

Quality of life and psychosocial functioning in people with severe and chronic mental diseases

Monographic Article

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Abstract:

People with chronic and severe mental diseases suffer from severe problems in their daily functioning and other issues that affect their quality of life. Many resources have been dedicated to help them address these problems. In the Autonomous Community of Madrid, there are services for people with chronic and severe mental diseases. In this study, we assess the quality of life and the functioning of 970 users of different social services of this network. The relationship among the instruments and the role of gender in terms of a person's quality of life and functioning are presented.

Key words: chronic and severe mental diseases, quality of life, psychosocial functioning, gender.

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INTRODUCTION

In his now classic definition, Liberman (1993) has pointed out three aspects that should be considered when defining severe and chronic mental diseases: diagnosis, functioning and duration. Focusing on the second of these two aspects, we can see that severe and chronic mental diseases often involve a deterioration that becomes evident in a range of disabilities mainly related to one's loss of the ability to adequately perform social roles (Casas, Escandell, Ribas and Ochoa, 2010).

In general, in spite of the lack of consensus on the meaning of the concept of psychosocial functioning, this concept often includes aspect such as self-care, autonomy, self-control, interpersonal relations, leisure and free time and cognitive functioning (Casas *et al.*, 2010). This concept focuses on what the person can do, the quality of daily activities and his/her need for assistance (Bacon, Collis and Plake, 2002).

In general, then, this concept refers to the different activities of an individual's day-to-day life and the level of support and care that he or she needs. However, although the importance of this domain has now been acknowledged, it is still difficult to assess since functioning is an abstract concept and to date, there has been little consensus on the specific components of this concept. For example, the role that subjective components play in this type of concepts has yet to be defined (Brekke and Long, 2000).

The way in which severe and chronic mental disease relates to the problems or limitations in global psychosocial functioning has become increasingly clear (Brekke, Lee and Green, 2005), and this has made the measurement of global functioning indispensable when studying severe and chronic mental diseases, and very useful for mental healthcare professionals when evaluating results (Thornicroft and Tansella, 1996; Vázquez, Muñoz, Muñoz *et al.*, 2000). This is because

global functioning is an important predictor of the use of services and thus provides essential information for the planning of such services (Phelan, Wykes and Goldman, 1996).

Bearing this in mind, over the past few decades, the care of people with severe and chronic mental disease has undergone important transformations, moving progressively from the symptomatic treatment of the illness to integral care of the person's needs within his/her own community, regardless of his/her symptomology. This has been captured in the models for psychosocial rehabilitation and accompanied by a rise in new types of resources and services for this population (APA, 2005; González and Rodríguez, 2002; Liberman, 1993; Prat, Gill, Barrett and Roberts, 2007).

One of the fundamental objectives of these resources—created within the framework of psychosocial rehabilitation—is to improve the quality of life of people with severe and chronic mental diseases and that of their families (Valiente, Vázquez and Simon, 2010). This has been achieved by changing the living conditions of those suffering from the illness and by improving internal aspects (affect, self-esteem, acceptance of the illness, etc.) (Tourinho, 2010).

The concept of "quality of life" refers to the global wellbeing of the individual and is determined by objective living conditions as well as the his/her subjective wellbeing (Lehman, 1993; Muñoz, Pérez, López and Panadero, 1999). In this regard, the studies done on conceptualization have been particularly significant. In Spain, one important study was done by Giner and Cols (2001), a study which yielded the *Seville Quality of Life Questionnaire*. This questionnaire incorporates a psychological conceptual model that is based on the quality of an individual's life and his/her subjective assessment of all of the aspects that influence his/her degree of satisfaction with life, including psychopathological aspects, ultimate fulfillment of needs, etc.

Severe and chronic mental disease have a major impact on people's lives, so the quality of life of those who suffer from this type of illness has been a constant theme when developing care programs for this group (Bobes, González and Bousoño, 1995; Hasanah and Razali, 2002). In fact, the im-

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provement of one's quality of life has been, as we have already seen, one of the specific objectives of these programs (Sederer and Dickey, 1996). Thus, the global quality-of-life assessment can be a very useful measurement since it is an indirect marker of one's global health status, social adaptation, and thus also a marker of the impact of intervention (Mubarak and Barber, 2003). In addition, it is closely related to other key aspects such as the symptomatology one experiences (Sañudo, Herrero, Lamas and Franco, 2010).

