

Assessment of Social Support of Patients with psychological Schizophrenia at Saudi Arabia

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Abstract:

Background:

Over the past few decades, healthcare services in Saudi Arabia have significantly improved; nevertheless, this has also presented issues for stakeholders, highlighting the need to raise the standard of healthcare. . Schizophrenia is a chronic illness that affects a patient's social interactions and relationships. Patients with schizophrenia often lament their lack of social support, which is a major contributing element to their prognosis. The purpose of this study was to evaluate social support in individuals suffering from schizophrenia. Methods: A convenience sample of 300 patients with a diagnosis of schizophrenia disorder from the inpatient and outpatient psychiatric departments of A cross-sectional questionnaire-based study surveyed 300 patients from outpatient clinics of PWS in two large psychiatric hospitals in Saudi Arabia's eastern province using a convenience sampling approach. were included in the study, which was conducted using a descriptive search strategy. A multidimensional measure of perceived social support and a sociodemographic and clinical characteristics sheet were used to gather data.-The study's findings showed that the majority of participants (89.5%) had low to moderate levels of social support. Social relationships and social support were positively correlated in a statistically significant way. **Conclusion:** Improving social support is advised when caring for people with schizophrenia since it has a significant impact on their prognosis and ability to recover. The useful and essential role of social support requires more research.

Key words: *social support, social relationships, and schizophrenia.*

Introduction:

Over the past few decades, healthcare services in Saudi Arabia have significantly improved; nevertheless, this has also presented issues for stakeholders, highlighting the need to raise the standard of healthcare. Increasing demands on healthcare services, rising prices, shifting disease patterns, a lack of a national health information system, and staff shortages are some of these difficulties. a large number of pilgrims each year; a shortage of local healthcare professionals; an increase in medical blunders; and lengthy wait times (Almalki et al. 2011; Qureshi 2010; Qureshi et al. 2013). In order to raise the standard of mental healthcare services in Saudi Arabia, the Ministry of Health (MOH) has stepped up its efforts, primarily through the creation of health

programs and policies. To the best of the author's knowledge, however, no additional research has been done on the standard of mental health services in Saudi Arabia.

The Saudi government today considers mental health to be a significant area of healthcare. A number of basic healthcare centers (PHCs) and specialty hospitals have been created in the Kingdom in an effort to increase access to mental health services for the Saudi populace (Ministry of Health, 2016). In order to address the requirements of mental health service users nationwide, the Saudi government established the General Department for Mental and Social Health (GDMSH) in Riyadh in 1983 as the first step in this direction (Ministry of Health 2017).

Accordingly, the GDMSH approved the First National Strategic Plan for enhancing and growing psychiatric services in Saudi Arabia, emphasizing the development of both skilled personnel and contemporary infrastructure, as well as raising the standard and accessibility of mental health care across the country (Al Habeeb & Qureshi 2010). Furthermore, the GDMSH protects service users' rights while providing all facets of professional mental health care, including PHCs and specialized therapeutic treatments. Psychosocial difficulties, such as deficits in interpersonal interactions, independent living, and working skills, are frequently linked to schizophrenia, a severe and incapacitating condition (Hoertnaglet et al., 2020). There are numerous variables that might either raise or lower the risk of schizophrenia. These elements include a person's sense of social support, which has a significant impact on treatment readiness (Gross, Vancampfort, Stubbs, Gorczynski & Soundy, 2016).

According to Zhang, Zhang, Yang, and Li (2017), social support is typically defined as mental and physical help and support from a variety of social groups, such as parents, relatives, and friends. In addition to actual support, which includes helpful behaviors, social support can also be defined as perceived support, which includes the perceived ease and accessibility of sympathetic relationships (Morin, Dhir, Mitchell & Jones, 2017). Social support has been acknowledged by the World Health Organization as a significant factor in both mental and physical health (WHO, 2016). It has been discovered that social support plays a significant role in assisting people with mental illness in managing the strains of life and sickness. Better social ties and social support are regarded as fundamental components of psychosocial treatment (Priebe, Omer, Giacco, & Slade, 2014; Huang, Sousa, Tsai & Hwang, 2008).

