

Subjective quality of life and basic psychotic symptoms in schizophrenic patients in various health care facilities. A preliminary study

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ABSTRACT

Introduction. Subjective quality of life in schizophrenia and its relationship with the basic psychotic symptomatology of the disease has gained great importance over the last few years. This is due, firstly, to the desinstitutionalization of these patients, who become integrated in health care facilities, which are increasingly less regimented; and secondly, to the development of new antipsychotic medicines. The objective of this cross-sectional study is to measure the relationship between subjective quality of life and basic psychotic symptomatology in patients with schizophrenia attended to in various health care facilities belonging to a mental health network.

Methodology. A total of 50 patients diagnosed with schizophrenia belonging to five health care facilities were assessed. Their subjective quality of life was measured by the *Cuestionario Sevilla de Calidad de Vida* (CSCV) (Seville quality of life questionnaire). Basic psychotic symptomatology was assessed by the Frankfurter Beschwerde Fragebogen (FBF-3) (The Frankfurt psychopathological inventory).

Results. It can be seen that the improvement of subjective quality of life is related to a decrease of schizophrenic people's basic psychotic symptomatology. However, such a relationship is not evident when a diversity of health care facilities is compared.

Conclusions. The relationship between subjective quality of life and basic psychotic symptomatology in patients with schizophrenia highlights the need to use not only pharmacological treatment but also other cognitive and psychosocial interventions which attend to the subjective experience of the disease in order to improve the quality of life of these patients, irrespective of the health care facilities.

Key words: schizophrenia, subjective quality of life, basic psychotic symptoms, *Cuestionario Sevilla de Calidad de Vida* (CSCV) (Seville quality of life questionnaire), Frankfurter Beschwerde Fragebogen (FBF-3) (Frankfurt psychopathological inventory).

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INTRODUCTION

The *II Plan Integral de Salud Mental de Andalucía (2008-2012)* (Second Andalusian comprehensive mental health plan. 2008-2012) highlights, among its general objectives, the need to *improve the quality of life (QL) of people with mental diseases and that of their families, and to encourage their recovery and social inclusion processes* (Consejería de Salud, 2008) (Regional Health Office, 2008).

Therefore, it seems to be clear that QL needs to be one of the priority objectives when coping with chronic illnesses such as schizophrenia, above all if we bear in mind that the advances in pharmacological treatment, with the appearance of second generation antipsychotics and the introduction of concepts such as *rehabilitation* and *community attention*, in the field of health, have contributed to the development of and have promoted QL assessment as an important measure of the efficiency of schizophrenic treatment (Bobes, García-Portilla, Bascaran, Saiz and Bousoño, 2007; Mohr, 2007).

On the other hand, the policy of deinstitutionalization has encouraged interest in learning about and assessing the true impact of QL in schizophrenic patients. However, in order to find out about this relationship, we need to study QL both from an objective perspective focusing on the professional's point of view and from the subjective experience of the ill people (Míguez, González, Alonso, Sanguino and García, 2005).

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Quality of Life has recently been defined, from this approach, as the cognitive and affective self-assessment of a chronically ill person at a given moment in his or her life. Therefore, the study needs to be carried out with the aim of developing and disseminating therapeutic methods that try to achieve something other than the mere disappearance of a disorder, and that is to try and improve the individual's perception of his or her own situation in order to become as integrated as possible in the social environment which best meets their needs (Gómez and Botella, 2007).

The research that deals with trying to study the relationship between psychotic symptomatology in schizophrenic patients and QL has shown an increasing interest in improving the symptomatic processes without forgetting about other aspects of the illness that can positively affect QL, such as the ill person's role performance and their ability to develop it autonomously (González, Villanueva, García and Arias, 2003), or individual perceptions, personal expectations and level of independence (Giner, Ibáñez, Cervera, Sanmartín and Caballero, 2001). Peralta and Cuesta's review study (1994) concludes that the QL of people diagnosed with schizophrenia can be affected both by negative and positive symptoms, and that it is necessary to go beyond classical symptomatology and learn about these ill people's subjective experiences (basic symptomatology) in order to be able to address the illness from cognitive interventions that may encompass the most basic deficiencies of a person. In her study of 93 patients with stable schizophrenia, Hirschberg (2005) finds a strong relationship between negative and positive symptomatology and a lower QL. Equally, the meta-analysis carried out by Shaun and Newhill (2007) finds, firstly, that most of the works examined show a significant negative relationship between negative schizophrenic symptomatology and QL; secondly, that the relationships between symptomatology and QL differ on the basis of the patient's environment, namely hospitalized or outpatients, and, thirdly, that psychosocial treatment improves wider aspects of QL. Finally, it is worth drawing attention to the relationship shown by recent studies among QL, depression and negative symptoms (Narváez, Twamley, McKibbin, Heaton and Patterson, 2008), as well as that between depressive symptoms and the state of general health in relation to objective QL (Marwaha *et al.*, 2008).

