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Hopelessness and life satisfaction in patients with serious mental disorders: A cross-sectional study

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ABSTRACT

OBJECTIVE: The main purpose of treatment and management in chronic mental disorders is to improve the quality of life (QOL). Hopelessness indicates a significant cognitive vulnerability that is associated with suicide risk. It is important for clinicians to have information about their patients' life satisfaction and spirituality. This study was conducted to determine hopelessness and life satisfaction in patients who received service from a community mental health center (CMHC).

METHODS: This cross-sectional study was conducted with patients diagnosed with psychosis (n=66) and bipolar disorder (n=24) according to Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria, at a community mental health center serving in a hospital located in eastern Turkiye. Data was collected by a psychiatrist between January and May 2019 with face-to-face interviews, using a questionnaire, Beck Hopelessness Scale (BHS) and Satisfaction with Life Scale (SWLS).

RESULTS: In the study, it was found that the mean BHS and SWLS scores of the patients did not differ significantly between the diagnosis groups ($p>0.05$). A moderately negative correlation was found between the patients' mean BHS and SWLS scores ($rs=-0.450$, $p<0.001$). In addition, it was determined that the hopelessness level of the secondary school graduates was low ($p<0.05$), the mean BHS score increased as the age and time from diagnosis of the patients increased ($p<0.001$), and there was a low negative correlation between the time from diagnosis and the mean SWLS score (rs: -0.208; $p<0.05$).

CONCLUSION: In this study, it was found that the hopelessness level of the patients was low, their life satisfaction was moderate, and as the hopelessness level increased, their life satisfaction decreased. In addition, it was determined that the hopelessness and life satisfaction levels of the patients did not differ by to the diagnosis groups. It is extremely important for mental health professionals to consider aspects such as hope and life satisfaction, which are key in the recovery of patients.

Keywords: Hopelessness; life satisfaction; serious mental disorder.

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Patients with serious mental disorders such as schizophrenia and similar psychotic disorders as well as mood disorders that highly debilitating due to their devastating effects on cognitive, managerial and social skills, or who are hospitalized for a long time, constitute the main target group of the community-based mental health model. Under this model, it is aimed to provide effective treatment in order to improve individual functioning, provide psychosocial support services, and ensure follow-up and treatment of patients in the environment they live in [1, 2]. Acceptance of the disease, hope, compliance with treatment, supportive environment and easy

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access to mental health services are among the key factors facilitating recovery in mental disorders [3]. Recovery is being able to lead a fulfilling, hopeful and meaningful life despite the limitations of the disease. Healing comes from hope. Belief in the healing process is very important for individuals to face and cope with their illness [4, 5].

Hope is defined as the ability to see a desirable outcome as a truth possibility [6]. Hope is an important determinant of subjective well-being and is a positive motivational state [7]. It is a positive feeling that connects expectations about the future along with the possibility of realization of such expectations and enables one to manage his/her own life in order to reach their goals. Thanks to hope, one would be able to foster a positive thought that he/she can cope with any negative situation [8]. Hope is also considered to be one of the most important determinants in the amelioration of mental disorders and can help individuals deal with their illness better and discover the meaning of life [9]. While hopelessness entails the prediction of future experiences or outcomes, hope focuses on previous and current experiences of success in goal expectation [7].

Hope is a cornerstone in the recovery of individuals with mental disorders such as schizophrenia. In a study with schizophrenia patients and their family caregivers, hope was conceptualized as a multidimensional construct that was a vital resource for participants [10]. A qualitative study conducted with 25 schizophrenic patients in three community mental health centers in South Korea indicated that according to the patients, the basic definition of hope entailed a meaning in life, happiness, expectation of a better future and more energy for life. The same patients also stated that they wanted mutual feelings of love in close interpersonal relationships [9]. Hope is effective on individuals' mental and physical health, well-being, satisfaction with life, motivation, self-efficacy and QOL [11]. It is stated that avoidance of happiness is associated with low hope level. In addition, hope is protective against depressive thoughts and depressive mood, and there is a negative relationship between hope and depression [12].

