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The quality of life in patients with schizophrenia in community mental health service – selected factors

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Abstract

The quality of life for patients with schizophrenia is an important issue nowadays, as the idea of de-institutionalisation in psychiatry is being implemented. The aim of this study was to analyze different determinants of the quality of life in patients with schizophrenia. The survey covered a group of 115 patients with schizophrenia from community mental health service centres in the Lublin Province of eastern Poland. The following methods were used: WHOQOL-BREF (WHO Quality of Life, BREF is a shorter version of the original instrument that may be more convenient for use in large research studies or clinical trials), HADS (Hamilton Anxiety and Depression Scale), PANSS (Positive and Negative Syndrome Scale), GAF (Global Assessment of Functioning). It was found that the quality of life was significantly lower in males, subjects who were divorced or widowed, living with parents, with worse living conditions and worse financial situation, financially dependent, with shorter period of time after last hospitalization, longer total period of time spent in hospital, lower GAF score, higher PANSS score, suicide attempt in the past, comorbid depressive and anxiety disorder, negative attitude of their families towards them and their treatment, and not-attending psychoeducation activities. It is crucial to treat the comorbid depressive and anxiety disorders in patients with schizophrenia due to the correlation between the serverity of those symptoms and the quality of life. The work policy should provide employment for patients in a stable psychic state, because patients who are unemployed and thus financially dependent declare a worse quality of life compared to those who are professionally active.

Key words

quality of life, schizophrenia, sociodemographic factors

INTRODUCTION

The aim of therapy for patients with schizophrenia used to be focused only on reducing the psychopathological symptoms, thus leaving them alone with many everyday life problems including: social functioning, employment, or lack of ability to cope with everyday duties. Nowadays, the main goal of psychiatric care is the improvement of the patients' quality of life.

Literature research reveals that mentally ill patients declare a lower overall quality of life compared to the general population [1,2]; it has also been proved that the quality of life in patients with schizophrenia depends on various determinants including: sociodemographic, clinical, economic or social factors.

There were many doubts regarding the reliability of subjective evaluation of the quality of life assessed by patients, especially due to lack of insight and the presence of psychopathological symptoms [3]. However, Voruganti L. et al. proved that patients with schizophrenia, during remisson and willing to cooperate, are capable of adequate estimation of their quality of life [4]. At present, there is an agreement on the validity of self-evaluation of the illness – and treatment – depending on the influence on the patients' quality of life.

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OBJECTIVE

The aim of this study was to analyze different determinants of the quality of life of patients with schizophrenia.

MATERIAL AND METHODS

The survey covered a group of 115 patients with schizophrenia from community mental health service centres in the Lublin Province of eastern Poland – 64 males (55.65%) and 51 females (44.35%). The range of age in the group was between 22-63; the average age therefore was 36.56 (SD=10.41)

The following methods were used: WHOQOL-BREF ((WHO Quality of Life, BREF is a shorter version of the original instrument that may be more convenient for use in large research studies or clinical trials), HADS (Hamilton Anxiety and Depression Scale), PANSS (Positive and Negative Syndrome Scale), and GAF (Global Assessment of Functioning).

RESULTS

The survey showed that in the group of subjects with schizophrenia the lowest average score for WHOQOL-BREF was noted in the psychological health domain (AM=11.38; SD=2.39), then in the social relationships domain (AM=12.02; SD=3.15) and environment (AM=12.70; SD=2.22) domain. The highest average score was recorded for the physical health domain (AM=13.22; SD=2.17).

The general quality of life was assessed better by females than males. However, there were no statistically significant differences between men and women in particular domains and in general perception of health.

There was a significant correlation between the civil status and the quality of life: unmarried and married subjects achieved statistically significant higher scores in psychological health, social relationships and environment domains than those who were divorced and widowed.

People who declared living with their parents or siblings assessed the social relationships domain significantly lower than those who declared living with their children or a partner. There were no significant correlations in the rest of the domains and two general questions.

The highest scores were recorded in respondents who declared good financial and living conditions. Those who assessed them as bad consistently had lower scores in all domains of the quality of life. The correlation was the most significant for the environment domain, followed by psychological health, physical health and social relationship domains.

Unemployed or financially-dependent respondents defined their general quality of life as low, while those who were occupationally active declared a high quality of life. There was no statistically significant correlation between occupational status and perception of one's health and particular domains of quality of life.

The total GAF score was another factor analysed: the higher the score, the better perception of the quality of life in all domains and of health status was noted. The strongest correlation was found in the environment domain (Tab. 1).

