The Functioning and Quality of Life of Depressive Patients with 12 Weeks of Psychiatric Care

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Objectives: *The purpose of this study was to obtain data about the functional status of depressive patients with 12 weeks of psychiatric care and find out if there is any correlation between improvement of clinical and functioning status.*

Material and Method: *A prospective descriptive study was conducted and quality of life instruments (SF-36) were used to assess 96 depressive patients with 12 weeks follow up.*

Results: *There was prominent functional disability with depressive patients. The response rate of depressive patients with 3-month psychiatric care was 67.7 %. The correlation between improvement in clinical status and quality of life of this group of patients did not significantly correlate.*

Conclusion: *Depressive disorder is treatable with a very good response rate but no significant correlation between clinical improvement and quality of life. There is limitations in psychological and role functioning of depressive patients after 3 months of care. It is recommended that continuing of care should be considered for quality of life improvement.*

Keywords: *Depression, Clinical status, Functional status,Psychiatric care, Quality of life*

J Med Assoc Thai 2005; 88 (9): 1261-66
Full text. e-Journal: *http://www.medassocthai.org/journal*

Depression is a common and disabling psychiatric disorder with an estimated lifetime prevalence in the community of 17%[1]. Long-term outcome studies showed that depressive disorders often recur and may become chronic in up to 25% of patients[2].

Depressive symptoms are associated with limitations in well-being and functioning. The clinical course of depression has been shown to be associated with functional outcomes (disability days) in a previous study[3].

The clinical outcome study[4] showed that adequate antidepressive treatment is effective in at least 65%-80% of patients and that the recovery to normal function of these patients saves considerable costs associated with untreated depression[5]. Depression has considerable mortality and morbidity, and significant numbers of patients respond inadequately to treatment. It would be useful to know whether, and for which patients, the method approach might increase compliance, reduce dropouts, or increase the speed, spectrum, and impact of the therapeutic effect.

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Measures of disease status alone are insufficient to describe the burden of illness; quality of life determinants such as pain, apprehension, depressed mood, and functional impairment must also be considered[6].

After two years' follow up, approximately 40% of patients with major depression were still affected and functionally impaired, while those with chronic minor depression (dysthymia) had the worst outcome. Fifty five percent had had a major depressive episode during these follow up periods[7].

Social functioning in relation to mental illness is important as it can limit the ability to function independently and because it may not be seen as a parallel course to that of the symptoms of the illness. Mental disorders in general are strongly associated with social dysfunctioning. For a long time social dysfunctioning was considered an epiphenomenon and just a part of the disease process.

There is growing evidence[8] that the course of symptoms and social dysfunction may vary independently; the social disability of a patient may be characterized with much more burden than by persistent psychiatric symptoms.

A patient's functional status can be assessed in multiple domains, especially interpersonal, domestic, vocational and educational. A patient's ability for himself or herself to independently live, and pursuit recreational activities, as well as his or her personal relationships are all important aspects to be considered. These variables may be evaluated with a quality of life and functioning scale.

In the present study the authors assessed change in the functioning and quality of life of patients with depressive disorders receiving 12 weeks of psychiatric care with Thai SF-36[9] at a University Hospital setting in Bangkok.

Material and Method

Patients

The study was a prospective descriptive design. It elicited data on the functional status of the depressive patients after 3 months of psychiatric care in the Out Patient Department of Psychiatry, Faculty of Medicine, Ramathibodi Hospital. The study was approved by the Faculty Ethics Committee. Informed consent was obtained from the patients before enrollment into the study.

Inclusion Criteria

Patients were included in the study only if they met all of the following criteria:

1. Males or females with the age ranged from 18-65 years.
2. New depressive episode.
3. Severity of the illness score > 18 on the Thai Hamilton rating scale for depression. (Ham - D Thai)[13].

Exclusion Criteria

Severe cognitive dysfunction due to mental retardation, dementia or other conditions.

Quality of life evaluation

The dimensions of quality of life are as follows[10]

1. Physical functions: for example, mobility, self care.
2. Emotional functions: for example, mood and affect.
3. Social functions: for example, intimacy, social support, social contact.
4. Role performance: for example, employment, housework.
5. Pain
6. Other symptoms; for example, fatigue, disease specific symptoms.

The Short Form 36 Health Survey (SF-36)[11,12] is a questionnaire that is widely used to measure health-related quality of life. It is a multipurpose short-form measure of general health status.

The SF-36 includes eight multi-item measures of functioning and well- being that represent physical and mental health status: physical functioning (10 items), role limitations due to physical health problems (4 items), role limitations due to emotional health problems (3 items), social functioning (2 items), emotional well-being (5 items), pain (2 items), energy and/or fatigue (4 items), and general health perception (5 items).

Procedure

All patients attending the Department of Psychiatric at the Ramathibodi Hospital were screened for depressive symptoms by using a self administered questionnaire. The potential cases were assessed further by the principal investigator. A mental status examination was carried out, and A HAM-D Thai score obtained a decision was made as to whether or not it met the entry criteria.