Life satisfaction reflects a subjective evaluation of the QOL and is an essential constituent of subjective well-being [13]. It is the state of harmony of what a person has and his expectations from life are, and is one of the main indicators of well-being [14]. Life satisfaction, which indicates the state of well-being in various aspects such as happiness and spirituality, is important for effective disease management [15]. Individuals who were hopeful were shown to be more positive about reaching their goals [16]. Furthermore, such patients had high motivation in their efforts to reach their goals and they were satisfied with what they achieved in life. In other words, hope was shown to be an important predictor of life satisfaction [15]. Subjective mental health was shown to be related to life satisfaction; additionally, prevention as well as treatment of mental disorders were important in increasing life satisfaction [17].

Highlight key points

- Hopelessness levels of patients were found to be low and their life satisfaction was moderate, also life satisfaction decreased with increased hopelessness levels.
- No differences could be identified between hopelessness and life satisfaction levels of the patients on the basis of their diagnosis.
- Evaluating mental needs of patients and including them in the treatment strategy is extremely important in terms of improving patient outcomes.

Since mental health plays an important role in shaping an individual's life satisfaction and well-being, mental health problems constitute a potential predictor of life satisfaction [18]. Individuals with mental disorders generally report lower life satisfaction scores compared to healthy controls. However, studies comparing different diagnostic groups in terms of life satisfaction are limited [19]. In a longitudinal study conducted in New Zealand, it was found that life satisfaction decreased in individuals with mental disorders (major depression, anxiety disorder, suicide, alcohol addiction, substance abuse) [18]. In a study conducted with 51 schizophrenic patients and 56 healthy controls in Canada, life satisfaction levels of the patients were found to be significantly lower than the controls [20]. In this context, psychiatric nurses and clinicians in psychiatry and mental health settings may play a unique role in enabling individuals to develop a positive and hopeful attitude and live a satisfactory life [3].

It is seen that there are few studies examining the concepts of hope, hopelessness and life satisfaction in patients with severe mental disorders, and a study that examined both hope and life satisfaction together in various mental disorders could not be found. The current study was conducted to examine hopelessness and life satisfaction, in patients who received service from a CMHC in eastern Türkiye. Examining these notions, which have an important place in the recovery of patients, is important in

terms of designing treatment and rehabilitation plans for patients, developing interventions to strengthen patients and their families, and contributing to the improvement of patient outcomes.

MATERIALS AND METHODS

Study Design and Participants

The research was conducted in a cross-sectional design. The population of the study included patients diagnosed with psychosis (schizophrenia, schizoaffective disorder and atypical psychotic disorder) and mood disorders (bipolar) according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [21] criteria and receiving service in a community mental health center within a hospital located in the east of Turkiye (n=192). In the study, it was aimed to reach the entire universe and no sample selection was made. The sample of the study consisted of 90 patients who met the following inclusion and exclusion criteria (46.9% of the population).

In this study, patients who were in stable condition and in remission formed the sample of the study. In addition, patients with an additional diagnosis of depression were not included in the study, since additional diagnosis (such as depression) was determined as an exclusion criterion.

Inclusion criteria:

- Having a diagnosis of psychotic disorder or bipolar disorder according to DSM-5 criteria,
- Receiving service from a community mental health center,
- Patients between the ages of 18-65 who volunteered to participate in the study.

Exclusion criteria:

- Having any neurological disease, mental disability, alcohol-substance abuse disorder that may hinder the application of the questionnaires,
- Having an additional psychiatric diagnosis (such as depression).

Measurement Tools

A Questionnaire, which includes the descriptive characteristics of the patients and information about the disease along with Beck Hopelessness Scale and Satisfaction with Life Scale were used to collect the data, Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV) was employed for confirming the diagnoses.

