Journal Homepage: -www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI: 10.21474/IJAR01/22713
DOI URL: http://dx.doi.org/10.21474/IJAR01/22713

REVIEW ARTICLE

FAMILY THERAPY IN MENTAL HEALTH CARE: A NARRATIVE REVIEW WITH INDIAN CONTEXTUAL AND PSYCHIATRIC SOCIAL WORK PERSPECTIVES

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Manuscript Info

Manuscript History
Received: 4 December 2025
Final Accepted: 8 January 2026
Published: February 2026

Key words:-
Family Therapy, Family-based Interventions, Systemic Therapy, Indian Mental Health, Psychiatric Social Work

Abstract

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

Introduction:-

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

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Method and Scope of This Narrative Review:-

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

Conceptual Foundations: Why Families Matter in Mental Health:-

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

Interaction patterns, boundaries, and hierarchies: A central idea across many systemic models is that dysfunctional family organization contributes to problems. Structural family therapy, for example, focuses on family boundaries, the rules governing who is involved in which interactions and hierarchies, the power or authority structure among family subsystems. Healthy families tend to have clear but flexible boundaries, allowing each member personal autonomy while still offering mutual support. In cohesive families, boundaries around parent–child and spousal relationships are neither too rigid (isolating members) nor too diffuse (leading to over-involvement). Dysfunction can arise when boundaries are unbalanced: enmeshment (over-diffuse boundaries) produces emotional fusion and dependency, whereas disengagement (over-rigid boundaries) isolates family members. Highly enmeshed families are characterized by pervasive involvement: family members are overly entangled in each other's activities and emotions, with limited personal space (Coe et al., 2018). In such systems, children may be drawn into adult problems or spouses may skip over one partner to involve a third (forming coalitions). These patterns can misalign authority (for example, a child assuming a parental role) and prevent individuals from functioning independently(Coe et al., 2018). By mapping these patterns and altering them (strengthening spousal boundaries, realigning parental leadership), structural approaches aim to reorganize the family so that symptoms no longer serve a family function.

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

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

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

As the evidence base grew, family therapy became recognized in clinical guidelines for many conditions. For example, the National Institute for Health and Care Excellence (NICE) recommends offering family intervention to all patients with psychosis who are in close contact with relatives (Hahlweg& Baucom,2023). Family therapy techniques have also been integrated into youth services, substance use treatment, and child welfare programs. Thus, what began as systems-informed clinical curiosity has evolved into a diverse set of evidence-based approaches that target relational factors across diagnoses.In India, structured family therapy has developed more recently, building on centuries-old traditions of collective caregiving but with few early formal programs. Historically, Indian families (often joint or extended) took primary responsibility for members' emotional problems, using elders and community networks in lieu of formal mental health care. The first systematic initiatives in family-based treatment are attributed to Dr. Vidyasagar and colleagues, who in the 1950s and 1960s introduced family interviews on psychiatric wards in Amritsar (Sovani, 2018).

NIMHANS in Bangalore and a few other institutions offered occasional family sessions and informal training in the 1970s, but a dedicated academic discipline took time to emerge. The Indian Association of Family Therapy (IAFT), founded in 1991, represents a milestone in cultivating training and practice standards (Sovani, 2018). Nevertheless, specialized education in family therapy (full-degree programs) remains limited, and many practitioners learn systemic skills ad hoc. Despite these gaps, scholars note that basic family therapy principles resonate well with Indian values of connectedness and shared responsibility. Structured family interventions have been introduced in India primarily through Western models, which have often been informally adapted to fit cultural norms and extended household arrangements. For example, joint-family decision-making may shift therapy goals, and culturally sensitive communication is essential when discussing issues like intergenerational conflict or stigma. In recent years, research and clinical reports have begun to demonstrate the feasibility of family-psychoeducation and problem-solving approaches in Indian settings, suggesting the potential for wider uptake if challenges (stigma, workforce limits) can be overcome (Sovani, 2018; Raj et al., 2025).

