The assessment of quality of life in clinical practice in patients with schizophrenia

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Introduction

Important predictors for a favorable long-term outcome in patients with schizophrenia are a shorter duration of untreated psychosis, better premorbid functioning, an early treatment response, a lower level of psychopathology or illness severity, and better daily

The aim of the present article is to review QoL scales used in studies investigating patients with schizophrenia over the past 5 years, and to summarize the results of QoL assessment in clinical practice in these patients.. Literature available from January 2009 to December 2013 was identified in a PubMed search using the key words "quality of life" and "schizophrenia" and in a cross-reference search for articles that were particularly relevant. A total of n=432 studies used 35 different standardized generic and specific QoL scales in patients with schizophrenia. Affective symptoms were major obstacles for QoL improvement in patients with schizophrenia. Though positive symptoms, negative symptoms, and cognitive functioning may be seen as largely independent parameters from subjective QoL, especially in cross-sectional trials, long-term studies confirmed a critical impact of early QoL improvement on long-term symptomatic and functional remission, as well as of early symptomatic response on long-term QoL. Results of the present review suggest that QoL is a valid and useful outcome criterion in patients with schizophrenia. As such, it should be consistently applied in clinical trials. Understanding the relationship between symptoms and functioning with QoL is important because interventions that focus on symptoms of psychosis or functioning alone may fail to improve subjective QoL to the same level. However, the lack of consensus on QoL scales hampers research on its predictive validity. Future research needs to find a consensus on the concept and measures of QoL and to test whether QoL predicts better outcomes with respect to remission and recovery under consideration of different treatment approaches in patients with schizophrenia.

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and social functioning at the beginning of treatment.[1] Outcome is further compromised by a high risk of medication nonadherence, service disengagement,[2] and comorbid disorders.[3] All these problems cause poor quality of life (QoL).[4] QoL improvement, in turn, has yet proven to be an important predictor for symptomatic remission and functional recovery in patients with schizophrenia.[1,5,6] Studies indicate that the adequate adaption of health care structures to unmet needs of patients with schizophrenia improves clinical outcomes and QoL.[7,8] However, though QoL assessment has visibly gained in importance since the amelioration of the definition of health and the introduction of QoL assessment in mental health research,[9] few studies investigate how results of QoL research should best be turned into daily clinical practice to improve outcome and treatment of patients with schizophrenia.[4]

The most widely used definition of QoL was given by the World Health Organization Quality of Life (WHOQOL) Group in 1995. The WHO defined QoL as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.[9] The deinstitutionalization of the chronically mentally ill into the community and a shift in therapeutic outcome criteria towards a diversification of clinical measurement, with an inclusion of patient-reported outcomes (PRO), brought further attention to the measurement of QoL, which has been increasingly considered in studies investigating the clinical course of patients with schizophrenia.[10-14]

Several general and disease-specific QoL scales were developed and successfully tested in patients with schizophrenia.[4,15] Nevertheless, in their recently updated review, Awad and Voruganti summarized the following challenges for QoL research: (i) there is still a need for a consensus on the definition and the underlying concept of QoL; (ii) there is an ongoing debate about the use of self-reports vs expert ratings of QoL; and (iii) there is still a need for standardized disease-specific QoL measures for patients with schizophrenia.[4] Moreover, the authors pointed out the failure of QoL research to affect clinical practice and brought up the question "what should we do with the data?"[2,16] The aim of the present article is: (i) to review QoL scales used in studies with patients with schizophrenia between 2009 and 2013; and (ii) to provide an overview about QoL assessment in clinical practice under consideration of symptoms, remission, and therapeutic interventions in patients with schizophrenia.

QoL scales used over the past 5 years in patients with schizophrenia

A PubMed search using the terms "quality of life" and "schizophrenia" during the past 5 years (2009-2013) was conducted. A total of n=886 papers were identified. Of those, n=336 (38%) did not use any QoL scale or did not investigate QoL in patients with schizophrenia, n=116 (13%) were reviews, n=13 (1%) reviewed QoL in patients with schizophrenia, and n=46 (5%) were not published in English. Eight of 432 studies used qualitative methods to investigate QoL. Information about the QoL scale used in the study was given in the abstract by n=177 (40%); n=46 manuscripts (10%) failed to give information about the QoL scale used.

