

The Modern Concept of Remission in Nonpsychotic Depressive Disorders

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Understanding of the modern concept of remission (RM) should take account of its multidimensional structure, which includes clinical (severity and nature of residual symptomatology, clinical type of RM), subjective (social functioning and self-assessment of patients' status), and integral (stability) characteristics, which have complex relationships with each other. Studies of 385 patients during pharmacotherapy and psychotherapy showed that the leading role in this structure is played by the clinical types of RM (complete, monosymptomatic, and polysymptomatic, and remission with the structure of minor depression), which on the basis of the dimensional approach creates a spectrum from the complete absence of any symptoms to subsyndromal depression. Clinical types of RM are defined by subjective and integral characteristics.

Keywords: depressive disorders, remission, dimensional approach.

Increases in the need for effective treatment promote the introduction of new standard assessments of treatment outcomes into clinical practice. In depressive disorders, this applies mostly to assessments of remission [1, 15].

Remission (RM) is phenomenologically defined as an asymptomatic period in the course of illness during which the patient does not meet any of the DSM-IV or ICD-10 criteria for diagnosis of major depressive disorder (MDD), i.e., the symptoms are minimal, for two months or more [15, 16]. However, despite the existing criteria which would seem to provide reliable differentiation between RM and MDD [19], the literature also addresses the possibility that the concept of RM should include such characteristics as functional recovery, quality of life, compliance, and subjective evaluation. Inclusion of this approach would, according to Zimmerman et al. [29] and Guelfi [16], be analogous to a qualitative transition with a change from the dichotomous assessment of efficacy to a new concept of efficacy.

Resolution of this problem is quite difficult because the question of the place of RM in the modern classification

of depressive disorders remains unclear, leading to significant controversy regarding the nature of residual symptoms. Some authors [7, 13, 23] regard these as resulting from the actions of antidepressants and psychotherapy or their side effects, others as the consequences of comorbid mental pathology (anxiety, personality disorders) [8, 24], others see them as due to the formation of negative changes of the asthenic or adynamic type on the background of nonspecific reductions in energy potential and the "vigilance of consciousness" [4, 5, 9, 11], and others regard them as a stage in the course of illness (settling of the illness) with persistent activity of the morbid process [3]. With respect to this latter point of view, the dimensional approach allows the whole range of psychopathological states to be distributed on a spectrum from the complete absence of residual symptoms to subsyndromal depression, and the position will determine the level of social functioning, the nature of patients' subjective assessments, and the occurrence of exacerbations/recurrences of depression.

However, Zimmerman et al. [28] pointed out that day-to-day functioning of patients during RM does not always correspond to complete social recovery, which, in the view of Mintz et al. [21], is due to the effects of concomitant illnesses (especially in elderly patients) or the presence of

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changes in these parameters prior to the onset of depression. This raises the question of whether the day-to-day functioning factor is independent of or linked with the clinical signs of RM. At the same time, studies of RM in schizophrenia produced similar results – recovery of clinical and social indicators in this category of patients could be simultaneous or dissociated [6, 10]. Complete recovery of social functioning is evidence for the onset of recovery, while its absence points to a state of RM.

Another equally important aspect of RM in depressive disorders is the existence of a “break” between objective (doctor’s) and subjective (patient’s) assessments. The studies reported by Zimmerman et al. [28] showed that doctors orient themselves primarily to clinical improvement, while patients focus on the recovery of subjective mental health and normal levels of functioning, including the elimination of symptoms of depression and feelings of optimism and self-esteem.

On the basis of the multidimensional model of RM, its stability is the main characteristic not only allowing this indicator to be included into the structure of RM, but also providing a measure of the patient’s recovery. A number of studies [14, 17, 18, 25, 26] have shown that this indicator is influenced not only by the clinical features of the course of depression (chronic or acute), but also the level of “cleanliness” of RM of residual symptomatology, the presence of concomitant pathology, both mental and somatic, and the number of previous depressive episodes, but also the level of social recovery of patients, the presence of stress situations, and psychosocial resources.