However, in spite of the proliferation of studies, most of them only investigate psychotic symptomatology from a classical approach to the illness and do not bear in mind the subjective perspective of the person assessed (Bobes *et al.*, 2007). Consequently, it is imperative to study in a direct way the empiric experiences of these sick people in the intercritical stages of the illness in which contacting and communicating with them improves remarkably. This way, we will learn about the symptomatology they show and what clearly affects their QL, in order to develop secondary and tertiary intervention strategies which allow us to address these symptoms and so diminish the schizophrenic patient's vulnerability and improve their QL (Peralta and Cuesta, 1994; Vargas, Jimeno-Bulnes and Jimeno-Valdes, 1995).

As for the health care facilities used by schizophrenic patients, most of the authors point out that the ill people who live in the community show higher satisfaction levels and QL when they recover their autonomy, independence and relationships with the environment,

above all if they maintain a support and resource network to protect themselves with (Barry and Zissi, 1997). A number of authors, among whom Björkman and Hansson (2002) and Goodwin and Madell (2002) stand out, advocate the need to intervene, not only in the symptomatology, but also in the reduction of the health care needs and to achieve good social support in order to improve subjective QL. A study carried out by Nelson, Brent and Walsh-Bowers (1999) shows that people who live in places similar to supportive apartments and group homes reflect higher levels of objective and subjective QL than those people living in larger health care facilities, such as board-and-care homes, where a larger number of people live, relationships with the workers are not friendly and there is less independence. Finally, Liebe and Kallert (2001) conducted a study which compared five groups of psychotic patients in various health care facilities by measuring QL and basic psychotic symptomatology (subjective experience of the disease) (Peralta and Cuesta, 1994). They concluded that both variables showed worse scores in those who lived in community residences than in those who lived in their homes. However, they qualify their results by suggesting that it is not only the kind of health care facility that influences the situation, but there are also other variables which play an important role in the subjective QL of the schizophrenic person, such as the social support or the isolation perceived by the patient.

In this context, we present a preliminary cross-sectional study with the goal of describing and relating subjective QL and basic psychotic symptomatology in a sample of patients diagnosed with schizophrenia, and verifying the differences that might exist between and among such variables and the health care facility used by the ill person.

METHOD

Participants

The study sample consisted of 50 patients diagnosed with schizophrenia according to the criteria stated by the DSM-IV-TR (APA, 2002), all were older than eighteen (45.28 ± 7.94) and whose illness had lasted for more than ten years (22.96 ± 8.17). It consisted only of men due to the fact that there are no hospitalized women in the Psychiatric Hospital and so it was decided to select men only in order to avoid data bias. Although it may at first suppose a bias, the fact is that some authors have not found any difference between men and women when they have assessed the variables measured in this study (Vila, Ochoa and Haro, 2003). Most of the people, 32, who constitute 62% of the sample, were diagnosed with paranoid schizophrenia. The rest of them were classified as follows: fifteen people (30%) with undifferentiated or unspecified schizophrenia, 3 (6%) with residual schizophrenia, and one person was diagnosed with disorganized schizophrenia (2%). As for the marital status of the sample, 74% (37 patients) were single and 26% (13 patients) were married or had a stable relationship. The educational level of the sample was 29 patients (58%) who were illiterate or with primary studies and, out of the remaining 21 patients (42%), 15 patients representing 30% of the sample had completed grade eight, 5 patients (10%) had completed secondary, vocational or post obligatory studies, and one of them (2%) had university education.

All the patients were voluntary participants in the study, were informed about its objectives and belonged to various health care facilities of the Andalusian mental health network: group homes (n = 10) and supportive apartments (n = 10) provided by the Fundación Andaluza para la Integración Social del Enfermo Mental (FAISEM) (The Andalusian Foundation for the integration of the mentally ill); people with their own or relatives' homes and who regularly turn to associations such as the Asociación de Allegados de Enfermos de Esquizofrenia de Sevilla (ASAENES) (The Seville Association for close friends of people suffering from schizophrenia (n = 10); the acute unit (total hospitalization) of the Virgen Macarena University Hospital (n = 10), and patients of the Psychiatric Hospital in Seville (n = 10).

