Assessment of the Quality of Life in Chronic Psychiatric Egyptian Patients

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Abstract:

Quality of life was always a curial question in patient's life with in mental or physical disorders. So we were interested in different chronic Psychiatric disorders. Material and Methods: One hundred and seventeen patients recruited from Damanhour Psychiatric illness, which were subjected to PCASEE scale as well as ICD-10 checklist criteria. Results: -There is a great impairment in all domains of QOL social in relation to mental illness as evidenced by the low scores of PCASEE questionnaire obtained in major affective disorder, schizophrenic disorder and obsessive-compulsive disorders. Discussion: Through out this study it has been emphasized that the QOL focuses on the autonomy of the patients with regard to what to do with their lives Furthermore, poor memory and concentration and nuclear thinking were an over all unsatisfactory life judgment about patient.

Introduction

Quality of life (QOL) is often defined in terms of subjective perception of life satisfaction, happiness, social relation, physical health and psychological well-being, objective indicators such as financial income, quality of housing and physical function are also considered ***(Stainfort, 1996).***

In 1970s the quality of life became an outcome measure in scientific literature. In 1977 it became a heading in Index Medicus. At that time, physicians were claimed to be omnipotent because it seemed that their attitude towards quality of life placed them in a position to cure every human misery, not only medically but also psychologically and socially.

In the 1980s, therefore, the term health-related quality of life (H.R.Q.O.L) was adopted. The original WHO definition of health was:"*a state of complete physical, mental and social well-being and not merely the absence of disease*". However, in chronic disorders the WHO definition of health has to be modified by accepting decreased degrees of well being. In other words, well being is a matter of degree.

Also in 1980, WHO released the International Classification of Impairments, Disabilities and Handicaps, (ICIDH). The original intention of ICIDH was to focus on the consequence of illness, especially in chronic disorders. Impairments were characterized by a permanent or temporary loss or abnormality of psychological, physiological or anatomical structures. The impairments are, of course, associated with the underlying cause of disease, but they have their significance in the chronicity of the disease processes.

According to ICIDH, disability often refers to a degree of dysfunction in the performance of social roles. Finally handicaps refer, in accordance with ICIDH, to the interaction between disability and the environmental situation, often defined as the subjective disadvantage of being ill. However, the term handicap has been difficult to define the consequences of illness as the final, subjective dimension on

the sequence underlying illness-related dimension of impairments and disabilities.

In Egypt, mental disorder is one of the main health problems in our community as about 30% of the population suffered any time of their life from psychiatric disorder needing to be diagnosed. Moreover, 40% of patients going to physicians whatever their specialties had at least one somatic symptom like headache, back pain secondarily to their disturbed psychological state *(Okasha, 1997).*

The Egyptian mental health foundation has noted that, there are only one psychiatrist for 150.000 Citizens and there are little number of psychiatric bed in hospitals which constitutes about 9000 bed in the private and public hospitals estimation that psychiatric bed make 1/10 of the whole beds in Egypt. So, a big portion of patients are treated as in outpatients where the goal of satisfactory treatment is to obtain a quality of life equal to the normal population and to reduce the economic costs including the direct expense such as mental health treatment and the indirect costs including the loss of patient productivity. However, such intangible "costs", outcome of the therapy, prediction of relapse and compliance should be measured as health related quality of life *(Sacks, 1992).*

So, from these important point of views, we are concerned to evaluate firstly the health-related quality of life holistically including the impairment and subjective well-being describes of by the patient. Secondly to highlight the impact of different psychiatric disorders on the different aspects of the QOL scale using PCASEE scale *(Bech, 1997).*

The aim of this study was to identify the impact of chronic psychiatric illness on the quality of life of Egyptian patients as well as the pattern of the impairment of QOL in the different psychiatric (i.e., diagnosis chronic schizophrenia, affective disorders, and OCD). As compared to healthy controls.

Subjects and Methods: -

Our study sample was recruited from the psychiatric outpatient clinic of Damanhour teaching hospital in Egypt (patient group N=117), who were diagnosed as any chronic mental disorders (over 2 years) with an average age ranging from 18 to 45years old either literate or illiterate from both sexes.

