Social Functioning in Depression: A Review

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Objective: This article reviews the available data on social functioning in depression and provides clinical guidelines and opinion on this important and expanding field.

Data sources: A MEDLINE search was conducted to identify all English-language articles (1988–1999) using the search terms *depression and social functioning, depression and social adjustment, depression and psychosocial functioning,* and *social functioning and antidepressant.* Further articles were obtained from the bibliographies of relevant articles.

Data synthesis: Depressive disorders are frequently associated with significant and pervasive impairments in social functioning, often substantially worse than those experienced by patients with other chronic medical conditions. The enormous personal, social, and economic impact of depression, due in no small part to the associated impairments in social functioning, is often underappreciated. Both pharmacologic and psychotherapeutic approaches can improve social impairments, although there is a lack of extended, randomized controlled trials in this area using consistent assessment criteria.

Conclusion: Despite this lack, it is becoming clear that not all treatments are equally effective in relieving the impaired social functioning associated with depressive disorders. Furthermore, efficacy in relieving the core symptoms of depression does not necessarily guarantee efficacy in relieving impaired social functioning.

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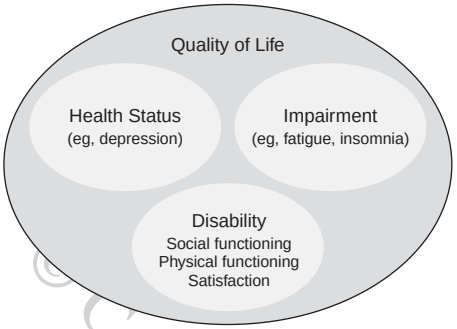
Depression is a widespread and debilitating illness with far reaching personal and economic implications for individuals, their families, and society as a whole. Globally, unipolar depression is responsible for almost 11% of the total years lived with a disability caused by any illness, defined as "any restriction or lack of ability to perform a normal human activity."[1(p100)] Bipolar disorder also represents a significant global burden, contributing 3% of the global years lived with a disability.

The impact of depression extends beyond the core symptoms, such as depressed mood and loss of energy, and affects individuals' quality of life, including the ability to function socially, maintain and enjoy relationships and work, and provide for themselves and family financially. Furthermore, the families of depressed patients may themselves be at greater risk for major depressive disorder.[2,3] The resulting additional stresses on interpersonal relationships may create a vicious circle, contributing to the chronic, recurrent nature of depression. Decreased capacity to work and impaired work productivity as well as increased health care and other social service utilization all contribute to the significant societal burden of depression,[4–7] with cost estimates in the United States alone reaching $43.7 billion in 1990.[8]

Quality-of-life issues are gaining increasing importance in relation to the treatment and outcome assessment of a range of medical and psychiatric disorders. A central feature of quality of life is an individual's ability to perform

Figure 1. Concept and Components of Quality of Life[a]



[a]Based on Murray and Lopez.[1]

and fulfill normal social roles, a concept termed *social functioning*. Psychiatric disorders are often strongly associated with impaired social functioning,[9,10] and the level of impairment experienced by depressed patients is at least as high as for those with other chronic general medical conditions, such as diabetes and heart disease.[9,10] Of considerable concern is the finding that these impairments may persist for years, even after symptom resolution.[10–12]

Vigorous treatment for depression in the clinical trial setting has generally been shown to improve the associated impairments in social functioning (e.g., references 13–16). However, symptomatic improvement does not necessarily lead to improved psychosocial functioning, and factors such as compliance with treatment may significantly reduce successful outcome rates outside the clinical trial setting.[17]

Despite the pervasive and significant burden imposed by depressive disorders, not only do depressed individuals frequently remain undiagnosed and undertreated,[18,19] but the usual care that patients receive is often insufficient to adequately address either their symptoms or their impaired social functioning.[20,21] In general, the clinical management of medical conditions has tended to focus largely on clinical signs and symptoms. However, impairment in quality of life (such as an inability to pursue normal social activities), rather than health status itself, is often the deciding factor leading people to seek health care. The aim of this article is to review the assessment and treatment approaches currently available to enable clinicians to provide optimal relief from the impaired social functioning associated with depressive disorders, and to highlight the pressing need for additional research in the field.

