A CLINICAL STUDY OF CHRONIC DEPRESSION

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SUMMARY

Nosological status of chronic depressive states have not been resolved as yet. Recent classificatory systems ICD-X and DSM-III-R have included chronic depression under affective disorders and have done away with the category of neurotic depression. The present study was undertaken with the aims of (a) to study clinical variables associated with major subtypes of chronic depression (chronic major depression and dysthymia) and (b) to investigate personality characteristics and life events associated with major subtypes of chronic depression. The sample was drawn from outpatients and inpatients as per DSM-III-R criteria. 30 patients were studied (21 chronic major depression and 9 dysthymia). They were administered Hamilton Depression Rating Scale, Eysenck Personality Inventory and Interview for recent life event (Paykel and Mangen, 1980) and details of sociodemographic and clinical variables were recorded. Symptomatically dysthymia and chronic major depression are indistinguishable. More patients of dysthymia have positive family history of depressive disorder. Dysthymics had significantly higher score on neuroticism. All chronic depressives tend to report more life stresses during the course of illness.

It is increasingly being recognised that all depression do not run a classical episodic course and as many as 15-20% of depression run a chronic course (Robins and Guze, 1979). Depression lasting 2 to 3 years are not uncommon and many have a unremitting course over decades or even a life time (Price, 1978; Kraines, 1967) However, inadequate treatment is not likely to be a major cause of chronicity since most depressions do remit spontaneously or pursue an episodic course (Krapelin, 1921; Murphy et al., 1974 and Angst et al., 1979).

Only recently the concept of chronic depression has attracted the attention of researchers. DSM-III for the first time included chronic forms of depression in its classification of affective disorders, which was further elaborated and modified by DSM-III-R. I.C.D.-X (draft) has also placed chronic depression under the category of affective disorders. Both these recent nosological systems have done away with the category of neurotic depression and added new categories of dysthymia and chronic major depression. This change represents an important theoretical shift and a reconceptualization of chronic depression.

Thus, it appears worthwhile to evaluate the clinical variable associated with chronicity in depressives. Some work in this regard has been done in West (Akiskal, 1983; Keller et al., 1982; 1986; Kocsis and Frances, 1987). Factors associated with chronicity in major depressive disorders have been studied by few workers (Weissman & Klerman, 1977; Hirschfield et al., 1986; Brown et al., 1988).

This study was undertaken with the following objectives:

1) To study clinical variables associated with chronic major depression and dysthymia.

2) To investigate personality characteristics and life events associated with chronic depression.

Material and Method

The study sample was drawn from freshly registered outpatients and inpatients of department of psychiatry, K.G's. Medical College, Lucknow. Patients giving history of depression for 2 years or more were screened for inclusion in the study. Subjects fulfilling DSM-III-R criteria for chronic major depression and dysthymia were included. Those without a reliable informant and below the age of 16 years or above 60 years were excluded.

Patients were assessed on semistructured proforma which included socio-demographic variables, present history, past history, treatment details, family history, personal history, permorbid personality assessment, clinical examination and mental status examination. They were also administered Hamilton's depression rating scale, Eysenck-personality inventory and interview for recent life events (Paykel and Mangen, 1980). This life event schedule is a list of
events for administration as a semi-structured interview. It contains 63 events and specific variables are grouped into categories like work, education, finance, health, bereavement, migration, family and social relationships. In addition, there is a facility for recording an event which can't be classified in these predefined categories. This life event's inventory has been designed for use for a six month review period, although it can be used for other time periods also. For each event rating of objective negative impact, independence and month of occurrence are recorded.

Data was analysed by Chi-square test and Student 't' test.

Observation

One thousand and thirty three new outdoor patients were screened. Fifty seven patients had history of depression of more than 2 years. However, 8 of these patients did not turn up for appointment, 13 patients were excluded as they did not fulfill the diagnostic criteria of DSM-III-R (7 had discontinuous illness, 4 had history of associated psychotic illness and 2 were on antihypertensive drugs). Besides these five patients were excluded due to lack of reliable informant, one patient was over sixty years of age (in all 27 patients were excluded from the study). Total study sample finally included thirty patients. Twenty one of these were diagnosed as cases of chronic major depression and 9 dysthymia as per DSM-III-R diagnostic criteria.

Mean age of chronic major depressives was 38.04 ± 9.2 years while of dysthymics was 32.0± 7.6 years. Majority of the chronic major depressive patients had duration of illness between 2-5 years and most of dysthymic patients had duration of more than 5 years. Prior to inclusion in the study most of the patients had sought medical treatment (76.6%) but less than 50% of them had received even 75 mg of imipramine/amitriptyline for three weeks. None of the patients had received ECT.

