The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 14, Issue 2, April- June, 2026
DIP: 18.01.185.20261402, DOI: 10.25215/1402.185
https://www.ijip.in

Research Paper

Association between Family Pathology and Quality of Life Among Patients with Schizophrenia

Rammurat Upadhyay[1]*, Prof. Vani Narula[2]

ABSTRACT

Background: Severe Mental illnesses have become major public health concern in society. Persons with mental illness often experience limited social support, which leads to isolation and adverse effects on their psychological and emotional wellbeing, and reduce overall quality of life for the person with mental illness. This paper attempts to understand the relationship between the family Support and quality of life (QOL) of Person with Schizophrenia. To towards this end: a correlation study was conducted at the Mental Hospital Varanasi), on 30 Patients with schizophrenia (ages from 25 -45 & duration of illness: >2 years) who had attended inpatient and outpatient services at the hospital. The data were collected using a socio-demographic form, the WHOQOL-BREF and the Family support Scale. The data was analysed on Statistical packages for social science (SPSSv16). **Result:** it was found that Instrumental and Appraisal support are very important elements in determining the quality of life.

Keywords: *Schizophrenia, Family support, Quality of Life, Family Intervention and psychosocial rehabilitation*

Over 1 in 300 adults worldwide suffer from schizophrenia, a severe and chronic mental illness that affects over 24 million people (World Health Organization [WHO], 2022). Significant functional damage results from its hallmarks, which include disruptions in perceptions, emotional response, social conduct, and mental processes. The illness is linked to varying durations of remission and relapse and usually appears in late adolescence or early adulthood (Tandon et al., 2020). Psychosocial and environmental factors are important in defining the course and outcome of the condition, even if pharmaceutical treatment is the mainstay of management.

It has long been known that the family environment has a significant role in both the prognosis and rehabilitation of people with schizophrenia (Pharoah et al., 2010). Families are the main caretakers in majority of developing nations, especially India, and are in charge of offering social integration opportunities, medicine supervision, and emotional support (Behera, Bhowmick, & Kumar, 2024). Conflict, criticism, emotional over-involvement, or neglect in family connections, on the other hand, can lead to increased stress, medication

[1]Research Scholar, Jamia Millia Islamia
[2]Department of social work Jamia Millia Islamia
*Corresponding Author

Received: March 12, 2026; Revision Received: June 04, 2026; Accepted: June 08, 2026

© 2026, Upadhyay, R. & Narula, V.; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (www.creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

non-adherence, and relapse all of which are phenomena that are categorized under "expressed emotion" (Hooley, 2007). Together, dysfunctional family dynamics which include hostile communication styles, poor problem-solving skills, and maladaptive patterns of behaviour are referred to as family pathology (Veeraraghavan & Dogra, 2000).

Family pathology can have a major negative impact on a person's quality of life (QoL) and recovery from schizophrenia. The term quality of life (QoL) describes how a person views their place in life in relation to their culture, values, aspirations, and expectations (WHOQOL Group, 1998). It includes aspects related to the body, mind, society, and environment. QoL is a multifaceted measure of recovery for people with schizophrenia that goes beyond symptom reduction; it captures social reintegration, subjective well-being, and contentment with life circumstances (Suttajit & Pilakanta, 2015). According to empirical research, stigma, social isolation, depressive symptoms, and inadequate family support are some of the best indicators of poor quality of life in people with schizophrenia (Lim et al., 2018; Wang, Zhang, & Li, 2020).

Recent studies highlight the reciprocal association between QoL and family functioning. While supportive families encourage medication adherence, mental stability, and resilience, dysfunctional family dynamics increase patients' stress and the intensity of their symptoms (Fujimaki et al., 2012). Better communication and emotional connectedness among families improve perceived life satisfaction, according to Wang et al. (2020), who found a strong positive link between family functioning and subjective QoL among Chinese schizophrenia rehabilitation patients. On the other hand, poorer quality of life outcomes are predicted by high levels of family pathology, especially in the social and environmental domains, which are critical for rehabilitation and independent functioning.

Knowing how family pathology affects quality of life becomes especially important in the Indian sociocultural context, where collectivist beliefs predominate and families play a significant role in providing care. There is no empirical study on how family pathology directly affects quality of life (QoL) among Indian patients with schizophrenia, despite the expanding body of literature on family load and expressed emotion. Determining the type and degree of this relationship is crucial for creating successful family-based therapies and psychoeducational programs, as family engagement is a major component of India's mental health care (Behera et al., 2024).

