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Quality of Life For Persons Living with Schizophrenia: More Than Just Symptoms

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Abstract

Quality of life is an important outcome for schizophrenia treatment. However, studies of quality of life among persons living with schizophrenia have focused primarily on symptomatology. This study sought to determine the influence of unmet need and social support on the quality of life of individuals with schizophrenia. Thirty-two patients living in the community with schizophrenia or schizoaffective disorder were assessed on quality of life, psychopathology, unmet need and social support. Hierarchical regression analyses indicated that unmet need and social support are important contributors to the quality of life of persons schizophrenia, even after controlling for symptomatology. Implications for schizophrenia treatment are discussed.

Schizophrenia is a psychiatric disability that presents a range of challenges for those with the illness and their families. With advances in neuroleptic and psychosocial interventions, treatments have expanded beyond simply reducing the symptoms associated with schizophrenia. Treatments today increasingly focus on improving quality of life, which can be broadly conceptualized as (1) objective quality of life, or a person's health status and access to resources and opportunities, and (2) subjective quality of life, or a person's sense of well-being and satisfaction with life (Lehman, 1988). This emphasis has necessitated the elucidation of factors that affect quality of life for persons with schizophrenia. To date, most research on the determinants of quality of life in schizophrenia has focused on the impact of psychiatric symptoms, and indicated that anxiety and depressive symptoms, in particular, have an important negative impact on quality of life (see Lambert & Naber, 2004 for review). Unfortunately, investigations into the psychosocial influences of quality of life have been sparse, which has narrowed treatment development efforts and provided a limited picture with regard to the quality of life individuals with schizophrenia can attain, as if control of symptoms is the most that can be expected.

The studies that have investigated the role of factors other than psychiatric symptoms in the quality of life of individuals in schizophrenia have suggested that both social support and the meeting of basic needs (e.g., housing) have an important positive impact on quality of life (e.g., Becker, Leese, Krumm, Ruggeri, & Vazquez-Barquero, 2005; Ritsner, 2003). For

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example, a recent study found that improvement in social support was a significant predictor of improved quality of life among individuals with schizophrenia living on inpatient units (Ritsner, 2003). While compelling, these studies have primarily relied on subjective measurement strategies and focused largely on persons residing on inpatient units. This is limiting because different factors may influence the quality of life of individuals living in community settings, and individuals with schizophrenia may throttle their expectations for quality of life, such that subjective evaluations are inflated compared to objective life circumstances (Katschnig, 1997). As such, it is necessary to examine the influence of social support and unmet need on subjective *and* objective quality of life among individuals living in the community. To date, the importance of these factors, above and beyond symptomatology, to individuals residing community settings is largely unknown. Such information is vital to guiding the development of community-based interventions for enhancing quality of life among individuals with schizophrenia.

Method

This research was conducted as part of a clinical trial of a novel online psychoeducation program for individuals with schizophrenia and their families. Participants included 32 individuals with schizophrenia/schizoaffective disorder, confirmed by the Structured Clinical Interview for DSM-IV. As can be seen in Table 1, participants were all adults, predominantly female, racially diverse, and most were not employed.

Quality of life was assessed using the brief version of the Lehman Quality of Life Interview (Lehman, 1988; QOLI), a reliable and valid measure of quality of life for persons with psychiatric disability. Because of the comprehensiveness of the QOLI and its large number of subscales, we computed composite indexes of both objective and subjective quality of life, by averaging across the various objective and subjective subscales.¹ The objective quality of life composite included participation in leisure and daily living activities, adequacy of financial resources, and frequency of different social and familial contacts. The subjective composite included general wellbeing, and satisfaction with one's familial and non-familial relations, health and safety, finances and employment, living situation, and leisure and daily living activities. The reliability of these composites were within acceptable ranges (range of $\alpha = .70$ to $.87$). Perceived social support was assessed with the self-report emotional/informational support subscale of Medical Outcomes Study Social Support Survey (Sherbourne & Stewart, 1991). Psychiatric symptoms experienced by individuals with schizophrenia were assessed using the expanded version of the Brief Psychiatric Rating Scale (BPRS; Lukoff, Liberman, & Nuechterlein, 1986). Both of these instruments have well-documented reliability and validity. Unmet need was assessed using a 36-item self-report scale asking participants to rate between 1 ("not at all") and 5 ("extremely well"), how well various basic and illness-related needs were being met (Rotondi, Eack, Newhill, & Anderson, 2006). Needs ranged from basic needs related to finances and transportation, to needs surrounding information about schizophrenia and its treatment, to needs related to building friendships and community integration. We found the reliability of this instrument to be good ($\alpha = .83$).