Study design and instruments for assessment

We carried out a descriptive cross-sectional study to which we applied the Frankfurter Beschwerde Fragebogen (FBF-3) (The Frankfurt psychopathological inventory) (Sullwold, 1977; Sullwold and Huber, 1986), which had been adapted to Spanish by Jimeno-Bulnes, Jimeno-Valdes and Vargas (1996). This is a self reported questionnaire consisting of 98 items in which the patient assesses the presence of subjective complaints in 10 clinical scales, namely loss of control, simple perception, complex perception, language, cognition and thought, memory, motor functions, loss of automatisms, anhedonia and distress, and irritability due to overstimulation. As a QL measure instrument we used the *Cuestionario Sevilla de Calidad de Vida (CSCV)*, (Seville Quality of

Life questionnaire), which had been designed as a specific measure of QL in schizophrenia (Giner *et al.*, 1999; Giner *et al.*, 2001). This instrument consists of 59 items grouped into two scales: one with 13 favourable aspect items measuring three factors, namely life satisfaction, self-esteem and harmony, and another scale with 46 unfavourable items which assess nine factors, namely lack of cognitive comprehension, loss of energy, lack of internal control, difficulty of emotional expression, difficulty of cognitive expression, estrangement, fear of loss of control, controlled hostility and self-esteem.

Statistic Analysis

The dependent variables went through a descriptive correlational study. Next, a variance analysis (ANOVA) was carried out among the various groups on the basis of the health care facility used. When significant differences were observed, the measures were compared in two by two by means of the t-student distribution. All the studies were completed by applying the SPSS 14 statistic pack (SPSS UK Ltd, Woking, United Kingdom).

RESULTS

First of all, we carried out a descriptive analysis of the scores of each of the participants in each one of the assessment instruments. Table 1 shows the means and standard deviations of each health care facility with each assessment instrument (CSCV and FBF-3) and the factors that they consist of.

	CH	VT (Pisos)	ASAENES	HUVM	HPP
<i>Cuestionario Sevilla de Calidad de Vida (CSCV) (Seville Quality of Life questionnaire)</i>					
F	3.48 (±0.58)	3.70 (±0.65)	3.28 (±0.69)	3.60 (±0.93)	2.88 (±1.15)
D	2.77 (±0.46)	2.55 (±0.73)	2.28 (±0.70)	2.52 (±0.82)	2.94 (±0.61)
SV	3.50 (±0.60)	3.76 (±0.78)	3.42 (±0.89)	3.58 (±1.08)	2.90 (±1.36)
AE	3.58 (±0.92)	3.73 (±0.59)	3.55 (±0.78)	3.43 (±1.00)	3.10 (±1.12)
ARM	3.40 (±0.60)	3.60 (±0.78)	3.65 (±0.61)	3.80 (±1.00)	2.75 (±1.22)
FAC	2.80 (±0.79)	2.48 (±0.84)	2.00 (±0.88)	2.48 (±0.63)	2.90 (±0.92)
PE	3.00 (±0.55)	2.58 (±0.75)	2.45 (±0.81)	2.75 (±1.03)	3.03 (±0.75)
FCI	2.96 (±0.65)	3.00 (±0.93)	2.91 (±1.05)	2.59 (±0.93)	3.25 (±0.92)
DEE	2.70 (±0.86)	3.36 (±0.75)	2.18 (±0.73)	2.44 (±0.84)	3.46 (±0.71)
DEC	2.63 (±0.56)	2.79 (±0.85)	2.43 (±0.88)	2.30 (±0.91)	3.10 (±0.57)
E	2.93 (±0.54)	2.73 (±0.81)	2.10 (±0.88)	2.80 (±1.07)	2.60 (±1.13)
MPC	2.23 (±0.54)	2.20 (±1.00)	1.83 (±0.60)	2.13 (±1.17)	2.30 (±1.22)
HC	2.20 (±0.67)	1.97 (±0.71)	1.77 (±0.74)	2.43 (±1.05)	2.67 (±1.13)
AU	3.23 (±0.72)	2.47 (±0.72)	1.93 (±1.10)	2.60 (±0.84)	2.87 (±1.18)
<i>Inventario Psicopatológico de Frankfurt (FBF) (The Frankfurt psychopathological inventory)</i>					
TOT	38.70 (±20.10)	36.10 (±22.30)	38.50 (±21.20)	33.20 (±22.20)	48.90 (±21.70)
PC	2.70 (±2.11)	3.30 (±2.26)	3.40 (±2.27)	2.30 (±2.31)	4.00 (±2.40)
PS	2.70 (±2.21)	2.30 (±2.21)	3.00 (±2.26)	2.50 (±2.01)	4.00 (±2.44)
P	3.90 (±2.46)	2.80 (±3.04)	3.50 (±2.54)	3.00 (±1.63)	4.10 (±2.55)
L	4.90 (±2.42)	5.10 (±3.41)	4.30 (±2.54)	3.20 (±3.04)	5.20 (±2.29)
CP	4.20 (±2.57)	5.20 (±3.04)	4.30 (±2.49)	4.10 (±3.17)	5.00 (±3.23)
ME	4.70 (±3.19)	5.30 (±2.90)	4.80 (±2.78)	3.60 (±2.50)	5.30 (±2.90)
MO	3.50 (±2.59)	1.90 (±2.55)	2.60 (±2.95)	2.30 (±2.35)	3.70 (±2.66)
PA	3.80 (±2.14)	3.80 (±2.39)	4.70 (±2.71)	4.40 (±3.02)	5.60 (±2.63)
D	3.10 (±1.79)	2.60 (±2.36)	3.20 (±2.34)	3.40 (±2.75)	6.00 (±2.74)
I	5.20 (±2.89)	3.80 (±2.44)	4.70 (±2.35)	4.40 (±2.50)	6.00 (±2.35)

