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Research Paper

Quality of Life and Psychosocial Dysfunction among Person with Schizophrenia

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ABSTRACT

Psychosocial dysfunction is expressly relevant to psychiatric disorders. Psychosocial dysfunction and Quality of Life (QOL) of the person with schizophrenia is being disrupted due to several regions. Schizophrenia has a synergistically corrosive effect on quality of life of the affected person that extends far beyond clinical symptoms. The aim of the study was to assess and compare the quality of life among the person with Schizophrenia and the level of their psychosocial dysfunction as well as severity of illness, so that an effective prevention strategy could be formulated in further. This study is a cross-sectional study consists of 60 individuals diagnosed with Schizophrenia. Tools: Socio-demographic and clinical checklist, PANSS, WHO-Quality of Life Scale and Dysfunctional Analysis Questionnaire. The result indicates that there is no significant difference between the genders of persons diagnosed with Schizophrenia on variables viz. Quality of life, psychosocial dysfunction. There was a significant negative correlation between quality of life and psychosocial dysfunction also there were significant negative correlation between severity of illness and quality of life. There was significant positive correlation between severity of illness and psychosocial dysfunction.

Keywords: *Schizophrenia, Quality of Life, Severity of Illness, Dysfunction*

Schizophrenia is one of the most chronic and debilitating of psychiatric illnesses. One of its hallmarks is sequelae of impairments in social, psychological and occupational functioning. These deficits in turn, interfere with an individual's sense of well-being. Life satisfaction act is a mediating factor between presence of a distressing event and psychological impairment. This is specifically true for satisfaction in the domains of emotional life, work, finance, self-confidence, health and overall satisfaction; which actually indicates that lower level of satisfaction whilst pair with distressing life events it can be cause of higher level of psychological dysfunction. Lowering one's expectations may be also seems to be a mechanism preferred by persons with schizophrenia living in the society, in order to maintain their self-esteem and subjective wellbeing. [1] Considering all these

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factors, it is very essential to elucidate the effect of the schizophrenic illness on the psychosocial functioning of the individual and the complex interaction between psychosocial dysfunction and quality of life.

The issue of quality of life is of special relevance to psychiatric patients, as social and contextual factors interact with the patient's disorder and factors such as income, social support and living conditions can be intimately related to psychopathology. This is particularly true for those persons who have been diagnosed with schizophrenia and who have fewer resources to cope with life difficulties. Each of the three different components of quality of life has different time implications. Subjective well- being and satisfaction with different life aspects, which is actually dependent on the patient's actual affective state, can fluctuate quickly. On the other hand, his functioning on social roles and environmental and living conditions change rather slowly. All basic human needs including their psychological needs comprise the need for autonomy, could be achieved by people in the community but persons diagnosed with schizophrenia often face difficulties because they have additional disease related needs, which normal people do not have as there could be lack of daily living skills or social skills and of cognitive skills. Recent finding having schizophrenia indicated that significant negative correlation between social support and psychosocial dysfunction.[2] Considering the disadvantaged condition of the psychiatric patients, assessment of quality of life in this population is very important, leading to a considerable amount of research in this area.

Quality of life is considered as a very useful concept and strategy in clinical psychiatry as well and a distal outcome, which is firmly consolidated and broadly demanded by families, clinicians and patients. [3]. Andreas et. al. (2010) concluded that the quality of life among person with schizophrenia is severely lacking hence they assessed between two groups with different interventions to compare the effects. Factors those could influence the quality of life of person with schizophrenia include psychopathological and psychosocial factors, and increasing of those factors may having a considerable negative effect on quality of life and wellbeing of the individual.[4] Many studies have suggested that the beliefs individuals perceived about their quality of life are important in predicting health outcomes. A study conducted by Michael et. al. (2011) found that 76% of the patients with Schizophrenic disorders who remained dissatisfied (64%) or worsened (12%) with their health-related quality of life over period. [5, 6] Quality of Life is a critical clinical outcome, directly related to deficits in functioning and disability, and is often considered a direct evaluation indicator of personal recovery outcomes among person with schizophrenia. [7]

Treatments for schizophrenia have focused primarily on reducing positive symptoms, often leaving affected person with several residual difficulties, including negative symptoms and impairment in cognition, everyday living skills and social/occupational dysfunction, while a study by Jenille et. al. have focused that treatments to improve the quality of life among person with schizophrenia should focus on negative symptoms and psychosocial dysfunction as well.[8] The family member of a person with schizophrenia exerts a great effect on the social functioning. Available researches indicates that every one in seven persons who have been diagnosed with schizophrenia will get recovery and function properly, which indicates that remission of positive symptoms is not the ultimate goal of the treatment process but a source for better social and cognitive functioning may lead to a better quality of life.[9]

