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Quality of Life among Schizophrenic Patients

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1.ABSTRACT

Background: Schizophrenia is a chronic disorder that influences Quality of life in the patients. Schizophrenic patients frequently complain of diminished quality of life which is acting as a critical factor in the prognosis of schizophrenia. **Aim**: This study aims at assessing quality of life among patients with schizophrenia. **Method:** The study was carried out using a descriptive research design on a convenience sample of 60 patients diagnosed with Schizophrenia at the Inpatient and Out-patient Psychiatric Department of Mansoura University Hospital. **Results:** Result in this study revealed that total score of schizophrenia quality of life about three quarter (75%) had low in quality of life with Mean ± SD is 44.58 ± 6.78. and positive correlation between quality of life and social support, marital status and personal hygiene. 65% of sample had single and 73.3% had insufficient income. 43.3% no one give support to patients. 78.3% of patients had insomnia. **Conclusion:** Quality of life plays an important role in the prognosis and recovery of schizophrenia; so it is recommended to enhance quality of life while caring for patients with schizophrenia. Further studies are needed about the intervention to enhance quality of life.

***Key Words*:** *Schizophrenia, Quality of life.*

2.Introduction:

Schizophrenia is an intense, incapacitating condition that is frequently associated with psychosocial difficulties, such as a lack of independence in daily life and a lack of ability to engage in active capacity (Hoertnagl et al., 2020).

Approximately 21 million people worldwide—1% of the population—suffers from schizophrenia. It was ranked as one of the top 10 diseases increasing the global burden of disease (Desalegn, Girma & Abdeta, 2020).

According to the Diagnostic and Statistical Manual of Mental Disorders [5th ed., DSM-5] (American Psychiatric Association [APA], 2013), psychotic disorders such as schizophrenia are "defined by anomaly in one or most of the following domains: hallucinations, delusions, troubled cognition (speech), grossly disturbed or abnormal motor behaviour (including catatonia), and passive symptoms". A patient's quality of life, social, interpersonal, or occupational functioning may all be negatively impacted by these symptoms (Alshowkan, Curtis & White, 2015).

In schizophrenia, the quality of life is drastically reduced. Patients with psychiatric problems may experience poorer quality of life due to a variety of circumstances, including age, the severity of psychopathology, the number of psychiatric hospitalizations, evasion, social anxiety, bad or no spouse, low education, unemployment, and a decline in self-esteem (Wartelsteiner et al., 2016).

The Effects of Schizophrenia on Quality of Life in schizophrenic patients:

Patients with schizophrenia may demonstrate poor performance, which has a severe influence on their capacity to carry out daily activities. Likewise, neurocognitive performance related to problem-solving, verbal learning, working memory, conversion speed, and attention reduced. Additionally, patients with schizophrenia frequently encounter prejudice and stigma, struggle to establish social connections, and exhibit poor public functioning. They find it difficult to manage the disease on their own in this situation, which puts their quality of life (QoL) at risk (Gomes, Bastos, Probst, Ribeiro, Silva & Corredeira, 2016).

Schizophrenic patients are seen as people whose quality of life (QoL) may be decreased for a variety of reasons related to their illness, so the primary concern in treating these patients must be to improve their QoL. As a result, mental health services should shift from a guarantee on treatment focused on fewer symptoms, based on a constrained conceptualization of health and disease, to a more comprehensive approach that takes quality of life (QoL), well- Priority to mental health has a more significant effect on life quality (Hsiao, Lu, & Tsai, 2018).

2.1The Study Aim:

The purpose of this study is to evaluate patients with schizophrenia's quality of life.

3.Subjects and method:

3.1Design of the study:

This study employed a descriptive research design.

3.2Setting:

The study was carried out in the psychiatric department's inpatient and outpatient clinics at the Mansoura University Hospitals.

3.3Study sample:

Its convenient sample met the listed prerequisites:

1. All patients with schizophrenia in accordance with the fifth edition's diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders.
2. Patients who have completed at least their second episode.
3. Age range of eighteen to fifty five years.
4. Each gender.
5. Has a communication skill.

3.4Tools: Two tools were utilized to collect data in this study:

Tool (1): Socio-demographic and clinical characteristics sheet:

The researchers created this sheet after studying recent related literature to cover socio-demographic traits and clinical data, such as the following:

- Patients' age, sex, level of education, marital status, occupation, place of residence, income, number of family members, and how the family is arranged are all Socio-Demographic factors.
- Clinical information includes family history, age at onset of schizophrenia and length of illness, hallucinations, delusions, medication compliance, social interaction, cleanliness, eating routine, and sleep hours and abnormality (El- Bilsha, 2019).

