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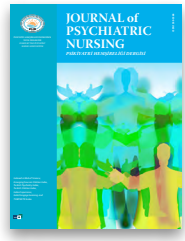

Original Article

The relationship between insight and quality of life in patients with schizophrenia

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Abstract

Objectives: The study was conducted to determine the relationship between insight and quality of life levels of individuals diagnosed with schizophrenia.

Methods: The data of this descriptive and correlational study were collected at a community mental health center (CMHC) in a province located in the Black Sea Region of Türkiye between February 2021 and July 2021. The population of the study consisted of 224 patients who were registered to the CMHC and diagnosed with schizophrenia according to DSM-V diagnostic criteria between the specified dates. According to the sample calculation for a known population, the minimum number of people to be included in the sample was calculated as 141 (confidence interval: 95%, margin of error: 5%). However, considering the possibility of withdrawals and/or losses during the study, we decided to include more people. Thus, the study was completed with 148 patients who volunteered to participate in the study and met the inclusion criteria. The three tools used to collect the data were the "Sociodemographic Data Form" prepared by the researcher, "Birchwood Insight Scale (BIS)," and "Quality of Life Scale for Patients with Schizophrenia (QLSPS)." Data were analyzed using the Statistical Program for the Social Sciences 22. In the analysis of the data, the Shapiro–Wilk test was used to determine whether the data were normally distributed. In the analysis of the data, numbers, arithmetic mean, percentile distributions, and standard deviation were used. While Pearson's correlation analysis was used to determine the relationship between the scales, the Cronbach's alpha coefficient was used to calculate the reliability coefficients of the scales.

Results: According to the study findings, the mean scores the patients obtained from the overall BIS and the QLSPS were 4.16±1.63 and 76.93±14.84, respectively. According to the analysis of the relationship between the sub-dimensions of the BIS and the sub-dimensions of the QLSPS, there was a negative and weak correlation between the mean scores obtained from the overall BIS and its Being Aware of the Symptoms and Being Aware of the Disease sub-dimensions and the mean scores obtained from the overall QLSPS and its interpersonal relationships sub-dimension. There was a negative, significant, and weak correlation between the mean score for the overall BIS and the mean scores for the occupational role, daily use of belongings, and activities sub-dimensions of the QLSPS ($p<0.05$).

Conclusion: The patients had a low level of insight and a high level of quality of life. A relationship was determined between the mean scores the participants obtained from the BIS and the mean scores that they obtained from the QLSPS.

Keywords: Insight; nursing; quality of life; schizophrenia.

Schizophrenia is a chronic disorder that progresses with impairments in thought, cognition, and affect, with remissions and relapses.[1] It is a mental health problem that progresses with severe disability and can affect individuals in various socioeconomic classes all over the world.[2,3] According to the data reported in existing epidemiological studies, the

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prevalence of schizophrenia in Europe ranges approximately between 0.6% and 0.8%.[4] According to the results of a study conducted in Türkiye, the lifetime prevalence of schizophrenia in the general population is around 1%.[5] The age at which the disease occurs is between 18 and 25 years of age for men and between 25 and 35 years of age for women.[6,7] Its symptoms, course, and outcomes vary from patient to patient and over time. The disease is always severe and requires treatment.[8] The main treatment of schizophrenia is the use of psychotropic drugs.[6] Medications used for treatment are aimed at preventing active disease symptoms.[6,7] Recently, in addition to psychopharmacotherapy, personalized therapies, psychosocial interventions, and educational programs have been included in the treatment of schizophrenia.[6] One of the important issues in the participation of patients in the treatment of schizophrenia is patients' having insight.[9] In her study conducted with patients with schizophrenia in Türkiye,[10] Gökdam reported that there was a positive relationship between the insight levels of patients diagnosed with schizophrenia and their treatment compliance levels.

