Full remission: a return to normal functioning

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The articles in this "Full remission in depression" section were written with one primary goal: to help those with major depressive disorders (MDD) achieve and sustain full remission. Although definitions of full remission vary, from a patient perspective, remission is the elimination of depressive symptoms and a return to premorbid levels of functioning.

Each article was developed by the primary author and critically reviewed by the coauthors. The basis for each review was a MEDLINE search, supplemented by a review of reference lists. However, the articles are not meant to be definitive reviews on the subjects. Because many of these topics have been reviewed previously, our focus was on newer articles and those that identified "full remission" as a focus of investigation.

There is no "level playing field" in the literature on optimal outcomes for MDD. Trials examining comparative rates of response, remission, relapse and recurrence differ in many parameters that may have an impact on outcome. Patient groups vary in severity, chronicity and treatment setting (i.e., inpatient v. outpatient). Duration of therapy and length of follow-up varies from weeks to months to years. Dosing and adherence issues are often overlooked, and attrition during follow-up is often disregarded. Perhaps the most important variation that complicates study comparisons is inconsistency of outcome measures.

In 1991, Frank and colleagues[1] proposed consensus definitions for terms used to describe the course of MDD. They defined partial remission as a period during which an improvement of sufficient magnitude is observed that the individual is no longer fully symptomatic but continues to display evidence of more than minimal symptoms.[1] This has been operationalized to mean a Hamilton Rating Scale for Depression – 17 item version ($HAM\text{-}D_{17}$) score in the 8–15 range. Response can be thought of as the point at which a partial remission begins. Full remission is defined as a period of improvement of sufficient magnitude such that the individual is virtually asymptomatic. The term relapse refers to the return of symptoms during remission, while recurrence implies a completely new episode of depression.[1] There is inconsistency in the literature regarding the length of time required for a patient to be asymptomatic before they are "in remission"; the length varies from 4 to 6 months.

When defining treatment stages, there is general agreement that the acute phase of treatment lasts until remission is achieved, and treatment given until the remission period is ended is called continuation therapy. Subsequent treatment is considered maintenance therapy.[2–4] This dichotomy between continuation and maintenance phases has, as yet, no scientific validity, and recent *Canadian Guidelines for Depression Treatment* recommend using only the terms "acute" and "maintenance" to describe phases of antidepressant treatment.[5]

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"Response" is generally defined as a 50% reduction in symptoms; however, this does not account for the initial severity of illness and may include "responders" who still have HAM-D scores at the high end of partial remission (e.g., 15). Full remission presents an even greater challenge; although many studies define a full remission as a score of 7 or less on HAM-D_{17}, this varies significantly. Criteria to define relapse and recurrence also vary greatly, from clinician opinion, to DSM-IV criteria for depression, to a HAM-D score above 15.

In the articles that follow, response data (i.e., at least a 50% reduction in symptoms) are cited, but the focus of the articles is full remission. The criteria vary, generally between a score of 7 or below and a score of 10 or below on the HAM-D_{17} and HAM-D_{21}, respectively. To offer some consistency and simplify data for the reader, HAM-D results have been cited when available. Regarding relapse and recurrence, no standard definitions are available. Evidence suggests that distinguishing between relapse and recurrence is not clinically relevant.[6] It follows, then, that the continuation and maintenance phases of treatment should be collapsed into maintenance therapy. Thus, acute therapy is that required to achieve full remission, and maintenance therapy is that needed to sustain the fully remitted state.[5]

Despite these limitations, a number of consistent points emerge that can help clinicians move toward the goal of achieving and sustaining full remission. First, it is important to use some type of rating scale to objectively measure therapeutic outcomes. Otherwise, how will we know that we have achieved full remission? A simplified, shortened version of the HAM-D with just 7 items may be a practical tool, and it is presented in this series of papers.

Second, the goal of treatment should be full remission. Anything less leaves a patient with depressive symptoms and an increased risk of subsequent depressive episodes. Patients need to be treated early and aggressively to a fully remitted state. Recently published data suggest differences between antidepressant agents in their ability to achieve full remission.[7] However, the concept requires further exploration, not only in the world of antidepressant pharmacotherapy, but also when evidence-based psychotherapies and combination treatments are being evaluated.

Third, maintenance therapy plays a vital role in reducing the risk of relapse. Patients who enter a maintenance treatment phase at full therapeutic dosages for 6–12 months reduce their risk of relapse by 50%.[8] In addition, some patients at high risk for relapse will benefit from long-term therapy. The need for maintenance therapy is further supported by evidence from neurological studies of changes in postmortem brain tissue that may be related to the course of illness and may be prevented with successful treatment.[9] A number of intriguing questions have been raised about the potential protective or inoculative role of cognitive behavioural therapy with or without pharmacotherapy and the application of this technique to various subpopulations of depressed patients.[10,11]

Finally, one must consider the therapeutic alliance.[12] A positive patient–caregiver relationship can improve adherence and have a favourable impact on outcome.

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