

PERSONAL AND SOCIAL FUNCTIONING IN PATIENTS WITH SCHIZOPHRENIA

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Abstract: Aim of the paper: To monitor personal and social functioning in patients with schizophrenia and to find out the difference regarding sociodemographic characteristics and out-patient or day hospital treatment.

Material and methods: The investigation included 120 subjects divided into two groups of 60 patients each with a diagnosis F20 according to MKD 10 criteria. Patients from the first group received out-patient care whereas those from the second group had day hospital treatment. Patients were of different age and gender, receiving regular antipsychotic therapy. They were included in individual and group psychosocial therapeutic procedures during the day hospital treatment. The investigation utilized the following diagnostic instruments: standardized clinical interview and PSP scale, Personal and social performance scale, Morosini, Magliano *et al.* 2000, and a non-standardized questionnaire of sociodemographic data, family support and existence of mental disorder in other family members.

Results: The results obtained have shown better personal and social functioning in patients who had family support, in those who are employed, in those with no mental disorder in other family members and in patients on day hospital treatment as opposed to patients receiving out-patient care.

Conclusion: Day hospital psychosocial therapeutic treatment in combination with regular antipsychotic therapy, family and social support helps in more rapid reintegration and resocialization and a better quality of life in patients with schizophrenia.

Key words: quality of life, personal and social functioning, schizophrenia.

Introduction

Over the last two decades psychosocial activities and attention have been directed towards the improvement of personal and social functioning of patients with schizophrenia, and not only treatment of their symptomatology. Schizophrenia is a chronic mental disorder that affects emotions, cognition, movement and behaviour and its severity and long-term duration lead to numerous consequences reflected on the quality of life of these individuals. The consequences are a result of the nature of the disorder as well as of poor and inadequate psychosocial therapeutic approaches by therapists and the broader surroundings. Poor psychosocial functioning imposes a low quality of life on these individuals. Quality of life means the ability of an individual to play socially-defined roles such as: homemaker, worker, student, spouse, family member or friend. In addition, this gives the individual a feeling of satisfaction with his/her ability to meet these roles, ability to take care of him/herself and to enjoy daily life.

Basic factors that determine psychosocial functioning of patients with schizophrenic disorder are:

- their premorbid functioning,
- cognitive functioning,
- negative symptomatology,
- a defeatist attitude on the part of the community,
- family circumstances, and
- adequate psychopharmacologic and psycho-social-therapeutic treatment [8].

An integrated approach in the treatment of patients with schizophrenic disorder comprises psychopharmacologic treatment, but also intensive psychosocial engagement. Psychosocial interventions include assertive training in a community, family interventions, training for social skills, support of the individual and his/her family, psycho-education of the entire family, cognitive interventions, etc. Psychosocial interventions conducted on a day hospital care basis would enable better therapeutic collaboration, effective pharmacological treatment, better control of patients over the disease and their life in general, their independent functioning and greater personal satisfaction [1, 2, 3, 7].

Aims of the paper

To monitor personal and social functioning in patients with schizophrenia and to find out the difference regarding sociodemographic characteristics and out-patient or day hospital treatment.

Material and Methods

This prospective study included 120 individuals with schizophrenic disorder, diagnosis F20 according to the MKB 10. They were of different age and gender, with different family and work status. The patients were divided into two groups: 60 individuals on out-patient care and 60 individuals on day hospital treatment. The subjects of both groups were evaluated using the mentioned diagnostic procedures at the beginning of treatment and 6 months after out-patient psychopharmacological individual treatment, while those from the second group were on day hospital treatment with pharmacological therapy, individual and group psychosocial interventions over a 6-month period.

Methods

The investigation was conducted by using the following structural and clinical test procedure:

standardized clinical interview;

Personal and Social Performance Scale (PSP) (Morosini PI, Brambila L, et al. 2000)

Non-standardized questionnaire regarding sociodemographic data, family support and existence of mental disorder in other family members.

Results

Regarding the total score on the Personal and Social Performance Scale (PSP) that assesses personal and social functioning and quality of life, the subjects were divided into three groups: subjects with a score of 0–30 (who needed intensive psychosocial support and care), subjects with a score of 31–70 (occasional psychosocial support and care), and subjects with a score of 71–100 (with mild disorders, but capable of individual functioning).

Table 1 presents the distribution of subjects from both sexes relating to the category of the total PSP score they belonged to. Twenty-nine (24.2%) male and 25 (20.8%) female subjects had need of intensive psychosocial support and care (total score 0–30), whereas 36 (30%) male subjects and 30 (25%) female subjects belonged to the category score from 31 to 70, indicating their need for occasional psychosocial support and care. The tested difference of the mean score on the PSP by gender was statistically insignificant ($p > 0.05$). Psychosocial functioning and quality of life in patients with schizophrenic disorders was not significantly dependent on the patients' gender.

