

Recognizing and Treating Chronic “Mild” Depression

Its manifestation may be subtle, its effects devastating

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Depressive disorders vary widely in presentation, symptom severity, and duration. Dysthymic disorder, often labeled “minor” or “mild” depression, has fewer and less severe acute symptoms than does major depression. However, dysthymic disorder may persist for years and remain unrecognized—both by the patients themselves (who may believe they just have “depressive personalities” and thus never seek treatment) and by their clinicians. Left untreated, it can be as debilitating as major depression, if not more so.

Depression affects more than 19 million adults in the United States each year.¹ It strikes women twice as often as it does men.¹ Most psychiatric research to date has focused on major depression, the acute, severe subtype. This article will instead focus on dysthymic disorder—so-called “mild” depression—and its management. It will describe how dysthymic disorder differs from major depression and what features the two disorders share. It will also discuss treatment strategies, including pharmacotherapy and psychotherapy.

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ABSTRACT: Dysthymic disorder is a chronic form of depression that is often wrongly dismissed as “mild.” Over time it can be even more devastating than major depression. Furthermore, dysthymic disorder often goes undiagnosed. Patients may suffer from it for years before realizing something is wrong. Guilt, self-doubt, and low energy erode interpersonal skills, diminishing the likelihood of social and occupational success. A basic treatment principle is that what works for major depression also works for “mild” depression. Pharmacotherapy options include selective serotonin reuptake inhibitors (often used as first-line treatment), tricyclics, and monoamine oxidase inhibitors. Psychotherapies such as cognitive behavioral therapy and interpersonal therapy also can be effective. (*Women Health Primary Care* 1999;2(11):855-861)

MAJOR V “MINOR” DEPRESSION

The term *depression* carries both a specific diagnostic denotation and a loose popular connotation. Its span includes bipolar disorder (manic depression), major depression (with and without delusional features), atypical depression, dysthymic disorder, and other presentations of varying symptomatic severity and duration.

Most clinicians use the term *depression* to refer to major depression. The adjective *major* implies that this is the serious form of depression and that other forms are minor. Yet this is far from true. The Rand Medical Outcomes Study² of more than 11,000 patients in medical and mental health settings found that having just two depressive symptoms (ie, subsyndromal depression) was more debilitating than having hypertension, coronary artery disease, diabetes, back problems, or lung disease. Subsyndromal depression was less debilitating than only one condition studied—active angina pectoris. Patients with subsyndromal depression spent too much time in bed, experienced inordinate pain, and functioned poorly in social and occupational roles.

Mild forms of depression, therefore, should not be dismissed lightly. The following discussion highlights the similarities and dissimilarities between major depression and dysthymic disorder. Both disorders are underdiagnosed in primary care settings.

Table 1. Diagnostic criteria for major depressive episode

Five (or more) of the following symptoms have been present nearly every day during the same two-week period and represent a change from previous functioning. At least one of the symptoms is either depressed mood or loss of interest or pleasure in daily activities.

- ◆ Depressed mood most of the day.
- ◆ Markedly diminished interest or pleasure in (almost) all activities most of the day.
- ◆ Significant weight loss (when not dieting) or gain (eg, greater than 5% of body weight in a month), or change in appetite.
- ◆ Insomnia or hypersomnia.
- ◆ Psychomotor agitation or retardation (observable by others).
- ◆ Fatigue or loss of energy.
- ◆ Feelings of worthlessness or inappropriate guilt.
- ◆ Diminished ability to think or concentrate, or indecisiveness.
- ◆ Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation, a specific suicidal plan, or suicide attempt.

In addition, the symptoms should:

- ◆ Not meet the criteria for a mixed mood episode.
- ◆ Cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ◆ Not be due to the direct physiologic effects of a substance (eg, an abused drug, a medication) or a general medical condition.
- ◆ Not be better accounted for by bereavement (ie, a diagnosis of depression can be considered if, after the loss of a loved one, symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation).