Major Schools and Core Clinical Mechanisms:-

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

Structural Family Therapy (SFT): Developed by Salvador Minuchin, SFT conceptualizes problems as byproducts of dysfunctional organization within the family system. Therapists assess family structure by observing interaction patterns (alliances, boundaries) and then enact changes (through enactment techniques) to strengthen appropriate subsystems. For instance, a therapist might intervene to realign a parent–child hierarchy or clarify boundary rules. Techniques include mapping (genograms, family sculptures) and active engagement to restructure family roles (Minuchin, 1974). The goal is to create clear, healthy boundaries and hierarchies, for example, reinforcing parental authority over decision-making so that children are not burdened with adult problems. In India, Minuchin's ideas of boundaries resonate culturally, as discussed by Indian authors who note that joint family structures often blur generational lines (Sovani, 2018). However, clinicians adapt SFT flexibly; for example, rather than directly challenging elders, they may use extended family coalitions to support change.

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

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

Experiential and Humanistic Family Therapies: Represented by thinkers like Virginia Satir and Carl Whitaker, these approaches focus on emotional expression, creativity, and the growth potential of each family member. Satir's Conjoint Family Therapy, for example, emphasizes validating emotions and building self-esteem, often through metaphors, role-plays, and sculpting exercises. Whitaker's symbolic-experiential approach allowed chaotic expression (through art or movement) to shake up stagnant patterns(Whitaker & Keith, 1981). These models assume that positive change occurs when families experience genuine connection and self-awareness. In an Indian context, the humanistic emphasis on harmony and warmth fits well, but some techniques (like Satir's family reconstructions) may be adapted to ensure cultural sensitivity. Both Satir and Whitaker trained many therapists; their basic tenet, treating the family as a whole person underlies much of family therapy's ethos(Satir, 1983).

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

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

Evidence and Applications Across Major Mental Disorders

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

Schizophrenia and Psychotic Disorders: Family interventions for schizophrenia have some of the strongest empirical support in mental health. Numerous meta-analyses and Cochrane reviews show that adding family therapy or psychoeducation to medication substantially reduces relapse and rehospitalization(Pharoah et al., 2010). For example, Rodolico et al. (2022) found that virtually all structured family programs (whether brief psychoeducation or longer multi-family therapy) lowered 12-month relapse rates much more than standard care. Mechanistically, these programs appear to work by lowering relatives' high expressed emotion and improving their coping skills, for instance, reframing patient behaviors more positively and establishing steady medication routines(Dixon et al., 2010; Falloon et al., 1984). Trials in diverse settings (including India) confirm that family psychoeducation can improve adherence and reduce symptom severity compared to pharmacotherapy alone. In practice, many schizophrenia programs incorporate at least brief family contact or education: for example, a common approach is a multi-session family management program teaching signs of relapse and communication skills, which caregivers report as empowering and protective.

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

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

Child and Adolescent Disorders: Family therapy is often central to child and adolescent treatment, especially for behavioral problems. Disorders like oppositional defiant or conduct disorder are embedded within complex networks of family, school, and peer influences. Two of the best-studied programs are Multisystemic Therapy (MST) and Functional Family Therapy. 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 Parenting Program) have been used to improve child outcomes, reflecting a shift toward preventive family interventions in public health settings (Varghese et al., 2002; Murthy, 2016). These developments, along with growing evidence from India-specific studies, suggest that family therapy principles can be effectively integrated within India's mental health system, provided there is cultural sensitivity and system-level support.

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

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

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

Challenges in Practice and Ethical-Clinical Complexities :-Working conjointly with families introduces unique challenges. Therapists must negotiate multiple viewpoints, loyalties, and agendas. Building a strong alliance can be difficult if one member resents another or if disclosure (abuse or substance use) triggers defensiveness. Therapists may find themselves balancing splitting alliances, where one family faction gravitate towards them. Cultural patterns of deference (younger members deferring to elders) can silence some voices in therapy, requiring skillful facilitation. Practical issues are also significant: scheduling family sessions that accommodate all members is notoriously hard, and irregular attendance can disrupt continuity. Moreover, crises (suicidality or violence) escalate these complexities, as therapists have to manage safety concerns within the entire system rather than a single client.Logistical challenges are amplified by resource constraints. In many public clinics, a single PSW or psychologist may see dozens of patients daily, leaving limited time for lengthy multi-person sessions. In India's crowded hospitals, privacy is also a concern; conducting family therapy in open wards or busy outpatient areas risks confidentiality and can inhibit openness. Stigma adds another layer: some families may be unwilling to attend joint sessions, fearing community members will recognize them or object to discussing mental illness.