As a result, the problem of RM in terms of the interaction of clinical, subjective, and integral characteristics has acquired importance not only for depressive disorders, but also for other mental diseases. Development of its multidimensional structure is particularly relevant.

The aim of the present work was to develop a modern multidimensional concept of RM taking cognizance of clinical (structure/severity of psychopathological symptoms, typology of illness), subjective (recovery of social functioning and patient’s assessment of status), and integral (stability) characteristics.

Materials and Methods

Investigations were performed at the Department of Therapy for Mental and Behavioral Disorders, Serbskii State Scientific Center for Social and Forensic Psychiatry at Moscow Psychiatric Hospitals Nos. 8 and 12.

The study included patients with ICD-10 diagnoses (F3): single depressive episode or recurrent depressive disorder with depressive episode, age from 18 to 65 years, and signed informed consent. The main exclusion criteria were: dementia, schizophrenia spectrum disorders, paroxysmal disorders, consumption of psychoactive substances, bipolar affective disorder, depressive disorders psychotic type, high risk of suicide, and chronic somatic disorders in severe decompensation.

The study cohort consisted of 385 patients: 312 receiving out-patient treatment and 73 receiving in-patient treatment. All cases were treated with antidepressants (240 cases) or psychotherapy (145 cases). A total of 21 patients (5.45%) left the study because of side effects or lack of therapeutic effect, and results from these patients were excluded from further analysis.

Patients’ mean age was 38.38 ± 11.91 years. Most patients were in higher or continuing higher education (56.1%), employed (55.84%), and unmarried (57.66%).

The diagnosis of “recurrent depressive disorder” (53.77%) was made more often than that of “depressive episode” (46.23%). The status of most patients was evaluated as being of moderate severity (54.81%) or, less often, severe (26.23%) or mild (18.96%). The mean Hamilton depression scale score (HAM-D-17) before treatment was 22.15 ± 4.59 . Psychopathological structures were mainly anxious (34.55%), asthenic (18.7%), hysterical (16.88%), and apathetic (14.29%) depression, which was generally characteristic of patients with mild and moderate nonpsychotic depression. Melancholic (10.65%) and hypochondriac (4.68%) depression were rarer; one patient (0.26%) had depression with compulsions.

The study was performed in two stages.

At the first stage (corrective treatment), the patients were randomized (2:1) to pharmacotherapy and psychotherapy groups. Pharmacotherapy consisted of treatment with second-generation antidepressants (selective serotonin reuptake inhibitors (SSRI) – escitalopram (10–20 mg/day), paroxetine (10–60 mg/day), or fluoxetine (20 mg/day)), or third-generation antidepressants (selective serotonin and noradrenaline reuptake inhibitors (SSNRI) – venlafaxine (75–220 mg/day) or milnacipran (50–100 mg/day)). Psychotherapy consisted of clinical transpersonal therapy. This method was chosen because of its demonstrated efficacy and duration, which are comparable with those of the pharmacotherapy of nonpsychotic depression. Sessions were conducted in groups of 8–15 patients. Courses of treatment consisted of 16 sessions each of 2–2.5 h (twice a week) for eight weeks.

The second stage of the study addressed indicators reflecting the quality of RM, i.e., clinical (severity/nature of residual symptomatology), subjective (functional recovery and patients’ assessments of status), and integral (stability) characteristics to identify groups of patients with similar values.

The tasks of the studies were addressed using clinical-psychopathological and psychometric methods employing standard quantitative scales: HAM-D-17 (Hamilton 17-points questionnaire), the Beck depression self-assessment, and levels of social adaptation on the Sheehan scale [27].

Results were evaluated statistically in SPSS 17.0.

