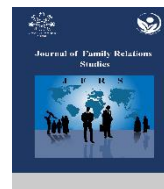




Contents lists available at <https://ecc.isc.ac/showJournal/39795>

Journal of Family Relations Studies

Journal home page: <http://jhers.uma.ac.ir/>



Research Paper

Comparison of physical health and family functioning in patients with obsessive-compulsive disorder, bipolar and normal



Crossmark

Behzad Malehmir¹ , Niloofar Mikaeli^{2*} & Mohammad Narimani²

1. MSc of Clinical Psychology, University of Mohaghegh Ardabili, Ardabil, Iran.

2. Professor, Department of Psychology, Faculty of Educational Sciences and Psychology, University of Mohaghegh Ardabili, Ardabil, Iran.

Use your device to scan and read article online



Citation: Malehmir, M., Mikaeli, N. & Narimani, M. (2023). [Comparison of physical health and family functioning in patients with obsessive-compulsive disorder, bipolar and normal (Persian)]. *Journal of Family Relations Studies*, 3 (11): 13-21. <https://doi.org/10.22098/jhrs.2022.10209.1042>

[10.22098/jhrs.2022.10209.1042](https://doi.org/10.22098/jhrs.2022.10209.1042)

ARTICLE INFO:

Received: 2022/01/23

Accepted: 2023/02/28

Available Online: 2023/12/15

Key words:

Physical Health,
Family Function,
Obsessive
Compulsive
Disorder, Bipolar
Disorder

ABSTRACT

Objective: The aim of this study was to compare physical health and family functioning in patients with obsessive-compulsive disorder, bipolar disorder and normal.

Methods: The present study was a causal-comparative study and the statistical population of the study includes all obsessive-compulsive and bipolar patients hospitalized and referred to Fatemi Hospital and psychiatric clinics in Ardabil in autumn, which were diagnosed by obsessive-compulsive and bipolar disorders. From this statistical population, 40 obsessive-compulsive individuals, 40 bipolar individuals and 40 normal individuals were selected by available sampling method and answered the physical health and family functioning questionnaires. Data were analyzed using SPSS-25 software.

Results: The results of the present study showed that there was a significant difference between physical health and its components in patients with obsessive-compulsive disorder, bipolar disorder and normal ($P < 0.01$). Also, this difference was significant in the family performance variable and its components in all three groups of normal, bipolar and obsessive ($P < 0.01$).

Conclusion: These results indicated that impaired family dysfunction and physical health increase the severity of obsessive-compulsive disorder and bipolar disorder. Therefore, paying attention to this result in psychotherapy plans and specialized interventions can be effective.

1. Introduction

The issue of mental health is very important in the world today. In proportion to the growth and development of industry, economy, etc the psychological problems of the people are also progressing. Communities also need people with mental and physical health in order not to lag behind other countries in terms of progress and development (SafarAlizadeh & HashemLou, 2014). Mental-behavioral disorder is a significant change in thinking, behavior, mood and emotion that is characterized by

personal distress or dysfunction in life. These changes are clearly abnormal, pathological, and reversible (Zadok, 2017). According to the World Health Organization (2008), the overall burden of disease is related to mental, neurological, and substance abuse disorders. According to the National Mental Health Survey, more than 1.5% of the population aged 15 to 64 have obsessive-compulsive disorder (Mental Health Center of the Ministry of Health and Medical Education).

*Corresponding Author:

Niloofar Mikaeli

Address: Department of Psychology, Faculty of Educational Sciences and Psychology, University of Mohaghegh Ardabili, Ardabil, Iran.

E-mail: nmikaeli@yahoo.com

One of the psychological disorders that affect people's mental, emotional and communicational health is obsessive-compulsive disorder or mental-practical disorder¹. This disorder is characterized by repetitive, resistant thoughts and repetitive behaviors associated with anxiety, and in most cases, diagnosed people have both mental and practical symptoms. Repetitive thoughts and actions resulting from obsessive-compulsive disorder are not pleasurable and voluntary, but these thoughts are involuntarily expressed and cause anxiety and worry in people (McCabe, et al., 2019). These mental or practical obsessions are a waste of time and cause significant disruption to the normal course of life, job function, normal social activities or relationships (Alavi Paydar, Khodabakhsh, MehriNejad, 2017).