As was reported by David,[11] Aubrey Lewis defined insight as "the individual's developing an accurate behavior toward morbid changes in himself or herself and realizing that the disease is mental".[12,13] In patients with schizophrenia, the patient's being aware of not only the disease but also the symptoms brought about by the disease, need for treatment, and social losses due to the disease is called insight.[2,14,15] Dankı et al.[14] stated that 50–80% of patients with schizophrenia had low insight levels.[14] Aslan et al.[2] emphasized that the low level of insight was a problem observed in most patients with schizophrenia. In another study, the low level of insight was associated with psychosocial dysfunction, poor quality of life, difficulty in compliance with treatment, and aggression.[13]

Patients with schizophrenia have difficulty in maintaining their individual roles due to factors such as cognitive and psychosocial deterioration, disability, repeated and long-term hospitalizations, drug side effects, level of income, and social isolation brought about by the disease.[16] They also have difficulty in meeting their own needs in situations where social interaction is required and experience social losses, which, though indirectly, decreases the quality of life of patients.[17] The World Health Organization (WHO)[18] defines the quality of life as "the individual's way of perceiving his/her life situation, consisting of his or her goals, expectations, standards, and concerns, within his or her culture and value systems."[18,19]

The patient's activities of daily living, interpersonal relationships, individual achievements, and feeling of well-being constitute the quality of life.[20,21] Quality of life is based on the individual's fulfilling activities of daily living and his or her functions.[22] Patients whose quality of life is low experience many problems such as introversion, increased depressive symptoms and anxiety, decreased treatment compliance, and inability to cope.[22] Therefore, one of the aims in schizophrenia treatment is to improve the quality of life of patients.[17]

What is presently known on this subject?

- In the literature, it is reported that schizophrenia affects the quality of life of patients with schizophrenia and that there is a relationship between the levels of insight and quality of life.

What does this article add to the existing knowledge?

- The results of the study revealed that the insight level of the patients was low and their quality of life level was high, and there was a weak, negative, and significant relationship between the mean scores the patients with schizophrenia obtained from the Birchwood Insight Scale and Quality of Life Scale for patients with schizophrenia.

What are the implications for practice?

- Based on the results of this study, it is expected that determining the level of disease awareness of patients with low insight would facilitate the planning of the effectiveness of psychosocial rehabilitation to be implemented in community mental health centers on the patients treatment process and thus would contribute to the quality of life of patients. It is also expected that this study would provide guidance for psychiatric nurses so that they include approaches in rehabilitation plans to increase patients' insight and quality of life levels.

According to the results of the study conducted by Gökdam,[10] some of the patients with schizophrenia think that they undergo treatment not due to their own will, but due to thoughts of people in their close circle that they need support. Some other patients diagnosed with schizophrenia notice the symptoms, become disturbed by this situation, and thus, they accept that they need treatment.[17] However, they may not accept that it is a mental illness, and attribute the symptoms to another cause.[10,17] Therefore, insight and quality of life are among the important factors that should be taken into account in the treatment of schizophrenia.[23]

Psychiatric nurses are health professionals who care about the patient from a biopsychosocial perspective, give the patient the care he or she needs, and positively affect the course of the treatment.[23] Psychiatric nurses, who are in constant contact with patients, take appropriate initiatives using their professional skills and equipment to help patients become aware of and cope with their disease, to increase the duration of their well-being, and to improve the quality of life of patients and their relatives during the treatment of individuals diagnosed with schizophrenia.[23,24]

Insight levels of patients with schizophrenia are thought to affect their quality of life. The review of the literature demonstrated that the number of studies in which the relationship between insight and quality of life in individuals diagnosed with schizophrenia was revealed is not many. In line with the results of the present study, it is expected that determining the level of insight in patients with schizophrenia will change the course of treatment of the disease positively, contribute to the quality of life of patients, and provide guidance for psychiatric nurses so that they could include approaches that increase insight and quality of life of patients in their

treatment plans. The present study was conducted to determine the relationship between insight and quality of life levels of individuals diagnosed with schizophrenia, hoping that it would contribute to the literature. The study was conducted in accordance with the Declaration of Helsinki.

Research Questions

In the study, answers to the following questions were sought:

- What is the insight level of patients with schizophrenia?
- What is the quality of life level of patients with schizophrenia?
- Is there a relationship between the insight levels of patients with schizophrenia and their quality of life levels?

Materials and Method

Type of the Study

The study is a descriptive and correlational study.

Study Variables

Independent Variable

Sociodemographic characteristics of the participants.

Dependent Variables

Birchwood Insight Scale (BIS) and Quality of Life Scale for patients with schizophrenia (QLSPS).

Population and Sample of the Study

The present study was conducted between February 2021 and July 2021 at a Community Mental Health Center (CMHC) in a province in the Black Sea Region of Türkiye. The population of the study comprised 224 patients who were registered with the CMHC between the aforementioned dates and diagnosed with schizophrenia according to DSM-V diagnostic criteria. The minimum sample size was calculated as 141 patients using the formula for a known population. However, considering the possibility of withdrawals and/or losses during the study, we decided to include more people. Thus, the study was completed with 148 patients who volunteered to participate in the study and met the inclusion criteria.

