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Research report

Social adjustment among treatment responder patients with mood disorders

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ABSTRACT

Background: Patients with major depression (MD) show reduced social adjustment when compared with healthy controls. However, even among treatment responders, significant differences in social adjustment occur. The main aim of the present work is to study several socio-demographic and clinical variables possibly influencing social adjustment in MD patients who responded to treatment.
Methods: Two hundred and eleven MD patients experiencing a depressive episode who responded to their current treatment were recruited within the context of a large European multicentre project. Our primary outcome measure was the association between 19 socio-demographic and clinical variables and total social adjustment scores, as measured with the Social Adjustment Scale (SAS). Secondary outcome measures included the associations between the same variables and SAS sub-scales, and the associations between these variables and self-esteem, as measured with the Rosenberg Self-Esteem Scale.
Results: A co-morbidity with anxiety disorders and the severity of residual depression symptoms were the strongest independent factors associated with poorer social adjustment, in terms of total and most sub-areas' SAS scores. Other variables associated with total and sub-areas' SAS scores were identified as well, although some variations across different areas were observed.
Limitations: The cross-sectional design, the retrospective assessment of data and the lack of a placebo control group.
Conclusions: Our results confirm that a co-morbidity with anxiety disorders and higher residual depression symptoms could reduce social adjustment among responder MD patients. Further longitudinal studies are needed to confirm our results.

1. Introduction

Major depression (MD) is a common and disabling mental disorder associated with a consistent impairment of individual functioning and with a significant reduction in the quality of life (American Psychiatric Association, 1994; Bartova et al., 2010; World Health Organization, 2001). Taking into account the large prevalence and the negative consequences of MD (Bromet et al., 2011; Kahl et al., 2012; Kessler et al., 2003), a considerable amount of research has focused over the last decades on the efficacy of psychotropic drugs used to treat these mental disorders, such as antidepressants. This has usually been done by means of specific questionnaires aimed at measuring symptom reduction over the short- and long-term period in MD patients treated with different drugs (Zimmerman et al., 2006). More recently, however, increasing attention has been given to factors other than simple symptom reduction in order to define the achievement of a positive outcome following successful treatment in depressed patients. This broadening of focus that

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includes, among other dimensions, social adjustment, is consistent with both patients' perspectives (Zimmerman et al., 2006) and the World Health Organization (1946) conceptualization of health.

Social adjustment can be defined as the adaptation of the individual to the social environment or the change of the environment by the individual to suit the self (Campbell, 2009). Consistent evidence suggests that social adjustment is impaired in individuals suffering from MD (Hirschfeld et al., 2000; Weissman, 2000). Previous findings suggested that patients suffering from MD show a significant reduction in social adjustment as compared with both healthy controls and subjects suffering from other medical disorders (Hirschfeld et al., 2000). In a large survey investigating social adjustment in MD patients, the largest deficits related to MD included physical, social and role functioning deficits, as well as negatively perceived current health and physical pain (Wells et al., 1989).

Of note, deficits in social adjustment do not tend to disappear even after apparent symptom resolution. As early as 1973 Paykel and Weissman (1973) found that improvement in social adjustment tended to be significantly slower than improvement in depressive symptoms. Subsequent studies consistently replicated and extended earlier findings by suggesting that the social adjustment of MD patients tends to remain significantly lower than that observed in comparable healthy controls in spite of symptom resolution (Furukawa et al., 2011, 2001; Hirschfeld et al., 2000; Judd et al., 2008). Among factors most consistently associated with poorer social adjustment in MD patients, factors including severity of depression, depression recurrence, lack of full remission, time spent depressed, co-morbid psychiatric disorders, personality traits, such as neuroticism, and older age seem to play a major role (Hirschfeld et al., 2000; Rytsala et al., 2006, 2005).

In addition to social adjustment, another dimension that has sometimes been investigated in association with MD is self-esteem. Self-esteem, encompassing both beliefs and emotions, reflects a person's overall evaluation or appraisal of his or her own worth (Hewitt, 2009). Low levels of self-esteem have been observed in MD patients. In particular, lower levels of self-esteem have been frequently associated with MD compared to healthy controls, even during recovery from symptoms (Pardoen et al., 1993; Serretti et al., 1999; Shapira et al., 1999). Current evidence, however, does not support a precise temporal relationship between depressive episodes and lower self-esteem (Angst et al., 2011; Brown et al., 1990a, 1990b; Lewinsohn et al., 1981).