Adapted from American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. 1994.³

MAJOR DEPRESSION

In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*,³ major depression is defined as the presence of at least five of nine symptoms for a minimum of two weeks (Table 1). The symptoms include neurovegetative disturbances (eg, insomnia or hypersomnia, increased or decreased appetite, and loss of energy), cognitive disruptions (eg, poor concentration, pessimism, and a negative outlook), and depressed mood.

Major depression can be debilitating or even lethal. It causes misery, impairs social functioning, and diminishes work capacity, and it is a major cause of suicide. The point prevalence of major depression is 5% to 9% in women and 2% to 3% in men.³ Although major depression may present at any point in the life cycle, women of childbearing

age are at greatest risk. By the year 2010, depression is predicted to be second only to cardiovascular disease as the most costly syndrome worldwide.

Studies have found that major depression is underdiagnosed in primary care settings.^{4,5} Under the strictures of managed care, many primary care physicians are able to spend only about eight minutes with each patient. Often, they only have time to focus on a particular symptom rather than on the whole patient. The detection of psychiatric disorders frequently suffers as a result. Some clinicians, regardless of time pressures, may simply focus on physical symptoms and therefore miss mood disorders.

DYSTHYMIC DISORDER

A chronic form of depression, dysthymic disorder was long dismissed

as unimportant because its acute symptoms are less severe than those of major depression and were felt to reflect a depressive character disorder (and thus was treated with long-term psychodynamic psychotherapy). Diagnostic criteria include three symptoms (rather than the five of acute major depression) that persist for at least two years (Table 2).

Patients with dysthymic disorder actually fare worse over time than do patients with major depression.⁶ This outcome is really no surprise: Patients with major depression may have a few terrible weeks or months, but with treatment, they often recover. In contrast, dysthymic patients may know nothing but suffering for decades or even their entire lives. Constant guilt, self-doubt, and low energy erode or inhibit interpersonal skills, diminishing the likelihood of social and occupational success. Dysthymic disorder makes life a persistent misery. To call it "mild" depression is misleading.

At least 3% of adult Americans suffer from dysthymic disorder.^{7,8} Like major depression, dysthymic disorder occurs two to three times more commonly among women than men.

People with dysthymic disorder often believe they simply have "depressive personalities," as being depressed is the only mood state they have ever known.⁹ They are frequently shy, hardworking, pessimistic, and socially isolated (they are usually unmarried). They often report passive suicidal ideation but are resigned to the misery of their lives. These people frequently have family histories of mood disorders. They may abuse alcohol in an attempt to self-medicate their mood, and they are at risk for other comorbid disorders, such as panic disorder and social phobia. Dysthymic patients are at high risk for eventually developing a superimposed major depression (double

depression), which only requires an additional couple of symptoms for a few weeks during a frequently lifelong dysthymic course.¹⁰

Likely to be seen as outpatients, people with dysthymic disorder are high utilizers of medical and mental health services.⁷ Until recently, however, these patients often received the wrong treatment: benzodiazepines rather than antidepressants.¹¹ Although major depression is underdiagnosed in clinical settings, dysthymic disorder is subtler and easier to miss. Both major depression and dysthymic disorder respond to antidepressant treatment, sometimes dramatically (see "Case vignette: A 39-year-old woman with dysthymic disorder," page 858).

TREATMENT OPTIONS

It is now well established that medications can effectively treat episodes of major depression and prevent relapses and recurrences. The availability of new drug classes, such as the selective serotonin reuptake inhibitors (SSRIs), has led to more aggressive treatment of depression by primary care clinicians, who had previously been concerned about using older medications because of their side effects, dosing schedules, and overdose potential. In addition, psychotherapies such as cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have also demonstrated efficacy as treatments for outpatients with major depression. But are these treatments helpful for patients with dysthymic disorder?