Significant symptoms of obsessive-compulsive disorder include reoccurring obsessive-compulsive disorder, which is time-consuming due to its extreme nature and leads to overt confusion. Obsessive-compulsive disorder includes disturbing thoughts, desires, and mental images that the person seeks to eliminate. On the other hand, practical obsessions (compulsions) include repetitive behaviors or mental actions that one feels one should act on to cope with the obsessions and calm oneself, which may appear as ritual behaviors (APA,2013). Regular washing, checking objects, specific repetitive behaviors or expressions, order and arrangement are the most common obsessive acts, each of which causes distress to the sufferer (AsliAzad, Manshaei & Ghamarani, 2019). Also, obsessive thoughts and mental images are recurrent, persistent and disturbing, which are very difficult for the diagnosed person to control (Amerio , Maina & Ghaemi, 2019). As a complex and chronic anxiety disorder, it affects 2 to 3% of the population of children and adults (Barton & Heyman, 2016) and is a serious mental health problem that is appeared in at least half of the clients in their childhood and adolescence (Ganji, 2013). Failure to treat obsessive-compulsive disorder at school age can lead to more damage in adulthood as well as other psychological and emotional damages such as depression (Rozenman, et al, 2019).

Another disorder studied in this study is bipolar depression, which is a mood disorder. Mood disorders are divided into unipolar and bipolar depressions based on the presence or history of a manic or hypomanic episode (APA, 2013). In these patients, the main characteristics include a feeling of constant sadness, loss of interest in an important part of life, and a fluctuation between excessive happiness and unhappiness, which can lead to serious harm to the

family, job, or community (Shakoori, Behbani, M, Beshkooch & Hashemi Razini, 2019). It affects one to two percent of the population and has many effects on interpersonal and social relationships such as suicide and job loss, because it is chronic (Koender & et al, 2020). It also causes changes in a person's energy, mood and practical ability. These are severe symptoms and disrupt interpersonal and environmental relationships (zamani, 2019). These mood swings usually last for weeks or months (Çuhadar & Çam, 2014). Unstable mood, cognitive impairment, the possibility of developing psychotic symptoms, poor economic status, unemployment, dismissal, marital issues, lack of continuing education, as well as multiple hospitalizations in psychiatric centers are also considered as complications of this disorder (Miziou & et al, 2015).

Since the most common dimension of health is physical health³, this dimension is easier to evaluate than other dimensions of health. Physical health is in fact the result of the proper functioning of the organs of the body (Tulchinsky & et al., 2000). If health, disease, and illness are rooted in the biological nature of the human race, then events related to disease must follow the same process statistically among groups of human beings living within a given geographical area, but this is not the case (Kingdon, 2009). Clinical evidence suggests that bipolar disorder is associated with decreased life expectancy and deteriorating physical health compared to the general population. The risk of suicide in these patients is twice the normal population and also the percentage of weight gain and cardiovascular disease is higher (Garcia & et al, 2010). Research evidence shows that obsessive-compulsive disorder is associated with severe problems in various areas of life such as quality of life, work, social and family relationships (Koran & Thienemann, 1996). The first study to examine health-related quality of life in this population showed that patients with obsessive-compulsive disorder are somewhat similar to normal people in the community when it comes to physical health. but in areas of mental health, including social functions are dysfunctional. Evidence suggests that this disorder is associated with negative physical health consequences (Pozza , Ferretti & Coluccia, 2019). Poor quality of life can lead to ineffective coping and adjustment mechanisms in individuals and increase stress in them, which is directly related to physical illness (Dadashzadeh , Arfaei, Mousavikia& Alizadeh, 2013).

The results of research show that the role and impact of the family and especially family functions in the formation and strengthening of mental disorders,

especially obsessive-compulsive disorder and bipolar disorder and in relation to the reduction of obsessive-compulsive disorder and bipolar disorder is confirmed (Putri & Khairunnisa, 2019). Many variables are involved in the formation and exacerbation of obsessive-compulsive disorder and bipolar disorder. One of the variables that can have a significant effect on exacerbating the symptoms of these disorders is family functioning. The family is considered as the basic unit of the interpersonal interaction system that influences the behaviors of members by sharing thoughts and paying attention to each other's needs and expectations (Yeom & Lee, 2019). Family functioning can be healthy when the family environment has clear connections, defined roles, cohesion, and emotion regulation. In contrast, poor family performance includes high levels of conflict, disorder, and poor behavioral and emotional control (Capri, et al., 2019). Frequent episodes of depression and mania affect a person's functioning in individual, professional, family, social and cultural domains (Jolfaei, Ataei, Ghayoomi & Shabani, 2019). In a study, family performance in pediatric trichotillomaniac disorder, obsessive-compulsive disorder and healthy individuals was examined. The results showed that family functioning in the two groups of obsessive-compulsive disorder and manic disorder was more impaired than the control group and high conflict, low cohesion and less organization were observed. Parents of children with manic expression disorder also reported lower expression and coherence than the group of obsessive-compulsive disorder (Peris, et al., 2019). Also, in a study examining family performance in bipolar individuals, they found that bipolar families showed higher levels of conflict, less cohesion, and organization than normal individuals (Peris, et al., 2019; Shalev & et al., 2018).

