

Original article

Social disability in different mental disorders

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Abstract

Objective. — To assess the social disability of people with different psychiatric disorders.

Methods. — Cross-site survey in five psychiatric hospitals (Dresden, Wrocław, London, Michalovce and Prague). Working-aged patients diagnosed (ICD-10) with schizophrenia and related disorders (F2), affective disorders (F3), anxiety disorders (F4), eating disorders (F5) and personality disorders (F6), were assessed at admission ($n = 969$) and 3 months after discharge ($n = 753$) using the Brief Psychiatric Rating Scale and the Groningen Social Disability Schedule. The main outcome measure was Interviewer-rated social disability.

Results. — During acute episodes patients with personality, eating and schizophrenic disorders functioned less effectively than those with affective or anxiety disorders. After controlling for age and severity of psychopathology, there was no significant effect of the diagnosis (during remission), sex, education and history of disorder on disability. Site, employment and partnership were significant factors for the level of social disability in both measure points.

Conclusion. — Severity of psychopathological symptoms, not the diagnosis of a mental disorder, was the most significant factor in determining the level of social functioning, particularly during the remission period. Site, employment and partnership appeared as significant factors influencing the level of social disability.

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1. Introduction

Interest in problems related to the social disability of people with mental disorders is increasing. Such problems have often been considered in the literature: related to the disability of people with schizophrenia [3], depressive disorders [5], anxiety and depressive disorders [12]. However, the issue has rarely been studied in the case of persons with eating disorders [2] and personality disorders [14]. Studies have been

carried out amongst various groups: patients of general hospitals with depressive disorders [1] and patients of health care services [11], as well as the general population of a country [9,14]. The World Health Organization (WHO) has carried out studies on the most commonly occurring psychiatric disorders in patients of health care services [12]. The large scale International Study of Schizophrenia (ISoS) was carried out in 18 centers in 14 countries [22]. Cultural differences in the frequency of disorders and their course were assessed. However, no study has yet focused on an international comparison of the social disability of persons with psychiatric disorders, or aimed at comparing types of disorders at different stages of severity. The aim of this study was to assess the social disability

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of people with different, serious psychiatric disorders and to evaluate the effect of sociodemographic and clinical variables on the level of disability at two different time points.

2. Subjects and methods

The study was based on data from the *European Day Hospital Evaluation* (EDEN) study [6,7], which was carried out in five European centers: the Department of Psychiatry and Psychotherapy of Dresden University of Technology, the Department of Psychiatry at Wrocław Medical University, the Unit for Social and Community Psychiatry, Newham Centre for Mental Health, London, the psychiatric hospital in Michałovce and the Psychiatry Department at Charles University, Prague. Objectives and methods of the EDEN study were presented elsewhere [6,7].

Working-aged (18–65 years) persons admitted voluntarily to psychiatric hospitals, who agreed to take part and were not excluded due to addictions, serious somatic diseases, dementia were assessed in accordance with the EDEN protocol [6]. Participants with a psychiatric disorder of diagnostic class F2, F3, F4, F5 and F6 (according to the ICD-10) were assessed just after the admission into hospital (time 1, $n = 969$) and 3 months after discharge (time 2, $n = 753$). The mean age of the whole sample was 38.9 (SD = 12.0). The majority of participants were female (60.9%). The patients had on average 12.3 years of education (SD = 2.8). 35.7% of the study group lived in a permanent relationship. Less than a third (31.3%) were professionally active. After 3 months the mean age of the sample was 39.5 years (SD = 12.1) with the majority being women (63.1%) (see Table 1).