Although the significance of this aspect has been acknowledged, it is not always easy to take it into account due to major issues related to how quality of life is assessed: there is imprecision, conceptual confusion, a lack of consensus on the measurements used and on the indicators, a lack of empirical evidence in the models, and other methodological issues (Bobes *et al.*, 1995; Muñoz *et al.*, 1999).

As we have already mentioned, an important number of resources have been developed over the past few years for the care of people with severe and chronic mental diseases. Specifically, the Autonomous Community of Madrid currently has a network of social services for people with a severe and chronic mental illness. The type of care it provides is based on the philosophy of psychosocial rehabilitation and the support for social and job integration as the guiding principle of the intervention (González and Rodríguez, 2002) and has been described in publications from this field (Rodríguez, Muñoz and Panadero, 2007). Although these resources began to be developed at the end of the 1980s, a major advance came with the *Social Services Plan for People with Severe and Chronic Mental Illness 2003-2007* by the Ministry of Family and Social Affairs of the Autonomous Community of Madrid. The plan revealed the growth and consolidation of a network directed towards the different psychosocial and social needs of people with chronic mental illness. The objectives of the network were to increase autonomy, improve their quality of life and promote social integration among the mentally ill while supporting their families. Within this network, different types of resources are currently available: Centers for Psychosocial Rehabilitation, Job Rehabilitation Centers, Social and Community Support Teams, Day Centers and Social Support, Accommodations (small residences, supervised flats and supervised rooms in boarding houses) and Specific Rehabilitation Resources for homeless people with severe and chronic mental diseases.

This network of centers and resources within the plan works closely with the Network of Mental Healthcare Services of the Ministry of Health and Consumption, which is responsible for the psychiatric care, rehabilitation and follow-up of people with chronic mental illnesses. They represent the channel for referrals of users to the resources of the social services network.

The results presented are part of a study which the Ministry of Family and Social Affairs of the Autonomous Community of Madrid requested from the Universidad Complutense de Ma-

drid. Specifically, Dr. Manuel Muñoz was asked to do a study aimed at making more information on care available along with the results of the network of social services for people with severe and chronic mental disease.

GOALS

The goals of this article are the following:

To describe the functioning and the quality of life of people with severe and chronic mental diseases who use the social services network reserved for this group in the Autonomous Community of Madrid, and to analyze the relationship between the two.

To analyze how the functioning and quality of life of the users is related to the gender of the participants.

To analyze the relationship between the two measurements of psychosocial functions utilized in this study, as well as how they relate to quality of life.

METHOD

Participants

The data included in this article correspond to 970 users of the social services network for people with severe and chronic mental disease during 2009. Specifically, these are users of the Day Centers and Social Support (294), Centers of Psychosocial Rehabilitation (357) and the Social Community Support Teams (319).

Some of the sociodemographic features of the participants are shown on Table 1. As can be seen on this table, the majority of users (62.5%) are men with a mean average age of 44.52 ($DT=9.62$). Specifically, 64.6% of the users are age 31-50 and more than 25% are age 51-65 (27.1%).

Information is also available on the number of months the individuals have been taking advantage of these resources. On average, the participants had spent more than two and a half years ($Average = 32.04$ months; $DT = 27.18$) in the facilities, although the variability was significant. Less than one in every five users had spent a year or less (17.8%) utilizing the facilities in which he/she was evaluated and approximately 10% had been receiving care for at least five years.

Instruments

As we have already mentioned, the data presented here correspond to a broader assessment that has already been described in previous articles (Muñoz, Panadero and Rodríguez, 2009; Muñoz, Panadero and Rodríguez, 2010). One of the

Table 1: Sociodemographic data of the participants and amount of time at the facility.

	n	%
Gender		
Male	606	62.5%
Female	364	37.5%
Age		
Average (DT)	968	44.52 (9.62)
18-30	68	7.0%
31-50	627	64.6%
51-65	263	27.1%
> 65	7	0.7%
Months at the center		
Average (DT)	879	32.04 (27.18)
0-6 months	47	4.8%
6-12 months	126	13.0%
1 - 2 years	232	23.9%
2 - 3 years	258	26.6%
3 - 4 years	83	8.6%
4 - 5 years	33	3.4%
5 years or more	100	10.1%

objectives consisted in increasing the information available on care and the results of the network of social services for people with severe and chronic mental disease. To achieve this objective, a proposal was made in terms of the domains to be considered and the most adequate instruments for assessment. The criteria utilized for searching for and selecting these instruments included: previous use of the instruments in studies assessing the results of programs that target this group, adequate psychometric criteria, the brevity and ease of application and the existence of a Spanish-language version.