Mental disorders lead to dysfunction of people with mental illness as well as their family members at different levels of physical, mental, social and economic (Akbari, Alavi, 2018). When a family member becomes ill, it somehow affects the performance of the whole family (Barlow, 2016). Therefore, attention and support for these people and their families can improve their psychological, social and economic functions and their families. Obsessio reduces the quality of life and causes many communication problems for people, Because it has many effects on people's lives such as wasting time, inability to concentrate and creating distraction, skipping main tasks such as education, work and also mental fatigue. Bipolar patients also experience mental (such as sadness, lack of self-confidence, sensitivity and irritability), intellectual (such as loss of decision-making ability and difficulty concentrating) and physical (such as loss of appetite and weight, sleep problems, feeling tired

and waking up earlier than the set time) problems. Therefore, recognizing these patients and examining their physical and mental health is essential to improving their life. (APA,2013) Our aim in this study was to compare physical health and family functioning in people with obsessive-compulsive disorder, bipolar disorder and normal people.

2. Materials and Methods

The present study was descriptive and causal-comparative in terms of basic purpose and data collection method. The statistical population of this study included all obsessive-compulsive and bipolar patients hospitalized and referred to Fatemi Hospital and psychiatric offices in December to February 2019 and June and July 2020 in Ardabil, which were received by obsessive-compulsive and bipolar disorders. From this statistical population, 40 obsessive-compulsive individuals, 40 bipolar individuals and 40 normal individuals were selected by convenience sampling. Inclusion criteria included willingness to participate in the study, being between 20 and 50 years old and exclusion criteria included lack of cooperation or lack of motivation and substance abuse.

To conduct the existing study, after obtaining the necessary permits and initial coordinations with the officials of Fatemi Hospital and clinics in Ardabil, the researcher referred to these centers for sampling and after initial agreements and their consent for cooperation, conditions and characteristics of the sample needed for the research was mentioned. Then the researcher spoke with each of the referred patients after reviewing their cases, and after obtaining their consent to participate in the study, they were first interviewed according to DSM-V criteria. After interviewing and confirming the psychiatrist's diagnosis, the researcher gave them physical health and family functioning questionnaires to fill out. Patients completed the questionnaires in the presence of the researcher and in case of ambiguity, it was resolved by the researcher's explanations. Frequency, mean and standard deviation reports were used to analyze the data in descriptive statistics and multivariate analysis of variance (MANOVA) using SPSS-25 software was used to test the hypotheses.

Physical Health Questionnaire (PHQ): Scott and Clovi (2003) composed a 14-item scale that included four components of headache, respiratory problems, gastrointestinal problems and sleep disorders. This questionnaire was standardized in accordance with the culture And Iranian society by Abbasi, Kimiai, Saffarian and Abedi (2018).

It consists of 14 items of seven Likerts and is measured in four components including headache, sleep disturbance, gastrointestinal, and respiratory problems. The answers to its 11 articles are never, hardly ever, rarely, sometimes, often, usually and always, and the options for the other 3 items are never, once or twice, 3 times, 4 times, 5 times, 6 times and 7 times and more. Therefore, a person's score on this scale is in the range of 14 to 98, which lower score indicates better physical health (Abasi, Kimiaei, Saffarian & Abedi, 2018). The internal consistency of this scale were reported 0.86 (Schat & Kelloway, 2003). In Waters (2015), the reliability of this scale were calculated 0.90 (Waters, 2015). In the study of Balali and Eskandarzadeh (2018), the reliability of this scale was 0.83. Also, in the study of Abbasi et al. (2017), the internal consistency of the whole questionnaire was 0.81. In addition, the results of this study showed that this scale has good validity and reliability.

Family Performance Scale (FFS): This scale was developed by Tavitian, Lubiner, Green, C., Gerbstein, and Veliser in 1987 to measure family performance and contains 40 items. The scoring of the questionnaire is considered as a 7-point Likert scale of (never: 1, almost never: 2, rarely: 3, sometimes: 4, often: 5, usually: 6 and always: 7). This scale consists of 5 components: 1- Positive emotions within the family 2- Family relationships 3- Family conflicts 4-

Family worries 5- Family support and encouragement (Tavitian & etall, 1987). In Mofid, Fathizadeh, Ahmadi and Etemad's research in 2016, the total reliability by Cronbach's alpha method was estimated to be 0.75, which is statistically appropriate, and this scale has a good concurrent and predictive validity and it is correlated with the FACES III family functioning scale.

