

The Correlates of Health Care Seeking Behavior in Obsessive Compulsive Disorder: A Multidimensional Approach

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SUMMARY

Obsessive-compulsive disorder (OCD) is a chronic, distressing, and disabling illness that influences the family, academic, occupational, and social functioning of patients. One of the 10 leading causes of disability worldwide is OCD; however, despite the considerable distress and disability associated with the disorder and the availability of treatment options, many OCD sufferers usually are not inclined to seek healthcare. The factors that may be central to healthcare seeking behavior in OCD has scarcely been described in the literature. It has been thought that the best predictor of healthcare seeking is severity of illness; however, individuals with OCD may have various barriers to seeking healthcare. Although non-disease and disease-related factors that may influence health care seeking are related in complex ways through reciprocal influences and feedback, each factor might be an independent predictor of use of healthcare services. This review aims to discuss the impact of the disease and general factors that impact healthcare seeking behavior in OCD. In this way, new information might be provided for the identification of targets to enhance the use of mental health services among OCD sufferers in the community.

Key Words: Obsessive-compulsive disorder, healthcare seeking behavior, health knowledge, quality of life, obsession, insight

INTRODUCTION

The treatment gap in people with mental health problems to use mental health services is considered an important public health problem. When all psychiatric disorders are taken in to account, although differences vary by country, the percentage of those with psychiatric disorders not receiving mental health care services ranges between 10% and 50%, even in developed countries. (Regier et al., 1993; Kessler et al., 1998; Bebbington et al., 2000; ESEMeD/MHEDEA 2000 Researchers, 2004; Kohn et al., 2004).

According to the findings of The National Epidemiological Catchment Area (ECA) Studies, which started in 1980 and first reported findings in 1984, the lifetime prevalence of obsessive-compulsive disorder (OCD) in the general population is 2%-3%. OCD is the fourth most prevalent psychiatric disorder after phobias, substance use, and mood disorders (Myers et al., 1984; Karno et al., 1988). The lifetime prevalence of OCD in Turkey was reported to be between 2.5% and 6.2%, and one-year prevalence was 0.5%-5.6% (Doğan et al., 1995; Erol et al., 1997; Kırpınar et al., 1997; Çilli et al., 2004). OCD is a chronic condition, which negatively affects an individual's family, academic, professional, and social functioning (Hollander et al., 1998). According to the findings of the World Health Organization (WHO), in general, OCD is on the tenth order among physical and mental disorders that negatively effect functioning, and on

the fifth order among women aged between 15 and 44 years (WHO, 1999).

Seeking professional help takes an average of 10 years after the onset of symptoms in OCD patients (Hollander et al., 1998). While Shapiro et al. (1984) found that less than 35% of adult OCD patients receive psychiatric care, it was reported that only 25% of adolescents with OCD receive help from a mental health professional (Whitaker et al., 1990). In the Turkish Mental Health Study, it was found that 13.7% of patients with any psychiatric disorder and 32.4% of the patients with OCD sought treatment in the last 12 months (Erol et al., 1997). Similarly, Beşiroğlu, et al. (2004) found that 31% of OCD who identified in the general population, had sought health care for OCD before. The percentages of individuals in various countries diagnosed with OCD who do not display health care seeking behavior (HCSB) are given in Table 1. Kohn et al. (2004) determined a median value based on the findings of all these studies and reported that 59.5% of OCD patients do not seek treatment.

Goldberg and Huxley (1992) specified 4 different filters for psychiatric disorders beginning with the period to make the decision to seek treatment through the hospitalization period. According to the authors, factors impacting decision making constitute the first filter. Other filters are related to the possible difficulties that might take place from health care seeking to hospitalization. Generally, factors such as transportation resources to and from health care services, socioeconomic factors, or health insurance issues can be the initial barriers preventing the use of health care services for mental disorders. In addition, each one of psychiatric disorders might differently impact on use of mental health care services as related to their physical, psychological, and social effects. Therefore, problems related to obtaining health care should be defined and discussed separately and specifically according to each disorder. It is clear that when the high prevalence of OCD is considered, an important proportion of patients are not able to benefit from professional treatment opportunities. In this regard, knowledge of the underlying reasons in OCD patients do not seek treatment will provide the opportunity to evaluate how mental health patients in general, and OCD patients in particular, will benefit more from mental health services. In addition, defining the factors related to HCSB de-

serve academic attention in order to understand the priorities of individuals who seek treatment and to determine treatment priorities in this regard. In this review, the role of general factors related to illness that fit the first filter described by Goldberg and Huxley, in relation to HCSB in patients with OCD will be discussed.

