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Psychological Aspects in Institutionalized Patients with Chronic Schizophrenia undergoing Pharmacological and Integrated Treatment

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The study is imperative to advance the understanding of how pharmacological and integrated treatment plays a role in various psychological aspects of institutionalized patients with chronic schizophrenia. An understanding of how subjective well-being, quality of life, spiritual well-being and perceived social support is different among pharmacological and integrated treatment takers can help in identifying strategies thereby enhancing patient's ability to manage to their symptoms and make informed choices. The aim of this study was to compare the quality of life, subjective well-being, perceived social support and spiritual well- being among the institutionalized patients of Schizophrenia taking pharmacological and integrated treatment. The present study was an institution based cross-sectional study conducted with total sample of 40 participants, which included 20 patients taking pharmacological treatment and 20 patients taking integrated treatment. Age range of the participants was between 40-65 years. All data were analysed using the Statistical Package for Social Sciences Version 23. Descriptive Statistics (Mean, Standard Deviation, Frequency and Percentages) and Inferential Statistics (Mann Whitney U Test and Correlation) were used to analyse the data. The findings suggest that institutionalized patients who were undergoing integrated treatment had better quality of life, subjective well-being, perceived social support and spiritual well-being as compared to patients taking pharmacological treatment.

Keywords: Schizophrenia, Institutionalization, Quality of Life, Subjective Well-Being, Perceived Social Support, Spiritual Well-Being

Schizophrenia is one of the severe mental disorders that is known to be the most harmful, distressing, and feared of all psychiatric disorders. It is a persistent, relapsing mental illness linked to a higher death rate, a lower quality of life, and a lower rate of recovery (Keshavan et al., 2011). It has an impact on a person's overall health, ability to function, autonomy, subjective well-being, and quality of life. One of the leading causes of disability worldwide, schizophrenia persists despite half a century of pharmacological and psychosocial interventions (Murray & Lopez, 1996).

Since the early detection of this mental illness, doctors have always considered rehabilitation to be the ultimate goal rather than treatment (Amador et al., 1994). According to Emil Kraeplin (1919), this illness causes "profound" and "terminal" dementia, which is an unavoidable decline. Eugen Bleular, characterizing the recovery as "recovery with defect" and "healing with scarring," shared a similarly pessimistic outlook (Holmes, 2001). In collaboration with Laborit, a Parisian surgeon, Delay and Deniker officially discovered chlorpromazine in 1952, making it the first antipsychotic used to treat schizophrenia. Antipsychotics have since become the cornerstone of schizophrenia treatment due to various advancements. The two categories of antipsychotic drugs are First generation and

Second generation. Second generation medications are currently typically regarded as first line therapy for individuals (Ann et al., 2012). Even when their psychotic symptoms are under control due to antipsychotic medication, about two-thirds of people with schizophrenia are unable to perform basic social roles such as being a worker, friend, parent, or spouse (Bellack et al., 2007). "Psychosocial rehabilitation, most commonly used in the context of mental illness, refers more specifically to the restoration of psychological and social functioning" (King et al. 2007).To help patients with schizophrenia reach a minimal level of functioning, psychosocial rehabilitation consists of a number of components. Training in basic living skills, independent living skills, money management, interpersonal relationships, time management, and social skills are typically included in the plan (Chaudhuri et al., 2001). One suggested strategy for improving the prognosis of schizophrenia patients is the combination of psychosocial and pharmaceutical approaches (Marder, 2000). Day care centers, halfway houses, long-term care facilities, shelter homes, day hospitals, and night hospitals are just a few of the alternative care options that have emerged as a result (Soddy and Ahrenfeldt 1967).

In modern medicine, quality of life has come to be seen as the ideal from a biopsychosocial perspective. This concept has served as the basis for a number of health economic analyses and is increasingly being used as an essential part of clinical research and patient care (Lehman et al. 1982). Patients with schizophrenia residing in long-term residential psychiatric facilities have a particularly sensitive quality of life when it comes to insufficient psychotropic medication and interactions between psychotropic drugs and concurrent medications. Improved prescriptions and avoidance of interactions by psychiatrists with the assistance of clinical pharmacists may have a favourable effect on Quality of Life (Jankovic et al., 2016).

