

## Quality and impact of Family Relationships on Psychiatric Patients: case control study

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### Abstract:

The family is the foundational and basic social unit that fosters the stability, wellbeing and sustainability of society. The quality of family relationships shapes and influences the social, psychological, and biological development and functioning of its members. This may be especially relevant to individuals with mental health problems. **Aim:** to assess the quality of family functioning, the aspects and magnitude of unhealthy family relationship, its correlates among families of mental health patients in a sample of Egyptian females, and its impact on their quality of life. **Methodology:** a case-control study of 1006 cases and 1007 controls of females aged 18 to 28 years recruited from the psychiatric and general medical outpatient clinics attendees at Al-Zahra Hospital in Cairo, respectively. All participants screened by a clinical psychiatric interview, and completed the Arabic translated version of the Family Assessment Device (FAD), and the Fahmy and El-Sherbini Egyptian Social Class Classification Scale. The cases group was further subjected to the Structured Clinical Interview for DSM-IV (SCID I and II) and the Lehman Quality of Life Interview - TL-30S (short version). **Results:** Both cases and controls were demographically similar and displayed unhealthy family function with respect affective response and affective involvement. Families of cases had statistically significant dysfunction with respect to general family functioning ( $p=0.001$ ), problem solving ( $p=0.030$ ), communication ( $p=0.018$ ), family roles ( $p=0.028$ ), and behavior control ( $p=0.016$ ). This dysfunctional profile correlated positively and significantly ( $p<0.01$ ) with mental illness. More than half (58.54%) of mentally ill patients were globally unsatisfied by their Quality of Life which correlated negatively with both their Axis I and Axis II mental disorder diagnosis. **Conclusion:** Females with mental illness are a disadvantaged group with a considerable degree of family dysfunction compared to normal population, and low satisfaction with their quality of life.

### Subjects and Methods

Ethical approval was granted from the ethics committee of Al-Azhar University for Girls to conduct a case-control clinical study at the Psychiatric Department of Al-Zahra Hospital, Cairo, Egypt. We hypothesized that some aspects of unhealthy family

relationships may be prevalent in families of mentally ill females compared to normal population, and that the quality of family relationships in families of mentally ill females may be correlated with their family structure, social status, and psychiatric morbidity. Furthermore, we wanted to

explore the relationship between the perceived aspects of quality of life of mentally ill females and the type of their psychiatric morbidity. A small pilot study was conducted to determine the size of the sample, translate, validate, and test the reliability of used instruments. Translation from English to Arabic and back translation with necessary semantic adaptation was done each by two independent bilingual language expert translators and reviewed by an expert committee for face validity and cultural applicability. Test-retest reliability was conducted on 30 subjects aged from 18 to 28 years over a 3 weeks period. The study proper recruited female subjects aged between 18-28 years from the attendees of the outpatient clinics at Al-Zahra Hospital. All subjects have to be residing or in regular contact with their families. All subjects were selected randomly from the outpatients attendance register. They were approached to participate in the study. Only subjects who consented to participation were included and received appropriate written information about the study and their rights. The Patients' group -A was recruited from attendees of the follow-up psychiatric outpatient clinic. All patients approached (n=1028) were screened using a clinical interview. Those with diagnosis of functional mental illness were included (n=1006), while those with organic pathology, comorbid substance use disorder, or learning disability were excluded (n=22). The control group- B (n=1007) was recruited from attendees of other medical or surgical outpatient clinics. All those approached were screened using a clinical interview (n=1061). Subjects with self reported past history of mental illness, or those displayed any life-time psychiatric symptomatology or substance misuses were excluded (n=54). All individuals

fulfilling the inclusion criteria in both groups were subjected to the Family Assessment Device (FAD) (Epstein, Baldwin, and Bishop, 1983). The FAD is a 60-item self-report instrument which measures the overall family functioning with respect to seven key areas; Problem-solving, Communication, Roles, Affective involvement, Affective responsiveness, Behavior control, and General functioning. Prior research demonstrated that the Family Assessment Device has very good reliability and validity (Miller, Epstein, and Bishop, 1985). Social class classification of all subjects was determined according to the Fahmy and El-Sherbini Egyptian Classification (1988). The patients group (A) was further subjected to the Structured Clinical Interview for DSM-IV (SCID) and Lehman Quality of Life Interview - TL-30S (short version). The semistructured clinical interviews SCID-I (clinician version) was used to determine major DSM-IV axis I diagnosis (First et al, 1997a), and SCID-II to determine DSM-IV axis II personality disorder diagnosis (First et al, 1997b). The Lehman Quality of Life Interview - TL-30S (short version) is a self reported 33 item reliable and valid instrument which assess several QoL domains as general living situation, daily activities and functioning, family and social relationships, finances, work and school, legal and safety issues, and health. If more than 40 percent of the items in any scale are missing, the entire scale is treated as a missing value (Traver, Duckmanton, and; 1998; Sajatovic, and Ramirez; 2003; Nørholm, and Bech, 2007). Compiled data were analyzed using Statistical Package for Social Science Version 11 (SPSS, 2002). For parametric data mean, standard deviation, and t-Test were used. For non- parametric data

