Quality of life in psychiatric disorders

Suprakash Chaudhury*, Poonam Rani Das¹, P S Murthy², Chetan Diwan³, Anand A Patil⁴ and Biswajit Jagtap⁵

¹Professor, Department of Psychiatry, Dr DY Patil Medical College, Hospital & Research Center, Dr D Y Patil University, Pune, India
²Ranchi Institute of Neuropsychiatry & Allied Sciences, Kanke, Ranchi, India
³Santhiram Medical College & General Hospital, Nandyal, A.P, India
⁴Karve Institute of Social Service, Pune, India
⁵Rural Medical College, Pravara Institute of Medical Sciences (Deemed University), Loni, India

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 impairment 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 impairments 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 patients’ subjective sense of well-being a fairly new phenomenon with schizophrenia have about their lives, and proponents of objective indicators argue 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].

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].

*Correspondence to: Suprakash Chaudhury, Professor, Department of Psychiatry, Dr DY Patil Medical College, Hospital & Research Center, Dr D Y Patil University, Pune, India, Tel: +91-9370386496; E-mail: suprakashch@gmail.com

Key words: quality of life; psychiatric disorders; treatment

Received: September 03, 2018; Accepted: September 19, 2018; Published: September 23, 2018
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 dimensions as being critical to QOL: physical function, psychological state, social interaction, and somatic sensation (e.g., 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 an 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 wellbeing. 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 theoretical construct consisting of functional adaptation and life satisfaction, which can be further, subdivided into objective and subjective theoretical 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.

**References**

1. Gellert GA (1993) The importance of quality of life research for health care reform in the USA and the future of public health. *Qual Life Res* 2: 357-361. [Crossref]
2. Tantam D (1988) Review article: Quality of life and the chronically mentally ill. *International Journal of Social Psychiatry* 34: 243-247.
3. Gill TM, Feinstein AR (1994) A critical appraisal of the quality of-quality-of-life measurements. *JAMA* 272: 619-626. [Crossref]
4. Rajkumar S, Thomas J, Srinivasan N (1992) Health related quality of life: Methodological issues. Paper presented in world congress on social psychiatry, New Delhi.
5. Okin RL, Pearall D (1993) Patients perception of their quality of life 11 years after discharge from a hospital. *Hospital and community Psychiatry* 44: 236-246.
6. Awad AG, Voruganti LNP, Heslegrave RJ (1997) A conceptual model of quality of life in schizophrenia: description and preliminary clinical validation. *Qual Life Res* 6: 21-26. [Crossref]
7. Barry MM (1997) Well-being and life satisfaction as components of quality of life in mental disorders. In: Quality of Life in Mental Disorders -Katschning, H., Freeman, H., Sartorius, N. eds. New York, NY: Wiley. 31-42.
8. Diener E (1984) Subjective well-being. *Psychol Bull* 95: 542-575. [Crossref]
9. Atkinson M, Zibin S, Chuang H (1997) Characterizing quality of life among patients with chronic mental illness: a critical examination of the self-report methodology. *Am J Psychiatry* 154: 99-105. [Crossref]
10. Corrino DJ (2002) Quality of life. Perspectives of people with mental illnesses and family members. *Psychiatric Rehabilitation Journal* 25: 350-358.
11. Gurin G, Verhoff J, Feld S (1960) Americans View Their Mental Health, New York, NY, Russell Sage Found.
12. Lehman AF (1997) Instruments for measuring quality of life in mental illnesses. In: Quality of Life in Mental Disorders -Katschning, H, Freeman, H, Sartorius, N. eds. (1997) New York, NY: Wiley. 79-94.
13. Baker F, Intagliata J (1982) Quality of life in the evaluation of community support systems. *Eval Program Plan* 5: 69-79. [Crossref]
14. Liu BC (1976) Quality of Life Indicators in U.S. Metropolitan Areas: A Statistical Analysis, New York, NY: Praeger Publishers.
15. Priebe S, Kaiser W, Huxley PJ, et al. (1998) Do different subjective evaluation criteria reflect distinct constructs. *Journal of Nervous and Mental Disease* 186: 385-392.
16. Calman KC (1984) Quality of life in cancer patients—an hypothesis. *J Med Ethics* 10: 124-127. [Crossref]
17. Wood-Dauphinee S, Williams JJ (1987) Reintegration to Normal Living as a proxy to quality of life. *J Chronic Dis* 40: 491-502. [Crossref]
18. Spilker B (1990) Introduction, in Spilker B (ed): Quality of Life Assessments in Clinical Trials. New York, Raven Press, Ltd., 3-10.
19. Schipper H, Clinch J, Powell V (1990) Definitions and conceptual issues, in Spilker B (ed): Quality of Life Assessments in Clinical Trials. New York, Raven Press, 11-24.
20. Katschning H, Freeman H, Sartorius N (1997) Quality of life in mental disorders. *American Journal of Psychiatry*, 45: 1094.
21. Clipp EC (2001) Quality of life, Encyclopedia of Aging 851-854.
22. Voruganti L, Heslegrave A, Awad AG, et al. (1998) Quality of life measurement in schizophrenia: reconciling the question of reliability. *Psychol Med* 28: 165-172. [Crossref]
23. Hofer A, Baumgartner S, Edlinger M, et al. (2005) Patient outcomes in schizophrenia: correlates with socio-demographic variables, psychopathology and side effects. *Eur Psychiatry* 20: 386-394. [Crossref]
24. Lehman A (1983b) The well-being of chronic mental patients: Assessing their quality of life. *Arch Gen Psychiatry* 40: 369-373. [Crossref]
25. Norman RM, Malla AK, McLean T, Voruganti LP, Cortese L, et al. (2000) The relationship of symptoms and level of functioning in schizophrenia to general well-being and the Quality of Life Scale. *Acta Psychiatr Scand* 102: 303-309. [Crossref]
26. Russo J, Roy-Byrne P, Reeder D, et al. (1997) Longitudinal assessment of quality of life in acute psychiatric inpatients: reliability and validity. *J Nerv Ment Dis* 185: 166-175. [Crossref]

