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A Comparative study of the level of dysfunction among Schizophrenic and BPAD (Manic) patients

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Abstract

Background:-Dysfunction is concerned with the functioning or malfunctioning of the individual at the movement, in comparison to his previous functioning or potentiality. Dysfunction is a strongly associated with mental disorders (Schizophrenia & Bipolar Affective Disorders) and affects the one or more major area of functioning (e.g; interpersonal relations, work or education, or self-care). **Material & Method:-** It is cross-sectional hospital based study using purposing sampling technique and to study and compare of the level of dysfunction of the patients of schizophrenia and bipolar affective disorder (mania). The research work was done at the outpatient department of Ranchi Institute of Neuro-psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi, Jharkhand, (India). The present study has two groups (schizophrenia and bipolar affective disorder (manic cases). The sample consisting of 75 subjects each diagnosed as schizophrenia and mania were included. Socio Demographic & Clinical Data Sheet and Dysfunction Analysis Questionnaire (DAQ) were used for data collection and Mean, SD, Chai square and t-test used for statistical analysis. **Result:-** Finding suggested that the level of dysfunction among schizophrenic patients were more than manic patients in all areas of dysfunction. **Conclusions:-** Dysfunction is strongly associated with psychiatric disorders e.g. schizophrenia and mania, In this study dysfunction occurs in many areas e.g. social. personal, family, cognitive and vocational but more dysfunction found in schizophrenic patients.

Keywords: Schizophrenia, BPAD (Mania), Dysfunction.

INTRODUCTION

Dysfunction is a psychosocial concept, which indicate the individual malfunctioning. Wolman (1973) has precisely defined dysfunction as “a failure of an organismic process, organ or system work properly”. Dysfunction is concerned with the functioning or malfunctioning of the individual at the movement, in comparison to his previous functioning or potentiality. Dysfunction is a strongly associated with mental disorders i.e. schizophrenia and bipolar affective disorders, involve dysfunction is one or more major area of

functioning (e.g; interpersonal relations, work or education, or self-care). Schizophrenic and manic, individuals academic progress is frequently disrupted, and the individual may be unable to finish school and college, many individual are unable to hold a job for sustained period of time and are unemployed at a lower level than their parents. The majority (60%-70%) of individual with schizophrenia do not marry and most have relatively limited social contacts. The dysfunction persists for a substantial period during the course of the disorder and does not appear to be a direct result of any single feature. Krapelin observed that the central features of schizophrenia include abnormalities in attention, association and volition. Schizophrenic patients exhibited their greatest impairments in judgments, attention, concentration, planning and anticipation and concept formation.

Schizophrenic peoples too have their own perceptions of reality, their view of world, however, is often strikingly different from the usual reality seen and shared by those around them. Living on a world that can appear distorted, changeable and lacking the reliable landmarks we use to anchor ourselves to reality, a person with schizophrenia may feel anxious and confused. This person may seem distant, detached or preoccupied and even sit at rigidly as a stone, not moving for hours and not uttering a sound.

There is growing awareness of psychiatric disorders (schizophrenia and mania) being a major cause of disability. Psychiatric illness leads to poor adaptability and cause dysfunction in one's family, social, personal, cognitive and vocational life. Recent advances in the field of psychopharmacology have made giant strides in the last few decades with the improve understanding of etiology pathogenesis and management of various diseases. However, soon it was realized that although medicine has been able to prolong the lives of the people, the quality of life suffer very badly because of continuing chronic illness. One of the important reason of poor quality of life was found to be the dysfunction caused by illness **(Tripathi et al,2001).**

It has been reported that patient with schizophrenia had greater disability as compared to manic depressive patients. Comparable finding that patients of schizophrenia had more disabilities have been noted in many other Indian studies too (**Kulhara,1997; Thara & Rajkumar,1995).**

