UNDERWRITING PSYCHIATRIC IMPAIRMENTS,
WITH EMPHASIS ON DEPRESSION

PART II: TREATMENT

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Psychiatric Terminology

For purposes of accurate risk classification, it is important to adopt a uniform terminology to describe the different phases of an episode of major depression. A document published in April, 1993 by the Agency for Health Care Policy and Research (AHCPR), United States Department of Health and Human Services, is ideal for this purpose. Definitions used to describe a depressive episode include:

- **Response**: Improvement with treatment
- **Remission**: A return to the asymptomatic state and the usual level of psychosocial functioning
- **Relapse**: A return of symptoms severe enough to meet the syndromal definition within 6 months following remission
- **Recovery**: Asymptomatic for at least 6 months following an episode
- **Recurrence**: A new episode

These definitions are used in the following narrative to describe a typical episode of major depression in which the patient progresses through the 3 phases of treatment (acute, continuation and maintenance).

Example: An asymptomatic patient begins to develop symptoms of depression over a period of days, weeks or months. The symptoms increase in severity and number until they meet the full syndromal definition of unipolar major depression. Acute phase treatment is started and a response occurs. If symptoms later worsen after initial improvement, the patient is then said to have experienced a relapse. Following an average of 6 to 12 weeks of treatment, a remission is declared, and the patient begins 4 to 9 months of continuation phase treatment. If symptoms severe enough to meet the syndromal definition of depression return within 6 months following remission, the patient has experienced another relapse. After remaining asymptomatic for 6 months, recovery is declared. Treatment may be tapered and discontinued in patients who have had only one or two episodes of major depression, or maintenance phase treatment may be initiated in those with a history of multiple episodes. A subsequent return of symptoms severe enough to meet the syndromal definition of major depression would represent a recurrence.

This terminology may eventually become part of the standardized vernacular of physicians who treat mental illness. In the meantime, underwriters must be cautious when using these definitions to evaluate depressive disorders. Psychiatrists are more likely to use this terminology correctly than primary care physicians. Also, other definitions exist and these may appear in attending physicians' statements. For example, recovery from an episode of depression is often defined for research purposes as "stable symptomatic remission for a minimum of 8 consecutive weeks following completion of treatment." The likelihood of relapse or recurrence after "recovery" is much higher with this definition than it would be with the definition used by the AHCPR.

Treatment of Unipolar Major Depression

The following description represents an optimal treatment plan as recommended in April, 1993 by the Depression Guideline Panel convened by the Agency for Health Care Policy and Research. The principal health care provider is the primary care physician or psychiatrist. A significant amount of informal help is often provided by non-professionals as well, such as family members, friends, clergy, family service agencies, welfare workers, ethnic healers, or Alcoholics Anonymous.

Treatment for major depressive disorder falls into five broad categories: medication, psychotherapy, medication plus psychotherapy, electroconvulsive therapy (ECT), and light therapy. The first three treatment options will be discussed in the context of "treatment of a typical depressive episode." ECT and light therapy will be discussed separately.

As noted earlier, treatment for major depression is divided into 3 phases: acute, continuation, and maintenance. The aim of all three phases is the attainment of a stable,
fully asymptomatic state and complete restoration of psychosocial function.

**Acute Phase Treatment**

Medication is the preferred treatment for moderate to severe major depression. The specific antidepressant chosen is based on factors such as type of depression, history of prior responses, possible side effects, other medical or psychiatric illnesses, and concurrent medications. Psychotherapy may be added, but it constitutes supportive rather than primary therapy. Moderate to severe depression may be treated with psychotherapy alone in the rare instances when medications cannot be taken, such as in pregnant or nursing women, men and women with certain medical illnesses, or some elderly patients. Psychotherapy alone may be used for mild to moderate depression. Current recommendations suggest that acute phase psychotherapy should be limited to 20 sessions.

Patients with more severe depressions are usually seen weekly for the first 6 to 8 weeks of acute phase treatment, followed by visits every 4 to 12 weeks after most symptoms have resolved. Those with less severe illness may be seen every 10 to 14 days for the first 6 to 8 weeks. For patients with an incomplete response, medication adjustments or changes are made, and psychotherapy may be added.

Most patients respond to acute phase treatment within the first 6 to 12 weeks. However, recovery is often delayed if the depression was present for a long period of time, and some people never fully recover. Acute phase treatment ends when the patient returns to the asymptomatic state and the usual level of psychosocial functioning, i.e., when remission occurs.

