

**CANMAT 2023 UPDATE:**  
**CLINICAL GUIDELINES FOR**  
**THE MANAGEMENT OF MDD IN ADULTS**

**QUESTION 6:**

What Should Be Done  
When a Patient is Better?



# How is remission maintained?

Maintaining remission is an important goal since the risk of recurrence increases with each subsequent MDE



## Psychological treatments

**Booster sessions** (e.g., 4 sessions over 12 months) to retain and encourage behavioural strategies



## Pharmacotherapy

**Optimize** therapy and treatment adherence:

- Maintain lowest effective dose
- Regular MBC to monitor symptoms and side effects



## Lifestyle factors

Attention to **modifiable** factors:

- Regular exercise
- Avoid substance misuse
- Healthy diet
- Quality sleep



## Peer support

Giving and receiving help from **individuals with lived experiences** of mental illness

- Individual
- Group
- Online

# Benefits of maintenance treatment

Maintenance pharmacotherapy and psychotherapy are both effective strategies to prevent depressive recurrence



Maintaining antidepressants can reduce relapse rates by 50%, with **flexible dosing** more effective than fixed dosing



Maintenance psychotherapy is a 1<sup>st</sup> choice for preventing recurrence in **mild to moderate MDD** and may confer longer-lasting benefits than antidepressants



Sequential psychotherapy after pharmacotherapy can prevent recurrence and increase **psychological well-being and resilience**

# Who needs longer-term antidepressant treatment?

Patients with risk factors for recurrence should continue antidepressant treatment for 2 years or more



## Factors with robust evidence

- Persistent residual symptoms (e.g., anhedonia, sleep problems, cognitive dysfunction)
- History of childhood maltreatment

## Other factors

- Greater episode severity
- Chronic depressive episodes
- Medical or psychiatric comorbidities
- Greater number of prior episodes
- Poor social support
- Persistent stressful life events

LoE, Level of Evidence



Level 1



Level 2



Level 3



Level 4

# Discontinuation symptoms

Experienced by up to 50% of patients when stopping long-term antidepressants, especially when stopping abruptly

- F** Flu-like symptoms
- I** Insomnia
- N** Nausea
- I** Imbalance
- S** Sensory disturbances
- H** Hyperarousal

## Discontinuation symptoms

Occur within days  
Often somatic in nature  
Usually mild to moderate severity  
Typically resolve within weeks  
or when dosing is restored to  
previous level

## Early recurrence symptoms

Occur within weeks  
Similar symptoms to the initial MDE

# Risk of antidepressant discontinuation symptoms

Antidepressants with shorter half-life are associated with greater incidence/severity & quicker onset of discontinuation symptoms

High risk*	Moderate risk*	Low or minimal risk*	
Paroxetine Venlafaxine	Citalopram Desvenlafaxine Duloxetine Escitalopram Fluvoxamine Levomilnacipran	Milnacipran** Sertraline Vilazodone TCAs MAOIs	Agomelatine** Bupropion Fluoxetine Mirtazapine Vortioxetine

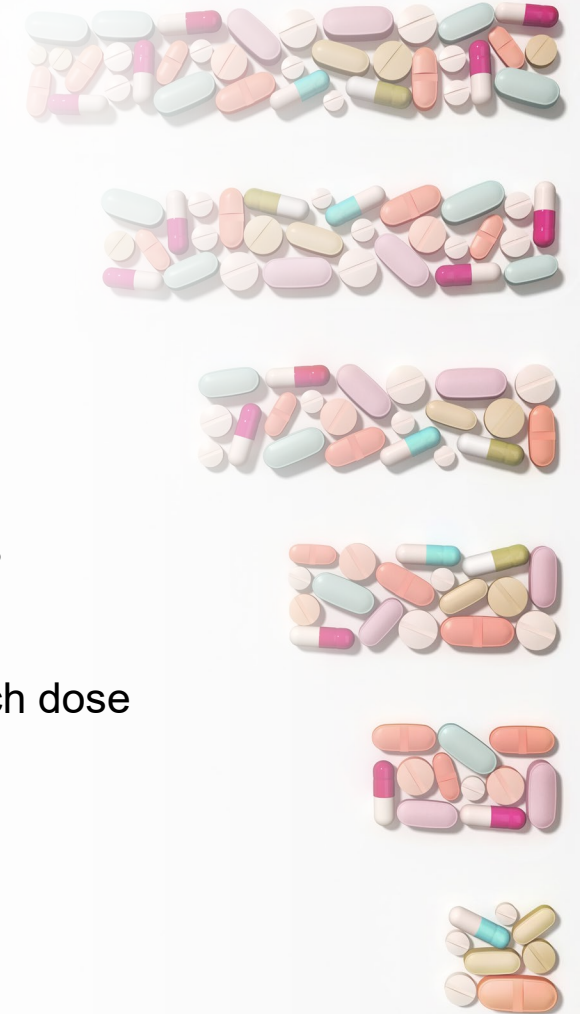
\*Risk categories are based on clinical studies, but risk and severity may vary for individual patients and specific medications. \*\*Not available in Canada.

