Sensitizing Clinicians and Patients to the Social and Functional Aspects of Remission

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Axis I disorders are defined by specific symptom constellations that are frequently accompanied by notable impairments in social functioning. Social role impairments diminish personal fulfillment, satisfaction, and quality of life. It is now clear that these findings suggest a broader definition of remission that involves not only the absence of symptoms but also improvement in psychosocial functioning. Clinicians and patients need to become sensitized to the role of social functioning and quality of life in the assessment of treatment outcomes. Although there has been a recent emphasis on the inclusion of social function and quality of life measures in the definition of and requirements for remission, numerous standardized scales for measuring these factors already exist. In addition, selection of efficacious therapeutic agents proven to promote both elimination of symptoms and return to full social functioning is important. Finally, significant improvement in both symptoms and function may be necessary to prevent not only relapse but also ensure full remission of anxiety and depressive disorders.
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Reliable and effective assessment of Axis I disorders often includes the utilization of a variety of standardized scales used for both diagnostic purposes and follow-up evaluations. Commonly used scales, such as the Hamilton Rating Scale for Depression[1] and the Hamilton Rating Scale for Anxiety,[2] measure the type and severity of symptoms that characterize the disorder. These scales are extremely useful and effective for diagnostic purposes and for assessing measurable improvement, particularly in the research setting.

However, the criteria used in a large research study may differ from those needed for individual patients in the clinical setting. Indeed, a discrepancy is frequently observed between treatment outcomes in clinical research versus clinical practice, with results from clinical practice typically being inadequate[3] because practicing clinicians may not use standardized scales regularly in assessing patients. Moreover, although the presence and the severity of symptoms are good indicators of a state of disorder, the absence of symptoms does not necessarily indicate a return to premorbid functioning. Other aspects of illness beyond symptoms are important to consider and monitor.

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Several studies have suggested that symptoms are only one measure of illness and that quality of life and social adjustment may be measures of illness independent of symptoms.[4,5] Another frequently missed assessment tool is the patient's perspective on the definition of "wellness," which represents a perspective encompassing aspects of well-being beyond the presence or absence of symptoms (e.g., self-reported or physician-rated quality of life, social adjustment, and resumption of premorbid levels of functioning, daily roles, and activities). Research findings continue to suggest the importance of returning the patient to a premorbid level of social functioning as part of achieving remission.

THE GOAL OF THERAPY

The goal of therapy should be both remission of symptoms and return to premorbid levels of psychosocial functioning. Achievement of 50% improvement on a rating scale as an indicator of response to therapy should not be the end goal. As with any general medical disorder, full remission should be a long-range objective in the treatment of Axis I disorders.

Numerous studies have shown that patients with major depression who have residual symptoms have higher relapse rates and relapse earlier than those without residual symptoms.[6–8] One may infer, then, that the likelihood of relapse of major depression is attenuated in patients who attain asymptomatic remission. Thus, residual symptoms associated with incomplete remission are important markers of vulnerability to relapse.

Although less extensively studied than in major depression, a similar pattern is observed in anxiety disorders. For

example, remission rates for panic disorder tend to be higher than remission rates for panic disorder with agoraphobia.[9] Keller and colleagues[9] have suggested that this greater probability that patients with panic disorder with agoraphobia will remain in episode and not achieve full remission compared with patients with panic disorder alone may be due to the additional persistent symptoms and the greater functional impairment of patients with panic disorder plus agoraphobia. Taken together, these data support the position that patients' residual symptoms during treatment are an indicator of their vulnerability to relapse and underscore the significance of achieving full remission.

With the goal of full remission in mind, how does the physician ensure the diminution of the patient's residual symptoms in the clinical setting? It has been suggested that by initially treating the disorder aggressively with a medication likely to produce remission, residual symptomatology can be prevented.[7] This point is especially relevant because patients who have persistent residual symptoms typically demonstrate a high degree of initial illness severity.[8] However, partial remission or presence of residual symptoms is a relatively common outcome in major depression[10] and thus may be a problem for a broad range of patients. Therefore, medications with robust efficacy may be useful for combating severe illness as well as preventing the persistence of symptoms, thereby increasing the likelihood of achieving remission. Numerous reports have indicated that therapeutic agents acting simultaneously through serotonergic and noradrenergic mechanisms may be more efficacious than single-mechanism agents in achieving remission and eliminating depressive symptoms.[7,10]

