COGNITIVE THERAPY FOR CHRONIC AND PERSISTENT DEPRESSION

Richard G. Moore
Addenbrooke's Hospital, Cambridge

and

Anne Garland
Nottingham Psychotherapy Unit

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Telephone (+44) 1243 779777

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ABOUT THE AUTHORS

Richard Moore works as a clinical psychologist in the Department of Cognitive and Behavioural Psychotherapies at Addenbrooke's Hospital in Cambridge. After obtaining an M.A. and a Ph.D. from the University of Cambridge and completing his clinical psychology training at the University of Edinburgh, he trained as a cognitive therapist at the Center for Cognitive Therapy in Philadelphia. He has been a therapist on major controlled trials of cognitive therapy for recurrent and residual depression in Edinburgh and in Cambridge. Through this and his subsequent experience working with depressed patients in the NHS, Richard has acquired expertise in providing cognitive therapy for both in- and out-patients with chronic and recurrent depressive disorders that have not responded fully to previous treatment. He is experienced at teaching practical clinical workshops to professional and postgraduate audiences and has presented research at a number of major international conferences. He is a Founding Fellow of the Academy of Cognitive Therapy.

Anne Garland is a nurse consultant in psychological therapies at the Nottingham Psychotherapy Unit. After training in cognitive therapy at Sheffield and Oxford, Anne worked as a therapist in two Medical Research Council funded trials investigating the efficacy of using cognitive therapy in the treatment of residual depression and bi-polar disorder. She has developed clinical expertise in the delivery of cognitive therapy across NHS service settings including primary care, community mental health teams, inpatient units and specialist psychotherapy services. Anne is also recognised nationally as a cognitive therapy trainer and clinical supervisor and has presented cognitive therapy skills based workshops and academic papers at both a national and international level. She was assistant course director to the Newcastle cognitive therapy course and also co-founder of the Salford cognitive therapy course. Anne is an active researcher investigating the impact of cognitive therapy training and clinical supervision initiatives on developing clinical competencies among health service staff. She is currently President-elect to the British Association of Behavioural and Cognitive Psychotherapies (BABCP) as a member of the psychotherapy accreditation sub-committee.

PREFACE

When we set out to write this book, we wanted to write a definitive work on the treatment of persistent depression with cognitive therapy. For some disorders, the development of cognitive therapy based on the cognitive model seems to have 'sewn up' treatment of the disorder in many cases. For example, for many patients with panic disorder, addressing the factors described in the cognitive model using the techniques recommended results in remediation of the problem with minimal risk of relapse. Such an approach to persistent depression would be welcome indeed. With this possibility in mind, we made heavy weather of describing cognitive therapy for persistent depression. It seemed that perhaps we were doing exactly what many patients with persistent depression do: having set our sights on an impossible ideal, we were thrown back by the disappointment of failing to live up to it. A different approach was needed. Therefore, the book does not present 'the answer to chronic depression'. Rather, it describes some of the ideas and experiences that were successful in endeavouring to develop and apply the therapy with many patients over the years . . . and some of our interventions that did not result in the desired or anticipated outcome.

We believe our difficulty highlights something important about the nature of persistent depression. For more acute disorders, acquiring clinical experience enables the clinician to home in on the one or two factors that are most important in addressing the patient's problems. Working with persistent depression, increasing experience seems to have the reverse effect. As the clinician sees more patients or gets to know each individual better, they become more and more aware of an increasing number of factors, all of which seem to be contributing to the problems. These include not only intrapersonal, cognitive, behavioural and emotional factors, but also interpersonal, relational, environmental, biological, historical and cultural factors. If this impression is correct, we will have to accept that no single approach to the treatment of persistent depression is likely to be universally successful. In presenting a cognitive approach to treatment, we have tried to balance focusing on cognition with acknowledging the role of many other factors. Therefore, we aim to consider the role of cognition among the plethora of factors contributing to the persistence of depression, to describe how to minimise the ways that all these factors may undermine

cognitive change and to suggest how cognitive changes may bring about changes in the wider sphere. We assume that patients might also benefit from biological, interpersonal and social approaches to which we do not give great attention here.