Results

RM was evaluated as a reduction in the total score on the HAM-D-17 scale. The proportions of patients achieving

TABLE 1. Frequency of Symptoms of Depression on the HAM-D Scale in Pharmacotherapy and Psychotherapy in RM

Symptom	Pharmacotherapy (n = 107)		Psychotherapy (n = 50)		p
	abs.	%	abs.	%	
Hypothymia	16	6.57	11	6.36	0.276
Feelings of guilt	13	5.49	8	4.62	0.509
Suicidal ideation	0	0	0	0	
Sleep disorders	25	10.55	24	13.87	<0.002**
Work and activities	24	10.13	14	8.09	0.448
Retardation	6	2.53	1	0.58	0.308
Agitation	2	0.84	8	4.62	<0.001**
Mental anxiety	33	13.92	29	16.76	<0.001**
Somatic anxiety	21	8.86	24	13.78	<0.0001***
Gastrointestinal symptoms	9	3.8	4	2.31	0.931
General somatic symptoms	30	12.66	22	12.72	<0.048*
Genital symptoms	17	7.17	10	5.78	0.525
Hypochondriasis	22	9.28	14	8.09	0.302
Weight loss	0	0	0	0	
Insight	19	8.02	4	2.31	<0.013*

Note. Differences between groups, χ^2 test: * $p < 0.05$, ** $p < 0.001$, *** $p < 0.0001$.

RM were essentially identical regardless of the treatment method: 45.53% with pharmacotherapy and 38.76% with psychotherapy.

Complete (asymptomatic) and incomplete (symptomatic) RM were discriminated on the basis of the absence or presence of residual symptomatology. Symptomatic RM was more common after pharmacotherapy and psychotherapy, the proportion with psychotherapy (92%) being significantly greater than that with pharmacotherapy (77.57%) ($p < 0.02$).

Symptomatic RM with residual symptom severity of 2.66 points with pharmacotherapy and 3.98 points with psychotherapy was characterized by heterogeneous residual symptoms, dominated by facultative symptoms: sleep impairment (10.55% and 13.78%, respectively), mental (13.92% and 16.76%, respectively) and somatic (8.86% and 13.78%, respectively) anxiety, and general somatic symptoms (12.66% and 12.72%, respectively), and hypochondriasis (9.28% and 8.09%, respectively) (Table 1). These were generally determined by the severity of the residual symptomatology. Among the symptoms specific for depression, the most frequent were loss of interest and activity (10.13% with pharmacotherapy and 8.09% with psychotherapy) and, more rarely, hypothymia (6.57% and 6.36%, respectively) and cognitive impairments (5.49% and 4.62%, respectively).

Use of the dimensional approach showed that heterogeneous residual symptomatology forms a spectrum of different states from the complete absence of any kind of disorder to subthreshold depression, in the form of four variants: complete RM, monosymptomatic RM, polysymptomatic RM, and RM with the structure of minor depression (Fig. 1).

Complete RM was characterized by the absence of any kind of residual symptomatology, and was seen more frequently after pharmacotherapy (22.43%) than psychotherapy (8%) and mainly in patients with first onset of psychogenic depression of anxious, asthenic, or hysterical structure of mild or moderate severity, with high levels of social integration (most patients had higher/continuing higher education, families, and jobs).

Monosymptomatic RM was characterized by stable isolated residual symptoms, mostly on the anxious, somatoautonomic, insomniac spectrum, which discriminated three types: monosymptomatic RM with anxious, somatoautonomic, and insomniac symptomatology.

Monosymptomatic RM with anxious symptomatology was characterized by anxiety spectrum symptoms (mental/somatic anxiety, algias), which were seen more often after psychotherapy (20%) than after pharmacotherapy (11.65%) and formed in patients with first episodes of psychogenic problems and, more rarely, unipolar depression of

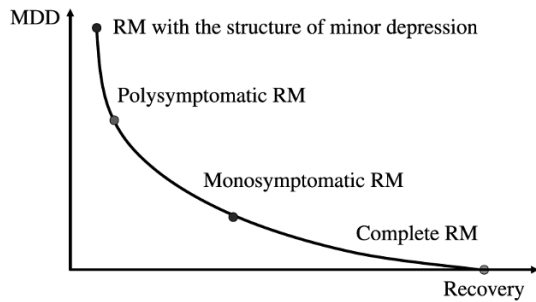


Fig. 1. Variants of RM.