3. Results

The results showed that the study sample was 120 people, including 40 people with obsessive-compulsive disorder, 40 people with bipolar disorder and 40 normal people; The study of demographic characteristics showed that 36.66 % of participants aged 20 to 29, 51.66 % were between the ages of 30 to 39 years and 11.66 % of study participants were in the age range of 40 to 49 years. Also, in terms of education, 40% of the subjects had an associate degree, in terms of marital status, 69.16% of the subjects were single and 30.84% were married. In terms of employment status, 73.45% of women participating in the study were housewives and 52.19% of men were self-employed. Table 1 describes the variables of family functioning and physical health and their components in three groups of normal people, patients with obsessive-compulsive disorder and patients with bipolar disorder.

Table 1. Description of family function variables and physical health

Group Variables	Normal		Obsessive Compulsive		Bipolar	
	Mean	Standard deviation	Mean	Standard deviation	Mean	Standard deviation
Positive emotions within the family	31.07	5.346	28.27	7.089	26.58	6.089
Family relationships	30.657	6.691	27.48	5.023	26.20	4.604
Family conflicts	26.15	4.423	29.12	6.505	27.17	6.887
Family worries	34.23	5.964	35.28	4.920	31.48	7.762
Family support and encouragement	34.37	6.811	29.73	5.800	25.85	5.816
Total family performance score	147.18	1.4938	110.98	2.6617	121.98	2.6617
Headache	10.23	3.52	13.60	3.01	17.25	2.86
Sleep disturbance	5.30	3.44	12.50	4.76	16.75	4.31
Gastrointestinal problems	9.05	3.44	12.50	4.76	16.75	4.31
Respiratory problems	7.40	2.46	8.45	3.68	10.88	3.08
Total physical health score	38.63	9.77	46.57	13.83	59.25	9.54

The results of Table 1 showed that the mean scores of family performance in the three groups of normal people, with bipolar disorder and obsessive-compulsive disorder are different and people with obsessive-compulsive disorder and bipolar disorder have lower average family performance than normal people. Also, according to the presented results, the average score of physical health in the group of normal

people is lower than people with bipolar disorder and obsessive-compulsive disorder. Due to the fact that a lower score in the physical health questionnaire indicates higher physical health, the rate of physical health in normal people is higher than people with obsessive-compulsive disorder and bipolar disorder. However, multivariate analysis was used to examine the significance of this difference.

Before using the multivariate analysis of variance test, in order to observe its hypotheses, Box and Levin test were examined. The box test confirmed the assumption of matrix-covariance homogeneity in those three groups of people ($p = 0.092$, $\text{BoxM} =$

228.851). This means that the equality of covariance matrices was observed in the three groups. Also, the results of Levin test ($F = 2.354$ and $P = 0.100$) were not significant for any of the variables, so the use of parametric tests was permitted.

Table 2. The result of the analysis of multivariate variance tests to compare the mean scores of physical health variable and family functioning variable in three groups of normal people. with obsessive-compulsive disorder and with bipolar disorder

Test name	Value	F	Significance	Eta coefficient
Pillais Trace	0/638	9/665	0/000	0/201
Wilks Lambda	0/363	8/570	0/000	0/181
Hotelling's Trace	0/567	10/769	0/000	0/221
Roy's Largest Root	0/565	21/845	0/000	0/361

Also, according to the results of Table 2, the effect of the group on the linear composition of dependent variables in the results of MANOVA tests for variables, was significant ($p = 0.000$). This significance indicates that there are significant differences between the three groups in a dependent

variable. Due to the significant effect of these tests, the groups were compared in two variables. The results of analysis of variance regarding the comparison of physical health and its components among the three groups were presented in Table 3.

Table 3. Test results of the analysis of multivariate variance to compare the mean scores of physical health variable and its components in three groups

Sources of change	The dependent variable	Total of the squares	DF	MS	F	Significance	Eta
Group	Headache	987.017	2	493.508	47.223	0.000	0.447
	Sleep disturbance	741.267	2	370.633	20.963	0.000	0.264
	Gastrointestinal problems	557.717	2	278.585	13.525	0.000	0.188
	Respiratory problems	254.117	2	127.058	13.111	0.000	0.183
	Total physical health score	8656.650	2	4328.325	34.364	0.000	0.370
Error	Headache	1222.450	117	10.448			
	Sleep disturbance	2068.600	117	17.680			
	Gastrointestinal problems	2412.275	117	20.618			
	Respiratory problems	1133.875	117	9.619			
	Total physical health score	14736.650	117	125.954			
Total	Headache	24842	120				
	Sleep disturbance	24250	120				
	Gastrointestinal problems	19561	120				
	Respiratory problems	10911	120				
	Total physical health score	301604	120				

According to Table 3, The result of the analysis of multivariate variance showed a statistically significant difference between the three groups of normal people, people with bipolar disorder and people with obsessive-compulsive disorder in headache ($F = 47.233$, $P < 0.01$), sleeping disorder ($F = 20.963$, $P < 0.01$), digestive problems ($F = 13.525$, $P < 0.01$), respiratory problems ($F = 13.111$, $P < 0.01$) and physical health ($F = 34.344$, $P < 0.01$).

