Original Article

A Comparative Study of Family Functioning as Perceived between Psychiatric Patients and Relatives

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Objective: To study perception of family functions between psychiatric patients and their relatives.

Materials and Methods: The 113 participants were selected based on the criteria. The patients were admitted to the hospital between December 2015 and November 2016, and the relatives of the patients were included as well. The demographic information was collected from medical records and additional interview of the patients' regarding family functions, social network, and social support. The patients and their relatives conducted the Chulalongkorn Family Inventory [CFI] and the Diagnostic Interview for Genetic Study [DIGS] Thai version. Data were analyzed using descriptive statistic and t-test.

Results: The mean of the patients' perceived family functioning score was 2.94 with standard deviation of 0.68, while the relatives' perceived family functioning score had the mean of 3.13 with standard deviation of 0.59. In other area of perceptions, the scores were quite similar particularly as both patients group and relatives group scores were in a good range of 69% and 73.5%, respectively.

Conclusion: The overall perceived family functions of the patients and their relatives were not statistically different except in the domain of affective response. Perceived family functions between psychiatric patients and their own family members demonstrated high level of agreement.

Keywords: Family functioning, Perception, Family

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Family function has universal expectations and similar roles across different corners of the world such as socioeconomic responsibility, education, cultural norms, beliefs, family bonding, religious responsibility, provision of love and affection in each stage of life, and biological responsibility that is significant to human evolution[1,2]. Contentment of each family heavily depended upon its functioning as each function affected one another within the family. According to McMaster Model of Family Functioning, "Open system" consisted of various subsystems including: individual subsystem, spousal subsystem, and sibling subsystem. Inappropriate engagement between the subsystems might create family conflicts as well as affect individual relationships[3]. Happy family should be able to function well within their personal responsibilities and health maintenance activities in a suitable environment[4]. Conversely, malfunction of the subsystems could create conflicts as researchers identified problems in relationships within family with psychiatric patients more than families without reported mental health problems[5].

The effectiveness of family function also reflected individual's perception of the subsystems including how an individual was treated in the family, the interpretation of various situations in the family and how he or she responded to them[6]. The

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interpretation of a particular situation partly depended upon their personal experiences but an appropriate response also required fundamental understandings based on the facts so that it coincided with the speakers' intentions or not too biased. Based on many studies, the perceptive involvement of family members with mental health problems contained moderate misunderstandings, although in some families there were no differences[7-10]. Yet, the average perceived family function scores in some families were able to identify the potential of family conflicts such as the study of family system according to suicidal individuals which found that their perception was only moderate to low responsiveness which illustrated potential family conflicts[7]. Family functions according to relapsed schizophrenic patients revealed acceptable family functions in different type of involvements. However, affective involvement scores seem to be in the lowest parameter of the family function in families with schizophrenia patients[8]. Hence, it was concluded that family function and perceptive involvement had a direct personal impact both emotionally and behaviorally.

Therefore, further studies regarding family functions and involvement in the same family of psychiatric patients is highly interesting, especially a comparison of perceived family functions between psychiatric patients and their relatives. In this particular group, the researchers hypothesized that the difference in perceptions of family members created risk factors of interpersonal conflicts within the family, higher risk of mental health problems, problems with personal care and risk of losing important human resources of the country. The result of this study aimed to improve the understanding of psychiatric patients and their families in order to establish more complete treatment, prevention and enhance families' resilience.

Materials and Methods

The cross-sectional study was conducted on patients admitted at the in-patient unit, Department of Psychiatry, Siriraj Hospital during 1 December 2015 to 30 November 2016. All admitted cases were invited to participate in the study. The inclusion criteria were patients admitted in the ward and at least 18 years of age. The exclusion criteria ruled out patients who did not have a family member involved in their treatment plan, all patients would be evaluated and received care according to the standards of the psychiatric ward. There were some cases that refused to join the study or refused to complete all questionnaires, some cases had both unstable medical and psychiatric conditions such as delirium and dementia, and other conditions that might interfere with the responds to the questionnaires such as mental retardation were excluded.

