Section: Psychiatry

Original Research Article

# A STUDY ON QUALITY OF LIFE IN SCHIZOPHRENIA PATIENTS AND THEIR FAMILY FUNCTIONALITY

**S. Sarath Ajay Kumar[1], MD. Shagufa Arsheen[2], Penumaka Sony[2], Lasya Priya Cheruvu[2], T. Satya Srivalli[2], P. Rashmitha Priyadarsini[3]**

[1]Assistant Professor, Department of Psychiatry, Siddhartha Medical College, Vijayawada, Andhra Pradesh, India.
[2]Department of Pharmacy Practice, VIPW, Vijayawada, Andhra Pradesh, India.
[3]Senior Resident, AIIMS, Mangalagiri, Andhra Pradesh, India.

*Received* : 11/02/2026
*Received in revised form* : 05/04/2026
*Accepted* : 24/04/2026

*Keywords:*
*Schizophrenia, Quality of life, Family Functionality.*

Corresponding Author:
**Dr. S. Sarath Ajay Kumar,**
Email: vijaetha.ajay@gmail.com

DOI: 10.47009/jamp.2026.8.3.10

Source of Support: Nil,
Conflict of Interest: None declared

*Int J Acad Med Pharm*
2026; 8 (3); 49-55

## ABSTRACT

**Background:** Schizophrenia is a severe mental illness causing disturbances in thought, perception, emotion, and behaviour, which has an impact on their standard of living and has a significant emotional and socio-economic impact on the family. The current study was designed to assess the quality of life and family functionality in individuals with schizophrenia. The aim is to study various socio-demographic factors and their influence on the quality of life in schizophrenia patients and their family functionality. **Materials and Methods:** A Prospective Observational Cross-sectional study was conducted on 103 patients diagnosed with Schizophrenia attending the Department of Psychiatry, Government General Hospital (GGH), Siddhartha Medical College, Vijayawada, Andhra Pradesh. Patients were evaluated using the instruments such as the WHO Quality of Life (BREF) and the McMaster Family Functioning Scale. **Result:** Majority of respondents were aged between 31–40 years (32.1%); Females (53.8%); married (52.8%); Hindus (65.1%); had secondary education (43.4%); unemployed (62.3%); and most belonged to middle (29.2%) socioeconomic classes; and lives in nuclear families (87.7%). Study revealed a statistically insignificant relationship between Religion and social relationships (0.022); Socioeconomic status, and psychological domain (0.017) in terms of Quality of life; and Statistically significant association is seen between Gender and overall family functionality (0.039), family activities (0.004) & confide each other (0.026); Education and family activities (0.023), Expressing feelings (0.018); Type of family and overall family functionality (0.010), expressing feelings (0.001), family support (0.014); Borderline significance is seen between Religion and Acceptance (0.050). **Conclusion:** Overall quality of life among respondents was moderate, with the lowest scores seen in the social relationships domain. While no significant association was found between overall quality of life and sociodemographic factors, marital status was significantly associated with social relationships, and socioeconomic status with the psychological domain. Family functioning was also found to be moderate, with lower scores in family activities and support. Significant associations were observed between gender, education, and type of family with family functioning.

## INTRODUCTION

Schizophrenia is a chronic, severe, and disabling psychiatric disorder characterised by disturbances in thought, perception, emotion, and behaviour. According to the World Health Organisation (WHO), schizophrenia affects approximately 24 million people worldwide and is among the leading causes of disability. The disorder typically manifests in late adolescence or early adulthood and follows a relapsing or continuous course, significantly impairing social and occupational functioning. Core symptoms include positive symptoms (hallucinations, delusions), negative symptoms (apathy, anhedonia, social withdrawal), and cognitive deficits, all of which contribute to long-term functional impairment.[1,2]

Beyond symptom reduction, improving quality of life (QoL) has emerged as a central goal in the management of schizophrenia. The WHO defines quality of life as individuals' perception of their position in life in the context of their culture, value systems, goals, expectations, and concerns. The WHOQOL-BREF is a widely used instrument that


ISSN (O): 2687-5365; ISSN (P): 2753-6556

evaluates QoL across four primary domains: physical health, psychological health, social relationships, and environment.[3] Patients with schizophrenia often exhibit impairments across all WHOQOL-BREF domains. Physical health is affected due to a sedentary lifestyle, medication side effects, and comorbid medical conditions. Psychological health is compromised by persistent symptoms, poor self-esteem, and emotional distress. Social relationships are markedly impaired due to stigma, social withdrawal, and difficulty maintaining interpersonal connections. Environmental factors, including financial instability, limited access to healthcare, and reduced opportunities for rehabilitation, further diminish overall quality of life.[4,5]

