Life in Family Buildings as a unique environment in Turkey

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Abstract

Family building (FB) is a building where residents of different flats are close relatives. Being quite common in metropolitar areas, these unique psychosocial environments remain underexamined. We aimed to research into the interactions within the family and psychosocial features of FBs. One hundred and one children living in FBs and FB-experiences of their parents were assessed by semi-structured interviews using K-SADS-PL. Mothers scored their satisfaction from FB-lifestyle in the scale of 0-100. The sample consisted of 35 girls and 66 boys. Mean age was 108±37.4 months. ADHD and anxiety disorders were the common diagnoses. Eighty-two families out of 101 lived in FBs, the mean duration was 10.7±5.6 years (range: 1-29 years). Only 6% was living in a rental, owned by a stranger. Eighty-two families out of 101 lived with paternal relatives (81.2%) and 28 children were found to be the most common diagnosis (n=75, 74%); followed by anxiety disorders (n=77, 76%).

Materials and Methods

Subjects

The study was conducted among patients who were admitted to Child and Adolescent Psychiatry Outpatient Clinic in Marmara University Hospital. 101 families that live in FBs volunteered to take part. There was no exclusion criteria.

Data collection tools

Sociodemographic information questionnaire. The form was conducted by the research team. Information about the child’s age, sex, developmental milestones, medical and psychiatric history, family history for psychiatric disorders; and parent’s complaints and comments about living in FBs were gathered.

The schedule for affective disorders and schizophrenia for school-age children–present and lifetime (K-SADS-PL) (Turkish version). K-SADS-PL is one of the most commonly used standardized semi structured diagnostic interviews in child and adolescent psychiatry. It is used to evaluate the psychopathology of children. It was developed by Kaufman et al.5 Turkish validation of the inventory was conducted by Gokler et al.6

Other conditions like developmental delay, mental retardation, learning disorders, autism spectrum disorders were diagnosed by the appropriate tests and clinical examination.

Results

There were 35 girls (34.7%) and 66 boys (65.3%) in the sample. The age range was from 1.4 years to 17.7 years and the mean age was 108±37.4 months. 20% of families defined their income as ‘poor’; 45% as ‘moderate’ and 35% as ‘sufficient’.

In our sample (n=101), attention-deficiency hyperactivity disorder (ADHD) was found to be the most common diagnosis (n=75, 74%); followed by anxiety disorders and intellectual disability (Table 1). One of the most common symptoms was enuresis/encopresis (14%). All participants were living in FBs, the mean duration was 10.7±5.6 years (range: 1-29 years). Only 6% was living in a rental, owned by a stranger. Eighty-two families out of 101 lived with paternal relatives (81.2%) and 28...
children’s parents had a consanguineous marriage. The decision of living in FBs was mostly made passively (65%), due to marriage or by the patriarchs. In only 14% of families, both partners planned and wanted to live in a FB aimfully. 10% declared that they were living in FBs because of economical obligations. The number of relative-occupied flats in the FB changed from two to ten. ‘Familial density’ of FBs was calculated by dividing the number of relative-occupied flats by the total number of flats in the building. The mean value for familial density \(d_{dam}\) in our sample was 0.7±0.3 (min. 0.06, max 1). When asked about the frequency of meeting with neighbor-relatives, 74% of families declared they met everyday and 33% reported they spent all day together. Although they live in separate apartments, 12% of families eat all their meals and 8% eat at least 3 to 5 days a week together with the relatives.

Sixty parents (59%) believed living in FB was interrelated to their children’s symptoms; and over 80% of them declared that they thought living in FB affected their children negatively. Sixty-six children had already been patients of our outpatient clinic when the study started. Only 7 of those families (11%) had received interventions (inquiry, information, advice, monitoring) targeting difficulties due to FBs. Three of these families were able to implement the limit setting suggestions into life; and they all reported positive outcome.

Mothers were asked to score their satisfaction from living in FBs, in the scale of 0 to 100. The mean satisfaction score (SSFB) was 59.1±33.8. Median score was 70; 41 mothers scored 50 points or less and 27% of mothers scored over 80 points. When asked about their preferences on housing; 54% declared they would like to live in a building without family-members.