Inclusion Criteria

The following criteria were included in the study:

- Being diagnosed with schizophrenia according to DSM-5 diagnostic criteria
- Being over 18 years old
- Volunteering to participate in the study
- Being able to communicate and collaborate
- Not having been diagnosed with a comorbid psychiatric diagnosis such as depression, personality disorder, and substance addiction.
- Being in the remission period (the period when the patient's treatment in the clinic is completed, active period symptoms are not observed and insight develops)
- Having no physical (speech, hearing impairment, etc.) or neurological disorders that would prevent the participant from being interviewed.

Data Collection Tools

Sociodemographic Data Form

The form prepared by the researcher consists of eight items questioning the respondents' age, sex, educational status, employment status, level of income, marital status, and a family history of schizophrenia or another psychotic disorder.[10,21]

BIS

The BIS was developed by Birchwood et al.[25] The validity and reliability study of the Turkish version of the BIS was performed by Sakarya in 1994.[26] The BIS is administered to assess whether the respondent is aware of the disease and the need for treatment and to what they attribute the symptoms of the disease. While Items 1 and 8 assess awareness of symptoms, Items 2 and 7 assess awareness of the disease, and Items 3, 4, 5, and 6 assess awareness of the need for treatment. Responses given to the items are rated on a three-point scale ranging from 0 to 2 points. The minimum and maximum possible scores that can be obtained from the BIS are 0 and 12, respectively. A score of ≥9 is considered as an indicator of good insight. In the present study, the Cronbach's alpha coefficient of the BIS was 0.69.

Quality of Life Scale for Schizophrenic Patients (QLSPS)

The QLSPS was developed by Heinrichs et al.[27] in 1984 to assess the quality of life of patients with schizophrenia receiving treatment. Soygür et al.[22] performed the validity and reliability study of the Turkish version of the QLSPS. The QLSPS consists of 21 items and the following four sub-dimensions: "interpersonal relationships," "occupational role," "psychological outcomes," and "daily use of belongings, and activities." Responses given to the items are rated on a seven-point scale ranging from 0 to 6.

Sub-dimensions

Interpersonal Relationships Sub-dimension

Items 1, 2, 3, 4, 5, 6, 7, and 8 are included in this sub-dimension. Minimum and maximum possible scores that can be obtained from this sub-dimension are 0 and 48, respectively.

Occupational Role Sub-dimension

Items 9, 10, 11, and 12 are included in this sub-dimension. Minimum and maximum possible scores that can be obtained from this sub-dimension are 0 and 24, respectively.

Psychological Outcomes Sub-dimension

Items 13, 14, 15, 16, 17, 20, and 21 are included in this sub-dimension. Minimum and maximum possible scores that can be obtained from this sub-dimension are 0 and 42, respectively.

Daily Use of Belongings, and Activities Sub-dimension

Items 19 and 20 are included in this sub-dimension. Minimum and maximum possible scores that can be obtained from this sub-dimension are 0 and 12, respectively.

The score that can be obtained from the overall QLSPS is calculated by summing the scores obtained from the four sub-dimensions. While the minimum possible score is 0, the maximum possible score is 126. The higher the score obtained from the scale is the higher the level of quality of life is. The Cronbach's alpha coefficient of the QLSPS was 0.99 in Soygür et al.'s study and 0.80 in the present study.

Collection and Analysis of the Data

The study data were collected from the participants by the researcher in private interview rooms using the face-to-face interview technique between February 2021 and July 2021. Before the interviews were held, necessary permissions to conduct the study were obtained. During the interviews, all safety precautions (wearing masks-gloves, using a pencil to fill in the forms, and complying with the distance rule) were taken to prevent infection risk since the study was conducted during the COVID-19 pandemic. The environment was ventilated after each meeting. Three forms were used in the study: The "Sociodemographic Data Form," "Birchwood Insight Scale" and "Quality of Life Scale for Patients with Schizophrenia." It took the participants approximately 15 min to respond to the Sociodemographic Data Form and questionnaires.

Ethical Issues

The present study was supported by the Atatürk University Scientific Research Projects Coordination Unit (Project Number: 2021–9202).

