

The Effect of Structured Relapse Prevention Planning on Attitudes to Recovery from Depression: a review of the literature and programme planning

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LITERATURE REVIEW

Introduction

In this paper, we will highlight issues relating to the management of depression and the prevention of relapse—this will include: a definition of terms; a summary of findings from key studies on relapse prevention planning; a short review of the impact of relapse prevention planning on clients with depression; the key aims and principles involved in conducting structured relapse prevention planning; and, a brief outline of the stages involved in developing relapse prevention plans with clients.

Defining the Terms

Most authors define depression, the main phases of treatment and recovery, and treatment components such as relapse prevention planning, to suit the purpose of their particular study. It is first worth considering these terms for the context of this paper, with reference to the available literature.

Depression

The term depression describes a spectrum of mood disturbance ranging from mild to severe and from transient to persistent (Peveler et al 2002). Around 2.3 million people experience depression in the UK at any time, 1:5 people who seek help in primary care have psychological problems, and 1:10 suffer from depression. Females are about twice as likely to experience depression as men (Simon et al 2002).

Depression has been classed as one of the most important diseases of our time (Pereira Gray 1992), with the prevalence of major depression being reported as 5 - 10% of people seen in the primary care setting (Geddes et al 2003). It is a serious illness in that it severely affects the individual's quality of life and is associated with a worrying number of deaths from suicide. However, depression is usually treatable and can be

efficiently managed in primary care. Some may respond to conventional doses of antidepressant drugs and many have benefited from psychosocial interventions, such as cognitive behaviour therapy (CBT) and relapse prevention planning.

Many studies have indicated that poor compliance with medication has been the cause or result of a relapse of mental illness and have recommended the use of CBT as an adjunct or alternative component of treatment.

Remission, Recovery, Relapse & Recurrence: phases of treatment and recovery

The treatment of depression can be explained as progressing through three phases: acute, continuation and maintenance phases. Acute treatment ends when the patient experiences a full *remission* of symptoms. However, it is very important to encourage the patient to continue the treatment that works for them in reaching *recovery*, which means maintaining their progress, a full remission of symptoms, for at least six months. If the patient experiences further symptoms before this time, then this is known as a *relapse*. If symptoms occur again after this period of remission, this is known as a *recurrence* of the depressive illness (Scott 1999).

In a study carried out in the USA and other parts of the world involving depressed primary care patients who were receiving antidepressant treatment, Lin et al (2003) reported that more than two-thirds had a history of recurrent depression, and about 20% experienced a chronic course of their depressive symptoms. Over one-third of these patients experienced a recurrence in the year that medication had been initiated, and the earlier that medication

was discontinued, the greater was the likelihood of relapse occurring.

Risk of Relapse

The risk of relapse or recurrence increases with the following (Angst 1999, Anderson 2003):

- the more severe the initial episode;
- the longer the duration of the initial episode;
- the longer the time since the last episode;
- the total number of previous episodes;
- the presence of residual or persisting symptoms;
- a lack of self-confidence; and,
- greater disruption to family and study / work.

Angst (1999) added that: recurrence after recovery from the initial episode of major depression is an important practice issue, with over 50% of patients experiencing a recurrence within three years. He recommended that those patients at increased risk of recurrence should receive long-term preventative treatment.

Effective Treatment Approaches

Many clinical studies and reviews have demonstrated that antidepressant drug therapy is an effective treatment for moderate to severe major depressive disorder, often as the first step in treatment, and that cognitive behaviour therapy is an effective treatment for mild to moderate depression and an effective adjunct to antidepressants in moderate to severe major depression (NICE 2004).

Enright (1997), in his review of the

clinical application of CBT, concluded that CBT is the treatment of choice for many mental health disorders including depression. In addition, four randomised controlled trials (Paykel et al 1999, Blackburn & Moore 1997, Fava et al 1998, Teasdale et al 2000) found that CBT based preventive interventions sequenced after a full or partial response to antidepressant medication provided significant protection against relapse or recurrence.

Scott et al (1997) studied the application of brief cognitive therapy in primary care, suggesting a potential benefit in the treatment of depression: the results provided encouraging evidence of health gain as a consequence of the intervention. King et al (2002) suggested that CBT is as effective as pharmacotherapy for treating depression in general practice, with the added benefit of reduced rates of long term relapse.

