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Social disability in schizophrenic, schizoaffective and affective disorders 15 years after first admission

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ABSTRACT

Background: Interest in social functioning of people suffering from mental illnesses has been increasing over the last few years. Only few studies have investigated differences in social functioning in affective, schizoaffective and schizophrenic patients in the long-term and in a comparative approach.

Method: The present study is part of a 15 year follow-up study on patients suffering from severe mental illness. The here reported findings refer to the data of a sample of 177 patients with life-time diagnoses belonging to the schizophrenic, schizoaffective or affective spectrum according to the ICD-10 criteria. Psychopathological, socio-demographic and other illness-related variables were assessed at the index hospitalisation and at the 15 year follow-up evaluation by using the assessment system published by the Association for Methodology and Documentation in Psychiatry (AMDP-system). Information about patients' social disability was assessed by using a modified and further developed version of the WHO disability assessment scale, the (Mannheim) Disability Assessment Schedule (DAS-M scale). Prevalence rates of social disability and differences in the severity of social disability between different groups of mental illnesses were evaluated. And the association between social disability, diagnoses and psychopathology was analysed.

Results: Compared to affective and schizoaffective patients, schizophrenic patients showed significantly higher levels of social disability in almost all domains. Severe to very severe levels of disability were found in 64% of schizophrenic patients and only in 19% of schizoaffective patients and 5% of affective patients. However, on a descriptive level all three diagnostic groups presented with similar maxima and minima in their profiles of social disability. Multiple regression analyses revealed that the apathy syndrome had the highest impact on the presence of severe social disability with all other psychopathological syndromes, gender, age and diagnosis having no statistically significant influence.

Conclusion: Findings indicate that patients' disabilities in different diagnostic groups seem to be of a similar quality and nature despite differences in their severity. The impact of psychopathology on disability seems to be more important than the one of diagnosis per se.

1. Introduction

Deficits in social functioning are a common feature in schizophrenia and other mental illnesses. The Global Burden of Disease project revealed that psychiatric conditions are five of the ten leading causes for years lived with a disability (Murray and Lopez, 1996). Though deficiencies in social adaption have already been considered and assessed in

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outcome studies on psychotic and affective illnesses over the last decades (Möller et al., 1988), problems related to the social disability of people with mental disorders have become of particular interest only during the last few years. Beyond psychopathology, improved personal and social functioning are nowadays considered as important outcome measures (Burns and Patrick, 2007). This development also needs to be seen in the light of the suggestion of standardised remission and recovery criteria for schizophrenia (Leucht and Lasser, 2006). These criteria are diverse, but usually require both remission of symptoms and good social and vocational functioning.

On that background, the present study aimed to evaluate social disability under naturalistic treatment conditions in patients suffering from severe and enduring mental illnesses after a 15 year course of their illness. So far, only few studies have investigated differences in social functioning/disability in affective, schizoaffective and schizophrenic patients in a comparative approach. The study also intended to establish differences in the severity of social disability between different groups of mental illnesses and to analyse the association between social disability and psychopathology. Given the wide range of deficits that interfere with functioning in daily life and in the community, scales that assess social disability in multiple dimensions may reflect an individual's social functioning and disabilities more accurately than scales assessing just one single (global) dimension (Burns and Patrick, 2007). Therefore, in this study, disability was assessed by using the Mannheim disability assessment schedule which covers a fairly comprehensive range of specific interpersonal and social roles (DAS-M, Jung et al., 1989). The concept of social disability that is applied in the DAS-M scale defines social disability as a disturbance caused by the presence of impairments. Disturbance in this context means that there is a dysfunction in the performance of specific roles (occupational, recreational, family related …) that would normally be expected of an individual by the social group or community to which they belong.