ILLNESS RELATED FACTORS

Age and type of onset

The mean age at onset in OCD is around 20 years. The age at onset is a little earlier in men than in women (Rasmussen and Eisen, 1992). In 72% of cases, the onset is gradual and in 28% onset is sudden. In 25%-65% of cases, events such as an illness, birth, pregnancy, or loss of a family member have an precipitating role (Lensi et al., 1996). While the age of onset in OCD patients with HCSB was 20.7 and 22.1 years, respectively, in 2 different studies, age of onset in OCD patients without HCSB was 20.0 and 19.3 years, respectively (Mayerovitch et al., 2003; Beşiroğlu et al., 2004). There were no differences in the age of onset in OCD patients with HCSB and those without HCSB in either study. It is believed that sudden onset of symptoms and onset due to a life event can accelerate HCSB. (Simonds and Eliot, 2001).

Severity

It has been thought that the severity of OCD has a central role in HCSB (Burns, 1995; Goodwin et al., 2002). Beşiroğlu et al. (2004) confirmed this by finding a difference in terms of symptom severity between OCD patients with and without HCSB. In addition, while the obsessions of patients with HCSB were more severe, there was no difference in terms of the severity of compulsions.

Because of its cognitive, emotional, and behavioral components, OCD impairs a patient's quality of life. Negatively affected quality of life and illness severity are directly related to the severity of illness (Koran et al., 1996). A reduction in the quality of life due to OCD severity may result in HCSB. As in all illnesses, OCD patients display coping behaviors that aim to decrease the effects of the illness. When the severity of the illness is quite intense, the compensating effect of these behaviors becomes insufficient, and in addition to HCSB, patients may seek treatment outside formal health services (Mayerovitch et al., 2003). More-

Table I. The Treatment Gap Among Patients with OCD in Field Studies in Different Countries*.

Country	Duration	Patients that do not seek health care seeking
Chile	Last 6 months	27.6%
Israel	Life time	36.4%
U.S.A.	Last 12 months	54.9%
Germany	Life time	59%
England	Last 12 months	60.0% and 68%
New Zealand	Last 12 months	62.7%
Turkey	Last 12 months	67.6%
Mexico	Life time	92.1%
Total mean		59.5%

* This table has been used with the permission of Robert Kohn (Kohn et al. 2004).

over, increased severity of the illness contributes to the development of additional psychiatric disorders, and HCSB can be related more to the secondary psychopathologies (Simonds and Eliot, 2001). The severity of the illness in 4% of OCD patients made it impossible for the patients to leave the house and hindered or delayed HCSB (Hollander et al., 1998).

Symptoms

Gibbs (1996) suggested that clinical and non-clinical populations display the same symptom structure and Salkovskis and Harrison (1984) agree with this idea. In addition, when drawing these conclusions, it is not clear whether the subjects who were defined as non-clinical meet the diagnostic criteria for OCD. The non-clinical population is considered to include those who had high scores on self-report questionnaires in field studies. Purdon and Clark (1993) suggested that sexual and aggressive obsessions are less common in the non-clinical population. Mayerovitch et al. (2003) found that aggressive obsessions are less common in cases that do not seek treatment. Similarly, Rasmussen and Tsuang (1986) reported that aggressive and sexual obsessions dominate the clinical picture, especially in periods when the illness is perceived as more severe, and that HCSB increases in this period. Beşiroğlu et al. (2004) found that aggressive and religious obsessions are significantly more prevalent in patients with HCSB.

The nature of obsessions that include violent, sexuality, and religion are different from other obsessions. These obsessions include thoughts that might evoke more shame in comparison to other obsessions, and are perceived as directly opposite to one's moral values and personality, and the person may perceive himself as a sinner or feel humiliated. Clinically, these obsessions are more disturbing and more anxiety provoking. Therefore, the degree of insight associated with these obsessions can be higher. Compulsions and coping behaviors accompanying these types of obsessions may also be different. Family involvement is more common in the patients with contamination, symmetry, or doubting obsessions. For this reason, families also engage in the symptoms. However, because aggressive and sexual obsessions are generally related to first-degree relatives, patients may feel ashamed to express their thoughts and can have difficulty incorporating rituals into their family life. Therefore, the shameful and humiliating nature of the symptoms may direct the patient to seek professional help in a shorter period of time. In patients with contamination and doubting obsessions, the symptoms, which can be tolerated for longer periods of time, may lead to HCSB when the accompanying compulsions become very severe, or due to the reactions of family members or other accompanying symptoms or psychopathologies.

