ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

RELATIONSHIP BETWEEN QUALITY OF LIFE AND SOCIAL SUPPORT AMONG PATIENTS WITH SCHIZOPHRENIA: A CROSS-SECTIONAL STUDY

Sridevi R G
[1]*Research Scholar, Institute of Social Sciences and Humanities, Srinivas University, Mangalore, Karnataka, India. ORCID ID: 0000-0001-8524-4554*

Article DOI: https://doi.org/10.36713/epra15598
DOI No: 10.36713/epra15598

ABSTRACT

Purpose: *Numerous studies have shown that people with severe mental illnesses like schizophrenia have poor quality of life (QoL) for a variety of reasons, including lingering symptoms, medication side effects, and a lack of social support. Social support is a critical component of treatment in the recovery process for people with mental illness. It has been extensively researched in other psychiatric conditions, but not as much in people with schizophrenia who live in the community. It has been shown that pursuing social support improves the prognosis for schizophrenia. The purpose of this study is to determine the variables linked to quality of life (QoL) and investigate the relationship between QoL and social support in patients with schizophrenia who are in remission.*

Methodology: *A cross-sectional, descriptive study is carried out in a Psychiatry outpatient department of a hospital in Shivamogga. Patients diagnosed with Schizophrenia as per International Classification Disorders – 10 diagnostic criteria are recruited for the study.*

Results:

Originality: *The current study is interesting because it investigates the relationship between Quality of Life and Social Support among Schizophrenia patients, which can help people overcome adversity and prevent them from developing mental health problems. Further progress in this area may benefit humanity's overall well-being in a variety of ways.*

Type of Paper: *Quantitative and cross-sectional.*

KEYWORDS: *Schizophrenia, Quality of life, Social support.*

1. INTRODUCTION

A complex, long-term mental illness, schizophrenia is typified by a wide range of symptoms, such as hallucinations, delusions, disordered speech or behaviour, and diminished cognitive function. For many patients and their families, the disease is incapacitating due to its early onset and protracted course (Lavretsky, et al. (2008). [1]). Negative symptoms, which are defined by loss or deficits, as well as cognitive symptoms, which include problems with attention, working memory, or executive function, frequently lead to disability (Dipiro, et al. (2014). [2]). Furthermore, positive symptoms like suspicion, delusions, and hallucinations can lead to relapse (Lavretsky, et al. (2008). [1]). Since schizophrenia is inherently heterogeneous, opinions on its etiology, pathophysiology, and diagnostic standards are divided (Rector, et al. (2011). [3]).

TYPES OF SCHIZOPHRENIA

It is commonly known that there are two subtypes of schizophrenia: positive and negative. There is still some disagreement regarding the evidence supporting other subtypes, especially one that is disorganized. There may be at least four subtypes of schizophrenia, according to the cluster analysis results: positive, negative, mixed, and disorganized. Patients with minimal symptoms make up a fifth subtype, which suggests the straightforward schizophrenia that Bleuler identified (Stahl, et al. (2013). [4]). Clinical descriptions are provided for the subgroups designated as "usual," "flagrant," "insightful," and "hypochondriacal." Should these subgroups be confirmed or replicated, they could hold significance when discussing future divisions of the schizophrenia spectrum (Dollfus, et al. (1996). [5]).

INCIDENCE OF SCHIZOPHRENIA IN INDIA AND THE WORLD

Based on data gathered over a century and a half from epidemiological studies, schizophrenia occurs in all populations, with prevalence rates ranging from 1.4 to 4.6 per 1000 people and incidence rates between 0.16 and 0.42 per 1000 people (Carpenter, et al. (1976). [6]).

After the "Ten Country Study" results were interpreted, there was a general consensus that schizophrenia is more common in low- and middle-income countries (LAMICs) than in high-income countries, and that people with the disorder have a better prognosis there. These views have been confirmed by recent publications in the most prestigious scientific medical journals (e.g. Mueser and McGurk 2004) (Jablensky, A (2000). [7]). Sex and diagnostic definition had no effect on incidence in the urban cohort. Females in the rural cohort showed a higher incidence for other diagnostic definitions and a lower incidence for Catego S+ (Menezes, P.R. (2010). [8]).

ISSN (Online): 2455-3662

EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

India is a nation renowned for its diversity and heterogeneity, and it has contributed to some of the earliest descriptions of schizophrenia. While it does not purport to be an exhaustive analysis of all Indian research in these fields, it does highlight some of the trends that have been noted over the past ten or so years (Wig, et al. (1993). [9]). Reviewing studies that were published in the Indian Journal of Psychiatry was done to see if there has been any real shift in this area over the past ten years. A number of studies on schizophrenia that were released between 1990 and 2000 were examined. (Thara, et al. (1993). [10]).

HOW SCHIZOPHRENIA AFFECTS FAMILIES

Throughout the protracted course of the illness, schizophrenia places a significant burden on both the person with the disorder and his or her family. The general overview of the advantages and disadvantages of schizophrenia for family caregivers (Avasthi, et al. (2004). [11]). Despite the introduction of novel treatment and care approaches in the last fifteen years, individuals with schizophrenia are still susceptible to relapses, which can result in severe symptoms such as delusions, hallucinations, and disruptive behavior, causing significant distress for all those affected (Shiraishi, et al. (2019). [12]). At least 25% of people worldwide suffer from mental illness, which causes a great deal of stress and hardship for them and their families. However, little is known about how this illness affects the quality of life for families. (Brown, et al. (1972). [13]). The findings imply that treating the patient's family support system better may have a positive impact on the patient's psychotic symptoms and social adjustment (Walton-Moss, et al. (2005). [14]). The influence of a sibling with mental illness on the lives of the subjects varied and was perceived to originate from both the family and the sibling, albeit in distinct ways (Hamada, et al. (2003). [15]).

