

Family Functioning in the Families of Psychiatric Patients: A Comparison with Nonclinical Families

Umaporn Trangkasombat MD*

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** Department of Psychiatry, Faculty of Medicine, Chulalongkorn University*

Objective: To examine family functioning in the families of psychiatric patients.

Material and Method: Families of psychiatric patients and nonclinical families were compared. There were 60 families in each group. The instrument included a semistructured interview of family functioning and the Chulalongkorn Family Inventory (CFI), a self-report questionnaire designed to assess the perception of one's family.

Results: From the assessment by semistructured interview, 83.3% of psychiatric families and 45.0% of nonclinical families were found to be dysfunctional in at least one dimension. The difference was statistically significant ($p < 0.001$). The average number of dysfunctional dimensions in the psychiatric families was significantly higher than in the nonclinical control group, 3.5 ± 1.9 and 0.98 ± 1.5 respectively, $p < 0.0001$. The CFI scores of the psychiatric families were significantly lower than the control group, reflecting poor family functioning. The dysfunctions were mostly in the following dimensions: problem-solving, communication, affective responsiveness, affective involvement, and behavior control. Psychiatric families faced more psychosocial stressors and the average number of stressors was higher than the control families, 88.3% vs 56.7% and 4.2 ± 2.7 vs 1.3 ± 1.47 stressors respectively, $p < 0.0001$.

Conclusion: Family functioning of psychiatric patients was less healthy than the nonclinical control. The present study underlined the significance of family assessment and family intervention in the comprehensive care of psychiatric patients.

Keywords: Family functioning, Family assessment, Psychiatric patients

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Family is the most important context of an individual. The primary function of a family unit is to provide a setting for the development and maintenance of family members on the social, psychological, and biological levels. In the McMaster Model of Family Functioning, a family must fulfill six basic functioning dimensions: problem solving, communication, affective responsiveness, affective involvement, roles, and behavior control⁽¹⁾.

Research and clinical evidence has suggested that abnormal patterns of family functioning are associated with psychiatric disorders. For example, a study in families of patients with posttraumatic stress dis-

order found a lower level of affective responsiveness and cohesion and a higher level of conflict compared with nonclinical families⁽²⁾. A study in the families of patients with anxiety disorders found an extreme level of affective involvement. The capacity to adjust to life stress was also low and the interaction between family members contributed to the maintenance of anxiety symptoms⁽³⁾. Tschann et al conducted a study in preschool children with difficult temperament and found that if families had high conflicts and high expressed emotion, children would exhibit a more aggressive behavior⁽⁴⁾. In patients with eating disorders, there was a significant association between self-reported depressive symptomatology and perceived poor family functioning⁽⁵⁾. A study of families of adolescents with substance abuse found roles and affective responsiveness to be problematic. Dysfunction in both dimen-

Correspondence to : Trangkasombat U, Department of Psychiatry, Faculty of Medicine, Chulalongkorn University, Rama IV Rd, Bangkok 10330, Thailand. Phone: 0-2256-5176. E-mail: familyinThai@yahoo.com

sions also predicted the risk of alcohol abuse in this population⁽⁶⁾.

Many studies found that family functioning influences the severity and the course of many psychiatric disorders. Research indicates that high expressed emotion (high EE), characterized by criticism, hostility, and overinvolvement, increases the relapse rate of schizophrenic patients^(7,8). Severe parental conflicts, poor affective involvement, and unresolved grief in the family contributed to difficulty in the development of autonomy in schizophrenic patients^(9,10). Goodyer et al found that in adolescents with severe depression poor family functioning was associated with the persistence of depressive symptoms after 36-week follow-up⁽¹¹⁾. A study in adults with depressive disorders found that when family functioning improved, depressive symptoms also improved^(12,13). The comparison of family functioning in families of children with major depressive disorder and children at high risk and low risk for future depression found that in the depressed group families functioned worse in behavioral control and general functioning, compared with the high risk group. In the high risk group families functioned worse in roles and affective involvement compared with the low risk group⁽¹⁴⁾.