Patient group was compared to 30 healthy volunteers matched for age, sex and social class,

Both groups were applied to: -

1. Sheet for socio-demographic state.
2. ICD-10 checklist (for patient group only) to re-evaluate the diagnosis of the patients.
3. Application of the PCASEE scale *(Bech, 1997)* clarifying the subjective expression of the QOL of the patients in domains as physical, cognitive affective, social, economic and ego (personality).

Tools Applied: -

PCASEE questionnaire *(Bech, 1997)* consist of six domains to estimate the degree of impairment in the QOL of the patient.

The domains are: -

1. Physical.
2. Cognitive.
3. Affective.
4. Social.

5. Economic and,
6. Ego (personality).

Each domain includes sub dimension (items) to specific the areas of impairment.

Physical problems include (sleep problem, sense of physical well being, appetite, experience of physical pain, energy).

Cognitive problems include (degree of concentration, memory problems, decision making, controlling of life, clear thinking).

Affective problems include (anxiety symptoms, getting away, felling comfortable with him, sadness, and irritability).

Social dysfunction includes (appreciation at work, doing home duties, performance at work, interest in daily activity, interest in social life).

Economic problems include (worries about financial state, ability to buy what he, she wants, ability to buy what he, she needs, ability to make ends meet, financial assistance).

Ego problems include (self-confidence, sexual attractiveness, hurt feelings, forgiving himself, hopes in life).

Scoring of the scale was done for each item from 0 to 2 where O stands for bad response, 1 for moderate response, and 2 for good response.

Results: -

1- ***Socio-demographic data:*** Demographic and clinical diagnosis characteristics of the study sample are presented in table (1) showing total number of each diagnosis as 49 patients (41.9%) having schizophrenic disorders and 62 patients (53%) with mood disorders, and 6 patients (5.1%) suffering from OCD.

2- Holistic assessment of QOL in different psychiatric disorder. There is a great impairment in all domains of QOL scales in relation to mental illness as evidenced by the low scores of PCASEE questionnaire obtained in patient group (N=117) compared to control group (N=30). (table 2)

3- Results of PCASEE questionnaire in-patients with major affective depressive disorder.

From our results we find that the group of patients with major affective disorder depressive type had a significant impairment ($P<0.05$) in cognitive (mean 2.5 ± 2.4) and social domains (2.45 ± 2.5) compared to control group (7.76 ± 1.9 and 8.2 ± 1.8) ***(fig1).***

i- Results of PCASEE scale in schizophrenic disorder.

Disorganized schizophrenia patients had a significant impairment in cognitive domains (1.2 ± 1) compared to controls (7.7 ± 1.9, $P < 0.05$), while patients within undifferentiated subtype have severe impairment in social and cognitive domains (2.1 ± 1 and 2.5 ± 2) compared to control (8.2 ± 1.8 and 1.7 ± 1.9 $P< 0.05$) and paranoid schizophrenic patients had statistically significant impairment in social (2.6 ± 0.5) and ego domains (1.8 ± 1.5) compared to normal controls (8.2 ± 1.6 and 4.07 ± 1.4 $P<0.05$) (fig 2).

ii- Results of PCASEE scale in schizo-affective disorder

It was found that schizo-depressive patients have global impairment in all domains of Q.O.L. scales with significant affection in physical, social and ego domains (2 ± 1.9 and 2.0 ± 1.7 and 0.17 ± 0.1) compared to control group (7.0 ± 1.8, 8.2 ± 1.6 and $4.0 \pm$

1.4 P< 0.05). While the schizomanic group have less affection in cognitive, social and ego domains (3.2 ± 2.4, 4.2 ± 1.5 and 1.8 ± 1.6) compared to control (7.7 ± 1.9, 8.2 ± 1.6 and 4.07 ± 1.4, P< 0.05).

iii- Results of PCASEE scale in obsessive compulsive disorders: -

Patients diagnosed as OCD (N=6) had significant impairment in ego and social domain (1.6 ± 1.2 and 0.2 ± 1.6) compared to control (4.07 ± 1.4 and 8.6 ± 2 p< 0.05).