Table 1. Means and Standard Deviations of the CSCV and FBF-3 on the basis of the health care facility

Facilities: PH (Protective homes); SA (Supportive apartments); ASAENES (*Asociación de Allegados de Enfermos de Esquizofrenia de Sevilla* = Seville's association for close friends of people suffering from schizophrenia); AUVM (Acute Unit. Seville's Hospital Universitario Virgen Macarena); PPH (Seville's Penitentiary Psychiatric Hospital). **Cuestionario Sevilla de Calidad de Vida (CSCV = Seville's Quality of Life Questionnaire):** F (Favorable); U (Unfavorable); LS (Life satisfaction); SE (Self esteem); ARM (Harmony); LCG (Lack of cognitive grasp); LE (Loss of energy); LIC (Lack of internal control); EED (Emotional expression difficulty); CED (Cognitive expression difficulty); E (Estrangement); FLC (Fear of losing control); CH (Controlled hostility); AU (Automatism). **Frankfurter Beschwerde Fragebogen (FBF-3) = The Frankfurt Psychopathological Inventory:** TOT (Total Inventory Score); LC (Loss of control); SP (Simple perception); CP (Complex perception); L (Language); CT (Cognition and thought); ME (Memory); MF (Motor functions); LA (Loss of automatism); D (Distress and Anhedonia); I (Overstimulation induced irritability).

When the relationship was assessed (Table 2), one can observe a clear relationship among the different CSCV and FBF-3 scales. In the same way, we can see how the total scores of both scales are significantly related in such a way that those subjects with lower basic

psychotic symptomatology have a favourable perception of their subjective quality of life ($r = -.496, p < .01$), whereas those suffering from a larger number of basic psychotic symptoms have a negative assessment of their subjective quality of life ($r = .304, p < .01$).

Inventario Psicopatológico de Frankfurt (FBF-3) (The Frankfurt psychopathological inventory).