A total of n=432 reports published in English between 2009 and 2013 were identified as studies using standardized QoL measures in patients with schizophrenia and provided the basis for the information included in this article. In n=432 QoL studies in patients with schizophrenia, 35 different generic and specific QoL scales were used. Most QoL scales (n=22; 60%) were used only once or twice, n=11 QoL scales were used in at least five studies during the past 5 years. In more than half of all studies (n=229; 53%) QoL was a primary outcome measure. The generic QoL scales most often used in studies investigating patients with schizophrenia were the following: (i) the WHO-Quality of Life Interview (WHO-QOL-Bref[9]); (ii) the Short Form 36 or Short Form 12 (SF-36/SF-12 [17]); and the EuroQOL (EQ-5D;[18] *Table I, Figure 1*). The most widely used schizophrenia-specific QOL scales were: (i) the Heinrich-Carpenter Quality of Life Scale (QLS);[19] (ii) the Quality of life, Enjoyment, and Satisfaction Questionnaire 18 (Q-LES-Q-18);[20] and (iii) the Subjective Wellbeing under Neuroleptics (SWN;[21] *Table I, Figure 1*).

Symptoms and QoL

There is an ongoing interest in the impact of core symptoms of schizophrenia on QoL. Nearly half of all patients with schizophrenia report an overall favorable QoL despite the presence of symptoms of psychosis. Numerous studies, including meta-analyses,

found higher levels of global clinical symptoms being associated with less favorable QoL in patients with schizophrenia.[22-25] For example, in a recent study in patients with chronic schizophrenia, of the total variance in QoL, clinical symptoms explained 50% and social variables explained 16%. Multivariate analyses confirmed that especially less depressive symptoms and a higher level of social functioning significantly predicted a higher QoL, explaining 53% of the total variance.[26] Most sociodemographic factors do not contribute significantly to self-rated QoL.[26] With the exception that higher rates of QoL were consistently reported by females compared with male patients with schizophrenia.[27]

Pooled data of 886 patients with schizophrenia showed that changes in all symptom areas were associated with changes in QoL. These and other findings have led to suggestions that QoL scales in patients with schizophrenia might share too much variance with symptoms and therefore not be a valid independent outcome criterion.[24] However, further multivariate analyses by Priebe et al demonstrated that only associations between changes in depression, anxiety, and hostility were significantly related with changes in QoL. The authors concluded that QoL changes are influenced by symptom change, in particular depression and anxiety, but the level of influence is not strong enough to compromise QoL as an independent outcome measure.[24]

Affective symptoms and QoL

Various cross-sectional and longitudinal studies confirmed a close association between depressive symptoms with impaired QoL in patients with schizophrenia.[28] The higher the level of depression

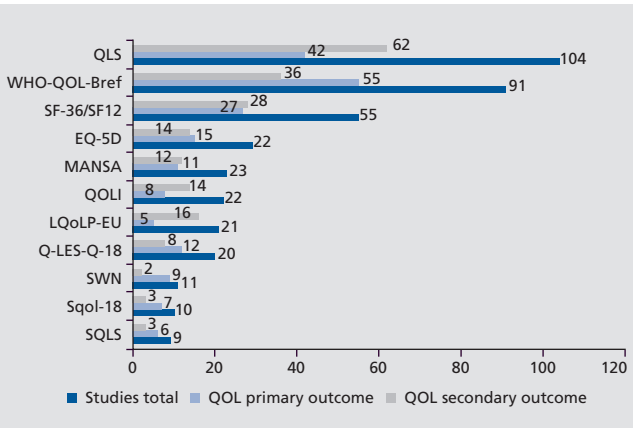

Figure 1. QoL scales used in patients with schizophrenia between 2009-2013 (n≥5 studies). QLS, Heinrich-Carpenter Quality of Life Scale; WHO-QOL-Bref, WHO Quality of Life Interview; SF-36/SF12, Short Form 36/12; EQ-5D, EuroQol; MANSA, Manchester Short Assessment of Quality of Life; QOLI, Lehmans Quality of Life Interview; Q-LES-Q-18, Quality of life, Enjoyment, and Satisfaction Questionnaire 18; LQoLP-EU, Lancashire Quality of Life Profile; SWN, Subjective Wellbeing under Neuroleptics; Sqol-18, Schizophrenia Quality of Life Instrument/Short Form; SQLS, Schizophrenia Quality of Life Scale

