations unless individuals become more differentiated (less emotionally fused). Key
172 concepts include the multigenerational transmission process and the family projection process.
173 Bowenian therapists often work with one person (the identified patient) but within a genogram-
174 informed context that examines family-of-origin patterns across generations(Bowen, 1978). The
175 idea is that understanding familial patterns and learning to self-regulate emotional reactivity
176 (rather than reacting to others) can change the system over time(Brown & Errington, 2024).
177 Techniques might include coaching a client to maintain a calm, rational position during heated
178 family discussions. While Bowenian therapy is less directive, its emphasis on long-term process
179 and education about family-of-origin issues has appealed to many psychiatric social workers.
180 Nonetheless, critics argue it can be slow and abstract; in India, the emphasis on generational
181 legacy may resonate, but practical barriers (large families, busy lifestyles) often mean therapists
182 use hybrid models instead.

183 **Experiential and Humanistic Family Therapies:** Represented by thinkers like Virginia Satir
184 and Carl Whitaker, these approaches focus on emotional expression, creativity, and the growth
185 potential of each family member. Satir's Conjoint Family Therapy, for example, emphasizes
186 validating emotions and building self-esteem, often through metaphors, role-plays, and sculpting
187 exercises. Whitaker's symbolic-experiential approach allowed chaotic expression (e.g. through
188 art or movement) to shake up stagnant patterns(Whitaker & Keith, 1981). These models assume
189 that positive change occurs when families experience genuine connection and self-awareness. In

190 an Indian context, the humanistic emphasis on harmony and warmth fits well, but some
191 techniques (like Satir's family reconstructions) may be adapted to ensure cultural sensitivity.
192 Both Satir and Whitaker trained many therapists; their basic tenet, treating the family as a whole
193 person underlies much of family therapy's ethos(Satir, 1983).

194 **Cognitive-Behavioral Family Therapy (CBFT):** These approaches incorporate CBT principles
195 into systemic work. Rather than focusing on unconscious processes, CBFT targets dysfunctional
196 beliefs, communication styles, and behaviors that maintain problems. Typical interventions
197 include structured psychoeducation, skill-building (communication training, problem-solving),
198 and behavioral contracts(Dattilio, 2005; Friedberg, 2006). For example, a therapist might teach a
199 family how to express negative thoughts without criticism, or assign exercises for practicing new
200 responses to triggers. Empirically, CBFT has been applied to a wide range of issues (depression,
201 anxiety, ADHD) and can be quite structured. In clinical practice, many programs for adolescent
202 issues or stress management use CBFT modules (Friedberg, 2006). For instance, a family
203 intervention for pediatric anxiety might involve teaching parents how to reinforce brave behavior
204 and not accommodate avoidance. Such structured programs can be well-received, especially
205 where time is limited and concrete strategies are valued.

206 **Family-Focused Therapy (FFT):** Originally developed for bipolar disorder (Miklowitz &
207 Goldstein,1997), FFT combines psychoeducation with skills training(Miklowitz et al., 2000). It
208 typically includes 21 sessions over 9 months: first educating family members about bipolar
209 symptoms and medication, then enhancing communication, and finally teaching collaborative
210 problem-solving(Miklowitz et al., 2000; Miklowitz & Goldstein,1997). Strong evidence shows
211 that FFT added to medication improves outcomes in bipolar patients, likely by stabilizing family
212 support and early warning signaling. FFT has since been adapted for high-risk youth, depression,
213 and other conditions. In effect, FFT is a hybrid that reflects CBFT and strategic elements
214 (structured sessions, use of homework) grounded in a systemic framework. Its emphasis on
215 relapse prevention and monitoring (e.g. spotting early mood shifts) is particularly relevant to
216 chronic conditions where family stress often precipitates episodes.

217 **Evidence and Applications Across Major Mental Disorders**

218 A robust evidence base now supports family interventions in multiple psychiatric conditions,
219 especially when measured against treatment-as-usual.

220 **Schizophrenia and Psychotic Disorders:** Family interventions for schizophrenia have some of
221 the strongest empirical support in mental health. Numerous meta-analyses and Cochrane reviews
222 show that adding family therapy or psychoeducation to medication substantially reduces relapse
223 and rehospitalization(Pharoah et al., 2010). For example, Rodolico et al. (2022) found that
224 virtually all structured family programs (whether brief psychoeducation or longer multi-family
225 therapy) lowered 12-month relapse rates much more than standard care. Mechanistically, these
226 programs appear to work by lowering relatives' high expressed emotion and improving their
227 coping skills, for instance, reframing patient behaviors more positively and establishing steady

228 medication routines(Dixon et al., 2010; Falloon et al., 1984). Trials in diverse settings (including
229 India) confirm that family psychoeducation can improve adherence and reduce symptom severity
230 compared to pharmacotherapy alone. In practice, many schizophrenia programs incorporate at
231 least brief family contact or education: for example, a common approach is a multi-session
232 "family management" program teaching signs of relapse and communication skills, which
233 caregivers report as empowering and protective.

