Prevalence of Quality of Life and Self Efficacy among Schizophrenic Patients

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Abstract: Background: Schizophrenia is a complicated mental illness that significantly impacts a patient's environment in addition to their health and well-being. Given that it is linked to a diverse range of symptoms that significantly impair their quality of life and self-efficacy, as well as their interpersonal relationships and personal care. **Aim**: The study **aims** to assess the self-efficacy and quality of life of individuals with schizophrenia. **Subjects and method:** A descriptive cross-sectional study methodology was used using a sample of 60 schizophrenia patients hospitalized to Mansoura University Hospital's psychiatric inpatient department. The data was obtained using three tools: socio-demographic characteristics and clinical data sheet, World Health Organization Quality Of Life (WHOQOL)-BREF and Self efficacy scale. **Results:** The study's findings showed that the majority of the patients (96.7%) had low self-efficacy, and the overall quality of life score was slightly lower than what I would have preferred (mean $\pm$ SD = 45.90$\pm$ 6.21). **Conclusion:** Improving quality of life and self-efficacy is advised when caring for people with schizophrenia since these factors are crucial to the prognosis and recovery of the condition. More research on the intervention to improve quality of life and self-efficacy is required. **Recommendation:** Improving self-efficacy and quality of life is advised when caring for individuals with schizophrenia. The intervention to improve self-efficacy and quality of life requires more research.

Key Words: Schizophrenia, Quality of life, Self-efficacy

INTRODUCTION

Schizophrenia as a heterogenous neuropsychiatric disorder linked to a complex network of genetic, neurobiological, and phenomenological attributes, is a disease that affects approximately 1% of the world's population. It is one of the top ten leading causes of global disability and classically occurs in teens or early twenties for most of its life-long duration. This state has profound effect for the quality of life, functioning in daily activities, personal control, Subjective well-being and reality test of the patient *(Zhang, Du, Chen, Yuan, & Cheng, 2023).*

It is argued that a neurodevelopmental theory, together with the mounting evidence of genetic factors involved in schizophrenia, was key to understand what are main issues in the pathophysiology of schizophrenia. The salient of this view is the reciprocal dynamics between pathogenic factors, environmental events and genetic susceptibilities. Less favorable environmental influences in the perinatal period, e.g., maternal viral infection, fetal malnourishment or extreme prematurity adversely affect the cerebral cortex, cerebellar vermis, limbic system brain stem and so called cerebral symmetry both functionally and histologically. In addition, people with schizophrenia usually have structural abnormalities including the lateral and third ventricles being hypertrophic (it is well known that caudal ventricular increments have a neurodevelopmental basis) *(Kim, 2017)*

Schizophrenia is a complex illness that profoundly permeates the surroundings of not only the patient but his environment also in the physiology and overall health. As the root of a myriad of symptoms that intensely eclipses interpersonal relationships, personal health and well-being of the patient as well as his sense of self efficacy and esteem. One of the major factor that drives effective implementation of social & daily life skills is self-efficacy which in turn is nothing but the belief or feeling about your confidence to do a behavior or a specific action *(Kurtz, Olfson & Rose, 2013).*

Quality of Life is the way in which they see their place within the cultural and value system that surrounds them. Objective, aspirations→standards→life focus are all related to the quality of life a person has. People with high quality of life are probably pretty capable or competent to meander about their life and social environment. For the low quality of life individual, they will have a hell of a time trying best reach their social self-actualization. The quality of life for a person depends on their physical, mental and social status, and personality as well as social autonomy and self-esteem *(WHO, 2012).*

Cardenas et al. (2013) examined whether self efficacy levels would have bridged the gap between capacity and functioning which manifested that a schizophrenic individual is capable of doing something but not able to. Self-efficacy also helps schizophrenic patients reach decisions and take action to

achieve goals, stay motivated, and maintain things that they can complete that need to be done for their recovery *(Dwidiyanti, Wiguna &Ningsih 2018).*

While self-efficacy is sometimes interpreted to relate more generally to the competencies that people have (outside a narrow definition), it is most useful for explaining and predicting behavior in a more specific situation. Psychotic disorders, such as schizophrenia in patients with psychotic diseases require a quite lot of self-efficacy to cope up with the difficulties that are linked to the illness. Low sensory self-efficacy could potentially lead to maladaptive coping *(Leon-Perez, Medina, & Munduate, 2011).*

2.1Aim of the study:

The study objective is to evaluate the self-efficacy and quality of life of individuals with schizophrenia.

SUBJECTS AND METHOD

3.1 Study design:

This study was carried out using a descriptive cross-sectional research approach.

