

A Community-Based Study on Quality of Life and Family Function among Urban Society Bangkok, Capital of Thailand

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Abstract: The relationship between quality of life and family functions have been mentioned in many aspects. The aim of this study is to analyze the influence of the functionality of the family in the quality of life of urban society and to determine the variables related to both dimensions.

Methods: This community based cross-sectional study by self-administered instrument was conducted to investigate the factors associated with quality of life and relationship between quality of life and family function among urban society, Bangkok; capital of Thailand

Result: The finding showed that 88% most of the 390 participants had average quality of life score 83.14(10.57). Higher QOL was significantly associated with following factors; age < 55 years, completing junior secondary school or above (educational level more than 9 years), employment, reporting no health problem or stressful life event and having good family functioning. Based on the results of the stepwise regression model, the educational level, employment, health problem, stressful event and family functioning variables were able to predict 26% of variance of the quality of life in participants (P <0.01). There was relationship between family function and quality of life showed significant difference in quality of life between high score and low score of quality of life included Problem solving, Communication, Roles, Affective response and General function(p=0.00), except in Affective involvement and Behavior control p=0.42 and p= 0.64 respectively.

Conclusions: The findings from this study revealed that Thai adult urban society has WHOQOL-BREF average moderate quality of life. There was relationship between family function and quality of life almost all dimensions of family function significant difference in quality of life between high score and low score of quality of life included Problem solving, Communication, Roles, Affective response and General function in urban society of Bangkok Thailand.

Keywords: quality of life, WHOQOL-BREF, family functioning, urban society.

1. INTRODUCTION

In 1993, WHO [1] defines Quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation of their goals, expectations, standards and concern. One of the factors in assessment of health status is quality of life that could be used to assess not only change in physical functional, mental and social aspect of patients' health but also used to assess new programs, instrument and new therapeutic strategies. In addition, measuring quality of life can quantify the impact of diseases and its new therapeutic strategies treatment and could be assess in physical, functional, mental and social support, and could quantify that impact individual's life[2].

There are plenty factors affect quality of life, such as age, gender, education, income, health care system, workplace, social, culture, community and family. Rodriguez-Sanchez et al.[3], reveal that there was a relationship between family function and quality of life.

The WHOQOL-BREF[5] is self-administered instrument being developed as a short version of the WHOQOL-100 for use in time restriction and less burden for respondent. Analysis of these extracted items showed four domains in context of quality of life include physical, psychological, social and environment. WHOQOL-BREF are noteworthy covers a very broad range of facets that were agreed by international consensus and cross-cultural validity evidence support of quality of life measurement. This has implication for its use in research involving a variety of intervention as well as health care service setting. WHOQOL-BREF Thai version is composed of 26 items 4 domains showing a good validity of 0.65. Each item is scored from 1 to 5 on ordinal scale, higher scores indicating a higher quality of life. Three items of the questionnaire must be reversed before scoring[6].

At some studies, family function is one of the indicators of quality of life and mental health of the family and its member[4]. The family function has been defined as “the ability of families to coordinate and adapt the changes throughout life, resolve the conflict, cooperate between members and success in disciplinary patterns, respect the boundaries between individuals and respect the rules and principles which help the family to protect the entire family system”. Basically, the family functional refers to the ability to cope with stress, conflicts and problems; so that family could be able to do its roles, duties and functions. Also, the family function show that how the family acts to meet the needs of their members and the community[7],[8],[9].

Dimension of family function includes general performance, problem solving, communication, roles, emotional response, emotional involvement and control of behavior.

An appropriated family function is necessary for the well-being of individual, family and society. A family with appropriated function can fulfill the emotional, mental and physical needs of its members. While inappropriate function fail to fulfill these need and could effect to their physical, social and emotional health.

Understanding the relationship between family function and quality of life is critical in order to provide patient-center health care system and intervention to improve quality of life. However studies evaluating family function and quality of life are scarce. This study aims to assess the relationship between family function and quality of life in one district of metropolitan in capital city of Thailand.

2. METHOD

This was a community based analytic cross-section study of one district in 50 district of Bangkok, metropolitan of Thailand. It was evaluated people 18-80 years old who lived in the study are for at least 2 years. Klong toei district was selected. A total 102,945 people were registered with the government office. Taro Yamane formula was used for calculation sample size that required 398 subjects. 400 subjects were recruited into the study. Written informed consent was obtained from all. Self-administered questionnaire, The WHOQOL-Bref questionnaire, Family Assessment device questionnaire and general information data were delivered.

