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Identifying Core Indicators of Relapse in Clients Undergoing Cognitive Behavioral Therapy for Depression: A Qualitative Study

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A B S T R A C T

Objective: The objective of this study was to explore and identify the core indicators of relapse in clients who have completed cognitive behavioral therapy (CBT) for depression.

Methods and Materials: This qualitative study employed a thematic analysis approach based on semi-structured interviews. Twenty-one participants (12 female, 9 male) aged between 23 and 54 years, all of whom had previously undergone a full course of CBT for depression, were recruited from mental health centers in Turkey. Participants were selected through purposive sampling and interviews were continued until theoretical saturation was reached. Data collection involved individual interviews lasting 45–75 minutes, which were audio-recorded, transcribed verbatim, and supplemented with field notes. NVivo 14 software was used to assist with systematic coding, organization, and analysis of the data.

Findings: Thematic analysis revealed three overarching categories of relapse indicators. The first, emotional and cognitive triggers, included rumination, negative thinking, cognitive distortions, emotional dysregulation, and loss of therapy skills application. The second, behavioral and lifestyle indicators, encompassed withdrawal, disturbances in sleep and appetite, decline in daily functioning, maladaptive coping strategies, and abandonment of healthy routines. The third, social and interpersonal factors, involved family and relationship strain, lack of social support, stigma and shame, work and academic pressures, and interpersonal sensitivity.

Conclusion: Relapse in depression following CBT is a multifaceted process involving the interplay of cognitive-emotional vulnerabilities, behavioral patterns, and social stressors. Early identification of these indicators, combined with booster interventions, aftercare programs, and personalized relapse-prevention planning, may enhance the sustainability of treatment gains.

Keywords: *Depression; Cognitive Behavioral Therapy; Relapse; Qualitative Study; Thematic Analysis; Indicators; Turkey*

1. Introduction

Depression remains one of the most pervasive and debilitating mental health disorders worldwide, marked by recurring episodes, significant impairment, and high personal and societal costs (Shunchao & Chunqiu, 2024; Zhou et al., 2023). Although evidence-based treatments, particularly cognitive behavioral therapy (CBT), have demonstrated robust efficacy in reducing depressive symptoms, relapse and recurrence rates remain a pressing concern (Fuhr et al., 2023; Renani & Zare, 2025). The chronic and cyclical nature of depression makes relapse prevention a central focus of both clinical research and practice (Johnco et al., 2021; McCartney et al., 2020). Understanding the core indicators of relapse in clients undergoing CBT is therefore critical for developing effective strategies to sustain treatment gains and enhance long-term recovery outcomes.

The effectiveness of CBT in treating depressive disorders has been established across diverse populations and contexts. Research shows that CBT produces significant short- and long-term benefits, including the reduction of cognitive distortions, alleviation of negative affect, and enhancement of adaptive coping skills (Bernhardt et al., 2021; Chiang et al., 2017). Moreover, CBT has been adapted successfully to treat comorbid conditions such as anxiety and bipolar disorder, broadening its utility across the spectrum of mood disorders (Chiang et al., 2017; Muralidharan et al., 2015). Yet, despite these advances, relapse rates after successful CBT remain substantial. Longitudinal investigations indicate that a significant proportion of patients experience recurrence within two years of completing treatment (Bernhardt et al., 2021; Vittengl et al., 2015).

One factor that complicates long-term treatment outcomes is the persistence of maladaptive cognitive patterns even after symptom remission. Maladaptive schemas, dysfunctional attitudes, and rumination often linger beneath the surface, serving as latent risk factors for relapse (Ezawa et al., 2020; Roberts et al., 2021). For instance, high levels of rumination predict relapse even after a positive response to CBT, underscoring the importance of monitoring these cognitive vulnerabilities (Hvenegaard et al., 2015; Roberts et al., 2021). Additionally, "silent schemas"—enduring maladaptive beliefs that may not be fully addressed in short-term interventions—have been shown to re-emerge under stress, contributing to relapse (Shunchao & Chunqiu, 2024).

