IMPACT OF FAMILY'S PERCEIVED EMOTIONS ON THE QUALITY OF LIFE OF SCHIZOPHRENIC PATIENTS

MS THESIS

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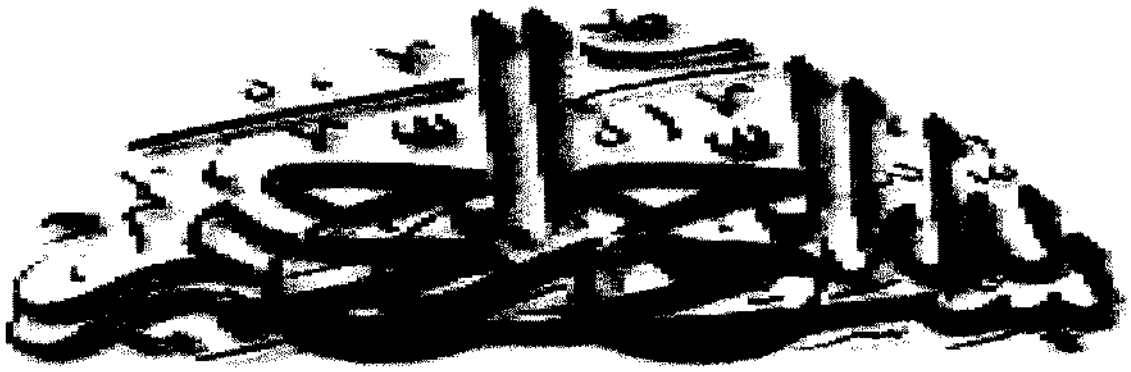

In the name of Allah the Most Gracious , the Most Merciful

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ABSTRACT

The purpose of the study is to explore the impact of family's expressed emotions on the quality of life of schizophrenic patients. For this purpose, a total sample of 70 schizophrenic patients, gender was equally distributed with males (n=35) and females (n=35) of age 20 to 50 years were selected from different government and private hospitals of Rawalpindi and Islamabad. The Urdu version of World health organization Quality of life-brief version (WHOQOL-BREF) and Family emotional involvement and criticism scale (FEICS) along with demographic sheet were administered. Estimate of the psychometric properties of the scales indicated that alpha reliability coefficient of World health organization Quality of life-brief version, WHOQOL-BREF, (r=.707) and Family emotional involvement and criticism scale, FEICS (r= .612) appears to be satisfactory for the present sample. To measure the relationship between the two variables Pearson Correlation was calculated. Correlation analysis showed significant negative relationship between psychological and social domain of WHOQOL-BREF (r= -.29, r=-.25) and criticism, and there is positive correlation between emotional involvement and psychological domain of WHOQOL-BREF.(r=.37). To test the gender based difference on WHOQOL-BREF and its subscale t-test was computed and the difference was significant. The result also shows that there is significant differences on the variables duration of illness. Anova and correlation were employed to analyze and interpret the results. The findings suggest that criticism from family towards patients leads to poor quality of life and emotional involvement leads to good quality of life. On the basis of findings of the study implications and suggestions were also forwarded. The results have been discussed in the context of prevailing values of Pakistani society.

Chapter 1

Introduction

Life is full of color, enthusiasm, laughter, successes and many more but all this becomes useless when a person is not healthier. Human behavior is quite predictable; almost everyone knows how to behave at a party, at a movie show, in a classroom etc. When two persons are familiar with each other they are able to predict how he or she will behave in different situations. However sometimes others behavior is very strange and unpredictable. They act like if they live in a different world and at this that is another group feel uncomfortable and label these people as "crazy" or "mentally ill".

When basic health requirements are not met, person becomes disturbed. If a person is healthy only then one can enjoy life and take part in various activities. Health is not just related to physical fitness but also to mental fitness. Health is the absence of any disease or infirmity, coupled with the complete state of mental, physical and social well-being (Taylor, 2003).

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2005).

A mental illness is an illness of the mind, it is a psychological or behavioral pattern associated with subjective distress or disability that occurs in an individual, and which is not a part of normal development. Such a disorder may consist of a combination of affective, behavioral, cognitive and perceptual components. People with a mental illness often behave in strange ways, or have strange thoughts. In the view of others, they have problems with other

people, or leading what is called a normal life. Mental illness is not a sign of weakness in individual's character or lack of intelligence. It affects people belong to all ages, genders, religions, occupational, economical & social circles. It may last for a short period or for many years or even a lifetime (Insel & Wang, 2010).

Schizophrenia is a major chronic illness that involves abnormalities in thought, perception, emotion, and behavior. The term "chronic illness" has several meanings. The concept of chronic illness is a relatively new phenomenon. Because of knowledge, pharmacological discoveries, and technical advances made in this century enhance the life expectancy, and people live for months or years with disease that previously would have quickly killed them. A large percentage of people with chronic illnesses remain untreated for various reasons. Some of the reasons are stigma, cost, unawareness & misunderstanding (Sidell, 1997). It is a common observation that after taking medications and hospitalization, patient with chronic illness like schizophrenia could become stable as well as could understand and respond to others around.

Schizophrenia

Schizophrenia is a mental illness in which the person suffers from distorted thinking, weird perceptual experiences against reality and logic, and inability to feel desirable emotions. It is an illness where the person's thoughts, perceptions, emotions and behavior are disturbed to a great extent. It is a brain disease that interferes in normal brain functioning. Because the brain is one of the most important organ of the body where thinking, feeling and understanding of the world takes place, a brain disease like schizophrenia disturbs thinking, feeling, understanding and consciousness in affected persons and makes their lives worse. Two major figures in psychiatry who studied the schizophrenic disorder were Emil Kraeplin and Eugen Bleuler.

Earlier, Morel, a French psychiatrist, had used the term demence precoce to describe deteriorated patients whose illness began in adolescence. Schizophrenia has only been considered a distinct mental disorder for the last 100 years. The history of schizophrenia can be traced back to documents written by the Pharaonic Egyptians as far back as 2000B.C. In these texts thought disturbances are mentioned that are commonly seen in schizophrenia. At that time it was thought that these mental disturbances were caused by demons and evil spirits and could be cured by exorcising. German psychiatrist Kraepelin (1856-1926), translated Morel's demence precoce into 'Dementia Praecox' a term that emphasized the change in cognition and early onset of the disorder in the year 1878 (Benjamin & Virginia, 2008).

Schizophrenia is a complex syndrome that has a devastating effect not only on the lives of the person affected but also on those of family members. This disorder can disturb a person's perception, thought, speech, and movement: almost every aspect of daily functioning (Berzins, Petch, & Atkinson, 2003).

The Swiss psychiatrist, Bleuler (1857-1939), coined the term "Schizophrenia", which replaced the term dementia praecox in the literature, and split the schizophrenic symptoms into 'positive' and 'negative' in the year 1911. The word comes from the Greek roots 'schizo' meaning split, and 'phrene' meaning mind to describe the fragmented thinking of people with the disorder, and divided the illness into 4 categories - the 4 'A's' - blunted 'Affect', loosening of 'Associations', 'Ambivalence', and 'Autism'. His intention was to show the separation between a person's personality, perception, memory and thinking. Both Kraepelin and Bleuler subdivided schizophrenia into categories, based on prominent symptoms and prognosis and finally came up with 5 sub-divisions namely , disorganized', 'catatonic', 'paranoid', 'residual', and 'undifferentiated' types of schizophrenia (Benjamin & Virginia, 2008).

A completely different approach to understanding the origins and cure of schizophrenia was propounded by a contemporary of Kraeplin, Bleuler and Meyer . Meyer, a brain pathologist, later became recognized as the dean of American Psychiatry. He maintained that there were no fundamental biological differences between patients who have schizophrenia and those who do not have the disorder, and that there were no fundamental differences in their respective psychological processes. Rather, he believed that the cognitive and behavioral disorganization associated with schizophrenia arose from inadequate early learning and habit deterioration (Martin, Elaine & David, 2001).

Other theorists like Kretschmer (1888-1926), compiled the data to support the idea that schizophrenia occurred more often among persons with asthenic, athletic or dysplastic body types rather than among persons with pyknic body types. Schneider (1887-1967), divided the symptoms into primary 'first-rank' symptoms, and secondary 'second-rank' symptoms in the year 1959. Jaspers (1883-1969), a psychiatrist and philosopher, his work paved the way toward trying to understand the psychological meaning of schizophrenic signs and symptoms such as delusions and hallucinations, and Meyer the founder of psychobiology, saw schizophrenia as a reaction to life stresses (Benjamin & Virginia, 2008).

Schneider (1887-1967) was one of the leaders in the effort to make the definition of schizophrenia more concise and easier. Schneider describes a series of first and second rank symptoms. If first- rank symptoms were present and no organic cause was evident, a diagnosis of schizophrenia was justified. First- rank symptoms were all related to hallucinations and delusional thinking; they are now described as positive symptoms. It also includes experiences of external control, such as having thoughts inserted into one's head or taken away, patient report feeling hypnotized or having robot like, under the control of others (Irwin & Barbara, 2005).

Schizophrenia is a psychotic disorder that has the most severe impact on people live and on the health care system (Sperling, 1999). The word psychosis was first used by Feuchtersleben in 1845 (Beer, 1995). Psychosis means abnormal condition of the mind, and is a psychiatric term for a mental state often described as involving a "loss of contact with reality", characterized by changes in their way of thinking, believing, perceiving and/or behaving. Psychosis is a serious but treatable medical condition that reflects a disturbances in brain functioning. People suffering from psychosis are described as psychotic. Psychosis is given to the more severe forms of psychiatric disorder, during which patient reports hallucinations or delusional beliefs (Gelder & Michael, 2005). Whereby behavior is outside socially acceptable norms (Russon, 2003).

The signs and symptoms of schizophrenia vary from person to person but typically a sufferer will show at least one, if not more, of these symptoms. A person diagnosed with schizophrenia may experience hallucinations (things a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel), delusions (false beliefs that are not part of the person's culture and do not change), and disorganized thinking and speech. The latter may range from loss of train of thought, loose associations of words, word salad, Social withdrawal, poor hygiene, and loss of motivation and judgment are all common in schizophrenia (Carson, 2000). Emotional difficulty, for example lack of responsiveness and impairment in social cognition is associated with schizophrenia (Brunet & Decety, 2006).

The symptoms of Schizophrenia are usually classified in to positive and negative categories. Positive symptoms represent a change in behavior, unusual thoughts or perception, including delusions, disordered thoughts and speech, and tactile, auditory, visual, olfactory and gustatory hallucinations. Positive symptoms generally respond well to medication

(DSM-V-TR, 2000). Negative symptoms represent a loss or a decrease in the ability to initiate plans; they commonly include flat or blunted affect and emotion, poverty of speech, inability to experience pleasure, lack of desire to form relationships, and lack of motivation. Research suggests that negative symptoms contribute more to poor quality of life and the burden on others than do positive symptoms. People with more negative symptoms often have a history of poor adjustment before the onset of illness and their response to medication is often limited (kneisl & Trigoboff, 2009; Velligan & Alphs, 2008; Carson, 2000).

DSM-V-TR (2000) distinguishes among subtypes of schizophrenia based on the pattern of symptoms. There are five subtypes: Paranoid, disorganized, catatonic, undifferentiated, and residual. Each has a characteristic symptom profile. Paranoid schizophrenia is marked by Hallucinations and delusions, typically auditory hallucinations and delusions of persecution or conspiracy, their cognitive skills and affect are relatively intact. They generally do not have disorganized speech or flat affect, and they typically have a better prognosis than people with other forms of schizophrenia. The classic feature the catatonic type is marked disturbance in motor function; this function may involve stupor, negativism, rigidity, excitement, or posturing. People with disorganized type of schizophrenia show marked disruption in their speech and behavior; they also show flat or inappropriate affect, such as laughing in a silly way at the wrong times. People who do not fit neatly into these subtypes are classified as having an undifferentiated type of schizophrenia; they include people who have the major symptoms of schizophrenia but who do not meet the criteria for paranoid, disorganized, or catatonic types. People who have had at least one episode of schizophrenia but who no longer manifest major symptoms are diagnosed as having the residual type of schizophrenia (Ho, Black & Andreasen, 2003).

