

## Depression and quality of life in first-episode psychosis

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### Abstract

**Aim:** Quality of life (QOL) has gained recognition as a valid measure of outcome in first-episode psychosis (FEP). This study aimed to determine the influence of specific groups of depressive symptoms on separate domains of subjectively appraised QOL.

**Methods:** We assessed 208 individuals with first-episode non-affective psychosis using measures of diagnosis (Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*), symptoms (Scale for the Assessment of Positive Symptoms, Scale for the Assessment of Negative Symptoms, and Calgary Depression Scale for Schizophrenia), functioning (Global Assessment of Functioning), insight (Birchwood Scale), duration of untreated psychosis (Beiser Scale), and QOL World Health Organisation Quality of Life Instrument (WHOQOL-Bref). We used multiple regression to determine the contribution of depressive symptoms to QOL domains while controlling for socio-demographic and other clinical characteristics.

**Results:** There were complete data for 146 individuals with FEP. Quality-of-life domains were consistently predicted by depressive symptoms including depressive mood and hopelessness rather than biological symptoms of depression with those experiencing more depressive symptoms reporting worse QOL. Those who were treated as in-patients reported improved QOL, and hospitalization was an independent predictor of most QOL domains. In-patients displayed greater levels of positive symptoms with those involuntarily detained displaying greater levels of bizarre behavior, thought disorder, and delusions.

**Conclusions:** These findings suggest that QOL is heavily influenced by depressive symptoms at initial presentation; however, as QOL domains are also influenced by admission status with in-patients being more symptomatic in terms of positive symptoms, subjective QOL assessment may be compromised during the acute phase of illness by both positive and depressive symptom severity.

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### 1. Introduction

Quality of life (QOL) has gained recognition as a valid measure of outcome in those with first-episode psychosis (FEP) [1]. At first presentation, poorer QOL is seen in those with greater severity of both positive [2,3] and negative symptoms [4] and is associated with a range of variables indicating an unfavorable course such as male sex [5], being single, comorbid substance misuse [6], and poorer premorbid functioning [7,8]. In addition, several studies have found that the duration of untreated psychosis (DUP) is linked with QOL; those experiencing lengthier delays before accessing

treatment show impaired QOL [6,8]. Quality of life has also been shown to be worse in those with FEP when compared with healthy controls [9] irrespective of whether the individual has remitted from their first episode of psychotic illness [8].

However, the results of studies of QOL in FEP have been inconsistent [7,10,11]. This may reflect the use of different instruments and varying QOL concepts adopted in each study [1,9]. Furthermore, subjectivity is central to the QOL concept [9,12]. Quality of life can be broadly separated into 2 opposing paradigms with objective indicators of material living conditions and subjective appraisals of one's own life representing each aspect [1]. It has been consistently shown that QOL is negatively influenced by general psychopathology [6,13] and, in particular, depressive symptoms [6,7,14]. However, it is still unclear which depressive symptoms

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influence QOL in FEP at first presentation. It is also unknown whether the presence of depressive symptoms affects QOL domains universally or whether their influence can distinguish one domain from another. This study aimed to determine the influence of specific groups of depressive symptoms on separate domains of subjectively appraised QOL. In addition, we aimed to evaluate the contribution of possible predictors of QOL such as positive and negative symptoms, DUP, treatment factors, and socio-demographic characteristics.

## 2. Methods

### 2.1. Participants and setting

Between February 2005 and February 2010, we assessed 338 consecutive individuals presenting with FEP within a geographically defined catchment area (population, 375 000). Of those, 208 (61.9%) had a nonaffective psychosis, and 146 of those had complete data on QOL measures. Non-responders on QOL measures did not differ from responders in terms of age, sex, marital status, treatment status, and diagnosis. Participants were identified from consecutive referrals of FEP to DETECT (Dublin and East Treatment and Early Care Team) and contacted within 72 hours of receipt of referral. Exclusion criteria were prior treatment with antipsychotic medication for more than 30 days, not meeting age criteria for adult mental health services (16–65 years), and having an existing learning difficulty that excluded them from written aspects of the study. Ethical approval was granted by the St John of God Order Provincial Ethics Committee, St Vincent's University Hospital Ethics Committee, and Newcastle Hospital Ethics Committee, and informed verbal consent was obtained from all participants. Providing a comprehensive assessment of the diagnosis, symptoms, and functional status of individuals with FEP in each study site has been adopted as best practice. As such, the information gathered from the clinical assessments is communicated directly to each clinical team.

### 2.2. Instruments

We established diagnosis of non-affective psychosis using the *Diagnostic and Statistical Manual for Mental Disorders* [15]. We assessed symptoms using the Scale for the Assessment of Positive Symptoms (SAPS) [16], Scale for the Assessment of Negative Symptoms (SANS) [17], and Calgary Depression Scale for Schizophrenia (CDSS) [18], and functional level was determined using the Global Assessment of Functioning [19]. Insight was measured using the Birchwood Insight Scale [20], and the participants' families provided information regarding the onset of psychotic symptoms using the Beiser Scale [21]. Quality-of-life scores were obtained using the WHOQOL-Bref [22] QOL domains: psychological well-being, environment, social relations, and physical health. An overall QOL score

is calculated using the initial 2 questions of the instrument regarding self-rated QOL.

Each participant was assigned 1 assessor, usually a post-membership registrar or clinical nurse specialist, who conducted at least 2 interviews with the participant and at least 1 interview with their family or significant other, and respondents also completed several self-assessments. The diagnosis of each participant was discussed during a consensus clinical meeting chaired by the Professor of Mental Health Research (EOC) or assigned equivalent. Clinician-rated assessments (Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [SCID-DSM-IV], SANS, SAPS, CDSS, and Beiser Scale) were subject to testing the reliability of separate ratings on 10 complete cases. Concordance in diagnosing patients with the SCID-DSM-IV ranged from 93% to 100%, and the intraclass correlation coefficients among raters for the SAPS were  $r = 0.66$  to  $0.99$ ; the SANS,  $r = 0.61$  to  $0.99$ ; and the CDSS  $r = 0.71$  to  $0.98$ . The current concordance for dating the onset of first signs of illness is 96% and 82% for dating the onset of psychosis. Protocol dictated that these assessments were conducted before participant-rated assessments, that is, WHOQOL-Bref and Birchwood Insight Scale.

### 2.3. Data analysis

The data were analyzed using PASW Statistics 18 (IBM SPSS Inc. 2010). Depression factors were obtained by conducting principal components analysis on items of the CDSS, as items were intercorrelated and, therefore, violated the assumptions of regression analysis. Four components were extracted (eigenvalues,  $>8$ ), accounting for 74% of the total variance. Components included depression-hopelessness, self-depreciation–pathologic guilt, guilty ideas of reference, and early morning waking. The DUP was log transformed to correct for positive skewness. We report all significant relationships at the  $P \leq .001$  level for bivariate and multivariate analysis; however, to control for type I errors that arise from multiple comparison, variables that were significantly correlated with QOL at the level of  $P \leq .01$  were entered into multiple regression. Independent variables (predictors) were entered in 2 separate blocks for each regression model: the first block containing variables found to be significant at the  $P \leq .01$  in bivariate analysis and the second block containing regression factors for depressive symptoms obtained by principal components analysis.

## 3. Results

There were complete data for 146 individuals (89 males and 57 females) presenting with first-episode non-affective psychosis. The mean age was 32.7 years (SD, 10.7), and the average DUP was 24.33 (SD, 40.2; Interquartile Range, 1–33.5) months. Most individuals were being treated as inpatients ( $n = 87$ , 60%) at the time of assessment. There

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