



## Original article

# Level of functioning, perceived work ability, and work status among psychiatric patients with major mental disorders



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## ABSTRACT

**Background:** Major mental disorders are highly disabling conditions that result in substantial socioeconomic burden. Subjective and objective measures of functioning or ability to work, their concordance, or risk factors for them may differ between disorders.

**Methods:** Self-reported level of functioning, perceived work ability, and current work status were evaluated among psychiatric care patients with schizophrenia or schizoaffective disorder (SSA,  $n = 113$ ), bipolar disorder (BD,  $n = 99$ ), or depressive disorder (DD,  $n = 188$ ) within the Helsinki University Psychiatric Consortium Study. Correlates of functional impairment, subjective work disability, and occupational status were investigated using regression analysis.

**Results:** DD patients reported the highest and SSA patients the lowest perceived functional impairment. Depressive symptoms in all diagnostic groups and anxiety in SSA and BD groups were significantly associated with disability. Only 5.3% of SSA patients versus 29.3% or 33.0% of BD or DD patients, respectively, were currently working. About half of all patients reported subjective work disability. Objective work status and perceived disability correlated strongly among BD and DD patients, but not among SSA patients. Work status was associated with number of hospitalizations, and perceived work disability with current depressive symptoms.

**Conclusions:** Psychiatric care patients commonly end up outside the labour force. However, while among patients with mood disorders objective and subjective indicators of ability to work are largely concordant, among those with schizophrenia or schizoaffective disorder they are commonly contradictory. Among all groups, perceived functional impairment and work disability are coloured by current depressive symptoms, but objective work status reflects illness course, particularly preceding psychiatric hospitalizations.

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## 1. Introduction

According to Global Burden of Disease Study, mental disorders (MDs) are highly disabling conditions [1,2]. Moreover, same study demonstrates that poor functioning (measured in years lived with disability and disability-adjusted life years), leading to weak labour engagement of people with MDs [3,4], has resulted in an increased socioeconomic burden of MDs [5]. In addition to generally reduced employment [4], subjects with MDs have more

difficulties in returning to work after sick leave [6–8] and tend to retire earlier [9,10] than the general population.

More specifically, major depressive disorder, bipolar disorder, and schizophrenia, along with anxiety disorders, are among the greatest contributors to the global burden of MDs [3]. Furthermore, depression is among the ten most disabling diseases worldwide [1,11]. However, most persons with depression and bipolar disorder manage to maintain employment status [12,13]. The accumulating vocational impairment is more severe in bipolar disorder than in depression, and the difference tends to grow over time [14]. In contrast to mood disorders, only about 20% of subjects with schizophrenia remain employed [15–17]. Interestingly, current labour status is often discordant with perceived work disability. Many authors have demonstrated that subjects with

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depression and, to some extent, bipolar disorder tend to overestimate their impairment in work ability [18–20], while subjects with schizophrenia spectrum disorders may underestimate it [21,22].

In addition to prevalence, the risk factors for MD-related disability have been extensively studied. Many general population and clinical sample studies demonstrate roughly similar associations of functional impairment and work disability in depression, bipolar disorder, and schizophrenia with numerous socio-demographic and clinical factors. These include, for instance, older age [23–25], duration and number of hospitalizations [26,15], educational level [23,25], and severity of current affective symptoms [22,24,27,28]. However, few clinical studies [29] have investigated functional impairment and its predictors concurrently in depression, bipolar disorder, and schizophrenia spectrum disorder within the same sampling frame and with similar methods. Therefore, similarities and differences between risk factors remain partly unclear. Moreover, we are not aware of studies investigating correlations between subjective and objective work disability across different mental disorders. Most studies on predictors of functional impairment in major mental disorders have investigated the impact of disorder-related symptoms (neurocognitive, affective, psychotic) [17,29–31]. Other clinical or psychological traits, e.g. comorbid borderline personality features and level of self-efficacy, may also considerably influence functioning [32–34].