Severity of illness as per Hamilton's depression rating scale in both the groups was almost similar (chronic major depression 24.61± 6.41, dysthymia 21.55± 4.45). Most of the patients did not have any associated psychiatric or physical illness. Patients of chronic major depression did not have any family history of psychiatric illness. However, patients of dysthymia had family history of depression in first degree relatives in significantly high percentage i.e. 33.3% of patients ($X^2=4.2$, d.f.= 1, p<0.05).

Table-1. ONSET OF ILLNESS IN PATIENTS OF CHRONIC DEPRESSION

|          | Chronic major depression (N=21) | Dysthymia (N=9) |
|----------|-------------------------------|-----------------|
| Acute    | 4 (19.0)                      | -               |
| Insidious| 17 (80.9)                     | 9 (100.0)       |
| Early    | 4 (19.0)                      | 7 (77.7)        |
| Late     | 17 (80.9)                     | 2 (22.2)        |

$X^2=9.35$, d.f. = 1, p<0.01

Table No. 1 shows that generally the patients of chronic depression had an insidious onset. Age of onset has been divided into early and late. Early onset means development of illness before 21 years of age and late onset means development of illness at or after 21 years of age. This division is in accordance with DSM-III-R classification system. Most of the patients of chronic major depression (80.9%) had a late while majority of the

Table-2. SYMPTOM PROFILE OF CHRONIC MAJOR DEPRESSION AND DYSTHYMIA

| Symptoms            | Chronic major depression (N=21) | Dysthymia (N=9) |
|---------------------|--------------------------------|----------------|
| Depressed mood      | 21 (100)                       | 9 (100)        |
| Feeling of heaviness/Ache/Exigwability | 21 (100) | 9 (100) |
| Loss of libido      | 20 (95.2)                      | 6 (66.6)       |
| Thoughts of death/suicide | 18 (85.7) | 4 (44.4) |
| Insomnia early      | 18 (85.7)                      | 7 (77.7)       |
| Psychomotor retardation | 18 (85.7) | 6 (66.6) |
| Anxiety-Psychic     | 18 (85.7)                      | 9 (100)        |
| -Somatic            | 18 (85.7)                      | 8 (88.8)       |
| Preoccupation       | 18 (85.7)                      | 8 (88.8)       |
| Loss of weight      | 14 (66.6)                      | 2 (22.2)       |
| Loss of appetite    | 17 (80.9)                      | 6 (66.6)       |
| Insomnia-middle     | 14 (66.6)                      | 7 (77.7)       |
| Diurnal variation   | 13 (61.9)                      | 4 (44.4)       |
| Insomnia late       | 13 (61.9)                      | 5 (55.5)       |
| Work-loss of interest | 10 (46.7) | 4 (44.4) |
| Psychomotor agitation | 9 (42.8) | 3 (33.3) |
| Guilt feeling       | 4 (19.0)                       | 3 (33.3)       |

(Symptoms are mutually inclusive. Figures in parenthesis indicate percentage).
patients of dysthymia (77.7%) had an early onset. This difference was found to be statistically significant ($X^2=9.35; \text{d.f.}=1; p<0.01$).

Table No. 2 shows that depressed mood, feeling of heaviness, easy fatigability, difficulty in sleeping, anxiety and somatic preoccupation are the commonest symptoms in the sample. Most of the symptoms listed are found to be comparable in both the groups. However, loss of libido, loss of weight, thought of death or suicide were more prominent in patients of chronic major depression.

Table 3 shows that means scores of neuroticism were significantly higher in patients of dysthymia.

Table No. 4 indicates that about half of chronic depressives had one or more stressful events during the period of 6 months before onset of illness. While nearly three fourth of the patients had some independent stressful life events during course of their illness.

Discussion

The sample of this study was taken from a psychiatric clinic which limits its usefulness. Secondly the sample size is too small due to which no generalisation can be made. Further one can not reliably comment on the epidemiological aspects of chronic depression with a clinic sample. The incidence of chronic depression is 15-20% when depression is followed for a period of time (Keller et al, 1982; Akiskal et al, 1978; Bronisch et al, 1985). Weisman & Myers (1978) have found incidence of chronic depression in general population to be around 4.5%.

In this study twenty one patients were of chronic major depression and only nine were of dysthymia. Small number of dysthymics in a psychiatric clinic is an expected finding as such patients are mostly treated by general practitioners. Other researchers in this area have also experienced similar difficulties in finding patients of dysthymia (Kocsis and Frances, 1987). All the dysthymics and 80% of chronic major depressives had insidious onset of illness. Akiskal (1983) and Kocsis et al. (1985) have also made similar observation. In the present study 80.9% patients of chronic major depression had late onset (i.e. 21 years or after) while 77.7% dysthymics had an early onset of illness and this difference was statistically significant ($p<0.001$). This is similar to findings of Pichot (1981); Akiskal et al. (1981, 1982). Majority of our patients of chronic major depression (57.1%) had a duration of illness of 2.5 years, and a good number of patients of dysthymia (44.4%) had a duration of more than ten years. Keller et al. (1982) and Kocisis et al. (1985) had reported more than 10 years duration of illness in about 50% of chronic depression.