Questionnaire Form: The form consisted of five questions that were used to identify descriptive properties (gender, age, education level) and disease-related characteristics of the patients (diagnosis, duration of the disorder).

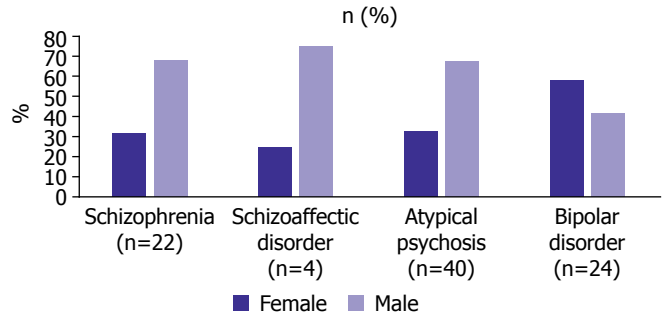

FIGURE 1. Gender of the patients.

Structured Clinical Interview for DSM-5-Clinician Version (SCID-5-CV): SCID-5-CV is a semistructured interview guide for making DSM-5 diagnoses, developed by First et al. [22] and Turkish adaptation was published by Elbir et al. [23].

Beck Hopelessness Scale (BHS): The BHS was developed by Beck et al. and measures the negative expectations of the individual about the future [24]. The validity and reliability study in Turkiye was conducted by Seber et al. [25]. The scale consists of 20 dichotomous items scored either 0 or 1. Zero is the lowest score that can be obtained from the scale while 20 is the highest score; a high score reflects a higher level of hopelessness. The scale has three sub-dimensions, and Chronbach's alpha coefficient was reported as 0.85 for the overall scale [25]. In this study, the overall scale scores were studied and the alpha coefficient was determined to be 0.81.

Satisfaction with Life Scale (SWLS): SWLS was developed by Diener et al. [26] to determine the satisfaction of an individual from his life and was adapted into Turkish by Köker [27] and Yetim [28]. The scale consists of five Likert-style items with 7 grades (1: strongly disagree, 7: strongly agree). The lowest score of the scale is 5, while the highest score is 35. A high score is accepted as an indicator of high life satisfaction. Chronbach's alpha coefficient was reported as 0.86 for the overall scale [27, 28] and was found to be 0.76 in the current study.

Data Collection

The data were collected by the psychiatrist, who is responsible for the community mental health center and took part in the research, between January and May 2019 by face-to-face interview method in a room suitable for interviews at the center.