Numerous benefits of high levels of social support for individuals with schizophrenia, including reduced mortality and morbidity, improved social functioning, and medication adherence, have been shown in an expanding body of research (Norman, Manchanda, Northcott, Harricharan, & Windellet, 2012).

It is widely accepted that a lack of support from friends or family reduces quality of life and increases the likelihood of drug addiction (Lu, Wen, Deng, & Tang, 2017). Reduced social activity and a diminished desire to form intimate relationships are strongly correlated with a lack of social support. For example, a person may experience social isolation due to persecutory delusions or inadequate social skills (Ahmed et al., 2019).

Aim of the study:

The purpose of this research is to evaluate the level of social support that individuals with schizophrenia receive.

Subjects and method:

Study design:

A descriptive, cross-sectional research design was used in this study.

Setting:

A post hoc power analysis was performed using G*Power 3.1.9.6 [22] to ascertain the smallest sample size necessary to test the study hypotheses. In our investigation, $N = 180$ ($f = 0.25$) was the sample size required to obtain 80% power for detecting a medium effect at a significance level of $p = 0.05$. 216 (63% response rate) of the 340 family caregivers we contacted responded. Consequently, the acquired sample size of $N = 216$ is sufficient to test the research hypotheses. Participants were chosen at from the King Fahad Hospital of University's psychiatry outpatient clinics in Eradah and Khobar, Saudi Arabia. Mental Health Complex, a community mental health hospital in Dammam

The 300 patients in the sample met the requirements listed below. Qualifications for inclusion; All patients with schizophrenia based on their medical records and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria.; . Patients in at least the second episode.;. The age range is 18–5.;. Both men and women;5. Able to communicate.

Tools:

Two tools were utilized to collect data in this study:

Tool 1: Clinical and sociodemographic characteristics sheet

The researchers created this sheet by analyzing recent related literature and covering clinical data and sociodemographic features, such as the following: Sociodemographic information includes the patient's age, sex, marital status, occupation, education, place of residence, and person they live with. Age at commencement of schizophrenia, family history, length of disease, hallucinations, delusions, emotional support, social relationships, hygiene, food habits, and sleep disturbance are examples of clinical data. (El-Bilsha, 2019).

Multidimensional Scale of Perceived Social Support (MSPSS)

Zimet, Dahlem, Zimet, and Farley (1988) created this scale. Family, Friends, and Significant Others are the three subscales of the short 12-item, self-administered MSPSS. A seven-point Likert scale, with 1 denoting "very strongly disagree" and 7 denoting "very strongly agree," is used for each item. Merhi and Kazarian (2012) translated and verified the scale into Arabic. For the entire sample, the internal consistency of the family, friends, and important other social support systems was good ($\alpha = 0.82$, $\alpha = 0.86$, and $\alpha = 0.85$, respectively). Age at commencement of schizophrenia, family history, length of disease, hallucinations, delusions, emotional support, social relationships, hygiene, food habits, and sleep disturbance are examples of clinical data. (El-Bilsha, 2019).

We translated the original English AC-QoL scale into Arabic using the techniques Sousa et al. [24] had used. Initially, the AC-QoL was translated into Arabic by two bilingual and bicultural translators. Both translators were knowledgeable in cultural and linguistic variances, medical terminology, and instrument construction. The directions, responses, and items on the questionnaire were all translated. A committee integrated two translated versions into one Arabic version (synthesis I).

Two multilingual, bicultural translators translated the Arabic questionnaire back into English. A committee reviewed each version of the questionnaire after resolving any ambiguities or contradictions, and they decided on the prefinal version (synthesis II). Twenty people who weren't involved in the study were used to test the initial version. After analyzing the findings and correcting any lingering problems, the Arabic AC-QoL scale was finalized. The Arabic scale was highly reliable (0.93, overall scale), whereas the original English scale had a Cronbach's α coefficient of 0.94.

