

Basic Family Relations, Parental Bonding, and Dyadic Adjustment in Families With a Member With Psychosis.

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Abstract

The aim of the current study is to describe and explore basic family relations, parental bonding, and dyadic adjustment in families with offspring diagnosed with a psychotic disorder. The sample was made up of 120 participants, 60 in the clinical group (GCL) and 60 in the comparison group (GCP). All participants were assessed using the Basic Family Relations Evaluation Questionnaire (CERFB), the Parental Bonding Instrument (PBI), and the Dyadic Adjustment Scale (DAS). The results showed differences between the clinical and comparison groups in terms of perceptions of basic family relations, dyadic adjustment and parental bonding. The clinical group recorded less favorable results for all of these variables. More specifically, the study observed significant differences between the groups in parental function, overprotection and caring. This study deepens our understanding of how family assessment and relational diagnoses can serve as prevention and intervention tools for families affected by a psychotic disorder.

Keywords: dyadic adjustment, marital functions, parental bonding, parental functions, psychotic disorder, relational diagnosis

Introduction

Over the past decade, clinicians and theorists have shown an increasing interest in the role of the families of patients diagnosed with psychotic disorders. For example, a number of studies working in this vein have shown interest in the relationships between the members of these families (Addington et al., 2001; Brown et al., 1972; Caqueo-Urizar et al., 2017; Leff et al., 1982; Onwumere et al., 2011). The World Health Organization (2013) has even considered the potential benefits of involving family in the Mental Health Action Plan.

Research into psychosis has long paid a great deal of attention to the variable of parental experiences, and a number of studies have gathered data on this variable using the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979). The results have shown that patients with psychotic disorders are more likely than non-clinical subjects to describe their parents (particularly their mothers) as less caring and more overprotective (Ballús et al., 1991; Helgeland & Torgersen, 1997; Onstad et al., 1994; Parker et al., 1988; Willinger et al., 2002). Working along similar lines, other authors have observed that families with psychotic members display greater levels of criticism, overprotection, double messages and disqualifying communication (Palma et al., 2019), and that patients tend to label their parents' functioning as negative and to perceive difficulties in attachment with their parents (Gumley et al., 2014).

Meanwhile, other authors have focused on the quality of the marital functioning in these families. In general, marital partners in such families showed difficulties in dyadic adjustment; less consensus and cohesion were observed in husbands; and less cohesion, satisfaction, and quality of life were observed in wives (Espina et al., 2003). Additionally, Linares (2012, 2019) showed that these families tend to exhibit deteriorations in marital function, issues that in turn affect parenting. Furthermore, poor conjugal functioning has been found not to lend to itself a good prognosis for patients.

Elsewhere, the literature on the role of family in psychosis has also emphasized the major impact of family stress, anxiety, and caregiver burden (Awad & Voruganti, 2008; Kate et al., 2014) and highlighted how these factors affect quality of life and undermine family dynamics during everyday life (Baronet, 2003; Hayes et al., 2015; Miller et al., 1986; Ribé et al., 2017).

In light of these findings, it is essential to incorporate interventions centered upon conjugal functioning as a complement to family intervention programs, since those parents who show mutual support, the capacity for

joint problem-solving in periods of stress and greater coping skills tend to play a more positive role in the well-being of their offspring (Zemp et al., 2016). It is also worth noting that several authors have found gender differences in the way mothers and fathers perceive their parental behavior, a fact which may be relevant and suggests that mothers and fathers should be assessed separately (Bersabé et al., 2001; Campreciós et al., 2014; Espina et al., 2003; Hidalgo & Menéndez, 2003).

In summary, the results of most of the literature reviewed focus on basic family relationships, parental bonding, and marital functions in people affected by psychotic disorders. Despite this existing body of research, we found no prior studies evaluating marital and parental functions at the same time. In fact, there was even a lack of studies considering these two factors as independent variables but examining how they influence one another.