It would be remiss to present such an approach without considering the values on which it is based. In working with individuals with persistent depression, the clinician will repeatedly be faced with patients' conviction that the therapy will not 'work'. Given that previous treatments received by these patients may have met with little success, a concern to demonstrate the effectiveness of this treatment must be central. Demonstrations of the effectiveness of therapy have played a vital part in the development and success of cognitive therapy generally. The approach we describe arose within this framework of a commitment to implementing treatments of established efficacy. The approach was developed for use in a randomised-controlled trial of cognitive therapy for patients with persistent depressive symptoms following treatment with medication (The Cambridge–Newcastle Depression Study, see Paykel et al., 1999). As well as drawing on our clinical work in the NHS, many of the examples given in this book draw on our experiences in treating patients in that study. The beneficial outcomes in that study (see Chapter 12) give us some confidence in presenting the procedures we used in the therapy.

However, when working with persistent depression, the possibility that, for at least some patients, therapy may not result in the desired level of improvement remains all too real. To view the effectiveness of treatment as the only important value underlying it would put both patient and therapist in a very vulnerable position. If both parties are desperate for the therapy to work, the resulting pressure can even work against the chances of improvement. An exclusive obsession with outcome, as is often seen in the current interest in evidence-based medicine, can therefore be counterproductive. In his ground-breaking work on chronic depression, McCullough (2000) emphasises the importance of the opportunity in therapy for chronically depressed patients to engage with a decent, caring human being. We believe this valuing of human care and decency is as important when working with persistent depression as concern about outcome. Without the latter, professed care and decency can ring hollow. However, we assume that embracing values of respect and care for depressed individuals, whatever the outcome or effectiveness of treatment, is of paramount importance. We hope that our presentation of this approach will contribute to the care and decency afforded to depressed patients, rather than to the competitive fervour often present in health care systems.

This is particularly important given that the kind of problems we address in this book seem to be increasingly typical of those most commonly seen

in psychological treatment settings. Many clinicians report that they are seeing more and more chronic and complex cases in their clinics. For many psychological therapists, it seems to be something of a rarity to see a case of acute depression, with a recent onset following long periods of good functioning. This may reflect the success of antidepressant medication in primary care in treating those acute cases, combined with increasing public awareness that depression can be treated. In attempting to grapple with this familiar problem of chronicity of depression, we have dodged some of the issues of definitional and diagnostic complexity. We use the terms chronic, persistent and resistant depression somewhat interchangeably. The essence of the problem we address is that patients have some symptoms of depression that persist despite treatments of known effectiveness and these continue to interfere with functioning and impair the individual's quality of life.

One result of this definitional imprecision is that patients considered to have persistent depression may have had varying degrees of exposure to psychological treatments. Some may have had exclusively biologically based treatments, others may have had various forms of psychological treatment. The majority will not have had an adequate trial of cognitive therapy. In view of the solid evidence of the effectiveness of standard cognitive therapy for depression, as described by Beck and colleagues (1979), we suggest that their approach should remain the basis for therapy with persistent cases. Much of the material we present therefore describes the application of standard cognitive therapy specifically with more persistent cases. Many of our suggestions—for example, relating to the rigidity of thinking in depression—can be traced back to the original work of Beck and colleagues. We believe there is merit in reiterating many aspects of the original approach and highlighting their importance in this patient group. In the years since the approach was first described, there has been important work in developing applications of cognitive therapy for more chronic disorders. Much of this has focused on intervening at the level of underlying beliefs. We attempt to illustrate how, in working with persistent depression, some of these more novel approaches can be integrated with standard cognitive therapy. In describing how the standard cognitive approach can be refined and broadened, we do not present that standard approach in detail. Readers who are not familiar with it should seek out Beck et al. (1979), Blackburn and Davidson (1990) or Judy Beck's *Cognitive Therapy: Basics and Beyond* (1995) before grappling with the approach described here.