Srivastava et.al (1991) conducted a research a study in cognitive deficits and associated features in patients with chronic schizophrenia and compared them with those in normal population. They compared the subject of multi measures of attention, executive function and memory. They found that patients with schizophrenia performed with poorly on all test of cognitive function. Negative symptoms had a strong association with cognitive dysfunction in all the domains. There was a study done by **Singh et al.(2002-03)** about nature and severity and dysfunction in chronic schizophrenia. Total sample size was 100 patients of schizophrenia diagnosed by psychiatrist according to ICD-10-DCR. Patients were the age range of 20 to 50 years, who were regularly coming in follow-up. Semi structured Performa Disability Assessment Scale developed by Behere and Tiwari(1991) was used, it measure the level of disability in five area of disabilities viz., personal, social, occupational, physical and general. Result indicates that most of the patients had disability in all areas and highest level of disability was found in occupational area and which was followed in social area. In personal area highest level of dysfunction was found on items "decreased desire to talk" and "poor decision making". Majority of the patient had mild to moderate level of dysfunction in most of the items. In social area highest level of visitors at home". Here also majority of the patients had mild to moderate level of dysfunction in most of the items. In occupational area highest level of dysfunction was found in "change in work schedule" and "decrease in work performance". In occupational area also majority of the patients had mild to moderate level of disability in the most of the items. Severe level of dysfunction was fund on "unemployment" "decrease in work performance" and change in work schedule". In physical area highest level of dysfunction was found on "weakness" and "fatigability". Majority of the patients had mild to moderate level of dysfunction in all the items. In "General area " highest level of disability was found on "mental tension" and "tension of the family members", in the area also majority of the patients had mild to moderate level of disability on all items. Findings of the present study suggested that patients with schizophrenia have disability in all areas e.g. personal, social, occupational, physical and general. Finding of the present study suggested that patient with disability in the all areas. Highest level of disability was in occupational area that was followed by social area.

In a another study in 2007 by Prasad et al in the neurocognitive impairment of schizophrenia. The aim of the study was to evaluate the cognitive impairment of schizophrenic patients and normal controls on certain test of PGIBBD and WCST. With the help of purposive sampling technique a group of 40 male and female patients with schizophrenia between the age ranges of 20-55 years was selected from the inpatients. Similarly 40 normal was selected of the study. Certain test of PGIBBD and WCST was administered in on both groups accordingly. Result indicated that normal control perform better on PGIBBD and WCST in comparison on the patients with schizophrenia. Result finding presented that various subtest of PGIBBD revels the fact of schizophrenic patients have poor performance on Revised Bhatia Short Battery of Performance Test of Intelligence as well as Verbal Adult Intelligence Scale as compared with normal controls. **Jai Prakash et al. (2005**) have also found impaired higher cognitive functioning on frontal lobe scales of Luria-Nebraska Neuropschological Battery (LNNB) in the case schizophrenia. **Josy K. Thomas et al (2004)** studies comparing psychosocial dysfunction and the related family burden between psychotic an non- psychotic disorders. The aim of the study was to assess and compare the extent and pattern of psychosocial dysfunction of patients and family burden in schizophrenia and OCD, and to find relationships between these two constructs in the two disorders. In comparison of global and area wise DAQ score in schizophrenia and OCD. The global score and personal, vocational, family and cognitive area scores were significantly higher in the schizophrenic group. Result also show that correlation between psychosocial dysfunction of patients and areas of family burden in schizophrenia and OCD. In schizophrenia there was a significant relationship only between dysfunction and disruption of family interaction. In OCD there were significant positive correlation family routine, disruption of family leisure, and disruption of family interaction. The finding of the present study reveal that patients with schizophrenia have more psychosocial dysfunction than the OCD group. However, there was no significant difference between schizophrenia and OCD patients with regard of dysfunction in 'social area'. This shows that both schizophrenia and OCD patients were equally impaired in social functioning. Dysfunction in other area such as vocational, families, personal and cognitive functioning were significantly higher in schizophrenic group.

A manic episode is defined by a distinct period during which there is an abnormally and persistently elevated, expensive and irritable mood. The period of abnormal mood must last at least 1 week (or less if hospitalization is required). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, and increased involvement in goal directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. A number of studies shown that some individuals with bipolar disorder have significant psychosocial impairment during inter episode intervals, but the methodologies used to define impairment have very widely. BPAD(M) substantial level of functional impairment are also characteristic of manic-depressive disorder, even when major clinical indices have improved.

Winokur and Colleagues (1969) documented theirs sample functional impairment in detail. For instance, 79% of these employed before their index episode lost their jobs during that episodes. Among those with incomplete remission during follow-, up, 73% have long term decrements in occupational status. Even more striking, 25% of those with complete remissions or only fun infrequent episodes developed similar occupational decrements. In another early study, 60% had less than satisfactory social recovery.