In the F2 diagnostic group a clear majority of patients had schizophrenia or schizoaffective disorders (56.6% and 26.7%, respectively). Among those with affective disorders (group F3), the most common diagnoses were depressive episodes (42.6%), recurrent depressive disorders (35.7%) and bipolar affective disorders (16%). In the group of patients with neurotic, stress-related and somatoform disorders (group F4), the most common diagnoses were anxiety disorders (30.1%), acute stress reaction and adjustment disorders (29.6%), phobias (12.1%) and obsessive-compulsive disorders (10.7%). The final group, which was inhomogeneous with respect to diagnostic group (F5 + F6, $n = 118$), consisted of patients with personality disorders—F6 (75.4%, of these 86.5% were emotionally unstable; the rest had mixed personality disorders) or eating disorders—F5 (24.6%).

2.1. Instruments

The Client Sociodemographic and Clinical History Inventory (CSCHI) [6], the expanded version 4.0 of the Brief Psychiatric Rating Scale, (BPRS) [20] and the Groningen Social Disability Schedule (GSDS-II) [21] were used.

The 24-item Brief Psychiatric Rating Scale allows for the evaluation of the severity of psychopathological symptoms ranged from ‘1’ (“not present”) to ‘7’ (“extremely severe”). The intra-class correlation coefficient was good (ICC = 0.78) [16].

GSDS-II is a semi-structured interview for assessing the functioning of a person in eight social roles over the previous month (in this study evaluating a month before hospitalization and the third month after discharge). Within the GSDS-II, a social role is defined as a complex of norms and expectations

Table 1
Characteristics of the sample within diagnostic groups

	F2 $n = 258$	F3 $n = 387$	F4 $n = 206$	F5 + F6 $n = 118$
Age (years, SD)	36.7 (11.3)	42.2 (11.4)	39.9 (11.8)	31.2 (11.1)
Gender (% females)	49.6	65.9	66.5	59.3
Education (years, SD)	12.38 (2.7)	12.44 (3.0)	11.75 (2.5)	12.26 (2.7)
Family status (%)				
Married	24.4	46.1	41	18.1
Single	21.7	18.9	15.6	19
Lived with family	53.9	35	43.4	62.9
Professional status (%)				
Working	16	33.4	41.5	40.2
Other activity (e.g. students)	10.5	15.9	13.7	20.5
Unemployed	25	29.5	30.7	31.6
Disability pensioned	48.4	21.1	14.1	7.7
Center (%)				
Wrocław	36.8	23.8	16.5	5.1
Dresden	10.9	24.0	18.0	25.4
London	19.8	22.0	11.2	18.6
Michałovce	22.9	11.1	28.6	19.5
Prague	9.7	19.1	25.7	31.4
BPRS scores				
Before hospitalization, Mean (SD)	2.12 (0.49)	1.99 (0.39)	1.82 (0.36)	1.95 (0.41)
3rd month after hospitalization, Mean (SD)	1.68 (0.5)	1.51 (0.39)	1.56 (0.39)	1.67 (0.45)
GSDS scores				
Before hospitalization, Mean (SD)	1.37 (0.58)	1.20 (0.49)	1.09 (0.55)	1.35 (0.60)
3rd month after hospitalization, Mean (SD)	0.95 (0.57)	0.79 (0.59)	0.75 (0.54)	1.02 (0.61)

prevailing within the so-called relevant reference group which comprises people who in social or other respect are of great importance to the individual. The assessment is carried out by giving ratings for each of the eight roles (the Overall Role Ratings), and for each of the dimensions of the role (the Dimensional Ratings). The rating scale self ranges from '0' ("no disability") to '3' ("severe disability"). Further guidelines for making ratings for each role are given in detail in the manual of the GSDS-II. A mean score based on all eight Overall Role Ratings were analyzed. Inter-rater reliability for the GSDS-II sum score of all overall role ratings was good (ICC = 0.77) [16].

