A Systematic Review of Psychological, Physical Health Factors and Quality of Life in Adult Asthma

Running title: Factors in asthma quality of life

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Abstract

Asthma is a common non-communicable disease, often characterised by activity limitation, negative effects on social life and relationships, problems with finding and keeping employment, and poor quality of life. The objective of the present study was to conduct a systematic review of the literature investigating the potential factors impacting quality of life (QoL) in asthma. Electronic searches were carried out on: MEDLINE, EMBASE, PsycINFO, the Cochrane Library and Web of Science (initial search April 2017 and updated in January 2019). All primary research studies including asthma, psychological or physical health factors and quality of life were included. Narrative synthesis was used to develop themes among findings in included studies in an attempt to identify variables impacting QoL in asthma. The search retrieved 43 eligible studies, that were grouped in three themes: psychological factors (including anxiety and depression, other mental health conditions, illness representations and emotion regulation), physical health factors (including BMI and chronic physical conditions) and multifactorial aspects, including the interplay of health and psychological factors and asthma. These were found to have a substantial impact on QoL in asthma, both directly and indirectly, by affecting self-management, activity levels and other outcomes. Findings suggest a complex and negative effect of health and psychological factors on QoL in asthma. The experience of living with asthma is multifaceted, and future research and intervention development studies should take this into account, as well as the variety of variables interacting and affecting the person.
Introduction

Over 235 million people worldwide are living with asthma, which is one of the leading non-communicable diseases worldwide. Symptoms, exacerbations, and triggers in asthma are associated with lower quality of life (QoL), tiredness, activity limitation, negative effects on social life and relationships, problems with finding and keeping employment, and reduced productivity. People with asthma are up to six times more likely than the general population to have anxiety or depression, and 16% of people with asthma in the UK have panic disorder, compared to 1% in the general population. People with brittle asthma (difficult-to-control asthma with severe, recurrent attacks) demonstrate even greater comorbidity and maladaptive coping styles. Psychological dysfunction is often unrecognized in primary care, despite being significantly associated with poor asthma outcomes, including asthma control and QoL. Indeed, the European Asthma Research and Innovation Partnership (EARIP) has identified understanding the role of psychological factors as an unmet need in improving asthma outcomes. They propose that anxiety and depression are present at all three stages of the experience of asthma: onset, progression and exacerbation.

A recent meta-analysis found that asthma diagnoses significantly increased the risk of psychological and health conditions (such as cardio-/cerebrovascular diseases, obesity, hypertension, diabetes, psychiatric and neurological comorbidities, gut and urinary conditions, cancer, and respiratory problems other than asthma). Additionally, studies have pointed towards an impact on QoL in people with asthma of additional health and psychological factors such as co-morbid anxiety or depression, higher BMI, professional status and feelings of lack of control over health. Such evidence reinforces the argument that the needs of people with asthma should be approached in
conjunction with these additional factors, rather than using a single-illness approach, aiming to reduce the adversity of people’s experience. However, the extent to which psychological and physical health factors interact and impact asthma outcomes is yet to be systematically explored. This systematic review aims to provide a narrative synthesis of the literature exploring psychological and physical health factors that influence quality of life in adults with asthma.

Results

Study Characteristics

The search and screening process identified 43 eligible papers, published between 2003 and 2019 (see Figure 1 for PRISMA flowchart 19). The characteristics of each study are summarised below in Table 1. Twelve studies were conducted in Europe 20-31, 17 in North America 12,32-47, 7 in Australia 17,48-53, 4 in Asia 54-57, and 3 in Africa 58-60. All papers employed a quantitative approach comprising 2 longitudinal studies 31,44 and 41 cross-sectional studies. Only 4 studies included a control group 21,28,29,31. Overall, the majority of papers had a large sample size (ranging between 40 and 39,321 participants; 30 papers included a sample size of over 100). The majority of studies recruited from primary care or the general population, using self-report to confirm a diagnosis of asthma. Only a few studies recruited from secondary and tertiary asthma clinics. There was a high occurrence (n=14) of exclusion criteria relating to specific demographic, or asthma characteristics, as well as mental health conditions and comorbidities, which restricted the study sample without a reason being given. Most studies used self-report measures 17,20-30,32-37,39,41-46,48,49,51-60, with a small proportion using psychiatric interviews to screen for mental health conditions 12,31,38,40,50. The majority of studies used asthma-specific QoL measures.
(n=29)\(^{21,27,28,30,32-36,39-42,44-48-51,54-56,58-65}\), 17 included a HRQOL measure (n=18)\(^{20,22,28,30,31,34-36,38,43,50-52,55,61,62,66,67}\), and 4 used general measures of QoL (n=7)\(^{26,35,45-47,57,68}\). Eleven papers used more than one measure of QoL\(^{28,30,34-36,50,51,55,61,62,64}\). The average age across included studies was 42.1 years (and 61.57% were female). Papers report prevalence rates of between 16.8% and 48.9% for depression and between 13.3% and 44.4% for anxiety\(^{20,27,33,38,50,56,58,60}\), with an average of 28.31% for a diagnosis of anxiety or depression. Across several studies, the prevalence of other mental health conditions was 28.31% on average (ranging between 28% and 80%)\(^{12,37,38,40,42}\). Between 72% and 86.9% of people with asthma had at least one additional physical condition, and between 21% and 26.3% had two or more\(^{34,56,62}\). 26.36% had on average, at least one other physical health condition. On average, people with asthma were significantly more likely to have a BMI of over 30 (and between 61% and 75.1% had a BMI over 25)\(^{26,45,59}\). The quality assessment identified that most studies were of a reasonable quality, however, it should be noted that some measures used could be considered inappropriate for the research aim or the population under investigation. Examples include measuring general QoL with an asthma-specific measure or administering a geriatric depression questionnaire to a young adult population.

**Narrative synthesis**

Narrative synthesis generated three overarching themes: psychological factors, health factors and multifactorial aspects (see Table 2 for themes and subtheme descriptions). Overall, patients with asthma demonstrated impaired QoL, which was further decreased by psychological factors (e.g. anxiety, depression, emotion regulation, illness perceptions), health risk factors (such as an increased BMI), and the presence of a co-existing mental health or physical condition (such as rhinitis, cardiovascular disease, diabetes, etc.). Having
more than one co-existing condition or psychological factor impacted overall QoL even more substantially. Results for each of the aspects found are presented below.

**Psychological Factors**

Within this first theme, four subthemes were generated. These comprised ‘anxiety and depression’, ‘other mental health conditions’, ‘emotional regulation’, and ‘illness representations’.

