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REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

# GROWING OLDER WITH SCHIZOPHRENIA

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VOL. 1 N.º 1 APRIL 2015

# ABSTRACT

Schizophrenia is a serious disturbance, with heterogeneous and variable course, causing a high degree of disability represents a high economic cost to society and family impact. It is a disorder with multiple facets regarding the etiology, phenomenology, course, and treatment, the most common is the tendency to chronicity and dysfunction (Chinchilla, 2008). The fact that it is a pathology with a very variable course and, therefore, with repercussions to different levels confronts us with the need to better understand the repercussions of the disease throughout the aging process. However, schizophrenia in the elderly has been guided by forgetfulness or lack of research. However, given the differences already known among young and elderly individuals with schizophrenia (Mausbach, Cardenas, McKibbin, Jeste, & Patterson, 2008) is important to investigate and better understand the effects of the passage of time in people with schizophrenia. A questionnaire was applied to 64 patients with a diagnosis of schizophrenia. The methodology of analysis and treatment of the data was the statistical analysis, following the construction of the database in Statistical Package for the Social Sciences (IBM SPSS Statistics 21). From here was triggered all the descriptive statistical analysis. The results do not indicate the cognitive deterioration and disfunctionality. The fact is that for individuals who are married, with children, living in a community can justify the favourable evolution of the disease. These evidences point to the need of people with schizophrenia remain in the community, with family and social support.


Descriptors: Aging; schizophrenia; repercussions

# INTRODUCTION

Resulting from epidemiologic studies conducted over the past 15 years, we are aware that mental disorders are the leading cause of disability and one of the leading causes of morbidity in current societies. According to the report made by the National Commission for the Restructuration of Mental Health Services (CNRSSM), of the ten leading causes of disability, five are psychiatric disorders. Worldwide, mental disorders account for an average of 30.8% of years lived with disability (AVI), and in Europe these values rise to about 40% (OMS, 2002). Beyond this severe framework, the predictions point to a significant increase of mental disorders in the future (CNRSSM, 2007; OMS, 2002; 2005).

Schizophrenia is a serious disturbance, with heterogeneous and variable course, causing a high degree of disability represents a high economic cost to society and family impact (OMS, 2002). It is a disorder with multiple facets regarding the etiology, phenomenology, course, and treatment, the most common is the tendency to chronicity and dysfunction (Chinchilla, 2008).

Thus, schizophrenia cannot be discussed as if it were a unique nosologic entity which comprises a group of disorders with heterogeneous causes and includes patients whose clinical presentation, response to treatment and disease course are very varied (Kaplan, Sadock & Grebb, 2003).

The fact that it is a pathology with a very variable course and, therefore, with repercussions to different levels confronts us with the need to better understand the repercussions of the disease throughout the aging process. However, schizophrenia in the elderly has been guided by forgetfulness or lack of research. According to Jeste and Nasrallah (2003) the elderly were excluded in more than 90% of published studies about schizophrenia which leads to a lack of evidence in what concerns this population. However, given the differences already known among young and elderly individuals with schizophrenia (Mausbach et al., 2008) is important to investigate and better understand the effects of the passage of time in people with schizophrenia.

# METHODS

*Population and Sample*

The population of the studied universe consists of people with a diagnosis of schizophrenia in the Municipality of Beja, they are users of the Department of Psychiatry and Mental Health (DPSM) of Hospital José Joaquim Fernandes of Beja.

The sick people were, in a first phase, identified by having as reference the epidemiological study conducted by Nunes (2011) that allowed the identification of persons with a diagnosis of schizophrenia who have appealed to the psychiatry consultations in DPSM (86 Users). These data have been complemented and updated using the records of the three intervention teams of that service and by applying the inclusion criteria defined by the researcher.

Were identified 114 patients with a diagnosis of schizophrenia, and 50 patients were excluded for the following reasons:

- 19 did not attend the DPSM in the period under which the data collection was not possible neither to carry out home visits.
- 16 refused to participate in the study.
- 9 because they were very damaged mentally and without communicational skills that would enable them to respond to the questionnaire.
- 6 because of residence change (out of county or district).

At the end of this selection process, which has gone through several stages, we obtained a sample of 64 people with schizophrenia (Figure 1).