Segal et al (2002) produced a highly commended book to help patients gain an awareness of their problems / symptoms. An integrated programme of mindfulness and cognitive therapy, this offers an innovative method for breaking the cycle of recurrent depressive episodes, which help patients recognise and manage future relapse episodes.

Therefore, CBT undoubtedly has much in its favour. It is an attractive, efficient therapeutic approach and produces good results in many instances. It has been described as the therapy to beat, and this has sharpened the minds of psychotherapy researchers worldwide (Holmes 2002).

CBT & Relapse Prevention Planning

Thase et al (1994) made comparisons

between male and female people with depression who were treated using cognitive-behaviour therapy. They found that whilst males attended significantly fewer therapy sessions, each group showed comparable responses to therapy, and patients with higher pre-treatment levels of depressive symptoms, especially females, had poorer outcomes.

With regarding to the risk of relapse following cognitive-behaviour therapy for depression, Thase et al (1992) compared relapse rates for fully recovered and partially recovered out-patients over a 12-month follow-up period following a 16-week, 20-session treatment protocol. They found that the following factors were correlated with an increased risk of relapse: history of depressive episodes; higher levels of depressive symptoms; higher levels of dysfunctional attitudes; a slower response to therapy; and being unmarried.

Key Relapse Prevention Study 1

Fava et al (1998) conducted a two stage sequential randomised study in which 45 consecutive out-patients, in remission from diagnosed recurrent depressive disorder following successful treatment with an anti-depressant, were randomly allocated to two groups: cognitive-behaviour therapy for residual symptoms; or, standard clinical management. Anti-depressant medication was gradually tapered off and discontinued for all clients within the 20-week treatment phase of their study. Of the original 45 clients, 5 were excluded from the study, as discontinuation from anti-depressant treatment was not possible, leaving 20 clients in each group. The experimental group received 10 sessions of CBT, which was supplemented by lifestyle

modification (education and daily scheduling) and well-being therapy (belief modification and relapse prevention strategies), as a result of the clinical challenge presented by these clients. Clients were followed up for two years, being independently re-assessed by a psychologist on eight occasions using the Paykel Clinical Interview for Depression, which was regarded as useful for assessing sub-clinical symptoms of depression.

Comparing the outcomes for the two groups, Fava et al (1998) reported that there were no statistical differences on any socio-demographic or clinical characteristics between the groups, that there was significant improvement in residual symptoms only in the CBT group, that 25% of the CBT group compared with 80% of the Clinical Management group had relapsed at two years, and that CBT was highly significant in delaying recurrence of depression at two years. They concluded that an amelioration of symptoms may reduce the risk of relapse in depressed out-patients by stopping the progression of residual symptoms into relapse prodromes.

Whilst a very favourable study for both the value of CBT and relapse prevention planning, their study had a number of limitations: their sample size was small; they used a naturalistic design, as patients were initially treated with different types of anti-depressant (tricyclics or SSRIs); there was no placebo-controlled withdrawal of medication; all of the treatment was provided by only one psychiatrist, with expert experience in affective disorders and CBT – the results may have been very different with multiple, less experienced therapists; and, it was unclear to what extent the results were

due to CBT, lifestyle modification or well being therapy.

Fava et al (1998) also raised some important issues:

that residual symptoms hinder lasting recovery (Fava et al 1998);

that the presence of residual symptoms after the completion of drug or psychotherapy treatment has been correlated with poor long term outcome (Fava et al 1996);

that the definitions used for recurrent depressive disorder (RDD) and for relapse differs between studies: Blackburn et al (1997) defined RDD as having had at least one previous episode of depression, whilst Frank et al (1990) & Fava et al (1998) defined RDD as having had at least three previous episodes of unipolar depression, with the immediately preceding episode being no more than 2.5 years before the onset of the current episode – this highlights the need to define and be clear about the key terms.

Similarly, in a study of 386 patients, who were randomised into two groups of a low intensity relapse prevention programme or usual primary care programme, Katon et al (2001) showed that those in the intervention group who were taking an antidepressant, with a high risk of relapse / recurrence, significantly improved. These primary care patients had a greater adherence to adequate doses of an antidepressant and had fewer depressive symptoms.

They recommended that there is a need to develop effectiveness models of continuation and maintenance treatment of primary care patients with recurrent or chronic depression and that primary care systems need to begin to adapt services to improve the care of patients

who experience recurrent and chronic medical and psychiatric illness. They concluded that a relapse prevention programme targeted to primary care patients with a high risk of relapse / recurrence who had largely recovered after antidepressant treatment showed significantly greater antidepressant adherence and fewer depressive symptom outcomes.