Table 1. Selected domains of quality of life in people with schizophrenia in correlation with GAF score

WHOQOL-BREF- domains	GAF	
	Statistical analysis	
	p	R
Physical health	p<0.05	R = 0.25
Psychological health	p<0.01	R = 0.37
Social relationships	p<0.01	R = 0.27
Environment	p<0.001	R = 0.35

The relationship between the quality of life and PANSS score was also significant. The better the quality of life declared, the lower the PANSS and its domains' scores. A similar correlation was found for general health status, except for the positive symptoms domain. The only significant negative correlation was noticed for general perception of health status and negative symptoms in the PANSS scale (Tab. 2).

A significant correlation was found between the severity of anxiety and depressive disorders and scores in general perception of quality of life, general health status, and all domains of quality of life. The more severe those disorders became, the lower the scores observed in all domains of the quality of life. The most significant relationship was noted between the intensity of anxiety and depressive disorders and psychological health domain (Tab. 3 and Tab. 4).

Table 3. Selected domains of quality of life in people with schizophrenia in correlation with anxiety and depressive disorders

Anxiety HADS WHOQOL-BREF-domains		Physical health	Psychological health	Social relationships	Environment
Norm	AM	14.49	13.33	13.81	14.14
	SD	1.99	2.09	2.98	1.78
	Me	14.29	14.00	13.33	14.00
Mild symptoms	AM	13.51	11.65	12.53	13.05
	SD	1.89	1.86	2.67	1.95
	Me	13.71	11.33	12.00	11.50
Moderate symptoms	AM	12.71	10.11	10.67	11.72
	SD	1.76	2.22	3.00	1.94
	Me	12.57	10.00	10.67	11.50
Severe symptoms	AM	10.34	9.03	9.21	10.36
	SD	1.85	1.72	2.95	2.23
	Me	10.86	9.33	8.00	11.00
Statistical analysis		p<0.001	p<0.001	p<0.001	p<0.001
		H=26.34	H = 35.76	H = 21.72	H = 28.92

Table 4. Selected domains of quality of life in people with schizophrenia in correlation with depressive disorders

Depression HADS WHOQOL-BREF-domains		Physical health	Psychological health	Social relationships	Environment
Norm	AM	14.31	12.77	13.60	13.71
	SD	1.88	2.01	2.86	2.02
	Me	14.29	12.67	13.33	14.00
Mild symptoms	AM	12.83	10.70	11.33	12.12
	SD	1.56	1.49	2.29	1.71
	Me	13.14	10.67	10.67	12.00
Moderate symptoms	AM	11.54	9.38	9.33	11.63
	SD	1.89	2.25	2.89	1.94
	Me	11.43	9.33	9.33	11.00
Severe symptoms	AM	9.71	7.67	8.44	9.50
	SD	1.58	1.01	2.48	2.37
	Me	9.14	7.67	8.00	9.50
Statistical analysis		p<0.001	p<0.001	p<0.001	p<0.001
		H = 35.44	H = 45.27	H = 34.32	H = 26.73

Table 2. Selected domains of quality of life in people with schizophrenia in correlation with PANSS score

WHOQOL-BREF-Domains	PANSS-P		PANSS-N		PANSS-O		PANSS-C	
	Statistic analysis		Statistic analysis		Statistic analysis		Statistic analysis	
	p	R	p	R	p	R	p	R
Physical health	p>0.05	R =0.02	p>0.05	R= -0.09	p>0.05	R = -0.06	p>0.05	R = -0.04
Psychological health	p>0.05	R = -0.09	p<0.05	R = -0.19	p>0.05	R = -0.14	p>0.05	R = -0.16
Social relationships	p>0.05	R = 0.02	p<0.01	R = -0.29	p>0.05	R = -0.10	p>0.05	R = -0.13
Environment	p>0.05	R = -0.07	p>0.05	R = -0.16	p>0.05	R = -0.13	p>0.05	R = -0.13

Positive attitude of families towards people with schizophrenia and towards treatment corresponded positively with assessment of the general quality of life. There was no correlation between general perception of health status and the family's attitude towards treatment, although the relationship between the evaluation of health status and the attitude of the family towards the respondent was statistically significant. When the attitude was positive, the perception of health was better.

No correlation was found between attending psychoeducation activities and the two general questions while a significant relation was noticed with an improvement of general quality of life in particular domains. The repondents who participated in psychoeducation activities had the highest scores. Those who, for any reason, did not want to take part in those activities had lower scores than those who did not participate because they had never before heard of such a psychoeducation programme. Only in the social relationships domain was this correlation not statistically significant.