An analysis of symptoms recorded on Hamilton's depression scale (Table-2) reveals that symptomatology in both group of chronic depressive is more or less similar. Depressed mood and feeling of heaviness were seen in all the patients (100%). However, loss of libido, loss of weight, thoughts of death or suicide were much more frequent in patients of chronic major depression.

The severity of illness as assessed on Hamilton's depression rating scale shows that the severity of illness in dysthymic group is only slightly lesser than the chronic major depressives. This may refute the assumption implied in the classificatory system that dysthymia is a minor illness more akin to...
neurosis. It also raised the question about the justification of separating these two categories. This point had also been raised previously by Kocsis and Frances (1987). They have questioned the validity of DSM-III-R categories of dysthymia and chronic major depression, as the inclusion criteria are so close to each other (acquisition of only two more symptoms would qualify a patient of dysthymia to be designated as that of chronic major depression). Consequently, diagnostic criterion themselves become questionable, whether these categories should be differentiated on the basis of number of symptoms or by severity of symptoms or whether such differentiation is actually required.

Associated psychiatric or physical illness can also play a part in maintaining chronicity (Akiskal et al., 1978, 1979; Grunhaus, 1988). Sanderson et al. (1990) have observed high comorbidity of anxiety disorders in a study of chronic depressives. However, in our sample most of the patients did not have any associated illness. Majority of our patients (80.6%) did not have family history of depression. However, dysthymics had significantly higher family loading for affective disorders. Toone and Ron (1977) and Carvey et al. (1986) have also observed low figures of associated psychiatric illness in their sample while others Akiskal (1981), Scott et al. (1988) have reported significantly higher familial loading in chronic major depressives of affective disorders.

EPI scores (Table-4) showed significantly higher scores of neuroticism in dysthymics (p<0.001) while extraversion scores did not differentiate between chronic major depression and dysthymia indicating that dysthymia may be more related to neurotic temperament. This is in agreement with most of the studies conducted in chronic depression (Zukerman et al., 1980; Charney et al., 1981, Pfohl et al., 1984). In fact increased neuroticism has emerged to be a single important factor in chronic depressives by many workers (Scott et al., 1988; Brown et al., 1988).

One may assume that chronicity would be related to life stressors. Large number of workers have reported that chronic depressives do have a number of stressful life events (Murphy et al., 1974; Akiskal, 1982, Scott et al., 1988). Akiskal (1982) and Scott et al. (1988) showed that 40-60% of patients of chronic depression had stressful events both before and after the onset of illness. Studies of events six months before onset of illness do not show significant differences between chronic and non-chronic depressives (Weissman and Klerman, 1977; Hirschfeld et al., 1986). This might indicate that stressful life events at the time of onset are similar in both chronic and non-chronic depressives. However, the experience of stressful events may be more relevant during course of chronic depressive illness. In our study 85.7% of chronic major depression and 77.7% of dysthymics experienced stressful events during course of illness. Brown et al. (1988) showed that change in life events were common before recovery in chronic depression. It is important to study whether the chronicity is a function of the experiences of the individual or it is the basic character of the disorder. The evidence thus far is not convincing either way. It is important to plan large scale general population studies to clarify these issues.

REFERENCES

Akiskal, H.S.; Bitar, A.H.; Puzanhan, V.R.; Rosenthal, T.L.; Parks, W. and Walker, W. (1978). The nosological status of neurotic depression: a prospective 3-4 year follow up examination in the light of the primary-secondary and the unipolar-bipolar dichotomies. Archive of General Psychiatry, 35, 756-766.

Akiskal, H.S.; Rosenthal, R.H.; Rosenthal, T.L.; Khashigian, M.; Khani, M.K. and Puzanhan, V.R. (1979). Differentiation of primary affective illness from situational, symptomatic and secondary depression. Archive of General Psychiatry, 36, 635-643.

Akiskal, H.S.; King, D. and Rosenthal, T.L. (1981). Chronic depression—Part I. Journal of Affective Disorder, 3, 297-315.

Akiskal, H.S. (1981). Sub-affective disorders: dysthymic cyclothymic and bipolar-II disorders in the borderline realm. Psychiatry Clinics of North America, 4, 25-46.

Akiskal, H.S. (1982). Factor associated with incomplete recovery in primary depressive illness. Journal of Clinical Psychiatry, 43, 266-272.

Akiskal, H.S. (1983). Dysthymic disorders: Psychopathology of proposed chronic depressive sub-types. American Journal of Psychiatry, 140, 1, 1-20.