Scale	Items	Dimensions	Self-rating/ expert-rating	Generic/disease specifics
Quality of Life Scale (QLS)[19]	21	4	SR+ER	DS
WHO Quality of Life Interview (WHOQOL-Bref)[9]	26	4	SR	G
Short Form 36/12 (SF-36/SF12)[17]	36/12	8+2/2	SR	G
EuroQol (EQ-5D)[18]	5	5	SR	G
Manchester Short Assessment of Quality of Life (MANSA)115	12+4	-	SR+ER	G
Quality of Life Interview (QOLI)[116]	143	8	SR	G
Quality of Life Enjoyment and Satisfaction Questionnaire 18 (Q-LES-Q-18)[20]	18	5	SR	DS
Lancashire Quality of Life Profile (LQOLP)[117]	100	9	SR	G
Subjective Wellbeing under Neuroleptics (SWN)[21]	38	5	SR	DS
Schizophrenia Quality of Life Instrument/Short Form (Sqol-18)[118]	41/18 (SF)	8	SR	DS
Schizophrenia Quality of Life Scale (SQLS)[119]	30	3	SR	DS

Table I. Quality of life (QoL) scales most often used in patients with schizophrenia between 2009-2013. SF, short form; SR, self-rating scale; ER, expert-rating scale; G, generic scale; DS, disease-specific scale

the stronger the negative impact on patients' QoL.[29] A strong impact of depression on QoL was especially found in the early course of illness.[30] Beyond depression, symptoms of anxiety, especially social anxiety, and anhedonia were significantly associated with QoL.[31] For example, a prospective observational study found an increase in social anxiety over 5 years significantly associated with a decrease in QoL in remitted patients with schizophrenia after discharge through a deinstitutionalization project.[32]

Affective symptoms clearly outweigh positive psychotic symptoms as a robust predictor of QoL in patients with schizophrenia.[33] In a long-term study over 10 years, improvement in QoL was best predicted by a reduction in self-reported symptoms of depression, sensitivity, or anxiety along with an increase in self-efficacy, social support, and emotion-oriented coping scores.[34] In an 18-month trial, QoL was best predicted by anxiety, depression, and self-esteem, and to a lesser extent by global functioning and social integration at both time intervals.[35] These findings are of major clinical relevance, as affective symptoms are amenable to specific therapeutic interventions, which need to be considered and included in integrative treatment approaches for patients with schizophrenia. With regard to clinical practice, future studies may focus on the effectiveness of interventions addressing affective symptoms in patients with schizophrenia.

Negative symptoms and QoL

The severity of negative symptoms is a predictor of poor patient functioning. Negative symptoms affect the patient's ability to live independently, to perform activities of daily living, to be socially active and maintain personal relationships, and to work and study.[36-39] Rabinowitz et al found that in 1447 outpatients with schizophrenia studied, the coexistence of prominent negative symptoms was independently associated with a significant decline in functional mental health, health utility, and expert-rated QoL.[38,39] This is in line with previous studies, which reported significant associations between negative symptoms with functional impairment and expert rated QoL, eg, measured with the QLS,[19] and no significant associations with self-rated QoL.[40-42]

There is a continuing debate as to whether QoL in patients with schizophrenia should best be assessed by self- or expert-rated scales or by a combination of both. Most researchers vote for a combination of self-rated QoL with expert-rated daily functioning for a comprehensive consideration of the different perspectives on clinical outcome.[43]

