LIVING BENEFITS AND DEPRESSION

Degree of Morbidity

It has been estimated that depression is responsible for the loss of 172 million work days yearly in the United States. Despite these impressive figures, there is still a tendency to view the functional limitations associated with depression as less significant than those associated with physical disorders.

This issue was addressed in the Medical Outcomes Study, which compared the functioning and well-being of patients with (1) depressive symptoms, (2) a depressive disorder (major depression, dysthymia, or major depression plus dysthymia), and (3) eight current chronic medical conditions (hypertension, diabetes, angina, advanced coronary heart disease, arthritis, back problems, lung problems, or a gastrointestinal disorder). In this study, both depressive symptoms and depressive disorders were associated with significant limitations in functioning and well-being. The poor functioning in the two psychiatric groups was actually comparable to or worse than that of patients with chronic medical conditions.

The deleterious effects of depression and medical impairments were additive. For example, the combination of current advanced coronary artery disease and depressive symptoms was associated with roughly twice the reduction in social functioning associated with either condition alone. This may be one of the reasons why patients with both depression and medical conditions are especially likely to seek medical care.

Chronic tinnitus offers a model for understanding the impact of major depression on medical illness. 15% of the adult population in Sweden and Great Britain experience tinnitus. However, only 2% of adults experience severe or disabling tinnitus. Intrinsic properties of the disease (loudness, frequency, etc.) do not account for the marked difference between disease prevalence and likelihood of disability. Studies and anecdotal reports document a high prevalence of psychiatric disease in patients with tinnitus, and suggest that the disability reported by many patients is more related to depression than the otologic illness. In other words, many patients disabled by tinnitus may have an imbalance between symptom production (due to tinnitus) and symptom perception (due to depression).

Morbidity With Different Depressive Disorders

Functional status is impaired by all of the depressive disorders. In a second report from the Medical Outcomes Study, the course of depression in 626 adult outpatients was charted over a 2-year period. Each participant had one of the following diagnoses: major depression, dysthymia, double depression (major depression plus dysthymia), or depressive symptoms without a current depressive disorder.

Patients with dysthymia alone experienced more symptoms of depression during each follow-up period than did patients with major depression alone, despite the fact that dysthymia is defined as more persistent but less severe in terms of symptoms. Many patients with depressive symptoms without a depressive disorder also had a poor prognosis. On some outcome measures, this latter group was similar to patients who initially had major depression alone, and a significant number developed major depression over the 2-year follow-up. The authors suggested that "patients with several current depressive symptoms, even in the absence of current disorder, should be carefully monitored for at least 1 year for a possible emerging major depression." The best indicator of prognosis was not DSM-III diagnosis, but a combination of severity of depressive symptoms and functional status.

These results were confirmed by a community-based study from the United States. Two interviews (1 year apart) were administered to 9900 subjects with depressive symptoms in an attempt to identify predictors of first-onset major depression. Depressive symptoms were defined as "the presence for 2 weeks of symptoms of major depression from at least two of the eight DSM-III criteria groups but insufficient to meet the criteria for the DSM-III..."
diagnosis of major depression." The relative risk of developing major depression was significant for both dysthymic disorder (odds ratio 5.5) and depressive symptoms (odds ratio 4.4). The authors concluded with the statement below, giving further credence to the use of psychiatric history as a predictor of risk:

“Our finding that depressive symptoms are predictive of a substantial proportion of cases of first-onset major depression is analogous to the public health finding that carcinoma in situ (stage 0) of the cervix is predictive of more advanced and invasive stages of cervical carcinoma.”

A final report from the National Institute of Mental Health is noteworthy because it suggests there may be one subgroup of depressive disorders with a more favorable prognosis, namely, minor depression without mood disturbance.³ 2980 participants were selected from a random sampling of households in North Carolina. Each was asked 4 questions pertaining to disability, including (1) number of days within the past 3 months in which the respondent missed work due to illness, (2) was late for work, (3) spent all or part of the day in bed, or (4) was kept from usual activities due to feeling ill. Follow-up was performed 1 year later, a time period chosen to decrease the likelihood that the minor depression was due to an adjustment disorder.

Depressive illnesses were categorized as:

1. Major depression (symptoms meeting the criteria for major depression)
2. Minor depression (one or more symptoms of depression, but without the criteria needed to diagnose major depression or dysthymia)
   - With mood disturbance (either depressed mood or anhedonia)
   - Without mood disturbance.

At every severity level of depression, affective impairment carried a significant risk of disability. Because of its greater prevalence, minor depression with mood disturbance accounted for 51% more disability days than major depression. Minor depression without mood disturbance was a common occurrence, but it was not significantly related to disability days.

