

Coping with stress and quality of life among patients with schizophrenia in Egypt and Saudi Arabia: effect of sociodemographic factors

Eman Elsheshtawy^a and Warda Abo Elez^b

^aBaljurashi Psychiatric Hospital, Al Baha Region, Saudi Arabia and ^bDepartment of Psychiatry, Faculty of Medicine, Mansoura University Hospitals, Egypt

Correspondence to Eman Elsheshtawy, Department of Psychiatry, Faculty of Medicine, Mansoura University Hospital, Mansoura, Egypt
Tel: + 0187455403; fax: + 26824738;
e-mail: emanmdy@yahoo.com

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Introduction

In Arab countries, epidemiological data about the ways of coping with general day stresses in schizophrenic patients and their quality of life are scarce. This study sought to determine whether there was a difference in ways of coping with stress and quality of life of schizophrenic patients attending the Baljurashi Psychiatric Hospital, AlBaha region, Saudi Arabia compared with schizophrenic patients at the Mansoura University Hospital, Egypt.

Materials and methods

A sample of 140 schizophrenic patients in Saudi Arabia and 140 schizophrenic patients in Egypt was enrolled. Data on sociodemographical and clinical variables were recorded. The following scales were utilized: Scale for Assessment of Positive Symptoms, Scale for Assessment of Negative Symptoms, Brief COPE Scale, and Self Report Quality of Life for Schizophrenia (SQLS).

Results

Saudi patients used less number of coping skills than Egyptian patients and were higher on self-distraction and acceptance; they were better on most items of SQLS. The duration of illness correlated positively with affection of motivation and energy subscale of SQLS in Egyptian patients ($r=0.259$, $P=0.002$), whereas in Saudi patients it showed no correlation.

Conclusion

Social factors are the most important determinants of quality of life rather than the symptoms. Long duration of illness has a negative influence on motivation and energy among Egyptian schizophrenic patients.

Keywords:

Arab, coping with stress, quality of life, schizophrenia

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Introduction

Globally, the incidence of schizophrenia is 1% of the population [1,2]. Schizophrenia is a chronic disorder with a heterogeneous presentation, which is marked by an array of symptomatology, variations in outcome, and responses to treatment [1–4]. Schizophrenia causes many disturbances, which have the propensity to have a pervasive impact on many areas of life functioning and subsequently on the quality of life (QOL) [1]. Sullivan *et al.* [5] noted that long-term psychotics are more vulnerable to stress, more dependent, and have greater deficits in living skills and in relationship with their social environment. Patients often report chronic difficulty coping effectively with both major and minor stresses [6,7]. They may possess a relatively limited repertoire of coping strategies and tend to avoid rather than actively attempt to solve problems [8–11]. Different coping strategies may reduce the negative influence of specific symptoms and distress on the subjective QOL of schizophrenic patients [12,13]. Maladaptive coping patterns are of larger importance because they have been linked to symptom exacerbation and failure

to sustain community tenure [14,15]. Studies identify QOL as an important (if not the most important) measure of the impact of schizophrenia and its respective treatment [16]. QOL of chronic patients is impoverished especially in the domains of housing conditions, family environment, social network, financial circumstances, and safety and practical skills [5]. In Arab countries, epidemiologic data about the ways of coping and QOL among schizophrenic patients are scarce. Egypt and Saudi Arabia share common life profiles, including language and religion, but are different with regard to cultural, historical, and financial aspects of life. Thus, there is a good reason to hypothesize that there would be a significant difference between the two samples in the QOL, and in the way they cope with stress and to propose that the Saudi sample might attain a better QOL and level of functioning than their Egyptian counterparts. The aim of this study was to explore the difference between Egyptian and Saudi schizophrenic patients regarding the patterns of cope employed in the face of general day-to-day stressors and its correlates and the difference in the QOL.

