S14 *Quality of life in mental disorders*

QUALITY OF LIFE IN DEPRESSION

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In relation to health and disease Quality of Life (usually called "Health Related Quality of Life" (HRQL)) is most often measured by instruments which capture nothing but subjective well-being. As a rule such instruments contain several items on depression anxiety. Their rating is organized in such a way that the presence of depression and anxiety move the score in the direction of a bad quality of life. Measuring quality of life in depression itself with such instruments will, therefore, automatically produce a result of the "Quality of Life" of a depressed patient being inferior. There are some instruments (e.g. the SF-36) which try to measure also functioning in social roles in addition to subjective well-being. Still, if functioning in social roles is merely judged by the patient himself this judgement is usually distorted by the depressed patient's negative perception of himself and the world. Study results on quality of life in depression must therefore be evaluated carefully. Results of our own methodological research will be presented supporting the view that quality of life in depression has to be evaluated at least on three dimensions: (1) subjective well-being, (2) functioning in social roles and (3) social and material environmental conditions. Furthermore, at least three groups of persons should evaluate quality of life in depressed patients: (1) the patient himself, (2) a close relative and (3) a professional worker.

S14 *Quality of life in mental disorders*

QUALITY OF LIFE IN SCHIZOPHRENIA

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The aim of this presentation is to review the different conceptual models of quality of life employed in schizophrenia and to analyze generic and specific instruments usually employed in this field, according to the following Medical Outcomes Trust guidelines: Conceptual and measurement model, reliability, validity, responsiveness, interpretability, burden, alternative forms and cultural and language adaptations. The most representative quality of life studies (clinical trials, etc.) made in schizophrenic patients will be reviewed. Quality of life data from a nationwide Spanish study made during 1996 with 274 patients will be presented. These patients were evaluated at baseline, 2, 4 and 8 months respectively, using the following instruments: for assessing Axis I: the Positive and Negative Syndrome Scale, the UKU (Commission of Clinical Trials) (side effects) and the Clinical Global Impression and Axis II: the SF-36 and the Disability Diagnostic Scale. Finally, conclusions will be drawn and remarks will be made on the need to assess schizophrenic patients on Axis II (disability level and in particular quality of life levels).

S14 *Quality of life in mental disorders*

Articulating Ethics and Quality of Life in Comprehensive Psychiatric Diagnosis

Juan E. Mezzich (New York), Margit Schmolke (Munich)

Concern for and commitment to the person of the patient constitute a crucial focus in psychiatry. Such concern and commitment are also pertinent to psychiatric diagnosis, a fundamental aspect of clinical care. They also explain why ethics and quality of life are emerging as critical concepts in comprehensive psychiatric diagnosis. A comprehensive diagnosis must pointedly include the patient's history, perspectives, rights, needs and expectations, all critical to an ethical approach to the person of the patient. A comprehensive diagnosis should additionally cover not only the traditional areas of health status (physical and emotional fitness, adaptive functioning and social supports) but also its more subtle aspects involving personal and spiritual fulfillment. This extended multidimensionality of health status combined with a subjective emphasis in its assessment corresponds well to recent conceptualizations of quality of life.

S14 *Quality of life in mental disorders*

Mental Health Policy and Quality of Life

by Professor Norman Sartorius Geneva

There are several reasons for the insistence that quality of life be a central goal of mental health policies. These reasons include the fact that, in many instances, quality of life will be the most sensitive indicator of effects of mental health programmes in general and psychiatric treatment in particular; that the public health importance of mental disorders is growing and that consequently, detailed information about the effects of interventions undertaken to help the mentally ill is important; that psychiatry is a discipline that should assume leadership in efforts to make health care in general more humane and that the advocacy of the notion that an improved quality of life is the central goal of health care exemplifies one of the roles of psychiatry in health care; and the fact that the participation of patients and families in the treatment process (which is of such importance in psychiatric care) will be facilitated if the goal of mental health programmes is improved quality of life.

These and other reasons for the insistence that an improved quality of life of patients and their families should be a central goal in mental health policies will be discussed.

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