**J Tre Bio Res, 2018**<ref> doi: 10.15761/JTBR.1000103** Volume 1(1): 3-4**
Chaudhury S (2018) Quality of life in psychiatric disorders

27. Lambert M, Naher D (2004) Current issues in schizophrenia: overview of patient acceptability, functioning capacity and quality of life. CNS Drugs 18: 5-17. [Crossref]
28. Harvey PD, Velligan DI, Bellack AS (2007) Performance-Based Measures of Functional Skills: Usefulness in Clinical Treatment Studies. Schizophr Bull. [Crossref]
29. Becchi A, Rucci P, Piacentino A, Neri G, de Girolamo G (2004) Quality of life in patients with schizophrenia—comparison of self-report and proxy assessments. Soc Psychiatry Psychiatr Epidemiol 39: 397-401. [Crossref]
30. Palmer BW, Heaton RK, Gladis JA, Evans JD, Patterson TL, et al. (2002) Heterogeneity in functional status among older outpatients with schizophrenia: employment history, living situation, and driving. Schizophr Res 55: 205-215. [Crossref]
31. Sciolla A, Patterson TL, Wetherell JL, et al. (2003) Functioning and well-being of middle-aged and older patients with schizophrenia: measurement with the 36-item short-form (SF-36) health survey. Am J Geriatr Psychiatry 11: 629-637. [Crossref]
32. Corrigan PW, Buican B (1995) The construct validity of subjective quality of life for the severely mentally ill. J Nerv Ment Dis 183: 281-285. [Crossref]
33. Jin H, Zisook S, Palmer BW, Patterson TL, Heaton RK, et al. (2001) Association of depressive symptoms with worse functioning in schizophrenia: a study in older outpatients. J Clin Psychiatry 62: 797-803. [Crossref]
34. Ruggeri M, Nosé M, Bonetto C, Cristofalo D, Lasalvia A, et al. (2005) Changes and predictors of change in objective and subjective quality of life: multivariate follow-up study in community psychiatric practice. Br J Psychiatry 187: 121-130. [Crossref]
35. Twa mley EW, Doshi RR, Nayak GV, Palmer BW, Golshan S, et al. (2002) Generalized cognitive impairments, ability to perform everyday tasks, and level of independence in community living situations of older patients with psychosis. Am J Psychiatry 159: 2013-2020. [Crossref]
36. Evans JD, Heaton RK, Paulsen JS, Palmer BW, Patterson T (2003) The relationship of neuropsychological abilities to specific domains of functional capacity in older schizophrenia patients. Biol Psychiatry 53: 422-430. [Crossref]
37. Patterson TL, Goldman S, McKibbin CL, Hughs T, Jeste DV, et al. (2001) UCSD Performance-Based Skills Assessment: Development of a new measure of everyday functioning for severely mentally ill adults. Schizophrenia Bull 27: 235-245. [Crossref]
38. Green MF, Nuechterlein KH (1999) Should schizophrenia be treated as a neurocognitive disorder? Schizophrenia Bull 25: 309-319. [Crossref]
39. Green MF (1996) What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry 153: 321-330. [Crossref]
40. Green MF, Kern RS, Braff DL, Mintz J (2000) Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the “right stuff”? Schizophrenia Bull 26: 119-136. [Crossref]