To conduct the study, ethics committee approval was obtained from the Faculty of Medicine Ethics Committee in a province located the Eastern Anatolia region of Türkiye (Number: B.30.2.ATA.0.01.00/10 Decision number: 60, Decision Date: December 17, 2020), and institutional permission was obtained from the center where the study was to be conducted (permission number: E-64247179-799). In addition, the participating patients were informed about the scope of the study, and their written consent indicating that they volunteered to participate in the study was obtained before they started to respond to the survey questions. To protect the privacy and security of the respondents, they were asked not to write their names and surnames in the data forms, and they were told that the data collected from them would be kept confidential and would not be disclosed to third parties.

Table 1. Distribution of the participants' descriptive characteristics (n=148)[10,21]

Characteristics	n	%
Age (years)		
18–28	12	8.1
29–39	33	22.3
40–50	59	39.9
51+	44	29.7
Sex		
Women	39	26.4
Men	109	73.6
Marital status		
Married	50	33.8
Single	98	66.2
Educational status		
Primary school	68	45.9
Junior high school	19	12.8
Senior high school	41	27.7
University	20	13.6
Employment status		
Employed	28	18.9
Not employed	120	81.1
Level of income		
Low	53	35.8
Moderate	59	39.9
High	36	24.3
Household		
Alone	6	4.1
Family	142	95.9
Presence of a family history of mental illness		
Yes	74	50.0
No	74	50.0

n: Number.

Analysis of the Data

Data were analyzed using the Statistical Program for the Social Sciences 22. Whether the data were normally distributed was tested with the Shapiro–Wilk test. It was determined that the data were normally distributed. Numbers, arithmetic mean, percentage distributions, and standard deviation were used in the analysis of the descriptive data. Pearson correlation analysis was used to determine the relationship between the scales and the Cronbach's alpha coefficient was used to calculate the reliability coefficients of the scales. $p<0.05$ was considered statistically significant.

Table 2. Distribution of the mean scores the participants obtained from the overall Birchwood Insight Scale and its subscales

	Birchwood insight scale		
Subscales	**Minimum and maximum possible scores that could be obtained from the scale**	**Minimum and maximum scores obtained from the scale**	**Mean±SD**
Awareness of symptoms subscale	0–4	0–4	1.75±1.24
Awareness of the disease subscale	0–4	0–4	1.05±0.90
Awareness of the need for treatment subscale	0–4	0–2.5	1.35±0.45
Total	0–12	0.5–9	4.16±1.63

Birchwood insight scale[25,26]. SD: Standard deviation.

Table 3. Distribution of the mean scores the participants obtained from the overall Quality of Life Scale for patients with schizophrenia and its subscales

	Quality of life scale for patients with schizophrenia		
Subscales	**Minimum and maximum possible scores that could be obtained from the scale**	**Minimum and Maximum scores obtained from the scale**	**Mean±SD**
Interpersonal relationships	0–48	10–42	27.95±6.49
Occupational role	0–24	1–24	13.06±5.45
Psychological outcomes	0–42	11–39	26.22±5.32
Daily use of belongings, and activities	0–12	3–12	9.68±2.26
Total	0–126	36–113	76.93±14.84

Quality of life scale for schizophrenic patients.[22,27] SD: Standard deviation.

Results

Descriptive characteristics of the patients who participated in the study are shown in Table 1.[10,21] Of them, 39.9% were in the age group of 40–50 years, 73.6% were men, 66.2% were single, 45.9% were primary school graduates, 81.1% were not employed, and 39.9% perceived their level of income as medium, 93.2% lived with their family, and 50% had a family history of mental illness.

The distribution of the mean scores the participants obtained from the overall BIS and its sub-dimensions is shown in Table 2.[25,26] The mean scores they obtained from the overall BIS and its sub-dimensions were as follows: overall BIS: 4.16±1.63, awareness of symptoms subscale:1.75±1.24, awareness of the disease subscale: 1.05±0.90, and awareness of the need for treatment subscale: 1.35±0.45.

The distribution of the mean scores the participants obtained from the overall QLSPS and its sub-dimensions is shown in Table 3.[22,27] The mean scores they obtained from the overall QLSPS and its sub-dimensions were as follows: overall QLSPS: 76.93±14.84, interpersonal relations subscale: 27.95±6.49, occupational role subscale: 13.06±5.45; psychological symptoms subscale: 26.22±5.32 and daily use of belongings, and activities subscale: 9.68±2.26.