Psychosocial dysfunctions in multiple psychosocial areas such as chronic schizophrenic patients may predict the course (long-term), outcome, and quality of life of these patients,

which obviously varies with years of treatment. A study by Swain et. al. (2017) confirms that there are distinct and significant psychosocial dysfunctions in personal, social, familial, cognitive and vocational spheres with the advancement of the duration of illness in chronic schizophrenic patients.[10]

Several researches suggested that an individual's negative emotional response and inability to function properly in daily living may decrease quality of life and as a priority interventions may offer a remedial approach to improve the psychosocial dysfunction and addressing psychiatric symptoms of person with schizophrenia is necessary to achieve favorable quality of life..[11,12]This indexed study can facilitate the formulation of effective prevention strategies- as not only illness has an impact on the efficient functioning of the individual and his/her sense of wellbeing but also, the availability of supportive resources influences the individual vulnerability towards the illness and the subjective sense of wellbeing is mediated by all these factors.

Aims: The aim of the present study was to assess the impact of severity of Schizophrenic symptoms on quality of life and psychosocial dysfunction also, to find out the association between quality of life and psychosocial dysfunction.

Objectives

Objectives of the study were (i)To compare the quality of life and psychosocial dysfunction of persons with schizophrenia (ii)To compare the psychosocial dysfunction of persons with schizophrenia (iii To find out the association between severe symptoms of Schizophrenia and quality of life, psychosocial dysfunction (iv)To find out the association between quality of life and psychosocial dysfunction

METHODOLOGY

Study design

This is a hospital based cross-sectional study, which used purposive sampling technique. Venue: Current study conducted at tertiary care setting based in Ranchi. Sample size: Sixty persons with schizophrenia (40 male and 20 female).

Inclusion criteria :(i)Person diagnosed with Schizophrenia as per ICD 10 DCR(ii)Individuals of both male and female(iii)Individuals who can comprehend the instructions(iv) Range of age between 18-50 years.

*Exclusion criteria:(*i)Person with any other co-morbid psychiatric illness(ii) History of any substance abuse(iii) History of head injury or any other significant medical condition.

Tools used

The following tools were used :-(i)Socio-demographic and clinical checklist- This is a semi-structured form which includes various socio-demographic characteristics such as age, domicile, education, occupation, marital status, socio-economic status and alist of clinical variables diagnosis, presence/ absence of any co-morbid psychiatric/ medical illness, onset of illness, progress of illness, severity of illness, episodes, treatment (Pharmacological/Non-Pharmacological) etc.(ii) **Positive and Negative Syndrome Scale** (by Kay et. al. in the year 1987.). This scale categorizes positive and negative symptoms as per the original concept given by Crow in the year 1980 and, it emerged in response to the need for a more authentic method for evaluating positive, negative and other symptoms specifically in schizophrenia.

It comprises of 3 subscales as well, those are: positive scale, negative scale and general psychopathological scale. There are total 30 symptoms mentioned and those are rated on a 7 point rating scale.[13](iii) **World Health Organization- Quality of Life Scale-BRE**F[14]- This scale (WHOQOL-BREF) is an abbreviated version of WHOQOL-100, developed in response to the broadening of focus in the measurement of health which is beyond of traditional health and indicative of mortality and morbidity. This scale consists of 26 items, distributed across four domains: Physical health, Psychological, Social Relationships (SR), Environment and the responses to the items have 5 options (iv) **Dysfunctional Analysis Questionnaire**- was coined by Pershad et. al. in the year 1985. This scale composed with50 items and those are paired into five domains- a. Social, b. Vocational, c. Family, d. Personal and e. Cognitive. These items on the scale have five alternatives and whilst scoring becomes high then it signifies greater level of dysfunction.[15].

Procedure

The study was conducted at a tertiary referral center (Central Institute of Psychiatry, Ranchi) situated at northeastern part of India. The persons diagnosed with Schizophrenia were chosen, according to the inclusion and exclusion criteria listed above. After taking informed consent from the patient researcher administered all the scales on them. Consequently, as per their response and standardized scoring procedures given on their corresponding manuals the questionnaires were scored by the researcher.

Statistical analysis

Firstly, computed t-test to analyze the significance of the difference between two groups on continuous variables. Then Chi-square test was computed to analyze the significant difference between two groups on discrete variables. Next computation was done for Spearman correlation to measure the association between different clinical variables. Finally, the results were tabulated and analyzed using standard statistical packages for social science (SPSS Version 14.0).