Patients and their relatives that were invited to participate in the research provided written consent, and their demographic information such as gender, age, and income which were subsequently collected from the medical records and additional interviews regarding family structure, social networks, and social support. Family functions were evaluated according to the Chulalongkorn Family Inventory [CFI][3]. The CFI was a self-rated questionnaire which evaluated family functions developed by Professor Dr. Umaporn Trangkasombat based on the McMaster's Family Assessment Device [FAD]. Cronbach's alpha of the CFI was 0.88. The 36 items assessment covered problem-solving skills, communication skills, affective responsiveness, affective involvement, behavioral control, general function and individual roles. The 20-minute interviews were conducted on the patients and their relatives. In addition, the Diagnostic Interview for Genetic Study [DIGS] Thai version was added to the data collection process. The DIGS was a semi-structure diagnostic interview tool for genetic study. The DIGS also had good validity and reliability[11]. The interviewer was trained to interview the patients before using this tool.

The data were analyzed using descriptive statistics such as frequency, mean, standard deviations, and t-test. The interpretations of family functioning by the patients and their relatives were done by combining the scores in each category and find the average of each question into 4 levels as followed: an average of 1.00 to 1.49 indicated the awareness of the participants' family who did not perform well in a particular area, an average of 1.50 to 2.49 indicated awareness of adequate performance, an average of 2.50 to 3.49 indicated awareness of good performance, and an average of 3.50 to 4.00 indicated an awareness of excellent performance.

Ethics consideration

This study was approved by Siriraj Institutional Review Board [SIRB] COA No. SI586/2015.

Results

There were 113 from 127 patients who met the inclusion criteria. From the total of 113 participants, the average age was 42.6 years old and mostly female who graduated with at least a bachelor degree. Demographic

data showed that 52.2% participants were single. 50.5% were unemployed, 61.1% had no debt, 67.3% were from nuclear family, 61.1% had no other disabled person in their family, 59.3% claimed that their relative could help them when need help, and 83.2% had some social networks (Table 1).

The assessment process of perceptive family functions was done by using the CFI. Particularly, problem solving skills indicated good performance in patients and their relatives at 46.9% and 45.1%, respectively. In other aspects that also mirrored good performances as communication scored 59.3% and 66.4%, affective responsiveness at 55.8% and 54.9%, and affective involvement at 54.0% and 55.8%, respectively. However, in the domain of behavior control, the patients' perceptive score was in good performance at 49.6% while the relative scores' adequate performance at 47.8%. For general function, the patients and their relatives scored similar performance at 49.6% and 47.8%, respectively. Adversely, perceived roles of the patients were at good performance of 50.4 while their relatives scored higher at 51.3% at excellent performance (Table 2).

The comparison study of perceived family functioning found that there were no statistical differences between the two groups. However, closer inspection revealed that the affective responsiveness between the patients and their relatives was statistically different at 0.05; the patients scored the mean of 2.94 with standard deviation at 0.68 while the relatives' mean was 3.13 with standard deviation of 0.59 (Table 3).

Discussion

The family institution was the first system that shaped humanity to coexist. Conflicts within the family institution created chaos and confusion which disrupted the system[12]. Therefore, family function affected family members and their path to successful

Table 1. Demographic data of the patients participated in the study (n = 113)

Demographic data	n (%)
Gender	
Male: female	40 (35.4):73 (64.4)
Age (mean ± SD: 42.7±17.8)	
≤20	8 (7.1)
21 to 40	48 (42.5)
41 to 60	38 (33.6)
>60	19 (13.3)
Level of education	
Less than bachelor's degree	44 (40.0)
Bachelor's degree/higher	66 (60.0)
Marital status	
Single: married: separate/divorce/widow	59 (52.2):40 (35.4):14 (12.4)
Occupation status	
Unemployed: employed	54 (50.5): 53 (49.5)
Liability issues	
No liability issues	69 (61.1)
Have some liability issues	44 (38.9)
Family structure	
Stay alone	7 (6.2)
Nuclear family	76 (67.3)
Extended family	29 (25.7)
Other	1 (0.9)
Social networks	
No social networks	19 (16.8)
Have some social networks	94 (83.2)
Family members with chronic illness/disability	
None	69 (61.1)
Have some members with chronic illness/disability	44 (38.9)

