

# Life Satisfaction and Suicidal Attempts Among Persons With Schizophrenia

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The relationship between subjective quality of life (QOL) and suicide attempts in patients with schizophrenia has been understudied. The current study tested the hypothesis that QOL is negatively associated with a history of suicidality of patients with schizophrenia. QOL, as measured by the Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-Q), was investigated in 227 inpatients with DSM-IV diagnosis of schizophrenia with and without a lifetime history of suicide attempts. The statistical analysis included analysis of variance (ANOVA), *t* tests, and analysis of covariance (ANCOVA). The patients who had attempted suicide multiple times were

**S**UBJECTIVE quality of life (QOL) is a non-specific perception of an individual's total existence,<sup>1-3</sup> and its assessment serves as an indicator of subjective well-being.<sup>4-6</sup> Most conceptualizations of health-related QOL include the dimensions of physical, social, and role functioning, mental health, and general health perceptions, including concepts such as energy, fatigue, pain, and cognitive functioning. These physical, psychological, and social domains of health are seen as distinct areas that are influenced by a person's experiences, beliefs, expectations, and perceptions.<sup>8</sup> While there is no universal operational definition of QOL, most researchers agree that patients' statements on satisfaction with major life domains of daily functioning are relevant indicators of subjective QOL.<sup>9-11</sup>

Subjective QOL has been investigated as an outcome measure for patients with severe mental disorders, particularly those with chronic schizophrenia.<sup>12-14</sup> QOL of persons with schizophrenia is significantly decreased compared to members of the general population.<sup>15-17</sup> Clinical variables associated with poor QOL of patients with schizophrenia are: negative symptoms,<sup>18,19</sup> general psychopathological symptoms,<sup>20,21</sup> depressive symp-

less satisfied with regard to a larger number of life domains than the nonattempters and the single attempters. The differences in QOL remained significant after adjusting for psychiatric history and current psychopathology variables, e.g., age of onset of the disorder, number and length of hospitalizations, and positive, negative, and depressive symptoms. Dissatisfaction with QOL in general and with reference to four specific domains was associated with repeated suicide attempts. Clinicians should include QOL in the evaluation of patients with schizophrenia that are suspected to be suicidal.

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toms,<sup>13</sup> medication side effects,<sup>15,16</sup> and overall duration of illness and hospitalizations.<sup>22</sup> A number of follow-up studies suggested that life is very difficult for a large number of patients with schizophrenia,<sup>23,24</sup> and they are more likely to despair about the quality of their lives,<sup>25</sup> yet few studies have explored dissatisfaction with different aspects of life as a putative factor of risk for suicidal behavior among them.

Clearly, reducing morbidity and mortality from suicidal behavior remains a clinical challenge in the care of patients with schizophrenia. Suicide risk in patients with schizophrenia is alarmingly high: between 10% and 13% of all people with this disorder die by suicide,<sup>26-29</sup> and as much as half of all patients report to have made suicide attempts at some time during the course of the disorder.<sup>30</sup> The risk factors include being male, young, and never married, being socially isolated in the community, having earlier age of onset of illness,<sup>31</sup> history of and/or current depression,<sup>32,33</sup> substance abuse,<sup>28,30</sup> prominent psychotic symptoms in the absence of negative symptoms,<sup>34,35</sup> and previous suicide attempts.<sup>36</sup> Attempted suicide is the strongest and, probably, the most universal of all known predictors of eventual suicide. Approximately 10% of persons who have been admitted to psychiatric treatment after a suicide attempt will eventually complete it<sup>37</sup>; an additional 10% to 50% will repeat their suicide attempts.<sup>38</sup>

To our knowledge, the association between life dissatisfaction and suicide has been explored in a single study showing that reduced QOL has a long-term effect on the risk of suicide in the Finnish general population.<sup>39</sup> Investigation of subjective

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QOL of persons with schizophrenia who have or have not attempted suicide would meaningfully enrich the pool of information we have on the possible factors that increase suicide risk in this disorder. It may thus have important implications for suicide prevention efforts, and target a high-risk group for therapeutic and rehabilitative interventions.

The present study explored the hypothetical association between QOL and suicidality among patients with schizophrenic disorders. With this purpose, we compared the satisfaction with QOL domains along with the psychiatric history and current levels of psychopathology between patients with schizophrenia who either never attempted suicide or had performed single or repeated suicide attempts.

## METHOD

### *Data Collection*

Data for this study came from the Sha'ar Menashe Psychiatric Hospital Longitudinal Study of Quality of Life (SMLS-QOL) of inpatients with severe mental disorders (SMD). A detailed description of the SMLS-QOL design, measures, and data collection was reported elsewhere.<sup>40</sup> In brief, data concerning all adult patients with SMD consecutively admitted to closed, open, and rehabilitation hospital units were collected by trained psychiatrists between August 1998 and August 2000. Patients were considered to have severe mental disorders if they had major mental illness and at least 2 years of major role dysfunction. The inclusion criteria were DSM-IV criteria for schizophrenia, schizoaffective, and mood disorders, age 18 to 65, inpatient status, and the ability to provide written informed consent.

