WELLBEING AS A COMPONENT OF LIFE QUALITY IN SCHIZOPHRENIA

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Abstract
Increased self-esteem, developed facilities of participation to the community life and extra satisfaction insures a superior life quality for the patient diagnosed with schizophrenia. The study includes 150 participants divided in 3 lots. Schizophrenia diagnosis was established according to the operational criteria from DSM-IV-TR (1994) and ICD-10 (1992). Life quality was evaluated by using the inventory of self-perceived wellbeing (ISBA; Adams, Bezner, & Steinhardt, 1997). The results revealed significant differences from life quality point of view regarding the occupational statute, educational level and the type of the disease. Self-perceived wellbeing of the individuals diagnosed with schizophrenia is lower as compared to the healthy persons; under the social, intellectual, spiritual and emotional aspects the persons diagnosed with paranoid schizophrenia are more affected than the ones having other forms of schizophrenia. Life quality in patients diagnosed with schizophrenia is lower as compared to general population and out of all types of schizophrenia, the paranoid one is the most affected.

Keywords: life quality, schizophrenia, occupational status, educational level

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Introduction

During the last decades, life quality became a valuable indicator more and more used for evaluating the impact of the psychosis on patients’ everyday life (Wegener, Redoblado-Hodge, Lucas, Fitzgerald, Harris, & Brennan, 2005). Barry (1997) discovered that extended hospitalizations of psychiatric patients had a negative effect on their subsequent evolution. During hospitalization gradually decrease the capacity of making a decision and of acting efficiently, the addiction increases, the socialization abilities and those of solving practical problems are lost; an affective, volitive and behavioral regressive mood is created and it pretends for the others to make major decisions with regards to the person in the situation and solving his own problems (Barry, 1997). Practically, all the individual performances required by an individual and dignified live decrease. The major interest for life quality in psychiatry derives from the fact that the patient develops most of his existence in the community. This fact should provide him increased self-esteem, increased facilities for participation to the communitarian life and satisfactions in his personal life. The therapeutic plan and objectives change according to classic mentality; the patient must also be respected as a human partner, he must be informed by the physician in a comprehensive manner on the nature of his disease, on the mechanism lying at its base, on the accessible and existent treatments as well as on their positive and negative effects (Lăzărescu, 1999).

Although there is no universal definition, life quality is usually considered as a multidimensional concept which includes subjective wellbeing and objective indicators of mental and physical functioning. World Health Organization (1995) suggests the following definition: „life quality is an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person's physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment” (The World Health Organization quality of life assessment WHOQOL group, 1995).

Many scales (Quality of Life Interview, Quality of Life Checklist, Quality of Life Index for Mental Health etc.) for life quality evaluation investigate different domains by evaluating daily needs: physical health, mental...
health, healthcare, safety and security, food, housing, education, workplace, religion, starting from personal experience (self-fulfillment, self-harmony, happiness, joy, love etc.).

In the case of the patient diagnosed with schizophrenia, life quality concept differs from the one used for describing somatic and psychical diseases which are less debilitating. Chronic patients diagnosed with schizophrenia have special needs, which have a profound influence on their existence and on their subjective wellbeing. For example, these patients must fight against the stigma associated with psychical disease. Many patients have poor financial resources and they are persons with permanent disability. Others have tensed family relations and/or can be separated by their origin family (parents and brothers).

Because of the chronic character and incomplete curing of the symptoms, a significant number of patients live in protected houses or/and hospitals. Consequently, these patients do not have an independent life, is very hard for them to have a family and to find/keep a job. Life quality scales issued for patients with schizophrenia grant special attention to their specific problems such as: resources management, access to healthcare, the nature of their personal and family relations and the use of their free time. Life quality scales which evaluate chronic somatic disease are mostly oriented on their physical problems, modifications according to the role and on the loss of specific abilities.

