Outcome of anxiety and depression in general health care

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Published in:
European Neuropsychopharmacology

DOI:
10.1016/0924-977X(94)90015-9

Publication date:
1994

They were also more sensitive, dependent and introverted and had a higher oral factor score than patients with other mental disorders. Thus, the predictors of mixed anxiety-depression are more abnormal than those for depression alone, at least in this study.

In addition to reviewing the world's literature on the role of personality in depression alone, anxiety disorders alone, and in mixed anxiety-depression, this presentation will include new data from a multisite trial of sertraline and imipramine on personality predictors of chronic and double depression.

S-1-3

Outcome of anxiety and depression in general health care: a three-wave 3.5-year study of psychopathology, disability and life stress

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Key words: Depression; Anxiety; Comorbidity; Outcome; Disability; Life events

Summary

The outcome of anxiety and depression in general health care settings was examined. At follow-up, many cases no longer met the criteria of their baseline diagnosis and disability levels had substantially dropped. However, partial remission, not full recovery, was the rule, and was associated with residual disability. Depression had better outcomes than anxiety; mixed anxiety/depression did worst. Life events often triggered improvement except amongst mixed anxiety/depression patients.

Introduction

Anxiety, depression, and mixed anxiety-depression (A + D) are common in primary care settings, often not recognized, and typically associated with mild (anxiety) to moderate (depression) disability. This combination of psychiatric disorder and associated disability has considerable impact on personal well-being, social relationships, productivity loss, and public health costs. The extent of this problem is highly dependent on the long-term course and outcome of these disorders. We followed up not only definite anxiety and depression disorders and cases detected by the GP, but also sub-threshold disorders, mixed anxiety/depression, and non-detected cases.

Methods

A two-stage sample design was employed. In the first stage, 1994 consecutive attenders of 25 GPs were screened for psychiatric illness with the General Health Questionnaire and by their physicians. A stratified random sample (n = 292) with differing probabilities was selected for the second-stage interview (psychopathology with the Present State Examination (PSE), disability with the Groningen Social Disability Schedule (GSDS), and life events and chronic difficulties with an adapted version of the London Life and Difficulty Schedule and Rating Procedures (LEDS)). Sampling probabilities were such as to ensure enrollment of 'new' GP-detected and non-detected cases. Baseline cases (n = 201) were reassessed 1 (n = 182) and 3.5 years later (n = 154).

The Bedford College (BC) study diagnosis was assigned to each patient using PSE scores and the diagnostic algorithm developed by Finlay-Jones et al. The BC classification includes four diagnostic categories: (1) depression (D), (2) borderline depression (BD), (3) anxiety (A), and (4) borderline anxiety (BA). Co-occurrence of (B)A + D is denoted as mixed A + D, and co-occurrence of BA + BD or A + BD as mixed borderline A + D. Four caseness levels were used to classify outcome: definite disorder (A, D, or A + D), borderline disorder (BA, BD, or BA + BD), non-specific PSE symptoms (> 3 but not (B)A or (B)D), and recovered (< 3 PSE symptoms).

Results and discussion

The follow-up data on psychopathology revealed two apparently contradictory findings. The binary outcome measure suggested that four-fifths recovered. The multi-categorical outcome measure, however, demonstrated considerable residual psychopathology. Substantially less than half the patients with a disorder recovered fully. In sum, a binary outcome measure

based on psychiatric classification systems may suggest too favorable an outcome. A multi-categorical outcome measure better reflects patient outcomes, since it highlights partial remission, mild symptoms, and residual disability.

The major difference between the three diagnostic categories was the greater proportion with residual psychopathology (borderline disorder or non-specific symptoms) among patients with anxiety and mixed (borderline) A + D relative to depression. At 1-year follow-up, mixed anxiety/depression did worst. With regard to baseline severity, patients with borderline depression did better than patients with definite depression. No such association between outcome and baseline severity was found among patients with anxiety and mixed A + D. The 1-year outcome of depression (21% still a case) was similar to that found in community studies (e.g. ECA). The 20% chronicity observed among our depressed patients was less than typically reported in outcome studies among depressed outpatients. Thus, the outcome of depression in primary care seems to be somewhat better compared to treated outpatient samples, due possibly to selective referral effects.

Disability was clearly related to diagnosis and severity of psychopathology. Most disability was found in the social and occupational roles, and among depressed and mixed A + D patients (level was similar to the disability found among psychiatric outpatients). Patients with (borderline) anxiety and non-specific psychiatric symptoms were less dysfunctional compared to patients with depression or mixed A + D. Functional outcome showed patterns similar to the outcome of psychopathology: substantial improvement of function but also residual dysfunction, in particular among patients with mixed A + D. The improvements in symptomatology and in disability were largely synchronous. Dysfunction in the social role was relatively stable, even among patients whose symptoms remitted. In particular in combination with borderline anxiety (which rarely remitted), dysfunction in the social role may reflect inadequate social skills and vulnerability.

Positive life change – difficulty reduction, fresh start events and delogjamming – often preceded improvement of anxiety, depression but not mixed A + D. However, it was neither a necessary nor a sufficient condition for remission of symptoms and disability.

The significance of our findings is twofold. They demonstrate the relatively high prevalence of mixed A + D, subthreshold disorders and non-specific psychiatric distress in general practice, all ill-defined but associated with mild disability. In addition, they stress that remission in symptoms and disability is usually only partial, although synchronous. In the current DSM-III-based research practice, these common, ill-defined disorders tend to escape further scrutiny. A multi-categorical outcome, or caseness measure, may also benefit clinical practice and community services. It forces the clinician to consider treatment of residual psychopathology, i.e. persistent life stress, biological vulnerability, and inadequate coping strategies and resources. It may be cost-effective to supplement short-term treatment with long-term programs. Psychosocial treatment, self-help programs, and maintenance pharmacotherapy may be treatment modalities appropriate to the health care setting.

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S-1-4

Mixed anxiety-depression: prevalence recognition and disability in the WHO-PPGHC study

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Key words: Mixed anxiety depression; Epidemiology; Treatment

Mixed anxiety and depressive disorder (MADD) is a mixed ICD-10 category used when both anxiety and depression are present but neither is severe enough to justify a diagnosis. This pragmatic category was proposed because such patients are common in primary care. We assessed the relevance of MADD in primary care patients in 14 different countries by evaluating the prevalence, the recognition by primary care physicians, the disability assessed by the Brief Disability Questionnaire, the severity assessed by the GHQ28, the treatment prescribed and consumed. In 1990–1992 the World Health Organisation organised a large epidemiological study in primary care aimed to describe in 14 countries the psychological problems