FAMILY FUNCTIONING AND SELF CONCEPT AS INDICATORS OF PSYCHOPATHOLOGY IN ADULTS

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EXAMINER-1

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EXAMINER-2

Dated: ------------------
To my family for their love and prayers and to all my teachers for their appreciation and encouragement
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ABSTRACT

The present study examines the role of family functioning and self-concept in psychopathology by comparing the groups of adults with psychopathology (patients) and without psychopathology (normal) on the variables of family functioning and self-concept. Further it examines the relationship between family functioning and self-concept. After detailed literature review, it was hypothesized that a) Adults with psychopathology would score high on the variable of ‘communication’ in family, as compared to their normal counterparts; b) Adults with psychopathology would score high on the variable of ‘control’ in family, as compared to their normal counterparts; c) Adults with psychopathology would score high on the variable of ‘involvement’ in family, as compared to their normal counterparts; d) Adults with psychopathology would score low on the variable of self-concept as compared to their normal counterparts; e) Family functioning (communication, control & involvement) would be a predictor of self-concept in the sample of adults with psychopathology.

The sample consisted of 180 unmarried adult volunteers. The entire sample comprised of two groups (i.e., 90 diagnosed patients with psychopathology and 90 normal adults). The first sample included adults falling in the three major classification of mental disorders, that is, 30 adult patients with the diagnosis of Psychotic Disorder (Schizophrenia), 30 adult patients with the diagnosis of Depressive Disorder (Dysthymia and Major Depression), and 30 adult patients with the diagnosis of Anxiety Disorder (Specific and Social Phobia, Obsessive Compulsive Disorder, and Generalized Anxiety Disorder). These individuals were diagnosed as having above mentioned disorders by
their respective psychiatrist and clinical psychologists according to the criteria of DSM-IV Text Revision (APA, 2000), and were selected from various psychiatric clinics and hospitals. The second sample of normal adults was drawn from different institutes and organizations of metropolitan city of Karachi, Pakistan. These individuals did not have history of psychological problems and had never sought any kind of psychiatric / psychological treatment (psychotropic medication / psychotherapy). The ages of participants in both samples ranged from 20 to 35 years with the mean age of 25.25 years (patients 25.22 years and normal adults 25.28 years). The entire sample belonged to middle socioeconomic class and the minimum educational level was intermediate. To further confirm the diagnosis and obtain clinical/ personal information, the examiner filled in the semi-structured interview form for psychological assessment designed by the Institute of Clinical Psychology, University of Karachi. General subscale of Family Assessment Measure-III (Skinner, Steinhauer & Santa-Barbara, 1984) and Six-factor self-concept scale (Stake, 1994) were administered in order to assess impairment in family functioning (Communication, Control, Involvement) and self concept of both groups (with psychopathology and normal) respectively.

One way Analyses of Variance (ANOVA) were applied to determine the difference between adults with psychopathology (psychosis, depression and anxiety disorders) and normal adults on the variables of family functioning (Communication, Control and Involvement) and degree of self-concept; Post hoc analyses were conducted to further assess the mean difference of normal group from three groups with psychopathology (Psychosis, Depression and Anxiety disorders). Multiple Regression
analysis was done to see the causal relationship between the variables of family functioning (Communication, Control and Involvement) and self-concept in sample with psychopathology, and additionally in entire sample. Additionally, t tests, Pearson product moment correlations, partial correlations and stepwise regression were calculated.

The results showed significant differences on the variables of family functioning and level of self-concept between adults with and without psychopathology. Adults without psychopathology have higher scores on family functioning variables which reflect deviant patterns of communication, inadequate control and involvement and in the families of adults with psychopathology as compared to their normal counterparts. Similarly, adults with psychopathology have lower scores on self concept as compared to normal participants. Further, it was also found that family functioning predicts self-concept in adults with psychopathology. Avenues for future research have also been suggested, while implications and limitations have been illustrated.
Communication, Control and Involvement

- Communication
- Control
- Involvement

Depressive (Schizophrenia) Psychotic Disorder

Anxiety Disorder (Dysthymia and Major Depression) Disorder

Specific and Social Phobia, Obsessive Compulsive Disorder and Generalized Anxiety Disorder

DSM-IV TR (APA, 2000) (Psychiatrist)

Family Assessment Measure

Six Factor Self- Worth General Subscale (Skinner, Steninhuai & Santa- Barbara, 1984)

Concept Scale (Stake, 1994)

Psychosis, Depression, Anxiety Disorders

ANOVA post hoc
Multiple Regression Analysis of control and involvement t-tests, Pearson product moment correlations, Partial correlation and Step wise regression.
CHAPTER I

INTRODUCTION

Epidemiological research has demonstrated the very considerable and previously underestimated burden that mental disorders impose on individuals, communities and health services globally (Ustun & Sartorius, 1995; Murray & Lopez, 1996). Studies carried out in India and Pakistan have likewise shown the high prevalence and disabling consequences of psychiatric disorders (Mumford, Saced, Ahmad, et al., 1997; Patel, Pereira, Couinho, 1998).

According to World Health Report (2001), 25% of the population in world, at sometime during their life are affected by mental and behavioral disorders. These disorders have great economic impact on societies and on the quality of life of individuals and families. These problems are present at any point in time in about 10% of the adult population. Twenty percent of all patients seen by primary health care providers have one or more mental disorders. The common disorders causing severe disability include Depressive disorders, Substance abuse disorders, Schizophrenia, Epilepsy, Alzheimer’s disease, Mental Retardation and disorders of Childhood and Adolescence (Gadit, 2003). The fact file based on available research data, as compiled from various studies (Gadit & Khalid, 2002; Gadit & Vahidy, 1999), gives the prevalence figures in Pakistan as: 6% for depression, 1.5% for schizophrenia, 1-2% for epilepsy and 1% for Alzheimer’s disease. Besides other social evils, these mental morbidities are responsible for the high suicide rate as noted recently. The prevalence
of depressive disorders is the highest, followed by schizophrenia and substance abuse in that order. Mirza and Jenkins (2004) report 34%, (range 29-66% for women and 10-33% for men) prevalence of anxiety and depressive disorders in Pakistan. World Health Organization (2001) specifies anxiety disorders, depressive disorders, and psychotic disorders as the common disorders causing severe disability.

In local context since its independence, Pakistan has persistently been riddled by poor socio-economic conditions, low literacy rate, political instability, and meager healthcare profile. The burning issues of recent times such as human right violations, corruption, unemployment, denial of justice, loosening of cohesion in society, discrimination and violence, have further aggravated the scenario which has culminated in upsurge of mental disorders (Gadit & Khalid, 2002; Mirza & Jenkins, 2004). Due to these high prevalence estimates, there is a clear need to identify and understand vulnerability and risk for psychopathology. Within the context of opportunities and risks, adults may be especially important because of their multiple roles that society expects from them within family and outside the family (Gadit, 2003).

Among various possible reasons found to be associated with psychopathology, the two major factors are family functioning and self-concept. Research reported that family functioning and self-concept has strong relationship with psychopathology (Henderson, Dakof, Schwartz, & Liddle, 2006). These two factors are also reported to be interrelated and have influences on each other. Positive emotional climate of the child's immediate environment help him develop high self-esteem and a positive self-
concept (Banham, Hanson, Higgins, & Jarrett, 2000). Thus in contrary, the negative family environment can have its relation to low self esteem/concept.

In 1994, the United Nations declared that families are the basic unit of society, and thus require special attention (Bowen & McKechnie, 2002). Family constitutes on members either related to each other on the basis of any biological or blood relationships or might be tied to each other due to any psychological or emotional relation. Basic ties among the members of family are their common goals related to the family. They share feelings, responsibilities, norms, household, and above all the same roof. Their goal is to progress the family and to overcome the obstacles standing together against the problems. Family is the most important factor that determines how a person views his or her life, himself and others around him/her. It is obviously the family which shapes an individual how he reason and analyze what happened in his surroundings. The family also shapes the attitudes of a person towards life. According to Jones, Beach, and Jackson (2004) “positive and negative family processes have potential effect on health behaviors”.

It is widely recognized that quality family interactions play a primary role in individuals’ physical and psychological development. The centrality of the family as a primary context for individual development has been documented for children (Bronfenbrenner, 1990) and adults (Stinnett, Walters, & Stinnett, 1991). The utmost importance of the family in the development of a person stresses the need of studying the family in context of family systems theory (Nichols & Schwartz, 1998). The system
theory is a paradigm that describes systems, or "set of elements standing in interrelations among themselves and with the environment" (von Bertalanffy, 1975). It is based on three key assumptions, that "system theories can unify science; system must be understood as the whole rather than in component parts; and human systems are unique in their self reflectivity" (Whitchurch & Constantine, 1993). Family systems theory stems directly from general systems theory and suggests that the family interaction environment significantly affects the individual's development (Nichols & Schwartz, 1998). Rothbaum, Rosen, Ujiie, and Uchida (2002) posit that family system theory is focused on family dynamics, including structures, roles, communication patterns, boundaries, and power relations. According to Whitchurch and Constantine (1993), families as a complex system composed of individuals interacting with one another process as an entire system, which can be understood shifting focus away from individuals to the relationships among them as a system (Whitchurch & Constantine, 1993). They further argued that intra family processes including family functioning, family conflict and family communication etc. can be best understood through system theory. Two primary concepts of family systems theory that relate to understanding family rules are the concepts of mutual causality and feedback loops. Mutual causality refers to the belief that no single part or individual in a system can organize or control the whole system, but rather it is through the reciprocal influence of the interaction of those members as a whole that family rules begin to form (Goldenberg & Goldenberg, 2004). This is unlike more traditional cause and effect explanations of linear thinking where "A" is said to cause "B" is said to cause "C". Instead, mutual causality means "A" "B" and "C" affect each other evenly without one individual part being able to manipulate the system by itself (Becvar & Becvar, 1996;
Feedback loops are the second concept used to understand family rules. Feedback is what allows the system member to know the effects of her/his behavior on others and, therefore, functions as a self-corrective mechanism (Becvar & Becvar, 1996). The feedbacks thus serve as the major source which shapes the family system. It helps the member to maintain homeostasis in the family by correcting the members according to the feedbacks. The individuals in the family are thus influenced by these feedback loops and acquired a repetitive family pattern. Cook and associates (1997) emphasize the importance of viewing the entire family as a system because having a family member with mental illness influences every member of the family with its "ripple effect." Consistent with the well illustrated literature of family as the most influential and dynamic system, Zabriskie and Mc Cormick (2001) assert that family system theory holds that families are goal directed, self-correcting, dynamic, interconnected systems that both affect and are affected by their environment and by qualities within the family system itself.

Three family systems concepts are directly related to family rules are affective responsiveness, affective involvement and behavioral control. Affective responsiveness is defined as the family's ability to respond to events with appropriate quality and quantity of emotional expressions (Epstein, Bishop, Ryan, Miller, & Keitner, 1993). Extreme levels of affective responsiveness (both high and low) within the family have been shown to indicate relapse in patients with psychological symptomatology (depression, alcoholism, adjustment disorder, bipolar disorder) after hospital discharge (Friedman et al., 1997). Affective involvement is family system term that has been defined as the
amount of interest and manner in which interest and investment is shown in the family (Epstein et al., 1993). It was also found that extreme affective involvement (e.g. enmeshment) is associated with problems of depression and anxiety, and that strong affective responsiveness (cohesion) is associated with psychological health and the lower occurrence of depression and anxiety (Barber & Buehler, 1996). Epstein et al. (1993) also discusses behavioral control as a major family system concept that relates to the family rule of monitoring. Behavioral control refers to patterns of behavior that a family uses for dealing with family situations. In other words, families develop behaviors for dealing with family circumstances, such as conflict. Communication is another variable of family functioning which deeply affects an individual. Peleg-Popko and Klingman (2002) revealed that children who come from homes with poor communication were more anxious and stressed than those from home with open family communication.

General family functioning has also been studied with respect to psychological health of its members. Based on family system theory is the Circumplex model of marital and family functioning, which determines family functioning as derived from indicators of cohesion, flexibility, and communication (Oslon, 2000). The Circumplex model developed by Olson, Russell, and Sprenkle (1979, 1983) proposes a system of classifying functional and dysfunctional families on the dimensions of cohesion, adaptability and communication. Cohesion refers to the emotional bonding that family members feel toward one another and is measured along a four-level continuum: disengaged, separated, connected, and enmeshed. Adaptability is defined as the ability of a family system to change its power structure, role relationships, and relationship rules in response to stress.
The third dimension in Olson’s model, communication, is what facilitates movement
toward end maintenance of balance between cohesion and adaptability. According to
Olson and Gorall (2003), a family who has good family communication will be better
able to alter their cohesion and flexibility to meet developmental and situational demands
that arise. Furthermore, family system with poor communication tend to have lower
functioning in regard to cohesion and flexibility, whereas family system with good
communication tend function higher (Olson, 2000). According to the Circumplex model
of family functioning, communication is the glue that holds the family together
(Masselam & Marcus, 1990). Olson (2000) stated that family systems with poor
communication tend to be unbalanced, whereas family systems with good
communication tend to be more balanced.

As the healthy communication among the family members is indicative of better
mental health, also there is a communication of rules in the family which have its crucial
effects on a person’s mental health as well as his/ her concept of the self; because rules
regulate how the system functions, the appropriateness and logic of the family rules
significantly affect family and individual mental health (Blevins, 1993). As Blevins
(1993) put it, these rules are seldom explicitly communicated to family members, yet are
just as potent in shaping and determining how a family functions, as are explicit or
written rules. Rules might be either explicit or implicit; protecting the family
environment and maintaining the homeostasis or say balance (Hoopes & Harper, 1987).
There is an established foundation of theoretical and clinical literature on how family
rules, considering as an integral part (Jackson, 1965; Becvar & Becvar, 1996; Broderick,
1993), are related to family process (Stoll, 2004). The most important are the implicit rules, further defined in two categories i.e., constraining or facilitating. Harper and Hoopes (1991) define constraining family process rules as constraining thoughts and feelings of self, while divide facilitative family process rules into three subcategories of Kindness, Expressiveness and connection, and Monitoring. Satir (1988) asserts that "rules contribute to relational self definition, relational development, and relational satisfaction". Facilitative implicit family process rules are reported to have contribution in building up self-esteem and a more positive and healthy self image in adolescents, which helps contribute to nourishing interpersonal relationships. When the facilitative rules are expected to be a safeguard against psychological symptoms, constraining family process rules should be related to the presence of such symptoms (Harper and Hoopes, 1991). Thus this is the nature of rules prevailing in a family environment which determines the mental health of its members.

The family context can be defined and redefined according to multiple dimensions e.g., perceived communication, control and involvement among family members. The process model of family functioning (Steinhauer, Santa-Barbara & Skinner, 1984) proposes that the overriding goal of the family is the successful achievement of basic developmental and crisis tasks that provide for the continued development of individual family members in a secure, cohesive, and effective environment. Successful accomplishment of these tasks requires the assumption of appropriate roles, engagement in effective communication, and appropriate expression of affect among family members. Family members must be emotionally involved with each other and be able to influence
each other's behavior in a consistent and productive fashion. All of this occurs against a background of cultural norms and values that the family shares. It has been consistently demonstrated through research that having a family member with a mental illness is associated with poor family functioning (Tamplin & Goodyear, 2001). Salki, Asukai, Miyake, Miguchi, and Yamauaki (2002) conducted a research on the characteristics of family functioning in depressed patients. Results reflect that members of depressive families perceived their family functioning to be significantly poorer than of control families, in the areas of problem solving, communication, roles, affective responsiveness, affective involvement and general functioning. Poor family communication skills were found to result in a number of problems for individuals, including shyness (Huang, 1999), communication apprehension (Elwood & Schrader, 1998; Hsu, 1998), unwillingness to communicate (Avtgis, 2000), and the development of reticence (Kelly et al., 2002).

Exploring the role of family in the development of psychopathology is not an easy task. Different opinions and theories emerge when we evaluate influences of the “family context”. However, an agreement always exist that family does matter. Lack of love, affection and emotional insecurity makes the individual’s personality weak, coward and fearful. Either placidity or rigidity is also learnt by imitation and emotional experiences in the family. Thus, throughout life, family is the most important source of primary relationships, comfort and reassurance. Stinnett (1979), coming from a family strengths research perspective, proposes that a successful or strong family "creates a sense of positive family identity, promotes satisfying and fulfilling interaction among members, encourages the development of family group and individual members, and is
able to deal with stress". Olson (1986) propose that families should be able to: 1) "cope with stress and problems in an efficient and effective way"; 2) "have and use coping resources both from within and from outside the family"; and 3) "have the ability to end up being more cohesive, more flexible and more satisfied as a result of effectively overcoming stress and problems". However, Epstein, Bishop, and Baldwin (1982), state the family unit provides the foundation for individual’s social, psychological, and biological development and maintenance. From a clinical perspective, some aspects of families must be held constant in order to examine how variations in family contexts are associated with variations in child, adolescent, and adult psychological deviation. This dynamic unit of social organization changes across history, setting, circumstances, and stage of the life cycle.

The other most basic task for our mental, emotional and social health, which begins in infancy and continues until we die, is the construction of our sense of self (Wylie, 1961). In defending the importance of the self-system, early self theorists devoted a significant amount of their theorizing to the identification of the crucial functions that self performs (Allport, 1955; Erikson, 1950).

While viewing the various concepts of self concept, it seems obvious that self concept is not a mere simple construct. Self-concept is believed to be a "multidimensional and dynamic system of beliefs" (Cole et al., 2001). The last decade of psychological research has witnessed a significant rise in the work on the self and related cognitive and affective processes (Tesser, 2000). Extensive research on self-concept
structure signifies the strong links between the organization of self-knowledge and its functional correlates such as everyday functioning, self-evaluation or psychopathology. Woolfolk and associates (1995) reported that the complexity of positive and negative self-knowledge can be distinguished from each other and may have differential effects on well-being. Fan and Fu (2001) have discovered that there is a positive relationship between self-concept and mental health. Self concept has played a central role in psychological theories and views. It has a long history in psychology, for Rogers, healthy person does or can assimilate experience into the self-structure. In healthy person, there is congruence between self and experience, openness to experience, and lack of defensiveness. In contrast, the neurotic person’s self concept has become structured in ways that do not fit organism’s experiences. The psychologically maladjusted individuals must deny to awareness significant sensory and emotional experiences. The results of denied or distorted experiences, is a rigid, defensive maintenance of self against experiences that threaten the wholeness of self and frustrate the need for positive regard. Psychotic behaviors are viewed as behaviors that are inconsistent with the self but have broken through the defensive processes (Rogers, 1959). Further he interpreted psychological pathology in terms of disturbed relationships between self and experiences.

Researchers have found that those individuals who have a negative view of self have a greater number of dysfunctional beliefs (Roberts et al., 1996). These dysfunctional beliefs may be sustained by the negative view of self since these individuals have a tendency to continually blame themselves for negative life events and consistently make negative attributions when examining their experiences (Janoff-Bulman, 1992). Having
more dysfunctional beliefs about the self and doubting one’s ability to successfully interact with others may contribute to higher levels of psychological distress (Cummings & Cicchetti, 1990; Gotlib & Hammen, 1992; Muller et al., 2000).

A number of studies highlight the significance of self concept and its relation with different psychopathological symptoms (Bohne, Kenthen, Wilhelm, Deckersback, & Jenike, 2002; Dowd, 2002; Ellet, Lopes, & Chadwick, 2003; Fan & Fu, 2001; Hoffmann, Baldwin, & Cerbone, 2003; Kim, 2003; Valentine, 2001); with neuroticism (Torres, 1983); with psychoticism (Fan & Fu, 2001; Fierro & Cardenal, 1996; Heaven, 1991) and with depression (Kernis & Whistenhunt, 1998). The studies evaluated the links between self-concept and psychopathology show inverse relations between both variables. According to Erol, Toprak and Yazici (2002) low self-esteem is strong predictor of psychopathology. Montt and Chavez (1996) found positive relationship between self-esteem and mental health. Negative self-focused thoughts, and inability to disengage from them (Lyubomirsky & Nolen-Hoeksema, 1993); stringent self-standards typified by perfectionism, and strong social dependence (Vertoggradov, Bannikov & Konkov, 1997) are the major part of depressive episodes. Depressed individuals are considered to have negative thoughts of self, in which the self is considered as bad and worthless (Hirvas, 2000). Self esteem has variously defined as related to psychotic symptoms (Barrowclough et al., 2003; Drake et al., 2004; Freeman et al., 2003; Guillem et al., 2005); anxiety (Muris, Meesters & Fijen, 2003), depression (Mann et al., 2004); psychological dysfunction, psychopathology, and maladjustment (Tzonihaki, et al., 1998) such as loneliness, depression, and anxiety. Further self concept also found to be
associated with psychopathological symptoms including obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, aggressiveness, paranoid ideation, and psychoticism (Garaigordobil, 2006). Individuals with a negative view of self lack coping resources for dealing with distress because they have not developed such emotional resources as trust, optimism, and self-control (Mikulincer et al., 1993).

Sullivan (1953) suggests that a significant component of personality is the self system (a person’s perception of the self), which develops out of relationships with significant figures in the environment. During infancy the developing self-system is influenced by the amount of anxiety the mother communicates, often in subtle way to the child. In later years, the self-system is influenced by reflected appraisals, how the individual perceives others as perceiving and responding to him or her. Of particular significance here is whether the person sees the self as good or bad as a result of perceptions of the evaluative judgments by others. Rogers (1959) also viewed the basic estrangement in humans as in between self and experience, which comes about because humans falsify their values for the sake of preserving the positive regard of others. If parents make positive regard conditional, their children will not accept certain values of experiences as their own, resulting in conflicts and maladjustment. Beck (1967; as cited in Beckam & Leber, 1995) also emphasizes the importance of positive views about self in context of psychopathology. He proposed that negative cognitive set- that is, the tendency to view the self, future and the world in dysfunctional manner is the essential component of depression. Those who regard themselves as unworthy, incapable and undesirable; and expect rejection and dissatisfaction are the depressed people.
Mead (1934) proposed that the self develops in two stages, first we internalize (incorporate into ourselves) other people's attitudes toward us, and second we internalize the standard of the society. In other words the self-concept is the social creation, the product of our learning through relationships with others (Baldwin & Holmes, 1987). In the same context it would be noteworthy to discuss what Gonca and Savasir (2001) found as the basic source of the 'interpersonal schema'. They discussed that an interpersonal schema is conceptualized as a generalized representation of self-other relationships, which is initially based on interactions with attachment figures such as parents, permitting the individual to predict interactions in a way that increases the probability of maintaining relatedness with these figures.

According to the symbolic interaction theory, an individual's self-concept is mainly acquired from the responses of significant others through social interaction. Parents have been frequently found to have a significant influence on the formation of an adolescent's self-concept (Galbo, 1984; Lackovic-Grigin & Dekovic, 1990; Peterson & Rollins, 1987) as they are the major source of interaction of an individual to its environment. Self-concept clarity (Campbell, 1990) as an important dimension of self concept structure reflects that one can control and adjust her/his behaviors according to situational demands only if he/she is clear about his/her capabilities. This self-knowledge reduces the feeling of anxiety created by engaging in behaviors that surpass one's capabilities. This clarity is a necessity for a healthy self structure. A person lacking such clarity might involve in behaviors which are not consistent to the self, and thus result is a state of anxiety. Purkey and Stanley (1991) indicate that when an individual
behaves in a manner inconsistent with the self, a state of discomfort develops. An individual while striving to meet the expectations of the family members, which are not consistent to what he/she expected to him/her, might feel discomfort, as fails to meet the standards.

Self-concept thus does not exist in a vacuum, as its development is influenced significantly by the immediate family context (McClun & Merrell, 1998). Family is considered as having the vital role in the development of self concept (Shek, 1998). As Rosenberg (1979) put it, individual's self-concept is deeply influenced by the attitudes of significant others with whom he or she most intensively interacts. Most of the time this influence starts early in the age, as children and adolescents living in families with high levels of conflict or discord are found to be more likely to have both externalizing and internalizing problems, immaturity, low self esteem, and academic difficulties compared with controls (Fendrich et al., 1990). General family processes may affect an individual's psychological well being; for instance, his self-perception directly or in combination with other factors. As Coleman et al. (1980) discusses that contradictory and disconfirming communications subtly and persistently mutilate the self-concept of a family member. The family specifically the parents are the major source of the development of self concept, as it was found that young healthy adults, and adolescents who perceive their parents as warm, accepting and supportive have higher self-concept as compared to those who viewed their parents as colder and rejecting (Litowsky & Dusek, 1985). Louw (1991) and Grobler (1996) also indicate family, as a social system, as an important determinant of one's self-concept development.
The development of psychopathology reported to be influenced by both family
(Keitner and Miller, 1990) and self concept (Hoffmann, Baldwin & Cerbone, 2003;
Erkolahti et al., 2003). Thus it is likely that factors such as family functioning and self
concept work together and contribute in the development of psychopathology. Research
indicates that family functioning and self concept jointly predict externalizing problems
in adolescent (Barber, Ball, & Armistead, 2003; Peiser & Heaven, 1996; Rabotej-Saric,
Rijavec, & Brajsa-Zganec, 2001). Self-concept was assumed to be a mediating variable
rather than an end product of family influence (Burns, 1982; Byrne, 1984).

While discussing the impact of stressors on a person’s mental health Davis
(2001), pointed out few resources which operate to create resilience. He includes self
esteem in personal factors; and cohesive family and warm and caring parents in
environmental factors which contribute in the ability to cope with adversity, and act as
the protective factors against psychopathology.

Self-concept, and its associated outcomes like self- efficacy, self-evaluation, or
self-ideal congruency, has come to be viewed as something that everyone possesses in
varying degrees. By determining the degree of self-concept possessed by an individual,
it becomes possible to assess, predict, control, or enhance an individual’s life. A
positive family functioning supports to control psychopathology. The sense of control
is not generalized, self-concept would be enhanced, and risk for dysfunctional family
decreased (Urbanc, 1999, 2000). The need is thus to evaluate the role of the two factors
individually and also to assess their interrelation, in order to develop better treatment planning and preventive measures.

Present research is an attempt to explore and highlight the effects of family’s maladaptive interactional patterns and distorted sense of self on the psychological well being of an individual, as well as the relationship of these two factors. These two factors appears to be associated and involved in hampering the adequate growth as well as functioning of a personality, thus play an important role in the development of psychopathology. Hence it will be useful for psychologist and other practitioners related to mental health discipline, to pinpoint the root causes of psychopathology and to prepare better strategies for prevention and treatment. Apart from its utility for the clinicians, it can also benefit the social policy makers. As the family functioning has its roots in the childhood especially, there is a dire need to make policies and maximize the awareness related to better practices in family. This study also addresses the importance of self concept and emphasizes the need of formulation of strategies to preserve the self concept of individuals from very outset. The explorations made by this study would help in effective policy making in order to prevent and minimize the chances of pathology and create a better mental health environment in Pakistan.
CHAPTER II

LITERATURE REVIEW

Various developmental pathways leading to the mental health or to the vulnerability to psychological disturbances are determined by the quality of family interaction and perception of self. It would be effective to first view the family and its significance in a person’s life, as well as its relation to and role in the development of psychopathology.

