



Effects of environmental deprivation on negative symptoms of schizophrenia: A nationwide survey in Japan's psychiatric hospitals

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Abstract

Research into the effects of environmental deprivation on negative symptoms of schizophrenia is limited, and few attempts have been made to differentiate secondary symptoms caused by the social environment. Japan's mental health system allows us to examine the extent to which understimulating social environments in hospitals contribute to negative symptoms of institutionalized patients while controlling for other factors. A random sample of inpatients of diagnosed with schizophrenia and hospitalized for 1 year or longer was drawn from the universe of inpatients attending a convenience sample of 20 hospitals across Japan. Data were collected for 549 study participants (a response rate of 91.5%). Measures included the Scale for the Assessment of Negative Symptoms (SANS), other clinical condition scales such as the Manchester Scale, and social condition scales including the Nurses' Opinion Scale and the Ward Restrictiveness Scale. Hierarchical regression analyses were conducted to determine the contribution of social environment to negative symptoms. Results showed significant correlations between negative symptom scales and most of the social environment scales, where social environment scales accounted for 18% of the variance in SANS scores. The study confirms the influence of understimulating social environments in psychiatric hospitals on negative symptoms.

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1. Introduction

There have been a number of efforts to distinguish primary from secondary negative symptoms of schizo-

phrenia, especially in the manner in which they relate to the treatment of negative symptoms and the pathology of schizophrenia (Carpenter et al., 1988; Buchanan and Gold, 1996; Kelley et al., 1999; Peralta et al., 2000). Primary negative symptoms represent core features of the disorder, while secondary negative symptoms are considered the result of factors extrinsic to the disorder or the symptoms, such as environmental

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deprivation (Wing and Brown, 1970; Curson et al., 1992), medical side effects, or circular effects of psychopathological symptoms of schizophrenia (positive symptoms or dysphoric affect) (Carpenter et al., 1985). Previous research on secondary symptoms has suggested that specific pharmacological and psychosocial treatments may be beneficial in reducing the severity of these symptoms (Buchanan and Gold, 1996). Therefore, in order to develop specific treatments for these secondary negative symptoms, it is prudent to clarify the causal mechanisms leading to specific secondary symptoms. However, to the best of our knowledge, there have been few attempts to differentiate secondary symptoms that are caused by the social environment or to assess the unique contribution of the social environment to the development of negative symptoms. Part of the difficulty in conducting studies that examine the links between the social environment of the institutionalized patient and his or her secondary negative symptoms involves identifying an appropriate research site. Work by Wing and Brown (1970) on the influence of understimulating social environments (environmental deprivation) in psychiatric hospitals on negative symptoms of schizophrenia has inspired psychiatric hospital reform and facilitated the development of community mental health programs in many countries. Consequently, there are but few Western institutionalized environments at present that permit the replication of this pioneering work (Curson et al., 1992).

In contrast, in Japan, the mental health care system remains primarily hospital-based, and, therefore, provides an opportunity to further study the impact of hospital-based environmental deprivation on negative symptoms of schizophrenia.

It is worth noting that few systematic efforts at deinstitutionalization have been made in Japan. In fact, until recently, the number of psychiatric beds had been rising (Oshima et al., 2002). The proportion of psychiatric beds per 100,000 people in 1998 was 284, which was the highest rate in the world (Oshima et al., 2002, 2003). In addition, inpatient wards are characterized by very restrictive environments (Oshima et al., 1996, 2002) with the percentage of unlocked wards not exceeding 40%. A nationwide survey revealed that the quality of living environments within psychiatric hospitals was much poorer than those within sheltered accommodation established under the Livelihood Protection Act, which

was enacted to ensure a minimum level of quality of life in Japan (Oshima et al., 1996).

As a result of these factors, we were able to replicate the Wing and Brown (1970) study using a large-scale nationwide cross-sectional survey (Oshima et al., 2003). In this study, we describe and examine the extent to which understimulating social environments in hospitals contribute to negative symptoms among institutionalized patients while controlling for other factors. As the deinstitutionalization movement in Western countries is still underway in terms of the development of alternative community services (Lamb and Bachrach, 2001), this study may also be useful in assessing the potential impact on patients of the use of community care programs such as residential care facilities that are more prevalent in Western countries and that may be similarly restrictive and understimulating environments.

2. Methods

2.1. Subjects and hospitals

Study participants were inpatients recruited from 20 psychiatric hospitals across Japan. These hospitals were included in an initial sample of hospitals that participated in a large-scale nationwide survey (see Oshima et al., 2003), but that have agreed to collection of more detailed data about patients based on working relationships they had with the authors. While a convenience sample, these hospitals were quite diverse in terms of ownership (private vs. public), size, and rehabilitation services available to patients and, therefore, encompass many of the between-hospital variations that are typically observed across the country. Next, in order to recruit subjects to participate in the study, an administrator at each hospital compiled a comprehensive list of all inpatients diagnosed with schizophrenia (according to DSM-III-R; American Psychiatric Association, 1987) that had been hospitalized for at least 1 year on the day the list was compiled. The investigator then randomly selected 30 subjects from each list based on patient identification numbers. Of a total of 600 possible subjects, 549 (91.5%) were enrolled in the study. Of these, approximately 59% were male with an average age of 51 (median=51) and a mean length of stay of

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