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EDITORIAL

QUALITY OF LIFE IN PSYCHIATRIC PATIENTS

Ancient Indian Literature considers health as a broad and global concept represented by from independent dimensions of physical, psychological, social and spiritual well being (Charak Samhita,1949). This conceptualisation of health is even broader than the modern concept of health as accepted by WHO which aims at restoring "a state of complete physical, mental and social well being". Till the turn of last century the main focus of treatment was on saving the lives but with the development of medicine as a science there has been a conceptual shift from simply treating the symptoms and prolonging life to improving the QOL of the patients. Chronic illnesses have replaced life threatening conditions as major challenges to clinicians and have brought with them issues such as : cost of treatment, disability, social impairment and burden of care. These issues directly or indirectly influenced the patients sense of well being and self esteem. A number of factors have contributed to such development - life threatening conditions have been replaced by chronic illnesses and with this the cost of treatment/care has become an important parameter. Cost utility, the concept which involves choice between different methods of treatment based on improvement it provides and the quality of life it gives, is increasingly in use in health care evaluations. In addition, family and patient's groups participation in decision about health care is also being seen as their desire to get therapies for better quality of life. The pharmaceutical industry has been quick to seize the opportunity and is motivated by genuine desire to develop better medications so that they can give better QOL to the patients. After all what matters for the individual patient with a chronic illness is how such an individual feels and functions on long term drug therapy.

The concept of quality of life is not so new. However, in its current form it was launched by late American President, Lyndon B. Johnson, during his presidential campaign in 1964, when he gave the idea that people were entitled to "a good quality of life". Thereafter, quality of life has been recognised as one of the mankind's fundamental needs. Initially, only few knew exactly what it meant, but it was evident from its wider acceptance that this concept was an important one. In simple words quality of life is a person's own subjective view of well being and satisfaction with his/her life. It is therefore completely subjective feeling state (Joyce, 1992). Rehumanising medicine and freeing it of high tech objective is the goal of the proponents of quality of life concept.

The WHO officially recognizes QOL as a subjective notion by stating that "the individual himself/herself should be the arbiter of their quality of life". Dunbar & Stroker (1992) pointed out that the difference between "self now" and "ideal self" could be used as a measure of QOL.

Another important aspect of QOL is that it is different from an individuals' health status and is a much broader term. It includes health status as well as other features such as environment, income and living standard. More recently, the WHO has explained that the division between these two concepts was that "QOL is defined by the patients subjective disadvantage of being ill, in contrast to health status, which is defined by clinical disability caused by disease". For example, although a patient who is prescribed lithium for a mood disorder may be in good health (stabilized), an increase in weight or having to take medicine daily may result in a low QOL. QOL therefore represents the impact of an illness and its therapy on the functional status of a patient, as perceived by the patient

himself or herself (Schipper et al.,1990). It is more than symptomatic improvement or deterioration and includes assessment of number of major domains specifically, illness related and treatment related impairments as well as psychosocial performance.

Various studies were conducted in USA during 1980's (Lehman,1988; Lehman & Burns, 1990; Spilker,1990; Intagliata,1982) using various quality of life measures. Results have shown that no single quality of life measures emerged as definitive changes within QOL domains independent of treatment may influence the participation and the effectiveness of treatment; measures of treatment benefits and adverse effects do not yield, conclusions regarding how a patient's QOL is affected as filtered through than person's own values beliefs and judgements.

Future scales for assessment of QOL need to be more specific for psychiatric population. The scales need to pick-up small changes which are expected in psychiatric patients. Since QOL is multidimensional construct it has to tape a number of domains including illness related and treatment related issues as well as psychosocial findings.