Anxiety and depression were notably the most commonly considered factors (n=30). A high prevalence of people with asthma showed symptoms of or clinical diagnoses of anxiety or depression, which appeared to play a key role in understanding the relationship between asthma and QoL. Overall, having a diagnosis of anxiety or depression was associated with poorer quality of life across all dimensions (e.g. activity limitation, physical or mental wellbeing, social or role functioning etc.), as well as health perceptions. A high prevalence of people with asthma showed symptoms of or clinical diagnoses of anxiety or depression, which appeared to play a key role in understanding the relationship between asthma and QoL. Overall, having a diagnosis of anxiety or depression was associated with poorer quality of life across all dimensions (e.g. activity limitation, physical or mental wellbeing, social or role functioning etc.), as well as health perceptions.

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In particular, one study (of undergraduate students aged 18-25, with childhood onset asthma) found that anxiety was significantly associated with asthma QOL, as was the interaction between anxiety and depression, while others found that generally anxiety and depression both predicted worse quality of life independently. One study found that the average asthma-related QoL scores for people with asthma and depression were 1.4 times lower compared to people with asthma and no depression.

Having current depression or anxiety was associated with worse QoL than was having a lifetime diagnosis; this was in turn was greater than having no depression or anxiety. Having a history of major depression was also significantly associated with worse physical and mental functioning, compared to those with asthma and no depression. There was considerable variability across variance explained, with depression found to account for
between 3%\textsuperscript{40} and 56%\textsuperscript{30} of the variance in QoL, whereas anxiety was found to account for between 2%\textsuperscript{40} and 68%\textsuperscript{21}.

In contrast, one study found that having either a depressive or an anxiety disorder significantly impacted asthma QoL, but having both was not significantly different than only having one\textsuperscript{40}, which is dissonant with other studies. Another study, of 90 people with difficult asthma found that having anxiety or depression had no significant effect on QoL\textsuperscript{48}. Additionally, although depression was associated with poorer QoL, it did not inflate the relationship between asthma severity and QoL\textsuperscript{29}. All other studies were significant but showed only small to moderate effect sizes. Having a full clinical diagnosis of anxiety or depression was not significantly worse (in terms of QoL) than having only some symptoms of anxiety and depression.

Studies also considered the impact of anxiety and depression on specific sub-domains of QoL and asthma-specific QoL. Having anxiety was not associated with physical functioning, mental health or health perception\textsuperscript{38} or the physical component of QoL\textsuperscript{20}.

Depression, however, was associated with significantly poorer QoL on physical dimensions and activity limitation\textsuperscript{20,21,23,30,38,45,53,55,58}, although one study found significant results only for participants with uncontrolled asthma\textsuperscript{22}. In relation to asthma-specific QoL, depression and anxiety were significantly associated with decreased asthma-specific QoL\textsuperscript{17,21,27,28,32,33,36,37,40,50,54,55,58,61,64,65}.

Nine studies looked at other mental health conditions, such as panic disorder with or without agoraphobia\textsuperscript{24,38,44,57}, personality disorders\textsuperscript{31}, alexithymia\textsuperscript{33}, somatization\textsuperscript{38}, mood disorders\textsuperscript{12,40,57}, schizophrenia, eating disorders, substance use disorders\textsuperscript{38} and general occurrence of any psychiatric disorder\textsuperscript{12,17}. The results in this sub-theme were mixed, but overall, they suggest that the presence of an additional mental health condition is
significantly associated with a decrease in QoL in patients with asthma [12,17]. Panic disorder was also shown to be both significantly [24] and non-significantly [57] associated with poorer mental and physical components of QoL. Alexithymia in people with asthma was not associated with poorer QoL [23]. Having asthma and a personality disorder was associated with lower general QoL [31], as well as lower scores for physical health, vitality, pain, general health, social function, mental health and emotional role (physical function was not significant). This association was not found for people without asthma, suggesting that it is the combination of conditions (asthma and co-existing mental health conditions) that may lead to the negative impact on QoL [31].

The emotion regulation subtheme included studies that explored the relationship between emotional states, negative affect (not related to anxiety, depression or other mental health conditions) or coping and QoL in people with asthma. QoL in asthma was found to be influenced by affect and a predisposition to negative states, as found by four studies [28,39,41,51]. For instance, a model of age, gender, negative affect and medical problems accounted for 20% of symptoms and 23% of activity limitation [39]. This was supported by findings that negative mood is associated with poor scores on both the mental and physical components of the Asthma Quality of Life Questionnaires (AQLQ) [28], as well as a positive correlation between active coping and asthma QoL [51]. Despite heterogeneity, the impaired QoL was associated with impulsive-careless coping [41], and avoidant coping [51]. Overall, the presence of psychological distress seemed to affect people with asthma more than people without asthma in terms of QoL.

Illness-related cognitions are people’s patterns of beliefs about the characteristics of their conditions, which in turn influence their appraisal of severity and can determine future behaviours [69]. A number of illness-related cognitions and perceptions significantly predicted
QoL in seven studies \cite{26,34,37,42,43,51,60}. For instance, asthma self-efficacy \cite{42} was positively associated with QoL. However, decreased QoL was significantly predicted by a series of varied illness perceptions: subjective illness severity, uncertainty in illness, illness intrusiveness \cite{43}, perceived disability \cite{60}, health beliefs and attitudes \cite{34}, perceived severity \cite{34}, level of confidence or self-efficacy in managing asthma \cite{51}, satisfaction with illness \cite{51}, anxiety sensitivity for physical concerns \cite{39} and satisfaction with life \cite{37}. Additionally, a model of subjective and objective illness severity accounted for 24% of the variance in QoL, further supporting the effect of illness perceptions on QoL \cite{34}.

**Physical Health Factors**

Two sub-themes were generated in the physical health factors theme: additional physical conditions and BMI.

Ten papers examined additional physical conditions in relation to quality of life in asthma \cite{25,27,34,39,46-49,52,53}, most only referred to “co-morbidity” or “medical problems” as a measure of frequency of additional conditions \cite{34,36,39}. Some studies looked at both general and individual co-existing conditions \cite{25,48,52} and others counted chronic conditions but did not include them in further analyses \cite{33,36,56,59}. Of the ones that did explore individual conditions, the highest impact seemed to be provoked by musculoskeletal conditions \cite{25}.

