



The associations between quality of life and clinical symptoms in individuals with an at-risk mental state and first-episode psychosis



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ABSTRACT

Quality of life (QOL) is strongly associated with severity of clinical symptoms and is often compromised in patients with chronic or first-episode psychosis (FEP). However, it remains unclear whether baseline QOL in individuals with an at-risk mental state (ARMS) for psychosis is higher or lower than that in patients with FEP, or what specific clinical symptoms relate to a decreased QOL in individuals with ARMS and FEP. The World Health Organization's WHOQOL-BREF, an instrument assessing QOL, was administered to 104 individuals with ARMS and 53 with FEP. Clinical symptoms were assessed by the Positive and Negative Syndrome Scale and the Beck Depression Inventory-II. We compared the four domain scores of the WHOQOL-BREF between the two groups, and calculated Pearson correlations between each WHOQOL-BREF domain score and the clinical symptoms and compared these correlations between the groups. We observed significant correlations between poor QOL and severity of depressive symptoms in both the FEP and ARMS group. No between-group differences were found in any correlation coefficients between WHOQOL-BREF domains and clinical symptoms. Thus, depressive symptoms should be investigated as a key factor relating to poor QOL in both individuals with ARMS and those with FEP.

1. Introduction

Over the past two decades, many studies have attempted to clarify the features of at-risk mental state (ARMS) for psychosis. An ARMS refers to a state indicating a heightened risk of developing psychosis. It has been defined using a variety of different criteria, such as the ultra-high risk (UHR) criteria (Yung et al., 2004); the cognitive disturbances (COGDIS) criteria, which are based on basic symptoms (Ruhmann et al., 2010); or some combination of the two. The UHR criteria are the most commonly used for assessing the ARMS, and demand fulfillment of one or more of the following: (i) attenuated psychotic symptoms, (ii) brief limited intermittent psychotic symptoms (BLIPS; a psychotic episode that resolves within one week), and (iii) state and trait risk factors (i.e., a recent decline in functioning plus either a first-degree relative with psychosis or a schizotypal personality disorder).

Most individuals with an UHR fulfill the criterion of attenuated psychotic symptoms (Cannon et al., 2008; Yung et al., 2008; Fusar-Poli et al., 2013a) and are more likely to have comorbid depressive or

anxiety disorders (Fusar-Poli et al., 2014). Regarding the outcome of ARMS, the rate of transition to psychosis has received the greatest attention thus far. However, the baseline functioning of individuals with ARMS is rather low, although it does not appear lower than that of individuals with first-episode psychosis (FEP) (Ballon et al., 2007; Chudleigh et al., 2011; Ohmuro et al., 2015). Furthermore, research has consistently indicated that only some individuals with ARMS actually develop established psychosis (Fusar-Poli et al., 2013b); however, a portion of those who do not develop psychosis suffer from continuous functional impairment (Addington et al., 2011). These findings indicate the importance of considering individuals with ARMS as a particular group requiring targeted help regardless of whether they actually transition into psychosis. As such, it would be important to monitor their well-being.

Regarding this latter point, quality of life (QOL) is often used as an index of well-being focusing on life satisfaction, and is regarded as an important measure for patients with a variety of psychiatric illnesses. As with cases of chronic schizophrenia (Ritsner et al., 2000; Kurs et al.,

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2005) or FEP (Bechdolf et al., 2005; Law et al., 2005), the QOL of individuals with ARMS has been reported to be compromised (Ruhmann et al., 2008; Hui et al., 2013). However, a rather limited number of studies have investigated the QOL of individuals with ARMS so far, and only a few of those studies that have investigated it compared the difference in magnitude or contents of QOL between subjects with ARMS and those with FEP (Bechdolf et al., 2005; Ruhmann et al., 2008). Therefore, it would be intriguing to understand what factors associate with QOL among individuals with FEP and ARMS and whether these factors are different or not.

In previous studies investigating the factors relating to QOL of individuals with schizophrenia or FEP, clinical symptoms—namely, negative symptoms, positive symptoms, depressive symptoms, or anxiety—were highlighted (e.g., Huppert et al., 2001; Addington et al., 2003; Sim et al., 2004; Tomotake et al., 2006; Aki et al., 2008; Cotton et al., 2010; Uzenoff et al., 2010). On the other hand, how clinical symptoms relate to QOL among individuals with the ARMS is intriguing, because although ARMS is a risk state for developing FEP, the clinical symptoms observed in individuals with the ARMS are somewhat different from those observed in individuals with FEP. For example, depression or anxiety symptoms are more frequently observed in individuals with the ARMS (Fusar-Poli et al., 2014) and positive and negative symptoms become exacerbated during and after transition to FEP. Therefore, comparison of QOL and its association with clinical symptoms between subjects with FEP and ARMS would be necessary to clarify the unique factors associated with QOL in individuals with ARMS. Further, this comparison might partly help our understanding of whether there would be changes in these clinical factors after the transition to psychosis. While a few studies have investigated the relationship between QOL and clinical symptoms among individuals with ARMS (Bechdolf et al., 2005; Ruhmann et al., 2008; Domínguez-Martínez et al., 2015), these findings are inconsistent. Thus, it remains unclear whether the clinical symptoms associated with QOL differ among individuals with FEP and those with ARMS.