The mothers mentioned some advantages and disadvantages for their life in FBs. In means of perceived advantages; 85% felt more secure; 82% got help in childcare, 65% got social and 31% got financial support. As disadvantages, families complained about limit setting difficulties (69%), extreme criticism and gossiping (54%), privacy issues (31%) and ‘not making decisions without consulting to elderly’ (18%). Correlations between FB-related data (SSFB and \(d_{dam}\)) and the perceived advantages, disadvantages and sociodemographic data are summarized in Table 2. No significant correlation was found between SSFB and \(d_{dam}\). SSFB was significantly and highly correlated to advantages of feeling secure, having social support, getting help in childcare and disadvantages of experiencing extreme criticism and having privacy issues (\(P<0.001\)). Hierarchical Multiple Regression was used to assess the ability of these advantages and disadvantages to predict levels of satisfaction (SSFB), after controlling for the influence of children’s age. Total variance explained by the model as a whole was 55.5%, \(F(6,93) = 19.34\), \(P<0.001\). Children’s age was explaining 4.6% of the variance in SSFB, as the advantages and disadvantages explained an additional 51%.

In the final model, only having social support and experiencing extreme criticism were found statistically significant. Having a higher beta value (\(\beta=-0.39\); \(P<0.001\)) extreme criticism is the most decisive element on SSFB (Table 3).

### Discussion

Two thirds of our sample was male, and this is compatible with the literature on the characteristics of children and adolescents admitted in child psychiatry outpatient units. ADHD and anxiety disorders being the most common diagnoses in our study was also supported by the literature.8,9

In addition to screening for

## Table 1. Frequency of children’s diagnoses in the sample (n=101).

| Diagnosis                          | Frequency | %   |
|-----------------------------------|-----------|-----|
| ADHD                             | 75        | 74.3|
| Anxiety Disorder                  | 23        | 22.8|
| Intellectual Disability           | 14        | 13.9|
| Autism Spectrum Disorder          | 8         | 7.9 |
| Language Disorder                 | 6         | 5.8 |
| Depression Disorder               | 5         | 5.0 |
| ODD                               | 2         | 2.0 |
| Learning Disorder                 | 2         | 2.0 |
| Psychotic Disorders               | 2         | 2.0 |
| Conduct Disorder                  | 1         | 1.0 |
| Tic Disorder                      | 1         | 1.0 |

**ADHD** = Attention Deficiency Hyperactivity Disorder. **ODD** = Oppositional Defiant Disorder.

## Table 2. Summary of the correlations between FB-related data (SSFB and \(d_{dam}\)) and sociodemographic features.

| Sociodemographic features | SSFB | \(d_{dam}\) |
|---------------------------|------|------------|
| Children’s age            | -0.21 | -0.37**   |
| Duration of FB life       | -0.003| 0.01      |
| Consanguineous marriage   | -0.08 | 0.06      |
| Birth weight              | -0.02 | 0.02      |
| Perinatal complications   | 0.15  | -0.02     |

## Table 3. Hierarchical multiple regression analyses predicting the mothers’ self-reported satisfaction scores from living in a family building (SSFB) (n=100).

| B       | SE B   | \(\beta\) | 95% CI                  | R²    | F    | \(\Delta R²\) | \(\Delta F\) |
|---------|--------|-----------|-------------------------|-------|------|----------------|-------------|
| Model 1 |        |           |                         |       |      |                |             |
| Constant| 79.95**| 10.18     | [59.76, 100.15]          | 0.05  | 4.69*|                |             |
| Children’s age (m)       | -0.19**| 0.09      | -0.21                  |       |      | -0.37 [-0.02]  |             |
| Model 2 |        |           |                         |       |      |                |             |
| Constant| 46.40**| 11.81     | [22.94, 69.85]           | 0.56  | 19.34**| 0.51          | 21.30**     |
| Children’s age (m)       | -0.03  | 0.07      | -0.03                  |       |      | -0.16 [-0.11] |             |
| Adv. - Security          | 10.97  | 9.03      | 0.12                   |       |      | -5.97 [28.91] |             |
| Adv. - Social support    | 17.91**| 6.56      | 0.25                   |       |      | 4.88 [30.93]  |             |
| Adv. - Childcare         | 13.86  | 8.22      | 0.16                   |       |      | -2.47 [30.18] |             |
| Disadv. - Criticism      | -26.07**| 5.31   | -0.39                  |       |      | -36.62 [-15.52]|             |
| Disadv. - No privacy     | -8.42  | 5.46      | -0.12                  |       |      | -19.27 [2.43] |             |

\(\text{CI} = \text{confidence interval; } B\text{ is for unstandardized coefficients. } \beta\text{ is for standardized coefficients. } \text{SE } B = \text{standard error for } B; \text{ (m) = months. Adv. = advantage. Disadv. = disadvantage. } P<0.05. \text{ **P}<0.01.\)
psychopathology; we also gathered significant amount of sociological data about life in FBs. More than three quarters of families were living with father’s relatives; and many of them reported that they wouldn’t choose to live in a FB if they had such an option. Patriarchal dominance may explain these mechanisms of decision making on housing. Although patriarchal structure has changed form eventually, it is still very common in Turkish society; and it’s the dominant culture in rural areas. The lack of free will when choosing their home environment can be interpreted as inadequate family independence and insufficient individuality of parents. That indicates the presence of a public health problem, as well.