Similarly, statistically and clinically significant decreases in activity levels were also found for people with asthma and multimorbid conditions \cite{52}. Other conditions investigated included respiratory conditions \cite{47}, diabetes \cite{25,48}, obesity \cite{48}, hypertension \cite{25,39}, gastro-oesophageal reflux disorder \cite{48}, rhinitis \cite{48,49}, vocal cord dysfunction \cite{48}, sleep apnoea \cite{48}, musculoskeletal disorders \cite{25,39}, arthritis \cite{39,52}, heart disease \cite{25}, stroke \cite{39,52}, cancer \cite{39,52}, osteoporosis \cite{52}, dysfunctional breathing \cite{48}, headaches \cite{39} and allergic status \cite{27,39}. The consensus was that
having an additional physical condition significantly decreased QoL in asthma the effect
being amplified with the addition of further conditions.

Eleven papers exploring BMI found that it consistently influenced QoL for people
with asthma both directly as a multimorbid factor, and indirectly by increasing the chance of
additional conditions and activity limitation \(^{25,26,28,29,35,42,44,45,48,56,59}\). In particular, one study
found that generic health status decreased for overweight and obese patients with asthma.
People with asthma with obesity had on average 5.05 more restricted activity days than
people without obesity or without asthma \(^{35}\). Other studies found that increased BMI was
an independent factor in predicting poorer QoL \(^{48}\) and that QoL was two times worse in
overweight and 3 times worse in obese people with asthma \(^{59}\). In contrast, one study found
that overweight BMI made no difference, however, being obese did \(^{27}\). Almost \(\frac{1}{2}\) of obese
patients, and 25% overweight patients had problems with mobility, pain, discomfort, self-
care and usual activities (compared to less than 15% people with asthma of normal weight)
\(^{26}\).

**Multifactorial Aspects**

Seven studies included statistical analyses to explore potential mechanisms for the
relationship between asthma QoL and additional physical conditions, BMI, and psychological
factors \(^{17,35,42,45,50,56,59}\). Results from studies in this group are complex, indicating that
people with asthma are at a higher risk of adverse outcomes (such as exacerbated
symptoms or decreased QoL) if they also have a high BMI and depression \(^{35,42,56,59}\). People
with current depression and asthma are more likely to be obese and 3.9 times more likely to
report fair or poor general health \(^{45}\). A few of these studies have explored the relationship
between these factors further. For example, people with asthma and obesity were more
likely to have additional physical co-morbidities and poorer QoL. Significant increases in major depression were associated with dyspnoea, and depression and perceived control of asthma significantly mediated between BMI and QoL. Higher BMI has also been associated with worse asthma-specific self-efficacy, which was in turn associated with decreased QoL.

Discussion

The aim of the present review was to synthesise the literature exploring health and psychological factors that influence QoL in adults with asthma. Previous evidence shows that QoL is generally lower in people with asthma and compounded by poor asthma control and severity. The narrative synthesis in the present study builds on this by identifying three themes, encompassing a number of factors that substantially explain further impairment in QoL for people with asthma. These were not limited to individual components but also combinations of co-existing conditions, risk factors, health and psychological factors, which consistently showed a negative impact on QoL.

Anxiety and depression were the most commonly reported psychological factors associated with impaired QoL, but effects were also found for other mental health conditions, illness representations and emotion regulation. These results are generally consistent with previous research showing not only that among people with asthma there are more people with depression than without, but with an increase in depression, the risk of asthma increased. Although the relationship between anxiety and depression and asthma-specific QoL were not further considered in the primary sources, they point towards either a link with activity limitation, or a cumulative impact of the interaction between these factors.
psychological factors, which in turn affect the quality of life of people with asthma.

Additionally, it is argued that people with asthma use more emotion-focused, and generally maladaptive coping strategies, such as avoidance. Despite this, psychotherapy, such as cognitive-behavioural therapy and counselling has had limited effectiveness in improving asthma outcomes.

Physical health factors, such as high BMI and co-occurring health conditions, were extremely common in people with asthma, consistent with existing literature. This affects quality of life both directly and indirectly, affecting self-management and illness perceptions. As such, non-pharmacological treatments such as lifestyle change and activity promotion could prove effective. For instance, a higher proportion of people with asthma seem to have overweight or obese BMI and weight loss interventions studies have been associated with improvements in asthma symptoms.

One of the fundamental components of reduced QoL is activity limitation, which is especially relevant to people with asthma, with or without additional conditions or psychological risk factors. This has been widely acknowledged by previous research, to the extent that it has been included as one of the components of asthma-related QoL measures, such as the AQLQ. Furthermore, it is not surprising that decreased QoL in adults with asthma is associated with depression or high BMI, both of which have been consistently associated with activity limitation. Additionally, depression was found to affect QoL on the physical components as well as the mental ones, which has interesting implications for future research and clinical practice.

It is important to note the high prevalence of anxiety, depression, and chronic conditions, despite frequent exclusion of comorbid psychiatric conditions. This was found throughout the included papers and is consistent with previous research (e.g.). This does
not only mean that psychological and health factors significantly add to the burden of living with asthma, but also that the occurrence of psychological dysfunction and health risk factors seem to be common in people with asthma. In addition, the complex nature of patients with chronic diseases such as asthma, with factors interacting, adds to the negative experience of living with asthma. Results are similar to previous meta-analyses and reviews, pointing towards conclusive evidence that additional factors (physical or psychological) decrease quality of life and functionality in asthma. Finally, these effects were consistent, regardless of the measure of QoL used (either asthma-specific, health-related or general). This suggests that the identified factors may affect people with asthma more than people without asthma, or that the cumulative impact of co-morbidities is greater than arithmetically assumed.

The quality of the present review needs to be discussed in relation to the methodology and robustness of the synthesis, determined by the quantity and quality of individual studies included. The quality assessment identified that most studies were of a reasonable quality overall, although all papers had one or two elements that were of a slightly lower quality (this included aspects such as recruitment from only one hospital reducing generalisability, or self-report vs objective measurement of weight for BMI calculations). However, this was not problematic for the purposes of this review as the focus was to identify potential factors considered in research rather than classify the methodological quality used to measure their impact on QoL. Additionally, the search terms in this review could have limited the number and kind of studies included. For instance, not every potential co-morbid condition was listed. This could be a focus for future research. Socio-demographic factors were not included, which can be considered a limitation, however, the breadth of the area was deemed too much for the scope of the present review.
and could also be the focus of future research. The majority of included studies were observational, and as such could not be used to determine causal mechanisms. However, the aim of this review was only to identify potential factors involved in decreased QoL in asthma, rather than build a causal model. Similarly, the impact of individual factors was not measured, and could be explored in future research.