DISCUSSION

Similar results can be found in studies undertaken by other authors from Poland and abroad. Górna et al. proved that in people with schizophrenia, within an average period of 5 years after the first hospitalization, the highest scores were observed in physical health (AM=14.3; SD=3.1), followed by environment (AM=13.5; SD=2.3), social relationships (AM=12.8; SD=3.3) and psychological health domains (AM=12.8;SD=3.4) [5]. Xiang et al. showed that the evaluation of the quality of life by subjects with schizophrenia was the highest in the physical health domain (AM=14.22; SD=2.48), followed by environment (AM=13.69; SD=2.27), psychological health (AM=13.64; SD=2.64) and social relationships domains (AM=13.13; SD=2.64) [6].

The question of differences in evaluation of the quality of life between males and females has been widely discussed in the literature, although many contradictions have been observed. Many surveys have shown that males had a worse quality of life than females, especially in the area of social functioning [7]. Jarema et al. proved that the quality of life was better in males with schizophrenia than in females [8]. In some cases, there was no significant relationship found between gender and the quality of life [9].

People with schizophrenia had problems with maintaining relationships, mainly because of the psychopathological symptoms. Many patients have low self-esteem and present a low estimation of their appearance, and thus have smaller chances to establish and maintain intimate relationships. Moreover, some of the psychotropic drugs cause decreased libido or impotency as a side effect. Limited social life, financial problems or stigmatization are also responsible for lack of relationships in patients with schizophrenia [3], although Skantze et al. did not prove such a correlation [10].

Higher income and a better financial situation also proved to be significant determinants of a better quality of life [11].

Occupational activity is another important factor that has an influence on the quality of life of patients with schizophrenia. The majority of researches have shown that patients who were employed declared a better quality of life [10], mainly in the general perception of health status and in physical health, psychological health and social relationships domains of WHOQOL-BREF [3]. Many patients, in spite of a stable health status, have problems with finding employment, probably due to many factors including side effects of neuroleptic drugs that impede the possibilities of finding employment [12], as well as frequent hospitalizations that interfere with maintaining a job. The phenomenon of stigmatization often prevents the patients from finding employment [13].

In 2005, Caron et al. proved that the total period of time spent in hospital was positively correlated with a better quality of life, and this was explained by the lower expectations of chronically ill patients [7]. Morover, Caron et al. proved that patients who were in hospital in the year following the survey had a lower quality of life.

Many authors underline the relationship between GAF score and subjective assessment of the quality of life in people with schizophrenia [14].

There are inconsistencies about the correlation between the presence of psychopathological symptoms and the quality of life. Narvaez et al. proved that the severity of positive symptoms has no influence on both subjectively and objectively measured quality of life [15]. However, there are many studies that confirm that the reduction of positive symptoms is an important factor for improvement in the quality of life in patients with schizophrenia [14].

In 2003, Ponizovsky et al. proved that dissatisfaction with the quality of life was strongly connected with repeated suicidal attempts in people with schizophrenia [16].

There are many published studies showing that depression and anxiety are strong predictors of the quality of life in schizophrenia [15]. It has also been proved that depressive symptoms have more influence on the quality of life than psychotic symptoms. A study from China in 2008 proves that depression measured with HDRS was negatively correlated with all WHOQOL-BREF domains, and anxiety measured with the use of BPRS scale was connected only with the psychological domain [6].

It is a well known fact that social support is considered one of the most important protective factors of mental health, and is also connected with a better quality of life in people with schizophrenia [17].

Many studies confirmed the positive influence of psychoeducation activities on the quality of life in people with mental disorders [18].

CONCLUSIONS

The connection between the quality of life of people with schizophrenia and some sociodemographic, economic or clinic factors has ben proved by many studies. There are inconsistencies in the selection of surveyed groups and methods and this leads to certain difficulties in comparing the results and drawing conclusions.

Despite this fact, knowledge about the predictors of the quality of life and exploration of this matter is an essential factor that allows taking care of the real needs of patients. The programmes supporting people with schizophrenia should concentrate on the factors that can improve the patients' quality of life, as well as use its best efforts to develop social support and diminish the process of stigmatization.

Lehman counted a list of conditions that can improve the quality of life of people with mental disorders, including better financial support, vocational training, more occupation offers, better protection against violation of regulations, more privacy, and better relations with other people [1].

Spiridonow et al. confirm that people with mental disorders declared that the most difficult issue for them were demanding their rights, making decisions, planning the day, and asking for help [2].

The results of many studies emphasize the meaning of knowledge and social skills next to pharmacotherapy in reducing the number of recurrences, improvement of social functioning, life satisfaction, and diminishing the burden on relatives [19].

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