Schizophrenia not only impacts individuals but also significantly affects their families, who often assume the role of primary caregivers. Family functioning plays a crucial role in the course and outcome of the illness. The McMaster Family Assessment Device (FAD), based on the McMaster Model of Family Functioning, assesses family dynamics across several domains: problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control, and general functioning.[6] Families of individuals with schizophrenia frequently experience dysfunction across these domains. Problem-solving abilities may be impaired by chronic stress and a lack of resources. Communication patterns often become strained, characterised by criticism, hostility, or emotional withdrawal. Role distribution within the family may become unbalanced as caregiving responsibilities increase. Affective responsiveness and involvement may be disrupted, leading to either emotional over-involvement or detachment. Behavioural control issues and overall family functioning are also adversely affected, contributing to caregiver burden and poorer patient outcomes.[7]

Understanding the interplay between quality of life in patients with schizophrenia and family functioning is essential for developing comprehensive treatment strategies. Interventions that target both individual and family-level factors—such as psychosocial rehabilitation, family therapy, and community support—can significantly improve outcomes. Therefore, assessing QoL using tools such as WHOQOL-BREF, alongside family functioning through the McMaster model, provides a holistic framework for evaluating and managing schizophrenia.

## MATERIALS AND METHODS

**Study setting:** Department of Psychiatry, Government General Hospital, Siddhartha Medical College, Vijayawada

**Study duration:** 6 months (October 2023 to March 2024)

**Study design:** Cross-sectional Observational Study

**Study population:** Patients diagnosed with schizophrenia

**Sample size:** 103

**Sampling Method:** Convenience Sampling

**Study criteria:**

**Inclusion Criteria**

1. Patients who have given consent for study participation.
2. Patients aged more than 18 years.
3. Patient fulfilling criteria for schizophrenia as per ICD-10.
4. Patients who are in maintenance treatment for schizophrenia.

**Exclusion Criteria**

1. Patients who are not willing to give consent for study participation.
2. Patients below 18 years of age.
3. Patients diagnosed with psychiatric illnesses other than schizophrenia.
4. Patients suffering from any chronic physical illnesses or substance use disorders.

**Study tools:**

1. A Semi-structured proforma to collect Sociodemographic data of the study participants
2. WHO Quality of Life scale (BREF)
3. McMaster family Functionality scale

**Ethical approval:** Prior approval from the Institutional Ethical Committee (IEC) was obtained. Written informed consent was obtained from the study participants before beginning the study.

**Study Procedure:** Patients diagnosed with schizophrenia attending the Department of Psychiatry, Government General Hospital, Vijayawada, were recruited into the study based on the selection criteria. The patient's demographic details and illness-related variables were collected using study tools. All the collected data was well documented in the designated data collection form.

**Statistical Analysis:** Data were initially entered into Microsoft Excel and subsequently analysed using SPSS version 31. Descriptive statistics were used to summarise the data, with categorical variables expressed as frequency and percentage, and continuous variables presented as mean ± standard deviation (SD). The independent sample t-test was used to compare means between two groups. For variables with more than two groups, one-way analysis of variance (ANOVA) was applied. All statistical tests were two-tailed, and a p-value of less than 0.05 was considered statistically significant.

## RESULTS

The table shows that the majority of respondents were aged between 31 and 40 years (32.1%), followed by those below 30 years (27.4%) and 41–50 years (25.5%), with only a small proportion above 50 years (12.3%). Females (53.8%) slightly outnumbered males (43.3%). More than half of the participants were married (52.8%), while 34.9% were single and 9.4% were separated or divorced. In terms


ISSN (O): 2687-5365; ISSN (P): 2753-6556

of religion, most respondents were Hindus (65.1%), followed by Christians (22.7%) and Muslims (10.4%). Regarding education, the largest group had secondary education (43.4%), though a considerable proportion was illiterate (31.1%). A majority of respondents were unemployed (62.3%), and most belonged to middle (29.2%), lower (27.4%), and lower-middle (26.4%) socioeconomic classes. Additionally, a vast majority lived in nuclear families (87.7%), with very few in joint or single-family setups.

**Table 1: Distribution of socio-demographic variables (N = 103)**

| Variable | | Frequency (n) | Percentage (%) |
|---|---|---|---|
| Age (yrs) | Less than 30 | 29 | 27.4 |
| | 31-40 | 34 | 32.1 |
| | 41-50 | 27 | 25.5 |
| | More than 50 | 13 | 12.3 |
| Gender | Male | 46 | 43.3 |
| | Female | 57 | 53.8 |
| Marital status | Single | 37 | 34.9 |
| | Married | 56 | 52.8 |
| | Separated/Divorced | 10 | 9.4 |
| Religion | Hindu | 69 | 65.1 |
| | Christian | 23 | 22.7 |
| | Muslim | 11 | 10.4 |
| Education | Illiterate | 33 | 31.1 |
| | Primary | 9 | 8.5 |
| | Secondary | 46 | 43.4 |
| | Graduation | 8 | 7.5 |
| | Post Graduation & Above | 7 | 6.6 |
| Occupation | Employed | 37 | 34.9 |
| | Unemployed | 66 | 62.3 |
| Socio-economic status | Upper | 6 | 5.7 |
| | Upper Middle | 9 | 8.5 |
| | Middle | 31 | 29.2 |
| | Lower Middle | 28 | 26.4 |
| | Lower | 29 | 27.4 |
| Type of family | Nuclear | 93 | 87.7 |
| | Joint | 7 | 6.6 |
| | Single | 3 | 2.8 |

