Subjective Quality of Life and Posttraumatic Stress Disorder

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Abstract: Subjective quality of life (SQOL) and its predictors were assessed in 117 patients with posttraumatic stress disorder (PTSD) in a specialized clinic. Scores were compared with other samples. PTSD patients had lower SQOL than the comparison groups. Higher levels of depression and anxiety, fewer PTSD avoidance symptoms, being older, and being from an ethnic minority were all independent predictors of lower SQOL. The high dissatisfaction with several social domains of life should be considered in treatment, and depressive and anxiety symptoms might be targeted to improve SQOL.

Key Words: Quality of life, posttraumatic stress, depression, anxiety, predictors.

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The association between quality of life (QOL) and posttraumatic stress disorder (PTSD) has been addressed in various studies. PTSD has been associated with lower QOL in US war veterans (Warshaw et al., 1993; Zatzick et al., 1997), refugees of war (Miller et al., 2002), and sexual assault survivors (Krakow et al., 2002; Zoellner et al., 2000). In addition, PTSD has been shown to be linked with poorer mental and physical health (Wolfe et al., 1994), increased violent behavior (Chemtob et al., 1994), marital, parental, and family adjustment problems (Jordan et al., 1992), poorer role functioning and occupational problems (Jordan et al., 1992; Zatzick et al., 1997a, 1997b), and less favorable performance in work and education (Stein et al., 1997). Patients who perceive trauma as a life threat (Holbrook et al., 2001) and those who experience multiple traumatic events (Johnsen et al., 2002) have been found to have a particularly poor QOL. Few studies have investigated heterogeneous samples in specialized clinics. This study focused on patients who access a specialized clinic and aimed to (a) establish levels of SQOL in general and in different life domains of patients who access the clinic, (b) compare these SQOL scores with those of samples with other mental disorders and a healthy group, and (c) identify what variables predict more or less favorable SQOL in the PTSD sample.

METHOD

Sample

All patients were referred to a specialized clinic for psychological treatment of trauma victims in East London, United Kingdom, and were formally diagnosed with PTSD using the Clinician Administered Post Traumatic Stress Disorder Scale (CAPS) based on DSM-IV criteria (Blake et al., 1990) between January 2002 and January 2004. Out of a total of 202 referrals within the study period, 85 failed to complete their baseline measures. Complete assessments were obtained for 117 patients (58%).

Design and Instruments

After referral, patients were given a first appointment and were sent a battery of routine questionnaires. These included the Manchester Short Assessment of Quality of Life (MANSA; Priebe et al., 1999), the Impact of Events Scale (IES; Horowitz et al., 1979), the Beck Depression Inventory (BDI; Beck and Steer, 1987), and the Beck Anxiety Inventory (BAI; Beck and Steer, 1988). At the first appointment, qualified clinicians assisted patients who were unable to complete the questionnaires. Interpreters were used for non-English speakers. The clinician also collected background information when the patient was first seen.

Comparison Groups

The SQOL scores of the study group were compared with those of 51 outpatients with schizophrenia, 70 female inpatients with depression, 42 female inpatients with alcoholism, and 207 medical students (Rudolf and Priebe, 1999a, 1999b; Priebe et al., 1995, 2000).

Statistical Analysis

Descriptive data were presented as means and SDs or number counts and percentages. One-way ANOVA and post hoc Scheffe tests were conducted for comparisons of SQOL between groups. On a multivariate level, forward stepwise multiple linear regression analysis was undertaken to assess predictors of SQOL. The dependent variable was the SQOL mean score. Potential predictors were the patients' sociodemographic characteristics and the BDI, BAI, and IES subscale scores.

RESULTS

Patient Characteristics

Patients had an average age of 37 years (SD = 8.9); 58% were male, 66% unemployed, and 84% in receipt of state benefits. Seventy-two percent were from ethnic communities: 22% black African, 8% black Caribbean, 8% Kurdish, 6% Kosovan-Albanian, 3% Turkish, 3% Indian, 2% Bangladeshi, 1% black other, and 19% from other ethnic minority groups. Thirty-five percent required language support, 28% were seeking asylum, and 54% were living in public sector

housing. Fifty percent were victims of war (55% of whom reported being tortured), 35% had crime-related trauma, and 15% were traumatized as a result of an accident.