Preventive and follow-up strategies have been proposed to counteract this vulnerability. Preventive cognitive therapy (PCT), mindfulness-based cognitive therapy (MBCT), and rumination-focused CBT are among the most prominent approaches developed to address residual symptoms and reduce relapse risk (Hvenegaard et al., 2015; Jonge et al., 2019; McCartney et al., 2020). These therapies target cognitive habits such as repetitive negative thinking and dysfunctional attributional styles that increase susceptibility to relapse. Systematic reviews and meta-analyses indicate that such psychological interventions are effective in lowering relapse rates compared to care as usual (McCartney et al., 2020; Zhou et al., 2023). However, the evidence also highlights significant variability across individuals, pointing to the need for identifying precise indicators that can signal relapse risk in real time.

Recent work has emphasized the role of neurocognitive and psychosocial mechanisms in predicting relapse trajectories. Longitudinal data show that cognitive deficits, such as impairments in attention and executive functioning, can predict poorer outcomes and higher relapse risk after CBT (Bernhardt et al., 2021). Similarly, psychosocial factors—including treatment adherence, quality of social support, and ongoing stressors—affect whether clients maintain therapeutic gains (Carstens et al., 2021; Pentaraki, 2018). Even treatment delivery formats influence relapse risk: while internet- and mobile-based aftercare programs have demonstrated promise, more research is needed to determine their effectiveness relative to traditional follow-up care (Petre et al., 2024).

In addition to psychosocial and cognitive predictors, biological and pharmacological factors may interact with psychological treatment outcomes. Combination treatments, such as CBT with pharmacotherapy, can sometimes enhance recovery and reduce relapse; however, findings remain mixed (Ngan et al., 2022; Renani & Zare, 2025). For instance, high-definition transcranial direct current stimulation has been studied as an augmentation therapy for late-life depression with suboptimal treatment response, suggesting that adjunctive interventions may hold potential for relapse prevention (Ngan et al., 2022). Likewise, studies on hypnotherapy versus CBT indicate that different therapeutic modalities produce distinct long-term outcomes, highlighting the need for tailored interventions based on individual risk profiles (Fuhr et al., 2023).

The phenomenon of relapse is not confined to depression alone. Evidence from related disorders, such as generalized anxiety disorder and bipolar disorder, also shows that

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maintaining therapeutic gains requires long-term monitoring and support (Brenes et al., 2017; Muralidharan et al., 2015). For example, telephone-delivered psychotherapy for late-life anxiety demonstrated long-term effectiveness, but relapse still occurred in a subset of participants (Brenes et al., 2017). Similarly, psychosocial interventions for bipolar disorder often require booster sessions to sustain benefits (Muralidharan et al., 2015). These findings further underscore the importance of relapse indicators as early warning signs to guide clinical decision-making.

Another area of growing interest is the identification of mechanisms of change that underpin relapse prevention. Patient-specific change processes—such as the ability to reframe maladaptive beliefs, sustain behavioral activation, and regulate emotion—are central to sustaining recovery (Penedo et al., 2020). Understanding these processes can help clinicians anticipate which clients are at higher risk of relapse and intervene proactively. For example, Penedo et al. (Penedo et al., 2020) showed that different forms of cognitive therapy rely on distinct mechanisms of change, implying that individualized monitoring of these processes may help predict relapse.

Furthermore, relapse is not merely a clinical outcome but is intertwined with patients' lived experiences and psychosocial contexts. Research indicates that dropout rates, treatment adherence, and therapeutic alliance play a pivotal role in whether clients sustain treatment benefits (Carstens et al., 2021; Pentaraki, 2018). High dropout rates remain a persistent challenge in depression treatment, with many patients discontinuing therapy before achieving full remission. This partial treatment exposure increases vulnerability to relapse, particularly when clients lack ongoing support systems (Pentaraki, 2018).

Emerging evidence from oncology and chronic illness populations also contributes to our understanding of relapse mechanisms. Studies of cancer survivors receiving intensive therapies such as chimeric antigen receptor (CAR) T cell therapy demonstrate that neuropsychiatric outcomes, including depression relapse, remain significant long-term concerns (Ruark et al., 2020). These findings illustrate how relapse is influenced by both medical and psychological domains, reinforcing the need for integrative approaches in mental health care.