In order to encourage the inclusion of family assessment and intervention in psychiatric rehabilitation frameworks in India, the current paper is intends to investigate the relationship between family pathology and quality of life among patients with schizophrenia. Knowing this connection should help social workers and clinicians concentrate on improving family situations that support recovery, autonomy, and a higher quality of life in addition to managing symptoms.

Need for the Study

For people with serious mental diseases, such as schizophrenia, the family continues to be the main source of caring, financial support, and emotional support in the Indian sociocultural environment. Because of this crucial role, treatment adherence, symptom management, and overall rehabilitation success can all be strongly impacted by the quality of family functioning. High levels of conflict, poor communication, emotional over-involvement, or neglect are examples of dysfunctional family dynamics that can worsen stress, raise the chance of relapse, and negatively impact a patient's quality of life (QoL).

There are relatively few Indian studies that expressly examine this association using standardized instruments, despite the fact that foreign research has proven a correlation between family functioning and quality of life in individuals with schizophrenia. Moreover, most existing studies focus predominantly on symptom reduction and relapse prevention, with less emphasis on subjective well-being and environmental satisfaction core components of QoL.

Therefore, it is essential to evaluate family pathology in connection to quality of life in an Indian clinical sample. Such studies can offer evidence that is culturally appropriate to direct community-based rehabilitation initiatives, family-centred therapies, and psychoeducation programs. Understanding how family dynamics affect quality of life (QoL) can improve the efficacy of psychosocial therapies, especially in light of India's expanding policy emphasis on community mental health services and caregiver empowerment.

By empirically examining the relationship between family pathology and domain-specific quality of life among individuals with schizophrenia, this study seeks to close this gap and advance evidence-based, family-inclusive mental health care.

Objectives

1. To assess family pathology among patients with schizophrenia.
2. To measure quality of life (overall and domain-wise) in the sample.
3. To examine the relationship between family pathology and QoL.

Hypothesis

Null hypothesis: There is no significant correlation between family pathology and quality of life among patients with schizophrenia.

METHODOLOGY

Research Design

The present study employed a correlational, cross-sectional design to examine the relationship between family pathology and quality of life among individuals with schizophrenia. This design was considered appropriate for identifying associations between variables within a defined time frame without experimental manipulation.

Sample

The sample consisted of 30 patients diagnosed with schizophrenia according to ICD-10 diagnostic criteria. Participants were between 25 and 45 years of age and had a duration of illness exceeding two years. The sample was selected through purposive sampling from both the inpatient and outpatient in mental hospital Varanasi.

Inclusion and Exclusion Criteria

Inclusion criteria:

- Diagnosis of schizophrenia as per ICD-10.
- Age between 25 and 45 years.
- Duration of illness greater than two years.
- Willingness to provide informed consent for participation.

Exclusion criteria:

- Presence of comorbid psychiatric disorders.
- Presence of severe physical illness that could interfere with participation.

- Duration of illness less than two years.

Instruments

1. **Socio-Demographic Data Sheet**: A researcher-designed proforma was used to collect basic socio-demographic and clinical information, including age, gender, education, marital status, occupation, duration of illness, and treatment status.
2. **Family Pathology Scale** (Veeraraghavan & Dogra, 2000): This standardized scale assesses dysfunctional family interaction patterns and pathological family dynamics. It provides a quantitative measure of the level of family pathology across various domains.
    - **Reliability:** The split-half reliability correlation of odd-even items was calculated by applying Spearman Brown formula. Reliability of the test through split half method is 0.70 and test-Retest reliability was0.79.
    - **Validity:** The face validity of the scale appeared to be high, as the items were prepared following intensive interview, of 300 couples regarding the extent of family pathology present in the family. The content validity was adequately assured as only these items were selected for initial scale f or which there was complete agreement amongst the experts.
3. **WHOQOL-BREF** (Saxena et al., 1998): The World Health Organization Quality of Life–BREF is a 26-item questionnaire that assesses perceived quality of life across four domains. Physical health, psychological well-being, social relationships, and environmental conditions. Higher scores imply a better perceived quality of life.

Discriminant validity

Following confirmation of the six-domain structure, mean scores for facets and domains were calculated for both ill and well sample papulations (see table 2.3). descriptive statistics for age and gender for those groups are presented in Table 2.4. The WHOQOL- 100 successfully discriminated between ill and well respondents across all six domains. The largest difference between the two groups were observed in the level of independence domain, where scores for ill participants were on average 18.5% lower than those of well participants. In contrast, differences in the environment domain were comparatively smaller, averaging around 5%.