A basic treatment principle is that what works for major depression also often works for "minor" depression. An exception is electroconvulsive therapy, which is usually reserved for psychotic, extremely severe, or treatment-refractory depression. Antidepressant medications¹² and psychotherapies¹³ have demonstrated efficacy in treating depression of mild-to-moderate in-

tensity. (Similarly, the treatments for bipolar disorder also ameliorate spectrum conditions such as bipolar II disorder, hypomania, and cyclothymia.) Medication and psychotherapy, which presumably have different mechanisms of action, may also be combined.

PHARMACOTHERAPY

Almost all antidepressant medications have roughly equal efficacy. Therapeutic response is generally 60% to 70% in patients with major depression and around 50% to 55% for those with dysthymic dis-

order. However, medications differ in their effects on individual patients and in their potential for producing adverse effects. Also, when prescribing any antidepressant, clinicians must consider potential drug-drug interactions, such as those related to the hepatic cytochrome P-450 system.¹⁴

Drug selection: Most primary care clinicians use SSRIs as first-line treatment for depression. Administered each morning, SSRIs can be started at what are often standard therapeutic dosages. For elderly patients, the starting doses can

Table 2. Diagnostic criteria for dysthymic disorder*

Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least two years.

Note: In children and adolescents, the mood can be irritable and the duration is decreased to at least one year.

Presence of at least two of the following:

- ◆ Increase or decrease in food consumption.
- ◆ Insomnia or hypersomnia.
- ◆ Low energy or fatigue.
- ◆ Low self-esteem.
- ◆ Poor concentration or difficulty making decisions.
- ◆ Feelings of hopelessness.

During the two-year period[†] of the disturbance, symptoms have not subsided for more than two months at a time.

No major depressive episode has occurred during the first two years[†] of the disturbance (ie, the disturbance is not better accounted for by chronic major depressive disorder or by major depressive disorder in partial remission).

Note: Before development of the dysthymic disorder, there may have been a previous major depressive episode, but it should currently be in full remission (showing no significant signs or symptoms for two months). If after the initial two years of dysthymic disorder the patient experiences superimposed episodes of major depressive disorder, he or she would be diagnosed with both dysthymic disorder and major depression.

The patient has never experienced a manic episode, mixed episode, hypomanic episode, or cyclothymic disorder.

The disturbance does not occur exclusively during the course of a chronic psychotic disorder, such as schizophrenia or delusional disorder.

The symptoms are not due to the direct physiologic effects of a substance (eg, an abused drug, a medication) or a general medical condition (eg, hypothyroidism).

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

* The onset of dysthymic disorder should be specified as *early* if it occurs before age 21 years or as *late* if it occurs at age 21 years or older.

† Or one year for children or adolescents.

Adapted from American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. 1994.³

Case vignette: A 39-year-old woman with dysthymic disorder

A divorced businesswoman and mother of a 5-year-old repeatedly presented to her primary care clinician complaining of headaches and gastrointestinal distress. Physical examination and laboratory tests were unrevealing. The patient reported feeling anxious and "under lots of stress." History-taking revealed that she suffered from insomnia, low energy, chronic depression, pessimism, thoughts of inadequacy, and guilt. Because she had felt this way much of her life, she had never thought to report it; moreover, she did not like to bother her doctor.

The patient was given a selective serotonin reuptake inhibitor. She initially experienced a worsening of her gastrointestinal symptoms but was encouraged by her doctor to continue drug therapy. Within two weeks, she noted not only significant relief of her physical symptoms but also the best mood she had ever experienced. At first she feared that she was getting "manic," but her doctor determined that her ability to sleep was not impaired, her thoughts were not racing, and she was not acting impulsively. The patient soon adjusted to her newfound euthymia.

be halved. If in doubt, a good rule of thumb is: Begin low and build up.

