► distress (psychological distress index) were investigated. The result showed there are significant correlations between QLSI scores and ► distress, ► health-related quality of life, and perception of ► disability (Coutu, Durand, Loisel, Dupuis, & Gervais, 2005).

## Cross-References

► Criterion Validity
► Disability
► Distress
► Functional Assessment of Cancer Therapy (FACT)
► Health-Related Quality of Life (HRQOL)
► Positive Affect
► Predictive Validity
► Quality of Life
► Short Form 12 Health Survey (SF-12)
► Stress

## References

Baker, F., Denniston, M., Hann, D., Gesme, D., Reding, D. J., Flynn, T., & Kennedy, J. S. (2007). Factor structure and concurrent validity of the Satisfaction with Life Domains Scale for Cancer (SLDS-C). *Journal of Psychosocial Oncology, 25*(2), 1–17.

Coutu, M. F., Durand, M. J., Loisel, P., Dupuis, G., & Gervais, S. (2005). Measurement properties of a new quality of life measure for patients with work disability associated with musculoskeletal pain. *Journal of Occupational Rehabilitation, 15*(3), 295–312.

Gregory, R. J. (2000). *Psychological testing, history, principles, and applications* (4th ed.). Boston: Allyn & Bacon.

McIntire, S. A., & Miller, L. A. (2005). *Foundations of psychological testing* (2nd ed.). Thousand Oaks, CA: Sage Publishing.

Murphy, K. R., & Davidshofer, C. O. (1998). *Psychological testing: Principles & applications* (4th ed.). Upper Saddle River, NJ: Prentice-Hall.

# Concussion

► Traumatic Brain Injury

# Conditional Cooperation and WTP

► Willingness to Pay for Private Environmental Goods

# Condition-Specific Measure

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## Synonyms

Condition-specific questionnaire; Disease-specific measure; Disease-specific questionnaire; Patient-reported outcome measure

## Definition

Condition-specific measures are either clinical measures or experiential measures. They are health-status questionnaires that are designed for specific diagnostic groups or patient populations. Their advantage is that they measure aspects that are particularly salient to a specific condition or patient group. Clinical measures assess signs, symptoms, and tests, whereas experiential measures are a type of ► patient-reported outcome measure that assess a range of dimensions of ► health-related quality of life such as physical functioning, mental functioning, and social functioning.

## Description

Condition-specific measures exist for an increasingly large variety of conditions. Two types of condition-specific measures have been described: (1) clinical measures which primarily assess signs, symptoms, and tests and (2) experiential measures, which capture the impact of a condition on the person affected by the

condition (Atherly, 2006). The measures can either be completed by clinicians who rate patients' outcome or health status or by patients themselves. The measures described in this entry are self-completed experiential measures, that is, patient-reported outcome measures (PROMs) which are completed by patients themselves.

The term "condition-specific measure" tends to be used interchangeably with the term "disease-related measure." However, Patrick and Deyo (1989) make a distinction between "condition" and "disease" specific, as not all conditions are diseases (e.g., back pain is a condition but not a disease, whereas Parkinson's disease can be referred to as either a condition or a disease). Even when this distinction is taken into consideration, the features of condition-specific and disease-specific measures are broadly the same. Some examples of condition-specific measures include the Aberdeen Back Pain Scale (ABPS) (Ruta, Garratt, Wardlaw, & Russell, 1994), the ▶ Asthma Quality of Life Questionnaire (AQLQ), and the ▶ Parkinson's Disease Questionnaire (PDQ).

Condition-specific measures assess a specific diagnostic group or patient population, often with the goal of measuring responsiveness or "clinically important" changes (Patrick & Deyo, 1989). An advantage of condition-specific measures is that they are specifically designed to assess aspects that are particularly salient to a specific patient group. Therefore, they should be less likely to display a floor or ▶ ceiling effect (Atherly, 2006) and more likely to be sensitive to change (Jenkinson & McGee, 1998). A systematic review of 43 randomized controlled trials (Wiebe, Guyatt, Weaver, Matijevic, & Sidwell, 2003) found that, in general, disease-specific measures are more responsive than generic measures where a therapeutic effect was found, although the responsiveness of measures may vary according to the context in which they are used.