QUALITY OF LIFE

Although QOL is regarded as a crucial result of treating schizophrenia, little is known about the factors that influence QOL in this population (Gerace, et al. (1993). [16]).

There has been a great deal of variation in research and conclusions about how schizophrenia affects quality of life (QOL). According to a meta-analysis of research using standardized measures, QOL in people with schizophrenia is noticeably lower than in healthy controls. (Narvaez, et al. (2008). [17]).

BURDEN OF CARE AND SOCIAL SUPPORT

A cross-sectional study involving 301 family caregivers was conducted. Our research suggests that caregiver burden is significantly impacted by family function. More research is needed to determine whether perceived social support plays a protective role in caregivers' health during the caring process (Dong, et al. (2019). [18]). There is little agreement on the connection between social support and health outcomes despite the wealth of research on the topic, both as a main focus of investigation and as a variable in larger studies. The study's conclusions imply that hospice social support services ought to be customized to the support requirements of the caregiver and should include an evaluation of the kind of assistance that should be provided (Chiou, et al. (2009). [19]).

2. REVIEW OF LITERATURE

Jenille M. Narvaez et al. (2008) studied Subjective and Objective quality of life in Schizophrenia. In this study, the clinical, functional, and cognitive predictors of subjective and objective quality of life in schizophrenia outpatients were looked at independently. 88 outpatients with schizophrenia or schizoaffective disorder were among the participants. More severe depressive symptoms and improved neuropsychological functioning were independent predictors of worse subjective QOL in the presence of multiple predictor variables. A lower objective QOL was predicted by more severe negative symptoms. Subjective or objective QOL did not correlate with functional capacity variables (Narvaez, et al. (2008). [17]).

Prabhakaran S et al. (2021) studies the Relationship between quality of life and social support among patients with schizophrenia and bipolar disorder. The study intends to determine the factors associated with quality of life (QoL) and investigate the relationship between QoL and perceived social support among patients with BD in remission and schizophrenia. For patients with schizophrenia alone, social support and quality of life showed a strong positive correlation. Therefore, it is imperative to incorporate psychosocial interventions that enhance social support into standard patient care (Prabhakaran S, et al. (2021). [20]).

In Psychiatric Symptoms and Quality of Life in Schizophrenia, Eack S. M. and colleagues (2007) found that while general psychopathology consistently showed a negative relationship with QoL across all study samples and treatment settings, positive and negative symptoms were more strongly related to poor QoL among studies of schizophrenia outpatients. Future research and treatment development implications are examined (Eack, et al. (2007). [21]).

Munikanan (2017) examined the relationship between social support and quality of life in patients receiving community mental health services who have schizophrenia. At Hospital Kuala Lumpur (HKL), 160 people with schizophrenia undergoing community psychiatric services participated in a cross-sectional study. Perceived social support was low for roughly 72% of the respondents, with friends and family providing the lowest level of support, followed by significant others. In Malaysia, individuals with schizophrenia who are already receiving official psychiatric services are significantly lacking in social support (Munikanan, et al. (2017). [22]).

Rudnick A. and colleagues conducted a study in 2001 to examine the relationship between seeking social support and quality of life in individuals with schizophrenia. Using a sample of 58 outpatients with a diagnosis of schizophrenia who did not have any co-occurring conditions, the study investigated this question. Cross-sectional assessments were made of social support seeking, symptoms (positive, negative, and extrapyramidal), and multidimensional self-reported quality of life. There was an inverse relationship between negative symptoms and the daily living activities quality of life domain. The quality of life was unaffected by other symptoms or social

ISSN (Online): 2455-3662

EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

support-seeking, and there was no interaction between the two in terms of quality of life. Therefore, seeking out social support may not be a helpful (or disruptive) strategy for managing symptoms of schizophrenia (Rudnick, et al. (2001). [23]).

Ruesch and colleagues (2004) conducted a study on occupation, social support, and quality of life in individuals with schizophrenic or affective disorders. The study included 261 subjects (102 women and 159 men), with average ages of 35 for men and 38 for women. Of these, 158 were diagnosed with schizophrenic disorders (ICD-10: F2) and 103 with affective disorders (ICD-10: F3). In this study, the association between an individual's work status and their subjective and objective quality of life (QoL) in individuals with SMI is examined. The findings imply that subjects who work generally have access to a wider social network and receive greater social support. A significant mediating factor in the association between occupation and subjective quality of life is social support. Income has a weak and unfavourable relationship (Ruesch, et al. (2004). [24]).

In a comprehensive and extended research endeavour, Pinho L G and colleagues (2020) conducted a study on Affectivity in schizophrenia: Its relations with functioning, quality of life, and social support satisfaction. The aim of the research was to assess the correlation between affectivity and clinical and sociodemographic traits, functioning, quality of life, and satisfaction with social support in individuals with schizophrenia. cross-sectional investigation on a group of 282 patients with schizophrenia. The findings showed that the following factors were associated with either positive or negative affect: the participants' employment status, gender, whether they smoked, hospitalizations within the previous year, use of benzodiazepines and antidepressants, quality of life, functioning, and satisfaction with social support (Pinho, et al. (2020). [25]).