A strength of the present review is that it uses a novel approach to QoL in asthma, by systematically taking into account additional aspects that influence the experience of living with asthma and impact QoL. Results suggest both a direct association of the identified aspects, as well as indirectly through interactions with other aspects of living with asthma, such as overarching illness perceptions and activity limitation. The present review emphasizes some interesting and novel findings for asthma and quality of life research. Three main implications for future research and practice are proposed. Firstly, for future research, the findings of this review should be used to further explore and understand the factors impacting QoL in people with asthma. It is crucial to explore the needs and experience of patients with complex medical problems, in order to unpick the different factors impacting on QoL. Secondly, the results are relevant for practitioners, particularly in primary care, as they draw attention to the prevalence of various physical and mental health factors that can interact and affect asthma outcomes. This could influence training or guidelines on potential factors to consider during appointments and consultations. Finally, most current non-pharmacological interventions for patients with chronic conditions tend to overlook the complex needs of patients in a multimorbidity context. As such, it is suggested that future intervention development should use a personalised, tailored approach that aims to address the needs of patients with complex medical problems in the wider context of their experience of living with asthma.
This review demonstrates that the themes and factors identified through inductive narrative synthesis illustrate that QoL in asthma cannot be determined in a simplistic way. The findings suggest a complex experience in living with asthma, one that has a stronger impact on QoL than the sum of its parts. People with asthma and their QoL cannot be viewed separately from the psychological and other health elements that they experience. Future research is encouraged to take a function-oriented approach to QoL in asthma, including management of multimorbid conditions when planning studies; clinical practice should also acknowledge the additional and complex needs of people with asthma by offering relevant, person-based tailored interventions.

**Method**

**Search Strategy**

The initial search was carried out in April 2017, and was updated in January 2019. Databases searched included MEDLINE, EMBASE, PsycINFO, the Cochrane Library and Web of Science. Search terms used comprised a combination of the following key terms: asthma (MESH term), psychological/psychosocial and factor/determinant/predictor, comorbid, multimorbid, anxiety, depression, illness perception, illness cognition, illness representation, locus of control, self-efficacy, risk factor, quality of life, health-related quality of life, wellbeing, distress, health status, burden. Additionally, a hand search of all the references of included papers was performed as well as a grey literature search on Google Scholar.

**Study selection**

Studies were included if they investigated psychological or physical health factors and included quality of life in adults with asthma as primary or secondary outcome.
Psychological factors were considered any modifiable factors including thoughts, beliefs, attitudes or emotions of people with asthma, as well as the presence of any co-occurring mental health condition. Physical health factors were defined as any physical co-morbid or multimorbid condition or risk factor. These were chosen to allow as much inclusivity as possible, and to reflect the exploratory nature of this review. Intervention studies were excluded, as they rarely considered the impact of health or psychological factors on QoL, but rather investigated how interventions improved asthma outcomes. Studies were excluded if they were conference abstracts, reviews, or not primary research or the full text not in English, German or Spanish language.

**Data Extraction and Quality Appraisal**

Data extracted comprised authors, year of publication, study sample, predictors, QoL measurement (outcome), and findings. The AXIS tool was used to assess the quality of included papers. This contains questions on study design, sample size justification, target population, sampling frame, sample selection, measurement validity & reliability, and overall methods and does not offer a numerical scale. No papers were excluded or weighted based on the quality assessment.

**Data Synthesis**

Due to heterogeneity of QoL measures and the range of variables used in the included studies, narrative synthesis was used to describe and group similar findings, explore patterns identified in the literature, and develop a narrative account of the results. This is an approach to systematic reviews involving the synthesis of findings from multiple sources and relies primarily on word and text to summarise the findings.
All data generated or analysed during this study are included in this published article.

Competing interests

The authors declare that they have no competing interests.

Author Contributions

S.S.—Conception of the review, synthesis, wrote the first draft, commented on drafts. B.A.—Conception of the review and day-to-day conduct of the review, commented on drafts, updated the review, revised the paper. S.K.—Conception of the review and day-to-day conduct of the review, commented on drafts, updated the review, revised the paper. M.T.—conception of the review, commented on drafts. L.Y.—conception of the review, commented on drafts. All authors read and approved the final version of the manuscript.
References