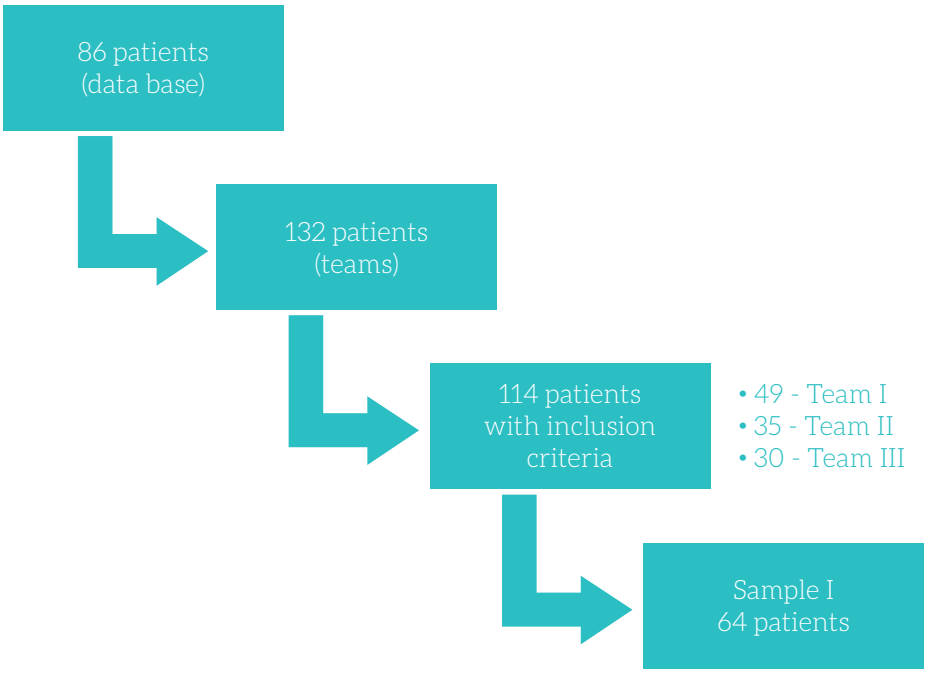


Figure 1. Process of Sample Selection

It was found that the "profile type" of the group of respondents corresponds to male gender, age-group between 40 and 49 years old, single, with no children, living alone, with a low level of education and without professional occupation.

More specifically, the study shows that in relation to the age variable is the average of 40.55, with ages between 22 and 64 years. The age group equal or over 50 years is 17.2% of the sample (n = 11), as can be seen in Figure 2:

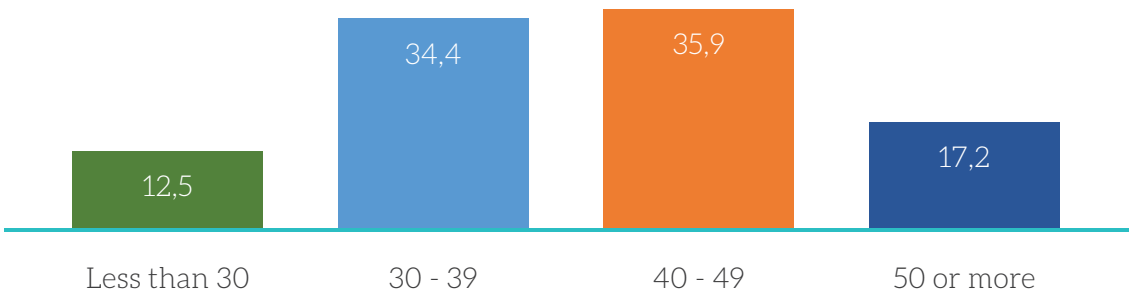


Figure 2. Sample Distribution by age classes

*Procedures and Instruments*

The instrument used was the result of a process of translation and adaptation of a questionnaire of Madrid Association of Friends and relatives of patients with Schizophrenia (2008), guaranteed the ethical and legal procedures.

These questionnaires were subjected to a process of translation and adaptation as recommended by Herdman, Fox-Rushby and Badia (1998).

After this procedure the questionnaire was composed of 44 questions, divided into five thematic Blocks: the first (Block A) relating to the socio demographic characteristics of the sample; the second (Block B) applied on trade-related labor and economic aspects; the third (Block C) concerning the family context; the fourth (Block D) on the health/disease situation of respondents; and the fifth block (Block E) on the degree of use and level of satisfaction with the social and health care resources.

The questionnaires took place between March and October 2013 when a psychiatric service users went to consultations and also in the homes of users in scheduled home visits situations. In most situations the questionnaires were carried out under the supervision and guidance of DPSM nurses who gave support to overcome any doubts expressed by the respondents.

*Procedures for data analysis*

The methodology of analysis and treatment of the data was the statistical analysis, following the construction of the database in Statistical Package for the Social Sciences (IBM SPSS Statistics 21). From here was triggered all the descriptive statistical analysis.

