Clinical Response of Depressive Patients in a Thai Psychiatric Care Setting

Ronnachai Kongsakon, MD, LLB, MSc*, Umaporn Udomsubpayakul, MS (Biostat)**, Urai Buranapichet, BSc (Nursing)*, Rungtip Presertchai, BSc (Nursing)*

** Department of Psychiatry, Faculty of Medicine, Ramathibodi Hospital, Mahidol University*
*** Department of Research Center, Faculty of Medicine, Ramathibodi Hospital, Mahidol University*

Objective: *To obtain data on the clinical outcome of patients with depressive disorders after three months psychiatric care in a Thai psychiatric unit.*
Material and Method: *A prospective descriptive study of 96 patients followed up for 3 months. The severity of depression was measured with the Thai version of the Hamilton rating scale for depression (HAM-D Thai).*
Results: *The response rate following 3-months psychiatric care was 67.7% (95%CI = 58.18-77.23). Fifty percent of the patients had a HAM-D Thai score of < 7 at week 12.*
Conclusion: *The treatment outcome in the Thai psychiatric setting described is comparable to that reported in other countries*

Keywords: *Depression, Clinical status, Outcome, Psychiatric care*

J Med Assoc Thai 2005; 88(8): 1110-14
Full text. e-Journal: *http://www.medassocthai.org/journal*

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

The Global burden of Disease study[3] by the World Health Organization (WHO) recently concluded that depression is one of the most debilitating health problems in the world. In 1990, it ranked fourth among all diseases. The WHO researchers predicted that, by the year 2020. Depression will rank second after heart disease and account for 15% of the disease burden in the world. Depression has been the focus of intense clinical research and policy concern in both general medical and mental health specialty practices.

Depressive symptoms are associated with limitations in well-being and functioning. In a previous study[4] the clinical course of depression has been shown to be associated with functional outcomes (disability days).

Correspondence to : Kongsakon R, Department of Psychiatry, Faculty of Medicine,Ramathibodi Hospital, Mahidol University, Bangkok 10400, Thailand. Phone: 0-2201-1478, 0-1771-1045, Fax: 0-2201-1061

The medical outcomes study collected data from 11,242 outpatients in the United States[5,6]. It showed that depressive symptoms, with or without major depressive disorder, impaired functional ability and well-being as much as the most common chronic medical conditions such as diabetes, chronic lung disease, hypertension, and heart disease.

The clinical outcome study[7] showed that adequate antidepressive treatment is effective in at least 65%-80% of patients and that the return of these patients to normal function 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, a structured systematic approach to treatment might increase compliance, reduce dropouts, or increase the speed, spectrum, and impact of the therapeutic effect.

The outcome of patients with depressive disorders treated in a Thai psychiatric setting is important to establish, while the response to acute treatment will provide information on the course of the disorder in a Thai population.

The question, What is the clinical response after a period of psychiatric care? led us to conduct an observational study to obtain data on the outcome and burden of patients with depressive disorders in a Thai psychiatric setting. The information thus gathered contributes to a better understanding of the course of depressive disorders and the impact of treatment on them. In addition, the findings provide data on the correlation between demographic variables and outcome measures, as well as the relationship between outcome variables.

The objective of the present study was to obtain data on the clinical and functional status of patients with depressive disorders who had received 3 months psychiatric care.

Material and Method

A prospective descriptive design was used to obtain the data on the clinical response of inpatients and outpatients following three months psychiatric care in the Department of Psychiatry, Ramathibodi Hospital, between June and December 1999, were obtained.

Subjects

Male and female patients aged 14-65 years who had depressive disorders, were selected for the present study. All of them had new depressive episodes, of depression with a severity score > 18 on the Thai version of the Hamilton rating scale for depression (HAM-D Thai)[8]. Each patient gave his or her informed verbal consent to participate in the present study which had been approved in the Ramathibodi Hospital ethics committee. Patients with severe cognitive dysfunction were not included in the study.

Measurement

A reduction of 50% in the HAM-D score from the baseline score was accepted as a clinical response to treatment for the purpose of the present study[9].

Procedures

All patients who came to the psychiatric care were screened for depressive symptoms by a self-administered questionnaire. Potential cases of depressive disorders were assessed further by the principal investigator who carried out a formal mental status examination and rated the patients on the HAM-D Thai scale. Those who met the diagnostic and severity criteria were included in the present study.