41. Lehman AF (1983) The effects of psychiatric symptoms on quality of life assessments among the chronically mentally ill. Eval Program Plann 6: 143-151. [Crossref]
42. Karow A, Pajonce FG (2006) Insight and quality of life in schizophrenia: recent findings and treatment implications. Curr Opin Psychiatry 19: 637-641. [Crossref]
43. Fitzgerald PB, Williams CL, Corteling N, Filia SL, Brewer K, et al. (2001) Subject and observer-rated quality of life in schizophrenia. Acta Psychiatr Scand 103: 387-392. [Crossref]
44. Stee ljevich SA, Palatnik A, Avila R, Bustin J, Cassone J, et al. (2005) Lack of extrapyramidal side effects predicts quality of life in outpatients treated with clozapine or with typical antipsychotics. Psychiatry Res 133: 277-280. [Crossref]
45. Brown S, Roe M, Lane A, Gervin M, Morris M, et al. (1996) Quality of life in schizophrenia: relationship to socio-demographic factors, symptomatology and tardive dyskinesia. Acta Psychiatr Scand 94: 118-124. [Crossref]
46. Brown S, Garavan J, Gervin M, Roe M, Larkin C, et al. (1998) Quality of life in schizophrenia: insight and subjective response to neuroleptics. J Nerv Ment Dis 186: 74-78. [Crossref]
47. Sainfort F, Becker M, Diamond R (1996) Judgments of quality of life of individuals with severe mental disorders: Patient self-report versus provider perspectives. Am J Psychiatry 153: 497-502. [Crossref]
48. Koivumaa-Honkanen H, Viinamaki H, Honkanen R, Tanskanen A, Antikainen R, et al. (1996) Correlates of life satisfaction among psychiatric patients. Acta Psychiatr Scand 94: 372-378. [Crossref]
49. Lehman A, Possidente S, Hawker F (1986) The quality of life of chronic patients in a state hospital and in community residences. Hosp Community Psychiatry 37: 901-907. [Crossref]
50. Lehman A, Slaughter J, Myers P (1991) Quality of life in alternative residential settings. Psychiatry Quarterly 62: 35-49.
51. Slaughter J, Lehman A, Myers P (1991) Quality of life of severely mentally ill adults in residential care facilities. Adult Residential Care Journal 5: 97-111.
52. Sullivan G, Wells K, Leuke B (1991) Quality of life of seriously mentally ill persons in Mississippi. Hosp Community Psychiatry 42: 752-755. [Crossref]
53. Lehman AF, Kernan E, DeForge BR, Dixon L (1995) Effects of homelessness on the quality of life of persons with severe mental illness. Psychiatr Serv 46: 922-926. [Crossref]
54. Bigelow D, Brodsky G, Stewart L (1982) The concept and measurement of quality of life as a dependent variable in evaluation of mental health services, in Stahler, G., Tash, W. (eds): Innovative Approaches to Mental Health Evaluation. New York, Academic Press, 345-366.
55. Breier A, Buchanan R, Irish D, Carpenter WT Jr (1993) Clozapine treatment of outpatients with schizophrenia: Outcome and long-term response patterns. Hosp Community Psychiatry 44: 1145-1149. [Crossref]
56. Meltzer H, Burnett S, Bastani B, Ramirez LF (1990) Effects of six months of clozapine treatment on the quality of life of chronic schizophrenic patients. Hosp Community Psychiatry 41: 892-897. [Crossref]