The predominance of positive symptoms as Type I schizophrenia and those with mostly negative symptoms as Type II schizophrenia. Type I schizophrenia was thought to be more responsive to medication because it arose from a disturbance in brain chemistry, possibly an abnormality in dopamine neurotransmission. Type II schizophrenia was characterized by a sudden onset of disorder in a person who seemed to be functioning well before the episode. (Fenton & McGlashan, 1991). Researches assumed that Type II, or negative-symptom schizophrenia, was associated with poorer long-term outcome (McGlashan & Fenton, 1992). Acute schizophrenia is characterized by the sudden onset of very florid symptoms. Quite frequently, one can point to a specific precipitating incident, usually a crisis that involved a severe social or emotional upset. Prior to that upset, their history may have been within normal bounds. In contrast Chronic schizophrenia involves a more prolonged and gradual period of decline, no specific crisis or stressor can be identified. Rather, the person's childhood history gives evidence of interpersonal problems, poor social adjustment, and social withdrawal (Carpenter, 1992; Fenton & McGlashan, 1991).

According to Breier (1991) the typical course of schizophrenia has three parts: a prodromal phase, active phase and residual phase. The prodromal phase precedes the disorder and is marked by deterioration from some higher level of functioning. Friends and relatives almost always notice behavioral changes, flattened affect, social withdrawal, and other negative symptoms, well before any positive symptoms appear. Once active phase symptoms appear, everyday life for people with schizophrenia becomes a harrowing profusion of ideas and images. In contrast to those in the prodromal phase, patients in the active phase do not seem to be aware that they are behaving strangely. The active phase can persist for weeks, months, or even years.

In residual phase usually, negative symptoms and mild level of positive symptoms persist (Bergam, Wolfson, & Walker, 1997).

Criteria for the diagnosis of Schizophrenia based on either the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, version DSM-V, or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, the ICD-10. These criteria use the self-reported experiences of the person and reported abnormalities in behavior, followed by a clinical assessment by a mental health professional. Symptoms associated with schizophrenia occur along a continuum in the population and must reach a certain severity before a diagnosis is made. (Van & Kapur, 2009).

Late adolescence and early adulthood are peak periods for the onset of schizophrenia, critical years in a young adult's social and vocational development. Schizophrenia affects 0.3–0.7% of people at some point in their life, (Van & Kapur, 2009) or 24 million people worldwide as of 2011. (WHO, 2011). It occurs 1.4 times more frequently in males than females and typically appears earlier in men (Picchioni & Murray, 2007). There are sex differences in the time of first occurrence, men tend to have their first episode of schizophrenia, when they are younger. (Faraone et al., 1994; Goldstein, 1997; Lewine, 1991). The peak ages of onset are 20–28 years for males and 26–32 years for females. (Castle et al., 1991). The long term prognosis for women is better than it is for men, perhaps because women with schizophrenia retain better social skills (Mueser et al., 1990). Onset in childhood is much rarer, as is onset in middle- or old age. (Kumra et al., 2001). Schizophrenia occurs at similar rates worldwide; its prevalence varies across the world, within countries, and at the local and neighborhood level (Kirkbride, Fearon & Morgan, 2007). It causes approximately 1% of worldwide disability adjusted life years (Picchioni & Murray, 2007).

Life expectancy is also lower among schizophrenics. This is partly the result of a high rate of suicide and deaths arising from exposure among the schizophrenic homeless. (Heila, Isometsa & Henriksson, 1997 Roy & Draper, 1995). The relapse rate is worst for those whose first episode occurred at a young age, probably because they never had the opportunity to develop adequate coping skills (Eaton, Mortensen & Herrman, 1992). People who do manage to survive into middle and old age have a good chance of a reasonable quality of life free of active symptoms (Harding, Zubin & Strauss, 1992).

The symptoms of schizophrenia can interfere in every aspect of a person's life. The clinical symptoms of schizophrenia involve problems with thinking and with communicating thoughts. Patients with schizophrenia have problems in many areas of cognition, these include general intelligence, reasoning, memory (long term and short term memory), and attention (Martin, Elaine & David, 2001). Schizophrenic patients also have early-stage deficits in visual processing; it is not surprising that they also show problems with other aspects of visual perception estimation of sizes (Strauss, Foureman, & Parwatikar, 1994), tracking of a moving visual stimulus (Kinney et al., 1998), and discrimination of tones (Holcomb et al., 1995, Schall et al., 1996) and backward masking tasks (Green, Nuechterlein, & Breitmeyer, 1997). The earliest writing on the nature of schizophrenia included comments about abnormalities in movement included unusual posturing of the head and limbs and involuntary movements of the face and limbs. (Walker, Savoie, & Davis, 1994). One of the major problem with everyday life is the difficulty in recognizing nonverbal cues relevant to human emotion and social interaction. (Hellewell, Connell, & Deakin, 1994).

A number of causative factors have been implicated for schizophrenia, including genetic influences, neurotransmitter imbalances, structural damage to the brain caused by a prenatal viral

infection or birth injury, and psychological stressors (Hirsch & Weinberger, 2003). Increasing attention has been paid to the developmental course of schizophrenia, which may shed some light on its causes (Asarnow, 1994; Walker, 1991). Schizophrenia undoubtedly has a genetic component. Individuals with a first-degree relative (parent or sibling) who has schizophrenia have a 10 percent chance of developing the disorder, as opposed to the 1 percent chance of the general population. Researchers are seeking the specific genetic factors that may be responsible for schizophrenia. Current evidence suggests that there are a multitude of genetic abnormalities involved in schizophrenia, possibly originating from one or two changes in genetic expression. About 60% of people with schizophrenia have no close relatives with the illness (Bassett et al., 2001).

Factors such as hypoxia and infection, or stress and malnutrition in the mother during fetal development, may result in a slight increase in the risk of schizophrenia later in life (Van & Kapur, 2009). People diagnosed with schizophrenia are more likely to have been born in winter or spring (at least in the northern hemisphere), which may be a result of increased rates of viral exposures in utero (Picchioni & Murray, 2007). The increased risk is about 5 to 8%. (Yolken , 2004).

Twin and adoption studies suggest that inherited genes make a person vulnerable to schizophrenia and then environmental factors act on this vulnerability to trigger the disorder. High levels of stress are believed to trigger schizophrenia by increasing the body's production of the hormone cortisol. Research points to several stress-inducing environmental factors that may be involved in schizophrenia (Selten, Graae, & Kahn, 2007).

Prevention of schizophrenia is difficult as there are no reliable markers for the later development of the disease (Cannon, Cornblatt, & McGorry, 2007). The evidence for the effectiveness of early interventions to prevent schizophrenia is inconclusive (Marshall & Rathbone, 2006). While there is some evidence that early intervention in those with a psychotic episode may improve short-term outcomes, there is little benefit from these measures after five years (Van & Kapur, 2009). Attempting to prevent schizophrenia in the prodrome phase is of uncertain benefit. (De Koning et al., 2009). Cognitive behavioral therapy may reduce the risk of psychosis in those at high risk after a year (Stafford et al; 2013). Another preventative measure is to avoid drugs that have been associated with development of the disorder, including cannabis, cocaine, and amphetamines. (Picchioni & Murray, 2007).

Schizophrenia has great human and economic costs. It results in a decreased life expectancy by 10–25 years. This is primarily because of its association with obesity, poor diet, sedentary lifestyles, and smoking, with an increased rate of suicide playing a lesser role. Antipsychotic medications may also increase the risk (Laursen, Munk-Olsen, & Vestergaard, 2012). These differences in life expectancy increased between the 1970s and 1990s (Saha, Chant, & McGrath, 2007). Schizophrenia is a major cause of disability, with active psychosis ranked as the third-most-disabling condition after quadriplegia and dementia and ahead of paraplegia and blindness (Ustun et al., 1999). Some people do recover completely and others function well in society (Warner, 2009). Most people with schizophrenia live independently with community support. In people with a first episode of psychosis a good long-term outcome occurs in 42%, an intermediate outcome in 35% and a poor outcome in 27% (Menezes, Arenovich, & Zipursky, 2006). Outcomes for schizophrenia appear better in

the developing than the developed world, Pakistan also has a collectivistic society (Isaac, Chand, & Murthy, 2007).

Expressed Emotions and Schizophrenia

Psychological and social factor serve to buffer the person from developing schizophrenia, or they can trigger the expression of symptoms. A great deal of research has studied how interactions within the family affect people who have schizophrenia for example. schizophrenogenic mothers was used for a time to describe a parent whose cold, dominant, and rejecting nature was thought to cause schizophrenia in her children (Fromm-Reichmann, 1988). Double blind communication was used to portray a communication style that produced conflicting messages, which in turn, caused schizophrenia to develop (Bateson, 1999). There are certain characteristics of interpersonal communication that seem to bear a relationship to the course of schizophrenia. These characteristics are referred to as expressed emotion, and they include measures of cynical, hostile comments toward the patient and marked emotional over involvement be a relative or other care provider (Kuipers, 1992).

Expressed emotion (EE) is one of the main contributing factors of schizophrenia (Butzlaff & Hooley 1998). The concept of expressed emotions was formulated by Brown 1956 and his colleagues in London. Expressed emotion is the critical, hostile, and emotionally over-involved attitude that relatives, family members, parents, siblings may have toward a family with a disorder. The expressed emotion can be high or low. High expressed emotion involves more criticism, hostility, and emotional over-involvement than low expressed emotion. A high level of expressed emotions in the home can worsen the prognosis in patients with schizophrenia

or act as a potential risk factor for the development and progress of schizophrenia. (Asarnow et al., 2001).

The three dimensions of high expressed emotions are hostility, emotional over-involvement and critical comments. The hostile attitudes of expressed emotion are negative toward the person with the illness. The family members put blame on this person because of the illness. The family perceives the person as the one who is in control of the course of the illness. The family believes that the cause of many of the family's problems is the patient's mental illness, whether they are or not. Critical attitudes are combinations of hostile and emotional over-involvement. The family members are more open to view other aspects that contribute to the mental illness and the behavior (Brewin et al., 1991). However, there is still negative criticism even though other contributions are viewed and accepted by the relatives. Critical expressed emotion from siblings and parents are the cause of future development of schizophrenia and increasing problems for the patient (Bullock, Bank, & Buraston, 2002). Contrarily, relatives may express their opinion on the mental illness with emotional over-involvement. The family members blame themselves for everything instead of the patient. This is commonly found in females. These family members feel that any negative occurrence is their fault and not because of the disorder. The family member shows a lot of concern for the patient and the disorder. This is the opposite of a hostile attitude (Lopez et al., 2004).

Origin of Expressed Emotions

To understand the origins of the concept "Expressed Emotion, (EE)" one has to go back to the 1950s for the seminal works by George Brown. In 1956, Brown joined the Medical Research Council Social Psychiatry (MRCSP) Unit of London, which was established in 1948

under Sir Aubrey Lewis's directorship. When Brown joined the MRCSP unit and at this point of juncture, the antipsychotic drug chlorpromazine was being widely used to treat schizophrenia patients that led to the discharge of long-stay patients after they became symptomatically stable and recovered functionally. However, many of these patients were to be readmitted soon after discharge due to symptom relapse. To understand the basis for the symptom relapse, a study was initiated by Brown and his colleagues with 229 men discharged from psychiatric hospitals, 156 of them with a diagnosis of schizophrenia (Leff , 2000).

