A brief version of the Subjects’ Response to Antipsychotics questionnaire to evaluate treatment effects


Abstract

Background: Monitoring patients’ experiences with antipsychotics may help to improve medication adherence and outcome. We aimed to develop a shorter version of a comprehensive 74-item self-report questionnaire suitable for routine monitoring of desired and undesired effects of antipsychotics.

Methods: Included were patients with psychotic disorders from seven mental health care organizations in the Netherlands, using antipsychotic medication, who completed the Subjects’ Response to Antipsychotics (SRA-74). Exploratory factor analysis (EFA) and similarity analysis based on mutual information were used to identify the latent factor structure of the SRA. Items were reduced according to their metric properties and clinical relevance upon consensus by an expert panel, using a Delphi procedure of three rounds. We determined the internal consistency of the shorter version using Cronbach’s alpha.

Results: SRA data of N = 1478 patients (mean age of 40 years, 31% females) were eligible for analysis. EFA extracted thirteen factors from the SRA-74, including four factors for desired effects (e.g. recovery of psychosis, cognition and social functioning) and nine factors for undesired effects (e.g. weight gain, flattened affect and increased sleep). Based on this solution 12 items were eliminated for statistical reasons. The expert panel eliminated another 28 items with redundant content, resulting in a 34-item version. The SRA-34 includes 10 desired and 24 clinically relevant undesired effects. Both the subscales for desired and undesired effects have a Cronbach’s alpha coefficient of 0.82.

Conclusions: The SRA-34 can be used to evaluate desired and undesired effects of antipsychotics in routine clinical practice and research.

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1. Introduction

Schizophrenia is a chronic psychiatric disease, commonly necessitating lifelong treatment with antipsychotics. Antipsychotics increase the burden of disease, when they affect patients’ physical, psychological, sexual and social functioning (Voruganti, 1996; Knegtering et al., 2003). Furthermore, self-report may save time and costs in routine clinical practice. Existing self-rating scales assessing experiences with antipsychotics either focus on quality of life, like the Subjective Well-Being on Neuroleptics (SWN) (Naber, 1995; Naber et al., 2001) and the Personal Evaluation of Transitions in Treatment (PETiT) (Voruganti and Awad, 2002), or focus on undesired effects, like the Liverpool University Neuroleptic Side Effect Rating Scale (LUNERS) (Day et al., 1995), and the Glasgow Antipsychotic Side-effect Scale (GASS) (Waddell and Taylor, 2008), see Wolters et al. (2009). In contrast, the Subjects’ Response to Antipsychotics (SRA) is a comprehensive assessment of 74 desired and undesired effects attributed to antipsychotic medication, divided over antipsychotics is important for disease management (Budd et al., 1996; Perkins, 2002). This requires a reliable and valid instrument.

Self-report is most optimal for the detection of often neglected, yet disturbing experiences, such as sexual side effects (Peuskens et al., 1998; Knegtering et al., 2003). Furthermore, self-report may save time and costs in routine clinical practice. Existing self-rating scales assessing experiences with antipsychotics either focus on quality of life, like the Subjective Well-Being on Neuroleptics (SWN) (Naber, 1995; Naber et al., 2001) and the Personal Evaluation of Transitions in Treatment (PETiT) (Voruganti and Awad, 2002), or focus on undesired effects, like the Liverpool University Neuroleptic Side Effect Rating Scale (LUNERS) (Day et al., 1995), and the Glasgow Antipsychotic Side-effect Scale (GASS) (Waddell and Taylor, 2008), see Wolters et al. (2009). In contrast, the Subjects’ Response to Antipsychotics (SRA) is a comprehensive assessment of 74 desired and undesired effects attributed to antipsychotic medication, divided over antipsychotics is important for disease management (Budd et al., 1996; Perkins, 2002). This requires a reliable and valid instrument.