Chi-square ( $\chi^2$ ) was used. For normalized data Pearson's product-moment Correlation coefficient (r) was used. Split half reliability was

## Results:

### Results of the Pilot Study:

The translated and back translated tools were nearly identical, slight disagreements on semantics were settled by discussions with the expert panel. The consensus of the expert panel indicated high face validity of both scales. Reliability testing of translated measures for both scales showed the following:

**1) Reliability of the Family Assessment Device (FAD):** the test-retest reliability Coefficient over a 3 weeks period across all 60 items ranged from 0.72-0.86. For individual subscales, Behavior Control (9 Items) had the highest reliability at 0.86, followed by Roles (11 Items) at 0.85, General Functioning (12 Items) at 0.84, Affective Responsiveness (6 Items) at 0.80, Problem Solving (6 Items) at 0.76, Affective Involvement (7 Items) at 0.74, and finally Communication (9 Items) at 0.72.

**2) Reliability of Lehman Quality of Life Interview short version (TL-30S):** the internal consistency reliabilities range from 0.79 to 0.88 for the subjective life satisfaction scales, and from 0.44 to 0.82 for the objective QOL scales. The test-retest reliability Coefficient over a 1 week period the subjective subscales were 0.58-0.95; and for objective QOL scales were 0.46-0.98.

### Characteristics of subjects:

Analysis of the demographic variables of both groups did not show statistically significant differences, indicating demographic homogeneity of the sample. The mean age for patients' group -A (n=1006) was 21.44

measured by Spearman-Brown prediction formula to calculate the internal consistency of the translated questionnaires.

$\pm 0.101$  years, and for the controls' group-B  $21.35 \pm 0.106$  years. In group A (71.89%, n=723) were singles, (16.94%,n=171) were married, (9.67%, n=97) were divorced, and (2.58%, n=26) widowed. While in group B (71.4% n=719) were single, (16.87%, n=163) married, (9.83%, n=99) divorced, and (2.58%, n=26) widowed. 84.27% (n=847) of group-A, and 84.51% (n=851) of group-B were living with their family of origin at the time of the study, while 15.72% (n=158) of group (A), and 15.49% (n=156) of group (B) were living with their family of marriage. With regards to the educational level, college student or graduates comprised 34.23 % (n=343) of group-A and 32.87% (n=331) of group-B, high school graduates or students were 21.75% (n=218), and 25.23% (n=254), preparatory school graduate were 17.96% (n=180), and 16.98% (n=171), primary school graduates 4.49% (n=45), and 3.67% (n=37), and non educated were 20.26% (n=203), and 19.67% (n=198) respectively. Analysis showed that most of the participants were residing in urbanized areas. 75.62% (n=761) of group-A and 69.31% (n=698) of group-B were living in urban areas, whereas 24.37% (n=245), and 30.68% (n=309), respectively were living in rural area at the time of the study.

### Family background:

The family structure of both groups did not reveal any statistical differences. The majority of participants come from families with at least one living parent. 79.20% (n=797) versus 20.79% (n=209) of group-A, and 79.34% (n=799) versus 20.66% (n=208) of group-B had living fathers. While

91.35% (n=918) versus 8.65% (n=88) of group-A, and 90.37% (n=910) versus 9.63% (n=97) of group-B had living mothers. The mean number of siblings for participants was  $3.85 \pm 0.085$  for group-A and  $3.70 \pm 0.106$  for group-B. The social classification of the family of origin based on Fahmy and

El-Sherbini (1988) construct showed some statistically significant differences as seen in (Table: 1). There was no statistical difference in relation to family crowding index and the mean number of room was  $2.42 \pm 0.30$  for group-A and  $2.35 \pm 0.030$  for group-B.

**Table (1): Social Classification of The Family of Origin**

		Control (B)		Cases (A)		$\chi^2$	P
		No.	%	No.	%		
<b>Farther Education</b>	Non	454	45.72	410	41.24	1.356	0.91
	Primary	130	12.73	116	11.30	2.371	0.078
	Preparatory	84	8.05	99	9.67	2.781	0.089
	High	193	19.14	207	20.57	2.149	0.0831
	College	146	14.36	174	17.21	4.171	0.028*
<b>Mother Education</b>	Non	634	62.96	596	59.48	2.456	0.073
	Primary	125	12.41	153	15.17	4.139	0.048*
	Preparatory	64	6.36	44	4.29	3.916	0.048*
	High	101	10.03	86	8.48	5.217	0.048*
	College	83	8.24	127	12.57	4.281	0.039*
<b>Social class</b>	High	16	1.59	35	3.39	2.789	0.054
	Middle	378	37.53	414	41.17	2.389	0.069
	Low	304	30.19	288	28.61	2.13	0.071
	Very low	309	30.68	269	26.81	3.915	0.045*

