Quality of Life and the Case for Antipsychotics

September 05, 2016 | Couch in Crisis [1], Psychopharmacology [2], Schizophrenia [3]
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The authors examine the literature on "quality of life" and how antipsychotics improve that for patients with schizophrenia.

How do we, as clinicians, assess the benefits and harms of any medication, including but not limited to psychiatric medications? More specifically, how do we decide whether long-term antipsychotic treatment does more good than harm—or vice versa, as some critics of psychiatry have claimed? Certainly, a careful examination of the literature on relapse and remission rates in schizophrenia spectrum disorders is an important part of the answer.

However, we reject the notion that this is the only criterion for judging the risks and benefits of long-term antipsychotic use. Equally, we do not believe that armchair analyses of the literature by non-clinicians will answer the risk to benefit question in a humane and judicious manner. On the contrary, we believe that working with psychotic patients, and appreciating their often profound suffering, is an essential part of the equation. Critics of psychiatry who have never spent time with patients and families coping with the ravages of schizophrenia simply do not grasp the human tragedy of this illness. These critics also miss the deep-seated satisfaction that comes from seeing severely impaired patients achieve remission, and even recovery—in which antipsychotic medication usually plays an important role.

As clinicians with many years of experience in treating patients with schizophrenia, our views on antipsychotic medication are shaped not only by our understanding of the scientific literature, but also by our personal care of many hundreds of patients over several decades. Recent studies that pointed to the benefits of long-term antipsychotic use in schizophrenia, including reduction of relapse rates and the risk of suicide, were examined previously. Here we examine the concept of quality of life (QOL) and what we know about its relationship to antipsychotic use. We focus primarily on placebo-controlled studies, despite the paucity of such investigations in the published literature.

What is meant by “quality of life”?
As Berlim and Fleck noted in their 2003 review, the concept of QOL is relatively new in the psychiatric literature and “embraces a whole spectrum of uses and meanings.” In general, however, QOL refers to “…how patients feel and how satisfied they are with treatment, besides the traditional focus on disease outcomes.” In 1998, the World Health Organization described QOL in these terms: “It is a broad-ranging concept affected in a complex way by … physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment.” Berlim and Fleck list nearly a dozen instruments or scales designed to measure QOL, including the Quality of Life Scale (QLS), the Wisconsin Quality of Life Index (W-QLI), and the Medical Outcomes Study Short Form-36 Items (SF-36). The main items on the original (21-item) version of the QLS are shown in the Table.

QOL and antipsychotic medication
Bobes and colleagues provide a comprehensive review of QOL in schizophrenia, based mainly on open-label and/or naturalistic studies. Only 2 studies compared QOL of patients who received an antipsychotic (either olanzapine or long-acting risperidone) with QOL of patients in the placebo group. Hamilton and colleagues evaluated patients (N = 76) over a 6-month period; Nasrallah and colleagues evaluated patients (N = 369) over 3 months. In both studies, patients who received the antipsychotic showed significantly greater improvement in QOL than those treated with placebo. Indeed, Nasrallah and colleagues found that long-acting risperidone (25 mg q 2 weeks) improved QOL to levels “not significantly different from normal,” based on the SF-36.

To be sure, Bobes and colleagues acknowledge the “wide range of adverse [antipsychotic drug] effects that may negatively affect the quality of life” in patients with schizophrenia, and they observe that atypical antipsychotics may not improve QOL more than typical agents. Nevertheless, the authors conclude that “…the longer the length of the illness, the worse the quality of life … the combination of psychopharmacological and psychotherapeutic treatment improve quality of life.” They also observed that “…patients integrated in community support programs demonstrate a
better quality of life than those who are institutionalized.” (Unfortunately, adequate outpatient and community supports are sadly lacking in many if not most parts of the US.)

One notable study not included in the review by Bobes and colleagues is that of Beasley and colleagues. This 52-week, double-blind, relapse prevention trial tested whether stable patients with schizophrenia who were taken off active drug treatment would experience greater improvements in long-term quality of life than those who were continued on antipsychotic treatment. The study found that, on average, Heinrichs-Carpenter Quality-of-Life Scale total scores improved by 4.3 ± 10.6 points during treatment with olanzapine (10 to 20 mg/d; n = 212), but decreased by 7.1 ± 14.6 points during treatment with placebo (n = 92; P < .001). The researchers also found that “... stable patients with schizophrenia who were taken off active drug treatment experienced no greater improvements in long-term quality of life than those who were continued on antipsychotic treatment, even in the absence of psychotic symptoms.”

Vothknecht and colleagues studied subjective well-being in patients with schizophrenia, using the Subjective Well-being Under Neuroleptic Treatment scale (SWN). They reviewed open and controlled trials between 1994 and 2010, covering 44 studies. Most studies were short-term (< 1 year), and none used a placebo control; rather, most compared one antipsychotic with another, with regard to improvement on the SWN. However, 6 studies had a duration of 1 year or longer (up to 3 years). The key conclusion of this review was that “subjective well-being of patients with schizophrenia improved during treatment in almost all studies.”

