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OUTPATIENTS OF FEDERAL NEURO- PSYCHIATRIC
HOSPITAL, YABA, LAGOS.**

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ABSTRACT

Purpose: Empirical evidence have shown that psychiatric out-patients often experience difficulties with getting back to normal family and work routines and relapse. This stimulated this study and made it imperative to examine the extent to which illness perception and perceived stress are implicated in fostering successful re-integration of out-patients back into the society, enhance total adherence to intake of prescribed medications, and increase being compliant to attending check-up at due time, among others.

Methodology: The study investigated illness perception and perceived stress as predictors of quality of life among psychiatric patients in Federal Neuro-Psychiatric Hospital Yaba, using predictive design. The research sample consisted of sixty-one (61) out-patients at Federal Neuro-Psychiatric Hospital, Yaba. This comprised of thirty-nine (39; 63.9%) males and twenty two (22; 36.1%) females with mean age of 34.29, S.D 5.60, respectively. The participants were selected by the researcher using purposive sampling technique. They were individually administered the World Health Organization Quality of Life (WHOQOL) – Brief scale, Illness Perception Questionnaire-revised (IPQ-R), and Perceived Stress Scale (PSS). Multiple linear regression statistics was used for testing research hypothesis.

Findings: The result revealed significant positive influence of illness perception on quality of life ($R^2 = .048$, R^2 (adjusted) = .015; $\beta = .205$, $p < .05$). It further revealed that perceived stress significant predicted quality of life ($R^2 = .048$, R^2 (adjusted) = .015; $\beta = .061$, $p < .05$). The researcher attributed these findings to the fact that psychiatric out-patients may by virtue of their health conditions might still not come to terms with their re-integration.

Recommendation: As a result of the study findings, psychiatric outpatients should be exposed to programmes and psycho-education capable of promoting positive view of their health. Doing so will result to having positive illness perception leading to improve quality of life, since the two variables shared positive relationship. It also recommends that the process of re-integrating psychiatric outpatients back into the society should be done very well, amidst equipping them with required skills and knowledge they will need in handling the stressors they will face, positively.

Keywords: *Illness Perception; Perceived Stress; Psychiatric Outpatients; Quality of Life.*

INTRODUCTION

Reduction in quality of life (QoL) has many consequences/outcomes which affect individuals and family/groups. A lot of time, a low quality of life (QoL), caused by psychological factors, tends to complicate human ill-health conditions, reduce general efficiency and may lead to maladaptive behavior, (Moore, Bockow, Ehde, Engel, 2011). The situation becomes further degenerative if patients, especially those yet to fully recover from illness, are put in perspective. In the light of this, effort to understand variables that may facilitate or inhibit/reduce QoL among psychiatric outpatients becomes of immense interest to research.

World Health Organization (WHO) (2000) defined quality of life (QoL) as individuals' perceptions of their position in life in terms their cultural background and value systems and in correlation with their expectations, concerns standards and goals. Quality of life (QoL) is an indicator of not only how well an individual function in daily life, but relates also to people's belief about their health's contribution to life (Chan, Li, Chung, Po, & Yu, 2004). Literature revealed that the concept of QoL initially meant 'a good life' which denoted material status, and possession of goods and property such as a house, its furnishings, a car, etc, and until the second half of the 20th century, the category of 'have' was replaced with 'be', that introduced aspects of personal freedom or satisfaction, education, and so on. Phillips (2006) postulated that QoL is a multifaceted phenomenon, determined by the cumulative and interactive impacts of numerous and varied factors like housing conditions, infrastructure, access to various amenities, income, standard of living, and satisfaction about the physical and social environment.

There are many reasons for the multi-dimensionality of the concept of QoL. It is made up of a number of social, physical and psychological domains that makes life more rewarding, WHO (2001) It also has a bearing on individuals' life situations, and perceptions of economic and social situations play a key role. Also, its measure is a subjective evaluation of one's situation expressed in particular beliefs and emotional states. Attempts at delimiting the concept of QoL led Schipper (1999) to the formulation of the concept of 'health-related quality of life' (HRQOL), which was defined as a functional effect of illness and its treatment as perceived by the patient. Revicki (1989) did note that QoL as it relates to health is a combination of aspects of social, emotional and physical components of illness and its treatment.