Harrow and colleagues (1990) found at 17 years of prospective follow-up after an index manic episode that 23% of patients were continuously unemployed, with 36% unemployed in comparison to pre episode level, occupation was significantly worse than in a comparison group of depressive patient without history of mania. In addition, 36% showed at least moderate impairment in social functioning. These deficits were unrelated to the presence of symptoms, with the expectation of psychosis, which was associated with profound impairment. In another study found that 28% of subject unemployed after index hospitalization of mania.

In a study with bipolar affective disorder (mania) population, MacQueen *et al.* (2000), noted than even a high number of previous episode dopes not distort patients ability to estimate function with euthymic. Authors also mentioned the primary limitation to the study was the number of episodes determined prospectively.

A recent study by Kerr et al. (1970) found that 82% BPAD patients followed for up to 1 year, attained functional recovery within 1 month of syndrome recovery, (which) suggested that most patients return to baseline enter-episode level of function within this time frame.

The National Depressive and Manic Depressive Association (NDMDA) member found that 37% of patients with bipolar disorder were currently unemployed (Lish *et al.*, 1994). Patient hospitalized for bipolar disorder had been employed in only 34% of case in one study in New Zealand, compared to 75% for the general population (Mcpherson *et al.,* 1992). Dion *et al.* (1988) in another study reported only 43% of patients with BPAD were employed six month after discharge from the psychiatric hospitalization and 21% were functioning at their expected level of employment.

PROBLEM TO BE INVETIGATED:

Comparative study of level of dysfunction among Schizophrenia and Bipolar Affective Disorder (Manic) cases. It has to be investigated to examine what type of dysfunction does mainly occur in both these disorders.

METHODOLOGY

Aim of the study

To study and compare of the level of dysfunction of the patients of schizophrenia and bipolar affective disorder (mania).

Objectives

-To find out the socio-demographic correlates the level of dysfunction of schizophrenia and bipolar affective disorder (mania) cases.

-To study and compare level of dysfunction of schizophrenia and bipolar affective disorder (manic) cases.

Hypotheses:

-There will be no significant correlation between socio demographic variables (like age, sex, marital status, socio economic status etc.) level of dysfunction of the patients of schizophrenia and bipolar affective disorder (mania).

-There will be no significance difference between level of dysfunction among schizophrenia and bipolar affective disorder (manic) cases.

Venue of the study:

The research work was done at the outpatient department of Ranchi Institute of Neuropsychiatry and Allied Sciences (RINPAS), Kanke, Ranchi, Jharkhand, (India). It is cross-sectional hospital based study using purposing sampling technique. The present study has two groups (schizophrenia and bipolar affective disorder (mania) cases). The sample consisting of 75 subjects each diagnosed as schizophrenia and mania were included.

Inclusion criteria for Schizophrenic Patients

- Diagnosed patient of schizophrenia according to DCR of ICD-10.
- In the age range 21 to 45 years.
- Patient of both sexes (male and female).
- Patient who will give consent to participate.

Exclusion criteria

- Co-morbid psychiatric disorder.
- History of alcohol and substance abuse.
- Family history of major physical/ mental illness.
- History of major head injury, seizure, or other neurological problems/ mental retardation etc.
- Uncooperative patient.

Inclusion Criteria for Bipolar Affective Disorder (Manic patients)

- Diagnosed patient of bipolar affective disorder (mania) according to DCR of ICD-10.

- In the age range of 21-45 years.
- Patient of both sexes (male and female).
- Patient who will give consent to participate.
- Patient with at least 2nd episode in last two years.

Exclusion Criteria:

- Co-morbid psychiatric disorder.
- History of alcohol and substance dependence.
- Family history of major physical and mental illness.
- History of significant head injury, seizure, neurological problems/mental retardation etc.
- Uncooperative patient.

Tools used for collection of data:

- Socio Demographic & Clinical Data Sheet.
- Dysfunction Analysis Questionnaire (DAQ).

Socio Demographic & Clinical Data Sheet

It is a semi structured Performa especially designed f Socio Demographic & Clinical Data Sheetfor this study. It contains information about socio-demographic variables like age, sex, education, marital status, religion, occupation and socio economic status, domicile, etc. Other than this following point will be included; diagnosis, history of previous admission, history of treatment, age of onset, episode, duration of present episode, family history of mental illness, any history of significant head injury, seizure, mental retardation etc.