Family Functioning and Psychopathology

There is not one universally accepted definition of family, and it is not likely that we will progress toward one soon (Settles, 1999). The family is a group of people forming the smallest unit of a society. It is known as the 'basic-building-block' of human society, which has its own specific function (Ahmad, 2003). Traditionally, the family has been defined as a unit made up of two or more people who are related by blood, marriage or adoption and who live together, from an economic unit, and bear and raise children (Benokraitis, 1996).

According to Nimkoff and Ogburn (1985), "a family is a socially sanctioned group of persons united by kinship, marriage or adoption ties, which generally share a common habitat and interact according to well defined roles." Burgess and Wallin (1953)
proposed one of the first transactional definitions when they defined family as "a unit of interacting personalities".

Ghani (2000) comments that, the forms and functions of family have varied around the world over the centuries. However, the family has been a universal, indispensable fact. It is probably the most important social institution for its multifarious functions and its significant roles where people make specific arrangements to fulfill needs in legitimate manners.

Kreppner and Lerner (1989) noted different perspectives on the family itself, including 1) A system focusing on general dimensions of family interaction and taking into account all family members 2) A series of dyadic interactions 3) The sum of interactions among all family sub groupings - dyadic, triadic, tetradic 4) A system of internal relations in reaction to broader contexts; such as, external social support, intergenerational and historic influences.

Wamboldt and Reiss (1989) classified definitions of family into three types. The first type, structural definitions, defines family by form, whereas the second and third types, task-orientation definitions and transactional definitions, define family by function and interaction, respectively. Describing the interaction and subjective feelings that define family system, he also define family as "a group of intimates [whose interaction generates] a sense of home and group identity; complete with strong ties of loyalty and emotion, and an experience of a history and a future". The meaning and boundaries of
family are often symbolized through family stories, family rituals, and other symbolic communication. Overall, the focus is not on the family's task performance but on the interaction among communicators (Whitchurch & Dickson, 1999). Interaction among family members according to the transactional perspective is characterized by the following: intimacy, interdependence, commitment, feelings of family identity, emotional ties, self-defined symbols and boundaries for family membership, and an ongoing history and future.

DeGenova and Rice's (2002) refer to structural, task orientation, and transactional components in one definition. According to DeGenova and Rice, "family is any group of persons united by the ties of marriage, blood or adoption, or any sexually expressive relationship, in which (1) the adults cooperate financially for their mutual support, (2) the people are committed to one another in an intimate interpersonal relationship, and (3) the members see their individual identities as importantly attached to the group with an identity of its own".

Although there is not one universally accepted definition of family but families plays a critical role in the development of individual characteristics. According to Epstein, Bishop, and Baldwin (1982) the family unit provides the foundation for individual's social, psychological, and biological development and maintenance. The McMaster model of family functioning (MMFF), described by Epstein, Bishop, and Baldwin (1984), assume that the primary function of the family unit is to provide a setting for the development and maintenance of these above mentioned functions. In
order to provide a solid foundation for healthy growth in these areas families must successfully accomplish a variety of basic, developmental, and hazardous tasks critical to individual and family system survival.

Olson, Sprengkle, and Russell (1979); Olson, Russell, and Sprengkle (1984); Olson and Lavee (1989) has been influential in designing a circumplex model of marital and family systems. The model depicts two dimensions—“cohesion” and "adaptability" and makes use of a third dimension called "communication". These three dimensions were drawn from the conceptual clustering of concepts from six social science fields, including family therapy (Kaslow, 1987).

Family cohesion is defined as the "emotional bonding that family members have toward one another" (Olson, Russell, & Sprengkle, 1984). Specific indicators for measuring the family cohesion dimension are emotional bonding, boundaries, coalitions, time, space, friends, decision-making, and interests and recreation. The cohesion dimension ranges from "disengaged" (very low) to "separated" (low to moderate) to "connected" (moderate to high) to "enmeshed" (very high). The extremes (disengaged or enmeshed) are considered problematic. Families falling in the middle of the dimension (separated or connected) are healthy, because family members can be both independent of, and connected to, their families (Zeitlin, Megawangi, Kramer et al., 1995).

The second dimension, "adaptability," is defined as "the ability of the marital or family system to change in its power structure, role relationships, and relationship rules
in response to situational and developmental stress" (Olson, Russell, & Sprengkle, 1984). This dimension ranges from "rigid" (very low) to "structured" (low to moderate), to "flexible" (moderate to high), to "chaotic" (very high). Again, a middle range of the dimension is considered to characterize a well-functioning family. A structured relationship is generally less rigid, less authoritarian, and more shared. A flexible relationship is even less rigid and the leadership is more equally shared. A rigid relationship (highly authoritarian) and a chaotic relationship (has erratic or limited leadership) are considered to be problematic for individual and relationship development in the end (Zeitlin, Megawangi, Kramer et al., 1995). Olson, Russell, and Sprengkle (1984) did acknowledge that as long as all the members are willing to accept the expectation of family togetherness, the family could function well.

Researchers and practitioners have increased their inquiries into how family systems function, and how they influence the behavior of individual members. Lacking of consistency in relations and chaotic behavior control in families, results in confused and disorganized family organization (Peterson, 1999). According to Whitaker and Keith (1981) healthy family is one that continues to grow in spite of whatever troubles come its way. Furthermore, the healthy family deals with stress by pooling its resources and sharing problems, not dumping them all on one family member.

According to Fennell and Weinhold (1997), healthy families have clear boundaries. Family rules are clear and enforced; family members have a clear understanding of their roles; individual autonomy is encouraged and their communication
is clear and direct, while dysfunctional families have rigid boundaries; rules and roles are unchanging; individual autonomy is sacrificed for family togetherness; lacks family unity and their communication is vague, indirect or coercive and authoritarian.

Satir (1972) described the normal family as one that nurtures its members. Individual family members listen to and are considerate of each other, enabling them to feel valued and love. Affection is fairly given and received. Moreover, family members are open and candid with each other. Anything can be talked about—the appointments, ears, hurts, angers, criticisms as well as the joys and achievements.

On the other hand dysfunctional families as described by Kempler (1981) are incapable of autonomy or real intimacy. They lack in communicating with each other and do not share the problems. Satir (1972) emphasize that troubled families are emotionally dead cold; they seem to stay together merely out of habit or duty. They don’t care about each other, in consequences of the lack of warmth in the family; these people avoid each other, and preoccupy themselves with work and other activities outside the family.

Minuchin (1974) reserves the label of pathological for those families who, when faced with a stressful situation, increase the rigidity of their transactional patterns and control, thus preventing any further exploration of alternatives. Normal families, by way of contrast, adapt to life’s inevitable stresses by preserving family continuity while remaining flexible enough to permit family restructuring.
Pathological families are considered to be trapped in dysfunctional, but very strong homeostatic patterns of communication (Jackson & Weakland, 1961). Their interactions may seem odd, and they may be unsatisfying. These families cling to their rigid and inflexible structures and respond to signs of change as negative feedback. The Baldwin-Schaeffer (1959) reported that disorganized families lack affection and involvement, have poorer communication and supervision/control, which will negatively influence both the development and behavior of the child. Suicide attempters are also more likely to report feeling that they are unwanted or burdensome to their families. There is a significantly high level of psychopathology among family members, particularly of suicide and depression (Beautrais, Joyce, & Mulder, 1996).

Family functioning has also been found to predict the course of several psychiatric disorders. For example, unhealthy family functioning is associated with a slower rate of recovery from a depressive episode (Cormy, 1987; Keitner, Ryan, Miller et al., 1995). A number of family environmental factors have been shown to be related to the development of mental disorders, including family stressors, numerous family relationship variables (e.g., conflict, support, and relationship quality). Significant family dysfunction has been reported across a variety of psychiatric disorders including: eating disorders (Garfinkel, Garner, Rose et al., 1983; Shisslak, McKeon, & Crago, 1990; Steiger et al., 1991); school phobia (Bernstein, Svingen, & Garfinkel, 1990); substance abuse (McKay et al., 1991); and depressive disorders (Gordon, Burge, Hammen, et al., 1989; Keitner & Miller, 1990; King et al., 1993; Miller, Keitner, Whisman, et al., 1992). Two previous studies also suggest that levels of family dysfunction are higher in the
families of psychiatric patients than in families with a medically ill member (Gordon, et al., 1989; Kabacoff, Miller, Bishop, et al., 1990).

Research studies that assess characteristics of family life, report reliable associations between them and a broad array of mental health risks, including internalizing symptoms, such as psychosis, depression, suicidal behavior, and anxiety disorders (Chorpita & Barlow, 1998; Kaslow et al., 1994). A number of studies have confirmed the existence of a significant degree of family dysfunction and adverse childhood experiences among suicide attempts (Beautrais, Joyce, & Mulder, 1996). A research on family functioning and major depression conducted by the Keitner and Miller (1990) indicate that the family plays an important role in the development and course of major depression. Studies using self-reports, interviews, and observational methods have consistently reported that depressed youths have discordant family and peer relationships (Asarnow et al., 1988, 1993; Beardslee et al., 1998; Billings & Moos, 1985; Downey & Coyne, 1990; Fergusson et al., 1995; Hammen et al., 1987; McCauley & Myers, 1992; Messer & Gross, 1995; Puig-Antich et al., 1985a,b, 1993; Stein et al., 2000; Sheeber & Sorensen, 1998; Tamplin & Goodyer, 2001). A similar pattern of discordant family relationships has been reported in depressed adults (Downey & Coyne, 1990; Zlotnick et al., 2000). Depression, like many other mental health problems, can be caused by a variety of factors. Joiner, Coyne, and Blalock (1999), stated that "regardless of what other factors may be involved, the interpersonal context affects greatly whether a person becomes depressed, the person’s subjective experience while depressed, and the
behavioral manifestations and resolution of the disorder. Consideration of the interpersonal context is simply a necessity for an adequate account of the disorder.

Family not only has a role in the development of disorders but also in the relapse and reoccurrence of psychiatric problems, as research indicates that family conflicts and negative family interactions can heap stress on family members with schizophrenia, increasing the risk of recurrent episodes (Masrh & Johnson, 1997). Evidence shows that people who become depressed do tend to encounter rejection in long-term relationships (Marcus & Nardone, 1992). Longitudinal studies of depression and family functioning show that depressed patients with persistent family dysfunction had poorer clinical outcome at 12 months (Keitner, Ryan, Miller, & Norman, 1992). A number of studies have shown that people with schizophrenia whose families are high in expressed emotion are much more likely to suffer relapse of psychosis than are those whose families are low in expressed emotion (Brown, Birley, & Wing, 1972; Hooley & Hiller, 1998; Kavanagh, 1992; Leff & Vaughn, 1981; Mintz et al., 1987; Parker & Hadzi-pavlovic, 1990). Extensive research has found that individuals suffering from a multitude of illnesses (e.g., schizophrenia, mood disorders, posttraumatic stress disorder etc.) and are over involved, critical, or hostile towards family members are more likely to experience relapse (i.e., another episode of symptoms) than are persons with the same illnesses (Barrowclough & Hooley, 2003; Wearden et al., 2000).

Family life is our first school for emotional learning; in this intimate cauldron we learn how to feel about ourselves and how others will react to our feelings; how to
think about these feelings and what choices we have in reacting; how to read and express hopes and fears. This emotional schooling operates not just through the things that parents say and do directly to children, but also in the models they offer for handling their own feelings and those that pass between husband and wife. How parents treat their children—whether with harsh discipline or empathic understanding, with indifference or warmth and so on—has deep and lasting consequences for the child's emotional life (Goleman, 1995).

Family dynamics, reflected in international patterns as well as values, influence effective functioning. The family’s strengths and failure include commitment, positive communication, spiritual values, appreciation and affection, sharing of time together and ability to cope with stress (Stinnett, 1979). Functional family process and personal maturation are characterized by openness to change, flexibility of response, the generation of personal choice or system options, an awareness of resources, an appreciation for difference as well as similarity, equality in relationships, personal responsibility, reasonable risk, freedom of experience and expression, clarity and congruent communication (Horne, 2000).

**Communication:** Communication is the human vehicle by which rules are transmitted in the system and identity formation is affected and affirmed. Communication is the foundation of the family system (Horne, 2000). Communication between human beings is supposed to be an important factor in how they behave toward each other. According to Watzlawick et al. (1967) "all communication—even the communicational
clues in an impersonal context—affects behavior”. Communication within the family is extremely important because it enable members to express their needs, wants, and concern to each other. Open and honest communication creates an atmosphere that allows family members to express their differences as well as love and admiration for one another. Through communication, family members are able to resolve the unavoidable problems that arise in all families (Epstein et al., 1993; Peterson, 1999).

All behavior transmits an interpersonal message, and each communication, either verbal or non-verbal, has two functions: the first to provide information, feelings and opinion, the second, to develop a relationship. This function of communication dictates how the information is to be interpreted and, consequently, defines the relationship between the individuals or system member’s communication. Families develop stable relationships among members through mutual agreement and the development of family rules (Horne, 2000).

Just as an effective communication is usually found in strong and healthy families; poor communication is usually found in unhealthy relationships. Marriage and family therapists often report that poor communication is a common complaint of families who are having difficulties. Poor communication is unclear and indirect. It can lead to numerous family problems, including excessive family conflict, ineffective problem solving, lack of intimacy, and weak emotional bonding (Epstein et al., 1993; Peterson, 1999). Communication Deviance (Schaffer et al., 1962) was proposed to represent characteristics of deviant family emotional climate. Asarnow, Goldstein, and
Ben-Meir (1988) studied depressed and schizophrenic-spectrum disordered youth interacting with their parents and found that more than half of the depressed youths had at least one parent who demonstrated communication deviance. In other studies that used self-report measures of family communication, families with a depressed member reported poorer communication than families with a schizophrenic or bipolar member (Miller et al., 1986).

Researchers have discovered a strong link between communication pattern and satisfaction with family relationship (Noller & Fitzpatrick, 1990). Bateson (1959, 1960) was one of the first investigators to emphasize the conflicting and confusing nature of communications among members of schizophrenic families. Satir (1976, 1988) identified four dysfunctional communication patterns common in families: blaming, placating, super reasonable, and irrelevant. Significantly, expressed emotion tends to be associated with familial communication deviance (Doance et al., 1985; Goldstein, 1985; Miklowitz et al., 1986).

According to the social skills deficit hypothesis (Lewinsohn, 1974), people lacking adequate social skills are at risk for developing depression because of their inability to create positive social experiences and avoid negative social experiences. One of the primary environment in which children learn communication skills is the family of origin (Burleson, Delia, & Applegate, 1995; Burleson & Kunkel, 2002). Consequently, parents who fail to properly teach or model effective communication skills to their children might inadvertently make those children vulnerable to subsequent depression.
Family communication is also defined as the ability of a family system to maintain open and clear channels of communication between members (Olson et al., 1983). It is expressed in empathy and attentive listening, readiness to self-disclosure, and sharing personal feelings without fear of criticism or retaliation, and with respect and regard for other members' beliefs and behaviors. Difficulties in communication and problem-solving behaviors have been widely observed in families with a depressed individual.

Communication deviance may be one of the stress related factors that increase the risk of development of schizophrenia in vulnerable individual (Goldstein, 1987). Some researches focus on the blurred, ambiguous, and confused communication pattern in families with schizophrenic members (Wynne et al., 1958; Wynne & Singer, 1963). They concluded that such family pattern contributes to the schizophrenic member's tendency to interpret events occurring around him/her in blurred or distorted ways. In turn, such confusion or occasional bafflement increases the schizophrenic's social and interpersonal vulnerability, both within and outside the family. Unclear communication by family members, especially powerful ones, can produce a stressful environment for other family members and can facilitate chaotic relations (Headman, 2003).

Sociologists, family therapists, and psychologists all study the influence of family role, relationships and communication pattern in the development of schizophrenia. Researchers have provided some evidence to support theories that deviations in parental communication influence the development of schizophrenia (Liem, 1980). Deviant
communication in families may contribute to the child's distortion of reality by concealing or denying the true meaning of an event or by injecting a substitute meaning that is confusing (Wynne et al., 1979). Rund (1986, 1994) found that communication deviance, expressed hostility, and over involvement characterize families in which offspring develops schizophrenia. Bateson et al. (1956) hypothesized that extreme cases of double binding in families was at the heart of schizophrenia (Headman, 2003).

Controlled comparison of interactions in families with, and without a person with schizophrenia, have found significantly higher level of communication deviance in the families of people with schizophrenia (Miklowitz et al., 1991). A study found interpersonal stressors to be significantly more common among schizophrenic people than among members of a matched control group (Schwartzic & Myers, 1977).

Families of schizophrenics tend to have unusual communication pattern (Wynne et al., 1975). Their verbal exchanges are variously described as blurred, muddled, vague, fragmented, or incomplete (Friedman & Friedman, 1970; Hassan, 1974; Lewis et al., 1981). Longitudinal study (Doane et al., 1981; Goldstein, 1985; Goldstein et al., 1978; Goldstein & Strachan, 1987; Lewis, Rodnick, & Goldstein, 1981) examines subjects who has been psychologically clinical patients, but not schizophrenic, as adolescents were followed into adulthood. The findings confirmed that communication deviance in family atmosphere did indeed predict the occurrence of adult schizophrenic spectrum disorder.
A number of scholars developed proposals that attributed schizophrenia to the exposure to, and participation in, dysfunctional communication patterns in the family. Some characterizations of such patterns are double bind interaction (Bateson et al., 1956), transactional disqualification (Sluzki et al., 1967), pseudo mutuality (Wynne, Ryckoff & Day, 1958); marital schism (Lidz, 1968; Lidz, 1973; Lidz & Fleck, 1985) and "scapegoating" (Ackerman, 1958). Singer, Wynne and Toohey (1978) studied over 600 families and gathered incontrovertible evidence that disordered styles of communication is a distinguishing feature of families with young adult schizophrenics. Similar disorders also appear in families of borderlines, neurotics, and normal, but are progressively less severe. Relapse into schizophrenia following remission is associated with a certain type of negative communication, directed at the patient by family members (Butzlaff & Hooley, 1998; Hooley & Hiller, 1998; Linszen, et al., 1997; Miklowitz, Goldstein, & Falloon, 1983; Vaughn, et al., 1984). Family conflict is also positively associated with loneliness (Johnson, LaVoie, & Mahoney, 2001; Ponzetti & James, 1997), and healthy family communication and emotional bonding are negatively associated with loneliness in young people (Uruk & Demir, 2003).

Control: Another important aspect of Family functioning is Control. Control is the process by which family members influence each other. It includes whether or not the family is predictable versus inconsistent, constructive versus irresponsible in its management (Skinner, Steinhauer, & Santa Barbara, 1995).
In the clinical domain, researchers, practitioners, and theorists continue to observe that psychopathology represents "diminished flexibility and constrictions in the affective, cognitive, and behavioral correlates of adaptational patterns" (Overton & Horowitz, 1991). However, this view of psychopathology as overlearned, automatized cognitive, affective, and behavioral patterns that are insensitive to environmental change and that interfere with social functioning (Cicchetti & Cohen, 1995; Mahoney, 1991) has rarely been empirically demonstrated. One notable exception is the circumplex model of adaptive family functioning (Minuchin, 1974; Olson, 2000) that assesses the state of a family system along the dimensions of flexibility and cohesion.

Control is the dominant feature of an unhealthy or negative family environment (Moos, 1974). The system is rigid--there is resistance to change (Minuchin, 1974). Family interactions related to the development of psychopathology show evidence of the three core aspects of rigidity. For example, internalizing behavior has been associated with a reduced range of (flattened) affective expression (Downey & Coyne, 1990; Field et al., 1985; Gelfand & Teti, 1990). All families experience some conflict, but the families of aggressive children engage in extended and escalating (i.e., perseverative) exchanges of coercive behavior (Patterson, 1982). It is the inability to flexibly exit those interactions that leads to psychopathology (Dumas et al., 2001; Gottman & Notarius, 2000). Thus, it is not only the content but the structure of parent-child behavior over time (i.e., rigidity) that can influence child adjustment. Messer and Beidel (1994) found that anxiety disordered children described their parents as promoting less independence. The most anxious children were those who reported the most parental control.
Methods of control or processes and forms of discipline can play an important role in the development of psychopathology in adults. Families that have no consistent style, or that jump back and forth between styles have a chaotic behavior control style. This style leaves family members confused about their individual roles and the rules that govern their family's organization (Peterson, 1999). Family rules may be implicit and/or explicit as they organize family interaction and maintain a stable system by defining and limiting member's behavior (Watzlawick, Beavin, & Jack, 1967). These family rules provide the establishment and maintenance of role expectation for each family member and subsystem, the definition of acceptable and non-acceptable behaviors and actions, and the provision of positive or negative consequences for behavior. Because of these rules, families tend to interact in repetitious ways, and interactions are governed by a small set of patterned and predictable rules (Horne, 2000).

Lytton and Zwirner (1975) found that compliance with immediate parental demands was maximized by power-assertive techniques involving physical control, punishment, and commands whereas compliance occurred less frequently following positive action or reasoning. Hoffman (1970) reported that inductive disciplinary techniques enhance the internalization of social rules and thus encourage socially competent moral behavior more effectively than power-assertive techniques. Richardson, et al. (1989) states that there was a strong correlation between lack of parental supervision and substance use independent of family structure. Parents could extinguish their children's undesirable behavior through punitive discipline (e.g., Aronfreed, 1968; Parke, 1975; Patterson, 1975) by attempting to determine whether or not parent's disciplinary
styles have a discernible impact not only on their children's current behavior, but also on future behavior in a variety of settings.

Family conflict, parental hostility, lack of support and harsh discipline has been related to adolescents' and adults' mental disorders (Cole & McPherson, 1993; Garber & Little, 1999; Garrison et al., 1990; Reuter et al., 1999). Along with parental over-control, low levels of emotional warmth, high levels of rejection, and the absence of autonomy promotion are also found to be predictive of high levels of psychopathological symptoms such as depression and anxiety disorder in youths (Muris, Meesters, & Van den Berg, 2003; Silk et al., 2003; Siqueland, Kendall, & Steinberg, 1996; Wenar & Kerig, 2000). According to Moos (1974) and Fowler (1980), two important dimensions of the family environment are control and cohesion. Healthy families are characterized by optimal cohesion; that is, family members display warm affective ties (Olson et al., 1979). As a form of social support, the family is an important resource in coping with stress. Besides the very occurrence of various stressors in a society there are characteristic coping styles of individuals which buffer the person against the ill consequences of unhealthy environment. However, the pathology due to stressors still results because of an inability of successful implementation of these coping strategies, as they relate to family environment. The link of family environment with coping strategies is deep rooted as family provides the context in which the individual first experiences various coping strategies. Furthermore, the individual can then begin to test coping strategies with family members. Finally, the individual can return to the family for particular types of coping such as advice-seeking and social support. It follows, then, that one's chosen coping
strategies are likely influenced by the conflict or cohesion that characterizes his or her family environment (Compas, 1987; de Anda et al., 2000; Lohman & Jarvis, 2000; Philips & Jarvis, 1994; Skinner & Wellborn, 1994; Stern & Zevon, 1990). Researchers have consistently demonstrated that parental rearing and family environment can either facilitate or hinder the development of autonomy and psychological health of family members, including coping strategies. Anxious rearing behaviors such as overly rigid or erratic discipline have been shown to be linked to increased incidence of avoidant coping strategies (Muris et al., 2000). On other hand support and cooperation is characteristic of adaptive coping and healthy family functioning (Lohman & Jarvis, 2000). The need is thus to enrich the family environment for better mental health possibilities. One of such an aspect required for the family is cohesion. Individuals who remain relatively healthy under stressful situations have been found to perceive high family cohesion (Hollahan & Moos, 1982). Individuals who perceive less family support have been found to experience more depression and work-related stress (Mitchell et al., 1983). However, if a person becomes overly dependent on supportive relationships; the relationships tend to be some strained. Instead of support, these strained relationships may generate more anxiety (Kerr & Bowen, 1988). Further, Silverman and Nelles (1988) found conflicted family environment as associated to development and exacerbation of anxiety.

**Involvement:** Involvement refers to both degree and quality of family member's interest in one another. It also includes the ability to meet the emotional and security needs of family members, while at the same time supporting family member's autonomy of thought and function. Several self-report studies have used measures of adaptability
and family cohesion. Adaptability is the flexibility (from rigidity to chaos) of the family in response to stress (Olson, Bell, & Portner, 1982). Cohesion is the emotional bonding that family members have toward one another. This variable ranges from enmeshment (an overidentification with the family) to disengagement (characterized by low bonding and high autonomy).

The degree to which family members are involved in each other's lives is an important factor in family functioning. The level can range from over involvement at one end of the scale to a total absence of involvement at the other. Families that show little, if any, interest or investment in each other except for shared instrumental (practical) functions, such as handling money, are an example of an underinvolved family. In this case, family members act more like boarders in a house than like family members (Estein et al., 1993; Peterson, 1999).

The popular concept of Emotional Expression comprises both (a) the level of emotional (over) involvement among family members and (b) the degree to which family members display critical attitudes toward and/or make hostile comments about the family member who has a mental disorder (Vaughn & Leff, 1976a, 1976b). Emotional expressiveness is embedded in a web of positive human relationships within and outside families (Boyum & Parke, 1995; Roberts & Strayer, 1996). A related finding shows that very close family relationships may be a setup for future loneliness (Andersson et al., 1990). Research has also suggested that depressed adolescents and adults report their parents to be "guilt inducing" rather than punishing and to be overprotective, emotionally
distant, and rigid in their child-rearing attitudes and practices (Brook et al., 1983; Susman et al., 1985; Hetherington & Martin, 1986; Gotlib et al., 1988). Thus, the perception that one's parents are unavailable, inflexible, or overprotective appears to be correlated with, and possibly results in the experience of depression.