Overall, current findings suggest that both social adjustment and self-esteem are impaired in individuals suffering from MD, even during periods free of symptoms. However, there is little evidence so far regarding the effect of socio-demographic and clinical features associated with these variables on MD patients who responded to their current treatment. It is important for clinicians to recognize that the symptom reduction is not necessarily associated with improved social adjustment (Furukawa et al., 2011; Hirschfeld et al., 2000; Judd et al., 2008)) and that patient expectations about recovery include a return to pre-morbid social and work functioning (Zimmerman et al., 2006).

As a consequence, the aims of the present work are to investigate possible associations between several socio-demographic and clinical variables, and social adjustment and self-esteem in MD patients who have responded to psychotropic treatments. On the basis of current findings, we expect that at least two different variables, including higher severity of residual depressive symptoms and psychiatric co-morbidities, could be negatively associated with social adjustment.

2. Methods

2.1. Sample

Two hundred and eleven patients suffering from MD were recruited in the context of the European multicentre project 'Patterns of treatment resistance and switching strategies in unipolar affective disorder'. Seven European centres took part in this project: (1) Department of Psychiatry and Psychotherapy, Medical University Vienna, Austria; (2) Department of Psychiatry, Chaim Sheba Medical Center, Tel-Hashomer, Israel; (3) Department of Psychiatry, Erasme Hospital, Universite Libre de Bruxelles, Brussels, Belgium; (4) Department of Psychiatry, Istituto Scientifico H. San Raffaele, Milan, Italy; (5) Department of Psychiatry, University Hospital Gasthuisberg, Leuven, Belgium; (6) Hôpital la Salpetriere, INSERM U302, Paris, France; and (7) Sint-Truiden, Psychiatric Center, Sint-Truiden, Belgium. A detailed description of the whole sample was reported elsewhere (Souery et al., 2007). Here, we report data on a subsample of patients for which information about social adjustment was available.

Recruitment of patients (from January 2000 to February 2004) was performed by means of a cross-sectional strategy with retrospective assessment and was based on consecutive ascertainment of MD patients in the specialist referral centres involved in the study. Inclusion criteria were: (i) meeting criteria for a depressive episode according to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) and (ii) having received at least one antidepressant at adequate dosage for at least 4 weeks during the current or most recent depressive episode. Exclusion criteria were: (i) patients with a mood disorder secondary to any primary psychiatric condition and (ii) patients not having received at least one adequate antidepressant treatment during the last depressive episode.

Diagnoses of co-morbid dysthymia, anxiety disorders (including panic disorder (15 subjects, 7%), generalized anxiety disorder (19 subjects, 9%), social anxiety disorder (18 subjects, 8%), obsessive compulsive disorder (8 subjects, 4%) and agoraphobia (16 subjects, 8%); note that some patients had two or more co-morbid anxiety disorders), alcohol and substance dependence, as well as the presence of melancholic and psychotic features during the current depressive episode were obtained for MD patients by means of the Mini International Neuropsychiatric Interview (M.I.N.I.) version 5.0.0 modified by the Group for the Study of Resistant Depression (Souery et al., 2007). Further clinical variables, such as the severity of residual depressive symptoms, and socio-demographic variables, such as age, that were previously associated with social adjustment were likewise recorded.

The 17-item Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960) was administered to all included patients. The last received treatment was recorded. Patients were classified as non responders if they reported a HAM-D score ≥17 after at least 4 weeks of one antidepressant treatment at adequate dose given for the current or most recent major depressive episode (Souery et al., 2007). The study protocol was approved by the ethical committees of all participating centres. After a complete description of the study was given, written informed consent was obtained from all subjects.

2.2. Outcome measures

The primary outcome measure of the present study was the association between a set of 19 socio-demographic and clinical variables and total social adjustment scores, as measured with the Social Adjustment Scale (SAS) (Weissman and Bothwell, 1976), among treatment responders. Secondary outcome measures included: (1) the association between the same variables and