A MEDLINE search was conducted to identify all English-language articles (1988–1999) using the search terms *depression and social functioning, depression and social adjustment, depression and psychosocial functioning,* and *social functioning and antidepressant.* Further articles were obtained from the bibliographies of relevant articles.

DEFINING SOCIAL FUNCTIONING

Quality of life is a multidimensional concept (Figure 1) encompassing, and fundamentally affected by, the following:

- health status (presence or absence of a disease or disorder and its severity),
- disability (any restriction or lack of ability [resulting from an impairment] to perform a normal human activity),[1] and
- impairment (any loss or abnormality of psychological, physiologic, or anatomical structure or function).[1]

Disability can be considered in terms of physical functioning, social functioning, and satisfaction, all of which have an impact on quality of life. Social functioning itself can therefore be considered a key feature of quality of life (see Figure 1). Although no agreement exists on a standard definition of quality of life, most definitions include objective components such as role functioning and environmental conditions, as well as subjective components such as satisfaction.

Although excellent agreement exists on the core symptoms of depression, to date there has been no standardized, widely accepted definition of social functioning. Paykel[22] described social functioning as "an individual's ability to function within their usual environment."[(pS9)] However, some variation exists in the precise domains measured by the currently available rating scales as well as in the terminology, wording, and measurement.[23] In spite of this fact, diagnostic instruments generally include the following as domains of social functioning: occupation, household role, marital functioning, parental role, family/kinship role, social role, leisure/general interest, and self-care.[23]

MEASURING SOCIAL FUNCTIONING

A wide range of non–disease-specific quality-of-life scales are available for use in the general medical setting that usually seek to measure subjective perceptions and reactions to health status. A number of scales have also been developed specifically for use with patients with depressive disorders, such as the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)[24] and the Quality of Life in Depression Scale (QLDS).[25] These scales have often been criticized as not being sufficiently focused and overly time-consuming to complete.[26,27]

Rating scales for the clinical symptoms of depression (e.g., the Hamilton Rating Scale for Depression, the Montgomery-Asberg Depression Rating Scale) rarely contain more than 1 or 2 items that directly examine social functioning variables. Therefore, these scales do not assess the precise effect of antidepressant medications on

social functioning. Specific rating scales have therefore been developed that focus on this aspect of quality of life.

Four scales reported to measure social functioning and that have been used in clinical trials of treatment for depressive disorders are the Social Adjustment Scale Self-Report (SAS-SR),[28] the 36-item Short-Form Health Survey (SF-36),[29] the Sheehan Disability Scale,[30] and the Social Adaptation Self-evaluation Scale (SASS).[27] A comparative overview of the content of these 4 scales is presented in Table 1.

The simplest approach to the assessment of social functioning is represented by the Sheehan Disability Scale, which consists of 3 items presented as visual analog scales. Patients are asked to rate themselves on a scale of 1 to 10 for their performance in the domains of work, social and leisure activities, and home life. The SF-36 consists of 36 items and represents a more global assessment covering overall health status, physical functioning, loss of function due to physical or emotional problems, and depressive symptoms. Both scales provide an overall picture of the status of depressed patients rather than a detailed examination of social functioning. The SAS-SR and the SASS have been designed specifically to examine social functioning and broadly examine the same areas (work, family, marital, parental, economic, and social). The SAS-SR also looks at sexual functioning and asks patients to consider their functioning over the previous 2 weeks. The SASS, on the other hand, asks about the patient's current level of functioning. Although they are broadly similar, there are a number of notable differences between the scales; for example, the SASS does not include an objective measure of work performance (e.g., days lost from work),[31] and only the SF-36 includes sexual functioning as a component of social functioning (see Table 1).

The development and use of rating scales designed to measure the impaired social functioning associated with depressive disorders allows a detailed examination of the global effects of depressive disorders and also permits an examination of potential differential effects between the available antidepressants.

SOCIAL FUNCTIONING AND DEPRESSION

Both symptoms (e.g., changes in sleep and appetite, fatigue, hopelessness) and social functioning (e.g., relationships, work) contribute to the depressive syndrome, a fact reflected in diagnostic guidelines such as DSM-IV.[32] Axis IV of DSM-IV outlines the assessment of psychosocial and environmental problems, whereas Axis V examines overall functioning, both psychosocial and occupational. In the case of depression, certain symptoms of the disorder such as loss of self-esteem and loss of interest in activities themselves compromise central components of quality of life and social functioning. Accordingly, distinctions between the symptoms of depression, impaired quality of life, and impaired social functioning are inherently less clear than is the case for other somatic disorders such as rheumatoid arthritis.