Cognitive dysfunction and QoL

Cognitive deficits are accepted as a core feature in schizophrenia spectrum disorders. Early and persistent cognitive dysfunctions are among the most critical determinants of functionality, and are associated with higher levels of disability and worse occupational outcome.[44-46] Studies on the relationship between cognitive performance and QoL have shown contradictory results. Kurtz and Tolman[47] found QoL inversely related to crystallized verbal ability, attention, working memory, and problem-solving, while Boyer et al[48] found no significant correlation between QoL and neuropsychological measures of attention, memory, or executive functioning in patients with schizophrenia. They proposed that functional outcomes might be mediated through metacognitive capacities, particularly Theory of Mind (TOM) abilities. One study found a significant relationship between decreased QoL and higher TOM skills in patients with schizophrenia, probably mediated by higher clinical symptom scores.[49] However, a recent study could not replicate these findings.[50] The authors discussed an unreliable insight about cognitive capacities as possible reason, and concluded that it is important to develop validated tools to improve social cognition and to provide rationales for therapies targeting cognitive skills in patients with schizophrenia. The importance of social cognition in patients with schizophrenia is further supported by results of studies, which found better insight into illness as well as higher self-stigma and anticipated discrimination associated with poor QoL.[51-55]

Results of a recent meta-analysis confirmed a positive link between neurocognition and expert-rated QoL (ie, daily functioning), but indicated that neurocognition is largely unrelated or for some neurocognitive domains even negatively related to self-rated QoL. It was concluded that interventions targeting cognition need to ensure that they attend to individuals' subjective life satisfaction to the same degree as they improve expert-rated functioning.[56] These findings provide further support for the use of a combination of QoL self-ratings with expert-rated functioning scales.

Clinical and functional remission and QoL

The symptomatic remission criterion for patients with schizophrenia is already well established, can be applied by clinicians at all stages of the disease, and facilitates cross-trial comparisons of therapeutic interventions.[1] The Remission in Schizophrenia Working Group defined symptomatic remission as the relative absence of positive and negative symptoms such as hallucinations, delusions, and disorganized speech and behavior.[57] The corresponding European Working group concluded that the definition of symptomatic remission enhances the conduct of clinical investigations and reset expectations for treatment outcome at a higher level.

Different cross-sectional and longitudinal studies found significant associations between symptomatic remission and QoL. Patients with schizophrenia who fulfilled the criteria for symptomatic remission showed significantly better QoL compared with patients in nonremission.[58] In particular, longitudinal studies found a significant association between QoL with symptomatic remission.[6,59] For example, Docherty et al found, after 1 year of antipsychotic treatment, a higher improvement in QoL and a better attitude towards treatment in patients who attained symptomatic remission compared with nonremitted patients.[60] Haynes et al reported in a prospective observational study that the failure to achieve symptomatic remission after start of treatment was associated with impaired QoL and functional outcomes after 3 years and higher subsequent health care costs.[59]

Baseline and early changes in QoL showed a high predictive validity for later symptomatic remission as well.[6,61] De Haan et al found an early improvement of subjective well-being in schizophrenia significantly associated with enduring symptomatic remission.[62] This was confirmed by a study of severely ill patients with schizophrenia. Though rate and time to response differed markedly between expert- and self-rated measures, the combined symptomatic, functional, and subjective outcome was best predicted by an early response in QoL.[5]

However, though interventional studies confirmed that symptomatic remission could be reached by approximately 40% to 60% of patients with schizophrenia spectrum disorders, remission frequencies differ markedly between different patient populations (eg, acute vs stabilized patients or first vs multiple episodes of psychosis).[1,63-69] Moreover, studies have shown that symptomatic remission is not necessarily associated with QoL improvement.[27,70] The remission criteria explicitly focus the core symptoms of schizophrenia. Other symptom clusters, such as affective symptoms of depression or anxiety, which exert a significant negative impact on all subjective outcomes across various studies and compromise QoL as reported previously, are not considered.[71-74] Persisting symptoms of depression and reduced QoL have therefore been found in remitted patients with schizophrenia at almost the same level compared to nonremitted patients.[27,70] For example in a prospectively investigated sample of never-treated patients with schizophrenia, 60% of the patients were in symptomatic remission after 3 years, but only 28% showed remission of both, symptoms and QoL.[64] Moreover, self- and expert-rated outcomes differed markedly in an observational study, which compared symptomatic remission assessed by patients, family members, and psychiatrists, with a preference on the patients' side for subjective outcomes and on the psychiatrists' side for the expert rated outcomes.[43]