Test- Retest reliability

Data used to assess test-retest reliability were drawn primarily from well respondents (87%of the sample) across fore centres participating in the WHOQOL-100 field trial. These centres included bath (n=90), Harare (n=100), Tilburg (n=116), and Zagreb (n=85). In all centres, respondents were students except in Harare, where the sample included randomly selected ill (n=50) and well (n=50) participants. The interval between test and retest ranged from 2 to 8 weeks. Correlations between item scores at the two time points were generally high (see Table 2.5), ranging from. 68 for the safety facet to .95 for the dependence on medication time when no interventions or significant life events occur. Nevertheless, additional test-retest reliability data are recommended to further strengthen the evidence for measurement stability.

Procedure and Ethical Considerations

Ethical approval for the study was obtained from the Institutional Ethics. Individuals who met the inclusion criteria were approached and informed about the purpose and nature of the study; written informed consent was obtained before participation; structured interviews and self-report questionnaires were used to collect data, depending on each participant's

cognitive and linguistic abilities; confidentiality, anonymity, and voluntary participation were strictly maintained throughout the study in accordance with ethical research standards.

Data Analysis

All data were entered and analysed using Statistical Package for the Social Sciences (SPSS, version 16.0). Descriptive statistics (mean, standard deviation, frequency, and percentage) were used to summarize socio-demographic and clinical characteristics. Pearson's product–moment correlation coefficient was employed to assess the relationship between total family pathology scores and WHOQOL-BREF domain and total scores. Statistical significance was set at $p < .05$ for all analyse.

RESULT

Table 1: Shows The Relationship Between Religious Groups and Schizophrenia.

Socio demographic		
Religion	Hindu	25 (83.3%)
	Muslim	5(16.7%)

The table presents the socio- demographic characteristics of respondents based on religion in terms of religion, most the participants are Hindu, comprising 50 respondents (83.3%), while 10 respondents (16.7%) identify as Muslim. This indicates that the sample is predominately Hindu, with a smaller representation from the Muslim community.

Table 2: Shows The Relationship Between Marital Groups and Schizophrenia

Socio demographic		
Marital	Married	15(50.0%)
	Unmarried	12(40.0%)
	Divorced/widowed	3(10.0%)

Regarding marital status, most respondents are unmarried, accounting for 33 individuals (55.0%). Married participants make up 24 respondents (40.0%), while a very small proportion, 3 respondents (5.0%), are either divorced or widowed. This suggests that the study population is population is largely unmarried, with married individuals forming a substantial minority.

Table 3: Shows The Relationship Between Educational Groups and Schizophrenia

Socio demographic		
Education	Primary	9(29.97%)
	Secondary	17(56.61)
	Higher secondary	4(13.32%)

Most respondents had a secondary level of education, with 17 individual (56.61%). This was followed by 9 respondents (29.97%) who completed primary education. only 4 respondents (13.32%) had higher secondary education, indicating that advanced schooling was less common in the sample.

Table 4: Shows The Relationship Between Family Type and Schizophrenia

Socio demographic		
Family type	Nuclear family	14(46.62%)
	Joint family	16(53.28%)

Regarding family structure, 16 respondents (53.28%) belonged to joint families, slightly higher than the 14 respondents (46.62%) from nuclear families. This suggests that joint family systems were somewhat more prevalent among the participants.

Table 5: Shows The Relationship Between Occupation and Schizophrenia

Socio demographic		
Occupation	Farmer	7(23.31%)
	Private job	16(53.28%)
	Businessman	2(6.66%)
	Unemployed	5(16.65%)

The largest group of respondents was employed in private jobs, with 16 individuals (53.28%). Formers accounted for 7 respondents (23.31%), while 5 respondents (16.65 %) were unemployed. The smallest category was businessmen, with only 2 respondents (6.66%). This indicates that private employment was the most common occupation among the participants.