Schizophrenia can devastate the lives of the patients and of their family. The persons suffering of schizophrenia also suffer of stress, disability, decrease of productivity and decrease of life quality (Sartorius, 1997). The development of life quality improvement programs for the patients with psychical disorders did not have sufficient progress as compared to other clinical disciplines (Hunt & McKenna, 1993). Psychiatrists use the questionnaires for mental status evaluation and the treatment schemes in the same time with the clinical interview. On the other side, the instruments for measuring life quality are not conceived in order to set the diagnosis, but as measures for assisting the patient’s health including obvious aspects for the patients (Skantze, Malm, Decker, May, & Corrigan, 1992). In present there is a range of instruments for measuring the mental health and its particularities connected to life quality. Researchers intensely claimed the development of a life quality evaluation instrument specific for schizophrenia, based on their subjective living, including only relevant elements, with impact on their lives (Awad, Voruganti,
& Heslegrave, 1997). These authors reported the lack of reliable, validated life quality scales, which were not sensible enough for detecting relatively small modifications that these patients presented. Although there are series of scales available for evaluating life quality in schizophrenia, they cannot be considered sensible enough for evaluating therapeutic interventions.

The most familiar scales for evaluating life quality are:

- **CAF (Community Adjustment Form) (Stein & Test, 1980).** The considered existence areas are: the quality of entertainment and of the house; the status and history of employment; sources and levels of income; nourishing, contacts with friends and family, legal issues, life satisfactions; self-esteem; medical care and the use of agencies (Stein & Test, 1980).

- **QLC (Quality of Life Checklist) (Malm, May, & Decker, 1981)** investigates the following areas: recreation; work; vocational rehabilitation; economic dependence; social relations; education; psychological dependence; internal experiences; the standard of the house; medical care; religion (Malm et al., 1981).

- **OQLQ (Oregon Quality of Life Questionnaire) (Bigelow, Brodsky, Steward, & Olson, 1982):** considers the following existence areas: psycho-pathological dissatisfaction-suffering; psychological well-being; stress tolerance global satisfaction of the basic needs; interdependence; personal interactions; spouse role; social support; work and home; availability for employment; work and job, time management; negative consequences of alcohol and other drug use (Bigelow et al., 1982).

- **QOLI (Quality of Life Interview) (Lehman, Ward, & Linn, 1982)** researches: family relations; social relations; recreations activities; finances; safety and legal issues; work and school; health (Lehman et al., 1982).

- **QLI-MH (Quality of Life Index for Mental Health) (Becker, Diamond, & Sainfort, 1993)** investigates: occupational activities; psychological wellbeing; physical health; daily activities; social relations; economical-financial situation; psycho-pathological symptoms; open questions regarding improvement and treatment (Becker et al., 1993).

- **QOL (Quality of Life) (The WHOQOL Group, Division of Mental Health, 1995)** investigates: physical health, mental health, interdependence degree, social relations, life environment, quality of spiritual life, which refers to the adherence to religious organization, religious convictions and believes.
• PWS (Perceived Wellness Survey) (Adams et al., 1997) which includes the following dimensions: physical, spiritual, psychological, social, emotional and intellectual (Adams et al., 1997).

Objectives

The purpose of this research is represented by life quality evaluation of our patients’ diagnosed with different forms of schizophrenia.

We propose ourselves: 1. The quantification of life quality deterioration for the patients diagnosed with schizophrenia by the means of the scale proposed; 2. The study a characteristic belonging to population; 3. The determination of differences between participants with regards to one studied variable (gender, age, marital status, occupational status, educational level, residence area, types of diseases, age of beginning, type of treatment); and 4. The institution of social-economic measures in order to socially reinsert the patients for the purpose of improving their life quality.

Method

Participants

The study includes 150 participants (50 without psychiatric diagnosis and 100 diagnosed with schizophrenia). Schizophrenia diagnosis was concluded according to the operational criteria from DSM-IV-TR (1994) and ICD-10 (WHO, 1992). The group of the schizophrenia diagnosed patients was hospitalized in the psychiatry section from Arad between 2009 and 2011.