Factors thwarting increased QoL of psychiatric outpatients could as well be militating against their effective transition to 'normal life' after re-integration, and could be very limiting, especially if one considers the possibility that such could predispose to failure of going for check-ups and decrease interest in taking medications. Such failure poses a challenge to their healing process which arguably reduces their QoL. Also, subjecting psychiatric outpatients to unhealthy human relationship via discrimination, stigmatization, or disrespect, for example, may decrease their interest in associating with people, and denies them of positivism such can provide. The overall effects should raise concerns, especially as such situation which could deny them of social support emanating from such relationship culminate to decrease in their QoL.

Evaluating the quality of life of psychiatric outpatients should involve going beyond the 'direct manifestations of an illness' to examining its effects on their daily life. Such evaluation could help to see how effective mental health interventions given to such outpatients have been. Compared to QoL of the general population, it is suspected that psychiatric outpatients could score worse or

lower on all or some of the domains of the World Health Organization Quality of Life-Bref (WHOQOLBref). Quality of life of individuals with various mental illnesses have been found to be considerably impaired (Barnes, Murphy, Fowler, & Rempfer, 2012; Masthoff, Trompenaars, Van Heck, Hodiament, & De Vries, 2006; Watson, Swan, & Nathan, 2011). The study by Masthoff et al., (2006) found Dutch outpatients diagnosed with an Axis I or Axis II disorder to score worse on all domains of the WHOQOLBref compared to the general population, and a meta-analysis found patients with anxiety disorders to have lower QoL than non-clinical controls (Olatunji, Cisler, & Tolin, 2007).

According to Juczyn (2006), assessment of QoL commonly takes into consideration the following three elements: (1) The functional capability of an individual (that is the means an individual has to satisfy his daily needs, and function in social roles; intellectual and emotional efficiency), (2) The way an individual perceives his/her situation in life (i.e. the level of satisfaction and contentment with life, and (3) Symptoms of an illness, and the general level of fitness following on the illness and age. Obviously, all psychiatric outpatients will not present same degree of quality of life, considering that their individual experiences, perception and interpretation of things, may differ, even when they share the same environment. As it turns out, patients diagnosed with the same disease, having similar medical history and prognosis can differ in respect of the sense of QoL. A very sick person can display a greater contentment with and enjoyment of life than a person suffering from a minor ailment. The QoL in illness, then, is not determined solely by the objective state of health. Accordingly, psychosocial factors allow creating an understanding of QoL that incorporates human qualities of the patient (Sheridan & Radmacher, 1998, cited in Juczyn, 2006). Consequently, it is suspected that how psychiatric outpatients perceive their illness and the stress they experience may be contributory to their QoL. Such becomes very important to examine, considering that enhancing the QoL of such outpatients is very integral in improving their recovery and re-integration back into the society, as well as in checkmating relapse, especially in the light that Federal Neuro-psychiatric Hospital, Yaba, Lagos State, is very much interested in arresting eventualities exposing these patients to inhibiting thoughts and perception. Thus, such arrest could engender increased positive view and self-worth among the outpatients.

Outpatients' perception of their illness seems to be an important variable affecting their health behaviour. What the individual regards as a health problem, may bear little relation to what is referred to as "disease". One may well perceive the state of one's health as being poor without there being any objective signs of disease, and vice versa. In different clime, studies (Keogh et al., 2007; Joseph, Burke, Tuason, Barker, & Pasick, 2009) have reported that illness perceptions are important determinants of behaviour which are associated with adherence to treatment and rehabilitation." Perception of illness is a patient's cognitive appraisal and personal understanding of a medical condition and its potential consequences" (Broadbent et al., 2014; Broadbent, Petrie, Main, & Weinman, 2006). Such perception is considered to be a predictor of depressive symptoms, attendance at cardiac rehabilitation clinics, functional status, return to work, and control over cardiovascular risk factors (Petriček et al., 2009). Negative perceptions increase anxiety and depression (Palacios, Khondoker, Achilla, Tylee, & Hotopf, 2016), and decrease QoL (Stafford, Berk, & Jackson, 2009).

After hospitalization, going back to the society may generate a cognitive model in psychiatric outpatients regarding how they will perceive the state of their mental health, especially as re-integration becomes a process where some may not fully accept and relate with them unconditionally. People faced with a new health threat will actively build cognitive models of this threat and this mental representation will determine how they respond (Leventhal, Meyer, & Nerenz, 1980). Factors facilitating such models may include their own medical knowledge or from personal experience of others such as family members. The outpatient's model of his or her illness will guide the person to reduce the danger of possible negative perception and can guide coping strategies that may be employed to reduce the emotional response associated with such perception.