Family's expressed emotion (Brown et al., 1962) is also a pattern of criticism, over involvement, over protectiveness, excessive attention, and emotional reactivity that create a vulnerability to relapse and poor social adjustment among schizophrenia patients (Hooley & Hiller, 1997; 1998). High levels of expressed emotion (excessive criticism and/or emotional over involvement) within the family have been shown to increase the likelihood of relapse after hospital discharge for patients with depression (Hooley, Orley, & Teasdale, 1986; Vaughn & Leff, 1976), bipolar disorder (Miklowitz, Goldstein, Nuechterlein et al., 1988), and schizophrenia (Brown, Birley, & Wing, 1972; Vaughn & Leff, 1976; Vaughn et al., 1984).

Families having lack of nurturance, lack of reciprocity and negative emotional climate where the psychological needs are not met have the possible outcomes for the child including inability to handle frustration, difficulty in accepting responsibility, social/ emotional immaturity, dependency, and lack of self-control and self-reliance (Barakat & Clark, 1999; Gonzalez-Mena, 1993). Healthy families are able to maintain a consistent level of involvement with one another, yet at the same time, not become too involved in each other's lives. Therefore, the focus is on how much, and in what ways, family members show their interest and investment in each other. Affective (emotional)
involvement is concerned with how much family members are involved with each other, and not with what a family does together. Many of problems are a function of how an individual’s emotional reactivity affects and is affected by the family emotional system. As the family emotional process intensifies, the individual experiences a greater need for emotional closeness (as well as a reaction to emotional closeness) and tends to become more dependent on others’ emotionality (Kerr, 1981).

Both over involvement and under involvement are patterns of behavior that can pose problems for families. Some under involved families share some interests but show very little investment of self in the feelings or life situations of other family members. Often, the members of such families are self-absorbed and invest in other family members only when they can gain something from the involvement (Epstein et al., 1993; Peterson, 1999). Marcus et al. (1987) found that inconsistent parenting, over involvement, and hostility toward the child predicted schizophrenia-spectrum outcomes (Serene Olin & Mednick, 1996).

In over involved families, the members become too involved and sometimes are overprotective of other family members. As a result, the overprotected members remain dependent and fail to grow and develop. Over involvement may create conflict and resentment among family members who try to break out of the dependency role (Epstein et al., 1993; Peterson, 1999). According to a study with children and adolescents and their parents, Hibbs et al. (1991) concluded that family members of patients with Obsessive Compulsive Disorder show high levels of emotional over-involvement.
Symbiotic involvement occurs when the involvement is so intense that the boundaries between two or more family members are blurred. Boundaries are the rules that define a person’s role in the family. Symbiotic involvement is thought to be the least effective type of involvement because family member’s boundaries are not respected. Without boundaries, it is difficult to identify who the parent is and who the child is because their roles are often confused (Epstein et al., 1993; Peterson, 1999). Adult’s poor family functioning and inadequate parental care have been associated with an increased risk of depression (Lapalme, Hodgins, & Laroche, 1997).

According to Colapinto (1991), a dysfunctional family by definition has failed to fulfill its function of nurturing the growth of its members. Families characterized by high levels of conflict, aggression, and hostility are often lacking in acceptance, warmth and support. The healthiest families have type of interaction called empathic involvement, where the members have an emotional investment in one another and care deeply about each other’s activities and feelings. Families, whose members show that they truly care about what others are doing, even though it may not be related to their own interests, are the most effective type of families (Epstein et al., 1993; Peterson, 1999). There is evidence that inadequate emotional nurturance (involvement) is independently associated with poor mental health outcomes (Repetti, Taylor, & Seeman, 2001).

Aversive family experiences during the formative years predispose people to the development of depression later in life. Many people with depression seems to have experienced difficulties in their families when growing up—more so than what would be
expected by chance alone. People who are depressed typically describe their family of origin as rejecting (Lewinsohn & Rosenbaum, 1987) and uncaring (Gotlib, Mount, Cordy & Whiffen, 1988; Rodriguez et al., 1996). Family factors seem common among people with depression (Parker, 1983; Sheeber, Hops, & Davis, 2001). Parker found depressed outpatients to be 3-4 times more likely than matched control subjects to have at least one parent who exhibited low care coupled with high protection, or “affectionless control”. High levels of conflict are also evident in the family backgrounds of many people with depression (Gilman et al., 2003; Meyerson et al., 2002; Sheeber et al., 2001). Very low and very high levels of family cohesion, to the point of enmeshment; also predispose people to develop depression (Jewel & Stark, 2003; Meyerson et al, 2002).

The lack of available social support from family members is also associated with depression (Segrin, 2003). In general, loneliness is negatively associated with perceived social support from the family (Perlman & Rook, 1987; Segrin, 2003) as well as family cohesiveness (Rich & Bonner, 1987). Coyne, Downey, and Boergers (1992) noted that “family systems associated with depression can be characterized by a lack of coherence and agency and a general emotional deregulation…. So that negative interactions are not repaired, disagreements are not resolved, negative affects becomes contagious, and there is little chance for negative affect to be transformed into positive affects”.

A cohesive family structure appears to be a protective factor against depression (Reinherz et al., 1989). In low cohesion families, there is little emotional involvement among members, there is an emphasis on separateness and distance, personal motives
predominate, and family members often do things on their own. In high cohesion families, members feel emotionally close to other members and there is emphasis on togetherness, shared time, and motives.

"A family ought to raise children who become autonomous, and it should provide sufficient emotional support for stabilizing the parents' personalities and continuing their emotional maturation. To the extent a family accomplishes these tasks, it can be considered competent; to the extent it fails at one or both tasks, it can be considered less competent or dysfunctional" (Lewis & Looney, 1983). Results of a series of British studies have suggested that emotional over involvement is a key component of reactions of family members to schizophrenic patients such over involvement was the single best predictor of relapse, even after the level of initial impairment is controlled (Gilhooly et al., 1989; Hooley et al., 1986; 1989; Miklowitz et al., 1988; Priebe et al., 1989; Vaughn & Leff, 1976).

Self Concept and Psychopathology

This section presents a review of the empirical evidence on the consequences of high and low self-concept on mental health. Previous literature shows that the consequences of low self-concept include having feelings of dependency, depression, anxiety and submissiveness (Halvorson, 1997; Luck & Heiss, 1972); having poor general health (Goldberg & Fitzpatrick, 1980; Robson, 1988); feelings of powerlessness, apathy, isolation, unloveability, withdrawal, passivity and compliance (Coopersmith, 1967); having the tendency to downgrade or denigrate others (Adler, 1926), or projection of one's own failings onto others (Bramel, 1963); showing reduced ability to choose jobs
well suited to one's needs and abilities (Korman, 1966); having a lessened association between performance and satisfaction (Korman, 1968); and having a tendency to accept unfavorable assessments as accurate (Swanson & Weary, 1982). Leith (1994) also found that clinical populations in particular (e.g. depressed adults, persons with mental retardation, rehabilitation patients) have problems with self-concept. It was also stated that a realistic positive attitude towards one's self-worth usually leads to higher level of personality adjustment (Syngg & Combs, 1949). On the contrary, an inadequate or unsatisfactory self-concept will place very real limitations upon the individual's behavior and level of adjustment.

Self-concept is one of the most popular ideas in psychological literature. Hazelton (1991) put it, "if you expect to be truly loved by others, you need to start by first learning to love yourself." Fierro (1990) claims that self-concept equals to self-knowledge, where all types of activities and cognitive contents are gathered. The self-judgment process is usually the cornerstone of the whole self-knowledge system. There are at least two kinds of self-judgment processes: descriptive and evaluative. Cardenal and Ferro (2003), who have recently defined self-concept as a group of descriptive and evaluative statements about oneself, believe that self-concept represents the manner in which the subjects portray, know and appraise themselves, pointing out that although the terms self concept and self-esteem are used interchangeably, self esteem is- strictly speaking- the evaluative component within self-concept and self-knowledge. This conception differs significantly from traditional ones in which the self-concept is universally considered to be a kind of organized informational summary of perceived facts about oneself, including such things
as one's traits, values, social roles, interests, physical characteristics, and personal history (Baumeister, 1995; Kihlstrom & Klein, 1994). Reviews of literature have found at least 15 different "self" terms used by various authors (Strein, 1993). Terms such as "self-concept," "self-esteem," "self-worth," "self-acceptance," and so on are also often used interchangeably and inconsistently, when they may relate to different ideas about how people view themselves. The source of self-concept during the development of an individual comes from self-evaluation, peer-evaluation, and defensive egotism (Salmivalli & Kaukiainen, 1999). Most research has been done on low self-esteem, thriving on the notion that negative responses are the result of a low self-concept (Raskin & Rogers, 1995). While Harter (1999) suggests that other concepts, such as self-image and self-perception, are equivalents to self-concept. Self-esteem is the evaluative and affective dimension of the self-concept, and is considered as equivalent to self-regard, self-estimation and self-worth. Campbell (1984) also put it in the same way and defines self esteem as the 'way in which an individual is able to express a positive idea about him/her'. This includes a personal evaluation, based on cognitive comparison, and is considered to be the evaluative component of the self-concept. It refers to a person's global appraisal of his/her positive or negative value, based on the scores a person gives him/her, in different roles and domains of life (Rogers, 1981; Markus & Nurius, 1986). The beliefs and evaluations people hold about themselves determine who they are, what they can do and what they can become (Burns, 1982). These powerful, inner influences provide an internal guiding mechanism, steering and nurturing individuals through life, and governing their behavior. People's concepts and feelings about themselves are generally labeled as their self-concept and self-esteem. These, together with their ability
to deal with life's challenges and to control what happens to them, are widely documented in literature (Bandura, 1977; Bowlby, 1980; Harter, 1999; Rutter, 1992; Seligman, 1975).

Besides the relationship of self concept with self esteem and its various corollaries, self-concept is defined as the sum of an individual's beliefs and knowledge about his/her personal attributes and qualities. It is classed as a cognitive schema that organizes abstract and concrete views about the self, and controls the processing of self-relevant information (Markus, 1977; Kihlstrom & Cantor, 1983). A person's self-concept, by virtue of it being a summary formulation of his or her status, is in the bargain a summary formulation of his or her perceived behavioral possibilities, and of the limits on these (Ossorio, 1978, 1998). Persons whose self-concept is that of "lowly nothing" will often express this interpersonally by behaving in ways that are self-effacing, deferential, nonassertive, and even servile. In contrast, others, whose conception of themselves is that they are "special persons" (Raimy, 1975), will frequently express this with behavior that is arrogant, demanding, presumptuous, condescending, and heedless of the desires and rights of others.

In research of relationship between self and ideal self concepts, it was concluded that health and self esteem are associated with small discrepancies between the self and ideal self concepts, including a study suggesting a relationship between high self-ideal discrepancies and depression (Higgins, Bond, Klein, & Straman, 1986). He further states that favorable aspects of the self may be rejected because they are inconsistent or discrepant with the self-concept. Lecky (1945) contributed the notion that self-
consistency is a primary motivating force in human behavior. Psychological functioning greatly relies on the "consistency or lack of consistency, between an individual's sensory and visceral experiences and the concept of self" (Raskin & Rogers, 1995).

Raimy (1948) introduced measures of self-concept in counseling interviews and argued that psychotherapy is a process of altering the ways that individuals see themselves. By far the most influential and persuasive voice in self-concept theory was that of Rogers (1947) who introduced an entire system of helping built around the importance of the self. In Rogers' view, the self is the central ingredient in human personality and personal adjustment.

Poor psychological adjustment has been shown to relate closely to psychopathology (Berman & Jobes, 1991; Kovacs, 1985) and negative self-concept or self-esteem. A weak or negative self-concept often distorts our perception of how others see us, generates feelings of insecurity, and sometimes fear. Our negative views causes to have difficulty conversing with others. This produces lack of confidence, feelings of unworthiness, inadequacy and inferiority. Even as our self-concept affects our ability to communicate, so our communication with others shapes our self-concept (Napoli, Kilbride & Tebbs, 1988).

Studies show inverse relations of self-concept / self-esteem with different psychopathological symptoms (Bohne et al., 2002; Dowd, 2002; Ellet et al., 2003; Fan & Fu, 2001; Hoffmann et al., 2003; Kim, 2003; Valentine, 2001); and with behavioral problems such as problems at school (Aunola et al., 2000; Garcia-Bacete & Musitu, 1993; Gonzalez et al., 1994) or shyness / timidity behaviors (Lawrence & Bennett, 1992; Neto,
The global view, sometimes conceptualized as "self-esteem" or "general self-concept," is the older and probably the more common view among counselors and therapists (Strein, 1993). Maslow (1942) and Raimy's (1949) clinical studies helped spawn a series of clinical studies on the relationship between self-concept and issues such as schizophrenia (Rogers, 1958), Rorschach characteristics (Bills, 1953), marital happiness (Eastman, 1958), the attitudes of psychiatric patients (Tolor, 1957; Wahler, 1958; Zuckerman, Baer, & Monashkin, 1956), and psychopathology (Zuckerman & Monashkin, 1957). Franken (1994) also suggests that self-concept is related to self-esteem; "people who have good self-esteem have a clearly differentiated self-concept. When people know themselves they can maximize outcomes because they know what they can and cannot do".

Research completed with adults verifies the relationship between self-evaluation and both social anxiety and depression. The relationship between depressive symptomatology and self-concept has been extensively examined (Higgins, 1987; Higgins, 1999). Various studies report negative correlations between self-concept / self-esteem and depression (Alfeld & Sigelman, 1998; Fan & Fu, 2001; Hoffmann, Baldwin & Carbone, 2003; Kim, 2003; Valentine, 2001). Depression has been linked to low self-concept, as a negative feeling toward the self is a characteristic of the deficiency (Kernis & Whistenhunt, 1998), caused by the inability to compensate for self imbalance, which expressed in terms of psychopathology (Comer, 1995). Depressed persons are found to be prone to excessive self-blame, self-criticism, and self-deprecation (Engel & DeRubeis, 1993; Haaga et al., 1991; Segal, 1988). A prospective study suggested that low self-
esteem may play a causal role in major depressive disorder (Maciejewski, 2000). Dobson and Drew (1999) conducted a research on the negative self-concept in clinical depression. Analysis shows that participants actively resisted taking blame for their depression and constructed themselves as worthy person. Cognitive theory and research holds that most depressed people are characterized by negative schemas which give rise to negative views primarily about the self (Haaga et al., 1991). They understand depression as a negative state or self-devaluing process occurring within the self, but one which has been brought about by "real" events rather than by a distorted sense of reality. Some theorists (McAdam, 1986; Ryan, Short, & Weed, 1986) demonstrate that negative self-talk leads to irrational thinking regarding oneself and the world. Cognitive theories are seen by some as in need of refinement because they fail to reflect observations that the lives of depressed persons do in fact contain more "negative realities" than is the case for nondepressed persons (Krantz, 1985).

Blatt et al. (1976) argue that depression vulnerability is associated with greater self-criticism, the need for autonomy or dependence on others (‘sociotrophy’), all highly stable factors accessing feelings of social inferiority and poor sense of agency. Zuroff et al. (1999) have embedded these characteristics within the socio-evolutionary framework, arguing that depression-prone individuals suffer from insecurities regarding attachment and social acceptance. In addition, the developmental nature of self-representations is argued to be a significant factor in the recovery of individuals with severe mental illness (Davidson & Strauss, 1992). They suggest that reconstruction of the self can only occur following acceptance of the disorder, allowing individuals to focus on
their sense of self and ‘move forward’ in life. Nevertheless, individuals then fall short of their preferred or aspired-to self, resulting in a sense of entrapment and loss (Birchwood & Iqbal, 1998).

Various forms of adult psychopathology, from schizophrenia to the neuroses (e.g., hysteria), involve fundamental impairments in representational structures or cognitive-affective schema. Concepts from psychoanalysis, cognitive developmental psychology, and attachment theory and research enable us to specify particular nodal points in the development of representational structures, and to consider how disruptions of this developmental process are involved in various forms of psychopathology in adults (Blatt, 1991).

The studies that have evaluated the links between the self-concept and psychopathological symptoms and behavioral problems also show inverse relations between both variables. A study conducted by Varni et al. (1996) showed that those subjects with the highest perception of pain intensity developed more anxious-depressive symptoms, had lower self-esteem and a higher number of behavioral problems. In addition, the study conducted by Garrick, Ostrov and Offer (1988) suggests that subjects with normal self-concept were significantly free from any physical symptoms, and Dowd (2002) establishes an inverse relationship between self-concept and somatic symptoms in adolescents.
Body image or body esteem correlated negatively with obsessive-compulsive symptoms in the study carried out by Bohne et al. (2002). Physical self concept has also correlated negatively with depression (Bohne et al., 2002; Erkolahti et al., 2003). Anxiety has been regarded as a predictive factor of low self-concept (Dowd, 2002) and Bohne et al., (2002) found an inverse correlation between body esteem and anxiety. Ellett, Lopes and Chadwick (2003); and Martin and Penn (2001) associated paranoid ideation with low self esteem. Negative correlations of self-concept were found with neuroticism (Torres, 1983) and with psychoticism (Fan & Fu, 2001; Fierro & Cardenal, 1996; Heaven, 1991). The results obtained from the studies show inverse correlations between antisocial behavior and positive self-concept / self-esteem. Regarding aggressive behavior, Marsh et al. (2001) study the characteristics of aggressive individuals (who are seen as troublemakers, who get into fights, and who are usually getting punished for getting into trouble) proving that they have low self concept. The development of psychopathology is the result of not being able to adapt to daily events (Halonen & Santrock, 1997). In the case of self, may be the misinterpretation of global threats assists in the maladaptive perceptions (Raskin & Rogers, 1995). When misinterpretation of a situation comes about, there are changes dependent on an individual's personality that may lead to mental instability and malfunction in daily activity (Bosson & Swann, 1999).

Furthermore, a low level of anxiety / shyness and withdrawal behaviors prove to be predictive variables of global self-concept (Garaigordobil et al., 2003), while on the same study, many anxiety / shyness and withdrawal behaviors predict a high negative self-concept. In addition, significant relationships have been found between high self-
concept and a higher tendency to defend the assaulted victim (Salmivalli, 1998), and to show an attitude of social respect (Yelsman & Yelsman, 1998).

**Family Functioning and Self Concept**

Demoulin (1999) defined self-concept as:

"the sum total of all experiences we are exposed to over time and the negative or positive weights we assign to those experiences — it is, in a small sense, a personal composite of ourselves...and ...consists of two major sub-components: self-efficacy which is our sensitivity toward some task and based on motivation, confidence, and ability to control stress associated with that task; and self-esteem which is a perception of self; and the weight that is placed on the perception of significant others".

System theorists predict that individuals who belong to poorly functioning support system, that are experiencing unresolved conflict, are at a high risk of emotional disturbance (Bowen, 1978; Hoffman, 1981; Minuchin, 1974). Previous studies have repeatedly suggested that families play a vital role in the development of self-concept (Bynum & Durm, 1996; Shek, 1998). The self does not exist within the individual but in the space between and among people, in conversational exchange (e.g., Cushman, 1990, 1995; Gergen, 1991, 1994, 1999, 2001; Gergen & Gergen, 1988; Harre, 1984; Sampson, 1977, 1985, 1989, 1993; Shotter, 1993). The presence of effective communication patterns is one of the most frequently mentioned characteristics of strong families (Swihart, 1988). Researchers characterize the communication patterns of strong families
as clear, open, and frequent. Family members talk to each other often, and when they do, they are honest and open with each other (Stinnett & DeFrain, 1985; Lewis, 1979; Epstein et al., 1983; Olson, 1986). Grotevant finds that individuals from families characterized by open and clear communication score higher on measures of self-esteem (Grotevant, 1983).

A person acting in a situation attends to both the reactions of others and to his or her own behaviors (Darley & Fazio, 1980). Both self-perceptions and others' reactions thus constitute feedback to the self-system. This feedback may be either congruent or incongruent with current or with desired self-images. The congruence, affective valence, and personal importance of this feedback, and the goals and interrelationship of the actors (Swann, 1984) determine the person's cognitive, affective, and behavioral reactions. People may bias their chances of receiving congruent feedback by the way they seek information in an interaction. The literature on hypothesis testing in social interactions suggests that people may be biased to seek, and hence to receive, confirmatory feedback (Darley & Gross, 1983; Fiske & Taylor, 1984; Nisbett & Ross, 1980; Semin & Strack, 1980; Shrauger & Schoeneman, 1979; Snyder & Gangestad, 1981; Snyder & Swann, 1978 a, b; Swann, 1984; Trope & Bassok, 1982; Trope et al., 1984). Feedback that is congruent with one's self-conceptions is self-affirming and can have positive affective consequences (Schlenker, 1985; Swann, 1985). When a person receives feedback that is incongruent with self-conceptions, he or she may (a) cognitively reconcile the discrepancy (b) act against it, (c) act in accordance with it. If the person acts in accordance with incongruent feedback, this may or may not lead to the person's
accepting the new identity (Snyder & Swann, 1978b, Fazio et al., 1981; Swann, 1984). The discrepancy of information with the preexisting self structure often leads to rejection of this information. Individuals are resistant to the incongruent knowledge about self (Markus, 1977; Swann & Hill, 1982; Tesser & Campbell, 1983). Individuals are likely to make situational attributions for any behavior they enact that is inconsistent with their self-view (Kulik et al., 1986). Thus an individual receiving negative feedbacks from environment or family no longer stand maintaining a positive self concept. Either he/ she may project the blame of his/ her behavior on to others or may experience guilt related to the acts. The discrepancy in environmental feedback and the existing self view might lead to depression, suspiciousness and else.

Identity theory offers an alternative approach to the classical hierarchical multidimensional conceptualization of self-concept. Self-concept using this approach is believed to develop from the interaction between the individual and the social structure (Howard, 1991). In 1921 Tsihs highlighted the roles that are socioculturally appropriate as perceived by the individual and are valued, are likely to be more salient in the individual’s identity hierarchy than less normative, nonprestigious, or incompetently enacted roles. The more salient the role-identity the more meaning, purpose, and behavioral guidance the individual should derive from its enactment and therefore, the more that identity should influence psychological well-being. Therefore, a role identity is interactive and is based not only on how the individual defines herself or himself but also how others perceive and relate to the individual in that role. Identity theory would predict those discrepancies between the wanted or ideal self and the perceived self could lead to
a reduction in self-concept (Thoits, 1991). Lopez and colleagues (2004) have begun to identify prosocial family processes, such as the expression of warmth and positive remarks that support clients on their road to recovery. However, research on adults with schizophrenia has been limited to studying the relationship of these prosocial behaviors to relapse (Bertrand et al., 1992; Ivanovic, Vuletic, & Bebbington, 1994; Weisman et al., 1993). Individuals are likely to experience interactions characterized by feelings of warmth, closeness, and positive regard as expressions of support, and social support has been strongly associated with improved quality of life for persons with serious mental illness (Baker, Jodrey, & Intagliata, 1992; Caron et al., 1998). In general, parents are an important source of emotional support throughout their child's adult life, and maintaining a close and supportive relationship with one's parents is associated with better psychological well-being in adulthood (Bengtson, Biblarz, & Roberts, 2002). In addition, an individual's self-concept is deeply influenced by the attitudes of significant others with whom he or she most intensively interacts (Rosenberg, 1979). A poor self-concept leads to difficulty in accepting responsibility, fear, apathy, anxiety, defensiveness, and lack of success (Harrelson, 1996).

Litovsky and Dusek (1985) found that high self-esteem adolescents perceived their parents as more accepting, as using less psychological control, and as not being overly firm in making and enforcing rules and regulating the adolescents' behavior, supporting the contention that optimal self-concept development takes place in an atmosphere of acceptance that allows the adolescent autonomy and the opportunity to
learn competencies. Lack of positive experiences and respect from others may also explain lower self-concepts (Fitts, 1972; Trope & Pomerantz, 1998).

Spurlock (1986) discussed that studies conducted after the height of the civil rights movement found that the development of self-concept in Afro-American children is influenced by the strengths and weaknesses of the family, extended family, or community; individual perceptions of untoward events or environments; and the ability to devise mechanisms to ward off threats to self-esteem. There are many possible reasons why negative view of self may interfere with healthy development and one’s ability to cope with stress. Crittenden (1997) proposed that children growing up in an abusive environment develop a style of interacting with others and their environment that leads them to be at greater risk for maladaptive functioning. He argues that in adulthood this style of interacting is based on the individuals’ use of affect to guide their behaviors, rather than cognition. This is likely to be particularly true of those who have an attachment style characterized by a negative view of self. These individuals are prone to feel the “rawness” of their emotions, are less likely to use cognition in evaluating their experiences, and are thought to have difficulty with their affective response. This will affect their ability to reason through difficult experiences in a positive fashion; they often tend to view themselves as being unable to cope with adversity (Crittenden, 1997).

The family circumstances of maltreated children impair the development of emotional self-regulation, empathy and sympathy, self-concept, and social skills. Over time, these youngsters show serious adjustment problems, including severe depression
and difficulties with peers (Cicchetti & Toth, 1998). The family, where parents provide a balance between control and independence is likely to produce a child who is competent, socially responsible, self-assured, and independent (Gonzalez-Mena, 1993). It is in this positive emotional climate that the child can develop high self-esteem and a positive self-concept (Banham, Hanson, Higgins, & Jarrett, 2000). In a large study of Baltimore school children, Rosenberg (1973) found that the credibility and the value of the significant other’s evaluations significantly affected the child’s self-concept. Adult’s trust in child’s potentials, acceptable status in the family, adequate support and help in the periods of crises, and social and economical status of the family create realistic and positive oriented self-concept. A poor self-concept is influenced by lack of love and security. This is manifested as being unhappy and miserable, having poor self-esteem, communication problems (Urbanc, 1999, 2000). Openshaw, Thomas and Rollins (1984) and Ryan (1993) pointed out that “Open and supportive communication styles foster rich affective relationships between parents and children, which contribute to higher and more positive views of the self”.

Herd (1994) reports family to be the most important support system because it provides emotional support, which is crucial in promoting self esteem and reducing depression, anxiety sickness and mortality. Strong family support seems to encourage self-reliance and reliance on others. The process of developing self-image and ideal self begins in the family and continues as the child attends school (Campbell et al., 2002). Siberfeld (1978) emphasized factors like intimacy, social integration through shared concern, reassurance of worth, the opportunity to be nurtured by others, easiness of
reliable alliance and guidance to be probably protective factors in these relationships. Cauce et al. (1992) found family support to have the most consistent and strongest relationship with adjustment, correlating significantly with general peer and physical competence. Cramer (1990, 1994) reported a unilateral relationship between self-esteem and the facilitativeness of the closest current relationship in which facilitativeness led to self-esteem over 3 months period in a small undergraduate sample. Sing and Lai-Kuen (2000) also conducted a study aimed at examining the relationships among family environment, depression and self-concept of adolescents in Hong Kong. Results showed that a cohesive, orderly, and achieving family environment is conducive to more positive development in adolescents, in terms of lower depression and higher self-concept.
CHAPTER III

PROBLEM

The results brought together in a series of important cross-national articles show that mental disorders are highly prevalent (Weissman et al., 1994; 1997). Indeed, prevalence of mental disorder was generally higher than that of any other class of chronic conditions (Kessler, 2001; Murray & Lopez, 1996). Even in Pakistan, considerable occurrence of mental disorders have been found, as the fact file based on available research data, as compiled from various studies (Gadit & Khalid, 2002), gives the prevalence figures in Pakistan as: 6% for depression, 1.5% for schizophrenia, and for anxiety it is 6%. It is also well illustrated that mental disorders have greater effects on role functioning than many serious chronic physical illnesses (Kessler, 2001; Ormel et al., 1994; Wells et al., 1989). The necessity is to monitor youth who express anxiety, depressive inclination or psychotic symptoms. The early identification of such tendencies and their treatment is important as the commonly occurring psychopathology in adulthood has the potential of resulting in chronic and impaired functioning later in old life.