Dziwota and team conducted a in-depth investigation in 2018, on Social functioning and the quality of life of patients diagnosed with schizophrenia. The study's goal is to present the most significant issues with social functioning and the overall quality of life for patients with schizophrenia, based on research done both in Poland and around the world. The findings showed that a patient's family has a significant impact on their social functioning. When taking the right steps, the patient's family can act as a co-therapist, greatly assisting the patient in adjusting to society and fulfilling a designated role. In the context of social cognition, an analysis of the social functioning disorders in patients with schizophrenia reveals that these disorders stem from a failure to recognize one's own and other people's internal states, despite the fact that mentalization is the foundation of social cognition (Dziwota, et al. (2018). [26]).

3. OBJECTIVES

1) To study the demographic profile of patients with schizophrenia
2) To find the extent to which patients with schizophrenia perceives social support.
3) To establish the quality of life of patients with schizophrenia in different domains.
4) To determine the range in each of the quality-of-life domains.
5) To find the correlation between perceived social support and quality of life.
6) To establish the role of gender differences in quality of life

4. HYPOTHESIS

1) There is no difference in the mean value of perceives social support.
2) There is no difference in the mean value in the domains of the quality of life.
3) There is no correlation between perceived social support and quality of life.
4) Gender differences has no influence on quality-of-life domains.

5. METHODOLOGY

A cross-sectional, descriptive study is carried out in a Psychiatry outpatient department of hospital in Shivamogga. Patients diagnosed with Schizophrenia as per International Classification Disorders – 10 diagnostic criteria w recruited for the study.

Sample: 45 patients were studied using nonprobability sampling, recruitment is done based on ICD – 10. Consent taken from the patient as well as the patients relative before conducting the study. Only patients in remission are included.

Instrument: The WHO Quality of life BREF Scale is used to assess quality of life and the Multidimensional Scale of Perceived Social Support is administered to assess social support. In addition, a questionnaire is used to study the psycho-social profile of patients.

Procedure: In a Psychiatry Outpatient department of hospital in Shivamogga, selected the patients diagnosed with Schizophrenia who are in remission. First the consent from patients and their relatives was sought. Confidentiality was assured. Firstly, general Psycho-Social profile was taken. Two scales were administered, namely

1.The WHO - QOL Quality of life BREF - The WHOQOL is a quality-of-life assessment developed by the WHOQOL Group with fifteen international field centres, simultaneously, in an attempt to develop a quality-of-life assessment that would be applicable cross-culturally. The WHOQOL-BREF is a 26-item instrument consisting of four domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environmental health (8 items); it also contains QOL and general health items.

2. The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) is a 12-item measure of perceived adequacy of social support from three sources: family, friends, & significant other; using a 5-point Likert scale (0 = strongly disagree, 5 = strongly agree) (Zimet, et al. (1990). [27]).

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

6. RESULTS

Demographic profile of patients.
Table 1: Age.

		Frequency	Percent
Valid	(18 to 30)	11	24.4
	(31 to 40)	19	42.2
	(41 to 53)	15	33.3
	Total	45	100.0

As see in Table 1, vast majority of the patients (42%) were in the age group 31 to 40 years. 33% were in the age group 31 to 40 years. A small percentage (25%) of them were in the age group 18 to 30 years.

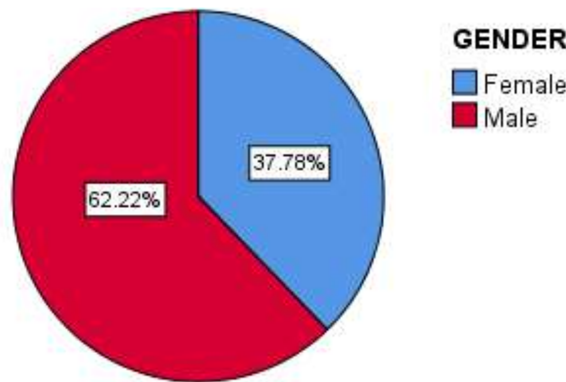


Figure 1: Gender

38% were female patients comparatively lesser than male patients 62%.

Table 2: Marital Status

	Frequency	Percent
Married	36	80.0
Unmarried	7	15.6
Divorced	2	4.4
Total	45	100.0

80% were married, 16% unmarried and 4% either divorced or widow.
It was intended to find perceived support using the Multidimensional Scale of Perceived Social Support Scale. The least one has scored was 2 and highest 7. Higher score indicates better perception of social support. The reliability of this scale in this case was found to be Alpha=0.918 which is excellent.

Table 3: Perceived Support

	Frequency	Percent
Low (1 - 2.9)	4	8.9
Moderate (3 - 5)	32	71.1
High (5.1 - 7)	9	20.0
Total	45	100.0

9% of the patients overall perceived low support from significant others, family and friends. A vast majority of patients (71%) perceived moderate support and 20% perceived high support.