The WHOQOL-BREF (Field Trial Version) produces a quality of life profile. It is possible to derive four domain scores. There are also two items that are examined separately: question 1 asks about an individual overall perception of quality of life and question 2 asks about an individual overall perception of their health. The four domain scores denote an individual perception of quality of life in each particular domain. Domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life). The mean score of items within each domain is used to calculate the domain score. Mean scores are then multiplied by 4 in order to make domain scores comparable with the scores used in the WHOQOL-100. Explicit instructions for checking and cleaning data, and for computing domain scores, are given. A method for the manual calculation of individual scores is given on the WHOQOL-BREF assessment form. The method for converting raw scores to transformed scores when using this method is given in these instructions. The first transformation method converts scores to range between 4-20, comparable with the WHOQOL-100. The second transformation method converts domain scores to a 0-100 scale.

Where more than 20% of data is missing from a assessment, the assessment should be discarded. Where an item is missing, the mean of other items in the domain is substituted. Where more than two items are missing from the domain, the domain score should not be calculated (with the exception of domain 3, where the domain should only be calculated if < 1 item is missing).

Any national items should be scored separately from the core 26 item of the BREF. During the analysis the performance of any national items will be examined for possible use in alter national studies. At this stage of field testing national and core items must not be mixed in administration or scoring of the BREF[5].

Data were collected using a demographic questionnaire which included age, sex, marital status, education level, socio-economic status, occupation, health problem and stressful event. In addition, the WHOQOL- Bref questionnaire was used to assess quality of life and the family function was assessed in all participants.

Family functioning was assessed by questionnaire that based on Family Assessment Device (FAD) questionnaire designed by Epstein and Bishop and Chulalongkorn Family Inventory by Trangkasombat U. Questions are available in 4 –Likert response from “strongly disagree= 1” to “fully agree = 4”. This instrument appraises seven family factors on a 4-point scale. Scores range from 30 to 120 and the higher the score, the better the family functioning.

Cronbach’s alpha coefficient of this test in the Epstein et al. study was 0.92, in the Trangkasombat study was 0.8 and in the present study was 0.8.

Data were analyzed using SPSS version 22 software. Data were analyzed using the independent t-test, and analysis of covariance and stepwise regression model. Pearson’s Product Moment Correlation was used for analyzing the associations among variables. All statistical tests were considered significant at level of 0.05.

This study was approved by the Institutional Review Board and the Research Ethics Committee of Faculty of Medicine, Chulalongkorn University. The objectives of the study were explained to all participants and all of them signed a written informed consent and were assured of the confidentiality of their individual information as well as the being voluntary for participating in the study.

3. RESULTS

In this study, data from 400 respondents were recruited into the study. Only 390 Subjects were completed all assessment.

The demographic variables and QOL scores are summarized in Table 1. The mean age of the participants was 58 years (SD 14.3). Approximately 78% were female, 50.2% were married, 27.3 % were unemployed, 60.5% reported having health problem and 28.2% had stressful life events. With regards to the WHOQOL-BREF, a majority (88%) of participants rated their overall QOL as average. Following QOL scores(mean, SD) were obtained: physical domain(24.2,3.3), psychological domain(21.7, 3.1), social domain(9.8, 1.9), and environmental domain(27.5, 4.2).a

Younger age was significantly associated with a better score on the total and all domains of QOL except environmental domain. Lower educational level, unemployment, having health problem or stressful life event and poor family functioning had significantly low scores on quality of life in all domains as compared to other group. (Table 2.)

The results on the WHOQOL-BREF correlation are presented in Table 3. There were statistically significant correlation among all domains of the WHOQOL-BREF ($p < 0.05$). Strong inter domain correlation was found among various domains particularly between physical and psychological domain. There was statistically significant negative correlation between various domains of the WHOQOL-BREF and age ($p < 0.05$).

Based on the results of the stepwise regression model, the educational level, employment, health problem, stressful event and family functioning variables were able to predict 26% of variance of the quality of life in participants ($P < 0.01$) (Table 4).

Table 5 showed the relation of family function and Quality of life. Almost all dimensions of Family function showed significant difference in quality of life between high score and low score of quality of life included Problem solving, Communication, Roles, Affective response and General function ($p = 0.00$), except in Affective involvement and Behavior control $p = 0.42$ and $p = 0.64$ respectively.