The group of the healthy patients (A) has 50 persons ranging between 20 and 65 years old (m=42.88; the proportion between genders being male/female = 1/1). Group A was divided in three subgroups in relatively equal proportions: between 20-34 years old; between 35 and 49 years old and between 50 and 65 years old.

Group B has 100 participants diagnosed with schizophrenia and includes two subgroups: subgroup B1 made of 50 participants diagnosed with paranoid schizophrenia (m=38.84, the proportion between genders being balanced 1/1) and subgroup B2 made of 50 participants (m=42.86; SD=12.32) out of which 26 men (52%) and 24 women (48%). The subgroup B2 includes participants diagnosed with other types of schizophrenia (undifferentiated,
simple, catatonic, disorganized, residual). For an accurate assessment, the data received from the patients were completed with extra information received from the family; this thing allowed us to eliminate the disparities between subjective statements and the objective data regarding the performance at job, the behavior and the social relations of the participants.

**Instruments**

Life quality was assessed using Perceived Wellness Survey (PWS). PWS was validated on Romanian population by Roşeanu & Răşcanu (2008) (α=.84). In our study, PWS is used in order to assess the life quality of the patients diagnosed with schizophrenia. Entirely, the inventory of PWS alpha Cronbach has the value: .86. The scale is applied in 30-40 minutes. It includes 36 statements to which the participant answers on Likert scale having 6 points (from „strongly disagreement” at „strongly agreement”), which indicates the extent to which the participant agrees with every declaration. The instrument includes the following dimensions of the well-being mood: (1) physical, (2) spiritual, (3) psychological, (4) social, (5) emotional and (6) intellectual. The score for each well-being dimension is obtained by summarization of the scores for each item included in the composition of this dimension.

**Work procedure**

The clinical interview includes data referring to hereditary-collateral and personal history, psychiatric history and the evaluation of the mental health which includes: aspect, perception disorders, attention and memory disorders, orientation disorders, thinking disorders, mood disorders, disorders of the instinctive life.

The patients were assessed by using a semi-structured interview in order to determine the demographic and clinical characteristics: age, gender, marital status, occupational status, educational level, age at the beginning of the disorder and pharmacologic treatment. Informed consent was obtained from all the participants. The research was carried out according to the ethical standards established in 1964 by the Declaration of Helsinki.

All assessments were carried out by a psychiatrist.
The inclusion criteria for B group are: age between 20 and 65 years old and without other psychiatric comorbidities. Exclusion criteria: other psychiatric comorbidities and severe somatic comorbidities.

**Experimental design**

Statistical analysis was made with SPSS program. The following statistic procedures were used: t test for independent samples, Pearson correlation coefficient, $\chi^2$ criterion, unifactorial variance analysis (ANOVA) and post hoc analysis with Games-Howell test - for unequal groups of subjects with unequal dispersions of the variables.

Independent variables are: gender, age, marital status, occupational status, educational level, residence area, type of schizophrenia, age at the onset of the disease, type of treatment. The dependent variables are the six dimensions of self-perceived well-being mood.

**Results and interpretation**

In our study, alpha Cronbach on scales is: psychological well-being: .81; emotional well-being: .78; social statute: .80; physical well-being: .78; spiritual statute: .86; intellectual statute: .81. On the whole inventory alpha Cronbach has the value: .86.

The results for the dependent variables are:

Average scores for the psychological well-being area are: group A $m=23,20$ (SD=2,86), for subgroup B1 they are $m=23,12$ (SD=2,86) and for subgroup B2 they are $m=23$ (SD=2,69);

For emotional well-being mood average scores are: group A $m=28,20$ (SD=3,28), subgroup B1 $m=21,24$ (SD=3,22) and subgroup B2 $m=24,34$ (SD=4,61);

Social statute area has the following average scores: group A $m=24,26$ (SD=2,48), B1 subgroup $m=18,52$ (SD=2,25) and B2 subgroup $m=20,46$ (SD=4,3);