Antipsychotic treatment and QoL

It is emphasized that outcome of antipsychotic treatment in patients with schizophrenia warrants a broader perspective than the reduction of symptoms of psychosis alone. The measurement of QoL has been approved by the Food and Drug Administration (FDA) as an outcome parameter for the assessment of novel antipsychotic treatment.[57,65,75,76] Various studies reported a significant QoL improvement under antipsychotic treatment, which is significantly associated with early treatment response, improvement in symptoms, subjective effectiveness, medication compliance, a low level of neuroleptic-induced dysphoria, and lower rates of antipsychotic side effects such as sedation, obesity, and sexual side effects.[61,77-81] Patients with a first episode of psychosis reported lower levels of QoL at the start of antipsychotic treatment and better QoL improvement during treatment, compared with patients with multiple episodes.[82]

After the introduction of second-generation antipsychotics (SGAs), early comparison studies found better QoL improvement under treatment with SGAs compared with first generation antipsychotics (FGAs). These results can be explained by differences in the

side-effect profiles, especially by a lower incidence of neuroleptic-induced dysphoria under treatment with SGAs. Lately, it has been discussed whether high dosages of FGAs, especially of haloperidol, in these early studies may partly explain the QoL differences.[83,84] The latter is supported by the fact that comparison studies with different SGAs or studies comparing SGAs with low dosages of FGAs failed to reveal significant QoL differences.[85] Barnes et al, for example, showed a comparable improvement in self- and expert-rated QoL (daily functioning) under treatment with both FGAs and SGAs, especially if patients were switched from one oral antipsychotic to another oral antipsychotic at the beginning of the study.[86] Furthermore, it should be noted that most comparison studies investigating antipsychotics in patients with schizophrenia used and still use the QLS,[19] a scale originally designed to assess the negative syndrome and patients' functioning rather than QoL from the patients' perspective as defined by the WHO.[9,87,88]

Therapeutic interventions and treatment programs and QoL

Various therapeutic interventions (including, eg, cognitive behavioral psychotherapy, psychoeducation, and different physical activities).[89-92] and treatment programs (eg, Assertive Community Treatment [ACT], case-management, home treatment, and rehabilitation) have been investigated regarding their primary or secondary effects on QoL in patients with schizophrenia during the past 5 years. All studies reported QoL improvement in patients with schizophrenia undergoing their respective therapeutic intervention or program. However, only a minority of studies with high methodological standards were able to show robust long-term effects on QoL. Good evidence, for example, is available for the effectiveness of ACT.[93] It has been confirmed that ACT improves quality of care for patients with schizophrenia.[94-96] Key features mediating the effectiveness of ACT were the multidisciplinary team approach with a small client/staff ratio, home treatment, high-frequent treatment contacts, "no drop-out policy," and the 24-hour availability.[97,98] Compared with standard care, ACT was found to be superior in terms of QoL improvement, treatment retention, number of hospital admissions, accommodation status, employment, patient satisfaction, and cost-effectiveness by controlled trials.[94,99] The decrease in the number of hospitalizations and days spent in hospital may be critical, as it has been proven that (re-)hospitalizations, especially in patients with a first episode of psychosis, cause a decrease in QoL.[100]

However, a significant QoL improvement in patients with schizophrenia has also been reported for other integrative treatment approaches including a combination of case management with home treatment or deinstitutionalization programs for patients hospitalized for a prolonged time.[101] An example of a successful translation of QoL research into clinical practice may be a recent study of Boyer et al, who reported that QoL assessment in combination with a feedback for clinicians was able to improve QoL outcomes in patients with schizophrenia.[102] Work status was of some, but minor importance to QoL, whereas satisfying and valuable activities were consistently associated with QoL domains. The findings indicate that satisfying and meaningful everyday activities could contribute to a better QoL for those who have a severe and lasting mental illness and could not be reintegrated into work.[103]