The objective of present study is three fold; Firstly to examine the differences between adults with and without psychopathology (patients & normal) on various variables of family functioning; as evidences indicate that emotional qualities of the family environment have significant role in various psychiatric disorders; even for those disorders for which genetic and other biological variables provide powerful etiological
explanations. The Family attributes have been conceptualized as generalized stressors that in conjunction with other biological and social factors overwhelm a biologically vulnerable family member and contribute to his or her disorder (Nuechterlein & Dawson, 1984; Zubin & Spring, 1977). Family factors have been implicated in the development of almost all major psychiatric illnesses. Tienari et al. (2004) have clarified that although biology accounts for much of the vulnerability to major mental illness, family factors are critical to its expression. Although the relationship of family with the mental health is well illustrated, however, family functioning is a vast area encompassing various family practices.

Perceived communication deviance, level of control and involvement are few of important factors of family functioning, which are associated with anxiety, depression and psychosis in adult. Literature reflects the significance of these variables as in the families of schizophrenics (Singer, Wynne & Toohey, 1978), communication is found to be more deviant than in the families of borderlines, neurotics, and normal, while Miller et al. (1986) found poorer communication in the families of depressive patient as compared to other clinical and normal groups. Similarly psychopathology is found to be associated with high control (Silk, Morris, Kanaya, & Steinberg, 2003), and Involvement (Serene Olin & Mednick, 1996). Therefore, assessing and studying these variables may help clinicians understand patients’ psychopathology. These considerations may be particularly important for patients with early psychopathology and help designing measures regarding prevention of mental disorders in Pakistan. As Spiegel and Wissler (1986) on the basis of researches conducted in their culture explained that counseling
programs helping family members of people with chronic schizophrenia learn to express their feelings without attacking or criticizing the person with schizophrenia may prevent family conflicts that can damage the person's adjustment. The current study will provide valuable information to professionals regarding treatment of mental disorders in our own cultural context. Results of present study will help in understanding the role that communication, control and involvement as important aspects of family functioning may have, in the development of psychopathology. Present study not only caters the difference of adults with psychopathology to the normal population on aforementioned variables of family functioning but also deals with various taxonomies of psychopathology. It deals adults with psychotic disorders, depressive disorders and anxiety disorders as separate categories and thus differentiates each of them with the normal adults. The study thus provides the information whether the individuals with these disorders may perceive their family as dysfunctional in any of the three aspects of family functioning. It addresses the family factors associated with various disorders. These findings will provide additional empirical support for the common practices among clinicians regarding treatment and assessment; and family members, typically a spouse, siblings or parents in preventing and handling of psychopathology in adults.

Second objective of research is to investigate the differences between adults with and without psychopathology in the level of self concept in order to determine its role in psychopathology; as research evidence reflect that low levels of self-concept is not only a central cause of various psychological problems, but is also an important contributing factor to a multitude of social problems. Muller and Lemieux, (2000) and Muller et al.,
(2000) found that negative view of self has a greater association with psychopathology than negative view of other. Individuals who have a negative view of self are more apt to blame themselves for negative events in their lives (Janoff-Bulman, 1992; Muller et al., 2000). Self Concept/ self esteem has been found to be related to the depression (Higgins, 1999), psychosis (Krabbendam et al., 2002), and mental health (Fan & Fu, 2001). Suman and Nagalakshmi (1987) found that normal differ significantly from the clinical groups in their self-concept, while comparing them with anxiety neurotics and alcoholics. The above remarks give credence to the idea that self-concept is an intrinsic and universal part of human experience.

A major problem in the area of self-concept research is the lack of a clear consensus definition. The term self-concept is defined in various ways by different researchers. As Crain and Bracken (1994) state that within the research literature on self-concept there is no universally accepted definition of the term and it is frequently used interchangeably with other terms such as self-regard, self-worth and self-esteem. Self-concept is also used in terms of "self-estimation, self-identity, self-image, self-perception, self-consciousness, self esteem, self-imagery, and self awareness" (Burns, 1982). The multidimensional nature of the self-concept has been demonstrated by a number of researchers (Byrne, 1984; Flaherty & Duseck, 1980; Marsh, Parker, & Smith, 1983; Norem-Hebeisen, 1976; Rosenberg, 1965, 1979; Shavelson, Hubner, & Stanton, 1976). Therefore, in this study through use of Six Factor Self Concept Scale an effort was made to cover overall multidimensional aspects of self-concept, which spans all possible areas of self concept.
Third objective of study is to investigate the contribution of transactional patterns of family in the formation of self-concept, in sample of adults with psychopathology. According to Weigel-Garrey et al. (1998) a home provides an arena in which self-knowledge, knowledge of others and knowledge of the environment begin. A number of researches address the importance of family climate and its relationship with self concept (Banham, Hanson, Higgins & Jarrett, 2000; Cicchetti & Toth, 1998; Openshaw, Thomas, & Rollins, 1984; Ryan, 1993). The family thus determines how an individual might view him/her self.

On the whole the present study has few potential concerns, which needs to be addressed. Major obstacle in formulating effective health data is the lack of robust epidemiological research in Pakistan. Our review highlights the absence of survey evidence and data from wider regions of Pakistan with regard to anxiety, depression and psychosis and the lack of outcome studies and prevention and treatment trials. It is the time now for Pakistan to build on this research effort by increasing investment in research capacity. It would also be helpful to have a national epidemiological survey and research of mental disorders. Such studies are useful to assess needs of the population, document the use of existing services, obtain valid information on prevalence and associated risk factors, and monitor the health of the population and trends.

It explores the importance and degree of impairment in two major aspects (family functioning and self concept) in unmarried adults with and without psychopathology; it has contributed only a small snapshot in Pakistan of what such an approach might
eventually provide. In addition, how psychopathology is developed, regarded, and/or tolerated within our culture might be studied by analyzing the conversation of people who have personally in acquaintance of psychiatric patients, who have worked with anxious, depressed and psychotic people in a professional capacity, or who have little familiarity with this population.

The current research endeavors to overcome the problem, which many of mental health professionals are facing in Pakistan regarding the treatment and assessment of psychologically disturbed adults and very high relapse rates. The role of family is highlighted as the major influencing factor in one’s life. Family counseling and family involvement especially during follow up or after termination of treatment is very important. Not only the importance of psychopathology in family is addressed but self concept the major associated factor of psychopathology is also emphasized. It will suggest clear markers apparent in adulthood, giving help to mental health professional. The achievement of the third objective of study facilitate the exploration of relationship between family functioning and self-concept enabling the practitioners to adapt the precautionary as well as remedial measures in order to enhance self image of an individual. The identification of factors involved and understanding of their relationships will provide an opportunity to break the cycle of psychopathology.
CHAPTER IV

HYPOTHESES

After detailed literature review and keeping in the view Pakistani culture, the following hypotheses were framed. It may be noted that higher scores on given variables of family functioning (communication, control & involvement) are indicative of greater dysfunction in family. However, high scores on the variable of self-concept are indicative of positive self-concept.

1. Adults with psychopathology would score high on the variable of communication in family, as compared to their normal counterparts.

2. Adults with psychopathology would score high on the variable of control in family, as compared to their normal counterparts.

3. Adults with psychopathology would score high on the variable of involvement in family, as compared to their normal counterparts.

4. Adults with psychopathology would score low on the variable of self-concept as compared to their normal counterparts.

5. Family functioning (communication, control & involvement) would be a predictor of self-concept in adults with psychopathology.
CHAPTER V

METHOD

The purpose of this study is to explore what role family functioning and self concept plays in the development of psychopathology. Furthermore it examines the relationship between an individual’s family functioning and self concept. This study will be conducted using the following steps: a) Selection of subjects (sample), b) selection of test instruments, c) data collection procedures, and d) statistical analysis of data.

Sample

Present study was conducted in psychiatric departments of various hospitals / clinics and Institutes / Organizations of Karachi, Pakistan.

The sample consisted of 180 unmarried adult volunteers. The entire sample was divided into two groups (90 diagnosed adult patients with psychopathology & 90 normal adults). The first sample included diagnosed patients falling in the three major classification of Mental Disorders according to the criteria of DSM-IV TR (APA, 2000) that is, 30 adult patients with the diagnosis of Psychotic Disorder (Schizophrenia); 30 adult patients with the diagnosis of Depressive Disorder (Dysthymia and Major Depression) and 30 adult patients with the diagnosis of Anxiety Disorders (Specific and Social Phobia, Obsessive compulsive Disorder, and Generalized Anxiety Disorder).
These individuals were diagnosed as having respective disorders by their psychiatrist and clinical psychologists according to the criteria of DSM-IV Text Revision (APA, 2000). Only those patients were included in the sample, which have been under psychiatric / psychological treatment for less than a year. Cases with comorbidity including Personality disorders / Mental Retardation and General medical condition (Axis II & Axis III) were excluded.

The second sample (normal adults) was drawn from different institutes and organizations of Karachi. These individuals had no history of psychological problem and had never sought any kind of psychiatric/ psychological treatment (psychotropic medication / psychotherapy). This was further confirmed through a detailed interview based on a semi structured interview form for psychological assessment designed by the Institute of Clinical Psychology, University of Karachi. The sample selected also had no history of physical illnesses, for e.g., Cancer, Diabetes etc. which were screened out while completing above mentioned interview form.

The ages of participants in both samples ranged from 20 years to 35 years with the mean age of 25.25 years (patients 25.22 years and normal adults 25.28 years). The entire sample belonged to middle socioeconomic class. Socioeconomic status of the participants was determined on the basis of household income and expenditure survey conducted by the Federal Bureau of Statistics (FBS, Government of Pakistan, 2001, cited in Ansari, 2003 & Siddiqui, 2003). This caution has been taken in order to control the possible effects of socioeconomic status on the results. The minimum education level was
intermediate, in order to ascertain better understanding of measures used in the present research. In order to control the effects of gender equal number of males and females were taken in both the groups of sample. Entire sample selected, was unmarried, living with their families of origin (mother, father and siblings). Family structure could not be controlled, however efforts were made to match the age, family structure and level of education in both groups.

Procedure

The objective of the entire study, procedures followed and material used were reviewed and approved by the Board of Advanced Studies and Research, University of Karachi. All recommendations of the Board were followed in the procedures of the study.

A letter of consent describing the research project and inviting participation was provided to the authorities of randomly selected Psychiatric departments of hospitals and clinics along with the questionnaires and assessment measures. After getting permission from authorities of these departments and clinics, the patients were approached through staff i.e., psychiatric nurses and was provided with a separate room. Before the administration of psychological tests, the researcher established rapport with the participants individually, and the purpose of the study was explained briefly to all the subjects. The subjects (patients) were informed that if they are willing to participate they have to sign the consent form (Appendix A) and complete all the assessment procedures. Confidentiality regarding information and results was assured. Once the rapport was
developed with the subject they were interviewed and the examiner filled in the semi-structured interview form for psychological assessment (Appendix B) designed by the Institute of Clinical Psychology, University of Karachi to further confirm the diagnosis and clinical / personal information. It consisted of items focusing on an individual’s demographic information, presenting problems, psychological symptoms, history of problem, medical, family, school, social/ friendship, sexual history, psychopathology in family and questions regarding mental status examination. The socioeconomic status was also determined and participants were screened out as only participants with middle socioeconomic status were included in the sample. Five major components composed the socio-economic status variables (father’s level of education, mother’s level of education, father’s occupation, mother’s occupation, residential area, number of siblings and family income). Ansari (2003), and Siddiqui (2003), reported socioeconomic status into three levels as Low, Middle and High on the basis of Household income and expenditure survey conducted by the Federal Bureau of Statistics (FBS), Government of Pakistan (2001). Low Socioeconomic Status has (Household having a monthly income of Rs. 14000 and below), Middle Socioeconomic Status (Household having a monthly income of Rs. 14000 to 30000) and High Socioeconomic Status (Household having a monthly income of Rs. 30000 and above). Only individuals fulfilling the criteria (as required in the design) were included in the sample and were continued for other assessment measures.

This study measures three distinct family interaction dimensions, communication, control and involvement. Another psychological variable that measured was self-concept.
General subscale of Family Assessment Measure-III (Skinner, Steinhauer & Santa-Barbara, 1984) (Appendix C) containing 50 questions about family functioning (only three selected subscales were used, as required in the present study). Participants rated each question using 4-point rating scale ranges from 1 to 4 (strongly agree, agree, disagree and strongly disagree). After a break of 10 minutes, participants completed the Six-factor self-concept scale (Stake, 1994) (Appendix D). Participants rate each of 36 questions using 7 point rating scale (never and almost never, true, usually not true, sometimes but infrequently true, occasionally true and always or almost always true) of 1 to 7. In the end participation of the subjects was acknowledged and highly appreciated.

The second sample of the study i.e., the normal sample was drawn from various institutions and organizations, situated in urban areas of Karachi. Same procedure, which was applied to the sample with psychopathology, was followed with these normal participants. The scales were administered individually by the same examiner in order to minimize any chance of procedural error in results. To further control the procedures used for two samples, an effort was made to assess the whole sample either clinical or control, in similar settings. The sitting arrangements, length of breaks and other environmental variables were made identical, throughout the study.

**Scoring and Evaluation**

After collection of data the answer sheets were scored. A number of forms were discarded due to various reasons e.g. failure to complete forms, as well as giving multiple
responses on various questions etc. In the case of sample with psychopathology Interview Form for Psychological Assessment was evaluated and diagnoses were reconfirmed according to the information presented in the case history (according to criteria of DSM IV-TR). The Family Assessment Measure-III and Six Factor Self-concept Scale were scored according to the instructions given in the manual. It should be noted that scores of Family Assessment Measure-III are in pathological direction such that high values are indicative of greater dysfunction in family. On the other hand, high scores on Six Factor Self-concept Scale are indicative of positive self-concept.

Statistical analysis

The statistical package for social sciences, SPSS version (12.0) was used to analyze the data. Statistical methods used for analysis of data in the present study were Analysis of Variance (ANOVA), Binary Logistic Regression, Multiple Linear Regression, Stepwise Regression Analysis, Pearson Product Moment Coefficient of Correlation, Partial Correlation and t-test.

One Way Analysis of Variance (ANOVA) was used to examine the mean differences on the measures of family functioning (Communication, Control, and Involvement) and self-concept between four groups i.e., three subgroups of adults having psychopathology (falling in the three major Axis I classification of Psychiatric Disorders of DSM-IV-TR, i.e., Psychotic, Depressive and Anxiety Disorders) and a group of normal subjects. The purpose of the present study was to compare the individuals with
psychopathology to the normal individuals; however, three groups of psychopathology were individually compared with the normal subjects in the analyses for better understanding. Post-Hoc HSD for multiple comparisons was applied to determine the significant mean differences on the variables of family functioning (Communication, Control, and Involvement) and self-concept between normal subjects and three subgroups of adults with psychopathology. The Levene test was used to examine the homogeneity of variances, a main assumption in ANOVA. It may be noted that the comparison between groups with psychopathology was not presented as it was not the purpose of the present study.

Further Binary Logistic Regression model was applied to determine the predictive relationship of the variables of family functioning (Communication, Control and Involvement) with the presence of psychopathology by considering the psychopathology as a dichotomous variable i.e., subjects with and without psychopathology. Similarly predictive relationship of the variable of self-concept with presence of psychopathology was also observed. However, Binary Logistic Regression for this purpose was done as an alternate statistical method to analyze the data in a different way.

Moreover, Multiple linear Regression analysis was conducted to find the causal relationship of the variables of family functioning (Communication, Control, and Involvement) with self-concept in sample with psychopathology. Additionally the stepwise regression analysis was also administered to assess the predicting relationship of
the Family functioning (communication, control and involvement) with self concept in sample with psychopathology.

Additionally Inter correlations were computed among the variables of family functioning (Communication, Control and Involvement), total self concept and subscales of Self-concept using Pearson Product Moment Coefficient of Correlation. Partial Correlations were computed to observe the relationship among above-mentioned variables after controlling the effect of age, duration of treatment, family structure and gender. t-test was conducted between groups with and without psychopathology to observe the differences on various subscales of self concept measure. An additional regression analysis was conducted to assess the predicting relationship of family functioning variables with self concept in entire sample. Analysis of Variance was conducted to assess the differences on family functioning variables among various groups of Psychopathology.

DESCRIPTION OF MEASURES

Interview Form for Psychological Assessment

This interview form is designed by Institute of Clinical Psychology, University of Karachi, which is based on the criteria of Diagnostic and Statistical Manual for mental disorders as well as other details necessary to screen out the diagnosis. It consisted of demographic information which focused on the subject's (age, sex, marital status, education, occupation, number of siblings, family structure, birth order, parent's
education and occupation, earning member's, languages etc.), presenting problems, history of problem, psychopathology in family, medical, family, school, social / friendship, sexual history and questions regarding mental status examination, symptoms of psychological disorders/personality disorder. It is a qualitative measure which usually takes 20-30 minutes to administer.

**Family Assessment Measure - Version III**

For the present study, family functioning is indicated by family members' scores on the Family Assessment Measure - Version III (FAM III; Skinner, Steinhauer, & Santa- Barbara, 1995), a measure of individual family members' perceptions of their family. Participants were asked to read the statements, and decide how well the statement applies to their family. They were asked to circle one of the provided answers. FAM III standard administration required the examiner to tell the respondents that there are no right and wrong responses; it is their opinion that matters. The FAM III is based on the Family Process Model of Family Functioning (Steinhauer, 1984) and is used to assess family problems/strengths in seven specific areas: task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms. Two additional subscales, denial and social desirability, are included in the measure as indicators of response styles that may make overall response validity questionable. The FAM consists of three components: (1) a General Scale, which focuses on the family as a system; (2) a Dyadic Relationships Scale, which examines relationships between
specific pairs; and (3) a **Self-Rating Scale**, which taps the individual's perception of his or her functioning in the family.

The FAM III is designed for use with family members above ten years old and takes approximately 30-40 minutes to complete. In completing the measure, respondents respond to a series of 50 statements by selecting one of four possible options: strongly agree, agree, disagree, and strongly disagree. Scores for the individual subscales can be used as interval data, or can be collapsed into previously determined categories and used as nominal data.

The FAM III is backed by a large body of research and has well-established psychometric properties (Skinner, Steinhauer, & Sitarenios, 2000). It has been used to study the relationship of family functioning to a number of child and family difficulties, including school phobia (Bernstein & Garfinkel, 1988; Bernstein, Svingen, & Garfinkel, 1990), emotional disturbance (Blackman, Pitcher, & Rauch, 1986), coping with disease (Cowen et al., 1985; Cowen et al., 1986), eating disorders (Garfinkel et al., 1983; Garner, Garfinkel & O'Shaughnessy, 1985; Garner et al., 1987), affective disorders (Laroche et al., 1984; Stark et al., 1990), and academic achievement (Gelcer, 1989; 1990; Gelcer & Dick, 1986).

As reported by Skinner, Steinhauer, and Sitarenios (2000), the FAM III has more than twenty years of research supporting it as a reliable and valid measure of family functioning. The measure was originally normed on 247 normal adults and 65 normal
adolescents, who participated as control subjects at various settings. The general scale, used in the present study, has obtained overall alpha coefficients of 0.94 for children and 0.93 for adults, indicating an excellent level of internal consistency.

Various studies have also helped to establish the FAM III as having discriminant and construct validity. The measure's ability to discriminate between groups, in terms of their family functioning, was demonstrated by Jacob (1991), who found significant differences between families with alcoholic, depressed and normal (non-clinical) fathers. Skinner, Steinhauer, & Santa-Barbara, (1983) and Forman (1988) obtained similar findings on the FAM III's discrimination ability. In establishing the measures construct validity, Bloomquist and Harris (1984) compared it to the MMPI; Bloom (1985) compared it with family idealization, cohesion, and expressiveness measures of the FACES; and Jacob (1995) compared it with the FES, FACES, and FAD. Other studies (Shekter-Wolfson & Woodside, 1990; Trute, Campbell, & Hussey, 1988; Woodside et al., 1995a, 1995b; Woodside et al., 1996; Johannson & Tutty, 1998) helped to establish the FAM III's clinical validity.

Six Factor Self-Concept Scale

The Six-Factor Self-Concept Scale is a 36-item self-rating scale developed by Jayne E. Stake (1994) designed to assess how adults feel about themselves. Participants asked to respond 36 statements that are worded both positively and negatively. Items were presented in mixed order with a 7-point rating scale. Participants were asked to read
each statement and circle one option based on their determination. It was also instructed
to describe the extent to which each items was true of them. This inventory utilizes a
seven alternative, forced choice format. Anchor point for the scale were never or almost
never true of me (1), usually not true of me (2), sometimes but infrequently true of me
(3), occasionally true of me (4), often true of me (5), usually true of me (6), and always or
almost always true of me (7). Items are scored in a positive or negative direction to
provide an overall assessment of self-concept. A high score is suggestive of positive self-
concept while a low score suggests a negative self-concept. The positive direction for
high scores on self-concept spans for overall scores and for all subscales except one that
is the Vulnerability. The high scores on vulnerability reflect negative self concept. The
scale is designed to be used with children, adolescents and adults.

The Six-Factor Self-Concept Scale is a multidimensional measure of adult self-
concept designed to have broad applicability across life settings, roles, and activities.
Developed through a series of exploratory factor analytic studies, the measure consists of
six subscales: Likeability, Morality, and four aspects of agentic functioning: Task
Accomplishment-the ability to complete tasks efficiently and capably; Giftedness-natural
aptitude and talent; Power-the ability to influence other effectively; and Vulnerability-
self-criticalness and inability to perform under pressure.

The congruence coefficients based on the rotated factor loadings for the adults
and students EFAs ranged from .90 to .96 (median = .94). After 6 weeks, test-retest
reliability coefficients in a sample of 61 undergraduates were as follows: power, .85;
Morality, .74; Likeability, .74; Task Accomplishment, .85; Vulnerability, .68; and Giftedness, .72. After 4 weeks, a sample of 57 undergraduates yielded somewhat higher coefficients: power, .84; Morality, .88; Likeability, .74; Task Accomplishment, .78; Vulnerability, .80; and Giftedness, .82. The coefficient for composite scores was .97 in both samples. These stability estimates and the internal-consistency value met the standards of reliability suggested for research measures (Nunnally, 1978).
## RESEARCH DESIGN

| INDIVIDUAL ADMINISTRATION OF MEASURES | TOTAL SAMPLE  
|                                       | N=180          |
|                                       | Adults with psychopathology | Normal Adults |
| i) INTERVIEW FORM FOR PSYCHOLOGICAL ASSESSMENT |             |               |
| i) FAMILY ASSESSMENT MEASURE - VERSION III | n=90          | n=90          |
|                                           | BREAK OF 10 MINUTES     |               |
| ii) SIX FACTOR SELF-CONCEPT SCALE         |               |               |
OPERATIONAL DEFINITION OF VARIOUS TERMS

Family Functioning

Family functioning is defined as family system processes used to "provide for the biological, psychological, and social development and maintenance of family members" (Skinner, Steinhauer & Santa-Barbara, 1995). The authors further define the variables of Family Functioning under study as follows:

Communication

Effective communication is the achievement of mutual understanding, so that the message received is the same as the message intended. If the message sent is clear, direct, and sufficient, then mutual understanding is likely to occur.

Control

Control is the process by which family members influence each other. It includes whether or not the family is predictable versus inconsistent, constructive versus irresponsible in its management.

Involvement

Involvement refers to both the degree and quality of family members' interest in one another. It also includes the ability to meet the emotional and security needs of family members, while at the same time supporting family member's autonomy of thought and function.
Self-Concept

The rating of self as one views self, across life settings, roles and activities in terms of Likeability, Morality, Task Accomplishment (i.e., the ability to complete tasks efficiently and capably), Giftedness (natural aptitude and talent), Power (the ability to influence other effectively), and Vulnerability (self-criticalness and inability to perform under pressure) (Stake, 1994).

Psychopathology

Psychopathology defines as groups, namely psychotic disorders; depressive disorders and anxiety disorders on Axis I, according to the diagnostic criteria of Diagnostic and Statistical Manual of Mental Disorders-Text Revision, (DSM-IV-TR; APA, 2000): the group named "psychotic disorders" consisted of schizophrenia; the depressive disorders included two disorders, namely major depression and dysthymia and "anxiety disorders" consisted of obsessive compulsive disorder, specific and social phobia and generalized anxiety disorder. The participants were unmarried adults with age ranged from 20 years to 35 years, living with their family of origin. The entire sample belonged to middle socioeconomic class, and has at least intermediate and maximum post graduate education. The individuals with any indication of co morbid Axis II and Axis III disorders were not included in the sample.

Normal Adults

These individuals were those who have never diagnosed as having any psychological disorders or no history of psychological problems; and never sought any
kind of psychiatric/ psychological treatment (psychotropic medication/ psychotherapy). Individuals having any chronic physical disease were not included in the sample. The participants were unmarried adults with age ranged from 20 years to 35 years, living with their family of origin. The entire sample belonged to middle socioeconomic class, and has at least intermediate and maximum post graduate education.
CHAPTER VI

RESULTS

In this chapter, our focus is on detailed statistical analysis of the research data. The data was analyzed using the Statistical Program for Social Sciences (SPSS, 12.0) and significance level of 0.5 was used for all the analysis.

The Demographic Information of both the samples is presented for their age education, gender and Family Structure. Descriptive statistic for sample with psychopathology, of normal sample and of total sample is also illustrated.