### *Patients*

For this study, we used only data on inpatients with schizophrenic disorders ( $N = 227$ ) extracting from the SMLS-QOL database. There were 72.7% patients with a paranoid subtype, 15.4% with a residual subtype, 6.6% with an undifferentiated subtype, and 5.3% with a disorganized subtype. A total of 181 patients were men (79.7%) and 141 were single (62.1%). The mean age at examination was 37.9 years ( $SD 9.8$ ). The mean duration of the disorder was 14.3 years ( $SD 9.5$ ), and the mean duration of the current hospitalization was 22.2 months ( $SD 47.9$ ). For the entire sample, the mean total score on the Positive and Negative Syndrome Scale (PANSS)<sup>41</sup> was 84.5 ( $SD 19.5$ ). The partial mean scores were: Positive Symptoms Scale, 17.5 ( $SD 5.9$ ); Negative Symptoms Scale, 24.8 ( $SD 6.9$ ); and General Psychopathology Scale, 42.1 ( $SD 10.5$ ). The mean total score on the Montgomery and Åsberg Depression Rating Scale (MADRS)<sup>42</sup> was 7.4 ( $SD 8.4$ ).

Attempted suicide was defined according to the clinical judgment of the psychiatrist at admission and reflected purposely inflicted self-harm with intent to die. All patients were assigned to one of three groups based on the presence and number of

suicide attempts: 124 patients, or 55% of the sample, had never attempted suicide (nonattempters, or NA); 75, or 33%, had had one suicide episode (single attempters, or SA); and 28, or 12%, had had two or more lifetime suicidal episodes (multiple attempters, or MA). The mean number of suicide attempts was 3.4 ( $SD 3.7$ ; range, 1 to 20 attempts). The methods used in the 103 most recent suicide attempts included drug overdose,  $n = 35$ ; hanging,  $n = 20$ ; cutting or stabbing,  $n = 15$ ; jumping from heights,  $n = 12$ ; and intentional self-harm by other means,  $n = 20$ . Most suicide attempts, 87%, were made during the preceding 5 years, with the most recent attempts during the year prior to the survey. The three groups did not significantly differ in terms of age at examination, gender ( $\chi^2 = 0.14$ ,  $df = 2$ ,  $P = .93$ ), and marital status ( $\chi^2 = 5.9$ ,  $df = 8$ ,  $P = .66$ ).

### *Measures*

Life satisfaction was assessed using the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)<sup>43</sup> selected from a variety of available QOL measures as a valid and reliable instrument that was developed for assessment of subjects with a variety of mental and medical disorders. This instrument had been successfully used with different categories of psychiatric patients, including outpatients and inpatients with schizophrenic, schizoaffective, and mood disorders.<sup>32,40,44</sup> It is a 99-item self-report instrument consisting of eight summary scales covering the domains of physical health (13 items), subjective feelings (14 items), leisure time activities (6 items), social relationships (11 items), general activities (14 items), household duties (10 items), school courses/work (23 items), and satisfaction with medication (1 item). Each of the 99 items is scored on a 5-point scale ("not at all or never" to "frequently or all the time") that indicates the degree of enjoyment and satisfaction achieved during the past week with regard to the particular activity or feeling described in the item. After the exclusion of the items on the household duties and school courses/work subscales, as irrelevant for our inpatients, the QOL Index (QOLI, an average of the seven remaining summary scales' scores) and each of the remaining summary subscales had excellent internal consistency reliability (Cronbach's  $\alpha$  ranged from 0.85 to 0.95). In the present sample, the QOLI score was 3.4 ( $SD 0.8$ ).

As noted, current levels of positive, negative, and general psychopathological symptoms of the study participants were assessed with the PANSS and of depressive symptoms with the MADRS. The inter-rater reliability scores, as measured by interclass coefficients, were 0.87 for the PANSS and 0.78 for the MADRS total scores.

In addition, details of psychiatric history, previous suicidal behavior, number and duration of psychiatric admissions, and basic demographic information were extracted from the patients' files.

### *Statistical Analysis*

All analyses were performed using the Number Cruncher Statistical System (NCSS-2000; NCSS Statistical Software, Kaysville, UT). Global group differences in continuous parameters were analyzed by one-way analysis of variance (ANOVA) comparing groups of patients with NA, SA, and MA. For single comparisons between groups, paired  $t$  tests or Wilcoxon rank-sum tests (when distributions were skewed) were used in case

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