The concept of QOL is quite new to psychiatry and has gained significance as a consequence of shift towards deinstitutionalisation and practice of community psychiatry. It is believed that the QOL of mentally ill would be greatly enhanced by living with family and in his own community rather than within the cold and impersonal walls of a mental hospital. There are a multitude of reasons which force us to stop thinking of psychiatric illnesses in terms of health status alone and adopt a wider vision encompassing QOL. Firstly, psychiatrists usually do not mention the side effects or social incapacities associated with the treatments they give to their patients. As many psychiatric illnesses require long term treatment, social and work factors play an important role bringing down the QOL. Secondly, diagnosis of an illness in psychiatry is not based on highly objective criteria as is the case with hypertension or arthritis. Because of this subjectivity sometimes it becomes very difficult to decide to whom, why or when to prescribe drugs. For example giving antidepressants to anyone who feels "unhappy" means that we are treating poor QOL with drugs, which is ridiculous. In such case ethics requires us to differentiate between illness and poor QOL and to answer the patient's problems adequately. Thirdly with the upsurge of chronic illnesses, the economic burden associated with these illnesses has become a major concern (Atkinson et al., 1997; Lehman,1996). Economic burden and cost-effectiveness of the treatment needs to be evaluated carefully especially in country like ours.

The importance of health related quality of life assessments in psychiatric patients in our country needs to be recognised. These assessments involve restructuring of clinical thinking from symptom improvement to improvement in the functional status of the patient. Such assessments can improve clinical decision making and can assist in making benefit versus risk judgements on any therapeutic approach. Any form of treatment should consider the holistic quality of life alongwith the subjective quality of life as an important outcome measure. It will serve as a reminder to clinicians that drugs are only a component in the wholesome management of psychiatric illnesses (Priebe et al.,1996). Drug regulatory bodies may be promoted to make QOL assessments a requirement for approval of newer drugs alongwith therapeutic and side effect evaluations. As health costs are becoming a major concern, data from such assessments can be used for allocation of resources as well as comparison of therapies. For all this to be accomplished there is a need for focusing research interests on the development of valid and reliable measures of QOL suited to the needs of the local psychiatric populations.

In our country quality of life assessment would also have to take into account social, economical and educational circumstances (Sell & Nagpal,1985).

Thus, quality of life and subjective well being have been relevant constructs and subject

of empirical research for several decades all over the world but not that much in India. To what extent quality of life is a useful criterion for the planning and evaluation of mental health care in our country needs to be addressed on a priority basis.

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REFERENCES

Atkinson,M., Zibin,S. & Chuang,H. (1997) Characterising quality of life among patients with chronic mental illness : a critical examination of the self report methodology. *American Journal of Psychiatry*, 154, 1, 99-105.

Charak Samhita (1949) *Warba Ayurvedic Society*, (Ed.) Kumar, Gulab, Jam Nagar.

Dunbar, G. & Stroker, M. (1992) The development of a questionnaire to measure quality of life in psychiatric patients. *British Journal Econ.*, 4, 63-73.

Intagliata, J.(1982) Improving the quality of community care of chronically, mentally disabled : the role of case management. *Schizophrenia Bulletin*, 8, 655-675.

Joyce, C.R.B. (1992) Report from European Standard for Clinical Trials Meeting in Strassbourg, 23-24 May,1991, on issues of concern in the standardisation and harmonisation of drug trials in Europe. Health related quality of life session. *Quality of Life News*, 1, 3, 10.

Lehman, A.F.(1988) A quality of life interview for chronically mentally ill. *Eval. Prog. Plann.*, 11, 51-62.

Lehman, A.F.(1996) Measures of quality of life among persons with severe and persistent mental disorders. *Social Psychiatry & Psychiatric Epidemiology*, 31, 2, 78-88.

Lehman, A.F. & Burns,B.J.(1990) Severe mental illness in the community. In : *Quality of Life Assessment in Clinical Trials*, (Ed.) Spilker, B., New York : Raven Press.

Priebe, S., Kaiser, W. & Huxley,P.(1996) Quality of life as a planning and evaluation criterion in psychiatric management. *Gesundhei Tswesen*, 58, 1 (suppl.), 86-90

Schipper,H., Clinch, J. & Powell,V. (1990) Definitions and conceptual issues, In : *Quality of Life Assessment in Clinical Trials*, (Ed.) Spilker, B., New York : Raven Press.

Sell,H. & Nagpal,R.(1985) Subjective well being. SERO regional health papers No.7, WHO, New Delhi.

Spilker, B. (1990) Introduction, In : *Quality of Life Assessment in Clinical Trials*, (Ed.) Spiker, B., New York : Raven Press.

WHO (1974) The constitution of the World Health Organisation. *WHO Chronicle*, 1, 29.

WHO (1991) Meeting on the assessment of QOL in health care. Geneva, 11-15 Feb.,1991. MNH/PSF/914.