One Way analyses of Variance (ANOVA) was administered to calculate the differences in the level of family functioning (communication, control and involvement) and self concept between the groups (three groups diagnosed with mental disorders and a group of normal adults). Further, Post hoc HSD analysis was conducted to assess the mean difference of scores of normal participants from groups with psychotic, depressive and anxiety disorders. In addition, Binary Logistic Regression model was applied to determine the predictive relationship of the variables of family functioning (communication, control and involvement) with the presence of psychopathology by considering the psychopathology as a dichotomous variable i.e., subjects with and without psychopathology. Similarly predictive relationship of the variable of self-concept with presence of psychopathology was also observed. Further, the relationship of variables of Family functioning is sought with the self concept in the sample with psychopathology.
(and on the entire sample as well), by applying the linear regression analysis. Additionally, the stepwise regression analysis was also administered to assess the predicting relationship of communication, control and involvement with self concept in sample with psychopathology.

Additionally Inter correlations were computed among the variables of family functioning (Communication, Control and Involvement), total self concept and subscales of Self-concept using Pearson Product Moment Coefficient of Correlation. Partial Correlations were computed to observe the relationship among above-mentioned variables after controlling the effect of age, duration of treatment, family structure and gender. t-test was conducted between groups with and without psychopathology to observe the differences on various subscales of self concept measure. Analysis of Variance was conducted to assess the differences on family functioning variables and self concept among various groups of Psychopathology.

It may be noted (already mentioned in chapter ‘V’) that Family Assessment Measurement Scale-III (FAMS) is scored in a pathological direction such that higher values of communication, control and involvement are indicative of greater dysfunction, while high scores on the measure of self concept reflects positive self concept.
DEMOGRAPHIC STATISTICS

Demographic Information of both the samples is presented for their age education, gender and family structure (Table A1 & A2). Further elaboration of demographic characteristics of various groups of psychopathology (Table B1 & B2), as well as the frequency of subjects with different mental disorders and their sub classification is also presented (Table C). The descriptive statistic including mean, standard deviation (Table D) of sample with psychopathology, of normal sample and of total sample for variables of family functioning and self concept is also illustrated. Descriptive statistic for the three groups with psychopathology was also individually presented (Table E).

Table A 1

Demographic Characteristics of Sample (Frequencies)

<table>
<thead>
<tr>
<th>Groups</th>
<th>Gender</th>
<th>Education</th>
<th>Family Structure</th>
<th>Mean Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Intermediate</td>
<td>Graduate</td>
<td>Master</td>
</tr>
<tr>
<td>Adults With Psychopathology</td>
<td>46</td>
<td>22</td>
<td>54</td>
<td>14</td>
</tr>
<tr>
<td>(n= 90)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Adults</td>
<td>45</td>
<td>22</td>
<td>52</td>
<td>16</td>
</tr>
<tr>
<td>(n= 90)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Sample</td>
<td>91</td>
<td>44</td>
<td>106</td>
<td>30</td>
</tr>
<tr>
<td>(N= n1+n2=180)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table A 2

Demographic Characteristics of Sample (Percentages)

<table>
<thead>
<tr>
<th>Groups</th>
<th>Gender</th>
<th>Education</th>
<th>Family Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Intermediate</td>
<td>Graduate</td>
</tr>
<tr>
<td>Adults With Psychopathology</td>
<td>51.11</td>
<td>24.44</td>
<td>60.0</td>
</tr>
<tr>
<td>(n= 80)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Adults</td>
<td>50.0</td>
<td>24.44</td>
<td>57.77</td>
</tr>
<tr>
<td>(n= 90)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Sample</td>
<td>50.55</td>
<td>26.66</td>
<td>58.88</td>
</tr>
<tr>
<td>(N= n1+n2=180)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Table B 1**

Demographic Characteristics of sample of various groups with Psychopathology (Frequencies)

<table>
<thead>
<tr>
<th>Groups</th>
<th>Gender</th>
<th>Education</th>
<th>Family Structure</th>
<th>Mean Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Intermediate</td>
<td>Graduate</td>
</tr>
<tr>
<td>Psychotic Disorders (n= 30)</td>
<td>15</td>
<td>15</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Depressive Disorders (n= 30)</td>
<td>15</td>
<td>15</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Anxiety Disorders (n= 30)</td>
<td>16</td>
<td>14</td>
<td>10</td>
<td>17</td>
</tr>
</tbody>
</table>

**Table B 2**

Demographic Characteristics of sample of various groups with Psychopathology (Percentages)

<table>
<thead>
<tr>
<th>Groups</th>
<th>Gender</th>
<th>Education</th>
<th>Family Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Intermediate</td>
</tr>
<tr>
<td>Psychotic Disorders (n= 30)</td>
<td>50</td>
<td>50</td>
<td>23</td>
</tr>
<tr>
<td>Depressive Disorders (n= 30)</td>
<td>50</td>
<td>50</td>
<td>17</td>
</tr>
<tr>
<td>Anxiety Disorders (n= 30)</td>
<td>53</td>
<td>47</td>
<td>33</td>
</tr>
</tbody>
</table>
Table C

Presentation of sample with Psychopathology across various disorders
(N=90)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Sub classification</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Schizophrenia)</td>
<td>Paranoid Type</td>
<td>10</td>
<td>11.11</td>
</tr>
<tr>
<td></td>
<td>Disorganized Type</td>
<td>6</td>
<td>6.67</td>
</tr>
<tr>
<td></td>
<td>Residual Type</td>
<td>6</td>
<td>6.67</td>
</tr>
<tr>
<td></td>
<td>Undifferentiated Type</td>
<td>8</td>
<td>8.89</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>Major Depression</td>
<td>19</td>
<td>21.11</td>
</tr>
<tr>
<td></td>
<td>Dysthymia</td>
<td>11</td>
<td>12.22</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Obsessive Compulsive</td>
<td>12</td>
<td>13.33</td>
</tr>
<tr>
<td></td>
<td>Phobia (specific, social)</td>
<td>5</td>
<td>5.56</td>
</tr>
<tr>
<td></td>
<td>Generalized Anxiety</td>
<td>13</td>
<td>14.44</td>
</tr>
</tbody>
</table>

Table D

Descriptive statistic of the variable of Family Functioning and Self Concept for the Sample

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sample with Psychopathology</th>
<th>Normal Sample</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev</td>
<td>Mean</td>
</tr>
<tr>
<td>Communication</td>
<td>9.41</td>
<td>2.04</td>
<td>6.60</td>
</tr>
<tr>
<td>Control</td>
<td>9.23</td>
<td>2.16</td>
<td>7.03</td>
</tr>
<tr>
<td>Involvement</td>
<td>9.30</td>
<td>2.64</td>
<td>6.76</td>
</tr>
<tr>
<td>Self Concept</td>
<td>78.43</td>
<td>40.78</td>
<td>134.05</td>
</tr>
</tbody>
</table>
Table E

Descriptive statistic of the variable of Family Functioning and Self Concept for the various groups with Psychopathology

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sample with Psychotic Disorders</th>
<th>Sample with Depressive Disorders</th>
<th>Sample with Anxiety Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev</td>
<td>Mean</td>
</tr>
<tr>
<td>Communication</td>
<td>9.67</td>
<td>2.04</td>
<td>9.93</td>
</tr>
<tr>
<td>Control</td>
<td>9.53</td>
<td>2.32</td>
<td>9.13</td>
</tr>
<tr>
<td>Involvement</td>
<td>9.07</td>
<td>2.70</td>
<td>9.40</td>
</tr>
<tr>
<td>Self Concept</td>
<td>69.70</td>
<td>45.69</td>
<td>79.06</td>
</tr>
</tbody>
</table>
HYPOTHESIS 1

Significant difference found between groups with and without psychopathology \((F = 30.596, \text{df} = 3, 176, p < .05)\) in the scores on the variable of communication which is presented in Table 1 (a). Table 1 (b) presents the post hoc HSD analysis, to reflect the difference of normal group from the three groups of psychopathology. Normal group is found to score significantly less than all three clinical groups \((p < .000)\). The high mean scores on communication is found in depressive, psychotic disorders and anxiety disorders, as compared to normal group, which indicate more communication deviance in the groups of adults with psychopathology. Followed by this is the graphic presentation of the mean differences found among group with psychopathology (psychosis, depression, anxiety) and group of normal adults (Graph 1). Additionally, a logistic regression analysis was conducted as alternate statistic to see the results in different way, whose summary is presented in Table 1 (c) & (d), which reflect communication as significant predictor of psychopathology \((Z = 6.35, p < .05; G = 70.852, p < .000)\).

Table 1

Summary of Analysis of Variance for the variable of Communication among Adults with Psychopathology and Normal Adults \((N=180)\)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>9.67</td>
<td>2.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>9.83</td>
<td>2.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>8.73</td>
<td>1.74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>6.60</td>
<td>2.05</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1 (a)

Post Hoc HSD Analysis among Normal and three Clinical subgroups for Communication

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>-3.07</td>
<td>0.43</td>
<td>.000</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>-3.23</td>
<td>0.43</td>
<td>.000</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>-2.13</td>
<td>0.43</td>
<td>.000</td>
</tr>
</tbody>
</table>

88
Graph I

Table 1 (b)

Summary of Logistic Regression with Communication as a predictor of Psychopathology

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Std. Dev</th>
<th>z</th>
<th>P</th>
<th>Odd ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-5.5978</td>
<td>0.8933</td>
<td>-6.27</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>0.7028</td>
<td>0.106</td>
<td>6.35</td>
<td>0.000</td>
<td>2.02</td>
</tr>
</tbody>
</table>

Table 1 (c)

G Value with Communication as a predictor of psychopathology

<table>
<thead>
<tr>
<th>G</th>
<th>df</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.852</td>
<td>1</td>
<td>0.000</td>
</tr>
</tbody>
</table>
HYPOTHESIS 2

Significant difference found between groups with and without psychopathology (F = 18.799, df = 3, 176, p < .05) in the scores on the variable of control which is presented in Table 2 (a), with the greater mean associated with group with psychotic disorders. Table 2 (b) present the post hoc HSD analysis, to reflect the difference of normal group from the three groups of psychopathology. The high mean scores on control is found in groups with psychotic, depressive, and anxiety disorders as compared to normal group, which indicate more inadequate control in the groups with psychopathology. Followed by this is the graphic presentation of the mean differences found among groups of adults with psychopathology (psychosis, depression and anxiety) and group of normal adults (Graph II), reflecting the lowest mean scores on Control of normal group. Additionally, a logistic regression analysis was conducted as alternate statistic to see the results in different way, whose summary is presented in Table 2 (c) & (d), which reflect control as significant predictor of psychopathology (Z = 5.68, p < .05; G = 49.299, p < .000).

Table 2

Summary of Analysis of Variance for the variable of Control among Adults with psychopathology and Normal Adults (N=180)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>9.53</td>
<td>2.32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>9.13</td>
<td>2.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>9.03</td>
<td>2.08</td>
<td>18.799</td>
<td>.000</td>
<td>3.176</td>
</tr>
<tr>
<td>Normal</td>
<td>7.83</td>
<td>1.78</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 (a)

Post Hoc HSD Analysis among Normal and Three Clinical groups for Control

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>-.250</td>
<td>.42</td>
<td>.000</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>-.210</td>
<td>.42</td>
<td>.000</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>-.200</td>
<td>.42</td>
<td>.000</td>
</tr>
</tbody>
</table>
Graph II

Mean Comparison for Control across Psychiatric Disorders and Normal Participants

<table>
<thead>
<tr>
<th>Groups</th>
<th>Mean Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>10.5</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>8.5</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>6.5</td>
</tr>
<tr>
<td>Normal</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Table 2 (b)

Summary of Logistic Regression with Control as a predictor of Psychopathology

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Coefficient</th>
<th>Std. Dev</th>
<th>z</th>
<th>p</th>
<th>Odd ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-4.7178</td>
<td>0.9412</td>
<td>-5.61</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>0.5840</td>
<td>0.1023</td>
<td>5.68</td>
<td>0.000</td>
<td>1.79</td>
</tr>
</tbody>
</table>

Table 2 (c)

G Value with Control as a predictor of psychopathology

<table>
<thead>
<tr>
<th>G</th>
<th>Df</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>49.299</td>
<td>1</td>
<td>0.000</td>
</tr>
</tbody>
</table>
HYPOTHESIS 3

Significant difference found between groups with and without psychopathology ($F = 18.513$, $df = 3, 176$, $p < .05$) in the scores on the variable of involvement which is presented in Table 3 (a), with the highest means associated with group with anxiety disorders. Table 3 (b) present the post hoc HSD analysis, to reflect the difference of normal group from the three groups of psychopathology. The high mean scores on communication is found in psychotic, depressive, and anxiety disorders as compared to normal group, which indicate more inadequate involvement in the groups with psychopathology (psychosis, depression, and anxiety). Followed by this is the graphic presentation of the mean differences found among groups of adults with psychopathology and group of normal adults (Graph III). Additionally, a logistic regression analysis was conducted as alternate statistic to see the results in different way, whose summary is presented in Table 3 (c) & (d), which reflect involvement as significant predictor of psychopathology ($Z = 5.61$, $p < .05$; $G = 49.907$, $p < .000$)

Table 3

Summary of Analysis of Variance for the variable of Involvement among Adults with Psychopathology and Normal Adults ($N=180$)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>9.07</td>
<td>2.70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>9.40</td>
<td>2.77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>9.43</td>
<td>2.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>6.76</td>
<td>1.87</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 (a)

Post Hoc HSD Analysis among Normal and Three Clinical groups for Involvement

<table>
<thead>
<tr>
<th></th>
<th>Mean difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Psychotic Disorders</td>
<td>-2.31</td>
<td>0.48</td>
</tr>
<tr>
<td></td>
<td>Depressive Disorders</td>
<td>-2.64</td>
<td>0.48</td>
</tr>
<tr>
<td></td>
<td>Anxiety Disorders</td>
<td>-2.68</td>
<td>0.48</td>
</tr>
</tbody>
</table>
Graph III

Mean Comparison for Involvement across psychiatric Disorders and Normal participants

Table 3 (b)

Summary of Logistic Regression with Involvement as a predictor of Psychopathology

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Coefficient</th>
<th>Std. Dev</th>
<th>z</th>
<th>p</th>
<th>Odds ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-4.1131</td>
<td>0.7408</td>
<td>-5.55</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>0.51985</td>
<td>0.09271</td>
<td>5.61</td>
<td>0.000</td>
<td>1.68</td>
</tr>
</tbody>
</table>

Table 3 (c)

G Value with Involvement as a predictor of psychopathology

<table>
<thead>
<tr>
<th>G</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>49.907</td>
<td>1</td>
<td>0.000</td>
</tr>
</tbody>
</table>
HYPOTHESIS 4

Significant difference found between groups with and without psychopathology ($F = 42.918$, $df = 3, 176$, $p < .05$) in the scores on the variable of self concept, which is presented in Table 4 (a), with the higher mean associate with normal participants. Table 4 (b) present the post hoc HSD analysis, to reflect the difference of normal group from the three groups of psychopathology, which is in favor of normal group ($p < .000$). The low mean self concept found to be associated with psychotic disorders, depressive and anxiety disorders as compared to normal group, which indicate that adults with psychopathology (psychosis, depression, and anxiety) have low self concept as compared to normal adults. Followed by this is the graphic presentation of the mean differences found among the groups of adults with psychopathology (psychosis, depressive and anxiety) and group of normal adults (Graph IV), with the highest mean self concept of normal group. Additionally, a logistic regression analysis was conducted as alternate statistic to see results in different way, whose summary is presented in Table 4 (c) & (d), which reflect self concept as significant predictor of psychopathology ($Z = -6.71$, $p < .05$; $G = 89.08$, $p < .000$).

Table 4

Summary of Analysis of Variance for the variable of Self-Concept among Adults with psychopathology and Normal Adults (N=180)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>$F$</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>89.700</td>
<td>45.69</td>
<td></td>
<td>42.918</td>
<td>.000</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>79.056</td>
<td>37.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>86.533</td>
<td>38.58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>134.055</td>
<td>24.26</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 (a)

Post Hoc HSD Analysis among Normal and Three Clinical Groups for Self Concept

<table>
<thead>
<tr>
<th></th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>54.355</td>
<td>7.03</td>
<td>.000</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>54.988</td>
<td>7.03</td>
<td>.000</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>47.522</td>
<td>7.03</td>
<td>.000</td>
</tr>
</tbody>
</table>
Graph IV

Table 4 (b)

Summary of Logistic Regression with Self Concept as a predictor of Psychopathology

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Coefficient</th>
<th>Std. Dev</th>
<th>z</th>
<th>p</th>
<th>Odd ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>5.0368</td>
<td>0.8134</td>
<td>6.19</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Self-concept</td>
<td>-0.045581</td>
<td>0.006737</td>
<td>-6.71</td>
<td>0.000</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Table 4 (c)

G Value with Self Concept as a predictor of psychopathology

<table>
<thead>
<tr>
<th>G</th>
<th>df</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.08</td>
<td>1</td>
<td>0.000</td>
</tr>
</tbody>
</table>
HYPOTHESIS 5

Linear Regression Analysis was conducted with family functioning (communication, control and involvement) as predictor of self concept in adults with psychopathology. The presentation of regression analysis includes model summary (Table 5 a), analysis of Variance (Table 5 b), and coefficients (Table 5 c). Family functioning is found to be a significant predictor ($R^2 = 0.345, F = 15.110, p < .000$) of self concept in Adults with psychopathology. For further interest stepwise regression analysis (Table 5 d) was conducted which demonstrated Family functioning variable of Communication ($R^2 = 0.133, F = 13.523, df= 1, 88, P < .05$) as significant predictor of self concept. After including the control in the equation Family functioning still remains significant predictor of psychopathology and an increase in the variance explained by family functioning in self concept was observed ($R^2 = 0.301, F = 18.696, df = 2, 87, p < .05$). At the last step the three variables in combination also ($R^2 = 0.345, F = 15.110, df = 3, 89, p < .05$) appears significant in predicting the aforementioned relationship. Table 5 (e), (f) & (g) present the model summary, analysis of variance and coefficients of linear regression analysis with family functioning (communication, control and involvement) as predictors of self concept in entire sample of adults. The findings also reflect family functioning as significant predictor ($F = 47.976, df = 3, 176, P < .05$) of self concept in entire sample ($N = 180$, adults with and without psychopathology).

Table 5

Summary of Linear Regression with Communication, Involvement and Control as Predictors of Self-Concept in Adults with Psychopathology

<table>
<thead>
<tr>
<th>Predictors</th>
<th>R</th>
<th>$R^2$</th>
<th>Adjusted $R$ Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>0.588</td>
<td>0.345</td>
<td>0.322</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5 (a)

Analysis of Variance for linear regression with Communication, Control and Involvement as Predictors of Self-Concept in Adults with Psychopathology

<table>
<thead>
<tr>
<th>Model</th>
<th>SS</th>
<th>Df</th>
<th>Ms</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>51087.466</td>
<td>3</td>
<td>17029.155</td>
<td>15.110</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>96920.634</td>
<td>86</td>
<td>1126.984</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>148908.1</td>
<td>89</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 5 (b)

Coefficients for linear regression with Communication, Control and Involvement as Predictors of Self-Concept in Adults with Psychopathology

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>180.983</td>
<td>18.139</td>
<td>9.977</td>
<td>.000</td>
</tr>
<tr>
<td>Communication</td>
<td>-1.101</td>
<td>2.175</td>
<td>-0.055</td>
<td>-.506</td>
</tr>
<tr>
<td>Control</td>
<td>-4.753</td>
<td>2.881</td>
<td>-0.251</td>
<td>-1.650</td>
</tr>
<tr>
<td>Involvement</td>
<td>-5.194</td>
<td>2.147</td>
<td>-0.336</td>
<td>-2.419</td>
</tr>
</tbody>
</table>

### Table 5 (c)

Stepwise Regression Analysis predicting Self Concept from variables of Family Functioning for Adults with Psychopathology

<table>
<thead>
<tr>
<th>Variables entered</th>
<th>Model Summary</th>
<th>ANOVA</th>
<th>Coefficients</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B</td>
<td>S.E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEP ONE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>R</td>
<td>0.365</td>
<td>0.133</td>
<td>-1.385</td>
<td>-7.302</td>
<td>1.986</td>
<td>-3.677</td>
</tr>
<tr>
<td>Communication</td>
<td>R²</td>
<td>0.133</td>
<td>0.123</td>
<td>13.523</td>
<td>1.986</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEP TWO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>Adj.R²</td>
<td>0.130</td>
<td>0.285</td>
<td>18.696</td>
<td>2.235</td>
<td>-0.066</td>
<td>-5.46</td>
</tr>
<tr>
<td>Communication</td>
<td>F</td>
<td>13.523</td>
<td>18.696</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>Sig</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEP THREE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>R</td>
<td>0.548</td>
<td>0.301</td>
<td>0.285</td>
<td>18.696</td>
<td>18.617</td>
<td>9.609</td>
</tr>
<tr>
<td>Communication</td>
<td>R²</td>
<td>0.301</td>
<td>0.285</td>
<td>18.696</td>
<td>2.235</td>
<td>-0.066</td>
<td>-5.46</td>
</tr>
<tr>
<td>Control</td>
<td>Adj.R²</td>
<td>0.285</td>
<td>18.696</td>
<td>2.235</td>
<td>18.617</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>F</td>
<td>15.110</td>
<td>5.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sig</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 5 (d)

Summary of Linear Regression with Communication, Control and Involvement as Predictors of Self-Concept in entire sample of Adults

<table>
<thead>
<tr>
<th>Predictors</th>
<th>R</th>
<th>R²</th>
<th>Adjusted R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>.671</td>
<td>.450</td>
<td>.440</td>
</tr>
<tr>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5 (e)

Analysis of Variance for Linear Regression with Communication, Control and Involvement as Predictors of Self-Concept in entire sample Adults

<table>
<thead>
<tr>
<th>Model</th>
<th>SS</th>
<th>df</th>
<th>Ms</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>152793.5</td>
<td>3</td>
<td>50931.66</td>
<td>47.975</td>
<td>.008</td>
</tr>
<tr>
<td>Residual</td>
<td>169841.7</td>
<td>176</td>
<td>106160.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>339635.2</td>
<td>179</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5 (f)

Coefficients for Linear Regression with Communication, Control and Involvement as Predictors of Self-Concept in entire sample Adults

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>213.684</td>
<td>9.761</td>
<td></td>
<td>21.891</td>
</tr>
<tr>
<td>Communication</td>
<td>-4.006</td>
<td>1.277</td>
<td>-0.228</td>
<td>-3.137</td>
</tr>
<tr>
<td>Involvement</td>
<td>-6.208</td>
<td>1.421</td>
<td>-0.373</td>
<td>-4.370</td>
</tr>
<tr>
<td>Control</td>
<td>-3.140</td>
<td>1.584</td>
<td>-0.163</td>
<td>-1.982</td>
</tr>
</tbody>
</table>
### ADDITIONAL FINDINGS

Stepwise Regression Analysis (Table 6) indicates that family functioning variables predict self concept in entire sample. Communication ($F = 76.251, df = 1, 178, P < .05$) individually explain 30% variation in self concept, however, this variation increased to 39% ($F = 56.626, df = 2, 177, p < .05$) when entered the control in the equation. At the last step the three variables explain the 45% ($F = 47.976, df = 3, 176, p < .05$) variations in the scores on self concept in entire sample. All the three variables besides being significantly correlated with each other appear as significant predictor family functioning in entire sample.

### Table 6

**Stepwise Regression Analysis predicting Self Concept from variables of Family Functioning on Entire Sample**

<table>
<thead>
<tr>
<th>Variables entered</th>
<th>Model Summary</th>
<th>ANOVA</th>
<th>Coefficients</th>
<th>Unstandardized coefficients</th>
<th>Standardized coefficients</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R, R², Adj. R², F, Sig</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP ONE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>0.548</td>
<td>0.300</td>
<td>0.296</td>
<td>76.251, .000</td>
<td>183.396</td>
<td>9.937</td>
<td>.000</td>
</tr>
<tr>
<td>Communication</td>
<td>-9.627</td>
<td>1.102</td>
<td>-0.548</td>
<td></td>
<td>19.346</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td><strong>STEP TWO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>-0.525</td>
<td>0.390</td>
<td>0.383</td>
<td>55.626, .000</td>
<td>21.336</td>
<td>10.232</td>
<td>.000</td>
</tr>
<tr>
<td>Communication</td>
<td>-5.979</td>
<td>1.254</td>
<td>-0.340</td>
<td></td>
<td>20.654</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>-7.036</td>
<td>1.375</td>
<td>-0.365</td>
<td></td>
<td>-4.767</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td><strong>STEP THREE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>-0.671</td>
<td>0.450</td>
<td>0.440</td>
<td>47.976, .000</td>
<td>213.684</td>
<td>9.791</td>
<td>.000</td>
</tr>
<tr>
<td>Communication</td>
<td>-4.096</td>
<td>1.277</td>
<td>-0.228</td>
<td></td>
<td>3.137</td>
<td>.002</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>-3.140</td>
<td>1.584</td>
<td>-0.163</td>
<td></td>
<td>-1.982</td>
<td>.049</td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>-6.208</td>
<td>1.421</td>
<td>-0.373</td>
<td></td>
<td>-4.370</td>
<td>.000</td>
<td></td>
</tr>
</tbody>
</table>

99
Besides the difference of overall self concept in adults with and without psychopathology, an additional analysis was made to observe the differences of the two groups on various subscales of self concept (Table 7). Analyses reveal significant differences for all subscales. It reflects that the deterioration in the self concept in adults with psychopathology not only limited to any particular area but encompasses all spheres of self concept.

