Personal and Social Performance among Patients with Schizophrenia

By
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February, 2025

This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH 2 & 3 and partial fulfilment of the requirements for the degree of

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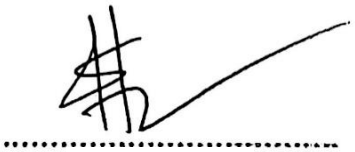

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Acknowledgement

Firstly, I thank the Almighty Allah for giving me the strength and perseverance to complete this thesis. My heartfelt gratitude goes to my parents and family members, who have always been supportive and inspired me throughout my academic journey. It would not be feasible to finish without the help of my family members. I want to say how grateful I am to my supervisor, Prof. Sk. Moniruzzaman, Professor and Head, Department of Occupational Therapy, BHPI and co-supervisor, Md. Azim Hossain, Lecturer, Department of Occupational Therapy for giving precious time, effort, and valuable feedback to help me succeed. I am also grateful to the Institutional Review Board (IRB) and the Department of Occupational Therapy, BHPI, for their unweaving support in providing vital information. I wish to express my gratitude to all my friend (especially Taslima Akter Mim) who have always supported me in my studies. I am also grateful to my elder sister (Sabiha Islam) for her constant support and for always making coffee for me while I was working on my thesis. Lastly, I am profoundly thankful to all the participants who shared their valuable insights and experiences. This study would not have been possible without their openness and willingness to contribute. I sincerely apologies if I have unintentionally omitted anyone deserving of acknowledgement.

Dedication

I dedicate this thesis to my parents and my sister, whose unconditional love, constant support, and encouragement have been my greatest strength throughout this journey. I also dedicate to a person whose support and inspiration played a meaningful role in completing this work. I also dedicate this work to all those who supported me in every possible way during my academic and personal endeavors.

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List of Abbreviations

ADL	Activities of Daily Living
BHPI	Bangladesh Health Professions Institute
BDT	Bangladeshi Taka
CI	Confidence Interval
CRP	Centre for the Rehabilitation of the Paralysed
DSM	Diagnostic and Statistical Manual of Mental Disorders
GAF	Global Assessment of Functioning
ICF	International Classification of Functioning, Disability and Health
IRB	Institutional Review Board
K–S	Kolmogorov–Smirnov Test
NIMH	National Institute of Mental Health
OT	Occupational Therapy
PANSS	Positive and Negative Syndrome Scale
PSF	Practical and Social Functioning Scale
PSP	Personal and Social Performance
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
WHO	WHO World Health Organization
WMA	WMA World Medical Association

Abstract

Background: Schizophrenia is a chronic mental disorder that frequently result in significant disruption of personal and as well as social performance. It has significant effect on patients and their participation in social life but in Bangladesh, there is limited information on personal and social performance of the schizophrenic patients.

Aim: This study aimed to assess the personal and social performance among patients with schizophrenia.

Methods: A cross-sectional study was conducted among 124 schizophrenia patients who were receiving treatment at selected hospitals and day care centre in Bangladesh. Data was collected by face-to-face interview using a sociodemographic questionnaire and the Personal and Social Performance (PSP) scale. Data were analyzed using descriptive statistics and due to the non-normal data distribution, Mann-Whitney U and Kruskal - Wallis test were performed. Linear regression analyses were also conducted.

Results: The average PSP score was 38.72, (SD ±19.48) which indicates the low to moderate level of functioning. Significant associations were observed between PSP scores and household activity involvement, anger or aggression control, personal hygiene, and family and social relationships ($p < .05$). These variables were identified as significant predictors of functional performance in the regression analysis.

Conclusion: The study says those who suffer from schizophrenia have significant impairment of personal and social functioning. Personal and social performance depends on performance and quality of functional engagement, practice of self-care, regulation of emotion and relationships.

Key Words: Schizophrenia, Personal and Social Performance, Functional Outcome, Bangladesh.

CHAPTER I: INTRODUCTION

1.1 Background

Schizophrenia is a chronic, disabling, and severe mental illness. It affects the way a person thinks, feels, and behaves. Kretschmer et al. (2022) and WHO report (2023) this is one of the world's most burdensome mental disorders that contributes most to the morbidity, disability and lowering of life-expectancy. Individuals diagnosed with schizophrenia display a range of symptoms consisting of the following positive symptoms (hallucinations, delusions), negative symptoms (Social functioning withdrawal, lack of motivation, flat affect) and cognitive impairment. These combinations of symptoms often interfere with living independently and meaningfully (Harvey & Strassnig, 2021; Bora & Murray, 2021).

Schizophrenia has a significant impact on the personal and social functioning of individuals. It manifests as an inability to self-care, maintain social and personal relationships, have productive roles, and participate in community life. Functional limitations are more disabling than the symptoms themselves and persist even when the individual improves with medications (Galderisi et al., 2018; Mucci et al., 2020). Functional recovery is now regarded as the main goal of psychiatric rehabilitation, necessitating the evaluation of personal and social performance as a core component of the assessment (Rocca et al., 2021).

According to Morosini et al. (2000), one of the most widely used scales to evaluate psychosocial functioning is the PSP, the Personal and Social Performance Scale, in schizophrenia. PSP is a measure of functioning in 4 different areas: socially useful activities, personal and social relationships, self-care, and disturbing and aggressive behaviors. Recent studies show that the PSP is reliable, culture-fair, and

sensitive to clinical change which makes it useful for clinical and research purposes in different populations (Brissos et al., 2022; Juckel et al., 2021). Functional assessment using PSP has become important in mental health practice because it provides a complete understanding of patient's ability to function in real life contexts instead of just focusing on symptomatology. (Nasrallah et al., 2008)

In Bangladesh, there is limited access to mental-health services along with stigma and socio-economic factors which negatively affect treatment outcomes. Schizophrenia is an important public health issue in Bangladesh (Hossain et al, 2021; Islam et al., 2022). Bangladesh's mental health infrastructure is not well developed and there is a lack of long-term psychosocial rehabilitation services. Many people with the schizophrenia continue to face functional impairments that limit their everyday life participation and negatively affect their quality of life (Ahmed et al. 2021). Family members are often primary caregivers. They can carry a heavy emotional, financial, and social burden. (Awad & Voruganti, 2008)

Sociodemographic features like age, gender, education, marital status, income, and duration of illness impact the functional outcome in schizophrenia according to recent studies (Ventura et al 2021, Jung et al 2020). For instance, longer illness duration, low education unemployment, leads to lower functioning level in people, essentially in the mental illness case. Nevertheless, the study shows that the results vary. Due to the special socio-cultural settings in Bangladesh, it is important to see the impact of these demographic factors in the personal and social performance of Bangladeshi patients. (WHO, 2013; Hossain et al., 202)

Occupational therapy primarily concerns the engagement in purposeful occupations and independence in daily living and participation in social and community activity which is essential for functional recovery. Occupational therapists assess how

people perform certain functions, look at how occupational performance and evaluating and designing intervention to increase social interaction, self-care, productivity and leisure participation (Boop et al., 2020; Samuel et al., 2023). Consequently, it is necessary to know the level of personal and social performance among patients with schizophrenia to enable the development of intervention strategies. In spite research on schizophrenia in Bangladesh increased, studies on personal and social performance remain scarce. Many of the published studies examine the prevalence, severity of symptoms, treatment adherence, and caregiver burden. Psychosocial functioning is less studied. This gap shows that there is a need for systematic research which measures personal and social performance with a reliable scale like the Personal and Social Performance. (Nasrallah et al., 2008)

Grasping how those with schizophrenia operate in their daily surroundings can help shape rehabilitation plans, direct occupational therapy, and encourage mental-health services in the community. Consequently, this study attempts to evaluate the personal and social performance among patients with schizophrenia and the sociodemographic factors of the functional outcomes. (Burns & Patrick, 2007)

1.2 Justification of the Study

Understanding how individuals with schizophrenia in Bangladesh function personally and socially is very important for many reasons. Functional impairments are a critical determinant of long-term disability and reduced quality of life. To treat the symptoms, the help of drugs is given. However, the recovery of function needs targeted drugs. On the other hand, occupational and psychosocial treatment can be really useful too. Without understanding the functional difficulties people have, it is difficult to plan rehabilitation effectively (Harvey et al., 2020; Rocca et al., 2021). The PSP scale gives a standardized and reliable way to assess everyday functioning. Yet, there has been

limited research on the PSP scale in Bangladesh. This study will provide local evidence about the applicability and usefulness of the PSP to evaluate functional performance in Bangladeshi patients with schizophrenia.

In addition, it can enable clinicians, in particular occupational therapists, to make sense of how clients operate across the range of life areas, such as self-care, social, productive and community functioning. The information can help determine specific occupational performance problems, develop individualized intervention and improve the effectiveness of the rehabilitation program.

Comprehending how sociodemographic variables impact functional performance can help offer culturally relevant mental-health services. In Bangladesh, the experiences of mental-health people are shaped profoundly by poverty, educational level, gender roles, and family structure. Health professionals can develop effective strategies for populations with functional impairment and priorities populations with the greatest need if the demographic groups most at risk of functional impairment can be identified (Islam et al. 2022; Ahmed et al. 2021).

The findings will increase knowledge which is necessary to improve community based mental health rehabilitation in Bangladesh. The transition of the country towards more recovery-oriented model of mental health care requires empirical evidence on functional performance in order to inform policies, appropriate resources and bolster mental health programmed. Hence, this study is justified as it can facilitate improved clinical practice, occupational therapy intervention planning and mental health policy.

1.3 Operational Definitions.

1.3.1 Schizophrenia

According to the American Psychiatric Association (2022), schizophrenia can be defined as a chronic psychiatric disorder entailing disturbances in thought, perception, and mood, which subsequently causes cognitive dysfunction.

1.3.2 Performance of the Personal Social

Morosini et al. (2000) developed a scale that clinicians use to assess a person's psychosocial functioning in schizophrenia. There are four domains that the scale looks into: socially useful activities, personal social relationships, self-care, and disturbing and aggressive behaviors. Higher scores indicate better functioning.

1.3.3 Personal Performance

The capacity of a person to execute 'activities of daily living' (ADLs), in an independent manner, for example, self-care, hygiene, household, and so on, (Bucci et al., 2021).

1.3.4 Social Performance

The power to communicate with others, make and keep friends, communicate with others and make and take part in social and community roles. (Brissos et al, 2022).

1.4 Aim of the Study

The aim of the study is to assess the personal and social performance among patients with schizophrenia.

CHAPTER II: LITERATURE REVIEW

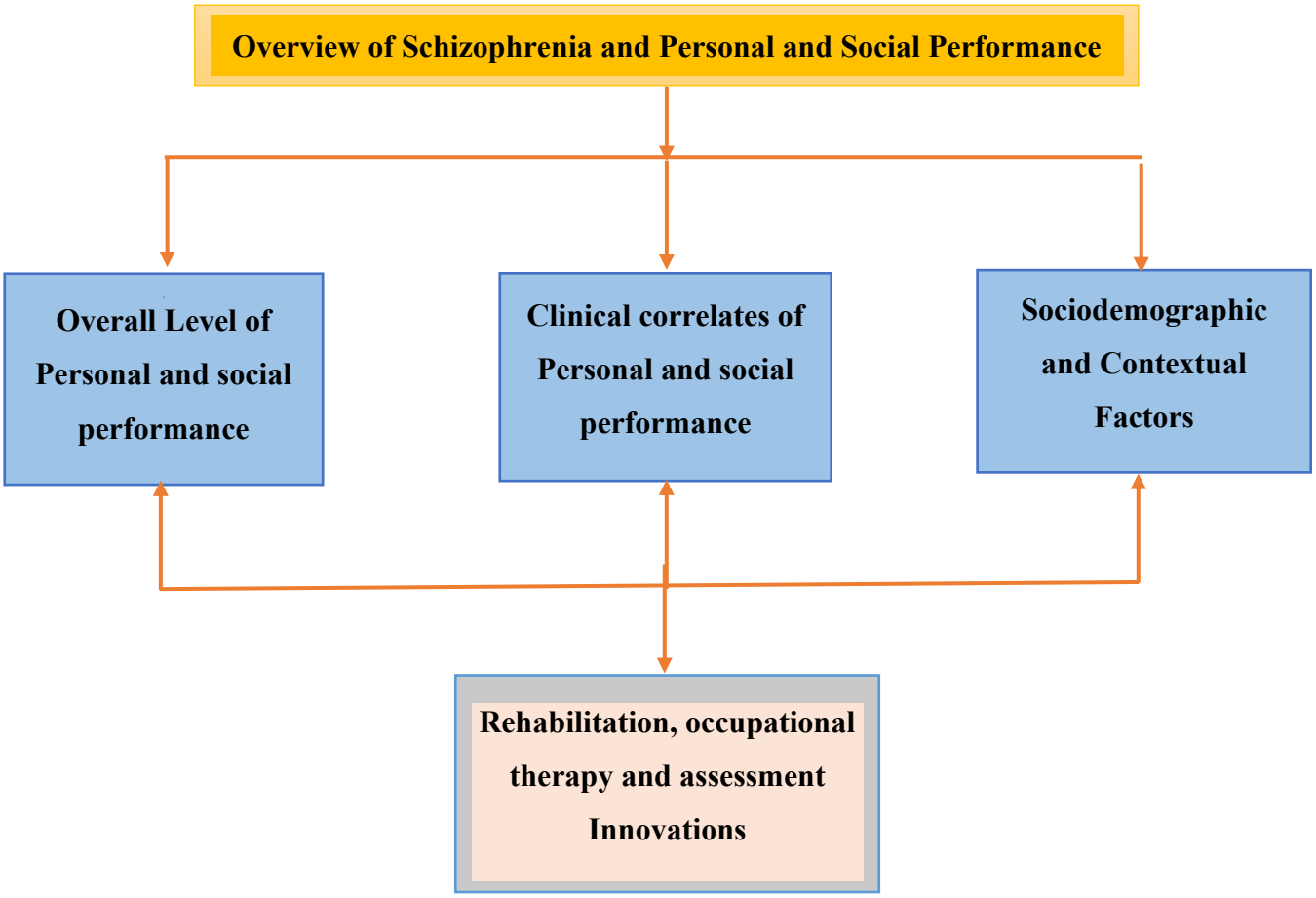
This chapter reviews empirical and conceptual literature on personal and social performance among patients with schizophrenia, with a specific focus on the Personal and Social Performance (PSP) scale. The review is organized into five sections: (i) an overview of schizophrenia and personal and social functioning, (ii) overall levels of personal and social performance, (iii) clinical correlation of PSP, (iv) sociodemographic and contextual factors and (iv) rehabilitation, occupational therapy and assessment approaches.

Searches were conducted in PubMed, Google Scholar, Embase, Medline, ScienceDirect and Google for articles published mainly within the last 10-15 years, using combinations of terms such as schizophrenia, personal and social performance, social functioning, negative symptoms, occupational therapy, social cognition and Bangladesh. The 14 key studies selected for detailed review include quantitative, qualitative and review papers from Europe, Asia and other regions, but none from Bangladesh using the PSP scale.

2.1 Overview of literature review findings

Figure 2.1

Overview of literature review findings



2.2 Overview of Schizophrenia and Personal and Social Performance

Schizophrenia is a chronic disorder that is heterogeneous, as it occurs in various forms. The positive, negative and cognitive symptoms of schizophrenia together produce a substantial disability in real-life functioning. Many people with schizophrenia cannot work or live independently or have close relationships. This is evident from large epidemiological and clinical studies even when acute psychotic symptoms are partially remitted.(Vauth et al., 2021). A recent macor study shows that impaired social function is a central defining feature of schizophrenia which remains poorly understood, but is found to be strongly linked to across domains of psychopathology and works across

positive, negative, disorganized and affective symptoms. (Handest et al., 2023).

Personal and social functioning is usually conceptualized as the capacity to carry out age-appropriate roles in everyday life such as self-care, work, study, social relationships and participation in community roles (Clausen & Ruud, 2024). Importantly, functioning is now recognized as partly independent from symptom remission; some patients retain significant functional impairment despite good symptom control, while others maintain relatively adequate functioning despite residual symptoms (Vauth et al., 2021).

