Islamic University

Palestine – Gaza

Faculty O f Education

FAMILY INTEGRATION EXPERIENCED BY FAMILIES OF PATIENTS DIAGNOSED WITH SCHIZOPHRENIA IN GAZA STRIP

Submitted by

Marwa Mahmood Shamiya(Shehada)

220094847

"A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master in community mental health"

Supervised by

Dr / Jamil el Tahrawy **Prof / Sameer Qoota**

2012

﴿يَرْفَعِ اللَّهُ الَّذِينَ آمَنُوا مِنكُمْ وَالَّذِينَ أُوتُوا

الْعِلْمَ دَرَجَاتٍ وَاللَّهُ بِمَا تَعْمَلُونَ خَبِيرٌ﴾

المجادلة(11)

Declaration

I certify that this thesis submitted for the degree of master is the result of my own research , except where otherwise acknowledged , and that this thesis has not been submitted for a higher degree to any other university or institution .

Name : *Signature:*

Marwa Mahmood Shamiya(Shehada)

Dedication

To my Dear Parents .

To my husband whose support never stopped.

To all my family members for their endless love and encouragement.

To souls of martyrs of Palestine.

And to all those who have given me the meaning of life.

Marwa

ACKNOWLEDGEMENT

This research study would not have been possible without the guidance and the help of several individuals, who in one way or another ,contributed and extended their valuable assistance in the preparation and completion of this study. First and foremost, my utmost gratitude to God, for answering my prayers for giving me the strength to plod on despite my constitution. Then thanks to Ministry of health and world health organization for giving us this great opportunity of master study. I would like to thank Islamic University in Gaza whose sincerity and encouragement I will never forget. Many thanks to Dr. Jameel El Tahrawy who was my inspiration as I hurdle all the obstacles in the completion of this research work. I also would like to thank my advisor Dr. Sameer Goota for his extraordinary support , guidance , patience and supervision . Special thanks to Dr. Atef El Agha , who had kind concern and consideration regarding my academic requirements. Dr.Ayesh Sammmour, for his patience and steadfast encouragement to complete this study; Also I offer my regards and blessings to all of those who supported me in any respect during the completion of the study .Last but not the least, my family especially my husband for his great support and patience .

Abstract

This study aimed at describing family integration as experienced by families having patient with schizophrenia from different aspects including psychological, social and economical factors . It also described sociodemographic data effect such as age , sex, duration of the disease and place of living of patient on these domains. The study also investigates the effect of caregiver job , educational level, address and health on family integration. It also described the effect of family factors such as average income and number of family members on family integration for families having schizophrenic patient The samplings of families were done by simple random procedure among families with schizophrenic patient in Gaza strip who are registered mainly in mental health clinics and in psychiatric hospital. Sample size is 140 families and the questionnaires were distributed to the research sample and 122 questionnaires were received .This study revealed that family integration experienced by families having schizophrenics is highly affected from the perspective of different domains and most significantly the psychological domain . Results revealed significant psychological effect . Average mean = 3.78, weight mean =75.52% .The second highest score was the economical effect on family integration.(The third highest score was the social effect on .Average mean=3.47,weight main=69.47%, family integration (average mean = 3.47,weight mean ==69.44,.The level of family integration in families with schizophrenic patients is highly affected psychologically , economically and socially .(average mean=3.57 ,weight mean=71.48). The results show that no differences at significant level &=0.05 regarding family integration due to duration of disease ,sex and age of the patient, family education ,family income ,number of family members and caregiver health and address. The most important recommendations are to establish comprehensive integral centers to help patient and his family psychologically , socially and economically and to establish alternative home for those patients and homeless also to activate the role of health provider and the family to help in overcoming the troubles associated with the existence of patients with schizophrenia in the family .

ملخص الدراسة

هدفت الدراسة لوصف مستوى الاستقرار العائلي لدى أهالي مرضى الفصام من أبعاد مختلفة نفسية ، اجتماعية و اقتصادية وتأثير العوامل الديموغرافية (العمر ، الجنس ،مكان الإقامة ، وغيره) بالنسبة لمريض الفصام على التماسك العائلي . أيضا هدفت الدراسة لوصف مستوى التماسك العائلي لدى أهالي مرضى الفصام و مدى تأثير وجود المريض داخل الأسرة أو في المؤسسة على التماسك العائلي . وصفت الدراسة تأثير الحالة الصحية لمقدم الرعاية و المستوى التعليمي و المهنة و العنوان على التماسك العائلي . تمت الدراسة في مراكز الصحة النفسية المجتمعية في قطاع غزة و قد اعتمد الباحث المنهج الوصفي التحليلي في الدراسة.عينة الدراسة تتكون من 140 من مقدمي الرعاية للمريض من أفراد العائلة تم اختيارها بصورة عشوائية بسيطة و تم توزيع 140 استبانه و تسلم 122 استبانه . تم تعبئة الاستبيانات في مراكز الصحة النفسية في الرعاية الأولية . عكست الدراسة التأثير الكبير للمريض النفسي على الاستقرار العائلي من النواحي النفسية ،الاجتماعية و الاقتصادية . و قد عكست الدراسة أن البعد النفسي قد سجل أعلى تأثير(الوزن النسبي يساوي 75.52%) و يليه البعد الاقتصادي (الوزن النسبي يساوي ,69.47%) ثم البعد الاجتماعي(الوزن النسبي يساوي 69.44). و قد أوضحت الدراسة تأثر الاستقرار العائلي لدى أهالي مرضى الفصام بغض النظر عن اختلاف العوامل الديموغرافية لدى المرضى و أسرهم و بغض النظر عن المستوى التعليمي لمقدم الرعاية و حالته الصحية . من اهم التوصيات انشاء مراكز تقدم رعاية شاملة لمريض الفصام و عائلته من النواحي النفسية و الاجتماعية و الاقتصادية . كما و اوصت الدراسة بانشاء البيوت البديلة للمرضى الذين ليس لهم ماوى . اوصت الدراسة ايضا بتفعيل دور العاملين الصحيين و العائلة للمساعدة في التغلب على المشاكل الناتجة عن وجود مريض الفصام

Table of Contents

List of Tables

List of Figures

List of Annexes

List of Abbreviations

Abb.	The complete part
WHO	World Health Organization
DSM IV	Diagnostic and Statistic Manual
UK	United Kingdom
USA	United States of America
IEQ	Involvement Evaluation Questionnaire
QOL	Quality Of Life
ECI	Experience Care giving Inventory
CCL	Coping Checklist
SSQ	Social Support Questionnaire
PANSS	Positive And Negative Syndrome Scale
GHQ	General Health Questionnaire
BPRS	Brief Psychiatric Rating Scale
SRRS	Social Readjustment Rating Scale
HRQOL	Health Related Quality Of Life

GDS	Geriatric depression scale
FPQ	Family Problem Questionnaire
FCQ	Family Coping Questionnaire
SNQ	Social Network Questionnaire
SF	Short Form
CBCL	Child Behavioral Checklist
SPSS	Statistical Package For Social Sciences
CMHC	Community Mental Health clinic
K-S	Kolmagroof -Samernoof

Chapter One

Research Framework

1-INTRODUCTION

Its known that human being is the first stone in the family building and the family is the first cell in the society building .Islam aims at establishing a community full of happiness ,love , mercy and cohesion .Family integration and good values are the right indication for a happy family from different domains psychological , social and economical. The ideal example of family integration is when every member in the family feels that he is responsible about all family members .The shifting of services that were offered to patients with schizophrenia from hospital based to community based put the responsibility of care giving on the family and community . Through the close observation of families having schizophrenic patient through working in inpatient department in the psychiatric hospital , I could see how much family integration is affected due to existence of schizophrenic patient .The importance of this study comes from the researcher believe that the family is the most important part in dealing with the patient with schizophrenia and to achieve good life for our families , parents and children especially because of the increased number of patients with schizophrenia .When I review previous studies on this subject , I found many foreign studies but very few Arabic studies .I could choose my study variables on the light of reading many studies on the same subject and depending on my own experience .Neglecting this type of studies may negatively affect family and family integration . Families play an essential role in supporting people with long term mental illness in the community and are focal in the social network of people with schizophrenia .Over 60%of those with a first episode of major mental illness return to live with relatives and this would seem to reduce only by 10-20% when those with subsequent admission are included. The caregiver role is often not without difficulties and may be associated with considerable personal cost . In schizophrenia, many family members experience significant stress and subjective burden as a consequence of their caregiver role. Not only is such stress likely to affect the well being of relatives and compromise their long term ability to support patient but it may also have an impact on the course of illness itself and on outcomes for the client.(**Norman Sartorius, et al ,2005,p.264**) This research describes the impact of schizophrenia on families and the impact of family stress on patient outcomes. It then outlines the background to the development of family intervention in schizophrenia, summarizes the research findings including the evidence base for such interventions, and concludes by drawing attention to important areas for future development.(**Norman Sartorius, et al, 2005,P.265**).

Since the Israeli Occupation of the west bank and Gaza strip in June 1967, life for Palestinians has been characterized by multiple social problems. The onset of the intifada in December 1987 added prolonged exposure to a staggering array of extreme political stressors, ranging from relentless punitive traumatic experiences of loss of life or limb, loss of freedom (e.g, imprisonment) and loss of property (e.g., demolition of houses). The post trauma environment brought with it a great upsurge of interest particularly among psychologist and psychiatrists, in studying the impact of political traumas of Palestinians. Particular attention has been paid to those injured during the Intifada. and the political prisoners, traumatized women, and families who experienced various forms of political violence. Studies of the injured indicated a high prevalence of post traumatic stress disorder and low levels of psychological adjustment, woman and members of affected families suffered from high psychological distress, low subjective wellbeing, and high levels of anxiety. The effects of stress associated with major life events and of political stressors on the mental health, psychological wellbeing, and on going life patterns of traumatized Palestinian families have shown that the experience of certain life events, or clusters of these events, can have deleterious effects on subsequent mental health status and may lead to schizophrenia. Now a day's Palestinian people meet challenges of wave of Israeli violence which aims to achieve maximal political goals by destroying their families and society psychologically ,socially and economically. This current political situation imposes further demand to work for achieving good simple life for Palestinian families and society. Studying the effect of existence of schizophrenic patient on family integration is very important . Because it disrupts previous family routine and modify the values of wife and family . It also creates a situation of utter chaos. Wife may feel that(everything in the world had ended and stopped. It would be better if the whole family could be wiped out . They may feel complete trauma, shock , and crushing . The aim of this study is to assess the effect of schizophrenic patient on his family integration and to try to assist this family to cope with this problem and continue their life at the optimal level of well being. Assessing family integration level between families having schizophrenic patient is very important in order to minimize the tension and stress experienced by the family . The process by which the schizophrenic patient affect family integration will be described as an arrest in life cycle of family. It is widely recognized that care in the community is based on a partnership between community services and caregivers/ families / relatives .There is currently a great deal of concern being expressed by users group and mental health

organization about the fact that families feel unsupported , carry too great burden of care , and that communication between services and families is often poor . home environment can have a significant positive or negative impact on relapse rates for severe mental health problems. (.**Gray ,et al ,2002,p.215**)

1.1 Research Problem

The main problem addressed in this study was :

What is the family integration level experienced by families having schizophrenic patient ?

1.2 Study Questions :

1. What is the level of family integration in families with patients of schizophrenia ?
2. Does the level of family integration in families with patients of schizophrenia differ due to duration of disorder ?
3. Does the level of family integration in families with patients of schizophrenia differ due to education of the family?
4. Does the level of family integration in families with patients of schizophrenia differ due to economical level of the family ?
5. 2. Does the level of family integration in families with patients of schizophrenia differ due to patient gender (male or female)?
6. Is there a statistically significant difference in the level of family integration in families with patients of schizophrenia between institutionalized patient and deinstitutionalized ?
7. Does family integration level in families with patients of schizophrenia differ due to age and health of the care giver ?

1.3 Main Hypothesis

1- **.** There is a statistically significant relation at the level of significance $\alpha=0.05$ between the level of Family integration and having a patient with schizophrenia.

2- There is a statistically significant difference at the level of significance $\alpha=0.05$ shows that the level of family integration in families with patients of schizophrenia differ due to duration of disorder.

3- There is a statistically significant difference at the level of significance α=0.05 shows that the level of family integration in families with patients of schizophrenia differ due to education of the family.

4- There is a statistically significant difference at the level of significance α=0.05 shows that the level of family integration in families with patients of schizophrenia differ due to economical level of the family.

5- There is a statistically significant difference at the level of significance α=0.05 shows that the level of family integration in families with patients of schizophrenia differ due to patient gender (male or female).

6- There is a statistically significant differences at the level of significance α=0.05 in the level of family integration in families with patients of schizophrenia between institutionalized patient and deinstitutionalized**.**

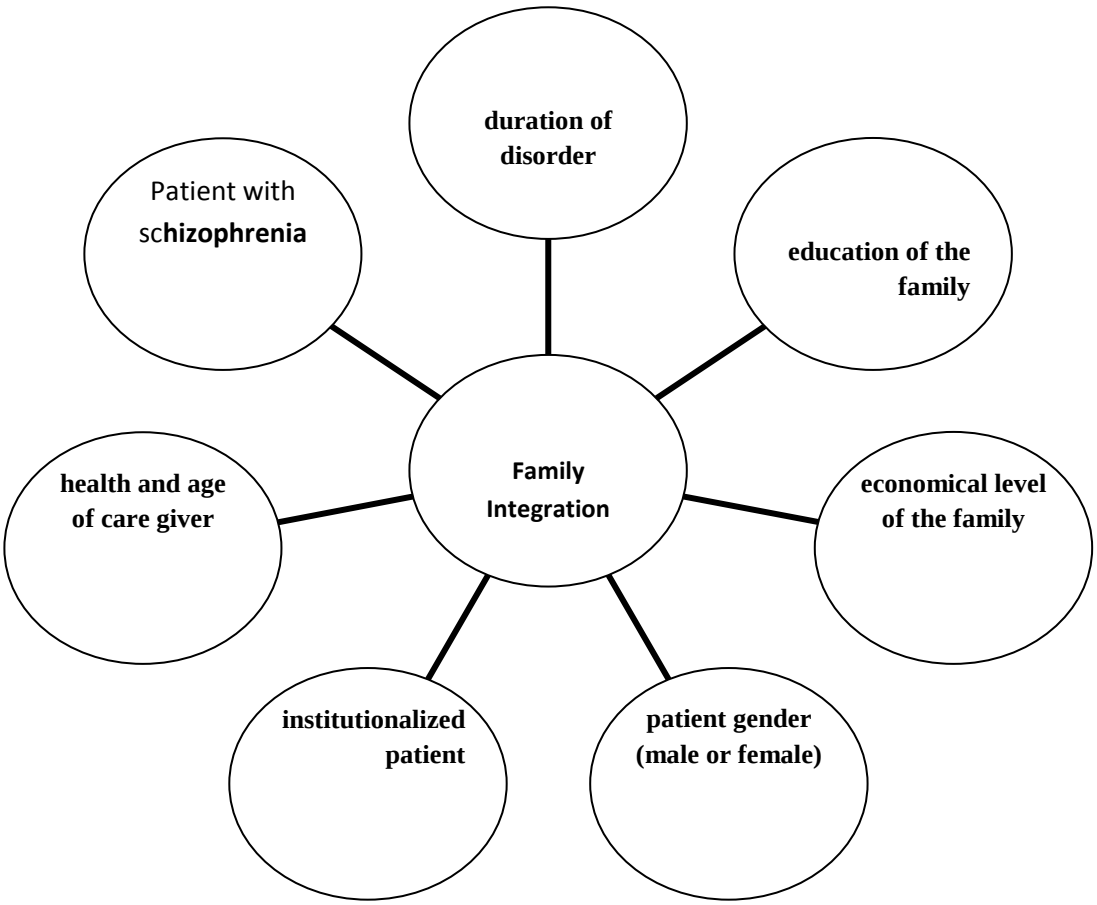
7- There is a statistically significant difference at the level of significance α=0.05 shows that health and age of care giver affect family integration in families with patients of schizophrenia**.**

1.4 Study Variables:

Independent Variable: patient with schizophrenia, duration of disorder**,** education of the family**,** economical level of the family**,** patient gender (male or female)**,** institutionalized patient, health and age of care giver**,** coping styles and social support, family attitudes toward mental health**).**

Dependent Variable: Family Integration**.**

Shape (1) Study Variables



Source: Designed by the researcher

1.5 Objectives

General objective

To assess family integration experienced by families having schizophrenic patient.

Specific objectives

1. To assess family integration in families with schizophrenic patients .
2. To explore the difference in family integration experienced by families having schizophrenic patient due to duration of mental disorder of patient . .
3. To explore the difference in family integration experienced by families having schizophrenic patient due to family education .
4. To investigate if the level of family integration experienced by families having schizophrenic patient differ due to economical level of the family .
5. To investigate if the level of family integration experienced by families having schizophrenic patient differ due to being patient institutionalized or not .
6. To know if the level of family integration experienced by families having schizophrenic patient differ due to patient gender (male or female)

1.6 Significant of the study : (Justification)

Care in the community is based on a partnership existing between community services and caregivers, families and relatives. There is currently a great deal of concern being expressed by user groups and mental health organizations about the fact that families feel unsupported , carry too great burden of care , and that communication between services and families is often poor. .Researches that had done also shown that home environment can have a significant positive or negative impact on relapse rates for severe mental health problems. There have been relatively few initiatives with families in routine clinical settings. (**Gray, 2002,p.27**).

- The importance of this study comes from the need for it in our Palestinian society in those days because we meet serious challenges of Israeli violence that lead to mental illnesses especially schizophrenia.
- I aim from this study to achieve good life for our families , parents and children by offering family programs that support the family abilities to deal well with the existence of patients with schizophrenia in the family .
- There is an accumulation of evidences, that the presence of patient with schizophrenia at home creates crisis for the family all over .