Over the 1-year follow-up, one-third of those with major depression became asymptomatic, one-fourth remained depressed at the level of major depression, and almost 40% fell into the minor depression groups. Minor depression with mood disturbance followed a similar pattern; most subjects improved, 10% developed major depression, and most had persistent depressive symptoms at the end of follow-up. Patients with minor depression without mood disturbance had the best prognosis; less than 2% developed major depression, only 5.6% developed mood disturbance, and persistent depressive symptoms were less likely than in subjects with minor depression with mood disturbance.

Psychiatric Disability Claims

Do people who are disabled because of depression return to work after their symptoms have improved? The answer may seem obvious, given that current treatment for depression is highly effective in alleviating symptoms. Nonetheless, the literature bearing on the relationship between symptoms and work outcomes indicates that work history, not symptoms, is the best predictor of long-term occupational outcome in the chronically mentally ill.⁶ Some authors even maintain that the relationship between past and future employment is so strong that it completely overshadows any effects of symptoms.

The relationship between treatment for psychiatric impairment and restoration of work capacity was addressed in a report that compiled data on work outcomes from 10 major studies. The goals were to determine the effects of psychiatric treatment and to identify prognostic factors associated with work restoration.⁷

Work impairment was divided into two categories: affective and functional.

1. Affective impairment
   - Feelings of inadequacy (ashamed of one’s work, unable to handle things at work)
   - Distress (feeling upset when at work)
   - Interest (lack or loss of interest in the job)
2. Functional impairment
   - Absenteeism
   - Performance adequacy
   - Interpersonal conflicts.

At every severity level of depression, affective impairment was more prevalent than functional impairment. There was a significant risk of affective impairment even at the low levels of depression typically found in dysthymia and "minor" depression. Functional impairment generally occurred only at moderate to high levels of depression. Affective impairment was often associated with impaired work performance even if the employee could carry out the functional job requirements.

Different patterns for symptom relief and return to work were observed. Symptom relief occurred more rapidly than improvement in work status, often by periods of 4 to 6 months or more. The best results were seen in patients who achieved symptom remission and avoided relapse during the period of disability. Rates of work recovery were similar for patients treated with either anti-
DEPRESSANT MEDICATIONS OR PSYCHOTHERAPY, ALTHOUGH OUTCOMES WITH PSYCHOTHERAPY WERE MORE VARIABLE. ONE OF THE STUDIES ANALYZED BY THE AUTHORS SUGGESTED THAT AN INTERVAL OF AT LEAST 18 MONTHS IS NEEDED TO ASSESS WORK STATUS AFTER RECOVERY FROM A DEPRESSIVE ILLNESS THAT AFFECTED THE ABILITY TO WORK.

ESTIMATING DEGREE OF IMPAIRMENT

One of the most difficult underwriting tasks is determining the degree of impairment in applicants with a history of mental illness. Psychiatric histories are so variable that even the most detailed underwriting guidelines cannot resolve all of the complexities.

DSM-IV provides one means for estimating impairment severity, namely, the "Global Assessment of Functioning Scale." This scale considers psychological, social, and occupational functioning on a hypothetical continuum of mental health and illness. Patients receive a score between zero and 100 depending on their current and recent functioning.

For example, a high score would be recorded in a patient with "absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, and no more than everyday problems or concerns." Conversely, a lower score would be given to a patient with "moderate symptoms, or moderate difficulty in social, occupational, or school functioning." Although this type of scale is useful in a clinical setting, it isn't very helpful for underwriting purposes. It is too vague and doesn't include the parameters that underwriters encounter in applications and attending physician statements.

A better estimate of the degree of impairment would be provided by the MOS 36-Item Short-Form Health Survey (SF-36™ — refer to addendum). This survey was developed by health researchers to measure physical well-being and quality of life from a patient's point of view. The questionnaire yields a composite quality-of-life score on a scale of zero to 100, as well as individual ratings in physical, social and emotional status. Unlike laboratory results, the survey tells how a person is functioning in the real world — how a disease might be affecting the ability to perform a job, go shopping or relate to family and friends.

As an example of the type of information revealed by this survey, researchers found that people with severe depression are as physically incapacitated as those with chronic heart disease, and people who scored very low consumed 10 times more hospital care than those who scored high.