THE IMPACT OF DEPRESSION AND ANXIETY ON SOCIAL FUNCTIONING

The presence and the severity of symptoms of depression or anxiety are the most commonly used markers for illness. However, it is well recognized that Axis I disorders can also have debilitating effects on social functioning and quality of life. Although psychiatry has traditionally considered functional social impairment to be a consequence of these disorders, diagnostic criteria for Axis I disorders do not consider social impairment in the definition of the disorders.[11] Nonetheless, clinicians frequently use psychosocial impairments as indicators of Axis I disorders, and these impairments may be as significantly incapacitating as the defining symptoms of a disorder.[11]

Quality of life is a multifactorial subjective measure of well-being that may include role fulfillment and health status as well as personal happiness and spiritual fulfillment.[12,13] Social role functioning is considered to be a fundamental measure of quality of life.[4] Role fulfillment encompasses work, family, and leisure, and leisure includes friendships and hobbies.[13] Diminished quality of life encompasses impairments such as fatigue and insomnia and disabilities such as social and physical dysfunction that occur as a consequence of Axis I disorders.[4]

Wells and colleagues,[11] using data from the Medical Outcomes Study (MOS) in combination with a depression symptom scale, compared the functioning of outpatients with depressive disorder or depressive symptoms, patients with no chronic conditions, and patients with chronic medical conditions such as hypertension, diabetes, coronary artery disease, arthritis, angina, gastrointestinal illnesses, lung illnesses, and back problems. Not surprisingly, patients with depression or depressive symptoms were found to have impaired physical, social, and role functioning and to spend more days in bed when compared with patients with no chronic conditions.[11] In addition, patients with symptoms of depression were found to have impairment of social and role functioning and morbidity similar to or worse than the impairment and morbidity experienced by patients with the chronic medical conditions studied.[11] This finding suggests that the diminished functioning and increased pain experienced by depressed patients can affect their quality of life so significantly that impairments in social functioning are comparable to or worse than those of patients with chronic medical conditions.

Quality of life and social functioning are severely compromised in patients with anxiety disorders as well. A study[14] using the MOS Short-Form Health Survey (SF-36) showed that in patients with panic disorder, the reduced quality of life caused by disorder-related impairments in physical health, mental health, and social functioning was worse than the quality of life of control subjects without a disorder, similar to the diminished quality of life observed in patients with depression, and in some instances worse than that observed in patients with other medical conditions. In addition, panic disorder appears to be associated with other factors that may affect quality of life such as self-reported poor physical and mental health, alcohol abuse, health care utilization, marital discord, financial difficulties, and suicidality, similar to factors observed in depression.[15]

Employing the SF-36 and the Work Productivity and Impairment scale, Wittchen and Beloch[16] showed that individuals with social phobia also show significantly lower quality of life due to impaired mental, emotional, and physical health. In addition, disease-specific impairments were strongly related to quality of life ratings.[16] Clinical and epidemiologic studies have shown that other anxiety disorders, such as obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder, are also associated with impairment in role functioning, work, and life satisfaction.[12] Thus, the impairment associated with depressive and anxiety disorders is broad and extends beyond the presence or absence of symptoms.

ADDRESSING SOCIAL FUNCTIONING AND QUALITY OF LIFE IN TREATMENT

The serious impairment of quality of life observed in anxiety and depressive disorders should be considered when deciding on a treatment option.[13] It has been recognized for quite some time that in depression, symptoms typically dissipate before role impairments are reversed.[5] More recent studies have corroborated the observation that symptoms and social functioning are independent measures that may have a different time course for improvement.[4]

Choice of drug and duration of treatment are important factors in the prognosis of social impairment in anxiety and depressive disorders. Pharmacotherapeutic agents known to be effective in alleviating symptoms of anxiety and depression are generally also effective in improving psychosocial impairment. In an 8-week trial using the Portuguese version of the Social Adjustment Scale Self-Report (SAS-SR) as an outcome measure in depressed patients, venlafaxine (a noradrenergic and serotonergic reuptake inhibitor) significantly improved social functioning, while amitriptyline (a tertiary amine that preferentially blocks serotonin uptake) did not prove to be as effective at improving social functioning.[17] A recent 6-month trial also showed dose-response efficacy of venlafaxine in attenuating social impairment due to generalized anxiety disorder.[18] In another study[5] examining the efficacy of amitriptyline in improving social functioning in depressed women, an 8-month evaluation demonstrated that the most pronounced remission occurred within the first 2 months, followed by a slower improvement in the following 2 months, followed by a stagnant course of improvement for the remaining 4 months. Depressive symptoms of anxiety improved more readily than social functioning.

