Communication Competence, Intimacy, and Recovery among patients with Schizophrenia

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Abstract

Background: Studies indicate that intimate relationships are common unmet needs among patients with schizophrenia. Those patients most of the time encounter significant challenges interacting with their immediate environment. Communication competence and intimacy are major contributing factors of everyday life of patients with schizophrenia that has significant influence on patient's recovery. By examining the intricate connection between communication competence, intimacy and recovery. **Aim**: to assess communication competence, intimacy and recovery among patients with schizophrenia and to explore the relationship between these three variables. **Research design:** A descriptive correlational design was utilized in this study. **Subject:** a convenient sample of 135 patients with schizophrenia at the inpatient psychiatric department, Tanta university hospital and Psychiatry, Neurology and Neurosurgery Center of Tanta university hospital. **Tools:** Four tools were used for this study namely, A socio-demographic and clinical data questionnaire, Interpersonal Communication Competence Scale, Intimacy scale and Recovery scale. **Results**: the study revealed a statistically significant positive correlation between communication competence and recovery as well as between intimacy and recovery. **Conclusion:** communication competencies and intimate relationships are interrelated and significantly influence mental health and recovery of patients with schizophrenia. **Recommendations:** Healthcare professionals and mental health practitioners should integrate interventions that improve communication and foster intimacy to enhance patients' outcomes. Additionally, holistic models of patient's care should be implemented to improve mental health recovery and foster community integration.

Key words: Communication Competence, Intimacy, Recovery, Schizophrenia

Introduction

Schizophrenia is a durable, complicated mental health condition affecting approximately 23 million people globally **(*GBD (2019) Diseases and Injuries Collaborators (2020).*** Symptoms are described as positive ones (hallucinations, delusions and alterations in behavior), negative symptoms(decreased ability to speak, flat, blunted, apathy affect and avolition), and cognitive symptoms (disturbed executive functioning and associative learning deficits).Schizophrenia as a chronic condition has its impact on social engagement, decision making, family interactions, and maintenance of interpersonal relationships with a devastating effect on patients' ability to communicate in a competent way **(Jauhar , Johnstone, & McKenna 2022) (Fritah, Chakit, Kassal, & El Hessni,2024)**.

Communication competence is defined as the ability to effectively and appropriately convey, interpret, and respond to messages in various interpersonal contexts. It involves not only speaking and listening skills but also understanding social cues, emotional expression, empathy, and adapting communication styles based on the situation and relationship **(Gonçalves, Sousa, Arasaratnam-Smith, Rodrigues, & Carvalheiro, 2020)**. Interpersonal communication competence plays a vital role in shaping adaptive functioning and health outcomes among individuals with schizophrenia **(Commey, Ninnoni, Ampofo, & Miezah, 2023)**. Effective communication and social interaction require a complex combination of skills, such as cognitive abilities, accurate facial expressions, and the ability to recognize emotions **(van Kleef & Côté, 2021)**. However, individuals with schizophrenia often exhibit significant impairments in communication competence, with emotional recognition being a central aspect of this deficit. In social settings, misinterpreting emotional cues can lead to heightened stress and disrupt interpersonal connections **(Javed & Charles, 2018)**. This stress, in turn, may exacerbate schizophrenic symptoms and contribute to the development of psychosis **(Dean, Scott, &Park, 2021)**.

Patients with schizophrenia have deficits in both verbal and nonverbal communication including disorganized speech, difficulties in identifying and describing feelings and difficulty interpreting social cues, these impairments can lead to misunderstanding, withdrawal or social rejection, further reinforcing loneliness and isolation. Also, it can hinder the development of trust, empathy and reciprocity which is considered a key component of intimacy **(Chapellier, Pavlidou, Maderthaner, von Känel, & Walther, 2022).**

Intimacy is regarded as a key component of social relationships, encompassing the sense of closeness, personal connection, and mutual belonging. It involves a deep emotional bond that develops through shared understanding and experiences. Individuals with schizophrenia frequently experience

difficulties in fulfilling their intimacy needs, which can hinder their recovery and overall well-being. **(Antony, Munivenkatappa & Desai, 2025).** The onset of schizophrenia is often accompanied by the deterioration of intimate relationships, and feeling of loneliness as individuals with schizophrenia struggle to establish intimate relationships for various reasons. **(Ropaj, Keatley, Dickson, Milroyd & Taylor, 2023)**. First, psychotic symptoms can cause social withdrawal, making it hard to initiate and maintain interaction with others. Second, individuals may face mental health- related discrimination which can lead to internalized stigma and reduced self-esteem **(Chan, Ho, & Bressington, 2019**). Despite these challenges, studies have shown that individuals with schizophrenia often express strong desire to love and companionship. Therefore, mental health professionals play a crucial role in addressing intimacy concerns, promoting healthy relationships and integrate these issues into comprehensive recovery plans **(Budziszewska, Babiuch-Hall, & Wielebska, 2020)**.