According to the findings of two different studies, there was no significant difference between

OCD patients with HCSB and those without HCSB, in terms of the frequency and severity of the compulsions (Mayerovitch et al., 2003; Beşiroğlu et al., 2004). Kolada et al. (1994) reported that the non-clinical OCD population is prone to suffer more from compulsions in comparison to the clinical population. This situation is explained in the following way: compulsions may have a role in decreasing anxiety due to their development secondary to obsessions and therefore, reduce HCSB (Mayerovitch et al., 2003). However, after a certain period of time, uncontrollable compulsions become a source of anxiety.

Insight

Patients with OCD may have insight degree regarding the excessiveness or meaninglessness of their obsessions in different levels. Gibbs (1996) suggested that the most important factor affecting HCSB following the severity of illness is insight degree. Beşiroğlu et al. (2004) found that high insight degree is the most important predicting factor in HCSB, together with the effect on the quality of life. What motivates the patient to seek treatment is not the actual severity of the illness, but the subjective perception about being or not being ill, and awareness of the impact of the illness on one's life. Insight degree can be different in each patient, and it is distributed over a continuum, ranging from good to poor. (Kozak and Foa, 1993). While Turksoy et al. (2002) showed that increased severity of illness is related with poor insight, Marazziti et al. (2002) were unable to show such a relationship. Whereas Beşiroğlu et al. repeated the findings of Turksoy et al. regarding OCD patients with HCSB, they did not find a relationship between severity and insight degree in patients without HCSB.

Duration and the clinical course of the disorder

OCD has a chronic course; in the retrospective evaluation of patients, it was found that in some patients (85%) the illness had a continuous course before health care seeking (Rasmussen and Tsuang, 1986). Only 10%-15% of patients show a progressive or an episodic course. It has been suggested that the obsessional symptoms of patients may change over time; however, this has not been proven (Rasmussen and Eisen, 1992). In addition, while obsessions dominate the clinical portrait in the beginning, over time, compulsions may become more severe and dominant (Okasha et al., 1994).

Both Mayerovitch et al. (2003) and Beşiroğlu et al. (2004) found that the duration of the illness is not a predicting factor for HCSB. In the light of these findings, it is believed that changes in the quality of the symptoms over time or negative consequences of the illness are more relevant to HCSB than duration of the illness.

Comorbidity and personality disorders

At least 50% of OCD patients that are admitted for treatment have another Axis-I disorder, and at least 40% have an accompanying personality disorder (Baer et al., 1990; Pigott et al., 1994; Tükel et al., 2002). OCD patients with HCSB are more likely to have an additional diagnosis in comparison to patients that do not display HCSB. Beşiroğlu et al. (2004) found that the rate of diagnosis of major depression is significantly higher in patients with OCD who sought health care, however this difference is not predictive of HCSB, according to regression analysis. Goodwin et al. (2002) and Mayerovitch et al. (2003) found that panic disorder and general anxiety disorder are more prevalent in OCD patients with HCSB. In particular, co-morbid panic disorder was predictive of HCSB. With their own specific effects, other accompanying diagnoses may result in HCSB by causing further negative influences on patient's quality of life.

Although there are no studies concerning the effect of co-morbid personality disorders on HCSB, it is hypothesized that comorbid personality disorders result in poorer insight about the problems experienced by the individual.