2.2. Statistical analyses

The data collected were analyzed using version 10.3.1 of Statistical Packages for the Social Sciences (SPSS). The mean GSDS scores was taken to be the dependent variable. Socio-demographic features (age, sex, education, family status, professional status, center) and clinical features (diagnostic group, the overall BPRS score, history of disorder—previously treated or not, duration of the disorder, number of previous episodes and psychiatric hospitalizations) were taken to be the explanatory variables. The Spearman rank correlation coefficient was used to assess the strength of association between GSDS scores and quantitative variables, such as age, years of education, duration of disorder. One-way analysis of variance was used to analyze the association between a quantitative variable and the overall result of GSDS. Models with interactions were not constructed due to small number of observation for some cells. In order to distinguish diagnostic groups which are uniformly affected by a given independent variable, the Scheffe test was used, together with Dunnett's test when variance depended on diagnostic group. These results were verified using the appropriate non-parametric test (the Kruskal–Wallis test). One-way and multivariate analysis of covariance was used to analyze the influence of the independent variables on the overall level of social disability taking into account the effect of two variables: the patients' age and the overall BPRS score. The choice of these two variables is justified by the significant association of the mean age and mean BPRS score with the social functioning of a patient. The post hoc multiple comparison procedure was used to verify the classification of diagnostic groups made with respect to a given variable. All statistical tests were two-tailed and used a significance level of 5%.

3. Results

3.1. Associations between the parameters analyzed

On admission to hospital no significant association between the education of a patient and the overall GSDS score was found (Rho = 0.033, $P = 0.331$ and Rho = -0.073 , $P = 0.066$ for the subsample of patients who had previously been treated in a psychiatric unit). There was a significant correlation between the overall GSDS score and age for the sample as a whole

(Rho = 0.078; $P = 0.021$). However, there was no such correlation in the subsample of patients who had been previously treated (Rho = -0.063 ; $P = 0.114$). The duration of a disorder was not correlated with the overall GSDS score for the subsample of patients who had previously been treated (Rho = 0.061; $P = 0.135$). The overall BPRS score was correlated with the overall GSDS score, both for the sample as a whole (Rho = 0.443; $P < 0.001$) and those who had been previously treated in a psychiatric unit (Rho = 0.453; $P < 0.001$).

Analysis of the data collected 3 months after discharge from hospital indicated a significant association between the overall GSDS score and both the overall BPRS score (Rho = 0.654; $P = 0.000$) and the duration of the disorder (Rho = 0.154; $P < 0.001$). Age and education were not associated with GSDS (Rho = -0.009 ; $P = 0.822$ and Rho = -0.065 ; $P = 0.091$, respectively).

Within one-way analysis of variance, it was found that there was no significant association between the mean GSDS scores and sex ($F = 3.2$; $df = 1$; $P = 0.073$ before admission to hospital and $F = 2.0$; $df = 1$; $P = 0.161$ 3 months after discharge). The other categoric variables analyzed were strongly associated with the overall GSDS score both on admission to and 3 months after discharge from hospital (see Table 2).

3.1.1. Diagnostic group

Significant differences in the overall GSDS score before admission were found between diagnostic groups F2 and F3 ($P = 0.006$), F2 and F4 ($P < 0.001$), as well as F4 and F5 + F6 ($P = 0.002$). Scheffe's test determined classes which displayed similar mean GSDS scores (the lowest scores were in groups F4 and F3, there was no significant difference between F3 and F5 + F6, F5 + F6 together with F2 had the largest scores). Three months after discharge there were significant differences between diagnostic groups F2 and F3 ($P = 0.045$), F2 and F4 ($P = 0.028$), F3 and F5 + F6 ($P = 0.022$), as well as F4 and F5 + F6 ($P = 0.013$). Again F4, F3 had the lowest GSDS scores and F2 and F5 + F6 had the highest GSDS scores.

3.1.2. Center

There were significant differences between the mean overall GSDS scores on admission in Wrocław and both

Table 2
The association between the overall GSDS score and categorical variables

Factor	At admission			3 months after discharge		
	<i>F</i>	<i>df</i>	<i>P</i>	<i>F</i>	<i>df</i>	<i>P</i>
Diagnosis	11.0	3	0.000	6.3	4	0.000
Center	6.7	4	0.000	3.6	4	0.007
Sex	3.2	1	0.073	2.0	1	0.161
Family status	10.3	2	0.000	4.3	2	0.013
Professional status	10.9	3	0.000	14.1	3	0.000
History of the disorder	11.2	2	0.000	7.4	2	0.001
No. of episodes ^a	2.1	2	0.118	7.2	3	0.000
No. of hospitalizations ^a	4.2	3	0.006	6.2	3	0.000

^a In the case of measurements made on admission only for the subsample of patients previously treated.