As such, in the current study, we directly compared the QOL of individuals with ARMS and FEP, examined whether poor QOL was correlated with the severity of clinical symptoms in these groups, and then compared the magnitude of the correlations between them. We hypothesized that the QOL of individuals with ARMS would be more compromised than that of patients with FEP, that this decreased QOL would be significantly correlated with severity of positive and negative symptoms only in the FEP group, whereas it would be significantly associated with depressive symptoms and anxiety in both the FEP and ARMS groups. Furthermore, the magnitude of the correlations of these relationships would be significantly different between these groups.

2. Methods

2.1. Participants

Participants were 104 Japanese-speaking individuals with ARMS and 53 patients with FEP who were between 14 and 35 years of age. The exclusion criteria were as follows: (i) serious risk of suicide or violence due to a personality disorder; (ii) current substance dependence; (iii) intellectual disability (IQ < 70); or (iv) neurological disorder, head injury, or any other significant medical condition.

The participants were recruited from the Sendai At-Risk Mental State and First Episode (SAFE) Clinic, a specialized clinic for early psychosis at Tohoku University Hospital (Mizuno et al., 2009; Katsura et al., 2014). Participants were mainly referred to the SAFE Clinic by local health providers or by self-referral. All of the participants were assessed with objective clinical measures by trained psychiatrists (NO, MK, CO, TK, FI, and KM) and subjective measures via self-report (described below); the diagnosis was ultimately confirmed by consensus at a meeting of the clinical team following completion of all assessments (NO, MK, CO, TK, YH, FI, and KM).

Table 1
Distribution of DSM-IV Axis I diagnosis and fulfilled ARMS criteria.

ARMS (n = 104)	FEP (n = 53)		
Diagnosis for DSM-IV axis I			
All mood disorders	32%	Schizophrenia	59%
Major depressive disorder	13%	Schizophreniform disorder	9%
Dysthymic disorder	3%	Schizoaffective disorders	2%
Depressive disorder NOS	13%	Delusional disorder	4%
Bipolar II disorder	1%	Brief psychotic disorder	6%
Mood disorder NOS	2%	Psychotic disorder NOS	17%
All anxiety disorders	62%	Bipolar disorder with psychotic features	4%
Panic disorder	4%		
Social anxiety disorder	31%		
Obsessive-compulsive disorder	10%		
Posttraumatic stress disorder	2%		
Generalized anxiety disorder	2%		
Anxiety disorder NOS	16%		
Somatiform disorder	7%		
Dissociative disorder	6%		
Eating disorder	4%		
Adjustment disorder	8%		
Pervasive developmental disorder NOS	5%		
Brief psychotic disorder	1%		
No axis I diagnosis	1%		
Fulfilled ARMS criteria			
Attenuated psychotic symptoms	81%		
BLIPS	2%		
State and trait factors	2%		
Attenuated psychotic symptoms plus state and trait factors	14%		
Attenuated psychotic symptoms plus BLIPS	2%		

ARMS: at-risk mental state; FEP: first-episode psychosis; NOS: not otherwise specified; BLIPS: brief limited intermittent psychotic symptoms.

Most of the participants who met the criteria for ARMS or FEP were evaluated within two weeks of their first presentation as baseline assessments for future comparative studies examining the clinical follow-up. The data reported herein were obtained from these baseline assessments of participants with ARMS or FEP who consented to participate in the study.

The ARMS group was assessed by psychiatrists and diagnosed using the Japanese version of the Comprehensive Assessment of At-Risk Mental States (CAARMS-J; Miyakoshi et al., 2009). Participants were considered to have ARMS if they had no history of DSM-IV psychotic disorders (except for brief psychotic disorder remitted within one week) and met one or more of the UHR criteria (see Section 1 for details) for ARMS developed by the Personal Assessment and Crisis Evaluation (PACE) Clinic in Melbourne, Australia (Yung et al., 2004). The distribution of comorbid diagnoses for DSM-IV Axis I disorders and the fulfilled UHR criteria in the ARMS group are summarized in Table 1. Fourteen (13%) of the participants with ARMS were ascertained to have made the transition to psychosis during the follow-up period.

Participants in the FEP group had experienced their first episode of psychosis and met the CAARMS criteria for psychosis (Yung et al., 2004); furthermore, they all had a Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) score of 4 or more on items for delusion, hallucinatory behavior, grandiosity, suspiciousness, or unusual thought content for more than 1 week. The distribution of baseline diagnoses in the FEP group is summarized in Table 1.

The study was approved by the ethics committees of Tohoku University Graduate School of Medicine and Tohoku University Hospital. Written informed consent was obtained from participants who were 18 years of age or older and from the parents of participants under 18 (with the written permission from participants to collect this information).

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