The proposal for domains and instruments that was presented and discussed with those responsible for the network of resources and the directors at the centers (who represented the professionals working with people with mental illness, since it was impossible to include all of the professionals from the centers in the process). The selection of domains and instruments included:

Psychosocial functioning:

For the evaluation of psychosocial functioning, a decision was made to apply the Global Assessment of Functioning (GAF; American Psychiatric Association, 2002) and the WHO Short Disability Assessment Schedule (WHO DAS-I; World Health Organisation, 2000), two of the questionnaires and scales more commonly used in psychosocial rehabilitation (Blanco, Navarro and Pastor, 2010).

The GAF is an instrument employed in Axis 5 of DSM-IV for the evaluation of general activity. It consists of a 100 point

scale in which the professional must evaluate both the severity of the symptoms the person is experiencing as well as the degree of deterioration in one’s school, job or social activities. The final assessment is determined by whichever of the two assessments is lower. Although the final assessment is a single score that reflects an individual’s global level of activity as accurately as possible, the scale is divided into ten activity levels.

This scale is one of those most frequently used in both clinical practice and research. It was created to predict the response to treatment and to support treatment planning (Moos, McCoy and Moos 2000) and shows a significant correlation with other assessments of functionality, high inter-rater reliability and test-retest reliability (Gaité, Vázquez-Barquero, Herrán *et al.*, 2005; Greenberg and Rosenheck, 2005).

A decision was also made to use the WHO DAS-I, proposed by the ICD-10, an instrument designed to provide a clinical assessment of disabilities. In this case, the clinical physician is responsible for determining a patient’s score based on information obtained from families, informants, medical records and his/her own observations. The evaluator must rate disabilities on a scale of 0 (“no disability”) to 5 (“maximum disability”) for each of the specific areas of functioning, that is: Self-Care, Job Functioning, Family Functioning and Social Functioning. When a person can only do an activity if he/she is helped by someone else, this is indicated as “functioning with assistance.”

In terms of the procedure for application, professionals from the facilities were in charge of completing these two instruments. At the end of 2009, the professionals completed these two instruments based on the users who were receiving care at that time.

Quality of life:

Although a proposal was initially made to use the Satisfaction with Life Domains Scale (SLDS; Baker and Intagliata, 1982), professionals pointed out several problems with the SLDS in terms of assessing quality of life. Since no instrument was found that better reflected the needs of the professionals, a decision was made to create a new assessment instrument based on the SLDS while respecting its question formulation outline and its response scale, both of which were considered adequate. Thus, different modifications were made using the SLDS and a participative process in which the opinions of the professionals at the centers were taken into account. Specifically, items were added on satisfaction with one’s health (physical state, mental health), sex life, partner and life in general.

The result was an instrument comprised of 26 items in which the user is asked about his/her satisfaction with dif-

ferent aspects of life. For the analog score, a seven-point visual analog scale was used with faces that go from one (maximum dissatisfaction) to seven (maximum satisfaction).

The resulting alpha coefficient of the tool is 0.955.

In addition, information is gathered on certain sociodemographic data (gender and age) and care (type of resources and number of months receiving care).

The definitive version of the tools and the application procedure were distributed to all the centers along with the database designed for coding the information of the instruments.

In this case, the instrument was completed by users at the request of the professionals from the different facilities which helped participants through the process in cases where it was deemed necessary.

As we have already mentioned, the data included here correspond to 2009.

Statistical Analyses

The statistical analysis consisted in a descriptive analysis of the different aspects considered and in the analysis of correlations (*Pearson*) to determine the relationship between the two measurements of functioning and between the two measurements and the quality of life. In addition, to analyze how gender related to the functioning and quality of life of the participants, the *t* test was used for independent samples. For the data analysis process, a system of statistical analysis and SPSS data management (Version 15 for Windows) was used.

