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A lifetime approach to major depressive disorder: The contributions of psychological interventions in preventing relapse and recurrence

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HIGHLIGHTS

- CBT delivered during the acute phase, does appear to have an enduring effect.
- Continuation psychological treatment appears to reduce risk for relapse.
- Preventive interventions have the largest effects for ultra high-risk individuals.

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ABSTRACT

Major depressive disorder (MDD) is highly disabling and typically runs a recurrent course. Knowledge about prevention of relapse and recurrence is crucial to the long-term welfare of people who suffer from this disorder. This article provides an overview of the current evidence for the prevention of relapse and recurrence using psychological interventions. We first describe a conceptual framework to preventive interventions based on: acute treatment; continuation treatment, or; prevention strategies for patients in remission. In brief, cognitive-behavioral interventions, delivered during the acute phase, appear to have an enduring effect that protects patients against relapse and perhaps others from recurrence following treatment termination. Similarly, continuation treatment with either cognitive therapy or perhaps interpersonal psychotherapy appears to reduce risk for relapse and maintenance treatment appears to reduce risk for recurrence. Preventive relapse strategies like preventive cognitive therapy or mindfulness based cognitive therapy (MBCT) applied to patients in remission protects against subsequent relapse and perhaps recurrence. There is some preliminary evidence of specific mediation via changing the content or the process of cognition. Continuation CT and preventive interventions started after remission (CBT, MBCT) seem to have the largest differential effects for individuals that need them the most. Those who have the greatest risk for relapse and recurrence including patients with unstable remission, more previous episodes, potentially childhood trauma, early age of onset. These prescriptive indications, if confirmed in future research, may point the way to personalizing prevention strategies. Doing so, may maximize the efficiency with which they are applied and have the potential to target the mechanisms that appear to underlie these effects. This may help make this prevention strategies more efficacious.

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Major depressive disorder (MDD) has a highly recurrent nature (Kessler et al., 2005; Kupfer, Frank, & Phillips, 2012), which is why one of the most important challenges in the management of MDD is the prevention of depressive relapse and recurrence. Individuals who suffer from a first depressive episode have a 40% to 60% chance experiencing a subsequent episode; individuals with 2 episodes have an approximate 60% chance; and individuals with three episodes the risk is as high as 90% (Eaton et al., 2008; Moffitt et al., 2010; Solomon et al., 2000). Such statistics emphasize the importance of interventions that can disrupt patterns of repeated depressive relapse/recurrence and enable sustained remission and recovery. Cosci and Fava (2013) recently hypothesized an integrated model of staging for unipolar depression in line with concepts used in the medical field and developmental psychology. For this staging model 5 stages were defined, which will require empirical validation. Stage 1 represents the prodromal phase including mood symptoms (sad mood, subsyndromal depression) and symptoms with mild functional decline (generalized anxiety, irratibility, anhedonia, sleep disorders), stage 2 represents the acute depressive episode, stage 3 the residual phase characterized by mood symptoms (depressed mood, guilt, hopelessness), dysthymia, and symptoms comparable to the prodromal phase (except anhedonia) and additionally anorexia and impaired libido. Stage 4 is characterized by recurrent depression and double depression and the last stage refers to chronic depression (as defined by DSM, lasting for a least 2 years (American Psychiatric Association, 2000)). Interventions that aim to prevent relapse/recurrence can either be applied in stage 2 (acute phase, examining prophylactic effects of acute psychological interventions) and in stage 3, the residual phase.

To guide this discussion, we first provide the operational key definitions of key change points in depression including response, remission, recovery, relapse and recurrence. Subsequently, we consider leading theories that explain the heightened vulnerability for MDD, followed by an overview of the types of psychological preventive strategies and its empirical evidence for the enduring effects of the psychological interventions. We next describe empirical evidence which subtypes of patients have the best outcomes in the acute phase, continuation phase, and preventives therapies available, (i.e., what preventive strategy works best for whom). We then review putative mediators; that is mechanisms underlying the effectiveness of psychosocial interventions with the potential to reduce relapse and recurrence. Finally, future directions for research are explored and recommendations for clinical practice are provided.

1. Definitions of response, remission, recovery, relapse and recurrence

Consensually agreed definitions for the constructs of response, remission, recovery, relapse and recurrence facilitate to comparisons across studies. The 'MacArthur Research Network on the Psychobiology of Depression' proposed operational criteria for each term (Frank et al., 1991) to guide the field. Fig. 1 depicts the main change points in the course of depression (Kupfer, 1991). For clarification we use this heuristic and propose the following definitions of episode, response, remission, partial remission, recovery, relapse, and recurrence in Table 1, modified somewhat from Frank et al. (1991); we also added the definitions of stable and unstable remission as they are implicated in the findings we discuss below.

We begin by noting that all references to response, remission, recovery, relapse and recurrence, start with reference to an existing or prior episode of depression. In the current diagnostic framework (American Psychiatric Association, 2013), an episode of MDD is defined as the presence of at least 5 of 9 possible symptoms for a period of at least two weeks, and with one of two key criterion symptoms being present (sad or depressed affect, and loss of interest or pleasure in usual activities, more days than not in the 2 week period). In most research, the episode that is used as the point of reference for the other events

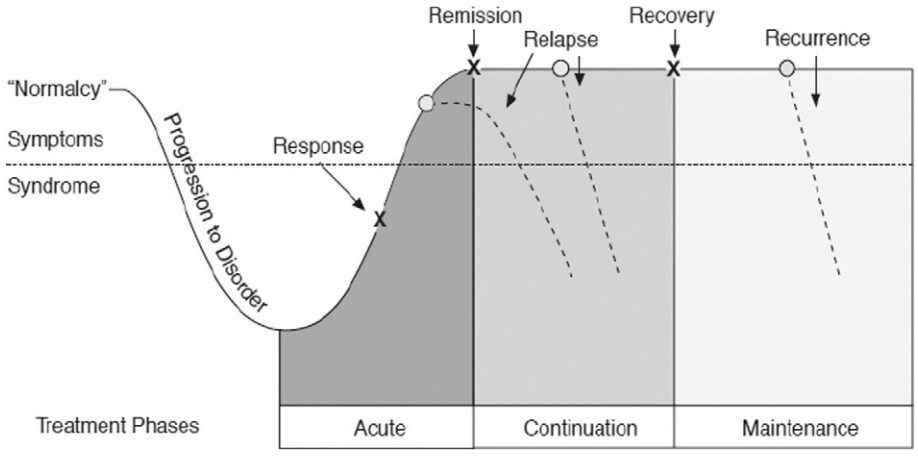

Fig. 1. Definition of response, remission, recovery, relapse, and recurrence (Kupfer, 1991). Note that acute phase treatment aims to promote a response as well as some level of remission. Continuation phase treatment aims to sustain remission, prevent relapse, and promote recovery. Maintenance phase treatment aims to foster or sustain recovery and prevent recurrence.