Table 1 – Табела 1

PSP scale/total score – distribution by gender
PSP скала вкyиен скор – дисyрибуциjа cйоред йолой

<i>PSP score</i>	<i>men</i>		<i>women</i>		<i>total</i>	
	N	%	N	%	N	%
1 0–30	29	24.17	25	20.83	54	45.0
2 31–70	36	30.0	30	25.0	66	55.0
total	65	54.17	55	45.83	120	100

Chi-square = 0.0085, df = 1, p = 0.93

Subjects under or up to the age of 30 and older than 30 years showed a non-significant difference concerning the distribution of the total score on the PSP scale for psychosocial functioning and quality of life. Five (4.2%) subjects up to the age of 30 and 49 (40.8%) older than 30 years belonged to the category 0–30 score. six (5%) subjects younger than 30 years and 60 (50%) above the age of 30 (Table 2) had a total score from 31 to 70.

Table 2 – Табела 2

PSP scale/total score – age distribution
PSP скала вкyиен скор – дисyрибуциjа cйоред возрасйа

<i>PSP score</i>	<i>≤ 30 years</i>		<i>> 30 years</i>		<i>total</i>	
	N	%	N	%	N	%
1 0–30	5	4.17	49	40.83	54	45.0
2 31–70	6	5.0	60	50.0	66	55.0
total	11	9.17	109	90.83	120	100

Yates Chi-square = 0.08, df = 1, p = 0.77

The marital status of the subjects had no significant influence on their psychosocial functioning and quality of life. Permanent support in psychosocial functioning was required by 39 (32.5%) single men and women, 8 (6.7%) married subjects, 6 (5%) divorced subjects, and 1 subject from the group widow/widower. Occasional psychosocial support and care was required by 35 (29.2%) single subjects, 26 (21.7%) married subjects, 4 (3.3%) divorced subjects and 1 widow/widower. The tested difference between the subjects with different marital status regarding the total score on the PSP scale was statistically not significant ($p > 0.05$) (Table 3).

Table 3 – Табела 3

PSP scale/total score – marital status
PSP скала вкупен скор – брачен статус

<i>PSP score</i>	<i>Marital status</i>				<i>total</i>
	Single	Single	Divorced	Widower/widow	
1 0–30	39 (32.5%)	8 (6.67%)	6 (5.0%)	1 (0.83%)	54 (45.0%)
2 31–70	35 (29.17%)	26 (21.67%)	4 (3.33%)	1 (0.83%)	66 (55.0%)
total	74 (61.67%)	34 (28.33%)	10 (8.33%)	2 (1.67%)	120 (100%)

$D_{max} = -0.19, p > 0.05$

The distribution of the categories total score on the PSP scale in the subjects with different levels of education was the following: in the group of subjects with a low level of education 12 (10%) had a total score 0–30, 5 (4.2%) had a score of 31–70; in the group with secondary education 30 (25%) subjects belonged to the category score 0–30, 42 (35%) to the category score 31–70; in the group with higher education 12 (10%) subjects had a total score of 0–30 while 19 (15.8%) had a score from 31 to 70. There was no statistically significant difference ($p > 0.05$) in the distribution of the total score on the scale for assessment of psychosocial functioning and quality of life in subjects with low, high and higher levels of education (Table 4).

Table 4 – Табела 4

PSP scale/total score – education of subjects
PSP скала вкупен скор – образование на испитанициите

<i>PSP score</i>	<i>Education</i>			<i>total</i>
	Low	high	higher	
1 0–30	12 (10.0%)	30 (25.0%)	12 (10.0%)	54 (45%)
2 31–70	5 (4.17%)	42 (35.0%)	19 (15.83%)	66 (55.0%)
total	17 (14.17%)	72 (60.0%)	31 (25.83%)	120 (100%)

$D_{max} = -0.15, p > 0.05$

The total score on the PSP scale in 42 (35%) unemployed subjects, 2 (1.7%) employed subjects, 2 (1.7%) students and 8 (6.7%) retired subjects was from 0 to 30, whereas 39 (32.5%) unemployed subjects, 22 (18.3%) employed subjects, and 5 (4.2%) retired subjects belonged in the category total score from 31 to 70. The tested difference between the subjects with different work status depending on the total score on the PSP scale was statistically significant ($p < 0.001$). We can conclude that employed subjects had a highly significantly better quality of life and they need only an occasional support in psychosocial functioning (Table 5).

