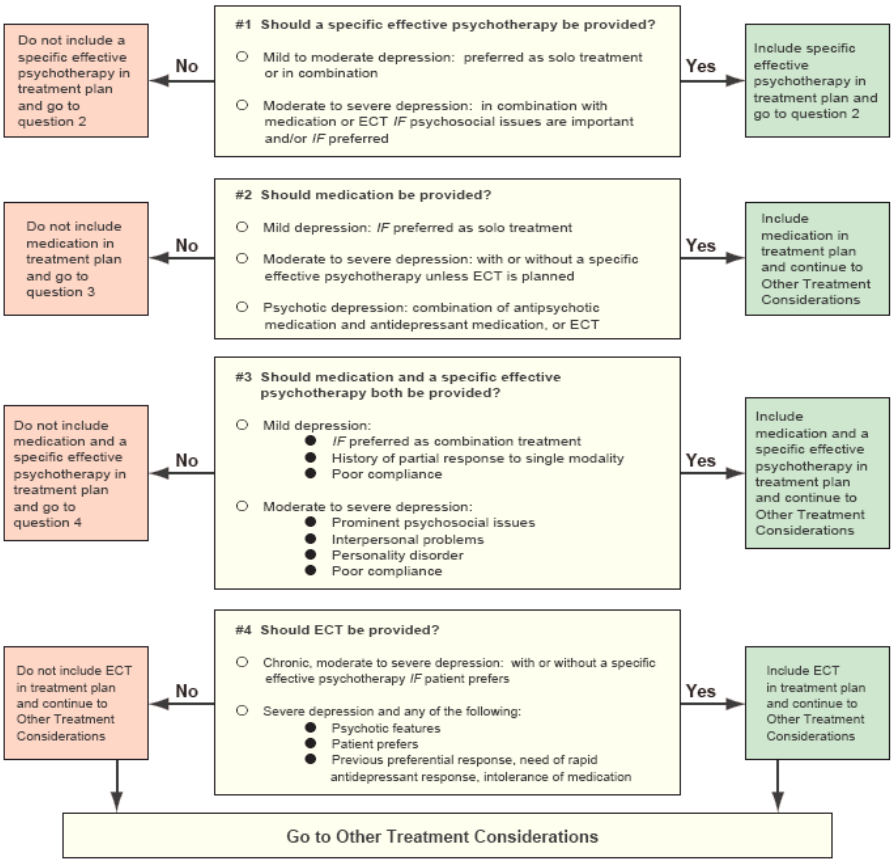
Adult Depression At A Glance*

For persons with depressive symptoms within the context of bipolar disorder, refer to the *Practice Guideline for the Treatment of Patients With Bipolar Disorder*.

ACUTE PHASE

Choose an initial treatment modality

The choice of an initial treatment modality – pharmacotherapy, psychotherapy, the combination of medications plus psychotherapy, or ECT – should be influenced by both clinical considerations (e.g., severity of symptoms and/or functional impact of symptoms) and preference of the person served. When pharmacotherapy is part of the treatment plan, it must be integrated with other treatments (e.g., psychotherapy).



Antidepressant medications

Use as an initial primary treatment modality for mild major depressive disorder and for moderate to severe major depressive disorder unless ECT is planned. A combination of antipsychotic and antidepressant medications or ECT should be used for psychotic depression.

Failure to respond

If at least moderate improvement is not observed following 6–8 weeks of pharmacotherapy, reassess the treatment regimen, and readjust the medications when necessary. Following any change in treatment, the person served should continue to be closely monitored. If there is not at least a moderate improvement in major depressive disorder symptoms after an additional 6–8 weeks of treatment, conduct another thorough review. When persons served fail to respond fully to treatment follow the steps in the diagram below.

