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Quality Of Life of Schizophrenics and Depressives In Relation To Gender and Residential Location

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ABSTRACT : *An attempt was made to study the subjective quality of life experiences of schizophrenics and depressives in eight major life areas in relation to gender and residential location and also to draw a comparative picture of subjective life experiences of schizophrenics vis-a-vis depressives. The clients approaching for psychiatric care in the outpatient department of the SCB Medical College, in Cuttack, Odisha, and diagnosed as either schizophrenics or depressives by a psychiatrist, were administered the Lehman Quality of Life Interview (QOLI). The sample consisted of 60 schizophrenics and 60 depressives evenly divided across gender (male and female) and residential location (urban and rural). The design was a 2 (schizophrenics and depressives) X 2 (male and female) X 2 (urban and rural) design with 15 subjects per cell. Subjects were individually administered the Lehman QOLI in the presence of one of their family members, who also provided substantial information about the patients. The results of ANOVA performed on the scores in major life areas revealed significant main effect of 'type of disorder', while the 'gender' influence was not significant in any of the areas. The residential location differences were significant in respect of clients' experiences of living situation, family and financial support and health. While in all the life areas, the depressives felt 'most dissatisfied', the schizophrenics felt either 'unhappy' or 'terrible' pointing out that life experiences are very hard for schizophrenics as compared to depressives. The influence of gender or residential location was very minimal compared to the type of disorder the client was suffering from. Psychiatric and psychological care to schizophrenics and depressives needs to take into consideration the type of disorder, the residential location of the patients and the life areas severely affected, with minimal emphasis on the gender of the patients.*

KEY WORDS : *Depressives, Quality of Life, Schizophrenics*

I. INTRODUCTION

In the last few decades, there has been an increased interest in studying the quality of life in mental disorders in general, and particularly in schizophrenia and depression, since both are disabling disorders associated with severe social and occupational dysfunction. Quality of life (QOL) may be defined as a person's sense of wellbeing and satisfaction with his/her life circumstances as well as a person's health status and access to resources and opportunities **(Lehman, 1997).** The World Health Organization defines quality of life as "individuals' perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns" **(WHOQOL, 1995).** A person's mental health depends on his/her quality of life. There are several factors in quality of life, such as financial, social, living situation, family relations, leisure activities, safety and legal problems, health, religion neighbourhood etc. Disturbances in any of the components of quality of life may affect mental health of a person. Why a person becomes mentally ill, and why a person is mentally healthy in spite of many stressful situations depends upon his/her adjustment required in response to the demands of the life situation. In quality of life research, a distinction is made between the subjective and objective quality of life experiences. Subjective quality of life experiences is about feeling good and being satisfied with things in general. Objective quality of life is about fulfilling the societal and cultural demands for material wealth, social status and physical well-being. The approach to the measurement of the quality of life derives from the position that there are a number of domains of living. Each domain contributes to one's overall assessment of the quality of life. **Gupta, Mattoo,**

Basu and Lobana (2000) found that it is possible to apply Quality of Life Scale in Indian context to study the quality of life of schizophrenics. Schizophrenia is a severe and debilitating disorder, which affects general health, autonomy, subjective well-being, and life satisfaction of those who suffer from it (**Solanki, Singh, Midha & Chugh, 2008).** These disturbances have a pervasive impact on many areas of life functioning and subsequently on quality of life. The domains include family and friends, work, neighbourhood, community, health, education and spiritual. **Rao and Nagalakshmi (1987)** studied the social competence of patients with schizophrenia. A qualitative analysis showed that those with schizophrenia were non-assertive, unable to make and keep friends and take decisions.