Cultural differences influence individuals' perceptions of family functioning. A study comparing mothers of British and Italian children and adolescents with anorexia nervosa found that British mothers perceived their families' communication and role definition as less healthy than did Italian mothers. In contrast, the Italians perceived their families' behavior control methods as less healthy than did British mothers. The authors explained that the findings might be due to differences between British and Italian interpretations of the role of "family", particularly giving the British emphasis on independence and the Italian emphasis on family life⁽¹⁵⁾.

Most of the research studies on family functioning were done in Western countries. No systematic investigation has been conducted to determine whether family functioning plays different roles within specific cultures. Because family is culturally defined⁽¹⁶⁾ and because culturally divergent attitudes toward family life might give different influences on psychiatric disorders, there is a need to identify differences in the functioning of families with different ethnic backgrounds. This case-control study was conducted with the aim to understand family functioning in the Thai context by looking into differences between families of psychiatric patients and nonclinical community families.

Material and Method

Sample

In the present study 120 families were recruited, 60 in each group. The case group consisted of families of patients who came for psychiatric treatment at the King Chulalongkorn Memorial Hospital, Bangkok, Thailand. The inclusion criteria were as follows. The diagnoses of psychiatric disorders were made by psychiatrists according to DSM IV⁽¹⁷⁾. The patient was not in acute illness or having symptoms that would interfere with family assessment such as agitation, auditory or visual hallucination, and severe paranoid or depressive symptoms. The patient had no intellectual problem and was able to read the questionnaire and to provide information concerning him/herself and the family.

The control group consisted of community families whose members had not been diagnosed with any psychiatric disorder. The family members who had severe medical or intellectual problems were not included in the family assessment.

Instruments

Two instruments were used in the present study. The first was a semistructured interview that was constructed in Thai language according to the McMaster Model of Family Functioning. The interview focused on six dimensions of family functioning: problem solving (the way the family resolves problems and conflicts), communication (the clarity and directness of information exchange in the family), affective responsiveness (the appropriateness of emotional response between members), affective involvement (the appropriateness of emotional attachment and interests family members have between one another), roles (the clarity and appropriateness of the distribution of family roles and responsibilities) and behavior control (the clarity and execution of family rules). The last instrument was the Chulalongkorn Family Inventory (CFI), which is a self-report questionnaire in the Thai language. It assesses the perception of one's family and comprises seven scales, six scales of family functioning according to the McMaster Model and a general functioning scale that taps the general functioning of the family. The CFI consists of 36 items, each with the score of 1 to 4 (higher scores reflect healthy functioning). A study in a community sample found the CFI to have good statistical property, with reliability (alpha) of 0.88, mean inter-item correlation of 0.1978 (min -0.4125, max 0.6385), and item-total correlation of -0.0198 to 0.7535⁽¹⁸⁾.

Procedure

After receiving an explanation about the purpose and the procedure of the present study as well as giving the consent, each family was interviewed for demographic data and significant psychosocial stressors. The researcher then assessed family functioning using the semistructured interview and direct observation of family interaction. After the interview, the researcher would rate the way each family functioned as either normal or dysfunctional. Afterwards, in the psychiatric family, the patient was asked to fill out the CFI. In the control family, one family member, mostly an adult child, filled out the CFI.

Statistical analysis

Data were analyzed using the SPSS 12.0 statistical package. For descriptive purposes, demographic and clinical characteristics between groups were compared using chi-square, Fisher's exact test or *t* tests, as appropriate. All values were reported as either percentages or mean \pm SD. All *p* values were based on two-tailed tests with $\alpha = 0.05$.

Results

Sample characteristics

The profile of the sample is as follows. Families in both groups were mostly nuclear families (66.7% and 63.3% respectively) and came from middle to low socioeconomic status. Most had only 1-3 offspring (65.0% and 66.7% respectively). The rate of separation and divorce was high (25.0% and 13.3%). There was no significant demographic difference between the groups. The patients in the case group ranged in age from 14-40 years, with the mean age of 29.3 years. Most were first-born and middle children. Thirty cases were diagnosed as major depression and dysthymia and 30 cases were diagnosed as schizophrenia. The duration of illness ranged from one month to 21 years, mean 3.6 years. Most had education in the college/university level but the rate of unemployment was high (30%). In the control group, the family members who filled out the CFI ranged in age from 14-45 years, with the mean age of 28.6 years. Most had received a bachelor's degree and were currently employed.