234 **Bipolar Disorder and Mood Instability:** In bipolar disorder, family-focused treatment (FFT)
235 was shown in landmark studies to increase time between episodes and reduce mood symptoms
236 (Berry et al, 2023). FFT's three-pronged approach (psychoeducation, communication, problem-
237 solving) aligns with what families need during mood swings namely, understanding the illness,
238 reducing blame, and co-managing triggers (e.g. sleep disruption or conflict)(Miklowitz et al.,
239 2020). In youth at high risk for bipolar, recent trials demonstrated that adding FFT delayed onset
240 of episodes and lowered suicidal thoughts (Berry et al, 2023). Clinicians find FFT particularly
241 useful when a patient's relapse is linked to family stress or routines being disrupted, since FFT
242 explicitly monitors early warning signs and sets up coping plans. Compared to schizophrenia
243 interventions that broadly target EE, FFT is disorder-specific but still views symptoms (e.g.
244 mania, depression) as interwoven with family dynamics. In sum, bipolar family interventions
245 have consistently shown better mood stability and enhanced engagement in care.

246 **Depression and Anxiety:** Family processes (such as chronic marital conflict or parental over-
247 involvement) play important roles in unipolar depression and anxiety, although most
248 interventions are still delivered individually. When families are engaged, therapy can reduce
249 relapse risk and improve recovery. Cognitive-behavioral family therapy or systemic approaches
250 address maladaptive interaction styles that may perpetuate a relative's depression, for example, a
251 parent who constantly criticizes or a spouse who avoids conflict. By changing communication
252 (e.g. encouraging supportive affirmations instead of reproach) and clarifying roles (so that, say,
253 adolescent routines are more consistent), family work can create an environment less conducive
254 to relapse (Dattilio & Epstein, 2005; Carr, 2019). While large trials are fewer than in psychosis,
255 meta-analyses indicate that family-inclusive CBT is as effective as individual therapy for
256 pediatric depression, and family psychoeducation modestly lowers relapse rates in adult
257 depression (Hahlweg& Baucom, 2023). Importantly, treating a depressed individual in isolation
258 sometimes overlooks stressors like caregiver burnout or adolescent-parent conflict; involving the
259 family can mitigate these sustaining factors. Thus, though not universally standard, systemic
260 approaches (including the addition of a few joint sessions) are increasingly recognized as
261 valuable adjuncts in mood and anxiety disorders.

262 **Child and Adolescent Disorders:** Family therapy is often **central** to child and adolescent
263 treatment, especially for behavioral problems. Disorders like oppositional defiant or conduct
264 disorder are embedded within complex networks of family, school, and peer influences. Two of
265 the best-studied programs are Multisystemic Therapy (MST) and Functional Family Therapy.
266 MST (designed for delinquency and severe conduct problems) involves intensive, home-based

treatment targeting multiple domains (family, peers, school, neighborhood) with heavy therapist involvement. It has consistently outperformed usual services at reducing recidivism and out-of-home placements. Similarly, Functional Family Therapy (Therapy for Youth, developed by Alexander and Sexton) combines engagement strategies with problem-solving to improve adolescent behavior (Alexander & Sexton, 2002). These programs use engagement, behavior planning, and generalization phases; for example, therapists may coach parents on consistent discipline, then reinforce progress in real-world settings. The evidence is strong: family-based treatments yield substantial reductions in arrests, substance use, and school dropout compared to alternatives. In community contexts, they also improve family functioning and parental mental health. For younger externalizing children, family management approaches (the traditional family management technique from early schizophrenia work) teach parents contingency management and monitoring.