The Present Study

The main objective of the current study is to describe and explore basic family relationships, parental bonding, and dyadic adjustment of families with offspring diagnosed with a psychotic disorder and to compare these families (clinical group; GCL) with a comparison group (GCP). Additionally, the study will conduct a comparison based on gender. To this end, the researchers posed the following two hypotheses:

1. The GCL will show lower levels of marital and parental functioning, high overprotection, low care, and lower levels of dyadic adjustment than the GCP.
2. A concordance will be observed between the couples' relationship scores (dyadic adjustment and marital function) and their parental relationship scores (parental function and parental bonding).

Method

Participants

A quasi-experimental design was implemented, using a comparison group selected by intentional non-probabilistic sampling. Forty families (120 participants) were included in the study: 20 families in the clinical group ($n = 60$) and 20 families in the comparison group ($n = 60$).

The inclusion criteria for the two groups were: (a) families must be of Spanish heritage; (b) families must be living together; (c) parents must take on parental roles; (d) families must have common biological offspring over 11 years old; and (e) patients must not have any offspring. Meanwhile, the following criteria were used to select participants in the clinical group: (a) families must have offspring diagnosed with a psychotic disorder according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013); and (b) patients must have exhibited clinical stability over the previous

three months, according to the criteria of the Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein, & Opler, 1987, validated for use with the Spanish population by Peralta & Cuesta, 1994).

Sample Description

In the GCL, the average age of the offspring was 29.65 ($SD = 7.15$), while the age of the parents averaged 60.28 ($SD = 7.32$). The couples had been married for 34.06 years on average ($SD = 6.95$). In terms of clinical variables, 30% of the patients had been diagnosed with a brief psychotic disorder, 45% with schizophrenia, 20% with schizoaffective disorder, and 5% with an unspecified psychotic disorder. The average age of the first psychotic episode was 21.65 ($SD = 4.6$), treatment time was on average 9.1 years ($SD = 6.95$), and the average number of hospitalizations in a psychiatric unit was 4.1 ($SD = 3.11$). In the GCP, the average age of offspring was 22.75 ($SD = 1.89$), the average age of parents was 55.43 ($SD = 5.56$), and the average length of marriage was 29.6 years ($SD = 6.33$).

Measures

Basic Family Relations Evaluation Questionnaire (Ibáñez et al., 2012). The CERFB consists of 25 items answered using a Likert scale. It assesses marital and parental relations. The instrument consists of two scales: marital functioning ($\alpha = .91$) and parental functioning ($\alpha = .92$). The scores for each are obtained from the sum of the items, indicating the degree of marital and parental functionality, with higher scores indicating greater functionality.

Parental Bonding Instrument (PBI). The Parental Bonding Instrument (PBI) is a self-administered instrument created by Parker et al. (1979) and adapted to the Spanish population by Ballús-Creus (1991). It consists of 25 items that evaluate two dimensions of parenting, yielding scores for the following scales: care ($\alpha = .88$) and overprotection ($\alpha = .74$).

Dyadic Adjustment Scale (DAS). The Dyadic Adjustment Scale (DAS) is a self-administered questionnaire created by Spanier (1976) and adapted to the Spanish population by Santos-Iglesias, Vallejo-Medina & Sierra (2009). It consists of 32 items that measure the perceptions of dyadic adjustment ($\alpha = .96$) of both members of a couple. This instrument is divided into four subscales: consensus (agreement on tasks and values; $\alpha = .90$), satisfaction (current state of the relationship; $\alpha = .94$), affectional expression (satisfaction with intimacy and sexuality; $\alpha = .96$) and cohesion (shared activities and interests; $\alpha = .86$).

Sociodemographic and clinical data questionnaire. These two ad-hoc questionnaires were designed to collect data on the families' socio-demographic and clinical variables. One questionnaire gathered information related to the parents, including age, gender, marital status, education and employment status. The other

collected each patient's age, gender, education level, employment status, psychopathological diagnosis and current treatment regime.