2.3. Statistical Analysis

For all data analysis, SPSS version 29 (IBM Corp., Armonk, New York) was utilized. Descriptive and inferential statistics, among others, were employed. The standard deviation (SD) and means

were used to summarize continuous variables. Frequencies and percentages were used to characterize categorical variables. While the sociodemographic data was considered an independent variable, the AC-QoL scores were considered a continuous dependent variable. We used the Kolmogorov-Smirnov test to examine the distribution of the research variables. Independent sample t-tests for two independent variables were used to compare the means of AC-QoL. A one-way analysis of variance (ANOVA) was employed to examine differences in mean AC-QoL scores with respect to other demographic characteristics for more than three independent variables. Since each group had a roughly normal distribution, we utilized ANOVA to compare sample averages and assess statistical significance. The AC-QoL total score is added to the "dependent" list when an ANOVA is performed. The "factor" list was expanded to include all additional factors as independent variables. For example, variables like the degree of caring and the patient connection were regarded as independent. SPSS was used for the computation. The sum of squares, degree of freedom, mean square, F, and level of significance were among the outcomes of the ANOVA test. The variability within and between groups is compared using the F statistic. The formula $F = \text{Variance between groups} / \text{Variance within groups}$ was used to compute the F-statistics. In every test, a P-value of less than 0.05 was regarded as statistically significant. In order to determine significance, SPSS compares the computed F-statistic to the F-distribution's crucial F-value at a certain significance level (e.g., $\alpha = 0.05$). Reject the null hypothesis and draw the conclusion that there are significant differences between the group means if the p-value is less than the designated significance level. Finding out if caregiver load and QoL are related among FCGs of PwS was the hypothesis. The alternative hypothesis contends that there is a relationship between the two variables, while the null hypothesis maintains that there is none.

All of the study's methods were accepted as ethical by the Institutional Review Board of Imam Abdulrahman Bin Faisal University (IRB-2023-01-118). Prior to answering any questions, each participant electronically completed a consent form.

Results:

according to Table 1, the study sample's mean $\pm$ SD was 33.76 ± 9.210 years, with ages ranging from 18 to 55. The age group of 30-55 years comprised more than half (62.5%) of the sample. Males made up 82.5% of the study's participants. Despite the fact that 14% of patients were illiterate, over one-third (42.0%) of patients had secondary, diploma, and technical education. In terms of marital status, 60.5% were unmarried. 44.5% of them were not working. The survey found that 80.0% of the participants were Saadian. Just 6% of the patients lived alone, whereas over two-thirds (69%) shared a home with their parents.

Table (1) Socio-demographic characteristics of schizophrenic patients (N= 200)

	N (300)	100%
Socio-demographic Characteristics		
Age (year)		
< 20	8	2.5%
20-< 30	105	35%
30-55	187	62.5%
Mean$\pm$SD	33.76 $\pm$ 9.210	
Sex		
Male	252	82.5%
Female	48	17.5%
Education		
Illiterate	42	14.0%

Read and write, primary, preparatory	85	31.5%
Secondary, diplome, technical	126	42.0%
Academic, higher education	37	12.0%
Marital status		
Single	180	60.5%
Married	64	18.0%
Divorced/Widow/Separated	64	21.5%
Occupation		
Not work	135	44.5%
Housewife	45	16.5%
Manual worker	106	36.5%
Governmental employee	8	2.5%
Residence		
Non- Saudi	60	20.0%
Saudi	240	80.0%
Live with whom		
Alone	18	6.0%
Mother or father	208	69.0%
Wife or husband	48	16.5%
Brothers or sisters	26	8.5%

More over half of the sample (58%) had schizophrenia that began between the ages of 20 and 30, and more than a quarter of the sample (26.5%) had schizophrenia that began before the age of 20. While 16.5% of the sample had a family history of mental illness, the majority of the sample (83.5%) reported no family history of mental disease. In terms of sickness duration, 39.5 percent of the patients in the study had been unwell for 1–5 years, and 38 percent had been ill for more than 10 years. Auditory hallucinations affected 46% of the patients. While over one quarter (24%) of the patients reported having delusions of persecution, more than two thirds (69.5%) of the patients said they had no delusions.