The PSP scale is a short clinician rated measure to assess the real-world functioning of people with schizophrenia. It evaluates four areas of functioning-socially useful activities (such as work and study), personal and social relationships, self-care and disturbing or aggressive behaviors on a 1-100-point scale, with higher scores indicating better functioning. (Jelastopulu et al., 2014). The PSP was envisioned to minimize directly overlapping with severity scales of symptomatology and to improve upon earlier global assessments such as the Global Assessment of Functioning (GAF) and the Social and Occupational Functioning Assessment Scale (SOFAS). (Jelastopulu et al., 2014)Validation studies in usual outpatient settings indicate moderate negative correlations of PSP with PANSS – more severe psychopathology is generally associated with worse functioning, but the constructs are not identical and can diverge in some cases.(Jelastopulu et al., 2014)

Recent methodological reviews confirm that the PSP is among the best-supported clinician-rated instruments for social functioning in severe mental illness. The instrument exhibits good internal consistency, structural validity and sensitivity to change over time.(Clausen & Ruud, 2024) All the while, more recent tools like the Practical and Social Functioning (PSF) scale, WHODAS 2.0 and performance-based

assessment have been developed within the International Classification of Functioning (ICF) umbrella to better capture activity and participation.(Clausen & Ruud, 2024). Tools based on digital and virtual reality technology are being developed to measure functional capacity and everyday behavior.(Searle et al., 2022).

2.3 The level of personal and social performance in schizophrenia

In most countries, the majority of patients with schizophrenia show moderate to severe impairment on a global functioning scale, even when receiving outpatient or community treatment. In a very large Greek outpatient sample (n=2010), approximately half the patients had baseline PSP scores of below 50, which according to the explanatory notes of the scale means “A marked difficulty in more than one domain of functioning or a severe dysfunction in at least one domain”.(Jelastopulu et al., 2014) This means that after the patient was treated for six months, they had improved. However, while they did get better, they still had a long way to go. Despite the improvement, patient remained in the moderate to severe disability range. (Nasrallah et al., 2008).

Clinical trials testing antipsychotics show that symptomatic improvement does not equal functional recovery. In a post-hoc analysis of a paliperidone extended-release trial, the change in the PSP score was only partially explained by the change in PANSS and CGI-S scores, as approximately 45% of the variability in PSP remained unexplained. This can indicate that the PSP captures functioning not explained by symptoms. (Vauth et al., 2021). Likewise, a phase 3 trial and 52-week extension of the long-acting injectable risperidone ISM found rapid and sustained improvements in PSP scores versus placebo. However, mean gains of around 10 points still left many patients short of fully independent functioning (Litman et al., 2023).

Research showed that social functioning is associated with all major

psychopathology domains past the existence of psychosis. These association effect sizes, whether small, moderate, or strong, include positive symptoms, negative symptoms, disorganized symptoms, and depressive symptoms. (Handest et al., 2023). Nonetheless, the heterogeneity of functional outcome measures and the important recognition that there is persistent disability, even with treatment, is resulting in social functioning being seen as more of a core manifestation of the disorder itself rather than its downstream consequence. (Green, 1996; Harvey & Strassnig, 2012)

Almost no data exists on the use of the PSP scale to measure functional levels of schizophrenia patients living in low- and middle-income countries. A Bangladeshi study that involved 100 patients assessed negative symptoms using the Scale for the Assessment of Negative Symptoms (SANS). Results show that avolition, alogia and affective flattening were highly prevalent. All these symptoms are implicated as strong predictors of poor functioning. (Bhuiyan et al., 2022) That study did not measure personal and social performance directly, indicating a need for local data to be used with PSP.

2.4 Clinical Factors Connected with Personal and Social Performance.

2.4.1 Negative symptoms and general psychopathology.

Data analysis and long-term data show that negative symptoms cause social dysfunction. Handest and co-workers performed a systematic review and meta-analysis in which they found general social functioning to be strongly associated with negative symptoms but also found significant associations with positive, disorganized and depressive symptoms, thereby challenging the view that only negative symptoms matter for functioning.(Handest et al., 2023) Improvements in the PANSS negative and general psychopathology scores during the intervention research are positively related to gains in the PSP (Vauth et al., 2021).

Data from Bangladesh, though limited, indicate that negative symptoms are prevalent and become increasingly common with illness duration and insidious onset. This may in part account for the high levels of disability seen clinically. (Bhuiyan et al., 2022) These findings align with international evidence that enduring negative indications foreshadow inferior success in jobs plus social functioning over time.

2.4.2 Cognition, social cognition and metacognition.

Cognitive impairments in areas such as concentration, recall, decision-making and interacting socially have been often connected to daily life functioning and workplace performance (Giuliani et al., 2024). A narrative review of metacognition, social cognition and social functioning came to the conclusion that impairments in both metacognitive capacity (the capacity to reflect about self and others) and social cognition (deficits in emotion processing, theory of mind, social perception and attributional style) are important determinants of functional disability in schizophrenia (Montemagni et al., 2024).

Patients display social perception deficits early in the disorder which probably will not evolve. In a Turkish study, emotion recognition and theory of mind was evaluated in schizophrenia spectrum disorder patients of different illness durations. The researchers found that illness duration was not related to social cognitive performance. Therefore, social cognitive deficits may be a trait and somewhat independent of the course of symptoms (Kamış et al., 2025). A study from Iran reveals how some emotions cause loss of intention recognition and mis-functioning of emotional regulation and attributional processes which ultimately shape one’s subjective experience of isolation, marginalization as well as inability to secure and sustain one’s job and relationship (Salarhaji et al., 2025).

Recent studies that targeted social cognition directly showed positive effects for cognitive and functional prognosis. The mSoCIAL intervention enhanced ability to recognize emotions, have a theory of mind and carry out functional abilities. The study found significant improvement in various real life domains such as work skills and interpersonal relationships compared to treatment as usual. The data suggests that social cognition can be altered and is a mediator between symptoms and PSP. (Giuliani et al., 2024).

2.4.3 Stigma, internalized beliefs and emotional distress.

Social withdrawal and poor functioning are linked to stigma, shame and lack of confidence. Adults with a legal guardian had more hospitalizations, longer illness duration, poorer interpersonal functioning and significantly lower perceived family support relative to those without a guardian in a Turkish inpatient sample (İzci et al., 2024). A logistic regression analysis revealed that an internalized stigma, social support and interpersonal functioning were all related to guardianship. The findings show how clinical and psychosocial factors interact to limit autonomy and social performance. (İzci et al., 2024).

2.5 Sociodemographic and Contextual Factors.

Environmental Resources and Sociodemographic Characteristics can Buffer or Exacerbate Functional Impairment. When looking at the literature concerning functional instruments, it can be seen that better scores on outcomes such as the PSP, PSF and the Social Functioning Scale are consistently associated with more education, employment and greater social network size (Clausen & Ruud, 2024).

Employment is particularly salient. The narrative of patients suffering from mental health independent is the theme of restoring identity through employment. As the patients narrate work brings structure to life and provides identity and worth. More

so, unemployment brings marginalization and identity crisis as they depend on families. (Salarhaji et al., 2025).

Family and community support is also important. A recent study on guardianship has shown that perceived social support from family and friends is strongly associated with higher social functioning. Also, when a person has lower perceived social support, a legal guardianship will be imposed on that person (İzci et al., 2024). Living among supportive relatives may prevent severe functional decline, while isolation may accelerate disability because disability rates are affected by context (Thornicroft, 2006).

In developed community mental health services high income countries, contextual supports, such as disability benefits, supported housing and vocational rehabilitation, can partially compensate for limitations caused by illness (Giuliani et al., 2024). There is a lack of research on the PSP from different low- and middle-income settings where educational opportunities, employment conditions and family roles are markedly different. Other than the research on negative symptoms, no research in Bangladesh has systematically examined the role of age, gender, education, marital status, employment or income on personal and social performance measured by PSP.(Bhuiyan et al., 2022)

2.6 Rehabilitation, occupational therapy and assessment Innovations

With consistent functional deficits, psychosocial and rehabilitative interventions are increasingly emphasized with pharmacotherapy. A review study using various techniques in 13 interventions found that different techniques given by an occupational therapist including skill training, cognitive-based OT, psychosocial OT, CBT-based OT, creative activities and peer-support programmes result in a significant improvement in the functional level and better quality of life in people with

schizophrenia (Anggraini et al., 2020).

Indonesia undertook an OT programme aimed at improving ADL amongst in-patients with schizophrenia, using pre-post comparisons. Organized questioning sessions on self-care and daily activities resulted in a great increase in independence scores with p-value of $p < 0.0001$. These gains translate directly to PSP domains, including those associated with self-care and socially useful activities (Haya & Agustina, 2024).

The OT review also looked at other studies combining group OT with individualized components (eg motivational interviewing, psychoeducation, self-monitoring and discharge planning), which were found to improve cognitive functioning, intrinsic motivation and social functioning compared to group OT alone. Three years of follow-up revealed that creative interventions built on activities were associated with sustained improvement in the performance and satisfaction of users (Anggraini et al., 2020).

Improvements in emotional recognition, theory of mind, and real-life functioning domains like work skills and social relationships have been demonstrated by remediation of social cognition (e.g. mSoCIAL) beyond conventional OT.(Giuliani et al., 2024) Some reviews argue that adding metacognitive and social-cognitive targets to rehabilitation may maximise gains in PSP. Specifically, the argument is that assistance to create coherent self-narratives and more accurate social-situational understanding could do this (Montemagni et al., 2024).

Finally, measurement science is also evolving. Looking at functional outcome tools reveal the shortcomings of solely focusing on global milestones like competitive employment in short clinical trials. They recommend using a combination of interviewer-rated measures such as the PSP or PSF, performance-based tasks and

digital measures (Clausen & Ruud, 2024; Searle et al., 2022) Tools such as smartphone data, ecological momentary assessment, and virtual-reality-based methods are assessed to capture subtle changes in daily functioning that may occur before large shifts in PSP scores (Searle et al., 2022).

Studies from diverse countries show that most individuals with schizophrenia have moderate to severe functional impairment when assessed on the PSP, even when clinically stable and receiving treatment. García-Portilla and colleagues (2011) reported the mean PSP score in the low to mid-range in a large Spanish cohort of out-patients indicating marked difficulties at work, in social relationship and self-care. In a later study focusing on negative symptoms, the same group demonstrated that patients with major negative symptoms had especially low PSP scores and were often unemployed or socially isolated (García-Portilla et al., 2021).

The Italian Foundation for Psychosis Research is a study of more than 900 patients with physical dysfunction living in the community. Using network analysis, Galderisi et al. (2018) showed that real-life functioning (measured with different functional scales, including PSP and the Specific Level of Functioning scale) was significantly impaired for the majority of participants, forming a separate cluster from psychopathology. In a study that followed the cohort for four years, Mucci et al. (2021) found that only a minority of patients obtained a ‘good outcome’ in terms of functioning; most remained in the moderate-disability range despite ongoing mental-health care.

Usually, the impairment is the greatest in social usefulness and interpersonal relationship for specific PSP domains. Individuals often have a lack of competitive employment, difficulties maintaining friendships and a limited ability to participate in community roles (Giuliani et al., 2021; Montemagni et al., 2024). Self-reliance

functioning tends to be somewhat better but still remains compromised in a good proportion of patients (Galderisi et al., 2020). Stable patients are less likely to display disturbing or aggressive behaviour. However, even low levels of behavioural dysregulation can hamper integration in the community Pappa et al., 2011.

Pharmacological studies using PSP as a measure show that control of symptoms does not equal complete functional recovery. In a trial of long-acting risperidone I. S. M., PANSS and C G I improvements were attended by significant but moderate increases in P S P which did not get many patients to independent functioning (Litman et al, 2023). Broader reviews show similar patterns: “antipsychotics and other biological treatments can improve functioning these treatments are frequently associated with a residual impairment in personal and social functioning” (Searle et al., 2022, p.17; Montemagni et al., 2024).

2.7 Key gaps of the study

- Very few studies assessed personal and social performance of schizophrenia patients and most studies were conducted in hospital based.
- Most studies utilized clinical samples from high-income countries. Moreover, there are no PSP-based studies from low-and middle-income countries including Bangladesh.
- Usually, the rest of the research acknowledged the relevance and importance of different sociodemographic predictors like education, income and employment, etc. but, it did not actually make a complete study of them in relation to their PSP scores.

CHAPTER III: METHODS & MATERIALS

3.1 Study questions, aim and objectives.

3.1.1 Study Questions.

What is the level of personal and social performance among patients with schizophrenia and is there any association between personal and social performance scores and selected sociodemographic factors among patients with schizophrenia?

3.1.2 Aim of the Study.

The aim of the study is to assess the personal and social performance among patients with schizophrenia.

3.1.3 Objectives of the Study

- To assess the overall level of personal and social performance among patients with schizophrenia.
- To identify the sociodemographic characteristics of the respondents.
- Identify the association between Personal and social performance score and sociodemographic factors.

3.2 Study Design

3.2.1 Study Method

Quantitative study is a technique that gathers and dissects mathematical information to recognize examples and connections. It guarantees objectivity, dependability, and generalizability by utilizing organized instruments like studies and state sanctioned tests.

This study will embrace a quantitative way to deal with give a goal and normalized evaluation of the individual and social exhibition of schizophrenia patients. The Individual and Social Presentation (PSP) Scale will be utilized to create

mathematical scores, taking into account examinations across people. Factual strategies will guarantee exactness in distinguishing critical elements affecting social working. Since the review will break down connections among segment and clinical factors, this approach will be the most reasonable for reaching significant inferences and illuminating proof-based mediations (Creswell and Creswell, 2018).

3.2.2 Study Approach

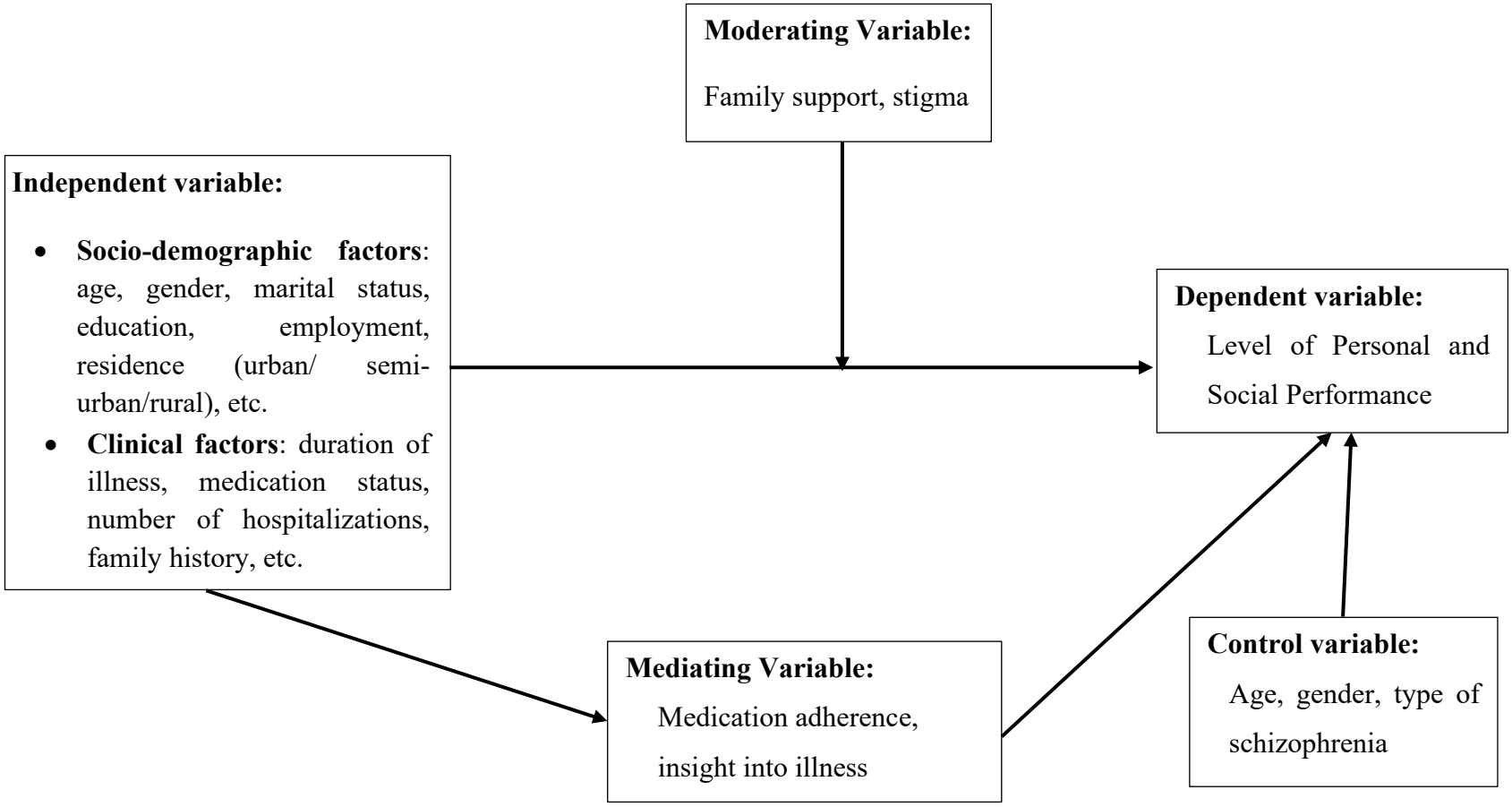
A cross-sectional study is one that involves the collection of data from a single population at one given time. Health and social scientists often use surveys to identify the prevalence of various conditions, measure other variables and study associations. This approach is quite economical, saves time, and enables many variables to be analyzed.