Table 1. Comparative Content of 4 Rating Scales Used in the Assessment of Social Functioning in Clinical Trials of Antidepressants[a]

Variable	SAS-SR	SASS	SF-36	Sheehan
No. of items	54	21	41	3
Time frame	2 weeks	current	4 weeks	4 weeks
Domain of functioning				
Work	+	+	+	+
Family	+	+	+	+
Marital	+	+		
Parental	+	+		
Economic	+	+		
Social	+	+	+	+
Sexual	+			
Psychiatric symptoms			+	
Physical health			+	
Disability			+	

[a]Abbreviations: SASS = Social Adaptation Self-evaluation Scale, SAS-SR = Social Adjustment Scale Self-Report, SF-36 = 36-item Short-Form Health Survey, Sheehan = Sheehan Disablity Scale. A "+" indicates one or more items included; a blank indicates no items included.

Patients with depression may have substantial deficits in social functioning. Weissman et al.[33] showed that acutely depressed women (N = 40) were significantly more impaired in major social roles (work, marital, family) compared with their nondepressed neighbors (N = 40). De Lisio et al.[34] examined social functioning in 176 outpatients diagnosed with major depression, bipolar disorder, or dysthymia and also found that disturbances were seen in all areas of functioning, most notably in work and social leisure activities. In a community sample of 4913 subjects, Fredman et al.[35] found that respondents with current major depressive disorder reported significantly poorer intimate relationships and less satisfying social interactions than those with past depression, other current disorders, and no psychiatric disorder. In the largest study of its kind, Wells and coworkers[9] examined the functioning and well-being of 11,242 outpatients and found that depressed patients experience significant impairments in multiple domains of functioning comparable to, or greater than, those experienced by patients with other chronic medical conditions.

Certain types of depression appear to be particularly associated with poor social functioning. For example, patients with double depression generally appear to have worse social impairment than those with major depression or pure dysthymia.[10,36,37] As part of a 2-year follow-up study, Hays et al.[10] examined baseline social functioning in patients diagnosed with dysthymia (N = 48), double depression (N = 61), or major depression (N = 76). Using the 2 social functioning items of the SF-36, they demonstrated statistically significant baseline differences between patients with major depression and double depression ($p < .05$). Similarly, Evans et al.[36] looked at 430 patients taking part in DSM-IV field trials and also found

that patients with double depression experienced worse social functioning than those with either dysthymia or episodic major depression. Leader and Klein[37] concluded that chronic, low-grade depressive symptoms and acute moderate symptoms have similar effects on social adjustment that are both significant and additive. Leader and Klein compared the overall social functioning of patients diagnosed with pure dysthymia (N = 41), double depression (N = 56), episodic major depression (N = 45), and normal controls (N = 45) using the SAS-SR. Total SAS-SR scores were significantly higher in all patient groups compared with normal controls ($p < .05$), and scores for patients with double depression were statistically significantly higher than those for patients with either dysthymia or episodic major depression ($p < .05$).

It is clear that patients with all forms of depression experience pervasive and significant impairments in social functioning. Whether these impairments persist between acute depressive episodes and whether current treatment regimens adequately address these impairments will be the focus of the remainder of this review.

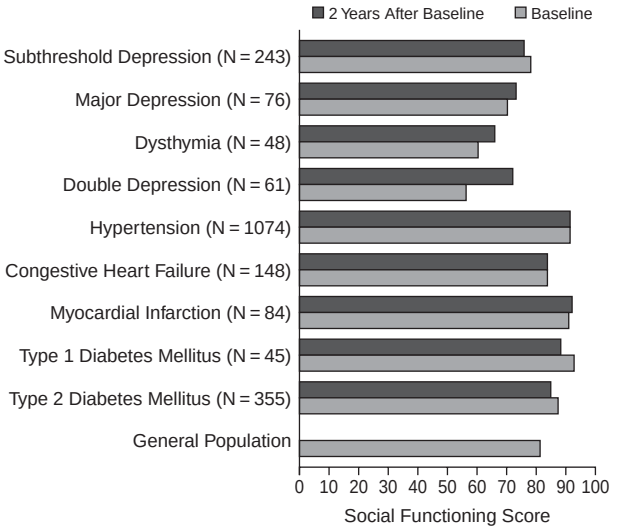
THE COURSE OF SOCIAL FUNCTIONING IN DEPRESSION