RESULTS

Description of psychosocial functioning and quality of life

In terms of user satisfaction with the different aspects considered, the average scores (scores ranged from a minimum of one to a maximum of seven) are presented on Table 2. The highest average scores refer to material aspects such as place of residence, neighborhood where the user resides, services and resources in the area, food and clothing. In all of these cases, the average satisfaction score was over five. This also occurred with other aspects related to the social relationships of users, specifically, the average satisfaction scores in terms of the people with whom they live (*Average* = 5.20 (*DT* = 1.61)), their relationship with their family (*Average* = 5.11 (*DT* = 1.70)), and their leisure activities (*Average* = 5.8; *DT* = 1.59).

On the other hand, lower satisfaction (under four) was found in aspects related to one's sex life (*Average* = 3.91; *DT* = 1.96), lack of friends (*Average* = 3.52; *DT* = 1.90), not having a partner (*Average* = 3.70; *DT* = 1.91) and not having a job (*Average* =

3.42; *DT* = 1.86).

In terms of psychosocial functioning evaluated through the GAF, the results are shown on Table 3. The GAF considers psychological, social and job activity along a hypothetical continuum of health-illness and a single value is selected that reflects the global level of an individual's activity as accurately as possible. As can be seen on the table, the average score of users was 50.03 (*DT* = 14.38). Although a single value is assigned to a person's functioning, the GAF scale is divided into ten activity levels. In the best cases, the scores of the participants were found in intervals 41-50 [25.8%; *Severe symptoms (i.e., thoughts of suicide, severe obsessive rituals, in-store theft) or any severe alteration of social, job or school activity (i.e. no friends, unable to keep a job)*] and 51-60 (28.5%; *Moderate symptoms (i.e. flat affect and circumstantial language, occasional bouts of anguish) or moderate difficulties in social, job or school activity (i.e. few friends, conflicts with co-workers or classmates)*).

To continue with the psychosocial functioning, this time assessed using the DAS-I, Table 4 shows the average scores of each of the scales considered as part of this instrument (Personal Care, Occupation, Family and Home, and Social Context) and the percentage of users with assisted functioning in each of these areas. The evaluator scores disabilities on a scale of zero ("no disability") to five ("maximum disability") for each of the specific areas of functioning. On the four scales, the average score was between two and three, which corresponds to a clear disability, i.e. *there is a notable deviation from the norm that interferes with social adaptation: the user is slightly disabled for a long period or moderately disabled for a short period* (40%). However, in spite of the fact that the same interval is used, it is important to note that the average score, which indicates a lower degree of clinical presentation, is that referring to personal care (*Average* = 2.02; *DT* = 1.42) while a higher score, that is, one which indicates a higher level of disability, is found for Occupation (*Average* = 2.92; *DT* = 1.40), which refers to functions such as a paid worker, student, housewife or husband, etc.

In terms of the number of users with assisted functioning, 16.1% of the people evaluated in the area of Personal Care needed support in this area, which is somewhat higher than those found in the area of Occupation (14.5%). In the areas of functioning in the family and home and in the social context, the percentages were 11.9% and 12.4% (respectively).

Relationship between the measurements of psychosocial functioning and quality of life and the other variables considered.

After the description of the quality of life and the psychosocial functioning of the users, the way both variables related to the gender of participants was evaluated.

With respect to the gender of users and its relation to psychosocial functioning, there were no significant differences

Table 2: Average quality of life score of the participants

	n	Average (DT)(1-7)
Which face is closest to how you feel with respect to your life in general?	586	4.52 (1.77)
your home/apartment/pace of residence?	585	5.28 (1.58)
your neighborhood as a place to live?	585	5.09 (1.70)
the food you eat?	580	5.54 (1.48)
the clothes you wear?	577	5.33 (1.42)
your overall health?	582	4.52 (1.74)
your physical state?	583	4.36 (1.75)
your moods?	580	4.49 (1.78)
the calmness of your life?	585	4.71 (1.80)
your problem/mental health illness?	584	4.00 (1.81)
the people with whom you live?	558	5.20 (1.61)
your friends?	522	4.87 (1.71)
If you don't have any friends, which face is closest to how you feel about not having any friends?	355	3.52 (1.90)
your relationship with your family?	557	5.11 (1.70)
Your relationship with your partner?	255	4.20 (2.07)
If you don't have a partner, which face is closest to how you feel about not having a partner?	484	3.70 (1.91)
your sex life?	508	3.91 (1.96)
your relationship with other people?	566	4.87 (1.55)
your job or other work?	285	4.26 (1.97)
If you don't have a job, which face is closest to how this makes you feel?	541	3.42 (1.86)
your education or other classes you are taking?	388	4.60 (1.81)
your recreational activities?	571	5.08 (1.59)
the services and facilities in your area?	568	5.29 (1.51)
your economic situation?	575	4.34 (1.79)
how you feel about yourself?	577	4.68 (1.81)
your life in general?	578	4.64 (1.77)

with respect to the global score on the GAF or on the scales of *Personal Care, Family and Home* functioning or the *Social*