The study will take on a cross-sectional design as it will provide a depiction of the personal and social functioning of schizophrenia patients in Bangladesh at a particular point in time. It will make it possible to assess various psychosocial domains such as social relations, self-care, and aggressive behaviors using the Personal and Social Performance (PSP) Scale. In addition, this method will help to identify key demographic and clinical factors affecting social functioning without requiring long-term follow-up. Because of the limited resources and time constraints, a cross-sectional method will be the most practical and effective method to achieve the study's objectives (Setia, 2016).

3.3 Conceptual framework

Figure 3.1

Conceptual framework



3.4 Study Setting and Period

3.4.1 Study Setting

The research was conducted in selected mental health hospital and day care centre including,

- National Institute of Mental Health & Hospital, Dhaka.
- Pabna Mental Hospital, Pabna.
- CRP-Rabia Noor Mental Health Day centre.

3.4.2 Study Period.

The total study period was from 15 June 2025 to 15 December 2025. The data collection period was from August 02, 2025, to September 15, 2025.

3.5 Study Participants.

3.5.1 Study Population.

The study population consisted of adult aged between 18-60 years both male and female, who had been diagnosed with schizophrenia and were receiving treatment at mental health hospitals and day care centers across Bangladesh.

3.5.2 Sampling Techniques

The study used purposive sampling, as the subject of study was decided to utilize people with definite clinical features, namely, cases of schizophrenia receiving care at mental health facilities. The researcher can purposefully sample participants according to the researcher's own inclusion criteria, thus allowing for a sample which is directly relevant to the researcher. In clinical and hospital-based studies, purposive sampling is therefore appropriate and widely used as the target population has unique characteristics (Polit & Beck, 2021; Creswell & Creswell, 2018).

3.5.3 Inclusion Criteria

- Diagnosed with schizophrenia by a qualified psychiatrist.
- Aged between 18 to 60 years.

3.5.4 Exclusion Criteria

- Suffering from severe physical illnesses or neurological disorders (e.g., stroke, Parkinson's disease) that could affect personal and social functioning.
- Unable to provide informed consent due to cognitive impairment or communication difficulties.

3.5.5 Sample Size.

The formula of one sample population is used to calculate the sample size:

$$n = \frac{z^2 p(1-p)}{d^2}$$

Where:

n = desired sample size

Z = standard normal deviation, usually set at **1.96**, which corresponds to **95%** Confidence Interval (CI).

p = estimated proportion of the population with the characteristic of interest (**0.5** for maximum variability assumption)

d = margin of error **0.05** (5% margin of error)

$$n = \frac{(1.96)^2 \times 0.5 \times (1-0.5)}{(0.1)^2}$$

$$= \mathbf{384.16}$$

According to this equation, the sample should be 384 participants. After matching the inclusion and exclusion criteria within a short period of time, the researcher reached 124 participants.

3.6 Ethical Considerations

The researcher maintained ethical considerations according to the Helsinki Act ‘s 2013 guidelines:

3.6.1 Ethical Clearance

Ethical clearance had been sought from the Institutional Review Board (IRB) explaining the study's aim, objectives, and purpose through the Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI). The IRB form number CRP-BHPI/IRB/07/2025/1119 (see in details appendix-A). The ethical processes were followed according to World Medical Association (WMA) created for medical research (World Medical Association Declaration of Helsinki, 2014).

3.6.2 Informed Consent

The researcher explained the aim, objectives, and purpose of the study to the participants through an information sheet (See appendix B for more details). The participants expressed their willingness to take part in the study and to have their data collected. Verbal consent was obtained from the participants.

3.6.3 Unequal Relationship

There was no opportunity for bias as the researcher did not know the participants. So, there was no chance of having a power relationship. The researcher used a standardized questionnaire for each participant to obtain data.

3.6.4 Risk and Beneficence

The participants did not involve any risk and did not get any benefit for participating in this study. The study's risks and benefits are among the most important considerations when doing research on human subjects. The researcher did not pay or offer any other benefit to the participants for giving data. The risk comprises both the possibility of injury and its consequences (Barke, 2009). The participants' provision of the

information was voluntary and came with no risk.

3.6.5 Confidentiality

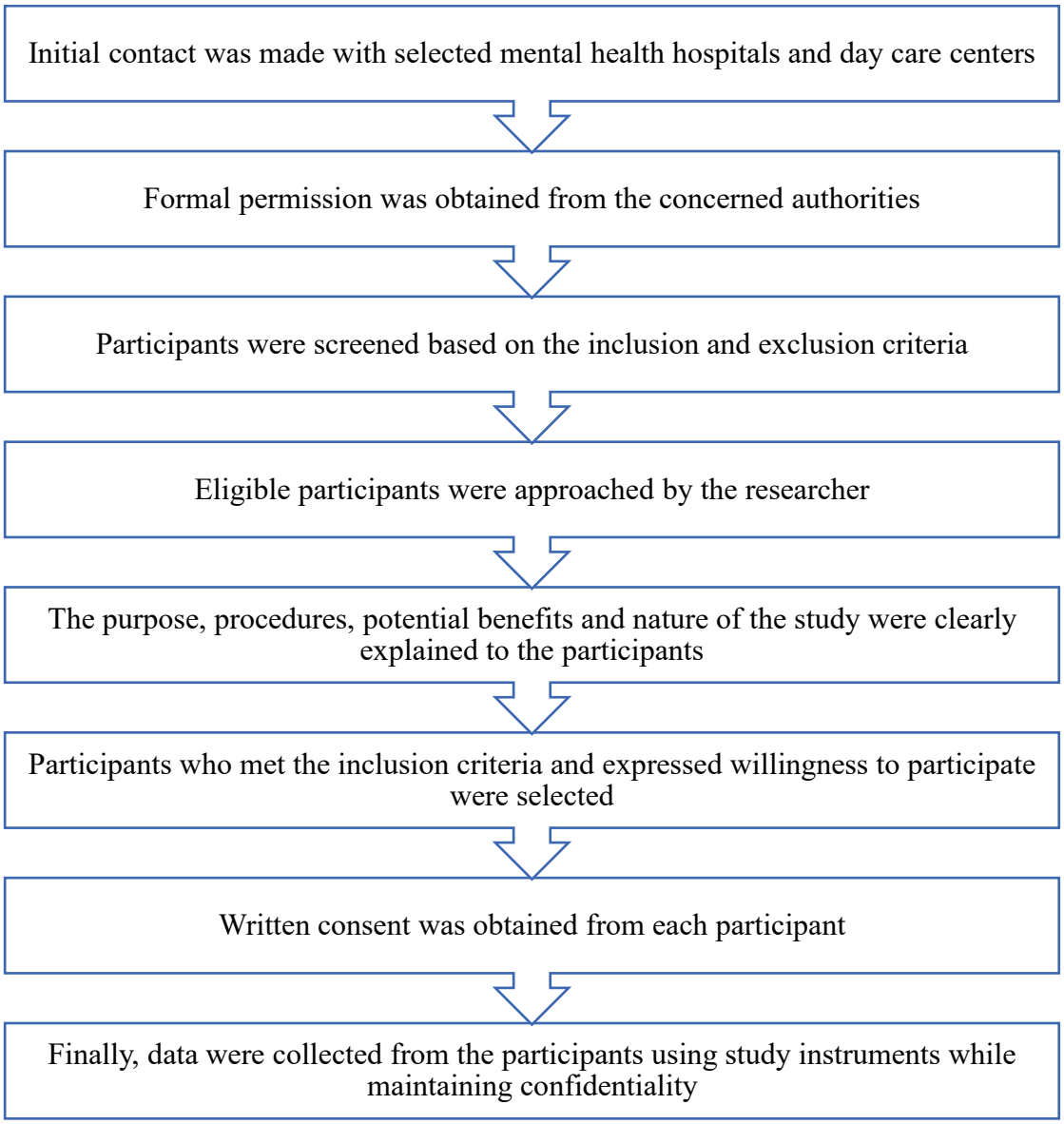
The researcher was highly concerned about the confidentiality of the participants' information. Their name, identity, and other sociodemographic information were not disclosed to anyone except the supervisor which was clearly stated in the information sheet. Besides this, any identical information of participants' will not be revealed for future uses, such as report writing, publication, conference, media or any written or discussion. The participants were clearly informed about confidentiality by an information sheet.

3.7 Data Collection Process.

3.7.1 Participant Recruitment Process

Figure 3.2

Participant Recruitment Process



3.7.2 Data collection method

The data was collected through a face-to-face survey by the researcher through a socio-demographic questionnaire, and the PSP Scale (For details about the tools, see section-3.7.3 "Data Collection Instrument"). The researcher administered the questionnaire in

person. Face-to face administration helped data quality and enhanced trustworthiness during data collection (Doyle, 2014). Several advantages existed for face-to-face surveys. These surveys were flexible and structured. They were founded on interpersonal communication and were controlled within the survey (Szolnoki & Hoffmann, 2013)

3.7.3 Data Collection Instruments.

- **Sociodemographic Questionnaire**: Participants' background information was collected using a researcher-developed sociodemographic and clinical information form. This section contained items on age, gender, marital status, level of education, occupation, monthly income, place of residence, duration of illness, and current treatment status. The purpose of the form is to detect factors possibly related to performance, both personal and social (see details in Appendix C).
- **Personal and Social Performance (PSP) Scale:** The researcher measured the level of personal and social performance among patients with schizophrenia using The Personal and Social Performance (PSP) scale. The PSP is a clinician rated tool to assess functioning in four domains: a. socially useful activities, b. personal and social relationships, c. self-care and d. disturbing and aggressive behaviors.

  Each domain of measure is rated on a six-point severity scale. The last overall score is taken between 1 and 100. Higher the score better is the functioning of the person.

3.7.4 Field Test

The researcher, with the help of the supervisor and an expert in formal Bengali writing, translated the questionnaire into Bengali, which is the native language of Bangladesh. To identify potential problems with the questionnaire, it was pretested among two respondents who were similar to the study population but outside the study area. After pretesting, the questionnaire was finalized with the necessary corrections for the study.

3.8 Data Management and Analysis

Data was collected from participants and analyzed using the Statistical Package for Social Science (SPSS) version 27. Research data management involves organizing, documenting, storing, and preserving data generated during the research process (Surkis & Read, 2015). Descriptive statistics was used to analyze and report the demographic variables, overall PSP. Descriptive statistical analyses were calculated to determine frequencies and percentages of survey responses, and appropriate statistical tests were adopted to examine the association or relationship between variables.

3.9 Quality Control and Quality Assurance

To ensure the quality and reliability of data the five stages of data lifecycle management were followed properly in this study. The data collection was conducted by face-to-face survey, data collection from participants was unbiased. Data entry into SPSS was carried out carefully to avoid mistakes, check out errors and missing data. Data analysis was carried out by recoding and computing. All the data was securely stored in google drive with a strong password to prevent unauthorized access. To protect confidentiality all will be destroyed after the study.

CHAPTER IV: RESULTS

A cross-sectional study was conducted on the Personal and Social Performance among patients with Schizophrenia. This section provides a statistical analysis of the findings. The findings of the study have been analyzed and represented by using table in a systematic way.

4.1 Sociodemographic characteristics

Table 4.1

Distribution of sociodemographic characteristics of the respondents

Personal Information of the respondents			
Variable	**Category**	**Frequency (n=124)**	**Percentage (%)**
Gender	Male	84	67.7
	Female	40	32.3
Age	18-30 years	72	58.1
	31-45 years	42	33.9
	46-60 years	10	8.1
	Mean=31.38 years, SD (± 9.580), Minimum= 18 years, Maximum=60 years		
Marital Status	Unmarried	66	53.2
	Married	42	33.9
	Divorced	15	12.1
	Widowed	1	.8
Educational Level	No formal education	9	7.3
	Primary	38	30.6
	Secondary	29	23.4
	Higher Secondary	31	25
	Graduate	9	7.3
	Postgraduate	8	6.5
Current Occupational status	Unemployed	92	74.2
	Student	3	2.4
	Housewife	17	13.7
	Day laborer	2	1.6
	Private job	3	2.4
	Government job	1	.8
	Business	5	4
	Farming	1	.8

Monthly family income	Less than 15000 Taka	69	55.6
	15001-60000 Taka	51	41.1
	More than 60000 Taka	4	3.2
	Mean=20975.81 Taka, SD (± 23968.209), Minimum= 1500 Taka, Maximum=200000 Taka		
Division	Dhaka	44	35.5
	Chattogram	21	16.9
	Rajshahi	10	8.1
	Khulna	10	8.1
	Barishal	20	16.1
	Sylhet	2	1.6
	Rangpur	4	3.2
	Mymensingh	13	10.5
Area of residence	Urban	32	25.8
	Semi-urban	15	12.1
	Rural	77	62.1
Living Arrangement	With family	117	94.4
	Alone	3	2.4
	Lives with maternal	1	.8
	uncle	1	.8
	Sister's home	2	1.6
	With Brother's home		
Religion	Islam	117	94.4
	Hinduism	7	5.6

Clinical characteristics of the respondents

Variable	Category	Frequency (n=124)	Percentage (%)
Duration of illness	Less than 5 years	63	50.8
	5.1-15 years	55	44.4
	More than 15 years	6	4.8
	Mean=6.759 years, SD (±5.2512), Minimum= 0.1year, Maximum=25 year		
Duration of Treatment	Less than 5 years	75	60.5
	5.1-15 years	44	35.5
	More than 15 years	5	4.0
	Mean=5.822 years, SD (±5.2431), Minimum= 0.1year, Maximum=24 year		
Type of Treatment Received Counseling or Psychotherapy	Yes	101	81.5
	No	23	18.5
Type of Treatment Received Occupational Therapy	Yes	54	43.5
	No	70	56.5
Type of Treatment Received Hospitalization	Yes	122	98.4
	Day care centre	2	1.6

History of Hospitalization	Yes	51	41.1
	No	73	58.9
Number of hospitalizations	1-5	48	94.1
	6-10	2	3.9
	11-15	1	2
	Mean=1.86, SD (±2.059), Minimum= 1 times, Maximum=13times		
Family History of Mental Illness	Yes	20	16.1
	No	104	83.9
Substance use history	Yes	34	27.4
	No	90	72.6

Functional & Social Background characteristics

Variable	Category	Frequency (n=124)	Percentage (%)
Engage in any work, academic study, or voluntary activities	Yes	10	8.1
	No	114	91.9
Participate in household tasks	Yes	67	54
	No	57	46
Maintaining personal hygiene	Yes	80	64.5
	No	23	18.5
	Sometimes	21	16.9
Relationship with family and friends	Good	38	30.6
	Fair	32	25.8
	Poor	39	32.5
	None	15	12.1
Last 6 months, attending any social events	Yes	10	8.1
	No	114	91.9
Difficulty controlling anger or aggression	Yes	85	68.5
	No	39	31.5

Table 4.1 shows the findings of the sociodemographic characteristics of the respondents. First part of the table shows the participant's gender, age, marital status, educational level, current occupational status, monthly family income, division, area of residence, living arrangement and religion. The total number of participants in this study was 124. Among them, male was 67.7% (n=84) and female was 32.3% (n=40). A majority of participants 59.1% (n=72) were between 18 to 30 years, The average age of the participants was 31.38 years, with a standard deviation of ± 9.580. Most respondents were unmarried 53.2% (n=66). Regarding education, 30.6% (n=38) had

completed primary education and 6.5% (n=8) had completed postgraduate education. Regarding most respondents were unemployed 74.2% (n=92). The average monthly family income was 20975.81 BDT., with a standard deviation of ± 23968.209. Furthermore, 92.7% (n=115) of the respondents reported a monthly family income below 15000 BDT. Most respondents were from Dhaka division 35.5% (n=44) and resided in rural areas 62.51% (n=77). And the religious distribution was Islam 94.4 (n=117) and Hinduism was 5.6% (n=7).