According to Table 3, the results of the analysis of multivariate variance showed a statistically significant difference between the three groups of normal people, people with obsessive-compulsive disorder and people with bipolar disorder in family functioning ($F = 2.074$, $P < 0.01$), positive emotions withing the family ($F = 5.345$, $P < 0.01$), family relationships ($F = 5.472$, $P < 0.01$), family conflicts ($F = 17.545$, $P < 0.01$), Family worries ($F = 3.850$, $P < 0.05$) and family support and encouragement ($F = 19.220$, $P < 0.01$).

Table 4. Test results of the analysis of multivariate variance to compare the mean scores of family performance variable and their components in three groups

	The dependent variable	Source	Total of the squares	DF	MS	The value of F	Significance	Eta
Family Function	Positive emotions withing the family	Group	413.067	2	206.533	3.345	0.006	0.084
		Error	4520.525	117	38.637			
		Total	103375	120				
	Family relationship	Group	405.017	2	202.508	5.472	0.005	0.086
		Error	4330.150	117	37.010			
		Total	99376	120				
	Family conflicts	Group	1272.050	2	636.025	17.455	0.000	0.230
		Error	4663.250	117	36.438			
		Total	93990	120				
	Family worries	Group	308.067	2	154.033	3.850	0.024	0.062
		Error	4680.925	117	42.008			
		Total	140935	120				
	Family support and encouragement	Group	1457.517	2	728.758	19.202	0.000	0.247
		Error	4440.450	117	37953			
		Total	113778	120				
	Total score of the family function	Group	27553.067	2	13776.533	22.074	0.000	0.274
		Error	73019.725	117	624.100			
		Total	2027173	120				

4. Discussion and Conclusion

The aim of this study was to compare physical health and family functioning in patients with obsessive-compulsive disorder, bipolar disorder and normal people. In general, the results of this study indicate that physical health in people with bipolar disorder is more affected than those with obsessive-compulsive disorder and normal people. This finding is consistent with the results of some researches (Young & Grunze, 2013; Witthauer, Gloster, Meyer & Lieb, 2014; Pozza, Ferretti & Coluccia, 2019). In general, the issue of mental health is correlated with physical health, and injury to each can affect the other. As expected, the physical health of the normal group was higher than the other two clinical groups. Also, according to similar research, it has become clear that people with bipolar disorder are more prone to obesity, high blood pressure, high blood sugar and type 2 diabetes due to their lifestyle than the general population, which are considered risk factors for cardiovascular disease threaten physical health. In addition, there is a possibility of self-medication and drug abuse to get rid of the symptoms in this group of patients, which in turn affects the physical health of people. Regarding the physical health status of people with obsessive-compulsive disorder, it has been found that patients often suffer from physical inactivity, which is associated with many chronic physical diseases. In addition, certain behavioral patterns are seen in people with obsessive-compulsive disorder that affect their physical health, such as frequent cleaning and exposure to chemicals that can lead to asthma or respiratory illness. Fears related to infection may also

shape unhealthy eating habits in people. Deficiency in serotonin metabolism is also part of the biochemical basis of migraine and obsessive-compulsive disorder, and studies on these two issues have shown that many people with obsessive-compulsive disorder also suffer from migraine headaches, which have a common biological cause (Witthauer, Gloster, Meyer & Lieb, 2014). Overall, the physical health of people with obsessive-compulsive disorder and bipolar disorder can be directly and indirectly affected due to inappropriate emotion regulation styles, maladaptive thought and behavioral patterns such as social isolation (in obsessive-compulsive disorder and bipolar disorder), suicidal ideation (in bipolar disorder) and in general, adopting an unhealthy lifestyle.

Another result of the study was that the mean scores of family performance in the three groups of normal people, people with bipolar disorder and people with obsessive-compulsive disorder are different and people with obsessive-compulsive disorder and bipolar disorder have lower average family performance scores than normal people. The bipolar group is significantly higher than the obsessive-compulsive group. The obtained results are in line with the research findings (Peris, et al., 2019; Shalev & et al., 2018; Moradi & Haghayegh, 2019; Iacono & et al., 2018). To explain this finding, it can be said that people who suffer from bipolar disorder show maladaptive behaviors that can lead to negative social interactions with others and accelerate the progression and increase of symptoms (Sabzevari, Mousavi, Jafari, & Azizi, 2017).