Key Relapse Prevention Study 2

Lin et al (2003) conducted a randomised trial of the prevention of depressive relapse in primary care patients who were at high risk of recurrent depression by evaluating the effects of a brief psycho-educational intervention on medication attitudes and the self-management of depression.

Of 702 eligible patients, recruited from four participating primary care clinics, 480 completing a baseline interview, of whom 386 were randomised to either the intervention group (N = 194) or to a control group of 'usual care' (N = 192). All of these patients demonstrated a substantial improvement of their index depression episode and had a high risk of relapse (= 3 or more lifetime depression episodes).

Over a 12-month period, the intervention group were offered: two sessions with a depression prevention specialist, who provided a manualised intervention following initial training and with ongoing weekly supervision; three scheduled telephone sessions; and, four scheduled personalised letters to monitor progress, remind and motivate patients to continue their self-care and follow their relapse prevention plan. The intervention involved each patient in writing and implementing their own relapse prevention plan, and also included evidence-based pharmacotherapy,

integrated cognitive-behavioural and motivational interviewing approaches, psycho-education on the prevalence and course of depression and its treatment, giving explanation about the high risk of relapse, a discussion of evidence that highlighted the value of maintenance pharmacotherapy in preventing relapse, individualised approaches for managing any medication side-effects, and enhancing self-efficacy for preventing relapse through self-management behaviours, such as monitoring depression symptoms and scheduling pleasant activities.

Following a face-to-face baseline interview, patients were given blind telephone interviews at 3, 6, 9 & 12 months. This involved monitoring their medication usage, attitudes towards medication, confidence in managing side-effects, and depression self-management. Attitudes to antidepressant medication were assessed by the use of a 12-item questionnaire rated on a 5-point likert scale (Katon et al 1996); a 0 – 10 scaling technique was used to measure patients' ratings of confidence in managing side-effects; and, self-management was assessed on five brief measures – participation in pleasant activities and social activities, monitoring depression symptoms, checking their early warning signs of depression, and planful coping (anticipating and planning to manage stressful situations).

88% of patients in the intervention group completed all assessments, which was significantly higher than the 76% for the usual care group. Whilst the baseline clinical characteristics for each group were very similar, intervention patients consistently reported more favourable attitudes towards taking medication, had a significantly higher level of confidence

in managing side-effects, were significantly more likely to self-monitor their depression symptoms, check for early warning signs and apply planful coping, and were more likely to continue their antidepressant and receive an adequate dose of antidepressant compared to the usual care group at 12-months follow-up. The symptom checklist depression score was significantly lower for the intervention group.

A very positive study for the use of brief relapse prevention planning, their study findings may however not generalise to populations with a more diverse ethnic or socio-economic mix, or to patients who choose not to participate in such a study. Furthermore, their study was limited by an over-reliance on self-report measures, even if these measures were practical and useful. It is also worth noting that the intervention effects on medication attitudes and confidence in managing side effects were only of a small to moderate strength.

Equally, in comparison with other authors' research of different mental disorders, Tait et al (2002), in their study of relapse prevention using a cognitive approach for clients who have schizophrenia, reported results that indicate a high adherence rate and suggest that continuous individualised early signs monitoring could be an effective tool in predicting relapse and facilitating early psychological intervention with clients who have schizophrenia.

Wright et al (2000), in their study of a relapse prevention programme delivered via bibliotherapy in the treatment of individuals with panic attacks, found that those who received the relapse prevention programme exhibited

significant reductions on measures of frequency of panic attacks, panic cognitions, anticipatory anxiety, avoidance and depression. The relapse prevention group seemingly attained a 'clinically significant change' in comparison with the controlled 'wait list' group.

Relapse Prevention Planning Approach: the process

Scientific studies indicate that problems like depression, anxiety and psychosis are not conditions that suddenly appear. As with other life conditions, such as diabetes or asthma, there is often a 'run-in time', and early intervention is always more effective. These problems provide plenty of clues that they are developing. Noticeable changes in thoughts, feelings and behaviour are good indicators, which can be viewed as early warning signs. These changes usually occur in the weeks or months before a return of the troublesome symptoms of these conditions (Wright et al 2000).

Relapse prevention planning can be described as a collaborative therapeutic activity programme with three principal aims:

To develop an individual relapse picture that helps to identify 'at risk' mental states.

