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Assessment of Family Environment among Mentally Ill Patients: Mixed Study

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Abstract
Background: Family has a significant role on the mental health of its members, thus its contribution can also be distinguished in pathogenesis. Numerous mental diseases have also been linked to the family environment (FE) for maintenance and relapse. **Aim:** To assess the family environment among mentally ill patients. **Design:** Descriptive mixed design of both quantitative and qualitative methods was used in the current study. **Setting:** The study was conducted at Psychiatry and Addiction Prevention Hospital- Cairo University Hospitals. **Sample:** Purposeful sampling was employed in this study of 73 psychiatric patients. **Tools:** Three tools were used for data collection; Socio-demographic data sheet, Brief Family Environment Scale and the interview guide for the qualitative data. **Results:** Majority of participants were male (82.2%). Participants' age was 18-60 years. More than half (56.2%) of participants had positive family environment. There were statistically significant positive relationships between family environment and gender, chronicity of disease and occupation of mother. Regarding qualitative results, seven themes emerged from results. This involved physical family support, positive family expressiveness, family awareness, family cohesiveness, family positive relationship and environment, family controlling and functional family. **Conclusion:** Quantitatively and qualitatively findings of the study revealed unexpected results that there was positive family environment of mentally ill patients. **Recommendations:** Future studies could focus on how FE domains interact with family members' mental architecture and may ultimately lead to disease.

Keywords: Family Environment & Mentally Ill Patients.

Introduction:
The family is the fundamental social unit that looks after the physical and emotional requirements of its members. For family members' mental health, the family environment is essential (**Shukla, 2018**). The family is a structure whose members are autonomous, and as such, both an individual's health and illness have an impact on the family and vice versa (**Durasov et al., 2017**). The family can be a foundation of health, healthy attitudes and family cohesion. The family serves as a bridge between the demands of the individual and society because it is a network of interconnected people that is responsive to changes in its internal and external surroundings. Family crises are referred to as the disturbed psychosocial equilibrium of the family system, and they are significant for development since the success of overcoming and resolving the crises depends on the continued growth of the person and the family as a system (**Minic, 2016**).

Family warmth and supportive comments are associated with patients' clinical and functional progress as well as better levels of positive self-evaluation (**Hinojosa-Marqués et al., 2021**). Family Cohesiveness served as a protective element (**Yu et al., 2015**). Family has an impact as an environmental component that can either protect or put patients with mental illnesses at risk for long-term results. The family environment affected early treatment seeking, adherence, and social support as well (**Verdolini et al., 2021**).

Dysfunctional family environment is the most well identified risk factors for the emergence of mental health problems in individuals with mental illnesses, which includes dysfunctional patterns of interpersonal interaction and problem solving. Moreover, familial environment plays a crucial role in individual functioning. Depressive symptoms were positively correlated with higher conflict and control rates (**Yu et al., 2015**). Numerous studies have discovered a link between a dysfunctional familial environment and a poor prognosis in individuals who are at high risk of developing psychosis, patients with first-episode psychosis (FEP), bipolar disorder and schizophrenia (**Verdolini et al., 2021**).

Additionally linked to youth reports of mental illness are family conflict, family support, and the quality of relationships between family members. For instance, internalizing illnesses in adolescents have been linked to family conflict, hostile parenting and harsh discipline (**Butler, 2015**). Conflicts within the family, marital violence, frequent stressful events, inconsistent punishment, parents' high-risk behaviors, lack of social support, and social isolation are among the risk factors (**Strle, 2018**). Families should be included in community-based rehabilitation,

according to the World Health Organization. While there is evidence that this is being done in low- and middle-income countries, this has not yet been reviewed (**Morillo et al., 2022**).

Significance of the study:

The impact of the family's dynamics and potential role on the mental health and general wellbeing of mentally ill people is poorly understood. Furthermore, little is known regarding the impact of the family environment on functioning and the family's role in the care of individuals with mental illnesses. To create future therapies focused on the functional recovery of patients' families and taking care of both the patients and their families, it is necessary to have a better understanding of these interrelationships.