**Table 7**

**t- test Analyses between the group with Psychopathology and Normal subjects for subscales of Self-Concept (df= 178)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Groups</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>SEx</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Psychopathology</td>
<td>90</td>
<td>22.71</td>
<td>8.27</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Normal</td>
<td>90</td>
<td>32.47</td>
<td>6.35</td>
<td>0.67</td>
<td>-8.876*</td>
</tr>
<tr>
<td>Likeability</td>
<td>With Psychopathology</td>
<td>90</td>
<td>22.47</td>
<td>9.38</td>
<td>0.99</td>
<td></td>
</tr>
<tr>
<td>Task Accomplishment</td>
<td>Normal</td>
<td>90</td>
<td>31.52</td>
<td>5.81</td>
<td>0.61</td>
<td>-8.131*</td>
</tr>
<tr>
<td></td>
<td>With Psychopathology</td>
<td>90</td>
<td>20.67</td>
<td>10.26</td>
<td>1.08</td>
<td></td>
</tr>
<tr>
<td>Power</td>
<td>Normal</td>
<td>90</td>
<td>31.53</td>
<td>8.01</td>
<td>0.84</td>
<td>-7.893*</td>
</tr>
<tr>
<td></td>
<td>With Psychopathology</td>
<td>90</td>
<td>29.63</td>
<td>6.37</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Vulnerability</td>
<td>Normal</td>
<td>90</td>
<td>19.02</td>
<td>7.22</td>
<td>0.76</td>
<td>10.449*</td>
</tr>
<tr>
<td></td>
<td>With Psychopathology</td>
<td>90</td>
<td>16.54</td>
<td>8.63</td>
<td>0.91</td>
<td></td>
</tr>
<tr>
<td>Giftedness</td>
<td>Normal</td>
<td>90</td>
<td>23.97</td>
<td>5.69</td>
<td>0.60</td>
<td>-6.808*</td>
</tr>
<tr>
<td></td>
<td>With Psychopathology</td>
<td>90</td>
<td>25.68</td>
<td>8.35</td>
<td>0.88</td>
<td></td>
</tr>
<tr>
<td>Morality</td>
<td>Normal</td>
<td>90</td>
<td>33.22</td>
<td>5.84</td>
<td>0.62</td>
<td>-7.023*</td>
</tr>
</tbody>
</table>

* p<0.05 (Note: The positive direction for high scores on self-concept span for overall scores and for all subscales except one that the Vulnerability. The low scores on subscale of vulnerability reflect positive self concept).
An analysis of relationship among variables of family functioning indicates significant relationship in the scores on three scales that are, communication, involvement, and control (Table 8 & 8 a). However, analysis reflects that relationship between involvement and control in adults with psychopathology is stronger (Table 8 a; \( r = 0.778, P < .05 \)) than the relationship of both of these variables with communication (Table 8 a; \( r = 0.596 & 0.476 \) respectively). Similarly in entire sample relationship between involvement and control in adults with psychopathology is stronger (Table 8; \( r = 0.714, P < .05 \)) than the relationship of both of these variables with communication (Table 8; \( r = 0.489 & 0.0559 \) respectively). The high correlation of the three variables of family functioning in entire sample (Table 8) as well as in adults with psychopathology (Table 8 a) reflects that the three variables might share variance while predicting self concept of the sample. Any research on the conditional nature of the three variables will be informative and will enhance understanding of the interactional nature of these variables.

Table 8

Intercorrelations among different subscale of family functioning and self concept

<table>
<thead>
<tr>
<th>Variables</th>
<th>Family Functioning</th>
<th>Self Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COM</td>
<td>CONT</td>
</tr>
<tr>
<td>Family Functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COM</td>
<td>1.000</td>
<td>0.558*</td>
</tr>
<tr>
<td>CONT</td>
<td>1.000</td>
<td>0.714*</td>
</tr>
<tr>
<td>INV</td>
<td>1.000</td>
<td>-0.626</td>
</tr>
<tr>
<td>Self Concept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>1.000</td>
<td>-0.888*</td>
</tr>
<tr>
<td>LA</td>
<td>1.000</td>
<td>0.815*</td>
</tr>
<tr>
<td>TA</td>
<td>1.000</td>
<td>0.730*</td>
</tr>
<tr>
<td>PO</td>
<td>1.000</td>
<td>-0.366*</td>
</tr>
<tr>
<td>VA</td>
<td>1.000</td>
<td>-0.329*</td>
</tr>
<tr>
<td>GN</td>
<td>1.000</td>
<td>0.627*</td>
</tr>
<tr>
<td>MO</td>
<td>1.000</td>
<td></td>
</tr>
</tbody>
</table>

* p<0.05

Communication=COM, Involvement=INV, Control=CONT, Total Self Concept= T, Likeability=LA, Task Accomplishment=TA, Power=PO, Vulnerability=VA, Giftedness=GN, Morality=MO
Table 8 (a)

Intercorrelations among different subscales of Family functioning and self concept for Adults with Psychopathology

<table>
<thead>
<tr>
<th>Variables</th>
<th>Family Functioning</th>
<th>Self Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COM</td>
<td>CONT</td>
</tr>
<tr>
<td>Family Functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COM</td>
<td>1.000</td>
<td>0.475</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>CONT</td>
<td>1.000</td>
<td>0.778</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>INV</td>
<td>1.000</td>
<td>-0.365</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
</tbody>
</table>

Self Concept

| T         | 0.888  | 0.333  | 0.832  | -0.368| 0.848 | 0.775 |
|           | (0.000)| (0.000)| (0.000)| (0.000)| (0.000)| (0.000)|
| LA        | 0.000  | 0.815  | 0.680  | -0.230| 0.738 | 0.855 |
|           | (0.000)| (0.000)| (0.029)| (0.000)| (0.000)| (0.000)|
| TA        | 1.000  | 0.774  | -0.224 | 0.734 | 0.744 |       |
|           | (0.000)| (0.034)| (0.000)| (0.000)| (0.000)| (0.000)|
| PD        | 1.000  | -0.187 | 0.631  | 0.495 |       |       |
|           | (0.000)| (0.077)| (0.000)| (0.000)| (0.000)| (0.000)|
| VA        | 1.000  | -0.231 | -0.087 |       |       |       |
|           | (0.000)| (0.029)| (0.414)| (0.000)| (0.000)| (0.000)|
| GN        | 1.000  | 0.603  |       |       |       |       |
|           | (0.000)| (0.000)| (0.000)| (0.000)| (0.000)| (0.000)|
| MO        | 1.000  |        |       |       |       |       |
|           | (0.000)| (0.000)| (0.000)| (0.000)| (0.000)| (0.000)|

Communication=COM, Involvement=INV, Control=CONT. Total Self Concept= T, Likeability=LA, Task Accomplishment=TA, Power=PD, Vulnerability=VA, Giftedness=GN, Morality=MO
Age, Education, Family structure as well as the duration of treatment are the factors which supposed to be having effects on the observed relationships. Partial-correlations among different subtests of family functioning and self concept for Adults with Psychopathology, reflects no effects of these variables on the relationship of communication, control and involvement. However, the relationship of total score on self concept with family functioning variables reflects few variations while controlling for the above mentioned demographics. The Major change observed is in relationship of communication and self concept, which though still significant reduces to -0.263 from -0.558 (see Table 8 b and 8 a).

Table 8 (b)

Partial-correlations among different subscales of Family functioning and self concept for Adults with Psychopathology, controlling for Age, Education, Duration of Treatment and Family Structure

<table>
<thead>
<tr>
<th>Variables</th>
<th>Family Functioning</th>
<th>Self Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COM</td>
<td>CONT</td>
</tr>
<tr>
<td>Family Functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COM</td>
<td>1.000</td>
<td>0.433</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>CONT</td>
<td>1.000</td>
<td>0.722</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>INV</td>
<td>1.000</td>
<td>-0.469</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>Self Concept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>1.000</td>
<td>0.868</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>LA</td>
<td>1.000</td>
<td>0.785</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>TA</td>
<td>1.000</td>
<td>0.754</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.169)</td>
</tr>
<tr>
<td>PO</td>
<td>1.000</td>
<td>-0.175</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.291)</td>
</tr>
<tr>
<td>VA</td>
<td>1.000</td>
<td>-0.170</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.177)</td>
</tr>
<tr>
<td>GN</td>
<td>1.000</td>
<td>0.534</td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td>(0.000)</td>
</tr>
<tr>
<td>MO</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.000)</td>
<td></td>
</tr>
</tbody>
</table>

| Communication=COM, Involvement=INV, Control=CONT, Total Self Concept=T, Likeability=LA, Task Accomplishment=TA, Power=PO, Vulnerability=VA, Giftedness=GN, Morality=MO |
The difference between the three groups with psychopathology was insignificant for the variables of communication (Table 9; $F = 2.631$, df = 2, 87, $p > .05$), control (Table 10; $F = 0.446$, df = 2, 87, $p > .05$), and involvement (Table 11; $F = 0.174$, df = 2, 87, $p > .05$). Same trend appears for the variable of self concept (Table 12; $F = 1.292$, df = 2, 87, $p > .05$). It indicates that family functioning and self concept is deteriorated in all the three groups including psychosis, depression and anxiety.

Table 9

Summary of Analysis of Variance for the variable of Communication among various groups of Adults with Psychopathology (N=90)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>9.67</td>
<td>2.04</td>
<td>2.631</td>
<td>.078</td>
<td>2.87</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>9.83</td>
<td>2.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>8.73</td>
<td>1.74</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9 (a)

Post Hoc HSD Analysis for the variable of communication among various groups with psychopathology

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>-0.167</td>
<td>0.517</td>
<td>.944</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>0.933</td>
<td>0.517</td>
<td>.174</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>1.100</td>
<td>0.517</td>
<td>.090</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>-0.933</td>
<td>0.517</td>
<td>.174</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>-1.100</td>
<td>0.517</td>
<td>.090</td>
</tr>
</tbody>
</table>
Table 10

Summary of Analysis of Variance for the variable of Control among various groups of Adults with Psychopathology (N=90)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>9.53</td>
<td>2.32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>9.13</td>
<td>2.11</td>
<td>0.446</td>
<td>.642</td>
<td>2, 87</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>9.03</td>
<td>2.08</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 10(a)

Post Hoc HSD Analysis for the variable of control among various groups with psychopathology

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>0.400</td>
<td>0.560</td>
<td>.756</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>0.500</td>
<td>0.560</td>
<td>.647</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>-0.400</td>
<td>0.560</td>
<td>.756</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>0.100</td>
<td>0.560</td>
<td>.983</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>-0.500</td>
<td>0.560</td>
<td>.647</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>-0.100</td>
<td>0.560</td>
<td>.983</td>
</tr>
</tbody>
</table>
Table 11

Summary of Analysis of Variance for the variable of Involvement among various groups of Adults with Psychopathology (N=90)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>9.07</td>
<td>2.70</td>
<td>0.174</td>
<td>.841</td>
<td>2.87</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>9.40</td>
<td>2.77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>9.43</td>
<td>2.51</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 11 (a)

Post Hoc HSD Analysis for the variable of involvement among various groups with psychopathology

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>-0.333</td>
<td>0.688</td>
<td>.879</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>-0.367</td>
<td>0.688</td>
<td>.856</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>0.333</td>
<td>0.688</td>
<td>.879</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>-0.033</td>
<td>0.688</td>
<td>.999</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>0.367</td>
<td>0.688</td>
<td>.856</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>0.033</td>
<td>0.688</td>
<td>.999</td>
</tr>
</tbody>
</table>
Table 12

Summary of Analysis of Variance for the variable of Self Concept among various groups of Adults with Psychopathology (N=90)

<table>
<thead>
<tr>
<th>Sample</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>F</th>
<th>Sig</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>69.700</td>
<td>45.690</td>
<td>1.292</td>
<td>.280</td>
<td>2.87</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>79.0667</td>
<td>37.175</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>86.533</td>
<td>38.560</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 12 (a)

Post Hoc HSD Analysis for the variable of Self Concept among various groups with psychopathology

<table>
<thead>
<tr>
<th>Sample</th>
<th>Depressive Disorders</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td></td>
<td>-9.366</td>
<td>10.495</td>
<td>.646</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td></td>
<td>-16.833</td>
<td>10.495</td>
<td>.249</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td></td>
<td>9.366</td>
<td>10.495</td>
<td>.646</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td></td>
<td>-7.466</td>
<td>10.495</td>
<td>.757</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Psychotic Disorders</td>
<td>16.833</td>
<td>10.495</td>
<td>.249</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Depressive Disorders</td>
<td>7.468</td>
<td>10.495</td>
<td>.757</td>
</tr>
</tbody>
</table>
Linear regression analysis indicates family functioning variables as predictors of self concept in various subgroups of adults with psychopathology (Table 13 & 13a). For psychotic disorders the variance explained by family functioning is 34% (F = 4.486, df = 3, 26, p < .05), for depressive disorders 43% (F = 6.640, df = 3, 26, p < .05), and for anxiety disorders it is 49% (F = 8.376, df = 3, 26, p < .05).

**Table 13**

Summary of Linear Regression with Communication, Control and Involvement as Predictors of Self-Concept in various groups of Adults with Psychopathology

<table>
<thead>
<tr>
<th>Groups</th>
<th>Predictors</th>
<th>R</th>
<th>R²</th>
<th>Adjusted R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>Communication</td>
<td>0.584</td>
<td>0.341</td>
<td>0.265</td>
</tr>
<tr>
<td></td>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>Communication</td>
<td>0.659</td>
<td>0.434</td>
<td>0.368</td>
</tr>
<tr>
<td></td>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Communication</td>
<td>0.701</td>
<td>0.491</td>
<td>0.433</td>
</tr>
<tr>
<td></td>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 13 (a)**

Analysis of Variance for Linear Regression with Communication, Control and Involvement as Predictors of Self-Concept in various groups of Adults with Psychopathology

<table>
<thead>
<tr>
<th>Groups</th>
<th>Model</th>
<th>SS</th>
<th>df</th>
<th>Ms</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>Regression</td>
<td>20648.459</td>
<td>3</td>
<td>6882.820</td>
<td>4.486</td>
<td>.011</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>39891.841</td>
<td>26</td>
<td>1534.302</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>80540.300</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>Regression</td>
<td>17385.841</td>
<td>3</td>
<td>5795.280</td>
<td>6.640</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>22692.025</td>
<td>26</td>
<td>872.770</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>40077.867</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Regression</td>
<td>21133.359</td>
<td>3</td>
<td>7044.453</td>
<td>8.376</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>21928.107</td>
<td>26</td>
<td>843.389</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>43121.467</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 13 (b)

Coefficients for Linear Regression with Communication, Control and Involvement as Predictors of Self-Concept in various groups of Adults with Psychopathology

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>213.684</td>
<td>9.761</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>Communication</td>
<td>-4.006</td>
<td>1.277</td>
<td>-0.228</td>
<td>-3.137</td>
</tr>
<tr>
<td>Involvement</td>
<td>-6.208</td>
<td>1.421</td>
<td>-0.373</td>
<td>-4.370</td>
</tr>
<tr>
<td>Control</td>
<td>-3.140</td>
<td>1.584</td>
<td>-0.163</td>
<td>-1.982</td>
</tr>
</tbody>
</table>
CHAPTER VII

DISCUSSION

The purpose of this chapter is to discuss the findings and consider the importance of self concept and communication, control and involvement as family functioning variables, as indicators of psychopathology.

Present study evaluated the difference in the level of family functioning (Communication, Control and Involvement) and self-concept among adults with and without psychopathology by using the measures of family functioning and self-concept in a sample of psychiatric patients and their controls drawn from Karachi city. It also addresses the relationship of family functioning and self concept, in sample with psychopathology. Present study discusses that how family functioning and self concept influence the psychological wellbeing of adults, yet, it does not mean that these factors are solely responsible for psychopathology. It is also noteworthy to mention that the factors analyzed in present study do not necessarily lead to mental disorders. Not necessarily all adults affected by these factors become mentally ill, similarly there are individuals diagnosed as psychologically disturbed, even though they haven’t experienced such influences. The presence of the factors only indicates the higher probability of mental disorders.
Impaired Family Functioning as indicator of Psychopathology

The family is the principle and most influential system to which a person will ever belong (McGoldrick & Gerson, 1985). Family provides us an opportunity to experience interaction within the family which shape the course of our entire lives and are forever carried with us. For the survival, human beings have to live in a system where they have strong ties with each other through sharing and caring. This sharing does not only take place at home rather it extends in the form of sharing of ideals, values, desires and goals. The members of the family are involved with each other and have strong influences on the lives of other members either from families of origin or from any newly developed family. Besides love and care, frustrations and affects a family shares; each and every family hold a specific home environment which can either be toxic for its members because of its intrinsic negative characteristics or be a refreshing and supporting buffer against other environmental stressors.

The family environment is one of the few important reasons of the development of psychopathology. As Keitner and Miller (1990) reported that family environmental factors have been found to profoundly influence the course of major affective illness. The family climate clouding with conflicts serve to be a noxious agent and mediator of psychopathology. Conditions ranging from living with irritable and quarreling parents to being exposed to violence and abuse in family, show associations with psychopathology in childhood, with lasting effects into the adult years. Overt conflicts and aggression in the family are associated both cross-sectionally and prospectively with an increased risk
for a wide variety of psychological problems in children and adults as anxiety, depression, and suicide (Emery, 1982, 1988; Grych & Fincham, 1990; Kaslow, Deering, & Racusia, 1994; Reid & Crisafulli, 1990; Wagner, 1997). Rund (1986, 1994) also found that communication deviance, expressed hostility, and over involvement characterized families in which offspring developed schizophrenia. Similarly Ginsburg, Silverman and Kurtines (1995) characterized the family environments of anxious children as highly conflictual and controlling, lacking familial support and cohesion, limited in participation in recreational and social activities, and poor in communication and problem solving.

A number of previous studies have reported impaired family patterns of psychiatric patients in comparison to normal control group. Our findings confirm these previous studies and extend them based on the following key findings. The present study shows that psychiatric patients scored high on the variable of Communication, Involvement, and Control in family as compared to the control group. Statistical analysis of the results indicate significant difference between groups with and without psychopathology on the variables of Communication (Table 1; \( F = 30.596, df = 3, 176, p < .05 \)), Control (Table 2; \( F = 18.799, df = 3, 176, p < .05 \)) and Involvement (Table 3; \( F = 18.513, df = 3, 176, p < .05 \)). Further results of Binary logistic regression analyses reveal that high scores on the variables of Communication (Table 1 (b) & (c); \( Z = 6.35, G = 70.852, p < .05 \)), Control (Table 2 (b) & (c); \( Z = 5.68, G = 49.299, p < .05 \)) and Involvement (Table 3 (b) & (c); \( Z = 5.61, G = 49.907, p < .05 \)) predict presence of psychopathology in adults. Findings regarding aforementioned three important variables of family functioning are discussed.
Communication deviance leads family to dysfunction. This fact can be well illustrated, as communication deviance is observed as high in the families of individuals with psychopathology (e.g., Milkowitz, Goldstein, & Neuchterlein, 1995; Singer, Wynne, & Toohey, 1978). Effective communication is defined by Skinner, Steinhauser and Santa-Barbara, (1995) as the achievement of mutual understanding, so that the message received is the same as the message intended. If the message sent is clear, direct, and sufficient, then mutual understanding is likely to occur. In this context the deviant communication can be defined as unclear or incomplete messages and excessive speech rate that result in poor understanding on the part of receiver. Communication problem occurs when family members send conflicting messages. These mixed messages include, for example, a positive verbal content but a negative facial expression or tone of voice.

Smith (1998) supported this view and stated that "planned, ongoing communication is the crucial missing link in many families". One can imagine that this missing link can distort the way one perceives the world. The child living in an environment having deviant communication patterns might not only get negative messages from the environment but also at risk of adapting the same interaction patterns. These patterns of interactions among family members become a model for the child as he/she learns about ways of communicating in personal relationships. This is an ongoing cycle thus promoting more conflicting messages leading to confusion both for the communicator and the person to whom the messages have been communicated. Mostly in families having persons with psychopathology the parents reflect such a communication pattern. Bugental, Kaswan, and Love (1970, 1971 & 1972) found that a significantly
higher proportion of mothers of disturbed youth produced conflicting messages than did the mothers of normal controls.

Research concluded by Van As (1999) found strong relations among concepts referring to the quality of the parent-child relation, i.e., parental support, family cohesion and positive parent-child communication. Poor communication is a common complaint of families who are having difficulties. As mentioned earlier in the previous sections, Epstein et al. (1993) found that when communication is unclear and indirect, it could lead to numerous family problems, including excessive family conflict, ineffective problem solving, lack of intimacy, and weak emotional bonding. Communication deviance is found to be higher in parents of patients with schizophrenia than it is in parents of either non-schizophrenic patients or healthy controls (Milklowitz, 1994; Milklowitz, Goldstein, & Neuchterlein, 1995). Milkowitz et al., (1991) found that parental communication deviance such as idea abandonment's, extraneous remarks, and ambiguous references are the distinguishing characteristics of parents of patients with schizophrenia.

Although there are other functions of the family which contributes to the member's mental well being, communication is perhaps the most important factor in family interaction. The effective functioning of the family demands to be clear, and open, thus enabling the person to learn more healthy interaction patterns and better interpersonal skills. It is largely through communication that we become what we are; it is through communication that we learn what we know; it is largely through destructive communication that problems in human relationships are created, and it is through
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meet demands of all family members and besides being greatly involved in her home and children can not manage to listen to the child effectively or to express what she is expected to as the care giver. Father limited to his role as bread winner and taking the responsibility of financial needs of the family, become detached and isolated from the family. His role becomes limited to the traditional one as the child’s playmate (Meyer et al., 1982) or bread winner (Zojia, 2001). Most of the fathers as being more preoccupied and strained do not clearly answer the child’s question or referred them to mother or to the school teachers. The communication with father become remarkably less and unclear and leave ambiguity in the mind of the children. Child starts making self interpretations and avoids communicating to any other responsible person after being denied to answer by father. These self interpretations due to his lack of information thus result in deviant and distorted thinking as well as detachment from the intimate figures. Most of the fathers and even mothers besides giving the child verbal message, that a child should communicate to them for their problems, fails to manage appropriate time for the purpose and thus let the child unanswered. The child experiences confusion as well as receives ambivalent messages from the parents, which result in mental stress for the child. Neither the parents, nor the child remains too close to share with each other. In most instances, the child feeling extreme desire to get appropriate involvement and time from the parents, appears indifferent and avoidant to parents. He/ she hate to express dependency (which he/ she assumes weakness) to the parents, while act aggressively to get more and more attention. The process goes on to the later ages and the person’s interaction even as the adult reflects same pattern. As Urbanc (1999 / 2000) asserts that parents usually do not know how to respond to the ambivalent messages of child, and feel confused. Confusion,
followed by aggression and lack of communication, bring a new quality to family relations (even to those that we would consider caring and understanding). At this point, adolescence becomes a family problem rather than an individual problem—it changes the family atmosphere and happens to the whole family, not only to an individual. A typical Pakistani family generally assumes the open communication in part of the child as negative. A Son/daughter is expected to be submissive and less expressive. The dissatisfaction and conflicts thus, when not allowed to be openly expressed remain unresolved and lead to great resentment and anxiety. Lack of love and affection in the families and their members inhibit affective communication. The members remain shy and less involved with each other. The lack of involvement might lead to emotional insecurity. Emotional security produces confidence in individual to convey his messages in powerful meaning and logics. Otherwise, members learn self-talk and weak communication style.

Another important reason as discussed earlier could be what Bateson gave the name of double bind communication. Bateson et al. (1956) especially discusses this theory in terms of Schizophrenic symptom formation and proposed that schizophrenic symptoms are an expression of social interactions in which the individual is repeatedly exposed to conflicting injunctions, without having the opportunity to adequately respond to those injunctions, or to ignore them. The conflict arises when a family member (especially a parent) gives the child simultaneous but contradictory messages on various levels of communication. For example a mother welcome the child on verbal level of communication, however, her posture remains stiff while he try to embrace the mother.
What child learn from the type of interaction is the shame and hesitation as well as rejection from the parents, from whom child desperately want attention and belongingness. As Docherty (1993) found evidences, that communication deviance is greater for parents of offspring with schizophrenia, it should be of importance to consider that the communication with parents is of major significance. Bateson et al. (1956) stipulate that double bind interactions have a pathogenic effect only if they occur in a context where the accurate discrimination of messages is of vital importance for the participants, and in a relational context, which is characterized by intense levels of involvement between the participants.

The well illustrated literature of the significance of communication deviance as a family dysfunction is not only limited to the schizophrenia but it is also important in the studies related to other disorders. Family dysfunction is regarded as vulnerability for psychological disturbances, the evidences clearly shows that family dysfunctions is in fact a stressor that increases the probability of mental illness in an already vulnerable individual. Several studies have pointed to the significance of family-environmental stress for depressive disorders in youth, with studies indicating that family stress is associated with poorer outcomes (Asarnow, Goldstein, Tompson, & Guthrie, 1993; McCauley et al., 1993) and poor response to treatment (Birmaher et al., 2000; Emslie et al., 1998).

As the poor communication is indicative of dysfunction, the affective communication pattern is one of the most frequently mentioned characteristics of strong
families. Good, clear, and direct communication can facilitate the process of establishing and clarifying family roles, rules, and boundaries. Researchers characterize the communication patterns of strong families as clear, open, and frequent. Family members talk to each other often, and when they do, they are honest and open with each other (Stinnett & DeFrain, 1985; Lewis, 1979; Epstein, 1983; Olson, 1986). On the other hand, unclear communication by family members, especially powerful ones produces a stressful environment for other family members and can facilitate chaotic relations. Communication helps a person to determine how he relates to the world. However, it is not the only variable which results in pathology. There are other factors as well which determine our approach toward life.

Control is another dominant feature of an unhealthy or negative family environment (Moos, 1974), in which the system is very rigid--there is resistance to change (Minuchin, 1974). Families that can adapt their family rules and roles have a flexible behavior control style. Healthy families characterized by optimal cohesion and warm affective ties (Olson et al., 1979), are capable of adjusting to changing family situations; whereas, rigid families have trouble when faced with changing or difficult family issues. The "anything goes" style of behavior control is known as the Laissez-faire style. Families with this style of behavior have few rules or standards that guide family interactions. Families that have no consistent style, or that jump back and forth between styles have a chaotic behavior control style. This style leaves family members confused about their individual roles and the rules that govern their family's organization. Each style influences how a family adapts to changing family situations. Therefore, the amount
of control family members feel have influence how they react to different family situations. Of the four styles, i.e., rigid, flexible, laissez-faire, and chaotic (Peterson, 1999); the flexible style is thought to be the most effective for healthy family interaction (Epstein, Bishop, Ryan, Miller, & Keitner, 1993). In addition, lack of consistency in relations and chaotic behavior control in families, result in confused and disorganized family organization (Peterson, 1999).

Family power structures are also revealed in the roles family members play and the rules they enforce. Peterson (1999) in his work found families with a rigid control are very inflexible and leave little room for negotiation and change. In such families, individual members are forced to conform or agree to a set way of doing things within the family. For example in patriarchal families, power centers around one powerful male, generally a father. This person takes on the primary leadership role, making decisions and rules, while the rest of the members follow. In this situation Teresa and Viktor (2001) argue that less powerful family members are typically more adaptable role takers and followers, simply because they have learned to be adaptable as a coping mechanism: “the powerless need to adjust to the powerful more than the reverse”.