Because in this article, we intend to study the "behavior" of the variable age group we preceded to its intersection with other socio demographic and clinical variables, relating to satisfaction with the resources used and with the aid received.

In view of the characteristics of the dependent variables, measured predominantly in nominal scale and other in ordinal scale were used for the evaluation of the association between variables, the tests of association of chi-square and coefficient of correlation of Spearman.

It was set a significance level of 0.05. The next item is the only presentation of results that have proved being statistically significant ($p < 0, 05$).

# RESULTS

The aggregate sample is composed of 64 individuals. Of these, 17.2% (n = 11) are aged between 50 and 64 years (figure 2), with a mean age of 40.55 years.

By the intersection between age groups and marital status emerges that, in spite of the predominance of "singles" in the total sample (53.1 % ), individuals of age classes higher are "divorced" or "married" (table 1) there is a statistically significant association between age and marital status (table 2).

| | | Marital Status | | | | |
|---|---|---|---|---|---|---|
| | | Single | Married | Divorced | Widowed | Total |
| Age Classes | Less than 30 | 23,5% | 0,0% | 0,0% | 0,0% | 12,5% |
| | 30-39 | 41,2% | 33,3% | 17,6% | 4,5% | 34,4% |
| | 40-49 | 29,4% | 16,7% | 64,7% | 0,0% | 35,9% |
| | 50 or more | 5,9% | 50,0% | 17,6% | 0,0% | 17,2% |
| Total | | 53,1% | 18,8% | 26,6% | 1,6% | 100% |

Table 1. Intersection between age groups and marital status

In table 2 are represented the statistically significant results of the tests of the *Chi-square and Correlation Coefficient of Spearman*.

There is a statistically significant association between age and the following variables: *marital status, ancestry, academic degree and job situation* (table 2). In relation to the standard of these associations, in a general way, in the age group consisting of subjects with 50 or more years predominate individuals married or separated, with children, with the 1st school cycle as academic degree and pensioners by invalidity (100 %). It is a profile that contrasts deeply with the subjects' profile of younger age groups.

| | $x^2$ | $r_s$ | $p$ |
|---|---|---|---|
| Marital Status | 26,29 | - | ,002 |
| Have or not have children | 12,10 | - | ,007 |
| Academic degree | 28,64 | - | ,018 |
| Job situation | 28,93 | - | ,016 |
| Income | - | ,473 | ,000 |
| Time of treatment | - | ,416 | ,001 |
| Responsible by medication | 16,20 | - | ,001 |
| Type of antipsychotics | 21,65 | - | ,010 |
| Frequency of psychiatry consultations | 28,28 | - | ,005 |
| Resources not provided | 29,40 | - | ,014 |
| Overall satisfaction with the resources | - | ,435 | ,000 |
| Satisfaction psychiatry consultation | - | ,315 | ,013 |
| Satisfaction psychiatric nursing consultation | - | ,479 | ,002 |
| Satisfaction nurse home visits | - | ,563 | ,004 |
| Satisfaction medical health center services | - | ,311 | ,029 |
| Satisfaction nursing services health center | - | ,385 | ,015 |
| Overall satisfaction with the aid | - | ,366 | ,003 |
| Average Satisfaction help 1 | - | ,263 | ,042 |
| Average Satisfaction help 2 | - | ,387 | ,003 |
| Average Satisfaction help 3 | - | ,412 | ,002 |
| Average Satisfaction help 4 | - | ,360 | ,013 |
| Average Satisfaction help 7 | - | ,454 | ,012 |
| Average Satisfaction help11 | - | ,554 | ,002 |

Table 2. Age Classes - significant Results of Chi-square test and Spearman's Correlation Coefficient
Help 1- Understand, from the beginning, the disease; Help 2- Information on action of drugs;
Help 3- Information about signs of relapse; Help 4- Helps to improve the emotional state
Aid 7- Information on economic support; Help 11- information on available resources.

With respect to the offspring, expose-if the results of the intersection between age classes and descendants ($p$ = 0.007) in table 3, which highlights the prevalence of individuals with children in the group of people with 50 or more years, in spite of the predominant individuals without children in the global sample (60,9%).