**Continuation Phase Treatment**

The goal of continuation treatment is to prevent relapse. If medications are stopped or continued in low doses after achieving remission with acute phase treatment, relapse rates average 25% within the first 2 months, 50% within 2 years, and as high as 75% in well-established, recurrent depressions. Poor experience with previous treatment regimens has led to recent recommendations that a new episode of major depression should be treated with antidepressants for a period of 4 to 9 months after remission, using the same medication and dosage that was administered during acute phase treatment. This important departure from prior recommendations was made because clinical studies demonstrated that lower doses of antidepressants are much less effective in preventing relapse. Continuation psychotherapy may be added to medication in order to improve psychosocial functioning. The efficacy of continuation psychotherapy alone as a treatment to prevent relapse is not well-established.

Continuation phase treatment generally ends when the patient has been asymptomatic for at least 6 months following the episode, i.e., after recovery has occurred. All patients with a single episode of major depression are advised to discontinue medication after 4 to 9 months of continuation phase treatment since only 50% will have another episode. If a second episode later occurs, antidepressants are again administered for 4 to 9 months after achieving remission. At that time, the patient becomes a candidate for maintenance phase medication.

**Maintenance Phase Treatment**

A single major depressive episode is associated with a 50% chance of a subsequent episode, two episodes with a 70% chance of a subsequent episode, and three or more episodes with a 90% chance of recurrent depression over a lifetime. This poor prognosis has prompted current recommendations for maintenance phase treatment.

The goal of maintenance treatment is to sustain recovery and prevent recurrence. Maintenance phase treatment consists of long-term administration of antidepressants in patients who have experienced recurrent episodes of major depression. The medication and dosage is the same as that used during acute and continuation phase treatment. This point is again worthy of emphasis, since studies have proven that lower antidepressant dosages, such as half the acute treatment dosage, are associated with poorer results.

The attached table provides an overview of current recommendations for maintenance phase medication. Previously, the World Health Organization recommended maintenance treatment for patients who experienced two depressive episodes within a 5-year period.

Maintenance psychotherapy is generally not indicated for patients who have had only one or two episodes of major depression. For those who have had three or more episodes, it may be added to medication in order to improve psychosocial functioning. Maintenance psychotherapy as the sole treatment to prevent recurrence is generally not recommended; it may delay the onset of the next episode, but it will not prevent it. The optimal length and frequency of continuation or maintenance psychotherapy used as an adjunct to medication is determined on a case-by-case basis. It is typically
administered weekly for up to 20 sessions, and at least once every 2 to 3 months thereafter as long as the patient remains on medication.

Patients are usually seen every 1 to 3 months during continuation and maintenance treatment to evaluate symptoms, efficacy, side effects and compliance. Ten to 20% of patients report some depressive symptoms during continuation or maintenance treatment. These symptoms are generally brief, mild, and self-limiting. Further evaluation is indicated if symptoms are severe or prolonged. The best long-term prognosis is in patients with full rather than modest symptomatic improvement.\(^6\)

**Duration Of Maintenance Treatment**

The length of maintenance treatment may vary from 1 year to a lifetime depending on the following variables:

- Number, frequency, and duration of prior episodes
- Degree of impairment during an episode
- Acuteness of onset
- Risk of suicide during an episode (especially if a prior attempt was near-lethal)
- Ability to tolerate medication
- Physician preference

There are no firm guidelines for deciding when to discontinue maintenance phase treatment. Two general rules are used in clinical practice. First, the stronger the indications for maintenance phase treatment, the longer its duration should be. Second, maintenance medication may be discontinued if there have been no recurrences during a period of time equal to a minimum of two previous cycle lengths.\(^7\) For example, patients in whom episodes occur in 2.5-year intervals should continue maintenance medication for at least 5 years. After stopping maintenance treatment, the first 6 to 12 months are the most critical with respect to the likelihood of recurrence.

In the longest maintenance phase trial ever conducted (5 years), researchers found that antidepressant medication in doses used for acute phase treatment (an average dose of 200 mg of imipramine per day) could prevent recurrent depression.\(^7\) The study group consisted of 20 patients with a history of multiple, relatively frequent episodes of major depression who had taken full-dose antidepressant medication for 3 years, and none of whom had experienced a recurrence. Eleven patients continued antidepressant treatment and 9 were switched to a placebo. After 2 additional years of follow-up (5 years total), 1 of 11 people in the treated group had a recurrence, compared to 6 of 9 people in the placebo group. Of the 6 placebo patients who had a recurrence, 5 episodes developed within the first 12 months after stopping medication. Noncompliance based on antidepressant blood levels was suspected in the treated patient who experienced a recurrence. One additional subject who had been assigned to the antidepressant group was dropped from the study because of noncompliance with the medication.