Table 2. Perception levels of family function among patients and their relatives (n =113 pairs)

Family Functions	Perception of levels, n (%)							
	Poor		Fair		Quite good		Very good	
	Patients	Relatives	Patients	Relatives	Patients	Relatives	Patients	Relatives
Problem solving	4 (3.5)	1 (0.9)	24 (21.2)	25 (22.1)	53 (46.9)	51 (45.1)	32 (28.3)	36 (31.9)
Communication	-	1 (0.9)	24 (21.2)	14 (12.4)	67 (59.3)	75 (66.4)	22 (19.5)	23 (20.3)
Affective responsiveness	3 (2.7)	2 (1.8)	24 (21.2)	12 (10.6)	63 (55.8)	62 (54.9)	23 (20.4)	37 (32.7)
Affective involvement	5 (4.4)	2 (1.8)	25 (22.1)	29 (25.7)	61 (54.0)	63 (55.8)	22 (19.5)	19 (16.8)
Behavior control	5 (4.4)	2 (1.8)	43 (38.1)	54 (47.8)	56 (49.6)	49 (43.4)	9 (8.0)	8 (7.1)
General function	3 (2.7)	-	12 (10.6)	10 (8.8)	56 (49.6)	54 (47.8)	42 (37.2)	49 (43.4)
Role	1 (0.9)	-	12 (10.6)	7 (6.2)	57 (50.4)	48 (42.5)	43 (38.1)	58 (51.3)
Total score	-	-	19 (16.8)	11 (9.7)	78 (69.0)	83 (73.5)	16 (14.2)	19 (16.8)

Table 3. Comparison of perceived family functioning between patients and their relatives (n =113)

Family functions	Patients		Relatives		*p*-value
	Mean	SD	Mean	SD	
Problem solving	2.9041	0.74762	2.9971	0.64280	0.202
Communication	2.9487	0.59688	3.0708	0.54177	0.108
Affective responsiveness	2.9416	0.67701	3.1327	0.59378	0.017*
Affective involvement	2.8549	0.68413	2.8637	0.63204	0.899
Behavior control	2.4845	0.62792	2.4226	0.61969	0.390
General function	3.1704	0.65594	3.2478	0.53842	0.248
Role	3.2419	0.63347	3.3864	0.54476	0.063
Total score	2.9494	0.50405	3.0320	0.42284	0.110

*$p<0.05$

social development. The objective of this study was to investigate the perceived responsibility of family function by the patients and their relatives in the same family using the CFI. The results revealed no significant differences in perceived family function of the two groups as most of the participants were part of the same family with similar socioeconomic backgrounds. The demographic information included that of the relatives, neighbors, communities, and relevant stakeholders that were able to provide assistances in times of emergency or when asked. This point of the study also illustrated the old-aged social networks that received support from their children was more significant than support from their peers[13]. It could be inferred that social supports had an extenuating effects on retired populations' well-beings[14]. Receiving assistance from one's social network strengthened the social support and experiences decreased in isolations. The information received from the participants revealed that family bonding reflects the balanced of social cooperation and social attachment in good level[13]. Families with more income than expenses were considered to have good socioeconomic status which attributed to high accessibility to various resources and subsequently made little or no differences on perceived family function[15-18].

