

## **Chronic Major Depression: A Myth Or A Reality**

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### **INTRODUCTION**

Depression is one of the most common clinical conditions seen in medical or psychiatric settings. Depression was long regarded as a disorder with a benign course of illness. Most episodes of depression were thought to be transitory. Kraepelin emphasized a favorable prognosis for the manic depressive disorder in comparison to schizophrenia and this hypothesis received a further boost with the introduction of antidepressant medications in the 1950s.<sup>1</sup> Yet depressive disorders frequently take a chronic course, and this has come into increasing focus.<sup>2-5</sup> Despite the long-standing notion that depression is a time limited illness that responds well to treatment, a significant minority of patients suffer from chronic depressive symptoms.

Chronic depression is variously defined as persisting for more than one year or more than two years, with a preference for the two-year definition.<sup>6</sup> Although there is no consensus regarding the criteria, DSM-IV<sup>7</sup> defines chronic depression as a condition where the full criteria for a major depressive episode have been continuously met for two years or more. Scott<sup>3</sup> and Keller et al<sup>8</sup> additionally allow for a period of symptomatic 'non-recovery' during a two-year episode, so that a period of partial remission falls within their definition. The most acceptable definition, available at present was put forward by Cassano et al.<sup>9</sup>: "Chronicity refers to symptomatic non-recovery for a period of 2 or more years and may be a sequel to one or more episodes of depression from which the patient doesn't recover".

The boundary with normality is particularly meaningful to draw in assessing chronic depression. Not all people who have a gloomy perspective of life qualify for a diagnosis of chronic major depressive disorder or dysthymic disorder. It is important to ensure that not only is there persisting depressed mood but also that each of the individual symptoms have persisted as well. In addition, the individual must suffer significant functional impairment in order to differentiate from the "aches and pains of every life".

The evaluation of chronic depression is further complicated by the fact that the patient is usually depressed at the time of assessment and is likely to remember past events in a negative manner.

Quality of life for those suffering from chronic depression is poor, resulting in occupational dysfunction i.e. unemployment, absenteeism, decreased work productivity, poor emotional health related to interpersonal problems, high rates of co-morbid anxiety disorders, alcohol use or dependence and high rates of physical disorders.<sup>10-12</sup>

Families face financial problems, there is disruption of routine family activities and family leisure, disruption of family interaction, physical and psychological health of others gets affected.

### **CLASSIFICATION OF CHRONIC DEPRESSION**

The classification of depression in DSM-II<sup>13</sup> was based on severity (psychosis v/s neurosis) and presumed causes (i.e. involuntal v/s reactive v/s personality pattern). In contrast, DSM-III<sup>14</sup> classification was based on symptom pattern, symptom severity and course. Duration of 2

weeks to diagnose major depressive episode was introduced. Dysthymic disorder was introduced into DSM-III to describe a non-episodic chronic depression with a symptom severity below that for major depressive disorder.

In recognition of the importance of chronic forms of major depressive disorder, DSM-III-R introduced a chronic specifier for episodes that have persisted for more than 2 years.<sup>15</sup>

DSM-IV provides two diagnoses for classifying chronic depression, which may be used by themselves or in combination; major depressive disorder and dysthymic disorder. Major depressive disorder and dysthymic disorder are differentiated on severity, chronicity and persistence.<sup>7</sup>

Most classically, major depressive disorder consists of one or more discrete major depressive episodes that can be distinguished from the individual's usual functioning, whereas dysthymic disorder is characterized by chronic, less severe depressive symptoms that have been present for many years. There has been controversy over which symptoms best define dysthymic disorder.<sup>16</sup> The results of the DSM-IV mood disorder field trial suggests that the presentation of dysthymic disorder may be more characterized by cognitive symptoms and less by vegetative symptoms.<sup>17</sup>

According to Frances et al<sup>16</sup> division between major depressive disorder and dysthymic disorder is somewhat artificial. Having two distinct definitions with two different criteria sets is an attempt to operationalise an algorithmic distinction. Alternatively, major depressive disorder and dysthymic disorder may be waxing and waning course of a single depressive disorder. Retrospectively, it can be quite difficult to determine the nature of the onset, especially as the difference between severe dysthymic disorder

and mild major depressive disorder can be very thin.