Michalovce ($P < 0.001$) and Prague ($P = 0.021$), and 3 months after discharge in Wrocław and Michalovce ($P = 0.017$).

3.1.3. Family situation

Significant differences in the mean overall GSDS score on admission were found between married people and both people living with their family ($P = 0.004$) and people living on their own ($P = 0.013$). Patients living on their own and living with their families had similar mean overall GSDS scores, which were higher than the mean score of married people. Three months after admission married people and people living on their own had similar mean overall GSDS scores, which were lower than the mean overall score of those living with their families, although there were no significant differences.

3.1.4. Professional status

On admission professionally active patients had a significantly lower mean overall GSDS score in comparison to both those registered as unemployed ($P < 0.001$) and those receiving disability benefits or retired ($P < 0.001$). The results for the overall GSDS scores 3 months after discharge were similar. Those professionally or otherwise active had a lower mean GSDS score than those unemployed, receiving disability benefits or retired.

3.1.5. History of disorder

Significant differences in the mean overall GSDS score were found between those who had not been previously treated in a psychiatric unit and those who had been treated earlier (a higher mean score) both before admission and 3 months after discharge ($P = 0.001$ and $P = 0.007$, respectively).

3.1.6. Number of episodes

In the subsample of patients who had been previously treated in a psychiatric unit, there was no association between the number of episodes and social functioning before admission. However, 3 months after discharge there was a significant difference between the social functioning of patients who had one previous episode and both of patients who had previously had at least five previous episodes ($P = 0.001$) and of patients for whom the number of previous episodes was not given ($P = 0.001$). Patients who had previously had at least five episodes or for whom the number of episodes was not given, had similar higher mean GSDS scores.

3.1.7. Number of hospitalizations

In the subsample of patients who had previously been treated in psychiatric units, the mean GSDS scores on admission of those patients who had been hospitalized at least four times significantly differed from the mean GSDS scores of those, for whom the number of hospitalizations was unknown ($P = 0.007$). Thus, no conclusion can be made from these results. Three months after discharge there were significant differences in the mean GSDS scores of those who had been in hospital just once and both those who had been hospitalized between two and four times ($P = 0.001$) and those who had

been hospitalized at least five times ($P = 0.006$). Patients who had been hospitalized more than once had higher mean GSDS scores.

3.2. Disability adjusted by psychopathology and age

3.2.1. At admission

The analysis taking into account the effect of age and the overall BPRS score indicated a significant association between the GSDS score and diagnostic group, center, family status, professional status, history of disorder and number of previous hospitalizations (Table 3).

There was a significant difference between the mean GSDS score in diagnostic group F4 and F5 + F6 ($P = 0.04$) (Fig. 1). Differences were also found between the social functioning of patients from Wrocław and London ($P = 0.001$), Wrocław and Michalovce ($P = 0.002$), as well as between London and Prague ($P = 0.004$) and London and Michalovce ($P = 0.012$) (Fig. 2). Married patients had a significantly lower mean GSDS score compared to those living with their family ($P = 0.004$) and those living alone ($P = 0.038$). Professionally active patients had a significantly lower mean GSDS score compared to those unemployed ($P = 0.025$) and to those on disability allowance ($P < 0.001$).

There was a significant difference between the mean GSDS scores of those who had and had not previously been treated ($P = 0.005$). Similarly, there was a significant difference between the mean GSDS scores of those who had previously been treated and of those for whom this information was not available ($P = 0.047$). Number of previous hospitalizations was associated with the overall GSDS score. However, the only significant difference was found between the group of patients who had previously been hospitalized at least four times and the group of patients for whom the number of previous hospitalizations was unknown ($P = 0.018$), which prevents any conclusions being drawn.