- The importance of this study is to guide for promotion and development of services offered for patient with schizophrenia and their families by offering special and effective programmes for families and health workers .
- The increased number of patients with schizophrenia creates serious effects and consequences on family integration .

In this study I try to focus attention and insight of this problem to all society members

1.7 Research Limitations:

1. Lack of statistically mental illness cases and reports .
2. The study included only the registered families who attended to mental health centers .
3. There is no governmental or no sufficient number of private institutions or other organization concern of this sample of people (schizophrenia).
4. There are no sufficient studies and researches in this subject .
5. Limitation of time .

1.8 Definitions

Family integration:

It is state of balance and lack of tension from three dimensions psychological , social and economical . . The family system and its efforts to maintain balanced functioning by using its capabilities (resources and coping behaviors) to meet its demands (stressors and strains) are emphasized. This effort to balance demands and capabilities is mediated by the meanings the family ascribes to events **.** (**Gray, 2002,p.222**).

Schizophrenia :

Schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history. About 1 percent of Americans have this illness.

People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated .People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking.(**Gray, 2002,p.218**).

Chapter Two

Conceptual Frame work

2.0 Introduction

Palestinian Society and Culture closely resembles the neighboring countries of Syria, Lebanon and Jordan. The Arabian culture also has a marked influence on the Palestine Society and Culture. The major aspects of the Palestine society and culture include the customs , religion , languages, literature, art ,costumes and music of the land and its inhabitants .The culture of Palestine is still alive in the countries of Israel ,although they are separate from the territory of Palestine . The major religions practiced by the culture and society of Palestine are those of Islam with a major section of the Sunni community, Druzism, Christianity, Samaritans' and Judaism. The **Gaza Strip** is a stretch of land along the Mediterranean. The main city in the Gaza Strip is called Gaza..It is one of the most densely populated areas on Earth. About 1.5 million people live on a surface of roughly 493 km². Israel withdrew from Gaza in 2005, and gave over the territory to Palestinian administration. Most inhabitants are related to the Arabs displaced from their homes during the Israel War of Independence in 1948. They live in cities which they call refugee camps. The main problems facing the area are war, unemployment, poverty and malnutrition. A people with one of the world's highest birth rates, the Palestinians care for their children with pride. Extended families help in caring for infants and young children. Because about half of the Palestinian population is under age fifteen, education is a prime concern. The school system in Gaza is based on Egypt's and the West Bank's system is based on Jordan's, and there are numerous literacy and cultural centers at all learning levels. Schools vary, but most children get a free public education, from kindergarten through high school. Children from well-to-do families may attend an Islamic or a Christian school. Obtaining a university degree is a high priority for Palestinians. Palestine boasts eight universities and four colleges, all of which grant bachelor's degrees in arts and sciences. A few also offer graduate programs, and Al-Najah University awards a doctorate degree in chemistry. The siege that Israel has imposed on the Gaza Strip since June 2007 has greatly harmed Gaza's health system, which had not functioned well beforehand. Many services and specialist and life-saving treatments are not available to Palestinians inside Gaza, and since the siege began, access to medical care in hospitals outside Gaza has decreased. In addition, as clashes between the army and armed Palestinians escalate, treatment of chronic patients, among them cancer and heart patients, is postponed, and the supply of medicines and medical equipment to Gaza is delayed. Furthermore, Palestinian internal disputes following

Hamas's intention to replace the heads of the health system and of the hospitals have led to labor strikes. ***n.wikipedia.org/wiki/Socialization***

The reduction, and sometimes total stoppage, of the supply of fuel to Gaza for days at a time has led to a decrease in the quality of medical services, reduced use of ambulances, and serious harm to elements needed for proper health, such as clean drinking water and regular removal of solid waste. Currently, some 30 percent of the Gaza Strip's residents do not receive water on a regular basis.

For example, in early 2008, diagnostic and dental services in 32 of the 56 emergency medical centers run by the Palestinian Ministry of Health stopped due to lack of fuel to operate the generators. In late February, 23 of the Ministry's 56 ambulances and seven of the 40 Red Crescent ambulances ceased operation because of shortage of fuel. 55,000 vials for vaccination of infants might go bad if the fuel supply to pharmacies is not renewed. Visits to outpatient clinics dropped by 29 percent since the beginning of 2008, which might delay diagnosis of illness.

The lack of medical equipment and medicines in Gaza is steadily increasing. According to figures of the World Health Organization, in January 2008, 19 percent of necessary medicines were lacking, primarily those needed in surgery and in emergency cases, antibiotics for initial care of children, and cancer drugs. 31 percent of vital medical equipment is lacking too. There is also a grave shortage of replacement parts for equipment and of disposable items, such as bandages, syringes, and plaster for casts.

Israel has cut back on issuing permits to enter the country for the hundreds of patients each month who need immediate life-saving treatment and urgent, advanced treatment unavailable in Gaza. The only crossing open to patients is Erez Crossing, through which Israel allows some of these patients to cross to go to hospitals inside Israel, and to treatment facilities in the West Bank, Egypt, and Jordan. Some patients not allowed to cross have referrals to Israeli hospitals or other hospitals. Since Hamas took over control of the Gaza Strip, the number of patients forbidden to leave Gaza “for security reasons” has steadily increased. ***n.wikipedia.org/wiki/Socialization***

Schizophrenia are responsible for a major social cost . The adverse consequences of such psychiatric disorders for relatives have been studied since the early 1950s, when

psychiatric institutions began discharging patients into the community. According to (**Walker, Pratt, & Eddy, 1995,p.44**)burden on the family" refers to the consequences for those in close contact with a severely disturbed psychiatric patient. (**Grad &Sainsbury 1963,p.544**) and (**Hoenig & Hamilton 1966,p.12**) developed the first burden scales for caregivers of severely mentally ill patients, and a number of authors further developed instruments trying to distinguish between "objective" and "subjective" burden. Objective burden concerns the patient's symptoms, behavior and socio-demographic characteristics, but also the changes in household routine, family or social relations, work, leisure time, physical health. Subjective burden is the mental health and subjective distress among family members.

2.1 Family Theory

Family systems theory has gained popularity in the last several decades as a tool for analyzing family functioning. In addition to examining dyads within the family (e.g., mother-child relationship or sibling relationship), family systems researchers and clinicians assess the views and actions of the entire family (**Seligman & Darling, 1997,p.359**). Other systems that interact with the family include friends, extended family members, society, school, and other service agencies. (**Morgan, 1988,p.18**). provides an explanation of this approach to family assessment: “The individual can be approached as a subsystem, or part of the system, but the whole must be taken into account.

Each family member, therefore, is a crucial part of the entire system. If a significant event happens to one family member, it affects the entire family. Thus, the functioning of the family unit is altered when one member of the family receives the diagnosis of a chronic disability (**Seligman & Darling, 1997,P.361**).

One of the major changes in the care of people with serious mental illness in the twentieth century was that the process of deinstitutionalization shifted the treatment of these people from state institutions to community care centers. This process had a substantial impact on the mental health system and on families of the people with mental illness as well .They assert that one of the unintended effects of doing away with state mental hospitals was the increased emotional and interactional burden which families had to deal with on a day-to-day basis. “The movement of community-based care implicitly but undeniably pulled the relatives of the mentally ill into a critical care-giving role (**Thompson & Doll, p. 379**).They assert that when it comes to the institutions that are involved in community care

for people with mental illness, the family's role is critical. Apart from anything else, the family are the people who spend a great amount of time caring for the persons with mental illness. In the last four decades, the dominant professional perception of the role of families of people with mental illness, particularly families of relatives with schizophrenia, has transformed from the people who cause the illness of their relatives or the people that create a hostile family environment, to the people whom are affected by the illness of their relatives . By the 1980s it had become the norm to have spouses, parents and close relatives take on the responsibilities of caring for their ill relatives (**Thompson & Doll, 1982,p.382**). In addition, They asserted that many families of people with schizophrenia had become "unwittingly, and sometimes unwillingly bear the day to- day burden of coping with a mentally ill family member. The burden is considerable: families are profoundly affected negatively by the responsibilities of their care giving function (**Dyck, Short & Vitaliano, 1999,p.61**). The responsibilities or rather demands of care giving include missing work, disturbance of domestic routines , supervision of a relative with mental illness, and dealing with societal stigma associated with mental disorder .Behavioral problems of the relative with mental illness add on the responsibilities of the caregivers.

2.2 Family Definition : is usually a unit composed of a number of people who are collectively affected by the illness of their relative. Each member of the family in his/her unique way usually plays a role in caring for his/her relative.(**Evavold, 2003,p.379**) asserted that though the philosophy and concept of family support and resources and services for families has started to feature in mental health system programmes, the pace at which family support is implemented is rather slow. Even though over the years families, to some extent, have taken partnership regarding the decision-making process about the treatment of their relatives with mental illness, many mental health professionals fall short of implementing this partnership. He observed that the lack of inclusion of families in care is a serious limitation because persons with schizophrenia upon discharge from the hospital return home to their families, who may not be emotionally, physically or materially prepared for this burden. He says one of the key ways in which we can see how important families are in decision-making about treatment is the fact that families are commonly centrally involved in whether people with schizophrenia receive any treatment at all. The

family is also involved in nursing care, economic support, arranging for health care treatment, and also ensuring compliance to medication (**Evavold,2003,P.379**)

2.3 FAMILY INTEGRATION : According to Dr. Murray Bowen, a specialist in human behavior, families are complex units that are bonded by strong emotional connections. The ways in which members of a family interact with each other and in relation to the group as a whole are often referred to as family integration. Traditions, communication styles, behavioral patterns and emotional interdependence all influence the integration between family members.**www.WorldLawDirect.com** Families that are very busy may not always take time to communicate openly. Younger members of a family learn communication skills from the older members, and patterns of conflict or anger tend to be acquired by the children. That effective listening skills and empathy are critical to developing integrated family communication. Countless variables affect the integration of a family, such as financial concerns, illness, death, divorce or substance abuse. Any one factor can adversely affect the relationships and integration within a family. periods of crisis can often occur, and an important measurement of a family's overall integration is how families adapt to change and crisis. **www.WorldLawDirect.com**

Family integration can often be adversely affected by crisis--illness, mental health issues, or trauma, such as a death or divorce. In these cases families should take part in counseling together to explore how their individual experiences and problems may be affecting other members of their household. Family therapy often focuses on improved communication and gradual change of unhealthy or maladaptive integration, such as violence or substance abuse.

http://www.livestrong.com/article/172058-the-definition-of-family-integration /#ixzz2DphMmgIm

According to Mosby's Medical Dictionary published in 2009, family integration is defined as the forces at work within a family that produce particular behaviors or symptoms. It is the way in which a family lives and interacts with one another that creates the dynamic. And that dynamic, whether good or bad, changes who people are, it burrows into their psyche, ultimately influencing how they view and interact with the world outside of their family. There are many different influencing factors (or combinations thereof) that can

alter the family dynamic--for better or for worse--beginning with the relationship between the parents. Influences can also include the number of children a family has, an absent parent, alcoholism, chronic illness, disability, substance abuse, physical abuse, death, social-economical status, divorce, unemployment, family values, parenting practices and the list goes on.

Just as in any other situation where people are expected to coexist, family members, most especially children, begin to take on particular roles within the family. These roles could very well be the due result of their family integration , and have little to do with conscience choice. Depending upon their position within the family, including their birth order, the roles quickly become an indelible part of the given role. In many dysfunctional families, especially those experiencing serious issues such as alcoholism, you will find the perennial peace-keeper, the scapegoat/ irresponsible child, the family hero/the responsible child, the care-taker and the mascot. Each role has a very specific duty to its family, and it is nearly impossible for a child to separate himself from it.**www.Grammarly.com**

There are many families whose integration is suffering in this country, families who are having a difficult time dealing with the serious issues in their life. When that happens, even the simpler problems seem more dramatic than they really are, and often times go unresolved. When a family becomes overwhelmed, unable to cope with life's everyday stress, and their relationships are falling apart, then it is a good time to get help. There are many resources for families in crisis, beginning with therapists who specialize in the family relationships. There is no shame in seeking professional help, only the hope for a better tomorrow.

http://www.ehow.com/about_6623839_meaning-family-integration_.html#ixzz2DpjEj4dv

2.4 Family care giving

care giving includes giving support and assistance to a family member who has special needs (**Walker, Pratt, & Eddy, 1995,p.402**).

2.4.1 Gender and family caregivers

The literature suggests that majority of caregivers are women. Care giving is often perceived as an exclusive purview of women because many of the demands of the sick people are often met by women in families (**Walker & Pratt,1995,p.410**)

2.4.2 Deinstitutionalization and mental health system

A major factor associated with family care giving in schizophrenia is deinstitutionalization. Deinstitutionalization can be described as a process where the mentally ill people are no longer residing in psychiatric hospitals for long periods of time but hospitalization is replaced by brief lodging in smaller and less isolated community-based centers (**Bachrach, 1993,p.534**). Deinstitutionalization generally consists of three component processes:

(1) The release of mentally ill people from psychiatric hospitals to alternative facilities in the community,

(2) the diversion of potential new admissions to alternative facilities, and

(3) the provision of special services for the care of mentally ill people who are not in hospitals

2.4.2.1 Problems with deinstitutionalization

(**Accordino et al. 2001,P.16**) assert that shifting the locus of care from state institutions to community health centers was not as effective as anticipated by the advocates of deinstitutionalization. One area in which there has been less success than at once hoped is in the rates of institutionalization and readmission to mental hospitals.(**Stiles, Culhane, & Hadley1996,P.23**) conducted a comparative study about the status of state mental hospitals in the United States between 1949 and 1988, and discovered that admission rates in 1988 nearly double those of 1949. Early optimism about deinstitutionalization saving costs has also proved unfounded. The process of moving people with mental illness from state institutions to community care failed to reduce the costs of caring for these patients (**Clarke, 1979 & Bachrach, 2001;P.57**). Good community care is probably at least as costly as in-patient care. However, (**Clarke 1979,P.461**) says that this issue of cost has not been settled, for example he cited a study done by Sharfstein and Nafziger both whom analyzed the costs and benefit of community versus institutional care for a single patient using cost comparison over a 3-year period. Their findings revealed that the cost of

community care was 2.05 times less than the cost of state hospital care. In addition, subsequent research also suggests that community mental health services are more cost-effective than state institutions (**Wiley-Exley, 2007,P.64**). A review of 42 economic assessments of developed countries showed that community centers provide care at a lower or equal cost in comparison to state hospitals .

2.4.2.2 Deinstitutionalization, family studies and schizophrenia

Deinstitutionalization is a policy that came about in the context of attempts to abolish the inhumane treatment that mentally ill individuals used to endure in state institutions. The policy was made possible by strong political leadership, lobbied by human rights organizations, and caring family members. Deinstitutionalization was not just a matter of getting people out of institutions, however; it was also about changes in how care of people associated with mental disorder is conceptualized**.** Family studies broadened the focus from people with schizophrenia to considering their families as well. Deinstitutionalization brought with it new challenges for families. Whereas in the past many family members had suffered at being excluded from the lives of their institutionalized relatives, now families had to face the challenge associated with having their relatives living at home. In addition, in the early days of family theories, the families had to contend with the challenges of being blamed by mental health professionals for causing the illness of their relatives. (**Accordino et al. 2001,P20**)

2.5 The satisfaction of care giving in families

Although care giving can lead to psychological, mental, physical and material burden, and stress, the care giving experience may still be satisfactory to some families. Majority of the participants in their study pointed out that looking after "their children made caregivers feel happier and closer to the children, enhanced caregiver's self – esteem, and provided insights about their personal strengths and values" (**Abelenda & Helfrich,2003, p. 28**)..

2.6 Negative factors associated with caregiver burden

Negative factors that are associated with caregiver burden include: self–blame and guilt experienced by parents, the financial strain of treatment, and the parents' responsibility to provide extensive supervision for the patients (**Loukissa, 1995,P.21**). making the experience of care giving difficult to bear.(**Glanville & Dixon,2005,P.42**) mentioned that symptom type (positive or negative) may contribute to family burden. For example,

positive symptom behaviors such as hallucinations and delusions together with a high degree of social dysfunction and recurrent relapses are often linked with greater family burden than negative symptoms of apathy and social withdrawal.(**Awad & Voruganti 2008,P.26**) cited a recent community survey that included 697 caregivers and 439 ill relatives with schizophrenia that identified the following ten negative impacts of schizophrenia on caregivers:

- A decrease in family social outings and activities
- Constant disagreements, disputes or fights among family members
- Depression in other family members (e.g. siblings of the ill relative)
- Embarrassment of other family members (caused by erratic behaviors)
- Economic difficulties
- Delay or cancellation of vacation plans
- Decreasing self – esteem or confidence in other family members
- Decline in the work or school performance of other family members
- Increase in alcohol use

Furthermore, (**Awad & Voruganti, 2008,P.149**) asserted that important issues that caregivers also reported to significantly contribute to their perception of burden are:

- Lack of motivation and poor self-care on the part of the person with mental illness
- Lack of access to crisis psychiatric care and hospitalization when needed
- Disrupted family dynamics and collective coping styles

2.6.1 Direct and indirect effects of care giving

Caring for ill relatives does not affect the caregivers only emotionally, but materially as well. It is against this backdrop that several studies investigated the material impact of mental illness, particularly the effects of the illness, schizophrenia has on caregivers. The effect of material cost of schizophrenia on caregivers has been subdivided into direct and indirect costs . (**Tessler & Gamache, 1994,P.72**)

2.6.2 Direct costs

Direct costs are medical and non–medical. Direct medical costs includes prevention, detention treatment, and rehabilitation services and comprise such services as hospitalizations, nursing home days, outpatient psychiatric visits, outpatient other physician visits, prescription drugs, and capital investments in medical facilities" (**Tessler & Gamache, 1994,P.149**)

2.6.3 Indirect costs

Indirect costs linked to schizophrenia are often more than economic. For example,(**Tessler & Gamache 1994,P.149**) asserted that indirect cost often include amount of time spent by caregivers fretting over their ill relatives. Relatives of the ill relatives worry about many issues, (e.g., matters that concern the safety and well–being of their relatives. They state that as the onset of schizophrenia often strikes early, the relatives who get affected by this enduring illness at the young age may not be able to work for themselves for the rest of their lives. As a result, caregivers may have to cut down on their working hours to look after their ill relatives.(**Lee et al. 2005,P.193**) cited a study in the UK by Guest and Cookson that looked into the absence of caregivers from work and the impact this had on productivity. The findings of the study revealed that indirect costs due to lost productivity accounted for 49% of the National Health Service expenditure on schizophrenia in the UK. (**Awad and Voruganti 2008,P.162**) also cited a study that gave estimates of the number of caregivers giving up their work to look after their relatives with schizophrenia ranged from 1.2% for first episode patients to 2.5% for exceedingly demanding long – term patients.