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

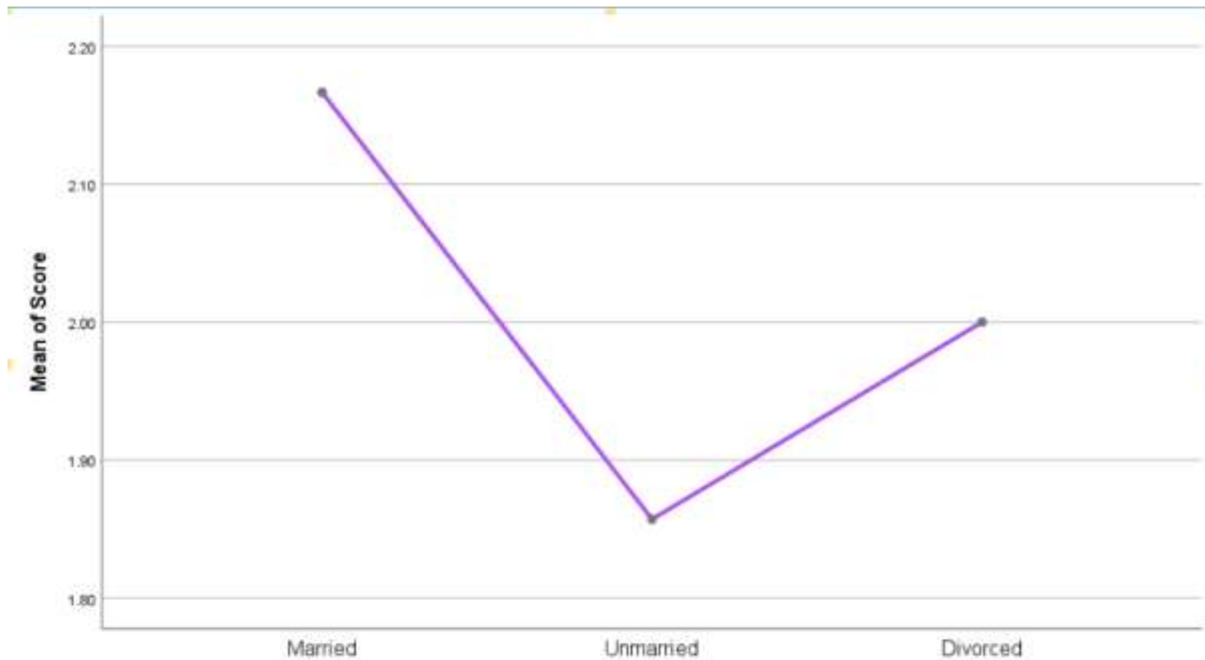


Figure 2: Marital Status and social support

Figure 2 shows that vast majority of the married patients received better family support compared to the unmarried and divorced/separated.

To test the hypotheses there is no difference in the mean value of perceived social support.
One sample t-test was done to determine whether the mean calculated from sample data collected from a single group is different from a designated value.

Table 4: Perceives social support

	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Sig Other	28.705	44	.000	17.66667	16.4263	18.9070
Family	29.644	44	.000	17.75556	16.5484	18.9627
Friends	28.095	44	.000	17.11111	15.8837	18.3386

Table 4 shows difference in the mean values if significant others(X=28.70), perceived family support(X=29.64) and perceived support from friends (X=28.09). Thus we reject the null hypothesis and conclude that there is a significant difference in the mean in the three areas.

WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. The WHO QOL scale used here has 4 domains – health, psychology, social relations and environmental factors.

Table 5: WHO QOL mean score

	Health	Psychology	Social Rel.	Environ ment
Mean	21.8667	18.7111	9.2667	25.9111
Std. Deviation	3.37504	2.93585	1.92354	4.28434

Domain 1 includes activities of daily living, sleep and health (X=21.86, SD=3.3)
Domain 2 includes self-image and self-esteem (X=18.71, SD=2.9)
Domain 3 includes personal relationships and social support (X=9.2, SD=1.92)
Domain 4 which is Environment includes home environment and financial resources (X=25.91, SD=4.28)

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

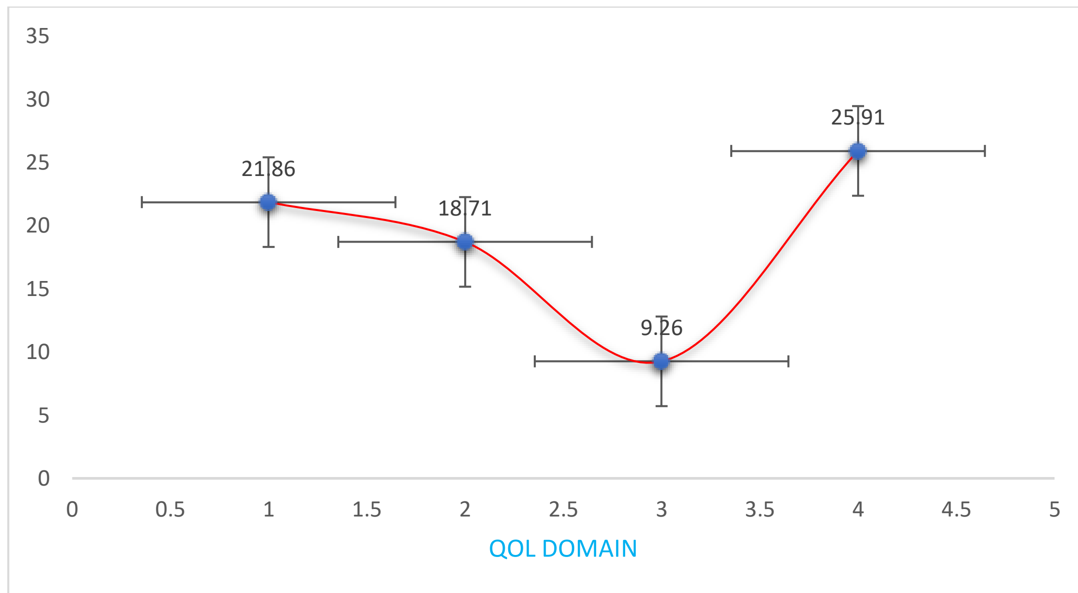


Figure 3: Graphic representation of the four domains.