The age group is also significantly associated with the person responsible for the management and administration of medication ($p$ = 0.001), type of *antipsychotics* are ($p$ = 0.010), frequency of consultations of psychiatry ($p$ = 0.005) and not provided resources ($p$ = 0.014). More specifically, it was observed that as the age increases, also increases the percentage of individuals who are self-responsible for medication management (table 4).

| | | Descendants | | |
|---|---|---|---|---|
| | | Yes | No | Total |
| Age Classes | Less than 30 | 12,5% | 87,5% | 12,5% |
| | 30-39 | 27,3% | 72,7% | 34,4% |
| | 40-49 | 39,1% | 60,9% | 35,9% |
| | 50 or more | 81,8% | 18,2% | 17,2% |
| Total | | 39,1% | 60,9% | 100% |

Table 3. Intersection between age classes and descendants

| | | Responsible for medication | | |
|---|---|---|---|---|
| | | Own | Family menber | Total |
| Age Classes | Less than 30 | 12,5% | 87,5% | 100,0% |
| | 30-39 | 63,6% | 36,4% | 100,0% |
| | 40-49 | 73,9% | 26,1% | 100,0% |
| | 50 or more | 100,0% | 0,0% | 100,0% |
| Total | | 66,7% | 33,3% | 100,0% |

Table 4. Intersection between age classes and responsible for medication

In relation to the type of *antipsychotics*, it is verified that individuals of older age classes are predominantly treated with typical antipsychotics and the younger age groups with atypical antipsychotics (Table 5).

| | | Type of antipsychotics | | | | |
|---|---|---|---|---|---|---|
| | | Typical | Atypical | Typical and atypical | Non-medicated | Total |
| Age Classes | Less than 30 | 0,0% | 62,5% | 25,0% | 12,5% | 12,5% |
| | 30-39 | 50,0% | 45,5% | 4,5% | 0,0% | 34,4% |
| | 40-49 | 26,1% | 34,8% | 30,4% | 8,7% | 35,9% |
| | 50 or more | 72,7% | 0,0% | 27,3% | 0,0% | 17,2% |
| Total | | 39,1% | 35,9% | 20,3% | 4,7% | 100% |

Table 5. Cross between age groups and type of antipsychotic

With regard to the association between age groups and frequency of psychiatric consultations, it is verified that in older age classes, consultations are less frequent than in younger age groups.

Regarding the resources not provided, the age group consisting of individuals with 50 years or more who did not respond to the question (63.6%) or reported having no need of any feature that had not been provided (27.3%).

By applying the Spearman correlation coefficient were obtained statistically significant correlations in what concerns income, time in treatment, overall satisfaction with the resources used and satisfaction with five resources (Table 2), overall satisfaction with the support received and with some types of aid received. All situations have positive correlations, and is possible to conclude that higher incomes, larger treatment time and greater satisfaction degree are associated with older age groups.

# DISCUSSION

Individuals with early-onset schizophrenia and whose aging is accompanied by the presence of the disease seem to present, along the aging process, additional problems when compared with younger individuals. Among these problems are the cognitive *deficits* and the decrease of their social networks (which originates that these patients do not marry and do not have children), lack of insight, comorbidities by the use of substances and side effects of antipsychotic long-term treatment (Krishnamoorthy & Baldwin, 2011). Although some of these characteristics have not been explored in our study others, however, allow us their comparison and discussion. The results for the comorbidities seem to rival, in some areas with these findings. Although these results are not statistically significant, because is observed a predominance of comorbidities in all age groups, 81.8% of subjects with 50 or more years (n = 9) feature related comorbidities. In what concerns the type of comorbidities is noted that in younger age classes predominate the nicotine and alcohol dependencies and in individuals with 50 or more years predominate somatic diseases.

In terms of marital status, the results of our study apart from the mentioned by Krishnamoorthy and Baldwin (2011) since the individuals that constitute the higher age groups are mostly married (in the group of 50 or more years) or divorced (in the group of 40 to 49 years). However, it should be noted that in the total sample the marital status of "single" is predominant (53.1 %) following the trend of the majority of studies with similar populations where there is also a high supremacy of single individuals (Carvalho, 2011; Simões do Couto et al., 2011; Xavier, Caldas de Almeida, Martins, Barahona, & Kovess, 2002).

Also the findings reveal that the patients themselves who are responsible for managing their own medication can be interpreted as a sign of autonomy instead of lack of critical or insight.

On the other hand, the results relating to the issue, about needy and not provided resources are revealing already a profound passivity or indifference since the majority did not respond to the question (although it is a question of easy interpretation) or responded saying they had not felt necessity for any resource that had not been provided. This situation is prevalent in older age groups, although it is present, albeit less pronounced, in the whole sample. . We infer that this apparent passivity may be related to the negative symptoms of schizophrenia which include decreased attention and concentration, blunted affect, poverty of speech and thought, the difficulty of feeling interest and pleasure in usual things (Afonso, 2010; Navarro, 2009). Indeed, the motivational deficits play a central role in the dysfunction caused by schizophrenia (Wolf et al.,2014) and, in this particular situation, may be related to the absence of criticism of the limited resources available.