Materials and methods

This was a comparative study of schizophrenic patients at the Psychiatric Department of Mansoura University Hospital, Egypt and the Baljurashi Psychiatric Hospital, Al Baha region in the Kingdom of Saudi Arabia, conducted simultaneously in both groups from 1 January 2009 to 1 July 2009. After approval from the ethics board, patients were recruited after they gave a written informed consent to accept joining the study to carry out some scales and more investigations for the patient to measure the effect of illness over their living environment; no financial or extramedication benefit would be received by the patients from joining the study. Diagnosis was made according to the criteria described by *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV). The age range was from 18–45 years, for a duration of more than 2 years. The stability of illness was for at least 3 months before assessment (stability of illness was defined as a clinical and functional stability as judged by the treating physician, reflected by the criterion of absence of exacerbation of illness requiring increase in drug dosages by 50%, as mentioned by Gupta *et al.* [17]) excluding patients who were changing their antipsychotic medication, which would suggest the absence of stability. Excluding patients with all axis 1 comorbidity or personality disorder or evidence of organic pathology that could explain the presenting symptomatology. This information was clarified from patient notes. All the patients who were included were subjected to physical examination and special questionnaire; the questionnaire was designed by the authors to tap into different sociodemographic variables. Socioeconomic status in Egypt was measured by the Fahmy and El-Sherbiny's Scale whereas in Saudi they are measured by some question, which determines the income, water, and electricity supply nearly similar to that of the Fahmy and El-Shirbiny's Scale, duration of illness, and medications received. Psychometric assessment was made by using the following tools:

- (1) SAPS and SANS [18,19] was developed by Andreason to measure positive and negative symptoms in schizophrenia; it was rated by the treating psychiatrist.
- (2) The Brief COPE [20] is a validated short form of the COPE inventory [21], which is a widely used measurement of coping in health-related research. The Brief COPE consists of 14 scales of two items each. Both cognitive and behavioral strategies of coping are included.
- (3) Self report on Quality of Life for Schizophrenia (SQLS) [22] have 30 items incorporated in three scales: (i) psychosocial (15 items), (ii) motivation and energy (seven items), and (iii) symptoms and side effects (eight items). Both Brief COPE and self-report on Quality of Life scales were translated by the research team and are subjects of translation in another study.

At the Baljurashi Psychiatric Hospital in Al-Baha, the total number of patients received from January 2009 till July 2009 (6 months) was 450; only 140 of them accepted to join the study and completed the questionnaires. An equal number of schizophrenic patients in Egypt were targeted.

Statistical analysis was conducted using the statistical package for the social sciences (SPSS version 12, IBM, Chicago, USA). For quantitative data, the unpaired *t*-test was used for group comparisons. For categorical data, the χ^2 -test was used for comparison between the groups. *P* value of less than 0.05 was considered to be statistically significant. Correlation studies were also conducted.

Results

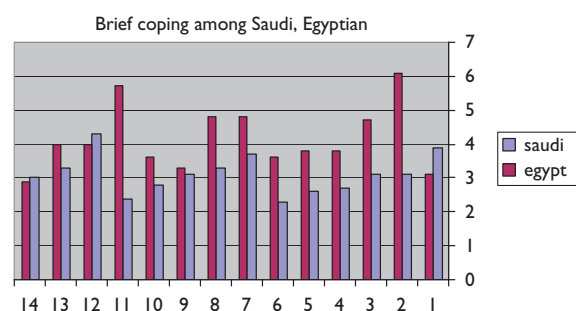
Table 1 shows that the patients of the Saudi group were relatively old, 43.6% of them were female patients, 42.3% were single, 32.9% were married, and 24.3% were divorced, nearly more than half of them having lower level of education, 75.7% of them came from rural areas and were nomads with relatively longer duration of illness, and 55.5% of them had a positive family history of psychiatric illness. A major proportion of them (70%) were on atypical antipsychotics with their scores on global assessment of functioning (GAF; 32.6 ± 7.1), SAPS (9.2 ± 2.3), and SANS (11.4 ± 2.5). Although Egyptians were observed to be relatively young, more male patients were included, more likely to be single or divorced, 85.5% were on typical antipsychotics, scored 28.5 ± 7 on GAF, scored 9.3 ± 2.4 on SAPS, and scored 12.8 ± 2.4 on SANS.