The group also lacked tact, poise and spontaneity in narrating personal experiences. Patients with schizophrenia living with their families often disrupted the daily routine of other members **(Rao, Barnabas & Gopinath, 1988).**In spite of differences in the methodology applied, various studies concerning the quality of life of schizophrenic patients have documented that QOL in schizophrenics is worse than that of the general population and that of other physically ill patients and that the longer the length of illness, the worse the quality of life. Young people, women, married persons, and those with a low level of education report a better quality of life. Psychopathology, especially negative and depressive syndromes, correlates negatively with quality of life. Patients integrated in community support programs demonstrate a better quality of life than those who are institutionalized. **Murali, Chaturvedi and Gopinath (1995)** observed that QOL is better in patients who are occupied and literate. While background and marital status was not related to QOL, they found that QOL was better in families with low levels of distress. Recently a systematic meta-analysis reported higher incidence of schizophrenia in men versus women (**Aleman, Kahn & Selten, 2003**). Several recent studies have reported that being born in an urban area was associated with increasing risk of developing schizophrenia (**Pedersen & Mortensen, 2001**). An increased risk of developing schizophrenia in urban compared to rural areas has been reported by many researchers since **Faris & Dunham's (1939)** original study of inner-city Chicago.

Depression is a serious and pervasive mood disorder. It causes feelings of sadness, hopelessness, helplessness, and worthlessness. Depression can be mild to moderate with symptoms of apathy, little appetite, difficulty in sleeping, low self-esteem, and low-grade fatigue. Or it can be more severe. **Rapaport, Clary, Fayyad and Endicott (2005)** have shown that subjects with depression who enter clinical trials have significant quality-of-life impairment, although the degree of dysfunction varies. Diagnostic-specific symptom measures explained only a small proportion of the variance in quality of life, suggesting that an individual's perception of quality of life is an additional factor that should be part of a complete assessment. Although, shortly after discharge, quality of life of patients, whose depression remitted, was better than that of patients with persisting depression; it was still slightly worse than that of the general population.

Depression is more common in women than in men. **Jaiprakash and Murthy (1997)** considered health status, education, life style, family relationship and social class, as some of the major affecting factors in the lives of women. Depression and hopelessness were associated with a poorer present QOL and also had an influence on the future QOL. Poor perception of quality of life is often seen as a consequence of depression while at the same time, poor QOL may also be a precursor to depression. The reduction in quality of life associated with symptoms of depression is comparable to that observed with chronically physically ill patients. In terms of socio-demographic variables, studies have shown that depression is more common in women **(Sethi & Prakash, 1979**), in younger subjects, **(Ponnudurai, 1996),** in subjects from poor economic background and in divorced and widowed **(Poongothai, Pradeepa, Ganesan & Mohan, 2009),** in subjects with poor nutritional status **(Mohandas, 2009),** and in those residing in nuclear families and urban areas **(Reddy & Chandrasekhar, 1998).**

The present study seeks to ascertain the subjective quality of life experiences of schizophrenics and depressives in urban and rural locations in the State of Odisha, India.

Objectives of the Study

[1] To study the subjective quality of life experiences of schizophrenics and depressives in eight major life areas in relation to gender and residential location.
[2] To draw a comparative picture of subjective life experiences of schizophrenics *vis-a-vis* depressives with reference to each of the eight different life areas.

II. METHODOLOGY

Sample

The sample consisted of 60 schizophrenics and 60 depressives drawn equally from the male and female groups and urban and rural residential locations. The eight resultant groups were: (i) rural male schizophrenics, (ii) rural female schizophrenics, (iii) urban male schizophrenics, (iv) urban female schizophrenics, (v) rural male depressives, (vi) rural female depressives, (vii) urban male depressives, and (viii) urban female depressives. There were 15 subjects in each group. Subjects were taken from the outpatient department of SCB Medical College, Cuttack, Odisha and were included in the sample after being diagnosed by a psychiatrist using a Brief Psychiatric rating Scale (BRPS) for schizophrenics and MADRS for depressive patients. All subjects belonged to the age group of 20-50 years.

Tool : The Quality of Life Interview (QOLI) **(Lehman, 1988)** was used to collect information on the respondents' quality of life. It is a structured self-report interview designed to be administered by a trained non-clinical interviewer. Lehman reports that test-retest reliability coefficients after three months are between 0.68 to 0.85 with an internal consistency of 0.95. The QOLI was developed specifically for persons suffering from severe forms of mental illness. It makes provision for measuring quality of life in eight major areas: general life satisfaction, living situation, daily activities, family, social relations, finance, safety and health. The QOLI assesses the life circumstances of persons with severe forms of mental illness in terms of what they actually do and experience (objective quality of life) and their feelings about these experiences (subjective quality of life or satisfaction). In the present study, the subjective quality of life was taken into account. The subjective quality of life indicators include individual items on the respondent's subjective reactions towards the objective indicators. These items are scored on fixed interval 7-point scales ranging from 1 (terrible) to 7 (delighted). A chart with seven different images from feeling 'terrible' to 'delighted' was also used whenever the respondents had problems comprehending the response categories. This test was administered individually.