Discussion

Important challenges for the treatment in patients with schizophrenia include the management of subobtimally controlled symptoms, enabling better daily life functioning and improvement of subjective QoL. Understanding the relationship between the different domains of symptoms and functioning with QoL is important because interventions that focus on psychotic symptoms or functioning alone may fail to improve subjective QoL to the same level. Affective symptoms, namely depression and social anxiety, self-stigma and social cognition are major obstacles for QoL improvement during long-term treatment in patients with schizophrenia. Though positive symptoms, negative symptoms, and cognitive functioning may be seen as largely independent parameters from subjective QoL, especially in cross-sectional trials,[104] long-term studies confirmed a critical impact of early QoL improvement on long-term symptomatic and functional remission and of early symptomatic response on long-term QoL.[5,6]

Approximately half of patients with schizophrenia in any kind of treatment achieve symptomatic remission, but only a minority of 15% to 25% reach a combined QoL, functional, and symptomatic remission.[69,105] Thus,

achieving symptomatic remission should not mask the ongoing need for therapeutic efforts aimed at improving persisting negative, affective, and cognitive symptoms exerting a potential impact on functional status and QoL. Moreover, patients and their relatives prefer a broader therapeutic view instead of a sole focus on symptomatic remission. Consequently, treatment outcome of patients with schizophrenia in clinical practice should be evaluated by a composite assessment of symptom severity, functioning, and QoL in order to guide early treatment decisions from a comprehensive and patient-orientated view.[1,31,106-108] It has been demonstrated that coping strategies that deal with daily stressors and emotional upset may also be useful in diminishing the adverse impact of psychiatric symptoms on QoL. Thus, therapeutic approaches that have targeted the core symptoms of psychosis should be complemented by the strengthening of coping strategies that deal with general daily stressors. In other studies, empowerment of patients with schizophrenia has been shown to mediate effects of symptoms on QoL and psychosocial interventions were able to increase the sense of empowerment and QoL.[109,110] From a research perspective, longitudinal studies are needed to assess the impact of different coping and empowerment strategies over time, and determine the relative merits of each strategy, as well as their effectiveness vs symptom-specific approaches.[111]

Generic QoL assessment might be a valuable tool in the comparison of different populations of patients, while disease-specific QoL assessment might be more useful to detect specific treatment effects.[19] In QoL assessment, the idea that there is not one "best" scale for all research questions, but that the best-fitting scale has to be selected depending on each study design or study sample, is accepted more and more. It is still controversially discussed as to which instrument should best be used for measuring QoL in schizophrenia. However, the present analysis showed a huge variation of QoL scales used in patients with schizophrenia, which complicate the comparison of results of different studies. Although an evidence base is limited in a number of important respects, including problems with the measures used to develop constructs in validation studies, doubts were reported regarding the use of generic measures of health as the EQ-5D and SF-36 alone in patients with schizophrenia.[112] The combination out of standardized generic and disease specific QoL instruments may be a useful alternative. However, the lack of consensus on QoL scales hampers research on its predictive validity. Future research needs to find more consensus on the concept and measures of QoL and to test whether QoL predicts better outcomes with respect to remission and recovery under consideration of different treatment approaches in patients with schizophrenia.

Different studies showed that early changes in QoL, as well as the clinical and functional status at entry-to-treatment programs have an important impact on long-term QoL and clinical outcome in patients with schizophrenia.[1] Especially in long-term treatment, not only the reduction of symptoms alone, but also treatment-related factors, such as the therapeutic alliance and the integration of care, continuously improve QoL in patients with schizophrenia.[70,93] Moreover, illness recovery models that consider that especially chronically ill patients benefit from well-executed psychosocial rehabilitation and treatment programs should be advocated.[113] A close collaboration between clinicians, researchers, and economists, and the investigation of therapeutic interventions is required to further improve the translation of QoL research into clinical practice.[4] For future research, the investigation of predictors for symptomatic and functional remission under consideration of integrated pharmacotherapeutic and psychosocial treatment programs, and their relation to QoL in patients with schizophrenia is recommended.[114] ❑