Tool (2): Schizophrenia–Quality of Life questionnaire (S-QoL-18):

Developed by the Schizophrenia Quality of Life Questionnaire (S-QoL18) (Boyer et al., 2010). The S-QoL 18 is a brief version of a 41-item French self-administered multidimensional QoL questionnaire intended for schizophrenia patients that asks about current circumstances. It has a total score and 18 items that describe the following eight dimensions: psychological well-being, self-esteem, relationships with family and friends, resilience, physical well-being, autonomy, and sentimental life (Index). With Cronbach's alpha for the subscales is satisfactory (Caqueo-Urzar, Boyer, Boucekine & Auquier, 2014).

The total score ranged from 18 to 90 with a higher score indicating a better quality of life. This tool demonstrated good psychometric characteristics with adequate reliability Cronbach's alpha is .72–.84 in European countries (Boyer et al., 2010), and adequate reliability Cronbach's alpha at Arabic translation is .82.

3.5Ethical considerations:

The Faculty of Nursing at Mansoura University's Research Ethical Committee provided its ethical permission, which was accepted. The Mansoura University Hospital's Head of Psychiatric Department provided official approval for conducting the research. Patients received information about the study's objectives, risks, advantages, and procedures. They were also advised that participation in the research was optional. Those who volunteered to participate in the research provided their informed consent and agreement. Participants received confirmation and assurance that their private information would be kept private. Participants were also told that they would not be punished if they abandoned the study at any time.

3.6Statistical analysis:

SPSS (Statistical Package for Social Sciences) version 22 was used to evaluate a set of data. Numbers and percentages were used to represent the qualitative characteristics. To determine a correlation between two typically quantitative variables, Pearson coefficient was used. Statistical significance was defined as a P value of (0.05).

4.Results:

Table (1) Explain that the patients' ages, which ranged from 18 to 60, had a mean and SD of (1.83 ±.64). 91.7 percent of the study samples were male. Nearly half of the sample (48.8%) had high school, a diploma, or some other type of technical education. As of marital status, 65.0% of people were single. Sixty-seven percent of the study's participants were employed. Regarding the place of residence, rural areas made up 51.7% of the study sample.

Table (2) shows that fifteen percent (15%) of them lived alone. 43.3 percent of the patients in the study's sample do not receive any emotional support from others. Most of the study's sample

(86.7%) did not initiate any social interactions. Evidence suggests that over half of the patients in the study (48.3%) performed personal hygiene with assistance, although 11.7% did not. (3.3%) refused to eat, and (16.7%) of patients had anorexia. More than 78% of the sample (78.3%) reported having trouble sleeping.

Table (3) Illustrate that more than two third (68.3%) had family history. Majority of the studied sample (88.3%) had hallucination more than half of the studied sample (51.7%) had auditory hallucination. Majority of the patients (86.7%) had delusion, nearly half of the sample (48.3%) delusion of persecution. According to smoking more than three quarter of studied sample (76.7%) were smokers.

Table (4) demonstrates that mean ± SD of total schizophrenia quality of life is 44.58 ± 6.78. Mean ± SD of Self-esteem dimension of schizophrenia quality of life has 5.23 ± 1.58, mean ± SD of resilience dimension 7.90 ± 1.95 but autonomy dimension mean and SD was 5.08 ± 1.83.

5.Discussion:

The goal of the current study was to evaluate people with schizophrenia's quality of life. According to the study's participant characteristics, more than half of the sample's participants were between the ages of 30 and 45. This outcome could be a result of schizophrenia's chronic nature and protracted nature, as well as The majority of age groups from this category motivate a person to enter a hospital and receive care because this is the period of production in their life and they are responsible for their family, which includes their wife and children. It may also be because they did not receive treatment after being discharged, which leads to relapses and their admission to the hospital. This outcome was consistent with the findings of Hamed, El-Bilsha, El-Atroni, and El Gilany (2014), who noted that more than half of patients were between the ages of 30 and 50. This outcome was in agreement with Forma, Green, Kim, and Teigland as well (2020).