**Table 2: Distribution of quality of life & family functionality**

| Quality of life | | Family functionality | |
|---|---|---|---|
| **Domain** | **Mean ± SD** | **Domain** | **Mean ± SD** |
| Physical Health | 18.56 ± 4.33 | Family Activities | 2.60 ± 0.78 |
| Psychological | 14.73 ± 3.79 | Acceptance | 4.36 ± 1.10 |
| Social Relationships | 7.69 ±2.00 | Decision Making | 4.95 ± 1.02 |
| Environment | 21.10 ± 5.04 | Expressing Feelings | 7.52 ± 1.59 |
| Total | 62.08 ± 12.75 | Family Support | 2.38 ± 0.61 |
| | | Confide in Each Other | 7.53 ± 1.11 |
| | | Total | 29.34 ± 4.48 |

The table indicates that among the quality-of-life domains, the highest mean score was observed in the environmental domain (21.10 ± 5.04), followed by physical health (18.56 ± 4.33) and psychological well-being (14.73 ± 3.79), while social relationships had the lowest mean score (7.69 ± 2.00). The overall quality of life mean score was 62.08 ± 12.75, suggesting a moderate level of quality of life among respondents. Regarding family functionality, the highest mean scores were observed in expressing feelings (7.52 ± 1.59) and confiding in each other (7.53 ± 1.11), while decision making (4.95 ± 1.02) and acceptance (4.36 ± 1.10) showed relatively higher mean scores. However, lower mean scores were observed in family activities (2.60 ± 0.78) and family support (2.38 ± 0.61). The total family functionality score was 29.34 ± 4.48, indicating an overall moderate level of family functioning.

**Table 3: Association of socio- demographic variables with quality of life**

| | | Physical Health | Psychological | Social Relationships | Environment | Overall |
|---|---|---|---|---|---|---|
| AGE (Yrs) | Less than 30 | 18.62 ± 3.84 | 14.21 ± 3.51 | 7.35 ± 1.89 | 19.72 ± 4.26 | 59.90 ± 11.74 |
| | 31-40 | 18.59 ± 3.46 | 15.24 ± 4.52 | 8.21 ± 1.88 | 22.27 ± 5.52 | 64.29 ± 13.79 |
| | 41-50 | 18.93 ± 4.77 | 15.15 ± 3.49 | 7.41 ± 2.10 | 20.89 ± 4.52 | 62.37 ± 11.74 |
| | More than 50 | 17.62 ± 6.45 | 13.69 ± 2.75 | 7.69 ± 2.25 | 21.54 ± 6.05 | 60.54 ± 14.53 |
| p-value | | 0.849 | 0.487 | 0.303 | 0.250 | 0.562 |
| GENDER | Male | 18.85 ± 5.03 | 15.09 ± 3.39 | 7.70 ± 1.74 | 21.55 ± 5.01 | 63.18 ± 12.23 |
| | Female | 18.52 ± 4.37 | 14.65 ± 4.12 | 7.91 ± 2.24 | 21.00 ± 5.37 | 62.08 ± 14.26 |