MAOI, monoamine oxidase inhibitor; TCA, tricyclic antidepressant.  
Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

# Protracted discontinuation symptoms and hyperbolic tapering

Protracted, severe and potentially irreversible discontinuation symptoms have been reported

- Protracted discontinuation symptoms are :
  - **Heterogeneous** in nature
  - Often occur with **overlapping conditions**
  - Require **individual attention** and assessment
  - Have mostly been reported in **case reports, user surveys and internet forums**
- **“Hyperbolic dose reduction”** approach has been proposed:
  - Fixed percentage (e.g., 10%) reduction in serotonin receptor occupancy with each dose decrease instead of a fixed dose reduction (e.g., 10 mg)
  - Extrapolated from PET studies
  - Has not been assessed in RCTs
  - Relies on compounding pharmacies and nonstandard doses of antidepressants
  - **Insufficient evidence** to recommend it



# Pragmatic approach to antidepressant discontinuation








Given uncertainty about discontinuation strategies, a pragmatic approach is recommended

Summary Recommendations	Level of Evidence
<ul style="list-style-type: none"><li>• <b>Taper gradually</b> over several weeks or months, extending the time between dose reductions towards end of taper*</li></ul>	
<ul style="list-style-type: none"><li>• <b>Fast tapering</b> over <math>\leq 2</math> weeks if antidepressant use is <math>&lt; 4</math> weeks</li></ul>	
<ul style="list-style-type: none"><li>• <b>Psychological treatments</b> (e.g., CBT, MBCT) during or preceding discontinuation can reduce discontinuation effects</li></ul>	
<ul style="list-style-type: none"><li>• If severe discontinuation symptoms occur, <b>return to previous higher dose</b> with a subsequent slower tapering schedule</li></ul>	
<ul style="list-style-type: none"><li>• Switch SSRIs/SNRIs to a <b>long-acting agent</b> (e.g., fluoxetine), which can then be tapered</li></ul>	
<ul style="list-style-type: none"><li>• <b>Monitor</b> symptoms during antidepressant tapering (e.g., DESS scale)</li></ul>	

LoE, Level of Evidence Level 1 Level 2 Level 3 Level 4

\*Unless there are clinical reasons requiring rapid discontinuation (e.g., serious side effects, serotonin syndrome, etc).  
CBT, cognitive behavioural therapy; DESS, Discontinuation-Emergent Signs and Symptoms; MBCT, mindfulness-based cognitive therapy.  
Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

# Recommendations for maintenance antidepressant treatment

Line of treatment	Summary Recommendations	Level of Evidence
<p><b>1<sup>st</sup> Line</b></p>	<ul style="list-style-type: none"> <li>Maintenance pharmacotherapy and/or psychotherapy can prevent recurrence after symptom remission is achieved</li> <li>Continue antidepressant treatment for <b>minimum 6 to 12 months</b> after symptom remission</li> <li>Patients with <b>risk factors for recurrence</b> should continue antidepressant treatment for <b>2 years or more</b></li> <li>For patients with recurrent and severe MDEs, use <b>sequential treatment*</b> to prevent recurrence</li> <li>When stopping antidepressant treatment, <b>taper gradually</b> for several weeks or months**</li> <li>If antidepressant use was &lt;4 weeks, tapering and discontinuation can be quick (i.e., ≤2 weeks)</li> <li>Psychological treatments can be added before or during antidepressant discontinuation to help with stopping treatment</li> </ul>	<ul style="list-style-type: none"> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> </ul>

LoE, Level of Evidence  Level 1  Level 2  Level 3  Level 4

\*Addition of psychotherapy after stabilizing on medications. \*\*More time between dose reductions near end of taper. MDE, major depressive episode.

Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.