"Happiness" or a positive subjective state based on cognitive and affective assessments of one's life can be a broad definition of subjective wellbeing (SWB) (Diener, 2000). It has been shown that emotional distress and poorer coping associated with psychotic symptoms, along with the psychosocial stress of stigma, social rejection, and discrimination, have a major negative impact on Subjective Well-Being in psychosis (Freeman et al., 2014). Individuals with psychosis may be less affected by well-established psychosocial determinants of wellbeing in the general population (Magallares, Perez-Garin, & Molero, 2013). Improvements in SWB have been linked to appropriate treatment and effective coping strategies (Firth et al., 2019).

Social support was described by Cobb (1976) as "information that gives the subject the impression that they are loved, respected, and a part of a network of mutual obligation." Power generally refers to a social support in the sense of providing the individual with physical and psychological aid in a unique situation, as well as basic social needs of the individuals such as love, loyalty, self-esteem, and the sense of being a part of a group" (Tan & Karabulut, 2005). According to some authors, people with psychosis may experience social deficits that are reinforced by changes in contemporary societies (Mueser & Bellack, 2005). For individuals with psychotic disorders, the size of their social network is relevant not only as an outcome of interventions, but also as a factor that influences their overall quality of life and service utilization (Harley et al., 2012).

Spiritual well-being, according to Moberg and Brusek (1978), is a two-dimensional construct made up of a horizontal dimension

and a vertical dimension, "God person's view of the meaning and fulfillment of life, independent of any religious allusions. According to Panzini et al.'s theory, patients' spiritual needs can be satisfied by practicing a religious faith. This is an essential aspect of providing holistic care and can enhance their quality of life. (Panzini et al, 2017). Treatment compliance and spiritual well-being are significantly correlated in individuals with schizophrenia. A lack of non-pharmaceutical options, stigmatisation of patients, long-term treatment, and excessive or insufficient social support can all be detrimental to schizophrenic people with low spiritual well-being. (Gültekin A, 2022).

Objectives:

- To assess the quality of life among the patients taking pharmacological and integrated treatment.
- To assess the subjective well-being among the patients taking pharmacological and integrated treatment.
- To explore the perceived social support among the patients taking pharmacological and integrated treatment.
- To assess the level of spiritual well-being among the patients taking pharmacotherapy and integrated treatment with chronic Schizophrenia.
- To study the relationship between quality of life, subjective well-being, perceived social support and spiritual well-being among patients taking pharmacological and integrated treatment.

Method

Sample

The sample consisted of 40 patients with two groups of 20 patients each diagnosed with schizophrenia by a psychiatrist taking pharmacological or an integrated treatment residing in an institutionalized care in Hospital for Mental Health, Ahmedabad. The integrated treatment consisted of pharmacological treatment and occupational therapy. All were aged between 45– 60 years, both male and female, had mental illness for more than 10 years. Sample was collected through purposive sampling technique. Patients residing in residential care, stable with medicines and able to give consent were included. Patient with co-morbid psychiatric illness, substance addiction, physical illness & disability were excluded.

Tools

Sociodemographic Form (developed by the researcher)

WHO-QOL-BREF (World Health Organization, Quality of Life-Bref) (World Health Organisation, 1998).

*SUBI (*The Subjective Well-Being Inventory) (Nagpal & Sell, 1985)

MPSS (Multidimensional Perceived Social Support) (Zimet, Dalhem, Zimet, and Farley, 1988)

SWB (Spiritual Well-Being Scale) (Paloutzian &Ellison, 1983).

Procedure

The study took place in Hospital for Mental Health, Ahmedabad and was approved by the ethical committee of Mahatma Gandhi Medical College and Hospital. Written consent was given by the head of the institution, caretakers and the patients. They were informed about the study as well as all the doubts were cleared. Initially, 50 patients were selected for the study, 10 patients were eliminated as they didn't meet the inclusion criteria. Following that, each tool was administered individually.

Results and Discussion

Table 1. Mean and Standard Deviation of Age of patients with Schizophrenia

	N	Mean	Std. Deviation
Age	40	50.85	7.634

Table 2. Frequency and percentages of various socio-demographic variables of patients with Schizophrenia (N=40)

Variables		f	%
Gender	Male	20	50.0%
	Female	20	50.0%
Education	Illiterate	13	32.5%
	Literate	27	67.5%
Family	Nuclear	20	50.0%
	Joint	13	32.5%
	None	7	17.5%
Marital Status	Married	15	37.5%
	Unmarried	14	35.0%
	Separated	4	10.0%
	Divorced	4	10.0%
	Remarried	3	7.5%
Residence	Rural	11	27.5%
	Urban	11	27.5%
	Semi-urban	18	45.0%
Treatment	Pharmacological	20	50.0%
	Integrated	20	50.0%