SF-36™ measures eight health concepts:

1. Physical Functioning - Extent to which health limits physical activities such as self-care, walking, climbing stairs, bending, lifting, and moderate and vigorous activities.
2. Role Functioning (physical) - Extent to which physical health interferes with work or other regular daily activities, including accomplishing less than wanted and limitations in the kind of work.
3. Role Functioning (emotional) - Extent to which emotional problems interfere with work or other regular daily activities, including decreased time spent on work, accomplishing less than wanted, and not doing work as carefully as usual.
4. Social Functioning - Extent to which physical or emotional problems interfere with normal social activities.
5. Bodily Pain - Intensity of and effect of pain on normal work, both inside and outside the house.
6. Mental Health - General mental health, including depression, anxiety, behavioral-emotional control, and general positive affect.
8. General Health Perceptions - General health perceptions, including current health, health outlook, and resistance to illness.

SF-36™ is currently being used by a consortium of health insurers and employers. The goal is to see if the data helps insurers improve the quality of care in their health care networks, and if employers can use the information to compare the quality of care provided by different groups. Researchers believe that SF-36TM could eventually guide doctors in their treatments, making them focus not just on correcting abnormal lab test results, but on patients' overall quality of life.

Different SF-36™ forms have been designed for self-administration, telephone administration, or administration during a personal interview. The 224-page SF-36™ Health Survey Manual and Interpretation Guide contains 12 chapters that address items such as scoring, validity, and norm-based interpretation (norms for seven age groups, men, women, and clinical populations). Forms have been published for use in the United States, the United Kingdom, and a Spanish-American language version. An international study is currently attempting to translate and culturally adapt the SF-36™ for use in 15 countries.

Because of copyright restrictions, SF-36™ can be used only with explicit approval of the MOS Trust, Inc. However, some of the concepts in this questionnaire may be very useful to underwriters. For example, questions in the survey were chosen specifically for their ability to determine functional status. Likewise, separate rating
scales were developed for each question in order to better assess degree of impairment. Finally, the survey yields information that applies to both mental and physical illnesses.

UNDERWRITING CONSIDERATIONS: SUMMARY

Degree Of Morbidity

- The functional limitations associated with depression are comparable to those of physical impairments.
- The deleterious effects of depression and somatic impairments are additive.

Morbidity With Different Depressive Disorders

- Functional status is impaired by all of the depressive disorders, including major depression, dysthymia and depressive symptoms.
- People with milder depressive disorders such as dysthymia and depressive symptoms are at risk for major depression for at least 1 year after the psychiatric diagnosis was made.
- The best prognosis is for patients with minor depression without mood disturbance.

Psychiatric Disability Claims

- Work history, not symptoms, is the best predictor of long-term occupational outcome in people with chronic mental illness.
- Depression is often associated with impaired work performance even if the employee is able to carry out the functional job requirements.
- People disabled because of depression may not return to work for 4 to 6 months or more after their symptoms have improved.
- Risk for future disability cannot be assessed for at least 18 months after recovery from a depressive illness that affected work status.

Estimating Degree of Impairment

- The MOS 36-Item Short-Form Health Survey (SF-36TM) provides an accurate estimate of the degree of impairment from physical and mental disorders.
- Some of the concepts in SF-36TM may be very useful to underwriters since survey questions were chosen specifically for their ability to determine functional status.

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SF-36™ HEALTH SURVEY

SF-36™ Questions

1. In general, would you say your health is:

2. Compared to one year ago, how would you rate your health in general now?

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
c. Lifting or carrying groceries
d. Climbing several flights of stairs
e. Climbing one flight of stairs
f. Bending, kneeling, or stooping
g. Walking more than a mile
h. Walking several blocks
i. Walking one block
j. Bathing or dressing yourself

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

a. Cut down the amount of time you spent on work or other activities
b. Accomplished less than you would like
c. Were limited in the kind of work or other activities
d. Had difficulty performing the work or other activities (for example, it took extra effort)

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

a. Cut down the amount of time you spent on work or other activities
b. Accomplished less than you would like
c. Didn't do work or other activities as carefully as usual

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

7. How much bodily pain have you had during the past 4 weeks?
8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

   a. Did you feel full of pep?
   b. Have you been a very nervous person?
   c. Have you felt so down in the dumps that nothing could cheer you up?
   d. Have you felt calm and peaceful?
   e. Did you have a lot of energy?
   f. Have you felt downhearted and blue?
   g. Did you feel worn out?
   h. Have you been a happy person?
   i. Did you feel tired?

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

11. How TRUE or FALSE is each of the following statements for you?

   a. I seem to get sick a little easier than other people
   b. I am as healthy as anybody I know
   c. I expect my health to get worse
   d. My health is excellent

References

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