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8 subscales (Wolters et al., 2006). It is constructed of lay term expressions, based on original patient statements which may be easier understood than some of the clinical terms in the LUNSERS (Waddell and Taylor, 2008). However, our own experience with the SRA-74 suggests that patients especially those with concentration difficulties find it a long questionnaire with many questions addressing the same clinical effect. Reducing the total number of items within the range of other scales (about 30 items) (Day et al., 1995; Naber et al., 2001; Voruganti and Awad, 2002; Waddell and Taylor, 2008) would increase its feasibility for screening purposes. The subscale structure of the SRA-74 has been established by a priori assumptions (Wolters et al., 2006) and so far, the latent structure has not been evaluated using more advanced statistical methods. The current study therefore explored the latent structure of the SRA by exploratory factor analysis (EFA) in a large cohort of patients with psychotic disorders. The main aim was to develop a shorter version of the SRA, while maintaining the latent structure.

2. Methods

2.1. Questionnaires

The SRA-74 consists of one subscale of 24 desired effects, seven subscales of 30 undesired effects of antipsychotics and 20 miscellaneous undesired effects not belonging to a subscale; Appendix A1 (Wolters et al., 2006). The subscales have good internal consistency (Cronbach's alpha $0.89–0.93$) and test–retest reliability (Pearson's r correlation $0.39–0.60$). The SRA is rated on a 3-point scale (not present/yes, mild/yes, severe). Patients received the SRA by mail to complete it at home. In case of difficulties in completing the questionnaire they received help from a trained nurse.

Trained nurses rated the level of psychotic symptoms using the Positive and Negative Symptom Scale for Remission (PANSS-R) (Opler et al., 2007). The patient's psychiatrist or case manager rated psychosocial functioning using the Global Assessment of Functioning scale (GAF; DSM-IV) (APA, 1994). A psychiatrist diagnosed each patient according to the Diagnostic and Statistical Manual of Mental Disorders—4th edition (DSM-IV) classification system (APA, 1994). Medication use over the past year was retrieved from medical records and confirmed with the patient.

2.2. Subjects

Patients with psychotic disorders receiving mental health care in the north of The Netherlands, Amsterdam and Dordrecht were invited to participate in the annual screening of their mental and physical health by the Pharmacotherapy Monitoring and Outcome Survey (PHAMOUS). Investigations were carried out between 2006 and 2010, in accordance with the latest version of the Declaration of Helsinki. Included were patients with psychotic disorders (DSM-IV codes 295.4–295.9, 297.1, 298.8 and 298.9), who used antipsychotics for at least one month and completed the SRA (maximally 2 items missing). In case a patient had participated in successive annual assessments, the first available measurement was selected for evaluation.

2.3. Latent structure

Exploratory factor analysis (EFA) was used to identify the latent factor structure of the SRA-74. Since one item of the SRA (about menstruation) was completed only by female participants, factor analysis was conducted on 73 items. In addition to EFA, we performed similarity analysis to visualize the latent structure of the SRA-74 (for a detailed description of the procedures, see Appendix A2).

2.4. Item reduction

Within each factor, items with loadings of $r < 0.30$ on all factors, cross-loading of $r > 0.30$ on two or more factors, or loading on a factor with a low main factor loading of $r < 0.50$ were considered non-factorable (Comrey and Lee, 1992). Non-factorable items were eliminated if there was no consensus about their clinical relevance by the expert panel (see below). Factorable items with high factor loadings of $r > 0.80$ and/or a highly similar content within the same factor were considered redundant. Of each pair of redundant statements, the item with least specific, most ambiguous or multi-interpretable (e.g. feelings that can be interpreted both literally and metaphorically) content was eliminated upon consensus by the expert panel.

2.5. Delphi procedure

A Delphi procedure consisting of three consecutive rounds was used to reach consensus about the clinical relevance of the items in the questionnaire (Hsu and Sandford, 2007). The expert panel, all native Dutch speaking, consisted of six psychiatrists, two neurobiologists and two psychologists. In the first round, the panelists received the full questionnaire including the results of the statistical analysis by e-mail. The experts were asked whether they agreed with the proposed item reduction. If not, they were asked to replace redundant items and to re-rank the clinical relevance of each item. In the third and final round, consensus was reached about the final version of the questionnaire. Items with consensus rates of more than 75% agreement within the panel were retained.