Ham-D scores were reassessed 2, 6 and 12 weeks after the starting of psychiatric care.

The psychiatric care for this group of patients was treatment in a medical setting with the average psychiatric practice experience of 13 staff = 10.36 years. The mode of treatment were antidepressants accompanied with supportive psychotherapy.

Data analysis

Baseline data on the patient's age, sex, diagnosis, severity of illness, duration of illness, education, supporting system, family history and previous psychiatric history were recorded. Physician's background data and the treatment administered were also recorded. For data in means, SD, 95% confidence intervals were calculated. Differences between the means were analysis by using ANOVA for repeated measurements and multiple comparison by the SNK test. All tests were two-tailed; statistical significance was set at $\alpha = 0.05$ of the magnitude of difference.

Results

Ninety six patients met the entry criteria and which 82 (85.4%) of these provided data at week 12. The authors failed to obtain complete data on fourteen patients; (14.5%). 12 of these were lost to follow up while two patients were dropped from the study because of deliberate self-harm.

The patients' baseline characteristics are summarized in Table 1. The recent stressor within 2-3 months showed 41% of the cases present with marital conflict, 41% problems with work, 53% problems with economics,7% problems with the law, 14.0% problems with a friend. 55.2% cases had a support system and 60.4% had no problem with the expense of the treatment.

The mean $\pm$ SD score on the HAM-D Thai scale on the baseline was 24.2 ± 4.6, The decreases in this during treatment are shown in Table 3.

The response rates at 12 weeks is shown in Table 4.

A post treatment Hamilton depression score of < 7 is a commonly used criterion for complete response(remission) to treatment among depressed patients[20,25]. Using this criterion, 48 (50.0%) of the presented patients remitted at week 12. Of the remaining 48 patients, 17 (17.7%) had at least a 50% reduction in their baseline Hamilton score (Table 5).

The changes is HAM.D Thai scores at the four treatment intervals are shown in Fig. 1. It will be noted that the reduction in scores is statistically

Table 1. Demographic characteristics of the patient sample (n = 96)

Demographic characteristic	N (%)	Demographic characteristic	N (%)
Age, Mean ± SD, Range	39.2±13.39, 17-65	Type of Depression	
Sex		Major depression	46 (47.9)
Male	15 (15.6)	Dysthymia	19 (19.8)
Female	81 (84.4)	Depression NOS	12 (12.5)
Education level		Atypical depression	12 (12.5)
None	6 (6.3)	Depression & psychosis	2 (2.1)
Elementary	35 (36.5)	Double depression	4 (4.2)
Secondary	16 (16.7)	Hx of medical illness	
Vocational	11 (11.5)	Yes	61 (63.5)
Bachelor's degree	26 (27.1)	No	35 (36.5)
Post graduate	2 (2.1)	Hx of depression	
Marital status		Yes	35 (36.5)
Single	30 (31.3)	No	61 (63.5)
Married	49 (51.0)	Hx of suicidal ideation	
Widow	17 (17.7)	Yes	53 (55.2)
Income		No	43 (44.8)
No income<5000 Bt.	41 (42.7)	Family Hx of depression	
5001-10000 Bt.	24 (25.0)	Yes	14 (14.6)
10001-20000 Bt.	18 (18.8)	No	81 (84.4)
>20000 Bt.	13 (13.5)	Alcohol use	
Occupational		None	74 (77.1)
None	14 (14.6)	Seldom	20 (20.8)
Student	11 (11.5)	Often	2 (2.1)
Governor	15 (15.6)	Family Hx of psychiatric illness	
Agriculture	3 (3.1)	Yes	20 (20.8)
Official	5 (5.2)	No	76 (79.2)
Private	9 (9.4)	Family Hx of medical illness	
Employee	17 (17.7)	Yes	31 (32.3)
Others	22 (22.9)	No	65 (67.7)
Medical expense problem		Dead of Family # in the past year	
Yes	38 (39.6)	Yes	21 (21.9)
No	58 (60.4)	No	75 (78.1)
Supporting system			
None	43 (44.8)		
Yes	53 (55.2)		