Significant life events (births, deaths, marriages), poor social support networks, poor marital relationships, and poor economic status have all been implicated as risk factors for the development, and relapse, of depressive disorders.[38,39] These findings may be more relevant to those with less severe depression in terms of short-term outcome,[40,41] although the level of family functioning has been identified as a significant predictor of long-term outcomes for this patient group.[42]

Depression is generally a chronic or episodic condition requiring long-term therapy. Therefore, it is valid to ask whether impairments in social functioning persist after resolution of the core depressive symptoms. The persistence of impaired social functioning even after apparent symptom resolution was recognized as early as 1973, when Paykel and Weissman[43] demonstrated in a study of depressed women that improvements in social functioning occurred over an 8-month follow-up period, but more slowly than improvements in symptoms, and residual impairments remained. To be included in the maintenance phase of the study, patients had to have exhibited a response (50% or more improvement) to an initial 1-month treatment with amitriptyline.

Mintz et al.[4] reviewed the original data from 10 studies to examine the effects of antidepressants and psychotherapy on the capacity to work. Patients (N = 827) had been treated with an antidepressant, psychotherapy, or placebo, and in most cases work impairment was measured using the functional components of the Social Adjustment Scale (absenteeism, performance adequacy, interpersonal conflict). The authors found that for those patients for whom treatment was symptomatically effective, work outcomes were good. However, improvements occurred more slowly than for symptoms, paralleling the findings of Paykel and Weissman[43] discussed above.

Figure 2. SF-36 Social Functioning Scores at Baseline and 2 Years After Baseline for Patients With Depressive Disorders and Chronic Medical Disorders[a]



[a]Data from Hays et al.[10] Abbreviation: SF-36 = 36-item Short-Form Health Survey.

Tweed[44] extended the analysis to a large sample of depressed people and used data from the Colorado Social Health Survey (N = 4745) conducted in community-dwelling adults over 18 years of age. Of these, 2687 respondents were assessed as having one or more depressive symptoms and were included in subsequent analyses. The model employed by Tweed confirmed that the social functioning of a community sample of depressed individuals is considerably impaired compared with normal controls and that these impairments persist after symptom resolution.

In a prospective study, where patients were recruited as they sought treatment, Coryell et al.[12] showed that patients with bipolar (N = 148) or unipolar (N = 240) major affective disorder were more likely to report a decline in job status and income by the end of a 5-year follow-up period compared with family members with no history of depression. Even those patients considered to have recovered during the final 2 years of the follow-up phase still experienced severe and widespread psychosocial impairments. Although the results of this study reflect treatment outcomes in a naturalistic setting, treatment regimens were not specified. In fact, a proportion of patients were receiving no antidepressant therapy during the follow-up period.

A 2-year observational follow-up study by Hays and coworkers[10] included more than 2000 adults with depression, diabetes, hypertension, recent myocardial infarction,

Table 2. Clinical Trials Examining Changes in Social Functioning Following Antidepressant Therapy[a]

Citation	Study Population	Treatment	Study Duration, wk	Rating Scale	Mean Social Functioning Score, Baseline to Endpoint	p Value
Kocsis et al[45]	Chronic depression	Imipramine (N = 11) Placebo (N = 13)	6	SAS-SR	Imipramine: 2.6 to 2.0 Placebo: 2.5 to 2.6	< .05[b]
Stewart et al[46]	Chronic depression	Phenelzine (N = 36) Imipramine (N = 47) Placebo (N = 48)	6	SAS-SR	Phenelzine: 2.0[c] Imipramine: 2.2[c] Placebo: 2.4[c]	< .01[d]
Friedman et al[47]	Dysthymia	Desipramine (N = 74)	10	SAS-SR	Responders: 2.4 to 2.0 Nonresponders: 2.6 to 2.4	< .0001[d]
Kocsis et al[48]	Dysthymia	Sertraline (N = 123) Imipramine (N = 122) Placebo (N = 123)	12	SAS-SR	Sertraline: 2.28 to 1.91 Imipramine: 2.28 to 1.94 Placebo: 2.23 to 2.06	< .01[b]
Miller et al[16]	Double depression and chronic major depression	Sertraline (N = 426) Imipramine (N = 209)	12	SAS-SR	Sertraline: 2.61 to 2.12 Imipramine: 2.58 to 2.15	NS
Heiligenstein et al[49]	Major depression; ≥ 60 years of age	Fluoxetine (N = 261) Placebo (N = 271)	6	SF-36	Fluoxetine: 59.8 to 66.7 Placebo: 58.1 to 65.1	NS
Dubini et al[14]	Major depressive disorder	Reboxetine (N = 103) Fluoxetine (N = 100) Placebo (N = 99)	8	SASS	Reboxetine: 25.1 to 35.3 Fluoxetine: 24.5 to 31.9 Placebo: 23.9 to 27.2	< .05[e]
Massana et al[50]	Major depressive disorder	Reboxetine (N = 63) Fluoxetine (N = 76)	8	SASS	Reboxetine: 27.3 to 35.7 Fluoxetine: 27.9 to 35.1	NS