A disadvantage of condition-specific measures is they cannot be administered to people without the condition, and therefore, comparisons cannot be made with other patient groups or population norms (Fitzpatrick, Davey, Buxton, & Jones, 1998; Jenkinson & McGee, 1998). Furthermore, condition-specific measures would be unlikely to capture unanticipated aspects of a condition (Fitzpatrick et al., 1998). These limitations can be addressed by generic measures which can be used in different population or patient groups. Condition-specific measures are meant to complement, not replace, generic measures, and the two types of measure are often used in combination.

Condition-specific measures can be used in a number of ways, including, as endpoints in clinical trials, to assess the health care needs of populations and to assist health care professionals in the provision of individual patient care (Fitzpatrick et al., 1998). In clinical practice, for example, condition-specific measures can be used to screen patients for health problems, to identify patients suitable for a given treatment, and to monitor the progress of a patient's health condition. It is important to note that measures developed and validated for one purpose cannot, necessarily, be automatically transferred and used for another purpose (Fitzpatrick et al.).

The development of a condition-specific measure typically involves the generation of items, reducing the number of items and pretesting and validating the measure. Ideally, items are generated by qualitative interviews with patients who have the condition, but items are also generated from the literature (Jenkinson & McGee, 1998). Items are reduced by selecting those that are the most commonly cited or that are rated as the most important by patients, and through the application of statistical methods (Guyatt, Bombardier, & Tugwell, 1986; Jenkinson & McGee, 1998). Guyatt et al. (1986) describe a "Rolls-Royce" and a "Volkswagen" model for developing instruments, where the "Rolls-Royce" model involves more in-depth steps at each stage (such as using qualitative interviews with patients for item generation, as opposed to generating items from

a review of existing instruments only) and larger (random) sample sizes than the "Volkswagen" model.

Condition-specific measures typically assess different dimensions of (health-related) quality of life including physical function, symptoms, global judgements of health, psychological well-being, social well-being, cognitive functioning, role activities, personal constructs, and satisfaction with care (Fitzpatrick et al., 1998). They may provide a profile of scores for each of the dimensions measured and/or a single overall score (index score) (Jenkinson & McGee, 1998). Grouping items into dimensions or an overall score has to be justified by presenting evidence of appropriate measurement properties (such as validity, ▶ reliability, responsiveness, and feasibility). Calculating the dimension scores can be as simple as summing the scores for each item within a dimension (e.g., AQLQ) or may involve transforming the raw (i.e., summed) score onto a scale from 0 to 100 (e.g., PDQ-39). Mostly, dimension scores cannot be calculated when items within the dimension are missing, although sometimes instructions exist on calculating scores when a small number of items are missing. Data imputation methods can be used to estimate the score of a missing item, thus allowing the dimension score to be calculated. There is, however, a general agreement that the best approach is to avoid missing data as much as possible.

The choice of which measure to use can be difficult as there are over 1,800 disease-specific (including population-specific) measures (Garratt, Schmidt, Mackintosh, & Fitzpatrick, 2002), and there can be more than one instrument for each condition. Choosing the appropriate measure is based on the research question, psychometric properties, and practical criteria (Atherly, 2006). The measure used should be able to answer the research question and cover the domains of interest. The measure needs to at least have been shown to be reliable, internally reliable, and valid, but other psychometric properties (feasibility, interpretability, acceptability, responsiveness) are also of importance (Fitzpatrick et al., 1998; Kane & Radosevich, 2011). The US Food and Drug Administration (FDA) (2009) has published guidelines for assessing the psychometric adequacy of PROMs. Practical aspects may include, for example, the method of administration or the length of the measure.