Participants were recruited by staff referral from community clinics ($n = 27$) and acute inpatient units ($n = 5$) in a large urban area in an eastern state, and interviewed using the aforementioned instruments. Participants were recruited if they had a diagnosis of schizophrenia/schizoaffective disorder, were 14 years or older, and had at least one psychiatric hospitalization within the past two years. This study was approved by the

¹The objective composite excluded the items "time spent reading a book and going for a ride", and money spent on self/month, employment status, victimization, and arrest history subscales due to low reliability or variability.

University of Pittsburgh Institutional Review Board, and all participants gave written informed consent prior to participation.

Results

A series of hierarchical regression analyses, controlling for age, race, and gender effects, were conducted to examine the influence, above and beyond symptomatology, of unmet need and social support on quality of life, by removing shared variance between the BPRS and QOLI prior to examining the influence of these factors. Results indicated that neither demographic characteristics nor psychiatric symptomatology were significantly related to objective quality of life, $R^2 = .04$, $F(1, 27) = .48$, *ns*. Further, unmet need and perceived social support also did not explain a significant amount of variance in objective quality of life, beyond symptomatology ($\Delta R^2 = .16$, $F(2, 25) = 2.48$, $p = .10$), with social support ($\beta = .36$, $sr^2 = .10$, $p = .09$) having a marginal, non-significant contribution, and unmet need making no significant contribution ($\beta = .16$, *ns*). When examining the influences of subjective quality of life, psychiatric symptomatology did have a substantial negative influence on quality of life, $R^2 = .17$, $F(1, 27) = 6.28$, $p < .05$. However, both fewer unmet needs ($\beta = .34$, $sr^2 = .09$, $p < .05$) and greater perceived social support ($\beta = .37$, $sr^2 = .11$, $p < .05$) were also significantly related to better quality of life, and continued to explain over 25% of the variance in subjective quality of life above and beyond symptomatology, $\Delta R^2 = .27$, $F(2, 25) = 7.50$, $p < .01$. Such findings highlight the importance not only of symptomatology, but also unmet need and social support to the quality of life of persons with schizophrenia.

Discussion

As newer medications are developed and control of the most troublesome symptoms of schizophrenia becomes a reality for most individuals, quality of life is emerging as an important treatment outcome. Most quality of life research has focused on the influence of symptoms, and research investigating other factors has been limited to subjective evaluations by persons residing on inpatient units. The findings from this study make an important contribution to the existing literature by demonstrating the importance of unmet need and perceived social support to the subjective quality of life of individuals living in the community with this disability. Although this study is limited by its cross-sectional design and small sample size, which may restrict the representativeness of our sample and generalizability of these results, these findings do provide further evidence that community-based interventions designed to improve quality of life should encompass both treatment to reduce the symptoms experienced by individuals with schizophrenia, along with interventions designed to enhance social support and address unmet needs, such as basic financial needs and the need for information about the illness. For psychosocial treatment researchers, these findings are not surprising. In fact, an understanding of the importance of unmet need and social support has been the impetus for the development of many of the psychosocial treatments that exist today, yet research on quality of life seems to have neglected these factors. Furthermore, community treatment continues to consist primarily of prophylactic antipsychotic medication and little, if any evidence-based psychosocial treatment. This research suggests that if we want to help individuals with schizophrenia lead full and satisfying lives, treatment developers need to attend to the psychosocial influences of quality of life, and substantial work needs to be done to ensure these treatments reach persons in the community, as these treatments are the most likely to satisfy unmet needs and enhance social support, and therefore improve the quality of life of the many individuals living in the community who experience this disability.

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Table 1

Sample Demographic and Clinical Characteristics.

Measure	<i>n</i> (%)
Gender (female)	21 (66%)
Mean (<i>SD</i>) Age	37.84 (10.65)
Race (Caucasian)	15 (47%)
Marital Status (married)	6 (19%)
Education (high-school or above)	26 (81%)
Employed	2 (6%)
Mean (<i>SD</i>) Age at Diagnosis	24.74 (9.23)
Mean (<i>SD</i>) BPRS Total	31.34 (8.26)
Mean (<i>SD</i>) Needs Met	3.30 (.49)
Mean (<i>SD</i>) Perceive Social Support	1.81 (.78)
Mean (<i>SD</i>) Subjective Quality of Life ^a	4.22 (.72)
Mean (<i>SD</i>) Objective Quality of Life	
Daily Activities ^b	3.06 (1.44)
Financial Adequacy ^c	3.88 (1.62)
Social Relations ^d	3.50 (.82)
Family Relations ^d	4.05 (.94)

Note. BPRS = Brief Psychiatric Rating Scale

^aSubjective items are rated on a scale between 1 “terrible” and 7 “delighted”, with higher scores reflecting better quality of life.

^bSubscale ranges from 0 to 6, with higher scores reflecting more involvement in activities of daily living and leisure.

^cSubscale ranges from 0 to 5, with higher scores reflecting greater financial adequacy.

^dItems are rated on a scale between 1 “not at all” to 5 “daily”, with higher scores reflecting more social and family involvement.