See accompanying Commentary *on pp. 60–65.*

Chronic Depression: Treatment in Primary Care

Depression—how should we treat it over time? This month's Commentary, which also appears in the February 2006 issue of *The Journal of Clinical Psychiatry* (2006;67:179–184), provides the primary care physician with a fascinating opportunity to listen in on a discussion among 5 psychiatrists, including several of the foremost investigators and conceptualizers regarding the disease process we call depression. Clearly, the chronicity of this disease is a dynamic area in which our understanding is progressing. The discussion has a number of implications for primary care physicians encountering depressive states in their patients.

First is the optimism with which we should approach all patients with depression, even those with chronic depression, whether it is the milder, indolent version we refer to as "dysthymia"; more severe chronic major depressive disorder; or "double depression," dysthymia followed by a major depressive episode. Such patients are not hopeless cases to be written off as impossible to treat effectively, and they are not as a group treatment resistant. Response rates to initial treatment for those with chronic depression are slightly less than for those with more acute episodes of depression, but about 45% to 50% of chronic depression patients will respond, and failure of an initial therapy still leaves a 50-50 chance that the patient will respond to a second treatment approach.

Second is the reality that many patients with chronic depression might be in such a state because they have never been diagnosed or offered treatment, including by us in primary care. They have not failed treatment; the medical and psychiatric community has failed them. Particularly if their decline into negative thinking and poor social functioning accompanied an early onset of chronic depression, they are often viewed as having a personality disorder or trait and thus being untreatable. Unfortunately, the disorder is such that they are ready to fulfill this view and adopt it themselves, only to further perpetuate their chronic depression.

Third is the recognition that success with patients with chronic depression requires ongoing active management. We in primary care are capable of such management and the mobilization of the treatments required. A proactive physician who maintains an expectation of improvement and adjusts treatment through titration of medication dose, switching, or augmenting, or referring for psychotherapy and monitoring its course, can provide a life-changing intervention. Since patients with chronic depression, compared to those with acute depression, are 10% to 20% less likely to respond to initial care, the early phase of pursuing different treatment options to find an approach that works is critical. If patients are allowed to disappear from therapy after less than optimal initial response, their absence should not be viewed as patient "noncompliance." Rather than patient failure to return or loss to follow-up, this disappearance all too often represents a failure on our part. However, increasing individual physician effort is not likely to be successful. Instead, we need to look toward reorganizing practice systems to actively recognize and manage such patients over the long term.

Fourth, we have options and real choice regarding the treatment of patients with chronic depression. We do not have overwhelming evidence to guide treatment decisions with this group. Consequently, patient preference is an important consideration and one that has been linked to success through increased adherence.

Fifth, while we do not have an immense base of evidence (particularly involving primary care patients), we do have evidence that pharmacotherapy and psychotherapy are both effective and that, particularly for severe cases, the combination is even more effective. Within the psychotherapies, an approach known as Cognitive Behavioral Analysis System of Psychotherapy (CBASP) might be particularly useful for patients with chronic depression. It is increasingly becoming available in our communities. Patients who have lived with depres-

sion chronically have often built long-standing dysfunctional ways of relating to others. CBASP includes a focus on analyzing and working on interpersonal issues in the here and now and thus gives patients support in relearning, or learning for the first time, the skills required to interact successfully in an adult world.

Sixth, knowing our patients and clarifying their life histories can be helpful. For patients with early-life stress—childhood abuse, neglect, or impoverished and uncertain environments—psychotherapy, including CBASP or cognitive-behavioral therapy, may provide a resilient therapeutic intervention. Similarly, for those with early onset of chronic depression, psychotherapy may be of great value in maturing life skills previously absent. Primary care physicians will not ordinarily provide such therapy directly, but can be invaluable in identifying for their patients effective therapists skilled in these techniques. Comanagement, with the primary care physician providing pharmacotherapy for instance, might be of great help.

Seventh, in the long term, the primary care physician is likely to be the professional best positioned to maintain these patients. As with many chronic diseases, relapses can be expected in chronic depression, and patients will discontinue psychiatric treatment at some point. For patients with a history of chronic depression, treatment discontinuation is highly likely to lead to a return of the depressed state. Even after a successful course of CBASP, such patients may revert to their old self-defeating ways of relating to the world; these may include not returning for care, including for "booster" psychotherapy. Primary care physicians are well positioned to provide the long-term monitoring and treatment that chronic depression requires, including long-term maintenance pharmacotherapy. We also are likely to have the only contact with patients who have relapsed as they show up for episodic medical care.

These patients are not "easy," and, unlike with long-term management of hypertension, we do not yet have medications that can be expected to be routinely highly effective with no side effects. Psychotherapies may involve personal expense and considerable time. Patients also may be confused about the nature of their disease and may lack a mental model of their disease adequate to make long-term treatment adherence a rational choice from their perspective. However, these are challenges that bring out the best in primary care—patient and family education, a long-term management and prevention practice approach, and motivational counseling to support change in behaviors. The results can be life-changing and even life-saving for our patients with chronic depression.

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