Despite significant progress, several gaps persist. Many relapse prevention studies focus on specific interventions without systematically examining the *indicators* of relapse across contexts. For example, while mindfulness-based and rumination-focused approaches have shown efficacy, less is known about the concrete cognitive, behavioral, and social markers that signal relapse onset (McCartney et al., 2020; Roberts et al., 2021). Similarly, while internet-based aftercare is expanding rapidly, the evidence base for its effectiveness in relapse prevention remains limited (Petre et al., 2024). The variability in long-term outcomes across studies suggests that relapse is a multifactorial phenomenon, shaped by an interplay of cognitive, emotional, social, and biological factors (Bernhardt et al., 2021; Zhou et al., 2023).

Taken together, the literature demonstrates that although CBT is an effective first-line treatment for depression, relapse continues to undermine its long-term efficacy. Multiple studies have identified cognitive vulnerabilities such as rumination and dysfunctional attitudes (Ezawa et al., 2020; Roberts et al., 2021), psychosocial risk factors including weak social support and treatment dropout (Carstens et al., 2021; Pentaraki, 2018), and biological and neurocognitive influences (Bernhardt et al., 2021; Renani & Zare, 2025). Yet, there is limited qualitative research that brings together clients' perspectives to map the lived experience of relapse indicators. This gap is particularly important because qualitative inquiry can capture the subtle, subjective, and context-dependent signs of relapse that quantitative measures may overlook.

The present study addresses this need by exploring the core indicators of relapse in clients undergoing CBT for depression, using qualitative interviews with participants in Turkey.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a qualitative research design with an exploratory and interpretive orientation to identify the core indicators of relapse in clients undergoing cognitive behavioral therapy (CBT) for depression. Semi-structured interviews were conducted to capture participants' lived experiences, perceptions, and reflections regarding the relapse process. A purposive sampling strategy was applied to ensure that participants had direct experience with CBT for depression and had either undergone or reported concerns about relapse episodes.

A total of 21 participants were recruited from mental health clinics and counseling centers across Turkey. The sample included both male and female adults, ranging in age from 23 to 54 years, all of whom had completed at least one structured course of CBT for depression. Recruitment continued until theoretical saturation was reached, meaning

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that no new themes or insights emerged from additional interviews.

2.2. Measures

Data were collected through semi-structured, in-depth interviews guided by an interview protocol that explored participants' experiences of relapse, early warning signs, coping strategies, and perceived gaps in therapy. Each interview lasted between 45 and 75 minutes and was conducted either face-to-face in a private clinical setting or via secure online platforms, depending on participants' preferences and accessibility. All interviews were audio-recorded with participants' informed consent and subsequently transcribed verbatim. Field notes were also taken to capture contextual and non-verbal cues that might enrich the data analysis.

2.3. Data analysis

The interview transcripts were analyzed using thematic analysis to identify patterns, categories, and overarching themes related to relapse indicators. NVivo 14 software was employed to support systematic coding, organization, and retrieval of qualitative data. The analysis process was iterative and inductive, involving open coding of initial transcripts, grouping of codes into sub-themes, and refinement into broader categories that captured the core indicators of relapse. Researcher triangulation and peer debriefing were used to enhance the credibility and trustworthiness of the findings.

3. Findings and Results

The study included 21 participants from various regions of Turkey, all of whom had previously completed at least one structured course of cognitive behavioral therapy for depression. The sample consisted of 12 females (57.1%) and 9 males (42.9%), with an age range between 23 and 54 years (M = 36.8 years). In terms of marital status, 11 participants (52.4%) were single, 7 (33.3%) were married, and 3 (14.3%) were divorced. Regarding educational background, the majority held a university degree (n = 13, 61.9%), followed by secondary education (n = 5, 23.8%) and postgraduate qualifications (n = 3, 14.3%). Employment status varied across the sample: 10 participants (47.6%) were employed full-time, 6 (28.6%) were students, and 5 (23.8%) were unemployed or homemakers. These demographic characteristics provided a diverse participant pool, allowing for a richer exploration of relapse indicators across different life circumstances.