2.7 Stigma and mental health

According to (**Thornicroft 2006,P.170**) there are three different stigma components that can be identified: stereotypes, prejudice and discrimination**.** stereotype deals with beliefs we may hold about people, and prejudice deals with attitudes based on these beliefs, and discrimination is a set of behavior which may follow from stereotypes and prejudice. People with mental illnesses are exposed to and affected by these three forms of stigma in their daily lives; for example the opportunities accorded to people with serious mental illnesses like schizophrenia are significantly constrained by public stigma (**Corrigan et al., 2002,P.28**). The challenges associated with stigma also affect the family because it is very unlikely that any of these obstacles can affect the person with mentally illness without

affecting the family as well, particularly the primary caregiver (**Jones & Hayward, 2004,P.140**). As providing care for a mentally ill relative may be a burdensome experience to many family members, stigma may make the experience even more difficult. Similarly The stigma attached to mental illness and the practical strains involved in caring for a patient are significant sources of stress for the family. Stigma also affects the families of people with mental illness purely because of their association with the persons with mental illness. (**Scheffer,2003,P.4**) asserts that it is common for families to report instances of "stigma by association resulting in discriminatory and prejudicial behaviors towards them"

2.8 Cohesion and Adaptability

A well-functioning family has a good balance of cohesion and adaptability (e.g., Olson, Portner, & Lavee**,(1985,p.4**)

2.8.1 Family cohesion is defined as: the emotional bonding that family members have toward one another (**Olson, Portner, & Lavee, 1985, p. 4**). The extremes on the continuum of cohesion in families are the concepts of enmeshment and disengagement. Highly enmeshed families are overly involved in and protective of their children's lives. Families who are close-knit, able to express emotions, supportive, and involved in outside recreational activities (a combination of characteristics that are between extreme enmeshment and disengagement) are better able to adapt to the stresses .

2.8.2 Adaptability is a measure of the family's ability to change in response to a stressful situation (**Olson, Russell, & Sprenkle, 1980,p.18**). On one end of the adaptability continuum is the rigid family that does not change anything within the system in response to a large stressor. Typically, this type of family holds to the rigid belief that the father is the head of the household, which would mean he would not assist with chores or childcare (women's work), possibly placing a large burden on the mother. This scenario may result in the mother having little time for herself or the other children in the family. The rigid family may have a difficult time caring for a disabled child who requires additional care because the other members of the family are unwilling to lessen the mother's increased burden .On the other end of the continuum are chaotic families who are characterized by unstable and inconsistent change. In chaotic families, the small number of rules may be constantly changing. There may be no family leader and there may be frequent role changes. Chaotic families can quickly vacillate between the cohesion concepts of

enmeshment and disengagement (**Turnbull 1986,P.99**). (**McCubbin 1988,P.6**) reported that on the family adaptability continuum, flexible and laissez-faire families are in between the rigid and the chaotic families. The flexible family system is high on predictability and high on adaptability. The laissez-faire family system includes moderate predictability and low adaptability. In laissez-faire families, inertia and indecision can take the place of organization and action. The flexible family system appears to be the most effective organization when caring for a child with a disability .well-functioning families are flexible, open to change, and resilient. Not only can a well-functioning family decrease the overall stress on the family system, it can improve the status of a child with a disability. The family environment is important to the child's welfare and development . In addition, family variables that foster development can improve the condition of a child with mental retardation (**Sameroff, 1990,p.93**).

The multiple pressures in the family environment include the amount of stress from the environment, the family's resources for coping with that stress, and the parents' flexibility in understanding and dealing with their child. These pressures play an important role in fostering or hindering a child's intellectual and social competencies. In addition, the experience of the developing child is partially determined by the beliefs, values, and personality of the parents, partially by the family's interaction patterns, and partially by society (**Sameroff, 1990,p.95**).

2.9 *Family's Conception of mental illness*

The balance of the family system can be restored by acquiring new resources (e.g., social support), learning new coping behaviors, and/or changing the way the situation is viewed. (**Seligman and Darling ,1997,p.9**) said"The degree to which the family is in trouble may depend on how it conceptualizes or reframes its life circumstance, how supportive family members are of each other, and how much social support is available outside of the family. Typically, the disruption of the family system begins with the recognition of mental illness . The ABCX family crisis model (**McCubbin1988,p.205**) is an explanation of the events following a significant change in the family. This model can describe the stress that assails the family after the recognition of mental illness . "A" stands for the stressor event (psychotic patient), "B" is the family's crisis-meeting resources, "C" is the way the family defines the event, and "X" is the crisis .

The “A” factor is a significant transition in the family’s life that can produce a change in the family system. The family may need to activate its existing resources to prevent the stressor from becoming a crisis. The “B” factor relates to the family’s flexibility and quality of relationships prior to the presence of the mental patient . One way in which the family can acquire more resources is by utilizing community services. The “C” factor is the way the family defines the event of having a mentally patient . This factor is a product of the family’s values and its previous experience in dealing with crises. These previous values and experiences may change after the diagnosed with mental illness . Ellis (1987) explains that it is not the event that is disturbing; it is the meaning attributed to the event that may cause distorted thinking. Functioning on all three factors together represents the family’s ability to cope and perhaps to prevent the stressor from creating a crisis (“X” factor). If a crisis does arise, the family may be unable to restore balance and stability in the system. Thus, the stress may never become a crisis if the family is able to draw upon adequate resources and if they perceive the situation as manageable (**Seligman& Darling**, **1997,361**).

2.10 Operational definition of family integration

It is state of balance and lack of tension from three dimensions psychological , social and economical . The family system and its efforts to maintain balanced functioning by using its capabilities (resources and coping behaviors) to meet its demands (stressors and strains) are emphasized. This effort to balance demands and capabilities is mediated by the meanings the family ascribes to events.

2.11 Schizophrenia

2.11.1 Historical Background

The word **schizophrenia** comes from the Greek word skhizein meaning "to split" and the Greek word Phrenos (phren) meaning "diaphragm, heart, mind". According to Medilexicon's medical dictionary, schizophrenia is "A term coined by (**Bleuler, 1939,p.436**)synonymous with and replacing dementia praecox as(**Kreaplin 1926,p.3**), denoting a common type of psychosis, characterized by abnormalities in perception, content of thought, and thought processes (hallucinations and delusions) and by extensive withdrawal of interest from other people and the outside world, with excessive focusing on one's own mental life. Now considered a group or spectrum of disorders rather than a

single entity, with distinction sometimes made between process schizophrenia and reactive schizophrenia. The "split" personality of schizophrenia, in which individual psychic components or functions split off and become autonomous, is popularly but erroneously identified with multiple personality, in which two or more relatively complete personalities dominate by turns the psychic life of a patient.". In 1910, the Swiss psychiatrist, Eugen Bleuler (1857-1939) created the term Schizophrenie. Schizophrenia is a mental disorder that generally appears in late adolescence or early adulthood - however, it can emerge at any time in life. It most commonly strikes between the ages of 15 to 25 among men, and about 25 to 35 in women. In many cases the disorder develops so slowly that the sufferer does not know he/she has it for a long time. While, with other people it can strike suddenly and develop fast. It is a complex, chronic, severe, and disabling brain disorder and affects approximately 1% of all adults globally. Experts say schizophrenia is probably many illnesses masquerading as one. Research indicates that schizophrenia is likely to be the result of faulty neuronal development in the brain of the fetus, which later in life emerges as a full-blown illness.(**WHO,1996**)

2.11.2 The brain

Our brain consists of billions of nerve cells. Each nerve cell has branches that give out and receive messages from other nerve cells. The ending of these nerve cells release neurotransmitters - types of chemicals. These neurotransmitters carry messages from the endings of one nerve cell to the nerve cell body of another. In the brain of a person who has schizophrenia, this messaging system does not work properly. (**Lee,Mcglashen,&Woods,2005,p.200**)

2.11.3 signs and symptoms of schizophrenia

There is, to date, no physical or laboratory test that can absolutely diagnose schizophrenia. The doctor, a psychiatrist, will make a diagnosis based on the patient's clinical symptoms. However, physical testing can rule out some other disorders and conditions which sometimes have similar symptoms, such as seizure disorders, thyroid dysfunction, brain tumor, drug use, and metabolic disorders.

According to Carbon Storage Report 2011. - **www.globalccsinstitute.com** the symptoms are classified into four categories:

- **Positive symptoms** - also known as psychotic symptoms. These are symptoms that appear, which people without schizophrenia do not have. For example, delusion.
- **Negative symptoms** - these refer to elements that are taken away from the individual; loss or absence of normal traits or abilities that people without schizophrenia normally have. For example, blunted emotion.
- **Cognitive symptoms** - these are symptoms within the person's thought processes. They may be positive or negative symptoms, for example, poor concentration is a negative symptom.
- **Emotional symptoms** - these are symptoms within the person's feelings. They are usually negative symptoms, such as blunted emotions

2.11.4 A list of the major symptoms:

- **Delusions** - The patient has false beliefs of persecution, guilt of grandeur. He/she may feel things are being controlled from outside. It is not uncommon for people with schizophrenia to describe plots against them. They may think they have extraordinary powers and gifts. Some patients with schizophrenia may hide in order to protect themselves from an imagined persecution.
- **Hallucinations** - hearing voices is much more common than seeing, feeling, tasting, or smelling things which are not there, but seem very real to the patient.
- **Thought disorder** - the person may jump from one subject to another for no logical reason. The speaker may be hard to follow. The patient's speech might be muddled and incoherent. In some cases the patient may believe that somebody is messing with his/her mind. (**DSM IV, 2004**).

Other symptoms schizophrenia patients may experience include:

- **Lack of motivation (a volition)** - the patient loses his/her drive. Everyday automatic actions, such as washing and cooking are abandoned. It is important that those close to the patient understand that this loss of drive is due to the illness, and has nothing to do with slothfulness.
- **Poor expression of emotions** - responses to happy or sad occasions may be lacking, or inappropriate.

- **Social withdrawal** - when a patient with schizophrenia withdraws socially it is often because he/she believes somebody is going to harm them. Other reasons could be a fear of interacting with other humans because of poor social skills.
- **Unaware of illness** - as the hallucinations and delusions seem so real for the patients, many of them may not believe they are ill. They may refuse to take medications which could help them enormously for fear of side-effects, for example.
- **Cognitive difficulties** - the patient's ability to concentrate, remember things, plan ahead, and to organize himself/herself are affected. Communication becomes more difficult. (**DSM IV,2004**)

2.11.5 Causes of schizophrenia

Nobody has been able to pinpoint one single cause. Experts believe several factors are generally involved in contributing to the onset of schizophrenia.
The likely factors do not work in isolation, either. Evidence does suggest that genetic and environmental factors generally act together to bring about schizophrenia. Evidence indicated that the diagnosis of schizophrenia has an inherited element, but it is also significantly influenced by environmental triggers. In other words, imagine your body is full of buttons, and some of those buttons result in schizophrenia if somebody comes and presses them enough times and in the right sequences. The buttons would be your genetic susceptibility, while the person pressing them would be the environmental factors.(**Baron,2001,p.68**)

2.11.5.1 Factors that are contribute towards the onset of schizophrenia:

A- Genes

If there is no history of schizophrenia in your family your chances of developing it are less than 1%. However, that risk rises to 10% if one of your parents was/is a sufferer. A gene that is probably the most studied "schizophrenia gene" plays a surprising role in the brain: It controls the birth of new neurons in addition to their integration into existing brain circuitry, according to an article published by Cell. A Swedish study found that schizophrenia and bipolar disorder have the same genetic causes(.**Baron,2001,p.68**)

B- B- Chemical imbalance in the brain

Experts believe that an imbalance of dopamine, a neurotransmitter, is involved in the onset of schizophrenia. They also believe that this imbalance is most likely caused by your genes making you susceptible to the illness. Some researchers say other the levels of other neurotransmitters, such as serotonin, may also be involved. Changes in key brain functions, such as perception, emotion and behavior lead experts to conclude that the brain is the biological site of schizophrenia. Schizophrenia could be caused by faulty signaling in the brain, according to research published in the journal *Molecular Psychiatry*.

C- Family relationships Although there is no evidence to prove or even indicate that family relationships might cause schizophrenia, some patients with the illness believe family tension may trigger relapses. (**Meehle,1962,p.937**)

C- Environment

D- Although there is yet no definite proof, many suspect that prenatal or perinatal trauma, and viral infections may contribute to the development of the disease. Perinatal means "occurring about 5 months before and up to one month after birth". Stressful experiences often precede the emergence of schizophrenia. Before any acute symptoms are apparent, people with schizophrenia habitually become bad-tempered, anxious, and unfocussed. This can trigger relationship problems, divorce and unemployment. These factors are often blamed for the onset of the disease, when really it was the other way round - the disease caused the crisis. Therefore, it is extremely difficult to know whether schizophrenia caused certain stresses or occurred as a result of them.(**Beebe,2003,p.70**)

E- Some drugs

Cannabis and LSD are known to cause schizophrenia relapses.

2.11.6 Treatment options for schizophrenia

Psychiatrists say the most effective treatment for schizophrenia patients is usually a combination of medication, psychological counseling, and self-help resources. Anti-psychosis drugs have transformed schizophrenia treatment. Thanks to them, the majority of patients are able to live in the community, rather than stay in hospital. In many parts of the world care is delivered in the community, rather than in hospital.

The primary schizophrenia treatment is medication. Sadly, compliance is a major problem. Compliance, in medicine, means following the medication regimen. People with schizophrenia often go off their medication for long periods during their lives, at huge personal costs to themselves and often to those around them as well.

The majority of patients go off their medication within the first year of treatment. In order to address this, successful schizophrenia treatment needs to consist of a life-long regimen of both drug and psychosocial, support therapies. The medication can help control the patient's hallucinations and delusions, but it cannot help them learn to communicate with others, get a job, and thrive in society. (**WHO,1996**)

Although a significant number of people with schizophrenia live in poverty, this does not have to be the case. A person with schizophrenia who complies with the treatment regimen long-term will be able to lead a happy and productive life.

The first time a person experiences schizophrenia symptoms can be very unpleasant. He/she may take a long time to recover, and that recovery can be a lonely experience. It is crucial that a schizophrenia sufferer receives the full support of his/her family, friends, and community services when onset appears for the first time. (**WHO,1996)**

2.11.7 Medications

The medical management of schizophrenia generally involves drugs for psychosis, depression and anxiety. This is because schizophrenia is a combination of thought disorder, mood disorder and anxiety disorder.

The most common antipsychotic drugs are Risperidone (Risperdal), Olanzapine (Zyprexa), Quetiapine (Seroquel), Ziprasidone (Geodon), and Clozapine (Clozaril):

A- Risperidone (Risperdal) - introduced in America in 1994. This drug is less sedating than other atypical antipsychotics. There is a higher probability, compared to other atypical antipsychotics, of extrapyramidal symptoms (affecting the extrapyramidal motor system, a neural network located in the brain that is involved in the coordination of movement). Although weight gain and diabetes are possible risks, they are less likely to happen, compared with Clozapine or Olanzapine.

B- Olanzapine (Zyprexa) - approved in the USA in 1996. A typical dose is 10 to 20 mg per day. Risk of extrapyramidal symptoms is low, compared to Risperidone. This drug may also improve negative symptoms. However, the risks of serious weight gain and the development of diabetes are significant.

C- Quetiapine (Seroquel) - came onto the market in America in 1997. Typical dose is between 400 to 800 mg per day. If the patient is resistant to treatment the dose may be higher. The risk of extrapyramidal symptoms is low, compared to Risperidone. There is a risk of weight gain and diabetes, however the risk is lower than Clozapine or Olanzapine.

D- Ziprasidone (Geodon) - became available in the USA in 2001. Typical doses range from 80 to 160 mg per day. This drug can be given orally or by intramuscular administration. The risk of extrapyramidal symptoms is low. The risk of weight gain and diabetes is lower than other atypical antipsychotics. However, it might contribute to cardiac arrhythmia, and must not be taken together with other drugs that also have this side effect.

E- Clozapine (Clozaril) - has been available in the USA since 1990. A typical dose ranges from 300 to 700 mg per day. It is very effective for patients who have been resistant to treatment. It is known to lower suicidal behaviors. Patients must have their blood regularly monitored as it can affect the white blood cell count. The risk of weight gain and diabetes is significant. (**Whitty&Devitt,2005,p.481**).

2.11.8 The prevalence of schizophrenia

The prevalence of schizophrenia globally varies a slightly, depending on which report you look at, from about 0.7% to 1.2% of the adult population in general. Most of these

percentages refer to people suffering from schizophrenia *"at some time during their lives"*. An Australian study found that schizophrenia is more common in developed nations than developing ones. It also found that the illness is less widespread than previously thought. Estimates of 10 per 1,000 people should be changed to 7 or 8 per 1,000 people, the study concluded. In the USA about 2.2 million adults, or about 1.1% of the population age 18 and older in a given year have schizophrenia.