Expressed Emotion – The Construct

George Brown recognized that it was essential to build up a consistent method of measuring emotional relationships between patients and their close relatives. It was surprising that in 1950s, the assessment of family relationships had little attention, because during that decade family therapy was only emerging. At this point of time, Brown was joined by Michael Rutter who was interested in the study of the emotional impact of parents with emotional problems on their children. They introduced an audio-taped interview method to measure the emotions and the relationships among the patients and their caregiver relatives. Initially, they focused on married couples, and only later on, they extended their work to include the parents of people with schizophrenia (Brown, 1985).

Components Of Expressed Emotions

Critical Comment

These are basically counted during the interview. Careful observations of direct communications among patients and caregivers prove that critical caregivers get involved in angry exchanges with the patient whom they seem unable to prevent or to step away from

(Hooley & Hahlweg, 1986). These potentially lead to physical violence, and it is the nature of some families with high EE. Patients who are unable to get up in the morning, who fail to wash regularly, or who do not participate in household tasks are criticized for being lazy and selfish; unfortunately, in this context, the caregivers fail to understand that these could be potential manifestations of negative symptoms of schizophrenia or any other psychotic disorder. This is reflected in the fact that 70% of critical comments were found to focus on these negative symptoms of schizophrenia rather than on the florid symptoms of delusions and hallucinations. By contrast, low EE caregivers are more capable to recognize aspects of the patient's behavior which are a manifestation of the illness

Examples: Family caregiver may express in an increased tone, tempo, and volume that patient frustrates them, deliberately causes problems for them, family members feel burden of patient, living with him is harder, commenting that patient is ignoring or not following their advices (Vaughn & Leff, 1976).

Hostility

It is rated as being absent or present during the interview and it is a consequence of unmanageable anger and irritation followed by critical comments and leads to rejection of the patient. Hostility is expressed by general criticisms or attitudes that are rejecting of the patient

Examples: Caregivers state that patient causing problems for them, wishing to live away from the patient, shouting at the patient, easily getting angry and getting irritation, patient can control himself, he is acting (Wearden et al., 2000).

Emotional Over Involvement

Emotional over involvement (EOI) manifests itself by over-emotionality, excessive self-sacrifice, over-identification, and extreme overprotective behavior with the patient. When Brown extended his initial research interest from married couples to the parents of schizophrenia patients, he became conscious of the need to develop a scale for assessing this phenomena. Parents of a child, who develops schizophrenia, always feel guilty for the child's illness. This chronic guilt leads them to initiate reparative efforts to make things better for the child, and in its extreme form can signify the over protectiveness for the sick person. Unfortunately, this has the effect of discouraging the person's skills and self-reliance, so that in the long run, over protectiveness hampers the person's recovery. It also leads to dependence of the patient on their caregiver. The patient then becomes worried about the outlook of having to cope without the continuous support of their caregiver and becomes dependent. This emotional overinvolvement is most commonly shown by parents, especially mothers, and occasionally by fathers, but rarely by other relatives.

Examples: Caregivers blame themselves for everything, feeling like everything is their fault; showing pity, not allowing the patient to carry out his day-to-day activities, neglecting self, giving less important personal needs rather than patient needs (Brown, 1985).

Warmth

It is based on kindness, care and concern, and empathy expressed by the caregiver while talking about the patient. It depends greatly on vocal qualities with smiling being a common accompaniment, which often conveys an empathic attitude by the relative. Warmth is a significant characteristic of the low expressed emotion family.

Examples: Caregivers state that patient tries to get along with everyone, he makes a lot of sense, he is easy to get along with, and it is good to have him around, patient's behavior is appropriate since it is not his/her pre-morbid self (Wearden, 2000).

Positive Regard

Positive regard comprises of statements that express appreciation or support for patient's behavior and verbal/nonverbal reinforcement by the caregiver.

Examples: Family states that they feel very close to the patient, they appreciate patient's little efforts or initiation in his day-to-day functioning, they state that they can cope with the patient and enjoy being with him/her (Hooley & Hahlweg, 1986).

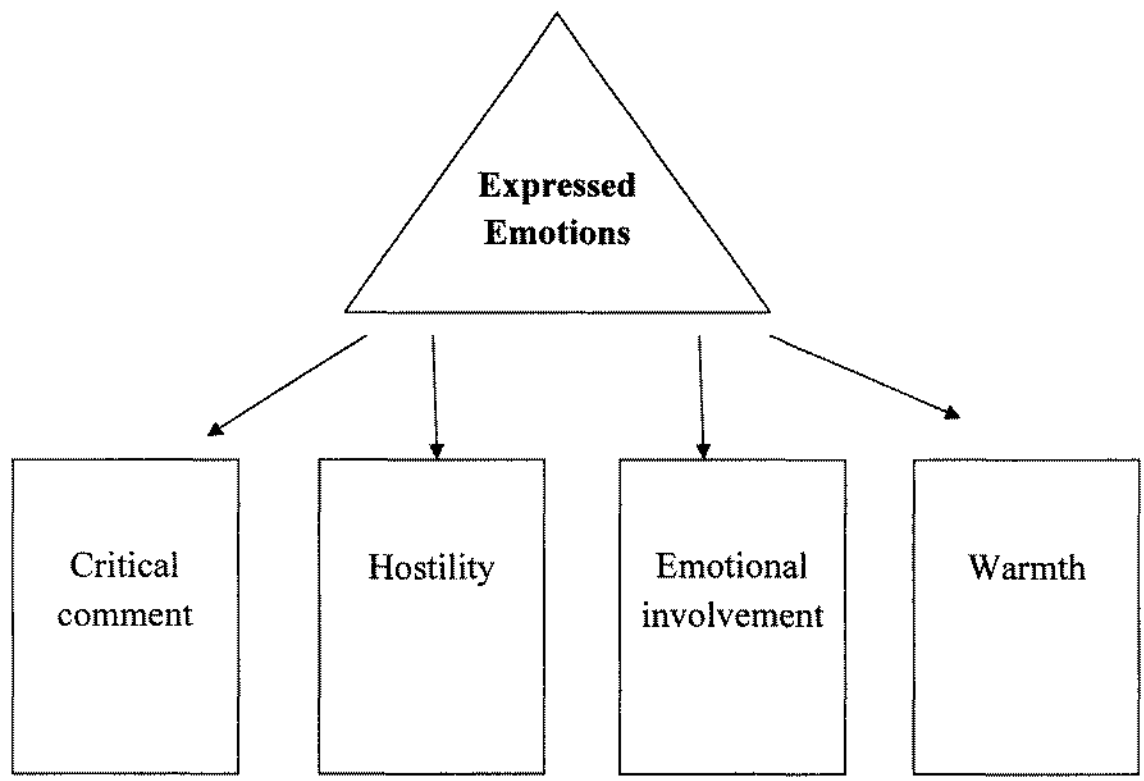

Figure 1: Factors assessing families expressed emotions in patients with schizophrenia.

Low expressed emotion occurs when the family members are more reserved with their criticism. The family members feel that the patient doesn't have control over the disorder. When the family is more educated and doesn't have to 'put up' with the patient and his/her disorder they are more likely to have low expressed emotion. High or low expressed emotion makes the patient feel trapped, out of control and dependent upon others. The patient may feel like an outsider because of the excessive attention received. Expressed emotion affects everyone in the home, raising the stress level for everyone. This is bad for the patient's recovery and for the family as a whole. The behavior of everyone around the patient influences the patient to relapse or progress with their illness (Mueser et al., 1993).

It is important to note that schizophrenia is not only a single mental disorder that is affected by expressed emotion: mood disorders and eating disorders are also worsened in such environments (Butzlaff & Hooley 1998). Researchers found that ratings of high expressed emotion in a family are a good predictor of relapse among people with chronic schizophrenia. (Bebbington et al., 1995). If schizophrenic patient live in a family with high expressed emotion, then the chances of relapse will be 3.7 times more than if he/ she lived in a family with low expressed emotion. (Parker & Hadzi-Pavlovic, 1990).

Cross-cultural research suggests that high expressed emotion is less common in developing countries, where family members seem more tolerant of eccentric behavior than in developed countries. This may be one reason why the outcome of schizophrenia is more positive in developing countries (Craig, Siegel, & Hopper 1997; Jablensky, Sartorius, & Ernberg, 1992; Lefley, 1992; Weisman, 1997).

The fact that the communication style of family members can affect the symptoms of schizophrenia has significant implications. The findings on expressed emotion point to the importance of providing patients with stable, supportive environments for rehabilitation. For example, the situation for both families and patients would be improved if there were safe and readily accessible daytime programs that offered high-quality treatment and, at the same time, reduced the caregivers' burden. The literature on expressed emotion is valuable for the understanding of causes leading to the development of symptoms of schizophrenia. It may also show how to treat people with this disorder so that they do not experience further psychotic episodes (Mueser et al., 1993).

King and Mike in 1999 used to determine the ability of expressed emotions to predict relapse in a sample of 69 schizophrenia outpatients using both conservative criteria (for 6- and 12-month rates) and standard relapse criteria (for 9- and 18-month rates). According to the conservative criteria, expressed emotions failed to predict 6- and 12-month relapse. According to the standard criteria, 9-month relapse rates were significantly greater among patients in high-expressed emotions households. In parental homes, relapse at both 9 months and 18 months was best predicted by fathers' critical comments and mothers' emotional over involvement. Relapse was not associated with medication compliance and the amount of contact with high expressed emotion relatives.

Quality of life of people with Schizophrenia

A specific interest regarding quality of life of patients with schizophrenia dates back to the de-institutionalisation process which took place in the 1960's and 1970's in several western countries (Bachrach, 1970). In fact, as a result of mental health reforms, the effects of the shift of

care from asylum to community health centers became a necessity for clinicians, researchers and health policy makers (Lamb, 1979).

Quality of life is defined as "Individuals' perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns." In the last two decades, there has been increasing interest in quality of life in schizophrenic patients, since schizophrenia is a severe, disabling, lifelong disorder, associated with severe social and occupational dysfunction. Furthermore, the development of atypical antipsychotics with broader efficacy and lower incidence of extra pyramidal side effects than typical neuroleptics has promoted greater interest from the patient's perspective (Bobes & Garcia-Portilla, 2005).

Hundreds of Quality of life instruments are available for use in research and clinical practice because the lack of conceptual clarity has led to variation in measurement of Quality of life (Bowling, 2003; Fayers & Machin, 2007). First, assessment has different focuses: emotional well-being, psychological well-being, social well-being, social roles, physical health, and functioning (Bowling, 2003). Second, the form of Quality of life instruments differs. There are single-item scales including a single global question, multi-item scales producing a total single score, and multi-item scales producing a profile of items (Fayers & Machin, 2007). Quality of life instruments used in psychiatric research and clinical settings are most usually multi-item scales and include Quality of life areas such as physical, psychological, social and environmental functioning (Danovitch & Endicott, 2008). Third, there are two strategies to assess Quality of life; subjective and objective (Dijkers, 1999; Priebe, 2007). Subjective assessment represents an individual's appraisal of his or her objective life conditions (Priebe, 2007). Objective assessment focuses on data that can be gathered without directly surveying the

individuals being assessed (Costanza et al., 2008), for example employment, social contacts and independent accommodation (Priebe, 2007). The scale World Health Organization Quality of life- brief version (WHOQOL-BREF) used in this study because of following reasons, firstly it has Urdu version, less time of administration, used in many studies in Pakistan, easy to administer especially on mentally ill patients and it has good reliability and validity.