Table 3. Frequency and percentages of clinical variables of patients taking Pharmacological treatment (N=20)

	Variables	f	%
QOL Physical Health	Low	0	0%
	Moderate	14	70%
	High	16	30%
QOL Psychological	Low	1	5%
	Moderate	15	75%
	High	4	20%
QOL Social Relationships	Low	5	25%
	Moderate	12	60%
	High	3	15%
QOL Environment	Low	0	0%
	Moderate	15	75%
	High	5	25%
Subjective Well-being	Low	0	0%
	Moderate	15	75%
	High	5	25%
Perceived Social Support	Low	0	0%
	Moderate	18	90%
	High	2	10%
Spiritual Well-being	Low	0	0%
	Moderate	18	90%
	High	2	10%

Note: N= Participants in each group, QOL =Quality of Life

Table 4. Frequency and percentages of clinical variables of patients taking Integrated treatment (N=20)

	Variables	F	%
QOL Physical Health	Low	0	0%
	Moderate	9	45%
	High	11	55%
QOL Psychological	Low	0	0%
	Moderate	7	35%
	High	13	65%
QOL Social Relationships	Low	4	20%
	Moderate	12	60%
	High	4	20%

QOL Environment	Low	0	0%
	Moderate	16	80%
	High	4	20%
Subjective Well-being	Low	0	0%
	Moderate	3	15%
	High	17	85%

Perceived Social	Low	0	0%
Support	Moderate	4	20%
	High	16	80%
Spiritual Well-being	Low	0	0%
	Moderate	4	20%
	High	16	80%

Note: N= Participants in each group, QOL =Quality of Life

Table 5. Mann-Whitney U Test for significance of study variables for pharmacological and integrated treatment taken by patients with Schizophrenia (N=40)

	Treatment			
Variables	Pharmacological (n = 20)	Integrated (n = 20)	Mann Whitney- U	Z Score
Mean Rank				
QOL Physical Health	14.33	26.68	323.500	3.355
QOLPsychological	13.53	27.48	339.500	3.803
QOL Social Relationships	15.83	25.18	293.500	2.568
QOL Environment	14.33	26.68	323.500	3.355
Subjective Well- being	13.93	27.08	331.500	3.569
Perceived SocialSupport	10.50	30.50	400.000	5.419
Family (PSS)	10.80	30.20	394.000	5.266
Friends(PSS)	12.75	28.25	355.000	4.244
Significant Others(PSS)	10.50	30.50	400.000	5.431
Spiritual Well-being	10.75	30.25	395.000	5.279
Religious Well-being	11.58	29.43	378.500	4.839
Existential Well-being	12.13	28.88	367.500	4.542

Note: N= Participants in each group, QOL =Quality of Life, Significant at p< 0.050

Table 6. Correlation analysis between study variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12
QOL Physical												
QOLPsychological	.671**											
QOL Social	.225	.290										
QOLEnvironment	.462**	.472**	.454**									
SWB	.389*	.669**	.175	.476**								

PSS	.541**	.579**	.321*	.478**	.498**							
PSS Family	.590**	.605**	.461**	.400*	.428**	.879**						
PSS Friends	.242	.286	.043	.217	.321*	.736**	.470**					
PSS Sig Others	.523**	.505**	.210	.481**	.457**	.899**	.750**	.556**				
SPW	.426**	.571**	.371*	.322*	.377*	.752**	.682**	.475**	.663**			
SPW Religious	.390*	.515**	.299	.288	.364*	.731**	.669**	.500**	.659**	.922**		
SPW Existential	.374*	.512**	.378*	.291	.308	.607**	.543**	.336*	.516**	.871**	.613**	

*Note: QOL= Quality of Life, SWB= Subjective Well-being, PSS = Perceived Social Support, SPW = Spiritual Well-being, Pearson's Correlation;*p*<0.05;**<0.01*