		TOT	PC	PS	P	L	CP	ME	MO	PAQ	D	I
Cuestionario Sevilla de Calidad de Vida (CSCV) (Seville Quality of Life)	F	-.496	-.474	-.319	-.343	-.428	-.368	-.327	-.321	-.510	-.551	-.477
	D	.304	.665	.739	.657	.689	.659	.622	.568	.715	.7454	.619
	SV	-.539	-.468	-.367	-.406	-.480	-.401	-.352	-.378	-.556	-.578	-.484
	AE	-.269	-.319	-.040	-.132	-.246	-.242	-.130	-.094	-.362	-.358	-.295
	ARM	-.509	-.489	-.426	-.359	-.405	-.336	-.384	-.366	-.439	-.534	-.500
	FAC	.565	.516	.432	.418	.623	.420	.414	.392	.464	.490	.517
	PE	.732	.569	.660	.614	.616	.621	.538	.536	.665	.681	.580
	FCI	.737	.685	.635	.629	.638	.687	.624	.425	.639	.613	.509
	DEE	.681	.616	.660	.516	.479	.520	.595	.373	.671	.668	.576
	DEC	.735	.584	.656	.543	.702	.543	.646	.519	.661	.669	.570
	E	.577	.378	.534	.529	.511	.479	.442	.530	.489	.514	.372
	MPC	.503	.428	.554	.422	.386	.517	.292	.363	.414	.512	.304
	HC	.238	.206	.308	.025	.252	.143	.156	.121	.260	.337	.180
	AU	.510	.369	.536	.503	.383	.320	.354	.472	.413	.513	.396

$p < .01; p < .05$ Table 2. Pearson's correlations between the CSCV and the FBF-3 scores

Once the relational analysis between subjective quality of life and basic psychotic symptomatology had been carried out, a multivariate analysis of variance (MANOVA) was used to verify whether there were significant differences between the group centroids by applying Wilks's Lambda test. Rao's F approximation was significant ($F = 2.497, p = .016$). Later on, a multivariate analysis of variance was done between all the variables that had proved significant in the multivariate analysis in order to find out whether or not there was any type of effect in relation to the health care facility used by the participants assessed. In general terms, the findings show that the health care facility variable does not significantly affect any of the variables

studied except for the ARM (Harmony) scale of the CSCV ($F = 2.798, p = .037$) and the D scale (distress and anhedonia) of the FBF-3 ($F = 3.050, p = .026$). Then, the t student test was used to find out the mean difference to verify which health facility illustrated the influence shown in the scales indicated. Table 3 shows that the patients hospitalized in the Penitentiary Psychiatric Hospital show lower ARM (harmony) and greater D (distress and anhedonia) than the rest of the patients, who had been assessed in other health care facilities, namely protective homes, supportive apartments, ASAENES (Seville's association for close friends of people suffering from schizophrenia) and acute units.

		<i>Student's t</i>								
		<i>VT (Pisos)</i>		<i>ASAENES</i>		<i>HUVM</i>		<i>HPP</i>		
	Media	t	p	t	p	t	P	t	P	
ARM (Harmony)										
	CH	3.37	-.719	.481	-1.009	.326	-1.146	.267	1.742	.099
	VT (Pisos)	3.60			.159	.876	.496	.626	2.126	.048
	ASAENE	3.65					-.402	.692	2.372	.029
	HUVM	3.80							2.350	.030
	HPP	2.62								
D (Distress and anhedonia)										
	CH	3.10	.533	.601	.916	-.100	-.289	.776	-2.795	.012
	VT (Pisos)	2.60			.596	.576	.696	.495	-2.964	.008
	ASAENE	3.20					-.175	.863	-2.449	.025
	HUVM	3.40							-2.112	.049
	HPP	6.00								

$p < .05$ Table 3. Student's t distribution between health care facilities and the ARM and D variables

DISCUSSION AND CONCLUSIONS

This study has found a clear relationship between basic symptomatology (subjective experience) and subjective QL. The relationship makes itself evident in the positive relationship between the total FBF-3 score

and the score in the unfavourable CSCV scale, and in the negative relationship which, on the other hand, is shown by the FBF-3 and the favourable CSCV scale. In other words, the people showing less basic symptomatology show greater life satisfaction, self esteem and harmony.

They feel more satisfied with the activities they perform in their daily life, with themselves and with the rest of the people surrounding them. However, the people with a greater score in the FBF-3 show less life satisfaction, self esteem and harmony; find it more difficult to understand what is happening around them (lack of cognitive grasp), feel they are more tired (lack of energy), cannot control what they feel or think (lack of internal control), find it difficult to relate affectively or emotionally (emotional expression difficulty), get disturbed when communicating with others or when they participate in conversations (cognitive expression difficulty) and have other problems, such as estrangement, fear of losing control, controlled hostility and automatism. In this respect, Leal *et al.* (1997) find a significant inverse correlation ($r = -0.16$) between the favourable CSCV scale and the negative symptoms measured by the Positive and Negative Syndrome Scale (PANSS) (Kay, Fiszbein and Opler, 1987), to such an extent that the individuals with more negative symptoms have lower scores on the favourable scales. Furthermore, a direct relationship exists between unfavourable scales and positive symptoms ($r = 0.41$). Following this line, other authors (Giner *et al.*, 2001) conclude that positive, negative and general symptomatology affect QL in schizophrenia. However, they invite a deeper analysis and a more detailed symptom assessment in which this study, we believe, would be included.