\* Significant at  $P < 0.05$ , \*\* Highly Significant at  $P < 0.01$ , \*\*\* Very High Significant at  $P < 0.001$

**Family function:**

Family Assessment Device revealed statistically significant differences in relation to healthy and unhealthy family functions in between groups across most of the instrument domains (Table 2). In General most of the families of the mentally ill patients in group- A had unhealthy family functioning compared to the families of the control group-B. This finding was statistically significant across all individual subscales, except for the subscales with affective component,

where affective response and affective involvement subscales did not show statistically significant difference denoting that families of both groups showed defective and unhealthy affective interactions. In contrast to controls, families of the mentally ill patients in group- A had specifically poor and unhealthy general family functioning ( $p=0.001$ ) in comparison to other subscales as Problem solving ( $p=0.030$ ), communication ( $p=0.018$ ), family roles ( $p=0.028$ ), and behavior control ( $p=0.016$ ) subscale.

**Table 2: Healthy and Unhealthy family functions**

	Group A				Group B				$\chi^2$	P
	Healthy		Unhealthy		Healthy		Unhealthy			
	No.	%	No.	%	No.	%	No.	%		
Affective responsiveness (AR)	279	27.74	727	72.26	451	44.78	556	55.21	3.959	0.047*
Affective involvement (AI)	301	29.92	705	70.08	463	45.98	544	54.02	3.368	0.066
Problem solving (PS)	448	44.56	558	55.64	685	68.03	322	31.97	4.681	0.030*
Communication (COM)	361	35.88	645	64.11	591	58.69	416	41.31	5.568	0.018*
Roles (R)	393	39.07	613	60.93	618	61.37	389	38.63	4.840	0.028*
General functions (GF)	245	24.35	761	75.65	569	56.51	438	43.49	12.80	0.001***
Behavior control (BC)	346	34.39	660	65.60	570	56.61	437	43.39	5.813	0.016**

\* Significant at  $P < 0.05$ , \*\* Highly Significant at  $P < 0.01$ , \*\*\* Very High Significant at  $P < 0.001$

**Psychiatric profile of mentally ill group:** Using the Structured Clinical Interview for DSM-IV, axis-I (SCID-I), Major Depressive Disorder was found to be the most prevalent disorder (45.02%, n= 453) among the mentally ill group. Anxiety disorders ranked the second with overall prevalence of 25.54% (n= 257). This comprised respectively of Obsessive Compulsive Disorder 36.57% (n=94), Generalized Anxiety Disorder 33.85% (n= 87), Panic Disorder 20.23% (n=52), and Phobic Disorders 9.33% (n= 24). Schizophrenia ranked the third (13.22%, n= 133) followed by Bipolar Affective Disorder (9.34%, n= 94), Somatoform Disorders (6.06%, n= 61), and finally others (0.79%, n= 8). Most of these disorders were chronic (62.60%, n= 621), only about one third of patients. Most of the patients were chronic sufferers (62.60%, n= 621). Only about one third of them (34.58%, n=343) presented in the acute phases of their illness, while (2.82%, n=28) had other or unspecified course of illness.

Comorbid personality disorder, as detected by SCID II, was seen in only 6.9% (n=70) of the patients sample. The majority of those had Mixed

Personality Disorder (47.14%, n= 33) or Borderline Personality Disorder (41.43%, n= 29), followed by Schizotypal Personality Disorder (7.14%, n=5), and Schizoid Personality Disorder (4.29%, n= 3)

**Quality of Life of mentally ill patients:** More than half (58.54%, n= 588) of mentally ill patients were globally unsatisfied by there Quality of Life (Table 3). Strikingly, but unsurprisingly with their degree of unhealthy family functioning, 68.45% (n= 686) of mentally ill patients were unsatisfied with their family relationships. Also 52.24% (n= 547) were unsatisfied by their current living situation. However, on the rest of the subscales the percentages of those who showed satisfaction were greater. 57.29% versus 42.77% were satisfied their social relations, 53.76% versus 46.23% were satisfied with their Financial status, 67.45% versus 32.55% were satisfied their occupational or scholastic life, 85.14% versus 14.86% satisfied and feels safe, and despite their mental health problems the majority (93.43%) of mentally ill patients are satisfied with their health.

