

MHNet has adopted the American Psychiatric Association's (APA) Practice Guideline for the Treatment of Major Depression. This synopsis is provided as a service to practitioners in the MHNet network and is distributed with permission of the APA. This guideline summary is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline, which is available at the APA's web site, www.psych.org. If you do not have access to this web site and would like a hard copy of the complete practice guideline, please contact MHNet's Corporate Quality Improvement Department at (512) 347-7900.

PRACTICE GUIDELINES FOR MAJOR DEPRESSION

MHNet monitors practitioner's adherence to the following elements in treatment of Major Depression:

- *Medication management*
- *Psychotherapy*
- *Conjoint therapy (combination psychotherapy and medication management)*

Depression is a term commonly used to describe various degrees of dysphoria. There are three principal reasons for distinguishing major depression from other conditions. The first is the potential for suicide if immediate treatment is not provided. The second is the possibility that the depression is being driven, in part, by biological determinants and may not respond to psychotherapy alone. The third is to identify coexisting and/or complicating conditions (e.g. substance-related conditions or medical conditions) that must be treated concurrently.

ASSESSMENT AND DIAGNOSIS

A diagnosis of major depression requires a comprehensive assessment to identify factors that need to be addressed in the overall treatment plan. In addition, an assessment of the patient's potential for suicide (hopelessness, ideation, plan, past attempts, family history) and the presence or absence of psychosis and coexisting or complicating conditions are critical in determining the treatment setting (inpatient, partial, intensive outpatient, or outpatient).

Patients are diagnosed as suffering from major depression if they have either a depressed mood or substantial loss of pleasure with significant distress and/or impairment in functioning lasting for at least two weeks. DSM IV requires at least four (three if they have both depressed mood and decreased pleasure) of the following:

- a) significant weight loss or gain (5% in a month),
- b) insomnia or hypersomnia almost every night,
- c) psychomotor agitation or retardation,
- d) fatigue or loss of energy,
- e) feelings of worthlessness or excessive guilt,
- f) impaired memory and concentration,
- g) ruminations about death or dying.

These criteria define major depression unless the symptoms are part of a bipolar disorder, are a direct consequence of substance abuse, or are secondary to a medical condition or bereavement. Further assessment of risks or consultation with a psychiatrist may be required when the patient presents one or more of these symptoms:

1. bipolarity
2. family history of affective disorders
3. prior episodes that required hospitalization
4. loss of pleasure in all or almost all activities or lack of reactivity
5. marked psychomotor retardation or agitation
6. significant anorexia or weight loss
7. early morning awakening or depression worse in the morning
8. history of suicide attempts
9. current medical condition

Assessment of geriatric patients must take place in close collaboration between the behavioral health specialist, medical care specialists, and those providing primary care.

Practitioners should consider the use of specific assessment instruments such as the Beck Depression Inventory (BDI) to refine clinical assessment and to provide for concurrent evaluation of progress and outcome.

TREATMENT PLANNING

The initial treatment of major depression requires a comprehensive treatment plan that addresses not only the symptoms of the illness, but the consequences as well. The plan of care should be based on a review of psychosocial resources currently available to the patient. The goals must be directly related to the symptomatic presentation and should include crisis stabilization, when appropriate. Special consideration should be given to patients with specific symptoms such as suicidal risk, psychosis, catatonia, atypical features, substance abuse, pseudodementia, or comorbid panic disorder. Special consideration should also be given to patients with a secondary diagnosis such as anxiety disorder, dysthymia, personality disorder, or seasonal affective disorder.

Treatment settings for major depression include inpatient, outpatient and partial hospitalization. Inpatient treatment is generally appropriate for individuals with suicidal risk, active psychosis, or profound inability to provide self-care. Individuals with less severe symptoms (e.g., weight loss, retardation or agitation, insomnia) can be effectively managed in a partial or intensive outpatient program where they can be closely monitored. Rapid intervention, early in the course of the illness, can obviate the need for inpatient or partial hospitalization.

ACUTE PHASE OF TREATMENT

Major depression can be classified as mild, moderate, or severe according to the degree of functional impairment. Somatic therapies [medications or electroconvulsive therapy (ECT)] are generally used for moderate depression, should always be used for severe depression, and should be considered for refractory mild depression. Crisis stabilization may be necessary for moderate or severe depression. Any active substance abuse must be identified and specific treatment provided. Most therapists provide a combination of therapies, addressing different issues in succeeding sessions as the patient improves.

Antidepressant medication should, in general, be initiated for a major depressive episode that includes profound feelings of worthlessness, active suicidal ideation, and marked impairment in function or psychotic symptoms. In general, treatment is initiated with one of the newer antidepressants (fluoxetine, paroxetine, sertraline, escitalopram, bupropion) because they tend to have fewer side effects and they are generally not lethal if taken in overdose. Failing an initial trial of these medications a trial of a serotonin-norepinephrine reuptake inhibitor (SNRI, venlafaxine or duloxetine) is warranted. Older tricyclic antidepressants (like nortriptyline, desipramine, and doxepin) are usually reserved for patients who have failed one or more trials of newer antidepressants, who have responded well to these medications in the past, or where medication cost is a significant factor. Monoamine oxidase inhibitors are only used as second or third line medications for refractory patients.