In 1980, DSM-III, replaced the category of neurotic depression with dysthymic disorder which legitimized the existence of chronic depression but perpetuated the idea that it is a minor illness arising as a consequence of an underlying personality disorder. DSM-III criteria differ from RDC (Spitzer et al, 1978) and ICD-9 criteria (WHO, 1978) only in the age of onset of the disorder (RDC and ICD-9 suggesting an onset in early adult life, DSM-III requiring two or more years of minor depression at any age).<sup>14,18-19</sup>

Scott in his review paper proposed a classification of chronic depression:<sup>3</sup>

1. Chronic Primary Major Depression: Usually of late onset, an unresolved major depressive episode without evidence of a pre-existing chronic minor disorder. The individual may have a unipolar or bipolar disorder.
2. Chronic Secondary Major Depression: An unremitting major depression arising secondary to physical ill health or non-affective psychiatric disorder.
3. Characterological or Chronic Minor Depression (Dysthymia Disorder): This covers a heterogeneous group of patients. The disorder had an ill-defined onset in early adulthood and appears to be interwoven with the character style. The symptoms are generally of minor nature.<sup>3</sup>

Double depression: Acute major depressive episodes are superimposed on an underlying chronic minor disorder. On recovery from the major depressive episode, the individual returns to his or her premorbid dysthymic baseline.<sup>20</sup>

### Relationship between subtypes

According to published research, chronic primary major depression accounts for approximately 30% of all chronic depressive illness. Chronic

secondary and characterological disorder have a worse prognosis than chronic primary depressions, but the outcome for all groups is unimpressive.<sup>9, 21-22</sup>

The relationship of chronic minor to chronic major depression is unclear. The minor disorder may be minor subsyndromal precursor or residue of the major disorder, differing only in severity or it may reflect a qualitatively different disorder that predisposes to, or arises as complication of, a chronic major depression.<sup>21</sup>

#### **Chronic depression v/s treatment resistance**

An important distinction needs to be made between treatment resistant depression and chronic depression. Term “chronic” refers to a prolonged, lingering condition whereas treatment resistance means a condition that is difficult to treat, regardless of its duration. Although chronicity may be the result of true resistance to treatment, it also is related to other factors. Significant proportions of depressed patients remain undiagnosed or continue to be treated improperly, thereby making chronicity a relatively common phenomenon in depression.

#### **Chronic depression v/s personality disorders**

Once a depressive episode is in progress, it is often difficult to reliably determine the patient's premorbid personality, as trait and state characteristics become confounded.<sup>23</sup> There are indications that premorbid ‘neurotic personality traits’, as assessed by the Eysenck Personality Questionnaire (EPQ) predict a chronic course of major depression.<sup>24-25</sup> It is also believed that experiencing a depression can bring about personality changes. Although little research has been done yet on the chronicity of depression in relation to personality disorders as classified by DSM, there is some evidence that treatment response is poorer when depression coincides

with a personality disorder.<sup>26</sup>

This implies a greater risk of chronicity. Chronic depression may occur with personality disturbance, particularly with borderline, histrionic, narcissistic, avoidant and dependent personality disorders. The boundary between chronic depression and personality disorder can be quite difficult to draw. DSM-IV defines personality disorder as a pervasive pattern of inner experiences that is maladaptive and inflexible with an onset by early adulthood. Sometimes it is difficult to differentiate between a chronic mood disturbance and a personality disorder. In fact, one of the disorders proposed for DSM-IV was a new personality disorder characterized by a pattern of depressive cognitions and behaviors (depressive personality disorder).<sup>7</sup>

Depressive and comorbid personality disorders relate to one another in 3 distinct ways:

1. Personality disorders may precede the development of depression and render an individual vulnerable to depression.
2. Depression may precede the personality disorder and foster the development of personality disorder.
3. There may be an interface between personality and depression, which has been deemed depressive personality disorder.

Hirschfield et al found that chronic depressives showed more emotional instability, less objectivity and a greater tendency to “break under stress”. They suggested that this meant that chronic patients were more “thin skinned”.<sup>27</sup> Several authors have suggested that any character abnormality found in chronic depressives represent deterioration in the personality as a secondary consequence of a prolonged illness.<sup>28</sup> Kraepelin has described such

cases, and Kraines reported that the exaggeration of premorbid neurotic traits was a common feature of chronic depression.<sup>28</sup>

Akiskal et al<sup>21</sup> noted that the illness was often classified as characterological by those who had not seen the patient during acute phase. Scott et al<sup>29</sup> suggested that while many chronic depressives were categorized as having personality disorder during the course of chronic illness, this diagnosis was rarely recorded in their case notes during previous illness episodes.

