



Research report

Quality of life in outpatients with depression in China

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ABSTRACT

Background: Quality of life (QOL) is an important outcome measure for patients with depression, but QOL research involving large samples of patients has been uncommon. The purpose of this study was to evaluate the QOL of Chinese outpatients with depression and its determinants.

Methods: Using a cross-sectional survey design, data were collected continuously from 19,984 outpatients; 19,950 usable questionnaires were obtained. Along with the QOL index (WHOQOL-BREF), the questionnaire also included participants' sociodemographic characteristics, outpatient visits, and medication use information.

Results: Less than 5% of depressed patients reported "good" or "very good" QOL, while less than 3% were satisfied with their general health. The overall score was low (54.12); four QOL domain (physical health, psychological, social relationships, and environment) scores (range, 35.03–40.10) were significantly lower than in other community population surveys. QOL scores were significantly lower among first-visit than non-first-visit patients. Medication users reported significantly higher QOL scores than non-users, with NaSSA more effective than SSRIs, followed by other types, SNRIs, and no medication, in that order.

Limitations: Since this was an observational, cross-sectional survey with continuous outpatient data collection method instead of random sampling, generalization of the results is limited, and causality cannot be determined. However, the "natural" observational design, large sample size, and similarity in findings with other studies reveal the "real world" QOL of depressed outpatients in mainland China.

Conclusions: Depressed patients had a low QOL, and the scores of first-visit patients with severe symptoms were significantly lower than non-first-visit patients. Though medication can improve patients' QOL, different types of medications have different impacts.

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1. Introduction

Depression is one of the most common mental illnesses, and it is regarded as a major public health problem worldwide. In the USA, the National Comorbidity Survey Replication (NCS-R) (2003) showed that the life-time and 12-month prevalences of depression were 16.2% and 6.6%, respectively (Kessler et al., 2003). According to the World Health Organization (WHO) (2006), the risks of lifetime depression for men and women were 7–12% and 20–25%, respectively. An epidemiological survey of the four provinces in China (Phillips et al., 2009) showed that the prevalence of major depressive disorder among the general population was 2.07%. He et al. (2009) found that the prevalence of depression in general hospitals was as high as 12.1%. The World Health Organization (WHO) (2001) reported that the burden of depression ranked 4th

among disabling diseases, projected to increase to 2nd in 2020, next to cardiovascular diseases.

Previous studies found that patients with depression experienced physical, psychological, and social problems, as well as declines in health-related quality of life, including increased financial pressure, social and family relationship issues, occupational dysfunction, increased days of absence from work, and poor health status (Johnson et al., 1992; Revicki et al., 1998). According to the WHO (The WHOQOL Group, 1998), health-related quality of life refers to individuals' goals, expectations, standards, and experiences of life within a particular culture and value system. This means that quality of life is rooted in the cultural and social environment within which an individual lives, and it reflects people's subjective feelings and experiences. Poor quality of life indicates that individuals encounter difficulties in their daily life due to illness or other reasons causing dysfunction or subjective hardship. Therefore, evaluation of health-related quality of life complements the assessment of patients' physical and mental health status because of its sensitivity to functional status. Thus, it was recommended by Ishak et al. (2011a) that quality of life can be

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used as an outcome assessment in intervention studies among patients with depression.

The validity and the reliability of the short version of the quality of life tool (WHOQOL-BREF) developed by the WHO has been tested in many countries. As an approved quality of life assessment tool, the WHOQOL-BREF has been widely used in populations such as communities, patients with chronic illness, and psychiatric outpatients.

Numerous studies have been conducted on quality of life among patients with depression in Western countries, while there have been few studies using large samples in Asian countries, especially mainland China. The SF-36 and EQ-5D have been commonly used assessment tools, and relatively few studies used WHOQOL-BREF. For example, [Shek \(2010\)](#) found that if “quality of life” was used as a key word, it came up with 32,331, 145,729, and 15,229 articles from PsycINFO, MEDLINE, and CINAHL databases, respectively. If “quality of life” and “Chinese” were used as key words, the search resulted in 721, 1271, and 314 articles from the same databases. Furthermore, if “quality of life”, “Chinese”, and “WHOQOL-BREF” were used as key words, the search came up with only 27, 40, and 22 papers.