**Resistant Cases**

Major advances have occurred in the treatment of depressive disorders. Nonetheless, it would be a mistake to assume that the morbidity and mortality associated with this impairment will no longer be significant underwriting concerns in the future. Long delays will occur before current therapeutic recommendations become standard medical practice. Even with adequate treatment using tricyclic antidepressant medication, 20% to 30% of depressed patients do not improve. These patients must be treated with neuroleptics, monoamine oxidase inhibitors, ECT, second-generation antidepressants, or psychostimulants.\(^8\)

**Electroconvulsive Therapy**

Electroconvulsive therapy (ECT) is usually reserved for very severe or psychotic depressions, or manic states that are not responsive to treatment with medication.\(^9\) In this form of treatment, a low-voltage alternating current is sent to the brain to induce a convulsion (seizure). Very few patients require ECT. However, it is recommended in the following situations:

- Severe depression that has not responded to adequate trial(s) of medication
- Psychotic depression (hallucinations or delusions)
- Depression associated with suicidal behavior, marked functional impairment, or severe neurovegetative symptoms
- Prior positive response to ECT
- Need for rapid response (suicidal, severely delusional, severe neurovegetative symptoms)
- Medical contraindications to medication.
A typical course requires 8 to 12 sessions over 3 weeks. Patients may or may not be hospitalized during the course of treatment depending on the severity of depression. ECT relieves depression in 75% to 85% of patients, as compared to medication, which is effective in 65% to 75% of patients with severe depression. One in 200 recipients of ECT report severe memory problems that remain for months or even years after treatment.

ECT continues to be unfairly stigmatized, even though it is probably safer than treatment with tricyclic medications or lithium, particularly in pregnant women or patients with cardiac conduction disorders. Some psychiatrists administer ECT early in the treatment process because they believe it results in more rapid resolution of life-threatening symptoms than does medication. Others suggest that ECT should be offered earlier in order to avoid months of suffering in patients who are not responding to medication treatment.

It is recommended that those responding to ECT should receive continuation phase treatment with antidepressant medications for at least 8 months, since 30% to 60% will relapse without such treatment. Psychotherapy alone following ECT is not recommended, although it may be used in combination with antidepressant medication. Continuation ECT, i.e., ECT administered at regular intervals after completing acute phase treatment, is an option for the rare patient who responds to ECT but is resistant to continuation phase medication. There is very little data in the medical literature concerning maintenance ECT.

Light Therapy

Light therapy is a relatively new treatment that is used only for well-documented mild to moderate seasonal, nonpsychotic, winter depressive episodes in patients with recurrent major depression or bipolar II disorders. Response typically occurs in 4 to 7 days, but may be delayed for up to 2 weeks. It may be a first-line treatment if there are medical reasons to avoid antidepressants, if the patient has a history of a positive response to light therapy, if the patient requests it, or if the physician considers it appropriate.

Compliance

Some patients fail to follow recommended treatment. They may feel that depression is not an illness but an indication of personal failure, a view that is constantly reinforced if medication is taken on an ongoing basis. Other reasons for noncompliance include lack of insight, personality factors, coping styles, beliefs about illness, fears of loss of self-determinism or dependence on the medication, and antidepressant side effects. This last factor is of particular importance. Antidepressants often must be taken for 2 weeks or more before significant improvement occurs, and side effects may become prominent well before relief is obtained. Unless strongly motivated, the patient may become discouraged and discontinue the medication, or reduce the dosage before a full therapeutic effect has been achieved.

Compliance is strongly influenced by cultural background. As noted in a South African report, lack of compliance results from a complex interaction of risk factors involving the patient, illness, physician, treatment setting, and medication. Problems with compliance are particularly likely in areas where Western concepts of illness and treatment are in conflict with those of the patient.

Given the fact that the first indication of noncompliance may be suicide, accidental death, or prolonged disability, failure to follow recommended treatment becomes especially important in high-risk patients. This includes those with a history of severe depression, prior suicide attempts or strong suicidal ideation, alcohol or drug abuse, and antisocial personality disorders. General indicators of noncompliance include:

- Failure to keep appointments, take medications, complete assignments, or finish the entire course of treatment (estimated at 10% to 30% of patients)
- Active resistance to treatment suggestions
- Unwillingness to accept the diagnosis
- History of involuntary hospital commitment
- Use of injectable psychiatric medications

Underwriting Considerations: Summary

Psychiatric Terminology

- Precise psychiatric definitions are helpful when reading attending physicians statements and underwriting manuals.
- The definitions used in this paper were taken from the Depression Guideline Panel of the AHHCPR, April 1993. Attending physicians, especially primary care physicians, often have a different meaning for terms such as response, remission, relapse, recovery, and recurrence.
Period Of Highest Risk

- A recurrence is more likely if there have been 2 or more episodes of depression, or if the episode was severe or prolonged (duration to remission greater than 3 months). Most recurrences develop within 6 to 12 months after recovery.

