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Quality of life in psychiatric disorders

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Abstract

The study of quality of life and subjective wellbeing of patient is a recent phenomenon which has gained attention only in last two decades. Less attention was given to treating long term impairement and chronic illness. Rather cure was given more importance. However, this trend has changed, and it has shifted to the concept of quality of life. Now the goal of treatment is to give the patient good quality of life, this becomes more important in cases where cure is impossible or there is long term impairements due to illness.

Introduction

In psychiatry, the concept of life quality has long been considered an important aspect of mental health. However, how psychiatric clinicians evaluate an individual's subjective experience has changed with the rise and fall of psychoanalysis. With the advent of cognitive behavioral approaches, clinicians emphasized the impact of a patient's environment and subjective appraisals of symptoms and life problems. Concepts of social adjustment and levels of functioning became relevant. With the increasing awareness of the multidimensionality of treatment outcome and the importance of patient satisfaction in health care, the construct of QOL has become an important area of investigation [1,2]. The field has developed considerably. In a 1994 QOL bibliography, more than 500 references were cited [3]. The QOL literature in addressing schizophrenia has been particularly difficult to summarize because of the disparities in the definition's researchers have used to operationalize the concept. The concept of quality of life (QOL) has assumed special significance in the medical field in the wake of a progressive move towards re-humanizing hi-tech medicines. It is no longer important merely to add years to the patients' life but adding quality in those years of life is more important. It is a fact that the focus of care of patients remains primarily, symptomatic treatment and issues such as emotional wellbeing, autonomy and so forth have been neglected [4]. The lack of emphasis on subjective reporting of quality of life is particularly striking in psychiatry, a field of medicine that has traditionally placed the subjective experience of patients as its main concern [5].

Concept of quality of life

Quality of life is the degree of wellbeing felt by an individual or group of people. Unlike standard of living, quality of life is not a tangible thing and so cannot be measured directly. It consists of two components: physical and psychological. The physical aspects include things such as health, diet and protection against pain and disease. The psychological aspect includes stress, worry, pleasure and other positive and negative emotional states. The quality of life of mentally ill has been a matter of concern for centuries. The main rationale of applying the concept of QOL in medical field is to understand whether a particular treatment just alleviates symptoms, or it improves the subjective wellbeing also. The study of quality of life (QOL) and the focus on patients' subjective sense of well-being is a fairly new phenomenon that has attracted professional attention only within the past two decades. Earlier medicine was dominated by the quest for cures, treating chronic illness as well as helping patients manage long-term impairment received less attention. However, this trend has shifted. Issues of quality of life become key when cure is impossible. Illness that cannot be eliminated must be managed, and the treatment goal becomes maintaining maximum function and a meaningful existence or QOL. Some researchers have conceptualized QOL largely as a subjective affair that only the patient can report whereas others have argued for the importance of including more "objective" indicators of QOL such as housing and health status, or frequency of social interactions [3,6-9]. Both sides of this argument are equally compelling. Proponents of subjective indicators of QOL point to the importance of understanding and acknowledging the unique perspectives individuals with schizophrenia have about their lives, and proponents of objective indicators emphasize the need for measures uncontaminated by mood states and cognitive disturbances [9,10]. Researchers have also differed with regard to how broadly they consider the concept of QOL to be. Some investigators define QOL as a global evaluation of one's total life experiences, others focus more narrowly on the absence of disease and health-related symptoms, and still others focus on discrete indicators of social and material wellbeing [11-13].

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Defining quality of life

Many definitions and theories of what constitutes QOL have been proposed. Most agree that the concept is multidimensional but disagree about how to define the parameters. Each of these definitions appears to have face validity, but the range of differences encompassed in these definitions has resulted in some investigators questioning the utility and distinctiveness of the concept [14,15]. Various writers have tried to define QOL.

- Calman [16] proposed that QOL is influenced by the difference between an individual's expectations and actual achievements.
- Wood, *et al.* [17] posited that the return to a previous level of functioning is a critical parameter to the QOL construct. They believe that a definition of QOL must consider the following domains: mobility, self-care, daily activities, recreation, socialization, family roles, presentation of self, and coping capacities.
- Spilker [18] defined these nonmedical components as psychological status, social interaction, and economic factors.
- Schipper, *et al.* [19] delineated several QOL paradigm properties--for example, multidimensionality, variability over time, and subjectivity. In their review of the literature, they also noted that researchers seemed to agree on the following 4 domains as being critical to QOL: physical function, psychological state, social interaction, and somatic sensation (eg, pain, nausea).
- Gill, *et al.* [3] proposed that QOL is "the perception and reaction" to health problems and to nonmedical components of one's life.
- QOL is a individual perception of their position in life in the context of the culture and value system in which they live and in relation to their goals and expectations, standards and concerns (The world health organization, 1995).

Though there is no universally accepted definition of QOL, the sense of wellbeing appears to be central to the concept of QOL. Hence QOL is understood from the patient's own evaluation of the impact of disease.

According to WHO, there are five domains in QOL viz:

1. **Physical domain**- measures physical problems like joint pain, hearing, vision and sleep difficulties
2. **Psychological domain**- measures the self-perception and cognitive ability.
3. **Social domain**- measures the level of social life, personal relations, social support, family acceptance and social interaction
4. **Environmental domain**- measures living conditions, security, availability of medical assistance, opportunity of recreation and facilities
5. **Spiritual domain**- measures of personal belief, faith in God, opportunity for religious pilgrimages and so forth.