The eligible patients were asked to complete the SF-36 before starting the psychiatric care. HAM-D Thai and SF-36 scores were reassessed after 3 months of psychiatric care.

Statistical analysis

All tests were two-tailed; statistical significance was set at α =0.05.

95 % confidence intervals was calculated for the mean and proportion of the outcome.

Dependent variables were continuous data. Repeated measured and paired t-test were used for the differences. Pearson correlation coefficient was applied for examining the degree of correlation between change of HAM-D and SF-36 score. With the correlation between change of HAM-D Thai and SF-36 score, statistical method was Pearson correlation.

Results

Ninety-six patients with depressive disorder were enrolled in the present study. Their age ranged from 18 to 64 years with a mean age of 39.2 years (SD. 13.39). Complete follow up data were obtained after 12 weeks of care in 82 patients (85.4%). Fourteen patients (14.5%) were not included in the analysis because 12 of them dropped out or were lost to follow up. These

patients were regarded as non-responders. The baseline characteristics shown in Table 1.

Baseline data of clinical and functional status

The mean score of the clinical status from HAM-D scale of the baseline was 24.3 (SD. 4.60), The mean score of the functional status of SF-36 was 446.0 (SD 81.03).

Response rate during 12 weeks of psychiatric care

Sixty-five patients (67.7%, 95%CI = 58.18-77.23, N = 96) had a 50% reduction in their baseline HAM-D Thai scores by week 12. and were, therefore, regarded as responders to treatment. Thirty-one patients (32.3%) were classified as non-responders.

Change in HAM-D and SF-36 scores during treatment

By week 2 the mean HAM-D score was reduced from its baseline level (24.3) to 13.0. There were then further reductions to 10.2 and 7.4 by weeks 6 and 12, respectively (Table 2). These changes were statistically significant at the 0.05% level. By contrast, the changes in the mean SF-36 scores (Table 3) were not significant.

The correlation between the improvement in the clinical status and quality of life was not statistically significant (Table 4).

There was a weak correlation between improvement in clinical status and the functional status.

Table 1. The baseline characteristics

Demographic characteristic		Total number (n = 96)	%
Gender	Male	15	15.6
	Female	81	84.4
Type of depression	Major depressive	46	47.9
	Dysthymia	19	19.8
	Depression not otherwise specified	12	12.5
	Atypical depression	12	12.5
	Depression & psychosis	2	2.1
	Double depression	4	4.2
Education level	None	6	6.3
	Elementary	35	36.5
	Secondary	16	16.7
	Vocational	11	11.5
	Bachelor degree	26	27.1
	Postgraduate	2	2.1
Marital status	Single	30	31.3
	Married	49	51.0
	Widow	17	17.7
Income per month (baht)	0-5,000	41	42.7
	5,001-10,000	24	25.0
	10,001-20,000	18	18.8
	>20,000	13	13.5

Table 2. Result of the repeated measure of HAM-D score in 4 periods of time

Period	Mean HAM-D (SD)	Wilks' Lambda	Sig (2 tailed)
0 week	24.3 (4.6)	F = 189.435	p < 0.001
2 week	13.0 (6.79)		
6 week	10.2 (6.02)		
12 week	7.4 (6.27)		

Table 3. Difference between baseline and endpoint functional status

Measurement	Mean (SD)	Compare mean	p value
Baseline SF-36	445.99 (81.03)	t = -0.505	0.615
End point SF-36	453.15 (79.07)		

Table 4. Correlation of clinical improvement HAM-D score and Improvement in functional improvement in each domain of SF-36 score

Variable	Pearson Correlation Coefficient (r)	Sig. (2-tailed)
Improvement in TOTAL SF-36	0.124	0.29
Physical functioning domain	-0.184	0.10
Role limitation due to Physical domain	-0.378	0.001*
Bodily pain domain	0.094	0.408
Social functioning domain	0.135	0.237
Mental health domain	0.252	0.024*
Role limitation due to Emotional domain	-0.204	0.076
General health perception domain	0.252	0.025*
Vitality domain	0.189	0.09

* Correlation coefficient is significant at the 0.05 level (2-tailed)

Discussion

Clinical response

The depressive patients in the present study suffered from significant medical and psychiatric comorbidities. In primary care, this is a common, disabling, costly, and treatable condition. However, the common pitfall is frequent unrecognition and therefore it is not treated. Despite the complicated pathology, the response of the presented patients to the psychiatric care in this group was substantial. The response rate as defined above, was 67.7% (95%CI = 58.18-77.23). However, the absence of a controlled group limits the conclusions that can be drawn from the study because the possibility of spontaneous remission cannot be excluded. Nevertheless, response rate of 67.7%, is comparable to that in other studies[14].

