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 metropolitan 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 lived with paternal relatives. Number of relative-neighbors in the building changed between 2-10. Forty-one mothers scored ≤50 for their satisfaction; 58% believed FBs affected their children's symptoms negatively. Examining the perceived advantages and disadvantages of FBs, 'extreme criticism' and 'social support' were the decisive items to predict mothers' satisfaction levels. Having both positive and negative effects, FB-lifestyle seem to complicate interpersonal relations within the family. This study has revealed some preliminary findings, but further studies are required in the field.

Introduction

Bringing two continents together, Turkey has a great multiplicity of cultures. People living in urbanized areas have European life styles; whereas in the suburbs of big cities and rural parts of the country, people live more traditional and conservative lives.[1] The social diversity reflects on housing as traditional houses and apartment buildings.[2] After the industrial revolution there was a sudden and mass migration of poverty-stricken farmers into the cities. The exodus from the countryside caused many problems. The most outstanding one was on housing. Migrants built shanties on public land.[3] Primitive FBs were formed, as the shanty owners built second and third floors to accomodate comings of migrated relatives and newlyweds. Later on instead of their shanties, constructers started to build FBs for these families. FBs today are jerry-built buildings with several floors and apartment units where relatives live in seperate apartments. The apartments are usually owned and occupied within the family, the spare apartments are either empty or for rent. Formed over 50 years time and still existing, the notion of FBs has become a phenomenon. Childhood family environments have a crucial role in mental and physical health development.[4] Thus this unique environment needs to be acknowledged further. In this study we aimed to research into the life in FBs; in terms of childrens's psychopathology, psychosocial features and interactions within the family.

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.

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Ethics

The study was approved by the Marmara University Medical School Clinical Studies Ethics Committee on 04 April 2014 and informed consent was obtained from all parents.

Statistical analysis

The statistical analyses were performed using SPSS 23; P<0.05 is considered as statistically significant.

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 patriaches. 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_{fam}) 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 (SS_{FB}) 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 (SS_{FB} and d_{fam}) and the perceived advantages, disadvantages and sociodemographic data are summarized in Table 2. No significant correlation was found between SS_{FB} and d_{fam}. SS_{FB} 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 (SS_{FB}), 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 SS_{FB}, 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 (β=-0.39; P<0.001) extreme criticism is the most decisive element on SS_{FB} (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.[7] 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 Disoerder	8	7.9
Language Disorder	6	5.9
Depression Disorder	5	5
ODD	2	2
Learning Disorder	2	2
Psychotic Disorders	2	2
Conduct Disorder	1	1
Tic Disorder	1	1

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

Table 2. Summary of the correlations between FB-related data (SS_{FB} and d_{fam}) and sociodemographic features.

Sociodemographic features	SSFB	d_{fam}
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
Milestones		
Speaking	0.14	-0.06
Walking	-0.07	0.15
Toilet training	-0.01	-0.03
Perceived advantages of FB		
Security	0.47**	0.08
Financial	0.25*	0.01
Social Support	0.60**	0.03
Childcare	0.46**	0.12
Perceived disadvantages of FB		
Limit setting difficulties	-0.09	0.17
Consulting to elderly	-0.21*	0.05
Criticism	-0.60**	0.06
No privacy	-0.35**	0.02

FB = Family building. SS_{FB} = Satisfaction scores of mothers from living in a FB. d_{fam} = familial density. *P<0.05. **P<0.01.

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	β	95% CI	R^2	F	ΔR^2	ΔF
Model 1					0.05	4.69*		
Constant	79.95**	10.18		[59.76, 100.15]				
Children's age (m)	-0.19*	0.09	-0.21*	[-0.37, -0.02]				
Model 2					0.56	19.34**	0.51	21.30**
Constant	46.40**	11.81		[22.94, 69.85]				
Children's age (m)	-0.03	0.07	-0.03	[-.16, .11]				
Adv. - Security	10.97	9.03	0.12	[-6.97, 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]				

CI = confidence interval. B is for unstandardized coefficients. β is for standardized coefficients. SE B = standard error for B. (m) = months. Adv. = advantage. Disadv. = disadvantage. *P<0.05. **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.[10,11] 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 in outpatient clinic that they can't set limits to their relatives about applying our suggestions or can't decide on their child's treatment plan because their patriaches think the child doesn't need the medication.

One may think, facing these difficulties; if they weren't happy, they would move out. Though this may not be the true-life. In traditional culture, moving out would mean betraying and disobeying the patriach; and for the father of our patient, it'd also mean not being a good enough son to his parents. In some of the families, it may even become a financial burden if the patriarch holds the control of the family business.

According to our results, FBs have a great range in number of apartments they contain. And while some FBs are in all-relative structure, some host outsider neighbors along with the family. To manage these diversities in analyses, we came up with the term, familial density (d_{fam}). Due to our clinical experience, we expected that d_{fam} would be significantly correlated with SS_{FB} and sociodemographic variables, though it wasn't. Apart from our limited sample size, we may argue that FB life style has influence on parents independent from the number of relative-neighbors.

In the study, one third of families spend all day together with at least one of their neighbor-relatives and only go to their seperate apartment at night for sleep. 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 (TUIK) 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.[12] Our SS_{FB} results of 27% scoring 80 or more as satistaction level was indeed very different. Our sample was mothers of a clinical population, all got married once, living in a FB; whereas TUIK 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 dimention 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 enviromental factor that affects mental health in children and parents.

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