3- Analysis of multivariable of PCASEE in relation to different psychiatric disorder: -

i- ***Physical problems:***

ii- Our results showed that patient with schizo-affective depressive type and severe type of major affective depressive disorder has severe impairment in subjective items of well being (0.67 ± 1, 0.35 ± 1), sleep disturbance (0.17 ± 0.9, 0.4 ± 2), appetite change (0.5 ± 1, 0.4 ± 1), experience physical pain (0.5 ±1, 0.3 ±1.2) and lack of energy (0.16 ± 1, 0.3 ± 2) compared to normal control (table 3).

iii- ***Affective impairment:***

Our study showing that affective domain was statistically significantly impaired in all patients groups compared to normal subjects. The greatest impairment was in patients with schizo-affective depressive and in depressive disorders especially the severe type in feeling anxious (0.33 ± 1 and 0.1 ± 2) changing his life (0.33 ± 2 and 0.15 ± 2) comfortable with himself, herself and (0.33 ± 1 and 0.1 ± 3) sadness (0.33 ± 2 and 0.2 ± 3) irritability (0.33 ± 2 and 0.2 ± 1, P< 0. 05) (table 4).

iv- ***Ego Problems: -***

Our study showing that ego problem were statistically significantly impaired in all groups of patients in subitems as sexual attractiveness, hurting feeling and difficulties forgiving oneself in schizo-affective depressive group of patient and in depressive disorder as well as in patients with OCD.(Table 5).

v- ***Social and Economic Domains:***

Analysis of our data showed that both social and economic domains were significantly impaired in all patient groups especially in-patients with obsessive compulsive disorder (table 6).

vi- ***Cognitive Impairment:***

All patients group showed some impairment in cognitive domains especially in the group suffering from schizophrenic disorder irrespective to the subtype of schizophrenia (table 7).

Table (1): Demographic And Clinical Characteristics Of Patient And Control Group.

Diagnosis	No	Age		Sex			
		Range	Mean (SD)	Female N %		Male N %	
Schizophrenic Disorder:							
Schizophrenia:	49	18 - 45	31.7 (9.4)	18	36.7	31	36.3
*Paranoid Schizophrenia	15	22 - 45	25(7.9)	7	46.7	8	53.3
*Undifferentiated Schizophrenia	8	20 – 45	36.5 (10.5)	2	25	6	75
*Disorganized Schizophrenia	6	18 – 33	23.8 (6.60	1	16.7	5	83.3

Table (1) Continue:

* Simple Schizophrenia	4	18 – 28	20.5 (6)	2	50	2	50
*Residual Schizophrenia	3	22 – 45	32.3 (11.7)	--	--	3	100
Schizo affective disorder							
* Schizo depressive	7	23 – 41	30.6 (6.7)	3	42.9	4	57
* Schizo Manic	6	24 – 45	33.8 (9.3)	3	50	3	50
Mood (Affective) Disorders:	62						
Depressive disorder:		20 – 45	36.1 (8.9)	31	64.4	15	32.2
* Mild	5	20 – 45	33.2 (10.7)	3	60	2	40
* Moderate	21	22 - 45	36.4 (8.4)	15	71.1	6	28.6
* Severe without psychotic feature	14	20 – 45	36.5 (9.4)	10	71.9	4	28.6
* Severe with psychotic featur	6	20 - 45	33.2 (10.7)	3	50	3	50
Mania:		18 – 30	21.8 (5)	7	100	--	--
Bipolar affective disorders	9	21 – 40	30.3 (8.8)	7	77.8	2	22.2
Obsessive Compulsive Disorder	6	22 – 35	27.7 (5)	1	16.7	5	83.3
Control Group	30	18 – 43	29.6 (8.2)	14	46.7	16	35.3

P = 0.003

Table (2): Difference between Patient and Control Groups Inresponse to Items of Q.O.L. Scale.

	Cases N = 117		**Control N = 30**		**Test of Significant**	
	Mean	**SD**	**Mean**	**SD**	**T**	**Test**
1- Physical	3.99	2.76	7.20	1.87		6.02 *
2- Cognitive	3.39	2.71	7.76	1.94		8.30*
3- Affective	3.78	2.86	6.80	2.09		5.40*
4- Social	3.63	2.52	8.26	1.68		9.50*
5- Economic	3.78	2.14	6.50	2.01		6.27*
6- Ego	1.52	1.64	4.07	1.14		7.75*

* = Significant. P <0.05

Table (3): Comparison between studied patient group in physical items of PCASEE: -