In our society (Pakistan) the patriarchal system is established in majority of families, which do not allow the members to communicate and share their opinions; even in those matters which can directly relate to their lives or careers. In majority of families the center of power is a person (father) who provides and contributes maximum financial support to family and gives dictations. The concept of right and wrong mostly depends on
the perception and experience of the dominant one. He introduces the rules in family and followers adapt the given roles by him. Any deviation in the practice of control in the families not only let a person confused, but let him more dependent on the family. It gives a progressive sense that one should not look forward for any decision out of the set. It hampers the person's capability to make decisions on its own and to resist anyone's decision to which he is not agreed. Bowlby (1988) found that over-controlling members may undermine the confidence of family members so that they become dependent, where as they develop indirect ways to resist control. This produce fear and dependency in the family members. As expected, family's high control is found to be linked to psychopathology, suggesting that individuals could interpret negatively any family attempt to limit their autonomy, a very important aspect of individual's life. Not only harsh and over control, but the inconsistent control is also found to be linked to psychopathology. Holmes and Robins (1987) found inconsistent and harsh discipline by parents, predict depression. Furthermore, Gerlsma, Emmelkamp and Arrindell (1990) reported in their meta-analysis no specific differences between depressives and patients with anxiety disorders. Both groups perceived more control by their parents than normal.

The issue of how much control is enough and how much autonomy is too much, is pertinent to populations at risk for emotional or behavior problems. It has been observed that when parents or grandparents are engaged in control, they try to resolve interpersonal disputes among family members under the shadow of their already existing perception about wrong and right. Thus, the member perceives themselves as victim of injustice while receiving the decision of the elders and either decided to submit or not. Either
choice promotes the escalation of frustration in family interaction. Submission if lead to
frustration can also result in anger, while not submitting to adult’s decision might lead to
shame, guilt as well as disturb interpersonal relationships. Hadley et al., (1993) reported
that the degree of family dysfunction was significantly related to internalized shame,
object relation deficits, presence of addiction, and emotional problems. It therefore
appears that dysfunction in the family of origin may effect several domains of an
individual’s life, two of which are problem solving communication, and global distress in
intimate relationships. In our culture adolescents and adult children (married or
unmarried) are expected to be obedient toward their parents. Sometimes there is even an
order of authority among the members themselves, with younger children being expected
to yield to older ones. There is an established pattern of dependence for the child to seek
advice and permission from parents when major issues confront their life, no matter what
age or what level of maturity the child has reached. Is a result, parents and children
(especially adult children) are simultaneously facing an authority crisis. Independent
behavior on the part of adolescents and adult children is not encouraged and parents hate
to loose authority. Now the adult members strive for independence, for the right to
govern their own lives and to make their own decisions. Parents have difficulties
changing pattern of child guidance and often uses inconsistent way of discipline. Some
times they become too rigid in controlling them to the extent that they physically and
verbally abuse them; on the other hand there are times they do not even care where their
children are. According to Balk (1995), the functioning of an ideal home enables
individuals to gain independence from and to remain connected with other family
members. Parents in an ideal home use democratic and authoritative methods of
parenting. Jaffe (1998) indicates that parents in an ideal home are warm, firm, involved and they use reasoning and persuasion to gain compliance. Discussions are often held with children and independent thinking is encouraged, resulting in the normal development and functioning of the family, which influence the system positively.

Though clear and appropriate boundaries distinguishing family subsystems from one another and clear rules that govern behaviors are thought to be critical for healthy family and child development (Minuchin, 1974), it is also important that these boundaries or rules do not become so rigid (or so loose) that the individuality of family members becomes compromised (Minuchin, Rosman, & Baker, 1978). Family with high control may ignore the individual because of their strong and rigid implementation of rule and boundaries. In this concern they don't take care of member’s personal needs and demands. They condemned emotional support which is necessity of person at the moment. As Reuter, Scaramella, Wallace, and Conger (1999) reported that family conflict, parental hostility, and harsh discipline have been related to adolescents’ psychopathology. What excessive control in family causes could be understood by considering the feelings of members, who find him caught between his personal/societal needs and the family's rigid rules and norms. The momentary flexibility might result in much psychological satisfaction, which preserve a person's mental health as well as enhance its positive interaction with in the family. Besides its great significance control is not the sole factor involved in shaping of the personality. There are other factors as well which determine how we see and understand the world and those living in the world. Involvement is one of these factors.
Involvement in present research refers to both the degree and quality of family members’ interest in one another. This interest might be expressed either overtly or might be repressed. This pattern then determines the emotional climate of the family. Family expressiveness or emotional climate is thought to be important in shaping children's beliefs about their own and other's emotionality (Dunsmore & Halberstadt, 1997) and emotional development is strongly related to healthy psychological functioning (Cicchetti, Ackerman, & Izard, 1995; Southam-Gerow & Kendall, 2002).

Swihart (1988) also reviews the basic concept as it manifests itself in strong families and stated that "strong families appreciated the uniqueness of each family member while cultivating a sense of belonging to the family. Individuals enjoyed the family framework which provided structure but did not confine". Thus, the development of the autonomy of its members, within a supportive environment, is an important function of the family, and a characteristic of strong families. Over involvement and preoccupation of family members regarding each other may create stress which influences the overall family environment. Data on diverse populations, including adults hospitalized for schizophrenia and depression (Vaughn & Leff, 1976), suffering from chronic pain (Mohammed, Weisz, & Waring, 1978), as well as children and adolescents with asthma and diabetes (Lamont, 1963; Minuchin, Rosmin, & Baker, 1978; Weiner, 1977) suggests that over involvement in close relationships may aggravate and perpetuate other problems. Emotional over involvement occurs in social relationships in which family members have become worrisome, overprotective, intrusive and excessively
indulgent and self-sacrificing in a way that burdens the patient and discourages autonomy and personal responsibility for self-care.

The most powerful method of the emotional development can be providing an environment where child has permission to share his emotions without any threat and fear of rejection, in a socially acceptable way. Even when at-risk individuals have opportunities to express their emotions in constructive ways, they are at lowered risk for adverse outcomes (Erickson, Korfmacher, & Egeland, 1992; Fraiberg, Adelson, & Shapiro, 1975). Conversely, at-risk persons who distance themselves from their emotions and do not experience or express them are at high risk for developing adverse outcomes (Cicchetti, Rogosch, Lynch, & Holt, 1993; Garmezy & Masten, 1994; Masten, 1994; Rutter, 1987; Werner & Smith, 1992). The child who has opportunity to express his/her emotions then develops an emotional competence. A number of theorists have suggested that emotional competence is thought to arise through experiences with the social environment, with parents exerting a strong influence on the socialization of emotional expression skills (Calkins, 1994; Kopp, 1989; Saarni, 1999). Emotion socialization can occur through direct instruction and contingent responding but also in indirect ways such as modeling, family's emotional climate, imitation, social referencing, expectancy communication, and exposure to emotionally eliciting stimuli (Saarni, 1999). Perhaps one of the most indirect methods of emotion socialization is through the emotional climate in the household (Halberstadt, Fox, & Jones, 1993; Thompson, 1990). Environment dominated by the persons high in the expression of emotions or with very low expressions is equally toxic and inhibits a person's spontaneous expression of emotions.
irrespective of his own relating style. Related research in the area of parenting practices suggests that expressed parental overinvolvement, criticism, and control may directly and indirectly influence regulatory abilities of both anxious children and children at risk for anxiety disorders (Dadds & Roth, 2001; Donovan & Spence, 2000; Hirshfeld et al., 1996; Siqueland et al., 1996). Dunsmore and Halberstadt (1997) suggest that the "over-all frequency, intensity, and duration of positive and negative emotional expressiveness in the family is important in the child's formation of schemas about emotionality, about expressiveness, and about the world". The more involved a particular child is in the emotional process of the family, the more dependent the child becomes on family relationships and the more anxiety he or she develops (Kerr & Bowen, 1988). An individual while getting an over involved expression of emotions from any member of the family either tries to escape the situations to avoid the discomfort or become dependent on the respective member, with increasing demand of attention and involvement. In the former case he/ she might be expected to react either harshly or with indifference; in the latter he/ she might be over demanding; failure to achieve compliance from care taker may push the person to some sort of deviant behavior which can facilitate his even irrational demands. Whereas families with less involvement may inhibit a person’s capability of spontaneous expression; thus making him prone toward depression. The individuals living in such family may have difficulty responding to their expression of emotions. The result would be a confusing and overwhelming state. Thus both high and low, expression of emotions and involvement may result in a more seriously disturbed interpersonal relationship in near members of family. In a study involving families of anxious children preliminary evidences were provided that through
discussion, parental practices influence the development of emotional skills (Barrett et al., 1996; Dadds et al., 1996). Child often fails to understand when and how to express. He even failed to know when and why others are behaving in a certain way and how to handle the situation socially to avoid any embarrassment. The confusion thus results in the distorted perception of the world as well as excessive reliance on unhealthy defensive personality structure.

With reference to adult’s (contributed in the present study) perception of involvement and its negative consequences, it’s hard to say that the way of interaction with high involvement can be a one way process. Usually the interaction and relations become characteristic patterns of a home environment as they form a vicious cycle. The greater expectations from young adults due to lack of financial resources; the greater involvement of parents in career decision making; the hindrance in personal independence as an adolescent grows into a young adult; and lack of acceptance of personal goals from the family as they are inconsistent to family’s goals for survival; all are the example of the situations where the boundaries of self from intimate ones get blurred and thus create a highly emotionally intrusive environment, uniquely affecting the person’s mental well being. The person thus becomes vulnerable to respond either in an emotionally over involved way or distantly, thus enhancing the mutual dissatisfaction and lessening tolerance for each other. The sacrifices one made after getting affected from family’s persuasion of interest and to meet the demands of family members, leads to anxiety in individual and enhance his expectations from the family. The reaction is of course a person with high involvement in the family or a highly constrained individual
with the same characteristic dealing with others in the family. Thus the function seems reciprocal and forms a never ending cycle. However it should be noted to discriminate that involvement is the pattern of interaction not the mere behavior with each other.

Unhealthy families unable to protect their boundaries do not give members room to negotiate their independence. Achieving this balance is often difficult in fast-paced culture. These families need to reduce the over involvement or to increase the low emotional involvement by some family members, which allows room for others to accept their family responsibilities. Healthy families are able to maintain a consistent level of involvement with one another, yet at the same time, not become too involved in each other's lives. Therefore, the focus is on how much, and in what ways, family members show their interest and investment in each other. Both over involvement and under involvement are thus the patterns of behavior that can pose problems for families (Epstein, Bishop, Ryan, Miller, & Keüner, 1993; Sherman, & Fredman, 1986; Olson, McCubbin, Barnes, Larsen, Muxen, & Wislon, 1983), which may effect psychological well being of its members.

While reasoning the emotionally involved family, it would be unwise to overlook the cultural context. Pakistani culture has been developed under conditions overpowered by various economic, social, political, psychological and religious conflicts intrinsic to it. The result of course is marked disappointment, failure, and hopelessness on the part of its people. As a result involvement in the family has increased as the social relations out of the family get restricted. In case of joint family structure the attention is not focused on
the immediate family and expression of emotions become balanced. But in nuclear family structure the chances of excessive involvement in the immediate family seems to interfere in the emotional development of the children in the family. The drastic changes in the environment of Pakistan, is supposed to be the major factor involved in the over involvement in the family. Connard (1996) discusses that many parents must cope with the threat of violent crime in their neighborhood. A family's response to demands and challenges from a community environment may promote or hinder family functioning and child development. Withdrawing emotionally, keeping children inside, and restricting child activity are coping strategies parents use when faced with violence in their neighborhood, but they may also impede normal development (Garbarino & Kostelney, 1993). In Pakistan, especially in Karachi the environment compelled people to strictly protect their children and other family members while going out for schooling, playing, buying and different other activities, which are creating fear and sense of insecurity in elder members. So, generally people are overly involved to protect their families, compelling family members to over-protect their children, adolescents and adult children. According to Kolb (1973) and Freeman, Kaplan and Sadlock (1980), parental over involvement has been regarded as similarly harmful in its consequences as deprivation of care, and has been blamed for having a determining influence on the development of a wide range of mental disorders.

The encouragement of individual members, expressing appreciation, and commitment to family, are all affective aspects of family life that are closely related to a dimension identified by several researchers as cohesion. Cohesion was indicated by
"open displays of affection among family members, working together well as a team, doing interesting things together, and finding home a fun place to be" (Rossi & Rossi, 1990). Olson defines cohesion as the feeling of closeness and attachment of family members to each other. Thus, Olson defines cohesion as a sum of, among other things, commitment, appreciation and support, and the encouragement of the individual within the context of the family (Olson et al., 1982). The encouragement of individual members encompasses a wide range of affective dimensions related to support, recognition and respect. Cohesive family environments, which are marked by such characteristics as warm, affective ties, were found to be predictive of decreased internalized symptomatology (Johnson, LaVoie, & Mahoney, 2001). The cohesiveness in the family of origin is of major significance as Rossi and Rossi (1990) points out that "Family of origin cohesiveness consistently and positively contributed to adult child-parent intimacy". The person maintaining others and his/her own boundaries of independence learn to express his concerns and affects with each other without any hard feelings. Such an intimate and positively involved environment might be helpful in shaping the healthy and strong environment of the family. The cold or distant relationships on the other hand are disastrous to the child health. When parents were cold, unsupportive, or neglectful, their offspring's social relationships throughout life were more problematic and less supportive (Booth et al., 1994; Bost et al., Graves, Wang, & Mead, 1998; Kerns et al., 1996; Larose & Boivin, 1998; MacKinnon-Lewis et al., 1997). The interaction thus goes on and develops a characteristic pattern of interaction within the family.
As discussed earlier not only the over involved attitude appears to be harmful. The families whose members do not have an emotional investment in one another, lacks care about each other’s activities, and feelings, show that they do not care about what others are doing are the most ineffective type of families. While on the other hand over involved families, create hard feelings among family members with intrusive and over-protective behavior. Some studies have found that high emotionally over involved parents make more intrusive statements (Strachan et al., 1986) or more ambiguous and unclear statements (Hubschmid & Zemp, 1989); others have found that they do not differ in behavioral interactions compared to low emotionally over involved parents (Hahlweg et al., 1989). Another research suggests that families with a depressed member (compared to normal families) tend to show more rejection, more dysphoria, and possibly more over protectiveness. They are less involved, display less happy affect, are poorer problem-solvers, give less positive-reinforcement, and have poorer role functioning. Also, the depressed members may have a perception of how the family is functioning that is at odds with those of the rest of the family (Katz, 1999). Thus a family either over involved or less involved both failed to provide the usual support system a person require for the handling of everyday life problems, and maintaining of psychological well being.

The members of a family with balanced expression of involvement provide an opportunity to exercise their autonomy with a sense of support and care from other members of the family. It is thus through this process that a person identify his/ her real potentials and healthy ways to relate the world. Each family is an important locus of emotion and identity for all of its members (Heard & Linehan, 1993; LaRossa & Reitzes,
1993; Sabatelli & Bartle, 1995). The members learn from the family how and where to show emotions, and what characteristics they have to interact with others, which is explained by Emde (1994) as "Humans have an ‘affective core’ that is intertwined with knowledge of our selves over time in relation to others". Bray asserts the significance of affects and emotions as "Affect and emotion usually set the tone and context for other family processes" (Bray, 1995). However, along with affects self concept of an individual is also a contributing factor which holds major significance in the development of psychopathology.

Self Concept and Psychopathology

There is a growing recognition among social psychologists of the importance of self concept and the development of a person's sense of self for a full understanding of human personality (Walsh & Vaughan, 1980). A number of previous studies have reported lower self-concept in psychiatric patients as compared to normal controls. Research has shown that a negative self-concept is often associated with clinical depression (Dobson & Shaw, 1987). There are a limited number of previous studies regarding self-concept of psychotic patients, although one recent large study has suggested that low self-esteem may be a risk factor for development of psychosis (Krabbendam et al., 2002). Nickols (1966) also reported that patients with psychotic disorders had low levels of self-concept as compared to control group. Previous studies have also found lower levels of self-concept in anxiety disordered patients as compared to controls (Cowen, 1976; Bond & Lader, 1976; Felix Gentil & Lader, 1979). Our findings confirm these previous studies and extend them.
based on the following key findings. The present study shows that the participants with psychiatric illness had lower self-concept than control group. Analysis of the results (Table 4; \( F = 42.918, \text{df} = 3,176, p < 0.05 \)) indicates significant difference between groups with and without psychopathology on the variable of Self-Concept. Further more results of binary Logistic Regression (Table 4 (b) & (c); \( Z = -6.71, p < 0.05, G = 89.09, p < .000 \)) also reveal Self-Concept as significant predictor of psychopathology.

Self-concept simply refers to how a person feels about him or herself. According to Baumeister (1998), self-concept is the interpretation and enactment of the idea of self in the environment. Self-concept is a construct made up of cognitive, behavioral, and affective components (Blascovich & Tomaka, 1991). The behavioral component is that aspect of self that is observable to others while the cognitive aspect is that part of self that is internal, private, and reflective (Marsh & Hattie, 1996). The affective component of self-concept includes the evaluative component of (good or bad) feelings about self (Harter, 1996). This evaluative or judgmental component of self-concept is self-esteem (Blascovich & Tomaka, 1991). Self-concept is the representation of the self based on the integration of these behavioral, cognitive, and affective components. Researchers have discovered that there is a noticeable difference in the characteristics of individuals with high (positive) self-concept and those with low (negative) self-concept. For the most part, individuals with a high self-concept tend to be happier, more confident, and less afraid of failure. They tend to take more risks, and when they do fail at a task, they tend to bounce back and try again. The opposite is true for individuals with a low self-concept. Harrelson (1996) states that "poor self-concept leads to, difficulty in accepting responsibility, fear,
apathy, anxiety, defensiveness, and lack of success”. For a person with low concept of self, the world appears as a misery. The sense of combating and struggling at every moment in life to preserve the image in front of others; sense of always remaining on guard, with the fear of being exposed to others; shame even on minor thoughts and feelings, make survival difficult for a person with low self-concept. Global self-concept can also act as protective coping resources. A study suggests that low self-esteem and a negative self-concept have been associated with greater emotional responses and increased self-protection efforts, thus resulting in the individual being more malleable to external cues (Baumeister, 1998). Conversely, Baumeister further suggested that, high self-esteem and positive self-concept are associated with a greater sense of ability and persistence in the face of failure. Moreover, individuals with positive perception of self endure threat, loss, and misfortune better than individuals with negative self-concept.

It would thus not be difficult to understand that why the low self-concept is undoubtedly the feature of all the psychological disorders under study. Previous researches with victims of different disorders not only acknowledge the presence of low self-concept in clinical population but also discuss the causal role of low self-concept in various disorders. Self-evaluation is crucial to mental and social well being. It influences aspirations, personal goals and interaction with others. Feeling low not only result in distorted perception of other’s actions and intentions, but result in decreased ability of communicating one’s own thoughts and intentions. It creates stress and the result is disturbed interpersonal relations, which are supposed to play major role in psychopathology. A negative view of self can also adversely affect interpersonal
functioning by hampering the ability to sustain satisfying relationships and secure attachments (Cole & Putnam, 1992). Previous research has found that when compared to those with positive self models, individuals with a negative view of self show lower levels of competent functioning in areas which encompass relating to and interacting with others (Bylsma, Cozzarelli, & Sumer, 1997). For this reason, it is thought that having a negative view of self may interfere with adaptive interpersonal functioning (Foa et al., 1989; Muller et al., 2001; Roberts et al., 1996). Researchers have argued that people with a strong self-concept may have coping strategies that are more problem-focused and less emotion-focused than the techniques employed by people whose self-concept is weak (Mullis & Chapman, 2000). Thus, depression stemming from stress may be averted by a strong self-concept, whereas a low self-concept increases the probability of being depressed (Pearlin et al., 1981; Burke, 1996; Rosenberg, Schooler, & Schoenbach, 1989).

The results stress the importance of self-concept as a protective factor and a non-specific risk factor in mental health, as self-concept has been found to be protective against stress (Longmore & DeMaris, 1997; Thoits, 1994). Evidences suggest poor self-concept as associated with a range of mental disorders either psychoses or neuroses. It seems likely that people who begin to seriously devalue themselves have difficulty maintaining the belief that life is meaningful. Life has little purpose if one's self lacks value or merit. It follows that morale and motivation dissipate quickly in the face of perceptions of meaninglessness and purposelessness. As individual grows and develops, various dimensions of the self become more or less important to the individual. Each dimension of self is also identified and interpreted based on the individual's ability to
successfully fulfill standards associated with that particular dimension. As a person with high self concept set goals accordingly and get motivated to strive for them, it is their self concept which help determine developmentally appropriate goals and motivate him/her for achievement of goals besides frustrations. Franken (1994) states that "there is a great deal of research which shows that the self-concept is, perhaps, the basis for all motivated behavior. It is the self-concept that gives rise to possible selves, and it is possible selves that create the motivation for behavior". The individual's self-concept has been shown to be highly influential in much of his or her behavior (Roid & Fitts, 1998). Individuals who see themselves in a positive light tend to act accordingly. Therefore we may conclude that important feature of people who become psychologically disturbed is that their self concept is low which makes them vulnerable and liable to crumble in the face of stress with which others would cope adequately.

In adulthood, the negative, incohesive self may be characterized by a lack of self respect, a lack of autonomy in relation to others, and a belief that the self is unworthy of love and support (Roberts et al., 1996). These negative feelings ultimately jeopardize adaptive psychological functioning and coping mechanisms (Foa, Steketee, & Rothbaum, 1989; Muller et al., 2000; Wolfe & McGee, 1994). The finding that self-perception predicts psychopathology has important implications for treatment. The results of the research by Muller and colleagues (2000, 2001) suggest that therapeutic intervention can be particularly beneficial if it provides clients with a combined promotion of positive self-development and opportunity for social connectedness.
Family Functioning and Self Concept

This portion explores the association between various aspects of family functioning and self-concept in adults with psychopathology. These aspects such as communication, involvement and control in the family are supposed to be crucial in determining the self concept in adults.

Consistent with the existing literature present study also reveals similar findings. Multiple Linear Regression analysis on the sample with psychopathology (Table 5 a, & 5b, $R^2 = 0.345$, $F = 15.110$, df = 3, 86, $P < .05$) indicate that family functioning is a significant predictor of Self-concept. Further stepwise regression analysis (Table 5c) with the three variables of family functioning entered as the predictors of self concept suggest significant variation explained by the variables under study. At step one Communication ($F = 13.523$, df = 1, 88, $P < .05$) explains 13 % variation in the scores on self concept. However, with the inclusion of control at second step ($F = 18.696$, df = 1, 88, $P < .05$) and then involvement at third step ($F = 15.110$, df = 1, 88, $P < .05$) the variation explained increase up to 30% and 34% respectively. It would be noteworthy to state that the variation explained by communication reduces after the inclusion of control at second step, and similarly after inclusion of involvement at third step lower down the variance resulted from the communication and control. It suggests the high correlation among the three variables (Table 8a) that is, between communication and Control ($r = 0.476$, $p < .000$), between communication and involvement ($r = 0.596$, $p < .000$), and between involvement and control ($r = 0.778$, $p < .000$); and the major role
of involvement, in communication and control. The three variables however, appear as the determinant of self concept in individuals. A poor self-concept is influenced by lack of love and security, which is manifested as being unhappy and miserable, having poor self-esteem, communication problems, and not being able to adjust to new social situations. According to Hattie (1992), the development of self-acceptance and self-esteem depends upon the quality and nature of the various interactions that occur. Essential to social interaction are the issues of empathy, trust, nurturance, and expectations. An immediate environment holding these characteristics would be beneficial for mental health. It is in this positive emotional climate that the child can develop high self-esteem and a positive self-concept (Banham, Hanson, Higgins, & Jarrett, 2000). An individual require relating to certain figures in his immediate environment for his survival. When these figures are capable of handling the emotions appropriately, meet the needs of person, can be confided over, the individual functions appropriately.

In disturbed families the members are not sensitive to each other's needs. The most emphasis usually lies on the personal needs and feelings. Problems are not shared; communication is deviant; environment is dominated by high involvement and high control exercised with each other. Billings and Moos (1984) stated that, when family members are less supportive of each other, result might be the low self-esteem, anxiety, and depression. Further Heilburn (1973) supported the view that dysfunctional parental rearing has an important negative impact on the development of self-concept which develops schizophrenic psychopathology. Empirical evidence suggests that adolescents
who are excessively constrained psychologically are more likely to develop internalizing problems whereas behaviorally over controlled youth are at greater risk for a drop in self-esteem (Robins, John, Caspi, Moffitt, & Stouthamer-Loeber, 1996).

Keeping in view the above mentioned researches it appears that relationship patterns in most instances are responsible for the development of person’s concept about the self, though the relationships patterns are also result of problems either in the individual or in the person to whom he/she relates. Already fearfuly avoidant and preoccupied adults are at greater risk of being involved in adult relationships which confirm their already negative views of self (Alexander et al., 1998; Carnelly, Pietromonaco, & Jaffe, 1994). In contrast, some adults identified as dismissing may overtly deny that they have interpersonal or psychological problems (Alexander et al., 1998; Kobak & Sceery, 1988). According to Main (1990), dismissing adults actually deny their negative affect as a way to avoid and protect against possible future rejection from attachment figures. The efforts might be to secure and preserve self from threats. Thus negative immediate environment either confirm the negative beliefs or threat individual’s belief system, both lead to dysfunction.

Not only the negative family environment result in deficits in self concept but the positive environment in family is expected to result in better outcomes. The most important relationship in the family reported to have major effects on the person is parent child relationship. A good parent according to Benjamin (1994) is able to provide a blend of emotional warmth and availability, acceptance and individuation, and structure,
protection and nurturance teaching”. Individuals whose relationships with their attachment figures are characterized by these parental behaviors would likely to internalize positive working models of self and others and exhibit healthy development, while those who perceive rejecting, blaming, and neglecting parental behaviors would exhibit interpersonal problems and a negative self-concept.

Like other societies of the region, in Pakistan the most influential family members are parents, who constitute one’s immediate family environment. Usually the family functioning revolves around the concept of parental practices and interaction. Certain parenting practices which may cause excessive feelings of inferiority include over-critical, over-demanding, over-protective, over-controlling attitudes. The negative can erect "roadblocks" in the child’s mind, as the message sent is one of judgment, blame and criticism for failing to meet expectations (Porter, 1997). In Pakistani society there is a great pressure on the male child for success, from the parents. Parents expect them to be outstanding and consider it their responsibility to look after their educational matters and career decisions even when they become older. As the child has grown up, he has to support the family along with father. For female child same expectations clouded the interaction in context of both education and home responsibilities. As the child fails to meet the high parental expectations, parent’s verbal and non verbal reflection of disappointment soon let the child to great distress, and low self concept. Dreikurs and Soltz (1995), states that the child who has been exposed to ongoing negative feedback, withdraws and stops communicating with the parent. This lack of communication and escape from the home environment as well as significant figures in the environment, in order to avoid criticism let the child detached to the family. This detachment soon leaves
the child with lack of support and resentment, leading toward the psychological vulnerability in the face of distress. González-Mena (1993) states that, a family where parents provide a balance between control and independence is likely to produce a child who is competent, socially responsible, self-assured, and independent. A research to investigate the relationship between self-esteem and family functioning was conducted by the Todd, Gustavo and Jessica (2000). The result demonstrated highly significant, though relatively low correlations between self-esteem and positive family affects; family communication; family conflict; family worries and anxieties; and family rituals.

