Short Communication

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Is there an "Inspiration" of QoL in the Field of Clinical Psychology and Psychiatry?

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ABSTRACT

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Quality of life (QoL) is mostly an indicator of the success of health and welfare programmes. It is used throughout the world as a sensitizing notion to inform social practices and interventions [1]. Quality refers to the level, standard or degree of excellence of something and that is contrasted with a Norton relevant to quality simply as a characteristic. The word life refers to the state of functional activity of a person, including aspects such as behavior, development, pleasures and overall manner of existence. The past decade has been increasing recognition of the importance of QoL as a crucial measure for describing subjective well-being in population studies as well as being an outcome measure in clinical trials [2]. QoL is a complex Norton. There is still no single universally accepted definition and the universality and heterogeneity of the use of the term creates enormous difficulties for a commonly accepted definition.

The concept is multidimensional, contains semantic polysemy and conceptual ambiguity, and is additionally defined differently from the various research fields (e.g., psychology, sociology, etc.) making its clarification a particularly difficult case. This ambiguity is reflected in the definitions used, while each author gives his own interpretation of this term. The lack of agreement of a commonly accepted definition and the necessary instruments for measuring it, led to many different interpretations, depending solely on the theoretical background of each author. Because of this universal meaning, it is so easily understood by professionals of various disciplines but it is also easily misunderstood. QoL is influenced by current events and the environment, but also colored by a person's past experiences, aspirations, personality and expectations [3]. According Lehman [4] QoL state to "the sense of wellbeing and satisfaction experienced by people under the current life conditions".. Shalocki [5] states that this is a social construction since every society aims to improve and elevate the quality of life of people.

Although there is universal agreement on the need for quality of life measurements, very little research has looked at how governments promote these findings to improve the lives of their citizens. Nowadays it is generally used to describe a variety of objective and psychosocial variables, including health status, functional behavior, symptomatology, perceptions, happiness, etc. Although in the field of research, several objective indicators are used such as physical health, functional ability, psychological wellbeing, financial situation. These indicators, alone, cannot provide a clear picture of quality of life without being accompanied by subjective assessments and personal values of individuals themselves, while the interaction between objective and subjective variables is under discussion [6,7]. The term references the general well-being of individuals and societies. The evolution of the concept of "QoL". reflects the shift from a paternalistic conception to the evaluation of the individual, to the growing interest in respect, autonomy, and the subjective experience of each person [8].

Recently, the term has been increasingly used for person-centered planning as a key condition for implementing policies and services, as an indicator for evaluating the results of therapeutic interventions, and as a model for exploring the impact of individual and environmental factors on people's assessments of their lives [9]. QoL is subjective and therefore must be evaluated from the patent's perspective and it must been seen as an action-orientated approach. Barry (1996) [10] believes that people's perceptions of their lives are influenced by the interaction of several factors, such as individual and clinical characteristics, psychological concepts, personal values and beliefs, objective conditions and various cognitive mechanisms that ultimately mediate and shape similar perceptions. Schlockiest Verdugo [9] state eight factors that mediate quality of life perceptions, which are the following:

1) Personal development,

2) Emotional wellness,

3) Self-management,

4) Interpersonal relationships,

5) Social inclusion,

6) Rrights,

7) Physical health, and

8) Material well-being.

Verdugo, et al. [11] emphasize that quality of life assessment should be based on three statutory principles:

1) It is important for all people and should be approached in exactly the same way for everyone, including people with intellectual disabilities,

2) Evaluation should focus on how people experience their lives and personal well-being, and

3) QoL evaluation reflects a mixture of two different meanings, something that is generally accepted and understood by all people and something that is meaningful to them about their lives, giving a personal interpretation to their experience. It follows that there is a need for a constant dialogue with the individual [12] and in this process of assessing the QoL no individual can be excluded despite the presence of cognitive deficits [13]. In addition, several core issues remain unresolved thereby limiting the practical application of its measurement [14]and the using measures that not truly assess QoL. In addition it is possible that no single, direct measure of life quality exists, or perhaps will ever exist.

QoL perception's cannot be restricted to a limited understanding of individual needs based on a reductionist approach of the term (focusing either on work production or on mental and physical health), and many believe that only the models that think on heal and rehabilitation are valid. But this opinion is wrong. The greater appropriation of the QoL theory and model proposed by Schalocki, et al. [9] is its global vision of the person, considering its holistic needs and planning the supports it requires in a global way. Not only support is needed in language of rehabilitation but also in other facets of the person's life that are essential for their personal well-being: interpersonal relationships, social inclusion, self-determination, personal development, exercise of their rights, physical, emotional and social wellbeing. Concepts are often used as synonyms, such as "health state" or "health related quality of life"., which are multidimensional, broad and include physical, psychological and social components of life, but are not related with the individual perception of the individual about his life, values, and expectations.

The health related QoL emphasizes the specific impacts that the prevention and treatment of disease have on the value of survival. Health care holds accountable only for those aspects that it may directly affect [15]. The tendency to equate well-being with health has sometimes led to the unwarranted conclusion that any health status measure is a QoL measure and that conversely, QoL need be measured only by health status measures [16]. In reality, this easy association does not exist. QoL measures are of a rather different order than health status measures. People with exactly the same condition (i.e., health condition) may make completely different assessments of their life quality. Emphasis should be placed on the uniqueness of the individual, as the expectations and personal meaning of each person can modify objective situations into subjective values and interpretations [17]. Several measures have been developed to assess the QoL experiences of persons with mental disorders but these measures have been developed in general health care and which have been applied to persons with psychiatric experiences.

Measurements of QoL among persons with mental disorders is a very active and fertile field of assessment research. Wrong choice of measuring tool can have negative consequences on the assessments of the quality of life perceptions of the respondents. The critical issue in the concept of QoL is the uniqueness of the individual [18]. The apparent proliferation of newer measures suggests that no current measure fulfills the needs of most researchers and clinicians. QoL assessment must reflect the degree to which people have experiences that are valued for them [19]. An instrument for measuring QoL must be appropriate for the setting and reflect the aims of the study and must be quick to administer and easy to understand. Psychiatry has been especially prolific in assessing non-disease aspects of its patents by using concepts such as "impairment"., "disabilities". "handicap"., "social functioning". "satisfaction"., "social support". and soon. A fair number of instruments to measure these aspects have been in existence for

some time, though without having been called "quality of life" [20]. The choice of a Qol measure should be determined by the intended application and in turn by the framework appropriate for the task.

An "inspiration". of QoL is not enough to explain the complexity of the concept. Evaluation of QoL through measurements demands a conceptualization and operationalization of the term using valuated instruments. Currently there is a wide range of instruments aiming to evaluate QoL. Descriptions of the development of these measures often include evaluation of the validity but lack details regarding the step from empirical data to items [21]. It needs careful scrutiny because very easily can become a vague label for a state subjective well-being without scientific value. In many cases designate a field for interest rather than a clearly defined scientific concept.

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