# Introduction

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The focus of this supplement is on four of the most chronic and common mental illnesses: panic disorder, obsessive-compulsive disorder (OCD), chronic depression, and treatment-resistant depression. Included will be the epidemiology, differential diagnosis, associated impairment, time to recovery, and time to relapse and recurrence. This will be followed by a discussion of the somatic and psychotherapeutic treatment of these conditions.

It is well established that approximately one third of people who suffer from major depression will have a chronic course marked by at least 2 years of illness. Approximately 50% of people with anxiety disorders also will have a course marked by chronicity of at least 2 years' duration. Of people with depression or anxiety, a high proportion will suffer relapse or recurrence after recovery.

Chronic depressive disorder is estimated to have about 3% to 5% prevalence in the United States, or represent one third of all people suffering from depressive disorders. There are high rates of psychosocial and physical impairment and a 15% probability of suicide for individuals hospitalized at least once with major depression.[1] High rates of comorbidity with other Axis I and Axis II disorders are now well documented.

Although diagnostic criteria have been refined, there is not yet sufficient evidence to validate the distinction between dysthymia, chronic major depression, and double depression. The so-called chronic depressive disorders, particularly dysthymia alone, had largely been discounted in importance until recently. The sufferers of these disorders were among the most difficult of patients to treat, and the limited data from controlled trials caused much frustration for clinicians. Treatment by clinicians tended to be exclusively psychotherapeutic in nature. There was a real question about whether or not the disorders belonged in the province of medical psychiatry.

As far as time to recovery is concerned, data confirm a high rate of chronicity with depressive disorders. A prospective naturalistic cohort study showed that 50% of people with panic disorder will not have recovered after 2 years, while panic disorder combined with agoraphobia has a 20% recovery rate.[2] With OCD, 83% have not yet recovered after 2 years. Those who do recover have a high rate of relapse and recurrence: approximately 40% for panic disorder alone, approximately 60% for panic and agoraphobia, and 20% for OCD (Keller MB. 1997. Unpublished data).

Data from Wells and colleagues[3] show that people suffering from either dysthymia alone or double depression have significantly greater impairment in functioning than those with present major depression alone, depressive symptoms, or past episodes of major depression. In addition to greater impairment in psychosocial and physical functioning, the presence of double depression or dysthymia shows a greater probability that the depressive symptoms will be more long-lasting and recurrent than in episodes of major depression.

The National Depressive and Manic Depressive Association sponsored a consensus conference in January 1996,[4] which concluded that less than 10% of the people in the

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United States currently suffering from major depression receive the proper treatment in an adequate dosage for a sufficient duration of time. One third of individuals with depression do not seek treatment at all. Approximately another one third receive some medical treatment but no mental health treatment. Of the final one third who do get mental health treatment, less than one half receive adequate treatment.

Approximately one quarter of the population will suffer from an anxiety disorder at some point in their lives. For each of the anxiety disorders, over half of the individuals who have had a lifetime diagnosis are still currently ill with that condition. That is one way of estimating the chronicity and persistence of these disorders.[5]

Regarding impairment in functioning, based on data from Wells et al.,[3] depressive symptoms conferred a degree of functional and physical impairment comparable to, if not greater than, that caused by other chronic medical disorders.[6] Data for panic disorder and OCD from the Harvard/Brown Anxiety Disorders Research Program (HARP) study found that both disorders confer the same degree of social functioning impairment and physical functioning impairment as depressive symptoms, with a greater degree of impairment than diabetes or arteriosclerotic heart disease.[2]

Over 80% of people with anxiety disorder have had some psychotropic treatment in the first 6 months, but even when they are treated, the vast majority receive substantially less than the recommended therapeutic dose.[7]

The cost estimate in 1990 for depressive disorders (approximately $44 billion) is comparable to that for coronary heart disease ($43 billion), AIDS ($60 billion), and cancer ($104 billion).[8] According to estimates from the Massachusetts Institute of Technology group, of the $44 billion cost estimate, only about 28% (just over $14 billion) is for what is considered direct cost (payment for the care).[9] The rest of the money is the indirect cost of lost productivity or early death due to suicide. In summary, these are chronic disorders that greatly impair their sufferers, and they deserve our focus and energy on better understanding and treatment.



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