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# Occupational adaptability and daily living among schizophrenia patients: A cross-sectional study

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**Abstract:**
Schizophrenia markedly impairs occupational adaptation and functional independence, limiting patient's ability to perform everyday activities. Therefore, it is of interest to assess the occupational adaptation and instrumental activities of daily living among 60 clinically stable adults with schizophrenia attending a tertiary mental health institute in Chennai. The mean occupational adaptation score was 81.80 ± 19.85, with 36.67% showing high adaptation, while the mean IADL score was 6.65 ± 1.28, with 63.33% demonstrating high functional independence. Occupational adaptation showed a significant positive correlation with daily living activities ($r = 0.39$, $p = 0.01$) and both outcomes were significantly associated with selected sociodemographic and clinical variables ($p \leq 0.05$). Thus, data shows the value of structured psychiatric rehabilitation to enhance occupational adaptation and promote functional independence among people with schizophrenia.

**Keywords:** Schizophrenia, occupational adaptation, career adaptability, psychiatric nursing, rehabilitation

**Background:**
Schizophrenia is a serious, persistent psychiatric illness that disrupts thought processes, perception, emotional response and social behaviour. Recent estimates from the Global Burden of Disease analysis indicate that around 23.6 million people worldwide live with the disorder and its raw prevalence has continued to increase in the past three decades, even though age-standardised rates have remained largely stable **[1].** The National Mental Health Survey estimated the lifetime prevalence of schizophrenia spectrum disorders in India at 1.41% and the current prevalence at 0.42%, with nearly 72% of current cases experiencing a treatment gap **[2].** Schizophrenia commonly begins during late adolescence or early adulthood and follows a long term, relapsing pattern, affecting education, work and family life over many years. Beyond its core symptoms, schizophrenia is uniquely disabling because of its impact on social participation. Findings from a study showed that nearly 87% of individuals with schizophrenia reported at least one form of negative discrimination, particularly affecting friendships, intimate relationships and the workplace **[3].** The illness also carries one of the highest premature mortality risks in psychiatry; systematic review evidence places the lifetime suicide rate at approximately 5%, with younger age and male sex identified as strong predictors **[4].** These outcomes underline that recovery in schizophrenia cannot be defined by symptom remission alone. Occupational adaptation; the capacity to adjust the inner resources of concern, control, curiosity and confidence to changing work demands; is consistently impaired in this population. Literature has long documented employment rates of only 20% among adults with schizophrenia, with stigma, fragmented services and benefits-related disincentives identified as the most consistent barriers **[5].** Vocational rehabilitation, such as the Individual Placement and Support (IPS) model, has showed competitive employment rates substantially higher than traditional pre-vocational training across multiple randomised controlled trials **[6].** However, occupational gains are constrained by deficits in attention, processing speed, working memory and executive function, which remain among the most powerful predictors of poor functional outcomes in schizophrenia **[7].** Equally important is the ability to manage instrumental activities of daily living (IADL) , higher order skills in managing money, using transportation, taking medications, preparing meals and shopping. The Lawton, Brody IADL scale, originally validated in older adults, remains one of the most widely used instruments to capture independence in these domains **[8].** In persons with schizophrenia, IADL deficits are not merely symptomatic by products but are tightly linked to neurocognition, motivation, social cognition and personal resources, which together explain over half the variance in real-life functioning **[9].** Therefore, it is of interest to assess the level of occupational adaptation among patients with schizophrenia attending a tertiary mental health institute in Chennai.

**Materials and Methods:**
**Study design and setting:**
A quantitative, non-experimental, cross-sectional descriptive study was conducted at the Outpatient Department of the Institute of Mental Health (IMH), Chennai, India. The population comprised adults attending the OPD with a documented diagnosis of schizophrenia. The institutional ethics

committee approved the study and all participants provided written informed consent.