	Schizophrenic disorders							Mood (affective) disorder				O.C.D	P-Value
	Schizophrenia					Schizo-affective		Depressive disorder			Bipolar		
Physical item	Paranoid	undiffertiated	disorganized	simple	residual	Manic	Depression	Mild	Mod	Severe			
1- sleep pattern	0.87	1.00	1.33	1.25	0.67	1.00	0.17	1.00	0.33	0.45	1.00	1.17	0.02*
2- physical well being	0.87	1.00	1.17	1.25	1.33	1.14	0.67	0.80	0.71	0.35	0.89	1.00	0.03*
3- Appetite	1.00	0.62	1.50	1.50	1.00	1.29	0.50	0.80	0.57	0.40	1.11	0.83	0.00**
4- Physical pain	1.00	1.00	1.33	1.25	1.00	1.29	0.50	0.60	0.62	0.35	1.00	0.83	0.00**
5- Energy	0.80	0.88	1.33	1.00	1.00	1.00	0.16	0.80	0.43	0.30	1.22	0.83	0.00**

*** Significant**

**** High significant**

Table (4): Comparison between studied patient groups on affective Items of PCASE: -

	Schizophrenic disorders							Mood (affective) disorder				O.C.D.	P-Value
	Schizophrenia				Schizo-affective			Depressive disorder			Bipolar		
Affective item	Paranoid	undiffert iated	disorganized	simple	residual	Manic	Depression	Mild	Mod	Severe			
1- Feeling anxious	0.80	0.88	1.00	0.50	1.00	0.71	0.33	0.60	0.43	0.10	1.00	0.67	0.03*
2- Changing his life	1.20	1.00	1.33	1.25	1.33	1.43	0.33	1.00	0.52	0.15	1.43	1.00	0.00**
3- Confortable with himself	0.93	0.88	0.83	0.75	1.00	1.29	0.33	0.40	0.83	0.10	1.14	1.00	0.00**
4- Saddnes	1.40	1.50	1.33	1.00	2.00	1.57	0.33	0.60	0.33	0.20	1.43	1.17	0.00**
5- Irritability	0.93	1.25	1.33	0.50	1.00	1.33	0.33	0.60	0.38	0.20	1.14	1.17	0.00**

*** Significant**

**** High significant**

Table (5): Comparison between studied patient groups on Ego Items of PCASEE

Ego item	Schizophrenic disorders							Mood (affective) disorder				O.C.D.	P-Value
	Schizophrenia				Schizo-affective			Depressive disorder			Bipolar		
	Paranoid	Undifferiated	disorganized	simple	residual	Manic	Depression	Mild	Mod	Severe			
self Confidence	0.20	0.20	0.22	0.21	0.20	0.20	0.00	0.10	0.00	0.00	0.10	0.00	0.15*
Sexual attraction	0.33	0.13	0.67	0.25	0.33	0.43	0.00	0.40	0.24	0.05	0.67	0.50	0.00**
Hurt feeling	0.33	0.63	0.83	0.75	0.33	0.43	0.00	0.20	0.00	0.05	0.67	00.17	0.00**
Forgiving himself	0.60	0.50	0.83	1.00	1.00	0.57	0.17	0.00	0.05	0.00	0.56	0.33	0.00**
Goals in life	0.15	0.20	0.15	0.22	0.30	0.30	0.10	0.20	0.15	0.10	0.25	0.33	0.45*

* Significant
** High significant

Table (6): Comparison between studied patient groups on Social items of PCASEE: -

	Schizophrenic disorders							Mood (affective) disorder				O.C.D	P-Value
	Schizophrenia					Schizo-affective		Depressive disorder			Bipolar		
Social item	Paranoid	Undiffertiated	Disorganized	simple	residual	Manic	Depresion	Mild	Mod	Severe			
appreciation at Work	0.20	0.20	0.22	0.21	0.20	0.20	0.00	0.10	0.00	0.00	0.10	0.00	0.15*
Home duties	0.33	0.13	0.67	0.25	0.33	0.43	0.00	0.40	0.24	0.05	0.67	0.50	0.00**
performing work	0.33	0.63	0.83	0.75	0.33	0.43	0.00	0.20	0.00	0.05	0.67	00.17	0.00**
Interest in daily activity	0.60	0.50	0.83	1.00	1.00	0.57	0.17	0.00	0.05	0.00	0.56	0.33	0.00**
Social life	0.15	0.20	0.15	0.22	0.30	0.30	0.10	0.20	0.15	0.10	0.25	0.33	0.45*