Individuals with psychotic symptoms (delusions and hallucinations) should receive antipsychotic therapy (olanzapine, risperidone, haloperidol). In the acute phase of the illness, severe agitation or insomnia can be treated with short acting benzodiazepines or benzodiazepine-like drugs (lorazepam, oxazepam, alprazolam for anxiety, temazepam or zolpidem for sleep).

ECT remains the most effective treatment for severe major depression, although its use remains controversial. The side effects of treatment (temporary memory loss) and the associated stigma tend to restrict its use. ECT should be

considered for treating refractory moderate or severe depression or when there is a need for a rapid treatment response (e.g., high degree of suicidality or florid psychosis). ECT can be readily performed on an outpatient basis. Maintenance ECT should be considered for patients who repeatedly relapse despite taking adequate doses of antidepressants and mood stabilizers.

Psychosocial services should be initiated during the acute phase of care. The level of acuity should influence frequency and focus of those sessions. When different professionals are providing somatic therapy and psychosocial care, communication between professionals is considered essential.

CONTINUATION AND MAINTENANCE OF SOMATIC THERAPY

The acute phase of the illness generally lasts for one to two months unless the individual is treatment refractory (about 20% of patients). If acute hospitalization is required, the patient can be quickly discharged if appropriate outpatient care has been arranged. ECT can also be provided on an outpatient basis. Partial hospitalization and/or intensive outpatient treatment should be provided when considered essential for purposes of transitional stabilization.

Most therapeutic issues can be resolved within two months unless there were significant psychological problems prior to the onset of the depression. After establishing an appropriate medication regimen, the psychiatrist should monitor the patient every one to three months. If anxiolytics, hypnotics, or antipsychotics were prescribed at the beginning of treatment, they can generally be discontinued within two months.

Antidepressant medication should be gradually discontinued after nine to twelve months of treatment. However, long-term maintenance antidepressant medication may be necessary to prevent relapse. Maintenance therapy should be strongly considered for patients with multiple episodes of major depression, those with severe depression, or those with concomitant dysthymia or panic disorder.

PSYCHOSOCIAL INTERVENTION

Research lends support to a planned and coordinated combination of somatic and psychosocial therapy in the treatment of Major Depression. All forms of psychosocial intervention should include at least these three elements:

1. Stabilization
2. Intervention
3. Relapse prevention

Preferred methods of psychosocial intervention are based on efficacy and effectiveness studies. Cognitive Therapy, Interpersonal Therapy and/or Behavior Therapy have significant support in the literature to justify their use in treatment of Major Depression. Selection should be based on the symptomatic presentation, patient preference, and the training and skills of the therapist. Unique presentations may require other alternatives and, if so required, should be justified in the proposal for care.

The therapist providing psychosocial intervention should assist the psychiatrist or other prescribing physician in monitoring compliance and potential side effects.

Before concluding the episode of care, the psychosocial therapist should collaborate with the patient to identify external and internal conditions that might

give rise to a relapse and develop a plan of action that permits early problem identification and resolution.

Education of the patient and the patient's family about the disorder should be considered as part of the psychosocial treatment package. If the patient is placed on medication, education becomes imperative. Many communities provide educational programs, some pharmaceutical companies provide programs, and many psychiatrist's offices provide such services. The arrangement of such services is considered the responsibility of the psychosocial therapist and should be included in the plan of care.

TREATMENT OF REFRACTORY DEPRESSION

A significant number of patients are refractory to traditional treatment. When this occurs, the clinician should explore the possibility of an underlying condition not previously identified or treated (e.g. substance abuse, family discord, medication non-compliance, or comorbid medical condition). If a re-assessment does not reveal untreated problems and several different psychotherapeutic techniques have been tried, creative medication regimens and/or ECT should be initiated. Recommended approaches include adding a second antidepressant in a different category, adding lithium, thyroid hormone, or a psychostimulant. Although commonly used, the efficacy of augmenting antidepressants with newer mood stabilizing drugs (divalproex, carbamazepine) has not been well tested.

In 2005 the Food and Drug Administration approved the use of Vagal Nerve Stimulation (VNS) for the treatment of severe refractory depression. Approval was based upon a relatively small sample and the benefit (approximately 30% of patients after a year of therapy) was modest. VNS should only be considered if the patient has failed adequate trials of all major categories of antidepressants as well as ECT. Many Health Plans consider VNS to be experimental.

INTENT

This practice guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The practitioner, in light of the clinical data presented by the patient and the diagnostic and treatment options available, must make the ultimate judgment regarding a particular clinical procedure or treatment plan.

REFERENCES

These guidelines were adapted from the American Psychiatric Association's practice guidelines [American Psychiatric Association: Practice Guidelines the Treatment of Patients with Major Depressive Disorder. *Am J Psychiatry* 2000; 157 (April suppl)]. The reader is referred to the original article for detailed references as well as the work group that prepared the APA guidelines. Rush AJ et al: Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRI's for depression. *N Engl J Med* 2006; 354:1231

Trivedi et al: Medication augmentation after the failure of SSRI's for depression. *N Engl Med* 2006; 354:1243

Avery DH et al: A controlled study of repetitive transcranial stimulation in medication-resistant depression. *Biol Psychiatry* 2006; 59:187