Substance Use Disorders: Among adolescents, family therapy has one of the best records for substance use. Well-validated treatments include Brief Strategic Family Therapy (BSFT) and Multidimensional Family Therapy (MDFT), both of which showed significant reductions in drug and alcohol use in randomized trials. For example, Robbins et al. (2011) found that a brief BSFT model reduced adolescent drug use and improved family communication more than usual care. A broader review found that family therapies cut adolescent drug use by about 40% more than individual-based treatments (Horigian et al., 2016). Importantly, involving families also boosts retention: youths who attend even a few family sessions are far more likely to complete treatment, as shown in a quality-improvement study of telehealth intensive programs (Bery et al., 2023). Mechanisms include improving parental monitoring and support, enhancing coping with peer pressures, and resolving family conflicts that might trigger substance use. In practice, family sessions in addiction treatment often begin with engaging resistant parents (sometimes via strategic alliances) and then focus on rebuilding trust and communication. Emerging models also incorporate cultural adaptations; for instance, some programs tailor engagement techniques to fit the values of specific communities or use multi-family groups as a cost-effective format.

Eating Disorders: The clearest application in this area is Family-Based Treatment (FBT) for adolescent anorexia nervosa (often called the Maudsley method). FBT empowers parents to take charge of refeeding and weight restoration in the home, essentially mobilizing the family as the treatment agent. Adherence to the manualized approach is crucial: studies show that fidelity to FBT protocols strongly predicts recovery(Dimitropoulos et al., 2019). Meta-analyses and guidelines now position FBT as a first-line therapy for teen anorexia, with remission rates around 70% in efficacy trials. More recently, FBT has also been adapted for bulimia and other eating disorders with promising results. The core idea is that family members, particularly parents, can become highly effective allies in interrupting disorder-maintaining behaviors (binge-purge cycles) and are better positioned than individual therapists to enforce nutrition and support. Research continues on optimizing FBT delivery (teletherapy formats) and on partialization for older adolescents.

Family Therapy in India: Sociocultural Relevance and Practice Realities

Traditional Indian family life, often organized as joint or extended households, embodies a relational ethos that aligns well with systemic principles (Raj et al., 2025). Interpersonal roles are interdependent, decision-making is collective, and elders or community networks historically mediated conflicts and emotional issues. A recent systematic review of Indian family mental health (2015–2025) highlights that supportive family environments correlate with better recovery from illnesses like schizophrenia and depression, whereas family conflict and criticism significantly raise risk of depression, anxiety, and even suicidal behaviors (Raj et al., 2025). Shared caregiving (as in joint families) is associated with lower overall morbidity than more isolated nuclear settings. However, families also face unique stressors: for example, cultural concerns such as infertility and dowry disputes remain common sources of marital strain, and adolescents may be caught between traditional expectations and modern pressures (dual careers, migration) (Raj et al., 2025). In India, the stigma of mental illness can be especially stigmatizing; many patients and families hide symptoms or delay seeking help. Indeed, educational interventions that reduce stigma have been shown to significantly increase treatment uptake. Conversely, when families are well-informed and engaged, they often serve as crucial enablers of care in a system where 70–90% of people with mental disorders lack access to services (Raj et al., 2025).

Clinical incorporation of formal family therapy in India has been gradual. Initial psychiatric training was heavily influenced by Western models, but Indian scholars quickly noted that family therapy's core ideas (connectedness, collective responsibility) resonated strongly with Indian values. For example, the notion of working with families can tap into the cultural norm of joint family problem-solving. Training programs, notably at NIMHANS and some medical colleges, have introduced systemic interviewing and basic family intervention modules, improving clinicians' skills in assessing family dynamics(Shah et al., 2000; Sovani, 2018). Yet, access to specialized training and supervision in family therapy remains limited for most mental health workers(Shah et al., 2000; Sovani, 2018). Many practitioners still rely on learning through informal mentoring rather than formal courses.

On the service side, practice in India often blends Western FT techniques with local adaptations. For example, therapists may encounter resistance if multiple family members attend sessions (due to logistical issues or stigma), so sometimes they conduct separate subgroup meetings or home visits to gather collateral information. Families frequently prefer concise, practical interventions; thus, many Indian therapists adopt a brief family therapy mindset, focusing on immediate problems rather than long-term exploration. Specialized content is also tailored: Indian families are sensitively engaged around issues like arranged marriages or caste conflicts, and therapists are attuned to language and cultural idioms. In community and rehabilitation programs, family work often takes the form of psychoeducation workshops for caregivers (on handling symptoms and side effects) and linking families to social supports (disability benefits or support groups) (Raj et al., 2025). Parent-training programs (locally adapted Triple P or Positive

345 Parenting Program) have been used to improve child outcomes, reflecting a shift toward
346 preventive family interventions in public health settings (Varghese et al., 2002; Murthy, 2016).
347 These developments, along with growing evidence from India-specific studies, suggest that
348 family therapy principles can be effectively integrated within India's mental health system,
349 provided there is cultural sensitivity and system-level support.