4. DISCUSSION

The study results found that gender no differences in quality of life, but age < 55 years had better in quality of life than > 55 years old, on the other hand; low education (< 9 years study), unemployment, health problem, stressful life event and poor family function were statistic significant difference in quality of life $p = 0.00$, $p = 0.01$, $p = 0.00$, $p = 0.00$ and $p = 0.00$ respectively. This was because participants had got 60% of health problem, high rate of unemployment at 27.3% that above average population.

In the study of Apidechkul T et al [10], found no differences in quality of life by gender in elderly people who live in rural and suburban in northern part of Thailand. But in suburban area the domain of physical health and social relationship had a higher quality of life than rural area. In study of Kilic et al [11], found higher score in women than men. But the study of

Orfila F et al[12], found elderly women in Spain had lower quality of life than men. The main factors were mainly due to a higher prevalence of disability and chronic conditions among female.

According to many studies conducted in Iran, Chinese, Turkish, Malaysia[13],[14],[15],[16],[17],[18]; reported chronic diseases such as diabetic patients, showed if there were worse family function there would also worse in quality of life and diabetic control. Not only people with chronic disease but also caregiver who are caring relatives with dementia and the family whose amphetamine addict[19], there were significant relationship between the family function and quality of life, and social support[20],[21], patients well-being[22], happiness[23] and life satisfaction [24].

Quality of life in the study of Hongthong D et al[25], had fair level in revealed that 4 factors prediction of quality of life among elderly lived in Phayao province, Thailand that was activity daily living, income, social alcohol drinking and present illness. This finding was also similar to others studies[26],[27] that disability or less activity associated with poor quality of life, financial problem associated with poor quality of life, social drink caused social cohesion, relaxing and social norm can have better quality of life than lonely non-drinker[28]. Physical health problem were also linked with quality of life consistent with the study of Miranda[29] that patients who suffered from chronically diseases can be affected by multi-morbidity in physical domain of quality of life.

Our study found that the factors which could significantly predict the quality of life at the $p < 0.05$ statistic significant included Education, Family function, Health problem, Stressful event and Employment collectively contributed 26% of the predicting power. In addition; Age, Physical, Psychological, Social and environment dimensions were not good predictors. Because our studied performed in urban society, there were a lot of stressful life event and also financial problem capital city of Thailand.

In the study of Wongsawat S[30]; performed in rural area of Nakhon Ratchasima province, north-east of Thailand found that the quality of life of most elderly were at good level included environment and psychological factor while social relationship and physical health were moderate. The factor which could predict quality of life included the ability of perform daily activity, the income, the congenital disease, the educational level and gender which could contributed 20.6 percent in power of prediction.

Good family function associated with positive outcomes for quality of life.

Family function has been defined as “the ability of families to coordinate and adapt the changes throughout life, resolve the conflict, cooperate between members and success in disciplinary patterns, respect the boundaries between individual and respect the rules and principles which help the family to protect the entire family system” includes general performance, problem solving, communication, roles, emotional response, emotional involvement and control of behavior. All of these dimension refers to the ability of family and its members to cope with stress, conflicts and problems[8].

In our study showed that Family Functioning included problem solving, communication, roles, affective response and general function had positive significant in quality of life, but not affective involvement and behavior control. Poor affective involvement may be related to family member’s fear and difficulty showing interest in other things and avoidant any participation at home. Behavior control refers to the respect the rules and standards of the family and know their duties in emergency situation. Affective (emotional) involvement is concerned with how much family members are involved with each other, and not with what a family does together. Both overinvolvement and underinvolvement are patterns of behavior that can pose problems for families. Behavior control is a key to successful family functioning. The fact that participants reported clinically significant unhealthy affective involvement and behavior control suggested that family members may have difficulty displaying a level of affective involvement that was empathic yet not overly protective. Family affective involvement was a predictor of family function. It may be that too much affective involvement can be perceived by elderly or low education participant as intrusive or unnecessary, particularly when in a mild or chronic disease state. On the other hand, elderly may be more likely to experience depressive symptoms if their family members show very little interest or involvement in them during times of distress. This can be especially difficult for elderly who may still require some assistance with disease management and chronic complication condition.

These may be due to the respondents had low level of education 56.8% (below the primary school) and 50.2% married marital status, its mean living alone or in the extend family.