In most cases, treatment will be successful when the bipolar disorder is continuous and doesn't have any drug usage pause. But even when the treatment is done properly, mood swings occur that must be reported (Alavi & et al., 2011). In contrast, the family of an obsessive-compulsive disorder patient reports severe disturbances in family dynamics and disturbances in family relationships that occur in both adults and children with obsessive-compulsive disorder, which accounts for 60 to 90% of the family anxiety (Geffken & et al., 2006). On the other hand, the family's hope for obsessive-compulsive disorder treatment may play a role in the process of solving problems and strengthening social support, but negative coping strategies along with denial lead to disruption in the family. A family understanding of obsessive-compulsive disorder is essential. If the disease is misunderstood, the family will feel frustrated and guilty. Caring for a person with obsessive-compulsive disorder will lead to severe psychological stress that may lead to family dysfunction. The family of an obsessive-compulsive patient feels guilty about not having enough time for the patient and considers themselves the cause of the disease or thinks that they are involved in the disease. They also feel that the presence of an obsessive-compulsive disorder patient in the family increases the risk of family dysfunction. Poor coping skills and lack of family awareness about the disease are other factors in family dysfunction. Family functioning is one of the important issues that can cause the continuation or reduction of disorders in individuals. Therefore, it seems that in this study, the families of the bipolar group were more effective than of the obsessive-compulsive group and had a greater role in solving problems. The family performance of the bipolar group is higher than of the obsessive-compulsive group.

The results of the present study showed that people with bipolar disorder have lower physical health and family functioning than patients with obsessive-compulsive disorder and normal people. The present study, like other studies, had limitations, including that the drugs used by patients in the study sample were not controlled and evaluated, and there was no distinction between type 1 and type II bipolar disorder and they were not evaluated. Due to the mentioned limitations, it is suggested that in future studies, the effects of drugs used by these patients be examined and the types of bipolar disorder be examined separately. Family performance was lower in the bipolar and obsessive-compulsive groups than in the normal group. It is suggested that sessions be held with psychologists to

educate families about obsessive-compulsive disorder and bipolar disorder, provide problem-solving skills, and revive social support for families to restore family dynamism in a healthy way.

5. Ethical Considerations

Compliance with ethical guidelines

All ethical principles are considered in this study. The participants were informed about the purpose of the research and its implementation stages. They were also assured about the confidentiality of their information and were free to leave the study whenever they wished, and if desired, the research results would be available to them.

Funding

This research did not receive any grant from funding agencies in the public, commercial, or non-profit sectors.

Authors' contributions

All authors have participated in the design, implementation and writing of all sections of the present study.

Conflicts of interest

The authors declared no conflict of interest.

Acknowledgments

This article is taken from the master's thesis in clinical psychology with ethics code IR.ARUMS.REC.1398.483 approved by Ardabil University of Medical Sciences. Therefore, I would like to express my gratitude and appreciation to the officials and staff of Fatemi Hospital, psychology clinics and psychiatric offices in Ardabil, as well as all those who responded to the questionnaires.

References:

- Abasi, F., Kimiaei, S. A., & MST, M. (2018). Psychometric properties of the Persian version of physical health questionnaire. *Research in Medicine*, 41(4), 275-281. <http://pejouhesh.sbmu.ac.ir/article-۱۷۴۱-۱-fa.html>
- Asl Alavi Paidar, S. S., Khodabakhsh, R., & Mehrinejad, S. A. (2017). Comparison of the Effectiveness of Behavioral-Cognitive & Metcognitive Approaches on Obsessive Compulsive Disorder. *Journal of Psychological Studies*, 13(1), 83-100. Doi: 10.22051/psy.2017.8147.1078
- Alavi, K, et al. (2011). "Effectiveness of group dialectical behavior therapy (based on core mindfulness, distress tolerance and emotion regulation components) on depressive symptoms in university students. 124-135. Doi:10.22038/JFMH.2011.881
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