Schizophrenia is not a 'very' common disease. Approximately 1% of people throughout the globe suffer from schizophrenia (or perhaps a little less than 1% in developing countries) at some point in their lives. It is estimated that about 1.2% of Americans, a total of 3.2 million people, have the disorder at some point in their lives. Globally, about 1.5 million people each year are diagnosed with schizophrenia. In the UK it is estimated that about 600,000 .(**WHO,1996**)

2.12 Previous Studies

1. In a study done by **Wageeh Abdel - Nasser Hassan,et al ,2011**" Burden and coping strategies in caregivers of schizophrenic patients" The aim of the present study was to explore burden and coping strategies in caregivers of schizophrenic patients and identify the relationship between burden and coping strategies among them. Caregivers were assessed by utilizing caregiver burden self report and ways of coping questionnaires. A descriptive correlation design was used for the study. The sample comprised of 100 caregivers of schizophrenic patients from psychiatric in patient and the outpatient clinic of Neuropsychiatry Department at Assiut University Hospital. The result revealed that level of burden reported by caregivers of schizophrenic patients was high. The most coping strategies used by caregivers of schizophrenic patients were self controlling, positive reappraisal and escape-avoidance.

2. In a sample of Arab subjects with schizophrenia in Kuwait **from Archives of Psychiatric Nursing Volume 25, Issue 5 , Pages 339-349, October 2011,** Global Perspective of Burden of Family Caregivers for Persons With Schizophrenia .. The aim was to know How does the relationship between domains of care giving (as in the Involvement Evaluation Questionnaire - IEQ-EU) and caregiver psychic distress

on the one hand, and caregiver's/patient's socio-demographics, clinical features and indices of quality of care. Consecutive family caregivers of outpatients with schizophrenia were interviewed with the IEQ-EU. Patients were interviewed with measures of needs for care, service satisfaction, quality of life (QOL) and psychopathology. There were 121 caregivers (66.1% men, aged 39.8). In regression analyses, higher burden subscale scores were variously associated with caregiver lower level of education, patient's female gender and younger age, as well as patient's lower subjective QOL and needs for hospital care, and not involving the patient in outdoor activities. Disruptive behavior was the greatest determinant of global rating of burden.. Despite generous national social welfare provisions, experience of burden was the norm and was significantly associated with patient's disruptive behavior. The results underscore the need for provision of community - based programs and continued intervention with the families in order to improve the quality of care services, such as home visits, crisis intervention, sheltered accommodation and sheltered work.

3. A study done by **Munish Aggarwal,et al,2011"** Experience of Care giving in Schizophrenia: a Study From India. Experience of care giving, on the contrary, is a broader concept that takes into consideration both negative and positive consequences of the disorder and is influenced by factors like social support and coping of caregivers. Fifty caregivers of patients with diagnosis of schizophrenia were assessed on Experience of Care giving Inventory (ECI), Coping Checklist (CCL), Social Support Questionnaire (SSQ) and General Health Questionnaire-12 (GHQ-12). Patients were assessed on Positive and Negative Syndrome Scale (PANSS). Maximum ECI score was seen in negative domains of handling the difficult behavior followed by negative symptoms, loss and dependency. Significant positive correlation was seen between total positive ECI score and the level of education of patients and caregivers. Regression analysis showed that use of problem-focused coping, seeking social support as a coping strategy and education of caregivers explained 30.6% of the variance of ECI positive score. The study showed that education of caregivers, coping strategies used by the caregivers and available social support influence the final appraisal of care giving. .

4. In a study done by **Kreisman, et al (2010)** has a topic " Family response to mental illness of a relative **"** Reviews data on the role of the family in the mental illness of one of its members. Psychological views of illness, effects of distance and closeness of the relationship to the patient, and typologies based on responses of families are discussed. The effects of attitudes on outcome are described. It is suggested that outcome is related to family attitudes toward the patient, family attitudes toward mental illness and hospitals, and family tolerance of deviance. The family's early reaction to the mental illness of a relative provides a framework for understanding the initial perception of deviant behavior, the attempts at explanation, and the response to the deviant. It is not known, however, to what extent tolerance and expectations reflect patient functioning or the extent to which they form patient functioning. It is concluded that this very complicated set of interacting factors will only be understood in the context of multivariate research

5. In a study done by **CM Pariante, B Carpiniello,2010**" Family burden in relatives of schizophrenics" The pattern of family burden was compared in 32 relatives of schizophrenic patients and 32 relatives of people with mental retardation, using a standardized semi structured interview named (Assessment of Disability and Family Burden). There were few quantitative differences between the two samples of relatives, although relatives of schizophrenics presented a tendency for a higher degree of both objective and subjective burden in some areas. Problems frequently reported were the presence of emotional distress, poor social relationships and lack of holidays or free time activities. Relatives of schizophrenics specifically claimed the presence of financial difficulties, while those of people with mental retardation were concerned by problems with neighbors.

6. Another study was done by **Chen ,Yan akun ,(2010)** with a topic " quality of life of caregiver**.** The objective of this cross sectional study was to identify the factors associated with health – related quality of life (HRQOL) Of family care giver of Chinese stroke patients. One hundred and twenty three stroke patients consecutively admitted to a stroke clinic and their 123 family care givers were recruited . The caregivers HRQOL were assessed with the short form 36(SF-36) . Two sub scores of the SF, the physical component summary scores served as the dependent variables .Independent variables comprised patients and caregivers demographic

data and physical and psychological conditions in relation to caregivers(HRQOL) .The severity of coexisting illnesses of both the patients and their caregivers was assessed using the cumulative illness rating scale . The geriatric depression scale (GDS) was administered to rate both the patients and their caregivers depressive symptoms .

7. Study done by **Robert Bland PhD, et al published in 2009** has a topic "Importance and meaning of hope for family members of people with mental illness" Focused in-depth interviews with 16 family members in Queensland and Tasmania, Australia.The data confirm the argument that hopefulness appears to be central to a family's coping with the impact of mental illness. Their definitions of hope, descriptions of what they hoped for, and the sources of their hope reflect issues of future orientation, positive expectation, and realism. Families drew their hopefulness from both formal and informal supports, from within and without .Health professionals need to be respectful of family hopes and aware of the role of hope and time in the process of grief and acceptance. Nurses should be mindful of their capacity to sustain or diminish the hopes of family members.

8. In a study done by **Aadil Jan Shah,et al ,2009**" Psychological Distress in Carers of People with Mental Disorders The recent literature on carers' burden in mental disorders is reviewed. Families bear the major responsibility for such care. Carers face mental ill health as a direct consequence of their caring role and experience higher rates of mental ill health than the general population. The production of burden in carers is a complex process and is related to gender, age, health status, ethnic and cultural affiliation, lack of social support, coping style, in addition to the stressors of the disorder itself. Carers appear to suffer from at least moderate levels of psychological symptomatology. The behavioral problems associated with mental disorders further increase the stress levels of carers. The findings from the review afford a comprehensive understanding of the care-giving situation with its outcomes, and its practical application in devising effective support strategies for family carers.

9. A study done by **Lorenza Magliano et al ,2009** " Family burden in long-term diseases". This study explored burden and social networks in families of patients

with schizophrenia or a long-term physical disease. It was carried out in 169 specialized units (mental health department, and units for the treatment of chronic heart, brain, diabetes, kidney, lung diseases) recruited in 30 randomly selected geographic areas of Italy. The study sample consisted of 709 key relatives of patients with a DSM-IV diagnosis of schizophrenia and 646 key relatives of patients with physical diseases. Each relative was asked to fill in the Family Problems Questionnaire (FPQ) and the Social Network Questionnaire (SNQ). In all selected pathologies, the consequences of care giving most frequently reported as always present in the past 2 months were constraints in social activities, negative effects on family life, and a feeling of loss.. Social support and help in emergencies concerning the patient were dramatically lower among relatives of patients with schizophrenia than among those of patients with physical diseases. In the schizophrenia group, both objective and subjective burden were significantly higher among relatives who reported lower support from their social network and professionals. The results of this study highlight the need to provide the families of those with long-term diseases with supportive interventions, including: (a) the management of relatives' psychological reactions to patient's illness; (b) the provision of information on the nature, course and outcome of patient's disease; (c) training for the relatives in the management of the patient's symptoms; and (d) the reinforcement of relatives' social networks, especially in the case of schizophrenia

10. In a study done by **Pamela Grandón et al ,2007"** Primary caregivers of schizophrenia outpatients: Burden and predictor variables" This article explores family burden in relation to relatives' coping strategies and social networks, as well as in relation to the patients' severity of positive and negative symptoms. Data on the severity of symptoms , caregivers burden ,coping skills (Family Coping Questionnaire [FCQ]), and social support (Social Network Questionnaire [SNQ]) were gathered from a randomized sample of 101 Chilean outpatients and their primary caregivers, mostly mothers. Low levels of burden were typically found, with the exception of moderate levels on general concerns for the ill relative. A hierarchical regression analysis with four blocks showed that clinical characteristics, such as higher frequency of relapses, more positive symptoms and lower independence-performance, together with lower self-control attributed to the patient,

decrease in social interests, and less affective support, predict burden. The results support the relevance of psycho educational interventions where families' needs are addressed.

11. In a study done by **Alejandra Caqueo-Urízar,et al (May, 2006)"** Burden of care in families of patients with schizophrenia" The current study examined family burden and its correlates in a medium income country in South America. Method: Forty-one relatives of patients with schizophrenia who were attending a public mental health outpatient service in the province of Arica, Chile, were assessed on Spanish versions of the Zarit Caregiver Burden Scale. Results: All caregivers show a very high degree of burden, especially mothers, older, with low educational level, without an employment and who are taking care of younger patients. Conclusions: As developing country, Chile has a few national social welfare and community rehabilitation programs for relatives of psychiatric patients, especially in this part of the country. This significantly influences the high level of burden experienced by these caregivers. These results suggest a close monitoring of carer's mental health and the provision of a family intervention and psycho-social support

12. In a study done by **Amer A et al (2006)** with a topic "The Relationship Between Psychological Well-Being and Adjustment of Both Parents and Children of Exiled and Traumatized Iraqi Refugees. This study has examined the relationship between psychological well-being and adjustment (in the host culture) of samples of both parents and children of exiled and traumatized Iraqi refugees in London. Participants included in this study were Arab and Kurdish Iraqi refugees; 61 families (mainly adult participants) with a total number of 162 children. The sample consisted of both parents and children who were, at the time of conducting this research (2003-2004),. The 30-item version of General Health Questionnaire (GHQ) and a short and modified version of the Child Behavioral Checklist (CBCL) questionnaire were used. The main results of this study appear to indicate that the estimated level of distress among parents who completed the GHQ was very high. It also suggests that parents or adult refugees in this study manifested poor mental health and this, in turn, was found to be associated positively with children's poor

adjustment in the host culture. Further results of *t* tests revealed that there were no significant differences found between male and female scores on the GHQ. Educational background was not a significant factor in determining the adjustment or the level of distress among the population of this study. Larger family size and refugee parents who had more than one child at home appeared to show vulnerability to distress more than those who had smaller families.

13. In a study for **Gayled. Gubman & Richard C .Tessler(2005)** which has a topic "The impact of mental illness on families" **:**Mental illness has far reaching effects on other family members ,as individuals and as members of a social system.. This article applies an illness behavior perspective to the study of family burden, reviews knowledge, and invites research by defining a number of issues, substantive and methodological, that need to be addressed. These include the definition and measurement of burden, diagnosis and course of illness, residence and kinship, social class, context, and coping, and the evaluation of social interventions designed to reduce burden and strengthen family supports. The article concludes with a discussion of family burden in terms of normative forces operating at the macro level.

14. In a study done by **Eur. J. Psychiatric. v.19 n.1 Zaragoza ene.- mar. 2005**" The effect of rehabilitation of schizophrenic patients on their family atmosphere and the emotional well-being of caregivers In this study the effect of the participation of schizophrenic patients in rehabilitation programes, on the atmosphere of their families and the emotional well-being of their caregivers are examined. Sixty six caregivers of patients in rehabilitation (group A) were compared with seventy caregivers of patients, not attending any rehabilitation program (group B), in terms of their family atmosphere and emotional well-being, assessed by the Family Atmosphere Scale and the CES-D scale respectively. The family atmosphere of the patients who were participating in a rehabilitation program was found to be more positive (higher degree of patient's acceptance, autonomy and compliance as well as fewer economic problems) than that of their counterparts, not in rehabilitation. Group A caregivers were also found to exhibit less depressive symptomatology.

15. A study done by **Ruzanna ZamZam,et al.2005** " Schizophrenia in Malaysian families: study on factors associated with quality of life of primary family caregivers. This study was aimed at highlighting the socio-demographic, clinical and psychosocial factors associated with the subjective Quality of Life (QOL) of Malaysian of primary family caregivers of subjects with schizophrenia attending an urban tertiary care outpatient clinic in Malaysia. A cross-sectional study was performed to study patient, caregiver and illness factors associated with the QOL among 117 individuals involved with care giving for schizophrenia patients. from multiple regression analysis, factors found to be significantly associated with higher QOL were higher educational level among caregivers in social and environmental domains; caregivers not having medical problem/s in physical and psychological domains; later onset and longer illness duration of illness in social domains; patients not attending day care program in environmental domain; physical and environmental domains.

16. Another study done **by Noreen Brady PhD,et al ,2005** to assess family burden in families having schizophrenia. The lifetime emotional, social, and financial consequences experienced by individuals with schizophrenia have significant effects on their families. Family responses to having a family member with schizophrenia include: care burden, fear and embarrassment about illness signs and symptoms, uncertainty about course of the disease, lack of social support, and stigma. Study findings about families in which parents are hostile, critical, or overly involved are equivocal about whether this negative environment contributes to patient relapse. This review summarizes the studies related to the family responses and emotional environment of families who have a member with schizophrenia

17. In a study done by **Lessenberry, et al ,(2004)** has a topic "Evaluating stress level of parents of children with disabilities " This review inspires a number of implications for clinical practice. Clearly, practitioners must recognize the important role of parental stress in a child's progress and development. The stressors and strains that a parent experiences and the coping resources and strategies utilized by him or her can all have a dramatic impact on the family system. The assessment of parental stress should become a routine part of a child's screening and evaluation. The assessment

can also take place periodically so as to assess changes in a parent's stress level over the course of a child's participation in treatment.

18. In a study done by **Freeman, et al (2003).**has atopic "Contributions of family leisure to family functioning among families that include children with developmental disabilities "The purpose of this study was to examine the contribution of family leisure involvement to family functioning among families of children with developmental disabilities. many implications arise from this study for both families of children with disabilities and professionals who work with them. Based on the findings it is important only to recognize that family leisure in general is quite important for families today, but that core family leisure involvement in particular, is an essential element of family life for families of children with developmental disabilities.

19. In study was conducted by **T. Shibre,et al ,2002,** within the framework of the ongoing epidemiological study of course and outcome of schizophrenia in a rural population of 15–49 years of age. Three hundred and one cases of schizophrenia and their close relatives participated in the study. Results: Family burden is a common problem of relatives of cases with schizophrenia. Financial difficulty is the most frequently endorsed problem among the family burden domains (74.4 %). Relatives of female cases suffered significantly higher social burden ($Z = 2.103$; $p = 0.036$). Work ($Z = 2.180$; $p = 0.029$) and financial ($Z = 2.088$; $p = 0.037$) burdens affected female relatives more often than males. Disorganized symptoms were the most important factors affecting the family members in all family burden domains. Prayer was found to be the most frequently used coping strategy in work burden (adj. OR = 1.99; 95 % CI = 1.08–3.67; $p = 0.026$).

20. In a study done by **Schwartz,et al ,(2002).** The topic was "Parents of mentally ill adult living at home": rewards of care giving **.**, This study reports evidence for the occurrence of positive outcomes of care giving for an adult child with a mental illness. Parents of adults with mental illness who live with them at home could express positive aspects about what was happening to them. The study reinforces earlier findings that care giving can be a rewarding experience, giving meaning , and enrichment... positive aspect of care giving. A possible explanation for this finding

might be that the extent to which parents perceive their care giving experience as psychologically and emotionally rewarding is a function of how parents perceive their role and responsibility in this situation--that is, how they "create meaning. This study has important implications for social work practice, in particular regarding support programs for parents caring at home for an adult with mental illness. Most such programs tend to overlook the positive aspects of care giving; rather, successful adjustment to life with a child with mental illness traditionally has been viewed as involving an attitude of acceptance. As a result of deinstitutionalization, more parents are faced with the challenge of caring for an adult child with mental illness and for a longer time. The issue of helping parents find meaning in and identify positive aspects of care giving is becoming more relevant.

21. Another study by **Kateharvey**, et al ,2001" Relatives of patients with severe psychotic disorders: factors that influence contact frequency To examine the predictors of frequent patient—relative contact, in particular the role of relatives' experience. UK700 trial data were used to determine baseline predictors of frequent contact and establish whether trial data were used to determine baseline predictors of frequent contact and establish whether relatives' experience at baseline predicted continued frequent contact 2 years later. Neither characteristics associated in the literature with relatives' 'burden' nor relatives' experience predicted patient—relative contact frequency. Instead, the predictors were mainly demographic. Many relatives experience considerable distress, but the evidence does not suggest that they avoid frequent contact with the patient as a consequence.

22. In a study done by **JudithA.Cook** has atopic "Intervention for family care givers(Oct,1999)" The purpose of this study was to determine whether parents participating in 14 National Alliance for the Mentally Ill-affiliated support groups in Illinois had significantly lower caregiver burden than a comparison group of parents not participating in support groups. Respondents included 120 parents: 86 participant 34 nonparticipants. Ordinary least squares regression analysis revealed that caregiver burden was significantly lower among support group participants,

those with lower depression, and those whose offspring had fewer unmet needs and days hospitalized.