Recovery is a process that enables individuals to enhance their health and well-being, pursue autonomous way of living, and endeavor to realize their full potential. This concept pertains to transcending the detrimental impacts of mental illness, encompassing symptom resolution and the cultivation of new meaning and purpose in life **(Sánchez-Guarnido, Ruiz-Granados, Garrido-Cervera, Herruzo, &Herruzo, 2024).** Recovery encompasses a four-dimensional framework: symptomatic, societal, functional, and personal recovery. ***Symptomatic recovery*** represents a biomedical framework for evaluating the outcomes of mental illness treatment, focusing on the objective alleviation of symptoms and the averting the relapse **(Mezes, Lobban, Costain, Longson, & Jones, 2021).**, ***Societal recovery*** concerns addressing public stigma surrounding mental disorders and enhance the status and rights of patients within the community **(van Aken et al., 2021).** ***Functional recovery*** represents a comprehensive and evidence-driven methodology that assists clients in transcending mere symptom management to attain an enhanced quality of life and adapt to skill deficits **(van Aken et al., 2021) (Badu, O'Brien, & Mitchell**, **2021).** ***Personal recovery*** is a person-centered methodology for treating mental illness, encompassing the process of individual psychological adaptation and development. It involves not merely returning to the premorbid self but rather achieving growth beyond it. Personal recovery involves an individual's perceived capacity to treat mental illness, their sense of purpose, and their confidence in leading a fulfilling life, regardless of the severity of the disorder **(Skar-Fröding et al., 2021).**

While much attention has traditionally been placed on symptom management, this research emphasizes the importance of social functioning and interpersonal connection as critical components of

holistic recovery. It is of great importance to expand our comprehension of the psychosocial dimensions of schizophrenia, particularly the interrelationship between communication competence, intimacy, and recovery. By exploring how communication skills influence the capacity for intimacy and, in turn, affect recovery outcomes

Aim of the Study

Assess communication competence, intimacy and recovery among patients with schizophrenia, and explore the relationship between communication competence, intimacy and recovery among patients with schizophrenia

Research questions

- What are the levels of communication competence, intimacy and recovery among patients with schizophrenia?
- What is the relationship between communication competence, intimacy and recovery among patients with schizophrenia?

Materials and method

Research design

A descriptive correlational design was utilized in this study.

Research setting

This study was conducted at the inpatient psychiatric department of Tanta university hospital with a capacity of 26 beds (13 beds for male and 13 beds for female) as well as at Psychiatry, Neurology and Neurosurgery Center. The center composed of two floors for psychiatric male with a capacity of 30 beds, one floor for psychiatric female with a capacity of 20 beds, two floors for child psychiatry and one floor for substance drug users. Both settings are affiliated to the Ministry of higher education and scientific research.

Subjects

Subjects of the current research were a convenient sample of 135 patients with schizophrenia. Epi-Info software was used to calculate the sample size based on the following parameters; a total population of (N=350 in 6 months), 95% confidence limit and a margin of error 5%. The program showed the minimum number of patients to be approached equal 124. Therefore, 135 patients were included in the study with the following criteria; 18 years or older, not in acute stage and absence of mental retardation, substance use disorder and other psychiatric comorbidity.

Tools

Tool I: Sociodemographic and clinical data questionnaire:

It was prepared by the authors to get necessary data about Socio-demographic status example patient age, sex, marital status, educational level, occupation, place of residence, income, and cohabitation. Clinical characteristics such as age of onset of illness, number of previous psychiatric hospitalization and mode of admission**.**

Tool II: interpersonal Communication competence scale (ICCs)

It was developed by **Rubin & Martin (1994)** to measure interpersonal communication competence. It is composed of 30 statements divided into ten subscales namely, self-disclosure, empathy, social relaxation, assertiveness, expressiveness, interaction management, supportiveness,

immediacy, altercentrism, and environmental control. All items rated on a five-point likert type ranging from 1 (almost never) to 5 (almost always). The scale covers 10 interpersonal communication skills. The total score ranged from 30 to 150. The higher the score the greater competence. The cutoff points of total competence reflected that; High competence >120, Moderate competence 90-120, Low competence <90.