At closer inspection, the data revealed that there was statistical significance of affective responsiveness between the patients' and their relatives at 0.05 which correlated with family function. From previous study, family functions in families with psychiatric patients were statistically lower than families without psychiatric patients especially in

communication, emotional responsiveness, and general role-taking[5]. The study of factors related to suicide attempts in Kailart district, Sukhothai Province found that emotional suppression, isolation, broken families, and highly individualistic society contributed to feeling detached from society[14]. Emotional responsiveness referred to the ability to provide an emotional response in appropriate context. In families that provided appropriate responses would be able to deal with the emotions and conflicts openly, while families that demonstrated emotions in an inappropriate context would have limitations in showing emotions such as exhibited too little emotions or unable to convey negative emotions. People who grew up in limited responsiveness environment were more likely to struggle with demonstration of emotions, problems with personality, or physical or mental problems[3]. Clark[19] stated that the correlation between an appropriate response and verbalizing emotions was able to demonstrate clear and direct message in patients who had improved in social skills and less likely to come into conflict with others. They possessed means of non-violence communications including fairness, forgiveness, explanations, and repetition for coherence understanding[20]. This was the aspects where the patients' and their relatives differ, in the aspect of high power distances, children were taught to believe and respect elders[21]. The scope of social behavior was then limited by family and social expectations to avoid confrontations and punishments by suppression, which correlated with Thai Rorschach study[14] that presented that Thai people had distinct characteristic differences than the western population. In addition, the cultural and environmental differences contributed to display of emotions which was more suppressed when compared to the western counterparts; this attributed to family conflict, problems in bonding and attachments as well as disagreements[22]. It could be inferred that for an individual who struggled to display properly an emotion might bring about misconceptions and misinterpretations between the patients and their relatives. It could indirectly caused long-term relationship problems in some families.

When considering the perception of the patients and their relatives, the results were in a good range. Although, in the area of behavior control, most patients demonstrated good level of perceptions, while their relatives only scored in the range of adequate perception. Behavior control referred to how each family manages the behaviors of members of the family within the scope that is socially acceptable. The differences in level of perception especially from the relatives at the level of adequate could explain why some families perceived low behavioral control when compared to the patients themselves. It might be attributed to the patients' conditions which required in-patient care and which resulted in many relatives experiencing a sense of inadequacy. In particular, behaviors of patients with chronic illness could be a stressor affecting the family as well as the caretaker[23] especially verbal aggression, and physical aggressions such as destroying household items. Psychiatric illnesses were considered chronic illness that required continuous treatments which involved continuous family involvement in the treatment plan as well. Subsequently, the family received physical, emotional, and social effects which were mostly negative and resulted in chronic stress that impacted their perceived capabilities.

The present study demonstrated that although the overall results showed no differences between perceived family function of the patients and their relatives, but emotional responses illustrated significant impact and must be taken into account when conducting treatment plans. As a crucial factor that directly affects the patients' behavior, emotional responses played different roles in mending family relationships as well as family function. Furthermore, from the study of patients with type 2 diabetes, family function and perceived support from family impacted self-care in the patients[24]. In the aspect of behavior control, although there were no statistical differences, but the relatives showed only adequate level of understanding in this area which prompted as area for further study.

Conclusion

The study that compared perceptions of family function by the patients and their relatives were measured by the CFI in patients within in-patient treatment of psychiatric ward between December 2015 and November 2016 in total of 113 pairs of participants. The results showed that affective responsiveness between patients and their relative had a statistical significance at 0.05 but not in other areas even though the scores were in a good range

What is already known on this topic?

Family function is one of the important parameters to assess psychiatric patients. From the previous studies, family function of the families without psychiatric patients scored better than the family with psychiatric patients as a member[4,5]. The studies that focused on the score of perceived family function of

patients showed that scores ranged from low to moderate score[7,8].

What this study adds?

This study added the new perspective of perception of family function. Most pervious researches usually compared family functions between family of a patient and family without a patient. This study focused on perceptions of each family member in the same family. The different perceptions between patients and their family might cause some conflict among them. This study showed that the overall perceptions of patients and their family were similar except the domain of affective responsiveness (p<0.05).