Angst, J.; Felder, W. and Frey, R. (1979). The course of unipolar and bipolar affective disorders in origin, prevention and treatment of affective disorders. New York: Academic Press.
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Bromisch, T. and Wittchen, Knieg, C. (1985). Depressive
Neurosis. Acta Psychiatrica Scandinavica, 237-248.
Brown, G.V.; Adler, Z. and Bifulco, A. (1988). Life e­
vents, difficulties and recovery from chronic
depression. British Journal of Psychiatry, 152, 487-498.
Charney, D.S.; Nelson, J.C. and Quatman, D.N. (1981).
Personality traits and disorders in depression.
American Journal of Psychiatry, 138, 128-129.
Carvey, M.J.; Tollefson, G.D. and Tusaion, V.B. (1986).
Is chronic primary major depression a distinct
sub-type ? Comprehensive Psychiatry, 29, 446-448.
Grunhaus, L. (1988). Clinical and psychobiological chara­
cacteristics of simultaneous panic disorder and major
depression. American Journal of Psychiatry, 145,
1214-1221.
Hirschfeld, R.M.A.; Klerman, G.L.; Andreasen, N.C.;Clay­
ton, P. I. and Keller, M.B. (1986). Psychosocial
predictors of chronicity in depressed patients. British
Journal of Psychiatry, 145, 648-654.
Keller, M.B.; Klerman G.L.; Lavori, P.W.; Fawcett, J.A.;
Coryell, W. and Endicott, J. (1984). Treatment
received by depressive patients. Journal of the
American Medical Association, 248, 1848-1855.
Keller, M.B.; Lavori P.W.; Rice J.; Coryell, W. and Hirs­
chfeld, R.M.A. (1986). The persistent risk of
chronicity in recurrent episodes of non-bipolar
major depressive disorder : A prospective follow up.
American Journal of Psychiatry, 143, 24-28.
Kocsis, J.H.; Frances, A.J. and Mann, J.J. (1985) Imiprai­
mine for the treatment of chronic depression.
Psychopharmacology Bulletin, 21, 698-700.
Kocsis, J.H. and Frances, A.J. (1987). A critical discus­
sion of DSM-III Dysthymic disorder. Archives of
General Psychiatry, 144, 1534-1542.
Kraepelin, E. (1921). Manic depressive insanity and para­
noia. Translated by : Bardat, R.M., (Eds) Robertson,
G.M.; Edinburgh : E. and S. Livingstone.
Kraines, S.H. (1967). Therapy of the chronic depressions.
Dis. Nerv. Syst., 28, 577-584.
Murphy, G.G.; Woodruff, R.A.; Herjanic, M. and Saper,
G. (1974). Variability of the clinical course of
Primary affective disorders. Archives of general
Psychiatry, 30, 757-761.
Paykel, E.S. and Mangen, S.P. (1980). Interview for re­
cent life events. St. Georges Hospital Medical
school.Department of Psychiatry.
Pichot, P. and Pulf, C. (1981). Is there an involutional
melancholia ? Psychiatry, 22, 2-10.
Pfohl, B.; Stangie, D. and Zimmermann, M. (1984). The implications
of DSM-III personality disorders for patients with
major depression. Journal of Affective Disorder, 7,
309-318.
Price, J.S. (1978). Chronic depressive illness. British Medical
Journal, 2, 1200-1201.
Robins, E. and Guze, S.B. (1979). Establishment of diagnostic
validity in psychiatric illness. Its application to
schizophrenia. American Journal of Psychiatry, 126,
983-987.
Scott, J.; Barker, W.A. and Eccleston, D. (1988). The newcastle
chronic depression study : Patient characteristic and
factors associated with chronicity. British Journal of
Psychiatry, 52, 25-33.
Sanderson, W.C.; Beck,T.A. and Beck,J.(1990). Syndrome
comorbidity in patients with major depression or
dysthymia: Prevalence & temporal relationship. Am. J.
Psychiat., 147, 1025-1028.
Toone, B.K. and Ron,M. (1977). A study of predictive fa­
tors in depressive disorders of poor outcome. British
Journal of Psychiatry, 131, 587-591.
Weissman,M.M. and Klerman,G.L. (1977). The chronic
depressive in the community : unrecognized and poorly
treated. Comprehensive Psychiatry, 18, 523-532.
Weismann, M.M. and Myers, J.K. (1978). Affective disorders in
U.S. urban community. Archives of General Psychiatry,
35, 1304-1311.
Zukerman, D.M.; Prusoff, B.A. and Weissman, M.M. (1980).
Personality as a predictor of psychotherapy and
pharmacotherapy outcome for depressed patients. J.
Consult. Clin. Psychology. 480, 730-735.