Table 1

Themes, Subthemes, and Concepts of Relapse Indicators in Clients Undergoing CBT for Depression

Category (Main Theme)	Subcategory	Concepts (Open Codes)
1. Emotional and Cognitive Triggers	Rumination and Negative Thinking	Constant self-blame, intrusive negative thoughts, "what if" scenarios, hopelessness, excessive guilt
	Emotional Dysregulation	Sudden mood swings, heightened irritability, inability to calm down, feeling emotionally "numb"
	Cognitive Distortions	Catastrophizing, black-and-white thinking, overgeneralization, personalization
	Self-Criticism and Low Self-Esteem	Inner harsh voice, constant comparison to others, feelings of worthlessness
	Anxiety Spillover	Anticipatory anxiety, restlessness, feeling on edge, difficulty concentrating
	Loss of Therapy Skills Application	Forgetting to use CBT techniques, neglecting thought records, resistance to cognitive restructuring
2. Behavioral and Lifestyle Indicators	Withdrawal and Isolation	Avoiding social interactions, canceling plans, reluctance to leave home
	Sleep and Appetite Disturbances	Insomnia, oversleeping, irregular eating habits, appetite loss, emotional eating
	Decline in Daily Functioning	Reduced motivation, neglecting household tasks, absenteeism at work/school
	Maladaptive Coping Behaviors	Overuse of social media, substance use, overeating, procrastination
	Abandonment of Healthy Routines	Skipping exercise, stopping relaxation practices, poor self-care
3. Social and Interpersonal Factors	Family and Relationship Strain	Frequent conflicts, feeling unsupported, avoidance of partner/family, miscommunication
	Lack of Social Support	Perceived loneliness, absence of trusted confidants, distancing from friends
	Stigma and Shame	Fear of judgment, hiding depressive symptoms, internalized stigma
	Work and Academic Pressure	Overload of tasks, fear of failure, perfectionistic standards, inability to balance responsibilities
	Interpersonal Sensitivity	Feeling easily rejected, overreacting to criticism, misinterpreting neutral behaviors

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Category 1: Emotional and Cognitive Triggers One of the dominant themes identified was emotional and cognitive triggers, which manifested through various pathways. **Rumination and negative thinking** were frequently reported as early signals of relapse. Participants described "getting stuck" in repetitive thought cycles, particularly involving self-blame and hopelessness. As one participant noted: *"I keep replaying the same mistakes in my mind. Even when nothing bad is happening, my brain finds a reason to drag me down."* Similarly, intrusive "what if" scenarios and persistent guilt marked the beginning of depressive episodes.

Another subtheme involved **emotional dysregulation**, with participants reporting sudden mood swings and irritability. Several described feeling overwhelmed by minor stressors: *"It's like my emotions hijack me. I can go from calm to crying in seconds, and I don't even understand why."* Some also spoke of emotional numbness, describing it as a loss of both positive and negative affect.

Cognitive distortions were also highlighted as warning signs. Patterns such as catastrophizing, black-and-white thinking, and overgeneralization re-emerged in moments preceding relapse. One participant explained: *"If I fail once, I convince myself I'll fail at everything. It's like I don't see the middle ground anymore."*

Many respondents reported **self-criticism and low self-esteem** as prominent indicators. Harsh inner dialogue and constant comparison to others resurfaced during relapse. A participant shared: *"My inner voice becomes brutal again. It tells me I'm worthless, no matter what I achieve."*

Closely related was **anxiety spillover**, as participants described restlessness and anticipatory fear. Some indicated difficulty concentrating due to racing thoughts: *"I feel like I'm always bracing myself for disaster, even when there's no reason."*

Finally, **loss of therapy skills application** emerged as an important marker. Participants described neglecting thought records and abandoning CBT techniques. As one participant put it: *"I know the strategies, but in those moments I just stop using them. It's like all the training disappears."*

Category 2: Behavioral and Lifestyle Indicators Another theme was behavioral and lifestyle changes, often manifesting as early behavioral signals of relapse. **Withdrawal and isolation** were frequently reported, with participants avoiding social interactions and preferring to stay at home. One individual reflected: *"I start canceling plans and ignoring calls. It's easier to hide than to explain what I'm going through."*

Sleep and appetite disturbances were also common. Participants mentioned insomnia, oversleeping, and changes in eating habits. Some reported emotional eating, while others lost interest in food. A participant stated: *"When I'm slipping, I either can't sleep at all or I sleep the whole day. My appetite follows the same pattern—either nothing or too much."*