3.2 Setting:

The study was carried out at Mansoura University Hospital's Psychiatry Inpatient Department.

3.3 Subjects:

60 patients with a diagnosis of schizophrenia who met the following requirements made up the study's subject: all patients with a diagnosis of schizophrenia based on their medical records, individuals of both sexes, aged 18 to 60, who possess the ability to communicate and are willing to participate.

3. Tool: Three tools were used to collect data, includes:

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

The researcher created this questionnaire after analyzing current, relevant literature. It contained details regarding:

- Information about the patient's name, age, sex, education, marital status, place of residence, etc.
- Clinical data: This covered family history, past psychiatric hospital admissions, diagnosis, illness start, and length of illness, among other things.

Tool II: World Health Organization Quality Of Life (WHOQOL)-BREF

A shorter form of the WHOQOL-100 is the World Health Organization Quality of life which consists of a 26-item assessment within the four areas which are categorized under QOL (physical, psychological, social and environmental). In addition this instrument has two independently analysed questions:question 1 asking a person their QOL, and question 2 asking the same person how they feel about their general health. The items are rated on a 5-point Likert scale ranging from 1 (low and negative perception) to 5 (high and good perceptions). Scores for the patients that report a great quality of life in the past two weeks, high scores. Domain score is calculated by averaging the scores of the items in each domain *(Carrasco, 2012).*

Tool (III): Self efficacy scale: (Appendix III)

This measure's original intention was to determine how people will fare and adapt on the one hand on trivial inconveniences as onmundane affairs of life and on whatever stressful *(Schwarzer and Jerusalem,1995)*. It is designed to measure the degree of optimistic self-belief and the capacity for experiencing a wide range of life adversities. The tool contains 10 things that highlight in different sport of problem-solving strategies and other competences. Each items refer to a kind of effective coping and points on internal-stable success attribution. The instrument had satisfactory psychometric properties demonstrating adequate validity and reliability (Cronbach's alphas varied from.76 to 0.90, being mostly in the high .80) to be the predictive scale on a composite final score that reckons between ten and forty, as the mean cutoff point of maximal score was equal to 20 by using a scoring 4-point Likert scale for ten elements at a time. So, overall self-efficacy score is from 10 to 40. Higher is the self-efficacy.The Arabic version was developed by *(Radwan, 1997).*

3.5Ethical considerations:

Ethical approval was obtained from the Research Ethical Committee of Mansoura University Faculty of nursing. Before starting the study, the head of Mansoura University Hospital psychiatric department agreed to the conduct of this research. Study Purpose, Risks and Benefits as well methodology was explained with the patients. Moreover, they were apprised that the participation in such study is entirely on voluntary basis As Informed consent of subjects who participated in the study In addition, subjects were informed that there were absolutely no penalties for dropping out of the study.

3.6Statistical analysis:

Analysis was done using SPSS version 22 Qualitative result was expressed as numbers and percentages. For parametric data, the "Mean ± SD (standard deviation)" was used to characterize a continuous variable.

RESULTS

Table (1): Patient distribution in the study based on sociodemographic traits:

Socio-demographic Characteristics	No(60)	%(100)
Age (years)		
18 > 30 years	16	26.7
18 > 30 years	29	48.3
45 > to less than 60 years	15	25.0
Mean ± SD = 32.20 ± 11.40 years		
Sex		
1.Males	39	65.0
2.Females	21	35.0
Level of Education		
1.Illiterate	6	10.0
2.Read & write	15	25.0
3.Diploma or secondary school	30	50.0
4.University	9	15.0
Marital status		
1.Married	8	13.3
2.Single	30	50.0
3.Divorced	16	26.7
4.Widow	6	10
Occupation		
1.Not working	42	70.0
2.House wife	11	18.3
3.Manual work	5	7.14
4.Professional work	2	4.3
Residence		
1.Urban	18	30.0
2.Rural	42	70.0
Income		
1.Insufficient	34	56.7
2.Sufficient	26	43.3
Total	60	100%

Table (1) reflects that the mean ± SD of the patients in the survey being 32.20 ± 11.40 years with a minimum to maximum age till 18 to under 60.48% of the study population were between the ages of 18 and 30.Males were represented by 65.0% of patients in the study. Results of their educational history, 35% had a diploma. In terms of marital status, 50.0% of the patients in the study were unmarried. In terms of occupation, 88.3% of the patients in the study were unemployed. Over two-thirds (70.0%) of the patients in the study dwell in rural areas according to the residency. In terms of income satisfaction, almost half of the patients in the study (56.7%) did not have enough money.