In particular, if the patient's family is the primary caregiver for the patient, nursing professionals may be in a unique position to assess the situation of the patient's family prior to illness, which may be helpful in the diagnosis and treatment of psychiatric illness, management process, recovery periods or rehabilitation, if the patient`s family represents the central reason of the patients' mental illness. For a family seeking treatment for one member with mental illness, mental health professionals may enhance patient gains by incorporating relevant cultural variables into treatment. So, the aim of this study is to assess the family environment among mentally ill patients.

Aim of the study: The aim of the present study was to assess the family environment among mentally ill patients.

Research question: What are the family environment dimensions levels of the mentally ill patients?

Subjects and Methods:

Design: Descriptive mixed design with both quantitative and qualitative methodologies was used in the current study to assess the family environment among mentally ill patients. The primary approach was the quantitative method which directs the study by fill in the study tools by asking patients while the secondary one was the qualitative method which provides a supporting role "embedded" or "nested" within the predominant approach to address various questions about patients' perceptions of their families in their own words and verbatim (concurrent nested strategy of mixed method).

Setting: The study was conducted at Psychiatry and Addiction Prevention Hospital- Cairo University Hospitals. It is serving a large group of people. It consists of three inpatient departments for psychiatric diagnoses; two departments for male patients (1 free and1paied department) and one department for female patients (free). The capacity of each department is 30 patients.

Sample: Purposeful sampling was employed in this study, choosing patients from in-patients wards who meet the inclusion criteria through two months, mentally ill patients who granted agreement to participate in the study and available at the time of data collection were included in the study. Inclusion criteria were; both genders, age 18-60 years old and patients live with caregivers or family members before hospitalization. Exclusion criteria were; patients with memory disorders, mental retardation, Alzheimer disease, patients with cognitive disorders or delusions toward their families.

Tools for data collection

Socio-demographic data sheet

It was developed by the researchers and it assesses the socio-demographic profile of participants. It consists of 15 items which are age, gender, marital status, educational level, diagnosis, current signs and symptoms, onset of the disease, occupation, age of father and mother, education of father and mother, current marital status of parents, family size, and ordinal position.

Brief Family Environment Scale (BFES)

It was developed by **Ching et al. (2015**) and was adopted for this study. It measures the family environment of the participants. There are 16 items total, which are broken down into three subscales: Cohesion (7statments; no.1-7), Expressiveness (3 statements; no. 8-10) and Conflict (6 statements; 11-16). It was translated into Arabic language using translation and back translation technique by experts in English language. The responses are yes/no questions; no=0, yes=1, there are 6 reversed questions (statement no.6-11). A total score was obtained by summing the 16 items, the higher value indicates positive family environment.

The Interview Guide (The qualitative data)

Note for patient's words, was used to collect answers of the patients on open-ended inquiries which was designed and documented by the researchers. Content analysis was performed by the researcher for the data collected. Open end questions as: What are the caregivers for you?, What about visits or telephone calls in hospital and how many numbers?, Speak about motivation from the family?, What is the family`s point of view to your illness?, What about the ability to work or you need for help?, What about the financial, moral and physical support?, What about the family interest with your doctor's appointments?, Speak about if the family represent a source of stress?, What about the family from your illness stigma?, What about forcing hospitalization from the family? And describe your relationship with your family?

Validity and reliability of tools: The Brief Family Environment Scale demonstrated good reliability in the present sample (Cronbach`s alpha was 0.95). Content validity was done by specialized experts; three psychiatric mental health nursing professors. The Content validity of the qualitative data is determined through an extensive review of literature related to family environment assessment and were submitted to a panels of 3 experts in psychotherapy and psychiatric nursing to test their validity and minor corrections were made.

Pilot Study: A pilot study was conducted at the beginning of the study. It included 7 patients (or 10% percent) of the total sample to investigate the feasibility and clarity of data collection tools. Participants included in the pilot study were included in the actual study sample .

