Depression is the leading global cause of life-years lived with disability and might be associated with premature mortality. A strong body of evidence demonstrates the coexistence of depression in many chronic medical illnesses. Onset of a disabling medical illness is, understandably, a risk factor for a depressive episode in vulnerable persons; however, a burgeoning field of research is discovering that depression itself might be a causal factor in different illnesses, such as ischemic heart disease, stroke, cancer, and epilepsy (Carpiniello et al., 2009).

On the one hand this evidence has strengthened the hypothesis that some common biological mechanism might underlie physical and mental disorders. For instance, inflammation appears relevant to mood disorder across several important domains. Patients who have major depressive disorder show alterations in immunologic markers including increases in proinflammatory cytokine activity and inflammation. Inflammation of the central nervous system is a pathologic hallmark of physical illnesses, such as multiple sclerosis (Gold & Irwin, 2009). Accumulating evidence from animal studies suggests that some aspects of depression and fatigue in multiple sclerosis may be linked to inflammatory markers. Further research is warranted to parse the reciprocal associations between inflammation and symptoms, comorbidities, and treatments effectiveness (Goldstein et al., 2009). Studies of this topic are needed, and might greatly contribute to shed light on the pathophysiology of depression, as thoroughly debated in this issue’s first Editorial by Carmine Pariante.

On the other hand, it is clear that, unfortunately, this evi...
evidence has not resulted in improved patient care. A number of well-controlled studies demonstrate the efficacy of antidepressants and psychotherapy in treatment of depression in medically ill patients. Sustained attention to this issue has been given by official bodies operating in the field of Health, an example of this being the Clinical Guidelines “Depression in adults with chronic physical health problems. Management and Treatment” issued in October 2009 by the NICE, under the leadership of Sir David Goldberg. In spite of this, the quality of depression care for medically ill patients attending General Practice and General Hospital care is often poor and depression is under-diagnosed and undertreated in these settings.

Many factors contribute to the poor quality of depression care in this subgroup of patients: provider-related factors such as disposition, skills, attitudes, and practice toward mental health care; patient-related factors including perceived stigma associated with mental disorders and treatment, confounding somatic and cognitive symptomatology, and a lack of patient awareness of psychological distress; lack of clarity on which indicators of outcomes should be prioritized: intermediate or short-term measures; mortality; morbidity and treatment complications; rates of relapse; readmission; return to work, physical and social functioning and other measures such as quality of life; general health status; costs (National Institute for Clinical Excellence, 2009).

Finally, scepticism about the relevance of quality-of-life targets in chronically or terminally ill patients also might preclude efforts at intervention. To counteract these beliefs with concrete actions, as detailed in the second Editorial of this Issue, Susan Block, Professor of Psychiatry and Medicine at the Harward Medical School in Boston, has dedicated most of her professional life to address the issues of diagnosis and treatment of depression in patients with advanced illness. As the conceptualizer, founder and National Program Director of the Project on Death In America Faculty Scholars Program, and Member of the American Boards of Internal Medicine and Hospice and Palliative Medicine, she has created a set of Core Competencies for Hospice and Palliative Medicine, to develop an intensive clinical training program in palliative medicine, inclusive of a specific approach to deal with depression in this group of patients.

But also the bidirectional interactions between depression and chronic medical illnesses might be a difficult to treat comorbidity. The interaction between diabetes and depression might be considered a good model to gain a deeper understanding of the topic. Depression has been shown to be associated with bio-chemical alterations, such as increased serum glucocorticoids, catecholamines, insulin resistance, and secretion of inflammatory cytokines, which could ultimately facilitate development of diabetes. Co-occurrence with depression in diabetic patients is associated with nonadherence to oral hypoglycemics, poor glycemic control, more severe symptoms, increased health-care costs (National Institute for Clinical Excellence, 2009; Serrano-Aguilera, 2009). Infine, il diffuso scetticismo sul fatto che l’obiettivo del preservare la qualità della vita sia in qualche modo meno rilevante nei pazienti cronici o terminali ha spesso precluso la messa a punto e l’attuazione di interventi mirati a questo sottogruppo di soggetti. Per contrastare tale attitudine con azioni concrete, come illustrato dettagliatamente nel secondo Editoriale di questo numero di EPS, Susan Block, Professor of Psychiatry and Medicine alla Harward Medical School di Boston, ha dedicato gran parte della sua vita professionale alla diagnosi e trattamento della depressione nei pazienti con malattie terminali. Come fondatore e Direttore del Project on Death in America
care costs, and progression and earlier onset of vascular complications, disability, and death (Evans et al. 2005).