III. RESULTS AND DISCUSSION

The mean scores of schizophrenics and depressives in eight major life areas are presented in Table 1 and the *F* values showing the main effects of gender, residential location and type of disorder and their interactions are presented in Table 2. There are varying numbers of items in each category of life areas. The mean is obtained by dividing the sum in each category by the number of items. Hence, the maximum possible score in each life area is 7. The mean scores are plotted in Figure 1 for easy visual inspection. The lower the mean, the patient feels more and more unhappy/ terrible; the higher the mean, the patient feels more and more pleased /delighted. Since the main effect of the type of disorder was significant for each of the life areas, the means of the schizophrenics and depressives combining gender and residential location are given in Table 3.

Table 1 - Means of Schizophrenics and Depressives on Various Dimensions of Quality of Life in relation to Gender and Residential Location

Gender	Group	a. General Life Satisfaction			b. Satisfaction with Living Situation			c. Satisfaction with Daily Activities		
		Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Male	Schizophrenia	1.40	1.93	1.67	1.90	2.49	2.19	1.31	1.50	1.40
	Depressive	2.10	2.13	2.12	2.58	3.35	2.96	2.28	2.11	2.19
	Total	1.75	2.03	1.89	2.24	2.92	2.58	1.79	1.80	1.80
Female	Schizophrenia	1.57	1.67	1.62	2.04	2.17	2.11	1.81	1.50	1.65
	Depressive	1.70	2.03	1.87	2.20	3.05	2.63	1.76	2.30	2.03
	Total	1.63	1.85	1.74	2.12	2.61	2.37	1.79	1.90	1.84

Gender	Group	d. Satisfaction with Family			e. Satisfaction with Social Relations			f. Financial Satisfaction		
		Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Male	Schizophrenia	1.90	2.28	2.09	1.77	1.85	1.81	2.00	3.37	2.68
	Depressive	2.55	3.42	2.98	2.50	2.21	2.35	2.18	3.32	2.75
	Total	2.23	2.85	2.54	2.14	2.03	2.08	2.09	3.34	2.72
Female	Schizophrenia	2.30	2.42	2.36	1.45	1.36	1.41	1.57	2.33	1.95
	Depressive	2.32	3.23	2.78	1.99	2.62	2.30	3.32	4.38	3.85
	Total	2.31	2.83	2.57	1.72	1.99	1.86	2.44	3.36	2.90

Gender	Group	g. Satisfaction with safety issues			h. Satisfaction with one's health		
		Rural	Urban	Total	Rural	Urban	Total
Male	Schizophrenia	1.56	1.83	1.69	2.41	2.82	2.61
	Depressive	3.76	3.91	3.83	3.19	3.23	3.21
	Total	2.66	2.87	2.76	2.80	3.02	2.91
Female	Schizophrenia	1.80	1.59	1.67	2.11	2.54	2.33
	Depressive	3.53	3.60	3.57	2.68	3.43	3.05
	Total	2.67	2.60	2.67	2.39	2.99	2.69

The *F* values obtained from ANOVA suggest that the main effects of type of disorder were significant for all the eight major life areas, while the gender difference was not significant for any of the life areas. The main effects of residential location were significant for four of the eight life areas: clients' satisfaction with living situation, family, finance and health. None of the second order interactions was significant except the interaction of gender with type of disorder for life aspects dealing with finance. It was only in the life area of daily activities that the third order interaction was significant.