As evident from the graph on the Brief COPE Scale, it was observed that Saudi patients were higher on self distraction, acceptance, and self blame subscales, whereas

Table 1 Sociodemographic variables in Saudi and Egyptian schizophrenic patients

Variables	Saudi patients N % (140)	Egyptian patients N % (140)
Age (mean $\pm$ SD) (years)	32.7 $\pm$ 8	30.7 $\pm$ 7.2
Sex		
Male	79 (56.4)	88 (62.9)
Female	61 (43.6)	52 (37.1)
Education		
Primary	44 (31.4)	12 (8.6)
Preparatory	51 (36.4)	20 (14.3)
Secondary	31 (22.2)	84 (60)
College	14 (10)	24 (17.6)
Occupation		
Employed	20 (14.3)	34 (24.3)
Unemployed	31 (22.1)	34 (24.3)
Student	11 (7.9)	12 (8.6)
Retired	21 (15)	20 (14.3)
Housewives	57 (40.7)	40 (27.1)
Marital status		
Single	60 (42.3)	88 (62.9)
Married	46 (32.9)	36 (25.6)
Divorced	34 (24.3)	16 (11.5)
Socioeconomic status		
Low	28 (20)	72 (51.4)
Middle	79 (56.4)	57 (40.7)
High	33 (23.6)	11 (7.9)
Residence		
Urban	34 (24.3)	57 (40.7)
Rural	106 (75.7)	83 (59.3)
Type of family		
Nuclear	21 (15)	105 (75)
Extended	119 (85)	35 (25)
Duration of illness	10.8 $\pm$ 6.8	9.7 $\pm$ 8.1
Positive family history		
Present	78 (55.5)	35 (25)
Absent	62 (44.5)	105 (75)

Figure 1



Brief COPE Scale among Saudi and Egyptian schizophrenic patients.

the Egyptians were higher on using most subscales of Brief Coping (Fig. 1).

Results on the QOL showed that Saudi patients were better on most items of the scale except for the Motivation and Energy Scale (Table 2).

Correlation studies revealed that, on coping with general stress, the SAPS score among Saudi patients was negatively correlated with self blame ($r = -0.202$, $P = 0.017$), whereas in Egyptians it was positively correlated with denial ($r = 0.240$, $P = 0.004$), behavioral disengagement ($r = 0.294$, $P < 0.001$), venting ($r = 0.24$, $P = 0.004$), and humor ($r = 0.284$, $P = 0.001$). SANS score had no correlation in Saudi patients, whereas in Egyptians it was negatively correlated with planning ($r = -0.232$, $P = 0.006$) and active coping ($r = -0.207$, $P = 0.014$).

Table 3 shows that in Egyptian schizophrenic patients, long duration of illness was correlated with poor motivation and energy, whereas it showed no correlation in the Saudi group of patients.

Discussion

Schizophrenia is a severe and debilitating disorder, which affects general health, functioning, autonomy, subjective well being, and life satisfaction of those who suffer from it [23]. As evident from the results, compared with Egyptian patients, it was clinically observed that there were more Saudi female patients in the study although both authors were females which explains the fact that Saudi patients prefer a female psychiatrist to deal with their female patients and are encouraged to get their female patients when they encounter with a female

Table 3 Correlation between duration of illness and quality of life in Egyptians versus Saudi schizophrenic patients

	Egyptians (<i>r</i>)	Saudis (<i>r</i>)
Psychosocial Scale	0.033	-0.116
Motivation and Energy Scale	0.259 ^a	-0.115
Symptoms and Side Effects Scale	0.122	-0.154

^aHighly significant at $P < 0.01$.

doctor whom they believe is more understanding and appreciative of female problems, and can uncover their face and speak openly (clinical observation, not a fact).

Higher percentage of the patients were married; as the Saudi patients are more dependent on their families regarding the expenses of marriage, they tend to marry early and live in extended families. This was supported by Abdullah Al-Sabaie [24] who explained that culturally, the large family enhances the sense of collective strength and influence in the community. High rates of divorce may be related to the effects of illness [24]. Saudi patients were of higher socioeconomic status relative to Egyptians, and they mostly belonged to middle class from rural and nomadic areas, whereas those of higher class were few. This could be explained by the fact that in the southern area of Saudi there are limited resources, less job opportunity, less level of education, and less contact with civilization than other Saudi areas. However, a high percentage of them were maintained on atypical antipsychotics, which are offered to patients by governmental hospitals because of high country resources. As Egyptian patients tend to live in nuclear families and only the typical antipsychotics were provided by governmental hospitals, it was evident that Saudi patients had relatively less negative symptoms and got higher scores on GAF probably due to the use of atypical antipsychotics.