Table 5 shows the highest and the lowest mean scores of WHOQOL-BREF domains was found for environment domain (Mean = 25.91) and social relationship (Mean = 9.26) respectively.

Figure 3 represents the four domains of quality of life. Higher score indicates higher quality of life in the respective domains. To test the null hypotheses there is no difference in the mean value in the domains of the quality of life.

Table 6: Quality of Life domains.

	Test Value = 0					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Health	43.462	44	.000	87.46667	83.4108	91.5226
Psychology	42.754	44	.000	74.84444	71.3163	78.3725
Social Rel.	32.317	44	.000	37.06667	34.7551	39.3782
Envt.	32.317	44	.000	148.26667	139.0203	157.5130

As seen in Table 6, a significant mean difference were observed of the domains in quality of life in relation to health (X=87.46), Psychology (X=74.84), Social relations (X=37.06) and Environment (X=148.26). Hence, we reject the null hypothesis.

To test the hypotheses, there is no correlation between perceived social support and quality of life.

Table 7: Correlation between perceived social support and quality of life

	Health	Psychology	Social Rel.	Environment
PSS (r)	0.355	0.348	0.509	0.657
P value	0.017	0.019	0.000	0.000

Table 7 shows the correlation between perceived social support and quality of life in each of the domains. It was found that there were significant correlations between perceived social support and health ($r=0.35$, $p<0.05$), Psychology ($r=0.34$, $p<0.05$), Social relations ($r=0.50$, $p<0.05$) and environmental factors ($r=0.65, p<0.05$). Thus, we reject the null hypothesis and conclude that higher the perceived social support higher is the quality of life among patients with schizophrenia.

The final hypothesis in this study states that gender differences has no influence on quality of life domains. Results of one-way ANOVA is shown in Table 8.

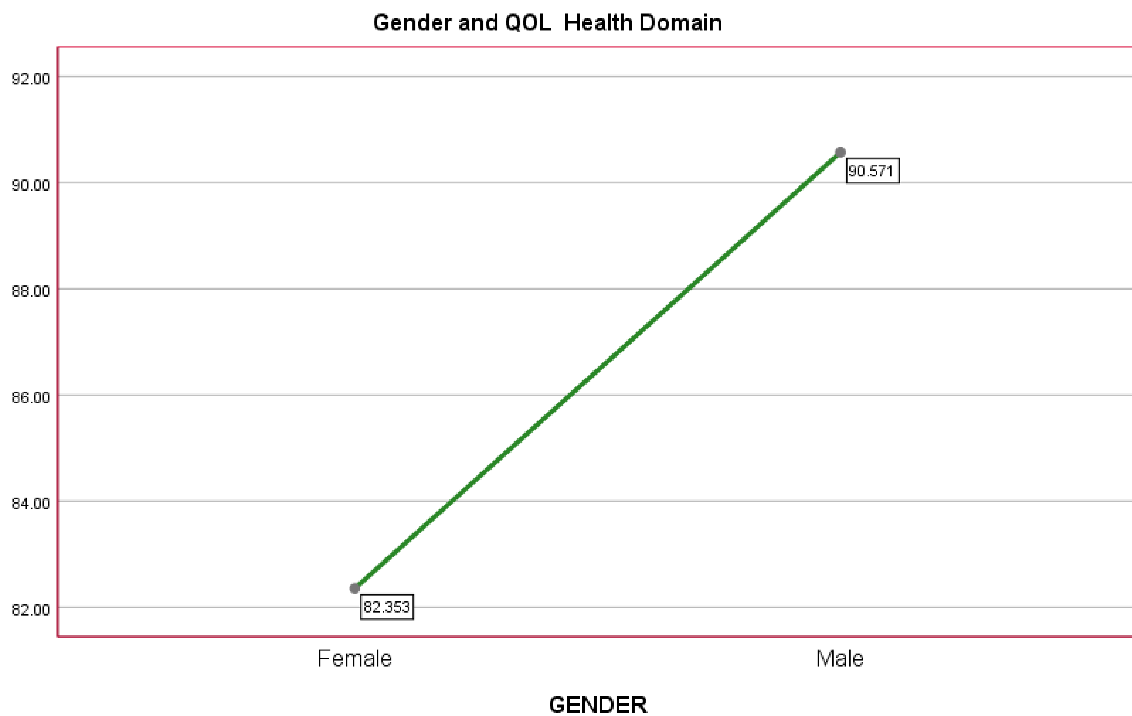
ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

Table 8: ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Health	Between Groups	714.461	1	714.461	4.206	.046
	Within Groups	7304.739	43	169.878		
	Total	8019.200	44			
Psy	Between Groups	39.172	1	39.172	.279	.600
	Within Groups	6028.739	43	140.203		
	Total	6067.911	44			
Social Rel	Between Groups	9.708	1	9.708	.161	.690
	Within Groups	2595.092	43	60.351		
	Total	2604.800	44			
Envt	Between Groups	155.321	1	155.321	.161	.690
	Within Groups	41521.479	43	965.616		
	Total	41676.800	44			

The results in Table 8, revealed a significant effect of health domain on gender, $F(1,43) = 4.206$, $p < 0.05$. Other domains were not significant.

Further analysis showed that male had better quality of life compared to female patients, particularly in the health domain. This is shown graphically in Figure 4.



ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

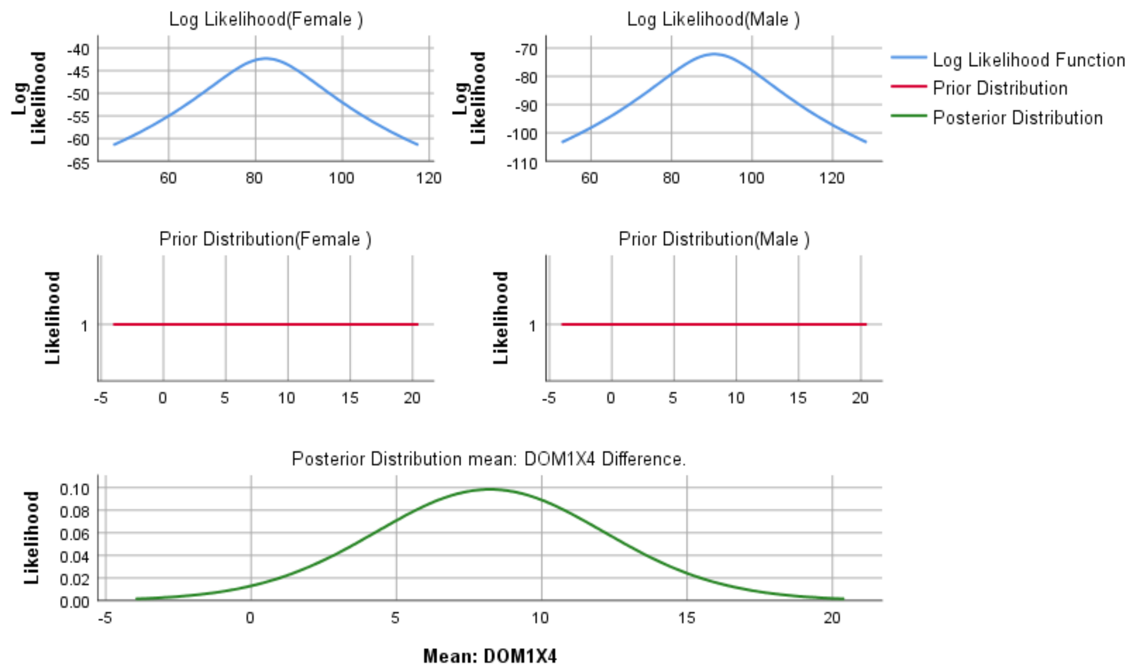


Figure 5: Bayesian interpretation of probability

Bayesian interpretation of probability confirms that male patients are more likely to have better quality of life compared to female patients. Thus, we reject the null hypotheses. Gender does influence quality of life among schizophrenic patients.

7. DISCUSSION

Patients suffering from schizophrenia have serious issues with personal and social relationships, which negatively impact their quality of life. Over the last two decades, psychosocial activities have been focused on improving the personal and social functioning of patients with schizophrenia, which includes more than just treating schizophrenic symptoms. Schizophrenia is a long-term mental illness that impairs emotions, cognition, and behavior. As a result, these people have poor psychosocial functioning and a low quality of life.

Vast majority of the patients (42%) were in the age group 31 to 40 years. 33% were in the age group 31 to 40 years. A small percentage (25%) of them were in the age group 18 to 30 years. The reason for this could be due to the late onset of schizophrenia seen in this sample.

People living with schizophrenia perceive low social support. In this study 9% of the patients overall perceived low support from significant others, family and friends. A vast majority of patients (71%) perceived moderate support and 20% perceived high support.
This study is similar to studies done by Munikanan, et al. (2017) which reported about 72% of the respondents had poor perceived social support, with support from significant others being the lowest, followed by friends and family (Munikanan, et al. (2017). [22]).

According to the findings of the study by A.S. Ebrahim et al. (2021), the majority of the participants (89.5%) had low to moderate social support. Social support and social relationships showed a statistically significant positive correlation. (Ebrahim, A.S, et al. (2021). [28]).

It was intended to find perceived support using the Multidimensional Scale of Perceived Social Support Scale. The least one has scored was 2 and highest 7. Higher score indicates better perception of social support. The reliability of this scale in this case was found to be Alpha=0.918 which is excellent.

Low quality of life is linked to one or more of the following, according to a study by Cardoso, C. S., et al. (2005) male gender, single marital status, low income plus low education, use of three or more prescribed psychoactive drugs, psychomotor agitation during the interview, and current follow-up care. Given that being single has been linked to poorer quality of life in the intrapsychic and interpersonal domains, it is possible that affective-sexual relationships are unstable in this patient population (Cardoso, C. S., et al. (2005). [29]).

The vast majority of the married patients received better family support compared to the unmarried and divorced/separated. To test this hypothesis there is no difference in the mean value of perceived social support. One sample t-test was done to determine whether the mean calculated from sample data collected from a single group is different from a designated value. The difference in the mean values if significant others(X=28.70), perceived family support(X=29.64) and perceived support from friends (X=28.09). Thus, we reject the null hypothesis and conclude that there is a significant difference in the mean in the three areas.

WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals,

ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 10| Issue: 1| January 2024|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2023: 8.224 || ISI Value: 1.188

expectations, standards and concerns. The WHO QOL scale used here has 4 domains – health, psychology, social relations and environmental factors. According to the study conducted by Katschnig, H. (2000) Subjectively assessed quality of life was found to be higher in the less educated and in female patients, and when a sense of control is experienced. If negative or extrapyramidal symptoms are experienced and stigmatization is perceived, subjective quality of life is reported as being poorer (Katschnig, H et al. (2000). [30]).
Results shows the highest and the lowest mean scores of WHOQOL-BREF domains was found for environment domain (Mean = 25.91) and social relationship (Mean = 9.26) respectively. To test the null hypotheses there is no difference in the mean value in the domains of the quality of life. A significant mean difference were observed of the domains in quality of life in relation to health (X=87.46), Psychology (X=74.84), Social relations (X=37.06) and Environment (X=148.26). Hence, we reject the null hypothesis.