Table 5 – Табела 5

PSP scale/total score – work status of the subjects
PSP скала вкупен скор – работен статус на испитаниците

<i>SP score</i>	<i>Work status</i>				<i>total</i>
	unemployed	employed	student	retired	
1 0–30	42 (35.0%)	2(1.67%)	2 (1.67%)	8 (6.67%)	54 (45.0%)
2 1–70	39 (32.5%)	22 (18.33%)	0	5 (4.17%)	66 (55.0%)
total	81 (67.50%)	24 (20.0%)	2(1.67%)	13 (10.83%)	120 (100%)

Kruskal-Wallis H = 15.13, p = 0.0005

Among subjects with a negative history of psychic disorders in the family, there were 24 (20%) with a total score on the PSP scale who belonged to the category 0-30 and the remaining 45 (37.5%) patients belonged to the 31–70 category. Among subjects who had a family member with psychic disorder, 30 (25%) had a total score from 0 to 31 and the remaining 21 (17.5%) a score from 31 to 70. The tested difference of the total score on the scale for assessment of psychosocial functioning and quality of life in the subjects with a negative or positive history of psychic disorder was highly statistically significant ($p < 0.001$). The need for permanent support in the psychosocial functioning was significantly more common in patients with schizophrenia who had a positive family history of psychic disorders (Table 6).

Table 6 – Табела 6

PSP scale/total score – family history of psychic disorders
PSP скала вкупен скор – семејна историја за психички распростира

<i>PSP score</i>	<i>Presence of psychic disorder in the family members</i>		<i>total</i>
	Yes	No	
1 0–30	24 (20.0%)	30 (25.0%)	54 (45%)
2 31–70	45 (37.5%)	21 (17.5%)	66 (55.0%)
total	69 (57.50%)	51 (42.50%)	120 (100%)

Chi-square = 6.85, df = 1, p = 0.0089

Subjects who thought that their family strongly supported them had a significantly smaller need ($p < 0.01$) of permanent care and support in their psychosocial functioning than those whose family did not support them or offered minimum support. In the category 0–30 of total score on the PSP scale, 10

(8.3%) subjects did not perceive their family as supportive, 34 (28.3%) felt limited support and only 10 (8.3%) subjects thought their family had strongly supported them. In the category 31–71, indicating a better quality of life and greater independence in psychosocial functioning, only 7 (5.8%) subjects received no support from the family, 22 (18.3%) had limited and 37 (30.8%) had strong family support (Table 7).

Table 7 – Табела 7

PSP scale/total score – support from the family
PSP скала вкупен скор – семејна поддршка

<i>PSP score</i>	<i>I perceive my family being supportive</i>			<i>total</i>
	no	little	strong	
1 0–30	10 (8.33%)	34 (28.33%)	10 (8.33%)	54 (45.0%)
2 31–70	7 (5.83%)	22 (18.33%)	37 (30.83%)	66 (55.0%)
total	17 (14.17%)	56 (46.67%)	47 (39.17%)	120 (100%)

Chi-square = 17.59, df = 2, p = 0.00015

Six months after the initiation of the investigation, only 3 (5%) subjects from the group receiving day hospital treatment (DHT) and as many as 24 (40%) from the group receiving out-patient care (AC) had a score 0–30, 40 (66.7%) from the DHT group and 36 (60 %) from the AC group had a score from 31 to 70, while only 17 (28.3%) from the DHT group had a score of from 71 to 100. The difference in the total score on the PSP scale between the subjects on day hospital treatment and those on out-patient care was highly statistically significant ($p < 0.001$), which was a result of significantly more frequent evidence of individuals suffering from schizophrenia and receiving day hospital treatment who were capable of individual functioning (Table 8, 8a).

Table 8 – Табела 8

PSP scale – DHT/AC
PSP скала – дневно-болнички прейман/амбулантиски прейман

<i>PSP/beginning</i>	<i>DHT</i>		<i>AC</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
1 0–30	25	41.67	29	48.33
2 31–70	35	58.33	31	51.67
total	60	100	60	100

Chi-square = 0.54, df = 1, p = 0.46

Table 8a – Табела 8a

PSP scale – DHT/AC
PSP скала – дневно-болнички и прейман/амбулантски и прейман

<i>PSP/6 m</i>	<i>DHT</i>		<i>AC</i>	
	N	%	N	%
1 0–30	3	5.0	24	40.0
2 31–70	40	66.67	36	60.0
3 71–100	17	28.33	0	0
total	60	100	60	100

U = 864.0, Z = -4.91, p = 0.000000

Discussion

The results obtained in this study have demonstrated unsatisfactory psychosocial functioning in both groups of patients, meaning a poor quality of life of patients with schizophrenic disorder [28, 30].

Our results revealed unsatisfactory individual and social functioning of the larger number of subjects. The majority of the patients with schizophrenic disorders have need of either permanent or occasional support from their surroundings in order to have normal functioning. Furthermore, the results show that patients with schizophrenia have severe difficulties in taking care of themselves, in work engagements, and in accomplishing personal relations and their maintenance.