There was a large percentage of Saudi patients having a positive family history of psychiatric illness, more commonly schizophrenia that was supported by Chaleby and Tuma [25] who observed that schizophrenia tends to cluster in families in Saudi Arabia due to high consanguinity supporting the genetic hypothesis of the disorder.

With regard to the results on Brief COPE Scale, as evident from the graph, Egyptians were more ready to use several strategies including problem centered and neutral strategies, whereas Saudi patients relatively used less number of coping skills and were higher on self distraction and acceptance. Carter *et al.* [12] have shown that effectiveness improves if participants use several strategies at the same time, whereas other researchers have argued the converse [26]. Contradictory findings may

Table 2 Self report quality of life in Egyptian and Saudi schizophrenic patients

	Egyptian patients (140)	Saudi patients (140)	Statistical test results d.f. = 139
SQLS			
Psychosocial Scale	40.98 ± 10.5	38.7 ± 9.2	$t = 2.540$, $P = 0.012$
Motivation and Energy Scale	41.99 ± 10.2	40.26 ± 8.5	$t = 1.788$, $P = 0.076$
Symptoms and Side Effects Scale	30.17 ± 11.2	22.63 ± 9.4	$t = 8.107$, $P < 0.001$

Significant at $P < 0.05$.

d.f., degrees of freedom; SQLS, self report quality of life for schizophrenia.

be related to different ways of measuring effectiveness just as Farhall and Gehrke [9] considered effectiveness as a multidimensional construct including a degree of control, anxiety level, and overall coping effectiveness. This was supported by a previous study done by Boschi *et al.* [27] on patients with nonfirst episode psychosis which explained that patients with severe symptomatology tended to endorse a greater number of coping strategies, suggesting that use of more strategies is a response to symptoms [26]. High self distraction observed among Saudi patients could be of value when it seemed inappropriate to include maladaptive strategies such as acting violently or using alcohol [28]. Certain distraction efforts that are actively pursued to eliminate a symptom are categorized as problem-centered strategy. Although acceptance is considered from the neutral defense that is commonly described by psychotics, this is in accordance with McGorry's suggestion that the trauma associated with psychosis may result in people believing that most situations exceed their coping skills [29].

From correlation studies, Egyptian patients with more negative symptoms were related to less use of problem focusing coping as planning and active coping, which is consistent with previous studies [26]. Those with high positive symptoms were correlated more with dysfunctional coping as denial and behavioral disengagement, whereas venting and emotion focused coping as humor. This could be explained, as patients with positive symptoms had denial as a part of lost insight and they were more likely to have behavioral disengagement. In addition, venting coping strategy is considered as part of acceptance that is commonly seen in psychotics. In Saudi schizophrenic patients, those who had high positive symptoms were correlated with less self blame probably due to impaired insight.

As evident from results, Saudi patients had better QOL as they scored less on most items of the scale except for Motivation and Energy Scale, which could be due to the previous factors explained such as early marriage and living in extended families; these factors carry most of the burden of psychosis that mental health system rely on them for post discharge care by the family [24]. Among the factors of good prognosis which were observed in Saudi schizophrenic patients are being married and having adequate psychosocial functioning before illness [30]. Together with availability of most recent medications with very few side effects, which are supplied freely to patients, and families of psychotics do not carry any expenses for medications together with rising awareness about psychiatric illness. It was evident that pharmacological therapies that result in symptom reduction can produce important improvements in health-related QoL [16]. In addition, lower level of education seen among Saudi patients could be predictor of better prognosis as it was found that in underdeveloped countries, patients with higher educational levels appear to have a worse evolution in the disease due to the higher social demands and expectations compared with patients with low schooling [30]. Although motivation and energy not significantly differ as impaired motivation and energy are considered to be a corner-stone effect of schizophrenic illness.