In the study of Elham Azmoude, et al[31]; showed behavior control (one of domains of family function) had the power of prediction in quality of life of diabetic women 17%, while other domains were not able to predicted. Furthermore 31% of

quality of life in healthy women can be predicted by emotional response, communication and general functioning that indicated general function played important role in family function in healthy women.

In the study of Sajjad Basharpour et al[32]; revealed that behavioral control, affective involvement dimension of family function played 33% of quality of life in western Azerbaijan Iran women. Furthermore, Alayi et al[33], Peterson-Post et al[34], Portes A et al[35], these result supported the importance of the family context and family factors on people's health and their quality of life. Since women, are dependent on their families and husbands, the stability within the family affects their health greatly

In addition Kaherizeh et al[36]; revealed general function can predict 21% of variation in quality of life of subject well-being in nurse. General function assessed overall health within the family. These finding play important role in the health family subject which can improve the quality of life of every family Styles of Behavior Control Researchers have identified four styles of family behavior control: rigid, flexible, laissez-faire, and chaotic. Of the four styles, the flexible style is thought to be the most effective for healthy family interaction. The flexible style of behavior control improves a family's ability to meet changing demands in and outside the family. Research shows that families who can adapt to changing situations are better able to meet the challenges that face them.³⁷ In addition, families with the ability to negotiate new roles and rules are better able to cope and adjust to life's changing circumstances. By using a Family Contract, The intervention should be by following the subsequent steps of the intervention by determining the question, clarifying the question and how can we share emotions? families can identify interests and concerns that may need to change, including the family's style of behavior.

This study has some limitations, including the fact that the data collection used self-administration, the cross-sectional study and data for family members were not collected and only related to the participants experiences, there might be barrier answers, a longitudinal study may more precisely reveal the family functioning and quality of life, In addition an observation method or semi-construction interviews about family function should be fulfill. There were some sample bias and could not representative of 50 district of metropolitan therefore the study could not generalized to other areas. Therefore future studies should cluster study design from difference districts to get more consolidated study and popular sample should be cluster to get rid of selection bias.

5. CONCLUSION

The results of this research showed that urban society has moderate to high quality of life and there was important relationship between family function and quality of life especially in high QOL score 96-130 in dimension of problem solving, communication, roles, affective response and general function. Moreover, the results of multiple stepwise regression showed that high education level, employment, no health problem, no stressful life event and the high score of family function can predict quality of life in urban society.

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Conflict of interest:

The authors declare no conflict of interest in this study.

Authors' contributions:

SS designed the study, worked in all stages of data collection and analysis, interpretation of data and was involved in drafting and revising the manuscript. SS made substantial contributions to conception and design, worked in all stages of data collection and analysis, interpretation of data, performed the statistical analysis and wrote the first draft.

Table 1: Characteristics of participants and Mean (standard deviation) of QOL domains and total (n=395)

variables	n/mean(SD)	Percent (corrected against missing data)
sex		
male	83	21.3
female	307	78.7

Marital status			
	single	65	16.6
	married	197	50.2
	widowed	99	25.3
	Divorced/separated	31	7.9
Educational level			
	Illiterate	12	3.1
	Primary	211	53.7
	Junior high school	54	13.7
	Senior high school	53	13.5
	Bachelor/higher	63	16.1
Employment			
	unemployed	108	27.3
	employed	279	72.7
Health problem			
	NO	118	30.5
	Yes	269	60.5
variables		n/mean(SD)	Percent (corrected against missing data)
Stressful event			
	No	280	71.8
	Yes	110	28.2
Age		58.48(14.30)	
Total QOL		83.14 (10.57)	
Physical domain		24.23 (3.27)	
Psychological domain		21.72 (3.06)	
Social domain		9.82 (1.88)	
Environmental domain		27.47 (4.19)	
Family functioning		83.26(10.15)	

Table 2: Comparison of mean scores(standard deviation) of QOL domains and total with variables