RESULTS

Table 1 Domain -wise Comparison between both the groups on Quality of life

VARIABLES		MEAN+S.D.	Df	t	P
QOL Physical Health	Male	22.05+3.5	58	0.31	0.76
	Female	21.75+3.62			
QOL Psychological	Male	17.8+3.55	58	1.09	0.2
	Female	18.87+3.59			
QOL Social Relationship	Male	8.8+2.09	58	1.03	0.31
	Female	8.17+2.28			
QOL Environment	Male	25.2+3.8	58	1.54	0.13
	Female	23.5+4.2			

Table 1 shows the comparison between the male and female schizophrenic patients in terms of quality of life. t-test has been administered to analyze the significance of the difference between male and female groups. The result indicates that there is no significant difference exists between male and female schizophrenic patients on the basis of quality of life ($p>0.05$).

Table 2 Domain -wise Comparison between both groups on the basis of Psychosocial Dysfunction

VARIABLES		MEAN+S.D.	df	T	P
Social Dysfunction	Male	54.5 + 17.3	58	0.43	0.67
	Female	52.8+ 12.5			
Vocational Dysfunction	Male	57.2 + 14.23	58	0.41	0.68
	Female	55.8 + 12.21			
Personal Dysfunction	Male	53.2+ 14.2	58	0.56	0.58
	Female	55.1 + 11.4			
Family Dysfunction	Male	54.1 + 14.2	58	0.07	0.44
	Female	53.0 + 12.5			
Cognitive Dysfunction	Male	55.0+ 11.62	58	0.37	0.71
	Female	53.8 + 11.01			

Table 2 shows that there was no significant difference between two groups on the basis of psychosocial dysfunction as well (p>0.05).

Table 3: Correlation between the Severity of Illness and Quality of Life

Variables		R	P
Panss Score	QOL (Physical Health)	-0.463	0.00**
	QOL (Psychological)	-0.489	0.00**
	QOL (Social Relationship)	-0.463	0.00**
	QOL (Environment)	-0.453	0.00**

Table4: Correlation between Psychosocial Dysfunction and Severity of Illness

Variables		R	P
Panss Score	Social Dysfunction	0.186	0.15
	Vocational Dysfunction	0.286	0.03*
	Personal Dysfunction	0.288	0.03*
	Family Dysfunction	0.136	0.29
	Cognitive Dysfunction	0.443	0.00**

Table 3 and 4 portrays the association between Quality of life, Psychosocial dysfunction and Severity of Illness, as delineated by the PANSS scores. To assess the correlation between the variables Spearman r has been computed. The results reveal a significant negative correlation exists between the Severity of Illness and all dimensions of Quality of Life (p<0.01). Results also suggests that a positive correlation exists between Psychosocial Dysfunction and the Severity of Illness [VOCATIONAL DYSFUNCTION (p<0.05), PERSONAL DYSFUNCTION (p<0.05) and COGNITIVE DYSFUNCTION (p<0.01)]. This means that with increase in the Severity of Illness is a corresponding deterioration in the subjective perception of well being and there is also a subsequent decline in the Psychosocial functioning of males and females diagnosed with schizophrenia.

Table 5: Correlation between Quality of Life and Psychosocial Dysfunction

Variables	R	P
QOL (Physical) &Social Dysfunction	-0.21	0.11
QOL (Physical) & Vocational Dysfunction	-0.34	0.01**
QOL (Physical) & Personal Dysfunction	-0.38	0.003**
QOL (Physical) & Family Dysfunction	-0.44	0.00**
QOL (Physical)& Cognitive Dysfunction	0.58	0.00**
QOL (Psychological) & Social Dysfunction	-0.11	0.42
QOL(Psychological) & Vocational Dysfunction	-0.27	0.04*
QOL(Psychological) & Personal Dysfunction	-0.25	0.06
QOL (Psychological)& Family Dysfunction	-0.18	0.18
QOL (Psychological)& Cognitive Dysfunction	-0.38	0.003**
QOL(SR) & Social Dysfunction	-0.29	0.02*
QOL(SR) & Vocational Dysfunction	-0.23	0.08
QOL(SR) & Personal Dysfunction	-0.31	0.02*
QOL(SR) & Family Dysfunction	-0.35	0.006**
QOL(SR) & Cognitive Dysfunction	-0.35	0.006**
QOL(Environment) & Social Dysfunction	-0.19	0.16
QOL (Environment) &Vocational Dysfunction	-0.22	0.09
QOL (Environment) & Personal Dysfunction	-0.32	0.01**
QOL (Environment & Family Dysfunction	-0.42	0.001**
QOL (Environment) & Cognitive Dysfunction	-0.496	0.000**

Table 5 interprets the association between Quality of life and Psychosocial dysfunction and Spearman r has been computed to assess the correlation. The results suggested that a significant negative correlation exists between the Quality of life and most dimensions of dysfunctional analysis questionnaire ($p<0.01$)

DISCUSSION

The present study includes two groups of people (40 males, 20 females) diagnosed with schizophrenia. There were different socio-demographic characteristics distributed in the two sample groups. The majority of the persons with schizophrenia hailed from urban domicile (40%) and as per their religion “Hinduism’ (83.3%) was more prominent. Mostly they have completed high school (48.3%) and predominantly they were unemployed because of their psychosocial dysfunction (55.9%) and specifically female subjects included in the study were mostly unemployed (33.3%). The occupation of the male sample tended to be farming or business (15%). Majority of the person with schizophrenia came from a background of joint family (71%) and had a low monthly income (<5000).