2.6. Statistics

Descriptive analyses and factor analysis were performed using Statistical Package for Social Sciences (PASW-18). Missing SRA-responses were imputed for patients with maximally 2 items missing, using the default settings of the multiple imputation method and random number generator (Mersenne Twister) of PASW-18. This cut-off was chosen as maximally 2.7% of responses were missing per patient which can be considered sporadically missing responses. Patients who completed all items of the SRA were compared to patients with maximally 2 items missing and to excluded patients (missing 3 or more items), with respect to: gender, age, duration of illness and inpatient/outpatient status using chi-square tests for categorical variables and Mann–Whitney U tests for continuous variables.

Prevalence rates of SRA items were based on dichotomized scores (no/yes). Factor analysis was conducted on the original 3-point scale of the SRA. The responses on the desired effects were reversed prior to factor analysis to obtain uniform scaling. The extraction method for EFA was Generalized Least Squares. The rotation method was Direct Oblimin with Kaiser Normalization, assuming a certain degree of correlation between factors (e.g. increased sleep with sedation). The number of factors to be retained was predefined by the Kaiser's criterion (eigenvalues $\geq 1$). Kaiser-Meyer-Olkin (KMO) and Bartlett's tests for sphericity were calculated to test whether the relationships among variables in the sample are adequate for factor analysis.

The internal consistency of the final version of the SRA was calculated for the factorable items within the desired effects subscale and undesired effects subscale. A Cronbach's alpha $\geq 0.80$ indicates good internal consistency (Streiner, 2003).
3. Results

3.1. Subjects

The number of patients included for evaluation was \( n = 1478 \) (66%) out of \( n = 2241 \) patients with psychotic disorders receiving routine outcome assessments in the selected mental health care organizations between 2006 and 2010. Excluded were \( n = 142 \) (6%) patients not using antipsychotics at the time of the interview, and \( n = 621 \) (28%) patients having three or more SRA-items missing. EXcluded patients were on average 4 years older (43.9 versus 39.9 years; \( p < 0.05 \)). Excluded patients (\( n = 621 \)) had a similar duration of illness than patients without missing items (\( n = 1206 \)), but were on average 4 years older (43.9 versus 39.9 years; \( p < 0.001 \)), consisted of relatively more female (38.6% versus 31.1%; \( p < 0.001 \)) and admitted patients (36.7% versus 28.3%; \( p < 0.001 \)).

On average, patients attributed 13 (56%) out of 24 desired effects to antipsychotics, compared to 18 (38%) out of 30 undesired effects. Patients most frequently reported the desired effects of the SRA-74, including 'My emotions have returned' (93%), 'My memory has improved' (92%) and 'I am more active' (90%); most frequently reported undesired effects were 'I need more sleep' (62%), 'My weight has increased' (60%) and 'I get physically tired more easily' (57%). All other statements had a prevalence rate above 5%.

3.2. Latent structure

Exploratory factor analysis extracted fourteen latent factors from the 73 SRA-items, explaining a total variance of 58% (Table 1). The correlation matrix of the data was considered factorable because the EFA solution passed the Kaiser-Meyer-Olkin (KMO) test with a significance value of >0.60 and the Bartlett’s test of sphericity was significant (\( p < 0.001 \)). All factors had high main factor loadings (0.58–1.00), except for factor 13 (0.31). Factor 13 consisted of items with heterogeneous content and low factor loadings.

Visual inspection of the similarity matrix gave comparable results as our exploratory factor analysis. All items with high factor loadings shared a relevant degree of mutual information (similarity). Within each factor, at least two items shared an amount of I > 0.20 mutual information, except for factor 13 (Appendix A3). The items within factor 13 displayed no sign of mutual dependence. Those items may have converged in an artificial factor because they had low prevalence rates in common. Thus only factors 1 to 12 and factor 14 were deemed reliable.