ISSN (O): 2687-5365; ISSN (P): 2753-6556

| | | | | | | |
|---|---|---|---|---|---|---|
| p-value | | 0.535 | 0.275 | 0.593 | 0.154 | 0.173 |
| MARITAL STATUS | Single | 18.14 ± 3.83 | 13.97 ± 3.72 | 7.05 ± 1.78 | 20.16 ± 4.75 | 59.32 ± 12.25 |
| | Married | 18.98 ± 4.90 | 15.41 ± 3.77 | 8.18 ± 2.11 | 21.88 ± 5.38 | 64.45 ± 13.39 |
| | Separated/Divorced | 17.80 ± 2.10 | 13.70 ± 3.71 | 7.30 ± 1.49 | 20.20 ± 3.49 | 59 ± 8.38 |
| p-value | | 0.554 | 0.133 | 0.022 | 0.233 | 0.120 |
| RELIGION | Hindu | 17.42 ± 3.78 | 14.06 ± 3.70 | 7.48 ± 1.90 | 20.36 ± 5.08 | 59.32 ± 12.24 |
| | Christian | 20.13 ± 4.19 | 15.61 ± 3.59 | 7.96 ± 2.10 | 22.26 ± 4.73 | 65.96 ± 11.18 |
| | Muslim | 22.46 ± 4.93 | 17.09 ± 3.73 | 8.46 ± 2.34 | 23.27 ± 4.67 | 71.27 ± 13.59 |
| p-value | | 0.640 | 0.509 | 0.986 | 0.235 | 0.106 |
| EDUCATION | Illiterate | 18.85 ± 5.03 | 15.09 ± 3.39 | 7.70 ± 1.74 | 21.55 ± 5.02 | 63.18 ± 12.24 |
| | Primary | 19.33 ± 4.09 | 17.22 ± 3.90 | 7.22 ± 2.49 | 22 ± 5.43 | 65.78 ± 11.72 |
| | Secondary | 18.52 ± 4.37 | 14.65 ± 4.13 | 7.91 ± 2.25 | 21 ± 5.37 | 62.09 ± 14.27 |
| | Graduation | 17.88 ± 2.36 | 12.50 ± 2.73 | 7.25 ± 1.49 | 20.38 ± 4.41 | 58 ± 8.60 |
| | Post Graduation & Above | 17.29 ± 2.87 | 12.86 ± 2.19 | 7.29 ± 1.38 | 19.29 ± 3.45 | 56.71 ± 9.34 |
| p-value | | 0.876 | 0.065 | 0.791 | 0.809 | 0.555 |
| OCCUPATION | Employed | 18.14 ± 3.83 | 13.97 ± 3.72 | 7.05 ± 1.78 | 20.16 ± 4.75 | 59.32 ± 12.25 |
| | Unemployed | 18.98 ± 4.90 | 15.41 ± 3.77 | 8.18 ± 2.11 | 21.88 ± 5.38 | 64.45 ± 13.39 |
| p-value | | 0.554 | 0.649 | 0.580 | 0.327 | 0.590 |
| SOCIO-ECONOMIC STATUS | Upper | 18.83 ± 3.76 | 15.83 ± 3.54 | 7.50 ± 1.38 | 20.17 ± 3.06 | 62.33 ± 8.38 |
| | Upper Middle | 15.67 ± 4.36 | 13.33 ± 2.65 | 7.67 ± 2.92 | 18.78 ± 5.95 | 55.44 ± 14.09 |
| | Middle | 19.32 ± 4.98 | 14.87 ± 3.49 | 7.55 ± 2.10 | 21.23 ± 5.33 | 62.97 ± 13.61 |
| | Lower Middle | 17.71 ± 2.88 | 13.14 ± 3.11 | 7.68 ± 1.61 | 21.14 ± 4.87 | 59.68 ± 10.73 |
| | Lower | 19.41 ± 4.58 | 16.31 ± 4.42 | 7.90 ± 2.13 | 21.83 ± 4.99 | 65.45 ± 13.47 |
| p-value | | 0.124 | 0.017 | 0.973 | 0.609 | 0.232 |
| TYPE OF FAMILY | Nuclear | 18.41 ± 4.19 | 14.61 ± 3.66 | 7.56 ± 1.91 | 20.76 ± 4.94 | 61.34 ± 12.26 |
| | Joint | 2.57 ± 4.18 | 16.57 ± 5.44 | 9.29 ± 2.14 | 24.71 ± 5.41 | 72.14 ± 16.52 |
| | Single | 16.33 ± 7.64 | 14 ± 3.46 | 8 ± 3.61 | 23 ± 5.29 | 61.33 ± 13.32 |
| p-value | | 0.117 | 0.399 | 0.084 | 0.108 | 0.096 |

The table shows the association between socio-demographic variables and quality of life domains. Overall, no statistically significant association was observed between most variables (age, gender, marital status, religion, education, occupation, and type of family) and the quality-of-life domains, as the p-values were greater than 0.05. However, a statistically significant association was found between marital status and the social relationships domain (p = 0.022). Additionally, socioeconomic status showed a significant association with the psychological domain (p = 0.017). Although not statistically significant, higher mean scores in overall quality of life were observed among individuals aged 31–40 years, females, married participants, Muslims, those with primary education, unemployed individuals, those belonging to lower socioeconomic status, and participants from joint families.