**Table 3: Quality of Life Satisfaction in Mentally Ill Patients**

		Global	Living situation	Work and activity	Family	Social relation	Financial	Work or school	safety	Health
Satisfied	No	418	481	659	320	575	540	543	850	932
	%	41.46	47.75	65.95	31.54	57.29	53.76	67.45	85.14	93.43
Unsatisfied	No	588	547	347	686	431	466	262	156	74
	%	58.54	52.24	34.05	68.45	42.77	46.23	32.55	14.86	6.57

**The correlates of family function:** We examined the correlates of family function (Table 4) across the seven

functional domains of the Family Assessment Devise.

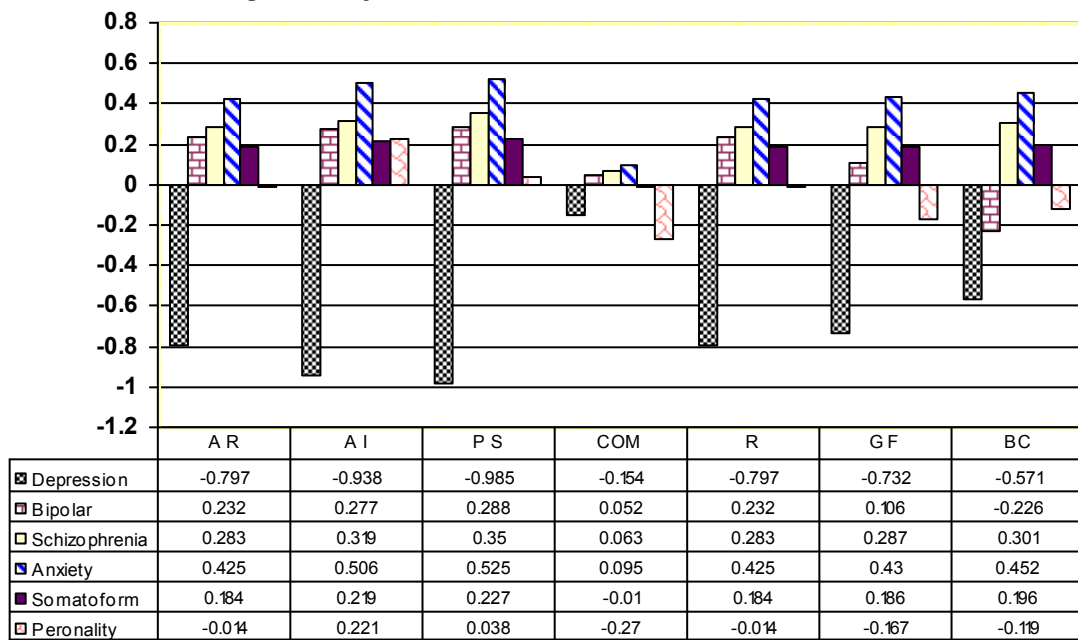
	<b>A R</b>	<b>A I</b>	<b>P S</b>	<b>COM</b>	<b>R</b>	<b>G F</b>	<b>B C</b>
<b>Mental Illness</b>							
SCID I	0.498**	0.593**	0.616**	0.485**	0.498**	0.504**	0.530**
• Depression	- 0.797**	-0.938**	- 0.985**	-0.154	- 0.797**	-0.732**	-0.571**
• Bipolar	0.232*	0.277 *	0.288 *	0.052	0.232*	0.106	- 0.226*
• Schizophrenia	0.283*	0.319*	0.350*	0.063	0.283*	0.287*	0.301*
• Anxiety	0.425**	0.506**	0.525**	0.095	0.425 **	0.430 **	0.452 **
• Somatoform	0.184	0.219*	0.227*	-0.010	0.184	0.186	0.196
SCID II	-0.014	0.221 *	0.038	-0.270*	-0.014	-0.167	-0.119
<b>Family Structure</b>							
Father presence	0.023	0.035	-0.004	0.079	0.116	0.061	0.024
Mother presence	0.112	0.123	0.149*	0.112	-0.071	0.058	-0.025
Sibling Number	0.050	0.072	0.062	-0.025	-0.183	-0.121	0.009
<b>Social Factors</b>							
Social class	-0.108	-0.047	-0.047	-0.177	-0.128	-0.144	0.010
Marital status	-0.044	0.067	-0.068	-0.205*	0.164	-0.055	0.086
Father education	-0.050	0.000	0.300*	0.247*	0.103	0.226*	0.147
Mother education	-0.074	-0.094	0.179*	0.073	0.002	0.143*	0.161*

\* Significant at  $P < 0.05$ , \*\* Highly Significant at  $P < 0.01$ , \*\*\* Very High Significant at  $P < 0.001$

**Mental Illness:** We found highly significant ( $p < 0.01$ ) and positive statistical correlation between SCID I and all the FAD domains. The current data also provided evidence of statistically significant correlations between family function and individual mental disorder categories (Figure 1). For Major Depressive Disorders there was negative correlation between all items of family assessment device, all showed high statistical significant, except for the communication domain. For Bipolar Affective Disorders patients there were positive correlations which were statistically significant for affective

response, affective involvement, problem solving and roles, but non-significant with respect of communication and general functioning. However, behavior control showed negative and statistical significant correlation. The diagnosis of schizophrenia had positive and statistically significant correlation with all items, except for communication it was non-statistical significant. The same finding was true for Anxiety disorders, while the diagnosis of somatoform disorders correlated positively with all items and negatively with communication. Finally, the presence of comorbid personality disorders had a non-statistical and negative correlation with most of FAD items.