The aim of the study was to assess the quality of life and psychosocial dysfunction on the basis of gender. Table 1 shows the comparison between the male and female schizophrenic patients in terms of quality of life. The result indicates that there were no significant difference exists between male and female schizophrenic patients on the basis of quality of life ($p>0.05$). Table.2 showed there were no significant difference between two groups (the gender) on the basis of psychosocial dysfunction as well ($p>0.05$). Previous finding also supported that there were no discernible differences in the perception of quality oflife for

men and women with schizophrenia [16]. Recent study on schizophrenia also indicated that There was no significant difference in QOL domain scores between genders [17]

A study conducted by Mishra et. al. focused on collaborative approach to improve the quality of life of the schizophrenic patients whilst they have chosen a tertiary care setting as well. According to them choosing a hospital based patient care unit to conduct a research is possibly the best way to successfully implement the treatment approach.[18]. Another study by Shafie et. al. (2021) was also worth mentioning, in this connection. They have suggested that the importance of treatments targeting quality of life to attend to both the clinical features socio-demographic characteristics of males and females diagnosed with Schizophrenia. Hence, they have selected a tertiary care setting to meet their criteria.[17]

The present study tried to compare quality of life and psychosocial dysfunction between male and female schizophrenic patients. While assessing the comparison between both groups on the basis of quality of life it was found that there is absence of significant difference between two groups in all dimensions of quality of life. This implies that the schizophrenic illness has a universal impact on their quality of life or subjective perception of well-being, irrespective of the patient's gender. This finding is in support with some other researches. Shafie et. al. mentioned in their study that it is important to find out that is there are any gender differences actually exists in terms of their quality of life or not. Further they have showed the differences in quality of life with males and females and it were revealed that there was no significant difference in the domains of quality of life between both genders.[17]

This study yielded a significant positive correlation between the severity of illness and psychosocial dysfunction (table-4), whereas a significant negative correlation between severity of illness and quality of life in all dimensions (table-3). The results reveal a significant negative correlation exists between the Severity of Illness and all dimensions of Quality of Life ($p<0.01$). Results also suggests that a positive correlation exists between Psychosocial Dysfunction and the Severity of Illness [vocational dysfunction ($p<0.05$), personal dysfunction ($p<0.05$) and cognitive dysfunction ($p<0.01$)]. This means that with increase in the Severity of Illness is a corresponding deterioration in the subjective perception of well being and there is also a subsequent decline in the Psychosocial functioning of males and females diagnosed with schizophrenia.

An explanation for this finding may be that schizophrenia typically produces impairments that affect their life adversely followed by experience of decreased level of life satisfaction. In this connection, Ang et. al. (2019) obtained similar findings in their study. They found that the severity of illness has an impact on quality of life in person with schizophrenia significantly.[19]

The domain of quality of life such as physical, psychological dimension and social relations was found to be significantly negatively correlated with psychosocial dysfunction in vocational, personal, cognitive and family areas (table-5). Thus, as psychosocial function in these areas deteriorates, so does quality of life in several domains. In accordance with the concept that maximum utilization of psychological potentials it is necessary in vocational and cognitive activities as well. Also logical sequelae of disturbed social functioning are being a manifestation in personal and family life of the person with schizophrenia. In a similar vein, psychosocial dysfunction in personal, family and cognitive areas were correlated negatively with the emotional domain of quality of life. This means that a

dysfunctional personal, family and cognitive life is likely to influence the individual's subjective perception of wellbeing in the environmental domain of quality of life, which encompasses accessibility to health care, financial resources, safety, information and recreational activities. Similar studies shows that the deficits in cognition have a direct impact on quality of life of the person with schizophrenia specifically in social areas as it could be a consequence of difficulties in social relations and social isolation of person with schizophrenia.[20]

CONCLUSION

There were no significant differences found between male and females diagnosed with schizophrenia on the variables viz. quality of life and psychosocial dysfunction. A significant negative correlation found between quality of life and psychosocial dysfunction. A significant negative correlation found between severity of illness and quality of life, psychosocial dysfunction.

Limitation And Future Direction

This study does not include any form of control group and small sample size. The assessment of quality of life was done in a subjective way, not in an objective way. Future studies may include a control group. An objective assessment of quality of life can be undertaken. An effective prevention strategy could be formulated to enhance the quality of life and lowering dysfunctions in person with schizophrenia

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Conflict of Interest
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