Table (2) Clinical Data of Schizophrenic Patients (N= 200)

Clinical data (Patient history) N (200)		
100%		
Age onset of schizophrenia		
Less than 20 years	70	26.5%
20-30 years	166	58.0%
More than 30 years	51	15.5%
Duration of illness		
Less than one year	4	1.0%
1-5year	96	39.5%
5-10 year	64	21.5%
More than 10 years	108	38.0%
Family history of Psychiatric illness		
No	267	83.5%
Yes	33	16.5%
Hallucinations		

No	116	43.0%
Yes	184	57%
If yes:		
Auditory	112	46.0%
Visual	18	6.0%
Auditory and visual	15	5.0%
No	169	69.5%
Yes	85	30.5%
If yes:		
Persecution	68	24.0%
Grandeur/Somatic/Erotic	23	6.5%

Over one-third of the patients (37%) require assistance and disregard personal hygiene, according to table (3). The majority of the sample under study (87.5%) said they eat alone, but 5.5% of patients suffer from anorexia and 4.5% refuse to eat. The majority of the sample (76%) said they had no sleep disturbances, although almost a quarter (22.5%) had trouble falling asleep. The moms and fathers of almost half of the patients (53%) provide them with emotional support. In terms of social relationships, 50.5% of the patients in the study don't start or keep relationships with other people.

Table (3) Clinical Data of schizophrenic Patients (N= 200)

Clinical data (physical and social characteristics) N (200) 100 %	%
Personal hygiene	
Neglected	7.0%
With assistance	30.0%
Alone	63.0%
Eating pattern of patient	
Refuse to eat	4.5%
Anorexia	5.5%
Eat with assistance	1.0%
Eat by himself	87.5%
Eat and ask for more	1.5%
Sleep disturbance	
No sleep disturbance	76.0%
Difficulty in the beginning of sleep	22.5%
Difficulty in continuity of sleep	1.0%
Wake up early and can't continue sleep	.5%
Emotional support	
None	12.5%
Mother or father	53.0%
Wife or husband	7.0%
Sisters or brothers	19.0%
Son or daughter	8.5%
Social relationship	

Neither initiate nor maintain relation with others	50.5%
Not initiate but maintain relation with others	26.0%
Initiate but not maintain relation with others	1.0%
Initiate and maintain relation with others	22.5%

More than half (61%) of the participants in the study reported moderate levels of overall social support, whereas 28.5% had poor levels, according to Table (4). The majority of the sample (78%) exhibited low levels of social support from significant people in terms of social support subdomains. This was followed by the fact that over half of the sample (54.5%) had little friend support. However, 71% of the participants reported having strong familial social support.

Table(4) Frequency distribution of Social support among schizophrenic patients according to multidimensional scale of perceived social support (MSPSS) scale and subscale

Social support (MSPSS) scale and subscale Frequency %	
Total social support	
Low	28.5
Moderate	61.0
High	10.5
Social support subdomains	
Social support by significant others	
Low	78.0
Moderate	5.5
High	16.5
Social support by family	
Low	14.0
Moderate	15.0
High	71.0
Social support by Friend	
Low	54.5
Moderate	30.0
High	15.5

Table 5 demonstrates a substantial positive connection ($r=.150$, $p=.034$) between the social support and social relationships of individuals with schizophrenia. Social support and the other clinical and sociodemographic factors, however, did not significantly correlate.