We aimed, first, to investigate perceived level of functioning and ability to work and objective work status within a cohort of psychiatric care patients with either schizophrenia or schizoaffective disorder, bipolar disorder, or depressive disorder. We expected notable functional impairment in all patients, with the most severe disability in the schizophrenia or schizoaffective disorder group. Second, we investigated associations of functioning and work ability with putative risk factors regarding preceding course (age at onset, number of hospitalizations) and current state of illness (affective symptoms) as well as clinical and psychopathological variables (self-efficacy, borderline personality traits). We hypothesized that correlates of functioning and work disability would be broadly similar across groups, but concordance between subjective and objective measures would be lower among patients with schizophrenia spectrum disorders.

## 2. Methods

### 2.1. Setting

The methodology of the Helsinki University Psychiatric Consortium (HUPC) study has been presented in detail in the authors' previous reports [35–37] and is only briefly outlined below.

The HUPC study was carried out in secondary mental health services, including 10 community mental health centres, in 24 psychiatric inpatient units, in one day-care hospital, and in two residential communities of the Helsinki metropolitan area in 2011–2012. The study was approved by the Ethics Committee of Helsinki University Central Hospital.

### 2.2. Sampling

Inclusion criteria were age of 18 to 64 years and provision of written informed consent.

Patients were randomly drawn from all eligible patients, stratified by setting. Patients with mental retardation, neurodegenerative disorders, or insufficient Finnish language skills were excluded. We recruited only patients, whose condition was stable enough to allow responding to the questionnaires. Of 1361 eligible

patients, 610 declined to participate and 304 were lost for other reasons. The final number of participants was 447, resulting in a response rate of 33%. In addition, 47 patients with a principal diagnosis of anxiety disorder, eating disorder, neuropsychiatric disorder, or substance use disorder were excluded from the current study, leaving 400 participants.

### 2.3. Diagnostic assessment

The principal clinical diagnoses given by attending psychiatrists were re-examined by the authors (K.A., I.B., M.K., and B.K.) following the criteria of the International Classification of Disease, 10th revision, Diagnostic Criteria for Research [38]. For the current study, patients were divided into three subgroups: schizophrenia or schizoaffective disorder (SSA,  $n = 113$ ), bipolar disorder (BD,  $n = 99$ ), and depressive disorders (DD,  $n = 188$ ).

### 2.4. Measure of functional impairment

The Sheehan Disability Scale (SDS) [39,40] is a three-item self-report scale to assess functional impairment on three domains: work, social life or leisure activities, and home life or family responsibilities. Each item is scored from zero to 10. The three items can be summed into a single dimensional scale of global functional impairment ranging from zero (no impairment) to 30 (high impairment). The SDS has no recommended cut-off score. However, a score of five and more on any of the scales is considered to indicate significant functional impairment.

### 2.5. Other measures

The Beck Depression Inventory (BDI) [41] is a self-report questionnaire for measuring the severity of depression symptoms. The Overall Anxiety Severity and Impairment Scale (OASIS) [42] is a self-report questionnaire to assess severity and impairment associated with anxiety. The General Self-Efficacy Scale (GSE) [43] is a self-report instrument to assess perceived self-efficacy regarding stressful life events. The McLean Screening Instrument for borderline personality disorder (MSI-BPD, hereafter MSI) [44] is a self-report questionnaire for screening for borderline personality disorder. All the scales had at least good internal consistency (Cronbach's alpha for total SDS 0.80; OASIS 0.84; BDI 0.91; GSE 0.93; MSI 0.92).

### 2.6. Assessment of work status and ability to work

In Finland, disability pension could be granted after 300 days of sick leave in a two-year period if the person was still considered unable to work or find employment that fits person's vocational qualifications because of an illness. That also applies to people working in a household. The Social Insurance Institution of Finland or other pension providers grant a pension based on the person's current and expected functional level presented in medical certificates of the attending physician. The authors collected information from medical records and certificates (for sick leave or disability pension) on a patient's current work/employment status, creating a three-item nominal variable (working, sick leave, or disability pension/rehabilitation subsidy). For further analyses, this variable was modified to a dichotomous as working and not-working (sick leave and disability pension/rehabilitation subsidy).

Patients were asked about their perceived ability to work, producing ordinal variable: 1 – able to work, 2 – reduced work ability, 3 – unable to work. For further analyses, this variable was transformed into the dichotomous form of able to work (items 1 and 2 combined)/unable to work. This categorization has been used also in previous studies [23,24]. Data on ability to work (work

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