Quality of Life

The concept of "disorder", as emphasized in the DSM-IV, describes a situation that is limited to the individual and refers a physiological or mental defect that are uniform across cultures. DSM-IV also requires the opinion of a physician indicating that the functioning of the patient is impaired in order to diagnose a disorder (American Psychiatric Association, 1994). On the other hand, the concept of "illness" defines an subjective awareness of physical or psychological pathology. In other words, for a label of "disorder", a objective evaluation is required, whereas for "illness", subjective assessment is necessary (Suser, 1990). The concept of health-related quality of life was developed in relation to the holistic understanding that manages the patient physically, psychologically, and socially,

based on the understanding of “there is no illness, there is the patient” (Lehman et al., 1983). Quality of life has been defined as the perception of one’s own condition within one’s own culture and value system (WHO, 1997). The concept includes an individual’s aims, standards, expectations, and areas of interest. Within the WHO definition of quality of life, there is physical health, psychological health, level of independence, social relationships, environment and personal beliefs. Although the concept of quality of life is related to illness and loss of functioning caused by the illness, it can also be independent of it (Suser, 1990).

Instruments that measure quality of life and provide the opportunity for subjective expression of multidimensional effects of the illness on an individual’s life and health also provide the opportunity to assess the causes and consequences of the illness and the ways an individual interprets the effects of the illness. In one way, they can contribute to indirect assessment of the insight degree. In this way, findings related to quality of life can be used to improve the doctor-patient relationship, in deciding the type of treatment, to follow-up the results of the treatment, to make comparisons between treatment approaches, to facilitate a better understanding of the nature of the illness, and in developing health care services (WHO, 1997). In addition, when a possible relationship between the development of the need for help and the degree to which one finds the patient role suitable for himself is considered, they can be used to assess the reasons that direct the individual to HCSB.

OCD influences the lives of the individual in a variety of ways, with its cognitive, emotional, and behavioral components (Hollander et al., 1998; Calvocoressi et al., 1998). The greatest impairment in OCD patients was defined in psychological health and level of independence domains (Koran et al., 1996; Beşiroglu et al., 2002). While impairments in psychological health are related to positive-negative thoughts, cognitive abilities, self-esteem, and body image, the level on independence domain reflects subjective perception of impairment in mobility, childcare, housework, and professional activities, dependence on medicinal substances and medical aids and work capacity. It was found that OCD and schizophrenia patients display similar impairments in functioning in these areas (Bobes et al., 2001). Individual perception of the subjective level of independence was found to

be the most important predictor of HCSB in addition to insight degree (Beşiroglu et al., 2002). In this regard, the problems experienced by the individual, which are the result of the severity of the illness, and the awareness of both the illness and its consequences are the most important factors associated with HCSB. Another area in which the negative effects of the illness are observed in a great degree is social relationships (Koran et al., 1996; Beşiroglu et al., 2002). There are problems adjusting to obsessive-compulsive symptoms and emotional dissatisfaction in more than half of married OCD patients (Emmelkamp et al., 1990). They may repeatedly demand reassurance from family members whether they have washed their hands or switched off the electricity. Excess contamination and ordering-arranging obsessions may result in placing limitations on the patient’s or family members’ daily lives, or as a result of hoarding compulsions, the house may become a difficult place to live in with all the excess collected material (Calvocoressi et al., 1995). It was found that ritualistic behavior has become very annoying to 87% of family members (Cooper 1996). There are changes due to patient symptoms in more than one third of their families’ routine home lives (Calvocoressi et al., 1995). In cases where the family shows resistance, there can be angry outbursts and an elevation in anxiety or depressive symptoms. Family members, who are affected by these problems, may blame themselves (Koran 2000). There can be sexual problems in 73% of OCD patients (Freund and Steketee, 1989). Psychological and social functioning of both patients and family members are influenced by additional problems such as communication difficulties in the family, lack of emotional participation, difficulties in sexual life, and feelings of shame. (Black et al. 1998). The negative effects of OCD on family life are at least as severe as those caused by schizophrenic and depressive patients (Magliano et.al 1996). Patients with OCD may occasionally face pressure, due to ritualistic behaviors, that are hard to resist and may become annoying. (Koran, 2000). The negative effects on family life or on social functioning may result in HCSB as a response to pressure from family members. Twenty-eight percent of patients expressed that they have engaged in HCSB because families became aware of the increase in their compulsions and pressured them. (Kıran, 2004).

NON-ILLNESS RELATED FACTORS

Age, gender, and marital status

Goodwin et al. (2002) found that older patients are more willing to use the health care systems in comparison to younger patients. There was no significant gender difference between OCD patients with and without HCSB (Goodwin et al., 2002; Mayerovitch et al., 2003; Beşiroğlu et al., 2004). Okasha et al. (1994) suggested that in some non-Western countries, males tend to seek treatment more than women due to socio-cultural norms, and expressed that the reason for this is a result of women's secondary social position behind men. In addition, while the symptoms of housewives are easier to manage in the home, as men spend more time outside the home find it is harder to create an environment to manage their symptoms, they might be more likely to seek outside help.