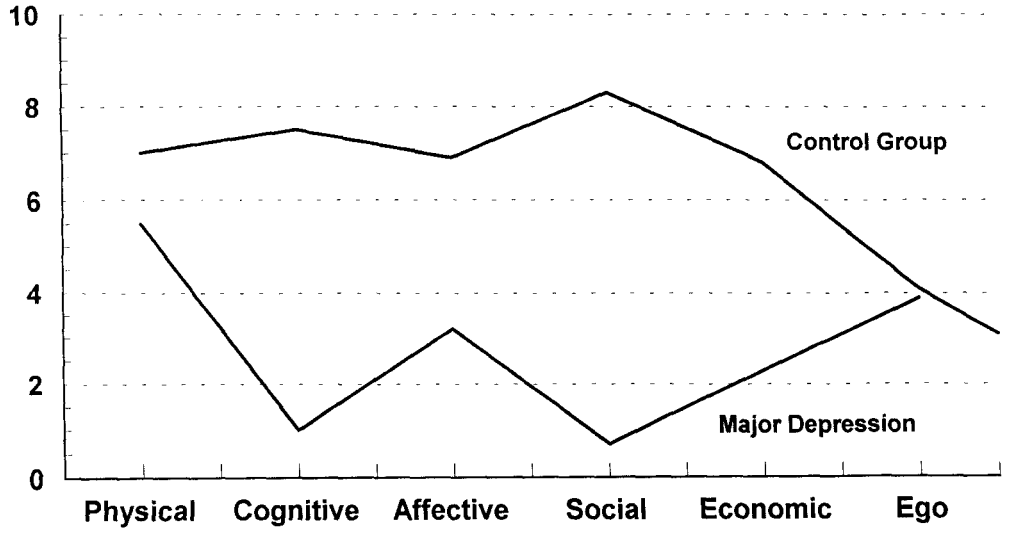
* Significant
** High significant

Table (7): Comparison between studied patient groups on Cognitive items of PCASEE

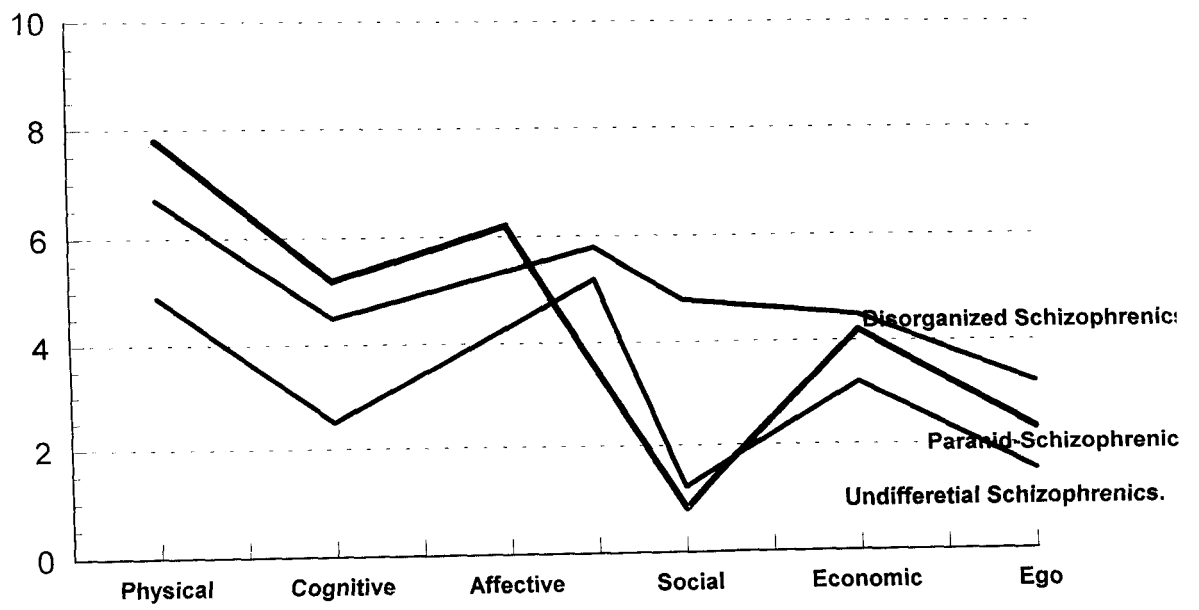
	Schizophrenic disorders							Mood (affective) disorder					
	Schizophrenia					Schizo-affective		Depressive disorder			Bipolar	O.C.D.	P-Value
Cognitive item	Paranoid	Undifferentiated	Disorganized	simple	residual	Manic	Depression	Mild	Mod	Severe			
Concentration	0.2	0.3	0.22	0.1	0.3	1.2	0.00	0.8	1.2	0.1	0.1	0.01	0.01*
Memory	0.3	0.13	0.17	0.2	0.5	0.4	0.2	0.9	0.9	0.2	0.67	0.50	0.00**
Decision maker	0.4	0.6	0.33	0.3	0.7	0.5	0.1	1.2	0.8	0.2	0.22	0.3	0.05*
Controlling Life	1.0	0.5	0.3	0.4	0.2	1.2	0.3	1.2	0.7	0.3	0.32	0.5	0.01**
Thinking	0.15	0.20	0.15	0.5	0.1	2.1	0.4	1.5	0.88	0.33	0.33	0.3	0.03*