Regarding sex and education, no significant association was found between sex and social functioning before admission to hospital. Similarly, the level of a patient's education did not have any effect on the overall GSDS score. Also, the number of previous episodes was not significantly associated with the overall GSDS score measured on admission.

3.2.2. Three months after discharge

Three months after discharge from hospital, adjusted by age and the overall BPRS score, a significant association between the overall GSDS score and three factors were observed: study center, family status and professional status. The remaining independent variables (sex, education, diagnostic group (Fig. 1), number of previous episodes and psychiatric hospitalizations) did not have any significant effect on GSDS score.

There were significant differences between Prague and Wrocław ($P = 0.045$), Michalovce ($P < 0.001$) and Dresden ($P = 0.001$) (Fig. 2). The mean GSDS score among professionally and otherwise active patients significantly differed from the mean score of those receiving disability benefit ($P = 0.036$; $P = 0.039$, respectively). A significant association

Table 3
The association between the overall GSDS score and categorical variables adjusted by psychopathology and age in both time points with adjusted means of overall GSDS scores (95% confidence interval)

Factor	At admission	3 months after discharge
Diagnosis	$F = 3.333$; $df = 3$; $P = 0.019$	$F = 2.303$; $df = 3$; $P = 0.076$
F2	1.286 (1.221–1.351)	Not applicable
F3	1.212 (1.158–1.265)	Not applicable
F4	1.181 (1.111–1.252)	Not applicable
F5 + F6	1.346 (1.251–1.441)	Not applicable
Center	$F = 6.950$; $df = 4$; $P < 0.001$	$F = 7.215$; $df = 4$; $P < 0.001$
Wrocław	1.333 (1.268–1.398)	0.851 (0.783–0.918)
Dresden	1.221 (1.150–1.292)	0.795 (0.724–0.867)
London	1.088 (0.986–1.189)	0.835 (0.740–0.931)
Michalovce	1.150 (1.080–1.221)	0.733 (0.660–0.805)
Prague	1.315 (1.244–1.386)	0.994 (0.924–1.063)
Sex	$F = 2.168$; $df = 1$; $P = 0.141$	$F = 0.089$; $df = 1$; $P = 0.766$
Education	$F = 0.307$; $df = 2$; $P = 0.736$	$F = 2.246$; $df = 2$; $P = 0.107$
Professional status	$F = 6.168$; $df = 3$; $P < 0.001$	$F = 4.105$; $df = 3$; $P = 0.007$
Professionally active	1.148 (1.090–1.205)	0.791 (0.733–0.849)
Otherwise active	1.213 (1.127–1.299)	0.761 (0.675–0.848)
Unemployed	1.278 (1.211–1.345)	0.891 (0.822–0.959)
Pensioned	1.330 (1.266–1.394)	0.916 (0.850–0.981)
Family status	$F = 6.114$; $df = 2$; $P = 0.002$	$F = 3.613$; $df = 2$; $P = 0.027$
Living with family	1.292 (1.240–1.344)	0.879 (0.825–0.933)
Living alone	1.281 (1.200–1.363)	0.894 (0.814–0.975)
Married	1.157 (1.100–1.214)	0.782 (0.723–0.840)
History of the disorder	$F = 6.855$; $df = 2$; $P = 0.001$	Not applicable
Previously treated	1.279 (1.241–1.317)	Not applicable
Previously not treated	1.139 (1.060–1.218)	Not applicable
Lack of information	1.139 (1.032–1.246)	Not applicable
No. of episodes ^a	$F = 1.179$; $df = 2$; $P = 0.308$	$F = 1.864$; $df = 3$; $P = 0.134$
No. of hospitalizations ^a	$F = 3.223$; $df = 3$; $P = 0.022$	$F = 1.719$; $df = 3$; $P = 0.162$
0	1.318 (1.237–1.399)	Not applicable
1–3	1.297 (1.239–1.356)	Not applicable
4+	1.358 (1.274–1.442)	Not applicable
Lack of information	1.163 (1.066–1.259)	Not applicable

^a In the case of measurements made on admission only for the subsample of patients previously treated.

was found between family status and the overall GSDS score. However, pairwise comparison of the groups did not indicate any significant differences between any two categories.