Functional status

The functional status of this group of depressive patients with the baseline of SF-36 (mean $\pm$ SD = 445.99 $\pm$ 81.03) compared to general psychiatric patients (Result from the instrument development Thai SF-36 scale (mean $\pm$ SD = 464.87 $\pm$ 81.03)[12], suggest that they were more disabled in functional status. People who suffer from depression often experience much more limitation of their daily functioning and well-being as do subjects with many chronic medical conditions[15]. In fact, depression tends to be more debilitating than diabetes meilitus, arthritis and hypertension, in terms of physical functioning (e.g., sport), role functioning (e.g. housework), in work or school, and normal social functioning. After 12 weeks of psychiatric care clinical changes were observed. There was no statistical significant improvement in functioning. SF-36 mean difference = 5.38 (90.93) there was no statistical significance. SF-36 is a general health measurement in quality of life. With the 12 weeks of treatment the authors noticed that the symptoms were decreased significantly but the quality or disability of the patients still remained. Once depression develops, it may result in further narrowing of social repertoire, compounding the problem[16]. Notwithstanding some of the difficulties in measuring social functioning and quality of life, progress has been made in defining the extent of these problems in depressive individuals. The impact of treatment of depression on these parameters is becoming increasingly recognized and evaluated in clinical trials. The present study suggests that effective treatment of psychiatric symptoms might be expected to lead to improvement in quality of life measurement. A better understanding of the clinical and social variables associated with quality of life will be of practical use to clinicians in the design as models of case management that are likely to have most impact on patients' subjective quality of life. The present study of depression shows the general practice in the caring

of depressive patients. The authors must concern the aspect on long-term functional improvement rather than on short-term clinical improvement because the disabilities of the patients still remain.

The profile of functioning and well-being corresponds well with known clinical features of depressive disorders. The profile raises the important policy question of where health care resources should be preferentially allocated; to a condition that is treatable, but associated with limitations in psychological and role functioning of people, is treatable, or to conditions that affect the physical functioning of persons and whose treatment response varies. Further research will need to assess the degree to which undiagnosed depressive disorder sufferers and other patient samples have morbidity profiles similar to those of the treated patients described here. In addition, future research should follow these multiple domains of health over time to evaluate both the short- and long-term course of functioning and well-being of patients with depressive disorders.

The present results lend further support to the suggestion that depressive disorder is a serious health problem with especially large consequences for role functioning, which can have large direct and indirect economic consequences for both the patient who is suffering from depressive disorder and his or her family members. Treatment for depressive disorder commonly includes medication or cognitive or behavioral psychotherapy that is aimed at specific social problems. More attention should be paid to refine clinical treatments for addressing problems in role functioning, given the substantial limitations reported here.

Conclusion

In summary, the present results demonstrate the effectiveness of psychiatric care, and a multidisciplinary approach to the treatment of depressive patients. Long-term course of functioning and well-being of patients with depressive disorders must be addressed because the improvement in functioning was not statistically significant in the short-term treatment with low correlation to clinical improvement. For zgeneral practice with the treatment in depressive patients, the disability and functioning of the patients must be incorporated in the modality of treatment besides medication.

Limitation

1. Limited interpretability can be drawn from the study because the study is only in one setting and there was no comparison with other programs

2. Depression is usually a chronic condition which requires long - term treatment. Therefore,a 3-month study may yield only (preliminary) limited information. Future longitudinal studies are required to determine the effectiveness of long-term treatment outcome.

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คุณภาพชีวิตของผู้ป่วยโรคซึมเศร้าภายหลังการรักษาด้วยกระบวนการจิตเวช 3 เดือน

รณชัย คงสกนธ์

วัตถุประสงค์*: เพื่อศึกษาคุณภาพชีวิตของผู้ป่วยโรคซึมเศร้า ที่ผ่านการรักษาด้วยกระบวนการจิตเวชระยะเวลา 3 เดือน และศึกษาความสัมพันธ์ระหว่างอาการซึมเศร้าที่ดีขึ้นภายหลังการรักษา 3 เดือนกับคุณภาพชีวิตที่เปลี่ยนไป*

วัสดุและวิธีการ*: ศึกษาโดยวิธีการพรรณนา ติดตามไปข้างหน้าระยะเวลา 3เดือน โดยใช้เครื่องมือ HAM-D และ SF-36 ในการวัดอาการซึมเศร้าและคุณภาพชีวิตในผู้ป่วยโรคซึมเศร้า 96 ราย*

ผลการศึกษา*: ผู้ป่วยโรคซึมเศร้ามีการสูญเสียคุณภาพชีวิตที่ชัดเจน ภายหลังการรักษาด้วยกระบวนการจิตเวช 3 เดือน พบอัตราการตอบสนองต่อการรักษาร้อยละ 67.7 แต่ไม่พบมีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติระหว่างอาการซึมเศร้าที่ดีขึ้น กับคุณภาพชีวิต*

สรุป*: โรคซึมเศร้าเป็นโรคที่ตอบสนองต่อการรักษาได้ดี แต่ปัญหาคุณภาพชีวิตของผู้ป่วยโรคซึมเศร้า ยังคงมีอยู่ภายหลังการรักษา 3 เดือน ซึ่งต้องได้รับการดูแลในระยะยาว เพื่อการมีการดำเนินชีวิตอย่างมีคุณภาพ*