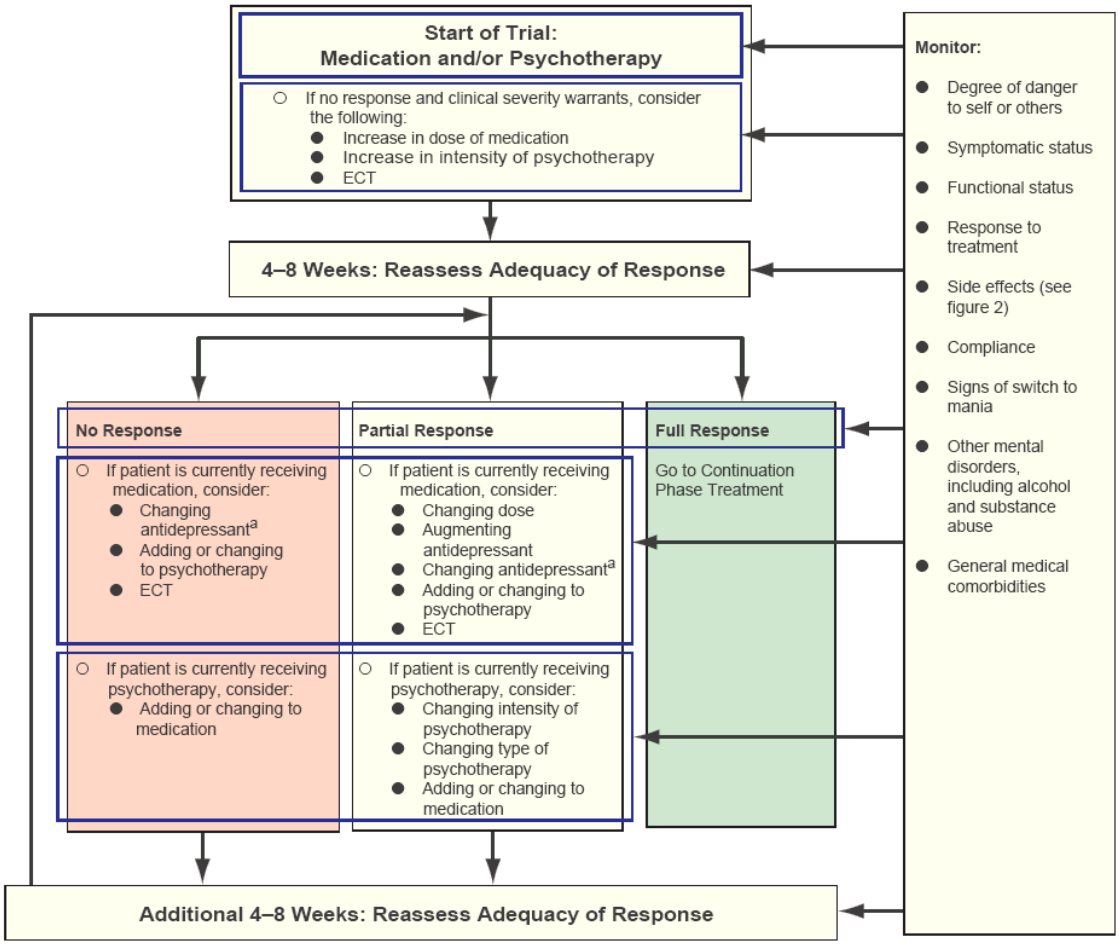
Psychotherapy

Psychotherapy alone as an initial treatment modality may be considered for persons with mild to moderate major depressive disorder. The preference of the persons served for psychotherapeutic approaches is an important factor that should be considered in the decision. Clinical features that suggest the use of psychotherapeutic interventions include the presence of significant psychosocial stressors, intrapsychic conflict, interpersonal difficulties, or a comorbid axis II disorder.

Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder.

Failure to respond

If after 4–8 weeks of treatment at least a moderate improvement is not observed, then a thorough review and reappraisal of the diagnosis, complicating conditions and issues, and treatment plan should be conducted.



Psychotherapy plus antidepressant medications

The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for persons with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder. Persons served with a history of only partial response to adequate trials of single treatment modalities may benefit from combined treatment. Poor adherence to treatment may warrant combined treatment modalities.

Electroconvulsive therapy

ECT should be considered for persons served with major depressive disorder with a high degree of symptom severity and functional impairment or for persons with psychotic symptoms or catatonia. ECT may be the treatment of choice when there is an urgent need for response such as persons who are suicidal or refusing food and nutritionally compromised.

CONTINUING TREATMENT

During the 16–20 weeks following remission, persons treated with antidepressant medications during the acute phase should be maintained on these agents to prevent relapse.