**Fig:1 Family Function Correlation with Mental Illness**



**Family Structure:** The presence of parents was positively correlated to the affective components, communication, and general family functioning. Interestingly, and in contrast, while paternal presence positively correlated with family roles it was negatively correlated to problem solving; maternal presence was the opposite. The number of siblings showed non-statistical and negative correlation with communication, roles and general function.

**Social Factors:** social class and marital status had non-statistically significant and mainly negative correlation with most items. On the contrary, Parents' education had mainly positive correlation with most items especially with regards to problem solving and general functioning.

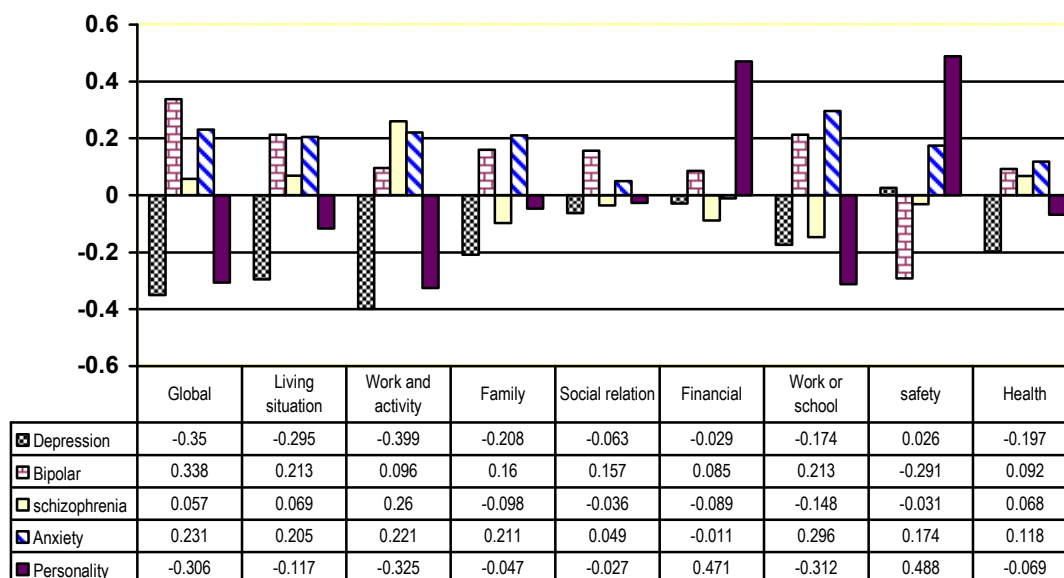
**Psychiatric morbidity and Quality of life:** Our study showed that there were a statistical significant correlations

between axis-I and axis-II diagnosis of mental illness and quality of life (Table 5). Axis I diagnosis had negative correlation with all quality of life indices, except for social relationships. For individual diagnostic categories Major Depressive Disorders had a negative correlation with all quality of life indices, except for safety. This was statistically significant for Global rating, living situation and work and activity. In contrast, Bipolar Affective Disorders Diagnosis correlated positively with all indices except safety which showed statistically significant negative correlation. Schizophrenia diagnosis showed statistical significant and positive correlation with work and activity only. While somatoform disorders showed non-statistical significant and negative correlation with almost all categorize of Quality of life. Comorbid Personality disorder diagnosis had statistically significant and negative correlation with global rating, work and activity, finance, work or school and safety (Figure 2).

	Global	Living situation	Work and activity	Family	Social relation	Financial	Work or school	safety	Health
<b>SCID-I</b>	-0.158	-0.135	-0.265*	-0.172	0.019	-0.011	-0.170	-0.065	-0.083
Depression	-0.35*	-0.295*	-0.399*	-0.208	-0.063	-0.029	-0.174	0.026	-0.197
Bipolar	0.338*	0.213	0.096	0.160	0.157	0.085	0.213	-0.291*	0.092
Schizophrenia	0.057	0.069	0.260*	-0.098	-0.036	-0.089	-0.148	-0.031	0.068
Anxiety	0.231*	0.205	0.221*	0.211	0.049	-0.011	0.296*	0.174	0.118
<b>SCID-II</b>	-0.306*	-0.117	-0.325*	-0.047	-0.027	0.471**	-0.312*	0.488**	-0.069

\* Significant at  $P < 0.05$ , \*\* Highly Significant at  $P < 0.01$ , \*\*\* Very High Significant at  $P < 0.001$

**Fig: 2 Quality of Life Correlation to Mental Illness**



## Discussion

The family is usually assumed to be the most natural of all human interactions and considered a bastion of our culture (Kessler, Beglund, Forster et al, 1997). It plays a vital role not only in personality development (Bigner, 1989); but also in illness behavior, illness pattern and illness management (El-Islam, 2001).