Petrie and Weinman (2006) stated that there is a consistent pattern to the way in which individuals make mental models of their illness and that studies found five main interrelated components that make up patients' views of their illness to include: identity of their illness, causal beliefs, timeline beliefs, beliefs about control or cure, and consequences. Among other things, it is suspected that the patient's view of the consequences associated with their illness, which included the effect the illness will have on their work, family, lifestyle and finances, reflects the subjectivity of people's view of the severity of their illness, which most often does not correlate with objective clinical assessment of the severity of the illness. This may cause, clients undergoing medical investigations to have negative illness perceptions of their condition and be less reassured by findings showing no pathology (Donkin, Ellis, & Powell, 2006).

Psychological factor of illness perception has been reported to be strongly associated with QoL of patients presenting with different health conditions. For example, illness perceptions in women with breast cancer have been shown to be an important co-variable of QoL (Kaptein et al., 2015). Higher scores on negative and threatening illness perceptions have been associated with lower QoL (Linder et al., 2015). The perception of the disease is related to a number of outcome measures in Rheumatoid Arthritis, including disability, low mood, pain and decline in physical function (Prajapati and Lis., 2014). It can lead to long-term loss of several functions of daily life such as the ability to travel, capacity to function at work, personal hygiene, functioning in social roles and financial independence (Van der Elst et al., 2015). In different climate, the study by Quiceno and Vinaccia (2010) found a directly proportional relationship between QoL and the perception of illness.

Another factor which may affect the QoL of psychiatric outpatients could be stressful exposure associated with likely discrimination or marginalization following the perception that they may be incapable of contributing meaningfully into the society, anymore. Such may expose them to the experiences of more undesirable events than desirable events in all areas of life functioning which can predispose them to stress. According to Selye, (1975), Stress can be a nonspecific responding of one's body to demands of adapting, neither the demand results in pain or pleasure). Stress is defined and operationalized by stimuli ('stressors'), subjective reports of an experience (humans only), and a general non-specific increase in arousal (activation, and the feedback to the brain from this response (Levine & Ursin, 1991). Although stressors can elicit different responses in different individuals depending on conditioning or interactions with the environment, stress response or "stress cascade" makes the body adjust to metabolic and physiological requirements demanded by homeostatic changes (Miller & O'Callaghan, 2002).

Stress can be viewed from four perspective; stress experience, stress stimuli, general stress response, the non-specific stress response. Physical characteristics of a stimuli that results in the stress responses and stress are not related (Levine & Ursin, 1991). A person's view of a stimulus as being threatening or pleasant is dependent on his or her appraisal of that particular instance which the stressful stimulus is experienced and this is based on past experience, (Lazarus & Folkman, 1984). Meanwhile, in experiencing stress, stimuli are evaluated or filtered by the brain, and psychological, emotional 'loads' are the most frequently reported stress stimuli (Levine & Ursin, 1991). As such, particularly important for many people are concerns and beliefs about the possible health consequences of the state.

Also, the general response to stress stimuli is a non-specific alarm response, eliciting a general increase in wakefulness and brain arousal, and specific responses to deal with the reasons for the alarm. Whether the alarm is pleasant or not is a threat to health. This may however result to ill-health if sustained. As such, increase in arousal manifests itself in many or most organ systems, with individual and situational variance in strength, reciprocal relations, and time parameters (Eriksen, Olf, Murison, & Ursin, 1999a). In addition, while it appears women and men share no difference in receiving stress from their environment, women are more likely to deal with psychological distress and men are more dealing with physical stress (Kukulja, Thiel, Wolf & Fink, 2008).

Some of the cases of relapse observed among outpatients of Federal Neuro-psychiatric Hospital, Yaba (FNPHY), Lagos State, could be prevented, especially if factors leading to decrease in quality of life among this population are known. Discovering such factors becomes very important so as to fathom their complications while planning for successful re-integration of these patients back into the society after discharge. Besides, huge resources have been expended in achieving successful treatment outcome for these outpatients; it becomes an issue of concern for research to continue in the effort of identifying factors impinging on their quality of life (QoL), with the interest being to forestall possible vulnerability to relapse resulting from this.