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La evaluación de la calidad de vida en la práctica clínica de pacientes con esquizofrenia

El objetivo del presente artículo es revisar las escalas de calidad de vida (CdV) utilizadas en estudios que investigan pacientes con esquizofrenia durante los últimos cinco años y resumir los resultados de la evaluación de la CdV en la práctica clínica en estos pacientes. Se identificó la literatura disponible en la base PubMed entre enero de 2009 y diciembre 2013 utilizando las palabras clave "calidad de vida" y "esquizofrenia" y en una búsqueda de referencias cruzadas para artículos especialmente relevantes. Un total de 432 estudios emplearon 35 escalas diferentes de CdV tanto genéricas como específicas estandarizadas en pacientes con esquizofrenia.
Los principales obstáculos para la mejoría de la CdV en pacientes con esquizofrenia fueron los síntomas afectivos. Aunque los síntomas positivos, los síntomas negativos y el funcionamiento cognitivo pueden considerarse como parámetros en gran medida independientes de la CdV subjetiva-especialmente en ensayos transversales-, los estudios a largo plazo confirmaron un gran impacto de la mejoría precoz de la CdV en la remisión sintomática y funcional a largo plazo, como de la respuesta sintomática precoz en la CdV a largo plazo. Los resultados de la presente revisión sugieren que la CdV es un criterio de resultado válido y útil en pacientes con esquizofrenia. Como tal debe ser aplicada sistemáticamente en ensayos clínicos. Es importante la comprensión de la relación entre síntomas y funcionamiento con la CdV, ya que las intervenciones que se enfoquen solo en los síntomas de la psicosis o en el funcionamiento puede que no mejoren la CdV subjetiva en el mismo nivel. Sin embargo, la falta de consenso sobre las escalas de CdV dificulta la investigación sobre su validez predictiva. A futuro la investigación requiere encontrar un consenso acerca del concepto y mediciones de la CdV y comprobar si ésta predice mejores resultados para la remisión y la recuperación tomando en cuenta las diferentes aproximaciones terapéuticas en pacientes con esquizofrenia.

Évaluation de la qualité de vie en pratique clinique chez les patients schizophrènes

Cet article évalue les échelles de qualité de vie (QdV) utilisées dans des études de patients schizophrènes ces 5 dernières années et résume les résultats de l'évaluation de la QdV en pratique clinique chez ces patients. Une recherche sur PubMed utilisant les mots clés « qualité de vie » et « schizophrénie » et une recherche de références croisées pour des articles très pertinents ont permis de sélectionner la littérature disponible de janvier 2009 à décembre 2013. Au total, 432 études utilisent 35 échelles de QdV standardisées différentes, spécifiques et génériques, chez les patients schizophrènes. Les symptômes affectifs constituent un obstacle très important à l'amélioration de la QdV chez ces patients. Les symptômes positifs, négatifs et le fonctionnement cognitif sont considérés comme des paramètres en grande partie indépendants de la QdV subjective, surtout dans les études croisées, mais les études à long terme confirment l'impact essentiel d'une amélioration précoce de la QdV sur la rémission fonctionnelle et symptomatique à long terme et d'une réponse symptomatique précoce sur la QdV à long terme. D'après les résultats de cet article, la QdV est un critère de résultat valable et utile chez les patients schizophrènes. À ce titre, les études cliniques devraient l'employer régulièrement. Il est important de comprendre la relation entre les symptômes et le fonctionnement par l'intermédiaire de la QdV car les traitements qui ne s'intéressent qu'aux symptômes de la psychose ou qu'au fonctionnement seul peuvent ne pas réussir à améliorer la QdV subjective de la même façon. L'absence de consensus sur les échelles de QdV entrave néanmoins la recherche sur leur validité prédictive. À l'avenir, la recherche doit trouver un consensus sur le concept et les mesures de QdV et vérifier si la QdV prédit de meilleurs résultats en ce qui concerne la rémission et la guérison en examinant les différentes approches thérapeutiques chez les patients schizophrènes.

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