The relationship between the mean scores the participants obtained from the BIS and QLSPS is shown in Table 4.[22,25–27] The analysis of the relationship between their scores for the overall BIS and QLSPS and their sub-dimensions demonstrated that there was a weak, negative, and significant relationship between their scores for the overall BIS and its awareness of symptoms and awareness of the disease sub-dimensions, and their score for the interpersonal relations sub-dimension of the QLSPS, and weak, negative and significant relationship between their score for the overall BIS and their scores for the occupational role, daily use of belongings, and activities sub-dimensions of the QLSPS ($p<0.05$).

Discussion

In the present study, conducted to determine the relationship between the levels of insight and quality of life in patients with schizophrenia, a relationship was revealed between their insight and quality of life.

According to the analysis of the descriptive characteristics of the participants, the majority of them are men, are single, do not work in any income-generating job, and live with their family, most of them are primary school graduates and have a family history of mental illness, and a small majority of them are in the age group of 40–50 years and perceive their level of income as medium (Table 1).[10,21]

Table 4. Relationship between the mean scores the participants obtained from the Birchwood Insight Scale and its subscales and the Quality of Life Scale for patients with schizophrenia and their subscales

Quality of Life scale for patients with schizophrenia				
Subscales	**Birchwood insight scale**			
	Awareness of symptoms subscale	**Awareness of the disease subscale**	**Awareness of the need for treatment subscale**	**Total score**
Interpersonal relationships subscale	r=-0.201	r=-0.284	r=-0.039	r=-0.322
	p=0.014*	p=0.000**	p=0.138	p=0.000**
Occupational role	r=-0.132	r=-0.123	r=-0.042	r=-0.211
	p=0.109	p=0.137	p=0.610	p=0.018*
Psychological outcomes	r=-0.023	r=-0.122	r=-0.036	r=-0.096
	p=0.779	p=0.140	p=0.662	p=0.247
Daily Use of Belongings, and Activities	r=-0.123	r=-0.121	r=-0.025	r=-0.208
	p=0.136	p=0.144	p=0.765	p=0.016*
Total score	r=-0.135	r=-0.002	r=-0.012	r=-0.108
	p=0.102	p=0.978	p=0.886	p=0.192

*: p<0.05; **: p<0.001. Birchwood Insight Scale[25,26]; Quality of Life Scale for Schizophrenic Patients.[22,27]

It is known that insight is an important parameter in terms of the clinical course of schizophrenia. In the present study, the mean score the participants obtained from the overall BIS was 4.16±1.63 (Table 2),[25,26] which can be considered as low if the average BIS score is taken into account. According to the review of studies conducted with patients with schizophrenia in the literature, patients' insight levels were low.[10,2,14]

In Gökdam's[10] study in which the effect of insight of patients with schizophrenia on their compliance with treatment was investigated, it was concluded that the insight levels of the patients with schizophrenia were low. In Dankı et al.'s[14] study, 50–80% of the patients with schizophrenia had a low level of insight. Aslan and Altınöz[2] emphasized that a low level of insight or unawareness of the disease was a common problem observed in most of the patients diagnosed with schizophrenia. In their study conducted with patients with schizophrenia, Ampalam et al.[28] determined that these patients lacked insight. The results of the present study indicating that patients with schizophrenia had low levels of insight are consistent with the results of several studies. These patients' having low insight score are probably due to the fact that they enter a process of denial and non-acceptance when they are diagnosed with schizophrenia, that they fear the stigmatization process, and that they delay the diagnosis process because they accept some symptoms as normal.

Quality of life is defined as "the way individuals perceive their own situation within the context of their own culture and value judgments, in connection with their goals, expectations, living standards, and concerns."[18,19] In the present study, the mean score the participants obtained from the overall QLSPS was 76.93±14.84 (Table 3),[22,27] which can be considered as high if the average QLSPS score is taken into consideration. In Kartal's[29] study in which the relationship between insight, and quality of life, depression, and symptom pattern in patients with schizophrenia was investigated, the mean score the participating patients with schizophrenia obtained from the QLSPS was high. In their study conducted to investigate the family environment, internalized stigma, and quality of life of patients with schizophrenia, Özçelik and Yıldırım[30] determined that the participants had an average level of quality of life. In their study, Katschnig[31] concluded that the quality of life levels of the patients diagnosed with schizophrenia were lower than were those of the general population, and individuals with physical and chronic diseases. In a study conducted in China to investigate the quality of life in patients with schizophrenia, the quality of life levels of the patients diagnosed with schizophrenia were significantly lower than were those of healthy individuals.[32] The results obtained from the present study are similar to those of some studies or different from those of some other studies. Since the quality of life is a complex concept,[33] the aforementioned difference between the results of the present study and those of other studies is probably due to the fact that the scales used were different, that patients' evaluations of their quality of life were subjective, and that in the present study, the outpatients who presented to the CMHC and were followed regularly there had a stable clinical course, and were in the remission period.