Variable		Physical	Psychological	Social	Environ mental	Total QOL	Family function
Sex	Male	24.6(3.2)	22.2(3.0)	10.3(2.0)	27.9(4.5)	85.2(10.8)	83.6(10.9)
	Female	24.2(3.3)	21.6(3.1)	9.7(1.8)	27.3(4.1)	82.6(10.5)	83.9(9.9)
	p-value	0.343	0.125	0.013*	0.294	0.059	0.728
Age	<55years	25.6(3.3)	22.5(3.1)	10.5(2.0)	28.1(3.7)	86.6(10.6)	85.7(11.3)
	>55years	23.9(3.2)	21.5(3.0)	9.6(1.8)	27.3(4.3)	82.2(10.4)	82.5(9.8)
	p-value	0.000**	0.005**	0.000**	0.118	0.001**	0.014**
Marital status	Single	25.2(3.5)	22.2(2.9)	10.4(2.3)	28.0(4.3)	86.1(11.4)	82.9(11.0)
	Married	24.4(3.1)	21.7(3.2)	10.0(1.6)	27.6(4.1)	83.6(10.2)	84.7(10.1)
	p-value	0.073	0.315	0.197	0.498	0.107	0.253
Education	<=9years	23.5(3.0)	21.2(2.9)	9.5(1.8)	27.1(4.1)	81.1(9.9)	81.9(9.5)
	>9years	25.9(3.2)	23.0(3.0)	10.5(1.8)	28.5(4.2)	88.0(10.8)	86.9(11.0)
	p-value	0.000**	0.000**	0.000**	0.003**	0.000**	0.000**
Employment	unemployed	22.9(2.9)	20.6(2.7)	9.3(1.8)	26.2(3.9)	78.9(9.2)	81.4(10.1)
	employed	24.8(3.3)	22.1(3.1)	10.0(1.9)	28.0(4.2)	84.9(10.7)	84.3(10.0)
	p-value	0.000**	0.000**	0.000**	0.000**	0.012*	0.012**
Health problem	No	25.8(3.2)	22.8(3.0)	10.5(1.8)	28.9(4.1)	88.2(10.3)	87.7(10.9)
	Yes	23.5(3.1)	21.2(3.0)	9.5(1.8)	26.8(4.1)	80.9(10.6)	81.3(9.2)
	p-value	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**

Variable		Physical	Psychological	Social	Environmental	Total QOL	Family function
Stressful event	no	24.3(3.2)	22.0(3.0)	9.9(2.0)	27.9(4.4)	84.1(11.0)	83.5(10.7)
	yes	24.0(3.5)	21.0(3.0)	9.5(1.5)	26.4(3.5)	80.6(9.2)	82.4(8.8)
	p-value	0.321	0.002**	0.062	0.003**	0.005**	0.382
Family support and functioning	Poor	22.5(2.8)	20.1(3.0)	8.7(2.3)	25.9(4.2)	77.4(10.4)	71.0(3.3)
	Good	24.6(3.1)	22.1(2.9)	10.1(1.7)	28.0(4.1)	84.6(10.1)	86.0(9.1)
	P-value	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**

*=p< 0.05, **=p< 0.01

Table 3: Pearson’s correlations among various domains of QOL and age

Variable	age	Physical	Psychological	Social	Environmental	Total QOL
age	1	-.321**	-.193**	-.259**	-.107*	-.203**
Physical		1	.766**	.565**	.588**	.856**
Psychological			1	.545**	.714**	.897**
Social				1	.591**	.736**
Environmental					1	.889**
Total QOL						1

*=p < 0.05, **=p< 0.01

Table 4: Linear regression for predicting QOL

Dependent Variable	Independent Variable	Standar dized β	pvalue	R ²	Adj R ²
Total QOL	Education	0.24	< 0.001	.272	.26
	Family functioning	0.23	< 0.001		
	Health problem	-0.21	< 0.001		
	Stressful event	-0.17	< 0.001		
	employment	0.14	0.007		

**=p< 0.01; Adj = adjusted; Total QOL = Total score of Quality of life

Table 5: The correlation of Family Function dimension and Quality of life

Family function domains	QOL	N	Mean	Std. Deviation	t	p-value Sig. (2-tailed)
Problem solving	high	315	2.6114	.39179	-3.655	.000
	low	43	2.8791	.75610		
communication	high	315	2.7420	.60472	-4.630	.000
	low	43	3.2098	.73462		
roles	high	315	2.3989	.58572	-4.616	.000
	low	43	2.8686	.86990		
Affective response	high	315	2.6460	.60064	-3.258	.001
	low	43	2.9767	.77884		
Affective involvement	high	314	2.97	.478	-.805	.421
	low	41	3.03	.564		
Behavior control	high	315	2.8540	.58792	.464	.643
	low	43	2.8081	.74169		
General function	high	310	2.65	.533	-6.548	.000
	low	43	3.23	.626		

Qol high=score between 96-130,

Qol low= score between 26-95.

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