350 **The Role of Psychiatric Social Workers in Family Therapy**

351 Psychiatric social workers (PSWs) are uniquely positioned to translate family therapy into
352 practice due to their dual expertise in clinical skills and knowledge of social systems. In many
353 Indian settings, PSWs function as the bridge between hospital-based care and community
354 reintegration. Key contributions of PSWs in family-focused care include:

355 **Comprehensive psychosocial assessment:**Comprehensive Psychosocial Assessment:
356 Psychiatric social workers (PSWs) in India routinely conduct detailed family assessments using
357 systemic tools. For example, Majhi et al. (2018) describe PSWs using family genograms to map
358 complex family structure and the biopsychosocial environment, including roles, communication
359 patterns, and supports. Similarly, Pillai and Parthasarathy (2014) report that NIMHANS PSWs
360 treat clinical problems as emerging from maladaptive family relationships, using comprehensive
361 family assessment and circular hypotheses as standard practice. These assessments explicitly
362 consider caregiver burden, economic stressors, social context and family history (through
363 genograms) to understand how illness affects and is affected by the entire family system (Majhi
364 et al., 2018; Pillai & Parthasarathy, 2014).

365 **Family intervention delivery:**PSWs actively deliver or co-facilitate formal family therapy using
366 systemic models. For instance, Shetty et al. (2023) describe a 10-session family intervention
367 program in a Bengaluru hospital, delivered by a trained psychiatric social worker, which
368 included six sessions of family psychoeducation, plus communication training and stress-
369 management (Shetty et al., 2023). This intervention was explicitly grounded in social work
370 methods (casework/group work) and systemic techniques (role-plays, enactments, reframing)
371 and proved effective in reducing high expressed emotion in caregivers (Shetty et al., 2023).
372 Thayyil and Rani (2020) similarly report a NIMHANS PSW using structural family therapy with
373 a patient and family, restructuring boundaries and hierarchy to resolve dysfunction (Thayyil &
374 Rani, 2020). In their case report, the PSW led sessions with the family to modify rigid parent-
375 child boundaries and power differentials, illustrating how PSWs apply Western models
376 (structural/strategic therapy) in Indian contexts (Thayyil & Rani, 2020). Notably, PSW-led
377 interventions often blend multiple approaches: Ponnuchamy et al. (2005) describe PSWs
378 facilitating a family support group in rehabilitation, using techniques like active listening,
379 ventilation and group problem-solving alongside psychoeducational talks (Ponnuchamy et al.,
380 2005). These studies highlight that PSWs in India both design and implement systemic
381 interventions (structural, strategic or psychoeducational) tailored to family needs and cultural
382 norms (Shetty et al., 2023; Thayyil & Rani, 2020).

Psychoeducation and adherence support: PSW's role is educating families about mental illness, treatment and relapse prevention. In the Bengaluru support-group example, the PSW regularly provided support, reassurance, and psychoeducation about illness management and caregiving strategies to attending relatives (Ponnuchamy et al., 2005). The Shetty et al. (2023) intervention explicitly included six psychoeducation sessions on schizophrenia delivered to caregivers (Shetty et al., 2023). Prior Indian studies consistently show such psychoeducation by PSWs improves family understanding of illness and reduces caregiver burden. In practice, PSWs teach families about symptom warning signs, medication adherence, and crisis planning, often using culturally-relevant examples (e.g. local role-plays, group discussions) to ensure comprehension and engagement.

Linkage and Community Support: PSWs bridge families to broader resources. Beyond therapy, Indian PSWs routinely advocate for patients' rights and connect families with welfare or rehabilitation services. For example, Ponnuchamy et al. (2005) note PSWs plan future goals and perform advocacy during support-group meetings. In one review, it is noted that mental health practitioners (including PSWs) can actively help caregivers link up with community support and advocacy organizations (e.g. family networks in Chennai, Pune, Bangalore) to reduce isolation (Philip et al., 2024). PSWs also assist families in obtaining disability certificates and government benefits, a key step since most state schemes require formal certification. In short, PSWs serve as a navigation point: they inform families of entitlements (pensions, travel concessions, legal aid) and mobilize local NGOs or self-help groups, ensuring families are connected with the social and medical supports they need (Philip et al., 2024; Ponnuchamy et al., 2005).