Thus, our aim has not been to revolutionise the theory of persistence of depression or to present ground-breaking technical developments. Rather, it is to use material derived from working with many cases of persistent depression to show how existing clinical theory and techniques can be

developed and applied in therapy. We have tried to convey as closely as possible the 'flavour' of working with people suffering from persistent depression and to be as practical as possible in suggesting how their problems may be addressed in cognitive therapy. To do this, we have used many clinical examples drawn from discussions with real patients. However, in order to protect their confidentiality and to ensure that the examples are generalisable, we have only used examples of situations described by multiple patients. The patients we describe are composites, each representing some features common to several patients that we have seen in our outcome study of NHS clinics. Of necessity, the more specific details are fictional. The dialogues are based on actual interventions, amended to protect confidentiality and edited in the interests of brevity. It should be remembered that work with patients often proceeds at an even slower pace and with more digressions than illustrated here. Despite these liberties with gospel truth, we believe that the dialogues, situations and 'factional' characters we describe are highly typical of patients with persistent depression seen in many clinics. We hope that therapists reading this book will recognise something of their patients in it and that any sufferers reading it will recognise something of themselves. To help readers to build up a picture of the patients that we refer to repeatedly throughout the book, we have provided brief biographies of each of the main patients described. The patients for whom such a biography is provided are indicated by their names being in italics when first mentioned within each section of text.

These clinical examples are used in the main body of the text in Chapters 1 to 10 to illustrate the model and clinical application of cognitive therapy with patients suffering from persistent depression. Chapters 1 and 2, covering the cognitive model and therapeutic relationship, style and structure, provide a framework that is essential throughout the course of therapy. Chapters 3 to 10 describe the nature of interventions implemented in each of the main phases across the course of therapy. In sequence, we describe assessment, socialising the patient into therapy, setting goals, using standard behavioural and cognitive techniques, working with underlying beliefs and helping the patients to maintain their gains beyond the end of therapy. Chapter 11 then discusses some of the practical and service-related issues that therapists encounter in working with these patients. Finally, Chapter 12 presents results of research into the outcomes and mechanisms of our own approach and those of other recently developed cognitive approaches to depression, before rounding up some of the main issues and themes presented throughout the book.

Before we present our clinical approach, our Introduction outlines the drastic significance of persistent depression in the lives of those who suffer from it, before setting out issues relating to definition, diagnosis, predictors of

outcome and treatment of persistent depressive symptoms. Although this introduction does not contain any clinical material, we believe that this information is important in understanding the context for the application of therapy described in the following chapters. Because it does not contain any clinical material, we forgive any enthusiastic clinicians who cannot restrain themselves from skipping straight to Chapter 1. We then hope that our account of cognitive therapy with these patients will assist therapists in gaining some inspiration to work with chronic depression and in helping their patients to find a greater degree of satisfaction and fulfilment.

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Introduction

THE CHALLENGE OF PERSISTENT DEPRESSION

In this introduction, you will find information on:

- Symptoms and consequences of persistent depression
- Difficulties in defining and diagnosing persistent depression
- Rates of persistent depression
- Factors that predict the persistence of depression
- Pharmacological strategies for treating persistent depression
- The reasons for pursuing psychological treatments
- The existing evidence on the effectiveness of cognitive therapy in persistent depression
- Recent developments in cognitive therapy that may be useful in adapting the standard cognitive approach to depression

They say time flies when you're enjoying yourself. When you're depressed, the moments creep miserably by, and to those with chronic depression, this misery is endless. Looking back, misery predominates. To those who dare to look forward, it seems certain that they will never experience any lasting relief. Chronic depression casts a very long, black shadow over the person's life.

In this book, we will be illustrating the advances that a cognitive approach can provide in understanding and treating persistent depression by describing the stories of several patients. As will become clear, there are as many different precise presentations of persistent depression as there are patients. For example, *Kate* described being tossed about by extremes of every different kind of unpleasant emotion, whereas *Stan* was mired in an unvarying bleak flatness of mood. *Elizabeth* was struggling to keep up standards of performance that others would have been proud to attain, whereas *Peter* struggled to keep going at all. Amid all the variety, the common factor is the ongoing suffering of anyone afflicted by persistent depression. As we describe below, persistent depression has drastic effects, not only on the mood of individuals, but also on their overall mental and physical

well-being, their daily functioning, their relationships, their working life and on society around them.