Table 2 - 'F' Statistics showing the Effects of Gender, Residential Location and Type of Disorder on Various Dimensions of Quality of Life

	df	General Life	Living Situation	Daily Activities	Family	Social Relations	Finance	Safety	Health
Gender (A)	1	1.10	0.78	0.09	0.01	2.16	0.30	0.40	1.92
Residential Location (B)	1	3.05	6.05**	0.16	4.85*	0.28	10.33**	0.11	6.43**
Type of Disorder (C)	1	3.92*	7.29**	15.18**	6.37**	20.96**	8.52**	92.17**	16.87**
A X B	1	0.05	0.16	0.12	0.04	1.45	0.258	0.44	1.32
A X C	1	1.36	0.29	1.89	0.84	1.28	7.39**	0.42	0.16
B X C	1	.00	0.91	0.67	1.53	.32	0.01	0.03	0.01
A X B X C	1	3.05	0.32	4.01*	0.09	3.01	0.16	0.22	1.16

$*p < .05$; $**p < .01$

Gender does not play an influential role in having the subjective experiences of satisfaction in different areas of life; males and females rate their satisfaction almost equally. The residential location does not make a difference in all life areas; dissatisfaction with living situation, family support, finance and health are the areas where urban or rural living makes a difference. Those living in urban areas had less poor quality of life compared to those living in rural areas. Compared to urban regions, in rural locations, the patients' living conditions were not good; their perception of family support was less favourable; they received less financial support to deal with their basic necessities; and their physical and emotional health was less proper. A few earlier studies conducted on the western population **(Pedersen and Mortensen, 2001)** showed that being born in urban regions increases the risk of schizophrenia. This may be true for the western culture where the urban-rural difference in basic physical facilities is minimal with urban living bringing more stress. In Indian culture, people living in rural areas are poorer and many fail to afford the basic necessities of life. **Murali, Chaturvedi and Gopinath (1995)** also pointed out that QOL is better in Indian patients who are occupied and literate. Urban people are more occupied and literate. The findings of this study do not support findings obtained in western culture by **(Pedersen and Mortensen (2001)**. The finding points out that besides the potential factor of residential location, culture plays an influential and interactive role in determining the nature and degree of differences in the quality of life of the psychiatrically ill. In each of the life areas, the subjective experience of dissatisfaction was noticed less with the depressives than the schizophrenics. While in many life areas, depressives felt mostly dissatisfied, the schizophrenics felt very unhappy or terrible (Table 3 & Figure 2). Schizophrenia is a more severe and debilitating disorder compared to depression and affects general health, functioning, autonomy, subjective well-being. It is, therefore, expected that the quality of life would be less satisfactory for schizophrenics. Most of the schizophrenics felt 'unhappy' or 'terrible'. The differences were more marked pertaining to subjective rating of satisfaction with general life situations, social relations, financial support and safety considerations. Compared to depressives, schizophrenics were more dissatisfied when it came to interacting with people or receiving support for taking care of the basic necessities of life.

Table 3 - Means of Schizophrenics and Depressives in respect of Subjective Feeling of Satisfaction in Major Life areas

Type of Disorder	General Life	Living Situation	Daily Activities	Family	Social relations	Finance	Safety	Health
Schizophrenics	1.68	2.14	1.53	2.23	1.61	2.31	1.69	2.47
Depressives	1.96	2.79	2.11	2.88	2.33	3.30	3.70	3.13