* Significant
** High significant

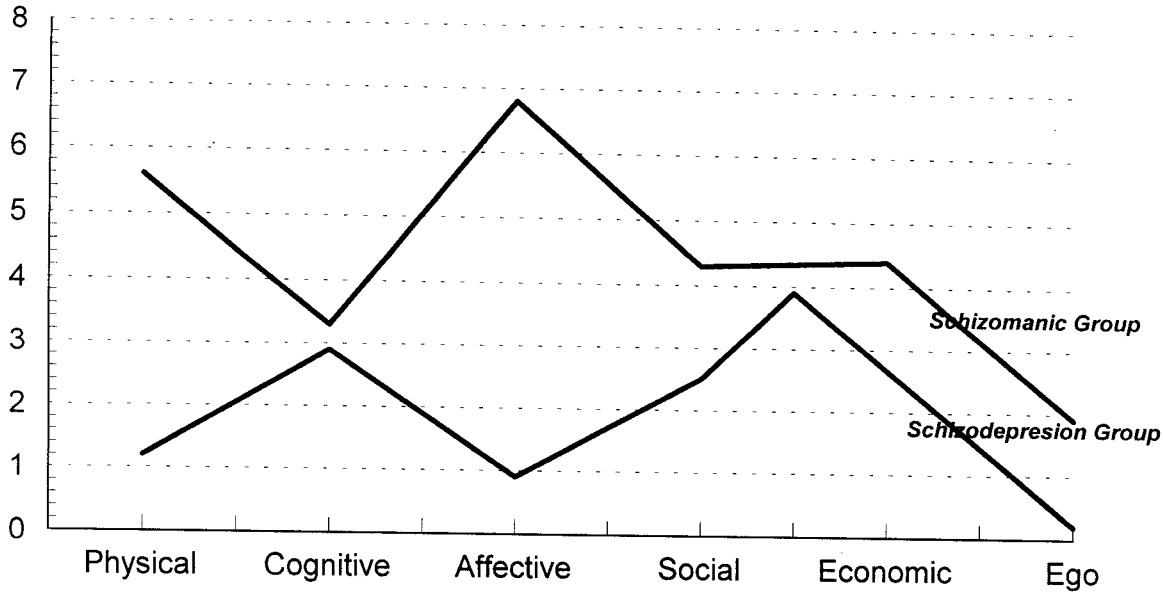
Fig (1) Showing The Relation of Response Major Depressed Patient Group and Control Group to PCASEE Scale



(Fig 2) Response of Disorganized, Paranid and Undifferentiated Schizophrenic in Relation to PEASEE Domains



(Fig 3) Response of Schizoaffective
(Schizodepressive and Schizomanic) in Relation to The PCASEE Domains



Discussion: -

Clinicians often perceive symptoms to be the major indicator of patient's well being while this study shows that there is subjective patient's assessment of symptoms and other dimensions of well-being which were expressed in the PCASEE scales. This is important since it is increasingly accepted that improve all aspects of patients quality of life needs to be addressed in all treatment strategies. Another important issue that was investigated is the relative importance of different domains of well being such as physical problems, cognitive problems, affective problems, social dysfunction, economic problems and ego (personality depression). Differences in degree of impairment would suggest the need for prioritizing different services.