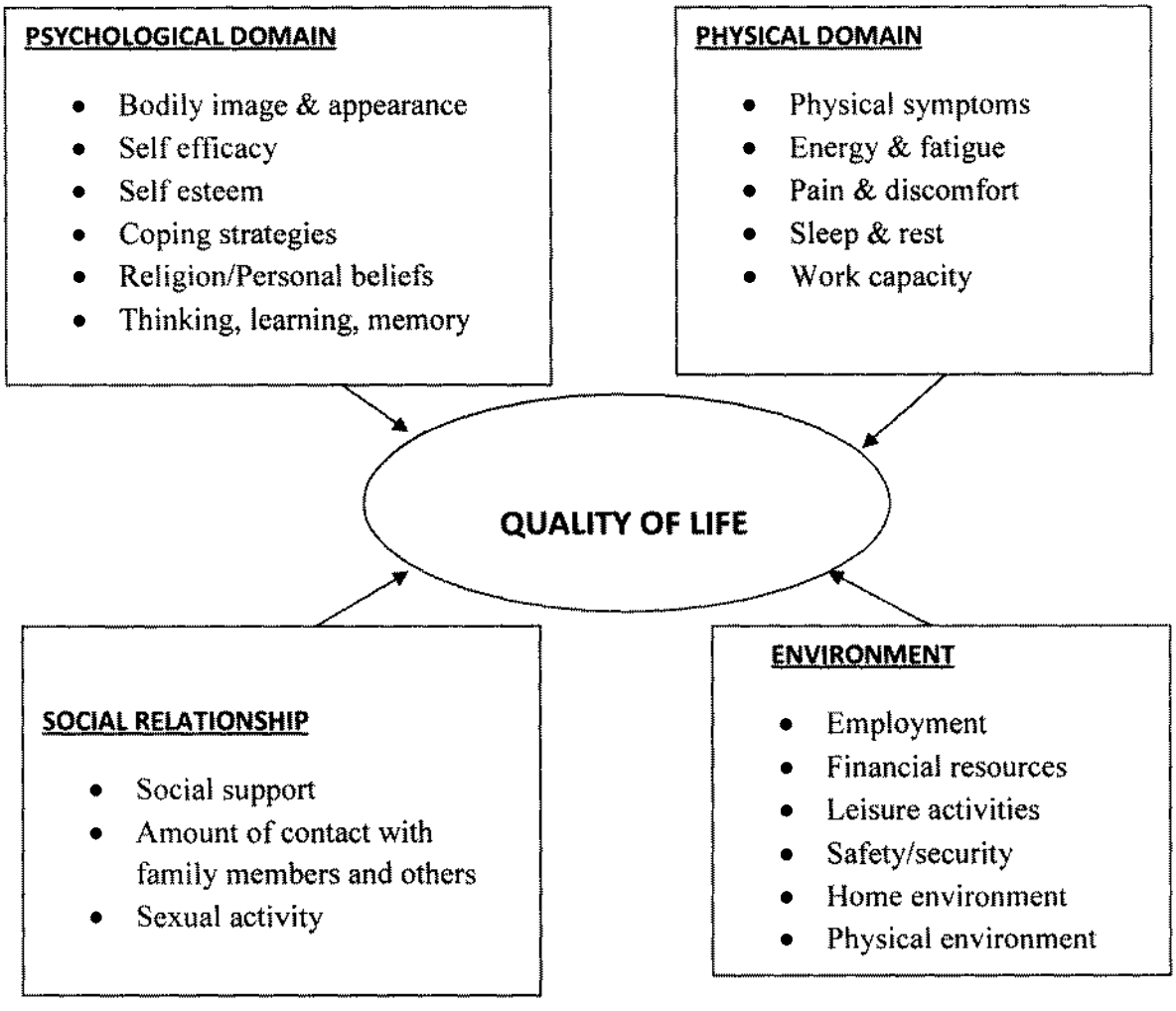

Figure 2. Factors assessing quality of life in patients with schizophrenia grouped according to the WHOQOL-BREF conception of quality of life domains.

Patients with schizophrenia are seen as individuals whose quality of life may be impaired for various reasons due to their illness, and thus the main concern in the treatment of these patients should be to enhance their quality of life (Ministry of Social Affairs and Health, 2004., Lasalvi,a et al., 2005., Knapp, et al., 2007, & WHO, 2008).

Quality of life measurement is based on the principle of applying medical care and interventions, taking into account patients' right of autonomy, which necessarily includes their opinion both during diagnostic evaluation and while formulating their care plan (Bobes, 2001). However, there are still doubts as to whether patients with schizophrenia are capable of self-assessment of their quality of life, because of their cognitive deficits and lack of insight into their illness (Bobes, 2005). Lehman et al., 1993 has demonstrated convergent validity in the perception of quality of life between patients and clinicians, but they have also recommended caution regarding the validity of quality of life assessments made by severely mentally ill patients. It is indeed feasible to collect statistically reliable quality of life data from chronic mental patients, and concluded that subjective quality of life assessments can be applied to such patients (Lehman, 1993). Browne et al; 1996 summarized the view of several authors, and stated that clinical evaluation of quality of life obtained from reports of psychiatric patients is desirable, since self reports can be influenced by persistent psychotic symptoms, the idiosyncratic views and values of these patients, and by the adaptation to adverse circumstances. Schizophrenic patients feel, experience, and are able to report their social deficits, which supports the thesis that quality of life can be assessed subjectively (Skantze et al., 1992).

Reviewing the various studies in the literature concerning the quality of life of schizophrenic patients, considerable differences are found in the methodology applied, thus

making it difficult to establish comparisons. However, it can be concluded that quality of life of schizophrenic patients is characterized, in general, by the following aspects:

1. It is worse than that of the general population and that of other physically ill patients.
2. Young people, women, married persons, and those with a low level of education report a better quality of life.
3. The longer the length of the illness, the worse the quality of life.
4. Psychopathology, especially negative and depressive syndromes, correlates negatively with quality of life.
5. Patients integrated in community support programs demonstrate a better quality of life than those who are institutionalized (Bobes & Garcia-Portilla, 2005).

Malm and colleagues in 1991 used the Quality of Life scale to describe the life quality of 40 schizophrenic outpatients 2 years after their last hospitalization, and noted unsatisfactory ratings for almost all patients in the domains of knowledge and education, relationships, finances, and leisure. The investigators concluded that the chronically mentally ill have an overall lower subjective life satisfaction than the general population, and they are particularly dissatisfied in the interpersonal and financial domains of their lives (Malm et al., 1991).

Numerous studies have examined factors associated with life quality. The literature focuses on demographic variables and symptom profiles; however, recent reports also correlate personality style and psychological insight into illness. (Goodman et al., 1997).

In terms of demographics, marital status and gender are believed to be unrelated to subjective life quality (Browne et al., 1996). For unmedicated schizophrenic subjects, it was reported that females had higher life quality than males (Shtasel et al., 1992). Further, Lehman

when married patients were assessed with the QOL interview claimed higher global satisfaction. The association of age with subjective life quality has conflicting findings, including negative correlations as well as no correlation. Several researchers have noted associations between residence and supports and QOL. Homelessness is correlated with the worst life quality: autonomy in the living situation is associated with greater life satisfaction. Another interview data also support the notion that educational level is negatively correlated with QOL (Lehman et al.,1995,1998). This is a particularly important finding, given the extent of homelessness in the chronically mentally ill and the push toward greater community tenure. Similarly, patients with poor social supports and lack of financial resources have a lower QOL (Koivumaa-Honkanen et al., 1996). By using a modified QOLC, it was found that patients who had higher levels of education perceived they had lower life quality, as did unemployed individuals (Skantze et al., 1992).

Investigations that linked symptoms and illness factors to life quality revealed that severe negative symptoms, the presence of tardive dyskinesia, and long duration of illness were all associated with lower QOL (Browne et al., 1996). Research supported link between negative symptoms and QOL, and also reported a correlation with positive symptoms. Unfortunately, there are no published reports on the association between disorganized symptoms and QOL (Meltzer et al., 1990).

Recent research on association variables has focused on the area of psychological and adjustment factors. One study reported that patients who attribute their problems to a mental illness have a lower QOL, and noted that increased insight correlated with lower subjective well-being. This finding has ramifications for insight-oriented treatments and stresses that increased awareness is not uniformly a benefit (Goodman et al., 1997).

"Theoretical array of present research"

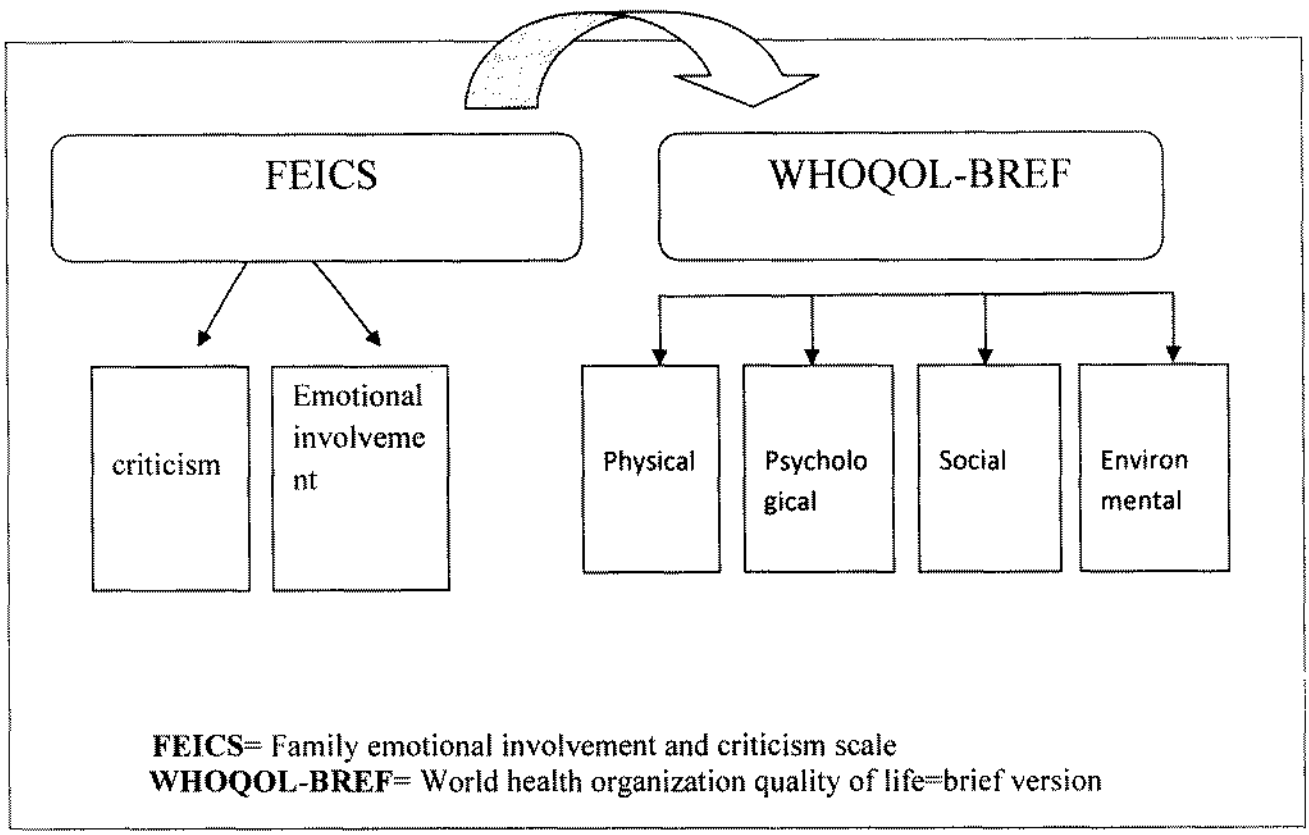

Figure 3: In the light of above given literature support present research is theorized as sketch above.

