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Brief report

Prevalence and risk factors for recurrence of depression five years after short term psychodynamic therapy

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ABSTRACT

Background: Follow-up research concerning the efficacy of treatment for depression is scarce and varies widely in clinical and methodological terms. Aim was to conduct a five-year follow-up study of recurrence of depression after short supportive Psychodynamic Treatment (PDT) alone or in combination with pharmacotherapy.
Methods: Patients who had been treated five years previously for major depressive disorder in a randomised control trial comparing short supportive PDT alone or in combination with pharmacotherapy, were traced. Patients who completed treatment were included. Recurrent episodes in the past five years were identified using CIDI. Severity of symptoms after five years was measured with the Hamilton Rating Scale for Depression and sub-scales Depression, Anxiety and Somatisation of the self-report Symptom Checklist 90.
Results: 52 (37%) patients of the original sample were localised. 42% had suffered from one or more recurrences during the follow-up period. There was no significant difference between the group who had received psychotherapy and the group who had received combined therapy during the acute phase. Young women and patients with more residual depressive symptoms and less somatic symptoms directly after treatment, were more at risk for recurrence.
Limitations: Relatively small study population. Furthermore it was not known if patients received other treatment during the follow-up period.
Conclusions: The long-term efficacy of PDT (with or without antidepressants) seemed to be comparable with other psychotherapies for depression. But the high recurrence rate urges us to shift the focus of depression treatment to improving long-term outcome and to the prevention of recurrence, in particular for young women and patients with residual symptoms of depression.

1. Introduction

Although depression is increasingly considered as a chronic and recurrent disorder long-term effect studies of treatment are relatively sparse (De Maat et al., 2007) and the results among these studies are not consistent (Westen & Morrison, 2001). In part this could be explained by the methodological and clinical heterogeneity of the follow-up studies (De Maat et al., 2006).This is also the case in effect and follow up (<1.5 year) studies with Psychodynamic Treatment (PDT) (De Maat et al., 2006; Dekker et al., 2003; Knekt & Lindfors, 2004; Shea et al., 1992).

Nevertheless, available studies to risk of relapse and recurrence of depression in various populations have identified several predictive factors such as female gender (Kuehner, 1999; Dekker et al., 2007), older age, loss of relationship either by divorce or decease and low education (Conradi et al., 2008; Barkow et al., 2003). In addition,

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residual depressive symptoms after treatment (Pintor et al., 2001; Judd, 2001; Paykel, 1998) and number of previous depressive episodes (Bockting et al., 2006; Conradi et al., 2008; Hamilton & Dobson, 2002) are frequently reported risk factors for recurrence.

All these studies looked at relative short-term follow-up studies which were not longer than 1.5 years. There are only a few long-term follow-up studies (Fava et al., 2004; Peselow et al., 1991; Wells et al., 2004).

In the maintenance study of Peselow et al., 1991, 60% of the patients who continued antidepressants for five years after acute treatment relapsed versus 85% of the patients who stopped medication. In the Fava et al. (2004) study patients who were treated during the acute phase with cognitive behaviour treatment had a relapse rate of 40% and clinical management-group 90% after six year follow up. Wells et al. (2004) compared care as usual in depressed primary-care patients with the addition of either nurse-supported medication adherence or Cognitive Behaviour Therapy (CBT). In both groups after five years, a depressive disorder was diagnosed in about 40%.

Reviews and meta-analyses have demonstrated that psychodynamic psychotherapy can be considered as an efficacious treatment for depression (De Maat et al., 2006, 2007, 2008, 2009; Driessen et al., 2010). However, so far as we know, there have been no long-term (>1.5 years) follow-up studies for psychodynamic treatment for depression. As a consequence, there is almost no insight into risk factors for recurrence after this kind of treatment. Our study looks at the long-term efficacy of a short and supportive PDT with or without pharmacotherapy, for depression. The research questions are: 1) How many patients suffered from a depression in the five years after treatment termination? 2) Is there an association between recurrence and type of treatment (short supportive PDT with or without pharmacotherapy)? 3) Which type of patients is at risk of recurrence?