### DEMOGRAPHIC CHARACTERISTICS

Chronic forms of depression are found in 9-31% of patients with mood disorders and in 3-5% of persons identified in community based epidemiological surveys.<sup>30</sup> For clinical populations, a prevalence of chronic depression (lasting at least two years) between 9% and 19% has been found.<sup>4-5,25,31-33</sup> This is consistent with earlier estimates.<sup>3,6</sup> Although its prevalence in the community is believed to be lower than in treated populations, it is unclear whether the course of depression would be essentially different.<sup>34-36</sup>

This wide variation in the prevalence of chronicity is probably attributable to the different populations studied, the non-uniformity of the diagnostic criteria for depression, the assessment method employed, and the definition of chronicity used. A depressive may be perceived as chronic because of the persistence of affective symptoms, impaired social functioning, or more rarely, because of change in symptomatology – the illness persisting in a non-affective form.<sup>37-38</sup>

Although the prevalence of depressive disorders is known to be higher for women than for men<sup>39,40</sup>, no gender differences have been found in clinical populations with regard to the risk of a chronic course.<sup>41-42</sup> However, one study found it to be higher in the females above 30 yrs of age.<sup>43</sup> An early age of onset has been

implicated as a risk factor in a clinical population but not in the general population.<sup>43-44</sup> In terms of socio-economic status, Keller et al<sup>4,5</sup> found an association between low income and chronicity for the clinical population, and Sargeant et al<sup>43</sup> linked a low level of education to chronicity in the general population.

### COURSE

The course of a major depressive episode is highly varied. Often no full recovery is achieved, but the depressive symptoms merely ease (partial remission). An estimated 40-60% of all adequately treated depressions achieve full remission, 30% achieve partial remission and 20% show no improvement at all.<sup>45</sup>

It is important to adequately define the terms recovery, remission and partial remission.

The average duration of a depressive episode is six months.<sup>6</sup> The Collaborative Study of the Psychobiology of Depression (CDS) by the National Institute of Mental Health (NIMH) in the USA is the largest clinical study done on the course of (major) depression, examining 431 depressed patients at six month intervals.<sup>4-5,27,31,46-48</sup> Of the patients with unipolar depression, 19% had not recovered after two years, 12% not after five years (Coryell et al, 1990) and 7% not after ten years.<sup>48</sup>

### CONCLUSION

Using the definition of chronic depression as persistent symptoms for two or more years, it is suggested that the prevalence of chronicity is 12-15%. The cumulative risk of developing a chronic illness is about 30% for an individual from a cohort of patients with major depression.<sup>49</sup>

From the studies done so far, one can infer that chronicity in major depression is multifactorial, but the number and quality of studies available is insufficient to allow any final

conclusions to be drawn. Female patients particularly those with neurotic premorbid personality traits suffer from chronic depression more frequently, especially if they fail to receive maintenance treatment. Individuals with unipolar disorders are more at risk, and those with a higher familial loading for such disorders are more vulnerable. Whether this represents a genetic predisposition is not clear; as yet, no specific biological markers have been identified. Review of literature also highlights the iatrogenic etiology of chronic depression in a significant number of patients. It is hoped that this problem will be resolved in future by the early introduction of adequate and appropriate antidepressant treatment.

Studies done later on chronic depression have employed more sophisticated methodologies but many of these studies involved small patient sample. More prospective work is needed to distinguish secondary complications from predisposing or precipitating factors; the paucity of biological research in the area is disappointing. The exclusion of chronic depressives from previous studies seemed to be a function of the atypical nature of illness, and because of the belief that personality disorder rather than affective illness predominated.

Interpersonal disturbances in such patients are usually secondary to the distortions produced by long standing depression. Therefore, observed pathological characterological changes like clinging or hostile dependence, demandingness, touchiness, pessimism, and low self-esteem are best considered as "post depressive personality" changes. The long durations of the disorder often leads the patients to identify with the failing functions of depression, producing the self-image of being a depressed persona. The self-image itself represents a malignant cognitive

manifestation of the depressive disorder and dictates vigorous treatment targeted at the mood disorder. More systematic and effective depression treatment programmes might have an important effect on long-term course and reduce the overall rates of chronic depression.

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