As the percentage of being married is high among OCD patients with HCSB, the percentage of unmarried patients is significantly higher among those without HCSB (Goodwin et al., 2002). This situation can be explained by the higher levels of awareness about the experienced problems or higher levels of impairment in social relationships due to obsessive-compulsive symptoms in married OCD patients.

Race, socioeconomic level, and education

Barker et al. (1990) proposed that for all psychiatric disorders, patients from low socioeconomic status tend to seek help less. As in many other illnesses, being a minority and of a low socioeconomic level was related to less use of the health care systems in OCD patients (Goodwin et al., 2002). While there was no relationship between the level of education and HCSB (Goodwin et al., 2002; Beşiroğlu et al., 2004), readiness for treatment was found to be related with high education level in individuals who do not seek treatment (Goodwin et al., 2002).

Mental health literacy

The concept of "mental health literacy" is defined as the knowledge, beliefs, and attitudes related to the recognition, management, and prevention of psychiatric disorders. Several aspects of this concept, which were first used by Jorm (2000), have been described.

a. The ability to recognize psychiatric problems or disorders

Unwanted, disturbing, and ego-dystonic thoughts, images, and impulses that are experienced in OCD can also be frequently seen in healthy individuals, but are experienced as less ego-dystonic, are more easily distracted, do not cause prominent anxiety, and do not require significant neutralization efforts (Insel, 1990). According to the cognitive approach, there is continuity between these two conditions (Rachman and De Silva, 1978). In other words, obsession as an illness symptom occurs as a continuation of less severe thought insertion in the beginning. The diffuse differentiation between these two conditions results in accepting symptoms as normal experiences and, in turn, not seeking professional help. In addition, poor insight resulting from the nature of the illness makes recognition more difficult. In a study conducted in Turkey, (Kıran, 2004) and in another study (Hollander et al., 1998), 56% and 34% of patients, respectively, expressed that the problems they are experiencing are not from the result of a psychiatric disorder. The propensity to explain contamination and washing obsessions and compulsions as meticulousness that is universal phenomenon or religious obsessions as Waswas (whisper of the Devil) complicates the perception of OCD as a medical condition. Patients regarding the symptoms as not important in the beginning and the thought that they can recover by themselves may hinder HCSB (Hollander et al., 1998).

b. The knowledge and beliefs about risk factors and causal relationships

In many societies there is a tendency to explain psychiatric disorders as the result of stressful life experiences. The role of biological factors is not adequately known (Link et al., 1999). Obsessive and compulsive complaints is frequently attributed to religious reasons or supernatural events by the environment if not by the patient (Okasha et al. 1994, Kıran 2004). This affects the management style, coping behaviors, and problem solving behavior of the individual (Razali et al., 1996).

c. Coping behaviors

Coping can be defined as all cognitive, emotional, and behavioral responses towards stressful

events in order to maintain functioning (Folkman, 1984). Coping behaviors toward stressful events may vary according to diverse factors such as age, gender, culture, and illness. Freeston et al. (1995) defined 15 different coping behaviors towards obsessive-compulsive symptoms in patients and found that some are not directed to adjustment. Coping behaviors that are more effective when illness is less severe lose their effects as the illness becomes more severe and individuals may seek a solution (Purdon and Clark, 1994).

d. Knowledge and beliefs about professional and self-help interventions

There can be negative attitudes towards the medical treatment of mental disorders in different parts of the world, especially beliefs related to the side-effects of psychotropic medications, such as they will cause numbness or addiction and that they don't provide a direct treatment, but only treat the symptoms, are common in many countries (Jorm, 2000).