To test the hypotheses, there is no correlation between perceived social support and quality of life. Results depicted the correlation between perceived social support and quality of life in each of the domains. It was found that there were significant correlations between perceived social support and health ($r=0.35$, $p<0.05$), Psychology ($r=0.34$, $p<0.05$), Social relations ($r=0.50$, $p<0.05$) and environmental factors ($r=0.65$, $p<0.05$). Thus, we reject the null hypothesis and conclude that higher the perceived social support higher is the quality of life among patients with schizophrenia.

The final hypothesis in this study states that gender differences has no influence on quality of life domains. Results of one-way ANOVA revealed a significant effect of health domain on gender, $F(1,43) = 4.206$, $p < 0.05$. Other domains were not significant. Further analysis showed that male had better quality of life compared to female patients, particularly in the health domain.

8. LIMITATIONS OF THE STUDY

There are a few limitations to the study at hand that must be considered. Because the study is cross-sectional, it can only provide a snapshot of the data at a single point in time. Furthermore, because the study only includes a small number of participants, the results may be less representative. Using non-probability sampling techniques risks skewing the sample's selection. When all of these factors are considered at once, it is difficult to draw generalizations that apply to a larger population.

9. FUTURE IMPLICATIONS

More studies need to be conducted in the area of quality of life and perceived social support.

While this study contributed significantly to our understanding of the relationship between quality of life and perceived support in schizophrenia patients. Future research options can enhance and deepen our knowledge in this field. The current study found that people with schizophrenia who were already receiving community-oriented services lacked social support, particularly from significant others, friends, and family. Furthermore, the presence of social support from family and friends contributes to a higher quality of life, which is an important indicator of recovery. As a result, improving social support should be prioritized in future service development for people with schizophrenia. These studies emphasize the importance of looking beyond symptom-reduction strategies to improve QoL in schizophrenia; additionally, they highlight how increased participation of families and communities in treatment significantly improves the quality of life of people with mental illnesses.

10. CONCLUSION

According to the current study's findings, the majority of schizophrenia patients have low social support and QOL. There is also a link between social support and QOL. As a result, social support should be an essential component of psychiatric treatment due to its importance in improving patients' QOL. Age, educational level, and employment status were also discovered to influence the level of social support.

Furthermore, employment, marital status, and the occurrence of relapse can all be linked to people with schizophrenia's quality of life. These findings can assist policymakers in improving the role of families in the treatment of mental health patients at both the family and community levels. Additional considerations in the planning of mental health programs are required in order to raise awareness and empower communities in the management of people with schizophrenia through mental health integrated service clinics.

REFERENCE

1. *Lavretsky, H. (2008). History of schizophrenia as a psychiatric disorder. Clinical handbook of schizophrenia, 3-13. Google Scholar↗ CrossRef↗*
2. *Dipiro, J. T., Talbert, R. L., Yee, G. C., Matzke, G. R., Wells, B. G., & Posey, L. M. (2014). Pharmacotherapy: a pathophysiologic approach, ed. Connecticut: Appleton and Lange, 4, 141-142. Google Scholar↗ CrossRef ↗*
3. *Rector, N. A., Stolar, N., & Grant, P. (2011). Schizophrenia: Cognitive theory, research, and therapy. Guilford Press. Google Scholar↗ CrossRef↗*
4. *Stahl, S. M., Morrissette, D. A., Citrome, L., Saklad, S. R., Cummings, M. A., Meyer, J. M., ... & Warburton, K. D. (2013). "Meta-guidelines" for the management of patients with schizophrenia. CNS spectrums, 18(3), 150-162. Google Scholar↗ CrossRef↗*
5. *Dollfus, S., Everitt, B., Ribeyre, J. M., Assouly-Besse, F., Sharp, C., & Petit, M. (1996). Identifying subtypes of schizophrenia by cluster analyses. Schizophrenia bulletin, 22(3), 545-555. Google Scholar↗ CrossRef↗*
6. *Carpenter, W. T., Bartko, J. J., Carpenter, C. L., & Strauss, J. S. (1976). Another view of schizophrenia subtypes: A report from the International Pilot Study of Schizophrenia. Archives of General Psychiatry, 33(4), 508-516.Google Scholar↗ CrossRef↗*
7. *Jablensky, A. (2000). Epidemiology of schizophrenia: the global burden of disease and disability. European archives of psychiatry and clinical neuroscience, 250, 274-285.Google Scholar↗ CrossRef↗*
8. *Menezes, P. R. (2010). Incidence and outcome of schizophrenia across the globe. Advances in Schizophrenia Research 2009, 3-17. Google Scholar↗ CrossRef↗*