Next part of the table shows the findings related to the clinical characteristics of the participants. The majority duration of illness among the participants 50.8% (n=63) were between less than 5 years. The average duration of illness of the participants was 6.759 years, with a standard deviation of ± 5.2512 and the majority duration of treatment among the participants 60.5% (n=75) were between less than 5 years. The average duration of treatment of the participants was 5.822 years, with a standard deviation of ±5.2431. The number of treatments Received Counseling or Psychotherapy were 81.5% (n=101) and number of treatments Received occupational therapy ware 43.5% (n=54). Nearly all participants 98.4%, (n=22) had undergone hospitalization, and only 1.6% (n = 2) reported attending a day care centre. History of hospitalization was found in 41.1% (n=51) of respondents where majority number of hospitalization 94.1% (n=48) were between 1-5 years, and 58.9% (n=73) had never been hospitalized. Regarding family history of Mental Illness were 16.1% (n=16) while 83.9 (n=104) hadn't any family history of Mental Illness. Furthermore, 27.4% (n = 34) of the participants had history of substance use, compared to 72.6% (n = 90) who had no substance use history.

And the last part of the table shows the Functional & Social Background characteristics of the participants. Only 8.1% (n=10) engage in any work, academic

study, or voluntary activities while the majority 91.9%, (n = 114) were not involved in any work, academic study, or voluntary activities. In the term of Participate in household tasks 54% (n=67) were participated but 46% (n=57) were not participated. Regarding 64.5% (n=80) maintained their personal hygiene properly but 16.9% (n=21) were maintained sometimes and 18.5 (n=23) were not maintained their personal hygiene. In the term of relationship with family and friends 30.6% (n=38) were good, 25.8% (n=32) and 32.5% (n=39) were fair and poor. And 12.1 (n=15) were no relationship with family and friends. Attending any social events last 6 month 91.9% (n=114) were not attended and only 8.1% (n=10) were attended. Lastly, 68.5% (n=85) of the participants faced difficulties controlling anger or aggression, where 31.5% (n = 39) did not face any difficulties.

4.2 Distribution of severity levels across PSP domains of the respondents.

Table 4.2

Distribution of severity levels across PSP domains of the respondents

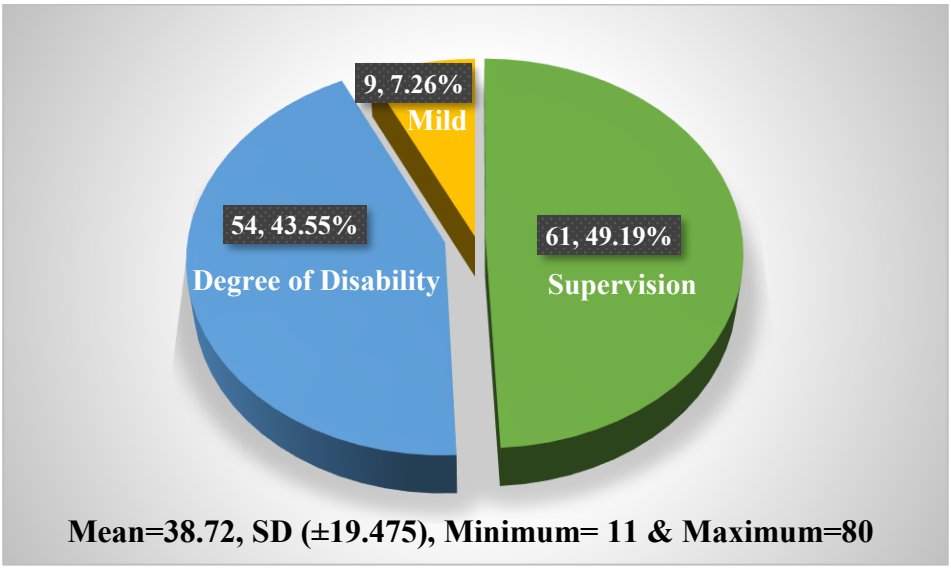
Variable	Frequency& Percentage n (%)					
	Absent	**Mild**	**Manifest**	**Marked**	**Severe**	**Very Severe**
Socially useful activities, including work or academic study	0(0)	11(8.9)	14(11.3)	32(25.8)	67(54.0)	0(0)
Personal and social relationships	1(0.8)	12(9.7)	36(29.0)	33(26.6)	42(33.9)	0(0)
Self-care	8(6.5)	27(21.8)	42(33.9)	33(26.6)	14(11.3)	0(0)
Disturbing and aggressive behaviors	29(23.4)	16(12.9)	10(8.1)	19(15.3)	33(26.6)	17(13.7)

Table 4.2 shows the Distribution of severity levels across PSP domains of the respondents.

4.3 Summary of Personal and Social performance total score

Figure 4.1

Summary of Personal and Social performance total score (N=124)



The Summary of Personal and Social performance total score are represented in figure 4.1. Scores from 1-30 were classified as supervision, 31-70 as degrees of disability and 71-100 as mild difficulty. Almost half (49.19%) of the subjects meet the supervision category and they require more functional support. Furthermore, 43.55% were classified as having some degree of disability and Around 7.26% of the participants were identified with mild difficulty. The average PSP score of the participants was 38.72, with a standard deviation of ± 19.475. And the minimum and maximum PSP score was 11 and 80.

4.4 Normality Test

Table 4.3

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	**df**	**Sig.**	**Statistic**	**df**	**Sig.**
Total personal and social performance score	.185	124	.001	.887	124	.001

Total personal and social performance score $p < .05$ (K-S = .001, S-W = .001), so data is NOT normally distributed, therefore use non-parametric tests.

Normality was checked using Lilliefors Significance Correction with Kolmogorov-Smirnov test and Shapiro-Wilk test Based on the results, Normality testing of total Personal and Social Performance score showed a significant deviation from normality (K-S $p < .001$, S-W $p < .001$). Therefore, non-parametric statistical tests were used.

4.5 Mann-Whitney U Test

Table 4.4

Mann-Whitney U test for Personal and Social Performance score across selected variables

Variable	Personal and Social Performance score			
	Category	**n**	**Mean Rank**	***p*-value**
Gender	Male	84	61.99	.818
	Female	40	63.58	
Religion	Islam	117	62.02	.540
	Hinduism	7	70.57	
Type of treatment received Counseling/ Psychotherapy	Yes	101	63.06	.716
	No	23	60.04	
Type of treatment received Occupational Therapy	Yes	54	67.36	.185
	No	70	58.75	
History of Hospitalization	Yes	51	66.82	.262
	No	73	59.48	
Family History of Mental Illness	Yes	20	60.88	.825
	No	104	62.81	

Substance Use History	Yes	34	71.62	.082
	No	90	59.06	
Engages in Work/Study/Voluntary Activity	Yes	10	75	.251
	No	114	61.40	
Participation in Household Tasks	Yes	67	74.77	**.001**
	No	57	48.08	
Attended Social Events (6 months)	Yes	10	51.40	.308
	No	114	63.47	
Difficulty Controlling Anger/Aggression	Yes	85	52.37	**.001**
	No	39	84.58	

Using Mann-Whitney U test, the study aimed to investigate the differences in the personal and social performance (PSP score) of various sociodemographic and clinical groups. Findings showed that gender did not significantly influence PSP scores (p =.818). This means that the levels of personal and social functioning of both genders were more or less the same. Similarly, there were no differences in Religion (p =.540), treatment received counselling/psychotherapy (p =.716) and occupational therapy (p =.185) received that resulted in a difference in scores on the PSP score. Clinical characteristics encompassing history of hospitalization, family history of mental illness, and substance use history do not exert a significant influence on the personal and social performance score (p =.262, p =.825, p =.082). There was no significant difference between those who participated and those who did not participate in work, academic study or voluntary activities (p = .251). Just like before, there were no differences in PSP scores associated with social event attendance in the last 6 months (p =.308).

Two variables did have significant differences. Those who regularly participated in household chores had a much higher PSP score compared to those who did not take part regularly (p=.001). Furthermore, people who had trouble controlling their anger or aggression had lower PSP scores than people that do not have trouble with these things (p =.001). The more people draw from their own resources to engage

in functional activities, and the more they self-regulate, the better their performance at personal and social levels.

4.6 Linear regression assessing the association between PSP Score and Participation in Household Tasks

Table 4.5

Linear regression assessing the association between Personal and Social Performance Score and Participation in Household Tasks

Predictor	**Personal and Social Performance Score**			**t**	***P*-value**
Participation in Household Tasks	**B (CI)**	**Std. Error**	**Beta**		
Yes	Reference				
No	-7.288(-10.522- -4.054)	1.634	-0.375	-4.461	.001

According to Table 4.5, the regression model has assigned participation in household activities as a predictor of total PSP score. This variable positively predicts personal and social functioning, as the model suggests.

Those defined as 'No' had on average a total PSP score that was 7.288 points lower than that of the reference group (those who participate in household tasks) - (B = - 7.288, SE = 1.634, β = – .375, t = - 4.461, $p < .001$). There is a moderate to strong negative relationship according to the standardized coefficient (β = −.375) Thus, not participating in household activities is associated with poor personal and social performance.

4.7 Linear regression assessing the association between PSP Score and Difficulty Controlling Anger/Aggression

Table 4.6

Linear regression assessing the association between Personal and Social Performance Score and Difficulty Controlling Anger/Aggression

Predictor	**Personal and Social Performance Score**			**t**	***P*-value**
Difficulty Controlling Anger/Aggression	**B (CI)**	**Std. Error**	**Beta**		
Yes	Reference				
No	9.557 (6.229-12.886)	1.681	0.458	5.684	.001

According to table 4.6 looks at Difficulty Controlling Anger/Aggression as a predictor of total PSP score. This factor also emerged as a significant predictor.

Compared to their reference group (who have difficulty controlling their anger/aggression), those in "No" have higher overall PSP scores by 9.557 points (B = 9.557, SE = 1.681, $\beta = .458$, $t = 5.684$, $p < .001$). The large standard coefficient indicates a strong positive association, significant absence of difficulty in controlling anger/aggression leads to marginally better personal and social performance among schizophrenia patients.

4.8 Kruskal-Wallis Test

Table 4.7

Kruskal-Wallis Test Results for Total Personal and Social Performance Score Across Grouping Variables

Variable	Personal and Social Performance score			
	Category	n	Mean Rank	*p*-value
Age	18-26	47	55.06	.198
	27-36	43	62.28	
	36-44	21	68.31	
	45-53	6	77.50	
	54-62	7	83.50	
Marital Status	Unmarried	66	59.11	.415
	Married	42	69.44	
	Divorced	15	59.87	
	Widowed	1	34.50	
Educational Level	No formal education	9	47.83	.423
	Primary	38	59.16	
	Secondary	29	62.07	
	Higher Secondary	31	73.23	
	Graduate	9	62.28	
	Postgraduate	8	55.13	
Current Occupational Status	Unemployed	92	59.19	.318
	Student	3	64.17	
	Housewife	17	77.12	
	Day laborer	2	31.25	
	Private job	3	87.33	
	Government job	1	79.00	
	Business	5	73.80	
	Farming	1	28.50	
Monthly family income	Less than 15000 Taka	69	63.43	.439
	15001-60000 Taka	51	63.02	
	More than 60000 Taka	4	39.88	
Area of Residence	Urban	32	62.63	.470
	Semi-urban	15	72.87	
	Rural	77	60.43	
Living Arrangement	With family	117	62.38	.190
	Alone	3	36.00	
	Others (maternal uncle, Sister's	4	85.75	

	home, Brother's home)			
Duration of illness	Less than 5 years	63	63.76	.251
	5.1-15 years	55	63.96	
	More than 15 years	6	35.83	
Duration of Treatment	Less than 5 years	75	64.31	.254
	5.1-15 years	44	62.32	
	More than 15 years	5	36.90	
Number of hospitalizations	1-5	48	25.82	.679
	6-10	2	33.75	
	11-15	1	19.00	
Maintain Personal Hygiene	Yes	80	75.89	**.001**
	No	23	34.76	
	Sometimes	21	41.86	
Relationship with family and friends	Good	38	76.68	**.002**
	Fair	32	68.02	
	Poor	39	47.13	
	None	15	54.77	

The Kruskal-Wallis H test is use to test to see personal and social performance score differs across categories based on sociodemographic factors. The findings have reflected that total PSP scores were not affected by Age (p =.198), marital status (p =.415), educational level (p =.423), current occupational status (p =.318), Monthly family income (p =.439), area of residence (p =.470), living arrangement (p =.190), Duration of illness (p =.251), Duration of Treatment (p =.254) and Number of hospitalizations (p =.679).

The results show that there was a little difference between personal and social functioning in this sample. Two variables showed statistically significant group differences. The PSP scores for the participants significantly varied based on their personal hygiene maintenance (p =.001). Those who maintain better personal hygiene have better personal and social performance. There was also a significant difference between the categories of relationship with family and friends (p =.002), suggesting that stronger more supportive relationships are correlated with better performance on the PSP.

4.9 Linear regression assessing the association between PSP Score and Maintain Personal hygiene

Table 4.8

Linear regression assessing the association between Personal and Social Performance Score and Maintain Personal hygiene

Predictor	Personal and Social Performance Score			t	*p*-value
Maintain Personal Hygiene	**B (CI)**	**Std. Error**	**Beta**		
Yes	Reference				
No	-9.963 (-14.074 - -5.852)	2.077	-0.399	-4.798	**< .001**
Sometimes	-5.287 (-8.128--2.447)	1.435	-0.307	-3.685	**< .001**

According to Table 4.8, the regression model has assigned Maintain Personal hygiene as a predictor of total PSP score. This table showed that personal hygiene was a significant predictor of total PSP score. The individuals categorized under “No” had a reduction in the PSP score by 9.96 points (B= -9.963, SE=2.077, β= -.399, p<.001) as compared to the reference group. Further, “Sometimes” individuals had a reduction of 5.29 points (B= -5.287, SE=1.435, β=–.307, p<.001). The study findings entail that low-level personal and social performance are strongly related to poor personal hygiene.

4.10 Linear regression assessing the association between PSP Score and Relationship with family and friends

Table 4.9

Linear regression assessing the association between Personal and Social Performance Score and Relationship with family and friends

Predictor	**Personal and Social Performance Score**			**t**	***P*-value**
Relationship with family and friends	**B (CI)**	**Std. Error**	**Beta**		
Good	Reference				
Fair	-2.780 (-7.269-1.710)	2.268	-0.125	-1.226	.223
Poor	-4.502 (-7.345- -1.658)	1.436	-0.323	-3.134	.002
None	-2.654 (-5.507-.199)	1.441	-0.179	-1.842	.068

Table 4.9, evaluated how the nature of relationships with family and friends affected Personal and Social Performance. The only other predictor of PSP score, Poor, displayed a 4.50-point drop from the reference category (B = –4.502, SE = 1.436, β = –.323, p = .002). The other categories of relationships had negative coefficients but were not statistically significant. The study suggests that both deficient personal hygiene and poor family or social relations are significant negative predictors of personal and social performance in patients with schizophrenia.

CHAPTER V: DISCUSSION

This study investigates the level of personal and social performance in schizophrenia in Bangladesh and seeks to find an association of functioning of people with schizophrenia with sociodemographic and functional features. In functional terms, these results reflect that the majority of the subjects were moderately to severely impaired as evidenced by the average PSP score of 38.72. Almost half of the participants required supervision. The proportion of individuals with mild functional difficulty was small within our sample. Studies from other countries show that persons with schizophrenia have low PSP scores when clinically stable and treated. The same pattern is seen in the clinical and functional scores in India. Studies that have used the PSP scale in Europe, Asia and elsewhere show that this group continues to have a markedly restricted capacity for social utility, interpersonal relationships and community involvement, with full functional recovery being relatively infrequent The findings from Bangladesh correspond to global evidence that functional impairment is a central persistent feature of schizophrenia (Galderisi et al., 2018; García-Portilla et al., 2011; Mucci et al., 2021).

The findings of the study show similar difficulties for the domain. Involvement in working, studying or volunteering is quite low, with only a small portion of study participants claiming to be in active involvement. Many people do not go to sexual events and many people reported that they find it difficult to control their anger or aggression. The findings here are similar to other studies that found that people with schizophrenia have big deficits in social participation, work function and relationship skills (Giuliani et al. 2021; Searle et al. 2022). Limited self-care was not as common as you would perhaps imagine. This finding is common to many international PSP studies.

