

Quality of life of people suffering from depression

Introduction

Experts that help people deal with their illness more often tend to advert on the importance of patient's quality of life. Many psychologists and physicians emphasize that improvement of subjective judgment of one's quality of life is as much important as the shortage of inconvenient somatic symptoms. This article contains results of surveys in QOL of people with depression diagnosis. Exact definition is difficult to think out because of the variety of symptoms that influence quality of life. Idea of quality of life conditioned by the sanity status is commonly described as multi-dimensional but the genre and number of area are different¹. Quality of life is presented as a global concept which includes psychological and social effects, physical activities, good aspects of well-being but also those negative caused by sickness and disability². M. Jarema³ thinks that quality of life can be taken as a subjective reception of satisfaction from life status in the context of needs and possibilities. Many researchers presupposes that quality of life sense is a subjective reference of person's life values. Quality of life is also perceived as a measure that helps to estimate the quality of programs and services offered to each person⁴. Interesting comprehension of the quality of life was presented by R. Schalock and K. Keith⁵ – creators of the questionnaire used in present survey. They claim that the quality of life is determined by four aspects:

- satisfaction coming from person's actual status
- sense of own competence; ability of dealing with current state (own productivity)
- sense of own strength and independence

¹ Karow A., Naber D., *Subjective well-being and quality of life under atypical antipsychotic treatment*. "Psychofarmacology" 2002, nr 162, s. 3-10.

² Osoba D. *Badanie jakości życia zależnej od stanu zdrowia pacjentów onkologicznych*. „Nowotwory” 1994, nr 43, s. 185-192.

³ Jarema M., Koniecznyńska Z., Głowczak M., Szaniawska A., Meder J., Jakubiak A. *Próba analizy subiektywnej oceny jakości życia pacjentów z rozpoznaniem schizofrenii lub depresji*. „Psychiatria Polska” 1995, nr 29, s. 641-654.

⁴ Juros A. *Poczucie jakości życia osób niepełnosprawnych a obraz gminy*. [w:] Juros A., Otrębski W. (red.), *Integracja osób z niepełnosprawnością w społeczności lokalnej*, Lublin 1997, s.297-309.

⁵ Schalock R., Keith K. *Quality of Life Questionnaire*. Worthington 1993.

- sense of social status and integration with local community

Most researchers agree that quality of life is a dimension under subjective evaluation. Gill and Finstein⁶ analyzed over 150 researches referring to quality of life described in literature. They stated that quality of life should be measured only supported by patient's feelings and opinions and not specialist's evaluation. Therefore research on patient's own opinion becomes very useful in quality of life statement. Literature also points out that quality of life is dynamically influenced by many internal and external factors and what is more it changes during period of time. Therefore analysis of the quality of life is essential in the case of people suffering from depression to include positive life periods during the healing process.

Depression – a change in quality of life

Particular changes in sphere of one's life contentment can be seen in life of those suffering from depression. In psychiatry term 'depression' is used to name the emotional person disorder illness. Typical endogenous symptoms of depression syndrome are:

- fall of basic mood

Sick people experience sadness, dejection, loss of joy of life. Sometimes experience listlessness and are unable to live in sadness nor in happiness.

- reduction of activity and psychical process rate

This manifests in thinking and pronouncement slowdown, sense of reduced intellectual activity, loss of vital energy and sense of constant physical weakness.

- disturbance of the circadian order and somatic symptom occurrence

People with depression suffer from sleep disorder and circadian rhythm (better mood in the evening, worse in the morning). Other symptoms are headaches, weight change (loss of body or getting fat), constipation.

- fear

People with depression can experience anxiety, movement excitement, tension, danger.

In endogenous depression units sometimes thinking disorders and complex activity disorder may occur. Sick people experience unpleasant sensations, have guilty mind complex, sometimes suffer from delusions of sinfulness, punishment, hypochondria, nihilism. Some depressed are fully convinced that they've been touched by serious somatic illness (e.g. AIDS, neoplasm). They make negative judgment of their own life situation, of past and future. Feeling of hopelessness, no support from relatives, disbelief in specialists assistance

⁶ Gill T.M., Finstein R.A. *A critical appraisal of quality of life measurements*. "Journal of American Medical Association" 1994, nr 27, s. 619-626.

can lead to suicidal thoughts or even actions. Depressed people find it difficult to maintain former social activities. As a result they appear to weaken the contacts with environment and even isolate, neglect themselves and own appearance⁷. Depressed person usually treats illness symptoms as permanent state, irreversible and in that way creates an image of the future. The balance of former achievements is fully negative. Sick person often becomes aware of his life situation as an absolute failure and is unable to cope with going to work or performing everyday-life activities. Although depression is a curable sickness depressed person is often convinced that it will last forever⁸. Latest research show that best effects can be obtained when psychotherapy and pharmacotherapy get combined.

