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Beyond Crisis Stabilization: How are We Improving Quality of Life?

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Quality of life has increasingly become an important issue to individuals involved in the treatment and care of those with severe mental illness. Families, patients, clinicians, and pharmaceutical companies are concerned with the impact of treatment upon a patient's quality of life. The recent concern with quality of life results from many changes within psychiatry. One change is the development of novel pharmacotherapies that decrease symptomatology while also increasing patient awareness (Meltzer, 1993). A second change is the shift from institutionalization to community based care. Patients are less frequently hospitalized for long periods of time and instead are active members of the community. Higher patient visibility makes it much more difficult to ignore quality of life issues. Community based care has also resulted in increased family involvement which further contributes to a focus on life quality.

There are numerous definitions that exist for quality of life. The World Health Organization (WHO) defines quality of life from an optimal health perspective as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Schipper and colleagues argue that the WHO definition is overly inclusive of social issues and thus not focus on the "sick" that are treated by physicians. His counter-definition is that quality of life "represents the functional effect of an illness and its consequent therapy upon a patient, as perceived by the patient" (Schipper, Clinch, & Powell, 1990). What is important in this definition is the focus upon the subjective interpretation of life quality by the individual and the inclusion of the intervention effects. However, mental health professionals must also concern themselves with patients social issues as these influence psychiatric outcomes and thus both definitions appear appropriate. No longer is it acceptable for the clinician to be the only judge of efficacy, it must also be shown that patients perceive interventions as beneficial.

The present study examines quality of life in subjects diagnosed with schizophrenia and those with a mood disorder (i.e. bipolar disorder, major depression). The following research questions are explored:

1. What are the differences, if any, between subjects diagnosed with schizophrenia and subjects diagnosed with a mood disorder on a quality of life measure? It may be that the groups exhibit different rates of change based on diagnosis.
2. Does subjective quality of life improve during short-term treatment?

(Mean rank = 29.7 vs 19.2; 29.0 vs 20.1). Marginal significance was also reached on the Subjective Feelings (p=0.08) and on the Medication Satisfaction (p= 0.07) subscales with schizophrenic subjects rating themselves higher in these areas (Mean rank = 28.3 vs 21.0,23.0 vs 16.8) No significant differences were found at discharge between the groups

Comparing the two groups on computed change scores (T1 - T2) revealed significant differences on the General Activities (p=0.014) and Medication Satisfaction (p=0.009) subscales and marginal significance on the Physical Activities (p=0.069) and Social Relationship (p=0.079) subscales which in each case indicated that those with mood disorders improved at a faster rate.

The lack of significant differences on many of the subscales allowed for the two groups to be collapsed into a singe group for further analysis. Pre-test/post-test MANOVAs were conducted to answer the second question of whether short-term treatment improves subjective quality of life. The results show that improved quality of life was found on five of the seven subscales (Table 2). Only the Leisure Activities and Social Relationships subscales failed to reach a level of significance.

Table 2
Significance of Q-LES-Q Differences

	Admit.	Disch.	F	p
Physical Activities	40.10	44.26	4.72	0.035
Subjective Feelings	43.33	50.93	25.33	0.000
Leisure Activities	18.46	20.37	2.69	0.108
Social Relationships	35.43	38.63	2.29	0.138
General Activities	43.59	49.31	9.50	0.004
Medication Satisfaction	3.38	4.00	6.06	0.019
Overall Life Satisfaction	2.92	3.81	15.73	0.000

A descriptive perusal of group differences, given that the sample size was extremely small, yielded some interesting trends. Subjects were divided into three groups representing subjects with schizophrenia (n=27), major depression (n= 12), and bipolar disorder (n=10) and compared on the Q-LES-Q subscales. On four of the admission subscales. subjects with bipolar disorder appeared to more closely resemble those with schizophrenia than those with a depressive disorder However, upon discharge no differences between the groups were noted.

METHODS

A total of 49 subjects participated in this study, Subjects were drawn from a residential short-term crisis unit (n=29) and from a psychiatric hospital (n=20). The residential unit is a pilot program begun in 1992 that offers 24 hour staff supervision, group therapies, and medication monitoring

INSTRUMENTATION

Quality of life was measured using the Quality of Life Enjoyment Scale (Q-LES-Q) developed by Endicott and colleagues (1993). The Q-LES-Q consists of 60 items encompassing the following five subdomains: Physical Activities. Subjective Feelings. Leisure Activities. General Activities. & Social Relationships. There are also single questions measuring satisfaction with medications and overall life satisfaction. Patients completed the Q-LES-Q upon admission and discharge from the facilities.

Concerns with the reliability and validity of the Q-LES-Q for use with the chronic mentally ill were addressed by calculating Cronbach's alpha for internal reliability on the subscales and on the total instrument (Table 1). Results indicate a high degree of internal reliability.

Construct validity was addressed by examining intercorrelations among the Q-LES-Q subscales. Comparisons among the subscales indicated a consistent pattern of positive correlations ranging from 0.47 to 0.87. These relationships reflect moderate to high construct validity among the Q-LES-Q subscales.

Table 1
Cronbach's Alpha for the Q-LES-Q

Physical Activities	0.975
Subjective Feelings	0.946
Leisure Activities	0.911
Social Relationships	0.921
General Activities	0.932
Total Q-LES-Q	0.975

SAMPLE DISTRIBUTION

Length of stay in this study ranged from 4-46 days with an average of 16 days . Subjects admitted to the residential unit averaged 13 days (SD=9) with a range of 4-42 days. Subjects admitted to the hospital averaged 23 days (SD=13) with a range from 6-56 days.

RESULTS

T-tests revealed significant admission differences between the two groups on the General Activities subscale (p=0.008) and on the Overall Life Satisfaction Question (p=0.03) suggesting that schizophrenic subjects perceived these areas more favorably than those with mood disorders.

DISCUSSION

The results of this study suggest that quality of life does improve during short-term treatment. Of note is the improvement experienced by both groups on the five quality of life subscales. those with mood disorders appeared to improve at a significantly faster rate on two of the subscales and at a marginally significant rate on two additional subscales. At discharge. b6th groups of subject appeared similar.

The division of the mood disorders group into subgroups, although extremely preliminary in nature, suggests that where differences were found, subjects with major depression had lower admission scores and also improved at the fastest rate. In addition, subjects with bipolar disorder more closely resembled those with schizophrenia on the subscales at admission.

There are a number of factors that likely contribute to the improvement noted in both groups. All subjects received medication adjustment and monitoring which provided the opportunity for stabilization. In addition, subjects were under 24 hour supervision which assured that their basic (i.e.. food, hygiene, etc) needs were being met. Finally, all subjects participated in psychosocial rehabilitation including regular groups therapies. It is difficult to discern which of these factors is primarily responsible for the noted improvement and it is probable that the results stem from the combination of these and other variables.

Due to the relatively recent inclusion of quality of life in psychiatric research, little is known about the effects of treatment on life quality. The current study, although limited in sample size, provides directions for future research. Further research is needed to examine the variables that impact subjective life quality. In addition, larger studies of quality of life arc necessary to validate these findings across treatment programs and within targeted samples. As the field of psychiatry continues to change, it will be increasingly necessary to demonstrate the effectiveness of interventions upon patients lives. Measuring quality of life is one method of accomplishing this task.

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