[a]Abbreviations: NS = not significant, SASS = Social Adaptation Self-evaluation Scale, SAS-SR = Social Adjustment Scale Self-Report, SF-36 = 36-item Short-Form Health Survey.
[b]Active treatment vs. placebo at endpoint.
[c]At endpoint.
[d]Responders vs. nonresponders at endpoint.
[e]Active treatment vs. placebo and reboxetine vs. fluoxetine.

and/or congestive heart failure. Although improvements in functional status were observed in the 428 patients with depressive disorder, limitations remained similar to, or worse than, those experienced by patients with other chronic medical conditions (Figure 2). Comparing baseline values, patients with depressive disorders experienced significantly worse social functioning ($p < .05$) than patients with other conditions, except for those with subthreshold depression compared with patients with congestive heart failure. Two years after baseline, all comparisons between depressive disorders and chronic medical conditions remained statistically significantly different ($p < .05$), except for subthreshold depression compared with congestive heart failure and type 1 diabetes mellitus. As with the study reported by Coryell and colleagues,[12] no details of the treatments received by depressed patients were reported.

Evidence from both controlled clinical trials and naturalistic follow-up studies has shown that impairments in social functioning are significant, pervasive, and persistent in depressed patients. However, it would appear that although adequate treatments for depressive disorders can reduce associated psychosocial impairment, acceptable outcomes are not yet being achieved in clinical practice.

PHARMACOTHERAPY AND SOCIAL FUNCTIONING

Traditionally, pharmacotherapy for depression aimed to relieve the acute symptoms of depression and restore euthymia. More recently, restoration of the usual/premorbid level of social functioning has become an increasingly important therapeutic target and an important feature of new antidepressant agents. A number of antidepressants have been studied for their efficacy in social functioning and, although the data are as yet extremely limited, in general have been shown to offer benefits for depressed patients. Table 2 presents the key social functioning data from a number of such studies[14,16,45–50] that have used the SAS-SR, the SF-36, or the SASS for the assessment of social functioning.

The effect of treatment with the tricyclic antidepressant imipramine has been studied by a number of groups,[4,16,45,46,48] and imipramine has generally been shown to improve social functioning over time in depressed patients. However, in none of the studies reported in Table 2 did the mean SAS-SR total score of patients treated with imipramine reach the previously estimated community norm value of 1.6,[33] although these were all acute treatment studies. Whether patients eventually return to community normative levels is a question that will require long-term research. One of the studies[45] used what could be considered a subtherapeutic dose of imipramine (50 mg/day), and none of the studies assessed social functioning for longer than 3 months. Desipramine has been assessed in a 10-week, open-label study[47] in which patients who responded to treatment (N = 36) on the basis of traditional symptom rating scales achieved better social functioning by the end of treatment (mean SAS-SR score = 2.0) than those who did not respond (N = 38; mean SAS-SR

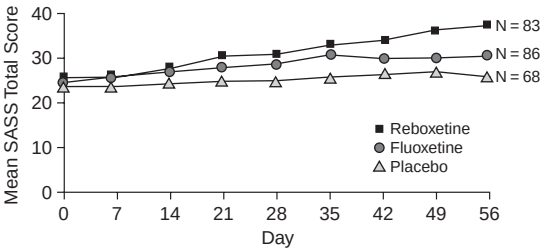
score = 2.4). The difference between responders and nonresponders was statistically significant, although again, community norms were not reached. The same group[51] recently reported the results of a continuation study in dysthymic patients in which those who responded to an initial 10 weeks of treatment received a further 6 months of therapy. On the basis of the SAS-SR scores, only 24% of patients achieved a normative level of social functioning at the end of 6 months of therapy even though euthymia was maintained in the majority of patients.