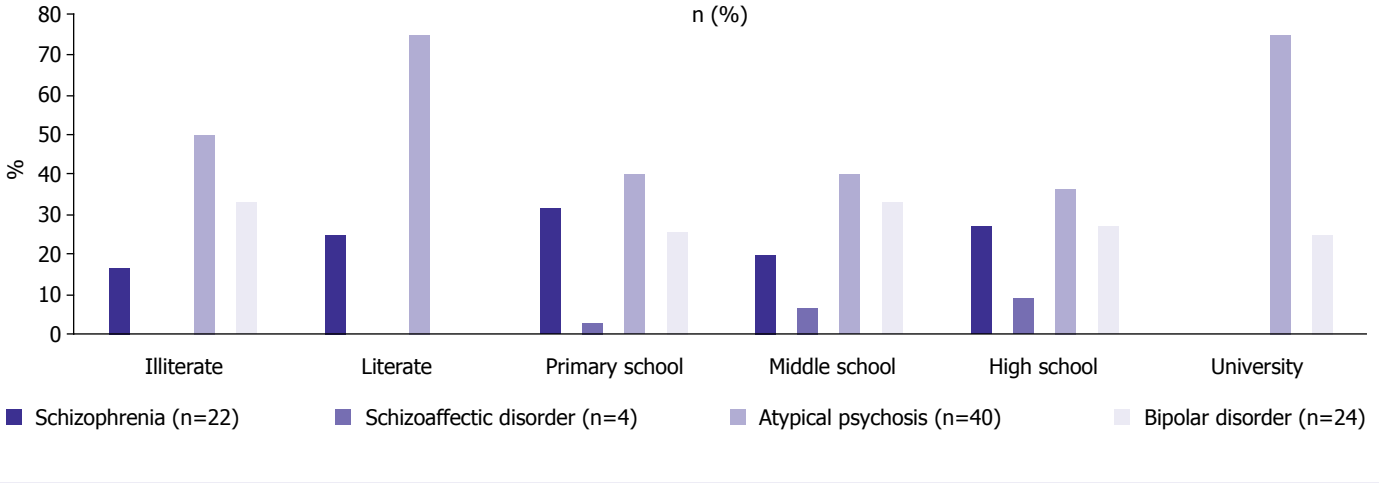

FIGURE 2. Education level of the patients.

Statistical Analysis

In the analysis of the data, conformity to the normal distribution was determined with the Shapiro Wilk test. Descriptive features were given in numbers, percentages, and mean values. The differences in the descriptive characteristics of the groups were compared using one-way analysis of variance (ANOVA) and chi-square test. Non-parametric (Kruskal-Wallis analysis of variance, Mann-Whitney U (MW-U), spearman correlation) tests were applied, since the mean scores of BHS and SWLS did not correspond to normal distribution. The Mann-Whitney U test was used as a further analysis tool to spot where the difference originated. Post hoc power analysis was performed to determine whether the sample size of the study was adequate. In the power analysis, it was determined that the study power was 0.99 at a significance level of 0.05 and 95% confidence interval (Correlation H1=0.63, lower critical r=-0.207, Upper Critical r=0.207, power 0.99). This value indicates that the sample is sufficient [29].

Ethical Considerations

Ethical approval was obtained from the University Human Research Ethics Committee (16/01/2019-01/02) and institutional permission (30/01/2019-771) were obtained from the hospital where the research was conducted. Written informed consent was obtained from the patients who participated in this study. The principles of the Declaration of Helsinki were taken into account while conducting this research.

RESULTS

Descriptive and Disease-Related Characteristics of Patients

68.2% (n=15) of patients with schizophrenia, 75% (n=3) of patients with schizoaffective disorder, 67.5% (n=27) of patients with atypical psychotic disorder and 41.7% of patients with bipolar disorder (n=10) were male and the difference between the patient groups did not reach statistical significance (p>0.05) (Fig. 1). The mean age of patients with schizophrenia was 39.3±9.8 years, those with schizoaffective disorder was 53.0±8.12 years, those with atypical psychotic disorders was 41.5±11.3 years, and the mean age of bipolar patients was 41.9±14.1 years. Patients with schizophrenia were the youngest and those with schizoaffective disorder were the oldest (p<0.05). 50% of patients with schizophrenia (n=11), 25% (n=1) of patients with schizoaffective disorder, 35% (n=14) of patients with atypical psychotic disorder, and 79.2% (n=19) of patients with bipolar disorder were primary school graduates (p>0.05) (Fig. 2). The mean duration of the illness was found to be 13.8±9.3 years in patients with schizophrenia, 22.0±8.4 years in patients with schizoaffective disorder, 14.5±9.5 years in patients with atypical psychotic disorder, and 12.3±10.2 years in patients with bipolar disorder (p>0.05). 24.4% (n=22) of the sampled patients (n=90) were diagnosed with schizophrenia, 4.4% (n=4) with schizoaffective disorder, 44.4% with atypical psychotic disorder (n=40) and % 26.7 (n=24) with bipolar disorder according to the DSM-5 criteria, (Table 1).