Table (5) Correlation between socio-demographic & clinical characteristics of the schizophrenic patients and social support Socio-demographic & clinical

	Social support	
characteristics	Pearson correlation(r)	Sig.(p)
Sex	-.115	.105
Marital status	-.118	.096

Occupation	.044	.535
Age at onset of disorder	.059	.407
Personal hygiene	.094	.186
Eating pattern	.074	.295
Social relationship .	150*	.034
Sleep disturbance	-.116	.102

Discussion: The study's main conclusions show that PwS's FCGs have a moderate quality of life. In terms of financial resources and medical professional support, they received the lowest scores on the AC-QoL scale. On the other hand, FCGs fared well on QoL tests that evaluated stress and happiness with caregiving. QoL was negatively impacted by the length of time spent providing care, the caregiver's educational background, PwS's clinical instability, and recent inpatient unit hospitalizations. The purpose of the current study was to evaluate social support in individuals with schizophrenia. According to a recent systematic analysis, moderate-to-severe carer burden is linked to chronic mental diseases, especially schizophrenia [26]. In line with the results of other studies, our participants reported a moderate financial burden [12, 28, 29].

Indirect expenses like rent, mortgages, groceries, and transportation, as well as direct expenses like prescription drugs and doctor's visits, usually add to the financial strain. Since we sourced participants from government facilities that provide free care, the financial impact is most likely the result of indirect expenditures. Many of those individuals will lose the capacity to take care of themselves or even work because schizophrenia usually first manifests in infancy. The features of the patients in this study showed that over half of the sample as a whole was in the 30- to 55-year-old age range. The long-term and chronic nature of schizophrenia disease may be the cause of this outcome. This outcome was consistent with the findings of Hamed, El-Bilsha, El-Atroni, and El Gilany (2014), who found that over half of the patients were between the ages of 30 and 50.

According to our observations, persons working in government and healthcare typically hold low-paying positions because they are either underproductive or lack a college degree. One factor contributing to these families' extreme financial difficulties is the absence of government support. According to a comprehensive review conducted across several European nations, the average percentage of indirect costs in overall expenditures was 44% [30]. According to a study conducted on 404 patients across five European nations, family members' top concerns were the patient's health as well as their own prospects and financial situation [31].

We discovered that caregivers were not happy with the practical and emotional assistance that medical staff offered. This research emphasizes how crucial psychological and educational treatments are in giving FCGs the tools they need to help someone with schizophrenia. To ensure their well-being, FCG of PwS needs both official and informal help from friends, family, the government, and medical experts. To provide PwS and their caregivers (social workers, psychologists, occupational therapists, and psychiatrists) the best treatment possible, a multidisciplinary approach is required. Local community resources like the Schizophrenia Society and support organizations can help raise the caliber of caregivers. The mental healthcare system should give FCGs' needs top priority in order to improve the standard of care for these patients who suffer from serious mental diseases like schizophrenia. Additionally, they ought to have access to services like respite care, which allows caregivers to take a brief vacation from their duties. A devastating mental condition, schizophrenia causes a great deal of emotional and financial strain on the patient's family.

In terms of hallucinations, this study found that over 50% of the sample experienced them, most often auditory hallucinations. This outcome could be the result of pharmaceutical non-adherence, which can exacerbate positive symptoms like hallucinations and make it harder for patients to regulate them. This outcome was consistent with Sayied and Ahmed's (2017) research conducted in Egypt. Furthermore, El Ashry and Abdel Al (2015) showed that auditory hallucinations were present in over 50% of patients with schizophrenia.

In terms of personal hygiene, this study showed that over one-third of the sample either did not practice personal hygiene or did so with help. This outcome might be the result of unpleasant symptoms and a decrease in daily living activities, such as poor personal cleanliness, in people with schizophrenia. This outcome was in line with a 2019 study conducted in Egypt by El-Bilsha, which found that over 50% of people with schizophrenia disregard their personal cleanliness. Furthermore, a study conducted in 2020 by Al-Maghraby, El-Bilsha, and El-Hadidy found that almost one-third of patients disregard personal cleanliness. According to the current study, 11% of eating patterns include food refusal, anorexia, and eating with assistance. This finding could be because nearly 25% of the sample believed they were being persecuted and refused to eat because they thought the food was tainted, or it could be because they no longer enjoyed eating and were avolitionists.