3.3. Item reduction

The number of items of the questionnaire was reduced to 52 after the first Delphi round of the expert panel and to 34 items after the second round. In total, 23 items were identified as non-factorable, see Fig. 1. Of those, 11 items were retained because of their clinical relevance. Of the 52 factorable items, 28 redundant items were eliminated upon consensus of the expert panel. For example, #33 ‘My feelings have returned’ was considered ambiguous and #11 ‘My thoughts are calmer’ could be substituted by the more specific statement #03 ‘I can think more clearly’. Similarly, the statements #16 ‘I think more slowly’ and #50 ‘I move more slowly’ were considered redundant to #13 ‘I react more slowly’. Some of the items were eliminated because they may be stigmatizing or evoke socially desired answers, e.g. #70 ‘My sex drive is too low’; or because the statement may be dependent on external factors such as the potentially limited social network of inpatients, e.g. #36 ‘I have more difficulty keeping up with conversations’. After the third Delphi round, consensus was obtained about the 34-item questionnaire (Appendix A4), consisting of 10 desired and 24 undesired experiences with antipsychotics.

3.4. Internal consistency of SRA-34

The internal consistency was acceptable for the desired subscale (Cronbach’s \( \alpha = 0.82 \); 9 factorable items), as well as for undesired subscale (\( \alpha = 0.82 \); 14 factorable items) of the SRA-34.

4. Discussion

The SRA-34 is a unique questionnaire to measure a combination of relevant self-reported desired and undesired effects in response to antipsychotic medication. This is the short version of the SRA-74 questionnaire retaining the latent structure by covering 10 desired and 24 undesired effects of antipsychotics. The SRA-34 is internally consistent, having Cronbach’s alpha values within the range of the previously reported values for the subscales of the SRA-74 (Wolters et al., 2006). Thus the SRA-34 can be considered a quick and reliable instrument to guide pharmaco-therapeutic treatment in clinical practice.

Exploratory factor analysis of the SRA-74 revealed new symptom dimensions, in addition to the original subscale structure as proposed by Wolters et al. (2006). First, desired effects were divided into four factors (recovery from psychosis, improvement in cognition, attention and social functioning). Second, we identified depressive symptoms as a factor, independent of other emotional experiences. The other factors remained the same (increased sleep, appetite and weight, slowed down behavior, sexual problems, EPS, social withdrawal and flattened affect). Similarity analysis was useful in identifying a number of items that did not belong to any of the factors, such as ‘dry mouth’ and ‘increased salivation’. Of those, experts retained the most clinically relevant items in the SRA-34 according to the Delphi consensus method.
Table 2
Exploratory factor analysis of the SRA-74, with the prevalence rates for each individual item.

<table>
<thead>
<tr>
<th>Factor Items</th>
<th>Factor loading</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appetite</td>
<td>1. I have an increased appetite 1.098 49%</td>
<td></td>
</tr>
<tr>
<td>2. Slowed down</td>
<td>16. I think more slowly 0.596 44%</td>
<td></td>
</tr>
<tr>
<td>3. Recovery cognition</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>4. Weight gain</td>
<td>46. I have gained too much weight 0.798</td>
<td>31%</td>
</tr>
<tr>
<td>5. Recovery</td>
<td>32. I am hungry more often 0.689 47%</td>
<td></td>
</tr>
<tr>
<td>6. EPS</td>
<td>12. My muscles are more tense 0.689 36%</td>
<td></td>
</tr>
<tr>
<td>7. Increased sleep</td>
<td>10. I sleep too much 0.784 49%</td>
<td></td>
</tr>
<tr>
<td>8. Social withdrawal</td>
<td>68. I am less anxious 0.307 80%</td>
<td></td>
</tr>
<tr>
<td>9. Flattened affect</td>
<td>0.866 78%</td>
<td></td>
</tr>
<tr>
<td>10. Depression</td>
<td>15. I feel down 0.578 33%</td>
<td></td>
</tr>
<tr>
<td>11. Female only</td>
<td>74. I menstruate less often 0.578 33%</td>
<td></td>
</tr>
</tbody>
</table>