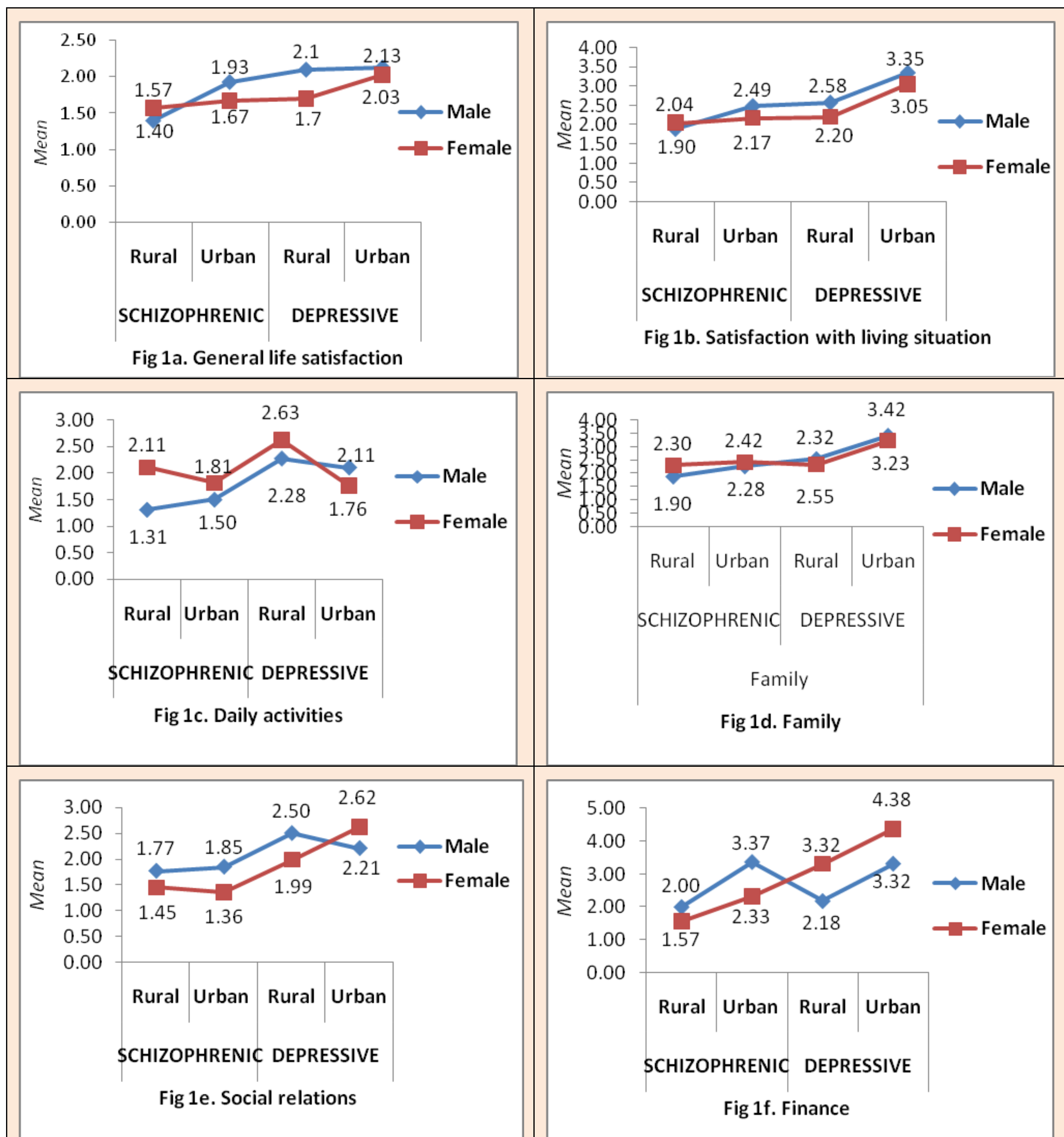

Fig 1a. General life satisfaction

Fig 1b. Satisfaction with living situation

Fig 1c. Daily activities

Fig 1d. Family

Fig 1e. Social relations

Fig 1f. Finance

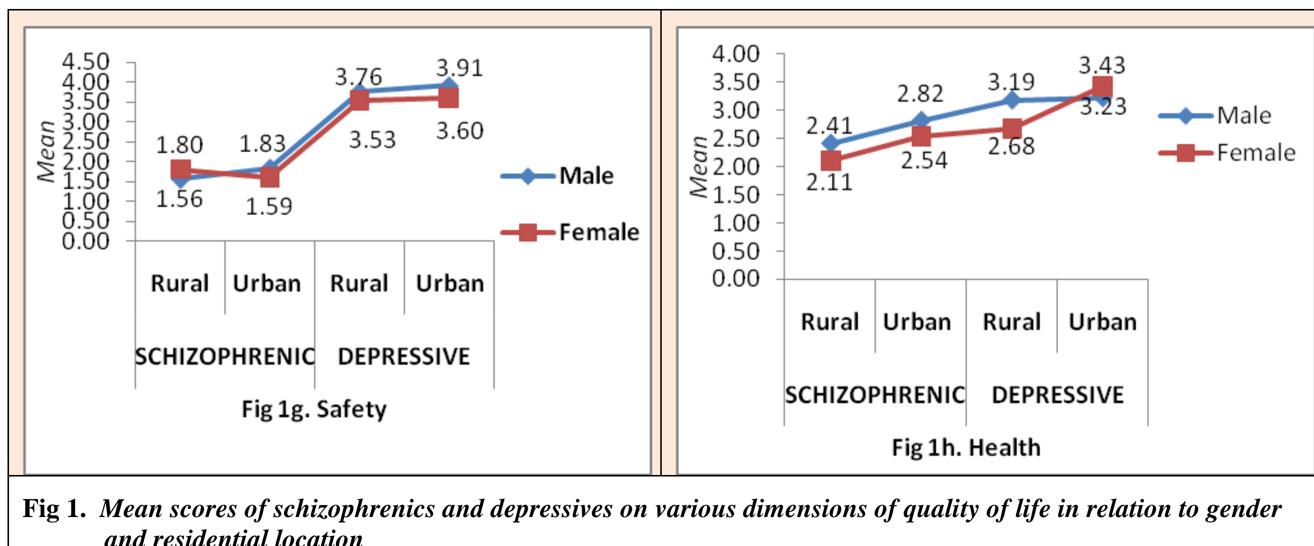

Fig 1. ***Mean scores of schizophrenics and depressives on various dimensions of quality of life in relation to gender and residential location***

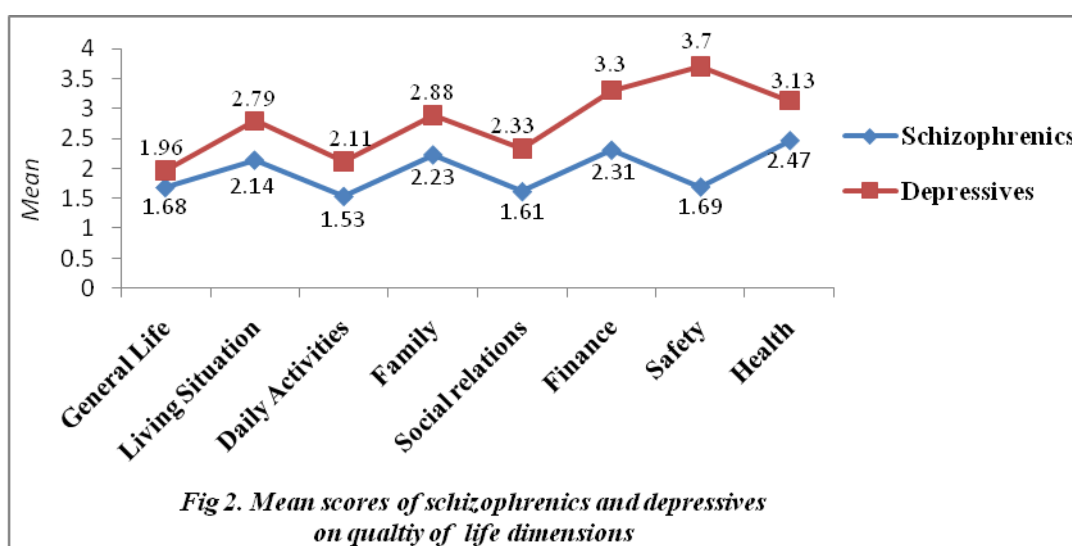

Fig 2. Mean scores of schizophrenics and depressives on qualtiy of life dimensions

Studies have shown that depression is more common in women **(Sethi & Prakash, 1979)**, in younger subjects, **(Ponnudurai, 1996),** in subjects from poor economic background and in divorced and widowed **(Poongothai, Pradeepa, Ganesan & Mohan, 2009),** and in those residing in nuclear families and urban areas **(Reddy & Chandrasekhar, 1998).** While among the females, the financial dissatisfaction was noticed less with depressives than with schizophrenics; the same was not true for females. The males experienced almost similar level of financial dissatisfaction irrespective of whether they were schizophrenics or depressives. While among schizophrenics, females experienced less dissatisfaction compared to males, among the depressives, the trend was not the same. The depressive females were less dissatisfied in the rural location and more dissatisfied in the urban location thus giving rise to a significant third order interaction of gender, residential location and type of disorder.