- Amerio, A., Maina, G., Ghaemi, S.N. 2019. Updates in treating comorbid bipolar disorder and obsessive-compulsive disorder: A systematic review. *Journal of Affective Disorders*, 256: 433-440. Doi:10.1016/j.jad.2019.06.015
- Asli Azad, M., Manshaei, G., & Ghamarani, A. (2019). The effect of mindfulness therapy on tolerance of uncertainty and thought-action fusion in patients with obsessive-compulsive disorder. *Quarterly Journal of Child Mental Health*, 6(1), 83-94. Doi: 10.29252/jcmh.6.1.8
- Balali, I., & Eskandarzadeh, F. (2018). Investigating the Factors Affecting the Physical Health of Turkish and Kurdish Ethnicities with Emphasis on Behavioral Dimension of Lifestyle (Case Study: Tabriz and Mahabad). *Iranian Journal of Sociology*, 19(4), 113-138. Doi: 20.1001.1.17351901.1397.19.4.5.6
- Barton, B., Heyman, I. 2016. Obsessive-compulsive disorder in children and adolescents. *Paediatrics and Child Health*, 26(12): 527-533. Doi:10.1016/j.paed.2016.08.011
- Capri, T., Gugliandolo, M.C., Iannizzotto, G., Nucita, A., and Fabio, R.A. 2019. The influence of media usage on family functioning. *Current Psychology*, Doi:10.1007/s12144-019-00204-1
- Çuhadar, D., Çam, M. O. (2014). Effectiveness of psychoeducation in reducing internalized stigmatization in patients with bipolar disorder. *Archives of psychiatric nursing*, 28(1), 62-66. Doi:10.1016/j.apnu.2013.10.008
- Dadashzadeh, H., Arfaei, A., Mousavikia, S., & Alizadeh, A. (2013). Evaluation and comparing of quality of life in patients with major depression and bipolar mood disorder in partial recovery phase with normal individuals. *Studies in Medical Sciences*, 24(5), 364-372. <http://umj.umsu.ac.ir/article-1-1774-fa.html>
- Ganji ,H. (2013). Psychopathology based on DSM5. Arasbaran Publications. Tehran.
- Garcia Portilla M.P- Saiz P.A- Benabarre A. Florez G. Bascaran M.T. Diaz E.M. Bousoño M. Bobes J. (2010). Impact of substance use on the physical health of patients with bipolar disorder. *Acta Psychiatrica Scandinavica* . 121:437-445. Doi: 10.32598/8.1.147
- Geffken, GR., Storch, EA., Duke, DC., Monaco, L., Lewin, AB., and Goodman, WK. 2006. Hope and coping in family members of patients with obsessive-compulsive disorder. *J Anxiety Disord*, 20:614-29. Doi:10.1016/j.cpr.2006.04.003
- Iacono, V., Beaulieu, L., Hodgins, S., and Ellenbogen, M. A. 2018. Parenting practices in middle childhood mediate the relation between growing up with a parent having bipolar disorder and offspring psychopathology from childhood into early adulthood. *Development and Psychopathology*, 30, 635–649. Doi:10.1017/S095457941700116x
- Jolfaei, AG., Ataei, S., Ghayoomi, R., and Shabani, A. 2019. High Frequency of Bipolar Disorder Comorbidity in Medical Inpatients. *Iranian journal of psychiatry*, 14(1):60. Doi: 10.32598/ijpcp.25.4.6
- Kingdon, C. (2014). *Sociology for midwives*. Andrews UK Limited.
- Koender, M.A., Mesman, E., Giltay, E.J., Elzinga, B.M., & Hillegers, M.H.J. 2020. Traumatic experiences, family functioning, and mood disorder development in bipolar offspring. *British Journal of Clinical Psychology*, Doi:10.1111/bjc.12246
- Koran, L. M., Thienemann, M. L., & Davenport, R. (1996). Quality of life for patients with obsessive-compulsive disorder. *The American journal of psychiatry*. Doi:10.1176/ajp.153.6.783
- McCabe, R. E., Rowa, K., Farrell, N. R., Young, L., Swinson, R. P., & Antony, M. M. (2019). Improving treatment outcome in obsessive-compulsive disorder: Does motivational interviewing boost efficacy?. *Journal of Obsessive-Compulsive and Related Disorders*, 22, 100446. Doi:10.1016/j.jocrd.2019.100446
- Miziou, S., Tsitsipa, E., Moysidou, S., Karavelas, V., Dimelis, D., Polyzoidou, V., & Fountoulakis, K. N. (2015). Psychosocial treatment and interventions for bipolar disorder: a systematic review. *Annals of general psychiatry*, 14(1), 1-11. Doi:10.3389/fpsyt.2015.00070
- Mofid, V, Fatehizadeh, M, Ahmadi, A, Etemadi, O.(2017). The effect of solution-oriented counseling on sexual satisfaction and family performance of women in Isfahan. *Knowledge and Research in Applied Psychology*, 17 (3): 73-80doi: Doi:10.22055/2017.12587
- Moradi, Z., & Haghayegh, S. A. (2019). Comparing of family functioning among depressed and non-depressed epileptic women's. *Family Pathology, Counseling and Enrichment Journal*, 5(1), 155-168. Doi:20.1001.1.24234869.1398.5.1.11.8
- Peris, T. S., Rozenman, M., Gonzalez, A., Vreeland, A., Piacentini, J., Tan, P. Z., & Ricketts, E. J. (2019). Family functioning in pediatric trichotillomania, obsessive compulsive disorder, and healthy comparison youth. *Psychiatry research*, 281, 112578. Doi:10.1016/j.psychres.2019.112578
- Pozza, A., Ferretti, F., Coluccia, A. (2019). Perceived physical health in obsessive-compulsive disorder: a protocol for a systematic review and meta-analysis. *BMJ open*, 9(6), e026261. Doi:10.1136/bmjopen-2018-026261
- Putri, A. A. H., & Khairunnisa, H. (2019, March). The relationship of family function and social media addiction among adolescents. In *4th ASEAN Conference on Psychology, Counselling, and Humanities (ACPCH 2018)* (pp. 127-130). Atlantis Press. Doi: 10.25215/0403
- Rozenman, M., Piacentini, J., O'Neill, J., Bergman, R. L., Chang, S., & Peris, T. S. (2019). Improvement in anxiety and depression symptoms following cognitive behavior therapy for pediatric obsessive compulsive disorder. *Psychiatry research*, 276, 115-123. Doi:10.1016/j.psychres.2019.04.021