Relationship between Expressed Emotions and Quality of Life

Past research has emphasized changing families, most typically by lowering expressed emotion, with little emphasis on the families' strengths, in particular, pro-social family processes that may enhance the life satisfaction of their loved one. As a recovery orientation focuses on the strengths of adults with mental illness, it should focus equally on the supportive presence of

families in the lives of clients. Research on the family's contribution to the quality of life of persons with serious mental illness has focused largely on negative family interactions associated with poorer outcomes. The concept of expressed emotion has received the most attention, with an emphasis on the family's role in relapse through criticism of and over-involvement in the life of the relative with mental illness. However, many families play a supportive role and serve as a safety net, because the demand for mental health services far exceeds their availability (Lefley, 1996).

Yet little is known about the types of family behaviors that enhance rather than detract from the quality of life of persons with schizophrenia. Some researchers have begun to identify pro-social family processes, such as the expression of warmth and positive remarks, that support clients on their road to recovery. However, research on adults with schizophrenia has been limited to studying the relationship of these pro-social behaviors to relapse. (Weisman et al., 1993, Lopez et al., 2004).

In addition, an individual's self-concept is deeply influenced by the attitudes of significant others with whom he or she most intensively interacts (Rosenberg, 1979). Because few persons with schizophrenia marry and have children, their self-concept may be particularly influenced by parental attitudes and siblings. Research indicates that persons with schizophrenia are profoundly affected in a negative way when living in environments characterized by high levels of criticism, be they the parental home or nonfamily settings. (Rosenfarb et al., 1995). The present research will focus this area with reference to schizophrenic clients in Pakistan.

Rationale of the Study

The main objective of the study was to find out the patient's families level of expressed emotion, which is operationalized in the forms of emotional over-involvement and criticism and affect of families level of expressed emotions on the quality of life of schizophrenic patients. The present study will likely to provide useful information in the field of research on schizophrenic patients, especially in research on the relationships between quality of life and expressed emotions of schizophrenic patients. The results will be helpful in finding answers to the questions that cannot be obtained through direct observation. This study will also provide guidelines to the families and researchers in understanding schizophrenic feelings, emotions, problems and what kind of support and care he or she wants from family. The rationale of this study is to highlight the importance of expressed emotions in the initiation, maintenance and recovery of their illness. What is the importance of family as a whole to treat people with this disorder so that they could experience psychotic episodes with less pain and discomfort. It will explore the role of expressed emotions in developing and maintaining symptoms of schizophrenia as well as how families contribute to either improve or effect the quality of life of schizophrenic patients.

Although the study on family expressed emotion and schizophrenia has been around for more than four decades, but the researcher's has not been able to study or identify the relationship between expressed emotions and quality of life of schizophrenic patients in Pakistan due to lack of research in this area. So, this study will be unique to link these two very crucial variables of life. Quality of life issues are crucially important, because they may powerfully predict an individual's capacity to maintain his or her social, emotional and physical well being and expressed emotions is a measure of the attitudes expressed by family members when talking

about the person whose behavior is disturbed. The rationale of this study was to study or to know how positive and negative expressed emotions affect quality of life of schizophrenic patients. Fewer researches has been done with schizophrenic patients because of chronic illness and availability of patients, the other aim to study schizophrenic patients is to plan therapeutic interventions and high lights the contributing factors which enhance the chances of relapse of schizophrenia.

Caring for a person with schizophrenia is highly challenging and it might result in negative emotional atmosphere in the patient's family. This emotional atmosphere means the quality of caregiver's attitudes and relationships toward the patients is a robust variable which can negatively affect both the patients and family. Moreover, this negative family atmosphere and low emotional involvement causes not only poor quality of life and re-hospitalization, but it has significant effect on the course of the patient illness. The symptoms of patient influence the family expressed emotions and this in turn influence the worst symptoms in patients. Hence, the treatment should attempt at a holistic, a multidisciplinary, bio-psychosocial approach which should manage the patient and family in all dimensions. Moreover, clinical practitioners need different outlook in assessing, providing interventions, and carry out research work.

Expressed emotions and quality of life information can help caregivers at home or nursing staff in hospitals about care that is needed to improve the quality of life and decrease the contributing factor which enhance the chances of relapse and try to maintain the likelihood of long term survival with highest quality of life possible. It will also open further evenues about the prevention and relapse of schizophrenia. This research also explore the other hidden areas about relationship between expressed emotions and quality of life of schizophrenic patients. The findings of this research will be beneficial as a whole as no other research has yet been done

specifically on these variables. Therefore, this study will be a landmark for the future studies and development of different intervention programs to guide the family members, patients, practitioners and research workers.

Chapter II

METHOD

Objectives

Following are the objectives of the study:

1. To explore the relationship between family's expressed emotions and quality of life of schizophrenic patients.
2. To study the expressed emotions in terms of criticism and emotional involvement of schizophrenic patients.
3. To study the different domains of quality of life of schizophrenic patients (physical, psychological, social & environmental).
4. To investigate the relationship between emotional involvement and criticism towards quality of life of schizophrenic patients.
5. To find out the difference in male schizophrenic patients quality of life in comparison to female schizophrenic patients.
6. To study the impact of expressed emotions on the domains of quality of life of schizophrenic patients.
7. To study the affect of demographic variables on quality of life of schizophrenic patients.

Hypotheses

For the above mentioned objectives following hypotheses were made:

1. Family criticism leads to low quality of life of schizophrenic patients.

2. There exists a relationship between emotional involvement and quality of life of schizophrenic patients.
3. There exist gender differences in quality of life and families expressed emotions among schizophrenic patients.
4. There exists a relationship between duration of illness and quality of life of schizophrenic patients.
5. There is a relationship between domains of expressed emotions and quality of life.

Operational Definitions

Schizophrenia

Schizophrenia is a chronic and severe mental disorder characterized by disintegration of thought processes and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking, and significant social or occupational dysfunction (Van & Kapur, 2009).

In the present study diagnosed cases of schizophrenia referred by psychiatrists were taken from psychiatric departments of different private and government hospitals, and reconfirm their diagnosis with the help of DSM-V diagnostic criteria through interview.

Quality of life

Quality of life is an individual's perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL-BREF, 1996).

In the present study high score on quality of life indicate high quality of life and its respective domains as mentioned onward.

Expressed emotions

Expressed emotions are defined as emotions displayed (criticism, hostility and emotional over-involvement), typically in the family setting, usually by a family or care takers (Asarnow et al., 2001). It is determined by critical comments, statements of dislike or resentment toward the patient by family members, and statements reflecting emotional over involvement, over concern, or over protectiveness for the patient (Roff & Knight, 1981).

In the present study Expressed emotions have both positive and negative impact on the quality of life of schizophrenic patients.

Participants

The study consist of sample size 70, including 35 males and 35 females schizophrenic patients. Sample was taken from OPD's of Rawalpindi and Islamabad hospitals. Stable Schizophrenic patients was taken from psychiatric departments of different private and government hospitals having at least 2 year history of diagnosis. The age range of sample lied between 20 to 50 years.

Instruments

1. World health organization Quality of life- brief version, WHOQOL-BREF (WHOQOL Group, 1996).
2. Family Emotional Involvement and Criticism Scale, FEICS (Shield & Cleveland, 1992).

3. Demographic sheet.

WHOQOL-BREF

The World health organization quality of life -brief version WHOQOL-BREF includes 26 items measuring the following domains: physical health, psychological health, social relationships, and environment. Two further items evaluate the individual's overall perception of quality of life and the individual's overall perception of their health. Domain scores are scaled in a positive direction (i.e. higher scores correspond to better quality of life). Each question is graded with a Likert-type scale for intensity (not at all - extremely), capacity (not at all - completely), frequency (never - always) and rating (1 = very dissatisfied, 2 = dissatisfied, neither satisfied nor dissatisfied, 3 = satisfied 4 = and 5 = very satisfied). This scale creates an analog scale ranging from 0-100, with zero as the lowest score and 100 as the highest score. The greater the score, the better the quality of life, whereas the lower the score, the worse the quality of life. The average score of items within each domain is used to calculate the domain score. Mean scores are then multiplied by 4 in order to make domain scores comparable with the scores used in the WHOQOL-100. Where more than 20% of data is missing from an assessment, the assessment should be discarded. Where an item is missing, the average of other items in the domain is substituted. Where more than two items are missing from the domain, the domain score should not be calculated (with the exception of domain 3, where the domain should only be calculated if 1 item is missing). The four domains of WHOQOL-BREF are as follows. (WHOQOL-BREF, 1996).

Physical Domain includes item 3,4,10,15,16,17 & 18 and it measures to what extent do you feel that physical pain prevents you from doing what you need to do? How much do you

need any medical treatment to function in your daily life? Do you have enough energy for everyday life? How well are you able to get around? How satisfied are you with you sleep?

Psychological Domain includes item 5,6,7,11,19&26 and it measures how much do you enjoy life? How well are you able to concentrate? Are you able to accept you bodily appearance? How satisfied are you with yourself?

Social Domain includes item 20,21&22, measures how satisfied are you with your sex life? How satisfied are you with your personal relationships? How satisfied are you with the support you get from your friends?

Environmental Domain includes item 8,9,12,13,14,23,24&25, measures how safe do you feel in your daily life? How healthy is your physical environment? Have you enough money to meet your needs? How satisfied are you with your transport?

Family Emotional Involvement and Criticism Scale (FEICS)

It is a 14-item scale which assesses two dimensions of Expressed emotions: Emotional involvement (EI) and perceived criticism (PC) in the family. It is important to address the emotional over involvement and criticism when working with families with member who has severe and persistent mental illness. Higher criticism and over involvement scores are associated with more mental healthcare visits to hospitals for biomedical and psychosocial services due to higher rates of relapses. This scale proposes that expressed emotion is an important variable in assessing and treating both biopsychological distresses. On 14-item scale, the Perceived Criticism subscale should clearly indicate negative attitudes and emotional over involvement scale clearly reveal high levels of emotional involvement. The 14 items are organized such that perceived criticism is assessed by even-numbered items and emotional over involvement is

measured by odd-numbered items. A 5-point Likert-type scale includes response options of almost never, once in a while, some, often, almost always. On this scale, high scores indicate greater levels of perceived criticism and emotional over involvement. (Shields et al., 1992).

Demographic sheet

Demographic sheet provides the detailed information about the background, gender, age, education, occupation, marital status and birth order etc that was helpful in research.

Clinical profile provides detailed information regarding patient's problems and nature of severity of illness, duration of illness, type of disease (both psychological and physical), and family history of illness, previous treatment, co-morbid disorder / symptoms, types of delusions and hallucinations and number of occurrences of schizophrenic episodes.

Research Design: The present study is composed of two stages:

Stage 1: Pilot study comprised of measuring the reliability of scales.

Stage 2: Main study was aimed to study the impact of family's expressed emotions on the quality of life of schizophrenic patients.

Translation of Family Emotional Involvement and Criticism Scale (FEICS)

For the purpose of translation, translation/ back translation approach was adopted and following guidelines recommended by Brislin (1973) were followed;

- Maximizing the content similarity between the original test and the target language version.
- Maintaining the relatively simple language level of the original test.

- Translating the test without substitution or elimination of any item.

Forward Translation

In forward translation process, instrument was translated in to target language that is urdu by professionals who were expert in Urdu language and were knowledgeable of the English-speaking culture. The translators were briefed about the purpose of research and were given instructions about the translation procedure. they were requested to emphasize on conceptual equivalence of items so as to convey the idea of the original statement.

Expert Panel

The bilingual (in English and Urdu) expert panel was convened for evaluation of translations. the committee consisted of skilled clinical practitioners. The committee members critically examined and reviewed the translations for each item selected the items so that the context and meaning of the item were not affected by the translation. For the selection of item the level of agreement between the committee members was given significant importance and the items which were not agreed by even a single committee member were given for retranslation by other language experts.