If “depression” were added to these key words, the number of papers that would appear in the search results would be far less. While quality of life is culture specific, oriental ethnicity has its own unique background. For example, Confucian ideology represents the personal characteristics of self-control, benevolence, modesty, and harmony. These features may lead to stronger endurance towards pain or illness and less expression of agony among Chinese than other cultural ethnicities. In addition, the outcomes of treatment, patient management, and the treatment effect in clinical practice can only be reflected in the evaluation of patients with depression who live in the communities. However, few studies have assessed the quality of life of outpatients with depression.

The aims of the study were to use WHOQOL-BREF as an assessment tool to examine: (1) the quality of life of outpatients with depression; (2) the relationships between the quality of life of outpatients with depression and a number of clinical covariates; and (3) the effects of medication on the quality of life of outpatients with depression.

2. Methods

2.1. Study design and sample

Using a cross-sectional survey design, participants were recruited from 30 psychiatric hospitals or psychiatric/psychological outpatient departments in general hospitals (9–2191 patients participated at each study site) in 17 provinces and municipalities, and 23 cities of mainland China. The recruiting sites were located in seven administrative regions in East, North, South, Central, Northeast, Southwest, and Northwest China (see [Fig. 1](#)).

All patients who met the diagnostic criteria of CCMD-3 depression and were capable and willing to complete the quality of life questionnaire during the study period were included in the study regardless of their first or non-first visit to the study sites and age. The exclusion criteria were: participants with psychotic disorders; participants with depression due to physical illness that may interfere with the study; participants who were unable to complete the study due to severe health issues; and participants with communication problems due to physical disability or language barriers. Ethics approval was obtained from the Shanghai Mental Health Center Ethics Committee. All participants provided their written, informed consent before starting the study.

2.2. Procedure

A continuous data collection method was used among outpatients during the period between January 2011 and February 2012. The participants were invited to complete the questionnaires concerning quality of life and related clinical information at their visits. The contents of the questionnaire included information on demographics, quality of life, and medication use.

2.3. Instrument

2.3.1. Demographics

Variables included name, sex, age, occupation, and education as reported by the participants

2.3.2. Medical treatment

Variables were hospital where the patient received treatment and whether or not it was a first visit (visit status) to the study site, as reported by the participants.

2.3.3. Medication use

Information of medication use at the clinical visits was recorded by the psychiatrists in the survey. Six types of medication were included: selective 5-HTs (e.g., SSRIs), 5-HT and NEs (e.g., SNRIs), NE and specific 5-HTs (e.g., NaSSA), other medications, concomitant medications, and medication non-use.

2.3.4. Quality of life

The short quality of life index (WHOQOL-BREF) is a simple version of WHOQOL-100, developed by the WHO. There are almost 15 versions in different languages, and it has been used all over the world. The Chinese version of the WHOQOL-BREF was issued by the China Quality of Life Research Collaboration Center in 1999 and has been approved by the WHO ([Fang, 2000](#)). Research ([Xia et al., 2012](#)) has shown that the Chinese version of the WHOQOL-BREF has high internal reliability, discriminant validity, and construct validity. In addition to the original 26 items, another two items characterizing the Chinese cultural background have been added to the Chinese version of the WHOQOL-BREF. Therefore, the WHOQOL-BREF in Chinese used in the present study comprised 28 items, and the response options ranged from 0 (very poor) to 4 (very good). There were two items in the original WHOQOL-BREF assessing general quality of life (item G1) and general health status (item G2). The remaining 24 items measured four domains of quality of life, including physical health (7 items), psychological (6 items), social relationships (3 items), and environment (8 items). The total scores ranged from 4 to 20 or from 0 to 100, with lower scores representing lower levels of quality of life ([Skevington et al., 2004](#)). The two items measuring Chinese cultural background were worded as “has your life been affected by family conflict? (F27)” and “how has your dietary pattern been? (F28)”. Moreover, an additional item (F29) was added following the WHOQOL-BREF, where participants were required to provide a self-evaluation in terms of their general quality of life: *would you please give a score to your general quality of life based on your physical, psychological, social relationships, and environment status (use 100% as a full score)*. Because these additional three items (i.e., F27, F28, & F29) were Chinese culture-specific, they were excluded from the analysis in the cross-cultural comparisons.

2.4. Analysis

SPSS version 17.0 was used for the analysis. Means and standard deviations were calculated for the continuous variables, and percentages were used for the categorical variables. Student's *t*-tests were used to compare the scores reported by the outpatients with

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