Family stressors in both groups were examined. In the case group, 53 families (88.3%) were found to have at least one family stressor, compared with 34 families (56.7%) in the control group. The difference was statistically significant (chi-square 14.96, $p < 0.001$). The average number of stressors in the case group was significantly higher than the controls, 4.2 (SD 2.7)

and 1.3 (SD 1.47) respectively, $p < 0.0001$. The frequency of each stressor was higher in the case group. Those with significance were divorce/separation, remarriage, extramarital affairs, poor relationship between family members, violence, alcohol abuse, and economic problems. Details are shown in Table 1.

Family functioning assessed by the semistructured interview

The assessment of family functioning by the semistructured interview and the family interaction observation found that the number of dysfunctional families (families with at least one dysfunctional dimension) was significantly higher in the case group than in the control (50 families or 83.3% and 27 families or 45.0% respectively, $p < 0.001$). In average, the clinical families had 3.35 dysfunctional dimensions (SD 1.95) compared with 0.98 dimensions (SD 1.48) in the control families ($p < 0.0001$).

When each dimension was examined, it was found that with the exception of roles, the rates of dysfunction in all dimensions were significantly higher in the case group than in the controls. Details are shown in Table 2.

Family functioning measured by the CFI

Table 3 shows mean CFI scores. In the case group, the total score was significantly lower than in the control group. Many scale scores were also lower. Those with statistical significance were communication, affective involvement, and general functioning.

Discussion

The present study aimed to examine functioning of Thai families by comparing between clinical and nonclinical groups. Through the semistructured interview, the psychiatric group was found to have a higher rate of family dysfunction than the nonclinical control. Dimensions found to be significantly dysfunctional were problem solving, communication, affective responsiveness, affective involvement and roles. In these dimensions the number of psychiatric families with dysfunction was 2-5 times higher than the nonclinical families.

By using the CFI to measure the perception of one's family in terms of functioning, it was found that the total score and the scale scores of the psychiatric group were significantly lower than the nonclinical group especially in communication, affective involvement, and general functioning. This means that psychiatric patients perceived their families' communication,

Table 1. Family stressors

	Psychiatric families		Nonclinical families		Chi-square or Fishers' Exact test
	N	%	N	%	
Parents deceased	14	23.3	10	16.7	0.83
Family member(s) deceased past year	2	3.3	2	3.3	0.00
Divorce/separation	15	25.0	6	10.0	4.68*
Remarriage	15	25.0	6	10.0	4.68*
Extramarital affairs	17	28.3	5	8.3	8.02**
Poor parental relationship	26	43.3	5	8.3	19.18**
Poor father-child relationship	22	36.7	4	6.7	15.91**
Poor mother-child relationship	27	45.0	2	3.3	28.42**
Poor sibling relationship	16	26.7	3	5.0	10.57**
Family violence	14	23.3	0	0.0	15.85**
Parental unemployment	10	16.7	6	10.0	1.15
Alcohol dependence	8	13.3	2	3.3	3.93*
Drug abuse	1	1.7	1	1.7	0.00
Economic problems	24	40.0	3	5.0	21.08**

* p < 0.05; ** p < 0.01

Table 2. Dysfunctional dimensions assessed by semistructured interview

	Psychiatric families		Nonclinical families		Chi-square
	N	%	N	%	
Problem solving	41	68.3	9	15.0	35.11***
Communication	43	71.7	18	30.0	20.84***
Affective responsiveness	41	68.3	9	15.0	35.11***
Affective involvement	45	75.0	8	13.3	46.42***
Roles	8	13.3	5	8.3	2.93
Behavior control	23	38.3	10	16.7	9.41**

** p < .01; ***p < .001

Table 3. Family functioning measured by the Chulalongkorn Family Inventory (CFI)

	Psychiatric families		Nonclinical families		Unpaired	p-value
	mean	SD	mean	SD		
Total score	96.02	19.71	113.78	16.10	4.30	0.04
Problem solving	2.33	0.79	3.01	0.70	1.74	0.19
Communication	2.77	0.75	3.10	0.58	7.06	0.01
Affective responsiveness	2.69	0.69	3.10	0.58	3.27	0.07
Affective involvement	2.71	0.73	3.29	0.60	6.28	0.01
Roles	2.88	0.65	3.14	0.57	0.44	0.51
Behavior control	2.56	0.69	2.80	0.57	1.61	0.21
General functioning	2.72	0.72	3.42	0.53	10.50	0.00

affective involvement, and general functioning as less healthy than did the nonclinical control subjects.