Tool III. Functional Analytic Psychotherapy FAPIS Intimacy scale)

This instrument was developed by **Leonard** et **al 2014**. It is 14 self-report measures developed to evaluate intimacy related behavior in interpersonal relationships (how open, emotionally, expressive and connected an individual feeling in interpersonal relationship). Each item is measured on seven points Likert type scale from 0=not at all to 6=completely. The score is revered in items from 10 to 14. The total score ranged from 0-84. The higher the score the greater the intimacy. Cutoff points represented as follows; low level of intimacy: 0-41, Moderate level of intimacy: 42-58, High level of intimacy: 59- 84

Tool IV: Recovery scale

It was established **Corrigan, Salzer, & Ralph, 2004**. It is a self-administered tool designed to assess recovery in individuals with serious mental illness. The instrument composed of 38 items classified into four recovery domains; Functional recovery (6 items) that measure "Doing Things I Value", for example; It is important to have fun, Personal recovery that measure (18 items) "Looking Forward", for example; I can handle it if I get unwell again, Clinical recovery (7 items) that measure "Mastering My Illness", for example; I can identify the early warning signs of becoming unwell, and Social recovery (7 items) that measure Connecting and Belonging, for example; I have people that I can count on. Each item of the scale is rated on four points Likert scale in which "4=completely true", "3=mostly true ", " 2=a bit true "and "1=untrue ". The total score of this scale are from 38 to 152. The higher scores indicate a high level of recovery, and the lower scores mean low level of recovery. Levels of recovery were calculated by cutoff points and summing scores as follows: low level of mental health recovery: 1-75, Moderate level of mental health recovery: 76-106, High level of mental health recovery: 107-152.

Method

- An official letter was presented to the authority of the director of the research settings to have the required permissions
- **Ethical considerations**
  Ethical approval was obtained from ethical committee at Faculty of Nursing, Tanta University. The code number is (491-6-2024). Consent was obtained from the patients after clarification of the aim of the study, privacy and confidentiality were assured, patients were reassured that the obtained information is confidential and used only for

purpose of the study, patients' right to refuse participation in the study were respected.

- Tools of the study were translated into Arabic language by the researchers and then back translation was done.
- A panel of five experts in psychiatric medicine and nursing examine the validity of the study tools.
- The pilot study was done on 14 patients to assure clarity and applicability of tools. Those clients are excluded from the actual study subjects.
- Cornbrash's Alpha was used to test reliability of communication competency scale, intimacy scale, and recovery scale and proved to be reliable (0.80, 0.91, and 0.85. respectively)
- **Actual study**

  Each patient with the predetermined criteria was contacted on an individual base and interviewed in privacy by the researchers. This was done to establish rapport and initiate relationship with clients, explain the purpose of the study then sign informed consent and complete the study tools.

  Each interview lasted between 30 to 45 minutes. Data collection was completed over a period of 3 months and started from June to September

Statistical analysis

SPSS software version 20 was utilized to process and validate the study data for tabulation and statistical analysis. Quantitative data were analyzed using measures such as mean, range, and standard deviation. A two-tailed test was applied with an alpha level of 0.05, considering a p-value ≤ 0.05 as statistically significant. Categorical data were presented using frequency tables and analyzed using the chi-square test. Pearson's correlation coefficient was employed to examine the relationships between variables.

Results

Table (1) presents the distribution of the patients studied according to their sociodemographic and clinical characteristics. The mean age was 10.09±35.56 years with the highest percentage being in the age group between 30-45 years. Concerning sex, 51.1% were female. As regards marital status, 42.2% of the subjects were single compared to 2.2% were widows.

Additionally, the about half of the subjects had secondary level of education (43.7 %), while 7.4% were illiterate. Speaking about residence, more than one half of them 64.4% lived in urban areas. Regarding working status, 65.9% weren't working compared to 34.1% were working. Those who stated that they haven't enough income represented 71.1 % and 72.6 % were living with their families.

As regard to age of onset of illness, the highest percentage 79.3% get the disease between age 20-30 years. While the number of previous hospitalization 74.1% of the subjects were admitted to the hospital more than three times. Finally regarding mode of admission to psychiatric hospital, 89.6% entered the hospital involuntary and only 10.4% were voluntary admission.