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Potential conflicts of interest

None.

References

1. Department of Women's Affairs and Family Development. Policies and plans for development of the family 2004-2013. Bangkok: Ministry of Social Development and Human Security; 2004.
2. Siriwannabut P. Family psychology. Bangkok: Chulalongkorn University Press; 1997.
3. Trangkasombat U. Family therapy and family counseling. 5th ed. Bangkok: Sunta Press; 2001.
4. Thanakroekkiat P, Kanjanawetang J, Neamskul W. A study of family health of families living in Uttaradit province. J Nurs Health Sci 2011;5:69-78.
5. Trangkasombat U. Family functioning in the families of psychiatric patients: a comparison with nonclinical families. J Med Assoc Thai 2006; 89:1946-53.
6. Tohchinda B. Personnel management. Bangkok: Ruamsarn Press; 2000.
7. Charoenkusol T. Family function as perceived by suicidal attempts [dissertation]. Chiang Mai: Chiang Mai University; 2002.
8. Thongkam A. Family function as perceived by recurrent schizophrenia [dissertation]. Chiang Mai: Chiang Mai University; 2003.
9. Thongphetsri N. Relationship between family factor and attempt suicide in one province of Thailand. Bangkok: National Research Council of Thailand; 2008.
10. Setachandana V. Epidemiology of intentional self-harm and suicide inBurirum Province. J Nakhon Ratchasima Rajanagarindra Psychiatr Hosp 2011; 11:51-9.
11. Sitdhiraksa N, Singhakant S, Ratta-apha W, Saisavoey N, Chantakan S. Diagnostic Interview for Genetic Studies (DIGS): Validity, inter-rater and test-retest reliability of the Thai version (Th-DIGS). Asian J Psychiatr 2008;9:104-13.
12. Klumsubanant S. Family therapy: The roles and challenges of social worker. In: Yordpret S, SombatL, Phatthanasri P, Lertsanporn P, Chamkajang K, Choktanawanich P, et al, editors. Social worker roles to create welfare state society: Challages and solutions. Vol. 2. Bangkok. J Print; 2011:364-79.
13. Hofstede G, Hofstede GJ. Cultures and organization: software of the mind. 2nded. New York: McGraw-Hill; 2005.
14. Suwannalert S, Pornbhipatkul S, Wanitrommanee K. The Rorschach test in normal Thai. JClinPsychol Club 1972;3:7-32.
15. Kotler P. Marketing management: analysis, planning, implementation and control. 9th ed. New Jersey:A Simon & Schuster; 1997.
16. Loudon DL, Della Bitta AJ. Consumer behavior: concepts and applications. 4th ed. New York: McGraw-Hill; 1993.
17. Chompikul J, Suthisukon P, Sueluerm K, Dammee D. Relationship in Thai families [research]. Nakhonpathom, Thailand: Asian Institute for Health Development Mahidol University; 2009.
18. Khamhom R. Social welfare in Thai society. 4tt ed. Pathumthani, Thailand: Thammasat Press; 2014.
19. Clark CC. Assertive skill for nurse. Wakefield, MA: Contemporary Publishing; 1978.
20. Bampenphol K, Laosophaphirom B, Watthanasit A, Winyuhattakit S. Family and attempted suicide in Nakornpatom province. J Clin Psychol 1999; 30:36-41.
21. Dangthong P. Socio-cultural and economic changes of Tambon Bangbaimai, Amphoe Muang, Suratthani Province [dissertation]. Suratthani: Nakhon Si Thammarat Rajabhat University; 2005.
22. Waranusantikule S. Social psychology: Theories and applications. Bangkok: Se-education; 2004.
23. Kasemkitwattana S, Prison P. Chronic patients'

family caregivers: A risk group that must not be overlooked. Thai J Nurs Counc 2014;29:22-31.

24. Boise L, Congleton L, Shonnon K. Empowering family caregivers: The powerful tools for caregiving program. Edu Gerontol 2005;31:573-86.