The majority of the study's participants were men. This outcome may be the result of stigmatisation and prejudice, whereby the symptoms are less severe in females than in males, necessitating home therapy rather than hospitalisation. This outcome was consistent with Mahmoud & Zaki's studies in Egypt (2015). This outcome also agreed with research by Altun, Karakaş, Olçun, and Polat (2018). This conclusion, however, conflicts with a study conducted in Egypt in 2009 by Ghanem, Gadallah, Meky, Mourad, and Kholy, which noted that the majority of participants were female.

Only 11.7% of the study's patients had no educated, and 48.3% had a diploma, secondary education, and vocational training. This might be because the majority of patients were from rural areas that don't place much emphasis on higher education and had large family sizes as a result of low income. The Egyptian study by Dewedar, Harfush, and Gemeay (2018), which found that 44.2% of patients had secondary education and 9.2% of them were illiterate, provided support for this finding. Additionally, this outcome was supported by an Egyptian study that found that 40% of patients with schizophrenia had completed at least a secondary education whereas 14% had no formal education (Mahmoud, Berma, & Gabal, 2017).

The majority of patients in the immediate study were from rural areas, according to the findings. This finding may be taken to mean that low educated rural residents, who are typically associated with greater impairment and poor quality of life, go to imposters and sheikhs before receiving treatment, which delays the patient's condition and increases the severity of symptoms and agitation. As a result, they avoid hospitals out of fear of embarrassment and stigma. This finding was in line with a study conducted in Egypt by El-Monshed & Amr (2020), which discovered that more than half of patients with schizophrenia came from rural areas. Additionally, this finding was in agreement with Dutesco et al. (2018), who stated that the majority of schizophrenia patients came from rural areas. In contrast to this finding, Southwest Ethiopia found that more than half of schizophrenia patients were from urban areas (Desalegn, Girma & Abdeta, 2020).

This study serves as a reminder that over half of the sample either neglected personal hygiene or completed it with assistance. This outcome can be as a result of the negative and positive symptoms that schizophrenia patient's experience, which keep them from taking care of their personal hygiene. This finding was corroborated by El-Bilsha (2019) Egyptian research, which noted that more than half of schizophrenia patients neglected personal hygiene.

Regarding eating habits, the current study found that 25% of the patients had issues with eating, including refusing food, anorexia, and eating with help. This outcome might be attributed to the fact that approximately 50% of the sample experienced a persecution delusion—a false

perception that food is contaminated. This finding corroborated the findings of Al-maghraby, El-Bilsha, and El-Hadidy (2020), who noted that more over one-third of the patients with schizophrenia refused to eat.

According to the current study's findings on sleep disturbance, more than one-third of the patients slept for fewer than four hours each night. This outcome may be the result of psychotic symptoms, which can produce dread and worries that impair regular sleep patterns at night, as well as hospitalisation and possible pharmacological side effects. This finding was supported by Al-maghraby, El-Bilsha, and El-(2020) Hadidy's study that more over one third of schizophrenia patients experienced sleep pattern disturbances. In the current study, more than 75% of participants report having insomnia, whether it be early, late, or intermittent.

In relation to social initiation, this study found that the majority of participants exhibited social initiation impairment? This finding suggests that schizophrenia symptoms including hallucinations, persecutory and grandeur delusions, along with poor speech, lead to avoidance of social interaction, anxiety, and low self-esteem. According to a study by Koenders, de Mooij, Dekker & Kikkert (2017), individuals with major mental illness are less satisfied with their interpersonal relationships. This outcome was in line with their findings.

According to Quality of life, this study indicated that three quarter of studied sample had low quality of life. And positive correlation between quality of life and marital status, social support. This result can be caused due to positive and negative symptoms of schizophrenia and recurrent of hospitalization and non-adherence of medication. This result was consistent with (Hasan & Tumah, 2019).

6.Conclusion:

Based on the findings in the present research, it can be concluded that majority of the studied participants have low in Quality of life.

7.Recommendations:

The results of this study have important therapeutic ramifications. They confirm the necessity of understanding and therapy not only the core symptoms of schizophrenia, but too the essential factors affect changes in QoL over time. In order to check the clinician's goals to the patients' subjective needs, psychosocial intervention and rehabilitation intervention should be directed to reinforce feelings of self-efficacy (empowerment), self-esteem, social support, and utilization of adjusting and/or coping strategies as well as to support patients and their cares during the process of social adaptation in the early stage of the disease. Further studies are needed about psycho-education program to improve Quality of life.