In the literature, it is stated that group-based psychoeducation programs improve the quality of life.[30,34] It is reported that group trainings increase social support and improve motivation in patients.[30,34] It is thought that the presence of

social supports, such as giving psychoeducation to the outpatients who followed up in the CMHC regularly, and enabling them to establish close relationships with individuals in their social circle and to live in a safe environment enabled them to obtain high scores from the QLSPS. The WHO associates quality of life with culture and personal perceptions of life.[18] Quality of life, which is a complex concept, is affected by people's physical health, psychological state, level of independence, and social relationships. Thus, quality of life is defined in several ways.[33] One of the common features of such definitions is as follows: "Quality of life is affected by universal and cultural value judgments."[35] In the present study, the high mean score the participants obtained from the QLSPS is considered as a reflection of culture.

Sub-factors affecting the quality of life are the individual's physical and psychological health status/well-being, adaptability, interpersonal and social interactions, and socioeconomic status.[31] In the present study, the participants obtained the highest score from the interpersonal relations sub-dimension of the QLSPS (Table 3).[22,27] The patients participating in the present study lived with their families (Table 1).[10,21] Their having high levels of interpersonal relationships were probably due to the fact that they lived with their families, that they received social support, and that they underwent effective group therapies provided in the CMHC.

The analysis of the relationship between the mean scores the patients obtained from the overall BIS and QLSPS and their sub-dimensions revealed that there was a weak, negative, and significant relationship between their score for the overall BIS and the interpersonal relations subscale of the QLSPS ($p<0.05$) (Table 4).[22,25–27]

Lack of insight is observed in most patients with schizophrenia, and generally, they are not aware of their disease, disease symptoms, effects of treatment, and social difficulties they experience.[36] In a study conducted with patients with schizophrenia in Nigeria, it was determined that sociocultural factors affected how the patient and his or her family interpreted the situation and the choice of treatment for mental disorders.[37] The concept of health should be considered as a whole within the social and cultural context.[38] Definition of mental health is influenced by the culture that defines it.[38] The present study was conducted in the Black Sea region of Türkiye. In this region, patients, as other people, are energetic in nature due to the influence of the region's culture, which probably affects the way they express their feelings, thoughts, and themselves, and perceive and maintain the quality of their lives. Thus, since the average insight level of these patients is low, they cannot perceive the negative effects of the disease, and with the influence of their culture, they tend to perceive the quality of their lives more positively and are willing to maintain their interpersonal relationships.

Some patients do not want to comment on the symptoms, accept or remember the symptoms due to the negative emotions brought about by the symptoms of the disease, on the contrary, they tend to overlook it and act as if there is no disease.[2] In the present study, there was a weak, negative, and significant relationship between the awareness of symptoms sub-dimension of the BIS and the interpersonal relations sub-dimension the QLSPS. (Table 4).[22,25–27]

Being diagnosed with schizophrenia is devastating for individuals. It is thought that overlooking the disease may be a cause of low insight. That their mean score was low for the awareness of symptoms sub-dimension and high for the interpersonal relations sub-dimension is probably because the patients with schizophrenia considered some of the disease-induced symptoms as normal and continued their social lives.

There was a weak, negative, and significant relationship between mean scores obtained from the disease awareness sub-dimension of the BIS and the interpersonal relations sub-dimension of the QLSPS ($p<0.05$) (Table 4).[22,25–27]

One of the aims of CMHCs is to integrate individuals with mental health disorders into society without breaking their bond with society and without exposing them to social stigma and isolation.[39] Among the duties of the community mental health nurse are taking initiatives to ensure the social adaptation of patients with mental disorders, providing psychiatric rehabilitation services, cooperating with the rehabilitation team, and supporting individuals with functional disorders and their families in the process of healing and adapting to the new situation.[24] The results of the present study demonstrated that patients with schizophrenia registered to the CMHC with low insight into their illness continued to establish social relationships with their environment. It is thought that patients with schizophrenia who maintain their interpersonal relationships with the presence of social support mechanisms (CMHC, family) perceive their quality of life as high, and in this context, they eliminate the disadvantage of having low insight levels.