**Inclusion criteria:**

**[1]** Age 18-60 years
**[2]** Clinical stability with no acute psychotic episode in the preceding six weeks
**[3]** Ability to comprehend and respond to questionnaire items
**[4]** Provision of written informed consent

**Exclusion criteria:**

**[5]** Comorbid psychiatric illness, neurological disorders or traumatic brain injury
**[6]** Recent (within six months) substance misuse
**[7]** Critical illness at the time of approach
**[8]** Concurrent enrolment in another study

**Sample size:**

Sample size was calculated using Cochran formula at a 95% confidence level, an assumed occupational performance proportion of 42% drawn from a previous community-based study and a 30% relative precision, yielding a required sample of 60 participants. Non-probability convenience sampling was used for recruitment.

**Data collection:**

Data were collected using the socio-demographic and clinical proforma, the Career Adapt-Abilities Scale (CAAS) and the Lawton, Brody IADL scale. Content validity of the proforma and tools was confirmed by nursing experts. A pilot study was conducted on 10% of the projected sample (six patients) to refine procedures; pilot participants were excluded from the main analysis. Each interview lasted 10 to 15 minutes and was conducted in a private OPD consultation cubicle. Ethical clearance was granted by the Institutional Ethics Committee of Madras Medical College, Chennai and permission to conduct the study was obtained from the Director of IMH.

**Statistical analysis:**

The collected data were entered into Microsoft Excel and analysed using SPSS. Karl Pearson's correlation coefficient was used to assess the relationship between occupational adaptation and daily activity scores. The Chi-square test was used to examine associations between the two functional outcomes and selected categorical socio-demographic and clinical variables. A p-value of 0.05 was considered statistically significant.

**Results:**

Among the 60 patients, 13.34% were aged 18–20 years, 20.00% were aged 21–25 years, and 33.33% each belonged to the 26–30 and 31–35-year age groups. Most participants were male (61.67%), married (65.00%), and Hindu (88.34%), while 45.00% resided in urban areas. Homemakers constituted the largest occupational group (68.33%), and 81.67% had a monthly income of ₹12,444 or less. Half of the participants lived in nuclear families (50.00%), and 85.00% reported no family history of schizophrenia. Paranoid schizophrenia was the predominant subtype (86.67%), and 91.67% were currently receiving antipsychotic medication. A total of 55.00% had a duration of illness of five years or less, while 50.00% had experienced one or two previous hospitalisations. The complete distribution is summarised in **Table 1**. The mean total CAAS score was 81.80 ± 19.85, equivalent to 68.17% of the maximum possible score, indicating moderate occupational adaptation. Categorically, 36.67% of patients demonstrated high occupational adaptation, 33.33% moderate adaptation, and 30.00% low adaptation. At the item level, the highest mean score was recorded for "Thinking about what my future will be like" (75.40%), whereas "Taking responsibility for my actions" had the lowest score (63.00%). The mean IADL score was 6.65 ± 1.28 out of 8 (83.12%), indicating a high overall level of independence. Independence rates were highest for telephone use (100.00%), followed by housekeeping and laundry (95.00% each), medication management (86.67%), transportation (81.67%), and food preparation (78.33%). Shopping (73.33%) and financial management (55.00%) were the weakest domains. None of the participants belonged to the low-activity category, while 63.33% demonstrated high and 36.67% moderate activity levels. A statistically significant, fair positive correlation was observed between occupational adaptation and IADL scores ($r = 0.39$, $p = 0.01$). Chi-square analysis revealed significant associations between occupational adaptation and male gender, nuclear family type, and absence of previous hospitalisation. Higher IADL scores were significantly associated with male gender, older age at symptom onset, and absence of previous hospitalisation. The remaining variables showed no statistically significant associations.