2. Methods

Patients all participated in a Randomized Clinical Trial comparing short supportive PDT (in earlier studies we called it ShortTerm Psychodynamic Supportive Psychotherapy) either alone or in combination with pharmacotherapy (De Jonghe et al., 2004). The effectiveness of this supportive PDT is examined in 5 trials and can be called good (Kool et al., 2000, 2003a, 2003b; Dekker et al., 2003, 2005, 2007, 2008; Driessen et al., 2007; de Jonghe et al., 2001, 2004; de Maat et al., 2008; Molenaar et al., 2006, 2011; Van et al., 2008a, 2008b, 2008c, 2009a, 2009b). In all these trials PDT was performed by trained and supervised psychiatrists and psychotherapists, consisted of 16 sessions and focuses on the affective, behavioural and cognitive aspects of relationships. Therapists were trained in the principles of PDT (based on the manual (De Jonghe, 2005)) in a 15 h course, and needed to finish one or more supervised therapies (depending on previous psychotherapeutic experience) in order to qualify for treatment in the research setting. Supervision on the integrity was based on audio-taped material of sessions and focused on the course of depressive symptoms, the optimisation of the therapeutic process, and the technical quality of interventions. The supervisors also controlled in supervision for adherence to the psychotherapy manual, although this was not structurally assessed. In the combined condition all patients started with venlafaxine according to the antidepressant study protocol (de Jonghe et al., 2004).

For this follow up study only patients who completed one of the original treatment options were approached.

Recurrence in the follow up period was measured by using the depression section of the Composite International Diagnostic Interview (CIDI, World Health Organisation, 1997). The interview was conducted according to the CIDI protocol by a trained researcher (third author).

Illness data at the beginning and end of the treatment were taken from the original study. Severity of depression was measured by both 17-item HDRS (Hamilton, 1967) and the Depression (SCL-D), Anxiety (SCL-A) and Somatisation (SCL-S) Scale of the Symptom Checklist-90 (Arrindel & Ettema, 1986).

The group of 140 patients who completed the original RCT (De Jonghe et al., 2004) between 1998 and 2002 was approached by telephone and asked to participate in this five-year follow-up study. Of this group 29% refused and 34% was untraceable (together with the non-respondents). Thus, 37% ($n = 52$) participated in the follow-up study (respondents).

There were no differences in baseline characteristics between respondents and non-respondents with regards to treatment condition, gender, age, educational level, living situation, employment status, duration of present episode, medication three months before the study, depressed episode within previous 5 years and scores on SCL-scales somatisation, depression and anxiety. More respondents than non-respondents were married (32% versus 14,9%, Chi-2 = 5.536, $p = .019$) and more respondents had achieved remission after treatment (46,2% versus 35,2%, Chi-2 = 6.674, $p = .024$).

Differences between respondents with and without relapse were analysed by using Chi2 for categorical and ANCOVA for continuous variables. The relationship between patient demographics, illness characteristics and post-treatment characteristics with recurrence was examined with logistic regression. These regression analyses were performed in three blocks: first the demographics, then illness at the beginning (with the significant variables of the first model), and finally illness at the end of treatment (with the significant variables of the second model). These analyses were also conducted with a Cox regression. In all tests, $p < .05$ was used as the level of significance.

3. Results

Of the 52 respondents 22 (42%) reported that they had suffered from at least one recurrent depressive episode during the five years after the termination of the treatment, 43% had one recurrence, 19% two recurrences, and 10% three, with 28% having four or more recurrences. There was no difference in recurrence-rates between PDT without AD (37%) and PDT with AD (44%) (Table 1).

For most patient and treatment characteristics, we found no differences between the groups with or without depressive episodes during the follow-up period in the bivariate analyses. With the exception of age and gender, patients with recurrent episodes appeared to be significantly younger. And