Depression and physical illness: more complex than simple comorbidity

David M Clarke

Depression alone is debilitating, and this effect is multiplied in people with physical illness

Depression is common when people have physical illness — every clinician knows that. And, as may be expected, the literature confirms that depression is worse with more severe disease, especially when there is poor social support and other adverse life situations.[1] What has been freshly highlighted over recent years, however, is the enormous impact of depression. Depression alone produces a level of disability equivalent to any other chronic disease and, when combined with physical illness, this effect is multiplied.[2] The recent World Health Organization World Health Surveys indicated that depression produced the greatest decrement in health of any chronic disease, and the comorbid state of depression incrementally worsened health more than any other disease combination.[3] Depression also increases consumption of health care resources; depression was associated with a 17%–46% increase in health costs in the large WHO LIDO study.[4]

So why don't we do something about this? There are a number of issues here. First, we would all accept that much sadness and upset in life are understandable. However, that doesn't remove the imperative to help and to relieve the suffering. Indeed, understanding the depression (as psychiatrists spend time trying to do) is the first step toward knowing how to respond. Having a debilitating or life-limiting disease will make some people depressed — in a similar way, perhaps, to grief. Having unrelenting pain wears down the spirit. Having advancing disease makes a person feel helpless. Facing an uncertain future creates apprehension. All these experiences can be part of what we call depression in the physically ill, and this depression may also include feelings of shame, guilt and loss.[5] Teasing out these phenomenological differences will help us respond appropriately.

Second, we need to know what to do, and it is important to recognise that simple things can often help. For example, giving good information to patients in a supportive and caring manner reduces anxiety and increases the sense of competence (reducing helplessness) and, although not sufficient on its own, is a central component of chronic disease management.[6] Participating in professionally led patient support groups also significantly reduces depression and improves coping.[7]

There are effective treatments (although more research into these is needed) (*page S54*),[8] and we know in part what works. The third issue, therefore, is how to implement what we already know, and this is where things are not so simple.

The WHO studies described above highlight the interaction between depression and physical illness. Each contributes to the worsening of the other. People are not going to get better unless both (or all) dimensions are tackled, and so we need new models that acknowledge this complexity.[9] These new models for clinical practice will need to be integrated. It is the same person who is depressed, has the physical illness and is socially isolated, so it is not possible to deal effectively with any one of these aspects alone. However, health care administration — at both government and health service levels — separates physical care from mental health care. This is not effective, efficient or cheap.[10] While this Supplement highlights the mental health problems associated with physical disease, there has been recent concern about the poor physical health of patients within mental health services.[11] It is now time to put into place structures that integrate physical and psychosocial health care. Such integration is absent from the National Chronic Disease Strategy; the word "depression" does not even appear in the National Service Improvement Frameworks.[12] Integration of physical and psychosocial health care will not happen without proper resources and, at present, the resources given to the mental health aspect are proportionately much less than the burden of disease attributable to it,[13] despite recent significant increases to the funding of mental health services in Australia. Physical health and mental health are closely linked,[14] so we return to the issue of complexity and the need for models of integrated care. Such models do exist,[15] but will take commitment and money[16] to introduce and evaluate.

One field in which there is substantial evidence for the benefit of psychosocial interventions is that of cancer. This evidence is summarised in the National Health and Medical Research Council (NHMRC) *Clinical practice guidelines for the psychosocial care of adults with cancer*.[17] Unfortunately, these guidelines have not been widely implemented in clinical practice. Kelly and Turner, in this Supplement (*page S90*), provide some suggestions to move this forward.[18]

In the area of heart disease, there have been a number of clinical trials of the effectiveness of antidepressant medication[19] or psychotherapy[20] to treat depression. These have shown modest effects, and have served to demonstrate how difficult it is to run trials in this field. Over the past few years, "*beyondblue:* the national depression initiative" has been developing partnerships with physical disease groups such as the Heart Foundation and Cancer Australia to sponsor research that integrates care for people with depression and physical illness. Chronic disease management models are being introduced to prevent the progress and secondary morbidity of chronic disease. It should be a relatively simple matter to incorporate methods for recognising and managing depression into these models.

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