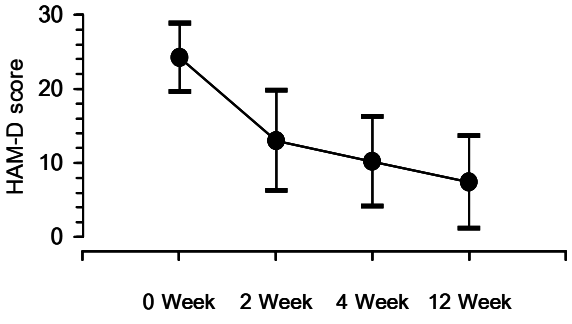

Fig. 1 The mean ± SD of HAM-D score in each period of observation

significant ($p < 0.001$).

The medication prescribed for the patients is shown in Table 6.

Discussion

As a group, the depressive patients suffered from significant medical and psychiatric co morbidity. In primary care this group of patients is common, disabling, costly, and treatable but patients are frequently unrecognized and therefore not treated. Nonetheless, their response to the psychiatric care was substantial.

The overall response rate among the presented patients was 67.7% (95%CI = 58.18-77.23) (Table 4).

Table 2. Number of the stressor from the last 2-3 months

Stressors in last 2-3 months	Present	Absent
Marital	41	55
Family	53	43
Problem Employment	41	55
Economic	53	43
Problem with Legal	7	89
Problem with friend	14	82

Table 3. HAM-D score in each period

	Baseline			
	0 week	2 weeks	6 weeks	12 weeks
Mean HAM-D (SD)	24.2 (4.6)	13.0 (6.8)	10.2 (6.0)	7.4 (6.3)

Table 4. Response rate after 3 months of psychiatric care

Outcome	N	%
Response	65	67.7 (95%CI = 58.2-77.2)
Non response	31	32.3

Table 5. The remission proportion rate in each observation period

	N	%	Total
2 weeks	16	16.7	96
6 weeks	29	30.2	96
12 weeks	48	50.0	96

Table 6. Medication and response rate

Mode of treatment	Non response	Response	Total
TCA	3	8	11
SSRI	10	13	23
TCA+BZP	5	14	19
SSRI+BZP	7	15	22
TCA+antipsychotic	4	4	8
SSRI+antipsychotic	-	1	1
TCA+SSRI	1	2	3
Admission	1	2	3
Total	31	59	90

TCT : Tricyclic Antidepressant , SSRI :Selective serotonin reuptake inhibitor, BZP: Benzodiazepine

The absence of a control group limits the conclusions which can be drawn from the study because the possibility of spontaneous remission in proportion of the presented patients cannot be excluded. However, the response is comparable to that in other studies[10]. There was no significant difference in the response rate to the various antidepressants prescribed for the presented patients (Table 6). This is in spite of the fact that other studies of long term treatment have revealed significant differences between the drug groups due to better compliance and fewer side effects in patients treated with SSRI compared with those treated with tricyclic antidepressants[11].

The average Hamilton depression scale score nearly halved during the first two weeks of treatment (from 24.2 at baseline to 13.0 at week 2; Table 3). This reduction lasted for 12 weeks, by which time half of the patients had a remission of their depressive symptoms (Table 5).

The proportion of patients who remitted (with a HAM-D Thai < 7) in week 2 was 16.7%; in 12 weeks this figure was 50%. Earlier research suggests that it takes more than 6 weeks for most patients to show a complete response and the rate of complete remission may be substantially lower. It means that with the new antidepressants there could be a better response rate in a shorter time of the treatment. Patients may show some improvement by the end of the first week of treatment[12] but may not fully respond for more than 4 to 6 weeks[13]. Therefore, the full response cannot be adequately assessed until after this period. In the present study the fully response was achieved earlier than that report in the earlier week.

Conclusion

The present results confirm the effectiveness of psychiatric treatment of patients with depressive disorders in the department of psychiatry in a university teaching hospital.

In the general treatment of such patients, long and short -term disability and functioning must be taken into account, in addition to depressive symptoms, and all relevant modalities of management should be applied.

Limitations

1. It is not possible to draw general conclusions from the present study, as the patients were a select group, the authors had no control group and treatment took place in only one setting.
2. Depressive disorders are mostly recurrent and

chronic and need long-term treatment. Therefore, a three month study is only able to provide limited (preliminary) information. There is a need for a longer term research.