All societies have a concept of “family”, its relative importance, structure, and functions, however, this vary according to the particular culture. In the Arabic culture, as well as other

collectivistic cultures, the extended family is often regarded as the basic unit. Some relatively recent contemporary Western models that herald individualism are, on the contrary, dominated by the nuclear family structure. El-Islam (2001) argued that the Arab family has traditionally contributed much more than in the West. However, it is now imperative to revisit the structure and function of the Arabic family particularly in the face of otherwise pervasive economic and social change in the Arabic world and the moves toward globalization and the fostering

of the newly discovered western cultural models. Hence, we considered it important to evaluate the family structure and function in an Arabic Egyptian sample, and investigate its aspects and quality in normal and mentally ill individuals. To our knowledge, this is the first Arabic comparative study of family functioning in individuals with and without mental illness.

One of the major problems facing family research is small sample sizes. This statistically under-powering increase the chance of false negative findings and decreases the generalizability of the conclusions. Although our study was limited by resource and funding constraints, one of its strengths was ability to recruit more than 2000 participants representative of 18-28 years old females in the catchment area served by the Al-Zahra University Hospital, which added to the power of the study. Furthermore, both groups were homogeneously matched with regards to the demographic background. There was no significant overall difference in mean age, social class, marital status, education, and place of residence. Hence, there was no need to statistically control for any potential confounding demographic variables, which might have affected the effect size of the study.

**Family Structure:** Describing the family structure is the initial step understanding its function. In this study family structure was investigated in relation to the presence and education of parents, and Sibling numbers. The focus on the immediate family structure in this study does not undermine the role of extended families; nevertheless it highlights the importance of such a close direct interpersonal interactions.

Parents are integral to the family functioning (Fisher, Kokes, Cole et al, 1987). Studies report that children and adolescents in lone-parent families are higher risk and more likely to suffer depression and anxiety disorders, commit delinquent acts, abuse substances and have difficulty at school.(Simons, 1996). Father presence in families is associated with better adjustment of children (Dubowitz et al 2001), along with paternal educational level, exert a great impact on its functioning. Our results showed that both are positively correlated to most of the healthy family functioning indices suggesting that presence and level of education of father have great influence on family functioning. Nearly the same findings were seen with respect to mother's presence and education. Yet, interestingly, there was a significant and negative correlation with mother's presence and family roles. The role confusion may be possibly attributed to the common cultural tradition where female siblings sometimes act-up into the mother's role.

Our analysis found a significant positive correlation between sibling number and affective involvement and problem solving. This may be due to siblings serving as guide for the patterns of psychosocial interactions and involvement with others (Bigner, 1989), and provide a template for problem solving. On the other hand rivalry occurs between most, if not all, siblings to a varying degree and reflects negatively on family roles (Leung and Robson, 1991) this was mirrored by our finding of a negative correlation between sibling number and the family role.

**Family Functioning:** In agreement with previous studies (Saeki, Askai,

Miyake et al, 2002), we found that in general the family functioning of the control group was healthier than the patients group. With respect to FAD subscales, we found that both groups displayed similar defects across the Affective subscales which can be interpreted as this unhealthy affective functioning in Egyptian families. Both the Affective Response (AR) and Involvement (AI) depend on the level of emotions expressed within the family. High expressed emotion can be viewed as a kind of social trait in many Egyptian families and the degree of family criticism in the Egyptian culture in general could be higher than that in Western cultures (Okasha et al 1994) where criticism may sometimes be taken as a sign of care and interest in any Egyptian enmeshed family (El-Islam, 1979). Cross cultural research indicated that unhealthy expression of emotion influence the risk and course of psychiatric disorders (Jenkins and Karno, 1992). We found significant differences in the Affective Responsiveness of families in the patients' group indicating that it might have played a role in susceptibility to psychiatric morbidity. These results are compatible with results of Tamplin and Goodyer (2001). Moreover, we found that the ability of the families of mentally ill subjects to resolve problems was significantly less than the controls. Similar finding in previous research (Koyama, Akiyama, Miyaka, 2004) argued that this may be also the result of over involvement, and sometimes detachment of family members.