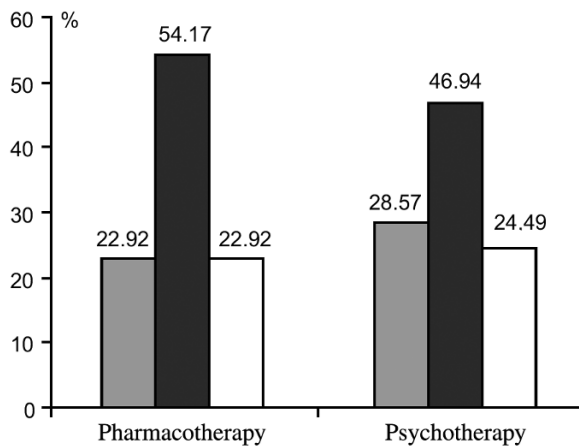


Fig. 2. Frequencies of variants of assessments in RM groups given pharmacotherapy and psychotherapy: ▨ appropriate; ■ hypergnosis; □ hypognosis.

anxious structure, moderate severity, hysterical features, and high levels of social integration.

Monosymptomatic RM with somatoautonomic symptoms was characterized by a variety of somatoautonomic abnormalities (autonomic dysfunctions, algias, sexual impairments), was seen more commonly in the psychotherapy group (8%) than the pharmacotherapy group (4.67%) and formed in patients with repeated psychogenic depression of anxious or asthenic structure, mild or moderate severity, with hysterical, psychasthenic, or schizoid features and high levels of social integration.

Monosymptomatic RM with symptoms of insomnia was associated with early and/or intermediate insomnia. This was seen only in pharmacotherapy (8.41%) and dominated in patients with first episodes of psychogenic depression of hysterical or asthenic structure, mild or severe severity, with hysterical accentuation and high levels of social integration.

Other variants of monosymptomatic RM were characterized by loss of interest and activities, hypochondriasis, and lack of insight into the illness, and was encountered only in pharmacotherapy (6.54%).

Polysymptomatic RM consisted of a constellation of symptoms facultative for the depressive state (somatoautonomic, hypochondriac, cognitive, adynamic, etc.). The leading symptoms identified three variants: polysymptomatic RM with somatohypochondriac symptoms, cognitive impairments, and adynamia.

Polysymptomatic RM with somatohypochondriac symptoms was manifest as the presence of a variety of somatoautonomic symptoms, anxiety, and hypochondria and was seen at similar frequencies in psychotherapy (10%) and pharmacotherapy (9.35%). This was recorded in patients with repeated episodes of psychogenic or unipolar depression of anxious or hysterical structure, moderate severity, hysterical or psychasthenic deviations, and social disintegration (on the background of a predominance of patients with higher/continuing higher education and stable jobs, with increases in the number of unmarried patients).

Polysymptomatic RM with cognitive impairments showed a combination of cognitive impairments with mental/somatic anxiety and lack of insight and was seen less frequently with psychotherapy (2%) than pharmacotherapy (8.4%). This type of RM showed a predominance of patients with first episodes of psychogenic depression of anxious or hysterical structure, hysterical or psychasthenic features, and social disintegration (with high proportions of patients with stable jobs and families, decreased numbers of patients with higher/continuing higher education).