Table 3: Scores in psychosocial functioning evaluated with the GAF.

	n	
GAF		
Average (DT) (1-100)	943	50.03 (14.38)
1-10	1	0.1%
11-20	18	1.9%
21-30	82	8.5%
31-40	120	12.4%
41-50	250	25.8%
51-60	276	28.5%
61-70	146	15.1%
71-80	36	3.7%
81-90	13	1.3%
91-100	1	0.1%

Context of the DAS-I. The statistical differences between men and women were only significant on the *Occupation* scale of the DAS-I. Specifically, in the case of the men, the average score on this scale was 3.01 (DT = 1.38) compared to 2.77 (DT = 1.42) in the case of women, which indicates significantly less disability among women than men ($t(888) = 2.50; p < 0.05$).

In addition, significant differences were found in some of the aspects considered in the quality of life assessment:

General satisfaction with health. In this case, the average score of men was 4.64 (DT = 1.60) while that of women was 4.28 (DT = 1.99) ($t(303.71) = 2.18; p < 0.05$).

Satisfaction with their relationships with the people with whom they live. The satisfaction of men was significantly higher in this aspect than that of women ($t(1.97) = 284.95; p < 0.05$); while the average score for men in this area was 5.29 (DT = 1.47), the score for women users was 4.98 (DT = 1.85).

Table 4: Scores in psychosocial functioning evaluated with the DAS-I.

	n	
Personal Care (<i>Average (DT)</i>) (0-5)	938	2.02 (1.42)
Assisted Functioning	156	16.1%
Occupation (<i>Average (DT)</i>) (0-5)	890	2.92 (1.40)
Assisted Functioning	141	14.5%
Family and Home (<i>Average (DT)</i>) (0-5)	933	2.57 (1.25)
Assisted Functioning	115	11.9%
Social Context (<i>Average (DT)</i>) (0-5)	938	2.69 (1.34)
Assisted Functioning	120	12.4%

Satisfaction among those who do not have a partner. In this case, the score of the women was significantly higher than that of men ($t(230.01)=-2.59$; $p<0.05$): the women's average was 4.07 ($DT = 2.08$) compared to 3.55 ($DT = 1.82$) in the case of the men.

Satisfaction with their sex life. In this case, the average score among women ($Average = 4.18$; $DT = 2.13$) was higher ($t(269.86) = -2.00$; $p<0.05$) than that of the men in the sample ($Average = 3.79$; $DT = 1.87$), that is, the female users were more satisfied with their sex life than the male users.

Satisfaction among users who are not employed. The satisfaction in this case was higher ($t(300.05) = 2.00$; $p<0.05$) among men ($Average = 3.53$; $DT = 1.77$) than among women ($Average = 3.17$; $DT=2.02$).

Relationship between the measurements of psychosocial functioning and the quality of life

The relationship between the two measurements of functioning was also analyzed, along with the way these measurements related to the subjective quality of life of the participants.

In this regard, the correlation between the measurements of psychosocial functioning (the GAF and the DAS-I) was calculated. The results indicated a statistically significant correlation between the score of the GAF and all of the scales of the DAS-I, specifically in terms of Personal Care ($r=-0.505$; $p<0.01$), Occupation ($r = -0.590$; $p<0.01$), Family and Home ($r=-0.550$; $p<0.01$) and functioning in the Social Context ($r=-0.589$; $p<0.01$).

On the other hand, with respect to the correlation of psychosocial functioning (as assessed by the professionals) and the different aspects of the quality of life considered by the users themselves, there were statistically significant correlations found between:

The GAF global score and satisfaction with food ($r=0.94$; $p<0.05$) and with not having a partner ($r=-0.101$; $p<0.05$).

The Personal Care scale of the DAS-I and satisfaction with one's place of residence ($r=-0.101$; $p<0.05$), food ($r=-0.93$; $p<0.05$) and clothing ($r=-0.117$; $p<0.05$).