Table 1. Descriptive and disease-related characteristics of the patients (n=90)

Descriptives	Schizophrenia (n=22)	Schizoaffectic disorder (n=4)	Atypical psychosis (n=40)	Bipolar disorder (n=24)	Test X^2, F	p
Gender (number)						
Woman	7	1	13	14	5.293	0.152*
Male	15	3	27	10		
Education						
Illiterate	1	0	3	2	9.778	0.873*
Literate	1	0	3	0		
Primary school	11	1	14	9		
Middle School	3	1	6	5		
High school	6	2	8	6		
University	0	0	6	2		
Age (years)						
(Mean±SD)	39.3 (9.8)	53.0 (8.12)	41.5 (11.3)	41.9 (14.1)	1.196	**0.0273****
Duration of illness (years)						
(Mean±SD)	13.8 (9.3)	22.0 (8.4)	14.5 (9.5)	12.3 (10.2)	1.226	0.248**
BHS	r_s=-0.450				**<0.001**	

*X^2: Chi-square; **F: ANOVA; **p<0.05.

Hopelessness and Life Satisfaction Levels of Patients

The hopelessness level of the patients was found to be low and their life satisfaction was moderate in the current study, as assessed by the lowest and highest scores obtained on the scales. The highest mean BHS score was found in patients with atypical psychosis (7.72±5.50), the scores of other diagnostic groups were found to be as follows; schizophrenia patients (6.86±4.21), schizoaffective patients (7.00±5.35) and bipolar patients (6.83±5.42) and no significant difference was found between the groups on the basis of the BHS scores (p>0.05). The highest mean SWLS score was found in patients with atypical psychosis (18.70±6.84), the scores of other diagnostic groups were found to be as follows; schizophrenia patients (16.68±6.18), schizoaffective patients (12.25±5.85) and bipolar patients (17.41±7.42); there was no significant difference between mean SWLS scores of diagnostic groups (p>0.05) (Table 2).

Relationship between the Level of Hopelessness and Life Satisfaction of Patients with Descriptive Features

No significant difference could be identified between the mean BHS and SWLS scores of the patients classified by gender (p>0.05) (Table 1). A significant difference was identified between the education level of the patients and the mean SWLS scores (p<0.05); through further analysis (MW-U) it was determined that the difference was mostly associated with the secondary school graduates. There was no significant difference between the level of education and the mean SWLS scores (p>0.05). The mean BHS score was found to increase significantly with age and time from diagnosis (rs =0.392, p<0.001; rs=0.238, p=0.024, respectively). No significant relationship could be identified between the age of the patients and the mean SWLS score (p>0.05), and there was a modest but statistically significant negative correlation with the time from diagnosis (rs: -0.208; p<0.05) (Table 3).

Relationship between Hopelessness and Life Satisfaction Levels of Patients

In the current study, a moderate negative correlation was identified between the mean BHS and SWLS scores of the patients (rs= -0.450, p<0.001), suggesting that as the hopelessness level of the patients increases, their life satisfaction decreases (Table 2).

Table 2. Among diagnostic groups BHS, SWLS mean score differences (n=90)

	Schizophrenia (n=22)	Schizoaffectic disorder (n=4)	Atypical psychosis (n=40)	Bipolar disorder (n=24)	Test	p
BHS (M±SD)	6.86±4.21	7.00±5.35	7.72±5.50	6.83±5.42	0.571*	0.903**
SWLS (M±SD)	16.68±6.18	12.25±5.85	18.70±6.84	17.41±7.42	3.251*	0.355**
	SWLS					p
BHS	rs=-0.450					<0.001

BHS: Beck Hopelessness Scale; SWLS: Satisfaction with Life Scale; M: Mean; SD: Standard deviation; *: Kruskal-Wallis variance analysis; **: P>0.05.