Table (2) illustrates the distributions of the studied patients according to their levels and mean scores of interpersonal communication competence subscales and total ICC. The table shows that 59.3% of the studied patients have low level of total interpersonal communication competence, in comparison to only 17.7% of them who had high level of total interpersonal communication competence. It can also be noticed that the total mean score of interpersonal communication competence was 72.47±26.84. **Regarding mean scores** of ICC subscales, it was noticed that, altercentrism , interaction management takes the highest mean7.6±2.75 followed by immediacy 7.5±2.70, whilst assertiveness , expressiveness take the same mean score 7.4±2.72, followed by social relaxation, supportiveness 7.1±2.9 and finally self-disclosure and empathy takes the same mean 6.9±3.1 , then the lowest one is environmental 6.9±3.05.

Figure (1) reveals the distributions of the studied patients according to their levels of recovery. It can be noticed that 48.1%, 43.0% of the studied patients had low level of social and personal recovery compared to 42.2% and 41.5%, who had high levels respectively. Regarding clinical and functional recovery, it was observed that 45.2% and 43.7% of the patients had moderate levels respectively as compared to 34.8% for both subscales who had low levels. Additionally, the figure shows that nearly half of the studied subjects had moderate level of total recovery (48.9%) compared to only 11.1% who had high level of total recovery.

Table (3)describes mean scores of recovery assessment subscales among the studied patients. The table elicits that studied patients' functional recovery, personal recovery, clinical recovery, and social recovery mean scores constituted (13.5±3.6 , 38.8±10.6 ,15.7±3.9, 14.2± 3.7) respectively. Also, the mean score of total recovery was 82.2±18.7

Figure (2) represents distributions **of the studied patients according to their levels of intimacy** scales, it illustrates that 43 % of them had a low level of intimacy while 39% of them had moderate level and only 18% had high level of intimacy.

Table (4) represents correlation matrix between recovery assessment scale**, interpersonal communication competence** scale**, and intimacy of patients**. Regarding the correlation between ICC and intimacy; a statistical significant positive correlation was found between **ICC** (self-disclosure, immediacy, environmental control, empathy, social relaxation, altercentrism, supportiveness, total ICC) and intimacy ($p=0.050^{*}$, p=0.031*, $p=0.039^{*}$, p=0.002**, p=0.000** , p=0.000 , p=0,000 , and p= 0.000 respectively), On the other hand, **ICC** subscales (assertiveness, interaction management and expressiveness) has no significant correlation with intimacy (p= 0.088, p=0.204, p= 0.094 respectively).

As regards the correlation between ICC and total recovery, a statistical significant positive correlation was

evident between ICC (self-disclosure, empathy, social relaxation, assertiveness, alter centrism interaction management, expressiveness, supportiveness, immediacy, environmental control and total ICC) and recovery (p=0.010, p=0.000, p=0.022, p=0.000, p=0.018, p=0.002, p=0.000, p=0.013, p=0.000, p=0.000, p=0.000 respectively).

Concerning the correlation between Intimacy and recovery; a positive significant correlation was noticed between recovery (functional, personal, clinical, social and total score) and intimacy (p=0.000, p=0.011, p=0.005, p= 0.000, and p= 0.000 respectively).

Table (1): Distributions of the patients studied according to their socio-demographic &clinical characteristics (No= 135).

Socio-Demographic characteristics	Number	%
Sex		
Male	**66**	**48.9**
Female	**69**	**51.1**
Age		
<30	**49**	**36.6**
30-45	**59**	**43.7**
>45	**27**	**20**
Mean ± SD	**10.09±35.56**	
Range	**(20-58)**	
Marital status		
Single	**57**	**42.2**
Married	**46**	**34.1**
Divorced	**29**	**21.5**
Widow	**3**	**2.2**
Educational Level		
Illiterate	**10**	**7.4**
Read & write	**46**	**34.1**
Secondary education	**59**	**43.7**
University degree	**20**	**14.8**
Residence		
Rural	**48**	**35.6**
Urban	**87**	**64.4**
Occupation		
Work	**46**	**34.1**
Not Work	**89**	**65.9**
Income		
Enough	**39**	**28.9**
Not Enough	**96**	**71.1**
Cohabitation		
Alone	**37**	**27.4**
With family	**98**	**72.6**

Age of onset of illness		
<20	**<20**	**<20**
20-30	**20-30**	**20-30**
>30	**>30**	**>30**
Mean ± SD	**26.4 ± 5.05**	
Range	**40-20**	
Number of previous psychiatric hospitalization		
Once	**7**	**5.2**
Twice	**28**	**20.7**
More than three time	**100**	**74.1**
Mode of current admission		
Voluntary	**14**	**10.4**
Involuntary	**121**	**89.6**