In general, SSRIs are well tolerated. Acute side effects, which tend to be mild, include dry mouth, jitteriness, gastrointestinal distress, and headache. Chronic side effects can include weight gain, a restriction of emotional range (not caring anymore) and, probably most damningly, sexual dysfunction. Various antidotes have been proposed to treat the sexual side effects of SSRIs.¹⁵

Nonpsychiatric clinicians have historically been uncomfortable in raising the doses of non-SSRI antidepressants to therapeutic levels—eg, to 200 to 300 mg/d for most tricyclic antidepressants (nortriptyline, the only exception, is titrated by serum levels) and to 60 mg/d or higher for monoamine oxidase inhibitors.

Typical therapeutic course: Antidepressant response follows a predictable sequence: first side effects, next physical improvement, then mood improvement. Depressed

patients, who may be discouraged when they initially experience only side effects, should be forewarned and encouraged to see the side effects as harbingers that the medication is getting into their system and starting to work.

Next, neurovegetative symptoms and work function may improve. Friends and family may notice a difference, but the patient is generally the last to know that he or she is getting better. It may take several weeks to see improvement, and the full benefits of a given dosage may not be apparent for at least four to six weeks. Once mood does improve, patients who have suffered from chronic depression may worry that the gains will fade or, like the patient described in the case vignette (see above), they may be frightened by "too" good a mood. Benefits tend to last at least as long as the medication is continued.

Patients who do not respond to an adequate antidepressant trial—a minimum of four weeks at a ther-

apeutic dosage—are likely to feel still more demoralized and depressed. They need reassurance that depression is treatable and that many other treatment options remain. Such patients may benefit from additional medication trials (nonresponse to one antidepressant does not preclude response to another), the addition of antidepressant psychotherapy (such as CBT or IPT), or referral to a psychiatrist for further treatment.

PSYCHOEDUCATION

Depressed patients are more likely to comply with treatment when properly educated about their condition. The treating clinician should present major depression and dysthymic disorder as medical illnesses that are prevalent, treatable, and not the patient's fault. No one wants to be depressed, yet depressed patients often blame themselves for their ills.

Most patients with depression are relieved to hear that they have a recognizable and treatable condition. Depressive disorders bear comparison to hypertension, asthma, and other potentially recurrent or chronic medical conditions. It may help to explain the biochemical rationale for treatment—namely, that medications affect neurotransmitters, such as serotonin (eg, SSRIs), norepinephrine (eg, nortriptyline, desipramine, reboxetine), or both (eg, venlafaxine), and that these effects will treat depression.

Stigma about psychiatric disorders and their treatment still exists, but it is declining. Almost everyone has heard about celebrities who have "come out" about their depression. Many patients may have read self-help books about depression or have done research on the Internet. They may benefit from referral to national patient advocacy organizations, such as the National Alliance for the Mentally Ill (telephone: 1-703-524-7600).

The families of patients with

depression also suffer and may benefit from psychoeducation. Furthermore, depression often runs in families. The clinician treating the patient described in the case vignette (page 858) would have done well to inquire into the health and functioning of the patient's spouse and child.

PSYCHOTHERAPY

Most clinicians lack the time and training to deliver formal psychotherapy for depression, but they should know that time-limited, efficacious treatments exist. CBT¹⁶ and IPT¹⁷ are manual-guided, once-weekly, 12- to 20-week therapies that were originally developed to treat major depression. Both have been repeatedly tested in randomized, controlled clinical trials and shown to be about as effective as medication for outpatients who have non-delusional major depression. Like medications, CBT and IPT have been less fully evaluated as treatment for dysthymic disorder, but they show promise for that as well.^{9,18}

CBT focuses on the irrational, negative thoughts that "automatically" arise in the minds of depressed individuals,¹⁶ such as: "I'm a loser"; "Nothing I do ever goes right, so why bother?"; "Things are too overwhelming for me to face"; and "Nothing will ever get any better." Because these thoughts fit their mood, depressed patients tend to take them for granted. Yet such thoughts cause suffering and discourage depressed patients from coping with life. CBT therapists help depressed patients to scrutinize such thoughts and weigh the evidence for and against believing them. As patients learn to do this, their negative thoughts—and their depressive syndrome—fade.