Polysymptomatic RM with adynamia was characterized by the combination of adynamia with symptoms of the anxious, insomniac, and somatoautonomic spectrum and was more common with psychotherapy (22%) than pharmacotherapy (12.15%). It formed in patients with repeated episodes of mild/moderate and, more rarely, primary mild/moderate/severe psychogenic depression with an anxious or asthenic clinical picture, hysterical or psychasthenic accentuation, and social disintegration (on the background of a predominance of patients with higher/continuing higher education and stable jobs, and an increased proportion of unmarried patients).

Other variants of polysymptomatic RM were seen in occasional cases.

RM whose structure was determined by minor depression was characterized by hypothymia combined with facultative symptomatology and was found at twice the frequency in psychotherapy (30%) as pharmacotherapy (15.89%), occurring in patients with repeated psychogenic or unipolar depression of anxious or asthenic structure, moderate severity, hysterical or schizoid features, and quite high levels of social integration.

Thus, the nature of residual symptomatology, reflecting its heterogeneous psychopathological structure, corresponded to its severity, such that the dimensional approach could be used to define the spectrum of states from the complete absence of any kind of symptoms to subthreshold depression.

TABLE 2. Frequencies of Subjective Assessments in Different Types of RM with Pharmacotherapy and Psychotherapy

Type of RM	Type of treatment	Assessment variant					
		appropriate		hypergnosia		hypognosia	
		abs.	%	abs.	%	abs.	%
Asymptomatic	PhT	2	18.18	6	23.08	0	0
	PsT	2	14.29	2	8.7	0	0
Monosymptomatic RM	PhT	1	9.09	9	34.62	3	27.27
	PsT	1	7.14	9	39.13	3	25
Polysymptomatic RM	PhT	7	63.64	7	26.93	7	63.64
	PsT	8	57.14	5	21.74	6	50
RM with the structure of minor depression	PhT	1	9.09	4	15.38	1	9.09
	PsT	3	21.43	7	30.43	3	25

Note. PhT – pharmacotherapy; PsT – psychotherapy.

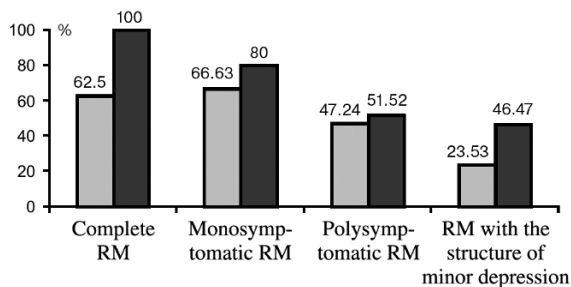


Fig. 3. Frequencies of formation of functional RM in patients with different clinical types of RM with pharmacotherapy and psychotherapy: ■) pharmacotherapy; ■) psychotherapy.

Patients' assessments of status and recovery of social functioning provide important subjective indicators of RM.

One of our previous reports [2] analyzed data from clinical-diagnostic scales (HAM-D-17 and Beck depression self-assessment scales) and divided patients into four groups on the basis of the ratio of objective to subjective severity: "appropriate assessment" – subjective and objective indicators were comparable; "hypergnosia" – subjective indicators were greater, i.e., patients "overevaluated" their condition; "hypognosia" – objective indicators were greater, i.e., patients "underevaluated" the severity of depression; and "anosognosia" – significantly greater objective indicators, the patient essentially denying depressive disorder. This division was used to evaluate subjective indicators such as quality of RM and patients' assessments of their status. A total of 48 patients receiving pharmacotherapy and 49 receiving psychotherapy were studied. Patients achieving the state of RM (Fig. 2) in both treatment

groups were dominated by patients with "hypergnosia," which was more frequent in pharmacotherapy patients than psychotherapy patients (54.17% and 46.94%, respectively). Other evaluations – "appropriate" (28.57% with psychotherapy and 22.92% with pharmacotherapy) and "hypognosia" (24.49% and 22.92%, respectively) were encountered more rarely and were more common with psychotherapy than treatment with antidepressants. There were no patients with "anosognosia" with either treatment method.