The results of the present study were similar to studies in other countries, which also revealed worse family functioning in chronic mental and physical disorders when compared with the normal controls. However, when dimensions of family functioning were considered, different cultures had different patterns of dysfunction. For example, a study in the United States found that when compared with normal families, families of depressed patients were more dysfunctional in every dimension^(19,20). When severity of depression was compared, families with severe depression were found to be more dysfunctional especially in problem solving, communication and behavior control⁽¹²⁾. A study in families with depression, alcoholism, and adjustment disorder found the perceived family functioning to be worse than the control families especially in communication and affective involvement⁽²¹⁾. A study in England found that adolescents with major depressive disorder perceived their families to have worse functioning than the community sample⁽²²⁾. In Japan Zaeki et al found that depressive families reported significantly worse family functioning than control families especially in problem solving, communication and general functioning⁽²³⁾. In a Turkish study, families of patients with bipolar disorder had healthier functioning than families of patients with schizophrenia and epilepsy. Schizophrenic patients reported problems in communication and behavioral control. The bipolar patients reported the problem-solving and general functioning to be problematic while patients with epilepsy perceived behavioral control and roles to be dysfunctional⁽²⁴⁾. Although the aforementioned studies found varied pattern of dysfunctions, a study by Friedman et al in families of patients with a wide range of psychiatric disorders found that the type of the psychiatric illness did not predict significant differences in family functioning⁽²⁵⁾. Different patterns of family dysfunction found in many studies may be due to other factors such as cultural differences, the types and severity of other psychosocial stressors, and families' coping strategies.

Having a family member in an acute phase of psychiatric illness was a risk factor for poor family functioning⁽²⁵⁾. In the present study, most subjects had chronic illness of more than 3 years. Chronic mental illness can cause dysfunction in many dimensions. For example, due to worry and concern there may be too much affective involvement. Moreover, taking care of psychiatrically ill members can be a great burden and

can affect the mental health of the caretakers. A study in families of depressed adolescents found that the mother's poor mental health was associated with family dysfunction⁽²²⁾.

Other psychosocial stressors can affect the already compromised family functioning. In the present study the psychiatric families had higher rates of stressors and the average number of stressors was higher than the nonclinical group. Most stressors were related to relationship problems such as divorce/separation, remarriage, extramarital affairs, poor relationship between family members and violence. The semi-structured interview revealed that these relationship problems had strong impact on family life by causing a great deal of tension and dysfunction. For example, an extramarital affair led to conflict between husband and wife, to poor communications and negative affective responsiveness. Tension and dysfunction caused by relationship problems may compromise the ability of the family to deal with the illness. Fiese et al found that when family relationships were trustworthy and rewarding there was less of an impact of the illness on families and their coping with the illness⁽²⁶⁾.

Two interesting points came up in the present study. The first was that family dysfunction was found in nonclinical families as well as in psychiatric families. The difference was that in the former group, the rate of dysfunction was lower and the dysfunction was confined to one or two dimensions while in the latter the dysfunction was pervasive, that is, it involved many dimensions. The second interesting point was that family dysfunction in many dimensions were interrelated especially between problem solving, communication, affective responsiveness and affective involvement. The semistructured interview found that dysfunction in these four dimensions usually occurred together. Families with poor problem-solving were poor in communication, affective responsiveness, and affective involvement as well. However, roles and behavior control were not found to be closely associated with other dimensions. Whether this finding is special in Thai culture or not needs to be explored more in a future study.