**Figure Legends**

Figure 1. PRISMA statement of included and excluded papers
<table>
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<th>Study</th>
<th>Sample</th>
<th>Study Design and Recruitment</th>
<th>Predictor</th>
<th>QOL Measurement</th>
<th>Findings- summary</th>
</tr>
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<tbody>
<tr>
<td>Adams et al (2004)</td>
<td>7619 people from the general population (834 with asthma)</td>
<td>Cross-sectional, population household interview</td>
<td>Kessler Psychological Distress Scale (K10), for a global measure of psychological distress, containing measures of depressive and anxiety symptoms experienced over 4 weeks + self-report of diagnosed psychiatric conditions</td>
<td>SF-12</td>
<td>Psychological distress was more common in people with asthma (17.9% vs 12.2%, p&lt;.01); mental health conditions were more common (16.2% vs 12.2%, p&lt;.01). People with asthma and psychological distress had significantly lower QoL than those with either asthma or psychological distress alone (the physical component summary of the SF-12). Among those with psychological distress, the mental component summary did not differ between people with or without asthma.</td>
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<tr>
<td>Adams et al (2004)</td>
<td>293 adults with asthma, at baseline and 232 at 12-months</td>
<td>Longitudinal study (measures at baseline and 12-month follow-up), patients recruited from outpatient clinics, emergency departments and inpatients at 2 hospitals</td>
<td>Coping scales to measure active, avoidance and denial coping, as well as other measures such as - self-efficacy in asthma, perceived emotional and social support, satisfaction with illness scale</td>
<td>SF-36 and the Modified Marks AQLQ</td>
<td>Avoidance coping and clinical asthma status were significant predictors of the Marks AQLQ, and the physical and mental components of the SF-36 in a regression model. Less avoidance was associated in an increase greater than one standard deviation for all scales. Similar trends were observed for active coping and self-efficacy, but not denial. Active coping was a significant predictor of the physical component ($r^2=0.69$) and satisfaction with illness was a significant predictor of the mental component ($r^2=0.54$).</td>
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<tr>
<td>Study</td>
<td>Participants</td>
<td>Study Design</td>
<td>Measurement of Comorbidity</td>
<td>Instrument</td>
<td>Findings</td>
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<tr>
<td>Adams et al (2006)</td>
<td>7,619 people from the general population (834 with asthma)</td>
<td>Cross-sectional, population household interview</td>
<td>Any additional condition from: diabetes, arthritis, heart disease, stroke, cancer, osteoporosis</td>
<td>SF-12</td>
<td>People with asthma were more likely to report a physical-comorbidity (odds ratio 19.9, 95% CI 1.5 to 2.2). People with asthma and other conditions reported more days unable to do usual activities (16.0 compared to 11.3 with asthma alone and 9.2 with other conditions). When controlling for age and gender, additionally, PCS scores significantly (statistic and clinical) decreased with the presence of an additional condition. Having two or more conditions (one of which was asthma) was associated with a lower SF-12 score than expected from the effects of asthma and the chronic condition alone.</td>
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<td>Adeyeye et al (2017)</td>
<td>201 adult participants with moderate and severe asthma</td>
<td>Cross-sectional, recruited from an asthma outpatient clinic</td>
<td>the Mini International Neuropsychiatric Interview (M.I.N.I) to assess the presence of anxiety and/or depression.</td>
<td>Mini-AQLQ</td>
<td>Presence of anxiety/depression was a significant independent predictor of the mini-AQLQ score, and of the emotional domain (p&lt;.001).</td>
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<td>Afari et al (2001)</td>
<td>50 adult participants with confirmed asthma</td>
<td>Cross-sectional, recruited from an asthma clinic</td>
<td>Diagnostic Interview Schedule for DSM-III-R</td>
<td>SF-36</td>
<td>Asthma patients with a lifetime diagnosis of depression reported worse physical functioning, mental health functioning and health perceptions (Fs ranged between 2.60 and 4.18, ps&lt;.05). Scores for anxiety followed similar trends but were non-significant.</td>
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<td>Al-kalemji et al (2013)</td>
<td>778 adult participants completed questionnaires (181 with</td>
<td>Cross-sectional, recruited from an earlier cohort</td>
<td>BMI, 2 questions on the 15D and participants were asked (yes/no) if they had anxiety or depression.</td>
<td>15D (measure of global QOL)</td>
<td>Depression was significantly associated with worse QOL on all domains (r= −0.076, CI −0.091 to −0.061), but it did not inflate the relationship between asthma severity and QOL (severity had an independent influence on QOL regardless of psychological state).</td>
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The number of comorbid conditions was significantly associated with QOL on all domains (range -0.21 to -0.33). Negative affect was associated with all dimensions, except for the environmental stimuli domain. AS-Physical concerns was associated with all QOL domains. A model of gender, age, negative affect and number of medical problems significantly predicted QoL, explaining 20.2% of the variance in symptom-related QoL and 22.7% of the variance in activity limitation (gender and age were not significant independent predictors, but both negative affect and number of medical problems were).

Scores for both anxiety and depression were significantly associated with worse QoL on the physical and mental dimensions. Increasing age, female gender, higher number of medications and symptoms of depression explained 48% of the variance in the physical component. Living alone and reporting symptoms of anxiety explained 33% of the variance in the mental component.

AQOL scores were significantly lower for people with depression and asthma (72.4 vs 98.6, p<.01); this was true for both groups (elderly and non-elderly).
<table>
<thead>
<tr>
<th>Study</th>
<th>Number of Participants</th>
<th>Study Design</th>
<th>Measurements</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coban &amp; Aydemir (2014)</td>
<td>174 adults</td>
<td>Cross-sectional, consecutive patients recruited from secondary care</td>
<td>HADs and allergic status</td>
<td>AQLQ</td>
</tr>
<tr>
<td>Deshmukh et al (2008)</td>
<td>110 adult patients</td>
<td>Cross-sectional, recruited patients who visited an emergency department in the past 18 months</td>
<td>HADs</td>
<td>AQLQ</td>
</tr>
<tr>
<td>Ekici et al (2006)</td>
<td>116 adult asthma patients and 116 matched</td>
<td>Cross-sectional, recruited from a respiratory disease clinic (matched</td>
<td>Negative mood was evaluated with a questionnaire including six mood subscales in 3 categories - nervous-anxious, hostile-angry and fearful-panicky.</td>
<td>SF-36 and AQLQ</td>
</tr>
</tbody>
</table>
healthy controls recruited from the community of visitors to the same hospital)