**Table 4: Association of socio- demographic variables with family functionality**

| | | **Family Activities** | **Acceptance** | **Decision Making** | **Expressing Feelings** | **Family Support** | **Confide in Each Other** | **Overall** |
|---|---|---|---|---|---|---|---|---|
| AGE (Yrs) | Less than 30 | 2.41 ± 0.73 | 3.93 ± 0.75 | 4.89 ± 1.08 | 7.24 ± 1.45 | 2.28 ± 0.52 | 7.28 ± 0.84 | 28.03 ± 3.69 |
| | 31-40 | 2.53 ± 0.70 | 4.52 ± 1.18 | 5.03 ± 0.90 | 7.50 ± 1.50 | 2.47 ± 0.56 | 7.70 ± 1.21 | 29.76 ± 4.30 |
| | 41-50 | 2.88 ± 0.80 | 4.51 ± 1.22 | 5.11 ± 1.15 | 7.77 ± 1.64 | 2.33 ± 0.67 | 7.55 ± 1.25 | 30.18 ± 4.73 |
| | More than 50 | 2.61 ± 0.96 | 4.53 ± 1.12 | 4.53 ± 0.87 | 7.61 ± 2.02 | 2.46 ± 0.77 | 7.61 ± 1.04 | 29.38 ± 5.70 |
| p-value | | 0.133 | 0.105 | 0.387 | 0.654 | 0.585 | 0.487 | 0.294 |
| GENDER | Male | 2.85 ± 0.79 | 4.37 ± 1.04 | 5.15 ± 1.03 | 7.80 ± 1.68 | 2.37 ± 0.68 | 7.80 ± 1.15 | 30.35 ± 4.21 |
| | Female | 2.40 ± 0.73 | 4.35 ± 1.16 | 4.79 ± 1 | 7.28 ± 1.49 | 2.39 ± 0.56 | 7.32 ± 1.04 | 28.53 ± 4.55 |
| p-value | | 0.004 | 0.932 | 0.073 | 0.097 | 0.893 | 0.026 | 0.039 |
| MARITAL STATUS | Single | 2.56 ± 0.76 | 4.29 ± 0.84 | 4.94 ± 0.88 | 7.35 ± 1.51 | 2.43 ± 0.55 | 7.45 ± 1.04 | 29.05 ± 3.74 |
| | Married | 2.66 ± 0.81 | 4.37 ± 1.22 | 4.96 ± 1.09 | 7.60 ± 1.65 | 2.37 ± 0.67 | 7.55 ± 1.20 | 29.53 ± 4.92 |
| | Separated/ Divorced | 2.40 ± 0.69 | 4.50 ± 1.26 | 4.90 ± 1.19 | 7.60 ± 1.57 | 2.20 ± 0.42 | 7.70 ± 0.82 | 29.30 ± 4.69 |
| p-value | | 0.596 | 0.867 | 0.983 | 0.741 | 0.570 | 0.818 | 0.881 |
| RELIGION | Hindu | 2.56 ± 0.77 | 4.40 ± 1.14 | 5.01 ± 1.05 | 7.56 ± 1.52 | 2.43 ± 0.62 | 7.50 ± 1.11 | 29.49 ± 4.52 |
| | Christian | 2.69 ± 0.82 | 3.95 ± 0.70 | 4.78 ± 0.99 | 7.26 ± 1.68 | 2.26 ± 0.54 | 7.69 ± 1.10 | 28.65 ± 3.86 |
| | Muslim | 2.64 ± 0.81 | 4.91 ± 1.30 | 4.91 ± 0.94 | 7.73 ± 1.85 | 2.27 ± 0.65 | 7.36 ± 1.12 | 29.82 ± 5.51 |