The scale of the problem of persistent depression has only recently begun to emerge. The latter half of the twentieth century saw great optimism surrounding the treatment of depression, as pharmacological and psychological treatments were found to be effective (Hollon et al., 1993). The substantial minority of patients who did not benefit from treatment seemed at first to receive little notice. Gradually, the continued suffering of individual patients and its effect on society has been reflected in consideration given to the diagnosis and treatment of persistent depression. It was not until 1987 that the diagnosis of chronic depression was included in the influential Diagnostic and Statistical Manual of the American Psychiatric Association with publication of the revised third edition (DSM-III-R). The lack of consensus over issues of definition and diagnosis has hindered the gathering of consistent information about predictors and possible causes of persistent depressive symptoms. As a result, although the potential treatment options are many, evidence that might inform decisions about the most beneficial treatments remains limited.

The majority of patients feel overwhelmed by helplessness in the face of the persistence of their depression. In view of the sketchiness of the available information on causes and treatments, clinicians too can feel helpless when faced with the prospect of treating persistent depression. In setting the scene for describing the treatment of persistent depression with cognitive therapy, we aim to present some of the information that is available. In this introduction, we first outline the nature of the problem by describing the symptoms of persistent depression and outlining some of its psychological and social consequences. We then discuss some of the main issues in defining and diagnosing chronic and persistent depression. We draw attention to the role of the inadequacy of treatment received by many patients, and highlight the distinction between chronicity and treatment resistance. We then review some of the main research findings on predictors of persistence of depression and put forward some of the reasons for pursuing psychotherapeutic treatments in chronic depression. Existing evidence on the use of cognitive therapy with patients with persistent depression is then reviewed, and more recent developments in cognitive therapy are described.

SYMPTOMS OF PERSISTENT DEPRESSION

There is considerable agreement across different diagnostic systems as to the symptoms required for diagnosing depressive disorders, whether

Table 1 Symptoms required to meet DSM-IV criteria for a Major Depressive Episode

To meet DSM-IV criteria, five or more of the following symptoms must have been present during the same 2-week period and must represent a change from previous functioning. At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by subjective report (e.g. feels sad or empty) or observation by others (e.g. appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide.

chronic or not. The symptoms required for diagnosing a major depressive episode in DSM-IV (Diagnostic and Statistical Manual of Mental Disorders (4th edition), American Psychiatric Association, 1994) are presented in Table 1. The same set of symptoms is used as the basis for diagnosing chronic depressive disorders.

There are differences between acute and chronic depression in the precise symptoms presented. Psychologically, patients with persistent depression are invariably demoralised and hopeless (Thase, 1994). For many patients, lack of motivation and lack of pleasure can present more of a problem than acute negative mood states. Patients usually experience their symptoms as being completely out of their control: they may feel powerless to change an unremitting background level of low mood or may experience upsurges of various unpleasant emotions 'for no reason'. This lack of control often results in helplessness and passivity. Thus, many patients have withdrawn from or compromised important roles or functions. Despite this perceived lack of control, patients often blame themselves and feel guilty, for both the depression and any external problems. There is some evidence that vegetative symptoms, such as appetite and sleep disturbance, occur less frequently than in acute depression (Keller et al., 1995). Biologically, complaints of lack of energy and fatigue seem to be more common and

more disabling than other symptoms. This combination of hopelessness, uncontrollable low mood, fatigue and lack of response to previous treatment is often enough to make the most enthusiastic therapist's heart sink. The symptoms of persistent depression and their assessment are described in more detail in Chapter 3.

CONSEQUENCES OF PERSISTENCE OF DEPRESSION

The toll exacted by depression extends not only to the devastation of the well-being of individual patients, but also to their families, their wider social and occupational contacts and to the health care system. The high levels of disability due to depression were documented by Wells et al. (1989). Even without specifically selecting for chronic depression, levels of disability in depression were greater than in other chronic medical conditions with the exception of heart disease. Persistent depression has even more drastic effects on the individual and their ability to carry out their role in society. In research on the consequences of depression, it has proved difficult to disentangle the antecedents of depression from its consequences. Many individual (e.g. low self-esteem) and social (e.g. lack of supportive relationships) factors may be both antecedents and consequences of persistent depression. In the next chapter, we will describe how a cognitive model must incorporate the reciprocal effects of these factors on depression and the effects of depression on these factors.