Average scores for physical well-being area are: group A $m=24,40$ (SD=6,02), subgroup B1 $m=15,62$ (SD=2,32) and subgroup B2 $m=17,44$ (SD=5,06);
For the spiritual statute area, the average scores obtained are: group A \( m=24,56 \) (SD=2,94), subgroup B1 \( m=16,8 \) (SD=2,26) and the subgroup B2 \( m=19,8 \) (SD=4,54);

Average scores for intellectual statute area are: group A \( m=24,82 \) (SD=1,89), subgroup B1 \( m=17,76 \) (SD=2,5) and subgroup B2 \( m=19,78 \) (SD=4,22).

For the independent variables we obtained the following results:

A. *Occupational statute:* F values are statistically significant in the case of the dimensions: emotional well-being \( F=4,030; \ p<.004 \), social statute \( F=2,878; \ p<.02 \), physical well-being \( F=5,868; \ p<.001 \), spiritual statute \( F=6,973; \ p<.001 \) and intellectual statute \( F=4,357; \ p<.002 \).

Post-hoc Games-Howell analysis reveals the following results:

a. Emotional well-being - workers or farmers, technicians or clerks and students or intellectuals obtain significantly higher scores as compared to retired persons and this indicates that the persons engaged in an intellectual activity and/ or lucrative activity, present a better perceived emotional well-being than professionally inactive persons due to retirement;

b. Social statute - students and intellectuals get significantly higher scores than retired persons and this indicates a higher perceived social status to the first category;

c. Physical well-being - workers or farmers, technicians or clerks and students or intellectuals obtain significantly higher scores as compared to retired persons and this indicates that the persons engaged in an intellectual activity and/ or lucrative activity, present a better perceived physical well-being than retired persons;

d. Spiritual statute - technicians or clerks and students or intellectuals obtain higher scores as compared to retired persons and this indicates a higher spiritual status in the case of the first category;

e. Intellectual statute - students and intellectuals get significantly higher scores than retired persons and this indicates a higher perceived social status to the first occupational category.

B. *Educational level:* F is statistically significant only in the case of the dependent variable: psychological well-being \( F=3,236; \ p<.04 \). Consequently, with regards to the scores for the psychological well-being, there are significant
differences between the three groups of participants - primary education, secondary education and university education.

Post-hoc Games-Howell analysis indicates that the persons with primary education tend to obtain significantly higher scores than the ones with secondary education. Educational level variable seems to have a limited and only partly influence on the self-perceived well-being.

C. Type of group: descriptive statistic indicators are presented in table 1 below.

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of squares</th>
<th>df</th>
<th>Mean Squares</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological well-being</td>
<td>1,01</td>
<td>2</td>
<td>0,50</td>
<td>0,064</td>
<td>.93</td>
<td>.01</td>
</tr>
<tr>
<td>Emotional well-being</td>
<td>1215,85</td>
<td>2</td>
<td>607,92</td>
<td>43,081</td>
<td>.001</td>
<td>.370</td>
</tr>
<tr>
<td>Social statute</td>
<td>852,52</td>
<td>2</td>
<td>426,26</td>
<td>43,021</td>
<td>.001</td>
<td>.370</td>
</tr>
<tr>
<td>Physical well-being</td>
<td>2147,37</td>
<td>2</td>
<td>1073,68</td>
<td>47,914</td>
<td>.001</td>
<td>.395</td>
</tr>
<tr>
<td>Spiritual status</td>
<td>1531,25</td>
<td>2</td>
<td>765,62</td>
<td>66,741</td>
<td>.001</td>
<td>.476</td>
</tr>
<tr>
<td>Intellectual status</td>
<td>1322,09</td>
<td>2</td>
<td>661,04</td>
<td>71,605</td>
<td>.001</td>
<td>.493</td>
</tr>
</tbody>
</table>

We notice the existence of significant differences between the three lots of participants in the following dimensions: emotional well-being, physical well-being, social statute, intellectual statute and the spiritual one.

