Introduction

Goal of Antidepressant Therapy: Response or Remission and Recovery?

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An apparent paradox has emerged in the management of the depressed patient. While randomized controlled clinical trial results and other lines of evidence have established that a variety of antidepressant treatments are capable of producing excellent efficacy outcomes, the actual long-term outcomes observed in clinical practice are rather disappointing. For example, on one hand, 90% to 95% of depressed patients can be expected to respond to one or a combination of antidepressant interventions,[1] and more than 50% of depressed patients will recover within 6 months of an index episode of depression.[2] On the other hand, during the 5-year follow-up period in one study, the majority of patients experienced a recurrence of depression,[3] and over an 18-month period following successful treatment of depression in another study, the proportion of patients who remained well was as low as 19%.[4] Indeed, results from several studies indicate that the percentage of patients who have a *very poor* outcome during long-term follow-up after a diagnosis of depression ranges from 11% to 25%.[5,6] Furthermore, the Medical Outcomes Study reported that depressed patients experienced markedly impaired social and physical functioning,[7] with overall levels of impairment greater than those of most chronic medical illnesses.

In addition to their impact on individual patients, the poor outcomes from depression are important because of their influence on the costs to health care systems and to society. While the direct annual health care costs of depression, including hospitalization, physician charges, and drugs, were estimated at $12.4 billion in the United States in 1990[8] and £222 million in the United Kingdom,[9] the indirect costs related to poor outcomes such as lost job productivity and premature death dwarf the direct costs. These indirect economic costs—which in 1990 totaled more than $31 billion in the United States[8] and probably occur at comparable levels in other countries—underscore the burden produced by poor treatment outcomes. Thus, there is a need to improve long-term treatment outcomes in depression.

It appears that a gap exists between treatment outcomes in clinical practice and those obtained in a research setting. Clinical practice outcomes may fall short of those obtained in the research setting for a number of reasons. These include underrecognition of depression, failure to initiate treatment when a diagnosis of depression is made, failure to select a treatment modality that has been proven to be effective, use of inadequate doses of antidepressants, failure to treat sufficiently to obtain full remission, inadequate duration of treatment, failure to recognize and treat relapses and recurrences, failure to recognize and to treat comorbid psychiatric and medical conditions, and patient noncompliance.

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The presentations in these proceedings focus on 3 of these potential deficiencies that physicians can correct once they understand the relevance of recent research findings: failure to treat to remission, inadequate duration of treatment, and failure to recognize or treat comorbid disorders, specifically anxiety disorders. Professor Jules Angst, Psychiatric University Hospital, Zurich, Switzerland, begins with a discussion of the epidemiology and natural history of depression and the poor outcomes that have been observed in longitudinal studies. Professor Ian Nicol Ferrier, University of Newcastle upon Tyne, England, continues with a discussion of the difference between treatment response and remission and provides support for adopting remission as the goal of antidepressant therapy. Dr. Michael E. Thase, University of Pittsburgh, Pennsylvania, United States, presents results from pivotal studies that document the need for long-term continuation and maintenance therapy to prevent relapse and recurrence for patients with major depressive disorder. Finally, Dr. David Bakish, University of Ottawa, Ontario, Canada, describes the impact of comorbid anxiety on treatment response and outcomes. He also highlights results from clinical studies of the efficacy of venlafaxine for treating major depressive disorder with concomitant anxiety and results from recent clinical studies of the efficacy of venlafaxine extended release (XR) for treating generalized anxiety disorder.

In summary, there is a need for improved recognition and treatment of depression to produce better long-term outcomes in this prevalent and disabling disorder. Although new treatment modalities would be welcome, the immediate and pressing challenge is to make more effective use of those treatment modalities already available. Three practical principles that have the potential to improve the current disappointing long-term outcome results in the treatment of depression are to treat patients aggressively to produce full remission of their depressive syndrome, to treat patients for an adequate duration of time to prevent relapse and recurrence, and to identify and treat comorbid disorders that complicate the course of depression.

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