Only a handful of placebo-controlled studies of QOL have been published since the 2007 article by Bobes and colleagues. Leucht and colleagues reviewed randomized trials that compared maintenance treatment with antipsychotic drugs compared with placebo, for persons with schizophrenia or schizophrenia-like psychoses. In addition to finding superiority of antipsychotic drugs compared with placebo in preventing relapse at 7 to 12 months, the researchers found some evidence that QOL was better in drug-treated participants (based on 3 randomized, controlled trials: n = 527; standardized mean difference, -0.62; confidence interval, -1.15 to -0.09).

Witte and colleagues undertook an 8-week randomized, double-blind, placebo-controlled trial of olanzapine (long-acting injection) versus placebo in 404 acutely ill inpatients with schizophrenia. Participants were randomized to olanzapine long-acting injectable (LAI) 210 mg/2 weeks (n = 106); olanzapine-LAI 300 mg/2 weeks (n = 100); olanzapine-LAI 405 mg/4 weeks (n = 100); or placebo (n = 98). All active treatment groups were superior to placebo on the QLS total score (P < .01).

Finally, in an 8-week, randomized, placebo-controlled study of patients with acute schizophrenia, Isitt and colleagues compared a new sustained-release formulation of risperidone (RBP-7000) with placebo. Patients (N = 337) were assessed on health status, subjective well-being, treatment satisfaction, and preference of medicine. Health-related QOL (HRQoL) was measured using several scales. Findings indicated a significantly greater improvement in HRQoL and overall well-being in patients randomized to RBP-7000. Patients who received RBP-7000 also reported greater medication satisfaction on the Preference of Medicine Questionnaire (POM).

Conclusions

There are certainly large gaps in our knowledge of how antipsychotic medication affects “quality of life,” compared with placebo or no medication treatment. In particular, most studies are not randomized or placebo-controlled, and of those that are, most are short-term (< 1 year). Our conclusions, therefore, must be considered provisional. Nonetheless, our review finds no support for the notion that antipsychotic medication worsens QOL for patients with schizophrenia. Considerable controlled evidence shows that antipsychotic treatment improves QOL by various measures—at least within the first year of treatment, and perhaps for as long as 3 years. Recently, Sohler and colleagues reviewed studies of patients with psychotic disorders that compared outcomes in those who received, or did not receive, antipsychotic medication during a follow-up period of at least 2 years. The researchers did not specifically study QOL; rather, they examined recidivism, negative symptoms, positive symptoms, and social functioning. Although the authors found the evidence base methodologically inadequate to determine the benefit-to-harm ratio of long-term antipsychotic use, they did not find evidence pointing to long-term harm from antipsychotics. Specifically, they concluded, “Our study did not support the hypothesis that long-term treatment with antipsychotic medication causes harm.”

Similarly, with regard to QOL, we find no placebo-controlled evidence that use of antipsychotics for up to a year causes any decline in QOL; indeed, the studies we reviewed show that antipsychotic treatment typically enhances QOL for patients with schizophrenia. That said, it is clear that we need more long-term (> 1 year), placebo-controlled studies of QOL and its relationship to antipsychotic
treatment.
The decision to continue antipsychotic medication for the long term requires more than a survey of
the research literature. It is a decision based, among other considerations, on the particular patient’s
history; risk factors; response to initial treatment; adverse effect burden; and perhaps most
important, the degree of suffering and incapacity the patient has endured as a consequence of
having schizophrenia. Thus, careful assessment of the patient’s QOL should also be a part of the
decision-making process, which should involve active and respectful collaboration with the patient
(and, sometimes, the patient’s family). An ongoing process of informed consent and periodic
monitoring of the patient’s response to treatment is essential.
The decision regarding long-term treatment is not a binary either/or choice; rather, the goal is to find
the best medication and dose, with the fewest adverse effects. For some carefully selected patients
with schizophrenia—and in most cases of “brief psychotic disorder”¹⁵—a slow tapering and
discontinuation of antipsychotic medication may be warranted, with close monitoring of the patient’s
response.
In our view, when non-clinician critics argue that most patients with schizophrenia would be “better
off” without long-term antipsychotic medication—or that antipsychotics have done more harm than
good—they misrepresent the best available evidence. Moreover, patients who impulsively
discontinue their medication on the basis of such misinformation are jeopardizing their health,
safety, and QOL.¹⁶ Our review suggests that amidst the shrill rhetoric of anti-psychiatry, the voices of
patients who have done well on antipsychotic medication often go unheard.
Note: We use the term “schizophrenia” in the syndromal sense; ie, we recognize that the DSM-5
construct of schizophrenia most likely represents a “final common pathway” with several different
etiologies; that there is probably a spectrum of schizophrenia-like conditions; and that the genetics
and pathophysiology of schizophrenia probably overlap with other types of psychotic illness. The
treatment of these conditions must be individualized, including decisions concerning the use of
long-acting antipsychotic medication.

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Table. Main QLS items

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Disclosures:
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References:


**For further reading**

Awad AG, Voruganti LN. The impact of newer atypical antipsychotics on patient-reported outcomes in schizophrenia. *CNS Drugs*. 2013;27:625-636.


**Links:**
[3] [http://www.psychiatrictimes.com/schizophrenia](http://www.psychiatrictimes.com/schizophrenia)
[4] [http://www.psychiatrictimes.com/authors/ronald-w-pies-md](http://www.psychiatrictimes.com/authors/ronald-w-pies-md)
[5] [http://www.psychiatrictimes.com/authors/joseph-m-pierre-md](http://www.psychiatrictimes.com/authors/joseph-m-pierre-md)