Telehealth approaches have offered some relief by enabling remote family meetings. Initial evidence suggests that incorporating family sessions via video can increase retention in youth programs (Bery et al., 2023). However, remote formats have downsides: technological issues, reduced nonverbal cues, and difficulties in managing group dynamics online can dilute therapeutic impact. For example, a household without a quiet private space might struggle to hold a focused session on a phone. Therapists must also ensure confidentiality on digital platforms, which requires extra vigilance.Ethical complexities are ever-present in family therapy. When multiple members attend, questions of confidentiality become knotty: how much of one person's disclosure can be shared with others? In India's patriarchal contexts, power imbalances (based on gender, age, or caste) can further complicate what clients feel safe to say. Therapists must be alert to abuse or coercion occurring within the family system; for instance, a wife might withhold reporting domestic violence in the presence of her husband. Clinicians often navigate these dilemmas by setting clear ground rules (we speak respectfully and one at a time) and, when needed, meeting privately with vulnerable members. At the same time, they must respect cultural norms of collective decision-making, finding a delicate balance between individual rights and family values. In all, family therapy in practice requires ethical finesse to manage competing interests, power 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 online. Important questions include how to handle confidentiality, how to train therapists in online group facilitation, and how to adapt materials (digitizing genograms or communication worksheets).Looking forward, India and similar low-resource settings would benefit from rigorous evaluations of structured family interventions across multiple disorders, not just relapse outcomes, but also measures like quality of life, family resilience, and functional recovery. Implementation science studies (hybrid effectiveness-implementation designs) could identify how best to integrate family work into busy clinics or community programs. Given the shortage of specialists, developing competency-based training and supervision pathways for PSWs and other mental health workers is critical; innovative models (mentorship networks, online learning, and practice-based workshops) should be tested. Additionally, extending family-based care to new areas, such as integrating family sessions into school mental health programs, addiction recovery homes, or digital health platforms, can widen access. Ultimately, expanding the family therapy evidence base with India-specific data will help tailor global knowledge to local realities and ensure that families are effective partners in mental health care.

Conclusion:-

Family therapy should not be viewed as an optional adjunct, but as a core element of comprehensive mental health care. By addressing the relational processes that influence symptom persistence and recovery, family-based interventions offer meaningful benefits across diagnoses. In schizophrenia and bipolar disorder, clinical experience and research alike highlight how disrupted family support often precedes relapse, underscoring the need for sustained family involvement. For child and adolescent problems and substance use disorders, systemic approaches are particularly valuable, because these conditions intrinsically involve family and social systems. In India's context, where caregiving, decision-making, and rehabilitation are deeply embedded in family life, neglecting the family dimension would compromise effective care.Psychiatric social workers have a pivotal role in translating FT principles into routine practice: they conduct contextual assessments, provide education, train skills, coordinate rehabilitation plans, and liaise with community resources. Enhancing structured training programs (including tele-supervision), strengthening multidisciplinary collaboration, and fostering culturally responsive models (including hybrid and digital formats) could greatly improve access to family-based care. Ultimately, recovery from mental illness is rarely achieved in isolation; engaging families as active partners not only improves clinical outcomes, but also honors the social fabric of support.

Use of Artificial Intelligence (AI) Tools:-

The authors affirm that no AI tools were used to generate ideas, interpret data, or create content 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.