23. In a study done by **(Roos,1998)** has a topic " The psychiatric outpatient's family as a support system." During 1998 the discharge of as many as possible psychiatric patients from long term psychiatric hospitals in the North-West Province, in other words deinstitutionalization were planned (Roos, 1998). Greater responsibility was therefore placed on families with a psychiatric patient as family member. The researcher's experience as a psychiatric community nurse was that these families were often not empowered to cope with supporting their family member in the community. Psychiatric outpatients were consequently re-admitted and families became discouraged. The research aimed to investigate the perceptions of the patient and the family regarding the contribution of the family as a support system. A further aim was to formulate guidelines for the psychiatric community nurse to mobilize the family as a support system. A qualitative design was followed. Participants were identified by purposeful, voluntary sampling. Data gathering took place by conducting semi structured interviews, which were transcribed and subjected to coding. The perceptions of both the patient and the family were that the family renders support regarding the patient's physical, psychological, social and spiritual dimensions. Conclusions regarding the patient, the family and the interaction between the patient and the family were formulated

24- In a study that was done by **Cook, et al in (1994)** and published in 2010 that Has A Topic " Age and family burden among parents of offspring with severe mental illness " discuss the relationship between caregiver age and level of burden experienced. Family burden reported by parents of offspring with severe mental illness was examined to determine whether burden increases with age. Older parents were troubled by cognitive dimensions of burden, while younger parents were distressed by their offspring's behavior, suggesting that interventions should vary according to parents' age .

2.13 conclusion

The increased number of mental ill patients especially schizophrenia every year due to many stressors like siege and difficult economical status , political conflicts and Israeli violence affect psychological wellbeing of all population . shifting of mental health services from hospital based to community based put most responsibility of care giving of schizophrenic patient on the family that affect family integration . Most studies that have been done on this subject were foreign .The reason for that is the lack of family social relationships in the west countries . The previous studies I mentioned in my research focused on variables that I didn't have as coping strategies and family psycho education .

Those variables are very important in supporting family and family integration.

It is concluded from the previous studies that shifting of mental care from hospital based to community based increased burden on family and caregiver . The previous studies also agree with my assumptions that family is the most important as a support system . family psycho education and management programs are very effective to help in family adjustment for existence of schizophrenic patient .The studies also confirmed the multi dimensional effects psychologically ,socially ,and economically on family integration .It confirmed that caregiver age and health affect their abilities to adjust to existence of psychotic patient . Also it confirmed the effect of social status and economical level on the family ability to adjust to existence of schizophrenic patient in the family. Another few studies reinforced earlier findings that care giving can be a rewarding experience, giving meaning, and enrichment , positive aspect of care giving . The studies revealed that social burden on families having schizophrenic patient is the greatest burden . The studies also revealed that families who enrolled to support and management programs experienced lower burden . For our country and culture this subject is new and the results will help to improve the quality of care given to the patient with schizophrenia and his family which will also improve family integration .

Chapter 3

Methodology

Methodology

3- Introduction

This chapter describes the methodology that was used in this research. The adopted methodology to accomplish this study uses the following techniques: the information about the research design, research population, questionnaire design, statistical data analysis, content validity and pilot study.

3.1 Research phases

The first phase of the research thesis proposal included identifying and defining the problems and establishment objective of the study and development research plan.

The second phase of the research included a summary of the comprehensive literature review. Literatures on family integration was reviewed.

The third phase of the research included a field survey which was conducted with family integration level experienced by families of patients diagnosed with psychotic illness in Gaza strip

The fourth phase of the research focused on the modification of the questionnaire design, through distributing the questionnaire to pilot study, The purpose of the pilot study was to test and prove that the questionnaire questions are clear to be answered in a way that help to achieve the target of the study. The questionnaire was modified based on the results of the pilot study.

The fifth phase of the research focused on distributing questionnaire. This questionnaire was used to collect the required data in order to achieve the research objective.

The sixth phase of the research was data analysis and discussion. Statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis. The final phase includes the conclusions and recommendations.

A one hundred and forty questionnaires were distributed to the research population and **one hundred twenty two** questionnaires are received.

Place of the study: The study were conducted in governmental community mental health clinics in Gaza Strip and psychiatric hospital .

Period of the study: The study was started on1/10/2011 and finished on 1/3/2012

Eligibility Criteria:

Inclusion criteria: Patient who diagnosed as schizophrenia, has family , patient age18-50 and live in Gaza **strip.**

Exclusion Criteria: Any**o**ne who was not diagnosed as schizophrenia .

Not have family , patient age < 18years or > 50 years old , not live in Gaza .

Research Design: descriptive cross sectional design**.**

3.2 Research methodology

3.2.1 Data Collection Methodology :

In order to collect the needed data for this research , we use the secondary resources in collecting data such as books, journals, statistics and web pages , in addition to preliminary resources that not available in secondary resources through distribute questionnaires on study population in order to get their opinions about the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip . Research methodology depend on the analysis of data on the use of descriptive analysis, which depends on the poll and use the main program (SPSS).

3.2.2 Study population

All families having schizophrenic patient in Gaza strip .number of registered files of schizophrenia in community mental health clinics in Gaza strip is about 1000 .

3.2.3 Sample size

The size of represented sample which were selected randomly were 140 families having a schizophrenic patient.

3.2.4 Sampling process

The samplings of families were done by simple random procedure among families with schizophrenic patient in Gaza city who are registered mainly in mental health clinics and in psychiatric hospital with size equal 140 families and the questionnaires were distributed

to the research sample and 122 questionnaires are received , and the following tables illustrated the properties of the samples.

First: Patient Data

1.Age:

Table No.(1) show that 29.5% from the sample age from " 18-30 years " , and 50.8% from the sample age from 31-50 years " , and 19.7% from the sample age from " More than 50 years " .

Table No.(1)
Age

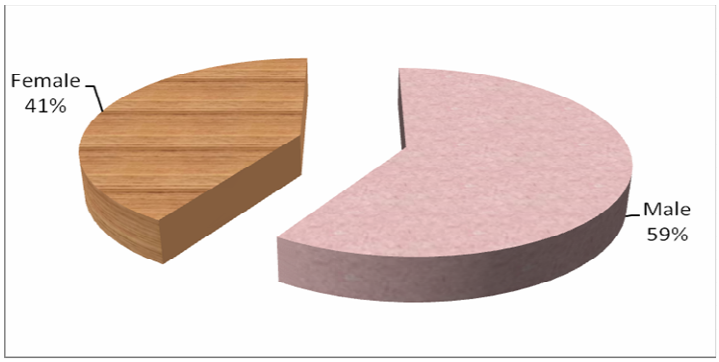
Age	**Frequency**	**Percentages**
18-30 years	46	37.7
31-50 years	76	62.3
Total	122	100

2.Sex

Table No.(2) show that 59.0% from the sample are " Male " , and 41.0% from the sample are " Female ".

Table No.(2)
Sex

Sex	**Frequency**	**Percentages**
Male	72	59
Female	50	41
Total	122	100



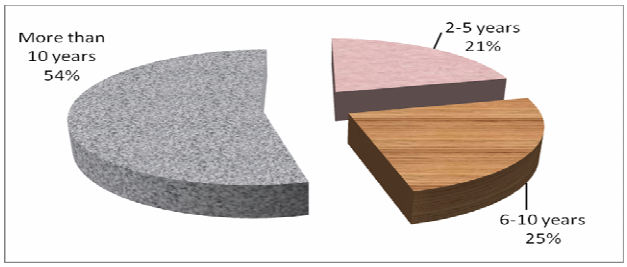
3.Duration of disease:

Table No.(3) show that 21.3% from the sample the Duration of disease from " 2-5 years " , and 24.6% from the sample the Duration of disease from "6-10 years " ,and 54.1% from the sample the Duration of disease from " More than 10 years ".

Table No.(3)

Duration of disease

Duration of disease	**Frequency**	**Percentages**
2-5 years	26	21.3
6-10 years	30	24.6
More than 10 years	66	54.1
Total	122	100



4-Address:

Table No.(4) show that 97.5% from the sample's address " Home " , and 2.5% from the sample's address " With relatives " .

Table No.(4)

Address

Address	**Frequency**	**Percentages**
Home	119	97.5
Institution	0	0
With relatives	3	2.5
Others	0	0
Total	122	100

Second : Care Giver

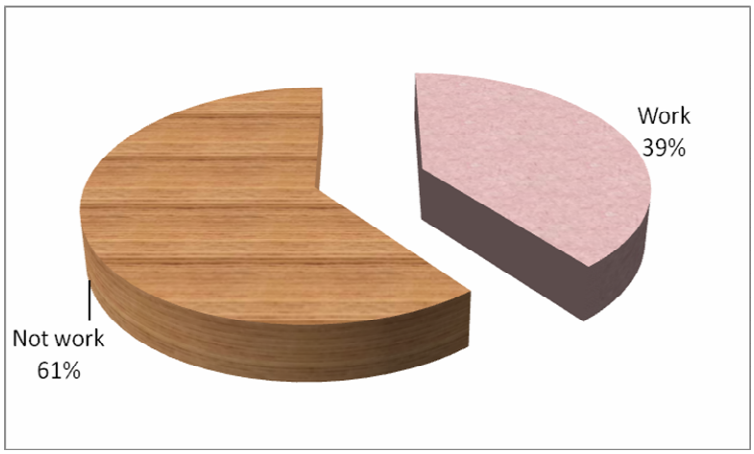
5.Job

Table No.(5) show that 39.3 from sample are " Work " , and 60.7 from the sample are " Not work "

Table No.(5)

Job

Job	Frequency	Percentages
Work	48	39.3
Not work	74	60.7
Total	122	100

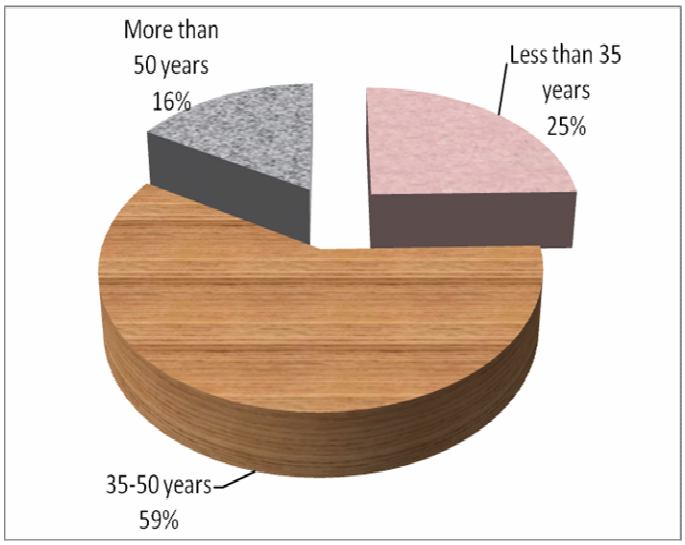


6.Caregiver Age:

Table No.(6) show that 24.6 % from the sample's age are " Less than 35 years " , and 59.0% from the sample's age are "35-50 years " , and 16.4% from the sample's age are " More than 50 years " .

Table No.(6)
Caregiver Age

Age	Frequency	Percentages
Less than 35 years	30	24.6
35-50 years	72	59
More than 50 years	20	16.4
Total	122	100



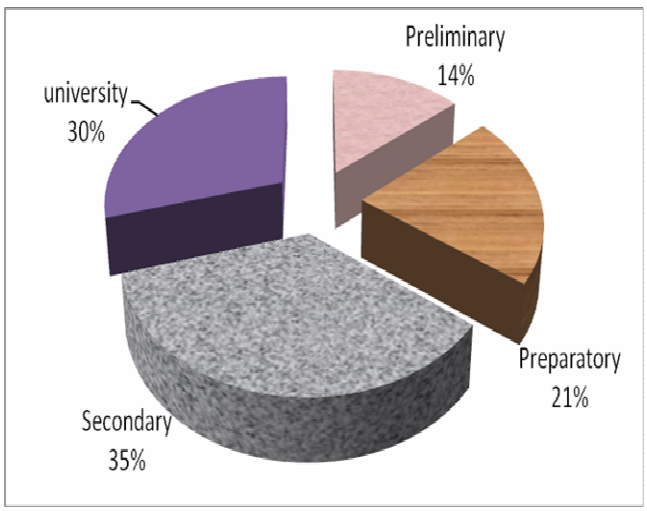
7. Educational Level

Table No.(7) show that 13.9 % from the sample the educational level are " Preliminary " , and 21.3 % from the sample the educational level are " Preparatory " , and 35.2% from the sample the educational level are " Secondary " , and29.5% from the sample the educational level are " university " .

Table No.(7)

Educational Level

Educational Level	**Frequency**	**Percentages**
Preliminary	17	13.9
Preparatory	26	21.3
Secondary	43	35.2
University	36	29.5
Total	122	100

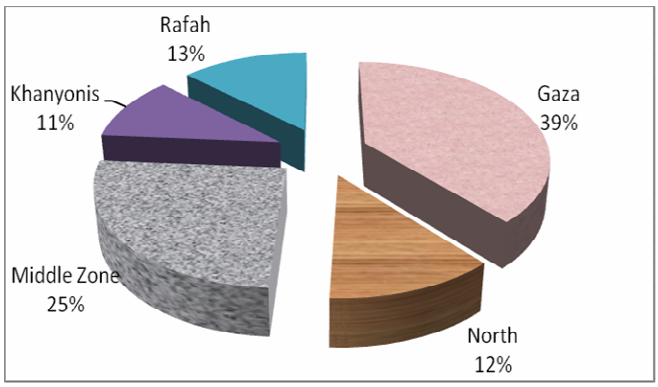


8. Address

Table No.(8) show that 38.5 % from the sample from " Gaza ", and 12.3% from the sample from " North ", and 25.4 % from the sample from " Middle Zone ", and 10.7% from the sample from " Khanyonis ", and 13.1% from the sample from " Rafah ".

Table No.(8)
Address

Address	**Frequency**	**Percentages**
Gaza	47	38.5
North	15	12.3
Middle Zone	31	25.4
Khanyonis	13	10.7
Rafah	16	13.1
Total	122	100

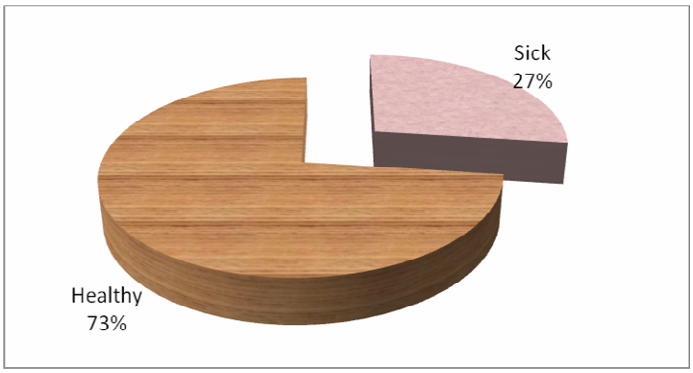


9. Care giver Health

Table No.(9) show that 27.0% from the sample the care giver health are " Sick " , and 73.0% from the sample the care giver health are " Healthy ".

Table No.(9)
Care giver Health

Care giver Health	**Frequency**	**Percentages**
Sick	33	27
Healthy	89	73
Total	122	100



Third : Family

10.Average income in shekels/ month

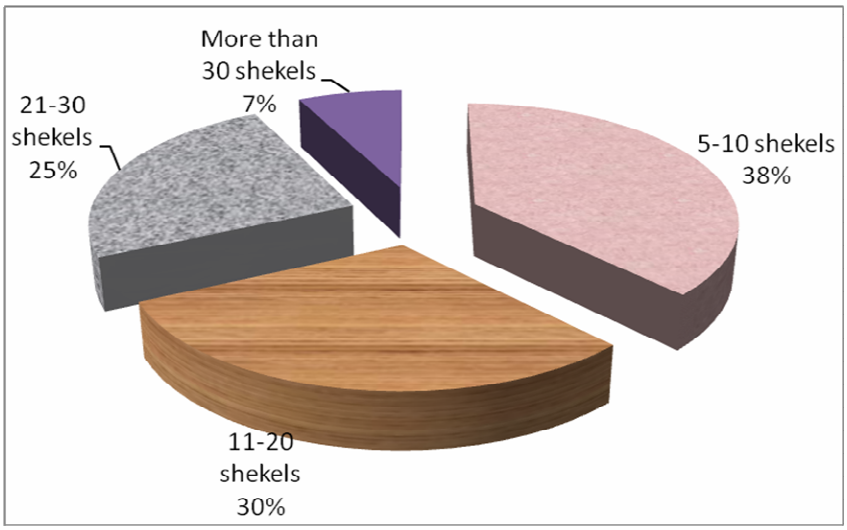
Table No.(10) show that 37.7% from the sample Average income from "5-10 shekels " , and 30.0% from the sample Average income from " 11-20 shekels " , and 24.6% from the sample Average income from "21-30 shekels " , and 7.4% from the sample Average income from " More than 30 shekels " .