**Table 1:** Distribution of patients (n = 60) across selected sociodemographic variables.

| Demographic variable | Category | n (%) |
|---|---|---|
| **Age (in years)** | 18-20 years | 8 (13.34%) |
| | 21-25 years | 12 (20.00%) |
| | 26-30 years | 20 (33.33%) |
| | 31-35 years | 20 (33.33%) |
| **Gender** | Male | 37 (61.67%) |
| | Female | 23 (38.33%) |
| **Marital Status** | Single | 19 (31.67%) |
| | Married | 39 (65.00%) |
| | Widowed | 2 (3.33%) |
| **Educational Qualification** | No formal education | 8 (13.33%) |
| | Primary education | 14 (23.33%) |
| | Secondary education | 18 (30.00%) |
| | Higher secondary education | 13 (21.67%) |
| | Graduate and above | 7 (11.67%) |
| **Employment Status** | Employed (government) | 4 (6.67%) |
| | Employed (private) | 15 (25.00%) |

| | | |
|---|---|---|
| | Homemaker | 41 (68.33%) |
| **Type of family** | Nuclear family | 30 (50.00%) |
| | Joint family | 27 (45.00%) |
| | Extended family | 3 (5.00%) |
| **Family History of Schizophrenia** | Yes | 9 (15.00%) |
| | No | 51 (85.00%) |
| **Monthly Income (INR)** | ≤12,444 | 49 (81.67%) |
| | 12,445–37,324 | 11 (18.33%) |
| **Religion** | Hindu | 53 (88.34%) |
| | Muslim | 5 (8.33%) |
| | Christian | 2 (3.33%) |
| **Residence** | Urban | 27 (45.00%) |
| | Sub-urban | 20 (33.33%) |
| | Rural | 13 (21.67%) |

**Discussion:**

The present study provides a focused picture of how patients with schizophrenia navigate two interlinked recovery domains: occupational adaptability and instrumental daily living. The aggregate moderate occupational adaptation (68.17%) coupled with high IADL independence (83.12%) suggests that, while routine self-care skills are largely retained in clinically stable outpatients, the more abstract demands of career planning, decision-making and curiosity-driven exploration remain comparatively constrained. This pattern aligns with the structural-equation findings of Mucci *et al.*, who showed in a four-year follow-up of community-dwelling patients that productive activities lag behind everyday life skills, with neurocognition and avolition emerging as principal drivers **[10].** Similarly, in older inpatients with schizophrenia, cognitive deficits and medical comorbidities were identified as significant predictors of functional impairment **[11].** A recent Indian cohort study using the Lawton instrument reported that only a minority of patients with schizophrenia achieved full IADL independence, with substantial difficulties concentrated in the finance and transportation domains **[12].** The higher independence observed in our sample likely reflects differences in selection: only clinically stable outpatients on regular antipsychotic therapy were included and the majority was homemakers whose daily routines reinforce living skills. Nevertheless, the same vulnerability around financial management (55.00% in our cohort) echoes prior work and points to a robust, gender-neutral target for skill-based nursing interventions. The significant gender effect favouring males in both occupational adaptation and IADL is consistent with a recent Indian cross-sectional report in which males scored higher on social-occupational functioning scales, plausibly because traditional household roles for Indian women may be under recognised by occupation-oriented instruments **[13, 14].** The positive correlation between occupational adaptation and daily activities ($r = 0.39$, $p = 0.01$) mirrors the path-analytic relationship reported by Thibaudeau *et al.* and van Aken *et al.* who showed that occupational dysfunction mediates the link between difficulty in daily life and recovery **[15, 16].** A meta-analysis of 59 studies confirms that social-cognitive and adaptive resources have a moderate positive association with IADL performance across diverse samples **[17, 18].** Together, these findings reinforce that strengthening adaptability is not separate from teaching daily-living skills; the two reinforce each other. Limitations include the small single-centre convenience sample, the cross-sectional design that precludes causal inference and reliance on self-report. Nonetheless, the findings have direct implications for nurse-led psychoeducation, family-based rehabilitation and structured vocational training in resource-limited Indian settings.

**Conclusion:**

Clinically stable adults with schizophrenia showed moderate occupational adaptation and largely preserved IADL functioning. Better occupational adaptation was significantly associated with better IADL performance. Individualised occupational and IADL training may enhance functional independence and support recovery.

**Conflict of interest:**

The authors declare no conflict of interest

**Funding:**

No external funding was received for this study.

**Ethical approval:**

Ethical approval was obtained from the Institutional Ethics Committee, Madras Medical College, Chennai and institutional permission from the Director, Institute of Mental Health and Chennai.

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