To develop a relapse plan (= relapse drill). This will provide an opportunity to promote engagement with services, closely working in collaboration with the client towards the mutual goal of relapse prevention.

To promote the client's understanding and self-control over re-occurring problems / symptoms.

The ultimate aim of relapse prevention planning is to help individuals make radical shifts in the management of their depressive symptoms (Segal et al 2002, Williams 2001). This therefore involves teaching patients how to learn, understand and manage their 'early warning signs', reinforcing personal responsibility and personal action planning. Even if this does not prevent relapse, it should help to reduce the impact and shorten the duration of the relapse.

Six Step Process

Relapse prevention planning is best achieved through a series of structured steps:

1. Engagement: using the client's own way of explaining things, to gather information that will help in becoming clearer and understanding what happened leading up to their most recent relapse
2. Identifying early warning signs: working collaboratively with the client to identify signs associated with relapse (as distinct from merely listing symptoms of the illness)—workbooks (Uttoxeter Mind 2003), practical worksheets (Scanlan & Minocki 2003) and card sort exercises (based upon: Birchwood, Spencer & McGovern 2000) can be used with the individual and their family to facilitate this
3. Timeline: *what happens when*—thinking about the last relapse, to establish which early warning signs occur first
4. Clarifying the relapse picture with the client and his/her family
5. Developing the relapse plan: being creative, to help the client and his/her family to identify personal coping strategies, a

pathway for gaining support and service interventions that are likely to help in minimising the risk of relapse

6. Checking understanding: to write up the relapse prevention plan and to rehearse it with the client

It is helpful to form a very individualised personal signs self-monitoring tool for use by the client, using their own list of early warning signs—as shown in Fig. 1. The client can use such a tool to monitor the frequency and degree to which their early warning signs are beginning to occur: a simple 0—3 rating scale can be used to indicate how much each sign is occurring and/or how bothersome this is becoming.

The client should be actively involved in developing a realistic personal action plan, incorporating strategies that s/he can continue to use or recommence in managing their early warning signs, as they begin to occur—as shown in Fig. 2 (an excerpt from a client's plan).

Summary & Conclusion

The value of RPP with depression has been extensively discussed and highlighted in many research studies, and identified as a valuable part of CBT intervention. Leading CBT experts have strongly advocated and recommended relapse prevention planning (RPP) to be included as a component part of CBT.

There is strong evidence in the literature reviewed of its effectiveness, and many leading CBT specialists are much in favour of structured RPP and acknowledge the significance and importance of its application. Relapse prevention strategies will certainly provide clients with skills that will allow them to manage their own affective

Fig. 1: Personal Signs Self-Monitoring Tool

My personal early warning signs	My ratings for each day of the week						
	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Difficulty sleeping							
Broken sleep pattern							
Not eating regularly							
Boredom							
Feeling frustrated & irritable							
Feeling full of energy but having nowhere to channel it							
Spending increasing periods of time alone							
Smoking more cigarettes – up to 20 cigarettes per day							
Thinking that things are pointless							
Thinking that nothing seems enjoyable							

Fig. 2: Excerpt from the personal action plan of a Relapse Prevention Plan

My personal early warning signs	Actions that are likely to help
Feeling frustrated & irritable	To try getting involved in various activities: physical exercise; television; listening to music; practising guitar; talking to friends, if they're available
Boredom	To remind myself that: <i>'the less you do, the less you feel like doing & the more you do, the more pleasurable things are likely to be'</i>
Feeling full of energy but having nowhere to channel it	To plan a variety of activities, which could include: playing football once / week; playing golf; going fishing; practising guitar
Smoking more cigarettes – up to 20 cigs. per day	To set myself some limits about my smoking
Thinking that things are pointless	To set myself realistic and achievable goals To try balancing things up – to remind myself of things that I've done well
Thinking that nothing seems enjoyable	To make a list of things that I find enjoyable – <i>some ideas are listed above</i> To rate how enjoyable different activities actually are To make a list of even small achievements as a way of encouraging myself

states in the absence of ongoing treatment and, therefore, empowering clients in the self-management of their depressive symptoms.

An important component of the cognitive-behavioural approach, relapse prevention planning presents both a valid and complementary method for enhancing the effectiveness of this approach. Providing structured RPP should result in helping clients to achieve the long-term aim of relief from depression and facilitating the acquisition of skills to prevent its recurrence.

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