The ratio of clinical types of RM and variants of subjective assessments are shown in Table 2. In complete RM, pharmacotherapy and psychotherapy produced appropriate assessments (18.18% and 14.29%, respectively) and/or hypergnosia (23.08% and 8.7%, respectively). Mono- and polysymptomatic RM and RM with the structure of minor depression showed a greater diversity of assessments, as appropriate assessments were also observed (9.09%, 63.64%, and 9.09% with pharmacotherapy and 7.14%, 57.14%, and 21.43% with psychotherapy, respectively), along with hypergnosia (34.62%, 26.93%, and 15.38% with pharmacotherapy and 39.13%, 21.74%, and 30.43% with psychotherapy, respectively) and hypognosia (27.27%, 63.64%, and 9.09% with pharmacotherapy and 25%, 50%, and 25% with psychotherapy, respectively).

Assessment of levels of social adaptation of patients achieving RM were studied on the Sheehan scale in 107 patients receiving treatment with antidepressants and 50 receiving psychotherapy. "Functional" RM, reflecting the patient's involvement in professional, family, and social activity, corresponded to the achievement of social maladaptation scores on of <5 points on the Sheehan scale at the end of treatment courses [12, 20]. In complete remission, the number of patients with functional RM with psy-

TABLE 3. Frequency of Exacerbations in Relation of Type of RM with Pharmacotherapy and Psychotherapy

Type of RM	Pharmacotherapy		Psychotherapy	
	abs.	%	abs.	%
Complete	5	26.32	0	0
Monosymptomatic RM	8	28.57	3	23.08
Polysymptomatic RM	15	55.56	7	50
RM with the structure of minor depression	9	60	3	46.67

TABLE 4. Frequency of Exacerbations in Relation to First/Repeated Episodes of Depression with Different Types of Clinical RM with Pharmacotherapy and Psychotherapy

Type of RM	Pharmacotherapy				Psychotherapy			
	DE		RDD		DE		RDD	
	abs.	%	abs.	%	abs.	%	abs.	%
Complete	2	10.53	3	15.79	–	–	–	–
Monosymptomatic RM	3	10.71	5	17.86	1	7.69	2	15.38
Polysymptomatic RM	3	11.11	12	44.44	3	20	4	26.67
RM with the structure of minor depression	1	6.67	8	53.33	–	–	7	46.67

Notes. DE – depressive episode; RDD – recurrent depressive disorder.

chotherapy (100%) was significantly greater than that with pharmacotherapy (62.5%). In symptomatic RM, the frequency of functional RM decreased with both psychotherapy (52.17%) and pharmacotherapy (49.4%, $p = 0.763$) and the formation of functional RM was determined by the clinical types of RM, decreasing in the order: monosymptomatic RM (80% and 66.63%, respectively), polysymptomatic RM (51.52% and 47.24%, respectively), and RM with the structure of minor depression (46.47% and 23.53%, respectively) (Fig. 3).

Correlation analysis of indicators of clinical and social improvement with psychotherapy and pharmacotherapy demonstrated a positive correlation between the severity of residual symptomatology assessed on the HAM-D and the level of social maladaptation assessed on the Sheehan scale with psychotherapy ($r = 0.551, p < 0.001$) and its absence with pharmacotherapy ($r = 0.145, p = 0.136$).

Thus, clinical types of RM with psychotherapy and pharmacotherapy had significant influence on the recovery of social functioning and patients' assessments of their status.

The RM stability parameter, reflecting the absence of exacerbations/recurrences of depression, was the most integral characteristic. During a one-year prospective observation period, 37 of 89 patients (41.57%) receiving courses of pharmacotherapy and 17 of 46 patients (36.96%) receiving

sessions of psychotherapy showed recurrences of depression, which is generally consistent with data published by Shea et al. [27].