ISSN (O): 2687-5365; ISSN (P): 2753-6556

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| p-value | | 0.782 | 0.050 | 0.640 | 0.657 | 0.419 | 0.679 | 0.692 |
| EDUCATION | Illiterate | 2.76 ± 0.86 | 4.60 ± 1.34 | 5.06 ± 1.11 | 7.36 ± 1.31 | 2.36 ± 0.65 | 7.51 ± 1.20 | 29.66 ± 4.76 |
| | Primary | 3.22 ± 0.83 | 4.22 ± 1.20 | 5.33 ± 1.11 | 9.22 ± 2.16 | 2.22 ± 0.66 | 7.88 ± 1.16 | 32.11 ± 4.91 |
| | Secondary | 2.37 ± 0.64 | 4.19 ± 1 | 4.80 ± 0.93 | 7.34 ± 1.49 | 2.39 ± 0.61 | 7.45 ± 1.10 | 28.56 ± 4.05 |
| | Graduation | 2.62 ± 0.74 | 4.37 ± 0.51 | 4.87 ± 1.12 | 7.50 ± 1.69 | 2.25 ± 0.46 | 7.62 ± 0.91 | 29.25 ± 4 |
| | Post Graduation & Above | 2.57 ± 0.79 | 4.43 ± 0.79 | 5 ± 1 | 7.14 ± 1.57 | 2.71 ± 0.49 | 7.57 ± 0.98 | 29.43 ± 4.50 |
| p-value | | 0.023 | 0.592 | 0.627 | 0.018 | 0.551 | 0.880 | 0.289 |
| OCCUPATION | Employed | 2.78 ± 0.75 | 4.27 ± 1.02 | 4.97 ± 0.96 | 7.89 ± 1.84 | 2.41 ± 0.76 | 7.70 ± 1.27 | 30.03 ± 4.84 |
| | Unemployed | 2.50 ± 0.79 | 4.41 ± 1.15 | 4.94 ± 1.07 | 7.30 ± 1.40 | 2.36 ± 0.52 | 7.44 ± 1.01 | 28.96 ± 4.24 |
| p-value | | 0.078 | 0.542 | 0.874 | 0.071 | 0.742 | 0.250 | 0.245 |
| SOCIO-ECONOMIC STATUS | Upper | 3 ± 0.89 | 4 ± 0.63 | 5.33 ± 0.82 | 7.50 ± 1.05 | 2 ± 0.63 | 8.17 ± 0.98 | 30 ± 3.29 |
| | Upper Middle | 2.56 ± 0.73 | 4.78 ± 1.09 | 5 ± 0.71 | 7.33 ± 1 | 2.33 ± 0.50 | 7.78 ± 1.09 | 29.78 ± 3.73 |
| | Middle | 2.52 ± 0.68 | 4.42 ± 1.06 | 4.87 ± 0.99 | 7.42 ± 1.80 | 2.42 ± 0.72 | 7.23 ± 1.23 | 28.87 ± 5.14 |
| | Lower Middle | 2.50 ± 0.75 | 4.32 ± 1.02 | 4.64 ± 0.73 | 7.39 ± 1.42 | 2.43 ± 0.57 | 7.54 ± 1 | 28.82 ± 3.84 |
| | Lower | 2.72 ± 0.92 | 4.28 ± 1.31 | 5.24 ± 1.33 | 7.79 ± 1.78 | 2.38 ± 0.56 | 7.66 ± 1.08 | 30.07 ± 4.83 |
| p-value | | 0.544 | 0.701 | 0.205 | 0.869 | 0.623 | 0.277 | 0.797 |
| TYPE OF FAMILY | Nuclear | 2.62 ± 0.79 | 4.33 ± 1.10 | 5.01 ± 1.03 | 7.50 ± 1.52 | 2.36 ± 0.60 | 7.54 ± 1.12 | 29.38 ± 4.44 |
| | Joint | 2.14 ± 0.37 | 4.42 ± 0.78 | 4.14 ± 0.37 | 6.42 ± 1.13 | 2.14 ± 0.37 | 7 ± 0.81 | 26.28 ± 2.49 |
| | Single | 3 ± 1 | 5 ± 1.73 | 5 ± 1 | 10.33 ± 1.15 | 3.33 ± 0.57 | 8.33 ± 0.57 | 35 ± 3.60 |
| p-value | | 0.199 | 0.583 | 0.095 | 0.001 | 0.014 | 0.204 | 0.010 |

The table presents the association between socio-demographic variables and family functionality. A statistically significant association was observed between gender and family functionality, particularly in family activities ($p = 0.004$), confiding in each other ($p = 0.026$), and overall family functionality ($p = 0.039$), with males showing higher mean scores compared to females. Education was also significantly associated with family activities ($p = 0.023$) and expressing feelings ($p = 0.018$). Additionally, the type of family showed significant associations with expressing feelings ($p = 0.001$), family support ($p = 0.014$), and overall family functionality ($p = 0.010$). No significant associations were found with age, marital status, occupation, or socioeconomic status across most domains. A borderline significant association was observed between religion and acceptance ($p = 0.050$).

## DISCUSSION

This study assesses Quality of Life in Schizophrenia patients using the WHO Quality of Life BREF Scale and Family Functionality of schizophrenia patients using the McMaster Family Functioning Scale. The majority of respondents were aged between 31–40 years (32.1%); Females (53.8%); married (52.8%); Hindus (65.1%); had secondary education (43.4%); unemployed (62.3%); and most belonged to middle (29.2%) socioeconomic classes; and lives in nuclear families (87.7%).

Quality of Life and its association with Socio-demographic variables: The overall quality of life mean score was 62.08 ± 12.75, suggesting a moderate level of quality of life among respondents. The highest mean score was observed in the environmental domain (21.10 ± 5.04), followed by physical health (18.56 ± 4.33) and psychological well-being (14.73 ± 3.79), while social relationships had the lowest mean score (7.69 ± 2.00). Similar to our findings, other studies have found that the lowest scores for WHOQOL-BREF were reported in the psychological domain of health (mean=11.6; SD=2.3), followed by the social domain (mean=12.2; SD=3.3) and environmental domains (mean=13.8; SD=2.4) and the highest score was seen in the physical health domain (mean=13.9; SD=2.6).[8] The highest QoL scores were in physical health, followed by environment, social and psychological domains.[9] Some others have reported a similar trend, but with social domain scores being lowest.[10]