References:-

1. Alexander, J. F., & Sexton, T. L. (2002). Functional family therapy: Principles and procedures. In F. W. Kaslow (Ed.), Comprehensive handbook of psychotherapy: Integrative/eclectic (Vol. 4, pp. 111–132). John Wiley & Sons.
2. Berry, K. R., Gliske, K., Schmidt, C., Ballard, J., Killian, M., &Fenkel, C. (2023). The Impact of Family Therapy Participation on Youths and Young Adult Engagement and Retention in a Telehealth Intensive Outpatient Program: Quality Improvement Analysis. JMIR formative research, 7, e45305. https://doi.org/10.2196/45305
3. Bowen, M. (1978). Family therapy in clinical practice. Jason Aronson.
4. Brown, J., & Errington, L. (2024). Bowen family systems theory and practice: Illustration and critique revisited. Australian and New Zealand Journal of Family Therapy, 45(2), 135-155. https://doi.org/10.1002/anzf.1589
5. Carr, A. (2019). Family therapy and systemic interventions for child-focused problems: The current evidence base. Journal of Family Therapy, 41(2), 153-213. https://doi.org/10.1111/1467-6427.12226
6. Coe, J. L., Davies, P. T., & Sturge-Apple, M. L. (2018). Family cohesion and enmeshment moderate associations between maternal relationship instability and children's externalizing problems. Journal of family psychology: JFP: journal of the Division of Family Psychology of the American Psychological Association (Division 43), 32(3), 289–298. https://doi.org/10.1037/fam0000346
7. Dattilio, F. M. (2005). Introduction to the special section: The role of cognitive–behavioral interventions in couple and family therapy. Journal of Marital and Family Therapy, 31(1), 7-13. https://doi.org/10.1111/j.1752-0606.2005.tb01539.x
8. Dattilio, F. M., & Epstein, N. B. (2015). Cognitive-behavioral couple and family therepy. In Handbook of Family Therapy (pp. 89-119). Routledge.
9. Dimitropoulos, G., Lock, J. D., Agras, W. S., Brandt, H., Halmi, K. A., Jo, B., ... & Woodside, D. B. (2020). Therapist adherence to family-based treatment for adolescents with anorexia nervosa: A multi-site exploratory study. European Eating Disorders Review, 28(1), 55-65. https://doi.org/10.1002/erv.2695
10. Dixon, L., Adams, C., &Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. Schizophrenia Bulletin, 26(1), 5-20. https://doi.org/10.1093/oxfordjournals.schbul.a033446
11. Falloon, I. R. H., & Pederson, J. (1985). Family Management in the Prevention of Morbidity of Schizophrenia: The Adjustment of the Family Unit. British Journal of Psychiatry, 147(2), 156–163. https://doi.org/10.1192/bjp.147.2.156
12. Friedberg, R. D. (2006). A cognitive-behavioral approach to family therapy. Journal of Contemporary Psychotherapy, 36(4), 159-165. https://doi.org/10.1007/s10879-006-9020-2
13. Hahlweg, K., & Baucom, D. H. (2023). Family therapy for persons with schizophrenia: neglected yet important. European archives of psychiatry and clinical neuroscience, 273(4), 819–824. https://doi.org/10.1007/s00406-022-01393-w
14. Haley, J. (1992). Problem-solving therapy. John Wiley & Sons.
15. Hans, G., & Sharan, P. (2021). Community-Based Mental Health Services in India: Current Status and Roadmap for the Future. Consortium psychiatricum, 2(3), 63–71. https://doi.org/10.17816/CP92
16. Horigian, V. E., Anderson, A. R., &Szapocznik, J. (2016). Family-Based Treatments for Adolescent Substance Use. Child and adolescent psychiatric clinics of North America, 25(4), 603–628. https://doi.org/10.1016/j.chc.2016.06.001
17. Majhi, G., Reddy, S., & Muralidhar, D. (2018). The use of family genogram in psychiatric social work practice. Open Journal of Psychiatry & Allied Sciences, 9(2), 98–102. DOI: 10.5958/2394-2061.2018.00034.4
18. McGinnis, H. A., & Wright, A. W. (2023). Adoption and child health and psychosocial well-being. In Encyclopedia of Child and Adolescent Health (Vol. 2, pp. 582–598). Elsevier. https://doi.org/10.1016/B978-0-12-818872-9.00115-1