Table (2) Distributions of The Studied Patients According to their Levels and mean scores of Interpersonal Communication Competence Subscales and total ICC (No= 135)

Interpersonal Communication Competence Subscales		Low	Moderate	High	Mean ± SD	χ^2 p
Self-Disclosure	Number	**83**	**33**	**19**	**6.9±3.1**	
	%	**61.5**	**24.4**	**14.1**		
Empathy	Number	**83**	**29**	**23**	**6.9±3.1**	
	%	**61.5**	**21.5**	**17.0**		
Social Relaxation	Number	**85**	**27**	**23**	**7.1±2.9**	
	%	**63.0**	**20.0**	**17.0**		
Assertiveness	Number	**76**	**35**	**24**	**7.4±2.72**	**759**
	%	**56.3**	**25.9**	**17.8**		**0.000**
Altercentrism	Number	**71**	**44**	**20**	**7.6±2.75**	
	%	**52.6**	**32.6**	**14.8**		
Interaction Management	Number	**66**	**48**	**21**	**7.6±2.75**	
	%	**48.9**	**35.6**	**15.6**		
Expressiveness	Number	**76**	**36**	**23**	**7.4±2.72**	
	%	**56.3**	**26.7**	**17.0**		
Supportiveness	Number	**84**	**29**	**22**	**7.1±2.9**	
	%	**62.2**	**21.5**	**16.3**		
Immediacy	Number	**71**	**44**	**20**	**7.5±2.70**	
	%	**52.6**	**32.6**	**14.8**		
Environmental Control	Number	**84**	**27**	**24**	**6.9±3.05**	
	%	**62.2**	**20**	**17.8**		
Total ICC	Number	**80**	**31**	**24**	**72.47±26.84**	
	%	**59.3**	**23**	**17.7**		

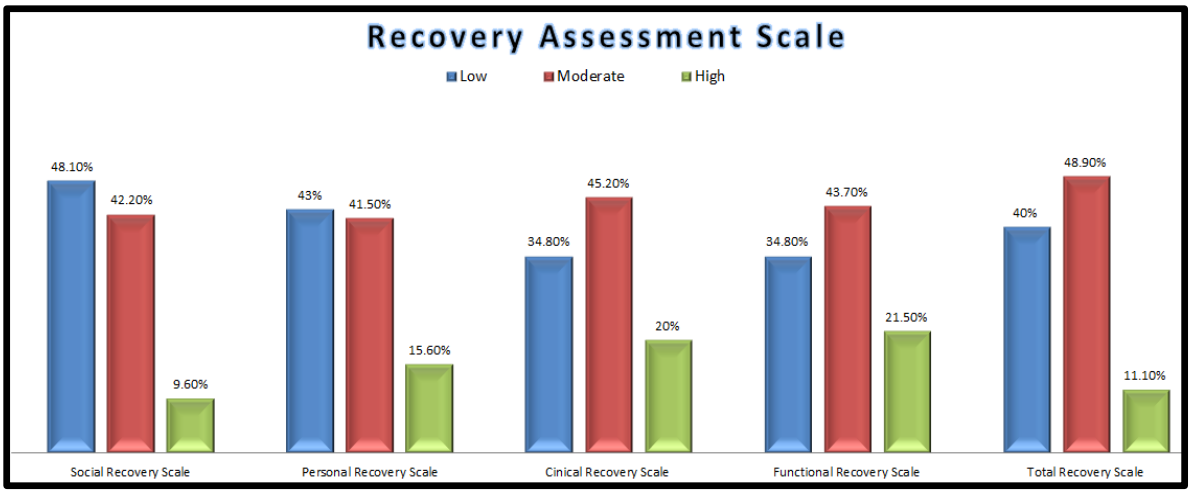

Figure (1) Distributions of the patients studied according to their levels of Recovery Assessment Scale (No= 135)

Table (3) Mean Scores of Recovery Assessment Subscales among the Studied Patients (No= 135)

Recovery Assessment Subscales	Mean ± SD	χ^2 p
Functional Recovery Assessment	13.5±3.6	644 0.000
Personal Recovery Assessment	38.8±10.6	
Clinical Recovery Assessment	15.7±3.9	
Social Recovery Assessment	14.2± 3.7	
Total Recovery Assessment Scale	82.2±18.7	