Table No.(10)

Average income in shekels/ month

Average income in shekels per month	**Frequency**	**Percentages**
500-1000 shekels	46	37.7
1100-2000 shekels	37	30.3
2100-3000 shekels	30	24.6
More than 3000 shekels	9	7.4
Total	122	100

500-1000



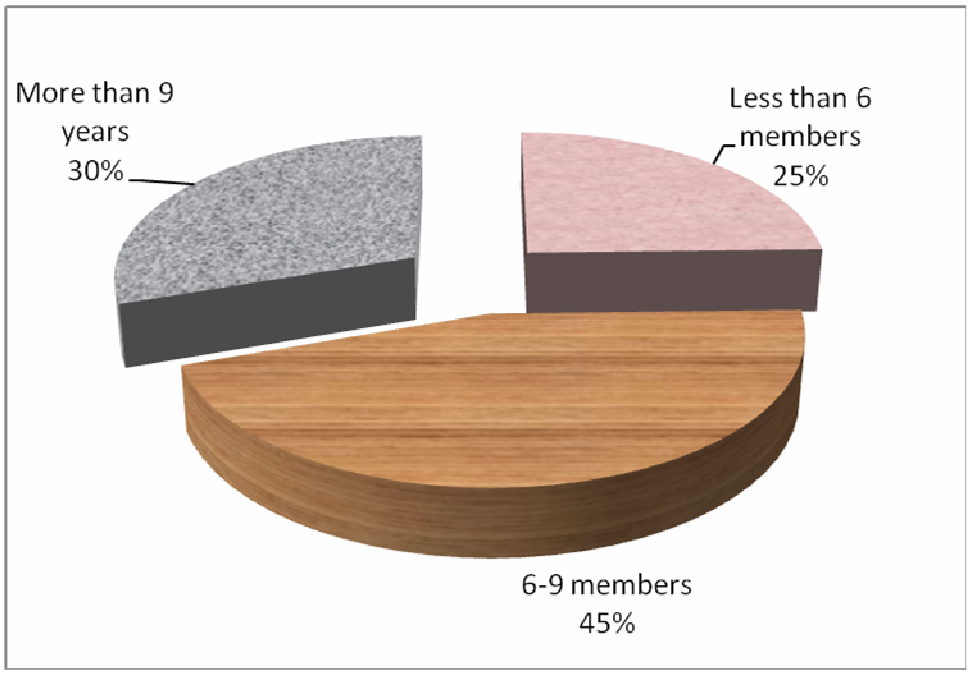
11. Number of family members

Table No.(11) show that 24.6% from the sample the Number of family members " Less than 6 members ", and 45.1 % from the sample the Number of family members " 6-9 members ", and 30.3% from the sample the Number of family members " More than 9 years ".

Table No.(11)

Number of family members

Number of family members	**Frequency**	**Percentages**
Less than 6 members	30	24.6
6-9 members	55	45.1
More than 9 years	37	30.3
Total	122	100



3. 3 Questionnaire content

The questionnaire was provided with a covering letter explaining the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage a high response. The questionnaire five _point likert scale included multiple choice question: which used widely in the questionnaire, The variety in these questions aims first to meet the research objectives, and to collect all the necessary data that can support the discussion, results and recommendations in the research.

The sections in the questionnaire will verify the objectives in this research related to family integration level experienced by families of patients diagnosed with schizophrenic illness in Gaza strip as the following:

First field: Essential Data consist of 12 items
Second field: Psychological Domain consist of 13 items

Third field: social dimension consist of 12 items.

Forth field: economical domain consist of 10 items.

And all questions follows likert scale as the following:

Level	Very low	Low	Moderate	High	Very high
Scale	1	2	3	4	5

3.4 Pilot Study

A pilot study for the questionnaire was conducted before collecting the results of the sample. It consisted of 25 questionnaires that chosen by simple random procedure. It provides a trial run for the questionnaire, which involves testing the wordings of question, identifying ambiguous questions, testing the techniques that used to collect data, and measuring the effectiveness of standard invitation to respondents .

3.5 Validity of the Instrument

We can define the validity of an instrument as a determination of the extent to which the instrument actually reflects the abstract construct being examined. "Validity refers to the degree to which an instrument measures what it is supposed to be measuring". High validity is the absence of systematic errors in the measuring instrument. When an instrument is valid; it truly reflects the concept it is supposed to measure. Achieving good validity required the care in the research design and sample selection . The amended questionnaire was by the supervisors and seven expertise in the tendering and bidding environments to evaluate the procedure of questions and the method of analyzing the results. The expertise agreed that the questionnaire was valid and suitable enough to measure the purpose that the questionnaire designed for.

3.5.1 Content Validity of the Instrument

Content validity test was conducted by consulting two groups of experts. The first was requested to evaluate and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem. The other was requested to evaluate that the instrument used is valid statistically and that the questionnaire was designed well enough to provide relations and tests between variables. The two groups of experts did agree that the questionnaire was valid and suitable enough to measure the concept of interest with some amendments.

3.5.2 Statistical Validity of the Instrument

To insure the validity of the questionnaire, two statistical tests should be applied. The first test is Criterion-related validity test (Pearson test) which measure the correlation coefficient between each item in the field and the whole field. The second test is structure validity test (Pearson test) that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of similar scale.

3.5.3 Criterion Related Validity :

1) Internal consistency:

Internal consistency of the questionnaire is measured by a scouting sample, which consisted of twenty five questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. Tables No.'s (12-14) below shows the correlation coefficient and p-value for each field items. As show in the table the p-Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to measure what it was set for.

Table(12)

The correlation coefficient between each item in the field and the whole field (Psychological Domain)

No.	Question	Pearson coefficient	p-value
1	Increase worry, tension and fear	0.706	0.000
2	Cause confusion and noise at home	0.771	0.000
3	Affect child rearing	0.646	0.000
4	Decrease integration between family members	0.745	0.000
5	Cause sleep disturbances between family members	0.618	0.001
6	Disturbed right decision making	0.604	0.001
7	Disturbed good communication and understanding between family members	0.634	0.001
8	Decrease emotional bonding between family members	0.493	0.012
9	Decrease family ability to face crisis	0.632	0.001
10	Decrease family integration	0.710	0.000
11	Increase emotional respond and fast decisions	0.692	0.000
12	Decrease self esteem	0.649	0.000
13	Cause frustration for family members	0.613	0.001

Table(13)

The correlation coefficient between each item in the field and the whole field (Social Dimension)

No.	Question	Pearson coefficient	p-value
1	Decrease sharing in social occasions	0.711	0.000
2	Affect marriage negatively between family members	0.548	0.005
3	Causes problems with neighbors	0.579	0.002
4	Decrease relative visiting	0.485	0.014
5	Causes not taking him in different social occasions	0.626	0.001
6	Preference of letting him at the institution when having social occasions	0.498	0.011
7	Shame from mention him in front of friends	0.592	0.002
8	Cause a lot of embarrassment in the social occasions	0.444	0.026
9	lower social status of the family	0.681	0.000
10	Causes social withdrawal	0.428	0.033
11	Affect academic achievement negatively for brothers and sisters	0.471	0.017
12	Decrease family ability to adapt and face crisis	0.753	0.000

Table(14)

The correlation coefficient between each item in the field and the whole field (economic domain)

No.	Question	Pearson coefficient	p-value
1	Increase daily cost	0.606	0.001
2	Cost special treatment and medicine	0.437	0.029
3	Need special kind of food	0.572	0.003
4	Spoil a lot of clothes	0.596	0.002
5	Spoil house furniture	0.486	0.014
6	Cause debts from relatives and neighbors	0.764	0.000
7	Need special costs for treatment travelling	0.430	0.032
8	Increase financial burden on the family	0.465	0.019
9	Good financial status decrease problems that result from having mentally ill patient	0.432	0.031
10	Good financial status increase family agreement about family standards	0.436	0.029
11	Good financial status helps in patient staying at home	0.678	0.000
12	Good financial status helps in integration , understanding and decrease tension between family members	0.478	0.016

3.5.4 Structure Validity of the Questionnaire

Structure validity is the second statistical test that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of likert scale. As shown in table No. (15), the significance values are less than 0.05 or 0.01, so the correlation coefficients of all the fields are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the fields are valid to be measured what it was set for to achieve the main aim of the study

Table No. (15)

Structure Validity of the Questionnaire

First	Title	Pearson correlation coefficient	p-value
1	Psychological Domain	0.768	0.000
2	social domain	0.708	0.000
3	economical domain	0.779	0.000

3.6 Reliability of the instrument

Reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring . The test is repeated to the same sample of people on two occasions and then compares the scores obtained by computing a reliability coefficient. For the most purposes reliability coefficient above 0.7 are considered satisfactory. Period of two weeks to a month is recommended between two tests Due to complicated conditions that the contractors is facing at the time being, it was too difficult to ask them to responds to our questionnaire twice within short period. The statistician's explained that, overcoming the distribution of the questionnaire twice to measure the reliability can be achieved by using **Cronbach's** Alpha coefficient and Half Split Method through the SPSS software.

3.7 Split Half Method

This method depends on finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) is computed according to the following equation :

Consistency coefficient = 2r/(r+1), where r is the Pearson correlation coefficient. The normal range of corrected correlation coefficient 2r/(r+1) is between 0.0 and + 1.0 As shown in Table No.(16), and the general reliability for all items equal 0.8819, and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at α = 0.05. It can be said that according to the Half Split method, the dispute causes group are reliable.

Table (16)

Split-Half Coefficient method

Number	section	No.	person-correlation	Spearman-Brown Coefficient	Sig. (2-(Tailed
1	Psychological Domain	13	0.7524	0.8587	0.000
2	social dimension	12	0.8125	0.8966	0.000
3	economical domain	10	0.7936	0.8849	0.000
	Total	35	0.7887	0.8819	0.000

3.8 Cronbach's Coefficient Alpha

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency. As shown in Table No. (17) the Cronbach's coefficient alpha was calculated for the first field of the causes of claims, the second field of common procedures and the third field of the Particular claims. the general reliability for

all items equal 0.9167. This range is considered high; the result ensures the reliability of the questionnaire.

Table (17)

Cronbach's Alpha for Reliability

Number	section		Cronbach's Alpha
1	Psychological Domain	13	0.8729
2	social dimension	12	0.9054
3	economical domain	10	0.8934
	Total	47	0.9167

3.9 Statistical Manipulation:

To achieve the research goal, researcher used the statistical package for the Social Science (SPSS) for Manipulating and analyzing the data.

3.9.1 Statistical methods are as follows:

1- Frequencies and Percentile

2- Alpha- Cronbach Test for measuring reliability of the items of the questionnaires

3- Person correlation coefficients for measuring validity of the items of the questionnaires.

4- spearman –Brown Coefficient

5- one sample t test

6- independent sample t test

7- one way ANOVA

Chapter Four

Data Analysis and Discussion

4.0 One Sample K-S Test

One Sample K-S test will be used to identify if the data follow normal distribution or not, this test is considered necessary in case testing hypotheses as most parametric Test stipulate data to be normality distributed and this test used when the size of the sample are greater than 50.

Results test as shown in table (18) , clarifies that the calculated p-value is greater than the significant level which is equal 0.05 (p-value. > 0.05), this in turn denotes that data follows normal distribution, and so parametric Tests must be used.

Table (18)

One Sample K-S

Number	section	No.	Statistic	P-value
1	**Psychological Domain**	13	0.761	0.609
2	**social Domain**	12	0.767	0.599
3	**economical domain**	10	0.987	0.284
	Total	35	0.625	0.830

Discussion and questions test

1. **what is the level of family integration in families with patients of schizophrenia ?**

For general table No.(19) show the results for all items of the field show that the average mean equal 3.57 and the weight mean equal 71.48 % which is greater than " 60%" , that means the level of family integration in families with psychotics is high at significant $\alpha = 0.05$

Table no.(19)
Family integration in families having patient with schizophrenia

No.	Existence of mental ill patient in my family	Mean	standard deviation	Weight mean
1	Psychological Domain	3.78	0.807	75.52
2	social Domain	3.47	0.888	69.44
3	economical domain	3.47	0.703	69.47
	All items	3.57	0.682	71.48

2. Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with psychotic illness in Gaza strip at level α =0.05 due to Duration of disease?

To answer the question we use the one way ANOVA and the result illustrated in tables no.(20) which show that the p-value equal 0.090 which is greater than 0.05 and the value of F test equal 2.461 which is less than the value of critical value which is equal 3.07 , that's means there are no differences at significant level $\alpha = 0.05$ in the statistical readings of the sample regarding the definition of the relationship between family integration level experienced by families having schizophrenic patient due to **Duration of disease**

Table No.(20) One way ANOVA test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Duration of disease

Field	Sources	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Psychological Domain	Between Groups	3.615	2	1.808	2.858	0.061
	Within Groups	75.272	119	0.633		
	Total	78.888	121			
social Domain	Between Groups	1.692	2	0.846	1.074	0.345
	Within Groups	93.752	119	0.788		
	Total	95.444	121			
economical domain	Between Groups	2.300	2	1.150	2.380	0.097
	Within Groups	57.495	119	0.483		
	Total	59.795	121			
All sections	Between Groups	2.236	2	1.118	2.461	0.090
	Within Groups	54.078	119	0.454		
	Total	56.315	121			

Critical value of F at df "2,119" and significance level 0.05 equal **3.07**

3. what is the level of family integration in families with regard to Psychological Domain?

The results shown in Table No. (21) as follows:

The three highest statements according to weight mean as follows:

1- In item No. (1) the weight mean equal " 90.16%" means (Existence of mental ill patient in my family Increase worry, tension and fear).

In item No. (2) the weight mean equal " 86.23%" means (Existence of mental ill patient in my family Cause confusion and noise at home).

2- In item No. (3) the weight mean equal " 79.84%" means (Existence of mental ill patient in my family Affect child rearing).

And the three lowest statements according to weight mean as follows

1- In item No. (8) the weight mean equal " 69.51%" that means (Existence of mental ill patient in my family Decrease emotional bonding between family members).

2- In item No. (9) the weight mean equal " 70.16%" that means (Existence of mental ill patient in my family Decrease family ability to face crisis).

3- In item No. (12) the weight mean equal " 68.20%" that means (Existence of mental ill patient in my family Decrease self esteem).

For general the results for all items of the field show that the average mean equal 3.78 and the weight mean equal 75.52 % which is greater than " 60%" that means the level of family integration in families with regard to Psychological Domain are large at significant level $\alpha = 0.05$

Table no. (21)
Psychological Domain

No.	Existence of mental ill patient in my family	Mean	standard deviation	Weight mean
1	Increase worry, tension and fear	4.51	0.795	90.16
2	Cause confusion and noise at home	4.31	0.971	86.23
3	Affect child rearing	3.99	1.124	79.84
4	Decrease integration between family members	3.71	1.236	74.26
5	Cause sleep disturbances between family members	3.86	1.116	77.21
6	Disturbed right decision making	3.67	1.087	73.44
7	Disturbed good communication and understanding between family members	3.61	1.080	72.13
8	Decrease emotional bonding between family members	3.48	1.115	69.51
9	Decrease family ability to face crisis	3.51	1.030	70.16
10	Decrease family integration	3.62	1.195	72.46
!!	Increase emotional respond and fast decisions	3.67	1.056	73.44
12	Decrease self esteem	3.41	1.066	68.20
13	Cause frustration for family members	3.74	1.043	74.75
	All items	3.78	0.807	75.52

4. What is the level of family integration in families with regard to Social Dimension ?

we test the opinion of the respondent Social domain and the results shown in Table No. (22) as follows:

The three highest statements according to weight mean as follows:

1. In item No. (1) the weight mean equal " 80.49%" that means (Existence of mental ill patient in my family Decrease sharing in social occasions).
2. In item No. (5) the weight mean equal " 75.57%" that means (Existence of mental ill patient in my family Causes not taking him in different social occasions).
3. In item No. (8) the weight mean equal " 73.44%" that means (Existence of mental ill patient in my family Cause a lot of embarrassment in the social occasions).

And the three lowest statements according to weight mean as follows

1. In item No. (3) the weight mean equal " 65.08%" that means (Existence of mental ill patient in my family Causes problems with neighbors).
2. In item No. (6) the weight mean equal " 63.28%" that means (Existence of mental ill patient in my family Preference of letting him at the institution when having social occasions moderately).
3. In item No. (9) the weight mean equal " 62.30%" that means (Existence of mental ill patient in my family decrees social class of the family moderately).

For general the results for all items of the field show that the average mean equal 3.47 and the weight mean equal 69.44% which is greater than " 60%" that means the level of family integration in families with regard to Social Dimension **are high at significant** level $\alpha = 0.05$

Table no.(22)

Social Dimension

No.	Existence of mental ill patient in my family	Mean	standard deviation	Weight mean
1	Decrease sharing in social occasions	4.02	1.117	80.49
2	Affect marriage negatively between family members	3.52	1.300	70.33
3	Causes problems with neighbors	3.25	1.270	65.08
4	Decrease relative visiting	3.48	1.115	69.51
5	Causes not taking him in different social occasions	3.78	1.139	75.57
6	Preference of letting him at the institution when having social occasions	3.16	1.393	63.28
7	Shame from mention him in front of friends	3.54	1.227	70.82
8	Cause a lot of embarrassment in the social occasions	3.67	1.094	73.44
9	lower social status of the family	3.11	1.194	62.30
10	Causes social withdrawal	3.26	1.163	65.25
11	Affect academic achievement negatively for brothers and sisters	3.47	1.337	69.34
12	Decrease family ability to adapt and face crisis	3.55	1.179	70.98
	All items	3.47	0.888	69.44

5. What is the level of family integration in families with regard to economical domain?

The results shown in Table No. (23) as follows:

The three highest statements according to weight mean as follows:

1. In item No. (1) the weight mean equal " 81.64%" that means (Existence of mental ill patient in my family Increase daily cost).
2. In item No. (2) the weight mean equal " 77.54%" that means (Existence of mental ill patient in my family Cost special treatment and medicine).
3. In item No. (8) the weight mean equal " 76.07%" that means (Existence of mental ill patient in my family Increase financial burden on the family).

And the three lowest statements according to weight mean as follows

1. In item No. (3) the weight mean equal " 64.75%" that means (Existence of mental ill patient in my family Need special kind of food).

2. In item No. (6) the weight mean equal 59.02" %", that means (Existence of mental ill patient in my family Cause debts from relatives and neighbors moderately).

3. In item No. (7) the weight mean equal " 50.16%" that means (Existence of mental ill patient in my family not Need special costs for treatment travelling).