19. Miklowitz, D. J., & Goldstein, M. J. (1997). Bipolar disorder: A family-focused treatment approach. Guilford Press.
20. Miklowitz, D. J., Simoneau, T. L., George, E. L., Richards, J. A., Kalbag, A., Sachs-Ericsson, N., & Suddath, R. (2000). Family-focused treatment of bipolar disorder: 1-year effects of a psychoeducational program in conjunction with pharmacotherapy. Biological psychiatry, 48(6), 582-592. https://doi.org/10.1016/S0006-3223(00)00931-8
21. Minuchin, S. (1974). Families and Family Therapy. Harvard University Press.
22. Murthy, R. S. (2016). Caregiving and caregivers: Challenges and opportunities in India. Indian Journal of Social Psychiatry, 32(1), 10–18.https://doi.org/10.4103/0971-9962.176761
23. Pharoah, F., Rathbone, J., & Mari, J. J. (2004). Family intervention for schizophrenia. In Schizophrenia Research (Vol. 67, No. 1, pp. 149-149). Amsterdam, Netherlands: Elsevier Science.
24. Philip, S., Jadhav, P., Sharda, A., Allam, A., Singh, A., Seralathan, M., Angothu, H., Rawat, V. S., Muliyala, K. P., &Thirthalli, J. (2024). Psychiatric rehabilitation in routine Indian mental health practice: A review of social protections for persons with mental health conditions. Indian journal of psychiatry, 66(3), 235–246. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_138_23
25. Pillai, R. R., & Parthasarathy, R. (2014). Psychiatric social work services in family psychiatry unit: A NIMHANS experience. Dysphrenia, 5(1), 71–74.
26. Ponnuchamy, L., Mathew, B. K., Mathew, S., Udayakumar, G. S., Kalyanasundaram, S., & Ramprasad, D. (2005). Family support group in psychosocial rehabilitation. Indian journal of psychiatry, 47(3), 160–163. https://doi.org/10.4103/0019-5545.55941
27. Raj, J., Goyal, N., & Senthil, S. (2025). Family mental health in India: A 10-year systematic review. International Journal of Indian Psychology, 13(4), 1691–1705.DOI: 10.25215/1304.155
28. Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., Miller, M., Burlew, K. A., Hodgkins, C., Carrion, I., Vandermark, N., Schindler, E., Werstlein, R., &Szapocznik, J. (2011). Brief strategic family therapy versus treatment as usual: results of a multisite randomized trial for substance using adolescents. Journal of Consulting and Clinical Psychology, 79(6), 713–727. https://doi.org/10.1037/a0025477
29. Rodolico, A., Bighelli, I., Avanzato, C., Concerto, C., Cutrufelli, P., Mineo, L., Schneider-Thoma, J., Siafis, S., Signorelli, M. S., Wu, H., Wang, D., Furukawa, T. A., Pitschel-Walz, G., Aguglia, E., & Leucht, S. (2022). Family interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. The lancet. Psychiatry, 9(3), 211–221. https://doi.org/10.1016/S2215-0366(21)00437-5
30. Rodolico, A., Bighelli, I., Avanzato, C., Concerto, C., Cutrufelli, P., Mineo, L., Schneider-Thoma, J., Siafis, S., Signorelli, M. S., Wu, H., Wang, D., Furukawa, T. A., Pitschel-Walz, G., Aguglia, E., & Leucht, S. (2022). Family interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. The lancet. Psychiatry, 9(3), 211–221. https://doi.org/10.1016/S2215-0366(21)00437-5
31. Satir, V. (1983). Conjoint Family Therapy (3rd ed.). Palo Alto, CA: Science and Behavior Books.
32. Shah, A., Varghese, M., Udaya Kumar, G. S., Bhatti, R. S., Raghuram, A., & Sobhana, H. (2000). Brief family therapy in India: A preliminary evaluation. Journal of Family Psychotherapy, 11(4), 41–53. https://doi.org/10.1300/J085v11n04_03
33. Shetty, K. V., Math, S. B., Marimuthu, P., & Rawat, V. S. (2023). Family intervention for expressed emotion in schizophrenia: Indian context. Indian journal of psychiatry, 65(4), 453–459. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_526_22
34. Sovani, A. V. (2018). Family Therapy in India. Annals of Indian Psychiatry, 2(2), 88–92. https://doi.org/10.4103/aip.aip_22_18
35. Thayyil, M. M., & Rani, A. (2021). Structural Family Therapy with a Client Diagnosed with Dissociative Disorder. Indian journal of psychological medicine, 43(6), 549–554. https://doi.org/10.1177/0253717620969067
36. Varghese, M., Kirpekar, V., & Loganathan, S. (2020). Family Interventions: Basic Principles and Techniques. Indian journal of psychiatry, 62(Suppl 2), S192–S200. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_770_19
37. Varghese, M., Shah, A., Udayakumar, G. S., & Murali, T. (2002). Family intervention and support in schizophrenia. World Health Organization & NIMHANS.
38. Watson, W. H. (2012). Family systems. In V. S. Ramachandran (Ed.), Encyclopedia of human behavior (2nd ed., pp. 184–193). Academic Press. https://doi.org/10.1016/B978-0-12-375000-6.00169-5
39. Whitaker, C. A., & Keith, D. V. (1981). Symbolic-experiential family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), Handbook of Family Therapy (pp. 187–224). New York: Brunner/Mazel.