Subjective Quality of Life

Posttraumatic stress disorder patients' scores on the SQOL domains were as follows: life in general, 2.5 ± 1.1; employment, 2.9 ± 1.4; finances, 2.5 ± 1.4; social relations, 3.1 ± 1.6; leisure activities, 2.7 ± 1.4; housing, 3.3 ± 1.8; personal safety, 3.1 ± 1.7; living situation, 4.2 ± 1.8; sex, 2.9 ± 1.5; family relationships, 3.8 ± 1.7; physical health, 2.9 ± 1.4; and mental health, 2.5 ± 1.2. Group comparisons showed lowest SQOL in the PTSD sample. The mean SQOL score for the study group was 3.1 ± 0.8 as compared with 4.6 ± 0.8 in the first admission schizophrenia group, 3.5 ± 0.9 in depressed women, 4.4 ± 0.9 in alcoholic women, and 5.3 ± 0.7 in medical students ($F = 144.5$; $df1 = 4$; $df2 = 472$; $p < .0001$). With respect to single SQOL domains, eight domains were assessed in all groups, with significant differences found in these domains across samples: life in general ($F = 102.4$; $df1 = 4$; $df2 = 521$; $p < .0001$), living situation ($F = 10.7$; $df1 = 4$; $df2 = 523$; $p < .0001$), family relationships ($F = 20.6$; $df1 = 4$; $df2 = 499$; $p < .0001$), leisure activities ($F = 97.2$; $df1 = 4$; $df2 = 513$; $p < .0001$), social relations ($F = 66.5$; $df1 = 4$; $df2 = 520$; $p < .0001$), finances ($F = 30.6$; $df1 = 4$; $df2 = 515$; $p < .0001$), personal safety ($F = 37.4$; $df1 = 4$; $df2 = 516$; $p < .0001$), and mental health ($F = 135.1$; $df1 = 4$; $df2 = 472$; $p < .0001$). In addition, post hoc Scheffe tests showed PTSD patients to have scored significantly lower in all domains compared with schizophrenia patients (except the living situation domain) and medical students. They also significantly differed from the depressed women sample on SQOL domains of social relations, leisure activities, financial situation, and personal safety, and from the alcoholic women on all domains except personal safety and mental health (Figure 1).

Subjective Quality of Life and Other Measures

The mean score on the BAI was 33.8 ± 11.9, on the BDI 34.4 ± 12.2, and on the IES 51.4 ± 15.5. The mean intrusion and avoidance IES subscale scores were 26.8 ± 7.8 and 24.6 ± 9.6, respectively. SQOL mean scores showed significant negative correlations with BDI ($r = -0.5$; $p < .001$) and BAI ($r = -0.4$; $p < .001$) scores, but no significant correlation with the IES total score ($r = -0.04$; $p = .659$) or the IES domains of avoidance ($r = +0.04$; $p = .742$) and intrusion ($r = -0.14$; $p = .189$).

Multivariate Prediction of Subjective Quality of Life

All background variables were regressed against the SQOL mean score using forward stepwise multiple linear regression. The BDI, BAI, and avoidance and intrusion IES subscale scores were also included in the model. The analysis identified five predictors. The BDI ($\beta = -0.269$; % variance = 25.3; $p = .02$) was the strongest predictor. BAI ($\beta = -0.369$; % variance = 4.5; $p = .002$) and age ($\beta =$