The majority of studies identify the relationship and diversity of quality of life in schizophrenic patients and certain sociodemographic characteristics [4, 5, 19].

The results indicate that the majority of these individuals are unemployed, unmarried and have a low level of education.

There was a significantly better functioning of those patients who had family support and who were employed as against the remaining patients, whereas subjects who had a family member with mental disorder had poorer individual and social functioning than those who did not have such members in their family.

Contrary to other studies, our results displayed no statistically significant differences by gender, education and marital status. Shtasel *et al.* in their study of schizophrenic patients detected better functioning of female subjects than male [31, 32]. On the other hand, Lehman in his study revealed that indi-

viduals who were married had a better quality of life than those who were not married [16, 17].

With regard to education many studies have noticed a poorer quality of life in those schizophrenic patients who had a higher level of education [21].

However, the 6-month continued treatment brought improvement in their functioning, which was statistically significant in those receiving day hospital treatment. Our results are in agreement with those presented by other authors, who speak of integrated psychopharmacological and psychosocial treatment that is indispensable for the re-inclusion of these patients in social functioning, taking care of themselves and their families, establishing social contacts, and employment, that is, inclusion in societal life.

Data presented in literature point to a poor psychosocial functioning of patients with schizophrenic disorder and a poor quality of life in general [5, 11].

Koivumaa-Honkanen *et al.* in their investigation used different scales for assessment of QOL in patients with schizophrenia and found poorer functioning in these patients as compared to the remaining psychiatric patients [15].

Sullivan *et al.* conducted a study among a population of schizophrenic patients divided into three groups (patients in psychiatric institutions, patients who lived alone and those who lived in centres for psychosocial support) and compared them with the healthy population. Using the interview for assessment of QOL, they obtained results which revealed a poorer quality of life in all three groups of schizophrenic subjects as against the healthy ones. The biggest differences were observed in satisfaction from social life, finances and employment.

Malm *et al.* using the semi-structured questionnaire (QOLC) for assessment of quality of life of 40 schizophrenic subjects 2 years after their last hospitalization, found dissatisfaction in almost all aspects of living and especially in social relations, education, finances, etc. [20].

Other researchers have presented the correlation between the presence of neuroleptic symptomatology, negative schizophrenic symptomatology and distinct depression with a low quality of life satisfaction [5, 21, 26, 29, 30].

The relationship between the treatment of these patients and their quality of life is underlined in many studies where the results obtained confirm better psychosocial functioning with the use of second-generation antipsychotics, a better quality of life in those subjects who had integrated psychopharmacological and psychosocial treatment (family intervention, supportive intervention, cognitive behavioural training for social skills, and especially in day hospital settings or other similar psychosocial facilities) [2, 7, 8, 9, 12].

Conclusion

Patients with schizophrenic disorder who have stronger family and social support and who are treated with socio-therapeutic procedures in day hospital services have better personal and social functioning and consequently a better quality of life than patients receiving out-patient care alone.

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Резиме

ЛИЧНО И СОЦИЈАЛНО ФУНКЦИОНИРАЊЕ КАЈ ПАЦИЕНТИТЕ СО ШИЗОФРЕНИЈА

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Апстракт: Цел на трудот е да се проследи личното и социјално функционирање кај пациентите со шизофренија и да се утврдат разликите во однос на социодемографските карактеристики и разликите во однос на амбулантскиот и дневно-болничкиот третман.

Материјал и методи: во истражувањето беа вклучени 120 испитаници поделени во две групи по 60 испитаници, со дг. Ф20 дијагностицирани според МКБ 10 критериумите. Тие од првата група беа амбулантски третирани, додека оние од втората група беа на дневно-болнички третман. Испитаниците беа од различен пол и возраст, на редовна антипсихотична терапија. Во текот на дневно-болничкиот третман беа вклучени во индивидуални и групни психосоциотерапевтски постапки. Истражувањето беше следено со следниве дијагностички инструменти: стандардизирано клиничко интервју, нестандардизиран социодемографски прашалник и скала за процена на

личното и социјалното функционирање, PSP Personal and social performance scale Morosini, Magliano *et al.* 2000.

Резултати: добиените резултати укажуваат на подобро лично и социјално функционирање на пациентите со семејна поддршка, вработените и пациентите кои немаат други членови со ментално растројство. Пациентите кои беа вклучени во дневно-болнички третман подобро функционираат од пациентите кои беа амбулантски третирани.

Заклучок: дневно-болничкиот психосоциотерапевтски третман во комбинација со редовната антипсихотична терапија, семејната и социјална поддршка доведуваат до побрзо реинтегрирање и ресоцијализирање и подобар квалитет на живот кај пациентите со шизофренија.

Клучни зборови: квалитет на живот, лично и социјално функционирање, шизофренија.

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