Our study data suggest that patients with schizo-affective depressive disorder judgments are more likely to suffer severe impairment on affective and ego aspects of quality of life than on physical, cognitive and social aspects. So as this group of patients express severe anxiety symptoms, sadness and irritability with poor self-confidence, sexual unattractiveness, and unclear goals in life. Reasons for such impairment may include patient's greater knowledge of his, her own symptoms and focusing on disorder- related aspects because of a presumed lack of control when clinicians emphasize these points.

On the contrary the work done by ***Sainfort et al., 1996*** emphasize that patients tended to suffer sever impairment in social and occupational aspects and they suggest that patient's adapt to their symptoms and discount them but over concerned with their social relationship.

Results of this study show that the group of patients with major affective disorder had significantly poor judgements in all aspects

of QOL scales especially in cognitive and social domains.

Furthermore, they suffer poorer memory and concentration, unclear thinking with no appreciation at work, poor achievement and no interest in daily activity with over all unsatisfactory social life. These items were of great importance clinicians as need to be aware of their patients' rating QOL scales in order to formulate a comprehensive clinical management plan. In a study done by ***Sintona etal., 1994***. They found that depressed patients with low quality of life scores relapsed 4 weeks later, even though their mood was in the neutral phase at the time of the study.

In our study, the group of patients with schizophrenic disorder had global impairment in QOL scales with especial disturbance in cognitive, social and ego aspects.

Patients with schizophrenic disorders have complex impairment in sub items of PCASEE such as poor concentration poor interest in daily activity, poor self-confidence and unclear thinking. Sub typing of schizophrenic disorders did not differ much regarding the sub items of the QOL scales (Fig 2). These data are in agreement with the work done by ***Becker (1999)*** who emphasized those schizophrenic patients and clinician judgments are more likely to coincide clinical aspects of the quality of life than on physical aspects of the QOL. Furthermore, clinicians tended to rate social support and occupation level low while patients rated them high. Reasons for such difference may include patient's greater knowledge of their own social support and occupational functioning In the world health organization in ***1996 Murray*** emphasized that in the treatment of schizophrenic the direct costs are higher than the indirect costs and about ¾ of all treatment costs for schizophrenic patients or hospital costs. It has been estimated that good social management with protection from adverse life events might reduce relapse of schizophrenic patients and make them less likely to be rehospitalized ***(Bebbington, 1996).***

Our data reveal that the group of patient with OCD had great impairment in judging their social and ego domains as they express poor self confidence, sexual unattractiveness; unclear goals in life as well as poor social life. Drug treatment for patients with OCD did not increase quality of life per se. However, the improvement of obsessive patient outcome in terms of quality of life is a fundamental goal to decrease the disability of the mental disorders ***(Kone., 1996).***

Further research needs to be done including larger number of patients as well as other psychiatric diagnoses. Also, more research is needed in this particular aspect on a transcultures well as the concept of quality if life is one of the concepts that tends to be coloured by culture

Last but not least, through out this study it has been emphasized that the QOL focuses on the autonomy of patients with regard to what they want to do with their lives. The patients decide when treatment is necessary or whether they accept treatment when it is prescribed. So, the QOL approach should increase patient compliance and outcome measure as progmatismic, which refers to the language of satisfactory experience in pharmacotherapy as well as psychotherapy which in turn increase the collaboration between doctors and patients in order to achieve satisfactory.

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مقياس تقييم جودة الحياة في المرضى النفسيين

أجريت الدراسة على ١١٧ مريض لتقييم مقياس جودة الحياة في المرضى النفسيين و أثبتت الدراسة ان مرض الاكتئاب و الفصام و الوسواس القهري يعتبروا من اكثر المرضى الذين يعبروا عن فقد الاهتمام بوظائف الحياة اليومية و تشتت الفكر و ضعف التركيز و هذه العوامل جميعها تؤدى إلى عدم الاستمتاع بالحياة اليومية و التعبير السيئ عن الحياة.