What is the place of the SRA-34 in comparison with existing instruments? The LUNERS (Day et al., 1995) and GASS (Waddell and Taylor, 2008) comprise detailed physical side effects. The SRA-34 not only contains important physical side effects, but also measures psychological effects of antipsychotics, such as emotional, cognitive and social functioning. The SWN and PETT questionnaire typically cover some of the latter psychological effects (e.g. My thinking is difficult and slow), as well as some desired subjective experiences with antipsychotics similar to the SRA-34 (e.g. I find it easy to keep in touch with people around me) (Naber et al., 2001; Voruganti and Awad, 2002), but no physical side effects. The SRA-34 can be used for a quick yet comprehensive evaluation of the patients' experiences with antipsychotics. Experiences in response to new medication can be evaluated by assessment of the SRA-34 before and after switching antipsychotics in daily clinical practice or clinical trials. Completing the SRA-34 should take a patient on average 5–10 min, about half the time needed to complete the SRA-74 (Wolters et al., 2006). Since we did not change the wording or add new items, we assume that the test-retest reliability of the SRA-34 is comparable with the original version. A next step in the development of the SRA-34 would be to test the feasibility in clinical practice and to validate the questionnaire by evaluating the association with clinical outcomes, e.g. whether (un)desired effects are predictive for antipsychotic non-adherence, switching, relapse psychosis or hospitalization.

A strong point of the current study is that our analysis was based on a large sample of patients with psychotic disorders using a wide range of antipsychotics and doses. Although we had a high response rate, responding patients were slightly younger and more likely to be male and treated as outpatients. This would suggest that some patient groups such as elderly and inpatients had more difficulties in completing the questionnaire. However, we believe that the exclusion of these patients did not lead to major bias of the results, as the current cohort appears to be representative for mental health practice with similar prescribing patterns and exploratory factor analysis is a robust method, especially in large samples. By reducing the SRA to 34 items, we hope that all patients will be able to complete the SRA. An inherent limitation of the current study is that patients may have difficulties in distinguishing antipsychotic effects from symptoms associated with the illness or effects of co-medication. This remains an important and challenging question for clinicians in daily practice. But because of the large sample size, we believe it unlikely that this introduced systematic bias in our analysis. Another possible limitation of the study was that we applied exploratory factor analysis to a three-point scale (SRA-74), which could lead to an overestimation of the number of factors (Woods, 2002). We minimized this risk by selecting the Generalized Least Squares method of EFA. Furthermore, the visual representation of the latent structure (by means of similarity analysis based on mutual information) enabled us to detect artificial correlations.

In the clinical situation, the SRA-34 can be used to discuss the balance between desired and undesired effects of antipsychotics with the
patient. In line with previous studies, our patients were rather satisfied with their antipsychotics (Hofer et al., 2002; Freudenreich et al., 2004). Asking patients to recall the beneficial effects of antipsychotics (e.g. from treatment-free periods) may support treatment adherence in an indirect manner (Tranulis et al., 2011). Insight in the patients’ appraisal of antipsychotics may help the clinician to understand the patients’ attitude towards medication and reinforces the process of shared decision making (Goff et al., 2010). Monitoring desired and undesired effects could thereby prevent relapse psychosis (Valenstein et al., 2002; Weiden et al., 2004) and an increase in costs associated (Gilmer et al., 2004). To conclude, we developed a quick and comprehensive tool to assess desired and undesired effects attributed to antipsychotics, feasible for use in routine clinical practice and clinical trials.

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Contributors
All authors contributed to the design of the study and have approved the final manuscript. Authors Irene M. Lako and Edith J. Liemburg analyzed the data. Irene M. Lako wrote the first draft of the manuscript.

Conflict of interest statement
All other authors declare that they have no conflicts of interest.

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Appendix A. Supplementary data
Supplementary data to this article can be found online at http://dx.doi.org/10.1016/j.schres.2013.02.027.

References