Procedure: Conduction of the current study started with an extensive literature review, selection and preparation of the data collection tools a review of related literature covering various aspects of the problem was carried out, using accessible books, journals, and internet to get familiar with the research problem. An agreement of the Scientific Research Ethics Committee of the Faculty of Nursing, Cairo University was obtained to carry out the current study with (IRP Approval Number: 2019041701). The hospital's administrator also gave his or her written permission. The objectives of the study were explained to the participants and asked to read the informed consent. Prior to the actual data collection, all the questions and queries were discussed and sorted out. Each participant signed a written consent after being properly informed. The researchers interviewed the patients 4 days in the week at the morning shift. The interview lasted about 20-30 minutes with each patient at the follow up room in the inpatient departments. Questions of three tools were asked and answers were recorded by the researchers. The study was conducted through two months from October to November 2022.

Ethical Considerations: An approval of the Scientific Research Ethics Committee of the Faculty of Nursing, Cairo University was obtained to carry out the current study with (IRP Approval Number: 2019041701). The hospital's administrator also gave his or her written consent. All participants were informed about the goals and advantages of the study. All participants were made aware that the participation was voluntary and the data collected will only be used for the study purpose. Prior to data collection, each participant signed an informed written consent form. Precautions were taken to guarantee confidentiality and anonymity through data collection and coding.

Statistical Analysis: The statistical package for social science (SPSS) version 21 was used to analyze the data. The mean and SD were used to express numerical data. Frequency and percentage were used to express quantitative data. Using Pearson correlation, relationships between various numerical variables were examined. Less than 0.05 in the probability (p-value) range was regarded as significant, and less than 0.001 as highly significant. Through transcription and content analysis of the patients' responses, qualitative analysis was employed to evaluate the family environment and transform their verbal statements into broad

Results

Part I: Quantitative results

Table (1): Demographic Characteristics of the Studied Sample (N=73)

Items	No.	%	Items	No.	%
Age/years			**Gender**		
13<20	8	11.0	Male	60	82.2
20 <30	31	42.5	female	13	17.8
30 <45	24	32.9	**Education**		
>45	10	13.7	Illiterate	3	4.1
M±SD (31.4 ±9.9)			Read and write	3	4.1
Diagnosis			Primary	10	13.7
Schizophrenia	45	61.6	High school	16	21.9
Bipolar	23	31.5	Bachelor degree	41	56.2
Depression	1	1.4	**Employment**		
Obsessive Compulsive Disorder	3	4.1	Working	29	39.7
Substance induce psychosis	1	1.4	Not working	44	60.3
Chronicity of disease/years			**Marital status**		
<1 **year**	28	38.4	Single	46	63.0
1<5 **years**	26	35.6	Married	13	17.8
5<10 **year**s	14	19.2	Divorced	8	11.0
>10 **year**s	5	6.8	Widow	6	8.2

Table (2): Demographic Characteristics of Family Structure of the Studied Sample (N=73)

Variable	No.	%	Variable	No.	%
Age of father			**Age of mother**		
45-55	47	64.4	31<45	9	12.3
dead	26	35.6	46≤55	51	69.9
Education of father			>55	13	17.8
Illiterate	11	15.1	**Education of mother**		
Read and write	11	15.1	Illiterate	19	26.0
Primary	10	13.7	Read and write	16	21.9
High school	9	12.3	Primary	5	6.8
Bachelor degree	19	26.0	High school	12	16.4
Dead	13	17.8	Bachelor degree	11	15.1
Family Size			**Status of marriage**		
1-2	4	5.5	Married	39	53.4
3-4	28	38.4	Divorced	5	6.8
5-6	25	34.2	Widow	20	27.4
7 and more	16	21.9	Separated	3	4.1
Orderinal position			Dead	6	8.2
First	27	37.0			
Second son/daughter	30	41.1			
Third	16	21.9			

Table (3): Frequency Distribution of Family Environment Scale of the Studied Sample (N=73)