For general the results for all items of the field show that the average mean equal 3.47 and the weight mean equal 69.47 % which is greater than " 60%" that means the level of family integration in families with regard to economical domain is high at significant $\alpha = 0.05$

Table no.(23)

economical domain

No.	Existence of mental ill patient in my family	Mean	standard deviation	Weight mean
1	Increase daily cost	4.08	1.033	81.64
2	Cost special treatment and medicine	3.88	1.132	77.54
3	Need special kind of food	3.24	1.206	64.75
4	Spoil a lot of clothes	3.41	1.290	68.20
5	Spoil house furniture	3.37	1.306	67.38
6	Cause debts from relatives and neighbors	2.95	1.232	59.02
7	Need special costs for treatment travelling	2.51	1.228	50.16
8	Increase financial burden on the family	3.80	1.111	76.07
9	Good financial status decrease problems that result from having mentally ill patient	3.58	1.043	71.64
10	Good financial status increase family agreement about family standards	3.57	0.961	71.48
11	Good financial status helps in patient staying at home	3.57	1.060	71.31
12	Good financial status helps in integration , understanding and decrease tension between family members	3.72	1.031	74.43
	All items	3.47	0.703	69.47

6. Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to education of the family?

To answer the question we use the one way ANOVA and the result illustrated in tables no.(24) which show that the p-value equal 0.643 which is greater than 0.05 and the value of F test equal 0.559 which is less than the value of critical value which is equal 2.68 , that's means there are no differences at significant level $\alpha = 0.05$ in the statistical readings of the sample regarding the definition of the relationship between family integration level experienced by families having schizophrenic patient **due to education of the family**.

Table No.(24)

One way ANOVA test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to education of the family

Field	Sources	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Psychological Domain	Between Groups	2.080	3	0.693	1.065	0.367
	Within Groups	76.808	118	0.651		
	Total	78.888	121			
social Domain	Between Groups	0.198	3	0.066	0.082	0.970
	Within Groups	95.247	118	0.807		
	Total	95.444	121			
economical domain	Between Groups	1.165	3	0.388	0.782	0.506
	Within Groups	58.630	118	0.497		
	Total	59.795	121			
All sections	Between Groups	0.788	3	0.263	0.559	0.643
	Within Groups	55.526	118	0.471		
	Total	56.315	121			

Critical value of F at df "3,118" and significance level 0.05 equal 2.68

7. Is there a difference at family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to level of the family income?

To answer the question we use the one way ANOVA and the result illustrated in tables no.(25) which show that the p-value equal 0.102 which is greater than 0.05 and the value of F test equal 2.11 which is less than the value of critical value which is equal 2.68 , that's means there are no differences at significant level $\alpha = 0.05$ in the statistical readings of the sample regarding the definition of the relationship between family integration level experienced by families having schizophrenic patient due to level of the family income.

Table No.(25)

One way ANOVA test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to level of the family income

Field	Sources	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Psychological Domain	Between Groups	1.057	3	0.352	0.534	0.660
	Within Groups	77.830	118	0.660		
	Total	78.888	121			
social Domain	Between Groups	7.378	3	2.459	3.295	0.023
	Within Groups	88.066	118	0.746		
	Total	95.444	121			
economical domain	Between Groups	1.921	3	0.640	1.306	0.276
	Within Groups	57.874	118	0.490		
	Total	59.795	121			
All sections	Between Groups	2.876	3	0.959	2.11	0.102
	Within Groups	53.438	118	0.453		
	Total	56.315	121			

Critical value of F at df "3,118" and significance level 0.05 equal 2.68

8. Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia **in Gaza strip at level α =0.05 due to patient gender (male or female)?**

To answer the question we use the Independent Samples Test and the result illustrated in table no.(26) which show that the p-value equal 0.928 which is greater than 0.05 and the absolute value of T test equal 0.091 which is less than the value of critical value which is equal 2.0, that's means There are no difference **in the statistical readings of the sample regarding** the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to gender .

Table No.(26)

Independent Samples Test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in **Gaza strip at level α =0.05 due to gender**

Field	Gender	N	Mean	Std. Deviation	T	P-value
Psychological Domain	Male	72	3.772	0.723	-0.061	0.951
	Female	50	3.782	0.923		
social Domain	Male	72	3.463	0.838	-0.128	0.898
	Female	50	3.484	0.964		
economical domain	Male	72	3.472	0.684	-0.021	0.983
	Female	50	3.475	0.737		
All sections	Male	72	3.569	0.651	-0.091	0.928
	Female	50	3.581	0.732		

Critical value of t at df "120" and significance level 0.05 equal 1.98

9.Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Number of family members?

To answer the question we use the one way ANOVA and the result illustrated in tables no.(27) which show that the p-value equal 0.403 which is greater than 0.05 and the value of F test equal 0.915which is less than the value of critical value which is equal 3.07 , that's means there are no difference **in the statistical readings of the sample regarding** the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Number of family members**.**

Table No.(27)

One way ANOVA test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in **Gaza strip at level α =0.05 due to** Number of family members

Field	Sources	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Psychological Domain	Between Groups	0.164	2	0.082	0.12	0.883
	Within Groups	78.723	119	0.662		
	Total	78.888	121			
social Domain	Between Groups	1.973	2	0.987	1.256	0.289
	Within Groups	93.471	119	0.785		
	Total	95.444	121			
economical domain	Between Groups	1.012	2	0.506	1.024	0.362
	Within Groups	58.784	119	0.494		
	Total	59.795	121			
All sections	Between Groups	0.853	2	0.427	0.915	0.403
	Within Groups	55.461	119	0.466		
	Total	56.315	121			

Critical value of F at df "2,119" and significance level 0.05 equal **3.07**

10. Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Care giver Health (Sick or healthy)?

To answer the question we use the Independent Samples Test and the result illustrated in table no.(28) which show that the p-value equal 0.411 which is greater than 0.05 and the absolute value of T test equal 0.831 which is less than the value of critical value which is equal 2.0, that's means There are no difference **in the statistical readings of the sample regarding** the family integration level experienced by families of patients diagnosed with psychotic illness in Gaza strip at level α =0.05 due to Care giver Health.

Table No.(28)

Independent Samples Test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Care giver Health

Field	Care giver Health	N	Mean	Std. Deviation	T	P-value
Psychological Domain	Sick	33	3.648	0.994	-0.927	0.359
	Healthy	89	3.824	0.727		
social Domain	Sick	33	3.199	1.050	-1.854	0.070
	Healthy	89	3.573	0.803		
economical domain	Sick	33	3.606	0.844	1.124	0.267
	Healthy	89	3.424	0.642		
All sections	Sick	33	3.474	0.873	-0.831	0.411
	Healthy	89	3.611	0.598		

Critical value of t at df "120" and significance level 0.05 equal 1.98

11. Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Address?

To answer the question we use the one way ANOVA and the result illustrated in tables no.(29) which show that the p-value equal 0.053 which is greater than 0.05 and the value of F test equal 2.411 which is less than the value of critical value which is equal 2.45, that's means there are no difference **in the statistical readings of the sample regarding** the family integration level experienced by families of patients diagnosed with schizophrenic in Gaza strip at level α =0.05 due to Address**.**

Table No.(29)

One way ANOVA test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with psychotic illness in Gaza strip at level α =0.05 due to Address

Field	Sources	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Psychological Domain	Between Groups	3.694	4	0.924	1.43	0.226
	Within Groups	75.194	117	0.643		
	Total	78.888	121			
social Domain	Between Groups	9.176	4	2.294	3.111	0.018
	Within Groups	86.269	117	0.737		
	Total	95.444	121			
economical domain	Between Groups	3.421	4	0.855	1.775	0.138
	Within Groups	56.374	117	0.482		
	Total	59.795	121			
All sections	Between Groups	4.288	4	1.072	2.411	0.053
	Within Groups	52.027	117	0.445		
	Total	56.315	121			

Critical value of F at df "4,117" and significance level 0.05 equal 2.45

12. Is there a difference in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Age of patient ?

To answer the question we use the one way ANOVA and the result illustrated in tables no.(30) which show that the p-value equal 0.998 which is greater than 0.05 and the value of F test equal 0.002 which is less than the value of critical value which is equal 3.07 , that's means there are no difference **in the statistical readings of the sample regarding** the family integration level experienced by families of patients diagnosed with schizophrenia in Gaza strip at level α =0.05 due to Age of patient**.**

Table No.(30)

One way ANOVA test in the statistical readings of the sample regarding the family integration level experienced by families of patients diagnosed with psychotic illness in Gaza strip at level α =0.05 due to Age of patient

Field	Sources	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
Psychological Domain	Between Groups	0.353	2	0.176	0.267	0.766
	Within Groups	78.535	119	0.660		
	Total	78.888	121			
social dimension	Between Groups	0.103	2	0.052	0.065	0.938
	Within Groups	95.341	119	0.801		
	Total	95.444	121			
economical domain	Between Groups	0.258	2	0.129	0.258	0.773
	Within Groups	59.537	119	0.500		
	Total	59.795	121			
All sections	Between Groups	0.002	2	0.001	0.002	0.998
	Within Groups	56.313	119	0.473		
	Total	56.315	121			

Critical value of F at df "2,119" and significance level 0.05 equal **3.07**

Chapter 5

Discussion

5-Introduction

This study aimed to describe family integration experienced by families having schizophrenic patient from different domains psychologically, socially and economically .It also aimed to describe how sociodemographic data such as age , sex, duration of the disease and address of patient affect these domains .Also it described the effect of caregiver job , educational level, address and health affect family integration .It also described the effect of family factors such as average income and number of family members on family integration for families having schizophrenic patient .from my experience I noticed that there is a great effect of having schizophrenic patient on family integration from different domains especially when shifting services from hospital base to community based .That change put great burden on family members and relatives who take care of the schizophrenic patient. Most schizophrenic patients stay at home and take their treatment through community mental health clinics (CMHC) .In this chapter the researcher introduced the main results as well discussion of these results on the light of previous studies . This part includes some implications and recommendations regarding family integration experienced by families having schizophrenics .Recommendations for further researches is included in this part as well .

5.1 Main Results

This study revealed that family integration experienced by families having schizophrenics is highly affected from the perspective of different domains ,psychological ,social and economical domains .The most significant domain which was approved according to the results is psychological domain .

Average mean = 3.78, weight mean =75.52%,.The second highest score was the economical domain of family integration experienced by families having schizophrenics. Average mean=3.47,weight main=69.47%, The third highest score was the social domain of family integration experienced by families having schizophrenic (average mean = 3.47,weight mean ==69.44.

The level of family integration in families with schizophrenic patients is highly affected psychologically , economically and socially .(average mean=3.57 ,weight mean=71.48,. The results show that no differences at significant level &=0.05 in the statistical readings

of the sample regarding family integration due to duration of disease ,gender and age of the patient, family education ,family income ,number of family members and caregiver health and address. The most prevalent effect on family integration experienced by family having schizophrenic patient is the psychological domain . The signs of psychological effect that appeared the highest are:

Worry , tension and fear

Confusion and noise at home

Child rearing negatively affected .

The second most important effect on family integration experienced by families having schizophrenic patient is the economical domain which was revealed highly through the following statements :

Existence of mental ill patient increase daily cost .

Existence of mental ill patient cost special treatment and medicine .

Existence of mental ill patient increase financial burden .

The third most important effect on family integration experienced by families having schizophrenic patient is the social domain which was revealed highly through the statements : Existence of mental ill patient decrease sharing in social occasions .

Existence of mental ill patient cause not taking him in different social occasions

Existence of mental ill patient cause a lot of embarrassment in the social occasions

To compare my study results with the previous study results as following :

In the study by Wageeh Abdel- Nasser Hassan et al ,2011, the study revealed that the burden reported by caregivers of schizophrenics was high and that means family integration is highly affected and that result agree with my study results .Also Wageeh study revealed that sociodemographic variables were not associated significantly with burden and that also agree with my study results .

In an arabic study from Kawait revealed that the psychological dimension that affect Quality Of Life for caregiver of schizophrenic patient scored the highest level and that also

agree with my study results. In an Indian study by Munish Aggarwal et al,2011, showed that education of caregivers , coping strategies and available social support influence the final appraisal of caregivers . That result ensure the importance of psycho education for the family . In a study published in journal ,2011revealed that burden of care is global issue affecting family caregivers in both developed and developing countries .The study that don by Kreisman et al ,2010 revealed that family integration level is affected by attitudes of family toward patient and toward mental illness and how the family could cope or tolerate the deviance . This result also ensure the importance of family psycho education about new concepts of mental health .In the study that done by CM Pariante et al revealed the presence of emotional distress, poor social relation ships and financial difficulties and those results ensure the results of my study. Another study by Robert Blad et al,2009,showed the importance of giving hope for care givers of schizophrenic patient. On the other hand, Aadi Jan Shah,et al,2009 show major psychiatric burden on caregiver of schizophrenic patient .The study by Lorenza Magliano et al ,2009 ensure all previous results and showed constraints in social activities , negative effects on family life and feeling of loss and that all results support my study results

Another study by Chilian Pamela Grandon et al,2007 ensure that family integration is affected psychologically, and socially and ensure the need for family psycho education .The study that done by Alejandra(2009) supported the results of Lorenza and all supported my study results .Finally all studies ensured family burden that result from having schizophrenic patient psychologically , socially and financially That means family integration level is highly affected psychologically , socially and financially from having schizophrenic patient .

5.2 Recommendations and further studies

As shown in the study shifting the care of mental health from hospital based to community based (deinstitunalization) increase burden on the family. So the impact of having schizophrenic patient is generally great and affect the family (the corner stone in our society). So heavy efforts must be done and cooperated to meet challenges and to implement policies and strategies to handle this problem successfully .

1-To establish comprehensive integral centers to help patient and his family psychologically , socially and economically .

2-To establish alternative home for those patients and homeless .

3-To activate the role of health provider centers through :

- Promotion the physical and psychological services offered to schizophrenic patient and his family by promotion treating facilities , proper diagnosis , investigation and management .

-Provide supportive counseling for family and care giver by placing them in touch with health care professional , family support group ,offering advices to maintain their integrity , encouraging group meeting , encouraging them for social mobility , fresh journeys , relief feeling of shame ,grief and guilt .

-Educational programmes for patients and their families ,

-Workshops and training programmes for all workers in this field .

4-To establish many of governmental institutions and private to cover big need of large numbers of mentally ill patients .

5-To activate the role of media to focus on the size and risks of the problem and how to deal with it through :

- Educational awareness programs of community at all levels to avoid neglecting and stigma.

- Educate family and care giver protection programs in coping strategies to maintain the life comfortable .

- Encourage families to attach with health provider for proper management .

6- Convey the problem to all whom are concerned and in responsible position and explain the size and impact of the problem in our society .

7- Develop various ways that families organize themselves to counteract the disintegrative effect of schizophrenics and enhancing participation in formal organizations .

8- Strengthen connection ,communication and cooperation with international organization that interest with this group of people for counseling , help and support .

9- Coordinate all efforts in this field .

10- There is little empirical work on the family with schizophrenic patients , so we recommended and encourage further researches in this field and the suggestive studies are:

- Maintenance of family integration for families having schizophrenic patients.

- Proper coping strategies for families having schizophrenics .

- Family psycho education and management programs.

REFERENCES

1-Abelenda, J., & Helfrich, C. A. (2003*); Family resilience and mental illness: The role of occupational therapy. Occupational Therapy in Mental Health, 19, 25-39.*

2-Accordino, M. P., Porter, D.F., & Morse, T. (2001). *Deinstitutionalization of persons with severe mental illness: Context and consequences. Journal of Rehabilitation, 6(2), 16-21.*

3-Amer A. Hosin[a]; Simon Moore[a]; Christina Gaitanou[a] - *Adjustment of Both Parents and Children of Exiled and Traumatized Iraqi Refugees Journal of Muslim Mental Health Volume 1, Issue 2, 2006, Pages 123 - 136*

4-Awad, A. G., & Voruganti, L. N. P. (2008). *The burden of schizophrenia on caregivers. Pharmacoeconomics, 26, 149-162.*

5-Alejandra Caqueo-Urízar and José Gutiérrez-Maldonado. Quality of Life Research *Vol. 15, No. 4 (May, 2006), pp. 719-724. Burden of care in families of patients with schizophrenia*

6-Aadil Jan Shah , Ovais Wadoo and Javed Latoo,2009. *Psychological Distress in Carers of People with Mental Disorders*

7-**Archives of Psychiatric Nursing Volume 25, Issue 5 , Pages 339-349, October 2011 *Global Perspective of Burden of Family Caregivers for Persons With Schizophrenia***

8-Baron, M. (2001). *Genetics of schizophrenia and the new millennium: Progress and pitfalls. American Journal of Human Genetics, 68, 299–312.*

9-Beebe, L. (2003). *Theory-based research in schizophrenia. Perspectives in Psychiatric Care, 39(2), 67-74.*

10-Bachrach, L. L. (1993). *American experience in social psychiatry. In D. Bhugra & J. Leff (Eds.), Principles of social psychiatry (pp. 534-548). Oxford: Blackwell.*

11 -Bleuler, E : ***Dementia Praecox Group of schizophrenia, 1939,p436-464***

Translatedby Zinkin.J.New York, International universities press,1950

12-Clarke, J. (1979). ***In defense of deinstitutionalization. Health and Society, 57, 461-.***

13-Cook,J.A.,Lefley, H.P, P.ckett,S.A. and Cohler,B.J.(1994).*Age and family burden among parents of offspring with severe mental illness.American Journal of orthopsychiatry 64;435-447.doi;10.1037/h0079535*

14 -Chen,yanakun,(2010).*Health – Related Quality of life in the family caregivers of stroke survivors . International Journal of Rehabilitation Research , v33,n3 p232-237 sep2010*

15-CM Pariante, B Carpiniello,2010, ***Family burden in relatives of - schizophrenics and of people with mental retardation: A comparative study European Psychiatry, Volume 11, Issue 8, Pages 381-385-***

16-Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K. et al. (2002). ***Challenging two mental illness stigmas: Personal responsibility and dangerousness. Schizophrenia Bulletin, 28, 293-309.***

17-Dyck, D. G., Short, R., & Vitaliano, P. P. (1999). ***Predictors of burden and infectious illness in schizophrenia caregivers. Psychosomatic Medicine, 61, 411-419.***

18-Diagnostic and Statistical Manual Of Mental Disorder DSM IV 2004s.