Psychological Consequences

On an individual level, demoralisation and the entrenchment of hopelessness are almost inevitable consequences of persistent depression. Although hopelessness is itself a common symptom in acute depression, effective treatments can alleviate it as patients perceive improvement in their other symptoms. However, when treatments that a patient has been told are effective prove not to be, then the belief that things cannot get any better is confirmed, leading to an entrenched sense of hopelessness. Although self-esteem is commonly viewed as an antecedent or vulnerability factor for depression, the persistence of depression can have crushing consequences for an individual's self-esteem. Similarly, it has been argued that the experience of persistent depression can result in changes in personality, including increases in dependency and neuroticism (Akiskal et al., 1983).

Social Consequences

The social withdrawal characteristic of most depression tends to become more disruptive as depression persists. For patients with chronic depression, this can entail severe disruption of their ability to keep up various social roles. Frequently, this is seen in an inability to establish or maintain intimate relationships, leading to a deficit in the degree of social support available. Impairments due to the poor marital and family relationships that often accompany persistent depression may be particularly marked for women (Kornstein et al., 2000). Where a patient has been living in a well-established family unit before the onset of the depression, other members of the family often compensate for the difficulties experienced by the patient. It is not uncommon to find spouses who are themselves overburdened having taken over tasks or responsibilities from the patient, or who have given up their social life rather than trying to carry on socialising alone. Children of patients may also have taken on responsibilities for household tasks or childcare for their younger siblings.

Occupational performance is often drastically compromised in chronic depression. In contrast to impairments in marital adjustment, impairments in work functioning may be relatively greater in men (Kornstein et al., 2000). Where depression persists, this frequently results in patients having to take long-term sick leave or medical retirement. Where unemployment triggered the initial onset of the depression, persistence of symptoms can rule out the prospect of getting back into work. This then has financial consequences, not only for the patient and their family, but also for the social system more widely.

These psychological and social consequences of persistent depression all have further implications for the depression: they make it more likely that the depression will persist. In the next chapter, the cognitive model describes a long-term vicious cycle whereby chronic depression results in negative psychological and social consequences that then serve to maintain the depression. Somewhat similar processes have been described biologically, whereby the persistence of depression disrupts important homoeostatic processes, particularly in the hypothalamic–pituitary–adrenocortical axis (Gold et al., 1988). This can result in the kindling of depression, such that with each new episode a chronic course becomes increasingly likely (see page 9). The consequences for the health care system can be serious. If efforts are made to save resources by treating milder, acute cases of depression less intensively, at least some of these cases are then more likely to experience chronic depression and thus require more intensive, longer-term and more costly treatments.

DIFFICULTIES IN DEFINING PERSISTENT DEPRESSION

There have been two main approaches to the definition of disorders characterised by the persistence of depressive symptoms. One is to consider simply the duration over which depressive symptoms have persisted. In this approach, someone is viewed as chronically depressed if they have suffered from depressive symptoms for a number of months or years with little evidence of relief. The alternative approach is to consider the degree to which attempts at treatment have been unsuccessful. In this approach, someone is viewed as persistently depressed if their symptoms have not been adequately alleviated by a course of treatment that might have been expected to be effective.

Chronicity over Time

In DSM-IV, various forms of persistent depression are defined according to the course of the disorder. In these criteria, a chronic episode of Major Depressive Disorder is diagnosed when symptoms have persisted for two years or more at a level that merits a diagnosis of major depression. Other diagnoses involving persistent depressive symptoms are also distinguished by the particular time course of the disorder. These include:

- Major Depressive Episode, in partial remission
- Major Depressive Disorder, recurrent, without interepisode recovery
- Dysthymic Disorder
- Dysthymic Disorder and Major Depressive Disorder ('double depression').