The work conducted by Bow-Thomas, Velligan, Millar and Olsen (1999) found a relationship between negative symptomatology and QL in all phases of the illness, unlike positive symptomatology, which is difficult to measure in the acute phases of the illness. However, these authors argue that the results need to be taken cautiously as the whole sample was taken from a hospital and they are all clearly influenced by the type of health care facility.

Another series of articles have reached findings similar to the ones in this study although the measures were, in the majority of cases, carried out in an objective way. Thus, Giner *et al.* (1999) found that psychotic symptoms affect QL although they do not bear in mind variables such as social support, educational needs or family relationships, due to the difficulty of obtaining this data in such a complicated sample.

The study by Karow, Moritz, Lambert, Schoder and Krausz (2005) obtains findings going in the same direction, as they find relationships between negative symptomatology and worse QL whereas the positive symptom relationship does not prove so clear and so they recommend new studies aiming at clarifying the relationship between symptomatology and subjective QL. If all seems to indicate the clear relationship between negative symptoms and subjective QL, other authors however find the same relationship with positive symptomatology (Kaskow *et al.*, 2001; Yu-Tao, Yong-Zhen, Chi-Ming, Wai-Kwong and Gabor, 2007, 2008).

Other studies fundamentally obtain relationships between negative symptoms and the general PANSS scale (Kay *et al.*, 1987), which gathers non specifically psychotic symptoms. In relation to this, depressive symptoms have a deleterious effect on the QL of schizophrenic patients (Bobes *et al.*, 2007; Narváez *et al.*, 2008; Shaun and Newhill, 2007). All of this justifies this present study, in which we try to give priority to subjective measures, that is, we really focus on what the schizophrenic person feels. Our intention is that, to those

treatments which now give priority to pharmacology, other alternatives which can alleviate these people's symptomatology, may be added and, in short, improve their QL.

As for the relationship among the context, basic psychotic symptomatology and subjective QL, our findings do not seem to confirm the influence of any health care facility on any of the two variables under study, unlike what has been observed in other studies (Mínguez *et al.*, 2005; Barry and Zissi, 1997; Bjorkman and Hansson, 2002; Goodwin and Madell, 2002), which do find a relationship between QL and place of residence, in such a way that the people living in the community have a better QL than the ones living in an institution. Perhaps we don't see this relationship in the present study, as the association is mediated by the presence of symptomatology. In this sense, Kaskow *et al.* (2001) pointed out the clear relationship between symptomatology and QL in a recent comparative study with communal or hospitalized patients.

Finally, the study by Liebe and Kallert (2001), very similar in its design to ours, finds symptomatology differences on the basis of health care facilities. They also argue that general life satisfaction does not systematically depend on the setting of the attention that these people make use of, but on other influential variables such as the assessment made of their own needs or of their purposes (goal achievement), which are generally affected by symptomatology. Consequently, QL is not only influenced by the fact that the environment may allow autonomy and independence, but also that social isolation is a variable to bear very much in mind. These findings may partially justify the results found by our study, namely that harmony differences can be significant depending on the health facility, as the people hospitalized in the Penitentiary Psychiatric Hospital have few relationships with the outside world and with the rest of the inmates, which might account for the low QL levels in this health care facility in respect to the other facilities. The same goes for distress and anhedonia, another significant variable, felt by the inmates when they feel deprived of freedom.

On the basis of the above comments, we conclude that there is a clear relationship between QL and basic psychotic symptomatology (subjective experience) in schizophrenia, in such a way that the greater the symptomatology the worse the QL expressed by the person suffering from the illness. Furthermore, we believe that there is no significant relationship among QL (measured by the CSCV), basic psychotic symptomatology (measured by the FBF-3) and the health care facility. This conclusion, which has methodological limitations, such as the sample size and the need to control other variables which make up QL does not nullify bringing this work close to such a complex illness as schizophrenia, from an eminently subjective perspective, as much as in the clinic as in the measure of QL. We believe that this change of perspective will better allow us to address and develop new therapeutic strategies, as we show that schizophrenic patients' control of their own symptoms is fundamental to improve their QL.

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