MATERIAL STUDIED

The researcher in the course of the study examined illness perception and perceived stress as predictors of quality of life among outpatients of federal Neuro-psychiatric hospital, Yaba, Lagos, Nigeria.

AREA DESCRIPTIONS

The study was carried out in a psychiatric hospital in Nigeria.

METHOD

Design

The study adopted predictive survey design.

Participant and Sampling Technique

The participants for this study consisted of sixty-one (61) outpatients from Federal Neuro-psychiatric Hospital, Yaba, Lagos State, who volunteered to participate willingly. The age ranged from 19 to 44 years, with a mean age of 34.29 and a standard deviation of 5.60. Thirty nine (39) (63.9%) of them were males, while twenty two (22) (36.1%) were females.

RESULTS

The hypothesis which stated that illness perception and perceived stress will predict quality of life among psychiatric outpatients was tested using multiple linear regressions and the result is presented in Table 1:

Table 1: Summary Table of Model Summary, ANOVA, and Coefficients of Illness Perception and Perceived Stress as Predictors of Quality of Life

Model Summary		ANOVA				Coefficients			
R Squared	Adjusted R Squared	Df	Total	F	Sig	Beta	Total	t	Sig
.048	.015	2	60	1.451	.043	'IP' .205	60	'IP' 1.593	'IP' .017
						'PS' .061		'PS' -.472	'PS' .039

***P* < .05 ('IP' = Illness Perception; 'PS' = Perceived Stress)**

The result in the table showed that the beta values indicate that illness perception significantly predicted quality of life among psychiatric out-patient ($\beta = .205, p < .05$). The Model Summary and ANOVA result coefficients showed that ($R^2 = .048, R^2$ (adjusted) = .015, $F = (2, 60) = 1.451, p < .05$).

The result also showed that perceived stress also predicted quality of life among psychiatric outpatients ($\beta = .061, p < .05$). The Model summary and ANOVA result coefficients also revealed that there was no significant prediction of quality of life by perceived stress ($R^2 = .048, R^2$ (adjusted) = .015, $F = (2, 60) = 1.451, p < .05$).

DISCUSSION

Treating psychiatric outpatients is very tasking, for it demands time, resources, and energy, among others. Obviously, managing the health of such outpatients requires that factors which foster vulnerability to relapse should be identified. This then necessitated that empirical studies should help to identify those factors capable of engendering relapse among this population. Present study then looked at the possibility of illness perception and perceived stress predicting quality of life among psychiatric outpatients. Accordingly, the findings obtained were interesting.

The first finding revealed that illness perception positively predicted quality of life among psychiatric outpatients. This means that the beliefs these outpatients hold about their health can affect their physical, mental, emotional, and social functioning. The belief they tend to uphold concerning their health (possibly emanating from their interaction with their environment) can affect their resolve to do their best in engaging only in things that enhances total remission of their presentation. This first finding suggests that being exposed to events that contribute in constructing negative beliefs or positive beliefs, about their health, can decrease or enhance the quality of life of psychiatric outpatients. The finding reported by Yaelim et al. (2019) concurred with this, where by, it was obtained that negative illness perception had a direct effect on a low sense of well-being

of the recruited participants. It further concurred with finding made by Morgan et al. (2014), where it was reported that illness perception was associated with indices of psychological well-being. These similarities could have resulted from both findings suggesting that illness perception has a way of limiting one's conception or belief of efficacy of treatment. Beliefs and thoughts are not automatic, but come through a process that involves consciously perceiving a situation in a particular way, (Mann, Ridder, Fujita, 2013). This may be heightened with the nature of interpersonal relationship the outpatients share with their environment.

This first finding further agreed with the finding made by Haanstra et al. (2015) that reported that changes in perceptions about consequences of Type 2 diabetes mellitus contributed significantly to the variance in changes in quality of life (QoL). Recognizing that belief remains impactful and could drive the actions of an individual, change from negative to positive perception of one's health, is expected to come with associated and equilibrated effect. It is on this premise that this first finding is seen as being in agreement with that report obtained by Haanstra et al., (2015). In the context that the perception is healthy, it ought to foster healthy quality of life, just as it would be expected to engender unhealthy quality of life if the perception is unhealthy. This view was further supported by the finding made by Tang et al., (2017) that low global QoL was significantly associated with dysfunctional illness perception.