References

1. Katon W, Schulberg H. Epidemiology of depression in primary care. Gen Hosp Psychiatry 1992; 14: 237-47.
2. Goodyer IM, Herbert J, Secher SM, Pearson J. Short-term outcome of major depression: I. Comorbidity and severity at presentation as predictors of persistent disorder. J Am Acad Child Adolesc Psychiatry 1997; 36: 179-87.
3. Murray CJL, Lopez AD, eds. The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.
4. Penninx BW, Guralnik JM, Ferrucci L, Simonsick EM, Deeg DJ, Wallace RB. Depressive symptoms and physical decline in community-dwelling older persons. JAMA 1998; 279: 1720-6.
5. Stoudemire A, Frank R HNaa. The economic burden of depression. Gen Hosp Psychiatry 1986; 8: 387.
6. Tollefson G, Souetre E TL, Potvin JH. Comorbid anxious signs and symptoms in major depression: impact on functional work capacity and comparative treatment outcomes. Int Clin Psychopharmacol 1993; 8: 281-93.
7. Frank E, Karp JF, Rush AJ. Efficacy of treatments for major depression. Psychopharmacol Bull 1993; 29: 457-75.
8. Lortrakul M, Sukanich P. SC. The reliability and validity of Thai version of Hamilton Rating Scale for depression. J Psychiatr Assoc Thailand 1996; 41: 235-6.
9. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23: 56-62.
10. Hirschfeld RM, Montgomery SA, Aguglia E, Amore M, Delgado PL, Gastpar M, et al.Partial response and nonresponse to antidepressant therapy: current approaches and treatment options. J Clin Psychiatry 2002; 63: 826-37.
11. Ticknor CB. Pharmacologic considerations in treating depression: a patient-centered approach. J Managed Care Pharmacy 2004; 10(2 Suppl): S8-15.
12. Ninan PT., Hassman HA, Glass SJ, McManus FC. Adjunctive modafinil at initiation of treatment with a selective serotonin reuptake inhibitor enhances the degree and onset of therapeutic effects in patients with major depressive disorder and fatigue. Journal of Clin Psychiatry 2004; 65: 414-20.
13. Corey-Lisle PK, Nash R, Stang P, Swindle R. Response, partial response, and nonresponse in primary care treatment of depression. Arch Int Med 2004; 164: 1197-204.

การตอบสนองทางคลินิกของผู้ป่วยโรคซึมเศร้าที่ได้รับการรักษาทางจิตเวชระยะเวลา 3 เดือน

รณชัย คงสกนธ์, อุมาพร อุดมทรัพยากุล, อุไร บูรณเชฐ, รุ่งทิพย์ ประเสริฐชัย

***วัตถุประสงค์**: ศึกษาการตอบสนองต่อการรักษาทางจิตเวชระยะเวลา 3 เดือนของผู้ป่วยโรคซึมเศร้า เปรียบเทียบก่อนและหลังการรักษา*

***วัสดุและวิธีการ**: Prospective descriptive study ศึกษาในผู้ป่วย โรคซึมเศร้า จำนวน 96 คน ที่มารับการรักษาแผนกจิตเวช โรงพยาบาลรามาธิบดี ติดตามการรักษา 3 เดือน ด้วยแบบวัด Hamilton rating scale for depression ฉบับภาษาไทย*

***ผลการศึกษา**: อัตราการตอบสนองต่อการรักษาทางจิตเวชระยะเวลา 3 เดือน ร้อยละ 67.7% (95%CI = 58.18-77.23) จำนวนครึ่งหนึ่งของผู้ป่วยมีอาการปกติ คะแนน HAM-D < 7 ภายหลัง 3 เดือน*

***สรุป**: โรคซึมเศร้า เป็นปัญหาทางสาธารณสุขที่สำคัญที่ผู้เกี่ยวข้องควรตระหนักถึงการสูญเสียความสามารถทางหน้าที่การงานทั้งก่อนและหลังการรักษาอย่างชัดเจน แต่เป็นโรคที่ให้การรักษาได้โดยมีอัตราการตอบสนองที่ดีในระยะเวลา เพียง 3 เดือน ภายใต้การรักษาขบวนการทางจิตเวช*