There was a weak, negative, and significant relationship between the mean scores obtained from the overall BIS and the professional role sub-dimension of the QLSPS ($p<0.05$) (Table 4).[22,25–27]

The quality of life of individuals with chronic diseases may deteriorate due to a number of symptoms and complications brought about by the disease.[40] Schizophrenia, a chronic disorder, impairs the patient's occupational functionality and causes disability.[41]

The purpose in providing care services to individuals with chronic mental disorders is to improve their ability to cope with the disease, its symptoms, and the difficulties brought about by the disease, and to prevent the exacerbation of acute symptoms.[42] Within this context, nursing interventions

should be aimed at helping patients with mental disorders learn or remember social behaviors that will enable them to continue their roles in society satisfactorily.[42] Patients with schizophrenia with low insight maintain their professional skills due to their lack of awareness of the impairment and loss of ability in occupational functionality brought about by the disease and thanks to the positive effects of nursing interventions implemented in CMHCs that support their role in society.

There was a weak, negative correlation between the mean scores obtained from the overall BIS and the daily use of belongings, and activities sub-dimension of the QLSPS ($p<0.05$) (Table 4).[22,25–27]

Patients diagnosed with schizophrenia have problems adapting to activities of daily living and establishing interpersonal communication and social relations.[43] The common goal of psychiatric nurses in the treatment of patients with schizophrenia is not only to provide drug therapy to relieve the symptoms of the disease but also to improve their functionality, self-esteem, and quality of life through the training provided in the CMHC.[44,45] In their study, Şahin and Elboğa[46] determined a decrease in symptom severity and a significant improvement in quality of life, insight, and social functioning in patients who received routine health services provided by the CMHC compared to patients who did not receive such services.[46] Based on the results of the present study, it can be concluded that the level of daily use of belongings and activities is high in patients whose insight level is low. The participating patients with schizophrenia whose insight scores were low took part in life, participated in activities, and continued their activities of daily living thanks to the support mechanism created by living with their families while they fulfilled their daily life skills, by the supportive effect of the psychosocial rehabilitation services (psychoeducation, self-care training, occupational therapy, supportive group therapy, and home visits) applied to the patients in the CMHC, by social support provided through follow-ups by the CMHC.

Limitations of the Study

The present study had some limitations. First, because the study was conducted in a single a CMHC and because the number of outpatients diagnosed with schizophrenia presenting to the aforementioned center was less than the targeted number due to the COVID-19 pandemic, the sample size of the study was not big enough. Thus, the results are applicable only to patients with schizophrenia participating in the study and cannot be generalized to all patients with schizophrenia. Because the study was conducted within a certain period, the long-term consequences of the relationship between insight and quality of life were not determined, which was the other limitation of the study.

Conclusion

In the present study, the presence of a weak, negative correlation between insight, and quality of life levels of the patients diagnosed with schizophrenia indicates that the parameters affect each other. While the mean scores obtained by the patients diagnosed with schizophrenia from the BIS were low, the mean scores they obtained from the QLSPS were high. Their obtaining high scores from the QLSPS can be attributed to their regular attendance at CMHCs, living with their caregivers, and cultural factors.

It can be concluded that there was a relationship between the mean scores the participants obtained from the BIS and the QLSPS. It is thought that nurses, who are health-care professionals who accompany patients mostly during the diagnosis, treatment, and rehabilitation stages of schizophrenia, approach the patient from a holistic perspective and take appropriate initiatives to improve their insight and quality of life, can make a difference in the treatment of schizophrenia.

In line with these results, it is concluded that psychiatric nurses should conduct motivational interviews with patients with schizophrenia by identifying factors affecting their insight levels and that programs to improve patients' quality of life should be implemented considering the fact that nurses' goals in treating patients with mental illnesses include supporting of patients' interpersonal relationships, maintenance of their home life, and individual and social roles. It was also concluded that because the mean score obtained from the QLSPS indicates that culture has a significant effect on the quality of life, future studies on the subject should be conducted in different cultures, and that because the results of the present study are only applicable to the patients with schizophrenia who participated in the present study, future studies to be conducted on the subject should include different sample groups.

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