The frequency of exacerbations/recurrences depended on clinical (clinical type of RM, type of course of depression (psychotherapy and pharmacotherapy)), subjective (level of functioning (pharmacotherapy)), and therapeutic (absence of maintenance therapy (psychotherapy and pharmacotherapy)) factors.

Thus, the number of exacerbations/recurrences in pharmacotherapy and psychotherapy increased almost twofold in the order: complete RM (26.32% and 0%, respectively), monosymptomatic RM (28.57% and 23.08%, respectively), polysymptomatic RM (55.56% and 50%, respectively), and RM with the structure of minor depression (60% and 46.67%, respectively) (Table 3).

The course of depressive disorder was very important for both pharmacotherapy and psychotherapy. While the occurrence of depressive episode in the pharmacotherapy group in all clinical types of RM showed only minor differences, recurrent depressive disorder significantly increased in polysymptomatic RM and RM with the structure of minor depression. The ratios of the proportion of recurrences of depressive episodes/recurrences of depressive disorder were 10.53%/15.79% in complete RM, 10.71%/17.86% in

TABLE 5. Frequency of Exacerbations in Relation to Presence/Absence of Functional Remission (FRM) and Nonfunctional Remission(NFRM) in Different Types of Clinical RM with Pharmacotherapy and Psychotherapy

Type of RM	Pharmacotherapy				Psychotherapy			
	FRM		NFRM		FRM		NFRM	
	abs.	%	abs.	%	abs.	%	abs.	%
Complete	1	5.26	4	21.05	0	0	0	0
Monosymptomatic RM	3	10.71	5	17.86	2	15.38	1	7.69
Polysymptomatic RM	4	14.81	11	40.74	4	28.57	3	21.43
RM with the structure of minor depression	2	13.33	7	46.67	3	20	4	26.67

TABLE 6. Frequency of Recurrence in Patients with Different Clinical Types of Remission in Relation to the Presence/Absence of Maintenance Therapy in the Pharmacotherapy and Psychotherapy Groups

Type of RM	Frequency of recurrences							
	Pharmacotherapy (n = 89)				Psychotherapy (n = 46)			
	with maintenance therapy		without maintenance therapy		with maintenance therapy		without maintenance therapy	
	abs.	%	abs.	%	abs.	%	abs.	%
Asymptomatic	2	10.53	3	15.79	0	0	0	0
Monosymptomatic RM	4	14.29	4	14.29	2	15.38	1	7.69
Polysymptomatic RM	4	14.81	11	40.75	4	28.57	3	21.43
RM with the structure of minor depression	3	40	6	20	2	13.33	5	33.33

monosymptomatic RM, 11.11%/44.44% in polysymptomatic RM, and 6.67%/53.33% in RM with the structure of minor depression. In psychotherapy, the proportion of patients with diagnoses of recurrent depressive disorder was maximal in RM with the structure of minor depression. The ratios of the two types of disorder as above were 7.69%/15.38% for monosymptomatic RM, 20%/26.67% for polysymptomatic RM, and 0%/46.67% for RM with the structure of minor depression (Table 4).

Exacerbations/recurrences arose significantly more rarely in the pharmacotherapy group in patients achieving functional RM than in those with incomplete recovery of social functioning (nonfunctional remissions). In this treatment group, the ratios of functional and nonfunctional RM in relation to clinical type of RM were as follows: 5.26%/21.05% in complete RM, 10.71%/17.86% in monosymptomatic RM, 14.81%/40.74% in polysymptomatic RM, and 13.33%/46.67% in RM with the structure of minor depression (Table 5). In psychotherapy, there were no exacerbations/recurrences of depression in complete RM, while in symptomatic RM the difference in the frequencies of recurrences in functional and nonfunctional

RM was not significant. Thus, in monosymptomatic RM, exacerbations/recurrences arose in 15.38% of patients with functional RM and 7.69% of those with nonfunctional RM, in polysymptomatic RM, exacerbations/recurrences arose in 28.57% of patients with functional RM and 21.43% with nonfunctional RM, while in RM with the structure of minor depression exacerbations/recurrences arose in 20% of patients with functional RM and 26.67% of patients with nonfunctional RM. Psychotherapy had the advantage over pharmacotherapy when functional RM was not attained in complete, monosymptomatic, and polysymptomatic RM, while pharmacotherapy was better when functional RM was present in all types of symptomatic RM.