The question thus arises why the family is so influential in determining the nature of self concept. Among few researchers who tried to answer the question Monane (1967) pointed out that in the family social system, each family member influences, and is influenced by the other members and producing a family environment, or climate (Moos, 1975). Family climate is determined by the interpersonal relationships among family members, the emphasis on personal growth, and system maintenance—the organizational basis of the family (Moos, 1974, 1984). Thus, family climate and relationship styles play a role in its members' self-evaluations and psychological health. The three characteristic patterns of the family functioning that is communication, involvement and control studied in this research found significantly different in those with psychopathology and normal individuals, and found to be related to self concept as well. What these three factors specifically cause is the sort of toxic environment, which set the stage for further pathology. The over involvement from the family members specifically the parents let the child dependent and shy. This over involvement most of the times also paired with over
control, demands the person to submit to the high expression of concerns reflected by the adult family member. The result of stepwise regression analysis reports that involvement is the major contributor in self concept; and in communication and control patterns in families as well. Child confronting with high involvement eventually lack decision making skills, his personal opinion get restricted, and when he exhibit the same behavior in settings other than the family including school/ college, workplace, the feedback confirm his prior self evaluations formed on the basis of family’s feedback. Acquisition of self-devaluated schema during the early years may also lead to a lack of confidence in future endeavors (Beck, 1973; Clark & Beck, 1989). Besides the over involvement, the lack of involvement also leave the child with the feeling of rejection and apathy. The child feeling left alone and helpless to get adequate attention and expression of emotions soon learn to stay behind and have experience low feelings. The feelings eventually lead to a person likely with a depressed personality. It would be interesting to note that all the possible implementations of involvement seems much interrelated to the exercise of control and methods of discipline, which also get evidence from present study. The lack of control however, might result in the child’s behavior problems. Feedback to which might lowered down his/ her self concept. Further when child feel his parents or care givers as indifferent to what he/ she is doing, too loose in control, child probably interpret it as the lack of involvement and the results will be the same, in this case too. In case of communication, besides previously discussed ambiguity and confusion of the child, child also fails to receive sense of feeling that someone is listening and understanding him/ her. Lack of open, clear and healthy communication also relate to the lack or excess of involvement. While the high involvement person likely to communicate inadequately,
similarly when a person in the family exercise ambivalent and unclear communication, it might be perceived as low involvement. In most of the instances when authority figures in the family donot want to communicate openly they exercise control inappropriately. However, the interesting interaction among the three variables of Family functioning is beyond the scope of our study and need to be addressed in future research. Besides this possible relatedness of communication, control and involvement, the most probable result of deviant communication is the detachment of the individual with family members as well as others in environemnt, because the person with rejected feelings becomes fearfull in making new relations and maintaining old ones. Individual fears that others might be similarly rejecting for him/ her. The sense that problems are shared will be possible only if the communication is empathic. Person not only suffers lack of self worth but also failed to learn communicational skills, which is necessary to form any other healthy relationships outside the family. Poor family communicational skills are found to be related to shyness (Huang, 1999) and development of reticence (Kelly et al., 2002).

The family with deviant practices or imbalance organization is thus the most crucial aspect of one’s life. Person might find him in a world from where no escape is possible; find him/ her incapable of dealing with stressors, either emerged from within or outside the family. The coping skills become low and appear ineffective. This further decreases self worth of a person.

It is also worthwhile to discuss whether the reported perceptions of the person about the family are true or not. The matter of fact is that not necessarily a person is
being treated, or has faced the practices he or she reported; these are his/ her mere perceptions which might be true or not. But this is what he/ she perceive. Similarly, Webster and Sobieszek (1974) found that credibility of evaluator has substantial effect on the individual’s task-specific self perceptions. Besides the debate that what would be the credibility of these perceptions as they are just self reported, an argument exists which needs to be answered that why a person feels in this way? There should be certain characteristics of the family environment (i.e., appreciation, empathy, support during stress etc.) which makes a person’s perception about family and its environment in a specific direction. The toxicity of environment influences the mental health of the person. For the better understanding of these toxic elements of the family environment the most reliable source are of course the victims.
CONCLUSION

When individuals move into adulthood, developmental goals focus on productivity, growth and intimacy including quest of good education, work and job, leisure and entertainment, creativity, and personal and group relationships. At one end good mental health enables individuals to deal with hardship while pursuing these goals in a positive direction, while at other end, untreated mental disorders can lead to lost productivity, unsuccessful life, disturbed relationships, and dysfunction. Both family functioning and self concept are vulnerability factors which effects an individual's functioning resulting in lack of social support and appreciation (other than family), unemployment, and insecurity etc. which may make the condition worst. Mental illness may also have a considerable and continuing effect on family interaction and growth, and this cycle thus continues, which can further provoke emotional and behavioral reactions that jeopardize mental health. Present research has contributed to our ability to recognize, the family factors which are solemnly responsible for the psychopathology.

Psychopathology is seen as occurring when certain norms in families cease to serve the needs and interest of the individual. Early theorist as Arieti (1966) discusses the role of family environment in the development of psychopathology, and stresses that culture and society are also one of the most important factors in psychopathology. Culture and society like the family remains important psychodynamic factors because they do affect the psychodynamics of the family and of the sense of self. Thus indirectly they may contribute greatly to the engendering of mental illness. Caligiuri et al. (1998)
assert that the family is affected not only by individual behaviors but also by the collective experiences of the entire family. The family with negative experiences might adapt distorted patterns of functioning as the whole. A family in its own is not mentally healthy and might lack the sense of worth; which it transfers in the mentally ill family member. If feeling insecure, overly indulged, highly emotionally expressive and frustrated from society, members tend to exercise greater involvement and control in family and their communication patterns deviate from that of the healthy ones. As Goldenberg and Goldenberg (1985) put it, the family might be thought of as a living, self-regulating system, which maintains constant exchange of information and energy and each member is being influenced by each other. This process thus continues and results in greater dysfunction in family.

Dysfunctional families are characterized by deviant communication, inadequate involvement and inadequate control, relationships that lack warmth and support, and neglect of the needs of family members. These families are vulnerable in multiple ways. First, several of these characteristics, most notably poor communication, inconsistent involvement and control represent immediate threats to the psychological growth of family members. Secondly, these individuals when fails to adapt to the threatening and stressful family environments, in result have increase likelihood of developing psychopathology. Third, dysfunctional families fail to provide children and adult members with important self-regulatory skills, leaving them unable to procure social support and family support or to deal with emotion-engaging interpersonal situations. A number of researches provide the evidences of importance of family/parenting practices in the development of psychological problems (see e.g., Yu & Seligman, 2002, Ruchkin,
Koposov, Eisemann, & Hagglof, 2001; Zahn-Waxler et al., 2000). The deviant practices in family results in the risks which are multiple and pervasive, and they are related to each other through common interpersonal, psychological, psychosocial and environmental pathways. They place individual not only at immediate risk, but also at long-term and life-long risk for adverse mental and physical health outcomes. This study has highlighted the need for education about family practices, and the need to raise awareness of the impact family has on self-concept of their members. Children (young or adult) need a supportive and friendly environment where caring elders (Parents or siblings) interact with them, using positive communication based on respect, reciprocity, warmth and organization; a balance expression of involvement and necessary exercise of control, avoiding too harsh or too lenient control. As individual need clear messages to function in this complex world, other family members must assist by meaning what they say and saying what they mean. Doherty in 1997, recommend that the importance and necessity of every family is to intentionally create opportunities to be together through family celebrations, special occasions, community involvement, and everyday family rituals such as playing games together or reading bedtime stories in order to strengthen the family. Thus the need is to promote necessary independence, autonomy and to communicate rules clearly as well as openly, while preserving appropriate level of involvement and belongingness.

Research results show beneficial outcomes of positive self-concept, which is seen to be associated with mental well-being and happiness (Zimmerman, 2000). On the other hand, Mann, Hosman and Schaalma (2004) assert that poor self-concept is associated
with a broad range of mental disorders and social problems, (e.g. depression, suicidal tendencies, eating disorders and anxiety). It is also associated with better recovery after severe diseases. Self-concept is found to be inversely related to anxiety (Grills & Ollendick, 2002); depression (Harter & Whitesell, 1996); psychopathological symptoms (Donnellan et al., 2005); psychological dysfunction, psychopathology, and maladjustment (Tzonihaki, et al., 1998) such as loneliness, depression, and anxiety. What make the risk as pervasive might be the distortions in self concept. Self-concept is believed to be a “multidimensional and dynamic system of beliefs” (Cole et al., 2001). The beliefs about self are learned through the interaction with the persons available in immediate environment. Self concept is influenced by the need for approval, positive regard, love, care and appreciation. In an ideal family the members are warm, firm, involved and they use reasoning and persuasion to gain compliance. Open discussions are often held among members and independent thinking is encouraged. Therefore in this environment members show interest in each others activities and sympathy are often expressed which strengthen the emotional bonds among them. Any deviation i.e. over-involvement or low involvement deteriorates the perception of self and also influences other family variables like pattern of communication and control. Involvement as having strongly related factor with control and communication can also result in the deviant communication as well as inadequate control when exercised intensely. The interaction of these three variables can result in a very stressful environment for the individual, to which coping might be very difficult because of unavailability of immediate support system; and can result in more devastating effects on mental health and self concept of the person. This self concept further deteriorated with both ongoing family practices and feedbacks and can result in
psychopathology. Research evidence suggest that the poor self-concept can result in a cascade of diminishing self-appreciation, creating self-defeating attitudes, psychiatric vulnerability, social problems or risk behaviors (Mann, Hosman, & Schaalma, 2004).

Regarding the development of psychopathology the perception of self as discussed by Baumeister (1998) is very important. According to him there are three types of information an individual will actively seek about the self i.e., accurate information; favorable information; and information that confirms existing beliefs about self. A threat to self-concept occurs when any of these three types of information is inconsistent and cannot be refuted. As reported in earlier chapters what Rosenberg (1979) states about self concept, individual's self-concept is deeply influenced by the attitudes of significant others with whom he or she most intensively interacts. What a family with deviant communication patterns reflects to the target member of the family is the sense of rejection and low worth. Same is true for the involvement and control; the two variables create a feeling of being dependent and worthlessness. Thus result can be the low self concept or to further infer- the psychopathology. Variables in the family (e.g., cohesion, communication, parenting quality), school (e.g., school bonding), and peer (e.g., peer support, peer antisocial behavior) contexts have been found to be related both to self-perceptions (Guay et al., 2003; Harter, Stocker, & Robinson, 1996) and to depressive and adolescent pathological symptoms (Pettit, Clawson, Dodge, & Bates, 1996; Vitaro et al., 2000). The family thus found to be related to self concept and both self concept and family functioning found to be related to psychopathology. The answer to the question that whether the prior self-concept affects subsequent family functioning or prior family
functioning affects subsequent self-concept is quite unclear as different studies report contradictory findings in different cultures. Hence we can assume that self-perceptions influence the way one acts, and these behaviors in turn influence one’s self-perceptions. Therefore, self-concept enhancement through quality family practices can serve as a key component in prevention and health promotion. The design and implementation of mental health programs with self-concept as one of the core variables is an important and promising development in health promotion.

Family dysfunction and low self-concept both lead towards psychopathology (Landazabal, 2006). Thus Family functioning and Self-concept are important risk and protective factor linked to a diversity of health and social outcomes. Intact family interaction and positive self-concept promote goals, expectancies, coping mechanisms, and behaviors that facilitate productive achievement and impede mental health problems. Results clearly demonstrate the pervasive significance of the self-concept model and family interaction affirm that it is indeed in the public interest to improve family functioning and enhance self-concept to maximize human potential. It can be concluded that the immediate environment and consistency in self perception contribute in the psychological wellbeing of individuals and make them able to utilize their potentials in favor of self, family and societal growth as results of the present study are in the favor of normal adults. Findings also indicate that self-concept and family functioning exert direct and shared effects on mental health and suggest that interventions for clinically referred adults should target both the individual and his/her family.
CHAPTER VIII

IMPLICATIONS AND RECOMMENDATIONS

CLINICAL IMPLICATIONS

Present Research will provide certain benefits for the practitioners / researchers in the field of clinical psychology and psychiatry, especially who are working in the subcontinent (e.g., Pakistan, India and Bangladesh), which can be understood by reviewing the following facts:

Present research will provide mental health professionals an understanding of perception of clients related to the family in a clear, nonjudgmental way. Research will enhance the understanding of the underlying factors involved in the development of psychopathology as well as self concept, with reference to family practices. Clinicians thus get benefit from it and can plan better therapeutic strategies for the maximum help of the clients. Patients' psychological problems are thought to result from a lifelong transaction between emotional vulnerability and invalidating features of the familial environment. The vulnerability factors, including self-concept, perceived communication deviance, over-involvement and inconsistent control, offer guidance to identify those at risk. Research will also help to enhance the contributions of all family members to emotion regulation and interpersonal skills deficits, as family interventions have become important component of treatment for a number of psychiatric disorders.
This research will improve our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly manifest special problems in this age group in Pakistan. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, despite of recovery of function by some individuals in mid to late life.

As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity, and personal relationships. Good mental health enables individuals to cope with adversity while pursuing these goals. Current research thus indicate a major draw back in pursue of these goals because of disturbed mental health. It would also be an important contribution as most of the previous studies on this issue addressed specifically children and adolescent age groups. Studies on the adult population seem rare. Present work has studied the issue in adults who are living with their family of origin.

Understanding the impact of personal perception of self as it applies to health behavior has important implications in developing effective strategies for health education interventions. This research also highlights the importance of caregivers in the development and maintenance of psychopathology. It also stresses the need for the awareness of caregivers about the better family practices. Counseling of caregivers thus provides better outcomes in the treatment of mental disorders, as family therapy is as necessary in the treatment of mental disorders as the individual therapy.
Better family practices will be helpful in reducing the chances of relapse, as after treatment a person need great amount of support to again relate to the community for survival. Family member’s response to the illness usually appeared in the form of deviant family practices including over involvement, expressed emotion and else. The reduction in these responses will help the person with mental disorder to better cope with his cure, which already pushes the person again in the world of anxiety and stress.

PUBLIC POLICY

This research will also provide certain benefits for the policy makers, Sociologist, social workers, and psychologist, which are illustrated below:

As untreated mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction, mental illness in adults can have a significant and continuing effect on whole society. Thus to avoid the increasing risk of mental illnesses, the policies should be needed to be designed and to be reevaluated, in order to successfully enhance awareness related to better family practices, and development of positive self concept in individuals from very outset.

For the improvement of family system and creating a change of attitudes in the social structure is required. A shift is required from number / statistic oriented approaches toward the need focused planning. The cooperation of families and care givers are also
required which should be included in the policies. Especially parents as being the major
decision makers in the family would be effective to be involved in the program.

Along with awareness, implementations of programs leading toward training of
parents as well as reinforcing the better attitudes in the family are the need of the day.
Modeling the better practices from media (electronic & print) will be the most effective
way toward pursue of abovementioned goals.

Some initiatives by the government have been taken in these areas. However,
there are still important gaps and insufficient focus on mental health needs. The focus is
to acquire much needed education of psychological disorders as well as to modify family
patterns, other dysfunctional patterns and improve self concept that affect, both the
family unit as a whole and, in particular, the individuals at risk. Policies are required
regarding the training of parents, facilitating the appropriate methods of discipline and
adequate family practices, to minimize the risk of mental disorders. School curriculum as
well as parental counseling may be a source of implementation of such policies.

Policies should be formulated for the welfare of care givers. As most of the care
givers are stressed out and need appropriate resources to ward off their anxieties,
frustrations and insecurities. Policies are also required to enhance the involvement of
community in intervention programs. After successful intervention person with mental
disorders have to rejoin the community. The lack of such resources leads him toward
segregation and distress.
For the better cure of such patients, rehabilitation is the most desirable treatment service. Rehabilitation centers, half way houses, day care centers are the requirement of person with mental disorders especially of those with chronic and severe condition, which require immediate attentions.

Better health facilities are required for the children, as there is dearth of such facilities, especially with regard to mental health services. Legislation of laws for the safety of children and preserving their rights would be helpful making child more secure.

**FUTURE RESEARCH AND RECOMMENDATIONS**

The present research can benefit from future refinements. Implications for future research include a longitudinal study that would investigate an individual’s level of self-concept over a period to clarify whether self-concept of these patients was lowered and family functioning was impaired before they became ill and if it was improved as, their illness has been cured.

The specific connections drawn between Family Functioning, Self Concept and Psychopathology must be considered speculative as data collected is self-reported by the psychiatric patients and normal adults. As most studies have relied on a single-respondent, more research in this area using multiple sources and measures, including an observational measure, is needed. In the future researches, one member of the family (other than the subject) should be interviewed to increase the validity of the responses. It
is suggested that a larger sample size be adapted to increase the statistical power of the analysis.

Styles of parenting in Pakistan along with the effects of family structure (nuclear & joint/extended) and its role in the development of mental disorders would also give interesting findings.

It would be of great value to control the effects of duration of illness in the future research, as it might interfere in one’s perception of family and self as the disease progresses.

In an attempt to understand the development of adult psychopathology, researchers have investigated a number of potential contributing factors, although more modern views suspect that individual pathology and significant family influences were viewed as the likely sources of adult psychopathology. As family’s effects on adult become evident, researchers and practitioners are increasing their inquiries into the influence of family functioning (communication, involvement, control) on individual behavior. The evidence showed that individuals with psychopathology came from families facing multiple psychosocial adversities. These families were found to have relatively high rates of marital instability, inter-parental conflict, and child neglect. Further research might sample and analyze the discourse of psychiatric patients above stated contexts to discover alternate negotiations of reality and identity among them.
LIMITATIONS

Present study has certain limitations which can be valuable to overcome in future research. The control group was not primary focus of the psychiatric assessment. Although they were interviewed and the examiner filled in the structured interview forms (case history sheet) for psychological evaluation designed by Institute of Clinical Psychology, University of Karachi to confirm the presence of any kind of psychological disorder. Hence, the presence of a psychiatric condition may have been overlooked.

Only those adults who belong to middle socioeconomic status and have at least intermediate level of education were included in this study. Therefore, the results of the study cannot be generalized to over all adult population. There is also a need to investigate the socioeconomic status as vulnerability factor for psychopathology along with family functioning in a country like Pakistan.

Current study relies on self report measures of family functioning and self concept; other assessment measures including observations, family interview and projective techniques might be more useful.

The subjects in this study were out and inpatients, which may limit the scope of study. An additional limitation to this research involves our inability to address the issue of sex differences in the relationships between family functioning, self-concept and psychopathology.
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APPENDIX A

CONSENT TO BE RESEARCH SUBJECT
Consent to be Research Subject

This research study is being conducted by Mr. Haroon Ur Rashid (PhD fellow) at the Institute of Clinical Psychology, University of Karachi. This study deals with the person’s perception of his/her self and his/her family, as it functions and its relation with the mental disorders. Furthermore, it also examines the relationship between an individual’s family functioning and self-concept. Measure used in this study includes an interview form comprising of items focusing on subject’s age, sex, marital status, etc which take 25-30 minutes to complete. Second measure is formal assessment scale named Family Assessment Measure Version III, used to assess individual’s perception about the family. It contains 15 statements which take 10-15 minutes to complete. Moreover, Six factors Self-Concept Scale is also included in the study which contain 36 items, is self rating scale which assesses how adults perceive about themselves. It takes 10-12 minutes to complete. There are minimal risks for participation in this study. However, you may feel emotional discomfort when answering questions about your family and the self. There are no direct benefits for participation in this study. It is hoped; however, that the knowledge gained from this study will help researchers, better understand the benefits derived from family functioning (Communication, Involvement & Control), and high self-concept in healthy life. All personal information will be removed from the results, and data will remain completely confidential. Only researcher will have access to data. Participation is voluntary and you have right to withdraw or refuse to participate any time. You have right to ask for feedback of your results as well as the outcome of study. If you have questions regarding this study, you may contact Mr. Haroon Ur Rashid at 92214613582, haroonrashid27@yahoo.com.

Thank you!

Name: ____________

Signature: ____________
APPENDIX B

INTERVIEW FORM FOR PSYCHOLOGICAL ASSESSMENT
INTERVIEW FORM FOR PSYCHOLOGICAL ASSESSMENT

FILE NO. ____________
Date ____________

Name ________________________________ Sex ____________
Date of Birth ____________ Age ________ Marital Status: S M D W Sep
Present Address ____________________________________________
Permanent Address __________________________________________

Phone ____________ Education ____________ Occupation ____________

Father’s Name __________________ Age ________ Edu ________ Occ ____________
Mother’s Name __________________ Age ________ Edu ________ Occ ____________
Spous’s Name __________________ Age ________ Edu ________ Occ ____________

Siblings: M ______ F ______ B.O ______ Children (Sex/Age) 1. ______ 2. ______

Family Structure (Nuclear/ Joint) ____________________________________________

Head of Family ___________________________ Earning members ____________
Income Group ___________________________ Heritage _______________________
Languages __________________________________________

Appearance __________________________________________

Information’s Name ___________________________ Relationship ____________
Informant’s Address/Phone ____________________________

Referred by ____________________________

Presenting Problems (verbatim) ____________________________________________

Assigned to: (for assessment) ____________________________________________
(for therapy) ____________________________________________

Fee. __________________ Payer ____________________________

Intake by: ____________________________________________

Other Information: ____________________________________________

Tentative Diagnosis ____________________________________________

Date of Termination ____________________________ Unilateral/Bilateral
Patient’s Name ____________________________ Case No ____________
Father's Name ____________________________ Date of intake: __________

Intake by: ________________________________

I. Presenting Problems (nature of problems, precipitating events, patient's feelings and thoughts about problems)
   ______________________________________
   ______________________________________
   ______________________________________

II. History of Problems (duration of present problem, change in nature, intensity, and/or frequency of problem overtime, prodormal manifestations, others past problems of a psychological nature, no. of attacks)
   ______________________________________
   ______________________________________
   ______________________________________

III. Prior Treatment (details of treatment sought presenting problems and from whom; when and what duration treatment undergone; nature of treatment methods; names and dosages of drug taken; ECTs, faith healing, etc.; response to treatments including adverse reactions and/or side effects)
    ______________________________________

IV. Medical History (most recent physical exam: date and results; current medications; health condition since childhood including details of serious illnesses/disabilities suffered and surgery undergone; eating and sleeping habits if remarkable and any change of same; use of stimulants, alcohols, and drugs)
   ______________________________________
   ______________________________________
   ______________________________________
V. Family History (migrations, births, marriages, serious illnesses, deaths, jobs of earning members, relationship with family members)

VI. School History (marks/divisions obtained, school problems, relationships with peers and teachers, extra-curricular activities)

VII. Work History (nature of jobs held and remuneration, reasons for job changes, relationships with juniors, colleagues, and bosses)

VIII. History of Friendships (nature and extent of relationships recreational activities, degree of religiosity, sexual history – premarital, marital, and extramarital relationships)

(use space below for additional information)
Orientation (person, place, time)

Sleep (Insomnia, nightmares, sleepwalking)

Attention (concentration, memory)

Perception (illusion, hallucination, auditory, visual, tactile, somatic, olfactory)

Thought (usual content including suspiciousness and delusions, conceptual disorganization including loosening of associations)

Affect (crying spells, depression, guilt feelings, suicidal, excitement, hostility, grandiosity, blunted affect)

Behaviour (speech: mute, talkative, abusive; motor: restless, assaultive, destructive, excited, motor retardation)

Mannerisms and posturing (unusual gestures, preservative movements)

Anxiety (tension, nervousness, phobias, obsessions/compulsions)

Somatoform (conversion, hypochondriasis, and other somatic complaints)
APPENDIX C

FAMILY ASSESSMENT MEASURE - VERSION III
On this page, you will find 15 statements about your family as a whole. Read each statement carefully and decide how the statement applies to your family. Make your response by placing a tick mark, for one of the provided answers (strongly agree, agree, disagree, or strongly disagree). Circle only one response for each item. Mark an answer for every statement: even you are not sure of your answer:

<table>
<thead>
<tr>
<th>S. No</th>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>When I ask someone to explain what they mean, I get a straight answer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>You don’t get a chance to be an individual in our family.</td>
<td></td>
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</tr>
<tr>
<td>3.</td>
<td>When I asked why we have certain rules, I don’t get a good answer.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>We argue about who said what in our family.</td>
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<td></td>
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<tr>
<td>5.</td>
<td>We feel love in our family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>When you do something wrong in our family you don’t know what to expect.</td>
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<td></td>
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</tr>
<tr>
<td>7.</td>
<td>I never know what’s going in our family.</td>
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<tr>
<td>8.</td>
<td>My family tries to run my life.</td>
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<td></td>
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<tr>
<td>9.</td>
<td>If we do some thing wrong. We don’t get a chance to explain.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>10.</td>
<td>We take the time to listen to each other.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>We feel close to each other.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Punishments are fair in our family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>My family lets me have my say, even if they disagree.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>We don’t really trust each other.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>We really ever do what is expected of us without being told.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

SIX FACTOR SELF-CONCEPT SCALE
Blow is the list of descriptions about people. For each one, please indicate how often you think the description is true of you. In making your judgments, consider all of your current life experiences, including work, family, school and social situations.

Use the following scale to describe yourself:

Mark 1 if it is never or almost never true of you.
Mark 2 if it is usually not true of you.
Mark 3 if it is sometimes but infrequently true of you.
Mark 4 if it is occasionally true of you.
Mark 5 if it is often true of you.
Mark 6 if it is usually true of you.
Mark 7 if it is always or almost always true of you.

1. Fun to be with
2. Hard worker
3. Dominant
4. Easily embarrassed
5. A natural talent
6. Loyal
7. Strong
8. Friendly
9. Productive
10. Lacks confidence
11. Law-abiding
12. Forceful
13. Has special talent
14. Plans ahead
15. Sociable.
16. Easily hurt
17. Acts as a leader
18. Trustful
19. Self-conscious
20. Works efficiently
21. Faithful
22. Aggressive
23. Easy to talk to
24. Bright and ingenious
25. Makes mistake when flustered
26. Honest
27. Good at meeting deadlines
28. Pleasant
29. Powerful
30. Creative
31. Easily rattled when people are watching
32. Trustworthy
33. Can concentrate well on task
34. Warm
35. Tough
36. Has innate ability