Integration in Teams and Cultural Adaptation: Indian PSWs work within multidisciplinary teams (psychiatry, psychology, nursing) and are formally included in national programs (each DMHP district team includes a psychiatric social worker (Hans& Sharan,2021)). When PSWs are scarce, psychiatrists become the sole point of contact, underscoring how PSWs relieve workload and bring unique skills (Philip et al., 2024). Indian policy documents stress that families are the key resource in care due to strong cultural interdependence. PSWs leverage this by adapting Western systemic models for joint-family settings, for example, involving elders or multiple generations in therapy, using hierarchical genograms, and emphasizing collective goal-setting. They tailor interventions to respect gender and age dynamics common in Indian households (Shetty et al., 2023; Thayyil & Rani, 2020). Through their liaison role, PSWs ensure that family therapy in India accounts for extended kin networks and community living arrangements, reflecting the country's unique social context.

In team settings, PSWs often coordinate care for families from hospital to home. They help adapt interventions for joint-family settings (for example, considering how a multi-generational family might share caregiving tasks) and emphasize culturally appropriate goals (such as resuming meaningful social roles within local norms). By combining clinical assessment with social

420 advocacy, PSWs make family therapy models operational in real-world Indian mental health
421 services.

Challenges in Practice and Ethical-Clinical Complexities

423 Working conjointly with families introduces unique challenges. Therapists must negotiate
424 multiple viewpoints, loyalties, and agendas. Building a strong alliance can be difficult if one
425 member resents another or if disclosure (abuse or substance use) triggers defensiveness.
426 Therapists may find themselves balancing splitting alliances, where one family faction gravitate
427 towards them. Cultural patterns of deference (such as younger members deferring to elders) can
428 silence some voices in therapy, requiring skillful facilitation. Practical issues are also significant:
429 scheduling family sessions that accommodate all members is notoriously hard, and irregular
430 attendance can disrupt continuity. Moreover, crises (like suicidality or violence) escalate these
431 complexities, as therapists have to manage safety concerns within the entire system rather than a
432 single client.

433 Logistical challenges are amplified by resource constraints. In many public clinics, a single PSW
434 or psychologist may see dozens of patients daily, leaving limited time for lengthy multi-person
435 sessions. In India's crowded hospitals, privacy is also a concern; conducting family therapy in
436 open wards or busy outpatient areas risks confidentiality and can inhibit openness. Stigma adds
437 another layer: some families may be unwilling to attend joint sessions, fearing community
438 members will recognize them or object to discussing mental illness.

439 Telehealth approaches have offered some relief by enabling remote family meetings. Initial
440 evidence suggests that incorporating family sessions via video can increase retention in youth
441 programs (Bery et al., 2023). However, remote formats have downsides: technological issues,
442 reduced nonverbal cues, and difficulties in managing group dynamics online can dilute
443 therapeutic impact. For example, a household without a quiet private space might struggle to
444 hold a focused session on a phone. Therapists must also ensure confidentiality on digital
445 platforms, which requires extra vigilance.

446 Ethical complexities are ever-present in family therapy. When multiple members attend,
447 questions of confidentiality become knotty: how much of one person's disclosure can be shared
448 with others? In India's patriarchal contexts, power imbalances (based on gender, age, or caste)
449 can further complicate what clients feel safe to say. Therapists must be alert to abuse or coercion
450 occurring within the family system; for instance, a wife might withhold reporting domestic
451 violence in the presence of her husband. Clinicians often navigate these dilemmas by setting
452 clear ground rules (we speak respectfully and one at a time) and, when needed, meeting privately
453 with vulnerable members. At the same time, they must respect cultural norms of collective
454 decision-making, finding a delicate balance between individual rights and family values. In all,
455 family therapy in practice requires ethical finesse to manage competing interests, power
456 differentials, and crises without fracturing the therapeutic alliance.

Limitations

A few limitations of this narrative review should be noted. First, its integrative design means it did not follow systematic search protocols (no PRISMA flowchart or meta-analysis). The goal was conceptual synthesis, not exhaustive evidence ranking, so some relevant studies may not have been included. Second, much of the cited evidence (especially for structured programs like multisystemic therapy or FFT*) originates from high-income countries. While there are emerging Indian studies on family interventions, large-scale trials in typical public sector settings are still sparse. Third, the diversity of family therapy models (differing in theory, intensity, format, and targets) makes it challenging to generalize about family therapy as a single entity. Outcomes such as caregiver burden, family functioning, quality of life, and long-term recovery are promising but under-studied, particularly in Indian contexts. Finally, although digital and hybrid interventions are gaining interest, current empirical data on issues like therapeutic alliance in tele-family therapy are still evolving.