Descriptive analysis of the socio-demographic variables such as age, gender, education, nature of family, marital status, residence and types of treatment of the patients with schizophrenia was tabulated in Table 1 and 2. Mean age of all the participants was 50.8 with a SD of 7.6. The comparison on the basis of the education depicted that 67.5% of the patients were literate whereas 32.5% were illiterate. Among the nature of family, the percentage of patients coming from nuclear family was 50%, followed by joint family which is 32.5% and 17.5 % of the patients had no family at all. According to the results of the earlier study, there was no statistically significant correlation between the characteristics of the schizophrenia patients— such as age, sex, length of illness, and inpatient status—and the illness (Widschwendter et al. 2018). The comparison on the basis of marital status showed that 37% of the participants were married, 35% were unmarried, 10% were separated, 10% were divorced and 7.5% were remarried which aligns with a study done in India by Thara et al (2003). The study revealed that fairly high marital rate of 70% was found among schizophrenia patients reporting that 70% of the patients with schizophrenia were married and 80% of the marriages were intact on follow up for up to 10 years, probably because of high rate of marriages and relative early age of marriage in India. Majority of the patients were from the semi-urban area i.e. 45% followed by urban (27.5%) and rural area (27.5%) which aligns with the study done by Schelin et al (2000) stating that higher incidence of Schizophrenia was in the capital & suburban areas as compared to rural areas. The percentage for treatment was equal for both the groups which are 50% for pharmacological and integrated treatment.

Descriptive analysis of clinical variables of patients taking pharmacological treatment was tabulated in Table 3. On Quality of Life, 70% of the patients had moderate whereas 30% of the patient has high Physical Health. In terms of Quality of Life, 5% patients had low, 75% patients had moderate and 20% had high Psychological Health. In terms of Quality of Life Social Relationships, 25% had low, 60% patients had moderate and 15% patients had high range. 75% patients were under moderate and 25% were low in terms of Quality of Life Environment. Owing to limitations imposed by clinical, sociodemographic, and economic factors, patients with mental disorders typically have a lower quality of life than the general population, particularly when evaluating psychological welfare as an indicator of an individual's mental health status (Makara-Studzinska et al., 2011). 90% of participants had moderate scores, which is consistent with research by Silva et al. (2011), which found

that among institutionalised patients, 38.9% had moderate impairment and 61.1% had severe impairment. On Subjective well- being, 15% had moderate and 85% had high scores. The findings of Subjective Well- being of the patient taking pharmacological treatment are consistent with the study done by Vothknecht et al. in 2011.The study revealed that subjective well-being of patients with schizophrenia improved during treatment in almost all studies. Higher percentages (90%) of participants had moderate scores and 10% had lower scores on Perceived Social Support. In this vein, Yadav (2010) established that individuals with mental illnesses who do not receive adequate support from their primary carers engage in any constructive activities, thereby diminishing their quality of life and overall well-being. For Spiritual Well-Being, the percentages were 90% and 10%, respectively.

Descriptive analysis of clinical variables of patients taking integrated treatment was tabulated in Table 4. On Quality of Life, 45% of the patients had moderate whereas 55% of the patient had high Physical Health. In terms of Quality of Life, 35% patients had moderate and 65% had high Psychological Health. In terms of Quality of Life Social Relationships, 20% had low, 60% patients had moderate and 20% patients had high range. 80% patients were under moderate and 20% were low in terms of Quality of Life Environment which aligns with the study done by Deenik et al (2018) showed that psychosocial functioning was improved in patients receiving multidisciplinary lifestyle enhancing treatment as compared to treatment as usual i.e. pharmacological treatment. Quality of Life was improved in patients receiving multidisciplinary lifestyle enhancing treatment. 15% received moderate scores and 85% had high scores on the subjective well- being scale. On perceived social support, a higher majority of participants (90%) had moderate ratings, while 10% had lower scores. In terms of Spiritual Well-Being, the percentages were 20% for Moderate and 80% for High.

The Table 5 represents the comparison of clinical variables which are quality of life, subjective well-being, perceived social support and spiritual well-being of patients taking pharmacological and integrated treatment. Results revealed that mean value of all the domains of Quality of Life is lower for patients taking pharmacological treatment as compared to patients taking integrated treatment indicating the difference in QOL Physical Health between both the groups. This was in line with the research done by Valiente et al. (2019), which showed that psychological interventions significantly improve the subjective wellbeing and quality of life of people with schizophrenia. In contrast, Wehmeier et al.'s 2007 study found that among outpatients with schizophrenia receiving antipsychotic treatments for a full year, there was an improvement in both subjective and objective quality of life as well as subjective well-being. Level of spiritual well-being is lower for patients taking pharmacological treatment as compared to patients taking integrated treatment indicating the difference. Overall, there is accumulating compelling evidence that suggests individuals with mental illnesses not only use religion or spirituality as a valuable coping mechanism, but that many find such coping to be beneficial (Koenig et al., 2008).