2. Methods

The present study is part of a long-term outcome project which was carried out at the Department of Psychiatry, Ludwig Maximilians University, Munich. The study was approved by the Ethics Committee of the medical faculty of the Ludwig Maximilians University, Munich. All patients who were consecutively admitted to the department during the period 1980 to 1982 for treatment of their first episode of a mood or psychotic illness were considered as subjects for this study. Subjects were excluded if they had a history of major medical illness, head injury or symptoms of drug or alcohol dependence at the time of psychiatric admission. Patients with a previous history of psychiatric hospitalisations for treatment of similar symptoms were also excluded.

Clinical diagnoses of patients were made during the index hospitalisation according to the ICD-9 and DSM-III criteria by means of a consensus among experienced psychiatrists, including at least one person with a professor's degree. Final diagnoses/life-time diagnoses were made at 15 year evaluations by a consensus of at least two senior psychiatrists, who had been trained for ICD-10 and DSM-III-R/IV diagnoses and who were blind for the patients' initial diagnoses.

At the index admission in total 359 patients met the criteria for the schizophrenic spectrum (133 patients; ICD-10: F20.x and F22.x), the schizoaffective spectrum (124 patients; ICD-10: F23.x, F25.x) or affective spectrum (102 patients; ICD-10: F30.x, F31.x, F32.x, F33.x). Ninety-one percent of index patients could be traced 15 years later. Nine percent of the index patients were not traceable at all. About 50% of index patients participated in a complete follow-up assessment. In 24% of patients only partial follow-up information was assessed. Five percent of index patients denied to take part in any follow-up evaluation. Twelve percent of patients were known to be deceased. There were no significant differences in age, gender and diagnosis between the sample with complete follow-up data and those with incomplete or missing follow-up data. Thus, a selection bias concerning these variables seems to be unlikely.

The data presented in this study refer to the data of a sample of 177 patients with life-time diagnoses belonging to the schizophrenic, schizoaffective or affective spectrum. In order to avoid comparison of too many diagnostic subgroups different ICD-10 diagnoses and sub-diagnoses were grouped into three overarching diagnostic groups: schizophrenic spectrum (ICD-10: F20.x and F22.x); schizoaffective spectrum (ICD-10: F23.x, F25.x); and affective spectrum (ICD-10: F31.x, F32.x, F33.x).

Psychopathological, socio-demographic (age, gender, marital state, and employment) and other illness-related variables were assessed at the index hospitalisation and at the 15 year evaluation by using a standardised documentation system published by the Association for Methodology and Documentation in Psychiatry (AMDP 2000; Bobon and Woggon, 1986; Faehndrich et al., 1983). The AMDP-system was developed in Europe to standardise the documentation of psychiatric files. Several studies indicated moderate to high inter-rater agreements for included items (Kuny et al., 1983; Renfordt et al., 1983). Each AMDP item can be graduated on a four-point (0–3) scale. Principal component analysis of AMDP ratings leads to several syndromal dimensions (Pietzcker et al., 1983; Angst et al., 1989). Analyses presented in this paper refer to the paranoid–hallucinatory, depressive, psycho-organic, obsessive–compulsive, manic, apathy, hostility, catatonic/stuporous and autonomic AMDP-syndrome. Apart from the ADMP system, patients were also assessed using other standardised clinical interviews and assessment scales at 15 year evaluations. Information about patients' social functioning/disabilities was obtained at a semi-structured interview at 15 year evaluation by using the Mannheim Disability Assessment Schedule (DAS-M scale, Jung et al., 1989). The Mannheim Disability Assessment Schedule (DAS-M) is a modified and further developed version of the WHO-DAS (WHO disability assessment scale), which has been used in many previous outcome studies (e.g. Wiersma et al., 2000). The DAS-M scale covers the following areas: self-care, spare time activities, pace of daily routines, communication/social withdrawal, considerateness and frictions, behaviour in emergencies, housekeeping activities, marriage or similar relations, sexual relationship with partner, parenting role, heterosexual role behaviour, work role behaviour and general interests/need for information. The DAS-M scale also includes a global estimate of social adjustment. Statistical analyses were carried out using the SPSS 10.0 Software for Windows.