4. Discussion

Many studies have highlighted the significance of the presence and severity of psychopathological symptoms in relation

to social functioning [1,5,10–12]. Wohlfarth et al. [23] found a moderate association between the severity of a psychopathology and social functioning, such that level of disability was high in the case of acute disorders and depression.

In the second stage of the analysis the effect of age and severity of symptoms was taken into account when analyzing the association between the social disability and the other factors analyzed. The differences between the diagnostic groups

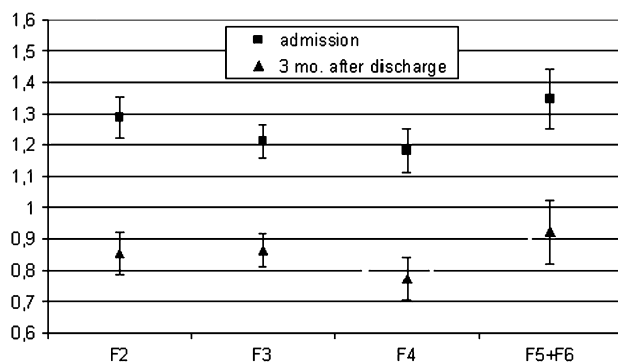


Fig. 1. Mean overall GSDS scores on admission and 3 months after discharge in the diagnostic group (95% confidence interval).

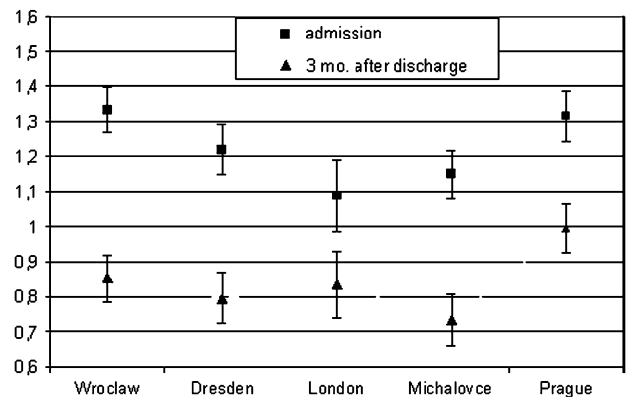


Fig. 2. Mean overall GSDS scores on admission and 3 months after discharge in the study centers (95% confidence interval).

was less apparent and referred to patients with anxiety disorders, whose level of social functioning before admission was the best, and patients having personality and eating disorders, whose level of social functioning was the worst. Three months after discharge, controlling for age and the severity of a disorder, there was no significant association between diagnosis group and social functioning. In their study carried out in Australia ($n = 980$) to assess the risk of psychosocial disability Gureje et al. [4] stated that this risk was comparable for patients with affective disorders and for those with schizophrenia. Diagnostic categories were not significantly associated with the risk of social disability. This conclusion is not unanimously supported [1,14]. They both quote the results of the Dutch NEMESIS study, as well as the Australian National Survey of Mental Health and Wellbeing, carried out on the general population. The severity of a disorder was assessed according to CIDI (mild, moderate, severe). However, a more accurate scale was not used. In the studies of Bijl and Ravelli the level of social functioning varied according to the psychiatric diagnosis—emotional disorders were associated with the lowest level of social functioning [1]. Sanderson and Andrews [14] stated that the level of functioning varied according to diagnostic group, but in a different way to the findings of Bijl and Ravelli [1]. The highest rate of social disability was associated with affective disorders (94%) and anxiety disorders (80%) in comparison to 70% of psychosis patients and 68% of personality disorders. It should be stressed that the Australian project was the only one in which patients with personality disorders took part.