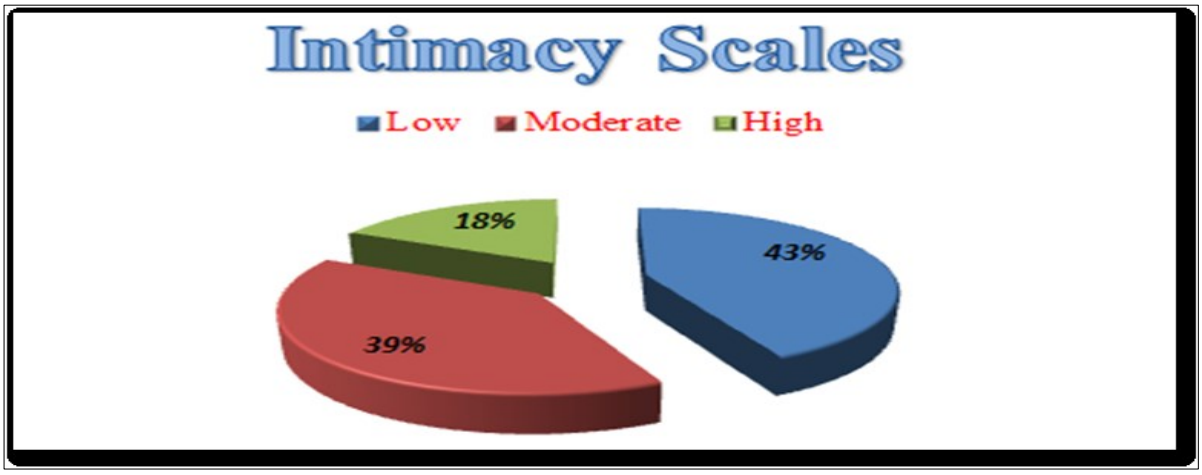

Figure (2) Distributions of the studied patients according to their levels of Intimacy (N= 135).

Table (4) Correlation Matrix between Recovery Assessment Scale, Subscales and Total Interpersonal Communication Competence Scale, and intimacy among studied patients

ICC	Intimacy		Recovery Subscales									
			Functional Recovery		Personal Recovery		Clinical Recovery		Social Recovery		Total Recovery	
	r	P	r	P	r	P	r	P	R	P	r	P
Self-Disclosure	**0.169**	**0.050***	**0.068**	**0.436**	**0.170**	**0.049***	**0.048**	**0.010***	**0.533**	**0.000****	**0.052**	**0.010***
Empathy	**0.087**	**0.002****	**0.461**	**0.000****	**0.137**	**0.112**	**0.627**	**0.000****	**0.087**	**0.000****	**0.421**	**0.000****
Social relaxation	**0.885**	**0.000****	**0.152**	**0.078**	**0.197**	**0.022***	**0.862**	**0.01***	**0.819**	**0.000****	**0.610**	**0.022***
Assertiveness	**0.148**	**0.088**	**0.234**	**0.006****	**0.660**	**0.000****	**0.033**	**0.002***	**0.128**	**0.138**	**0.889**	**0.000****
Altercentrism	**0.829**	**0.000****	**0.116**	**0.197**	**0.011**	**0.895**	**0.101**	**0.246**	**0.214**	**0.013***	**0.215**	**0.018***
Interaction Management	**0.110**	**0.204**	**0.271**	**0.003****	**0.004**	**0.961**	**0.062**	**0.01***	**0.069**	**0.426**	**0.021**	**0.002****
Expressiveness	**0.145**	**0.094**	**0.149**	**0.085**	**0.032**	**0.709**	**0.941**	**0.000****	**0.326**	**0.000****	**0.506**	**0.000****
Supportiveness	**0.689**	**0.000****	**0.886**	**0.000****	**0.506**	**0.000****	**0.176**	**0.041***	**0.747**	**0.000****	**0.514**	**0.000****
Immediacy	**0.056**	**0.031***	**0.126**	**0.145**	**0.421**	**0.000****	**0.113**	**0.191**	**0.102**	**0.011***	**0.717**	**0.013***
Environmental control	**0.178**	**0.039***	**0.132**	**0.127**	**0.118**	**0.174**	**0.106**	**0.220**	**0.710**	**0.000****	**0.588**	**0.000****
Total (ICC)	**0.767**	**0.000****	**0.161**	**0.031***	**0.666**	**0.000****	**0.892**	**0.015***	**0.109**	**0.025***	**0.353**	**0.000****
Intimacy	**----**	**----**	**0.871**	**0.000****	**0.907**	**0.011***	**0.636**	**0.005***	**0.769**	**0.000****	**0.817**	**0.000****