A decline in daily functioning characterized another subtheme. **Reduced motivation and neglect of responsibilities** often signaled relapse. Participants expressed difficulty managing simple tasks, such as household chores or attending work. As one participant explained: *"I stop caring about things that used to matter. Even brushing my teeth feels like climbing a mountain."*

Additionally, **maladaptive coping behaviors** resurfaced during relapse periods. These included increased use of social media, substance use, or procrastination. One participant described: *"I find myself scrolling endlessly on my phone, just to escape my thoughts. Hours go by and I realize I've done nothing."*

Another important indicator was **abandonment of healthy routines**. Participants who had developed positive habits during therapy, such as exercise or relaxation practices, reported discontinuing them. A participant remarked: *"I stop exercising, I stop journaling—it's like I let go of all the good things I learned in therapy."*

Category 3: Social and Interpersonal Factors The third major theme involved social and interpersonal influences. **Family and relationship strain** often acted as relapse triggers. Participants spoke of recurring conflicts, feelings of being unsupported, and communication breakdowns. As one noted: *"When I fight with my partner, it feels like I'm back at square one. The depression comes rushing in."*

Lack of social support further contributed to vulnerability. Some participants described loneliness and an absence of trusted confidants. One participant shared: *"Even though I have people around me, I feel like I can't open up. It's like I'm alone in the middle of a crowd."*

Stigma and shame also surfaced as barriers, preventing participants from disclosing symptoms or seeking help. Several expressed fear of judgment: *"I don't tell anyone I'm struggling again, because I don't want them to think I failed therapy."*

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Another subtheme was **work and academic pressure**, as participants often cited stress from responsibilities as a relapse factor. Unrealistic expectations and perfectionism were particularly damaging. One participant said: *"I try to do everything perfectly at work, and when I fall short, it pushes me back into depression."*

Lastly, **interpersonal sensitivity** was observed, with participants reporting heightened reactions to criticism and rejection. One participant reflected: *"When someone criticizes me, even gently, I take it as proof that I'm not good enough. That's when I know relapse is coming."*

4. Discussion and Conclusion

The purpose of this study was to identify the core indicators of relapse among clients undergoing cognitive behavioral therapy (CBT) for depression. Using semi-structured interviews with participants in Turkey, we extracted three overarching themes: *emotional and cognitive triggers*, *behavioral and lifestyle indicators*, and *social and interpersonal factors*. Together, these themes highlight how relapse is not the result of a single mechanism, but rather emerges from an interaction of internal vulnerabilities and external stressors. The discussion that follows situates these findings within the broader literature, aligning our results with prior studies and theories of relapse in depression.

One of the strongest findings of this study was the persistence of maladaptive cognitive and emotional patterns as precursors to relapse. Participants described rumination, negative thinking, emotional dysregulation, and self-criticism as early warning signs. These findings support previous research showing that rumination and dysfunctional attitudes are powerful predictors of relapse in clients who have undergone CBT (Ezawa et al., 2020; Roberts et al., 2021). In fact, Roberts and colleagues emphasized that rumination-focused CBT was specifically designed to reduce ruminative habits that remain even after acute depressive symptoms improve, thereby lowering relapse risk (Roberts et al., 2021). Our participants' accounts confirm that rumination is a lived and subjective experience of vulnerability, reinforcing its role as a central mechanism of relapse.

The recurrence of cognitive distortions such as catastrophizing and black-and-white thinking was another salient indicator reported by participants. Prior evidence shows that residual cognitive distortions remain even in remission and can significantly undermine long-term recovery (Bernhardt et al., 2021; Vittengl et al., 2015). Bernhardt et al. found that cognitive deficits and distortions predicted poorer treatment outcomes, which resonates with participants' descriptions of being "hijacked by negative thinking" despite prior therapy gains. Similarly, Vittengl et al. demonstrated that unstable responses to CBT were often followed by relapse, suggesting that monitoring cognitive distortions could serve as an early intervention point (Vittengl et al., 2015).