Arab families tend to make strong restricted rules especially around females in the age group of this study. The ultraconservative upbringing, the subordinate position, and the stereotyped view of their function as dependant, powerlessness, passive,

childbearing housewives pose several role limitations among many Arabic females (Saif El Dawla, 2001; Douki, and Nacef, 2002; Douki et al 2003). There is also a gender role imbalance that is skewed towards favoring males. This culturally persistence of male dominance causes further restriction female roles (Abukhalil, 1997). It is therefore expected that a demographically homogenous Arabic female population show increased prevalence of unhealthy role functioning. Yet we found a statically significant difference between patients and control groups which may be indicative of more stringent role limitations and unhealthier role functioning among mentally ill females that can lead to a more subordinate and disadvantageous social position.

Women in our culture are exposed from childhood to various behavior controls. Their behavior is continuously under scrutiny and criticism, for either social or religious reasons (Okasha et al 1994). In our sample unhealthy behavioral control was statistically high in families of the mentally ill group. It seems that these families exert more behavioral control on their mentally ill daughters. Perhaps this is due to the culturally ingrained attributions that mentally ill have weakness of personality, faith and morals and liable to irresponsible, deviated, and dishonorable behaviors (El Islam, 2001). Hence, families may feel the need to be over-controlling and highly protective to prevent any possible dishonorable behavior that can affect the dignity or societal status of the family.

**Family Functioning and Mental Illness:** In a comparable study (Friedmann et al., 1997) results indicated that psychiatric illness was a risk factor for poor family functioning

and pointed out that the type of psychiatric illness did not predict differences in family functioning. The same was postulated by Bachmann et al (2002) and Heikkila et al. (2002). In our study there was a statistically positive correlation between axis-I diagnosis and family function. This was true across all disorders, except for Major Depressive Disorders which had negative correlation. A similar finding was published by Koyama et al (2004) and was associated to the tendency of depressive patients to attribute problems to internal (i.e. self-blaming) causal factors (Kinderman and Bentall, 1997). The discrepancy between researches in this respect suggests differences between how depressed patients view their family functioning. Keitner et al. (1990) found depressed patients are heterogeneous with respect of their report on family functioning whereas suicidal depressive patients viewed their family functioning more negatively, non-suicidal depressive patients on the contrary viewed family functioning more positively. Hence, the interpretation of subjective accounts on family function in depressed patients should be interpreted in the context of the clinical picture.

Family Functioning and Mental Illness have a complex bidirectional relationship. Dysfunctional families have high rates of mental illness (Ben-Noun, 1989), and mental illness itself stresses the family and causes dysfunction (Trangkasombat, 2006). The cause-effect in this relationship is very difficult to ascertain, especially in chronic conditions where several factors interplay to fuel the dysfunction. When chronic mental illness impinges on a family member it becomes a major source of unremitting stress for every member of the family (Phelan, Bromet, and Link 1998). The

ability of the family to preserve its functional integrity depends on its pre-existing internal family resources, and the availability and degree of external help. Okasha et al (1994) argued that extended families in an Arab culture were more tolerant of mental illness than were western nuclear families, and that families believe it is their obligation and right to be the essential caretakers for sick family members. Certainly, this is a positive cultural attitude; however the resilience of these families and their ability to accommodate is not unlimited. Unfortunately, many services in Arab countries utilize family care as a remedial strategy to compensate for the lack of services and resources. The lack of such services and the increasing burden of mental illness bleed internal family resources dry, and leave the family confronted with several obligations that are not met by external resources. This contributes to increased stress and conflicts within the family environment and brings about more dysfunction predisposing other family members to ill health (Coyne and DeLongis, 1986; Cohen and Edwards, 1989; Lefton, 1994).

**Quality of life, mental health and family functioning:** Quality of life, mental health and family functioning are interwoven constructs. Mental disorders are important determinants of quality of life (Alonso et al 2004), so as family relationships (Lehman, 1983). Hence our finding that mentally disordered group displayed poor perceived family functioning and low global quality of life satisfaction. Looking at specific disorders there was apparent inter-disorder variation in quality of life satisfaction. Further analysis of this finding requires prudent scrutiny, as when dealing with mental disorders, the widely accepted consensus is that subjective perspective

of the patient is prone to measurement distortions (Atkinson, Zibin, Chuang, 1997). Reports about subjective well-being, social functioning, living conditions, etc often tend to simply reflect altered psychological states. Katschnig (2006) described several forms of psychopathological fallacies these include the "affective fallacy", the "cognitive fallacy", and the "reality distortion fallacy". The most relevant of these fallacies is the affective fallacy. Schwarz and Clore (1983) noted that individuals employ their current affective state in making judgments and interpreting information on how happy and satisfied they are. Our analysis showed that Major Depressive Disorders had a negative correlation while Bipolar Affective Disorders correlated positively with most of the LQOL indices. Research showed that depressed patients usually rate well-being, social functioning, and living conditions as worse than observed (Beck, 1976; Morgado et al, 1991). The opposite is true for a manic patients who over rates subjective well-being (Katschnig; 2006). Reality distortion fallacy may be apparent in psychotic disorders and can lead to wrong conclusions.