The study discovered through calculations that elderly individuals have weak correlations with higher PSP scores. Older adults functioned a bit better than younger adults. Some studies indicate that a longer duration of illness or earlier onset is associated with worse functioning. As indicated by other studies, older persons who reach a steady state of the illness may not be able to accommodate their daily routines and family responsibilities more easily (Giuliani et al., 2021). In Bangladesh, older adults often play a bigger role with their families in the household which seems to support their involvement in household chores, decision-making and socialising. These factors may be reflected in higher PSP ratings. So, age might collect personal adjustment as well as capture the effect of strong family structures which support functioning, in this context. (Nasrallah et al., 2008)

The researcher's statement about the relationship of socio-demographic variables with physical activity was as follows: "There is no association of educational level with physical activity". This contradicts the regression results of many studies in high-income countries. Research from Spain and Italy found that people who are more educated and employed are functionally better (Galderisi et al., 2018; García-Portilla et al., 2021). Most people in the study were unemployed. Also, the study found most people didn't involve in work, study or voluntary activity. The association could not be detected because of the lack of variability in occupational status. Structural unemployment and stigma, along with a lack of vocational rehabilitation options in Bangladesh, may hinder work from turning into jobs. People who can work don't have the right job. This weakens the link between functioning and employment. In the same way, the differences between these groups are not statistically different as almost all participants live at home with similar religions. (Hossain et al., 2021; Marwaha & Johnson, 2004)

PSP scores did not significantly relate to the duration of illness, treatment, or hospitalization history. According to some extensive studies, the longer a patient is ill, and the more times they are hospitalized, the worse their functioning becomes. However, studies like the one below that examine a single moment do not portray all of that. (Harvey & Strassnig, 2012)

The amount of time that a person was ill and how long they received treatment for were highly correlated in the present sample which that most people receive treatment for almost the whole time of the illness. If we fail to analyze symptoms affecting daily coping skills, just looking at duration won't meaningfully predict functioning. A number of international works have shown that, after accounting for sociodemographic and simple clinical variables, negative symptoms, cognitive deficits and social cognition predict functioning much better (García-Portilla et al., 2021; Montemagni et al., 2024).

PSP scores had significant association to participation in household tasks and difficulty in controlling anger/aggression. People who help out at home are more effective than their counterparts. According to the occupational therapy theory, the performance of appropriate daily activities leads to better psychosocial adjustment, self-efficacy and role competence (Haya & Agustina, 2024). Getting involved with household chores can help you develop a daily schedule, boost motivation, make your life more meaningful, and enhance your personal and social functioning. In fact, those individuals who reported trouble controlling their anger or aggression had lower scores on the PSP. It is not surprising that you came to this conclusion, as disturbing behaviour is one of the core domains of the PSP. Previous studies have found that a lack of control over one's behaviour leads to lower social acceptability, greater stigma, poorer

relationship quality, and disruption to work and community participation If someone has trouble controlling their anger, that may indicate that they have more serious symptoms or a lack of insight. (Pappa et al., 2011; García-Portilla et al., 2011).

People with schizophrenia suffer from negative symptoms, weak motivation, low metacognition and neurocognition and also low social cognition. Systematic reviews of functioning in SZ consistently show this. The impact of these factors remains unknown as we do not measure them. The impact of sociodemographic factors was likely attenuated in the sample due to unmeasured negative symptoms and cognitive deficits that impacted functioning. Studies indicate that negative symptoms, particularly avolition, anhedonia, and asociality, have strong aversive and dysfunctional effects on performance in work, social and independent living domains. The processes of social cognition and metacognitive together affect one's capability to comprehend social signals, maintain relations and navigate social contexts. These methods likely had a significant but unseen influence in the shaping of PSP outcomes. (Kirkpatrick et al., 2006; Foussias & Remington, 2010).

The results matter in real life for health-care providers of Bangladesh. The patient's symptoms and personal and social functioning as assessed with the PSP are helpful in-patient assessment. Managing anger should be part of the treatment. Emotional regulation is often overlooked. Psychoeducation and training in behaviour along with strategies to manage irritability and behaviour ups and downs help in better functioning.

The results highlight important messages for occupational therapy, namely, the importance of interventions that promote daily activity participation, performance of household chores, habit formation, and routine establishment.

Occupational therapists are important professionals that help people in enhancing

functioning through enabling, acquiring, adapting, and rebuilding skills for participation in meaningful activities. The study's findings on significantly low employment levels exhibit a glaring need for enhanced vocational rehabilitation and supported employment programmes. The author suggestions by the widening of community-based rehabilitation services and decreasing stigma could offer better opportunities to people with schizophrenia to use real-life roles and achieve community living (World Health Organization, 2010).

The use of a reliable assessment tool, investigation of an underserved population and multiple service settings all lend strengths to this study. Despite this, findings were occasionally difficult to interpret because of the cross-sectional design, purposive sampling, absence of assessments of symptoms and cognition, and small variation in the major predictors. The findings were consistent with international research despite these limitations, and they also help to shed more contextual light on functional impairment in Bangladesh. (Harvey & Strassnig, 2012; Green et al., 2000)

Schizophrenia influences the functionality of Bangladesh and the people of Bangladesh, particularly in terms of social and productive role. When one used household activities and controlled anger, it predicted functioning well. The remaining sociodemographic variables did not matter. Due to these results, therapeutic actions that concentrate on functioning rather than symptoms should be taken as soon as possible. It consists of biological, psychosocial and occupational therapies. (Lehman et al., 2004; Burns, 2004).

CHAPTER VI: CONCLUSION

6.1 Strengths and Limitations

6.1.1 Strengths

- Data was collected through a face-to-face survey using a standardized scale, eliminating the possibility of bias during both data collection and data entry processes.
- The study population has a particular and focused specific group in mind.
- Data life cycle management was followed to maintain the quality of the data in this study.
- Study-related data was securely stored in Google Drive with a strong password.
- To ensure data validity, all data used in this study will be destroyed after a certain period.
- This was the first study about Personal and social performance among persons with Schizophrenia in Bangladesh and globally.
- This study's findings assist rehabilitation health professionals in creating a comprehensive rehabilitation service plan for patients with Schizophrenia.

6.1.2 Limitations

There are certain limitations to the study.

- The study could not be performed on a larger sample owing to time constraint. The aim was to recruit more participants for this study but data was collected from only 124 participants as the study was allowed.
- The pool of recruitment was reduced as a few of the participants were hard to reach or refused participation. At times, some participants did not or could not provide information after consenting.

- Participants were recruited from mental health hospitals and day care centres, which may overrepresent individuals who are actively engaged in treatment. Patients living in the community without regular service contact were not included.
- Data were collected within a limited time frame, which may not capture variations in functioning related to symptom fluctuations or treatment changes over time.

6.2 Practice Implication

6.2.1 Recommendation for further practice

- Personal and Social Performance (PSP) assessment should be routinely used in clinical settings to evaluating the outcomes alongside symptom's severity in patients with schizophrenia.
- Occupational therapy interventions focusing on daily livings activities, household task, productivity should be strengthened in mental health facilities.
- Structured programs addressing personal hygiene and selfcare skills should be integrated into treatment plans, as these factors were strongly associated with better functioning.
- Family education and counseling should be promoted to strengthen interpersonal relationship and social support, which are essential for functional recovery.

6.2.2 Recommendation for further research

- A larger sample should be taken from various areas of Bangladesh to replicate this study.
- A longitudinal study is also suggested to check the change in PSP scores over a period of time. Furthermore, they would find out whether any socio-

demographic and clinical variables affect functionality in either direction.

- Negative symptoms, cognition and social cognition have a strong influence on the functional outcome Future research should use standardized measures of these variables.

6.3 Conclusion

The aim of the study to assess the personal and social performance of patients with schizophrenia. According to the study, schizophrenia patients experience significant problems related to personal and social functioning. Most need supervision or have a functional disability. Community participation in Bangladesh is hindered by low social participation and weak social relations. Some daily movements are more significant than some sociodemographic in influencing our functional outcomes. To have a meaningful rehabilitation of patients, it is vital for the rehabilitation programs to be both community-based and culturally relevant so as to improve daily functioning, not just control symptoms. Individuals diagnosed with schizophrenia can have greater independence and an improved quality of life with the help of an occupational therapist for meaningful activities.

CHAPTER VII: REFERENCE

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APPENDICES

Appendix A: Ethical Approval Form & Permission letter

IRB Approval Letter

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

Ref: CRP-BHPI/IRB/07/2025/1119 Date: 21.07.2025

To
Md. Nahidul Islam Shihab
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21, Student ID: **122200423**
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal **Personal and Social Performance among Patients with Schizophrenia** by ethics committee.

Dear Md. Nahidul Islam Shihab,
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned dissertation, with yourself, as the principal investigator and Prof. Sk. Moniruzzaman, Professor & Head, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The Following documents have been reviewed and approved:

SL No.	Name of the Documents
1	Research Proposal
2	Personal and Social Performance Scale (English & Bangla)
3	Information sheet & consent form

The purpose of the study is to assess the personal and social performance of patients with schizophrenia. The study involves use of a Personal and Social Performance scale to explore what is the level of personal and social performance among patients with schizophrenia that may take 20 to 30 minutes to fill the questionnaire and there is no likelihood of any harm to the participants. There is no benefit to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8:30 AM on 17 June, 2025 at BHPI (50th IRB Meeting).

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,
Muhammad Millat Hossain
Associate Professor, Project and Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404, Mobile: +88 01730059647
E-mail : principal-bhpi@crp-bangladesh.org, Web: bhpi.edu.bd

Permission for PSP Scale

SPECIAL TERMS No 120671

These Special Terms ("Special Terms") are issued between Mapi Research Trust ("MRT") and Md Nahidul Islam Shihab (User).

These Special Terms include the terms and conditions of the General Terms together, the Agreement, which are hereby incorporated by this reference as though the same was set forth in its entirety and shall be effective as of the Special Terms Effective Date set forth herein.

All capitalized terms which are not defined herein shall have the same meanings as set forth in the General Terms.

These Special Terms, including all attachments and the General Terms contain the entire understanding of the Parties with respect to the subject matter herein and supersedes all previous agreements and undertakings with respect thereto. If the terms and conditions of these Special Terms or any attachment conflict with the terms and conditions of the General Terms, the terms and conditions of the General Terms will control, unless these Special Terms specifically acknowledge the conflict and expressly states that the conflicting term or provision found in these Special Terms control for these Special Terms only. These Special Terms may be modified only by written agreement signed by the Parties.

1. User information

Category of User	Student
User contact details	Name: Md Nahidul Islam Shihab Email: shihabmdnahidulislam@gmail.com Phone: 01624567142

2. General information

Effective Date	Date of acceptance of these Special Terms by the User : 16 Aug 2025
Expiration Date (Term)	Upon completion of the Stated Purpose or full provision of translations, as applicable

3. Identification of the COA

Name of the COA	PSP - Personal and Social Performance Scale
Developer	Morosini P
Copyright Holder	Managed by Wiley
Copyright notice	PSP © Blackwell Munksgaard 2000, managed by Wiley
Bibliographic reference	Morosini PL, Magliano L, Brambilla L, Ugolini S, Pioli R. Development, reliability and acceptability of a new version of the DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS) to assess routine social functioning. Acta Psychiatr Scand. 2000 Apr;101(4):323-9 (PubMed abstract; Wiley Online Library)
Module(s)/version(s) needed	• PSP

4. Context of use of the COA

The User undertakes to use the COA solely in the context of the Stated Purpose as defined hereafter.

4.1 Stated Purpose

Observational studies, Marketing, Clinical practice and Educational projects

Title*	Personal and Social Performance among patients with Schizophrenia
Project reference	
Type of project*	Educational purpose
Sponsor*	N/A
Disease or condition*	Schizophrenia
COA used as primary end point	Yes

Permission from National Institute of Mental Health (NIMH) for Data Collection

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালক ও অধ্যাপকের কার্যালয়
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট ও হাসপাতাল
শের-ই-বাংলা নগর, ঢাকা- ১২০৭

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/ ২৫৯০ তারিখঃ ২৪/৮/২৫

বরাবর

এসকে মনিরুজ্জামান
অধ্যাপক এন্ড প্রধান
অকুপেশনাল থেরাপি বিভাগ
পক্ষাঘাতগ্রস্তদের পূনর্বাসন কেন্দ্র (সিআরপি)
চাপাইন, সাভার, ঢাকা।

বিষয় : গবেষনা সংক্রান্ত তথ্য (ডাটা) সংগ্রহের অনুমতি প্রদান প্রসঙ্গে।

উপরোক্ত বিষয়ের আলোকে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), ঢাকা এর বিএসসি চতুর্থ বর্ষের শিক্ষার্থী কে জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, শেরে বাংলা নগর, ঢাকায় "Personal and Social Performance among Patients with Schizophrenia" বিষয়ক গবেষনা সংক্রান্ত থিসিসের তথ্য উপাত্ত (ডাটা) সংগ্রহের জন্য অনুমতি প্রদান করা হলো।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা।

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/ তারিখঃ

অনুলিপি অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহনের জন্য প্রেরন করা হলো ঃ-

১। সহযোগী অধ্যাপক, চাইল্ড, এডলোসেন্ট এন্ড ফ্যামিলি সাইকিয়াট্রি বিভাগ, এনআইএমএইচ, ঢাকা।।
২। সহযোগী অধ্যাপক, জেরিয়াট্রিক এন্ড অর্গানিক সাইকিয়াট্রি, এনআইএমএইচ, ঢাকা।
৩। ড. মোঃ জহির উদ্দিন, সহকারী অধ্যাপক, ক্লিনিক্যাল সাইকোলজি, এনআইএমএইচ, ঢাকা।
৪। মোঃ জামাল হোসেন, সাইকিয়াট্রিক সোসাল ওয়ার্কার, এনআইএমএইচ, ঢাকা।
৫। রেসিডেন্ট সাইকিয়াট্রিস্ট, এনআইএমএইচ, ঢাকা।
৬। প্রশাসনিক কর্মকর্তা, এনআইএমএইচ, ঢাকা।
৭। পরিচালক মহোদয়ের ব্যক্তিগত সহকারী, জাতীয় মানসিক স্বাস্থ্য ইনষ্টিটিউট, ঢাকা।
৮। সহকারী লাইব্রেরিয়ান, এনআইএমএইচ, ঢাকা।
৯। অফিস কপি।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা

Permission from Pabna Mental Hospital for data collection

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালকের কার্যালয়
মানসিক হাসপাতাল, পাবনা।
e-mail:pmh@hospi.dghs.gov.bd

স্মারক নং-মাহাপা/কমিটি/২০২৫/ তারিখ:

অফিস আদেশ

অত্র কার্যালয়ের বহিঃ পত্র নিবন্ধন নং-২০৩১ তারিখঃ ২৫/০৮/২০২৫ খ্রি. মোতাবেক বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) ঢাকা এর Md. Nahidul Islam Shihab, (4th Year, B.Sc.in Occupational Therapy, Student ID-122200423, BHPI, CRP, Savar, Dhaka) কর্তৃক মানসিক হাসপাতাল, পাবনায় "Personal and Social Performance among Patients with Schizophrenia" শিরোনামে ডাটা কালেকশনের জন্য আবেদন করায় এবং অত্র কার্যালয়ের Ethical Committee এর সুপারিশ ক্রমে উক্ত বিষয়ে গবেষনা করার অনুমতি প্রদান করা হলো।

(ডা: শাফ্‌কাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।

স্মারক নং-মাহাপা/কমিটি/২০২৫/ তারিখ:

অনুলিপি সদয় অবগতি/অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য:

১। সিনিয়র সচিব, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
২। মহা-পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা। দৃষ্টি আকর্ষণঃ সহকারী পরিচালক (সমন্বয়)।
৩। মহাপরিচালক, স্বাস্থ্য শিক্ষা অধিদপ্তর, মহাখালী, ঢাকা।
৪। ডা: এহিয়া কামাল, চিকিৎসা তত্ত্বাবধায়ক,মানসিক হাসপাতাল, পাবনা।
৫। ডা: আহসান আজিজ সরকার, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৬। ডা: মো: রাজিবুর রহমান, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৭। ডা: এ কে এম শফিউল আযম আবাসিক সাইকিয়াট্রিষ্ট (ভারপ্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
৮। ডা: মো: রুহিদ হোসেন, জুনিয়র কনসালটেন্ট, জেনারেল হাসপাতাল, পাবনা।
৯। বোরহান উদ্দিন হায়দার, সাইকিয়াট্রিক সোসাল ওয়ার্কার (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১০। মো: মজাহার আলী, সাইকিয়াট্রিক সোসাল ওয়ার্কার, মানসিক হাসপাতাল, পাবনা।
১১। মো: জাকির হোসেন, সমাজসেবা কর্মকর্তা (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১২। মো: আলমগীর হোসেন, সমন্বয়কারী, বাংলাদেশ লিগ্যাল এইড এন্ড সার্ভিসেস ট্রাস্ট (BLAST), পাবনা ইউনিট।
১৩। Prof.SK Moniruzzaman, Professor & Head, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka.
১৪। Md. Nahidul Islam Shihab, (4th Year, B.Sc.in Occupational Therapy, Student ID-122200423, BHPI, CRP, Savar, Dhaka)
১৫। প্রধান সহকারী/পিএ/পরিসংখ্যান বিভাগ, মানসিক হাসপাতাল, পাবনা।
১৬। অফিস নথি।

(ডা: শাফ্‌কাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।
ফোন: ০২৫৮৮৮০-৫২১২

Permission from CRP-Rabia Noor Mental Health Day Centre for data collection

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)
CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 02/08/2025

To
The Project Manager,
Meaningful Social Access for Persons with Mental Health Needs
CRP, Chapain, Savar, Dhaka-1343

Subject: Regarding permission for data collection for undergraduate research.