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Study Design</th>
<th>Inclusion Criteria</th>
<th>Instruments</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erickson et al (2002)</td>
<td>603 adults with asthma</td>
<td>Cross-sectional, recruited patients who were enrolled in a managed care organization.</td>
<td>Number of comorbidities and health belief questionnaires (based on the Health Belief Model)</td>
<td>AQLQ and SF-36</td>
<td>Number of comorbidities was significantly associated with decreased QOL on all 10 components and the overall score ($\beta$ ranging from -0.062 to -0.360, significant for summary AQLQ, activity limitation, symptoms and exposure to environmental stimuli, and all components of the SF-36, including composite mental and physical summaries); Illness perceptions (symptom-derived severity and perceived severity) were both significant predictors of the physical component of the SF-36 and of all subscales of the AQLQ ($\beta$ values ranged from -0.155 to -0.237).</td>
</tr>
<tr>
<td>Favreau et al (2014)</td>
<td>643 adults with asthma</td>
<td>Longitudinal, 4-3 year follow-up, recruited from tertiary care</td>
<td>Primary care evaluation of mental disorders interview (to assess panic disorder), anxiety sensitivity index (to assess panic-anxiety)</td>
<td>AQLQ</td>
<td>Having a diagnosis of PD did not significantly predict total AQLQ scores. Higher anxiety sensitivity at baseline predicted worse symptoms ($\beta = -0.013, p&lt;.01$), and emotional distress ($\beta = -0.014, p&lt;.01$), but not overall AQLQ. This stayed true when controlling for covariates (age, gender, years of education, smoking, major depression, medication use and baseline scores).</td>
</tr>
<tr>
<td>Faye et al (2015)</td>
<td>60 adults with asthma</td>
<td>Cross-sectional, consecutive patients recruited from</td>
<td>DSM-IV-TR criteria for Panic and Agoraphobia (including the Panic and Agoraphobia scale to assess the severity of panic disorder), number of</td>
<td>WHO QOL BREF scale and the WHO disability</td>
<td>83.3% of people with 4 or more panic symptoms (not qualifying for panic attack diagnosis) reported ‘sensations of shortness of breath’, ‘fear of choking’ and ‘fear of dying’.</td>
</tr>
<tr>
<td>Study</td>
<td>Sample</td>
<td>Design</td>
<td>Methodology</td>
<td>Outcomes</td>
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<tr>
<td><strong>Goldney et al (2003)</strong>&lt;sup&gt;50&lt;/sup&gt;</td>
<td>3010 interviews conducted (299 with adults with asthma)</td>
<td>Cross-sectional, population interview (random sample)</td>
<td>Dyspnoea dimension of the AQLQ to determine dyspnoea; PRIME-MD (psychiatric interview tool) to determine depression.</td>
<td>AQLQ and SF-36</td>
<td>QOL scores were significantly lower on the physical (44.3 vs 49.3) and environmental (43.5 vs 47.6) domains for participants with panic disorder compared to those without panic disorder. All participants with PD had poor QOL (significantly lower when compared to those without).</td>
</tr>
<tr>
<td><strong>Gonzalez-Barcala et al (2012)</strong>&lt;sup&gt;26&lt;/sup&gt;</td>
<td>2125 adult participants with asthma</td>
<td>Multi-stage cross-sectional, recruited from primary care clinics</td>
<td>BMI, Incidence of Stressful events, presence of allergy sensitization</td>
<td>EQ-5D</td>
<td>Increases in major depression were associated with dyspnoea (44.2% with depression and dyspnoea, compared with 17.9% with depression and no dyspnoea, p&lt;.01). This group of people showed significantly lower scores on all domains of the SF-36 (suggesting that depression could be a mediating factor).</td>
</tr>
<tr>
<td><strong>Hommel et al (2002)</strong>&lt;sup&gt;32&lt;/sup&gt;</td>
<td>64 adolescents and young adults with asthma (18-25 years old)</td>
<td>Cross-sectional, recruited from the community</td>
<td>IDD (to assess depression), the Beck Anxiety Inventory and subjective illness severity</td>
<td>LVAQ</td>
<td>LVAQ was significantly correlated with subjective severity (r=.48, p&lt;.01). The combined influence of anxiety and depression accounted for 14% of the variance in QoL; depression contributed significantly to variance in QoL (t=2.65; p&lt;.05) before anxiety was introduced in the model; anxiety demonstrated a significant main effect on asthma-specific QoL (t=2.58; p&lt;.05).</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Study Design</td>
<td>Measures</td>
<td>Outcome</td>
<td>Findings</td>
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<tr>
<td>Hullmann et al (2013)</td>
<td>74 adult participants with asthma (and 74 with allergies)</td>
<td>Cross-sectional, recruited from a university</td>
<td>Mishel Uncertainty in Illness Scale - to assess 4 components of illness uncertainty (ambiguity, uncertainty, lack of information and unpredictability); Illness Intrusiveness Scale - to assess the illness-induced interference with various life activities</td>
<td>SF-36</td>
<td>The overall model (including illness uncertainty and illness intrusiveness, gender and asthma severity) accounted for 59.3% of the variance in SF-36 scores for the physical component and 19.6% for the mental component. Illness Intrusiveness and illness uncertainty were significant independent predictors of the physical component, but not of the mental component.</td>
</tr>
<tr>
<td>Kolawole et al (2011)</td>
<td>81 adult patients with asthma</td>
<td>Cross-sectional, consecutive patients recruited from an asthma clinic</td>
<td>HADs</td>
<td>Mini-AQLQ</td>
<td>Presence of anxiety symptoms ($\chi^2=7.9$, $p&lt;.05$) and depressive ($\chi^2=6.45$, $p&lt;.05$) symptoms (according to HADs) was significantly associated with decreased QoL.</td>
</tr>
<tr>
<td>Krauskopf et al (2013)</td>
<td>317 participants with asthma aged over 60</td>
<td>Cross-sectional, recruited from outpatient health clinics (secondary care)</td>
<td>PHQ-9 (to assess symptoms of depression)</td>
<td>Mini-AQLQ</td>
<td>Patients with depression showed poorer quality of life than those without (mean score difference in AQLQ = -1.4, $p&lt;.001$).</td>
</tr>
<tr>
<td>Kullowatz et al (2007)</td>
<td>88 adult patients with asthma</td>
<td>Cross-sectional, recruited from a larger study conducted at a pulmonary clinic</td>
<td>HADs</td>
<td>Living with asthma questionnaire (LVAQ) and SF-12</td>
<td>After controlling for demographics and symptom severity, anxiety accounted for considerable variance in SF-12 mental wellbeing and LAQ psychological wellbeing (explaining 22% and 9% of the variance respectively). Including depression accounted for additional variance an additional 8% and 2% respectively) For physical wellbeing, depression was significantly associated, explaining 6% of the variance, but not anxiety. Significant associations were found between anxiety</td>
</tr>
<tr>
<td>Study</td>
<td>Patients</td>
<td>Design</td>
<td>Methodology</td>
<td>Outcome Measures</td>
<td>Findings</td>
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<tr>
<td>Lavoie et al (2004)</td>
<td>406</td>
<td>Cross-sectional, consecutive</td>
<td>Structured Psychiatric interview - the Primary Care Evaluation of Mental Disorders to detect the most common psychiatric disorders, according to the DSM-IV</td>
<td>AQLQ</td>
<td>Despite no differences in pulmonary functions, people with psychiatric disorders reported significantly lower AQLQ on all individual scores and total score (mean score 5.3 vs 4.6, p&lt;.01).</td>
</tr>
<tr>
<td>Lavoie et al (2006)</td>
<td>504</td>
<td>Cross-sectional, consecutive</td>
<td>Primary Care Evaluation of Mental Disorders - PRIME-MD</td>
<td>AQLQ</td>
<td>Independent effects of depression on AQLQ (F=38.5, p&lt;.01) and anxiety on AQLQ (F=18.06, p&lt;.01, total score) but no significant interaction effect (the multiple regression model containing severity, sex, age, depression and anxiety and the interaction accounted for 22% in the interaction). There was a significant independent effect of depression (explaining 3% of the variance in AQLQ) and anxiety (explaining 1% of the variance). They were significant predictors on every sub-scale, explaining between 1% and 3% of the variance in AQLQ subscales.</td>
</tr>
<tr>
<td>Lavoie et al (2008)</td>
<td>557</td>
<td>Cross-sectional, patients</td>
<td>Psychiatric Interview to assess mental disorders, Asthma Self-Efficacy Scale</td>
<td>AQLQ</td>
<td>ASES scores were significantly correlated with AQLQ, suggesting that being confident in one’s ability to control asthma symptoms is associated with better quality of life (r=0.62, p&lt;.01). Lower ASES scores were also significantly correlated with a higher BMI and having a comorbid mood or anxiety disorder.</td>
</tr>
<tr>
<td>Lomper et al (2016)</td>
<td>96</td>
<td>Cross-sectional, recruited from</td>
<td>HADs (measured both anxiety and depression but only performed an analysis of correlations between</td>
<td>SF-36</td>
<td>There was a significant difference in the mental component between people with or without depression (51.4 vs 71.8, p&lt;.05) in the group of people with</td>
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</table>
controlled asthma, 63 with uncontrolled asthma) allergy clinic. depression and QoL controlled asthma. There was no significant difference between people with or without anxiety.