Regarding the medication can be seen that, unlike advocated by some authors, patients with 50 or more years are predominantly treated with typical antipsychotics (or conventional). According to Krishnamoorthy and Baldwin (2011) the risk of developing extrapyramidal side effects, urinary incontinence and falls by the use of conventional antipsychotics is fairly high. The very use of anticholinergics to counter the extrapyramidal effects, only itself also causes significant side effects in older people as confusion and delirium. In a literature review conducted by Jeste et al. (2005) it was concluded that atypical antipsychotic drugs are the treatment of choice in elderly patients with dementia or schizophrenia. However, we appeal to the caution and risk assessment-benefits for its use. Other studies show, following the replacement of typical and atypical antipsychotics for sequence monitoring periods for the evaluation of the results, the use of atypical antipsychotics advantages such as fewer side effects and better quality of life (Finkel et al., 2009; Ritchie et al, 2006).

However, the conventional antipsychotics *dépôt* are quite indicated in patients with problems of medication adherence (Krishnamoorthy & Baldwin, 2011). Although the study reveals a total adherence to medication in the age group under consideration, there is, also, that the majority is medicated with intramuscular antipsychotic and being this presentation predominant in atypical antipsychotics, we infer that this is an age group mostly medicated with typical intramuscular antipsychotics.

As to the levels of satisfaction with the resources used and with the aid received, it was observed that the older age groups are, overall, more satisfied than younger groups. However, when it comes to populations with schizophrenia seem to be little doubt about the ability of evaluating these people about aspects of their own life, due to cognitive deficits or lack of awareness of

morbidity. According to Doyle et al. (1999) there is a tendency for people with schizophrenia they deal with high degrees of satisfaction despite the adversities of life. These authors also indicate the low expectations as additional factors that could justify a higher satisfaction with the objective life conditions.

Nevertheless, our interpretation about the greater satisfaction as evidenced by the group of older patients with resources and aid received is anchored in the fact that it is a group with a long-term progression of the disease and soon, with a long-term contact with the services and professionals, which may translate into a higher satisfaction with these same services and professionals. It is important to interpret the results statistically significant between age classes and some resources used. It appears that these results are observed in the resources that come from two professional classes: nurses and doctors.

These results may have justification in the relationship of trust and closeness that usually is established between these two professional classes and the patient. When it comes specifically to nurses, the relationship client-professional nursing is guided by established partnership with the customer, in respect for their abilities and in the value of your role. This relationship develops and strengthens along a dynamic process, which is aimed at helping the client to be proactive in achieving its health project (Order of Nurses, 2002). Although the nurses have traditionally their care practice in psychiatry and mental health, more closely linked to activities in the hospital, physical care, medication administration or management of the team of nursing, in recent decades has operated a substantial change in contexts where were exercised the functions. With the process of deinstitutionalisation and consequent transfer of care needs for the community, nurses have evidenced great relevance in the field of mental health community. Thus, with the advent of Community paradigm, nursing won a new space for psychiatric care and preventive in the community context of mental health (Alencar & Fernandes, 2010). The results that have emerged from this study related to the support and resources provided by nurses fall within the field of operations of nurses in the community and may be justified by the nature of proximity and partnership established between nurse-client.

# CONCLUSION

It appears that the socio demographic and clinical profile of older age groups is significantly distant from younger groups in various areas.

In elderly groups predominate subjects married, with children, with the 1st cycle of schooling, disability pensioners, which make the management of their medication, with good adherence

to the therapeutic regimen, with long-term progression of the disease (greater than 10 years) and treated with conventional antipsychotics. They are mostly satisfied with the resources used and aid received, Revealing having not needed, in general, resources or aid that had not been provided.

These findings do not indicate the cognitive deterioration and disfunctionality. The fact is that for individuals who are married, with children, living in a community can justify the favourable evolution of the disease. In fact, it is admitted nowadays, more clearly, that families can have a significant influence, not only on the issue of direct occurrence of relapses, but also in the whole process of recovery of their patients, by the way that in daily life, is taken into account their weaknesses and particular sensitivities, giving them emotional support and instrumental activities of daily life in compliance with the therapy prescribed, and stimulating properly their skills (Brito, 2011).

These evidences point to the need of people with schizophrenia remain in the community, with family and social support.

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