Fischer et al. (1999) described the attitudes towards psychotropic medication as the most important barrier to HCSB in people with all psychiatric disorders. Twenty-five percent of OCD patients expressed that they did not engage in HCSB due to this reason (Hollander et al. 1998). In addition, a percentage of patients (7%) do not engage in HCSB because they think they can solve the problem alone (Kıran, 2004).

e. Attitudes reducing recognition and appropriate help seeking

Psychiatric patients and their relatives excessively worry about stigmatization and believe that the illness will be interpreted as a sign of weakness, or that it would lower their social status. They experience difficulty in telling their complaints even to the people closest to them before seeking treatment (Jorm, 2000). Because of the nature of their symptoms, patients with OCD may hide their symptoms about getting arrested, shame or fear of their thoughts becoming true when expressed. (Salkovskis, 1989). In studies conducted in Turkey, it was found that 30% of OCD patients do not engage in HCSB, due to their hesitations about being judged negatively by others (Kıran, 2004). Hollander et al. (1998) and Goodwin et al. (2002) found that 13% and 20% of OCD patients, respectively, posit the same reason for not seeking

treatment. Rasmussen and Tsuang (1984) suggested that even when patients engage in HCSB, they express symptoms that they believe will appear as less absurd and hide other symptoms. When not directly asked about symptoms, 38.5% of patients cannot express them. While patients and families experience the anxiety about being stigmatized due to the erroneous attitudes about illness in non-western countries, fear of losing one's job or social network can be anxiety provoking in the developed western countries (Jorm, 2000).

f. Other care seeking behaviors besides mental health services

While spiritual beliefs may help in coping with the illness, they sometimes may result in the development of problematic attitudes towards the illness (Insel, 1990). Thirty-three percent of OCD patients in Turkey expressed that they had received non-medical treatment such as from a religious leader or a healer (Kıran, 2004). Because of the influence of socio-cultural environment in many societies, patients can seek health care from informal sources (Okasha, 2004). It was found that OCD patients tend to show such inclinations more than patients who have other psychiatric disorders. When all mental disorders are taken in to account, 1% of the patients in Ankara, and 14% of the patients in Erzurum received their initial treatment in this way (Kılıç et al., 1992; Kırpınar et al., 1994).

As in all psychiatric illnesses, OCD patients may have a tendency to get help outside the mental health services. They may turn to non-psychiatric physicians with the tendency to express their psychiatric symptoms with somatic complaints in the hope that they would be more understood and less criticized. Both the psychosomatic nature of some dermatological illnesses and other dermatological illnesses, such as eczema due to excess hand washing compulsions explain use of dermatology clinics (Fineberg et al., 2004). Patients do not express the symptoms by themselves when the doctor fails to ask them directly. Even in mental health clinics, 38% of patients did not describe their symptoms when not asked (Kıran, 2004). In addition, due to patients highlighting other comorbid psychiatric symptoms and displaying somatic symptoms, doctors may fail to diagnose the obsessive-compulsive symptoms. Millar and Tallis (1999) found that general practitioners failed to diagnose 83% of patients with OCD.

Other factors

Patients' opportunities to use treatment services, their beliefs about the quality of the service received or hoped to be received, abilities to gain new information about health, transportation, income, support of volunteer groups and not having health insurance may be related to HCSB (Simonds and Elliot, 2001; Goodwin et al., 2002). All these factors, which are not specific for OCD, may influence the HCSB of all psychiatric patients.

CONCLUSION

As in all psychiatric disorders, non-illness and illness related factors that may influence health care seeking are related in complex ways through reciprocal influences and feedback. However, each of factors might be independent predictors of use of health services. For example, not having health insurance can be the most important factor. Conducting a study that takes all illness-related and non-illness-related factors into account seems to be difficult. The exclusion of non-illness-related factors in the study by Beşiroğlu et al. provided an opportunity to evaluate the effects of illness-related factors.

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With its effects on the individual and his environment, and its high prevalence, OCD has been accepted as a social health problem. Although 50% of illnesses that result in impairment are psychiatric disorders, the presentation of information about psychiatric disorders is still insufficient. As seen in Table 1, when the high percentage of those not seeking help in Turkey is taken into consideration, it is believed that this issue should be managed more urgently. First of all, determining the attitudes of the general population and professionals towards OCD, and arranging various educational campaigns and conferences that target the attitudes that were found to be negative would be helpful to increase the recognition of the illness and change negative attitudes toward the illness. On the other hand, there is a need for research that would increase the knowledge and abilities of general practitioners. Moreover, defining the general factors (non-illness-related) that impede HCSB for all mental health problems would be beneficial in developing general mental health policies. Conducting research based on the contemporary approaches of WHO about quality of life will provide the opportunity to make both regional and international comparisons for Turkey.

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