Dysfunction Analysis Questionnaire (DAQ)

The scale has developed by Pershad, D. Verma, S. K. Malhotra, & A. Malhotra, S. (1985). There are five areas in the Dysfunction Analysis Questionnaire (DAQ) these are "Social" "Vocational" "Personal" "Family" and "Cognitive" areas. Each area contains 10 items. Each item has five alternative answers these are score from 1 to 5. The scale has highly satisfactory test-retest and split-half reliabilities which ranged from .77 to .97.

1. One score indicates better than pre-morbid level of functioning.
2. Just as pre-morbid level of functioning.
3. Slightly impoverished functioning.
4. Moderate dysfunction and
5. Marked deterioration in functioning.

The present tool has been developed with a view that not only the patient but anyone, who is living with patient, can assess his functioning and day- to-day life. The questionnaire can be used as self-administration or individual administration (like structured interview). Sometime an item may not be applicable to a patient. It was therefore, decide that the row score on a subscale was to converted into percentage and the weighted score may be arrived at, on the basis of the items applicable to him. The formula used for such attenuation was as follows.

$$\text{Attenuated percentage score} = \frac{100 \text{ X obtained row score}}{\text{No. of items attenuation X } 5}$$

On each subscale the maximum raw score that can be attained is 50. An attenuated percentage score of 40% in each scale would mean "No dysfunction" compared to a reference point of pre-morbid level. An attenuated percentage score lower than 40% would mean better functioning than the pre-morbid level. Whereas more than 40% would mean dysfunction. Higher the score greatest the dysfunction.

Procedure

The schizophrenic and manic patients have taken in study, which are co-operative and met in the inclusion criteria. Socio-demographic and clinical data sheet filed after interview of the patients. Socio demographic and clinical datasheet and Dysfunction Analysis Questionnaire were administered.

Statistical Analysis

Data of present study is described using number, percentage, mean, SD, chi square, and t-test. Chi square was done between comparison of socio-demographic variables of mania and schizophrenia. Mean and SD was done in both groups. T-test was done for the comparison of socio- demographic variables and level of dysfunction in both groups.

RESULTS

Table-1 (A): - Showing Socio-demographic characteristics of Manic and Schizophrenic patients in Age, Sex, Marital status, Education and Domicile.

Variables	**Mania** N (%)	**Schizophrenia** N (%)	χ^2 **df**	**(p)**	**Significance Level**
Age			0.1175 df=2	0.9429	NS
21-30	22 (29.33)	23 (30.66)			
31-40	43 (57.33)	41 (54.66)			
41-45	10 (13.33)	11 (14.66)			
Total	75 (100%)	75(100%)			
Sex					
Male	50 (66.66)	48 (64.00)	0.1472	0.7012	NS
Female	25 (33.33)	27 (36.00)	df=1		
Total	75(100%)	75(100%)			
Marital Status					
Married	43 (57.33)	46 (61.33)	0.2763	0.5991	NS
Unmarried	32 (42.66)	29 (38.66)	df=1		
Total	75(100%)	75(100%0			
Education					
Illiterate	9 (12.00)	18 (24.00)			
Up to 10^{th}	54 (72.00)	45 (60.00)	3.8182 df=2	0.1482	NS
Above 10^{th} to Master Degree	12 (16.00)	12 (16.00)			
Total	75(100%)	75(100%)			
Domicile					
Rural	38 (50.66)	46(61.33)			NS
Urban	37 (49.33)	29 (38.66)	1.7587 df=1	0.1842	
Total	75(100%)	75(100%0			

Table-1(B) Showing Socio-demographic characteristics of Manic and Schizophrenic patients Religion, Occupation, Family Type and Socio-Economic Status.

Variables	**Mania** N (%)	**Schizophrenia** N (%)	χ^2 **df**	**(p)**	**Significance Level**
Religion					
Hindu	49 (65.33)	57 (76.00)			
Muslim	18 (24.00)	12 (16.00)	2.0895 df=2	2.0895 df=2	NS
Others	08 (10.66)	06 (08.00)			

Total	75 (100%)	75(100%)			
Occupation					
Employed	46 (61.33)	48 (64.00)	0.1425 df=1	0.7058	NS
Unemployed	29 (38.66)	27 (36.00)			
Total	75(100%)	75(100%)			
Family Type					
Nuclear	30 (40.00)	26 (34.66)	0.4844 df=1	0.4864	NS
Joint	45 (60.00)	49 (65.33)			
Total	75(100%)	75(100%0			
Socio Economic Status					
Up to Rs. 3,000	43 (57.33)	46 (61.33)	1.1187 df=2	0.5716	NS
Up to Rs. 6,000	29 (38.66)	28 (37.33)			
Above Rs. 6,000	03 (04.00)	01 (01.33)			
Total	75(100%)	75(100%)			