Back Translation

The complied version was then back translated from target language to source language. Using the same approach as that outlined in the first step, the instrument was back translated to English by the separate bilingual experts. As in the initial translation, emphasis in the back-translation was on conceptual and cultural equivalence and not linguistic equivalence. Committee approach was sought for the review of back translations and the consistent items

were then cross checked with the original items. The purpose of the approach was to identify points of equivalence and to resolve the translation inaccuracies. Then a final draft was prepared for pilot testing.

Pilot Study

A sample of 30 schizophrenic patients age range 20-50 years were taken from different government and private hospitals of Rawalpindi and Islamabad for pilot study. This study included the complete range of variables of the respondents as required for main study. The purpose of doing initial study was to measure the reliability of the scale. The Chronbach alpha reliability of FEICS was satisfactory.

Procedure

Standardized scales were used in order to carry out the main study. The scales were administered on both male and female schizophrenic patients of age group 20 – 50 Years. For data collection permission was taken from heads of different psychiatry departments respectively. The sample of 70 both male and female schizophrenic patients were taken from the psychiatry department of different private and government hospitals of Rawalpindi and Islamabad. The researcher gave the verbal instructions about the scales and gave time for the completion, and the participants were asked to give honest answers about themselves, their feelings, emotions and family behavior .

Statistical analysis

Statistical analysis was done according to the requirements of the data. SPSS 16.0 windows evaluation version was used. In this research dependent variable was Quality of life and

independent variable was family emotional involvement and criticism. Descriptive statistics was used. Mean and standard deviation was computed. To test the reliability of the scales Cronbach's alpha was used. Pearson's Co-efficient of Correlation was computed to assess the relationship between two variables. To test the difference between the variables and scale t-test was calculated. Analysis of variance was analyzed to test the difference of variables with regard to both scales. Linear regression analyses was applied to assess the quality of life of schizophrenic patients as a predictor variable on outcome variable families expressed emotions by controlling the effect of demographic variables.

Chapter III

RESULTS

The results section provides an explanation of what was found in the study.

Table 1

Descriptive statistics of World health organization Quality of life-brief version and Family expressed emotions and criticism scale. (N= 70).

Variables	No. of items	M	SD	Skewness
Physical	7	15.95	3.92	.516
Psychological	6	16.51	3.07	.135
Social	3	8.88	2.85	.429
Environmental	8	22.45	4.88	.695
Criticism	7	13.82	4.25	.403
Emotional involvement	7	12.82	3.13	.492

Table 1 indicates mean, standard deviation and skewness of domains of World health organization Quality of life-brief version and subscales of Family emotional involvement and criticism scale. The skewness values show that the sample is normally distributed.

Table 2

Demographic characteristics of Schizophrenic patients (N = 70)

Variables	*N*	%
Gender		
Male	35	50
Female	35	50
Birth Order		
Youngest	24	34.3
Middle	22	31.4
Eldest	23	32.9
Educational Background		
Illiterate	22	31.4
Primary	12	17.1
Middle	9	12.9
Matric	18	25.7
Intermediate	3	4.3
Bachlors	5	7.1
Master & above	1	1.4
Area of Residence		
Urban	59	84.3
Rural	11	15.7
Marital status		
Married	22	31.4
Unmarried	46	65.7
Duration of Illness		
Less than 5 years	51	72.9
More than 5 years	19	27.1

Demographic characteristics of Schizophrenic patients (N = 70)

Variables	*N*	%
Family history		
Yes	17	24.3
No	53	75.7
Occupation		
Government	14	20
Private	3	4.3
Skilled	17	24.3
Unskilled	35	50
Disease		
Physical	5	7.1
Psychological	55	78.6
Both	10	14.3
Total	70	100.0

Table 2, Represents the distribution of schizophrenic patients on the basis of gender, education, birth order, marital status, occupation, Area of residence, Disease, duration of illness and family history. As seen in the table the gender distribution of the sample was equally divided (Male=35, Female=35). The educational field of the sample include seven categories showing that the frequency of illiterate patients are more among other categories. Among marital status unmarried 97.1% has highest percentage. Birth order include youngest, middle and eldest, youngest has high percentage. Among area of residence Urban 84.3% has highest range. Among disease psychological 78.6% has more percentage. Duration of illness having duration of less than 5 years 72.9% is high. Patients with no family history 75.7% has highest percentage.

Table 3

Chronbach Alpha reliability analysis of World health organization quality of life-brief version (WHOQOL-BREF), and Family emotional involvement and criticism scale (N=70).

Scales	No of Items	Alpha reliability
WHOQOL-BREF	26	.707
FEICS	14	.612

Note: WHOQOL-BREF= World health organization Quality of life-brief version & FEICS= Family emotional involvement and Criticism Scale.

Table 3 shows reliability analysis of World health organization Quality of life-brief version (WHOQOL-BREF) and Family emotional involvement and Criticism scale (FEICS). The table shows that WHOQOL-BREF (α= .707) and Family emotional involvement and criticism scale (α = .612) have satisfactory internal consistency and both the scales are reliable instruments for the present population of research.

Table 4

Correlation Matrix between subscales of World health organization Quality of life-brief version and Family expressed emotions and criticism scale. (N=70).

Scales	Criticism	Emotional Involvement
Physical		
Psychological	-.29*	.37*
Social	-.25*	
Environmental		

Note. *p< 0.05

Table 4 displays the inter scale correlation among subscales of World health organization quality of life-brief version and family expressed emotions and criticism scale. The result shows that subscale e.g. Psychological and Social domains are internally correlated with criticism at the significant level of 0.05, but there is a negative relationship between them, and there is a positive relationship between emotional involvement and psychological domain.

Table 5

Regression Analysis for the World health organization quality of life-brief version and Perceived Criticism (N=70).

Variable	B	SEB	β	t	F
(Constant)	73.95	3.62			
PC	-.48	.25	-.23*	-4.9	37.9

Note: B= Unstandardized coefficient, β= standardized coefficient, SE= standard error

R= -.23 R^2 = .153 *p<.05

Table 5 shows regression analysis for World health organization quality of life-brief version and perceived criticism. It is revealed that perceived criticism is a negative predictor of WHOQOL-BREF , showing the beta values (β =-.23, t= -4.9, *p<.05). The model is accounting for 15.3% variance in WHOQOL-BREF and PC.

Table 6

Regression analysis for the world health organization Quality-brief version of life and Emotional involvement (N=70).

Variable	B	SEB	β	t	F
(Constant)	67.0	4.6			
EI	.56	.11	.38**	4.2	30.55

Note: B= Unstandardized coefficient, β= standardized coefficient, SE= standard error

R= .38 R^2 = .140 **p<.01

Table 6 shows regression analysis for WHOQOL-BREF and Emotional involvement. It is revealed that emotional involvement is a significant predictor of quality of life , showing the beta values (β =-.38, t= 4.2 , **p<.01). The model is accounting for 14% variance in WHOQOL-BREF and EI.

Table 7

Mean, Standard Deviation, t-value, p and Cohen's d values on subscales of WHOQOL-BREF between Male and Female (N=70)

Variable	Male (n= 35)		Female (n= 35)				95% CI		Cohen's d
	M	S.D	M	S.D	t	p	LL	UL	
Physical	16.11	3.66	13.80	4.22	.33	.74	-1.57	2.19	0.08
Psychological	17.37	2.88	12.65	3.05	2.41	.00	.297	3.13	0.58
Social	9.22	2.91	6.54	2.79	1.06	.01	-.674	2.04	0.25
Environmental	23.17	5.09	18.7	4.62	1.22	.02	-.894	3.75	0.29

Note. LL= lower limit, UL= upper limit, CI= Confidence Interval, M= mean, SD= Standard deviation WHOQOL-BREF = World health organization quality of life.

df= 68, *p<0.05

Table 7 show the results of t-test for comparing gender based mean differences on WHOQOL-BREF and its subscales. The table shows significant gender differences on the variable WHOQOL-BREF along its subscale. Here the result displays that males have greater score (M=16.11) on physical domain than females (M=13.80). Due to high score on physical domain males also show high scores on psychological (M=17.37), social (M=9.22) & environmental domain, (M=23.17) as compared to female (M=12.65), (M=6.54) & (M=18.7) & Values of Cohen's d indicate that how much mean difference found between male and female on quality of life. Result is significant at .05 level.

Table 8

Mean, Standard Deviation, t-value, p and Cohen's d values on subscales of FEICS between Male and Female (N=70)

Variable	Male (n= 35)		Female (n= 35)		t	p	95% CI		Cohen's d
	M	S.D	M	S.D			LL	UL	
EI	11.60	6.41	16.05	9.85	.60	.54	.75	-1.95	.02
PC	14.60	8.75	12.05	7.75	.22	.65	-2.50	1.58	.01

Note. LL= lower limit, UL= upper limit, CI= Confidence Interval, M= mean, SD= Standard deviation FEICS= Family emotional involvement and criticism scale, PC= Perceived criticism, EI= Emotional involvement

$p>0.05$

Table 8 show the results of t-test for comparing gender based mean differences on family emotional involvement and criticism and its subscales. The table shows non-significant gender differences on the variable FEICS along its subscale.

Table 9

Mean, Standard Deviation, t-value, p and Cohen's d values of WHOQOL-BREF and duration of illness (N=70)

Variable	<5 years (n= 51)		>5 years (n= 19)		t	p	95% CI		Cohen's d
	M	S.D	M	S.D			LL	UL	
WHOQOL-BREF	69.17	8.38	51.89	8.84	6.15	.000	12.7	11.8	1.23

Note: LL= Lower limit, UL=Upper limit, CI= Confidence interval, M= Mean, SD= Standard deviation

***p<.001

Table 9 shows Mean, Standard deviation, t-value, p and Cohen's d values of quality of life and duration of illness. There is significant difference found between less than 5 years (M=69.17) and more than 5 years (M=51.89) at .001 level of significance.

Table 10

Analysis of Variance (ANOVA) among disease on WHOQOL-BREF, FEICS and its subscales (N=70)

	Physical (n=5)		Psychological (n=55)		Both (n=10)			
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F (df)*	*p*
WHOQOL-BREF	65.40	5.59	67.61	9.74	75.80	8.33	10.27 (2,68)	.000
FEICS	29.20	7.19	25.58	4.64	41.30	6.64	15.76 (2,68)	.000
PC	15.40	4.03	13.14	3.84	26.80	5.39	9.22 (2,68)	.000
EI	13.80	4.08	12.43	2.80	19.50	4.03	.901 (2,68)	.646

Note: WHOQOL-BREF= World health organization quality of life-brief version, FEICS= Family emotional involvement and criticism scale, PC= perceived criticism, EI= Emotional involvement

In Table 10 ANOVA results indicate that there is a significant main effect between the type of disease (physical, psychological and both) and Family's expressed emotions, criticism and quality of life. Results on WHOQOL-BREF ($F(2,68)$, = 10.27, $p<.001$) on FEICS ($F(2,68)$,=15.76, $p<.001$) and on PC ($F(2,68)$,=9.22, $P<.001$),. There is a non-significant effect of disease on emotional involvement ($F(2,68) = .901$, $p=.646$).

Chapter IV

DISCUSSION

The present study was initiated to understand the impact of family's expressed emotions on the quality of life of schizophrenic patients and to find out which gender is affected more. Another purpose of this research was to examine the affect of different demographic variables on the quality of life of schizophrenic patients. For this purpose the instruments applied reflected a good level of reliability for the present sample of the study, World health organization quality of life -brief version, WHOQOL-BREF (.707), and Family emotional involvement and criticism scale, FEICS (.612) , respectively.