The Occupation scale of the DAS-I with place of residence ($r=-0.088$; $p<0.05$) and one's neighborhood as a place to live ($r=-0.103$; $p<0.05$).

The Family and Home scale of the DAS-I and one's accommodations ($r=-0.092$; $p<0.05$) and relationship with the family ($r=-0.151$; $p<0.01$).

The Social Context scale of the DAS-I and place of residence ($r=-0.107$; $p<0.05$) and leisure activities ($r=-0.097$; $p<0.05$).

CONCLUSIONS AND DISCUSSION

This work presents the results obtained in quality of life and psychosocial functioning in a sample of users of social attention resources for people with severe and chronic mental disease in the Autonomous Community of Madrid. Taking into account the population targeted by these resources, the results of the psychosocial functioning of the participants were to be expected, to a certain extent, since they show significant disability. The Global Assessment of Functioning (GAF) reveals significant problems in this regard, pointing out moderate to severe difficulties among the participants, with average scores quite close to those noted by other authors in samples with similar characteristics (Hansson, Middelboe, Sørgaard *et al.*, 2002). The DAS-I helps to specify which areas of psychosocial functioning are particularly affected among this population. However, all of the scales considered for this instrument reveal a clear problem, which is especially accentuated in the case of the area "Occupation," which tells us about people's performance in their job, studies, housework, etc.

This article has also addressed the coherence between the two measurements of functioning utilized. This mainly arises from the limitations that some authors have noted in terms of the GAF, especially the fact that it groups symptoms and functioning in a single score (Bacon *et al.*, 2002; Moos *et al.*, 2000). Some authors have pointed out that the scope of this instrument is more closely related to the scales of symptoms than with other measurements of functioning, which means that it is fundamentally influenced by the symptoms users experience. In this case, the results obtained are in line with those of other authors who have noted the correlation between this measurement of global functioning and other measurements of functioning (Gaité *et al.*, 2005; Greenberg and Rosenheck, 2005) since significant correlations have been found between the two instruments utilized for measurements.

Over the past two decades, different works have attempted to clarify the relationship between quality of life and functioning in the case of people with severe and chronic mental diseases

(Becker, Leese, Krumm *et al.*, 2005; Norman, Malla, McLean *et al.*, 2000). However, these works have not produced solid or consistent results, mainly due to the complex way in which quality of life is constructed. On many occasions, research into quality of life has centered on the influence of the symptoms; in other cases, only subjective aspects have been considered. Finally, in still other works, the measurements have been supplemented by objective markers of the living conditions of these individuals, aspects which appear to have only a weak connection (Fitzgerald, Williams and Corteling, 2001). Naturally, this has produced major differences in terms of the results obtained and in the conclusions of the different works (Eack, Newhill, Anderson and Rotondi, 2007). In this case, the relationships between both aspects also appear to be weak, although in some cases, certain connections appear in a way that could be expected. Thus, for example, the Functioning scale in the family and home context of the DAS strongly relates to satisfaction with one's accommodations and one's relationship to the family, and in the case of Personal Care, there is a correlation with certain more "physical" aspects related to accommodations, food and clothing.

Different studies have pointed out the existence of major differences in diverse aspects of men and women with severe mental diseases, including psychosocial functioning (Usall, Araya, Ochoa *et al.*, 2001) and to a lesser extent, quality of life (Bengtsson-Tops and Hansson 1999; Eack *et al.*, 2007; Picardi, Rucci, Giovanni *et al.*, 2006). In general, these works have noted better psychosocial functioning among women. In our case, as in that of other authors (Hintikka, Saarinen, Tanskanen *et al.*, 1999), no differences appeared when functioning was considered as a single Global Assessment of Functioning (GAF). Significant differences only appeared with respect to one of the scales of functioning evaluated with the DAS, Occupational functioning. As in other previous studies (Andia, Zisook, Heaton *et al.*, 1995; Galuppi, Turola, Nanni *et al.*, 2010; McGlashan and Bardenstein, 1990; Test, Burke and Wallisch, 1990), women seem to present fewer difficulties in this area.

In summary, although it is necessary to point out that this work has certain limitations such as the measurement of the quality of life (which only considers subjective aspects), the selection of the sample, the lack of a control group, etc., it has attempted to provide a comprehensive description of two key aspects for the understanding of the situation of people with severe and chronic mental diseases in the context of Spain: their quality of life and psychosocial functioning.

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