Table 3. Comparison of the mean BHS and SWLS scores according to the descriptive and disease-related characteristic of the patients (n=90)

Descriptive features	BHS	Test p	SWLS	Test p
Gender	M±SD	MW-U=827.500	M±SD	MW-U=789.500
Woman	7.51±4.41	Z= -1.122	16.40±6.97	Z= -1.788
Male	7.07±5.55	p=0.262	19.19±6.95	p= 0.074
Education status				
Illiterate	7.67±3.44	KW=12.667	17.00±3.16	KW=4.056
Literate	9.00±7.12	***p=0.027**	18.75±4.57	p=0.541
Primary school	7.97±4.93		16.03±6.95	
Junior high school	3.67±2.72		19.80±7.33	
High school	7.05±5.24		18.55±7.32	
University	10.13±6.77	rs=0.392$	17.38±7.19	rs= -0.203$
Age (years)	41.61±11.87	**p<0.001**$	41.61±11.87	p=0.055
Duration of diagnosis (years)	14.12±9.69	rs=0.238$	14.12±9.69	rs= -0.208$
		p=0.024*		***p=0.049**

BHS: Beck Hopelessness Scale; SWLS: Satisfaction with Life Scale; M: Mean; SD: Standard Deviation; *: P<0.05; MW-U: Mann Whitney-U; KW: Kruskal-Wallis variance analysis; rs: Spearman correlation.

DISCUSSION

In the current study, the hopelessness levels of the patients with serious mental health disorders were low and their life satisfaction was moderate. According to the diagnosis groups, the hopelessness and life satisfaction levels of the patients were not different. Furthermore, it was found that as the hopelessness level of the patients included in the study increased, their life satisfaction decreased. In addition, it was determined that the hopelessness level of the secondary school graduates was low. The results obtained from this study are discussed in line with the relevant/similar literature.

The main purpose of treatment and management in chronic mental disorders is to improve the quality of life. Quality of life is multidimensional and has different components such as life satisfaction and general well-being [30]. It has been reported that schizophrenia patients with high hopes have a higher QOL [31]. In this sense, it is important to measure life satisfaction and hope in mental disorders. However, the use of self-report measures in psychiatric patients is an important condition as it may

cause distress due to cognitive impairment or cognitive prejudice. In this study, subjective evaluations of hopelessness and life satisfaction of patients who are in remission and whose condition is stable, whose outpatient treatment is planned and followed regularly in a CMHC were made.

Hopelessness may exacerbate the risk of depression and suicide, highlighting a feeling of pessimism for the future. It was also reported to be an important independent factor in the prediction of suicidal behavior [32]. Also, hopelessness was shown to be an important component of psychoses, especially the psychopathology of schizophrenia [33]. In this study according to the scores that can be obtained from the scales, the hopelessness levels of the patients were found to be low and their life satisfaction was moderate. Additionally, it was determined that the hopelessness level of patients with psychotic disorder was higher, although not significant, compared to other diagnostic groups. In a study of Aguilar et al., it was shown that the mean BHS score was higher in schizophrenia patients (7.6±4.1) compared to other psychosis patients (5.2±3.9), and hopelessness was positively associated with depressive symptoms [33]. In a study conducted in the United Kingdom, it was found that hopelessness and self-esteem together with stigma could affect symptomatic and subjective recovery and psychosis experience [34]. Like the results of this study, in the study of Klonsky et al., it was found that the level of hopelessness in patients with chronic mental disorders did not differ between the diagnosis groups. In addition, it has been reported that patients who attempt suicide have significantly higher BHS scores [35]. In a study conducted with schizophrenia patients in Türkiye, the level of hopelessness (6.21±4.16) was found to be like the results of this study [36].

Life satisfaction and psychological well-being are shown as predictors of QOL [37]. In a study conducted with schizophrenic patients hospitalized in the psychiatry ward in Romania, it was reported that low QOL in patients was affected by the severity of symptoms and cognitive decline, and low QOL could be considered as an indicator for suicidal behavior. It was emphasized that the correct therapeutic management of patients with schizophrenia can improve their life satisfaction and treatment outcomes [38].