Procedure

Psychiatrists and psychologists from the outpatient psychiatric unit at the Hospital de Mataró selected families who met the inclusion criteria for the clinical group. They then asked for their participation in the study and obtained signed consent. The comparison group was made up of 20 families, chosen from a total sample of 175 families from a previous study. The sociodemographic variables (age, gender and place of residence) of the comparison group largely matched those of the clinical group. The two groups were comparable ($p > 0.05$) in terms of the age of the patients and their parents, gender composition, length of conjugal relationship, number of children, level of education and place of residence.

Data collection was carried out through interviews with the family and by administering questionnaires. The data collected from the parents included the sociodemographic and clinical questionnaires, the CERFB, the DAS, and the PBI. In both groups, the patient block utilized the sociodemographic and clinical questionnaires and the PBI to answer questions related to their parents.

Data Analysis

The sociodemographic and clinical data were analyzed descriptively by member (father, mother, son/daughter), group and gender. A descriptive analysis was also conducted for the CERFB variables (marital and parental functioning), the PBI variables (care and overprotection) related to parents and children, and the DAS variables (consensus, cohesion, satisfaction, affectional expression, and total dyadic adjustment). The Mann–Whitney U test was used for intergroup analysis to compare the means of the independent samples. Finally, for the purpose of intragroup analysis of the variables, a correlation study was carried out using the Spearman correlation coefficient. The results were analyzed with IBM SPSS software Statistics 22.

Ethical Approval

The research presented in this article was approved by the Clinical Research Ethics Committee of the Hospital de Mataró with reference E04PRNG7B200-1023-001. The purpose of the study was explained to the family members, and they were told that participation was voluntary. All participants involved in the study gave informed consent, and participants' anonymity has been preserved.

Results

As can be seen in Table 1, marital and parental functioning were lower in the GCL than in the GCP, with a significant difference between men in terms of parental functioning. With regard to the “care” variable, parents and children in the GCL recorded lower scores than those in the GCP. With regard to overprotectiveness,

parents from the GCL had lower scores than those in the GCP, who exhibited a more adaptive parental link. In contrast, patients from the GCL perceived a higher degree of overprotectiveness of the part of their fathers. In terms of mother/son and son/mother relationships, the perception of overprotectiveness was higher in the GCL than in the GCP. Finally, both men and women in the GCL had lower scores than those in the GCP for the DAS variables.

Table 1

Descriptive analyses for variables according to the Parental Bonding Instrument, PBI; Dyadic Adjustment Scale, DAS; Basic Family Relations Evaluation Questionnaire, CERFB) and comparative analysis between the clinical group (GCL) and the comparison group (GCP).

Variable	GCL		GCP		U	p
	(n _{families} = 20)		(n _{families} = 20)			
	(n _{total} = 60)		(n _{total} = 60)			
	M	DT	M	DT		
PBI						
Care						
Father – child	24.8	6.13	25.6	6.32	-.556	.57
Mother – child	25.7	4.9	27.55	6.05	-1.12	.26
Child – father	21.05	6.04	25.15	6.99	-2.3	.02*
Child – mother	24.6	7.16	29.95	4.85	-2.38	.01*
Overprotection						
Father – child	8.6	5.81	8.75	3.97	-.461	.64
Mother – child	10.2	6.44	7.5	3.92	-1.34	.16
Child – father	13.25	7.23	7.75	6.01	-2.46	.01*
Child – mother	13.05	6.11	9	6.11	-1.86	.06
DAS						
Consensus						
Men	50.55	10.74	52.65	5.3	194	.87
Women	47.6	13.6	49.25	9.29	197.5	.94
Cohesion						
Men	16.3	5.06	18.3	4.19	158	.25
Women	14.75	6.13	17.1	5.5	158.5	.26
Satisfaction						
Men	40.20	7.53	41.9	5.54	182	.62
Women	36.05	9.7	40.1	6.25	147	.15
Affectional expression						
Men	8.6	3.39	9.35	1.78	197.5	.94
Women	8.65	2.75	9.2	2.09	182	.62
Total						
Men	115.65	21.67	122.2	14.11	172	.44