This outcome was consistent with El-Bilsha's (2019) findings. Furthermore, Al-Maghraby et al. (2020) found that almost one-third of the individuals with schizophrenia refused to eat. According to this study, the majority of the sample exhibited social relationship impairments; half of them did not establish or maintain social relationships with others. This finding suggests that schizophrenia patients' constant preoccupation with hallucinations, persecutory delusions, and speech impairments make it difficult for them to engage with others. A study by Koenders, de Mooij, Dekker, and Kikkert (2017) found that patients with severe mental illness are less satisfied with their interpersonal relationships, which was consistent with this finding.

According to the current study, 28.5% of patients had low total social support, whereas over half of the sample had moderate total social support. This outcome could be explained by the fact that schizophrenia patients frequently experience feelings of unlove and unhappiness as a result of delusions and hallucinations. Lack of social support can also result from behavioral and emotional disengagement as well as social stigma.

this finding is in line with a 2019 study by Mekonen, Boru, Yohannis, Abebaw, and Birhanu in Ethiopia, which found that 21.5% of patients had low perceived social support while over half of the patients had medium perceived social support. Furthermore, this finding was consistent with a study by Chronster, Chou, and Liao (2013) that demonstrated a low level of overall social support. Furthermore, just half of the schizophrenia patients in an Egyptian study by Eweida, Maximos, and Sharif (2017) received social assistance. On the other hand, a study conducted in Malaysia by Shin et al. (2020) found that the average score for perceived social support was high. This discrepancy in results could be interpreted as a result of the sample or study context.

This study found that over half of patients had low social support from friends, and the majority of the sample had low social support from significant others as well. This finding could mean that friends and family of people with schizophrenia avoid frequent contact and support because they see patients as a burden. Furthermore, because they mostly depend on the social and emotional support of their family members, particularly their parents, people with schizophrenia were unable to maintain relationships with friends and significant others.

This outcome was consistent with the Harfush & Gemeay (2017) study conducted in Egypt. Additionally, this finding was supported by a study conducted in Malaysia by Munikanan et al.

(2017), which found that 72% of respondents had little perceived social support, with friends and family providing the least amount of assistance. This outcome was likewise in line with Hasan and Tumah's (2019) findings. However, a study conducted in Jordan by Hamaideh, Al-Magaireh, ABU-Farsakh, and Al-Omari (2014) contradicted the findings of the current study and found that significant others were the greatest source of social support that Jordanian patients with schizophrenia perceived, followed by family members and friends.

The current study showed that over two-thirds of the group under investigation had strong familial social support. This finding may be explained by the fact that the majority of mentally ill persons in poor nations like Egypt reside with their families, which accounts for the higher degree of social care that families provide. This finding was consistent with that of Caqueo-Úrizar et al. (2015), who noted that family members provided strong social support for individuals with schizophrenia. Similarly, El-Monshed & Amr (2020) found that family social support was more common than that of friends and significant others.

The current study demonstrated a substantial positive association between social support and social relationships. This finding suggests that schizophrenia disease negatively affects patients' personalities and that frequent hospital stays prevent social interaction and participation with friends and family, which erodes social support. This finding was linked to Millier et al. (2014), who declared that social support and social relationships had a substantial positive association.

Conclusion: The majority of the people under investigation have low to moderate levels of social support, according to the results of the current study. To the best of our knowledge, despite its limitations, this is the first study to examine caregiver burden and quality of life among PwS caregivers. The QoL of our subjects was moderate at best. Low support from medical experts and a moderate financial burden were observed by carers.

QoL was negatively impacted by the caregiver's educational background, recent hospitalization, and the number of hours spent providing care. Doctors should ask about the caregivers' network of support and encourage family members to share tasks, particularly for those who give care for more than 12 hours a day. Furthermore, as they are more likely to have a lower quality of life, those who have just been released from an inpatient unit should be given priority for additional psychosocial support.

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