Table 6: Shows The Relationship Between Income Groups and Schizophrenia

Socio demographic		
Income	<10000	17(56.61%)
	10000-20000	13(43.29%)

Regarding income distribution, 17 respondents (56.61%) earned between 10,000-20,000, making it the most respondent income group. Meanwhile, 13 respondents (43.29%) reported earning less than 10,000

Table 7: Shows The Relationship Between Residence Groups and Schizophrenia

Socio demographic		
Residence	Rural	17(56.61%)
	Urban	13(43.29%)

The largest group of respondents lived in rural areas, with17 individual (56.61%), while 13 respondents (43.29%) were from urban areas. This indicates that rural residents formed the largest portion of the study sample.

Table 8: Shows the socio-demographic variables of individuals with Schizophrenia

Variables	**Schizophrenia** **M ± SD**
Age	36.70±8.64
Age of started illness	28.26±6.30
Duration of illness	9.12±5.23

The mean age of the participants was 36.70±8.64 years, suggesting that most respondents were middle- aged adults. The average age of onset of illness was 28.26 ± 6.30 years, indicating that schizophrenia commonly began in early adulthood. Additionally, the mean duration of illness was **9.12 ± 5.23 years**, reflecting that many participants had been living with the condition for a considerable period.

Table: 9 Correlation relation between Family pathology, and Quality of life with Schizophrenia

Scale /variable	QOL Social Relationship	QOL Physical Health	QOL Psychological	QOL Environmental	QOLTOTAL
Family pathology	.159	.284	.180	.517**	.567**

***. Correlation is significant at the 0.01 level (2-tailed)*

Correlational Analysis

Pearson's product–moment correlation analysis revealed a statistically significant positive association between family pathology scores and poorer scores on the environmental domain of the WHOQOL-BREF. Specifically, higher levels of family pathology were associated with lower perceived quality of life in the environmental domain, indicating that dysfunctional family dynamics may adversely influence individuals' perceptions of their surroundings, access to resources, and safety.

Despite not reaching statistical significance, the associations between family pathology and other dimensions of quality of life, including social relationships, psychological well-being, and physical health, demonstrated a consistent negative tendency (Repetti et al., 2002). This pattern suggests that family dysfunction may exert a broad influence across multiple well-being domains, even when effects are not pronounced within specific outcome measures (Ryan & Deci, 2001). The observed association with the environmental domain of quality of life aligns with earlier work emphasizing the role of social, familial, and contextual conditions in shaping subjective well-being beyond symptom severity (World Health Organization, 1995; Skevington et al., 2004; Zubrick et al., 2000).

Sample Characteristics

The study sample comprised 30 participants diagnosed with schizophrenia. Participants were between 25 and 45 years of age, with a mean illness duration exceeding two years. Detailed socio-demographic and clinical characteristics are presented in the supplementary demographic table.

DISCUSSION

The present findings highlight a significant relationship between family pathology and environmental aspects of quality of life among individuals with schizophrenia. Specifically, participants who reported higher levels of dysfunctional family interactions such as poor communication, inadequate problem-solving, and heightened interpersonal conflict also perceived lower quality of life in environmental areas, including financial stability, access to health and social care, safety, and opportunities for recreation or employment.

These results are in line with earlier studies showing that family functioning is a significant factor in determining the subjective well-being of individuals with schizophrenia (Kuipers et al., 2010; McFarlane et al., 2003). Research has shown that improved psychological adjustment and general life satisfaction are associated with supportive communication, family cohesion, and lower levels of expressed emotion (Butzlaff & Hooley, 1998; Hooley, 2007). Evidence also indicates that negative symptoms, depressive symptoms, and family or social support operates jointly in shaping quality-of-life outcomes, reflecting the multifactorial nature of recovery in schizophrenia (Ritsner et al., 2003; Norman et al., 2000).

Family-based psychosocial interventions, including psychoeducation, problem-solving approaches, and caregiver support programmes, have demonstrated effectiveness in reducing relapse rates, lowering family burden, improving caregiver experience, and strengthening long-term patient functioning in systematic reviews and meta-analyses, including Cochrane reviews (Pharoah et al., 2010; Pitschel-Walz et al., 2001). In this context, the present findings provide empirical support for integrating structured family interventions into hospital- and community-based rehabilitation frameworks to promote quality of life and relapse prevention (McFarlane, 2016).