Overall, no statistically significant association was observed between most variables (age, gender, marital status, religion, education, occupation, and type of family) and the quality-of-life domains, as the p-values were greater than 0.05. Contradictory findings were seen in a study done by Meher A.C. et al., which found a significant association between the socio-demographic characteristics and the quality of life in schizophrenia.[8] However, a statistically significant association was found between marital status and the social relationships domain ($p = 0.022$),


ISSN (O): 2687-5365; ISSN (P): 2753-6556

indicating that married individuals had better social relationship scores compared to others. People with schizophrenia usually have problems in maintaining relationships, primarily because of their psychopathological symptoms. Other causes include low self-esteem and an inability to maintain intimate relationships. Additionally, psychotropic drugs may lead to decreased libido or impotency. While a limited social life and related stigmatisation may also be responsible for a lack of relationships, a few studies, such as the one by Skantze et.al., did not find any correlation between these factors.[11] Additionally, socioeconomic status showed a significant association with the psychological domain ($p = 0.017$), though the overall association is not significant, suggesting that psychological well-being varied across different economic groups. Meher A.C. et al. found that higher socio-economic status led to better quality of life, and this is corroborated by other studies as well.[8,12] Although not statistically significant, higher mean scores in overall quality of life were observed among individuals aged 31–40 years, females, married participants, Muslims, those with primary education, unemployed individuals, those belonging to lower socioeconomic status, and participants from joint families. Overall, these findings indicate that while most socio-demographic variables did not significantly influence quality of life, certain factors like marital status and socioeconomic status play an important role in specific domains. There have been conflicting reports regarding the QoL differences between males and females with schizophrenia. Many studies have found that males are more predisposed to a poor QoL associated with schizophrenia as compared to females.[13] However, some have reported a better QoL in males, and some other studies have reported no significant difference between the genders.[14,15] Occupational activity has an influence on the QoL in patients with schizophrenia. Previous evidence suggests that patients who were employed showed a better QoL, especially in the physical and psychological domains of QoL.[11,16] However, it is also to be noted that many patients have challenges in finding employment despite a stable health status. This is probably due to other factors influencing employability, such as side effects of neuroleptics and frequent hospitalisations, and most importantly, stigma.[17,18]

Family Functionality and its association with Socio-demographic variables: The total family functionality score was $29.34 \pm 4.48$, indicating an overall moderate level of family functioning. Expressing feelings ($7.52 \pm 1.59$) and confiding in each other ($7.53 \pm 1.11$) showed the highest mean scores, reflecting positive interpersonal dynamics within families. Studies have shown that communication patterns in families with a schizophrenic member are often marked by high levels of criticism and hostility, which can exacerbate symptoms and hinder recovery.[19] Decision making ($4.95 \pm 1.02$) and acceptance ($4.36 \pm 1.10$) showed relatively higher mean scores, indicating better functioning in these areas. However, lower mean scores were observed in family activities ($2.60 \pm 0.78$) and family support ($2.38 \pm 0.61$), suggesting weaker engagement and support systems. Research suggests that family members often struggle to maintain clear and supportive roles, leading to increased stress and burden.[20] Affective responsiveness is crucial for emotional support, and its deficiency can lead to a lack of empathy and understanding within the family, further isolating the individual with schizophrenia.[21] Research consistently shows that families of individuals with schizophrenia face numerous challenges that impact their functioning. For instance, a study by Magliano et al. found that family burden is high in schizophrenia, with many family members experiencing significant emotional distress, social isolation, and financial strain.[22] Additionally, psychoeducational interventions have been shown to improve family functioning by enhancing communication skills, problem-solving abilities, and emotional support.[23]

A statistically significant association was observed between gender and family functionality, particularly in family activities ($p = 0.004$), confiding in each other ($p = 0.026$), and overall family functionality ($p = 0.039$), with males showing higher mean scores compared to females. Education was also significantly associated with family activities ($p = 0.023$) and expressing feelings ($p = 0.018$), indicating that these aspects of family functioning vary with educational level. Additionally, the type of family showed significant associations with expressing feelings ($p = 0.001$), family support ($p = 0.014$), and overall family functionality ($p = 0.010$), suggesting better functioning in certain family types. No significant associations were found with age, marital status, occupation, or socioeconomic status across most domains. A borderline significant association was observed between religion and acceptance ($p = 0.050$). Overall, these findings indicate that gender, education, and type of family play an important role in influencing different dimensions of family functionality.

## CONCLUSION

Most participants in the study were females, married, unemployed, and living in nuclear families. The overall quality of life among respondents was moderate, with the lowest scores seen in the social relationships domain. While no significant association was found between overall quality of life and sociodemographic factors, marital status was significantly associated with social relationships, and socioeconomic status with the psychological domain. This highlights the importance of family support and financial stability in managing Schizophrenia. Family functioning was also found to be moderate, with lower scores in family activities and support. Significant associations between gender, education, and type of family with family functioning suggest


ISSN (O): 2687-5365; ISSN (P): 2753-6556

that schizophrenia affects family dynamics differently, emphasising the need for targeted psychosocial interventions to improve support, communication, and overall well-being.

