S72. Quality of life

Chairmen: P Bech, J Orley

QUALITY OF LIFE IN ANXIETY

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The Zurich cohort study followed an enriched sample of the community over a fifteen year period. Five interviews were carried out when the subjects were aged 20 until 35. The last interview assessed quality of life. The questionnaire was concerned with the preceding 12 month period and appraised 9 domains of life: work/housework, finances, parents/siblings, friends, partner, own family, physical well-being, psychological well-being, childhood in retrospect. Diagnoses of 6 anxiety disorders were made according to DSM-III criteria: panic disorder, GAD, agoraphobia, social phobia, specific phobia, OCD; in addition, panic attacks (> 1/3) and subthreshold obsessive-compulsive syndromes were diagnosed. In comparison to controls, across all domains, OCD subjects scored lowest in quality of life, followed by subjects with panic disorder, agoraphobia, GAD and social phobia. Simple phobia did not reduce quality of life substantially. Physical and psychological well-being was generally reduced among subjects with anxiety disorders whereas the consequences for work and finances or relationships with partners and friends were less severe. Subjects with OCD, agoraphobia and social phobia showed lowered quality of life in partnerships. In retrospect the quality of life of childhood was seen as lower than the quality of the actual life. This was also shown to be the case for the controls.

THE VALIDITY OF QUALITY OF LIFE MEASUREMENTS IN MAJOR DEPRESSION

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The clinical outcome measures of major depression are disability scales like the Hamilton Depression Scale (HAM-D), i.e. clinically rated symptoms. In contrast, quality of life scales in depression are typically self-rating scales. Among depression questionnaires the Beck Depression Inventory (BDI) is a disease-specific scale while the Zung Self-rating Depression Scale (SDS) is a generic scale based on the Affect Balance Scale, i.e. measuring both positive and negative well-being.

The most widely used quality of life scale is the Psychological General Well-Being Scale (PGWB) which also is based on the Affect Balance Scale. Clinical Studies with PGBW have shown that the scale has high validity in predicting early dropping out of patients of the acute treatment of depression (better than clinicians' scales) and in predicting recurrence of depression in long-term treatment of manic-melancholic patients. The PGWB has also been used to define recovery in medium-term continuation therapy. i.e. as a quality of assessment criterion.

QUALITY OF LIFE INSTRUMENTS IN SCHIZOPHRENIA: A COMPERATIVE STUDY

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A comparative study is currently underway to assess the performance of various generic and specific Quality of Life instruments.

A group of schizophenic outpatients receiving different neuroleptic maintenance treatments is presently being studied with the use of the following instruments for obtaining information on:

- sociodemographic and clinical data (Ad hoc protocol)
- psychopathology (Positive And Negative Syndrome Scale);
- disability level (Disability Assessment Scale);
- quality of life [Medical Outcomes Study Short Form-36, Lehman's Quality of Life Interview (short version), and the Sevilla Quality of Life Scale (currently being developed in five Spanish universities, namely, Sevilla, Oviedo, Valencia, Madrid and Pamplona)].

Our analysis focusses on relationships between the category "General Life Satisfaction" and the various subcategories related to psycopathology, disability and quality of life and sociodemographic and clinical parameters.

Several different statistical methods will be employed (correlation analysis, multiple linear regression, multidimensional scaling, etc.). All statistical methods will be used as explorative rather than confirmative tools.

QUALITY OF LIFE: THE WHOQOL

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WHO has developed an instrument (set of questions) to assess quality of life (QOL), working in 14 different countries around the world, both developed and developing. The development process involved the holding of focus groups in each centre to explore the concept of QOL and its components and to suggest ways of asking about those components. It became evident that there was high agreement about what aspects of life were considered important. These fall into 6 domains; physical, psychological, level of independence, social relationships, environment and a spiritual domain. Each domain is explored by a set of subdomains (facets) e.g. the physical by pain and discomfort, energy and fatigue, sleep and rest. Although some centres around the world suggested somewhat different ways of exploring a particular facet (e.g. self-esteem), the analysis of data did not justify including items that were idiosyncratic to a particular culture. There was therefore a common core of questions that explained QOL very adequately in all participating centres.

The instrument developed (the WHOQOL), is a generic one which was piloted on a wide group of patients, including psychiatric. This paper presents data relating to the application of the WHOQOL to psychiatric patients and examines the question as to whether a condition specific instrument is necessary, or whether in fact, a generic QOL instrument should suffice for psychiatric patients. This in turn depends on how quality of life is defined.

QUALITY OF LIFE IN PSYCHIATRY

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Quality of life is an elusive concept and there is little consensus about its definition. Consequently, it is difficult to devise methods for the measurement of quality of life in any of the groups concerned with health care — the patients, their families, their communities and staff providing health care.

Measuring quality of life in mental health care is even more complex because of difficulties in communication (which are core symptoms for certain mental disorders) and because of the overlap of certain psychiatric symptoms (e.g., some of the symptoms of depression) and statements which people make about their quality of life.

The paper will summarize the difficulties and issues arising in