The comorbidity between depression and diabetes has requested the development and testing of the effectiveness of specific forms of psychotherapy, as described in the editorial by Jeffrey Gonzales, as part of his hallmark work in this field (Saffren et al., 2008). His studies identified psychosocial factors associated with treatment adherence in adults with type 1 and type 2 diabetes and targeted strategies to administer individual and group CBT to treat depression and improve adherence and self-care in this group of patients.

In conclusion, the Editorials published in this issue of EPS not only highlight the pathogenetic, clinical and treatment specificity of depression in co-morbidity with physical illnesses, but also challenge the model of interdisciplinary collaborative care, whose focus should be placed on:

a) close collaboration between primary and secondary physical health services and specialist mental health services;

b) a range of interventions including patient education, psychological and pharmacological interventions, and medication management;

c) long-term coordination of care and follow-up.

Multidisciplinary and innovative interventions in this area should thus contribute to re-shape and improve the real world practices in liaison psychiatry and general hospital psychology.

REFERENCES


Faculty Scholars Program e Membro dell’American Boards of Internal Medicine and Hospice and Palliative Medicine ha sviluppato un programma di training clinico intensivo in medicina palliativa, inclusivo di uno specifico approccio per affrontare la depressione in questo gruppo di pazienti.

Ma anche le interazioni bidirezionali fra depressione e disturbi fisici cronici possono dare origine ad una comorbilità difficile da gestire. L’interazione fra diabete e depressione può costituire un buon modello per meglio comprendere questo aspetto. È stato dimostrato che la depressione è un fattore di rischio per il diabete tipo 2 in quanto è associata con alterazioni biochimiche, quali aumentati livelli sierici di glucocorticoidi, catecolamine, insulino-resistenza, secrezione di citochine, che possono favorire l’insorgenza del diabete. È inoltre stato dimostrato che la depressione in corso di diabete è associata a bassa adesione agli ipo-glicemizzanti orali, scarso controllo glicemico, sintomi più gravi, aumentati costi sanitarì e progressione precoce verso complicanze vascolari, disabilità e morte (Evans et al., 2005).

La frequente comorbilità fra depressione e diabete ha indotto i clinici ed i ricercatori a mettere a punto e testare l’efficacia nella pratica di forme specifiche di psicoterapia, come descritto nell’Editoriale di Jeffrey Gonzales, quale parte del suo lavoro magistrale in questo ambito (Saffren et al., 2008). I suoi studi hanno identificato i fattori psicosociali associati all’adesione ai trattamenti nei pazienti affetti da diabete di tipo 1 e 2 ed hanno individuato strategie mirate per somministrare una terapia ad orientamento cognitivo-comportamentale, individuale o di gruppo, mirata a trattare la depressione, migliorare l’aderenza e la cura di sé in questo gruppo di pazienti.

In conclusione, gli Editoriali pubblicati in questo numero di EPS non solo illustrano il modello patogenetico, il profilo dei rischi e le possibilità di trattamento per la depressione in comorbilità con malattie fisiche, ma forniscono anche spunti di riflessione sul modello interdisciplinare della “collaborative care”, centrato su:

a) stretta collaborazione fra servizi sanitari di primo e secondo livello e servizi specialistici per la salute mentale;

b) una serie di interventi che includono informazioni, terapie psicologiche e farmacologiche, gestione medica;

c) coordinamento a lungo termine della presa in carico e follow-up.

Gli interventi multidisciplinari ed innovativi sperimentati in quest’ambito potranno contribuire non poco a riformulare e migliorare le pratiche nei servizi del mondo reale per quanto riguarda la psichiatria di liaison e la psicologia ospedaliera.

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