Table (2): Distribution of the studied sample according to clinical data:

clinical data	No(60)	%(100)
Psychiatric illness in the family		
1.No	38	63.3
2.Yes	22	36.7
Duration of disease		
1.Less than 1 years > 2 years	21	35.0
2. 2 > 5 years	18	30.0
3. 4> 10 years	12	20.0
4. 10 +	9	6.7
Mode of hospital admission		
1.Involuntary	35	58.3
2.Voluntary	25	41.7

Number of hospitalization		
1.Once	28	46.6
2.Twice	23	38.3
3.Three times	5	8.3
4.Four times	1	1.7
5.Five times	3	5.0
Previous psychiatric treatment		
1.No	5	8.3
2.Yes	55	91.7
Drug adherence		
No	17	28.3
If Yes (N=43)	43	71.6
Yes regularly	14	23.3
Yes interrupted	29	48.3
Suicidal thoughts		
1.No	53	88.3
2.Yes	7	11.7
Total	**60**	**100%**

Table (2): shows that almost two-thirds (63.3%) of the participants had a family history of mental illness. Across the length of illness, 1 in 3 (35%) of those in the study identified having had been unwell for five to nearly 10 years. 58.3% of the study had a hospital admission that was involuntary. (91.7%) of the participants were on psychiatric medications. Medication adherence revealed that 28.3% of study participants did not adhere to medication regimen. Ten percent of the study participants endorsed suicidal thoughts.

Table (3): Distribution of studied sample according to Physical condition:

Physical Condition	No(60)	%(100)
Physical illness		
1.No	48	80.0
2.Yes	12	20.0
Personal hygiene		
1.Neglect	10	16.7
2.Done with assistance	29	48.3
3.Done alone	21	35.0
Eating		
1.Refuse eating	30	50.0
2. Anorexia	28	46.7
3. Overeating	2	3.3
Sleep hours		
1.Less than 4 hours	10	16.7
2. 4– 6	19	31.7
3. More than 6	31	51.7
Sleep problems		
Insomnia		
1. No	7	11.7
2. Yes	53	88.3
If yes:		
1. Early Insomnia	12	20.0
2. Interrupted Sleep	21	35.0
3. Late Insomnia	20	33.3
Total	60	100%

Table (3): demonstrates that over one-fourth (26.7%) of the cohort under study is physically unwell. Two-thirds (65%) of the patients in the study neglected their personal hygiene, and 1.7% needed assistance to do so. In terms of eating patterns, anorexia affected over half (46.7%) of the participants in the study. 16.7% of the participants in the study slept for fewer

than six hours every day. Additionally, almost two-thirds (70%) experienced sleep disruption, early insomnia (33.7%), disrupted sleep (11.7%), and late insomnia (15%).

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

	Mean ± SD
Total score of quality of life	45.90± 6.21
Dimensions: • Physical domain	14.983 ± 2.22
• Psychological domain dimension	12.15 ± 3.19
• Social domain	8.31 ± 2.19
• Enviromental domain	14.10± 3.19

Table (4): indicates that the overall quality of life score is 45.90± 6.21, which is little lower than what I would want.

Table (5) Frequency distribution of the studied sample according to Self Efficacy to 60 participants:

Scoring system of Self Efficacy scale	**N**	**%**
Self Efficacy **low Self Efficacy (less than 20)**	49	96.7%
High Self Efficacy (more than or equal 20)	11	3.3%
Total	60	100 %

Table (5): demonstrates that the majority of patients (96.7) in the study showed low self-efficacy.

DISCUSSION

The present study's findings regarding the sociodemographic features of the patients under investigation showed that, with a mean and standard deviation of 32.20 ± 11.40, over half of the patients were in the 30 to 45 year old age range. According to *El-Bilsha, Saber, and Abd-Eraof (2023),* over half of the patients were in the 30 to 50 year old age range. This is also in line with *Forma, Green, Kim, and Teigland (2020).*

The majority of study participants were male patients. What could be the reason for this outcome maybe because relatives of female patients may hesitate from coming forward due to stigma and can be partly explained by the higher probability of male patient being hospitalized (severe symptoms of schizophrenia in men than in women) in comparison with females. Considers the results with previous research on Egypt by *Mahmoud & Zaki (2015).* Additionally, this outcome aligned with a study conducted by *Altun, Karakaş, Olçun, and Polat (2018).* However, this outcome did not align with a study conducted in Egypt by *Ghanem, Gadallah, Meky, Mourad, and Kholy (2009).* Additionally, *Osuji & Onu (2019)* found that women outnumbered men.