The study sample consisted of total 150 patients. There were two groups of the patients (Schizophrenia and Mania).75 schizophrenics and 75 Bipolar Affective Disorder currently manic patients were taken to the study and diagnosed accordingly to DCR-ICD-10 criteria. Table-1(A) is showing the socio-demographic characteristics of schizophrenia and manic patients. The age group of the patient was classified into three categories i.e. 21-30, 31-40, 41-45. 30.66% patients of schizophrenia and 29.33% patients of Manic were in age range of 21-30 years. 54.66% in schizophrenia and 57.33% in mania belongs to the age range of 31-40 years. And 13.33% manic and 14.66% schizophrenic patients belongs to the age range of 41-45 years. Out of 75 manic patients 50 patients were male and 25 patients were female and out of 75 patients of schizophrenia 48 patients were male and 27 patients were female.In respect of marital status of manic patients, 57.33% subjects married and 42.66% were unmarried. Similarly in schizophrenia 61.33% cases married and 38.66% patients were unmarried. About education, out of 75 patients, 9 were illiterate, 54 patients educated up to matric level and 12 patients educated up to master level in manic cases and in schizophrenia 18 patients were illiterate, 45 patients educated up to matric level and 12 patients were above matriculation. In respect of domicile, 38 patients were in rural area and 37 patients from urban background in mania and in schizophrenia 46 patients were in rural area and 29 patients belongs to urban background.

Table 1(B) is showing the religion of patient was classified into three groups, Hindu, Muslim and others. In respect of Mania, 65.33% patients were of Hindu community and 24% patients were Muslim and 10.66% patients belong to other community. In respect of schizophrenia, 76.00% were Hindu, 16% were Muslim and 8% belongs to other community. About occupation 61.33% patients were employed and 38.66% were unemployed in manic group and in schizophrenia, 64% patients were employed and 36% patients were unemployed. Categories of the family type in the two groups i.e. nuclear and joint. Out of 75 in Mania, a 40% patient belongs to nuclear family and 60% belongs to joint family and 34.66% patients belongs to nuclear and 65.33% belongs to joint family in schizophrenia. The socio-economic status of the patients was classified into three categories, monthly income up to Rs.3,000, up to Rs.6,000 and above Rs.6,000. 57.33% patients were up to Rs.3,000 monthly income and 38.66% were up to Rs.6,000 monthly income and 3% were above Rs.6,000 monthly income in manic group. Similarly in schizophrenia, 61.33% patients were up to Rs.3,000 monthly income and 37.33% patients were up to Rs.6,000 and single patient was above Rs.6,000 monthly income. X2 values suggested that there is no significant difference in socio demographic variables of schizophrenia and mania

Table-2:- Showing Mean, SD and 't' value of dysfunction level of manic and schizophrenic patients.

Variables (Area of Dysfunction)	Mania		Schizophrenia		*t* Value df=148
	Mean	SD	Mean	SD	
Social	53.11	7.20	62.61	9.51	6.897**
Vocational	53.31	7.89	61.85	9.70	5.915**
Personal	47.69	8.06	57.51	9.87	6.674**
Family	53.31	8.33	58.56	10.30	3.432***
Cognitive	44.84	6.30	53.84	9.30	6.939***

***P < 0.001 level
**P < 0.01 level

Table 2 is showing level of dysfunction in two patient groups. The level of dysfunction was ranked on the Dysfunction Analysis Questionnaire. To know the statistical difference in the level of dysfunctional between the two groups '*t*'-test was administered . Finding suggested that the level of dysfunction among schizophrenic patients were more than manic patients in all areas. Statistically significant difference was found in all the areas of dysfunction e.g. social, personal vocational, Family and Cognitive. Social area ('*t*'=6.897,df=148,P<0.01 level) vocational area ('*t*'=5.915, P<0.01 level) vocational area ('t'=6.674, P<0.01 level), Family area ('*t*'=3.432, P<0.001 level) and in cognitive area ('*t*'=6.939, P<0.001). Result suggested that in comparison to manic patient, schizophrenic patient had more significantly in Family and Cognitive areas.

