Functional impairment recovers after episodes of major depression


How is functioning affected by a major depressive disorder?

METHODS

Design: Cohort study.

Setting: Netherlands Mental Health Survey and Incidence Study (NEMESIS), a general population study in Dutch people aged 18–64 years conducted in three waves: 1996, 1997, and 1999.

Population: 165 people who had a major depressive episode (DSM-III-R) between 1996 and 1998 but not in the 12 months before baseline or between 1998 and 1999. Control group of 4178 people who did not have a major depressive disorder at any time during the study or 12 months before baseline.

Prognostic factors: Worsened functioning to lower score on any of the eight subscales of the Short Form-36 Health Survey, SF-36, (at follow up than at baseline) was correlated to demographic (sex, age, and educational), personality variables (neuroticism, mastery, and self-esteem), social support and clinical variables (severity and nature of depressive episode, comorbidity, somatic illness, and treatment). Level of functioning before and after a major depressive episode was compared with levels in people who did not suffer depression before or during the study.

Outcomes: Depression (assessed with the Composite International Diagnostic Interview, CIDI) and functional disability (assessed with the SF-36).

Follow up period: Two years.

MAIN RESULTS

The study found that in the majority of people who suffered a major depressive episode, levels of functioning returned to premorbid levels following recovery (except in psychological health and psychological role functioning, which were significantly different at baseline and follow up—see http://www.ebmentalhealth.com/supplemental for table). For those people whose functioning did not improve after their depressive episode (15%–40% of participants), poorer physical functioning was significantly associated with age (p<0.01), neuroticism (p = 0.03), and social support (p = 0.03). Poorer physical role functioning was associated with comorbid anxiety (p = 0.02) and social support (p = 0.05). Poorer psychological health was associated with sex (p = 0.04), mastery (p = 0.01), low social support (p = 0.02), severity of depression (p = 0.01), and comorbid anxiety (p = 0.03). Poorer social functioning was associated with mastery (p = 0.03) and somatic illness at follow up (p = 0.01) and poorer general health was associated with comorbid substance misuse (p = 0.04) and somatic illness at follow up (p = 0.02). The study also found that at both baseline and after recovery, all but one subscale of functioning levels were lower in people who had suffered a major depressive episode than in the control group (significance ranged from p = 0.13 to p<0.001 for different subscales of functioning). For psychological role functioning, however, levels were not significantly lower in the cohort at follow up compared with the control group (p = 0.13).

CONCLUSIONS

After recovery, functional impairments return to levels similar to those before a major depressive episode.

NOTES

The value of the control group in this study is not clear; cohort and control were not balanced for levels of functioning at baseline. Control group was also significantly older and included more males than the cohort with depression.

Commentary

This study is unique in that it assesses functioning before the depressive episode in subjects who later develop depression. Thus, the study adds a new dimension to the trait-state discussion, by providing an answer to an important question raised by follow up studies:14a were the residual functional limitations present before the depressive episode, or did they arise as a consequence of the disorder? Post-episode functioning was shown to return to pre-episode levels. This is good news for the patients and their clinicians, for it suggests that depression itself does not lead to a progressive worsening of functioning. However, the finding that both pre- and post-episode functioning were reduced compared with healthy controls, suggests that vulnerability or “trait” factors may be present before the onset of, and between depressive episodes.1

This population based study represents an excellent example of what can be achieved when samples and methodology from psychiatric epidemiology are used to provide answers to questions raised in smaller clinical studies. Despite the limitations of loss to follow up and possible report biases, the general applicability to primary healthcare samples or outpatient samples will be high. However, there may be selection biases in clinical studies performed on samples of severely ill patients (inpatients) beyond the factors that are explored in the present study, and thus caution should be used in extrapolating the results to such patient groups. Of importance to the clinician are the findings that a lower degree of mastery, lower social support, and co-occurrence of substance abuse or anxiety disorder predicted poorer functioning after recovery. Subjects with such characteristics should therefore be detected as early as possible in the course of depression and followed closely, in order to optimise their chances of functional recovery.

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