	Women	107.05	28.45	115.65	21.42	171.5	.44
CERFB	Marital function						
	Men	52.65	13.91	55.75	8.29	-.460	.64
	Women	51.4	10.85	51.9	10.85	-.054	.95
	Parental function						
	Men	41.6	5.6	45.25	5.82	-2.15	.03*
	Women	41.4	6.68	43.6	5.65	-.989	.32

* $p > .05$, ** $p \geq .005$, *** $p \geq .001$.

As can be seen in Table 2, there were significant differences between the scores for the variables of care and overprotectiveness for fathers and those for children, evidence of discordance between the perceptions of these family members. In contrast, no statistically significant differences were observed between mothers and children. Father/mother differences in the GCP were calculated by a comparison of means; the results did not show significant differences between parents in terms of basic family relations (marital function $U = -.47$, $p = 0.63$, parental function ($U = -.07$, $p = 0.94$), PBI (care $U = -.51$, $p = 0.6$; overprotection $U = -.89$, $p = 0.37$), or dyadic adjustment ($U = -.85$, $p = 0.39$).

Table 2

Parental bonding differences between father/patient and mother/patient for the clinical group (GCL).

	Fathers ($n = 20$)		Mothers ($n = 20$)	
	Care	Overprotection	Care	Overprotection
	r (p)	r (p)	r (p)	r (p)
Child ($n = 20$)				
Care	.509 (.022*)	.114 (.63)	.44 (.052)	.082 (.73)
Overprotection	.072 (.76)	.609 (.004**)	.104 (.66)	-.332 (.15)

* $p > .05$, ** $p \geq .005$, *** $p \geq .001$.

Table 3 shows the bivariate correlations between study variables in the GCL. Marital functioning (CERFB) showed a positive and significant correlation with parental functioning (CERFB). This same effect was also observed in the DAS and all its subscales (consensus, cohesion, satisfaction, and affectional expression). Regarding parental functioning measured by the CERFB, results showed a significant correlation with the PBI. It should be noted that parental functioning also presented a positive and significant correlation with the DAS and its subscales, with the exception of the cohesion subscale. All DAS variables showed a positive and significant correlation among them, except for affectional expression and cohesion, which did not show such a correlation.

Table 3

Bivariate correlations between study variables according to the Parental Bonding Instrument, PBI; Dyadic Adjustment Scale, DAS; Basic Family Relations Evaluation Questionnaire, CERFB) in the clinical group (GCL).

	1.	2.	3.	4.	5.	6.	7.	8.
CERFB								
1. Marital function	–							
2. Parental function	.45**	–						
PBI								
3. Care	.16	.43**	–					
4. Overprotection	-.26	-.39*	-.09	–				
DAS								
5. Total	.80**	.51**	.24	-.25	–			
6. Consensus	.65**	.50**	.30	-.18	.84**	–		
7. Cohesion	.58**	.29	.04	-.12	.78**	.52**	–	
8. Satisfaction	.83**	.46**	.13	-.30	.82**	.58**	.54**	–
9. Affectional expression	.57**	.51**	-.01	-.27	.56**	.49**	.27	.56**

* $p > .05$, ** $p \geq .005$, *** $p \geq .001$.

Discussion

The findings confirm the first hypothesis of the study. The CERFB results indicate that parents of patients with psychotic disorders tend to perceive a greater degree of deterioration in their parental and marital function than parents without any offspring diagnosed with these pathologies. More specifically, men in the GCL perceived their parental function as more deteriorated and closer to a dysfunctional level, but fewer differences were found between the women in the two groups. The same effect was observed for marital function. In other words, the differences between the clinical and comparison groups were greater among men than women. Overall, these results suggest that these families tend to display more dysfunctional relationships, a finding that echoes the results in the literature (Brown et al., 1972; Linares 2012, 2019; Miller et al., 1986).