Discussion

Communication in schizophrenia is a complex area with significant challenges. Patients with schizophrenia may experience many difficulties with various aspects in relation to communicating with others **(Fiorillo, & Sartorius, 2021)**. Communication competence continues to emphasize its multifaceted nature and its crucial role in various aspects of life. It is seen as more than just effective message transmission. Moreover, Communication competence and intimacy are deeply intertwined, therefore, effective communication skills are essential for building and maintaining intimate relationships. Competency entitles the individuals' ability to clearly express their thoughts, feelings, and needs, and actively listen to their partners. This competency fosters a deeper sense of connection and understanding. In turn, strengthens the emotional bond and intimacy between people (**Soid, Muhammad, & Norman, 2025) (Commey, et al., 2023)**.

The current research showed that most of the patients demonstrated low or moderate level of intimacy (fig.2). Patients with schizophrenia may lack the ability to form an intimate relationship for many reasons. Among these reasons, symptoms of schizophrenia are either positive or negative. Negative symptoms such as apathy, blunting affect, and avolition are likely to reduce the quality of a relationship. These symptoms also make patients indifferent to their surroundings, facing obstacles in creating meaningful social contacts, and gradually diminish their interactions with others **(lee, et al., 2024)**. Consequently, they withdraw into an inner private world and experience difficulties communicating, approaching or engage with other people. Moreover, the patients impaired capacity to understand the emotions of others as well as to express their own emotions definitely hider their ability to form social bonds (**Kimhy, et al., 2012)**.

Additionally, positive symptoms such as delusional beliefs lead to difficulty trusting others, being open to people, as well as feeling lack of security within intimate relationships. Moreover, the underlying dynamics of low self-esteem and low self-confidence are undoubtedly interfered with the formation or maintenance of meaningful intimate relations or even any form of competent communication. **(Benavides, Brucato, & Kimhy, 2018).** Hallucinations as a positive hallmark of schizophrenia may also act a critical role in the problems of intimacy. They significantly absorb patients to the extent that affect patients' attention to surrounding people and their willingness to relate to others. **(Abdelraof, Hamed, &Abd ELhay, 2023)**.

Another contributing factor to intimacy difficulties in patients with schizophrenia is the experience of discrimination linked to their mental illness, which often results in internalized stigma and feeling of inadequacy (**Caiada et al., 2024)**. When individuals internalize such negative perceptions, it can lead to social withdrawal and a diminished

sense of self-worth within intimate relationships. These outcomes (social isolation and feelings of worthlessness) are ultimately impair social functioning and reduce opportunities for forming close emotional bonds **(Mannarini, Taccini, Sato, & Rossi, 2022)**. Supporting this view, **Gronholm, Ali, Brohan, & Thornicroft, 2023)** found that nearly two-thirds of individuals with schizophrenia anticipated being discriminated against, prompting them to avoid pursuing intimate relationships. **Barker & Vigod (2020)** further noted that other factors, such as repeated hospitalizations and difficulties maintaining independent living, can also hinder the development and sustainability of intimate connections in this population.

Consistent with the present study findings, **Yang et al.,(2023)** stated that patients with schizophrenia are unable to experience enjoyment, preventing them from initiating intimate relations, as well as the claim of **Geiger et al. (2005)** that flatness and inadequacy of affect, lack of interest, and concentration deficits hamper the social ability and skills of psychotic patients to initiate intimate rrelationships. Moreover**, Doron et al. (2014)** found that there was a statistically significant lower grades of commitment for relationships among patients with schizophrenia. Astonishingly, all these findings were in conflict with **Yechieli (2004)** who reported high rates of cohesion in relationship among couples with schizophrenia.

Findings of the present study revealed that more than half of the studied patients had low level of communication competence. This reflects the patients' inability to create, end conversations, reveal information and /or achieve commination goals that influence contact in social situations. The nature of schizophrenia itself might be the cause of communication with this competence disturbance. Language impairments (oral and expressive language) in patients with schizophrenia affect definitely verbal and non-verbal communication. These language and communication impairments are also linked to executive function deficits& social cognition impairments which are characteristics in schizophrenia. This result goes with the study of **Porcelli et al. (2020) and Park & Han (2018)** that people with chronic schizophrenia are characterized by core communication disturbances, related to emotional expression, empathy competence, communication competence, and interpersonal relationship skills dimensions.