Table 6 displays the correlation between the clinical variables—quality of life, subjective well-being, perceived social support, and spiritual well-being—of patients receiving pharmacological and integrated treatment. It was discovered that there was a positive correlation between subjective well-being and the Quality of Life domains of environment, psychological health, and physical health. In a 5-year follow-up study on improvements in both, Haan et al. (2008)

found a significant relationship between early improvements in quality of life and subjective well-being, and consequently, the long term course of the disease. Patients with lower quality of life tend to have lower treatment compliance, which can result in illness relapses and hospital readmissions (Naber et al., 2001). Numerous other writers have also emphasised the importance of wellbeing and quality of life when it comes to treatment compliance. Perceived Social Support was also found to positively correlate with the Quality of Life domains of Environment, Social Relationships, Psychological Health, and Physical Health. Perceived social support, particularly from friends and family, was found to be a significant predictor of higher QOL across all domains. Thoits (2011) asserts that social support from close friends and family can help victims of chronic illness live more independently in the community and lessen the negative effects of the illness (Kopelowicz et al., 2005). In people with schizophrenia, social relationships have been demonstrated to be a highly significant predictor of wellbeing. Families are also thought to contribute to improved quality of life (QOL) because they may be instrumental in reducing the financial, social, and emotional burdens that individuals with mental illness bear (Razali et al., 2012). According to Guedes de Pinho et al. (2018), social support is important and affects the quality of life for people with schizophrenia because it helps them deal with stressful situations in daily life. Furthermore, there exists a positive correlation between the domains of Perceived Social Support and Subjective Well-Being. In a similar vein, Bronowski et al. (2016)

discovered that social support is believed to be a health-promoting element that supports people with schizophrenia in their recovery process by teaching them improved coping skills that allow them to reclaim their health and feel subjectively well-off despite the limitations of their illness. Similar to this, Shah et al. (2011) looked into the relationship between spirituality and QOL, specifically if spirituality helps people with residual schizophrenia in other QOL domains like physical and psycho-social. According to their research, spirituality and religiosity significantly affect the general quality of life for schizophrenia patients. Subjective well-being and spiritual well-being are positively correlated. This interpretation is supported by Alptekin et al. (2005), who found that using religion as a coping mechanism was linked to improved life satisfaction and a decrease in negative symptoms in schizophrenia patients. Additionally, religion is known to contribute to subjective well-being. Spiritual well-being is positively correlated with perceived social support. This finding adds to the body of evidence showing the positive relationship between religiosity and social support (Levin & Vanderpool, 1989). Patients frequently receive support from friends and family, are encouraged by spiritual pursuits, and find solace and support in their beliefs. Rebuilding one's sense of self and accelerating healing are two more benefits of spiritual well-being (Mohr et al., 2004).

Limitations

Regarding this research work, there are a number of limitations that must be acknowledged. The study's findings may be constrained by the specific characteristics of the sampled populations such as the data was not collected from the deinstitutionalized patients who could have added up in the findings. Additionally, no objective assessment was utilised to check the patient's current state of health, which would have impacted the assessment results. The study's sample size was relatively small. Additionally, convenience and purposive sampling were used in the study to select participants who had given consent to take part. As a result, the sample could not accurately reflect the target population.

Participants who consented for the study might differ systematically from those who did not, potentially introducing a bias in the findings. The generalizability to bigger populations and across demographic groups may therefore be limited by these characteristics. It is suggested that future studies use a larger and more varied sample to improve the results' external validity.

Clinical Implications

The study carries significant clinical implications for the field of mental health, offering a multifaceted perspective on different treatment modalities and its effect on various psychological aspects of patients with chronic schizophrenia. Understanding how integrated treatment interacts with these variables could guide mental health professionals in tailoring intervention. These can include promoting social contact and inclusion, and improving coping strategies, particularly for negative symptoms. By incorporating the study's findings, more emphasis can be given on integrated treatment for patients with Chronic Schizophrenia for comprehensive psychotherapeutic approach as it can lead to effective treatment outcomes.

Future Suggestions

Future longitudinal research must be conducted to validate the connection between these variables and well-being; this would offer more solid proof that these aspects should be given top priority in care planning and that enhancing patients' general well-being is important. Since the goal of the current study was not to gather participants' distinct perspectives on schizophrenia care, more research involving clinicians, carers, and patients is required, along with questions specifically tailored to their experiences living with and treating schizophrenia.

Conclusion

In conclusion, this study showed that institutionalized patients who were undergoing integrated treatment had better quality of life, subjective well-being, perceived social support and spiritual well-being as compared to patients taking pharmacological treatment. The findings offer valuable insights into the areas of focus for patients taking pharmacological treatments such as physical health, psychological health, social relationships, etc.

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