IPT focuses on depression as a medical illness and helps patients recognize the connection between depressed mood and recent life events, such as deaths (complicated bereavement or pathologic grief),

role disputes (struggles with significant others), and role transitions (major life upheavals or changes).¹⁷ If patients can improve their life situation—and, contrary to their expectations, they usually can—the depressive syndrome will lift. Despite its impressive research record, IPT was, until recently, less widely practiced than CBT; therapists trained in IPT may be harder to find.

Psychotherapies may also smooth out interpersonal difficulties and life frictions that may precipitate future depressive episodes. But all psychotherapies may not be equal. Far less research has been

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done on the utility of many other forms of psychotherapy, such as psychodynamic psychotherapy, as treatments for depression.

OTHER TREATMENTS

Many Americans, disaffected by the lack of attention they received from medicine under managed care (managed cost is more like it), have sought alternative treatments for their ills. *Hypericum perforatum* (St. John's wort) is a popular example of a "natural" remedy for depression. Although some methodologically suspect German studies support the use of St. John's wort for mild depression,¹⁹ its efficacy and safety as an antidepressant are only now under investigation in the United States.

Given the availability of clin-

ically proven safe and effective treatments for depression, St. John's wort currently cannot be recommended for depressed patients. Patients who have been self-medicating with St. John's wort should be told to discontinue the drug before starting treatment with an SSRI or other antidepressant. This underscores the need to question patients carefully about all medications and herbal remedies—as well as alcohol and illicit drugs—they are using during any routine medical evaluation.

MAINTENANCE TREATMENT

There was once a myth that depression was a one-time occurrence in menopausal women—so-called *involutional melancholia*. In fact, depression may arise at any point in the life cycle; it tends to recur and may become chronic.²⁰ Individuals who have one episode of major depression carry at least a 50% lifetime risk of having a second episode; the risk rises to 80% to 90% after three to four episodes of depression.

Ongoing treatment is thus often necessary for prophylaxis against depression. Pharmacotherapy has demonstrated efficacy in protecting against relapse and recurrence of major depression²¹ and dysthymic disorder.²² Psychotherapies have begun to show prophylactic efficacy as well.²¹

Patients recovering from an acute depressive episode are often told to take antidepressant medication for six months, but this may well be too short a duration. Even when in symptomatic remission, such patients have usually suffered a great loss of self-confidence and experience some shakiness in functioning. I recommend that patients continue taking antidepressants for at least a year, a period of protection during which they can regain their confidence. If they have had multiple episodes of depression, I recommend maintenance medica-

tion for at least several years. (Some patients, convinced by the pain of the illness, swear by medication and would not think of relinquishing it.) Research has shown that maintenance medication should be continued at its acute dosage.²¹ Treatment with IPT, even at the low "dose" of one session per month, also has shown maintenance benefits in treating highly recurrent major depression.²¹

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Recognizing and Treating "Mild" Depression

PRIMARY POINTS

Dysthymic disorder is characterized by a depressed mood that persists for at least two years and by the presence of two additional symptoms of depression. In contrast, major depression is marked by a depressed mood or loss of interest that persists for at least two weeks and by the presence of four additional depressive symptoms.

Most primary care clinicians use selective serotonin reuptake inhibitors as first-line treatment for depression. These medications, administered daily each morning, can be started at standard therapeutic dosages. The therapeutic response is generally 60% to 70% for patients with major depression and around 50% to 55% for patients with dysthymic disorder.

Treatment compliance increases when depressed patients are properly educated about their condition. Clinicians should present major depression and dysthymic disorder as medical illnesses that are prevalent, treatable, and not the patient's fault.

Cognitive behavioral therapy and interpersonal therapy have been shown to be about as effective as medication for outpatients with nondelusional major depression. Although these forms of psychotherapy are less well studied in patients with dysthymic disorder, they show promise in this setting as well.