

Dysthymic disorder and double depression: Prediction of 10-year course trajectories and outcomes

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Received 2 August 2006; received in revised form 8 December 2006; accepted 5 January 2007

Abstract

We sought to identify baseline predictors of 10-year course trajectories and outcomes in patients with dysthymic disorder and double depression. Eighty-seven outpatients with early-onset (<21 years) dysthymic disorder, with or without superimposed major depression, were assessed five times at 30-month intervals for 10 years. Baseline evaluations included semi-structured diagnostic interviews for Axis I and II psychopathology and childhood adversity. Direct interview and family history data were collected on first-degree relatives. Follow-up assessments included the Longitudinal Follow-up Evaluation and Hamilton Depression Rating Scale. Using mixed effects growth curve models, univariate predictors of depression severity and functional impairment at 10-year outcome included older age, less education, concurrent anxiety disorder, greater familial loading for chronic depression, a history of a poorer maternal relationship in childhood, and a history of childhood sexual abuse. In addition, longer duration of dysthymic disorder also predicted greater impairment 10 years later. Predictors of a poorer trajectory of depressive symptoms over time included ethnicity and personality disorders; predictors of a poorer trajectory of social functioning included familial loading of chronic depression and quality of the childhood maternal relationship. Thus, demographic, clinical, family history, and early adversity variables all contribute to predicting the long-term trajectory and outcome of DD. These variables should be routinely assessed in clinical evaluations and can provide clinicians with valuable prognostic information.

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Keywords: Dysthymic disorder; Double depression; Prognosis; Predictors of course and outcome

1. Introduction

Dysthymic disorder (DD) is defined as a mild, chronic depressive condition. In a 10-year naturalistic follow-up of an outpatient sample, we recently reported that the estimated rate of recovery from DD was 73.9%, however the median time to recovery was 52 months, and the estimated relapse rate was 71.4% (Klein et al., 2006). Although DD is typically characterized by a mild-moderate level of depres-

sive symptoms, almost all individuals with DD experience exacerbations that meet criteria for a major depressive episode (MDE), or “double depression”, at some point (Keller et al., 1995; Klein et al., 2006).

Given the chronicity of DD, it is important to identify factors that predict its long-term course and outcome in order to supply clinicians and patients with information about prognosis and provide clues regarding the development and maintenance of the disorder. Unfortunately, the literature on prognostic factors in DD is sparse, and generally limited to brief follow-up periods. A 2-year follow-up of double depression reported that age, marital status, and number and duration of MDEs did not predict recovery from DD (Keller et al., 1983). A combined retrospective/

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prospective follow-up of depressed children found that earlier age of onset (Kovacs et al., 1997) and comorbid externalizing disorders (Kovacs et al., 1984) predicted longer duration of DD, while sex, superimposed MDE, and comorbid anxiety disorders failed to predict recovery from DD (Kovacs et al., 1984, 1989, 1997). Finally, in a report based on the first 5 years of our 10-year naturalistic follow-up study, we found that comorbid anxiety disorders, cluster C personality disorder traits, and family history of bipolar disorder predicted a lower rate of recovery from DD (Hayden and Klein, 2001). In addition, after controlling for initial level of depression, anxiety disorders, cluster C traits, family history of DD, poor childhood relationships with parents, and a history of sexual abuse predicted a higher level of depressive symptoms at the 5-year follow-up. Demographic variables, age of onset of DD, and history of MDEs and substance use disorders did not predict recovery or level of depression at follow-up (Hayden and Klein, 2001).

This paper examines the baseline predictors of 10-year course trajectories and outcomes in DD and double depression. It extends our previous report (Hayden and Klein, 2001) in several ways. First, the length of the follow-up period has been doubled from 5 to 10 years, allowing us to examine predictors of long-term course and outcome. Second, as functional impairment may be at least as important an outcome as symptomatology, we examined predictors of the course of social functioning as well as depressive symptoms. Finally, our previous report used survival analysis to examine predictors of recovery and multiple regression analysis to examine change in symptoms between baseline and 5-year follow-up. In this paper, we use mixed effects growth curve models as an alternative data analytic strategy. Mixed effects growth curve models have a number of advantages over survival analysis and multiple regression analysis. Unlike survival analysis, mixed effects models do not require the creation of somewhat arbitrary categories such as “recovery” and “relapse”, and instead allow for the full continuum of symptom variation. In addition, they utilize all observations for each individual, rather than censoring observations after the first “event” (e.g., recovery) (Singer and Willett, 2003). Mixed effects models also have several advantages compared to traditional multiple regression approaches. They can (1) include more than two waves of assessments; (2) incorporate information about mean level change over time, rather than being based entirely on the covariance between assessment points; (3) distinguish predictors of the trajectory of change from predictors of the level of the dependent variable at outcome; and (4) model individual differences in trajectories over time (random effects) rather than assuming that the pattern of change is the same for all participants (fixed effects) (Bryk and Raudenbush, 1992; Curran, 2000; Singer and Willett, 2003).

2. Method

The sample and methods have been described previously (Klein et al., 1995; Klein et al., 2006). The sample included

97 outpatients with DSM-III-R early-onset DD (with or without superimposed MDEs). We focused on the early-onset (<21 years) subtype as it is the prototypical form of DD (Kocsis and Frances, 1987). Patients were 18–60 years old, and were selected from consecutive admissions to the University Outpatient Psychiatry Department and Psychological Center. Several patients were also referred from the University Counseling Center and a community mental health center.

At least one follow-up was completed with 87 (89.7%) patients. Fifty-six patients completed all four follow-up assessments, 13 completed three follow-ups, 6 patients completed two follow-ups, and 7 patients completed only one follow-up. The mean length of follow-up was 112.4 months (SD = 24.2). DD patients who completed, and did not complete, at least one follow-up did not differ on any of the baseline predictors examined in the study.

As this was a naturalistic study, treatment was not controlled. However, we obtained information about treatment from patients and medical records. Treatment was coded using four-point scales for the adequacy of antidepressant medication and the intensity of psychotherapy (Keller et al., 1987). On average, patients received probably or definitely adequate levels of pharmacotherapy for 26.9% of the follow-up period (SD = 31.2), and were in weekly or biweekly psychotherapy for 26.7% of the follow-up (SD = 27.7). (For more detail on the sample's treatment experience, see McFarland and Klein, 2005). The study was approved by the Stony Brook University Institutional Review Board, and written informed consent was obtained from all patients following a complete description of the study.

2.1. Baseline evaluation

The baseline evaluation included the Structured Clinical Interview for DSM-III-R (SCID; Spitzer et al., 1990), 24-item modified Hamilton Depression Rating Scale (HAM-D; Miller et al., 1985), Personality Disorder Examination (PDE; Loranger, 1988), and Early Home Environment Interview (EHEI; Lizardi et al., 1995).

The EHEI is a semi-structured interview that assesses aspects of the early home environment prior to age 15, including physical abuse (being hit hard or often enough to leave bruises, draw blood, or require medical attention), sexual abuse (non-consenting genital contact initiated by someone at least five years older), and two scales summarizing the quality of the relationship with each parent. Physical and sexual abuse are scored present or absent. The maternal and paternal relationship scales include six items: rarely spent time or engaged in activities with parent, lack of parental supervision, rarely confided in parent, constantly criticized by parent, often rejected by parent, and rarely felt loved by parent. Scores range from 0–6, with higher scores indicating poorer relationships.

Family history information was obtained from patients for all first-degree relatives older than 14 years ($N = 446$)

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