DISCUSSION

Clinical outcome of schizophrenia and bipolar affective disorder cannot be understood only from the point of view of psychopathology. Psychological and environmental factors facilitate or impede recovery and determine the prognostic status. So, personal and environmental strengths are also extremely important and require specific consideration. In this context the present study was carried out which contributed same information application for clinical intervention and for further research. The present study examined the way in which people having Schizophrenia and Bipolar Affective Disorder (Mania) have dysfunction in different spheres of life and this way in which the social support system is related to the dysfunction. The present study is a comparison study which aim to examine and compare and dysfunction level of the schizophrenic patients and Bipolar Affective Disorder (Manic) Cases. Sample was collected by purposive sampling method on OPD basics and total size was 150. 75 patients were schizophrenic group and 75 patients from manic groups. During a particular time period it was more convenient to collect date purposively. It was time bound study and it was not possible to first enlist all patients and then select patients for the study, hence non-probating (purposive) sampling was used.

Result shows about age factor of both age groups 57.33% in Mania and 54.66% in schizophrenia patients belongs to age group of 31-40 years. In the area of sex variable 66.66% male patients were manic group and 64.00% male patients from schizophrenic group. And in both groups large number of married patients in Manic group. 43 patients were married and in schizophrenia group 46 patients were married. Out of 150 in both groups 59.33% were married. Result of the study shows that about socio-economic status 57.33% in mania and 61.33% in schizophrenic belongs to income of below Rs3,00o. Out of 75, three patients of mania and out of 75, one patient is schizophrenic have monthly income was aboveRs.6, 000.

Hoeining and Hamilton (1966) found that factors like age, sex social class and marital status of the patients had little effect on the burden, unlike the duration of the illness and patients psychopathology. It was found that76% of patients had some kind of adverse effect on the households. Brown and Birley (1972) and Vaughan and Leff (1985) had found that the relapse rate of schizophrenic was double in males than females and rate of relapse was significantly in unmarried as compared to married.

About the educational status in both groups, 72% patients from Manic and 60% schizophrenics were educated up to matric level. Some studies shows that lower level of education (illiterate or literate) is related to poor outcome in schizophrenia. About the occupation of the patients, result shows that 64% patient in schizophrenic and 61.33% in Manic were employed. They employed as labour or mazdoor etc. Strauss and Carpenter (1977) had claimed that the quality of useful work or to meaningful work involvement is a significant contributory factors to determine good prognosis of the schizophrenia. In another study, Caplan et.al (1985) found husbands undermining behavior negatively, Tripathi et.al (2001) found that the socio-demographic and clinical variables like age, sex, duration of illness, marital status, mode of onset and premorbid functioning which are correlated to course and outcome have also been reported to have an effect on disability affected the health and function of their wives.

For the compare of Socio-demographic variables of schizophrenic and manic. Chi square (x^2) has been done. But result shows that there was no significant in any area of socio-demographic variables of each age, sex, marital status, domicile etc. in manic and schizophrenic patients.

Compared the various areas of dysfunction to schizophrenic and manic patients.

After compared the various areas of dysfunction in schizophrenia and mania, result shows that all areas of dysfunction e.g. social, vocational, personal, family and cognitive were statistically highly significant on 0.001 levels. It means dysfunction is the major factor in both schizophrenic and manic groups. Earlier study reported that higher level at extraversion and neuroticism are associated with poor vocational functioning in schizophrenia. Higher levels of both these personality traits and this sample were strongly associated with poor performance on an overall measure of work performance and on four of five subclasses assessing different domains of work function. Higher levels of extraversion and neuroticism significantly predicted poor function accounting for between 7% and of the variance in global cooperativeness, work quality, work habits and personal presentation measures of work behavior. Result indicated that personality feature may be implicated in psycho-social dysfunction in schizophrenia and Mania in domains of work. In another study, cognitive impairment closely associated with deficits in psycho-social function and exclusive function in schizophrenia. Lieberman (1982) found that those who have adequate in health promoting behavior are less prone develops. Same type of health problems and are more likely seek medical care than those who have low support.

CONCLUSION

Dysfunction is strongly associated with psychiatric disorders e.g. schizophrenia and mania, In this study dysfunction occurs in many areas e.g. social. personal, family, cognitive and vocational but more dysfunction found in schizophrenic patients.

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