## Cross-References

- ▶ Asthma Quality of Life Questionnaire
- ▶ Ceiling Effect
- ▶ Disease-Specific Measure
- ▶ Disease-Specific Questionnaire
- ▶ Floor Effect
- ▶ Health-Related Quality of Life
- ▶ Parkinson's Disease Questionnaire (PDQ-39)
- ▶ Patient-Reported Outcome Measure
- ▶ Randomized Clinical Trial
- ▶ Randomized Controlled Trial (RCT)
- ▶ Reliability
- ▶ Sensitivity to Change

## References

Atherly, A. (2006). Condition-specific measures. In R. L. Kane (Ed.), *Understanding health care outcomes research* (2nd ed., pp. 165–183). London: Jones and Bartlett.

Fitzpatrick, R., Davey, C., Buxton, M. J., & Jones, D. R. (1998). Evaluating patient-based outcome measures for use in clinical trials. *Health Technology Assessment, 2*(14), 1–74.

Food, U. S., & Administration, D. (2009). *Guidance for industry: Patient-reported outcome measures: Use in medical product development to support labeling claims*. Rockville, MD: U.S. Food and Drug Administration.

Garratt, A., Schmidt, L., Mackintosh, A., & Fitzpatrick, R. (2002). Quality of life measurement: Bibliographic study of patient assessed health outcome measures. *British Medical Journal, 324*, 1417–1421.

Guyatt, G. H., Bombardier, C., & Tugwell, P. X. (1986). Measuring disease-specific quality of life in clinical trials. *Canadian Medical Association Journal, 134* (8), 889–895.

Jenkinson, C., & McGee, M. (1998). *Health status measurement: A brief but critical introduction.* Abingdon: Radcliffe Medical Press.
Kane, R. L., & Radosevich, D. M. (2011). *Conducting health outcomes research.* London: Jones & Bartlett Learning.
Patrick, D. L., & Deyo, R. A. (1989). Generic and disease-specific measures in assessing health status and quality of life. *Medical Care, 27*(3), S217–S232.
Ruta, D. A., Garratt, A. M., Wardlaw, D., & Russell, I. T. (1994). Developing a valid and reliable measure of health outcome for patients with low back pain. *Spine, 19*(17), 1887–1896.
Wiebe, S., Guyatt, G., Weaver, B., Matijevic, S., & Sidwell, C. (2003). Comparative responsiveness of generic and specific quality-of-life instruments. *Journal of Clinical Epidemiology, 56*(1), 52–60.

## Condition-Specific Questionnaire

▶ Condition-Specific Measure
▶ Disease-Specific Questionnaire

## Conduct Disorder

▶ Deviance

## Conduct of Life

▶ Lifestyle(s)

## Conference Board Consumer Confidence Index

▶ Consumer Confidence Index

## Confidence

▶ Trust

## Confidence in Government

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### Synonyms

Governance; Government, quality of; Trust in government; Trust in institutions

### Definition

In states where democratic elections exist, confidence in government to do what is right is a crucial variable to sustain human development and to improve people's ▶ quality of life. Confidence in government is closely related to the concept of trust in government and the legitimacy of their acts. Tyler (2006) has shown that people obey the law not only because they fear punishment but mainly because they trust in the law, institutions, and the national government. One of the critical dimensions to have confidence in government is the extent of administrative ▶ corruption that exists in the country. The quality of the delivery of public services is also an important variable.

Confidence in government is a complex and multidimensional concept that includes trust in police, trust in members of parliament or senate, trust in civil servants, the extent of administrative corruption in the country, the regulatory context, and the efficiency with which public services are provided. Confidence in government is closely related to the concept of social capital and good governance so that a decline in social capital may lead to a decline in confidence in government which in turn is a critical impediment for human development. Confidence in government is a variable that has been included in the World Values Survey (Inglehart et al., 1997, 2000) so that it allows cross-national comparisons of its effect on ▶ life satisfaction (Welzel & Inglehart, 2010).