Out of the 76.6% of individuals that constitute the population under study living with their parents, only 3.3% were single and lived by themselves. It may explain this, that at least half of patients (50%) were single and that so many more patients (56.7%) reported cash problems. It may also be because our parents loyally watch out for us and care for us the best of all. In line with this result, *Guedes de Pinho, Pereira, and Chaves*

(2018) noted that over half of patients resided with their family. Furthermore, a study by *Mohammed & Ghaith (2019)* in Egypt corroborated this result. Furthermore, According to *Henry & Jombo (2015)*, the majority of the sample lived with their relatives.

Results of the present study also showed 88.3% non-functional samples as per the current study. This may be a result from patients tended to have inadequate communication skills as well,interactionally unfocused and doomed to decrease of their productivity as well as catering families. This was also in agreement with a previos study in Egypt by *Soliman, Mahdy, and Fouad (2018),* which found that half of patients with schizophrenia did not have a job. Furthermore, a study conducted in Tanta, Egypt, by *Harfush and Gemeay (2017)* found that over 50% of individuals with schizophrenia were unemployed.

Over two-thirds (70%) of the participants in this study came from rural regions. This data could be interpreted as showing that people in rural regions often turn to elders for traditional therapy, postpone getting psychiatric care, and have a negative effect on mental health. As a result, the delay in receiving psychiatric treatment led to chronic disease and hospitalization. This outcome was consistent with a study conducted in Egypt by *El-Monshed & Amr (2020),* which discovered that over 50% of individuals with schizophrenia were from rural areas. Furthermore, this finding was consistent with *Dutesco et al. (2018),* who noted that the majority of schizophrenic patients came from rural areas. Alternatively, **Desalegn, Girma, and Abdeta (2020)** refused

the claim that over half of schizophrenia patients in southwest Ethiopia came from urban areas.

Nearly two-thirds of individuals in this current study had a confirmed family history of mental health disorder. Coming to this conclusion is affected by the things inherited and genetic, that frequently are risk factors for mental illness. This result was in agreement with *Kiwan et al. (2020)*. Because schizophrenia is a chronic illness approximately one-third of the samples had a diagnosis between five and ten years within its duration ,*El-Bilsha(2019)* agrees with this notion.

43.3% (more than one third) of the studied samples had an age between 5-10 years which is linked to the long-standing course of schizophrenia. Moreover, 20% of the studied samples failed to adhere to prescribed medication, and two thirds (66.7%) of studied samples discontinued treatment overall. That result was supported by *El-Bilsha (2019).*

Nearly two-thirds of the patients were hospitalized against their will as a result of findings from the current study. This outcome could potentially be explained by fear of stigma and a dearth of knowledge about the disorder. Over 60% of those with a mental illness were admitted against their will according to a study in Egypt conducted by *Ibrahim, Callaghan, Mahgoub, El-Bilsha, and Michail (2015).*

In terms of eating, the present study found that more than half all of the patients have eating disorders, in this category like anorexia ,refusal eating, and eating with assistance. It could be interpreted that schizophrenic patients had delusion of persecution that the food is contaminated. This finding was consistent with the findings of *Al-maghraby, El-Bilsha, and El-Hadidy (2020)*, who found that almost one-third of patients with schizophrenia refused to eat.

The current study findings showed sleep duration was less than 6 hours and half of group studied having sleep disturbance altogether. The psychotic symptoms, along with the depressive symptoms of schizophrenia may lead to fear and anxiety that disturb usual sleep at night — this could be from hospitalization, Just like the above. In line with earlier observations of *Al-Maghraby, El-Bilsha, and El-Hadidy (2020),* They discovered that insomnia affected about one-third of people with schizophrenia. These results corroborate the discovery by *Reeve, Sheaves, and Freeman (2019)* that sleeplessness affects 50% of patients with psychosis.

In quality of life this study showed that three quarters of the sample under study had poor quality of life. The negative and positive symptoms clusters of schizophrenia as well multiple hospitalizations are what is driving this outcome. This was consistent with *Karow, Wittmann, Schöttle, Schäfer, & Lambert (2022).*

According to Self Efficacy, This study showed that most of the studied sample had low self-efficacy. This finding might

be associated with negative symptoms of schizophrenia and poor social competence. This result was consistent with *Liao, Lee, Hsu& Yen, (2021).*

CONCLUSION

Current study investigated self-efficacy and quality of life association in schizophrenia. In line with expectations these features of schizophrenia are useful descriptive attributes that will help to the precise care of schizophrenic subjects. Furthermore, it can be used as a basis for cross global comparisons and future developments.

RECOMMENDATIONS

The above results suggest that this study can be useful for the management and more specific screening of schizophrenia patients according to characteristics of self-efficacy, quality of life.

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