A major depressive episode, partially remitted, is diagnosed when significant depressive symptoms persist, but at a level where they no longer meet the full criteria for major depression. Such a partially remitted episode can be a first episode of major depression, or can be the latest in a series of episodes. If previous episodes also did not remit completely before the onset of the next episode, this would entail a diagnosis of 'Major Depressive Disorder, recurrent, without full interepisode recovery'. There are many cases where low-level depressive symptoms have persisted for many years, with at best only brief periods of relief. Where such symptoms have persisted on more days than not for two years before the occurrence of any episode meeting full criteria for Major Depression, the ongoing symptoms are classed as Dysthymic Disorder. For some patients, these constant low-grade symptoms provide a backdrop to occasional more intense episodes that do meet the criteria for a full Major Depressive Episode. The term

double depression has been coined for this pattern of disorder, where one or more depressive episodes are superimposed on pre-existing Dysthymic Disorder (Keller & Shapiro, 1982). In patients with persistent depressive symptoms, movement between higher and lower levels of symptoms is common: the presence of residual symptoms following partial remission or of dysthymia confers a high risk of recurrence of a major depressive episode (Judd et al., 1998).

This approach to definition and diagnosis takes no account of any treatments that a patient may have received. In these modern times when few patients with depression have not been treated with pharmacological and possibly psychological treatments, this presents a problem. For most patients, the time course of symptoms cannot be considered independently of treatments received over time. For example, two patients might receive a diagnosis of chronic depression by DSM-IV criteria. One may have received an inadequate dose of medication many months ago with little further follow-up. The other may have had trials of several classes of antidepressants at maximal doses along with augmentation with lithium. Clearly, the aetiology and prognosis for these two patients would be very different, as the latter patient is likely to present a far greater challenge in subsequent treatment. Chronicity of symptoms in itself is less of a problem, as the symptoms may respond to a suitable standard treatment. Persistence of significant symptoms even once standard treatments have been adequately implemented presents a greater challenge.

Treatment Resistance

An alternative to defining persistence of depressive symptoms simply according to time course or chronicity has therefore been to focus on treatment resistance (for comprehensive reviews, see Amsterdam et al., 2001). Little consensus has emerged as to standard criteria for defining treatment resistance in depression. However, it has become clear that definitions must address two issues: adequacy of treatment and degree of response to treatment. Attempts to define adequacy of treatment have focused exclusively on antidepressant medication. The term *treatment resistance* could include a lack of acceptable response to minimal standard doses of medication (e.g. 150 mg/day of imipramine or equivalent). Alternatively, the term could be reserved only for disorders that persist in spite of attempts to treat initial non-response more aggressively with higher doses of medication (e.g. above 300 mg/day of imipramine or equivalent). There has been a similar lack of agreement over what constitutes a lack of acceptable response to treatment. Treatment resistance could include those who respond only partially to treatment or could be reserved for those who do not respond at

all. Failure to respond to treatment has variously been defined according to degree of improvement in symptom levels (e.g. less than 50% reduction in score on a standard measure of depressive symptoms) or through remaining above some criterion on a measure of symptoms (commonly 7 on the Hamilton Rating Scale for Depression; Hamilton, 1960).

One way of dealing with this lack of consensus has been to propose that different levels or stages of treatment resistance should be defined. The different stages reflect the number and intensity of treatments that have been tried without success. Thus, in Thase and Rush's (1995) system, Stage I resistance reflects failure of one adequate trial of an antidepressant medication and subsequent stages reflect failure to respond to a broadening range of subsequent treatments. Stage V resistance reflects failure to respond to numerous classes of antidepressant (including tricyclic medications and monoamine oxidase inhibitors) and a course of ECT. The stages in this system are thus based mainly on the number of different medications tried. For many patients, a lack of satisfactory response to strategies such as taking supra-maximal doses of a particular medication or combining such medication with mood stabilisers are further indicators of degree of resistance. If some consensus can be reached on the weighting of non-response to these various treatment strategies, this kind of approach seems to offer the most promise for some degree of standardisation to be forged.

Persistent Depression

Whether they are defined according to temporal chronicity or treatment resistance, persistent depressive symptoms are a problem in themselves, with a drastic impact on the well-being of the individual and their functioning in their social network. Comparing different diagnostic subtypes of persistent depression, McCullough et al. (2000) found few differences between them in demographic and clinical variables, family history and response to treatment. Even in patients who show some degree of response to treatment, the presence of residual symptoms following treatment is a strong predictor of subsequent relapse and recurrence (Paykel et al., 1995). Thus, patients do not need to meet full criteria for chronic major depression for their depression to follow a chronic and relapsing course, with a huge detrimental impact on their own lives and on the lives of those around them.