Quality of life involves two dimensions – adaptive functioning including self-care and social roles and life satisfaction or subjective wellbeing [20]. Some authors have considered a third dimension of QOL which is "external resources", such as standard of living and social support. There is lack of consensus among the researchers about the constituent factors of QOL which creates a diversity in the conceptualization of QOL and its measurement [21]. Clipp proposed three models of QOL:

Model 'A': It states that quality of life represents a single theoretical construct with multiple measurable indicators.

Model 'B': Posits that quality of life is a multidimensional theoritical construct consisting of functional adaptaion and life satisfaction, which can be further, subdivided into objective and subjective theoritical elements with measurable indicators.

Model 'C': Expands on model 'B' and posits that quality of life can be conceived as two measurable global indicators – adaptive functioning and life satisfaction, that are determined by various subjective and objective indicators of wellbeing, which in turn may be influenced by demographic and stress variables. QOL has been measured from two different viewpoints. One is subjective QOL rated by the patients themselves and other is objective QOL rated by observers. Although patients of schizophrenia were thought to be unable to assess their QOL due to their cognitive deficit it was assumed that symptomatically stabilized patients were able to evaluate their QOL by themselves [22]. Subjective well-being and quality of life (QOL) are increasingly being recognized as important treatment outcomes in patients with schizophrenia [23]. Until recently, treatments for schizophrenia have focused mainly on reducing positive symptoms, often leaving patients with numerous residual difficulties, including negative symptoms and impairment in cognition, everyday living skills, and social/occupational functioning. More comprehensive treatments are needed, and improved QOL should be a primary treatment goal. However, the predictors of QOL in schizophrenia are not well understood. Although no universal definition of QOL exists, it usually includes subjective well-being and objective mental and physical functioning indicators [22,24-27]. Subjective QOL focuses on life satisfaction, whereas "objective" QOL focuses on participation in activities and interpersonal relationships. Although Harvey and colleagues suggest that patients' self-report of functional capacity may be problematic, other research demonstrates that self-report measures of QOL are more valid than clinician-report QOL measures, and that QOL can be rated accurately and consistently by patients [22,28,29].

So it can be concluded from various conceptualizations of QOL that although the concept is indeed broad, specific parameters do exist. QOL can be thought of as a multidimensional set of components consisting of a person's (1) satisfaction with his or her life as a whole, or general wellbeing, (2) observable social and material wellbeing, or objective QOL; (3) satisfaction with his or her social and material wellbeing, or subjective QOL; and (4) health and functional status, or health-related QOL. These dimensions of QOL, are supported by a considerable body of literature, both in psychiatry and other disciplines, and unique measurement techniques.

Predictors of subjective QOL

There are many predictors of subjective QOL. Lower everyday functioning capacity and greater severity of positive, negative, and depressive symptoms have been associated with worse QOL [23,25,30-35]. Although such psychiatric symptoms have been associated with subjective measures of QOL [23,25,32,34], symptom reductions alone often do not result in meaningful improvements in QOL because other problems remain like difficulty with everyday functioning, lack of social contacts, unemployment, and stigmatization.

Cognitive abilities are associated with functional capacity and community outcomes [35-40] and may also affect life satisfaction. Poorer cognitive performance and self-reported functional status (e.g., unmarried, lower social functioning, smaller social support network)

are correlated with lower subjective QOL [25,32,41]. On the other hand, better cognitive abilities may translate into better insight, more depression, and lower subjective well-being. Demographic and clinical characteristics also influence subjective QOL, with women and those with less education, longer illness duration, and higher antipsychotic dosages reporting greater life satisfaction [23,32,34]. The link between greater illness severity and better subjective QOL may be due partially to the effects of impaired insight [42].

Predictors of objective QOL

Patients' self-reports of everyday functioning and activities have also been used to assess objective QOL and are distinct from self-reports of overall life satisfaction [24]. Indicators of objective QOL include living situation, marital status, employment status, driving status, and involvement in social activities. Generally, patients with less severe psychiatric symptoms and better cognitive performance report better outcomes on objective QOL indicators [23,30,31,33,34]. Performance-based functional capacity also has been found to predict objective QOL, particularly in terms of driving and living independence [30,35]. In some studies, the severity of negative symptoms or the presence of tardive dyskinesia was reported to be associated with a poor objective QOL. Levels of insight into the illness showed no significant relationship with QOL level [43-46].

Measurement of quality of life

There are several issues to consider when measuring QOL. The first is whether to use objective or subjective ratings. Initially, it was determined with objective assessments in which the clinical observations were compared to established standards, similar to a global assessment scale [47]. However, such objective assessments made by clinicians correlated poorly with patients' subjective ratings of their quality of life and so objective assessment was believed to be inaccurate reflections of patient well-being [48]. Emphasis over the past 15 years has been on the development of subjective-ratings scales that are completed by the patient. There are controversies that whether patients with schizophrenia can accurately assess their quality of life or not. Reality distortion and the deficit syndrome limit the psychotic patient's ability to correctly perceive external cues.

Applications of quality-of-life data

With the increasing development and use of various QOL measures, data have been collected about patients' quality of life. There have been 3 broad applications of these scales:

1. Descriptive studies in which the QOL of various populations of chronically mentally ill is measured and compared [49-52].
2. Association studies in which patient characteristics are associated with QOL [48,50,53].
3. Intervention studies in which QOL is used as an outcome variable [54-56].

Conclusion

Quality of life is an important concept in mental health. Since a number of psychiatric disorders are difficult to cure, now the stress is on improving the quality of life of patients. Apart from psychiatry the concept of quality of life is widely used to assess the efficacy of treatment of chronic disorders.

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