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Association between social contact frequency and negative symptoms, psychosocial functioning and quality of life in patients with schizophrenia

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ABSTRACT

The lack of social contacts may be an important element in the presumed vicious circle aggravating, or at least stabilising negative symptoms in patients with schizophrenia. A European 2-year cohort study collected negative symptom scores, psychosocial functioning scores, objective social contact frequency scores and quality of life scores every 6 months. Bivariate analyses, correlation analyses, multivariate regressions and random effects regressions were conducted to describe relations between social contact and outcomes of interest and to gain a better understanding of this relation over time. Using data from 1208 patients with schizophrenia, a link between social contact frequency and negative symptom scores, functioning and quality of life at baseline was established. Regression models confirmed the significant association between social contact and negative symptoms as well as psychosocial functioning. This study aimed at demonstrating the importance of social contact for deficient behavioural aspects of schizophrenia.

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1. Introduction

Schizophrenia is a multidimensional disorder that prevents people from having a normal social life. Integration in the labour market is rare; participation in social networks is low as is psychosocial functioning (Fleury et al., 2013). There is evidence that social deficits are closely related to negative symptoms of schizophrenia and both may lead to reduced quality of life (Breier et al., 1991; Fenton and McGlashan, 1991; Katschnig, 2000; Norman et al., 2000). Low frequency of social contacts is one aspect of low participation in social networks; and this, combined with negative symptoms, may be an important therapeutic domain (Kirkpatrick et al., 2006). Different dimensions of the disorder and emotional/social concomitants form a complex network of inter-related factors. Some of these converge in impaired role function performance. Patients with schizophrenia find themselves caught in a vicious circle, as all the elements of the disease reinforce each other. Low frequency of social contacts is similar to the negative symptom “social withdrawal”, yet it has a different focus. Whereas

“social withdrawal” relies upon different aspects of social integration as estimated by the interviewer, frequency of social contact items ask the patient for facts concerning contact only. Solely based on rare social contact, the process of social construction of reality (Berger and Luckmann, 1966) – necessary to share concepts of reality with other people – is disturbed. Patients’ concepts of reality become more and more idiosyncratic as they grow farther apart from other people’s interpretations of the world. More social contact would imply more chance of developing socially shared concepts of reality (Fig. 1).

Poor social contact implies poor emotional exchange. Socio-emotional functioning, one aspect of psychosocial functioning requires emotional exchange. In patients with schizophrenia, deficits in social interaction are related to problems in the domain of handling emotions as communicative signals (Csukly et al., 2013). More social contact would train the ability of interpreting other people’s emotions. This would be a step toward less emotional withdrawal.

Although several studies have assessed the relationship between psychotic symptoms and functioning or quality of life (Smith et al., 2002; Rocca et al., 2009; Weinberg et al., 2009; Brüne et al., 2011; Corcoran et al., 2011), little information is available on the role of social contact in this area. Since the elements are interrelated in a multidirectional way it is important to make the

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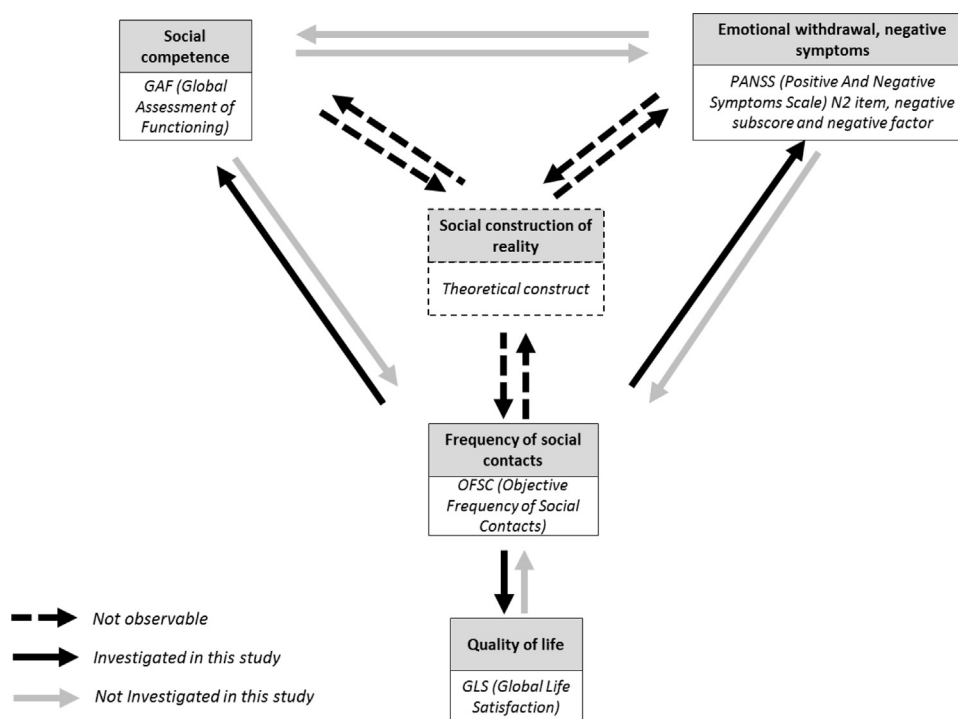


Fig. 1. Presumed vicious circle.

circle explicit, as the reasoning also tends to be circular.

