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Research report

Prognosis of depressive disorders in the general population– results from the longitudinal Finnish Health 2011 Study

Niina Markkula [a,*], Tommi Härkänen [b], Tarja Nieminen [c], Sebastián Peña [b], Aino K. Mattila [d], Seppo Koskinen [b], Samuli I. Saarni [e], Jaana Suvisaari [a]

[a] National Institute for Health and Welfare, Department of Mental Health and Substance Abuse Services, Helsinki, Finland
[b] National Institute for Health and Welfare, Department of Health, Functional Capacity and Welfare, Helsinki, Finland
[c] Statistics Finland, Helsinki, Finland
[d] Department of Adult Psychiatry, Tampere University Hospital, Tampere, Finland
[e] Turku University Hospital and the University of Turku, Turku, Finland

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ABSTRACT

Background: Depressive disorders are among the most pressing public health challenges worldwide. Yet, not enough is known about their long-term outcomes. This study examines the course and predictors of different outcomes of depressive disorders in an eleven-year follow-up of a general population sample.
Methods: In a nationally representative sample of Finns aged 30 and over (BRIF8901), major depressive disorder (MDD) and dysthymia were diagnosed with the Composite International Diagnostic Interview (M-CIDI) in 2000. The participants were followed up in 2011 ($n=5733$). Outcome measures were diagnostic status, mortality, depressive symptoms and health-related quality of life. Multiple imputation (MI) was used to account for nonresponse.
Results: At follow-up, 33.8% of persons with baseline MDD and 42.6% with baseline dysthymia received a diagnosis of depressive, anxiety or alcohol use disorder. Baseline severity of disorder, measured by the Beck Depression Inventory, predicted both persistence of depressive disorder and increased mortality risk. In addition, being never-married, separated or widowed predicted persistence of depressive disorders, whereas somatic and psychiatric comorbidity, childhood adversities and lower social capital did not. Those who received no psychiatric diagnosis at follow-up still had residual symptoms and lower quality of life.
Limitations: We only had one follow-up point at eleven years, and did not collect information on the subjects' health during the follow-up period.
Conclusions: Depressive disorders in the general population are associated with multiple negative outcomes. Severity of index episode is the strongest predictor of negative outcomes. More emphasis should be placed on addressing the long-term consequences of depression.

1. Introduction

Depressive disorders are the second leading cause of years lived with disability worldwide (Global Burden of Disease Study Collaborators, 2015). Both major depressive disorder (MDD) and dysthymic disorder (DD) may have a chronic or fluctuating course, and recurrence is common (Hardeveld et al., 2010, Klein et al., 2006). Recovery, which can be defined as having no significant signs or symptoms of the disturbance for four months or longer (Frank et al., 1991), is achieved by approximately 60–70% of persons with depressive disorders in general population samples (Agosti, 2014, Rhebergen et al., 2011). Rates of recurrence vary according to the study setting: in specialized mental health care, up to 85% have recurrent episodes over a 15-year follow-up, whereas the figure is 35% in the general population (Hardeveld et al., 2010). Dysthymic disorder is often considered more chronic in nature, but over long follow-up periods, recovery rates resemble those of MDD. However, despite the chronic and recurrent course of illness for many patients, it has been estimated that about half of the individuals diagnosed with major depressive disorder recover and do not develop recurrent episodes (Eaton et al., 2008, Hardeveld et al., 2010).

In order to target interventions efficiently, we need information on factors that help identify patients at greater risk of unfavourable

Abbreviations: IPW, Inverse probability weights; MI, Multiple imputation; M-CIDI, Composite International Diagnostic Interview, Munich version

* Correspondence to: National Institute for Health and Welfare, Mental Health Unit, P.O. Box 30, 00271 Helsinki, Finland.
E-mail address: niina.markkula@helsinki.fi (N. Markkula).

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outcomes. However, most information on prognosis and outcomes of depressive disorders is derived from clinical samples, which may not be representative of people with MDD and dysthymia in the general population. In previous studies, severity and duration of the disorder as well as comorbidity have been identified as risk factors of an unfavourable course of illness, but there are mixed findings on sociodemographic factors, such as sex and age (Eaton et al., 2008, Holma et al., 2008, Spijker et al., 2001). Childhood adversity, low social support and adverse life events have been associated with worse prognosis (Gilman et al., 2013, Leskelä et al., 2006, Rhebergen et al., 2011). Further, prognosis extends beyond presence or absence of diagnosis; information on residual symptoms, quality of life and mortality is also important. Little is known about the predictors of these broader outcomes.