Items	Yes		No	
	No.	%	No.	%
Cohesion				
1-In our family we really help and support each other	**49**	**67.1**	**24**	**32.9**
2-In our family we spend a lot of time doing things together at home.	**41**	**56.2**	**32**	**43.8**
3-In our family we work hard at what we do in our home	**51**	**69.9**	**22**	**30.1**
4- In our family there is a feeling of togetherness	**49**	**67.1**	**24**	**32.9**
5- My family members really support each other	**47**	**64.4**	**26**	**35.6**
6-I am proud to be a part of our family	**53**	**72.6**	**20**	**27.4**
7- In our family we really get along well with each other	**46**	**63.0**	**27**	**37.0**
Expressiveness				
8-In our family we can talk openly in our home.	**50**	**68.5**	**23**	**31.5**
9- In our family we sometimes tell each other about our personal problems.	**48**	**65.8**	**25**	**34.2**
10- In our family we begin discussions easily.	**53**	**72.6**	**20**	**27.4**
Conflict				
11-In our family we argue a lot.	**30**	**41.1**	**43**	**58.9**
12-In our family we are really mad at each other a lot.	**19**	**26.0**	**54**	**74.0**
13-In our family we lose our tempers a lot.	**32**	**43.8**	**41**	**56.2**
14-In our family we often put down each other.	**21**	**28.8**	**52**	**71.2**
15-My family members sometimes are violent.	**24**	**32.9**	**49**	**67.1**
16- In our family we raise our voice when we are mad.	**30**	**41.1**	**43**	**58.9**
Total score	**Mean± SD (10.5±5.7)**			
Percent score	**65.6%**			

Table (4): Frequency Distribution of Family Environment dimensions among of the Studied Sample (N=73)

Family environment Subscale	High(≤8)		Low(> 8)	
	No.	%	No.	%
Cohesion	45	61.6	28	38.4
Expressiveness	42	57.5	31	42.5
Conflict	32	43.8	41	56.2
Total	41	56.2	32	43.8

Table (5): Relation between Family Environment and Demographic Characteristics of the Studied Sample (N=73)

Demographic characteristics	Family environment	
	ANOVA test	p
Age	**.45**	**.71**
Gender	**3.9**	**0.048***
Diagnosis	**1.3**	**.27**
Chronicity of disease	**3.4**	**.049***
Education	**.77**	**.54**
Work	**.18**	**.66**
Marital status	**2.2**	**.08**
Age of father	**.08**	**.77**
Age of mother	**.58**	**.55**
Occupation of father	**1.0**	**.39**
Occupation of mother	**7.1**	**.001***
Education of father	**.69**	**.62**
Education of mother	**.69**	**.63**
Status of marriage	**1.3**	**.25**
Family size	**.85**	**.47**
Order in family	**.83**	**.43**

- *Significant at p-value<0.05*

Table (6): The Indicators for Answers of the Patients on Open End Questions:

Codes and numbers of patients	Subthemes	Themes
1. What are the caregivers for you? - The brother or sister (12) - My self (1) - The father or mother (20) - The husband (1) - The sons (1) - The neighbors (1)	**- Caregiver from first degree**	**Physical Family support**
2. What about visits or telephone calls in hospital and how many numbers? - All visit me (13) - In time of visit (7) - In home only (3) - One per week (1) - Father only (2) - Very few (2) - No someone ask me (11)	**- Positive family actions** **- Family responsibility** **- And duties**	**Physical Family support**
3. Speak about motivation from the family? - No motivation (12) - All with me (10) - Encourage me to recured (13)	**- Family Openness**	**Positive family Expressiveness**
4. The vision of the family to your illness? - No peak in the topic with me (5) - Ordinal (14) - No problem (4) - As any disease (2) - The problem in community (2) - Understand my illness (3) - See you psychiatric patients or crazy (2) - Shame thing (1) - Hate the disease (1)	**- Empathy among family members**	**Family Awareness**