In this study, although there was no significant difference between the diagnostic groups in terms of hopelessness and life satisfaction levels of the patients, the hopelessness level was found to be the lowest in patients with bipolar disorder. In a study conducted in Italy patients with mood disorders, serious hopelessness was found in 47% of the patients and it was shown that hopelessness is a major predictor of poor health and social functioning [32]. A Turkish study including patients with bipolar disorder reported that patients who had a history of suicide attempt (n=31) had high levels of hopelessness and anxiety [39]. A study conducted by Valtonen et al. with patients with bipolar disorder, indicated that the hopelessness levels of the patients could differ markedly; the levels were found to be highest in the depressive and mixed illness periods and lowest during euthymia, hypomania, or manic episodes. Hopelessness was found to be independently and strongly associated with depression and anxiety [40]. Life satisfaction scores could differ among different psychiatric diagnosis groups and the scores were reported to be the lowest in those with trauma-related disorders [19].

In the study of Bilge et al. with patients hospitalized in the psychiatry clinic, like the results of this study, it was found that the life satisfaction level of the patients was moderate and the level of life satisfaction of patients with schizophrenia (18.17±7.97) and bipolar disorder (18.48±7.19) was very close to each other. has been reported [41]. In a study conducted by Goldberg & Harrow with patients with mood disorders, it was reported that recurrent depression decreased life satisfaction in mood disorder subtypes, and most patients with bipolar and unipolar disorder described moderate life satisfaction during a follow-up period of 7-8 years [42]. In a study conducted in Serbia, patients with mental disorders reported significantly lower life satisfaction than participants from the general population [43]. In a study conducted with schizophrenia patients by Kurtz et al., it was shown that depression and cognitive function were associated with life satisfaction, but not with objective psychosocial status. The importance of treating depression as a means of increasing subjective life satisfaction has been noted [44]. In the current study, the relatively positive results regarding hopelessness and life satisfaction in patients with severe mental disorders can be considered because the patients were in remission and not in periods of episodes, and that their follow-up and treatment were followed closely at the CMHC.

In the current study, it was noted that gender did not have a significant effect on the hope and life satisfaction of the patients; however, the level of hopelessness level was found to be significantly lower among secondary school graduates. In addition, it was found that as the age of the patients and the time from diagnosis increased, hopelessness increased, and life satisfaction decreased with

an increased time from diagnosis. The total QOL scores of schizophrenic patients who applied to a community psychiatry center and a neuropsychiatry hospital outpatient clinic in Nigeria were significantly higher in women, married people, patients with higher education levels and those who received service from a community psychiatry center, but there was no difference in terms of time from diagnosis [30]. In another study, it was reported that women with major depressive disorder/dysthymic disorder had higher life satisfaction than men with these disorders [45]. A study conducted in Türkiye with patients who applied to a CMHC and participated in regular rehabilitation programs, reported that female patients were more compliant with treatment than men, and single patients compared to married ones [46]. These varying results can be explained by the severity of mental disorder symptoms and the effect of sociocultural characteristics.

Limitations

A lack of control on the disease-specific variables that may affect the patients' perception of hopelessness and life satisfaction can be considered as the first limitation of the study. The second limitation is the number of patients, due to the limited number of patients that could be recruited from a single community mental health center in the city where the research was conducted.

The third limitation of the study is that the number of patients is not close to each other, and the number of some patient groups is very small.

Conclusions

In the current study, hopelessness levels of patients with serious mental health disorders were found to be low and their life satisfaction was moderate, moreover life satisfaction decreased with increased hopelessness levels. Additionally, no differences could be identified between hopelessness and life satisfaction levels of the patients based on their diagnosis. In this context, it should be considered as one of the strategies to instill hope and increase life satisfaction in patients with mental disorders, and the mental needs of patients should be recognized and should not be neglected. Evaluating these needs of patients and including them in the treatment strategy is extremely important in terms of improving patient outcomes. It is recommended to conduct further comprehensive studies in the future, by considering the concepts of belief and spirituality, along with hope and life satisfaction of psychiatric patients, and address these issues as a whole.

Ethics Committee Approval: Ethical approval was obtained from the University Human Research Ethics Committee (16/01/2019-01/02) and institutional permission (30/01/2019-771) were obtained from the hospital where the research was conducted.

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