- After a single brief episode (duration to remission 3 months or less), the period of highest risk is the first 12 months after remission. This estimate is based on 6 months until a recovery can be declared, plus an additional 6 months of observation.

- With a history of 2 or more episodes, or 1 prolonged episode (duration to remission more than 3 months), the period of highest risk is the first 18 months after remission. This estimate is based on 6 months until a recovery can be declared, plus an additional 12 months of observation.

Medication

- Optimal treatment uses full-dose antidepressant medication.

- Relapse/recurrence is more likely if continuation medication is not administered following remission.

- Chronic administration of antidepressants may indicate a more favorable risk in some cases, since patients with recurrent depression who remain on long-term, full-dose antidepressants are more likely to be concerned about their health.

- With a history of 3 or more episodes of depression, recurrence is almost inevitable unless maintenance medication is administered for 3 to 5 years (or more) following recovery.

- In cases with 3 or more episodes of depression, risk is highest in applicants who do not receive maintenance phase medication during the first 3 to 5 years following the last episode, intermediate for those still on medication, and lowest in applicants whose maintenance medication has been discontinued after 3 to 5 years (and no recurrences have developed for 1 or more years).

- After stopping maintenance medication, risk of recurrence is highest in the first 12 months.

- Physician visits during maintenance medication treatment average every 1 to 3 months. More frequent visits may indicate increasing symptoms, and less frequent visits may indicate lack of compliance.

- Two general rules apply concerning the optimal time to stop maintenance phase medication: (1) the stronger the indications for maintenance phase treatment, the longer its duration should be, and (2) maintenance medication may be discontinued if there have been no recurrences during a period of time equal to a minimum of two previous cycle lengths.

- Disease severity and likelihood of noncompliance are higher if multiple psychiatric medications are taken, such as combinations of antidepressants, lithium, and neuroleptics.

Psychotherapy

- Recurrence is more likely if psychotherapy rather than medication is used as primary therapy.

- Adding psychotherapy to antidepressant medication may indicate a complex case, incomplete response to medication, or a concerted effort to achieve maximal function.

- An unusually long course of psychotherapy (more than 20 sessions) may indicate incomplete recovery.

Electroconvulsive Therapy (ECT)

- ECT identifies a period of severe impairment. The period of highest risk is similar to that of applicants with 3 or more major depressive episodes, i.e., during the first 18 months after the last episode.

- Recurrence is likely if continuation or maintenance ECT is being administered.

- ECT should generally be followed by continuation and maintenance medication.

Compliance

- With a history of noncompliance, risk is greater in applicants with history of severe depression, strong suicidal ideation, prior suicide attempts (especially if near-lethal), alcohol or drug abuse, and antisocial personality disorders.

- Risk is higher if antidepressant medication was discontinued (or taken in subtherapeutic dosages) prior to achieving a full therapeutic effect.
• It is important to specifically ask attending physicians about compliance.

General Comments

• Up to 20% of patients report some depressive symptoms during continuation or maintenance treatment. Early relapse/recurrence is likely unless the symptoms are mild and brief.

• Recovery is often delayed if the depression was present for a long time; some people never fully recover.

• The risk is higher when depression occurs with other psychiatric impairments such as one of the "wild cluster" of personality disorders (antisocial personality, borderline personality, and narcissistic personality), substance abuse, prior near-lethal suicide attempt, double depression, schizophrenia, or a psychotic disorder.

The risk is lower if there is an effective network of social support such as family members, friends, clergy, family service agencies, welfare workers, ethnic healers, or Alcoholics Anonymous.

Considerations for Maintenance Medication

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<thead>
<tr>
<th>Considerations</th>
<th>Strength of Indication</th>
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<tbody>
<tr>
<td>1. Three or more episodes of major depressive disorder</td>
<td>Very strongly recommended</td>
</tr>
<tr>
<td>2. Two episodes of major depressive disorder and</td>
<td></td>
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<tr>
<td>(a) Family history of bipolar disorder*</td>
<td>Strongly recommended</td>
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<tr>
<td>(b) History of recurrence within 1 year after previously effective medication was discontinued</td>
<td>Strongly recommended</td>
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<tr>
<td>(c) A family history of recurrent major depression*</td>
<td>Strongly recommended</td>
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<tr>
<td>(d) Early onset (before age 20) of the first episode</td>
<td>Strongly recommended</td>
</tr>
<tr>
<td>(e) Both episodes were severe, sudden, or life-threatening in the past 3 years</td>
<td>Strongly recommended</td>
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* A family history is a positive, clear-cut history in one or more first-degree relatives.

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References