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is **"Personal and Social Performance among Patients with Schizophrenia"** with myself & Prof. Sk. Moniruzzaman, Professor & Head, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as my thesis supervisor. The purpose of this study is to assess the personal and social performance of patients with schizophrenia and I have to use "Personal and Social Performance scale" which includes Personal and Social Performance of Schizophrenia patient. In order to fulfill the objectives of this study, I would like to collect data from individuals who are currently receiving services from Rabia Noor Mental Health Day Centre and the data collection period is from 02/08/2025 to 15/09/2025. I assure you that collected information that will be used solely for academic purpose and confidentiality will be maintain in accordance with ethical guideline. Your permission and support would be invaluable in facilitating the successful completion of my research.

So, I therefore, pray and hope that you would be kind enough to grant me permission to collect data for my study and oblige thereby.

Sincerely yours,
Shihab
Md. Nahidul Islam Shihab
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200423
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Permission is granted for data collection from CRP-Rabia Noor Mental Health Day Centre and strongly advised to maintain ethical standards and confidentiality in accordance with code of ethics related to the Psychosocial field.

Rabiul (R209)
09.08.25

Md. Rabiul Hasan
Project Manager
Mental Health Project-CRP

Recommendation from the Head of the Department:

Prof. Sk. Moniruzzaman
Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter.

Appendix B: Information Sheet & Consent Form [English and Bangla Version]

Explanatory statement, Information Sheet, Consent and Withdrawal Consent Form (English Version)

Participant Explanatory Statement

BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
Department of Occupational Therapy
CRP-Chapain, Savar, Dhaka-1343,
Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Code no.: ……...

Research information

Research title: Personal and Social Performance among Patients with Schizophrenia.

Researcher: Md. Nahidul Islam Shihab, B.Sc. in Occupational Therapy (4th Year), Session: 2020- 2021, Bangladesh Health Profession Institute (BHPI), Savar, Dhaka-1343

Supervisor: Prof. Sk. Moniruzzaman

Professor & Head, Department of Occupational Therapy, Bangladesh Health Profession Institute.

Co-Supervisor: Md. Azim Hossain

Lecturer, Department of Occupational Therapy, Bangladesh Health Profession Institute.

Research place: Bangladesh Health Profession Institute.

What is the purpose of this research?

The purpose of this study is to evaluate the personal and social performance of individuals diagnosed with schizophrenia in Bangladesh. This study seeks to better understand how schizophrenia impacts everyday life and social integration by

evaluating many elements of psychosocial functioning such as socially helpful activities, personal and social interactions, self-care, and disturbing/aggressive behaviors. The study will also look at characteristics that influence functioning, which will provide important insights into how schizophrenia affects people's general well-being. Finally, the data will be used to guide therapeutic treatments, enhance patient care, and influence mental health policy in Bangladesh.

What does the research involve?

This study examines the personal and social functioning of persons diagnosed with schizophrenia in Bangladesh. The research will assess several aspects of psychosocial functioning, such as socially beneficial activities, personal and social interactions, self-care, and disturbing/aggressive behaviors. It will assess patients' overall functioning and identify factors that influence their psychological well-being, such as demographic characteristics (age, gender, education) and clinical aspects (symptom severity, therapy).

Why were you chosen for this research?

You were chosen for this study because you were diagnosed with schizophrenia, which is the subject of this investigation. The purpose is to learn how people with schizophrenia in Bangladesh interact socially and personally.

Source of funding

The research has been carried out on a self-funded basis.

Consenting to participate in the project and withdrawing from the research

Before participating, you will be given complete information about the study's objective, methods, potential risks, and benefits. If you decide to participate, you will have to complete an informed consent form. Participation is entirely optional, and you may withdraw from the research at any moment without incurring any penalty or loss

of rewards. You will also receive a withdrawal form for your records.

Possible benefits and risks to participants

You are unlikely to gain any direct benefits from participating in this research; however, information gained from this research will contribute to the ongoing development and improvement of rehabilitation service for the patient with schizophrenia in Bangladesh. It leading to better treatment options, improved social integration, and targeted interventions.

The research has been designed to have low risk. However, discussing sensitive topics may cause discomfort. The researcher will ensure a comfortable and safe environment to address any concerns.

Confidentiality

Your identity and personal information will remain totally secretly. The data will be anonymized, and all identifiable information will be erased. Only authorized workers will have access to the information, protecting your privacy and confidentiality.

Storage of data

Collected data will be stored on a password-protected computer and locked cloud system, accessible only to the researchers conducting this study. Hard paper copies of data will be stored in locked filing cabinets at Bangladesh Health Professions Institute (BHPI).

Results

The results of the research will be used to assess the personal and social performance of patients with schizophrenia and will be shared with relevant healthcare providers and policymakers. The findings may contribute to improving mental health care and inform interventions in Bangladesh. You may request a summary of the project results by emailing any of the project investigators using the above contact details.

Complaints

Should you have any concerns or complaints about the conduct, you are welcome to contact the supervisor and co-supervisor.

Supervisor

Prof. Sk. Moniruzzaman

Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute, CRP
Savar, Dhaka-1343
Call: +880 1716-358212
Email: skmonirot@gmail.com

Co-supervisor

Md. Azim Hossain

Lecturer
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343
Call: +880 1521-215034
Email: azim.bhpi_21@yahoo.com

Thank you
Md. Nahidul Islam Shihab

Consent form

This research is a part of Occupational Therapy course and the name of this researcher is Md. Nahidul Islam Shihab. He is a student of BHPI in Occupational Therapy in 4th year. The study is entitled as "Personal and Social Performance among Patients with Schizophrenia". In this study I'm agree to participate and participating voluntarily. The purpose and nature of the study has been explained to me clearly. I will not be bound to answer to anybody and I understand that I can withdraw from the study without repercussions at any time whether before it starts or while I am participating. I understand that it will have no influence on my present or future status as a patient in this clinic. I will receive the same care as any other patient seen in this institution. There will be no penalty or loss of benefits to which I am otherwise entitled. I also understand that all the information collected from interview used in the study would be kept safe and confidentiality. Only researcher will be eligible to assess in the information for her publication. I give permission for my interview with the researcher and I agree to quotation/publication of extracts from my interview. My name and address will not publish anywhere in this study. I can consult with researcher and research supervisor about the research process and I am willing to participate in the study with consent

Participant's

Signature……. Date: ……

Signature/finger print**: ……**

Phone: ……

Researcher's

Signature…… Date: ……

Withdrawal of consent form

(Applicable only for voluntary withdrawers)

Research title: " Personal and Social Performance among Patients with Schizophrenia"

Name of investigator: Md. Nahidul Islam Shihab, 4th year, B.Sc. in Occupational Therapy, BHPI, CRP, Savar, Dhaka-1343

I, _____ (the participant), confirm that, I wish to withdraw all of my data from the study before data analysis has been completed and that none of my data will be included in the study. I request that all records associated with my participation be securely removed, and I ask that my decision be fully respected. I appreciate your understanding and cooperation in this matter.

The signature of the participant: …… Date: .....

Explanatory statement, Information Sheet, Consent and Withdrawal Consent Form (Bangla Version)

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
অকুপেশনাল থেরাপি বিভাগ
সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩,
ফোন: ০২-২২৪৪৪৫৪৬৪-৫, ২২৪৪৪১৪০৪, মোবা: ০১৭৩০০৫৯৬৪৭

কোড নম্বর: .....

অংশগ্রহণকারীদের জন্য ব্যাক্ষামূলক বিবৃতি

গবেষণার বিষয়: সিজোফ্রেনিয়া রোগীদের ব্যক্তিগত ও সামাজিক কর্মক্ষমতা।

গবেষক: মোঃ নাহিদুল ইসলাম শিহাব,

বি.এসসি. ইন অকুপেশনাল থেরাপি (৪র্থ বর্ষ), সেশন: ২০২০-২০২১ ইং, বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩

তত্ত্বাবধায়ক: অধ্যাপক শেখ মনিরুজ্জামান,

অধ্যাপক ও প্রধান, অকুপেশনাল থেরাপি বিভাগ, বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩

সহতত্ত্বাবধায়ক: মোঃ আজিম হোসেন,

লেকচারার, অকুপেশনাল থেরাপি বিভাগ, বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩

গবেষণার স্থান: বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

পর্ব ১ তথ্যপত্র

ভূমিকাঃ

আমি মোঃ নাহিদুল ইসলাম শিহাব, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট এর বি.এসসি. ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্র হিসেবে স্নাতক শিক্ষাবর্ষক্রম (২০২০-২০২১) সেশনে অধ্যয়নরত আছি। বিইচপিআই থেকে বি.এসসি. ইন অকুপেশনাল থেরাপি শিক্ষা কার্যক্রম সম্পন্ন করার জন্য একটি গবেষণা প্রকল্প পরিচালনা করা বাধ্যতামূলক। এই

গবেষণা প্রকল্পটি অকুপেশনাল থেরাপি বিভাগের অধ্যাপক, অধ্যাপক শেখ মনিরুজ্জামান এর তত্বাবধানে ও লেকচারার মোঃ আজিম হোসেন এর সহতত্বাবধানে সম্পন্ন করা হবে। এই অংশগ্রহণকারী তথ্য ও পত্রের মাধ্যমে গবেষণা প্রকল্পটির উদ্দেশ্য, উপাত্ত সংগ্রহের প্রণালী ও গবেষণাটির সাথে সংশ্লিষ্ট বিষয় কিভাবে রক্ষিত হবে তা বিস্তারিতভাবে আপনাকে উপস্থাপন করা হবে।

যদি আপনি গবেষণায় অংশগ্রহণ করতে ইচ্ছুক থাকেন, সেক্ষেত্রে এই গবেষণার সম্পৃক্ত বিষয় সম্পর্কে স্পষ্ট ধারণা থাকলে সিদ্ধান্ত গ্রহণ সহজতর হবে। অবশ্য এখন আপনার আংশগ্রহণ আমাদের নিশ্চিত করতে হবে না। যেকোন সিদ্ধান্ত গ্রহণের পূর্বে, যদি চান, আপনার আত্মীয়-স্বজন, বন্ধু অথবা আস্থাভাজন যেকারো সঙ্গে এই ব্যাপারে আলোচনা করতে পারেন। অপরপক্ষে, অংশগ্রহণকারী তথ্যপত্রটি পড়ে যদি কোন বিষয়বস্তু বুঝতে সমস্যা হয় অথবা যদি কোন কিছু সম্পর্কে আরো বেশি জানার প্রয়োজন হয়, তবে নির্দ্বিধায় প্রশ্ন করতে পারেন।

এই গবেষণার উদ্দেশ্য কী?

এই গবেষণার উদ্দেশ্য হলো সিজোফ্রেনিয়া রোগে আক্রান্ত ব্যক্তিদের ব্যক্তিগত ও সামাজিক কার্যক্ষমতা কেমন থাকে, তা জানা। আমরা বুঝতে চাই এই রোগ কীভাবে একজন মানুষের দৈনন্দিন জীবনযাপন ও সামাজিক যোগাযোগে প্রভাব ফেলে।

এই গবেষণায় কিছু গুরুত্বপূর্ণ বিষয় বিশেষভাবে দেখা হবে, যেমন- সামাজিকভাবে উপকারে আসে এমন কাজ, পরিবার ও সমাজের সঙ্গে সম্পর্ক কেমন থাকে, নিজের যত্ন নিতে পারেন কিনা, বিরক্তিকর বা আক্রমণাত্মক আচরণ আছে কি না।

এছাড়াও, কোন কোন বিষয় এই কাজগুলোতে সমস্যার কারণ হয়ে দাঁড়ায়—যেমন বয়স, লিঙ্গ, শিক্ষা, চিকিৎসার ধরন ইত্যাদি—সেগুলো চিহ্নিত করার চেষ্টা করা হবে। গবেষণার ফলাফল ভবিষ্যতে সিজোফ্রেনিয়া রোগীদের জন্য চিকিৎসা পদ্ধতি উন্নয়ন, সেবা প্রদান এবং মানসিক স্বাস্থ্য নিয়ে নীতিনির্ধারণে গুরুত্বপূর্ণ ভূমিকা রাখবে।

গবেষণায় কী অন্তর্ভুক্ত আছে?

এই গবেষণায় বাংলাদেশের সিজোফ্রেনিয়া রোগে আক্রান্ত ব্যক্তিদের ব্যক্তিগত ও সামাজিক কার্যকারিতা মূল্যায়ন করা হবে। গবেষণায় মানসিক ও সামাজিক কার্যকারিতার বিভিন্ন দিক মূল্যায়ন করা হবে, যেমন—সামাজিকভাবে উপকারী কাজকর্ম, পারিবারিক ও সামাজিক সম্পর্ক, নিজের যত্ন নেওয়া, এবং বিরক্তিকর বা আক্রমণাত্মক আচরণ। অংশগ্রহণকারীদের সামগ্রিক কার্যকারিতা মূল্যায়নের পাশাপাশি, এমন কিছু উপাদানও বিশ্লেষণ করা হবে যেগুলো তাদের মানসিক সুস্থতাকে প্রভাবিত করে, যেমন—বয়স, লিঙ্গ, শিক্ষা, উপসর্গের তীব্রতা, এবং প্রাপ্ত চিকিৎসা।

আপনাকে কেন এই গবেষণার জন্য বেছে নেওয়া হয়েছে?

আপনাকে এই গবেষণায় অন্তর্ভুক্ত করা হয়েছে কারণ আপনি সিজোফ্রেনিয়া রোগে আক্রান্ত, যা এই গবেষণার মূল বিষয়। এই গবেষণার উদ্দেশ্য হলো বাংলাদেশের সিজোফ্রেনিয়া রোগীরা কীভাবে ব্যক্তিগত ও সামাজিকভাবে মেলামেশা করেন, তা বোঝা।

অর্থায়নের উৎস

এই গবেষণাটি স্ব-অর্থায়নে পরিচালিত হয়েছে।

গবেষণায় অংশগ্রহণের জন্য সম্মতি প্রদান এবং গবেষণা থেকে সরে আসা

গবেষণায় অংশগ্রহণ করার আগে, আপনি গবেষণার উদ্দেশ্য, পদ্ধতি, সম্ভাব্য ঝুঁকি এবং সুবিধাগুলি সম্পর্কে পূর্ণাঙ্গ তথ্য পাবেন। যদি আপনি অংশগ্রহণ করতে চান, তবে আপনাকে একটি সম্মতি ফর্ম পূরণ করতে হবে। অংশগ্রহণ সম্পূর্ণ স্বেচ্ছায়, এবং আপনি যেকোনো সময় গবেষণায় অংশগ্রহণ থেকে সরে আসতে পারেন। আপনি আপনার রেকর্ডের জন্য একটি প্রত্যাহার ফর্মও পাবেন।

অংশগ্রহণকারীদের জন্য সম্ভাব্য সুবিধা এবং ঝুঁকি

গবেষণায় অংশগ্রহণের মাধ্যমে আপনি কোনো সরাসরি সুবিধা পাবেন না, তবে এই গবেষণার মাধ্যমে অর্জিত তথ্য সিজোফ্রেনিয়া রোগীদের পুনর্বাসন সেবার উন্নয়ন এবং অগ্রগতিতে সহায়ক হবে। এই গবেষণার মাধ্যমে ভবিষ্যতে আরও ভালো চিকিৎসা পদ্ধতি, সমাজে সহজে মিশে যাওয়ার সুযোগ, আর ব্যক্তির প্রয়োজন অনুযায়ী সাহায্য দেওয়ার সুযোগ তৈরি হতে পারে। এই গবেষণায় ঝুঁকি খুবই কম। তবে কিছু সংবেদনশীল (ব্যক্তিগত) বিষয় নিয়ে কথা বলার সময় সামান্য অস্বস্তি লাগতে পারে। গবেষক

চেষ্টা করবেন যাতে আপনি স্বস্তি ও নিরাপত্তার সঙ্গে কথা বলতে পারেন এবং আপনার যেকোনো চিন্তা বা সমস্যার যথাযথ সমাধান করা যায়

গোপনীয়তা

আপনার নাম ও ব্যক্তিগত সব তথ্য গোপন রাখা হবে। যেসব তথ্য আপনি দেবেন, তা কোনোভাবেই বাইরে প্রকাশ করা হবে না। আপনার পরিচয় যেন কেউ বুঝতে না পারে, সেইভাবে তথ্যগুলো সংরক্ষণ করা হবে। শুধু অনুমতি পাওয়া কিছু নির্দিষ্ট ব্যক্তি (যেমন গবেষক দল) এসব তথ্য দেখতে পারবে, এবং তারা আপনার গোপনীয়তা ঠিকভাবে রক্ষা করবে।