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Table (1) frequency distribution of studied sample according to Socio-demographic characteristics (N 60):

Socio-demographic characteristics	N (60)	%(100)
Age		
• 18 < 30 years	18	30%
• 30 < 45 years	34	56.7%
• 45 to 60 years	8	13.3%
Mean ± SD = 1.83 ± .64		
Gender		
• Male	55	91.7%
• Female	5	8.3%
Educational level		
• Illiterate	7	11.7%
• Read& write /primary/Preparatory school	13	21.7%
• High school	29	48.3%
• University / post graduate	11	18.4%
Marital status		
• single	39	65.0%
• married	10	16.7%
• divorced & separated	11	18.3%
Occupation		
• not working	20	33.3%
• working	40	66.7%
Place of residence		
• Urban	29	48.3%
• Rural	31	51.7%
Income satisfaction		
• Insufficient	44	73.3%
• Sufficient	16	26.7%
Total	60	100%

Table (2): frequency distribution of studied sample according to Social condition and physical condition (N 60)

Social condition	N (60)	100 %
Living with whom (Cohabitation)		
• Alone	9	15.0%
• Parents	39	65.0%
• wife/ husband and children	10	16.7%
• Brothers/sisters	2	3.3%
Support system		
• No one	26	43.3%
• Parents	24	40.0%
• Wife/ husband and children	3	5.0%
• Brothers/sisters/ relatives	7	11.7%
Social Interaction		
• Social Initiation interaction		
No	52	86.7%
yes	8	13.3%
• Maintenance interaction		
No	17	28.3%
Yes	43	71.7%
Personal Hygiene		
• Neglect it	7	11.7%
• Need help	29	48.3%
• Make personal hygiene alone	24	40.0%
Eating habit		
• Refuse eating	2	3.3%
• Anorexia	10	16.7%
• Eat and ask more	3	5.0%
• Eat alone	42	70.0%
• Eat with help	3	5.0%
Insomnia		
• No	13	21.7%
• Yes	47	78.3%
If yes:		
Early Insomnia	8	13.3%
Interrupted Sleep	8	13.3%
Late Insomnia	31	51.7%
Total	60	100%

Table (3): Frequency distribution of the studied sample according to clinical data (N 60)

Clinical data	N(60)	100%
Family history		
• No	19	31.7%
• Yes	41	68.3%
Presence of Hallucination		
• No	7	11.7%
• Yes	53	88.3%
If yes type of hallucination		
• Auditory	31	51.7%
• Visual	3	5.0%
• Auditory and visual	19	31.7%
Presence of Delusion		
• No	8	13.3%
• Yes	52	86.7%
If yes type of delusion		
• Grandeur	7	11.7%
• Persecution	29	48.3%
• Grandeur and persecution	5	8.3%
• Persecution and reference	11	18.3%
Mode of Admission		
• Involuntary	41	68.3%
• Voluntary	19	31.7%
Smoking		
• No	14	23.3%
• Yes	46	76.7%
Total	**60**	**100%**

Table (4) Frequency distribution of the studied sample according to QoL to 60 participants:

Schizophrenia-quality of life scale			
	Mean ± SD	**Min**	**Max**
Total Schizophrenia Quality of life	44.58 ± 6.78	26	62
Dimensions: Self-esteem dimension	5.23 ± 1.58	2	8
Resilience dimension	7.90 ± 1.95	3	13
Autonomy dimension	5.08 ± 1.83	2	8
Physical well-being dimension	5.05 ± 1.65	2	8
Family relationship dimension	5.05 ± 2.44	2	10
Friend relationship Dimension	3.1 ± 1.25	2	6
Sentimental life dimension	3.21 ± 1.87	2	10
Psychological well-being dimension	9.91 ± 3.12	3	15

Table (5) Correlation between socio-demographic & clinical characteristics of the schizophrenic patients and Quality of life

	Socio-demographic & clinical characteristics	**Pearson correlation(r)**	**Sig.(p)**
Quality of Life	Marital status	.446**	.000
	Suffer from hallucination	-.038	.774
	Suffer from delusion	-.032	.811
	Way of admission to hospital	.260*	.045
	Personal hygiene	.365**	.004
	Number of admission	-.185	.156
	Social support	.365**	.000

**Correlation is significant at the level 0.01*Correlation is significant at the level 0.05