This study examines different outcomes of depressive disorders in a general population sample: recovery and persistence of disorders, level of depressive symptoms, health-related quality of life and mortality, and various predictors of these outcomes, such as sociodemographic factors, childhood adversity, different dimensions of social capital, psychiatric comorbidity and disorder characteristics. We expected to see higher level of depressive symptoms and lower health-related quality of life than in the general population. Based on existing literature, we hypothesised that severity of the disorder, somatic and psychiatric comorbidity, childhood adversities and low level of social capital would be associated with negative outcomes.

2. Methods

2.1. Study sample and participants

The Health 2000 Survey (http://www.terveys2000.fi/) conducted in years 2000–2001 was a nationally representative survey of the Finnish population based on a sample of 8028 adults aged 30 years and over (Heistaro, 2008). The study used a two-stage clustered sampling of 15 largest towns and 65 health districts in Finland. Persons over 80 years were oversampled (2:1). The study consisted of a home interview, self-administered questionnaires and a comprehensive health examination. In total, 7112 persons (89%) participated in at least one part of the study.

The Health 2011 Survey (http://www.terveys2011.info) is a follow-up study of the Health 2000 Survey (Koskinen et al., 2012). All members of the Health 2000 Survey sample alive and living in Finland who had not refused to participate were invited to take part. The study population consists of 5733 persons, out of whom 4 620 (80.6%) participated in at least one part of the study (Fig. 1).

The study had approval of the Ethics Committee of the Hospital District of Helsinki and Uusimaa. Participants provided written informed consent.

2.2. Psychiatric assessment

Psychiatric disorders in 2000 and 2011 were assessed with the Munich version of the Composite International Diagnostic

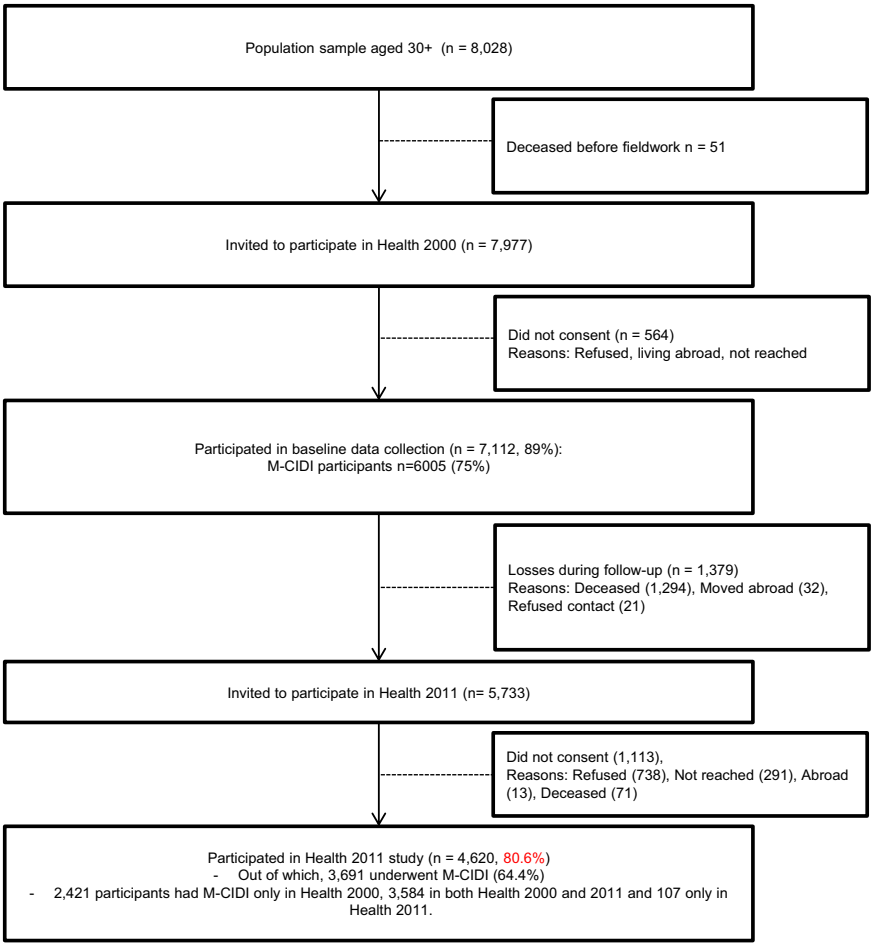

Fig. 1. Participation in the different phases of the study.