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Childhood trauma, depression and negative symptoms are independently associated with impaired quality of life in schizophrenia. Results from the national FACE-SZ cohort

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ABSTRACT

Objectives: Depression and negative symptoms have been associated with impaired Quality of life (QoL) in schizophrenia (SZ). However, childhood trauma may influence both QoL and depression in SZ patients, with consequences for the management of impaired QoL in SZ patients. The aim of the present study was to determine if childhood trauma was associated with impaired QoL in schizophrenia.
Method: A sample of 544 community-dwelling stabilized SZ patients enrolled in FACE-SZ cohort were utilized in this study (74.1% males, mean aged 32.3 years, mean illness duration 10.6 years). QoL was self-reported with the S-QoL18 questionnaire. Childhood trauma was self-reported with the Childhood Trauma Questionnaire. Depression was measured by the Calgary Depression Rating Scale for Schizophrenia. Psychotic severity was measured by the Positive and Negative Syndrome Scale for Schizophrenia (PANSS). Other clinical factors, treatments, comorbidities, functioning and sociodemographical variables were also recorded, with validated scales.
Results: Overall, 151 participants (27.8%) had a current major depressive episode and 406 (82.5%) reported at least one episode of historical childhood trauma. In multivariate analyses, lower QoL total score was associated with a history of childhood trauma ($\beta = -0.21$, $p < 0.0001$), psychotic negative symptoms ($\beta = -0.11$, $p = 0.04$), current depression ($\beta = -0.0.38$, $p < 0.0001$) and male gender ($\beta = -0.16$, $p < 0.0001$).
Conclusion: Impaired QoL is independently associated with negative symptoms, depression and childhood trauma in schizophrenia.

1. Introduction

In 1948 the World Health Organization (WHO) defined health as not only the absence of disease, but also the presence of physical, mental and social well being (WHO, 1948). Subsequently, most branches of medicine began systematically assessing patients' subjective views of illness and symptoms, leading to the emergence of the construct of quality of life (QoL) as a promising clinical domain (Testa and Simonson, 1996). While there is still debate as to the definition of this construct and what it encompasses (Awad and Voruganti, 2012), indicators of QoL routinely include satisfaction with life/happiness (SWL), subjective evaluations of specific living conditions and objective assessments of functioning (Gladis et al., 1999).

QoL measurements are now an important aspect of the evaluation of the treatments and care provided to patients with schizophrenia (SZ) (Boyer et al., 2013a). QoL encompasses several important dimensions for patients and their families, such as psychological status, functional abilities, personal well-being, social interaction, economic status, vocational status, and physical health (Cramer et al., 2000). The use of QoL measures may provide information to clinicians regarding the general health status of their patients that might otherwise go unrecognized, thereby improving patient satisfaction and health outcomes (Boyer et al., 2013b). The knowledge of the factors that are determinants of QoL in SZ patients may assist clinicians in tailoring the most appropriate and effective interventions. However, the determinants of QoL remain poorly understood in this population.

Over recent decades, numerous studies have investigated the utility of psychotic symptoms, depression and functioning as predictors of QoL (Boyer et al., 2012; Fervaha et al., 2013; Meesters et al., 2013). Despite conflicting results due to the heterogeneity of study designs, selected characteristics, the sample examined, and the manner in which QoL has been defined and measured, general trends have emerged. A meta-analysis revealed that the strongest association was found between QoL and depression, outweighing the QoL effects of psychotic symptoms (Eack and Newhill, 2007) However, measures of functioning have been only moderately associated with QoL (Auquier et al., 2013). Importantly, six clinical predictors (including depression), explained only 20% of the QoL variance in a recent study (Fervaha et al., 2013), underscoring the need to better identify other factors that more adequately describe QoL in SZ patients.

Childhood maltreatment is a strong independent risk factor for suicidal attempts in SZ (Hassan et al., 2016), possibly aggravated by the development of depressive symptoms and feeling of hopelessness in adult life. From a biological point of view, history of childhood neglect has been found to predict disorganization in schizophrenia through grey matter decrease in dorsolateral cortex (Cancel et al., 2015). SZ patients with a history of childhood trauma may benefit from specific targeted therapies, such as cognitive behavioral therapy, which is commonly used in the management of SZ, although not always with significant efficacy in the treatment of trauma in SZ (Steel et al., 2016). It may therefore be hypothesized that history of childhood trauma may directly impact the QoL of patients with SZ. However, the association between childhood trauma and QoL in adults with SZ has not been explored to date.

The aims of the present study were (i) to determine the prevalence of a history of childhood trauma in a large non-selected multicentric sample of community-dwelling SZ patients (ii) to determine whether a history of childhood trauma was associated with impaired QoL and/or depression in adult SZ.

2. Materials and methods

2.1. Design

The FACE-SZ (FondaMental Academic Centers of Expertise for Schizophrenia) cohort is based on a French national network of 10 Schizophrenia Expert Centers (Bordeaux, Clermont-Ferrand, Colombes, Créteil, Grenoble, Lyon, Marseille, Montpellier, Strasbourg, Versailles), set up by a French scientific cooperation foundation, FondaMental Foundation (www.fondation-fondamental.org) and created by the French Ministry of Research in order to build a platform that links systematic clinical assessment to research (Schürhoff et al., 2015).

Inclusion criteria: Consecutive, clinically stable patients (defined by no hospitalization and no treatment changes during the 4 weeks before evaluation) with a DSM-IV-TR diagnosis of SZ or schizoaffective disorder were included in this study. Diagnosis was confirmed by two trained psychiatrists of the Schizophrenia Expert Centers Network. All patients