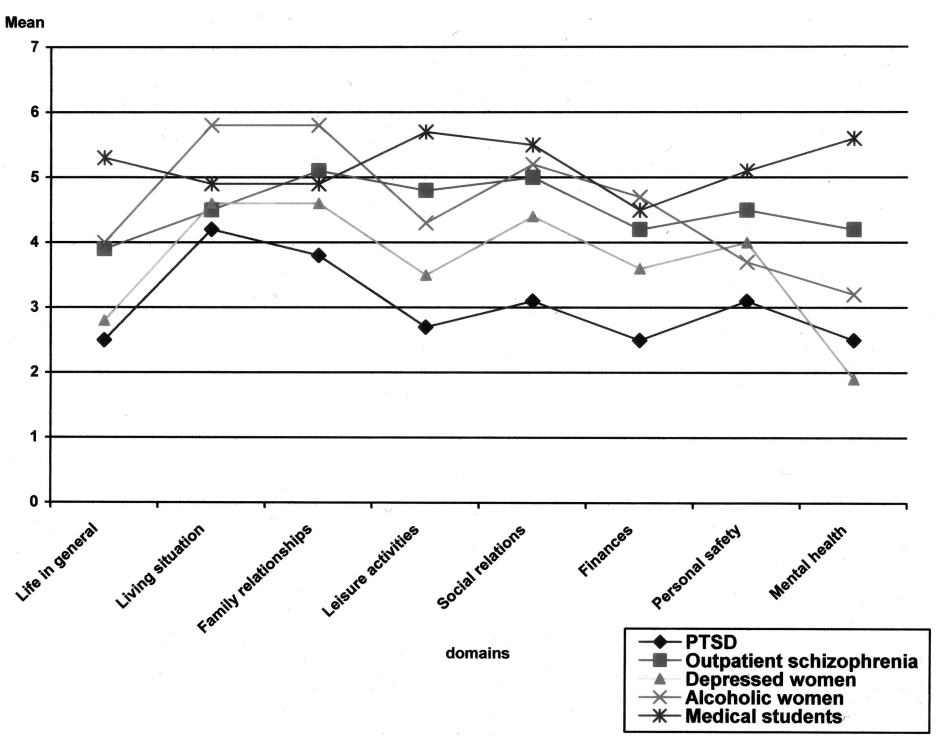

FIGURE 1. Comparison of SQOL scores of PTSD patients with four other samples.

−0.258; % variance = 4.7; $p = .008$) negatively predicted SQOL, whereas not being an ethnic minority ($\beta = +0.312$; % variance = 6.3; $p = .003$) and IES avoidance score ($\beta = +0.234$; % variance = 4.4; $p = .017$) were positive predictors of SQOL. The overall variance explained in the model was 45.2% (F model = 11.89; $df1 = 5$; $df2 = 61$; $p < .0001$).

DISCUSSION

This study assessed SQOL in the diverse clientele of patients accessing a specialist PTSD service in East London. On average, these patients were explicitly dissatisfied with almost all aspects of their life (≤4 on the MANSA). This is an unusual result for psychiatric outpatients, who mostly show scores above 4, *i.e.*, in the range of satisfaction. When compared with nonclinical subjects and with other groups with mental disorders, these PTSD patients had lower scores in all SQOL domains with the single exception of mental health. PTSD patients appeared dissatisfied not only with their mental health but similarly with other life domains, *e.g.*, financial situation, and life in general. This suggests that PTSD patients may not regard mental health as their only or main problem, and might support the hypothesis that—in the view of the PTSD sufferers in general, and refugees in particular (37% of the study group were seeking asylum)—social inclusion and material support may be at least as important as specific psychological or medical interventions (Summerfield, 1999, 2001). Higher levels of depression and anxiety, less avoidance, being from an ethnic minority, and being older all independently predicted lower SQOL. The BDI score alone explained 25% of the variance of SQOL. Combined, depression, anxiety, and PTSD avoidance symptoms explained 34.2% of the variance, whereas the other two predictors added a further 11% to the predictive equation. The positive association between avoidance and SQOL appears atypical. It might suggest that avoidance is a more successful coping strategy within this group of severely affected patients. The predictive association between depressive symptoms and SQOL was shown in the univariate and multivariate analyses and has also been found in other samples (*e.g.*, Priebe et al., 2000). Treating depression, therefore, might be an effective way of improving SQOL in PTSD patients and in other groups.

Increased age and being from an ethnic minority group also predicted lower SQOL. Being older may make it harder to adjust after a traumatic experience and maintain a favorable level of QOL despite ongoing symptoms. Patients from ethnic minorities may be socially more excluded. They may therefore have fewer internal and external resources to cope with trauma, subsequent symptoms, and their impact on social functioning and quality of life. Alternatively, the findings might reflect distinct referral patterns for patients from different age groups and ethnic communities. The exact nature of the associations identified in this study should be addressed in future research, including studies with longitudinal designs and less selective samples.

The study has methodological limitations: 42% of all patients in the clinic did not complete all assessments, so they were excluded from the analysis. Thirty-five percent were administered questionnaires through an interpreter, which may have distorted the self-ratings. Finally, the data were collected in a specialized clinic, and the results may not be generalizable to PTSD patients in other settings.

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