ডেটা সংরক্ষণ

আপনার দেয়া সব তথ্য পাসওয়ার্ড দিয়ে নিরাপদ রাখা কম্পিউটার ও একটি নিরাপদ অনলাইন ক্লাউডে সংরক্ষণ করা হবে, যেটা শুধু গবেষণার সাথে জড়িত গবেষকরা দেখতে পারবেন। যেসব তথ্য কাগজে লেখা থাকবে, সেগুলো বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)-এর তালাবদ্ধ ফাইল ক্যাবিনেটে সুরক্ষিতভাবে রাখা হবে।

ফলাফল

এই গবেষণার ফলাফল সিজোফ্রেনিয়া রোগীদের ব্যক্তিগত ও সামাজিক কার্যক্ষমতা মূল্যায়নের কাজে ব্যবহার করা হবে। এ তথ্য সংশ্লিষ্ট চিকিৎসক, স্বাস্থ্যসেবা প্রদানকারী এবং নীতিনির্ধারকদের সাথে শেয়ার করা হবে, যাতে মানসিক স্বাস্থ্যসেবা আরও উন্নত করা যায়। এই ফলাফল বাংলাদেশে সিজোফ্রেনিয়া রোগীদের জন্য প্রয়োজনীয় সাহায্য ও হস্তক্ষেপ পরিকল্পনায় কাজে লাগতে পারে।আপনি চাইলে গবেষণা শেষ হলে একটি সারসংক্ষেপ পেতে পারেন। এজন্য নিচে দেওয়া যোগাযোগের ঠিকানায় যেকোনো একজন গবেষককে ইমেইল করতে পারবেন।

অভিযোগ

যদি আপনার কোনো মতামত বা অভিযোগ থাকে, আপনি গবেষণার তত্ত্বাবধায়ক ও সহতত্ত্বাবধায়ক এর সাথে যোগাযোগ করতে পারেন।

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ক্রমিক নংঃ

সম্মতিপত্র

এই গবেষণা বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট এর বি.এসসি. ইন অকুপেশনাল থেরাপি বিভাগের অধ্যয়নের একটি অংশ এবং গবেষকের নাম মোঃ নাহিদুল ইসলাম শিহাব। তিনি বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট এর বি.এসসি. ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষে অধ্যয়নরত একজন ছাত্র এবং তার গবেষণার বিষয় "সিজোফ্রেনিয়া রোগীদের ব্যক্তিগত ও সামাজিক কর্মক্ষমতা"।

এই গবেষণায় আমি একজন অংশগ্রহণকারী এবং আমি এই গবেষণার উদ্দেশ্য পরিষ্কারভাবে বুঝতে পেরেছি। আমি এই গবেষণায় অংশ গ্রহণের জন্য সম্মত আছি এবং তথ্য বিশ্লেষণ সম্পন্ন হওয়ার আগে যে কোন সময় আমার অংশগ্রহণ প্রত্যাহার করতে পারব। এই জন্য আমি কারো কাছে জবাব দিতে বাধ্য থাকব না। আমি বুঝতে পেরেছি যে, এই গবেষণায় অংশগ্রহণ করার ফলে আমি কোন ধরনের ক্ষতির সম্মুখীন হবো না। এই গবেষণার সাক্ষাৎকারের সকল তথ্যগুলো গবেষণার কাজে ব্যবহার করা হবে, সেগুলো সম্পূর্ণ ভাবে গোপনীয় থাকবে এবং আমার নাম ও পরিচয় প্রকাশ হবে না।

আমি গবেষণার পদ্বতি, জটিলতা অথবা সুফলের ব্যাপারে যে কোন প্রশ্নের উত্তর দেওয়ার জন্য এই গবেষণার তত্ত্বাবধায়ক ও সহতত্ত্বাবধায়ক এর সাথে আলোচনা করতে পারব। আমি উপরের সকল তথ্য সম্পর্কে জানি এবং এই গবেষণায় অংশগ্রহণে সম্মতি জানাচ্ছি।

অংশগ্রহণকারীর

নাম:..... তারিখ:.....

অংশগ্রহণকারীর স্বাক্ষর: ..... ফোন: .....

গবেষকের

স্বাক্ষর:..... তারিখ:.....

সম্মতি প্রত্যাহার পত্র

(শুধুমাত্র স্বেছায় প্রত্যাহারকারীর জন্য প্রযোজ্য)

গবেষণার বিষয়: সিজোফ্রেনিয়া রোগীদের ব্যক্তিগত ও সামাজিক কর্মক্ষমতা

শিক্ষার্থী গবেষকঃ মোঃ নাহিদুল ইসলাম শিহাব, ৪র্থ বর্ষ, বি.এসসি. ইন অকুপেশনাল থেরাপি, বিএইচপিআই, সিআরপি, সাভার, ঢাকা-১৩৪৩

আমি, _____ (অংশগ্রহণকারী), নিশ্চিত করছি যে, তথ্য বিশ্লেষণ সম্পন্ন হওয়ার আগে আমি আমার সমস্ত তথ্য এই গবেষণা থেকে প্রত্যাহার করতে চাই এবং আমার কোনও তথ্যই গবেষণায় অন্তর্ভুক্ত করা হবে না। আমি আমার অংশগ্রহণের সাথে সম্পর্কিত সমস্ত সাক্ষ্যপ্রমাণ নিরাপদে সরিয়ে ফেলার অনুরোধ করছি, এবং আমার সিদ্ধান্তকে সম্পূর্ণরূপে সম্মান করার আহ্বান জানাচ্ছি। এই বিষয়ে আপনার সহানুভূতিশীল এবং সহযোগিতার জন্য আমি কৃতজ্ঞ।

অংশগ্রহণকারীর স্বাক্ষর/ আঙুলেরছাপ: .....

তারিখ:.....

Appendix C: Questionnaire [English and Bangla Version]

[Sociodemographic Question English Version]

Section A: Personal Information

1. **Name of the Participant:**
2. **Age** (in years): _____
3. **Gender**:
   ☐ Male ☐ Female ☐ Other
4. **Marital Status**:
   ☐ Unmarried ☐ Married ☐ Divorced ☐ Widowed
5. **Educational Level**:
   ☐ No formal education ☐ Primary ☐ Secondary
   ☐ Higher Secondary ☐ Graduate ☐ Postgraduate
6. **Current Occupational Status**:
   ☐ Unemployed ☐ Student ☐ Housewife
   ☐ Day laborer ☐ Private job ☐ Government job ☐ Business ☐ Other: _____
7. **Monthly Family Income** (in BDT):
8. **In which district is your permanent residence?**
9. **Area of Residence**:
   ☐ Urban ☐ Semi-urban ☐ Rural
10. **Living Arrangement**:
    ☐ With family ☐ Alone ☐ In rehabilitation center ☐ Other: _____
11. **Religion**:
    ☐ Islam ☐ Hinduism ☐ Christianity ☐ Buddhism ☐ Other: _____

Section B: Clinical Background

12. **Diagnosis**:
    ☐ Schizophrenia (Confirmed by Psychiatrist? ☐ Yes ☐ No)
13. **Duration of Illness**: _____ years/months
14. **Duration of Treatment**: _____ years/months

15. **Type of Treatment Received** (select all that apply):
    ☐ Medication ☐ Counseling/Psychotherapy ☐ Occupational Therapy
    ☐ Hospitalization ☐ Others: _____

16. **Current Medication**:
    ☐ Yes ☐ No

17. **History of Hospitalization**:
    ☐ Yes ☐ No If yes, number of times: _____

18. **Family History of Mental Illness**:
    ☐ Yes ☐ No If yes, specify relation: _____

19. **Substance Use History**:
    ☐ Yes ☐ No If yes, what substance? _____

Section C: Functional & Social Background (related to PSP Scale)

20. **Do you currently engage in any work, academic study, or voluntary activities?**
    ☐ Yes ☐ No If yes, specify: _____

21. **Do you participate in household tasks (e.g., cleaning, cooking)?**
    ☐ Yes ☐ No

22. **Do you maintain personal hygiene (e.g., bathing, grooming)?**
    ☐ Yes ☐ No ☐ Sometimes

23. **How would you describe your relationship with family and friends?**
    ☐ Good ☐ Fair ☐ Poor ☐ None

24. **In the past 6 months, have you attended any social events (e.g., wedding, birthday)?**
    ☐ Yes ☐ No If yes, please explain: _____

25. **Do you experience difficulty controlling your anger or aggression?**
    ☐ Yes ☐ No If yes, how often? _____

[Sociodemographic Question Bangla version]

ক: ব্যক্তিগত তথ্য

১. অংশগ্রহণকারীর নাম:

২. বয়স (বছরে):

৩. লিঙ্গ:

☐ পুরুষ ☐ মহিলা ☐ অন্যান্য

৪. বৈবাহিক অবস্থা:

☐ অবিবাহিত ☐ বিবাহিত ☐ তালাকপ্রাপ্ত ☐ বিধবা/বিপত্নীক

৫. সর্বোচ্চ শিক্ষাগত যোগ্যতা:

☐ আনুষ্ঠানিক শিক্ষা নেই ☐ প্রাথমিক ☐ মাধ্যমিক

☐ উচ্চ মাধ্যমিক ☐ স্নাতক ☐ স্নাতকোত্তর

৬. বর্তমান পেশাগত অবস্থা:

☐ বেকার ☐ শিক্ষার্থী ☐ গৃহিণী

☐ দিনমজুর ☐ প্রাইভেট চাকরি ☐ সরকারী চাকরি ☐ ব্যবসা ☐ অন্যান্য:

_____

৭. পারিবারিক মাসিক আয় (টাকায়):

৮. আপনার স্থায়ী ঠিকানা কোন জেলায় অবস্থিত?:

৯. বাসস্থান এলাকা:

☐ শহর ☐ উপশহর ☐ গ্রাম

১০. বাসস্থান ব্যবস্থা:

☐ পরিবারের সাথে ☐ একা ☐ পুনর্বাসন কেন্দ্রে ☐ অন্যান্য: _____

১১. ধর্ম:

☐ ইসলাম ☐ হিন্দু ☐ খ্রিস্টান ☐ বৌদ্ধ ☐ অন্যান্য: _____

খ: চিকিৎসা-সম্পর্কিত পটভূমি

১২. রোগ নির্ণয়:

☐ সিজোফ্রেনিয়া [মনোরোগ বিশেষজ্ঞ দ্বারা নিশ্চিত? ☐ হ্যাঁ ☐ না]

১৩. অসুস্থতার সময়কাল: _____ বছর/মাস

১৪. চিকিৎসার সময়কাল: _____ বছর/মাস

১৫. প্রাপ্ত চিকিৎসার ধরন (যেটি প্রযোজ্য):

☐ ওষুধ ☐ কাউন্সেলিং/সাইকোথেরাপি ☐ অকুপেশনাল থেরাপি ☐ হাসপাতালে ভর্তি

☐ অন্যান্য: _____

১৬. বর্তমানে ওষুধ নিচ্ছেন?

☐ হ্যাঁ ☐ না

১৭. আপনি কি এই অসুস্থতার কারনে পূর্বে হাসপাতালে ভর্তি ছিলেন?

☐ হ্যাঁ ☐ না যদি হ্যাঁ, কয়বার: _____

১৮. আপনার পরিবারের আর কোন সদস্য কি এই রোগে আক্রান্ত ছিলেন?

☐ হ্যাঁ ☐ না যদি হ্যাঁ, সম্পর্ক লিখুন: _____

১৯. অতীতে আপনি কি কখনো কোনো নেশাজাতীয় দ্রব্য ব্যবহার করেছেন:

☐ হ্যাঁ ☐ না যদি হ্যাঁ, কোন ধরনের নেশা? _____

গ: কার্যকরী ও সামাজিক পটভূমি (PSP স্কেলের সাথে সম্পর্কিত)

২০. আপনি কি বর্তমানে কোনো কাজ, পড়াশোনা বা স্বেচ্ছাসেবী কার্যক্রমে জড়িত আছেন?

☐ হ্যাঁ ☐ না যদি হ্যাঁ, অনুগ্রহ করে উল্লেখ করুন: _____

২১. আপনি কি ঘরের কাজ (যেমন, পরিষ্কার-পরিচ্ছন্নতা, রান্না) করেন?

☐ হ্যাঁ ☐ না

২২. আপনি কি ব্যক্তিগত পরিচ্ছন্নতা বজায় রাখেন (যেমন গোসল, সাজসজ্জা)?

☐ হ্যাঁ ☐ না ☐ কখনো কখনো

২৩. পরিবার ও বন্ধুদের সাথে আপনার সম্পর্ক কেমন?

☐ ভালো ☐ মোটামুটি ☐ খারাপ ☐ নেই

২৪. গত ৬ মাসে আপনি কি কোন সামাজিক অনুষ্ঠানে (যেমনঃ বিয়ে, জন্মদিন) অংশগ্রহণ করেছেন?

☐ হ্যাঁ ☐ না যদি হ্যাঁ, অনুগ্রহ করে উল্লেখ করুন: _____

২৫. আপনার কি রাগ নিয়ন্ত্রণে সমস্যা হয়?

☐ হ্যাঁ ☐ না যদি হ্যাঁ, কতবার হয়? _____

[Scale English Version]

Personal and Social Performance Scale (PSP)©

Step 1. Please rate the patient on his/her level of functioning during the reference period

There are 4 main domains of functioning considered in this scale.

		Absent	Mild	Manifest	Marked	Severe	Very Severe
(a)	Socially useful activities, including work or academic study	□	□	□	□	□	□
(b)	Personal and social relationships	□	□	□	□	□	□
(c)	Self-care	□	□	□	□	□	□
(d)	Disturbing and aggressive behaviors	□	□	□	□	□	□

The main domains (a) – (c) include subdomains as follows:

(a) socially useful activities include cooperation with household tasks, voluntary work, "useful" hobbies such as gardening

(b) relationships include relationships with a partner (for persons with a partner) or relatives and social relationships

(c) self-care includes personal hygiene, personal appearance, dressing.

For each domain, rate the worst functioning in the most relevant subdomain.

There are two different sets of operational criteria to judge the degree of difficulties: one for domains (a) – (c) and one for domain (d).

Degrees of severity areas (a)-(c)

(i) **Absent**

(ii) **Mild**: known only to someone who is very familiar with the person

(iii) **Manifest**: difficulties clearly noticeable by everyone, but not interfering substantially with the person's ability to perform his/her role in that area, given the person's sociocultural context, age, sex and educational levels

(iv) **Marked**: difficulties interfering heavily with role performance in that area; however, the person is still able to do something without professional or social help, although inadequately and/or occasionally; if helped by someone, he/she may be able to reach the previous level of function

(v) **Severe**: difficulties that make the person unable to perform any role in that area, if not professionally helped, or lead the person to a destructive role, however, there are no survival risks

(vi) **Very severe**: impairments and difficulties of such intensity to endanger the person's survival

Degrees of severity area (d)

(i) **Absent**

(ii) **Mild**: corresponding to mild rudeness, unsociability or whingeing

(iii) **Manifest**: such as speaking too loudly or speaking to others in a too-familiar manner or eating in a socially unacceptable manner

(iv) **Marked**: insulting others in public, breaking or wrecking objects, acting frequently in a socially inappropriate but not dangerous way (e.g. stripping or urinating in public)

(v) **Severe**: frequent verbal threats or frequent physical assaults, without intention or possibility to severe injuries

(vi) **Very severe**: defined as frequent aggressive acts, aimed at or likely to cause severe injuries

Operational definitions for assessing a patient's disturbing and aggressive behaviors (domain (d)):

- In this context, “frequent” means the behavior occurred more than once in the reference period or is judged likely to happen again in the next six months. If the disturbing/aggressive behavior is not frequent, the degree of severity may be decreased by 1 level, e.g. from severe (v) to marked (iv).
- In this context, an injury is assessed as severe if it requires an emergency room visit.
- **Step 2. Please select a 10-point interval**

Specific criteria for each 10-point interval, as specified below, are based on different combinations of severity (absent to very severe) in the 4 main domains.