- Sabzevari, MA, Mousavi ,A, Jafari, JR, Azizi ,FM, Ajali, A. (2017). Comparison of mind theory in patients with bipolar disorder and healthy individuals and its relationship with personality dimensions. *J Health Promotion Management*; 6(6). Doi:10.21859/jhpm-07045
- Safaralizadeh F, Hashemloo L, Bagheriyeh F, Motearafi H. (2014) The prevalence obsessive- compulsive disorder in students in Khoy University in . *IJPN* 2014; 2 (2) :13-21
- Schat, A. C., Kelloway, E. K. (2003). Reducing the adverse consequences of workplace aggression and violence: the buffering effects of organizational support. *Journal of occupational health psychology*, 8(2), 110. Doi:10.1037/1076-8998.8.2.110
- Shakoori, Mahsa, Behbani, Maryam, Beshkooh, Shahnaz, Hashemi Razini, Hadi.(1398). The diagnostic role of metacognition, emotional schema and mind reading in distinguishing between unipolar and bipolar depression with a cognitive approach. *Journal of Cognitive Analytical Psychology*, 10 (39): 63-78. Doi:20.1001.1.28222476.1398.10.39.5.8
- Shalev, A., Merranko, J., Goldstein, T., Miklowitz, D. J., Axelson, D., Goldstein, B. I., and Birmaher, B. 2018. A longitudinal study of family functioning in offspring of bipolar parents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 58, 961–970. Doi:10.1016/j.jaac.2018.10.011
- Tavitian, M. L., Lubiner, J. L., Green, L., Grebstein, L. C., and Velicer, W. F. 1987. Dimensions of family functioning, *Journal of Social Behavior and Personality*, 2, 191-204. Doi:10.1016/S0191-8869(99)00257-3
- Tulchinsky, T. H., & Varavikova, E. A. (2000). 2- Expanding The Concept of Public Health. *The New Public Health*. Doi:10.1002/ijc.27708
- Vaters, C. A. (2015). Motivation and well-being: A test of self-determination theory using a person-centered approach. Doi:10.1016/j.actbio.2015.07.037
- Witthauer C, Gloster AT, Meyer AH, Lieb R.(2014). Physical diseases among persons with obsessive compulsive symptoms and disorder: a general population study. *Social psychiatry and psychiatric epidemiology*. 1; 49(12):2013-22. Doi:10.1037/1040-3590.10.2.176
- Yeom, H. E., & Lee, J. (2020). Gender difference in the relationship among family function, health behavior, and stress in midlife. *The International Journal of Aging and Human Development*, 91(4), 476-500. Doi:10.1177/0146167203254
- Young AH, Grunze H. (2013). Physical health of patients with bipolar disorder. *Acta Psychiatrica Scandinavica*. 127:3-10. Doi:10.1080/02673843.2022.1590851
- Zadok, Z. (2017). *The Fight in the Haze: Critical discourse analysis of Indonesian prime-time television talk shows addressing the 2015 Indonesian Haze* (Doctoral dissertation, The University of Waikato). Doi:10.1515/aof-2017-0017
- Zamani, N. (2019). The Effect of Interpersonal and Social Cycle Therapy on Impulsivity, Distress Tolerance, and Emotional Regulation Difficulties in Patients with Borderline Personality Disorder and Bipolar Disorder: a Case-Control Study: Assessment of Two Patients. *Journal of Health Promotion Management*, 8(5), 41-48.. Doi:10.1080/13540602.2016.827453