Duration of pharmacotherapy is considered an important parameter in achieving remission—particularly in patients who initially achieve only a partial remission.[7,19] Remission during the acute phase of treatment is ideal because patients may fare better during the continuation phase of therapy.[20] Thus, the ideal scenario is complete remission of symptoms during the acute phase of treatment and ongoing evaluation of social functioning during the continuation phase.[20]

The mechanism of drug action may be an important aspect of efficacy in social functioning. Agents that act through the serotonergic system may be useful in the treatment of anxious depression, whereas agents that act on the noradrenergic system may be useful in reversing social role impairments.[21] There is, however, tremendous overlap in functions served by serotonin and norepinephrine, particularly in depressive and anxiety disorders.[21] Moreover, patients with anxiety or depressive disorders typically suffer from both symptoms of anxiety and/or depression and impairment in social functioning. Conversely, patients who present with impairment in social functioning may be suspected of having residual symptoms from an Axis I disorder such as major depressive disorder.[11] These patient profiles, taken together with the ascribed activity of serotonin and norepinephrine in depression and anxiety, may explain why dual-mechanism agents appear to be most effective in achieving full remission.[7]

Table 1. Comparisons of Social Functioning Scales[a]

Variable	SAS-SR	SASS	SF-36
Items	54	21	41
Time frame	2 weeks	…	4 weeks
Work	✓	✓	✓
Family	✓	✓	✓
Marital	✓	✓	
Parental	✓	✓	
Economic	✓	✓	
Leisure	✓	✓	✓
Sexual	✓		
Symptoms			✓
Physical health			✓
Disability			✓

[a]Adapted, with permission, from Weissman.[23] Abbreviations: SAS-SR = Social Adjustment Scale Self-Report, SASS = Social Adaptation Self-evaluation Scale, SF-36 = Short-Form Health Survey.

Moreover, just as quality of life indices are useful in determining the severity of illness and in choosing an appropriate treatment, quality of life is also a practical treatment outcome measure.[12,15] This concept characterizes a relatively new and evolving objective, because measures of symptoms have been the standard outcome measure for psychiatric disorders, according to current treatment guidelines. Remission from Axis I disorders is manifested not only by the apparent absence of symptoms but also by a substantial reduction in psychosocial impairment and improvement in quality of life.

Although the concept of including social function and quality of life measures in the definition of and requirements for remission is fairly recent, numerous standardized scales for measuring these factors exist already. The strengths and weaknesses and the appropriate uses of these scales have been extensively reviewed and compared.[12,22–27] Of particular interest is the SAS-SR, modified from the original, lengthier Social Adjustment Scale.[22,24,25] This scale measures instrumental and affective aspects of work, family, and social performance (Table 1).[23] The advantages of the SAS-SR are that it can be used for a wide variety of disorders, it is sensitive to change, it can be completed quickly, and there is a fair degree of agreement between patients' self-reports of their status and spouses' reports of the patients' status.[25] However, the SAS-SR is somewhat complex and may have limited usefulness in chronically ill individuals or in young or elderly individuals who are not in the work force or in family situations assessed by this scale.[25]

Another useful scale is the Social Adaptation Self-evaluation Scale, which is simple to use, with definite

targeting of the measurement of social behavior[26,27]; however, it may offer less precision in its assessment of work role performance and family role functioning than the SAS-SR.[27] There may be an inherent risk of an overestimation of symptom severity when relying on the self-report of severely ill patients[11,20]; nevertheless, patients' perspectives on parameters of their own illness and impairment may be a crucial tool in reaching the goal of remission and are of clinical consequence.

CONCLUSIONS

Broader, more integrative measures of remission, as well as attention to symptom resolution, should be incorporated into treatment plans for Axis I disorders. In addition to utilizing measures of social functioning, quality of life, and return to daily roles and premorbid levels of social functioning, the patient's own perspective on wellness should be gathered. This can help both patients and physicians stay on top of the disorder. Similarly, cessation of premorbid social and functional activities may serve as a signal that illness is returning or worsening. Clinicians and patients alike should be trained to be sensitive to fluctuations in social functioning or quality of life, which are potent indicators of the state of illness or wellness. It is necessary to choose efficacious therapeutic agents that promote both elimination of symptoms and return to full social functioning to prevent relapse and ensure remission.

Drug names: amitriptyline (Elavil and others), venlafaxine (Effexor).

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