It was also found that during acute episode patients from Wrocław functioned at the lowest level and 3 months after hospitalization patients from Prague functioned at the lowest level. Patients from London functioned most effectively both prior to and after hospitalization.

The WHO Collaborative Study on Psychological Problems in General Health Care carried out in the first half of the 1990s in 15 countries [12] was one of the few international studies comparing the social functioning of patients with various psychiatric disorders. The General Health Questionnaire (GHQ) was used in choosing the sample, since the initial sample was taken from the population of patients from general health care. The Composite International Diagnostic Interview (CIDI) and GSDS were used in the study itself. On the basis of the results from this study it was found that there was a significant difference in the level of professional disability of patients having affective disorders, anxiety disorders and alcoholism, from 13% in Seattle (USA) to 59% in Groningen (Holland). There were significant differences between the number of days taken in sick leave in the previous month from 1.0 day on average in Santiago (Chile) to 11.9 in Bangalore (India) and Ibadan (Nigeria). Simon et al. [18] concluded on the basis of these results that depressive disorders were associated with social disability regardless of the study center, but the level of social disability varied from center to center. Sanderson and Andrews [14] also carried out a multi-center study on the social functioning of patients. Based on a large sample of psychiatric patients ($n = 1439$) chosen from an original sample taken from the Australian population, he found that the place of residence (urban or rural) played a significant role, as

well as migration (native English speakers compared to immigrants from non-English speaking countries), in the level of social functioning. It appears that there are other significant factors apart from those that have been considered in multi-center studies on social functioning.

Controlling for age and severity of psychopathological symptoms, there is no significant association of both sex and education with social functioning either before admission or after discharge. In their comprehensive study of the Australian population Sanderson and Andrews [14] also found that that was no association between education and social functioning. Many authors have found that male psychiatric patients show a higher level of social disability than female patients [13,14,17], which is not confirmed by this study. On the basis of studies carried out in Europe and North America it was estimated that 40% of males suffering from schizophrenia show moderate or acute social disability compared with just 25% of females [17]. The proportion of schizophrenic patients showing social disability was lower in South America, India and Africa [8]. Salokangas et al. found that females suffering from schizophrenia function better than males both socially and professionally [13].

Moreover, it was found that the number of previous episodes and hospitalizations did not have a significant effect on the social functioning of patients. This seems to indicate that the severity of psychopathological symptoms is a more significant factor in determining the level of social functioning of a patient than the history of a disorder or the type of disorder.

Professional employment or other such activities (studying, running a household, voluntary work, working in sheltered employment) was associated with better social functioning, as did having a partner. Patients with a permanent partner showed a significantly higher level of social functioning than people living on their own, or with their family (but not having a partner). Van Os et al. [19] also found that professional employment was a positive factor in determining the level of social functioning. Sanderson and Andrews [14] found that lack of professional employment in the past year was associated with social disability, which is in agreement with these results. It is beyond the scope of this paper to discuss whether professional status is a cause or a consequence of social disability. It is not easy to arrive at an unambiguous answer, which can be seen on the basis of other studies confirming the positive influence of professional employment in counteracting the development of psychiatric disorders [15,16]. This question also refers to the other factors considered and a solution to this problem may only be found by long-term prospective studies with an assessment of the functioning of a person before he/she becomes ill. The fact that the sample was restricted to patients requiring hospitalization is a significant limitation on the interpretation of the results obtained. Almost all the studies cited were based on a sample of outpatients, patients of basic healthcare services, or the general population.

5. Conclusions

The severity of psychopathological symptoms, not the diagnosis of a mental disorder, was the most significant factor in

determining the level of social functioning, particularly during remission periods. Site, employment and partnership appeared as significant factors influencing the level of social disability. The level of social disability should be monitored during standard psychiatric care.

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