**Family interventions:** Perhaps because of the lack of financial and human resources, some Arab clinicians may overestimate the effectiveness of biological treatments. Pharmacotherapy which controls and attenuates symptoms tends to minimize mental health professionals' awareness of the continuing distress of the family (Biegel, Song, Milligan, 1995). Research suggests that, in spite of adequate drug treatment, disturbing problems persist for many individuals and their families (Marsh, and Johnson, 1997). Hence, the pressing need for other psychotherapeutic

interventions in order to improve the functioning and quality of life of patients and families. Several studies (Saeki et al., 2002; Derisley et al., 2005) indicate the importance of family intervention in treatment of psychiatric disorder. Lehman, (1983) suggested that family interventions might improve patients' quality of life. For example, in schizophrenia, successful family intervention decreases mean cost of patient care, reduces relapse rates, and improves quality of life (Perlick et al., 2001). In bipolar disorder multifamily group therapy treatment reduces patient relapse rates and improves patient quality of life (Chakrabarti, Kulhara, Verma, 1992). Studies also showed family interventions are effective in depression (Sandler, 1992; Diamond, 2002). Therefore Working with family relationships may prevent psychiatric morbidity, help treatment and rehabilitation of present psychiatric morbidity and help other family member to cope with it. A greater understanding of universal and cultural specific family assessment and interventions may contribute to enhance training and therapeutic interventions.

**Conclusion:** Females with mental illness are a disadvantageous group with a considerable degree of family dysfunction compared to normal population, and low satisfaction with their quality of life. Family intervention is a cost-effective therapeutic modality that can improve both family functioning and quality of life. Mental health services in Egypt and the Arab countries should invest more in psychosocial interventions and community support for patients and families

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## نوعية و تأثير العلاقات الاسرية على المرضى النفسيين: دراسة ضابطة

**مقدمة:** الأسرة هي الوحدة الاجتماعية الأساسية التي تعزز الاستقرار والصحة و الإزدهار في المجتمع. نوعية العلاقات الاسرية تؤثر على طبيعة و تطور و كيفية تشكيل الشخص البيولوجي و الاجتماعي و النفسي و خاصة للمرضى النفسيين. **هدف الدراسة:** هو تقييم نوعية العلاقات الاسرية و مظاهرها غيرالصحية بأسر المرضى النفسيين بالمقارنة بالأصحاء في عينة من الأناث المصريين وتأثيرها على منظور جودة الحياة لدى المرضى النفسيين. **منهجية الدراسة:** تمت الدراسة على عينة مكونة من مجموعة اولى من ١٠٠٦ حالة و مجموعة ثانية ضابطة من ١٠٠٧ كلاً من الأناث بين سن ١٨-٢٨ سنة من بين المترددين على العيادات الخارجية بمستشفى الأزهراء الجامعي بالقاهرة. المجموعة الاولى جندت من المترددين على العيادة النفسية و المجموعة الثانية من المترددين على العيادات الطبية الاخرى. تم فحص كل المشاركين في الدراسة عن طريق مقابلة سريرية نفسية و عمل مقياس تقييم أداة الأسرة المترجم باللغة العربية بالإضافة الي مقياس. تصنيف الفئة الاجتماعية المصري لفهمي والشربيني. **نتائج الدراسة:** كانت النتائج الديموغرافياً مماثلة في العيانتان على حدّ سواء و تماثلت المجموعتان في وجود تفاعلات اسرية مضطربة في الإستجابة عاطفية و التورط عاطفية و لكن المجموعة الاولى من الحالات اوضحت اختلال وظيفي في التفاعلات الاسرية و خاصة في دور الاسرة العام و افرادها و قدرتهم على حل المشاكل و التواصل و التحكم في التصرف و وجدت الدراسة ان الاختلال الوظيفي و التفاعلات الاسرية المضطربة ترتبط إيجابياً وبشكل ملحوظ بوجود مرض نفسي و نوع العلة العقلية و تتأثر بعوامل اخرى كهيكل الاسرة و تواجد الابوين و الحالة الاجتماعية و وجدت الدراسة ان أكثر من نصف المريضات النفسيين غير راضين على نحو شامل عن جودة الحياة و ارتباطها ارتبط سلبياً مع محور المرض النفسي المشخص أو محور اضطرابات الشخصية. **الاستنتاج:** المريضات النفسيين تمثل مجموعة مضرّة بسبب وجود درجة عالية من الاختلال الوظيفي للأسرة و انخفاض رضائهم عن جودة الحياة