With the aim of identifying the role of maintenance pharmacotherapy and psychotherapy, numbers of exacerbations/recurrences were analyzed in relation to the presence (pharmacotherapy in 46 patients (51.69%) and psychotherapy in 27 patients (59.57%)) and absence (pharmacotherapy in 43 patients (48.31%) and psychotherapy in 19 patients (40.43%)). The presence/absence of maintenance therapy in both groups had no effect on the proportion of exacerbations/recurrences in complete RM (10.53%/15.79% with

pharmacotherapy and 0%/0% in psychotherapy) and monosymptomatic (14.29%/14.29% with pharmacotherapy and 15.39%/7.69% with psychotherapy) RM, as well as with psychotherapy in polysymptomatic RM (28.57%/21.43%) (Table 6). In pharmacotherapy, an increase in the proportion of exacerbations/recurrences without maintenance therapy with antidepressants was seen in polysymptomatic RM (14.81%/40.75%), while with maintenance therapy in RM with the structure of minor depression (40%/20%) and with psychotherapy in RM with the structure of minor depression (13.33%/33.33%). Overall, psychotherapy gave better values than pharmacotherapy without maintenance therapy in all clinical types of RM apart from RM with the structure of minor depression.

In psychotherapy as compared with pharmacotherapy, exacerbations/recurrences of depression were seen at later periods both with maintenance therapy (3–4 months with pharmacotherapy and 6–11 months with psychotherapy) and without maintenance therapy (3–5 months with pharmacotherapy and 4–11 months with psychotherapy).

Discussion

The objective, subjective, and integral characteristics addressed here can be regarded as important determinants of a modern multidimensional concept of RM, with quite complex connections with each other. The clinical parameters of RM showed significant heterogeneity in psychopathological states, forming a spectrum of states from the complete absence of symptoms to subthreshold depression, forming four variant series (clinical types of RM): complete, monosymptomatic, and polysymptomatic RM, and RM with the structure of minor depression. The minimal residual symptoms were seen in monosymptomatic RM, the structure of which was determined by a stable isolated facultative single symptom. Polysymptomatic RM, consisting of a constellation of facultative symptoms (apart from those of the somato-hypochondriac type), and RM with the structure of minor depression were determined by symptoms typical of depression (adynamia, cognitive impairments, and hypothyria), supporting the presence of an active psychopathic process.

Subjective assessments and the recovery of social functioning constitute important features of RM. There are determined by the clinical types. Regardless of the treatment method, the frequency with which functional RM was formed decreased in the order: complete RM, monosymptomatic RM, polysymptomatic RM, and RM with the structure of minor depression, while patients' assessments of their status in asymptomatic RM were determined by hypognosia and/or appropriate assessments, while all variants of symptomatic RM (mono- and polysymptomatic RM, RM with the structure of minor depression) were very variable, i.e., with hypergnosia, appropriate assessments, and hypognosia. The existence of correlational links between the severity of residual symptomatology and functional recovery and the greater clarity in the ratios of clinical

types, and variants of subjective assessments in psychotherapy suggest greater levels of linkage, with lower levels in pharmacotherapy.

The stability of RM depends on clinical (type and recurrence), subjective (functional/nonfunctional RM), and therapeutic factors (presence/absence of maintenance therapy). Maintenance therapy using psycho- or pharmacotherapy decreased the number of exacerbations in all types of RM, lengthening the duration of the stable state.

Overall, subjective and integral characteristics are to a significant extent determined by the clinical types of RM, reflecting their leading role in multistructural RM.

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