100-91	Excellent functioning in all four main areas. He/she is held in high consideration for his/her good qualities, copes adequately with life problems, is involved in a wide range of interests and activities
90-81	Good functioning in all four main areas, presence of only common problems or difficulties
80-71	Mild difficulties in one or more of areas (a)-(c)
70-61	Manifest, but not marked difficulties in one or more areas (a)-(c) or mild difficulties in (d)
60-51	Marked difficulties in one of areas (a)-(c), or manifest difficulties in (d)
50-41	Marked difficulties in two or more, or severe difficulties in one of areas (a)-(c), with or without manifest difficulties in (d)
40-31	Severe difficulties in one and marked difficulties in at least one of areas (a)-(c), or marked difficulties in (d)
30-21	Severe difficulties in two areas (a)-(c), or severe difficulties in (d), with or without impairment in areas (a)-(c)
20-11	Severe difficulties in all areas (a)-(c) or very severe difficulties in (d) with or without impairment in general areas (a)-(c). If the person reacts to external prompts, the suggested scores are 20-16; if not, the suggested scores are 15-11.
10-1	Lack of autonomy in basic function with extreme behaviors but without survival risk (ratings 6-10) or with survival risk, e.g. death risk due to malnutrition, dehydration, infections, inability to recognize situations of manifest danger (ratings 5-1).

Step 3. Please use clinical judgment to adjust the score within the 10-point interval

- Adjust the score within the 10-point interval (e.g. 56, 64, 78), taking into account the level of difficulties in other areas of social function, such as:

- physical and psychological health care
- lodging, area of residence, living space care
- contribution to household activities, participation in family life or residential/day-center life
- intimate and sexual relationships
- child care
- social network, friends and helpers
- keeping of social rules
- general interests
- financial management
- use of transport, telephone
- coping skills in crisis

- Suicidal behavior and risk are not taken into account in this scale

Overall score |___|___|___|

Summary meaning of PSP total score

71-100:	These ratings reflect only mild difficulties
31-70:	These ratings reflect varying degrees of disability
1-30:	These ratings reflect functioning so poor that the patient requires intensive support or supervision

[Scale Bangla Version]

ব্যক্তিগত ও সামাজিক কর্ম ক্ষমতা স্কেল (PSP)©

ধাপ ১: অনুগ্রহ করে রোগীর কার্যকারিতার স্তরটি মূল্যায়ন করুন, উল্লেখযোগ্য সময়কাল (রেফারেন্স পিরিয়ড) ধরে।

এই স্কেলটি মোট চারটি প্রধান ক্ষেত্রকে অন্তর্ভুক্ত করে:

	অনুপস্থিত	মৃদু	প্রকাশ্য	প্রকট	গুরুতর	অতিগুরুতর
(ক) সামাজিকভাবে উপযোগী কর্মকাণ্ড (যেমন: পেশাগত কাজ বা একাডেমিক অধ্যয়ন)	□	□	□	□	□	□
(খ) ব্যক্তিগত ও সামাজিক সম্পর্ক	□	□	□	□	□	□
(গ) আত্ম-পরিচর্যা	□	□	□	□	□	□
(ঘ) বাধাসৃষ্টিকারী ও আক্রমণাত্মক আচরণ	□	□	□	□	□	□

মূল অংশ (ক) থেকে (গ) এর মধ্যে কিছু উপ-অংশ থাকে:

(ক) সামাজিকভাবে উপকারী কাজ বলতে বোঝায় — বাড়ির কাজকর্মে সাহায্য করা, স্বেচ্ছাসেবামূলক কাজ করা, আর গার্ডেনিং-এর মতো কাজ যেটা উপকারী শখ হিসেবে ধরা হয়।
(খ) সম্পর্ক বলতে বোঝায় — যাদের জীবনসঙ্গী আছে, তাদের সঙ্গে সম্পর্ক কেমন, আত্মীয়স্বজনদের সঙ্গে যোগাযোগ কেমন, আর সমাজে অন্যদের সঙ্গে যোগাযোগ কেমন
(গ) আত্ম-পরিচর্যা বলতে বোঝায় — নিজেকে পরিষ্কার-পরিচ্ছন্ন রাখা, নিজের চেহারা ও পোশাক-আশাক ঠিক রাখা। প্রত্যেকটা ক্ষেত্রে, ওই বিষয়ের সবচেয়ে খারাপ অবস্থাটা দেখে রেটিং দিতে হবে।

(ক) থেকে (গ) পর্যন্ত ক্ষেত্রগুলোর জন্য এক ধরনের মানদণ্ড, আর (ঘ) অর্থাৎ আক্রমণাত্মক আচরণের জন্য আছে আরেকটা আলাদা মানদণ্ড।

(ক) থেকে (গ) ক্ষেত্রগুলোর জন্য অসুবিধার মান

(i) **অনুপস্থিত**
(ii) **মৃদু**: শুধু খুব ঘনিষ্ঠ বা পরিচিত কেউ বোঝে যে কিছু সমস্যা আছে
(iii) **স্পষ্ট**: সমস্যাগুলো সবার কাছে স্পষ্টভাবে দৃশ্যমান, তবে ব্যক্তির সামাজিক-সাংস্কৃতিক প্রেক্ষাপট, বয়স, লিঙ্গ এবং শিক্ষাগত যোগ্যতা বিবেচনায়—তা ওই ক্ষেত্রে তার ভূমিকা পালনে উল্লেখযোগ্যভাবে বাধা সৃষ্টি করে না।
(iv) **লক্ষণীয়**: ওই ক্ষেত্রে সমস্যা এতটাই যে, তা ব্যক্তির ভূমিকা পালনে গুরুতরভাবে বাধা সৃষ্টি করে; তবে ব্যক্তি এখনও কিছুটা কাজ করতে পারে, যদিও তা পর্যাপ্ত নয় বা মাঝে মাঝে করে এবং পেশাগত বা সামাজিক সহায়তা ছাড়াই। তবে, যদি কেউ সাহায্য করে, তাহলে সে আগের কর্মক্ষমতার স্তরে ফিরে যেতে পারে
(v) **গুরুতর**: যদি পেশাদার সাহায্য না পাওয়া যায়, তাহলে সে ওই কাজ একেবারেই করতে পারে না। কখনও আবার এমনভাবে আচরণ করে যা নিজের বা অন্যের ক্ষতি করতে পারে — তবে এতে জীবনসংশয় থাকে না
(vi) **খুব গুরুতর**: এমন মাত্রার সীমাবদ্ধতা ও সমস্যাবলি, যা ব্যক্তির জীবনের টিকে থাকার জন্য হুমকিস্বরূপ।

(ঘ) ক্ষেত্রের জন্য অসুবিধার মান

(i) **অনুপস্থিত**
(ii) **মৃদু**: যা হালকা রূঢ় আচরণ, অন্যদের সঙ্গে বেশি মেলামেশা না করা বা অভিযোগ করার মতো হতে পারে
(iii) **স্পষ্ট**: যেমন: খুব জোরে কথা বলা, অন্যদের সঙ্গে অতিরিক্ত পরিচিতভাবে কথা বলা, অথবা সামাজিকভাবে অগ্রহণযোগ্যভাবে খাওয়া
(iv) **লক্ষণীয়**: প্রকাশ্যে অন্যদের গালি দেওয়া, জিনিসপত্র ভাঙা বা নষ্ট করা, বা সামাজিকভাবে অস্বাভাবিক কিন্তু বিপজ্জনক না এমন আচরণ করা (যেমন: প্রকাশ্যে কাপড় খুলে ফেলা বা প্রস্রাব করা)
(v) **গুরুতর**: ঘনঘন হুমকি দেওয়া বা শারীরিক আক্রমণ করা, তবে গুরুতর আঘাতের উদ্দেশ্য বা সম্ভাবনা নেই
(vi) **খুব গুরুতর**: এটি এমন আচরণ হিসেবে বিবেচিত হয়, যা বারবার আক্রমণাত্মক হয়ে থাকে এবং গুরুতর আঘাতের কারণ হতে পারে

রোগীর বিরক্তিকর এবং আক্রমণাত্মক আচরণ মূল্যায়নের জন্য কার্যকরী সংজ্ঞা (ক্ষেত্র (ঘ))

- এক্ষেত্রে, "ঘন ঘন" মানে হলো — আচরণটি রেফারেন্স পিরিয়ডে একবারের বেশি ঘটেছে বা পরবর্তী ছয় মাসে এটি আবার ঘটার সম্ভাবনা রয়েছে। যদি বিরক্তিকর/আক্রমণাত্মক আচরণটি ঘন ঘন না হয়, তবে এর তীব্রতার মাত্রা ১ ধাপ কমানো যেতে পারে, যেমন: গুরুতর (v) থেকে লক্ষণীয় (iv) করা যেতে পারে।

- এক্ষেত্রে, একটি আঘাতকে গুরুতর হিসেবে বিবেচনা করা হয় যদি তা জরুরি বিভাগে (ইমারজেন্সি রুম) যাওয়ার প্রয়োজনীয়তা সৃষ্টি করে।

ধাপ ২: অনুগ্রহ করে ১০ পয়েন্টের মধ্যে একটি নম্বর নির্বাচন করুন

প্রত্যেকটি ১০ পয়েন্টের জন্য বিশেষ মানদণ্ড, যা নিচে দেওয়া হয়েছে, তা ৪টি মূল ক্ষেত্রের তীব্রতা (অনুপস্থিত থেকে অত্যন্ত গুরুতর) অনুযায়ী তৈরি করা হয়েছে

১০০-৯১	চারটি মূল ক্ষেত্রেই খুব ভালো কার্যকারিতা। সে তার ভালো গুণের জন্য উচ্চ মূল্যায়িত, জীবনসংক্রান্ত সমস্যা ভালোভাবে মোকাবিলা করে এবং বিভিন্ন ধরনের আগ্রহ ও কার্যক্রমে অংশগ্রহণ করে
৯০-৮১	চারটি মূল ক্ষেত্রেই ভালো কার্যকারিতা, তবে কিছু সাধারণ সমস্যা বা অসুবিধা রয়েছে
৮০-৭১	(ক)-(গ) এর এক বা একাধিক ক্ষেত্রে হালকা সমস্যা
৭০-৬১	(ক)-(গ) এর এক বা একাধিক ক্ষেত্রে স্পষ্ট, তবে গুরুতর নয় এমন সমস্যা অথবা (ঘ) ক্ষেত্রে হালকা সমস্যা
৬০-৫১	(ক)-(গ) এর একটির ক্ষেত্রে গুরুতর সমস্যা, অথবা (ঘ) ক্ষেত্রে স্পষ্ট সমস্যা
৫০-৪১	(ক)-(গ) এর দুটি বা তার বেশি ক্ষেত্রে গুরুতর সমস্যা, অথবা (ক)-(গ) এর একটিতে গুরুতর সমস্যা, (ঘ) ক্ষেত্রে স্পষ্ট সমস্যা থাকতে পারে বা নাও থাকতে পারে
৪০-৪১	ক)-(গ) এর একটিতে গুরুতর সমস্যা এবং কমপক্ষে একটি ক্ষেত্রে গুরুতর সমস্যা, অথবা (ঘ) ক্ষেত্রে গুরুতর সমস্যা
৩০-২১	(ক)-(গ) এর দুটি ক্ষেত্রে গুরুতর সমস্যা, অথবা (ঘ) ক্ষেত্রে গুরুতর সমস্যা, (ক)-(গ) এর ক্ষেত্রে সমস্যা থাকতে পারে বা নাও থাকতে পারে।
২০-১১	ক)-(গ) এর সবগুলিতে গুরুতর সমস্যা, অথবা (ঘ) ক্ষেত্রে অত্যন্ত গুরুতর সমস্যা, (ক)-(গ) এর ক্ষেত্রে সমস্যা থাকতে পারে বা নাও থাকতে পারে। যদি ব্যক্তি বাহ্যিক ইঙ্গিতের প্রতিক্রিয়া দেখায়, তবে পরামর্শিত স্কোর ২০-১৬; যদি না দেখায়, তবে পরামর্শিত স্কোর ১৫-১১
১০-১	মূল কাজকর্মে স্বায়ত্তশাসনের অভাব এবং চরম আচরণ, তবে জীবন সংকটের ঝুঁকি ছাড়া (স্কোর ৬-১০), অথবা জীবন সংকটের ঝুঁকি রয়েছে, যেমন: অপুষ্টি, পানিশূন্যতা, সংক্রমণ, বা প্রকাশ্যে বিপদ সনাক্ত করতে না পারা (স্কোর ৫-১)

ধাপ ৩: অনুগ্রহ করে ১০ পয়েন্টের মধ্যে স্কোরটি আপনার পেশাগত মূল্যায়ন অনুযায়ী ঠিক করুন।

- ১০ পয়েন্টের মধ্যে স্কোরটি সামঞ্জস্য করুন (যেমন: ৫৬, ৬৪, ৭৮), অন্য সামাজিক কার্যকারিতার ক্ষেত্রে সমস্যা স্তরের বিষয়গুলো বিবেচনা করে, যেমন:

- শারীরিক এবং মানসিক স্বাস্থ্যসেবা
- বাসস্থান, বাসস্থানের এলাকা, বসবাসের জায়গার যত্ন
- গৃহস্থালী কাজের অবদান, পারিবারিক জীবন বা আবাসিক/দিনের কেন্দ্রের জীবনে অংশগ্রহণ
- ঘনিষ্ঠ এবং যৌন সম্পর্ক
- শিশুদের যত্ন
- সামাজিক নেটওয়ার্ক, বন্ধু এবং সহায়কেরা
- সামাজিক নিয়মকানুন মেনে চলা
- সাধারণ আগ্রহ
- আর্থিক ব্যবস্থাপনা
- পরিবহন, টেলিফোন ব্যবহার
- সংকটকালীন পরিস্থিতিতে মানিয়ে নেওয়ার দক্ষতা

- এই স্কেলে আত্মহত্যার আচরণ এবং ঝুঁকি বিবেচনায় নেওয়া হয় না

মোট স্কোর |___|___|___|

PSP মোট স্কোরের সারসংক্ষেপের অর্থ

৭১-১০০:	এই স্কোরগুলো শুধু হালকা ধরনের সমস্যাকে প্রকাশ করে
৩১-৭০:	এই স্কোরগুলো বিভিন্ন মাত্রার অক্ষমতা বা সমস্যাকে বোঝায়
১-৩০:	এই স্কোরগুলো এমন খারাপ কার্যক্ষমতা বোঝায়, যেখানে রোগীর জন্য শক্তভাবে সহায়তা বা পর্যবেক্ষণ প্রয়োজন

Appendix D: Supervision record sheet

Supervision record sheet

Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: Personal and Social Performance among Patients with Schizophrenia

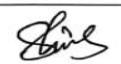
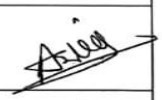
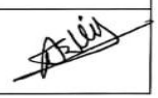
Name of student: Md. Nahidul Islam Shihab

Name and designation of thesis supervisor: **Prof. Sk. Moniruzzaman**
Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute, CRP, Savar, Dhaka-1343

Name and designation of thesis Co-supervisor: **Md. Azim Hossain**
Lecturer
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	28/05/2025	BHPI, Office Building	Tittle Discussion	1h	Good		
2	29/05/2025	BHPI, Library Building	Tittle & Proposal discussion	2.5h	Good		
3	14/06/2025	BHPI, Library Building	Tittle & Scale discussion	2h	Good		

4	14/06/2025	BHPI, Library Building	Discussion on IRB Presentation	3h	Got clear idea about IRB presentation		
5	16/06/2025	BHPI, Library Building	Feedback and Final discussion on IRB Presentation	1.5h	Got more clear idea about IRB presentation		
6	18/06/2025	BHPI, Library Building	Review on IRB presentation Feedback	1h	Good		
7	24/06/2025	BHPI, Library	Sociodemographic Question checking	2.5h	Minor correction advised		
8	10/07/2025	BHPI, Library	Discussion on Literature review and methodology	3h	More updated literature needed		
9	23/07/2025	BHPI, Library	Information sheet, Consent form and withdrawal form checking	2.5h	well		
10	14/08/2025	BHPI, Library	Final feedback on data set	2h	Good		
11	25/08/2025	BHPI, Library	Overall research feedback	10 min	Progress satisfactory		
12	26/08/2025	BHPI, Library	Conceptual framework Discussion	2.5h	Need more study		
13	30/08/2025	BHPI, Library	Review on Conceptual Framework	5min	Improved and acceptable		
14	02/09/2025	BHPI, Library	Discussion on Data input in SPSS software	3h	Good		
15	15/10/2025	BHPI, Library Building	Discussion on Result making on SPSS software	3.5h	Good		

16	05/11/2025	BHPI, Library	Result checking and result writeup	3.5h	Formatting correction required		
17	12/11/2025	BHPI, Library	Discussion writeup	1.5h	Expand discussion depth.		
18	12/12/2025	BHPI, Library	Discussion on 1st draft and overall research	2.5h	Good		
19	29/12/2025	BHPI, Library	Feedback on 1st draft	2h	Good		
20	03/02/2026	BHPI, Library	Discussion on 2nd draft and overall research	2.5h	Final review satisfactory		

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face-to-face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.