Post-hoc Dunnett T3 analysis reveals the following relevant aspects of the study:

- The persons in the healthy lot (A) obtain significantly higher scores as compared to the ones in the paranoid schizophrenia lots (B1) and other forms of schizophrenia (B2) to all five dimensions above mentioned; so, the healthy
ones present a perceived emotional and physical condition which is superior as compared to those diagnosed with schizophrenia as higher social, intellectual and spiritual statute;

- The persons diagnosed with paranoid schizophrenia (B1) present, as compared to the ones diagnosed with other forms of schizophrenia (B2), significantly lower scores for the dimensions: emotional well-being, social statute, intellectual and spiritual status and this indicates a pregnant deterioration under these aspects.

Referring to variables: gender, age, marital status, residence area, age at the beginning of the disease and the type of treatment, we did not obtain statistically significant differences for none of the six domains of life quality.

**Discussions**

Our study is the first research which uses PWS for the patients from Romania diagnosed with schizophrenia. Significant differences between the group of healthy participants and the groups of the patients diagnosed with schizophrenia are concordant with the result from the literature of specialty. Similar results can be found in the studies made by two authors from Poland and China. Górna, Jaracz, and Rybakowski (2008) proved that in the case of the persons with schizophrenia, with average of 5 years since the first hospitalization, the higher scores were observed in physical health (m=14,3; SD=3,1), followed by environment (m=13,5; SD=2,3), social relations (m=12,8; SD=3,3) and psychological domains (m=12,8; SD=3,4). When evaluating the life quality of their subjects with schizophrenia Xiang, Weng, Leung, Tang, and Ungvari (2008) obtained high scores in the domain of physical health (m=14,22; SD=2,48), followed by the scores by the environment (m=13,69; SD=2,27), psychological health (m=13,64; SD=2,64) and social relations (m=13,13; SD=2,64). From the point of view of the age at the beginning of the disease, although our research did not obtain significant differences, Priebe, Roeder-Wanner, and Kaiser (2000) proved that the symptoms from the beginning have a higher impact on life quality mainly on social relations. During the initial phase of the disease takes place the most important part of clinical and psycho-social deterioration, as compared to the chronic phase of the disease. During this phase, although the decline of the patient’s functioning caused by the affection is almost complete, the patients adapt themselves better to their new life situation (Priebe et al., 2000). As
expected, a chronic disability mental disease such as schizophrenia is not only limited to symptomatology, we can state that there is a “second disease”: the reactions of the social environment to stigmatization and self-stigmatization of the patients, which are negative predictors and they reduce life quality.

Conclusions

The patients diagnosed with schizophrenia have a lower life quality as compared to general population. We claim the following assumption: the perceived well-being of the individuals diagnosed with schizophrenia is lower as compared to healthy persons, and the fact that under some aspects – social, intellectual, spiritual and emotional– the persons with paranoid schizophrenia are more affected as compared to other forms of schizophrenia.

In all six domains evaluated, the category represented by students and intellectuals got higher scores than the category formed by retired persons. According to the results of our study regarding the occupational status, the perception on physical and emotional health lower for retired persons is a factor which also determines a lower perception regarding their social activism. The result obtained is due to lower incomes which can facilitate or limit social activism. Another moderating variable could be the marital statute, as long as the widows get lower scores for some areas of well-being and which usually are older and implicitly many in the retired persons population.

Educational level influences psychological well-being so that participants with primary education got higher scores than the ones with secondary education.

Subjective reflection of life quality in schizophrenia is based on fewer domains that appear now in the actual generation of life quality questionnaires. Considering this step, for the future it would be utile to develop a life quality interview which should reflect only those domains: resources’ management, access to healthcare, the nature of personal and family relations and spending free time, these being representative for the preoccupations of these individuals.

Actual tendency to therapeutically approach schizophrenia both with pharmacologic treatment (atypical anti-psychotics) and with programs for cognitive re-adaptation which determine the reduction of direct, indirect and long term costs, transferring the schizophrenic patient from the hospital in the community.
References