In the uncontrolled asthma group, depression was associated with poorer QoL on both physical and mental components (48.6 vs 30.3 and 57.5 vs 33.7 respectively, ps<.01). Anxiety was also associated with poorer QoL on both physical and mental components (54.8 vs 30.8 and 62.7 vs 40.5, ps<.01).

**Maalej et al (2011)**

| 200 adult participants with asthma | Cross-sectional, recruited from outpatient respiratory departments | BMI and presence of comorbidities (out of diabetes, hypertension, hypercholesterolemia, rhinitis and sinusitis) | AQVAT (Arabic version of the AQLQ) | Higher BMI was correlated with higher number of comorbidities (p<.01 for diabetes, hypertension, hypercholesterolemia, GERD, rhinitis and sinusitis) and with lower QOL (11.48 vs 64.35, p<.01 between people with normal and obese BMI). |


| 230 adult people with asthma | Cross-sectional, recruited from outpatients tertiary care | A screening question for depression and the Geriatric Depression Scale | AQLQ and SF-36 | Participants with positive screening scores for depressive symptoms had significantly lower AQLQ and SF-36 scores (as well as significantly worse scores on each individual domain, p<.05). Depression score was a significant predictor of AQLQ, explaining 23% of the variance. |

**McCormick et al (2013)**

| 44 adults with asthma | Cross-sectional, recruited from secondary care | Maladaptive coping (based on the transactional stress models of health) assessed with the Social Problem Solving Inventory Revised: Short Form | Mini-AQLQ | Controlling for variance associated with gender, age and income, people with higher impulsive-careless scores scored lower on QoL ($\beta=0.79$, p<.01). Problem-solving style was the only significant independent predictor of QOL. |

**Miedinger et al (2011)**

<p>| 60 adult participants with occupational asthma | Cross-sectional, people recruited after being evaluated for a permanent | Primary Care Evaluation of Mental Disorders - PRIME-MD; Psychiatric Symptoms Index | AQLQ &amp; the St-Georges Respiratory Questionnaire | Significant medium to high correlations between the PSI and AQLQ (r=-.619); having any mood or psychiatric disorder according to PRIME-MD showed significant medium correlations with all subscales of the AQLQ (r=0.417 for any psychiatric disorder and composite |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Study Design</th>
<th>Instruments / Variables</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nishimura et al (2004)</strong></td>
<td>162 adult patients with mild to severe well-controlled asthma</td>
<td>Cross-sectional, consecutive patients recruited from an outpatient secondary care clinic</td>
<td>HADs and presence of dyspnoea, Living with asthma questionnaire (LVAQ) and SF-36</td>
<td>Having anxiety or depression according to HADs scores showed mild but significant correlations with both QOL questionnaires (scores ranging from 0.31 to 0.60). Severity of dyspnoea was also associated with both, with correlation scores ranging from 0.22 to 0.56.</td>
</tr>
<tr>
<td><strong>Oga et al (2007)</strong></td>
<td>87 adult Patients with stable asthma</td>
<td>Longitudinal, recruited from an outpatient secondary care asthma clinic 6 months after treatment and follow-up 5 years</td>
<td>HADs</td>
<td>Changes in HADs scores were significantly correlated with changes in AQLQ on both anxiety and depression scales ($r = -0.6, p&lt;.01$ and $r = -0.5, p&lt;.01$ respectively), but not changes in physiological measures. HADs scores overall remained similar over the 5 year follow-up period.</td>
</tr>
<tr>
<td><strong>Oguzturk et al (2005)</strong></td>
<td>70 patients (with stable asthma and aged over 60) and 40 age-matched controls</td>
<td>Cross-sectional, recruited from a secondary care respiratory clinic (matched controls were recruited from local mosques)</td>
<td>HADs</td>
<td>Patients with earlier onset asthma (duration &gt;8 years) had lower QoL scores than those with recent onset asthma. Anxiety and depression were significant predictors of AQLQ scores, anxiety accounted for 49% and depression for 41% of the total score.</td>
</tr>
<tr>
<td><strong>Pate et al (2018)</strong></td>
<td>18856 people with asthma</td>
<td>Cross-sectional, sample recruited from</td>
<td>Additional chronic conditions, BMI, presence of depression</td>
<td>Having additional conditions (PR=4.26), depression (PR=1.97), as well as either underweight (PR=1.82), overweight (PR=1.19) or obese (PR=1.76) BMI were all</td>
</tr>
<tr>
<td>Study</td>
<td>Type</td>
<td>Design</td>
<td>Measures</td>
<td>Findings</td>
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<tr>
<td>Powell et al (2015)</td>
<td>Cross-sectional</td>
<td>Rhinitis was assessed using a visual analogue scale, Six Item Short-Form State Trait Anxiety Inventory</td>
<td>AQLQ-M</td>
<td>QoL scores were predicted by presence of rhinitis, anxiety and prior history of rhinitis (medians 0.63 vs 1.06, p&lt;.01 for pregnant women with asthma, with and without current rhinitis).</td>
</tr>
<tr>
<td>Sandez et al (2005)</td>
<td>Cross-sectional</td>
<td>Beck’s Depression Inventory and the Panic-Fear Scale of the Asthma Symptom Checklist</td>
<td>SF-36 (MCS and PCS components)</td>
<td>Panic-Fear (PF) and age accounted for 22.8% of variance in PCS and depressive symptoms accounted for 48.6% of the variance in MCS. PF was significantly and negatively correlated with both MCS and PCS (r=-0.53 and r=-0.36 respectively, ps&lt;.05). Depressive symptoms were only significantly correlated with MCS (r=-0.69, p&lt;.05).</td>
</tr>
<tr>
<td>Strine et al (2008)</td>
<td>Cross-sectional</td>
<td>PHQ-8, self-report diagnosis of depression, BMI</td>
<td>General Health, Activity Limitation, Physical/Mental Health Impairment (Yes/No Questions)</td>
<td>Among adults with asthma, people with current depression were significantly more likely than those without depression to report more mean numbers of days in the past 30 days of physical distress (OR=4.7), mental distress (OR=14.3), activity limitations (OR=7.0), depressive symptoms (OR=23.6), anxiety symptoms (OR=9.8), insufficient sleep (OR=6.3), pain (OR=6.0), and fatigue (OR=13.3). There was a dose response relationship between depression severity and the mean number of days of physical distress, mental distress, depressive symptoms, fatigue, anxiety symptoms, and activity limitations. Those with current depression were also significantly more likely to have an obese BMI.</td>
</tr>
<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Recruitment Method</td>
<td>Comorbidities</td>
<td>Outcome Measures</td>
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<tr>
<td>Tay et al (2016) [48]</td>
<td>90 patients</td>
<td>Cross-sectional, consecutive patients recruited from a difficult asthma clinic</td>
<td>Having one of 8 comorbidities: Allergic rhinitis, chronic rhinosinusitis, gastroesophageal reflux disease, obesity, obstructive sleep apnoea, anxiety or depression, dysfunctional breathing and vocal cord dysfunction.</td>
<td>AQLQ</td>
</tr>
<tr>
<td>Urbstonaitis et al (2019) [47]</td>
<td>5857 adults</td>
<td>Cross-sectional, sample recruited from wider telephone population study of 39321 (BRFFS sample)</td>
<td>BMI, presence of respiratory comorbidity</td>
<td>General Health, Activity Limitation, Physical/Mental Health Impairment (Yes/No Questions)</td>
</tr>
<tr>
<td>Vasquez et al (2010) [61]</td>
<td>76 adults</td>
<td>Cross-sectional, recruited from a secondary care pneumology department.</td>
<td>Cognitive Depression Index (subscale of the Beck Depression Inventory); Trait Subscale of the State-Trait Anxiety Scale; the Twenty-Item Toronto Alexithymia Scale - this has three dimensions: DIF, DDF and EOT; SF-36 and The St George’s Respiratory Questionnaire to measure disease-specific impairment</td>
<td>Trait anxiety, depression scores and alexithymia were included in a regression model that explained between 23% and 39% of variance in QoL. Depression was a significant independent predictor and associated with all sub-scales of the SF-36, as well as all the sub-scales of the SGRQ.</td>
</tr>
</tbody>
</table>
| Vortmann & Eisner (2008) [35] | 843 patients | Cross-sectional, recruited patients who were hospitalized for asthma in the previous 4 | BMI from self-reported height and weight, atopic history; Center for Epidemiologic Studies Depression Scale | Marks Asthma QOL Questionnaire and the SF-12 and daily activity restriction | Compared to normal BMI, general physical health was significantly worse in those with obese BMI (mean score decrement of -6.31), and overweight BMI (mean score decrement -2.42). Asthma-specific quality of life was significantly worse in the underweight group (mean score difference 8.66 points), and obese group (4.51 points). People with obese BMI also had a higher
Obese patients had significantly higher risk of depressive symptoms. Depression was found to be a significant mediator of the relationship between obesity and health status, asthma QoL and restricted activity days. 