In the treatment of psychiatric patients, cultural differences and characteristics that are more relevant for each cultural group need to be taken into account. The present study points to the relationship between family functioning and mental illness in the Thai context. Common unhealthy dimensions found in the present study were problem solving, communication, affective responsiveness, affective involvement,

and behavior control. Therefore, in the treatment of psychiatric patients, it is of prime importance to help families functioning well especially in these areas. A comprehensive care that includes family assessment and other aspects of family work care must be provided. Family therapy, which was found to be highly effective in improving family functioning in many dimensions^(18,27-30) must be included.

Conclusion

A case-control study of family functioning revealed more dysfunction in psychiatric families compared with nonclinical families. By using the semistructured interview and self-report questionnaire, the dimensions that were found to be dysfunctional were problem solving, communication, affective responsiveness, affective involvement, and behavior control. This research underlined the significance of family assessment and family intervention in the comprehensive care of psychiatric patients.

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การปฏิบัติหน้าที่ของครอบครัวผู้ป่วยจิตเวชเปรียบเทียบกับครอบครัวทั่วไป

อุมาพร ตรังคสมบัติ

วัตถุประสงค์: เพื่อศึกษาการปฏิบัติหน้าที่ของครอบครัวในครอบครัวของผู้ป่วยที่เป็นโรคทางจิตเวช

วัสดุและวิธีการ: ทำการเปรียบเทียบระหว่างกลุ่มครอบครัวผู้ป่วยจิตเวชและกลุ่มครอบครัวที่ไม่เคยมี สมาชิกป่วยทางจิตเวช จำนวนกลุ่มละ 60 ครอบครัว เครื่องมือที่ใช้คือ เครื่องมือสัมภาษณ์ แบบ semi-structure เพื่อประเมินการปฏิบัติหน้าที่ของครอบครัวและเครื่องมือ Chulalongkorn Family Inventory (CFI) ซึ่งเป็นแบบสอบถามความคิดเห็นต่อการปฏิบัติหน้าที่ของครอบครัว

ผลการศึกษา: จากการสัมภาษณ์พบว่า ครอบครัวผู้ป่วยทางจิตเวชร้อยละ 83.3 และครอบครัวที่เป็นกลุ่มควบคุมร้อยละ 45 มีการปฏิบัติหน้าที่ของครอบครัวบกพร่องอย่างน้อยหนึ่งด้าน ความแตกต่างนี้มีนัยสำคัญทางสถิติ ($p < 0.001$) จำนวนด้านที่ปฏิบัติหน้าที่บกพร่องโดยเฉลี่ยในกลุ่มผู้ป่วยสูงกว่าในกลุ่มควบคุมอย่างมีนัยสำคัญ คือ 3.5 ± 1.9 ด้านเปรียบเทียบกับ 0.98 ± 1.5 ด้านตามลำดับและ $p < 0.0001$ คะแนน CFI ในกลุ่มผู้ป่วยต่ำกว่ากลุ่มควบคุมอย่างมีนัยสำคัญ ซึ่งแปลว่าครอบครัวผู้ป่วยมีการปฏิบัติหน้าที่ที่ไม่ดี ด้านที่พบว่ามี การปฏิบัติหน้าที่บกพร่องในอัตราสูง คือ การแก้ปัญหา การสื่อสาร การตอบสนองทางอารมณ์ ความผูกพันทางอารมณ์ และการควบคุมพฤติกรรม นอกจากนี้ยังพบว่า ครอบครัวผู้ป่วยมีปัจจัยเครียดทางจิตสังคมสูงกว่ากลุ่มควบคุมคือร้อยละ 88.3 เปรียบเทียบกับร้อยละ 56.7 และจำนวนปัจจัยเครียดโดยเฉลี่ยก็สูงกว่าอย่างมีนัยสำคัญ คือ 4.2 ± 2.7 ปัจจัยเปรียบเทียบกับ 1.3 ± 1.47 ปัจจัย ($p < 0.0001$)

สรุป: ครอบครัวของผู้ป่วยจิตเวชมีการปฏิบัติหน้าที่ที่บกพร่องกว่าครอบครัวทั่วไป ผลการศึกษานี้ชี้ว่า การประเมินครอบครัวและการบำบัดครอบครัวเป็นสิ่งที่ยังคงสำคัญอย่างยิ่งในการดูแลผู้ป่วยทางจิตเวช