Codes and numbers of patients	Subthemes	Themes
5. What about the financial, moral and physical support? - Support me (25) - Prayer and ask recovery (10) - Buy medication (9) - No support (10)	**- Family Caring**	**Family Cohesiveness**
6. What about the ability to work or need for help? - Unable to work (12) - Depend on myself and work (24)	**- Inner stress or effort**	**Disease control**
7. What about the family interest with your doctor's appointments? - There are interest from all (25) - Mother only or father or my sister only (5) - No interest (7)	**- Family Caring**	**Family Cohesiveness**
8. Speak about if the family represent a source of stress? - Family need me to work (8) - Control my actions (3) - Feel me weak (3) - Compel me on decisions regarding (work, education, marriage, Childbearing and my responsibilities within the family (5) - No stress from family (39)	**- Family Love each other**	**Family Positive relation and environment**
9. The stigma of your illness from the family? - They want to exert from my illness (22) - Family did not feel me anything (13) - Deny my disease (4) - Did not go with me to doctor (4) - Yes stigmatize me (13) - Refuse the answer (1)	**- Awareness of the family**	**Family Expressiveness with each other**
10. What about forcing hospitalization from the family? - My family discover my disease (6) - My family start my treatment (5) - Bring the police or ambulance care (8) - Force me (29) - Admit with my will (4)	**- Family Intolerance**	**Family Controlling**
11. Describe your relationship with your family? - No problem (32) - We are cooperative (5) - We love each other (4) - Very good (5) - No relation every one of the family in your problem (3) - My brother hate me and the others very good (3) - Very bad (12) - Stress me (3)	**- Inner peace from the family**	**Functional family**

Part I: Quantitative results

Table (1): Shows that, the majority of participants were male (82.2%). Participants' age was 18-60 years Mean± SD (31.4± 9.9). Regarding education levels, (56.2%) of the participants were bachelor degree. The most common diagnosis of participants was schizophrenia (61.6%). Concerning employment and marital status, more than two thirds of participants (60.3%, 63%) were not working and single respectively. More than one third (38.4%) of participants were mentally ill less than one year.

Table (2): Demonstrates that, more than two thirds of participant`s father and mother age group was 45-55 years (64.4%, 69.9%) respectively. More than half (53.4%) of participant`s parent were still married. Regarding education, (26%) of participant`s fathers had Bachelor degree, while, (26%) of participant`s mother were illiterate. Concerning family size, (38.4%) of participant `s family consisted of (3-4)

persons. Less than half of participants (41.1%) were the second son/daughter.

Table (3): Illustrates that, more than two thirds of participants (72.6%) reported that they proud to be a part of their families, in cohesion subscale. Regarding expressiveness, more than two thirds of participants (72.6%) begin discussions easily with their families. While, less than half (43.8%) of participants had family conflict; lose our tempers a lot. A total score mean was (10.5 ±5.7).

Table (4): Shows that, about two thirds (61.6% &57.5%) of participants reported cohesion and expressiveness with their families respectively. While, less than half (43.8%) of participants had conflict with their families. More than half (56.2%) of participants had positive family environment.

Table (5): Shows that, there were statistically significant positive relationships between family environment and gender, Chronicity of disease and Occupation of mother where (P=0.048*, .049* &.001*) respectively.

Part II: Qualitative results

There were two main processes for data analysis of the data collected by the study of the family environment of the psychiatric patients: (1) data preparation and (2) data analysis. The process of data preparation involved transcription and translation. Interview data were transcribed from spoken words into textual data by the researcher. After that, transcriptions were translated into English by the researcher. The translation was checked by a bilingual expert. Textual data from the interviews were manually analyzed by using thematic analysis technique. The process of data analysis involved a thematic analysis, which is a method for identifying, analyzing, and reporting themes and concepts with qualitative data. Data were analyzed using the six steps of thematic analysis were; 1) Familiarizing with the data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining themes, and 6) producing the report **(de Casterlé et al., 2021**).

Table (6): The patients throw down numbers of answers to report their opinions and feelings in different family situations and coping strategies for answering the open end questions. A numbers of comments were categorized into number of codes according to the essences of each meaningful unit of data. These codes were conceptualized as nine subthemes and seven themes according to the objective of the questions; each theme is elaborated in more detail along with quotes from the patients' comments to illustrate codes or essences under the themes.

1- Physical Family Support

- Caregiver from first degree (subtheme in the first question).
- Positive family actions (subtheme in the second question).

The first theme emerged from the data was involving presence of physical family support of the participants involved in the study which was presented from the first degree of their care givers and represent positive family actions as a key subthemes were emerged from the most of patient's answers on the questions of "what are the caregivers for you?" And "what about visits or telephone calls in hospital and how many numbers?" The most prominent expressions that the patients described as a form of the physical support were **"My father or mother brought me the hospital and interested with the doctor appointment and all visit me"** (Thirty three of the participants).

