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Predictors of remission from chronic depression: A prospective study in a nationally representative sample

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Abstract

Purpose: The aims of this study were to identify predictors of remission from chronic depression in a prospective longitudinal general population survey; second, to determine the relative level functioning and well-being of those in remission.
Methods: The sample included respondents who met the criteria for major depressive disorder from Wave 1 (2001–2002) and through Wave 2 (2004–2005) of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC).
Results: Panic Disorder, Generalized Anxiety Disorder, Cluster B personality disorders and a history of Physical Abuse were correlated with reduced likelihood of chronic depression remission. The functioning and well-being of the remitted group was below the norm.
Conclusions: These prognostic factors are similar to those found in clinical samples. Despite remission from chronic depression, a significant proportion have impairments in functioning.
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1. Introduction

Several studies of large clinical populations found that a considerable proportion of patients had persistent forms of major depression disorder (MDD). The National Institutes of Mental Health (NIMH) Collaborative Program on the Psychobiology of Depression study observed that 7% of subjects with major depression did not remit during the first 5 years of follow-up [1]. Twenty-five percent of patients in Sequential Treatment Alternatives to Relieve Depression trial had a current episode of MDD lasting >2 years [2].

General population studies have also observed that the prevalence of chronic depression to be considerable. Three cross-sectional, retrospective, studies have been conducted. The Canadian Community Health Study observed that 26.8% of subjects with a lifetime MDD had an episode which endured ≥2 years [3].

Three prospective follow-up of general populations have noted substantial rates of persistent depression. The Zurich Cohort Study observed that 23% had a chronic course of depression over a 20 year follow-up period. [4]. A similar rate, 20%, over 2 years, was found in The Netherlands Mental Health Survey and Incidence Study (NEMESIS), [5]. The Baltimore Epidemiologic Catchment Area (ECA) reported that 15% cases with MDD dot not have a 1 year period of remission over the course of 23 years [6].

Few prospective studies of clinical samples have examined predictors of chronic depression. Two large prospective longitudinal studies of clinical populations with mood disorders were found in the literature. A 10-year prospective study of a relatively large cohort of patients with Dysthymic Disorder (DD), with or without superimposed MDD, found that older age, less education, concurrent anxiety disorder, greater familial aggregation for chronic depression, a history of childhood sexual abuse, and personality disorders predicted more impaired functioning and depression severity [7]. The NIMH Collaborative Program observed that among the subgroup who recovered from MDD, mild chronic depression increased the risk of relapse to MDD [8]; and a longer episode of MDD was associated with longer time to remission [9].

The only prospective study which examined predictors of remission from chronic depression was derived from a clinical sample [7]. Since clinical samples typically represent more severe forms of psychopathology, it is unclear if Klein et al. [7] findings are applicable to the general population. Hence, this study sought to identify predictors of remission in a prospective longitudinal study. A secondary aim was to determine the relative functioning and well-being of those in remission.

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2. Methods

2.1. Sample

This study used data from both waves of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC). The nationally representative 2001 to 2002 Wave 1 sample contained 43,093 U.S. adults 18 and older living in households and noninstitutional group quarters (response rate = 81.0%). The 2004 to 2005 Wave 2 follow-up sample contained 34,653 of the original respondents, 86.7% of those eligible for reinterview, for a cumulative response rate of 70.2%. Detailed information on the sample design and weighting is available where [10,11] instruments have exhibited a good level of reliability, $\kappa = 0.74$ [12]. This report is based on a subsample of Wave 1 NESARC respondents classified with chronic depression who were reinterviewed at Wave 2 (N = 411).

All potential respondents were informed in writing about the nature of the survey, uses of the survey data, voluntary nature of their participation, and legally mandated confidentiality of identifiable survey information. The research protocol received full ethical review and approval from the U.S. Census Bureau and the U.S. Office of Management and Budget.

2.2. Measures

Chronic Depression was defined as a current episode of MDD of >2 years' duration and/or dysthymic disorder at Wave 1. The Alcohol Use Disorders and Associated Disability Interview Schedule–DSM-IV Version (AUDADIS-IV) [12] was used to assess psychiatric disorders.

All personality disorders were assessed by algorithms requiring the specific numbers of diagnostic criteria, as well as evidence of long-term maladaptive patterns of thinking, functioning and emotion [13–17]. Personality disorders, except for antisocial, were assessed with an introduction and repeated reminders asking respondents to answer about how they felt or acted "most of the time, throughout your life regardless of the situation or whom you were with." Subjects were asked not to include symptoms occurring only when depressed, manic, anxious, drinking heavily, using drugs, recovering from the effects of alcohol or drugs, or physically ill.

Avoidant, dependent, histrionic, obsessive-compulsive, paranoid, and schizoid personality disorders were assessed at Wave 1; borderline, narcissistic, and schizotypal were assessed at Wave 2. Lifetime antisocial personality disorder was assessed at Wave 1, with adult symptoms re-assessed at Wave 2.

This study measured functioning with the RAND MOS-36 Item Short Form Health Survey (MOS-36). The MOS-36 [18] consists of 36 items that measure domains of physical health, emotional health, social functioning and general quality of life. The scale comprised measures assessing eight different components of health including: physical disability (e.g. does your health limit you in completing moderately physical activities such as vacuuming?), physical role functioning (e.g., have you had any problems with your work or other regular daily activities as a result of your physical health?), emotional role functioning (e.g., have you had any problems with your work or other regular daily activities as a result of your emotional health?), perceptions of general health (e.g., rating of overall general health), mental health (e.g., have you been calm ? Have you been depressed?), vitality (e.g., did you feel full of pep?), bodily pain (e.g., how much did pain interfere with you normal work?), and social functioning (e.g., how much of the time has your physical or emotional problems interfered with social activities? [19] Lower MOS scores indicate impaired functioning; higher scores indicate better functioning.

2.3. Statistical analyses

Weighted frequencies, and their respective 95% confidence intervals were computed to derive sociodemographic correlates and clinical features of chronic depression at Wave 1. *Univariate statistics were used to test for significant demographic and clinical differences between remitters and non-remitters*. *Variables which manifested significant between group differences* ($p < .10$) *were then entered into a logistic regression model* [20]. The SPSS complex analysis module was used to adjust for the complex survey design and population sampling weights using the computer package SPSS Complex Samples Statistics (Version 14.0) [21].

Differences between MOS scores at follow-up between the remitted group and the general population were examined with pairwise t-tests. Given sufficiently large samples, any difference will eventually achieve statistical significance even if its clinical significance remains negligible. Because effect sizes are independent of sample size, effect size (ES) was calculated for each comparison. Cohen [22] offered the following *approximate* guidelines for interpreting ES scores: 0.20 (small), 50 (medium) and 0.80 (large).

3. Results

The majority of respondents with chronic depression were female and white; nearly half had attended some college; 82% earned less than $35,000; and 60% were not working full-time at Wave 1 (Table 1).

The majority of the sample, *62*%, *had dysthymic disorder with superimposed major depression*. The most prevalent past year comorbid Axis I disorder in the sample was generalized anxiety disorder; approximately one-third had a Cluster A, B, or C personality disorder; high rates of childhood abuse were reported (Table 2). *Sixty-seven percent of the cases no longer met criteria for Dysthymic Disorder or Major Depression at Wave* 2.

Multivariate logic regression results revealed that older age, separated or divorced marital status, cluster PDs A and B panic disorder, generalized anxiety disorder, and a history

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