Careful assessment of risk for suicide is crucial. An assessment of the presence of suicidal ideation is essential, including the degree to which the person served intends to act on any suicidal ideation and the extent to which the person served has made plans for or begun to prepare for suicide. The availability of means for suicide should be inquired about and a judgment made concerning the lethality of those means. Major depressive disorder is frequently associated with functional impairments, and the presence, type(s), and severity of dysfunction should be evaluated. Identified impairments such as deficits in interpersonal relationships, work, living conditions, and other medical or health-related needs should be addressed.

Psychotic features

Major depressive disorder with psychotic features carries a higher risk of suicide than major depressive disorder uncomplicated by psychosis and constitutes a risk factor for recurrent major depressive disorder. Major depressive disorder with psychotic features responds better to treatment with a combination of an antipsychotic medication and an antidepressant medication than to treatment with either component alone. Lithium augmentation is helpful in some persons who have not responded to combined antidepressant-antipsychotic medication treatment. ECT is highly effective in major depressive disorder with psychotic features and may be considered a first-line treatment for this disorder.

Catatonic features

Catatonic features may occur in the context of mood disorders and are characterized by at least two of the following manifestations: immobility, as evidenced by catalepsy or stupor; extreme agitation; extreme negativism; peculiarities of voluntary movement, as evidenced by posturing, stereotyped movements, mannerisms, or grimacing; and echolalia or echopraxia. Catatonia often dominates the presentation and may be so severe as to be life-threatening, compelling the consideration of urgent biological treatment. Immediate relief may be obtained by the intravenous administration of benzodiazepines such as lorazepam or amobarbital and continued oral administration of benzodiazepines may be helpful. Concurrent antidepressant medication treatments should be considered. When relief is not immediately obtained by administering barbiturates or benzodiazepines, consider ECT.

Alcohol or substance abuse or dependence

Because of the frequent comorbidity of major depressive disorder and alcohol or other substance abuse, it is crucial to obtain a detailed history of substance use of the person served. When a problem is suspected, consider questioning a collateral for confirmation. If the person served is found to have a substance use disorder, a program to secure abstinence should be a principal priority in the treatment. A person suffering from major depressive disorder with comorbid addiction is more likely to require hospitalization and to attempt suicide, and less likely to comply with treatment than persons who do not have this problem. Remediation of an underlying major depressive disorder may assuage or ameliorate the substance abuse.

Major depressive disorder–related cognitive dysfunction (pseudodementia)

Major depressive disorder is often accompanied by signs and symptoms of cognitive inefficiency. Some persons have both major depressive disorder and dementia, while others have major depressive disorder that causes cognitive impairment (i.e., pseudodementia). In the latter case, treatment of the major depressive disorder should reverse the signs and symptoms of cognitive dysfunction. Many persons complain that their thoughts are slowed and their capacity to process information is reduced; they also display diminished attention to self-care and to their environment. Such cognitive dysfunction is a reversible condition that resolves with treatment of the underlying major depressive disorder.

Dysthymia

Antidepressants - including tricyclic antidepressants, SSRIs, other newer agents, and MAOIs - have been found to be effective in the treatment of dysthymia and chronic major depressive disorder. In general, antidepressive treatment for dysthymia is similar to that for episodes of major depressive disorder. Psychotherapy, including interpersonal therapy, cognitive behavioral therapy, cognitive therapy, and behavior therapy, has also been shown to be effective in treating persons with dysthymia and chronic major depressive disorder (Refer to: "Dysthymia at a glance")

Seasonal major depressive disorder

Some individuals suffer annual episodes of major depressive disorder with onset in the fall or early winter, usually at the same time each year. Some suffer manic or hypomanic episodes as well. Major depressive disorder episodes frequently have atypical features such as hypersomnia and overeating. The range of treatments for major depressive disorder may be used to treat seasonal affective disorder, either in combination with, or as an alternative to, light therapy. As primary treatment, light therapy may be recommended as a time-limited trial, particularly in outpatients with clear seasonal patterns. In persons with more severe forms of seasonal major depressive disorder, its use is considered adjunctive to psychopharmacologic intervention.

*Adapted from Karasu TB et al. Practice Guideline for the Treatment of Patients with Major Depressive Disorder Second Edition, APA Practice Guidelines, April 2000.