2- Positive Family Expressiveness

- Family Openness (subtheme in the third question).
- Awareness of the family (subtheme in the ninth question).

The second theme emerged from the data was involving presence of positive family expressiveness among each other's which was clarified in the family openness of participants as a key subtheme were emerged from the patient's answers on the questions of "speak about motivation from the family?" The most prominent expressions that the patients described as a form of positive family expressiveness were "**all my family with me, motivate me and my family encourage me to recovered"** which were in the emerged codes (Twenty two of the participants). Regarding to the awarness of the family which was the most prominent subthem emerges from the answeres of patients on ninth question "the stigma of your illness from the family?" The most of patient's expressions that were described as a form of family expressiveness and awarness were "**they want to exert from my illness, family did not feel me anything regarding to stigma"** (thirty five of the participants).

3- Family Awareness

- Empathy among family members (subtheme in the fourth question).

The third theme emerged from the data was the family awareness which was clarified in the empathy among family members of participants as a key subtheme was emerged from the patient's answers on the questions of "the vision of the family to your illness?" The most prominent expressions that the patients were described as a form of family awareness and empathy among family members were **"My disease as any disease, understand my illness, ordinal, No problem and the problem in the community"** which were in the emerged codes (Twenty five of the participants).

4- Family Cohesiveness

- Family caring (subtheme in the fifth and seventh question).

The fourth theme emerged from the data was the family cohesiveness which was clarified in the Family caring of participants as a key subtheme was emerged from the patient's answers on the question of "what about the financial, moral and physical support?" And "what about the family interest with your doctor's appointments?" The most prominent expressions that the patients were described as a form of family awareness on fifth question were "**My family Support me, buy my medication, visit me and prayer and ask the recovery for me"** (forty four participants). Where the patients' expressions on seventh question were **"There are interest from all and Mother only or father or my sister only"** (thirty participants).

5- Family Positive Relation and Environment

- Family Love each other (subtheme in the eighth question).

The fifth theme emerged from the data was the family positive relation and environment which was clarified in the family love each other of participants as a key subtheme was emerged from the patient's answers on the question of "speak about if the family represent a source of stress?" The most prominent expressions that the patients were described as a form of family positive relation and environment on eighth question were **"Family did not control my actions, family did not feel me weak, family did not compel me on decisions regarding (work, education, marriage, childbearing and my responsibilities within the family and No stress exactly from family"** (thirty nine participants).

6- Family Controlling

- Family intolerance (subtheme in the tenth question).

The sixth theme emerged from the data was the family controlling which was clarified in the family intolerance of participants as a key subtheme was emerged from the patient's answers on the question of "What about forcing hospitalization from the family?" The most prominent expressions that the patients were described as a form of family controlling were **"My family discover my disease, my family start my treatment, bring the police or ambulance care, and force me on hospital admission"** (forty eight participants).

7- Functional Family

- Inner peace from the family (subtheme in the eleventh question).

The seventh theme emerged from the data was the functional family which was represented in the Inner peace from the family emerged from participants' answers as a key subtheme on the question of "Describe your relationship with your family?" The most prominent expressions that the patients were described as a form of functional family were **"No problem in our family, we are cooperative, we love each other and very good family"** (forty six participants).The result of the qualitative part of the study may be affected with the patient's disease or fear from increased period of treatment or hospitalization although the information of the participants in the study for voluntary participation and the result will not affect the treatment plan or discharge. Moreover the negative answers of the participant represents the smallest number of answers so the researcher did not mentioned in the finding comments but it must be considered and following studies should be carried in other sittings and with different cultures.