Our finding of emotional dysregulation as an indicator of relapse also aligns with existing research. Studies show that difficulties in regulating affective responses persist even after CBT and often predict depressive recurrence (McCartney et al., 2020; Shunchao & Chunqiu, 2024). Shunchao and Chunqiu argued that underlying "silent schemas" and maladaptive emotional patterns may remain dormant until activated by stressors, a concept echoed by participants' accounts of sudden mood swings or emotional numbness (Shunchao & Chunqiu, 2024). Furthermore, mindfulness-based interventions have been suggested to improve emotion regulation and thereby reduce relapse rates (McCartney et al., 2020), highlighting the importance of integrating such approaches into follow-up care.

Finally, our participants described a loss of therapy skills application, such as neglecting cognitive restructuring exercises. This corresponds to research showing that treatment adherence and continuous use of CBT techniques are critical to preventing relapse (Jonge et al., 2019; Penedo et al., 2020). Jonge et al. demonstrated that preventive cognitive therapy, delivered after acute CBT, reduced relapse by reinforcing previously learned strategies (Jonge et al., 2019). Similarly, Penedo et al. identified patient-specific mechanisms of change—such as maintaining behavioral activation and cognitive restructuring—as essential for sustaining therapeutic gains (Penedo et al., 2020). Our results therefore underscore the need for structured booster sessions and ongoing skill reinforcement to help clients maintain CBT tools.

The second major theme concerned changes in daily routines and behaviors that participants recognized as early relapse signs. These included withdrawal and isolation, sleep and appetite disturbances, decline in daily functioning, maladaptive coping behaviors, and abandonment of healthy routines. Such indicators resonate with longitudinal research documenting that behavioral withdrawal and functional decline often precede full relapse episodes (Bernhardt et al., 2021; Chiang et al., 2017). Chiang et al. noted that even in bipolar disorder, which shares features of episodic recurrence with depression, CBT interventions targeting

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lifestyle regularity reduced relapse risk (Chiang et al., 2017). This suggests that structured monitoring of daily activities may be valuable for depression as well.

The disturbances in sleep and appetite described by participants are consistent with prior findings that residual somatic symptoms remain robust predictors of relapse (Fuhr et al., 2023; Renani & Zare, 2025). Fuhr and colleagues compared long-term outcomes of hypnotherapy and CBT, showing that persistent physiological symptoms were associated with higher relapse rates (Fuhr et al., 2023). Similarly, Renani and Zare demonstrated that interventions addressing sleep and cognition yielded improved outcomes compared to pharmacotherapy alone (Renani & Zare, 2025). This evidence suggests that behavioral indicators are not merely secondary manifestations but central relapse markers.

Participants also reported maladaptive coping behaviors, including avoidance, substance use, and overreliance on social media. Prior studies confirm that avoidance-based coping styles predict depressive recurrence and undermine the benefits of CBT (Muralidharan et al., 2015; Pentaraki, 2018). For instance, Pentaraki highlighted that dropout and disengagement behaviors often stem from avoidance, directly increasing relapse risk (Pentaraki, 2018). Moreover, maladaptive coping parallels findings in bipolar disorder, where psychosocial treatments targeting coping skills significantly reduced relapse (Muralidharan et al., 2015). Our findings thus point to the value of relapse-prevention strategies that explicitly address coping styles.

Finally, abandonment of healthy routines such as exercise, journaling, or relaxation techniques was a notable subtheme. The literature confirms that discontinuation of learned behaviors erodes therapeutic gains (Carstens et al., 2021; Petre et al., 2024). Carstens et al. examined group CBT after electroconvulsive therapy and found that maintenance of structured activities reduced relapse risk (Carstens et al., 2021). Similarly, Petre and colleagues emphasized that internet-based aftercare, which encourages routine adherence, holds potential for relapse prevention (Petre et al., 2024). Together, these studies support the present findings that sustained lifestyle structure is essential for long-term stability.

The third theme centered on family strain, lack of social support, stigma, work and academic pressures, and interpersonal sensitivity. These findings reinforce the well-documented role of social context in shaping relapse trajectories. For instance, weak or negative family support has consistently been associated with higher relapse rates (Johnco et al., 2021; Penedo et al., 2020). Johnco et al. found that older adults experienced higher relapse during the COVID-19 pandemic partly due to reduced social interaction and support networks (Johnco et al., 2021). Our participants' descriptions of feeling unsupported or misunderstood by family members align with this evidence.