19-Eur. J. Psychiat. v.19 n.1 Zaragoza ene.-mar. 2005. ***The European Journal of Psychiatry http://dx.doi.org/10.4321/S0213-61632005000100005 . The effect of rehabilitation of schizophrenic patients on their family atmosphere and the emotional well-being of caregivers***

20-Evavold, S. A. (2003). ***Family members of the mentally ill and their experiences with mental health professionals.***

21-Freeman & Zabriski,(2003) . ***Contribution of family leisure to family functioning among families that include children with developmental disabilities***

22-Grad J, Sainbury P. ***Mental illness and the family. Lancet. 1963 Mar 9;1(7280):544–547. [PubMed].***

23-Gray, D. E. (2002). Ten years on: ***A longitudinal study of families of children with autism. Journal of Intellectual & Developmental Disability, 27, 215-222.***

24-Gayled. Gubman , Richard C Tessler,(2005). ***The Impact of Mental illness on families, Concepts And priorities***

25-Glanville, D. N., & Dixon, L. (2005). ***Caregiver burden, family treatment approaches and service use in families of patients with schizophrenia.***

26-Hoenig , J.&Hamilton,M.V.(1966). ***The schizophrenic patient in the community and his effect on the house hold. International Journal of social psychiatry 12,165-176.***

27 -Judith A. Cook, Tamar Heller and Susan A. Pickett-Schenk (Oct., 1999), pp. 405-410.***The Effect of Support Group Participation on Caregiver Burden among Parents of Adult Offspring with Severe Mental Illness Family Relations Vol. 48, No. 4, Interventions for Family Caregivers***

28-Jones, S., & Hayward, P. (2004). ***The role of the family: Coping with schizophrenia – a guide for patients, families and caregivers.***

29- Kreisman, Dolores E.; Joy,Virginia(1974) D. Schizophrenia Bulletin, Vol 1(10), 34-57. ***Family response to the mental illness of a relative*** *.*

30 -K raepelin ,E : ***Psychiatry 2,3 ,1926****.*

31-Lessenberry,Beth M,Rehfeldt,Ruth Anne(2004). ***Evaluating stress levels of parents of children with disabilities***

32-Lorenza Magliano, Andrea Fiorillo, Corrado De Rosa, Claudio Malangone, Mario Maj,2009. ***Family burden in long-term diseases: a comparative study in schizophrenia vs. physical disorders*** **Social Science & Medicine,** ***Volume 61, Issue 2, Pages 313-322***

33-Loukissa, D. A. (1995). ***Family burden in chronic mental illness: A review of research studies. Journal of Advanced Nursing, 21, 248-255.***

34-Lee, C., McGlashan, T., & Woods, S. (2005*). Prevention of schizophrenia: Can it be achieved? CNS Drugs, 19(3), 193-206.*

35-McCubbin, M. A., & H. I. (1988). ***Family systems assessment. , resources, and coping.pp6,202,237.***

36-Meehl, P. (1962). ***Schizotaxia revisited. Archives of General Psychiatry, 46, 935–94***

37- Munish Aggarwal,et al Published online before print October 29, 2009, doi: 10.1177/0020764009352822 Int J Soc Psychiatry May 2011 vol. 57 no. 3 224-236 ***Experience of Caregiving in Schizophrenia: a Study From India***

38--Noreen Brady PhD, RN, CNS, LPCC; Gail C. McCain PhD, RN, FAAN; The Sarah Cole Hirsh Institute for Best Nursing Practices of the Case Western Reserve University Frances Payne Bolton School of Nursing,2005 ***"Living With Schizophrenia": A Family Perspective***

39-Norman Sartorius , Julian Leff , Juan JoseLopez_Ibor ,Mario Maj and Ahmad Okasha(2005) Families and Mental Disorder: ***From Burden to Empowerment . John Wiley &Sons , Ltd. ISBN:0-470-02382-1***

***40*-n.wikipedia.org/wiki/Socialization**

41-Olson, D. H., Russell, C. S., & Sprenkle, D. H. (1980). ***Circumplex model of marital and family systems II: Empirical studies and clinical intervention.p.18,3-28***

42-Olson, D. H., Portner, J., & Lavee, Y. (1985). ***FACES III. Family Social Science, University of Minnesota, p.4,383-387***

43-Pamela Grandón ,Cristina Jenaro, Serafín Lemos 2007. ***Primary caregivers of schizophrenia outpatients: Burden and predictor variables***

44-Robert B land phD1, Yvonne Darlington phD2 (2009)". ***The Nature and Source of Hope ; Perspectives of family Caregivers of peopleWith Serious Mental Illness***

45-Roos,(1998). ***The psychiatric outpatient family as a support system, Maintain Compliance-Data Security Mental health ,Tips & Tool***

46-Ruzanna ZamZam,et al.2005 ." ***Schizophrenia in Malaysian families*****"**

47-Scheffer, R. (2003). ***Addressing stigma: Increasing public understanding of mental illness*****. Toronto: Centre for Addiction and Mental Health**

48-**Stiles, P. D., Culhane, D. P., & Hadley, T. R. (1996).** ***Before and after***

Deinstitutionalization .Administration and Policy in Mental Health, 23, 513-526.

49-Sameroff, A. J. (1990). ***Neo-environmental perspectives on developmental theory (p.93-113) .New York:Cambridge University Press.***

50-Schwartz,et al ,(2002). ***The topic was "Parents of mentally ill adult living at home": rewards of care giving .,***

52-Seligman, M., & Darling, R. B. (1997). Ordinary families, special children (2nd ed.). New York: Guilford Press.p359-365

53- T. Shibre, D. Kebede, A. Alem, A. Negash, N. Deyassa, A. Fekadu, D. Fekadu, L. Jacobsson and G. Kullgren, Social Psychiatry and Psychiatric Epidemiology , 29 July 2002 Volume 38, Number 1, 27-34, DOI: 10.1007/s00127-003-0594- ***Schizophrenia: illness impact on family members in a traditional society – rural Ethiopia***

54-Tessler, R., & Gamache, G. (1994). ***Continuity of care, residence, and family burden in Ohio. The Milbank Quarterly, 72, 149-169.***

55-Thompson, E. H., & Doll, W. (1982). ***The burden of families coping with the mentally ill: An invisible crisis. Family Relations, 31, 379-388.***

56-Thornicroft, G. (2006). ***From stigma to ignorance, prejudice and discrimination.***

(pp. 170-203). New York: Oxford University Press.

57-Walker, A., Pratt, C., & Eddy, L. (1995). ***Informal Caregiving to aging family members: A critical review. Family Relations, 44, 402-411.***

58-Wiley-Exley, E. (2007). ***Evaluations of community mental health care in low- and middle-income countries: A 10-year review of the literature. Social Science & Medicine, 64, 1231-1241.***

59--Whitty, P., & Devitt, P. (2005). ***Surreptitious prescribing in psychiatric practice. Psychiatric Services, 56(4), 481-483. Retrieved from http://ps.psychiatryonline.org.***

60- World Health Organization. (1996). ***Nations for mental health: Schizophrenia and public health. Geneva. Switzerland:. www.globalccinstitute.com***

61-Wageeh Abdel –Naser Hassan, Ikram Ibraheem M ohamed, and Nadia Ebrhim Sayed .*Burden and coping strategies in care givers of schizophrenic patients* . Journal of American science .2011,7(5):802-811{(ISSN:1545-1003) http://www.American Science.org.

62-www.WorldLawDirect.com

63-www.livestrong.com/article/172058-the-*definition-of-family-integration*
/#ixzz2DphMmgIm
64-www.Grammarly.com

65-www.ehow.com/about_6623839_*meaning-family-integration*_.html#ixzz2DpjEj4dv

66-Zam Zam et . International Journal of Mental Health Systems 2011,5:16 http://www.ijmhs.com/content/5/11/6 *Schizophrenia in Malaysian Families :Astudy on factors associated with quality of life of primary family caregiver* .

س

APPENDICES

Annex (1)

Panel of Experts

Dr. Anwar El Abadsa

Dr.Jameel El Tahrawey

Dr.Atef El Agha

Dr. Moneer Abo El Jedian

Dr. Ayesh Samour

Dr .Mohammed Abu Sebah

Dr.Khadra El Amassey

بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
كلية التربية
عمادة الدراسات العليا

رقم الاستبانة:

تاريخ تعبئة الاستبانة:

استبانه لقياس

" التماسك العائلي لدى أهالي مرضى الفصام في قطاع غزة"

"FAMILY INTEGRATION EXPERIENCED BY FAMILIES OF PATIENTS DIAGNOSED WITH SCHIZOPHRENIA IN GAZA STRIP"

الأخ الفاضل . . . الأخت الفاضلة . . . السلام عليكم ورحمة الله وبركاته،،،

أضع بين أيديكم هذه الاستبانة التي تهدف إلى التعرف على درجة الاستقرار العائلي لدى أهالي المرضى النفسيين من الأبعاد المختلفة النفسية والاجتماعية والاقتصادية وغيرها.

وحيث أنني أومن بأنكم خير مصدر للمعلومات المطلوبة،واعهد بكم الاهتمام والمساعدة لمؤازرة الأبحاث العلمية التي تهتم بخدمة مجتمعنا وتطويره ، لذا توجهت إليكم وكلي أمل في أن أجد التعاون من قبلكم وذلك من خلال الإجابة على أسئلة هذه الاستبانة، علما بأن الإجابة ستعامل بسرية تامة، وسوف تستخدم لأغراض البحث العلمي فقط.

شاكرين لكم حسن تعاونكم معنا

وتفضلوا بقبول فائق الاحترام والتقدير

الباحثة

مروة شامية (شحادة)

معلومات أساسية:

أولا: بيانات المريض

1-الفئة العمرية التي تنتمي لها:

□ 18-30 سنة □ 31-50 سنة □ أكثر من 50 سنة

2- الجنس □ ذكر □ أنثى

3- تاريخ المرض من 2-5 سنوات من 6-10سنوات أكثر من 10

4- مكان الإقامة: □ البيت □ المؤسسة □ عند الأقارب □ مكان آخر حدد .....

ثانيا الشخص مقدم الرعاية:

5-**المهنة** □ يعمل □ لا يعمل 6- **العمر** ..... 7- **صلة القرابة:** .....

8-المستوى التعليمي □ ابتدائي □ اعدادي □ ثانوي □ جامعي

9-**العنوان** □ غزة □ الشمال □ الوسطى □ خانيونس □ رفح

10- **الحالة الصحية لمقدم الرعاية في الأسرة:** □مريض □ غير مريض

ثالثا:الأسرة:

11- متوسط دخل الأسرة بالشيكل/ شهر □ من 5-1. □ من 11-20 □ من 21-30 □ اكثر من 30

12-عدد أفراد الأسرة .....

التأثير النفسي :

ضع/ي صح أمام الذي تعتقد /ين أنه الأقرب إلى قناعتك :

م	وجود مريض نفسي في أسرتي:	بدرجة كبيرة جدا 5	بدرجة كبيرة 4	بدرجة متوسطة 3	بدرجة متدنية 2	بدرجة متدنية جدا 1
1	يزيد القلق و التوتر و الخوف					
2	يسبب فوضى و إرباك في البيت					
3	يؤثر في تنشئة الأطفال في الأسرة					
4	يقلل الانسجام بين أفراد الأسرة					
5	يسبب اضطراب في النوم بين أفراد الأسرة					
6	يؤدي إلى ارتباك في اتخاذ القرارات السليمة					
7	يقلل التواصل و التفاهم بين أفراد الأسرة					
8	يقلل الأمان العاطفي بين أفراد الأسرة					
9	يقلل من قدرة العائلة على مواجهة الأزمات					
10	يقلل من التوافق الأسري					
11	يزيد من سرعة الانفعال و التسرع في اتخاذ القرار					
12	يسبب عدم الثقة بالنفس					
13	يسبب الإحباط لأفراد الأسرة					

التأثير الاجتماعي

م	وجود مريض نفسي في أسرتي:	بدرجة كبيرة جدا 5	بدرجة كبيرة 4	بدرجة متوسطة 3	بدرجة متدنية 2	بدرجة متدنية جدا 1
1	يقلل من المشاركة في المناسبات الاجتماعية					
2	يعيق عملية الزواج من أفراد الأسرة					
3	يسبب مشاكل مع الجيران .					
4	يقلل من زيارة الأقارب.					
5	يسبب عدم اصطحابه في المناسبات .					
6	يفضل إبقاؤه في المؤسسة عند وجود أي مناسبة					
7	يخجل الإخوة و الأخوات من ذكره أمام أصدقائهم					
8	يسبب الكثير من الإحراج أمام الضيوف و في المناسبات .					
9	يقلل من المكانة الاجتماعية للأسرة					
10	يسبب العزلة الاجتماعية					
11	يشوش على إخوته أثناء الدراسة					
12	يقلل من قدرة الأسرة على التكيف و مواجهة الأزمات					

التأثير الاقتصادي

الرقم	وجود مريض نفسي في أسرتي	بدرجة كبيرة جدا 5	بدرجة كبيرة 4	بدرجة متوسطة 3	بدرجة متدنية 2	بدرجة متدنية جدا 1
1	يزيد من المصاريف اليومية .					
2	يكلف علاج خاص و دواء					
3	يحتاج نوعية خاصة من الطعام					
4	يتلف الكثير من الملابس و لا يحافظ عليها					
5	يتلف محتويات المنزل (الأثاث و غيره)					
6	يسبب الديون من الأقارب و الناس					
7	يحتاج مصاريف خاصة للسفر للعلاج.					
8	يزيد العبء المادي على الأسرة .					
9	يقلل الوضع المادي الجيد المشاكل المترتبة على وجود مريض نفسي .					
10	يزيد الوضع المادي الجيد من الاتفاق في الرأي حول المعايير الأسرية .					
11	يساعد الوضع المادي الجيد في بقاء المريض النفسي في البيت .					
12	يساعد الوضع المادي الجيد على الاستقرار و التفاهم و تقليل التوتر بين أفراد الأسرة .					

WITH THE NAME OF GOD

ISLAMIC UNIVERSITY

OF GAZA

FACULTY OF EDUCATION

DEANARY OF TOP STUDY

Questionaire number /

Date /

QUESTIONAIRE TO MEASURE

"FAMILY INTEGRATION EXPERIENCED BY FAMILIES OF PATIENTS DIAGNOSED WITH SCHIZOPHRENIA IN GAZA STRIP"

Dear brother ….. Dear sister

Peace from God on you

I put this questionnaire in your hands which aim to investigate family integration level for families having schizophrenic patient from different domains .Psychological , social and economic domains. Since I believe that you are the best source of information , and I know your interest and help in supporting scientific researches which concern in developing and serving our society .So I come forward you with hope that I will find cooperation in answering this questionnaire . I guarantee privacy and confidentiality in dealing with your information and it will be used only for scientific research only .

Thanks for your cooperation

Researcher

Marwa Mahmood Shamiya (Shehada)

Essential Data

First: Patient Data

1- **Age** ☐ 18-30 ☐ 31-50 ☐ More than 50

2- **Sex** ☐ Male ☐ Female

3- **Duration of disease** ☐ 2-5 ☐ 6-10 ☐ More than 10

4- **Address** ☐ Home ☐ Institution ☐ With relatives ☐ Others

Second : Care Giver

5- AGE …… -6 Job ☐ Work ☐ Not work

7- Kind of Relationship: …….

8- **Educational Level** ☐ Elementary ☐ Preparatory ☐ Secondary ☐ university

9- **Address** ☐ Gaza ☐ North ☐ Middle Zone ☐ Khanyonis ☐ Rafah

10- **Care giver Health** ☐ Sick ☐ Healthy

Third : Family

11- **Average income in shekels/ month** ☐ 500-1000 ☐ 1100-2000 ☐ 2100-3000 ☐ More than 3000

12- **Number of family members:**

Psychological Domain

NO.	Existence of mental ill patient in my family	Very high 5	High 4	Moderate 3	Low 2	Very low 1
1	Increase worry, tension and fear					
2	Cause confusion and noise at home					
3	Affect child rearing					
4	Decrease integration between family members					
5	Cause sleep disturbances between family members					
6	Disturbed right decision making					
7	Disturbed good communication and understanding between family members					
8	Decrease emotional bonding between family members					
9	Decrease family ability to face crisis					
10	Decrease family integration					
11	Increase emotional respond and fast decisions					
12	Decrease self esteem					
13	Cause frustration for family members					

SOCIAL DIMENSION						
NO	**Existence of mental ill patient in my family**	**Very high 5**	**High 4**	**Moderate 3**	**Low 2**	**Very low 1**
1	Decrease sharing in social occasions					
2	Affect marriage negatively between family members					
3	Causes problems with neighbors					
4	Decrease relative visiting					
5	Causes not taking him in different social occasions					
6	Preference of letting him at the institution when having social occasions					
7	Shame from mention him in front of friends					
8	Cause a lot of embarrassment in the social occasions					
9	lower social status of the family					
10	Causes social withdrawal					
11	Affect academic achievement negatively for brothers and sisters					
12	Decrease family ability to adapt and face crisis					

ECONOMICAL DOMAIN

NO	Existence of mental ill patient in my family	Very high 5	High 4	Moderate 3	Low 2	Very low 1
1	Increase daily cost					
2	Cost special treatment and medicine					
3	Need special kind of food					
4	Spoil a lot of clothes					
5	Spoil house furniture					
6	Cause debts from relatives and neighbors					
7	Need special costs for treatment travelling					
8	Increase financial burden on the family					
9	Good financial status decrease problems that result from having mentally ill patient					
10	Good financial status increase family agreement about family standards					
11	Good financial status helps in patient staying at home					
12	Good financial status helps in integration , understanding and decrease tension between family members					