Long duration of illness in Egyptian schizophrenic patients was associated with poorer motivation and energy, this may be due to the influential effect of schizophrenia on motivation together with the role played by typical antipsychotics with high side effects and negative influence on motivation and energy. This could explain the contrary, as in Saudi patients no correlation was observed, this may be due to the use of atypical antipsychotics by a large proportion of them.

Conclusion

It was concluded that Egyptian schizophrenic patients used more number of coping strategies, whereas Saudi schizophrenic patients were better on coping with stress and on most domains of QOL. Social factors are the most important determinant on the QOL, rather than the symptoms. This was in accordance with recent studies addressing QOL for individuals with schizophrenia and other severe mental illnesses that identified a number of important influential factors, such as social support, unmet need, and medication side effects [16]. However, most of the research examining factors affecting QOL has primarily focused on the impact of psychiatric symptoms, especially negative symptoms [16]. It is also known that the progress of schizophrenic patients is better in developing countries because of more handling of patients in families and in society and less institutionalization [23].

Clinical implications and recommendation

- (1) Progress of patients is better in developing countries such as Egypt and Saudi Arabia because of better handling in families and in society, and less institutionalization.
- (2) Careful management of negative symptoms of schizophrenia because of its negative effects on QOL.

Limitations

- (1) Some of the findings are based on self-reported information, and thus some reporting bias might have occurred.
- (2) The study took place at only two sites with small number of patients, which will affect the generalizability of results.
- (3) The results of this study shouldn't be generalized to all schizophrenic patients as severe, unstable, and disturbed patients with active symptoms were excluded from the study.

There is no conflict of interest to declare.

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الملخص العربي

دراسة مواجهة الضغوط وجودة الحياة بين مرضى الفصام السعوديين والمصريين:

تأثير العوامل الاجتماعية والديموجرافية

ايمان الششتاوى*- وردة ابو العز**

* مستشفى بلجارشى للصحة النفسية- المملكة العربية السعودية

**قسم الطب النفسي- كلية الطب -جامعة المنصورة

تهدف هذه الدراسة إلى استكشاف الفرق في طرق التعامل مع الضغوط وجودة الحياة بين مرضى الفصام السعوديين والمصريين، ومعرفة مدى تأثيرها بالعوامل الاجتماعية والديموجرافية..

وقد أجريت الدراسة على عينة تشمل مائة وأربعين (140) مريضاً بالفصام تم اختيارهم من بين المترددين على العيادة الخارجية النفسية ومرضى القسم الداخلي بمستشفى بلجرشي للصحة النفسية بمنطقة الباحة بالمملكة العربية السعودية، ومائة وأربعين (140) مريضاً بالفصام من بين المترددين على العيادة النفسية بمستشفى المنصورة الجامعي بجمهورية مصر العربية وكانت حالتهم مستقرة بالعلاج. وقد تم اختيار المرضى طبقاً للتقسيم الأمريكي الرابع لمرضى الفصام . وقد تم لهم جميعاً إجراء:

- 1- تجميع بيانات خاصة بالمتغيرات الاجتماعية والديموجرافية من سجلات المرضى
- 2- فحص اكلينيكي ونفسي شامل
- 3- مقياس تقييم للأعراض الموجبة والسالبة لمرضى الفصام
- 4- مقياس المواجهة المختصر
- 5- التقرير الذاتي لجودة الحياة لمرضى الفصام

ولقد أظهرت النتائج أن المرضى السعوديين قد استخدموا عدداً أقل من استراتيجيات المواجهة بالنسبة للمرضى المصريين ولكنهم كانوا أكثر استخداماً للقبول والإلهاء، في حين أنهم كانوا أفضل في معظم نتائج جودة الحياة. ولقد كان لطول مدة المرض تأثير سلبي على الحافز والنشاط بين المرضى المصريين في حين أنه لم يظهر له تأثير واضح بالنسبة للمرضى السعوديين.

ومن هنا نستنتج أن العوامل الاجتماعية تلعب دوراً أساسياً في التأثير على جودة الحياة بالمقارنة بالأعراض المرضية، وذلك بعض من أهمية التدريب على استراتيجيات المواجهة ضمن التأهيل الاجتماعي النفسي لمرضى الفصام