The starting point of this analysis is the key role of negative symptoms in the course of the disease, their chronicity and their relation to poor functional outcome and poor quality of life. The research question was defined as follows: “is social contact an element in the presumed vicious circle, associated with more negative symptoms and particularly more emotional withdrawal, and with deterioration of psychosocial functioning and quality of life?” As there is no real therapeutic option today (Buchanan, 2007; Kring et al., 2013), it would be important to identify a means toward reintegration of patients with schizophrenia and improvement of their socio-emotional functioning. Reinforcement of social contact may be considered as such, if lack of (or very low frequency of) social contact is shown to predict aggravation of negative symptoms.

The objective of this study is to describe the pre-supposed association between social contact frequency and negative symptoms, particularly emotional withdrawal, as well as with psychosocial functioning and subjective quality of life. It was deemed crucial to evaluate both cross-sectional and longitudinal associations between these elements. As anxiety and depression – two symptoms often accompanying schizophrenic disorders – are also related to poor psychosocial functioning and poor quality of life, they should be controlled (Katschnig, 2000; Buchanan, 2007).

2. Methods

2.1. Data source

EuroSC is a naturalistic follow-up of a cohort of people with schizophrenia over a period of two years, with five visits at 6-month intervals. A detailed description of the cohort was published earlier (Bebbington et al., 2005). The principle objective of this cohort was to identify and describe the types of treatment and methods of care for people with schizophrenia and to correlate these with clinical outcomes, states of health, and quality of life. The subjects were selected to provide a representative sample of patients treated in each catchment area. The centres and sampling procedures were chosen to suit the national organisation of mental health care and the information systems that could be exploited for the study. In France, the selected locations included northern France (Lille), central France (Lyon

and Clermont-Ferrand), and southern France (Marseille and Toulon). Each of these areas covers an urban centre of approximately 1 million inhabitants living in the city or in medium-size towns. The study in Germany was carried out in four catchment areas: Leipzig and Altenburg in former East Germany, and Hemer and the County of Heilbronn in former West Germany. In the UK, the selected locations included two centres, Islington, a socially deprived inner-city area of London, and a reasonably affluent semi-rural area of Leicestershire. For each country, the specific locations were chosen because they are socio-demographically distinct and have different styles of service delivery. In each centre, a cohort of patients with schizophrenia and in contact with secondary psychiatric services was identified and assessed. One thousand two hundred and eight patients with schizophrenia were included in the study, 288 in France, 618 in Germany, and 302 in the UK. Where possible, random sampling was used (all the French centres and in London), otherwise the exhaustive inclusion approach was used. This involved the definition of a smaller catchment area, with the aim of including all patients with schizophrenia in the area. All mental health services in the area were contacted in order to identify patients previously or currently treated by them. Patients were screened to establish informed consent, and whether they met the inclusion/exclusion criteria.

This project was conducted in accordance with the Declaration of Helsinki (WMA, 2008). Subjects were aged between 18 and 64 years at the time of enrolment in the study, had a diagnosis of schizophrenia according to DSM IV criteria (APA (American Psychiatric Association), 1994), and had provided a signed informed consent.

2.2. Data collection

After consent was obtained, patients were interviewed by a trained independent psychiatrist, and the initial battery of assessments was completed. The data collected included socio-demographic information, and clinical information. Socio-demographic information included country, gender, age, length of illness, family situation and diagnosis. All were collected at the baseline visit. Clinical information included the Positive and Negative Symptoms Scale (PANSS) (Kay et al., 1989; Bell et al., 1992), the Calgary Depression Scale for Schizophrenia (CDSS) (Addington et al., 1990), the Global Assessment of Functioning (GAF) (Endicott et al., 1976) and the Quality of Life Interview (QoLI) (Lehman, 1983). All these measures were collected at each visit by the interviewer.

The PANSS evaluates the level of psychiatric symptoms in patients with schizophrenia. Several subscores of interest in this study were used, including item N2 (relative to emotional withdrawal), item G2 (relative to anxiety), the negative factor (as mean of items N1, N2, N3, N4, N6, G7 and G16) and the negative subscore (as mean of items N1, N2, N3, N4, N5, N6 and N7) (Kay et al., 1989). The negative subscore includes cognitive aspects (deficits in abstract thinking and stereotyped thinking) which the factor leaves out, and instead includes motor retardation and active social avoidance. The item N4, estimating social withdrawal, takes into account behavioural aspects of social integration inferred from other data assessed

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