Negative illness perception can increase the number of times psychiatric outpatients miss check-ups. Forming such belief could decrease motivation to attend medical appointments. This first finding suggests that where negative illness perception is present, it can increase the likelihood that quality of life of those upholding such belief may not be at its optimal. This may be obtainable, especially when such belief disposes the outpatient not to be attending periodic medical check-ups. Such check-ups did afford the outpatient the opportunity to inform the doctor of any complaint he or she has. To this effect, the finding reported by Whitmarsh et al., (2003) agrees with this first finding. These scholars reported that illness perceptions predict attendance at cardiac rehabilitation programmes in participants with mental illness. The similarity of the findings of the two studies can be better understood from the perspective that illness perception differs from individual to individual and while it may increase clinic attendance in some outpatients, it can decrease same in some others.

Meanwhile, it is important to note that illness perception having a positive prediction with quality of life, could suggest a possibility of having illness perception increasing the number of symptoms a psychiatric outpatient is experiencing. For instance, by increasing the likelihood of missing clinic attendance as at when due, an outpatient may not be good enough to grapple with associated challenges such inability may result to. Such inability may prevent the outpatient from having his or her drug adjusted or changed, as well as deny him or her the opportunity of letting the team in charge of his treatment know of any concern he or she may be experiencing. This forms the basis upon which this finding and the findings reported by Furze et al., (2005) are in agreement. Jaremo et al., (2017) found that participants who reported unhelpful illness beliefs were also more likely to report an increased number of symptoms of depression and anxiety.

Furthermore, the second finding of this study suggested that the subjective view of stress by psychiatric outpatients may have direct impact on their quality of life. Specifically, it was obtained that perceived stress negatively predicted quality of life among psychiatric outpatients. Such negative prediction suggests a view that while the stress perceived by psychiatric outpatients is on

the increase, their quality of life will be on the decrease, and while such perception is on the decrease, their quality of life should improve.

Generally, many factors may predispose psychiatric outpatients to stress, as well as how they perceive and interpret such stressors. It becomes very necessary to understand how the view of events or interpersonal interactions psychiatric outpatients experience tends to affect their quality of life. This second finding amplifies this necessity, as was same for the finding made by Shekhar et al., (1983), they reported that the frequency and types of undesirable life events in all areas of life experienced by psychiatric outpatients was significantly higher compared to matched controls in previous one year. These two findings underscore the need to know that stress in itself may not be the issue, but how psychiatric outpatients interpret them.

One possibility is that perception psychiatric outpatients have for the stressors they encounter will play a significant role in determining if they can effectively manage the stress or not. Being inundated with stressors may not be the actual problem, but the perception that one lacks the capacity, ability, or capability to handle the stressors. Chan (1999) reported that more stress symptoms were experienced by caregivers who had reported increased difficulty in managing caregiver tasks. A finding as that underscores the need to understand that the effect of stress is subjectively determined. The same thing can be said of this second finding, where by, in the context that psychiatric outpatients perceive the stressors they face as insurmountable, especially as it concerns their health, the associated effect can be seen in how difficult it will be for them to manage the stressors. Perhaps, such may lead to lack of motivation to continue treatment, which may eventually end up in relapse. To that effect, the finding reported by Chan (1999) is in agreement with the second finding obtained in this study.

CONCLUSION

This is a study that was driven by the need to forestall relapse among psychiatric outpatients. Due to the link between thoughts and actions, illness perception and perceived stress, which happens to be by products of thought processes, especially the interpretation aspect, were examined to determine how they could predict quality of life. Results obtained were interesting and revealed that while illness perception predicted quality of life positively; perceived stress did so, negatively.

RECOMMENDATIONS

In line with the findings made, the following recommendations were made:

Accordingly, considering that illness perception was found to be a positive predictor of quality of life among the participants, psychiatric outpatients should be exposed to programmes and psychoeducation capable of promoting positive view of their health. Doing so will result to having positive illness perception leading to improve quality of life, since the two variables shared positive relationship.

Similarly, psychiatric outpatients may by virtue of their health condition be predisposed to some unfriendly interpersonal relationship with some people who may be finding it very difficult to accommodate them unconditionally. How they interpret such experience, among other stressors they may encounter, remains important in achieving effective treatment. It is therefore recommended that the process of re-integrating psychiatric outpatients back into the society should

be done very well, amidst equipping them with required skills and knowledge they will need in handling the stressors they will face, positively.

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