Living in a FB, is like living in a building and a traditional house at the same time. For better or for worse, it is different from living in the same neighbourhood with your relatives. In literature, family is known as a protective factor for psychiatric disorders. However during our practice we realized that life in FBs can sometimes be complicated for our patients and their parents. Besides feeling more secure and getting more family support in social, financial, childcare areas; they experience more gossiping, privacy issues and child-rearing difficulties. “My mother-in-law enters whenever she likes, even without knocking, even in the middle of the night,” says one of the mothers in our study. That was because in their building, keys were hanging outside the doors of flats. Another mom was complaining about upbringing difficulties she was facing, as “When I say no to my son, he runs upstairs to grandma and grandpa’s; and they grumble to me about how I must do whatever their little prince wants”. Many parents complain about their children’s symptoms being interrelated to living in a FB and for children, this may mean closeness and diversity in relationships, as well as an enmeshed family setting.

In accordance with our preconceptions, an important finding in the present study was that many families showed low-satisfaction for living in a FB. Turkish Statistical Institute’s (TUİK) Life Satisfaction Research in 2013 was conducted among 196203 people all around Turkey. According to the results; out of 6360 women living in Istanbul, 78.5% declared their satisfaction about their residential housing as either satisfied or very satisfied. Our SS FB results of 27% scoring 80 or more as satisfaction level was indeed very different. Our sample was mothers of a clinical population, all got married once, living in a FB; whereas TUİK study was community based, the participants were over 18 but not all of them were married nor gave birth and they weren’t asked about living in a FB. Although these results should not be interpreted as the result of a FB life-style only, the difference between satisfaction scores are remarkable.

The regression analyses point out that ‘experiencing extreme criticism’ becomes decisive when predicting satisfaction scores. They also relate high satisfaction to having social support in FB. Starting from this point of view we may come to a conclusion that psychological stress seems to identify satisfaction rather than concrete stress like economical dependence, childcare help etc. Parents’ belief that their children’s symptoms were interrelated to living in the FB and mostly in a negative way was another important finding, showing that this issue should always be handled properly in clinical practice regardless of their diagnosis. The environment FBs provide may alter the way the parents perceive their children’s behavioral symptoms. On the other hand, symptom presentation of certain disorders (i.e. ADHD) may be more complicated in FBs due to limit setting difficulties. Although limit setting and behavioral interventions had high efficiency in FB residents, in outpatient visits counselling about the difficulties in FBs was quite rare. This may be explained by insufficient literature work on the topic, limited time for assessment or frequent change of rotating doctors. In clinical evaluation and management, approaching FB as an environmental variable and asking the family members about their life and satisfaction from it, may help to increase the quality of mental health service for both children and their families.

Limitations
Some limitations exist in the present study. As it was conducted using a clinical sample, it should be kept in mind that many people who didn’t or couldn’t come to the outpatient clinic were not assessed. As our hospital is located in a suburban county of Istanbul, most of our data came from that location. Standardization for age, diagnosis, duration of therapy among patients was not established. Although we did some regression analyses to predict satisfaction, the sample size was not big enough for factor analyses of advantages and disadvantages.

Conclusions
As a unique sociocultural environment in Turkey, it was important to have a better understanding on the FBs, and their impact on children and families. Our study showed that the phenomenon of FBs arose years ago and still lives on because it corresponds to some requirements in life, like social support, feeling secure, help in childcare. But the study also pointed to mothers’ low satisfaction scores in association with extreme criticism. Mothers’ relating their offsprings’ symptoms to FBs was also of notice. The present study introduces a relatively new dimension of Turkish culture to the researchers worldwide. The supportive environment families offer for couples and children, seem to change in FBs due to the dynamics of interpersonal relations. More clinical research is definitely needed in this underexplored field; as well as epidemiological and community based studies to discover the psychological influence of FBs. In the future, after more studies in the field we may identify the FB life as a unique environmental factor that affects mental health in children and parents.

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