The utmost and remarkable outcome of this research was the association between family's expressed emotions and the quality of life of schizophrenic patients. In this study a sample of stable schizophrenic patients will be taken from psychiatric departments of different private and government hospitals of Rawalpindi and Islamabad having at least 2 year diagnosis, age range twenty to fifty years consisting of different demographic variables was taken. To measure variables two scales, World health organization quality of life-BREF (WHOQOL-BREF) and Family emotional involvement and criticism scale (FEICS), were administered and they seemed to be reliable for the present sample of the study. Alpha coefficients and reliability was calculated on present data, and values indicated a satisfactory result. (Table 1). Four domains of WHOQOL-BREF i.e., physical, psychological, social and environmental and two subscales of FEICS i.e., Criticism and emotional involvement were found to be correlated with each other (Table 4).

Measuring the quality of life for people with mental health problems is of interest currently because of concerns about the emphasis of mental health services on reducing symptoms. Yet our review identified the importance of family criticism and emotional involvement on the quality of life of schizophrenic patients. It was assumed that high level of criticism from the family members towards the schizophrenic patients leads to low quality of life. Result revealed that criticism negatively predict quality of life (Table 5). To test this hypothesis, linear regression analysis was applied. The variables which were controlled were age, gender & duration of illness. A negative relationship was found between perceived criticism and quality of life of schizophrenic patients. Results was defended with the previous researches, which stated that there is a significant association between expressed emotions and quality of life in patients with mental illness at residential facilities (Sharir et al., 2007). According to them high expressed emotions leads to good quality of life and low expressed emotions leads to poor quality of life. The results of another study also shows the importance of family support to quality of life for patients with mental illness (Mares et al., 2002; Goldberg et al., 2003; Nelson el at., 1995).

Studies of life events and family environmental factors have provided empirical support for the idea that schizophrenic symptoms are exacerbated by stressful circumstances (Docherty et al, 1998). It is recognized that people diagnosed with schizophrenia in families where there are high levels of criticism, hostility or over involvement, have more frequent relapses. (Droogan & Bannigan, 1998). If the patient suffering from schizophrenia lives in a stressful environment, such as being criticized and labeled as a mad person by family members, the patient may not feel loved or accepted and may eventually suffer a relapse.

Conley and Baker (1990), believe that family response and reaction to mental illness of a family member has a major impact on the long-term outcome of the disorder. Low level of emotional involvement and high levels of criticism on the patient from the family members are highly predictive of symptomatic relapse. Families are usually the primary social resource for patients. Patients suffering from schizophrenia in particular, depend largely on relatives in times of stress. the longer the patients remain ill, the less able they are to develop new sources of support.

A two-year study was conducted on the sample of Indian patients, the influence of family expressed emotion on the course of schizophrenia. the condition was that the emotions expressed by the key relative towards the patient and his behavior constitutes the best prognostic indicator of relapse nine months after hospital discharge. Other studies have indicated that the relative capacity of expressed emotions is equally valid when taking into account other variables of prognostic value, such as age, symptom patterns and pre-morbid adjustment (Tarrier et al., 1994).

The findings of the next hypothesis revealed that there is a significant result between family emotional involvement and quality of life of schizophrenic patients. (Table 6). The result shows that if emotional involvement is high towards the patient from the family member then there will be good quality of life. To test this hypothesis, linear regression analysis was applied. The study is supported with previous findings done by Carlsson in 2003, he concluded that emotional involvement of key care-givers was found to have a significant association with quality of life of schizophrenic patients.

Bentsen & Boye (2012) concluded that expressed emotion is a significant and robust predictor in schizophrenia, studied pattern of EE in 90 schizophrenic patients over the follow-up period of 3 years. Analysis revealed that high critical comments (CC) were associated with earlier first and second readmissions and longer hospital stay. Findings also indicated that patients from high critical comments households are at higher risk of relapse for the long-term, even if they take their medications regularly. A high level of emotional overinvolvement (EOI) was associated with, as concerns the parents spending more time with patient; and as concerns the patient, no substance abuse, less aggressive and uncritical behavior reported by the relatives.

Hooley indicated that there may be positive aspects of high expressed emotion as well as potentially negative consequences of low expressed emotion. She has suggested that the attitudes and behaviors of high expressed emotion relatives may actually promote higher levels of functioning than do those of low expressed emotion relatives. In other words, in between relapses patients from high expressed emotion households may achieve greater levels of functioning than those in low expressed emotion homes who never relapse.

Hahlweg et al., 1998 said that the differences between low and high expressed emotion families are striking. It appears that low expressed emotions from family members towards patient are actively supporting the patient. They provided a positive nonverbal climate, and emotional involvement, show concern for the patient, and try to find solutions to the problems. They interact with the patients recovery, seeing that they indeed have a disorder and need support rather than criticism in order to overcome the obstacles they face.

Viewing the impact of demographic variables like gender on the quality of life of schizophrenic patients and in terms of expressed emotions the differences were explored. (Table

7 &8). Results of this assumption are supported by the data. Males have better quality of life than females. Many studies support this notion, Kujur, kumar, & Verma in 2010 concluded that males showed higher level of QOL than their female counterparts.

Farmer, Kilbourne, & McCarthy in 2008 conducted a research on gender differences in health related quality of life for veterans with serious mental illness, they concluded that female and male veterans with serious mental illness differed on different domains of QOL, women were more impaired than men on the domains of QOL. Tore Bonsaksen (2012), examined the gender differences with regard to quality of life in patients with severe mental illness, he concluded that women had lower levels of quality of life and trended towards being more depressed than men. Xiang and his colleagues in 2010 found gender differences in sociodemographic and clinical characteristic and the quality of life of Chinese schizophrenia patients and concluded that female gender is independently associated with lower scores on psychological, social and environmental aspects of QOL. On the contrary findings are also consistent with the research conducted in 1996 by Skantz showing no significant differences between males and females regarding social adjustment, age, duration of illness and expressed emotions.

Demographic variable i.e., duration of illness(less than 5 years and more than 5 years) has significant results on quality of life. (Table9). T-test was applied to assess the difference between the duration of illness. The results shows that the patients having duration of less than 5 years has good quality of life rather than duration of illness greater than 5 years.

It was also theorized that schizophrenic patients having the history of physical problem as well as psychological have poor quality of life, low family emotions and high criticism.(Table

10) To test this hypothesis Analysis of variance was applied and the mean scores of quality of life, family's expressed emotions and perceived criticism with respect to physical, psychological and both were assessed.

Conclusion

Overall the study has demonstrated that family's expressed emotions appear to be a significant predictor of high or low quality of life of schizophrenic patients. The scale which was used in this study to measure family's expressed emotions was Family emotional involvement and criticism scale (FEICS), it has two subscales i:e., Perceived criticism and Emotional involvement, both are opposite to each other. Criticism is negatively correlated with quality of life and emotional involvement is positively correlated with quality of life. The study has provided evidence for gender differences in quality of life since males have good quality of life as compared to females. There is no gender differences in family's expressed emotions. This research also focuses on the duration of illness, which shows that schizophrenic patients with less than 5 year duration have better quality of life as compared to duration of more than 5 years. Type of disease also shows significant results on WHOQOL-BREF, FEICS & PC.

In the context of Pakistani society, schizophrenic patients have poor quality of life due to many reasons. In this study, family's expressed emotions has significant effect on the quality of life of schizophrenic patients.

Limitations

The results of the current study should be interpreted in the background of following limitations, which may have affected the observations:

1. Current study, based exclusively on hospital based patients with illness duration of two years or more were included to make the sample homogeneous. This, however, limits the generalization of results from the present study of schizophrenic respondents having acute illness.
2. The sample size may be regarded as small and hence generalization of our findings to all patients is not possible.
3. Only stable patients were included so results could not be generalized to severe schizophrenics.
4. Another short come of the current study is that the scale of expressed emotions (FEICS) have been constructed, standardized, and validated in the western countries and while applying in different cultural context, one has to consider various methodological constraints because it can affect the results. As in present study it was only translated but not validated.
5. The present study is cross sectional and only limited to Rawalpindi and Islamabad hospitals.

Thus, future studies should be planned and carried out keeping the view in methodological limitations mentioned above.

Recommendations

People with schizophrenia have poor quality of life as compared to the general population, and the reasons for it may be numerous. To find out the causes of the poor quality of life of schizophrenic patients, studies that include a thorough assessment are needed.

The following recommendations are made on the basis of the above conclusions and discussion:

1. The psychosocial interventions such as psycho education, communication skills, problem-solving strategies, social skills and occupational training, crisis management, and healthy coping strategies with the ongoing pharmacotherapy proved effective in reducing the high and low family emotions and improving the treatment outcome.
2. The importance of the current study demands that a series of future studies be carried out in order to replicate the present one by taking larger sample.
3. Rehabilitation services, agencies of various types, training and employment needs and many types of counseling, all with a primary focus on helping families and patients to cope with a problem, are of importance to the families.
4. There should be collaboration between the professional team, patient and his/her family, is essential for the effectiveness of patient treatment.
5. Future research should stress on the feasibility and efficacy of the strength-based or resiliency-based interventions with ongoing psychosocial interventions at individual or group level for the persons and families of schizophrenia to deal with the negative emotional atmosphere(criticism) of the family.

6. The assessment of expressed emotions can be accurate when the clinical rater is trained. Thus, postgraduate training programs should give emphasis to train the students of psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing in the measurement of expressed emotions. They should be trained in both qualitative-quantitative and structured-semi-structured interview methods.
7. Professionals should provide affordable treatment plan, because most of the population cannot afford proper treatment.
8. Families should be informed about the duration of the treatment of the patient.
9. The scale "Family emotional over involvement and criticism scale" (FEICS) used in this study is quite brief and easy to administer but in future researches another scale or structured interview should be administer to assess the expressed emotions in schizophrenic patients.

Clinical Implications

Expressed emotions has been recognized as an important outcome of psychiatric treatment of schizophrenic patients and measuring Quality of life can improve knowledge of the effectiveness of interventions or positive emotions used in psychiatric treatment. By following different clinical implications we can improve the quality of life of schizophrenic patients and educate their families.

1. Hospital staff should be aware that Quality of life is a multidimensional concept of which schizophrenic patients have their individual definition.

2. Plane of instructions on how routine Quality of life assessment in clinical settings can be successfully implemented should be developed.
3. Give patients opportunities to exercise self-determination as far as possible.
4. Collaborate with family members according to schizophrenic patient's and family member's needs .
5. Nurses should be trained to assess and guide to improve the patient's Quality of life.
6. In nurse-patient relationships nurses should discuss the patient's individual experiences and goals related to family emotions and daily based activities and guide the family accordingly.
7. Different educational methods of life adjustment should be available for the stable schizophrenic patients.
8. Make it possible for patients to engage in various kinds of healthy activities.
9. Take care of patient's safety and privacy .
10. Take care of patient's physical health and medication.
11. Treatment plans should be made together with patients and family considering the factors that improve Quality of life of patient's (patient's general activities, social relationships, emotions, physical health, living conditions and housing situations).

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ANNEXURE A

TYPES OF DELUSIONS

TYPES OF HALLUCINATION

Primary Diagnosis: _____

Secondary Diagnosis: _____

Hospital: _____

ذاتی کوائف ناجم

نام: _____ عمر: _____ جنس: _____

بہن بھائیوں میں کون سا نمبر ہے: _____ ازدواجی حیثیت: _____

تعلیم: _____ پیشہ: _____ ماہانہ آمدنی: _____

رہائشی علاقہ: _____

۱: آپ کس بیماری میں مبتلا ہیں؟

_____

۲: یہ بیماری آپ کو کب سے لاحق ہیں؟

_____

۳: کیا خاندان میں یہ بیماری کسی اور کو بھی ہے؟

_____

۴: کیا پہلے آپ اس بیماری کا علاج کرا چکے ہیں ر کیا پہلے کسی ہسپتال میں داخل رہ چکے ہیں؟

_____

۵: آپ کو کس طرح کے دسوسے آتے ہیں؟

_____

۶: کسی قسم کا خوف یا اندیشہ محسوس ہوتا ہے؟

_____

۷: دن میں کتنی بار ایسے خیالات آتے ہیں؟

_____

ANNEXURE B

Annex-1

WHO QOL BRIEF.

