Introduction

Chronic Major Depression: A Review and Update

A. John Rush, M.D.

Major depressive disorder has commonly been conceptualized as an episodic, recurrent condition. However, recent findings[1,2] indicate that a chronic course is far more common than originally believed. Further evidence[3,4] indicates that even if the major depressive episode "ends," meaning that symptoms are insufficient in number or pervasiveness to meet DSM-IV criteria for an episode of major depression, many patients still have "residual symptoms," which, in turn, are associated with poorer function and a worse prognosis[1,5] than are found in patients who attain a fully remitted or "asymptomatic" state. Thus, a chronic course may entail (1) an extended period (≥ 2 years in a full-blown major depressive episode); (2) a recurrent, episodic course with residual symptoms (i.e., incomplete interepisode recovery); or (3) the co-occurrence of major depressive disorder and dysthymic disorder, which classically is itself characterized by incomplete interepisode recovery.

Harold A. Pincus, M.D., and Amy R. Pettit introduce the topic of chronic depression by providing epidemiologic and course of illness data, followed by information on the burden of illness for both society at large and the affected individual patient, including cost data. They conclude with a discussion of the effect of conceptualizing depression as a chronic condition on the structure and procedures recommended for daily clinical practice.

David L. Dunner, M.D., reviews the evidence for the efficacy of medication, psychotherapy, and their combination in the treatment of chronic depression, including dysthymic disorder. Recent results of the comparison of nefazodone, Cognitive Behavioral Analysis System of Psychotherapy (CBASP),[6] and the combination are presented,[7] including data on the acute, continuation, and crossover phases of that landmark study.

Andrew A. Nierenberg, M.D., highlights key issues in the long-term management of chronic depression. The data provide strong evidence for the need to attain full symptom remission, as opposed to a simple response in which residual symptoms are still present. He provides important comments on the need to select among antidepressant agents for the longer term that have minimal/modest side effect burden. Finally, the role of psychotherapy in preventing relapse is discussed.

Madhukar H. Trivedi, M.D., and Beverly A. Kleiber, Ph.D., provide a seminal discussion on the potential utility of treatment algorithms to provide a highly efficient but individually tailored approach to patients with chronic depression by raising the following questions, which are discussed in the context of an incompletely successful first (or second) treatment: (1) Which treatments are recommended and at what steps? (2) How long should a treatment be tried before declaring failure? and (3) When

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The symposium "Chronic Major Depression: A Review and Update" was held May 9, 2000, in Boston, Mass., and supported by an unrestricted educational grant from Bristol-Myers Squibb Company.

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should the initial medication be augmented with a second treatment, as opposed to switching from one treatment to another?

Finally, Lydia J. Lewis, Executive Director of the National Depressive and Manic-Depressive Association (National DMDA) provides a front-line view of many issues encountered by depressed patients seeking professional help. She highlights patient, provider, and health care system obstacles to preferred care and the role of the National DMDA in public education, as well as in patient and provider education.

This series of incisive and informative articles provides both basic and more recent information that, if applied in routine daily practice, will certainly improve both the quality of care and the clinical outcomes of those individuals afflicted with chronic depression. The reconceptualization of depression as a more chronic or recurrent illness than previously recognized has direct implications for restructuring our clinical practices and for changing incentives and attitudes of both patients and providers. The reader is sure to find these reports highly informative.

REFERENCES

1. Keller MB, Lavori PW, Mueller TI, et al. Time to recovery, chronicity, and levels of psychopathology in major depression: a 5-year prospective follow-up of 431 subjects. Arch Gen Psychiatry 1992;49:809–816
2. Lavori PW, Keller MB, Scheftner W, et al. Recurrence after recovery in unipolar MDD: an observational follow-up study of clinical predictors and somatic treatment as the mediating factor. Int J Meth Psychiatr Res 1994;4:211–229
3. Fava GA, Grandi S, Zielezny M, et al. Cognitive-behavioral treatment of residual symptoms in primary major depressive disorder. Am J Psychiatry 1994;151:1295–1299
4. Miller IW, Keitner GI, Schatzberg AF, et al. The treatment of chronic depression, pt 3: psychosocial functioning before and after treatment with sertraline or imipramine. J Clin Psychiatry 1998;59:608–619
5. Judd LL, Akiskal HS, Maser JD, et al. A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. Arch Gen Psychiatry 1998;55:694–700
6. McCullough JP Jr. Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy. New York, NY: Guilford; 2000
7. Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the Cognitive Behavioral Analysis System of Psychotherapy, and their combination for the treatment of chronic depression. N Engl J Med 2000; 342:1462–1470