9. *Wig, N. N., Varma, V. K., Mattoo, S. K., Behere, P. B., Phookan, H. R., Misra, A. K., ... & Bedi, H. (1993). An incidence study of schizophrenia in India. Indian Journal of Psychiatry, 35(1), 11. Google Scholar↗ CrossRef↗*
10. *Thara, R., Padmavati, R., & Nagaswami, V. (1993). Schizophrenia in India. Epidemiology, phenomenology, course and outcome. International Review of Psychiatry, 5(2-3), 157-164.Google Scholar↗ CrossRef↗*
11. *Avasthi, A., & Singh, G. (2004). Schizophrenia research: Indian scene in last decade. Indian journal of psychiatry, 46(2), 115-124. Google Scholar↗ CrossRef↗*
12. *Shiraishi, N., & Reilly, J. (2019). Positive and negative impacts of schizophrenia on family caregivers: a systematic review and qualitative meta-summary. Social psychiatry and psychiatric epidemiology, 54, 277-290. Google Scholar↗ CrossRef↗*
13. *Brown, G. W., Birley, J. L., & Wing, J. K. (1972). Influence of family life on the course of schizophrenic disorders: A replication. The British Journal of Psychiatry, 121(562), 241-258.Google Scholar↗ CrossRef↗*
14. *Walton-Moss, B., Gerson, L., & Rose, L. (2005). Effects of mental illness on family quality of life. Issues in mental health nursing, 26(6), 627-642.Google Scholar↗ CrossRef↗*
15. *Hamada, Y., Ohta, Y., & Nakane, Y. (2003). Factors affecting the family support system of patients with schizophrenia: a survey in the remote island of Tsushima. Psychiatry and clinical neurosciences, 57(2), 161-168.Google Scholar↗ CrossRef↗*
16. *Gerace, L. M., Camilleri, D., & Ayres, L. (1993). Sibling perspectives on schizophrenia and the family. Schizophrenia Bulletin, 19(3), 637-647. Google Scholar↗ CrossRef↗*
17. *Narvaez, J. M., Twamley, E. W., McKibbin, C. L., Heaton, R. K., & Patterson, T. L. (2008). Subjective and objective quality of life in schizophrenia. Schizophrenia research, 98(1-3), 201-208.Google Scholar↗ CrossRef↗*
18. *Dong, M., Lu, L., Zhang, L., Zhang, Y. S., Ng, C. H., Ungvari, G. S., ... & Xiang, Y. T. (2019). Quality of life in schizophrenia: A meta-analysis of comparative studies. Psychiatric Quarterly, 90, 519-532. Google Scholar↗ CrossRef↗*
19. *Chiou, C. J., Chang, H. Y., Chen, I. P., & Wang, H. H. (2009). Social support and caregiving circumstances as predictors of caregiver burden in Taiwan. Archives of gerontology and geriatrics, 48(3), 419-424.Google Scholar↗ CrossRef↗*
20. *Prabhakaran, S., Nagarajan, P., Varadharajan, N., & Menon, V. (2021). Relationship between quality of life and social support among patients with schizophrenia and bipolar disorder: A cross-sectional study. Journal of Psychosocial Rehabilitation and Mental Health, 8, 137-145. Google Scholar↗ CrossRef↗*
31. *CrossRef↗*
21. *Eack, S. M., & Newhill, C. E. (2007). Psychiatric symptoms and quality of life in schizophrenia: a meta-analysis. Schizophrenia bulletin, 33(5), 1225-1237. Google Scholar↗ CrossRef↗*
22. *Munikanan, T., Midin, M., Daud, T. I. M., Rahim, R. A., Bakar, A. K. A., Jaafar, N. R. N., ... & Baharuddin, N. (2017). Association of social support and quality of life among people with schizophrenia receiving community psychiatric service: A cross-sectional study. Comprehensive psychiatry, 75, 94-102. Google Scholar↗ CrossRef↗*
23. *Rudnick, A., & Kravetz, S. (2001). The relation of social support-seeking to quality of life in schizophrenia. The Journal of nervous and mental disease, 189(4), 258-262. Google Scholar↗ CrossRef↗*
24. *Rüesch, P., Graf, J., Meyer, P. C., Rössler, W., & Hell, D. (2004). Occupation, social support and quality of life in persons with schizophrenic or affective disorders. Social psychiatry and psychiatric epidemiology, 39, 686-694. Google Scholar↗ CrossRef↗*
25. *Pinho, L. G., Pereira, A., Chaves, C., Sequeira, C., Sampaio, F., Correia, T., ... & Ferré-Grau, C. (2020). Affectivity in schizophrenia: Its relations with functioning, quality of life, and social support satisfaction. Journal of Clinical Psychology, 76(7), 1408-1417. Google Scholar↗ CrossRef↗*
26. *Dziwota, E., Stepulak, M. Z., Wloszczak-Szubzda, A., & Olajossy, M. (2018). Social functioning and the quality of life of patients diagnosed with schizophrenia. Annals of Agricultural and Environmental Medicine, 25(1), 50-55. Google Scholar↗ CrossRef↗*
27. *Zimet, G. D., & Farley, G. K. (1988). Perceived social support. Journal of personality assessment, 52, 30-41. Google Scholar↗ CrossRef↗*
28. *Ebrahim, A. S., El-Bilsha, M., & Elhadidy, M. (2021). Social support among patients with schizophrenia. Mansoura Nursing Journal, 8(2), 13-25. Google Scholar↗ CrossRef↗*
29. *Cardoso, C. S., Caiaffa, W. T., Bandeira, M., Siqueira, A. L., Abreu, M. N. S., & Fonseca, J. O. P. (2005). Factors associated with low quality of life in schizophrenia. Cadernos de Saúde Pública, 21(5), 1338-1340. Google Scholar↗ CrossRef↗*
30. *Katschnig, H. (2000). Schizophrenia and quality of life. Acta Psychiatrica Scandinavica, 102, 33-37. Google Scholar↗*