Meanwhile, the results obtained using the PBI are also in agreement with those of prior studies. For example, the parents in the GCL perceived their degree of parental bonding as more deteriorated than those in the comparison group (Ballús et al., 1991; Helgeland & Torgersen, 1997; Onstad et al., 1994; Parker et al., 1988; Willinger et al., 2002). Specifically, members of the clinical group were found to be more overprotective and controlling and less likely to encourage the independence and autonomy of their children. They also perceived themselves as less caring and more emotionally distant and indifferent. Their offspring agreed, as they also described their parents as less caring and more overprotective. However, they were more likely to perceive higher levels of overprotection from their fathers. This result was not expected, because in general fathers tend to be less overprotective and intrusive than mothers (Parker et al., 1982). More broadly, it should be noted that

marital and parental functioning can be affected by family stress and caregiver burden (Awad & Voruganti, 2008; Kate et al., 2014), affecting quality of life and family dynamics (Baronet, 2003; Hayes et al., 2015; Infurna et al., 2016; Ribé et al., 2017).

Finally, the results of the DAS show that parents in the GCL reported a lower degree of dyadic adjustment with their partners than families in the non-clinical group. While the differences found in this study did not reach the level of statistical significance, the scores for all the factors associated with the quality of the marital relationship were lower in the GCL. At the same time, it is worth highlighting that our results are in concordance with Espina et al. (2003), who also found that both men and women in clinical families tend to perceive a lesser degree of cohesion with their partners, and that women in these families tend to be less satisfied with their marital relationships. These findings shed some light on the impact of the spousal relationship on family dynamics, as a deteriorated marital relationship can affect the relations between parents and children (Linares, 2012, 2019).

With regard to the second hypothesis, we observed a concordance between the couples' relationship scores recorded using the CERFB and those obtained via the DAS. There was also consistency between the parental relationship scores assessed by the CERFB and those collected via the PBI. It should be noted that parental function (as measured by the CERFB) showed a correlation with the scores for marital functioning and with several subscales of the DAS. These results suggest us that parental and marital functions have similarities and influence each other, and that aspects involved in marital functioning influence parental functioning, and vice versa. For this reason, health professionals and clinical researchers should involve marital and parental treatment in psychotherapeutic measures (Caqueo-Urizar et al., 2017; Espina et al., 2003; Palma et al., 2019).

Limitations

The main limitation of the study was the difficulty in recruiting a sample. Firstly, in order to collect data on family relationships, researchers must persuade family members to open themselves up and share intimate details about themselves and their families, something they are not always willing to do. This is one reason why family assessment poses a special challenge to researchers. A number of also failed to meet the inclusion criteria for the study because the parents were separated.

Conclusions and Implications for Practice: Future Directions

In conclusion, the results confirmed the theoretical hypotheses posed and are in accordance with most of the literature reviewed. Nonetheless, this study has taken a new approach to family evaluation by assessing marital and parental functions at the same time. We are convinced that these functions should be examined together, because family relations influence each member in a different way, affecting interactions and family

dynamics. Therefore, marital and parental evaluations can shed essential light on relational and familial diagnoses. This information can have an impact on the prevention, assessment and treatment of psychotic disorders. For this reason, we would advocate taking the family as a whole into account as a clinical variable when determining a treatment approach or a therapeutic plan. In the same vein, we are working on the creation of a CERFB subscale to evaluate co-parenting and separate or divorced parents' relationships. With this tool, researchers and clinical professionals will be able to include new family modalities in their assessment. In conclusion, the results allowed us to underline the importance of using family assessment instruments to perform family evaluations and interventions. We believe these actions will directly lead to improvement in both patients and their families, in line with current recommendations in the mental health field.

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