The selective serotonin reuptake inhibitors sertraline and fluoxetine have also been included in clinical studies in which social functioning has been assessed and have also been shown to improve social functioning over time.[16,49] Miller et al.[16] showed that successful treatment with either sertraline or imipramine produced significant improvements in most areas of psychosocial functioning. Furthermore, these improvements appeared as early as week 4 of treatment and represented between 40% and 80% of the total improvement observed. Fluoxetine has been assessed in one study[49] using the SF-36 scale. Heiligenstein et al.[49] examined patients aged 60 years and over in a 6-week trial and showed that although significant improvements were found both in mental health and role limitations due to emotional problems, physical functioning, and bodily pain, no significant difference was found between the treatment groups in social functioning. However, it was suggested that a return to social functioning occurs later than would be observed in a 6-week trial.

The most intensive studies of the effect of pharmacotherapy on social functioning are 2 controlled clinical trials[14,15,50] in which the selective norepinephrine reuptake inhibitor (selective NRI) reboxetine was compared with the SSRI fluoxetine and placebo using the SASS to monitor social functioning over time. Both studies were conducted over 8 weeks, and patients were asked to complete the SASS at weekly intervals. The first study[14,15] included a placebo control, and improvements were seen in both active treatment groups. Statistically significant differences were observed between active treatments and placebo after 1 week (Figure 3). At the last assessment, the mean SASS total score for patients in the reboxetine group had reached "normal" (35 points or above)[27]; however, this was not so for patients in the fluoxetine or the placebo group (mean SASS total score: reboxetine, 35; fluoxetine, 32; placebo, 27). In the subgroup of patients who achieved symptomatic remission, only those in the placebo group did not achieve community norms by last assessment (mean SASS total score: reboxetine, 42; fluoxetine, 36; placebo, 32). However, statistically significant differences remained between the reboxetine and fluoxetine groups.

A further direct comparison between reboxetine and fluoxetine supports the results of the placebo-controlled study. In this smaller 8-week study,[50] no statistically significant differences were detected between the reboxetine and fluoxetine groups. However, in patients who achieved symptomatic remission, a statistically significant difference in favor of reboxetine was determined. Interestingly, these 2 antidepressants were also assessed using the symptom rating scales; no statistically significant differences were found between antidepressants in either study.

Figure 3. Social Adaptation Self-evaluation Scale (SASS) Total Score: Mean Values Over Time in Patients in the Reboxetine, Placebo, and Fluoxetine Groups[a]



p < .05:								
Reboxetine vs placebo	*	*	*	*	*	*	*	*
Fluoxetine vs placebo	*	*	*	*	*	*	*	*
Reboxetine vs fluoxetine						*	*	*

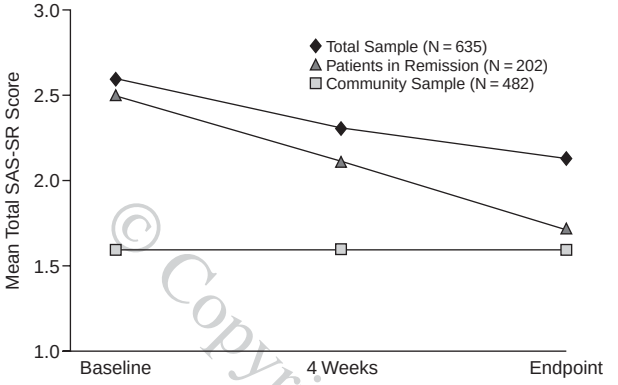
[a]Reproduced with permission from Dubini et al.[15]

Other antidepressants, such as phenelzine[13,46] and L-deprenyl,[13] have also been assessed for their effect on social functioning, and in general appear to improve social functioning over time. Agosti and coworkers[13] used the Longitudinal Interval Follow-up Evaluation (LIFE)[52] to assess social functioning in 61 chronically depressed patients treated over 6 weeks with either L-deprenyl, phenelzine, imipramine, or placebo. Antidepressants were superior to placebo in improving work and home functioning, relationships with relatives, sex frequency, and life satisfaction. No comparison of the individual antidepressants was presented.