Discussion:

Since family environment established a supposed change mechanism, the presented study was to assess the family environment among mentally ill patients. Additionally, it is crucial to understand that family cohesion is one of many treatment goals that will be important in reducing psychiatric symptoms in both patients and caregivers. Within the development of family cohesion, there may be certain perspectives that are more relevant to treatment results than those captured by the Family Environment Scale (FES) **(Brown & Weisman de Mamani, 2018).**

With respect to socio-demographic data, the current study showed that, less than half of participants were young adult, and more than half of the participants were highly educated, the most common diagnosis was schizophrenia. Concerning employment and marital status, less than two thirds of participants were unemployed and single. These results were congruent with **Dewangan et al. (2018)**, but the study found that, the risk of suffering from schizophrenia increase with advancing age. The results also, agreed with **Tabaee et al. (2018)** who found that, two thirds of participants were single. From researcher's point of view, lower marriage rate in mentally ill patients can be explained in the context of Egyptian culture perception that the mentally ill patient is stigmatized and mental illness can hinder also the employment future.

Concerning the gender, the current study showed that, the majority of participants were male, there was possibility that women mentally ill patients might have limited access to psychiatric care. Moreover, current results showed that there was significant positive relation between gender and family environment. In agreement with these results **Ragheb et al. (2008)**, who interpreted the Arab families have a tendency to have severe norms, particularly regarding females. Numerous role restrictions are

placed on Arabic women by their ultraconservative upbringing, their position of subordination, and the preconceived idea of their role as dependent, helpless, passive housewife who bear children.

In answering our research question, regarding, the family environment, the study results in the quantitative and qualitative part showed that about two thirds of participants reported cohesion and expressiveness with their families and revealed in the emerged themes number (2, 4, 5 & 7). While, less than half of participants had conflict with their families which congruent with the negative answers of participants on questions number (8, 9, 10 and 11). Two thirds of participants had positive family environment. These results were not expected; this may be attributed to several explanations. First, the availability of support system which was revealed in the first emerged theme **physical family support** in question one. Presence of support may provide a means to adapt to circumstances within the caregiver role leading to more resilience.

Second, more than half of the participants in the current study have schizophrenia, which is a chronic condition; as a result, it may gradually decrease the perceived stress on the carer as they become habituated to the patients' changing behavior patterns over time and may develop greater resilience. This goes with the study's findings as more than a third of the participants with schizophrenia engaged in it for a period of time longer than five years, which is supported by **Abd El-Ghafar et al. (2018)**.Third is the nature of our culture. It is known that Egyptian family is more accepting and devoted to their loved ones, because of their sense of commitment to an unavoidable circumstance. In this regard, prior studies revealed that acceptance and knowledge of the disease's characteristics could help the family remain united despite the patient's unfavorable conduct. Family caregivers can find a variety of solutions to their crisis when they can accept the diagnosis and view a crisis scenario positively.

The results of the current study contradicted with the study of **Verdolini et al. (2021)** who found that, no specific family environment style was associated with functioning in First episode patients and **Koutra et al. (2014) & Tabaee et al. (2018)** who found that, psychiatric patients displayed unhealthy family function. It might be due to that the data were collected through self-reports, which could have easily suffered from some social desirability and recall bias, leading to generate the potential for misclassification and miss-measurement.

The results of the current study was congruent with the result of **Abd El-Ghafar et al.(2018**) who found that, one-quarter of family caregivers have high level of resilience and approximately half of them have moderate level of resilience. Moreover, **Hesi et al. (2013) & Bishop & Greeff, (2015)** indicated that, one of the elements linked to resilience is the presence of a strong support network. Furthermore, a study by **Amagai et al. (2016)** that examine the families of schizophrenic patients found that, there was a sense of mission that encouraged a family caregiver to care for a sick family member. The caregivers of the patient started to believe that it was their own problem and developed an inner awareness to deal with the circumstance effectively.

Conclusion

Findings of the study revealed unexpected results that there was positive family environment among mentally ill patients quantitatively and qualitatively, extended family might have a role. About two thirds of participants reported cohesion and expressiveness with their families, while, less than half of participants had conflict with their families. There exists significant relationship between gender, chronicity of disease and occupation of the mother and family environment.

Recommendations

- Psychiatric mental health nurse should take the early opportunity to identify any disruption in families to prevent a potential decline in mental well-being and psychological problems of psychiatric patients.
- Provide families of patients with mental illnesses with longer-term disease and culturally appropriate family psycho-educational programs for the families with knowledge deficit.
- Future studies could focus on how FE domains interact with family members' mental architecture and may ultimately lead to disease.

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