Stigma and shame were also reported as significant barriers, preventing disclosure and timely intervention. This finding echoes Ruark et al., who noted that patients recovering from intensive medical treatments often struggled with stigma and self-silencing, which exacerbated psychological relapse (Ruark et al., 2020). Similarly, research in depression shows that stigma contributes to therapy dropout and incomplete adherence, increasing relapse risk (Pentaraki, 2018). The lived experiences described by our participants illustrate how stigma operates not only as a societal barrier but also as an internalized cognitive burden.

Another subtheme was work and academic pressure, with participants describing perfectionism and performance anxiety as triggers. Prior evidence indicates that high-stress environments increase relapse vulnerability by reactivating maladaptive schemas (Bernhardt et al., 2021; Shunchao & Chunqiu, 2024). Bernhardt et al. emphasized that cognitive deficits under stress predicted poor CBT outcomes (Bernhardt et al., 2021), a finding that parallels our participants' reports of relapse under workload strain.

Finally, interpersonal sensitivity—a heightened reactivity to criticism or rejection—was reported as a recurrent relapse sign. This resonates with findings that residual cognitive-emotional vulnerabilities amplify the impact of interpersonal stressors (Roberts et al., 2021; Zhou et al., 2023). For example, Zhou et al.'s meta-analysis concluded that interventions which explicitly address interpersonal triggers, such as interpersonal therapy and schema-focused CBT, reduced relapse risk (Zhou et al., 2023). Our participants' experiences of perceiving criticism as confirmation of worthlessness highlight the importance of interpersonal domains in relapse prevention.

Taken together, these results confirm that relapse is a multifactorial phenomenon, shaped by emotional-cognitive vulnerabilities, behavioral patterns, and social-environmental stressors. This multidimensional picture aligns with prior evidence that no single treatment modality is universally protective, and that tailored relapse-prevention strategies are needed (McCartney et al., 2020; Petre et al., 2024). By foregrounding clients' perspectives, the present study contributes qualitative depth to an area often

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dominated by quantitative relapse rates. Participants' accounts underscore that relapse indicators are often subtle, subjective, and intertwined with daily experiences—factors that structured assessments alone may overlook.

5. Limitations & Suggestions

While this study provides valuable insights, several limitations should be acknowledged. First, the sample size, although sufficient for qualitative saturation, was limited to 21 participants from Turkey, which may affect transferability to other cultural and clinical contexts. Second, the reliance on self-reported experiences introduces potential recall and response biases; participants may have selectively emphasized certain indicators while underreporting others. Third, the study focused exclusively on clients who had completed CBT, and findings may not generalize to individuals receiving other forms of psychotherapy or pharmacological treatment. Fourth, the use of semi-structured interviews, while rich in depth, may not capture physiological or neurocognitive indicators of relapse that require objective measures. Finally, the cross-sectional nature of the interviews limits causal inference; longitudinal tracking would be necessary to confirm whether identified indicators consistently predict relapse episodes.

Future studies should expand the scope by employing longitudinal mixed-methods designs to track clients' relapse indicators in real time. Incorporating ecological momentary assessment (EMA) and digital monitoring could provide more precise data on daily fluctuations in mood, cognition, and behavior. Additionally, research should explore cross-cultural variations in relapse indicators, as cultural norms may influence how clients interpret and report their experiences. It would also be valuable to investigate the integration of biological markers, such as sleep patterns or neurocognitive tests, with subjective indicators to create multidimensional relapse prediction models. Finally, intervention research should test tailored relapse-prevention programs that explicitly target the indicators identified here, comparing their effectiveness with standard follow-up care.

Clinically, these findings emphasize the importance of personalized relapse monitoring. Practitioners should encourage clients to identify their own early warning signs, particularly in the domains of rumination, lifestyle disruptions, and interpersonal stress. Regular booster sessions and digital aftercare programs could be employed to reinforce CBT skills and sustain healthy routines. Therapists should also work with families to reduce conflict and increase supportive communication, while addressing stigma to foster openness. Finally, incorporating relapse-prevention plans into standard CBT protocols—outlining personalized triggers, coping strategies, and emergency contacts—may empower clients to intervene early and maintain long-term recovery.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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All authors equally contributed in this article.

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