In general, it would appear that patients who recover symptomatically can be expected to experience a positive change in social functioning. The quality of remission in depression requires consideration of the number and severity of residual symptoms, the level of social functioning, and the adverse effects of treatment. Studies suggest that patients who achieve remission on treatment with antidepressants have substantially improved social functioning, but do not always return to their premorbid levels (Figure 4).[16] However, Dubini et al.[15] found that those patients who achieved symptomatic remission following treatment with either reboxetine or fluoxetine also achieved a normal level of social functioning, although mean SASS total scores for patients in the reboxetine group remained statistically significantly superior to those for patients in the fluoxetine group.

Quality of remission is an important consideration in the treatment of depression, and the possibility of a differential effect between the newer antidepressants raised by the studies reported by Dubini et al.[14,15] and Massana et

Figure 4. Social Functioning (mean SAS-SR total score) Before, During, and After Treatment With Sertraline or Imipramine[a]



[a]Data from Miller et al.[16] Abbreviation: SAS-SR = Social Adjustment Scale Self-Report.

al.[50] warrants further examination. Data over longer time periods (12 weeks or more) are required to draw firm conclusions about the validity of these results. When evaluating the global benefits of any antidepressant, the extent to which it offers improvements in symptomatology, as opposed to a return to euthymia and normal levels of social functioning, is an important consideration. As Kocsis and colleagues[45] stated: "If antidepressant medication merely reduced depressive symptoms, social impairment might persist and lead to further personal and business failure and to a cycle of demoralization."[(p999)]

PSYCHOTHERAPY AND SOCIAL FUNCTIONING

Psychotherapy is an interactive treatment for depression that aims to relieve core symptoms and restore normal social functioning. Some time-limited psychotherapies are recommended by the American Psychiatric Association[5] and the Depression Guideline Panel.[53] Psychotherapy targets 3 main areas: symptoms, social functioning, and personality. A range of psychosocial interventions have been developed and studied to varying degrees. These include interpersonal psychotherapy,[54] cognitive-behavioral therapy,[55] and psychoeducation.[56]

The development of interpersonal psychotherapy focused attention on social, interpersonal functioning as an outcome measure in the treatment of depression, and a number of key studies[11,57–59] have examined its effects. While the benefits of psychotherapy were demonstrated in all these studies, the data appear to suggest that the effects of psychotherapy may be less rapid than those seen with antidepressant therapy. However, this approach remains useful, particularly in patients for whom medication is unsuitable (e.g., during pregnancy, in refractory or noncompliant patients) and as a maintenance therapy. Furthermore, its use in combination with pharmacotherapy may promote compliance with treatment and reduce the dropout rate. The effectiveness of certain psychotherapeutic approaches in the treatment of depressive disorders is clear. However, whereas a number of early studies also showed significant benefits in social functioning, more recent studies appear to have neglected this important area of outcome research.

CONCLUSIONS AND RECOMMENDATIONS

Impairments in social functioning associated with depressive disorders are serious and pervasive. They affect not just the individual, but also marriages, families, and work environments. Deficits in social functioning often persist after symptomatic recovery, and, if untreated, such persistent impairments may contribute to a poor prognosis in long-term depressed patients. In clinical practice, an integrated approach is recommended that should include an assessment of social functioning in addition to the standard symptom assessment.

Clinical tools are available that begin to address the problem of impaired social functioning. A number of specific rating scales are available, suitable for use both in clinical trials and for monitoring patients under more standard care. Antidepressants in general appear to relieve the symptoms of impaired social functioning, although recent evidence raises the possibility of differential effects between the antidepressant classes.

Additional research is recommended in a number of areas. These include the time course of impaired social functioning compared with that of depressive symptoms, the efficacy of the various psychotherapeutic approaches currently available in relieving impaired social functioning acutely, the comparative efficacy of individual antidepressants, and long-term efficacy of both psychotherapy and pharmacotherapy in improving social functioning.

Drug names: amitriptyline (Elavil and others), desipramine (Norpramin and others), fluoxetine (Prozac), phenelzine (Nardil), sertraline (Zoloft), reboxetine (Vestra).

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