The manifested low level of communication competency in the present study could be attributed also to the socio-demographic characteristics of the studied patients. As the highest percentage of the studied patients in this study were single, divorced, or widow and unemployed. This goes in accordance with **Fernández Modamio et al., (2017**) found that being single, divorced or widowed, in addition to unemployment may affect

interpersonal communication competence.

Results of the present study showed that most of the patients studied have low and moderate levels of recovery. This might be attributed to chronicity of schizophrenia and severity of its symptoms. Literatures reported other contributing factors such as noncompliance with medication, lack of social support, stigma, prolonged hospitalizations, and restricted access to psychosocial interventions and/or rehabilitation services **(Bian et al., 2019)(Franco-Rubio , Puente-Martínez , & Ubillo-Landa ,2024)**. Consistent with this result, **Jääskeläinen et al (2013) & Charlson et al (2018)** reported that the proportion of individuals with schizophrenia who met the criteria for recovery and appeared stable over time was only 13.5%, suggesting that functional recovery is undoubtedly impaired in schizophrenia. In addition, **Lahera, Gálvez, Sánchez, & Pérez-Fuster, 2018** claimed that functional recovery as a desired outcome in schizophrenia is low and heterogeneous. Conversely, a study by **Vita and Barlati (2018)** stated that roughly half of schizophrenia patients recovered or significantly improved over the long term, suggesting that functional remission in schizophrenia is possible. Moreover**. Mahmoud, Ali, & Elbaz, 2021** conveyed that most patients with schizophrenia in their study had a high level of functional recovery.

The current study revealed a statically significant positive correlation between total levels of intimacy and recovery. Explanations that could be given for this finding is that when patients with schizophrenia are involved in intimate relationships, they receive strong social support. Strong social support equip the patients with a sense of being respected and cared for by others. Consequently, they are less likely to experience societal discrimination which in turn maximizes their levels of recovery. Moreover, support from families and/or friends plays an important role in promoting patient compliance with treatment plan through encouraging optimism, self-esteem and self-control, and buffering the stress of being ill which in turn decrease symptoms and improve recovery. **(Faraji, et al., 2015; Barbieri, Amato, Passafaro, Dal Corso, & Picciau, 2014)**.

Consistent with this finding a study by **El-Monshed, & Amr, (2020)** stated that patients with schizophrenia who have limited relationships with family, friends, and romantic partners experience poorer mental health recovery. Additionally, a study by **Hamza, Berma, & El-said, 2022** found a statistically significant positive correlation between the perceived social support and recovery. Furthermore, this comes in agreement with the research carried out by **Skar-Froding et al., (2021)** reported that, recovery was significantly associated with higher perceived social support.

Concerning the relationship between intimacy and communication competence, the finding shows that there was a statistically significant correlation between communication competence and intimacy. It was reported that communication

competence and intimacy are deeply intertwined, as effective communication skills are essential for building and maintaining intimate relationships. When individuals clearly express their thoughts, feelings, and needs, and actively listen to their partners, this fosters a deeper sense of connection and understanding. In turn, this can strengthen the emotional bond and intimacy between partners. Communication competencies in relationships can deeply foster intimacy by forming a close emotional connection with other people through mutual self-disclosure. Consistent with this finding, a study **by (Laurenceau, Barrett, & Pietromonaco, 1998)** found that self-disclosure, as a key aspect of communication competence, is positively associated with intimacy in relationships. Similarly, a study by **Guerrero, Andersen, and Afifi (2007)** demonstrated that effective conflict management skills, as another component of communication competence, are linked to higher levels of intimacy and relationship satisfaction. These findings highlight the crucial role of communication in fostering intimacy and the importance of developing effective communication skills for building and maintaining healthy relationships.

Conclusion

The study provides evidence that intimate relationship and communication competence plays an important role in recovery among patients with schizophrenia. Patients with higher communication competence are more capable of forming and maintaining intimate relationships, which in turn contributes positively to their recovery process.

Recommendations

- Social inclusion program should be integrated with the treatment plan for patients with schizophrenia.
- Promote holistic, recovery-oriented approaches that go beyond symptom management to address intimacy and communication skills training.
- Enhancing intimate relationships and communication competence among patients with schizophrenia may be a major aim of psychiatric nursing interventions in mental health services.
- Integrating social skills training and emotional awareness interventions in treatment programs is a must. This can contribute to the development of more person-centered, recovery-oriented mental health services, ultimately improving patients' quality of life, social inclusion, and long-term well-being.
- Policy makers and mental health professionals need to prioritize psychosocial rehabilitation alongside pharmacological treatment in schizophrenia care.

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