In this article research results on QOL of people with depression will be presented. They are a part of a bigger research project carried over group of individuals affected by psychical disorders. Quality of life will be interpreted likewise expressed by R. Schalock and K. Keith⁹, makers of the questionnaire used in empirical survey. They claim that:

I Contentment

II Ability / Productivity

III Activity potential / Independence

IV Society membership / Society integration

Subject of survey and kind of tool used in program

The purpose of conducted studies was a recognition QOL of people treated from depression. Subject comprehends two basic questions: What is the level of quality of depressed people life? and What is the relationship between quality of life and: age, sex, education, living standards, hospitalization number, start of an illness, family status. The survey was conducted on the basis of Quality Of Life Questionnaire by R. Schalock and K. Keith translated and adapted by A. Juros. It consists of 40 questions which are grouped in four areas that determine measure of QOL:

I Contentment

II Ability / Productivity

III Activity potential / Independence

IV Society membership / Society integration

⁷ Pużyński S., *Depresje i zaburzenia afektywne*, Warszawa 1999

⁸ Koszewska I., Habrat – Pragłowska E., *O depresji, o manii, o nawracających zaburzeniach nastroju*, Warszawa 2003.

⁹ Schalock R., Keith K., *Quality of Life Questionnaire*, Worthington, 1993.

Each of the measures contains 10 three-point scales valued 1,2,3. Maximum point number in particular measures is 30 and in for scale - 120. Higher result determines higher sense of QOL. Theoretical average number is 80. Conducted studies presupposed that global result from 40-60 remains low, 61-80 and 81-100 is average and 101-120 is above-average. Possible result value is between 10-30 so theoretical average number is 20. Result between 10 and 15 is ranked as low, 16-20 and 21-25 average, and 26-30 above-average¹⁰.

Analized group

24 patients that finished hospital treatment participated in the survey. Among them 17 women (70,8%) and 7 men (29,2%). Those person were classified on the basis of medical documentation analysis and specialized team opinion. Survey was conducted individually on each patient being in the state o remission, just before leaving hospital. Patients were informed about the purpose of survey and agreed to fill up the questionnaire. Patients that took part in survey were classified with depression according to ICD-X standard, aged 38-64 (M=52,2; δ =5,5), average level of hospitalization was M=4,7 and standard deviation δ =3,1, average illness duration M=11,0 with standard deviation δ =8,9. There was no alcohol or drug addicts and no people suffering from central nervous system injury.

Among examined patients most of people had liberal education (54,2%) none had higher education, two person had medium education (8,3%) and other two had elementary education (8,3%), 29,2% had occupational education. Most of them remains married (58,3%), another group are people who lost their spouse (20,8%), 3 people are divorced and another 2 are single (8,3%). Great majority lives with their spouse (54,2%), 20,8% of patients live with children, 4 people are lonely (16,7%), one person lives with parents (4,2%) and one men with his concubine (4,2%). 14 respondents live in the city (58,3%) and 10 in the country (41,7%).

RESULTS

Survey results on the field be of general quality of life are illustrated in the table no.5.

¹⁰ Otrębski W. Poczucie jakości życia osób z lekkim i umiarkowanym upośledzeniem umysłowym. [w:] Francuz P., Oleś P., Otrębski W. (red.). Studia z psychologii w Katolickim Uniwersytecie Lubelskim, Lublin 2001, s.31-49.

Table 5. Research results on quality of life extracted from the Schalock Questionnaire for all group.

SCALE	GROUP	
	M	δ
QUALITY OF LIFE (TOTAL)	71,9	11,7
CONTENTMENT	17,3	4,9
ABILITY / PRODUCTIVITY	12,9	3,7
ACTIVITY POTENTIAL / INDEPENDENCE	23,1	4,6
SOCIETY MEMBERSHIP / SOCIETY INTEGRATION	18,6	3,0

M – average, δ – standard deviation

Examined persons obtained results lower than theoretical average but comprised in lower average. Three of them (contentment M=17,3; competence / productivity M=12,9; integration with community M=18,6) are lower than theoretical average, however highest result was obtained in activity/ independence (M=23,1) which is slightly higher than theoretical average. We can state on the basis of conducted survey that subjective sense of QOL of depressed people is understated. Patients evaluating their actual life situation tend to underline the lack of happiness, contentment and accumulation of feelings such as affection of solitude. Great majority of examined patients due to illness disability was not able to keep their work due to illness disability which directly caused lowering of their sense of productivity. They complain on lack of entertainment possibilities. Survey shows that respondents rarely make acquaintance among society. In examined patients own opinion they are fully capable of everyday duty activities without any help. More of those don't feel independent and state that their life is in some kind depended from others.

In order to check the dependence between variables such as: education, civilian status, illness period, recurrence of hospitalization and sense of QOL statistical tests were applied. However only correlation between civilian status and 1 of 4 spheres became merely essential which was contentment aspect ($r=0,40$, $p<0,05$). Other varieties didn't even reached significant level to claim as effective in this particular survey. Analyzed data is preliminary due to the fact that the small group of patients engaged in the studies.

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