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Methodology</th>
<th>Measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wijnhoven et al (2003)</td>
<td>395 patients with asthma, aged 40-75</td>
<td>Cross-sectional, participants recruited from general practice.</td>
<td>Presence or absence of: diabetes mellitus, hypertension, cardiac disease, cerebrovascular disease, musculoskeletal disease and malignancies and asked if they had any other chronic condition. Co-morbidity was defined as 1) presence of co-morbidity; 2) number of co-morbid conditions; 3) presence of specific co-morbidity</td>
<td>Disease-specific instrument: Quality of Life in Respiratory Illness Questionnaire; generic instrument: the Dutch version of the Nottingham Health Profile (NHP)</td>
</tr>
<tr>
<td>Yilmaz et al (2014)</td>
<td>97 adult patients with asthma and 97 healthy controls</td>
<td>Cross-sectional, recruited from a secondary care outpatient chest disease clinic.</td>
<td>SCID-II (structured method of interview, according to the DSM-III-R to diagnose axis II personality disorders)</td>
<td>SF-36</td>
</tr>
<tr>
<td>Theme</td>
<td>Subtheme</td>
<td>Description</td>
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<tr>
<td>Psychological Factors</td>
<td>Anxiety and Depression</td>
<td>Included people with clinical anxiety or depression as well as people showing symptoms (or scoring high on scales such as the HADS) 17,20-22,27,30,36,37,54,55,58,61,65,66,68.</td>
<td></td>
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</tr>
<tr>
<td>Other Mental Health Conditions</td>
<td>Panic disorder with or without agoraphobia 24,38,44,57, personality disorders 31, alexithymia 23, somatization 38, mood disorders 12,40,57, schizophrenia, eating disorders, substance use disorders 38 and general occurrence of any psychiatric disorder 12,17</td>
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<tr>
<td>Emotion Regulation</td>
<td></td>
<td>Negative affect 28,39, or coping 41,51.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness Representations</td>
<td></td>
<td>Illness-related cognitions 26,34,37,42,43,51,60, subjective illness severity, uncertainty in illness, illness intrusiveness 43, perceived disability 60, health beliefs and attitudes, perceived severity 34, self-efficacy, satisfaction with illness 51, anxiety sensitivity to physical concerns 39 and satisfaction with life 37</td>
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</tr>
<tr>
<td>Multifactorial Aspects</td>
<td>Interactions between conditions, BMI, psychological factors and anxiety and depression 17,35,42,45,50,56,59</td>
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</tr>
</tbody>
</table>
Records identified through database searching (n = 12827)

Additional records identified through other sources (n = 253)

Records after duplicates removed (n = 8683)

Records screened (n = 838)

Records excluded (not relevant) (n = 7845)

Full-text articles excluded, with reasons (n = 140)
  Record could not be accessed (n = 12)
  Not primary research (n = 8)
  Not English full text (n = 1)
  Did not include a predictor of QoL (n = 97)
  Did not consider QoL (n = 13)
  Participants were not adults (n = 7)
  Not clear on the % of asthma patients (n = 2)

Full-text articles assessed for eligibility (n = 183)

Studies included in synthesis (n = 43)

Figure 1. PRISMA statement of included and excluded papers