**Limitations**

1. This was a cross-sectional study conducted at a single centre over a brief period with limited resources. A prospective follow-up study would yield better information about the quality of life and family functioning, thus adding to the existing literature and assisting in relevant measures to be taken.
2. The study represents only a small sample of India's large population and hence cannot be generalised to the entire population.
3. Future research with a larger and randomly drawn sample from the multiple centres may validate or challenge these findings.

## REFERENCES


1. World Health Organisation. (2022). Schizophrenia fact sheet.
2. Addington, D., & Addington, J. (1999). Neurocognitive and social functioning in schizophrenia. Schizophrenia Bulletin, 25(1), 173–182.
3. World Health Organization. (1996). WHOQOL-BREF: Introduction, Administration, Scoring and Generic Version of the Assessment. Geneva: WHO.
4. Awad, A. G., & Voruganti, L. N. (2000). Intervention research in psychosis: Issues related to the assessment of quality of life. Schizophrenia Bulletin, 26(3), 557–564.
5. Kuyken, W., Orley, J., Hudelson, P., & Sartorius, N. (1994). Quality of life assessment across cultures. Social Psychiatry and Psychiatric Epidemiology, 29(5), 198–205=-0 98
6. Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. Journal of Marital and Family Therapy, 9(2), 171–180.
7. Test, M. A., & Stein, L. I. (1976). Practical guidelines for the community treatment of markedly impaired patients. Community Mental Health Journal, 12(1), 72–82.
8. Meher, A. C., Satpathy, S., Supakar, S., & Pradhan, P. C. (2022). Quality of life in patients with schizophrenia: A hospital-based cross-sectional survey from South Odisha. International Journal of Health Sciences, 6(S5), 1732–1738. https://doi.org/10.53730/ijhs.v6nS5.9041
9. Górna K, Jaracz K, Rybakowski F, Rybakowski J. Determinants of objective and subjective quality of life in first-time-admission schizophrenic patients in Poland a longituinal study. Qual Life Res. 2008;17:237–47.
10. Xiang YT, Weng YZ, Ch-M L, Tang WK, Ungvari GS. Subjective quality of life in outpatients with schizophrenia in Hong Kong and Beijing: relationship to socio-demographic and clinical factors. Qual Life Res. 2008;17:27–36.
11. Skantze K, Malm U, Dencker S, May P, Corrigan P. Comparison of quality of life with standard of living in schizophrenic outpatients. Br J Psychiatry. 1992;161:797–801.
12. Cardoso CS, Caiaffa WT, Bandeiro M, Siqueira AR, Silva-Abreu MN, Penido Fonesca JO. Factors associated with low quality of life in schizophrenia. Cad Saude Publica. 2005;21(5):1338–48.
13. Caron J, Lecomte Y, Stip E, Renaud S. Predictors of quality of life in schizophrenia. Commun Ment Health J. 2005;41(4):399–417.
14. Jarema M. The study of quality of life as an alternative form of evaluation. New Med. in Polish;3:15–6.
15. Dimitriou P, Anthony D, Dyson S. Quality of life for patients with schizophrenia living in the community in Greece. J Psychiatr Ment Health Nurs. 2009;16:546–52.
16. Chan S, Yu IW. Quality of life of clients with schizophrenia. Issues and Innovations in nursing practice. J Adv Nurs. 2004;45(1):72–83.
17. Wyatt RJ. Neuroleptics and the natural course of schizophrenia. Schizophr Bull. 1997;23:3–9.
18. Chan S, Cheng BS. Creating positive attitudes, the effects of knowledge and clinical experience of psychiatry in student nurse education. Nurse Educ Today. 2001;21:434–43.
19. Sullivan AE, Miklowitz DJ. Family functioning among adolescents with bipolar disorder. J Fam Psychol. 2010;24(1):60-7. doi: 10.1037/a0018183.
20. Smith J, Birchwood M. Schizophrenia and the family: burden, risk factors, and intervention. Int 2010;22(2):142-9.
21. Hesse K, Klingberg S. Examining the cognitive model of caregiving–a structural equation modelling approach. Psychiatry Research. 2014;217(3):171-6.
22. Magliano L, Fiorillo A, Malangone C, De Rosa C, Maj M; National Mental Health Project Working Group. Patient functioning and family burden in a controlled, real-world trial of family psychoeducation for schizophrenia. Psychiatr Serv. 2006;57(12):1784-91.
23. Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. Cochrane Database Syst Rev. 2010;(12). doi: 10.1002/14651858.CD000088.pub3




ISSN (O): 2687-5365; ISSN (P): 2753-6556