IV. CONCLUSION

There were noticeable differences in all the components of quality of life of schizophrenics and depressives. The subjective ratings by both the groups revealed that depressives felt 'mostly dissatisfied', while schizophrenics felt very 'unhappy' or 'terrible'. Compared to the depressives, schizophrenics felt more dissatisfied in areas of quality of life pertaining to social relations, financial support and physical safety measures. The urban-rural differences were noticed in favour of those living in urban regions, particularly in areas pertaining to living situation, family support, financial support and health issues. Gender differences were not significant suggesting that males and females perceived their life experiences in each of eight components of quality of life almost the same way.

The implication is that the psychiatric and psychological care to schizophrenics and depressives needs to take into consideration the type of disorder, the residential location of the patients and the life areas severely affected with minimal emphasis on the gender of the patients.

REFERENCES

[1] **Lehman, A. F. (1997)** Instruments for measuring quality of life in mental illnesses. In Katschnig, H., Freeman, H., & Sartorius, N. Edition, *Quality of Life in Mental Disorders*. New York: Wiley, 79-94.

[2] **WHOQOL. (1995)** The World Health Organization Quality of Life Assessment (the WHOQOL): position paper from the World Health Organisation. *Social Science Medicine, 4*: 1403–1409.

[3] **Gupta, N., Mattoo, S. K., Basu, D. & Lobana, A. (2000)** Psychometric properties of quality of life (QLS) scale – a brief report from India. *Indian Journal of Psychiatry, 42* (4), 415-420.

[4] **Solanki, R. K., Singh, P., Midha, A. & Chugh, K. (2008)** Schizophrenia: impact on quality of life. *Indian Journal of Psychiatry,* 50 (3), 181–186.

[5] **Rao, S. & Nagalakshmi, S. (1987)** Social competence in schizophrenics, neurotic depressives and normals. *Indian Journal of Psychiatry, 29*, 367–72.

[6] **Rao, K., Barnabas, I. P., Gopinath, P. S. (1988)** Family burden in chronic schizophrenia. *Indian Journal of Psychological Medicine, 10*, 131–5.

[7] **Murali, T., Chaturvedi, S. K. & Gopinath, P. S. (1995)** *Quality of life in chronic schizophrenics-I.* Paper presented at the Richmond Fellowship Asia Pacific Forum International Symposium on "Innovation in Psychiatric Rehabilitation", November, Bangalore, India.

[8] **Aleman, A., Kahn, R. S. & Selten, J. P. (2003)** Sex differences in the risk of schizophrenia: its relationship to place of birth. *Archives of General Psychiatry, 60,* 565-571.

[9] **Pedersen, C. B. & Mortensen, P. B. (2001)** Evidence of dose-response relationship between urbanicity during upbringing and schizophrenia risk. *Archives of General Psychiatry, 58,* 1039-1046.

[10] **Faris, R. & Dunham, H. (1939)** *Mental disorders in urban areas. Chicago, IL*: University of Chicago Press.

[11] **Rapaport, M. H., Clary, C., Fayyad, R. & Endicott, J. (2005)** Quality of life impairment in depressive and anxiety disorders. *American Journal of Psychiatry, 162* (6), 1171-8.

[12] **Jaiprakash, I. & Murthy, V. N. (1997)** Psychiatric morbidity and menopause. *Indian Journal of Psychiatry*, *23*, 242-246.

[13] **Sethi, B. B. & Prakash, R. (1979)** Depression in Industrial population. *Indian Journal of Psychiatry, 21*, 359-61.

[14] **Ponnudurai, R. (1996)** Suicide in India. *Indian Journal of Psychological Medicine, 19*, 19-25.

[15] **Poongothai, S., Pradeepa, R., Ganesan, A. & Mohan, V. (2009)** Prevalence of depression in a large urban South Indian population - The Chennai Urban Rural Epidemiology Study (CURES-70). PloS One, 4: E7185.

[16] **Mohandas, E. (2009)** Roadmap to Indian Psychiatry. *Indian Journal of Psychiatry, 51*, 173-179.

[17] **Reddy, M. V. & Chandrashekhar, C. R. (1998)** Prevalence of mental and behavioural disorders in India: a meta-analysis. *Indian Journal of Psychiatry, 40*, 149-57.

[18] **Lehman, A. F. (1988)** The quality of life interview for the chronically mentally ill. *Evaluation and Program Planning*, *11*: 51-62.