گاؤں/ شہر: _____

براہ مہربانی ہر سوال کو غور سے پڑھیں پچھلے دو ہفتوں کے دوران اپنے احساسات کی روشنی میں سکیل میں دیئے گئے اس نمبر پر دائرہ لگائیں۔ جو آپ کے احساسات بہترین ترجمانی کرتا ہو۔

	بہت خراب	خراب	نہ خراب نہ اچھی	اچھی	بہت اچھی
1. آپ اپنے معیار زندگی کو کس سطح پر پاتے ہیں؟	1	2	3	4	5

	بہت غیر مطمئن	کافی حد تک غیر مطمئن	نہ مطمئن نہ غیر مطمئن	مطمئن	بہت مطمئن
2. آپ اپنی صحت کے بارے میں کس حد تک مطمئن ہیں؟	1	2	3	4	5

مندرجہ ذیل سوالات ان تجربات سے متعلق ہیں جو پچھلے دو ہفتوں کے دوران آپ پر گزرے۔

	بالکل نہیں	معمولی مقدار میں	درمیانی مقدار میں	کافی مقدار میں	انتہائی مقدار
3. جو کام آپ کو کرنے کی ضرورت ہے آپ کا جسمانی درد اس میں کس حد تک رکاوٹ بنتا ہے؟	1	2	3	4	5
4. آپ کو اپنی روزمرہ زندگی میں کام کرنے کے لیے طبی علاج کی کتنی ضرورت ہے؟	1	2	3	4	5
5. آپ زندگی سے کتنا لطف اندوز ہوتے ہیں؟	1	2	3	4	5
6. آپ کس حد تک اپنی زندگی کو بامعنی محسوس کرتے ہیں؟	1	2	3	4	5

	بالکل نہیں	معمولی	درمیانہ/درمیانی	بہت	بہت زیادہ
7 آپ میں توجہ مرکوز کرنے کی صلاحیت کتنی اچھی ہے۔	1	2	3	4	5
8 آپ اپنی روزمرہ زندگی میں خود کو کتنا محفوظ محسوس کرتے ہیں۔	1	2	3	4	5
9 آپ کا طبی ماحول کتنا صحت مند ہے؟	1	2	3	4	5

مندرجہ ذیل سوالات ان تجربات سے متعلق ہیں جو پچھلے دو ہفتوں کے دوران آپ پر گزرے۔

	بالکل نہیں	تھوڑا سا/تھوڑی سی	کچھ حد تک	بہت حد تک	مکمل طور پر
10 کیا آپ روزمرہ زندگی کے لیے کافی توانائی رکھتے ہیں؟	1	2	3	4	5
11 کیا آپ اپنی جسمانی شکل وصورت کو قبول کر پاتے/ پاتی ہیں؟	1	2	3	4	5
12 کیا آپ کے پاس اپنی ضروریات پوری کرنے کے لیے کافی رقم ہے؟	1	2	3	4	5
13 آپ کو روزمرہ زندگی کے لیے درکار معلومات کتنی میسر ہیں؟	1	2	3	4	5
14 آپ کو فرصت کے لمحات گزارنے کے موقع کس حد تک میسر ہیں؟	1	2	3	4	5

	بالکل نہیں	معمولی	درمیانہ/درمیانی	بہت	بہت زیادہ
15 آپ اپنے آپ کو کسی کام کے لیے جسمانی طور پر آمادہ کر پاتے ہیں؟	1	2	3	4	5

مندرجہ ذیل سوالات میں پوچھا گیا ہے کہ آپ نے اپنی زندگی کے مختلف پہلوؤں کے بارے میں گزشتہ دو ہفتوں کے دوران کتنا اچھا اور مطمئن محسوس کیا۔

	بہت غیر مطمئن	کافی حد تک غیر مطمئن	نہ مطمئن نہ ہی غیر مطمئن	مطمئن	بہت مطمئن
16 آپ اپنی نیند سے کتنے مطمئن ہیں؟	1	2	3	4	5
17 آپ اپنی روزمرہ زندگی کے معمولات ادا کرنے کی اہلیت سے کتنا مطمئن ہیں؟	1	2	3	4	5
18 آپ کام کے لیے اپنی استعداد سے کتنے مطمئن ہیں؟	1	2	3	4	5
19 آپ اپنے آپ سے کتنا مطمئن ہیں؟	1	2	3	4	5
20 آپ اپنی ذاتی تعلقات سے کتنا مطمئن ہیں؟	1	2	3	4	5
21 آپ اپنی جنسی زندگی سے کتنے مطمئن ہیں؟	1	2	3	4	5
22 آپ اپنے دوستوں سے ملنے والے سہارے سے کتنے مطمئن ہیں؟	1	2	3	4	5
23 آپ جس جگہ رہتے ہیں وہاں کے حالات سے کتنا مطمئن ہیں؟	1	2	3	4	5
24 آپ طبی سہولیات تک اپنی رسائی سے کتنا مطمئن ہیں؟	1	2	3	4	5
25 آپ اپنے ذرائع آمدورفت سے کتنا مطمئن ہیں؟	1	2	3	4	5

	کبھی نہیں	شاذونادر	بعض اوقات	اکثر اوقات	ہمیشہ
26 آپ کو کتنی بار منفی احساسات جیسا کہ افسردگی، مایوسی، اضطراب، ڈیپریشن، ہوتے ہیں؟	1	2	3	4	5

نام: _____ عمر _____ جنس مرد/عورت _____

ایڈریس: _____ تعلیم: _____ پیشہ: _____

ازدواجی حیثیت: شادی شدہ/غیر شادی شدہ/طلاق شدہ/رانڈ/رنڈوا

ممبران فیملی: _____

فون نمبر: _____

ANNEXURE C

نیچے دیے گیے سوالات آپ اور آپ کے خاندان کے بارے میں ہیں۔ جس کسی کو بھی آپ اپنے خاندان میں شامل کرتے ہیں برا مہربانی ان
کے ساتھ اپنے تعلقات کے بارے میں جواب دیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

1 میں پریشان ہو جاتا/ جاتی ہوں اگر میرے گھرمیں کوئی پریشان ہو۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

2 میں جو کچھ بھی کرتا/کرتی ہوں میرے گھر والے اُسے مان لیتے ہیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

3 میرے احساسات کے بارے میں میرے گھر والے جانتے ہیں ۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

4 میرے گھر والے میرے دوستوں میں حامیاں تلاش کرتے ہیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

5 جب مجھے پیسوں کی ضرورت پڑتی ہے میرے گھروالے مجھے دے دیتے ہیں ۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

6 میرے گھر والے میرے پیسوں کے استعمال کرنے پر شکایت کرتے ہیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

7 میرے گھر والے میرے بتانے سے پہلے ہی جان جاتے ہیں کہ میں کیا سوچ رہا رہی ہوں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباہمیشہ

8 میرے گھر والے میرے دوستوں کو پسند کرتے ہیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

9 میں اکثر گھر والوں کے بتانے سے پہلے ھی سمجھ جاتا/جاتی ھوں کہ وہ کیا سوچ رھے ھیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

10 میرے گھر والے میرے تفریح کرنے کے انداذ پر شکایت کرتے ھے۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

11 اگر میں پریشان ھوں تو میرے گھر والے بھی پریشان ھو جاتے ھیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

12 میرے گھر والے ھمیشہ مجھے تبدیل کرنے کی کوشش کرتے رھتے ھیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

13 اگر میں خود سے کہیں نہ جا پاؤں تو میرے گھر والے مجھے لے جاتے ھیں۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

14 مجھے ھر کام میں بہت محتاط رھنا پڑتا ھے ورنہ میرے گھر والے مجھے شرمندہ کریں گے۔

0.تقریبا کبھی نہیں 1-کبھی کبھار 2.بعض اوقات 3.اکثر 4.تقریباھمیشہ

From: Sara Zahid [mailto:ashsmili@yahoo.com]
Sent: Tuesday, April 12, 2011 5:29 AM
To: Shields, Cleveland G
Subject: URGENTLY REPLY

Assalam-o-Aleikum Respected Sir,

My name is Ayesha Zahid, student of Ms clinical psychology IIUI (Internationsl Islamic University). Sir i am not sure but i got your email from google related to this scale (FEICS), so just making sure i am contacing the right person .Sir i need your scale (family emotional involvement and criticism scale FEICS) for my research work, i want to use this scale in my research, kindly give me permisiion to use your scale in my research, and mail me your scale with scoring, i will be greatful to you. Waiting for your urgently positive reply, because i have very short time.Thankyou.

From: "Shields, Cleveland G" <cgshield@purdue.edu>
To: Sara Zahid <ashsmili@yahoo.com>
Sent: Tue, April 12, 2011 12:57:55 PM
Subject: RE: URGENTLY REPLY

You are certainly welcome to use the scale. I would like to know a bit more about you.

Tell me where your university is located.

With what population are your going to use the scale?

If you are not in an English speaking country, how do you plan to translate it?

From: Sara Zahid [mailto:ashsmili@yahoo.com]
Sent: Monday, March 19, 2012 9:18 AM
To: Shields, Cleveland G
Subject: Re: HI

Respected Sir I am little bit worried and confused...I need your help, will you please guide me, i will be very thankful to you. Sir i did my pilot study just to check the reliability of FEICS scale, (you send me the details of English version of this scale, its Cronbach's alpha was 0.72), but i translated in to Urdu, so want to check the reliability of Urdu version, I have some questions:

1- I want to know that only item 2 and 8 will be reversed?

[CGS] yes, only 2 and 8 are reversed

2- Odd numbers are emotional involvement? and even numbers are perceived criticism?

[CGS] yes, this is correcting

3- You mention the ranging as (produces two scales ranging from 0-28) what does it mean?

[CGS] that just means that the total scores and person could get on the scale could range from zero to 28. For example, if a person answered 0 to all items they would get a 0 score if they answered

4- Is this coding is correct " RECODE FEICS02 FEICS08 (0=4) (1=4) (2=2) (3=1) (4=0) INTO FEICS02R FEICS08R.VARIABLE LABELS FEICS02R 'reversed' /FEICS08R 'Reversed'."

[CGS] I think this is correct.

Psychometric questions

1. You develop this scale for normal population or specifically for schizophrenics?

for a normal population or really a population of medical patients

2- Any specific age range or not?

A wide age range

3- For both male or female? (any gender limitation)?

No

4- For both married and unmarried (about marital status)?

Does not matter

5- Can I use this scale for hospitalized patients (psychiatric patients)?

yes

6- What should be the ideal sample size?

This depends on what you are going to do with your data.

8- Any limitation regarding to educational level (educated or non-educated)?

Not really

9- At last but not least the basic purpose of this scale in your mind?

It was to assess the concepts of Expressed Emotion with a self-report scale.

From: Ayesha Zahid [mailto:ashsmili@yahoo.com]
Sent: Tuesday, April 10, 2012 10:44 AM
To: Shields, Cleveland G
Subject: Re: hi

HI,

Thanks a lot for your previous mail, sorry to disturb you again Sir, but i have few more questions to ask, i will be very thankful to you if you answer my questions.

1. After data analysis I got Cronbach's alpha reliability of FEICS is .602, is that acceptable? (Urdu version is used on patients).

[CGS] these are good enough for research work.

2. Is there any negative correlation between these two sub scales (EI and PC)?

[CGS] yes, EI measures closeness and PC measures negativity (criticism), so they are usually negatively correlated