CONCLUSION AND RECOMMENDATIONS

The present study establishes that family pathology is significantly associated with lower quality of life, particularly within the environmental domain, among individuals with schizophrenia. This research emphasizes how crucial family relationships are in shaping patients' opinions about safety, resource accessibility, and general environmental satisfaction. It further emphasizes that the quality of family interactions constitutes a critical determinant of psychosocial well-being beyond the direct effects of illness symptomatology. Family-based psychosocial therapies and structured family assessments should be standard components of clinical care in mental health services to address these issues. Treatment adherence, relapse risk, and general quality of life can all be improved by evidence-based strategies such psychoeducation, training in communication and problem-solving techniques, and relapse-prevention planning. These interventions would improve the continuum of care and promote long-lasting recovery results if they were incorporated into community-based and hospital-based rehabilitation programs.

Policymakers and service planners should give caregiver education and family support infrastructure top priority within community mental health frameworks. Targeted interventions that increase caregiver competence and resilience can lessen the stress on families, enhance treatment collaboration, and foster more supportive recovery environments. For mental health services to be effective over the long run, a systemic emphasis on family empowerment is necessary.

Implications for Future Research

To improve generalizability, future research should try to reproduce these results in bigger and more varied samples. To elucidate the causal relationships between family pathology and particular quality-of-life domains, longitudinal and multi-informant approaches are advised. Furthermore, investigating mediating elements including coping methods, social support, and symptom intensity may offer a better understanding of the processes relating to family dynamics and wellbeing. Best practices for incorporating family-centred care into standard psychiatric rehabilitation would be further informed by comparative studies that look at the effectiveness of various family-based intervention approaches across cultural and service contexts.

REFERENCES

Behera, S., Bhowmick, I., & Kumar, P. (2024). *Family functioning in persons with schizophrenia: Cross-sectional study across genders.* Indian Journal of Psychiatric Social Work, 15(2), 3–10. https://doi.org/10.29120/IJPSW.2024.v15.i2.616

Fujimaki, K., Morinobu, S., Yamashita, H., Takahashi, T., & Yamawaki, S. (2012). Predictors of quality of life in inpatients with schizophrenia. *Psychiatry Research, 197*(3), 199–205. https://doi.org/10.1016/j.psychres.2011.10.023.

Hooley, J. M. (2007). *Expressed emotion and relapse of psychopathology.* Annual Review of Clinical Psychology, 3, 329–352. https://doi.org/10.1146/annurev.clinpsy.2.022305.095236

Lim, M. W. Z., Liao, Y., Gillanders, D., et al. (2018). Determinants of health-related quality of life in schizophrenia: Beyond the medical model. *Frontiers in Psychiatry, 9*, 712. https://doi.org/10.3389/fpsyt.2018.00712.

Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2010). Family intervention for 10schizophrenia. *Cochrane Database of Systematic Reviews*, 2010(12), CD000088. https://doi.org/10.1002/14651858.CD000088.pub3.

Saxena, S., Carlson, D., Billington, R., & Orley, J. (1998). The WHO quality of life assessment instrument (WHOQOL-BREF): Results of field trials. *Psychological Medicine, 28*(3), 551–558. (Original WHOQOL-BREF field trial report.)

Suttajit, S., & Pilakanta, S. (2015). Predictors of quality of life among individuals with schizophrenia. *Neuropsychiatric Disease and Treatment, 11*, 1371–1379. https://doi.org/10.2147/NDT.S81024.

Tandon, R., Gaebel, W., Barch, D. M., Bustillo, J., Gur, R. E., Heckers, S., et al. (2013). *Definition and description of schizophrenia in the DSM-5.* Schizophrenia Research, 150(1), 3–10. https://doi.org/10.1016/j.schres.2013.05.028

Veeraraghavan, V., & Dogra, A. (2000). *Family Pathology Scale*. National Psychological Corporation.

Wang, L., Zhang, P., & Li, H. (2020). Correlation analysis of the quality of family functioning and subjective quality of life in rehabilitation patients living with schizophrenia in the community. *International Journal of Environmental Research and Public Health, 17*(7), 2481. https://doi.org/10.3390/ijerph17072481.

World Health Organization Quality of Life Group. (1998). *The World Health Organization quality of life assessment (WHOQOL): Development and general psychometric properties.* Social Science & Medicine, 46(12), 1569–1585. https://doi.org/10.1016/S0277-9536(98)00009-4

World Health Organization. (2022). *Schizophrenia fact sheet.* https://www.who.int/news-room/fact-sheets/detail/schizophrenia

Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Upadhyay, R. & Narula, V. (2026). Association between Family Pathology and Quality of Life Among Patients with Schizophrenia. *International Journal of Indian Psychology*, *14*(2), 2023-2031. DIP:18.01.185.20261402, DOI:10.25215/1402.185