In this book, we have taken a broad view of persistent depressive disorders. We have mainly used the term *persistent depression* to encompass presentations involving either temporal chronicity or treatment resistance. Where

we have used the terms *chronic* or *resistant* depression, this has generally been in the service of enlivening the text, and not to specify one kind of presentation rather than another. We assume that the therapeutic approach we describe will have some relevance to patients with any of the above disorders. It has been tested with patients suffering from residual depressive symptoms following adequate treatment of a major depressive episode in the Cambridge–Newcastle Depression Study (see Chapter 12 for details of the study design and outcomes). This study included patients with varying numbers of previous depressive episodes and patients with underlying dysthymia.

HOW COMMON IS PERSISTENCE OF DEPRESSION?

Although depression is often considered to be a treatable condition, it is now clear that a sizeable minority of patients suffer chronic or persistent depressive symptoms. The lack of consensus over definitions of persistent depression has led to variations in estimates of how commonly it occurs. The most widely used methodology has been to follow up samples of patients diagnosed with depression over a number of years. Such studies have rarely attempted any control over the treatment received, so can give little information on the relative numbers of patients with different degrees of treatment resistance. In a review by Scott (1988), rates of symptomatic non-recovery after two years of follow-up ranged from 1% to 23% across a number of studies. Some of these studies pre-dated the era of modern treatments, however. More recent studies still consistently show that rates of persistence of depression remain around 20% over two years of follow-up, despite the increased availability of effective treatments (Keller et al., 1984; see Paykel, 1994, for a review). Longer-term follow-up studies have also found evidence of significant persistence of depression. Winokur et al. (1993) found a poor outcome in over 10% of their depressed sample at a five-year follow-up. Two studies which examined outcomes over periods in excess of 15 years following hospitalisation found rates of chronic symptoms of 25% (Lee & Murray, 1988) and 11% (Kiloh et al., 1988).

Even when patients do make a satisfactory recovery from an initial episode of depression, rates of relapse are high. Rates of relapse within a year of recovery from an episode of depression are typically 30% (Lavori et al., 1984). The probability of relapse is strongly linked to the presence of residual depressive symptoms following response to treatment (Paykel et al., 1995). There is some evidence that each successive episode of depression carries an increasing risk of chronicity (Kupfer et al., 1989), which has been termed the kindling hypothesis of resistant depression (Post, 1992). Some individual patients show a pattern of less satisfactory response to

treatment with each successive episode (for example, see the case of Marion described on page 113). The factors within the cognitive model that might contribute to this increasing risk of chronicity are discussed in the following chapter.

THE ROLE OF MISDIAGNOSIS AND INADEQUATE TREATMENT

A number of other psychiatric (e.g. early onset psychotic disorders) and physical conditions (e.g. thyroid dysfunction) can present with symptoms similar to depression. Where such conditions are diagnosed as depression, alleviation of the symptoms with antidepressant treatments is hardly to be expected. In such cases of non-response, chronic or treatment-resistant depression may be diagnosed. Such diagnosis is likely to be misleading, as treatment of the alternative condition may lead to alleviation of the depression-like symptoms. It is therefore important that such other conditions have been considered and are unlikely before a diagnosis of a persistent depressive disorder is reached.

In addition to such misdiagnosis, chronic depressive symptoms may result from inadequate treatment. It is self-evident that delay in starting an effective treatment will result in a longer duration of illness before treatment is introduced. Even once treatment is commenced, inadequacy of treatment with medication may account for some persistence of symptoms in some patients. Studies of depressed patients designated as treatment resistant have consistently found that a sizeable proportion of such patients have in fact received inadequate treatment (e.g. Quitkin, 1985). Many such patients have been prescribed subtherapeutic doses. Even when prescribing has been adequate, some patients are found not to have reached adequate plasma levels, possibly reflecting non-compliance. It is hardly surprising to find depressive symptoms persisting in patients who have received inadequate treatment. These findings suggest that in at least some cases, although the depression may be chronic in duration, it may not be resistant to treatment. In some cases where treatment has hitherto been inadequate, achieving satisfactory prescription and monitoring of medication may result in alleviation of the depressive symptoms.