Implementation Implications and Future Directions

In resource-constrained services, a **stepped-care** approach to families could be practical. For example, nearly all families can initially receive brief engagement and psychoeducation from a clinician or trained health worker. More intensive interventions, such as structured communication or problem-solving modules, would then be reserved for families at higher risk (those with very high expressed emotion, repeated crises, or multiple relapses). Group-based formats (multi-family groups or family support groups) may also extend reach while conserving therapist time; these have been successfully used in some Indian clinics for schizophrenia and mood disorders. Another strategy is peer-facilitated groups of caregivers, which harness community solidarity.

Cultural adaptation is essential. Effective family therapy in India must honor joint-family norms (for instance, involving elders in planning), hierarchical decision-making, and gender roles. Therapists already commonly modify language and examples (focusing on family duty, karma concepts or local proverbs) when working with diverse Indian families. Future research should systematically identify which components truly require modification. It will be important to distinguish core ingredients (open communication training) from surface features that can be varied. At the same time, all adaptation efforts should align with rights-based care: families should not override an individual's autonomy simply on cultural grounds. Participatory models, where patient and family members have input on goals, help maintain person-centeredness.

Emerging evidence underscores the promise of digital and hybrid delivery. Video conferencing and smartphone platforms can allow families scattered across geography to participate in therapy. Preliminary findings (Berry et al., 2023) show that each telehealth family session can boost treatment engagement markedly. Hybrid models (combining occasional in-person meetings with remote check-ins) may be especially useful for working families or during circumstances like pandemics. However, more research is needed on how to preserve engagement and alliance

495 online. Important questions include how to handle confidentiality, how to train therapists in
496 online group facilitation, and how to adapt materials (digitizing genograms or communication
497 worksheets).

498 Looking forward, India and similar low-resource settings would benefit from rigorous
499 evaluations of structured family interventions across multiple disorders, not just relapse
500 outcomes, but also measures like quality of life, family resilience, and functional recovery.
501 Implementation science studies (hybrid effectiveness-implementation designs) could identify
502 how best to integrate family work into busy clinics or community programs. Given the shortage
503 of specialists, developing competency-based training and supervision pathways for PSWs and
504 other mental health workers is critical; innovative models (mentorship networks, online learning,
505 and practice-based workshops) should be tested. Additionally, extending family-based care to
506 new areas, such as integrating family sessions into school mental health programs, addiction
507 recovery homes, or digital health platforms, can widen access. Ultimately, expanding the family
508 therapy evidence base with India-specific data will help tailor global knowledge to local realities
509 and ensure that families are effective partners in mental health care.

510 **Conclusion**

511 Family therapy should not be viewed as an optional adjunct, but as a core element of
512 comprehensive mental health care. By addressing the relational processes that influence
513 symptom persistence and recovery, family-based interventions offer meaningful benefits across
514 diagnoses. In schizophrenia and bipolar disorder, clinical experience and research alike highlight
515 how disrupted family support often precedes relapse, underscoring the need for sustained family
516 involvement. For child and adolescent problems and substance use disorders, systemic
517 approaches are particularly valuable, because these conditions intrinsically involve family and
518 social systems. In India's context, where caregiving, decision-making, and rehabilitation are
519 deeply embedded in family life, neglecting the family dimension would compromise effective
520 care.

521 Psychiatric social workers have a pivotal role in translating FT principles into routine practice:
522 they conduct contextual assessments, provide education, train skills, coordinate rehabilitation
523 plans, and liaise with community resources. Enhancing structured training programs (including
524 tele-supervision), strengthening multidisciplinary collaboration, and fostering culturally
525 responsive models (including hybrid and digital formats) could greatly improve access to family-
526 based care. Ultimately, recovery from mental illness is rarely achieved in isolation; engaging
527 families as active partners not only improves clinical outcomes, but also honors the social fabric
528 of support.

529 **Use of Artificial Intelligence (AI) Tools**

530 The authors affirm that no AI tools were used to generate ideas, interpret data, or create content
531 in this review. Automated tools were employed only for language editing and improving

readability. All intellectual content, analysis, and conclusions in this manuscript are the work of authors.

Declaration of Conflicting Interests

The authors declare that they have no conflicts of interest related to this work.

Ethical Considerations

This study is a narrative review based solely on previously published literature. It involved no new data collection from or about human participants, and no identifiable personal information was used. Therefore, formal ethical approval was not required.

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