More worryingly, there is also evidence that delay in starting treatment and inadequate initial treatment can increase the likelihood of subsequent non-response even when adequate treatment is commenced (Scott, 1988; Guscott & Grof, 1991). Thus, although failure to respond to inadequate treatment should not itself be considered as a sign of treatment resistance, true treatment resistance can result from a lack of prompt or adequate

treatment. Such problems are likely to be less common with more recently introduced medications, due to lower side-effect profiles and easier prescribing. It is clear that, to lower the likelihood of depressive symptoms becoming persistent, pharmacotherapy should be prompt, adequate and properly monitored.

PREDICTORS OF PERSISTENCE OF DEPRESSION

In follow-up studies of depression, the associations of a wide range of factors with recovery from and, conversely, persistence of depression have been examined. In addition to the consistent relationship found between treatment factors and persistent depression described above, a number of sociodemographic and patient-related factors have been found to be important.

Social and Demographic Factors

A number of studies have found depression to be more likely to persist in older patients (e.g. Keller et al., 1986) and in women (e.g. Berti Ceroni et al., 1984). Negative life events occurring after the onset of an episode of depression have been found to be associated with chronicity (Scott et al., 1988). Of these life events, marital and interpersonal difficulties were found to be particularly common in patients with chronic compared to acute depression, and redundancy was particularly common in males with chronic depression. There has been some debate as to whether such events are causes or consequences of persistence of depression (Gotlib & Hammen, 1992). We shall discuss in the next chapter how undesirable events and situations are likely consequences of depression that serve to prolong and entrench depressive symptoms.

Patient Factors

A number of factors concerning the patient's history, premorbid personality and presentation of depression have been found to be important predictors of chronicity. A greater number of previous episodes and a family history of depression have both been found to predict persistence of depression (Scott et al., 1988). Neuroticism has consistently been found to predict chronicity and poorer treatment response in depression (Scott et al., 1988). Cognitive factors, in particular high levels of dysfunctional attitudes, are associated with poor response to medication or psychotherapy (Sotsky

et al., 1991). Although biological or endogenous symptoms in themselves are not consistently associated with persistence, Scott (1994) found that a combination of neurotic premorbid personality with an endogenous symptom profile was particularly likely to be associated with chronic rather than episodic depression. This suggests that chronicity may result from an interaction between psychological and biological factors. Psychotic symptoms have been related to a more chronic course in several studies (including Scott, 1994).

Comorbidity

Comorbidity of depression with a number of disorders must be considered. Around a third of patients with major depression are found to have pre-existing dysthymia, which significantly influences the course of the depressive episode (Keller et al., 1995). In double depression, where a major depressive episode is superimposed on pre-existing dysthymia, patients are less likely to recover fully, but tend to return to their previous dysthymic level (Keller et al., 1983). Such patients remain at higher risk of relapse into a further depressive episode than patients without comorbid dysthymia. Other comorbid psychiatric disorders are common in depression, including anxiety states, substance misuse and personality disorders. Comorbid personality disorders have been found in around a half of patients with chronic depression (McCullough, 1996). They are associated with greater likelihood of persistent depressive symptoms following treatment (e.g. Shea et al., 1990).

PHARMACOLOGICAL TREATMENT OPTIONS

Not surprisingly, the rate of spontaneous remission in patients with chronic depressive symptoms is low (McCullough et al., 1988). This reinforces the importance of identifying effective options for active treatment. Given the possibility that lack of improvement may have been due to lack of adequate treatment, there is a need to ensure that patients presenting with persistent depressive symptoms have had an adequate trial of some standard treatment of established efficacy, whether biological or psychosocial. Even where the chronic course of symptoms to date may be in part attributable to not having received adequate treatment, response to standard treatments in patients with depressive symptoms of long duration is compromised (Scott, 1988). Thus, response to standard medication regimens in patients with persistent depressive symptoms is not high. In one large study of patients with chronic or double depression, less than one-fifth of patients