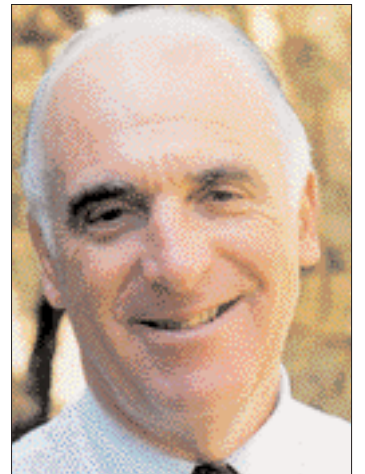
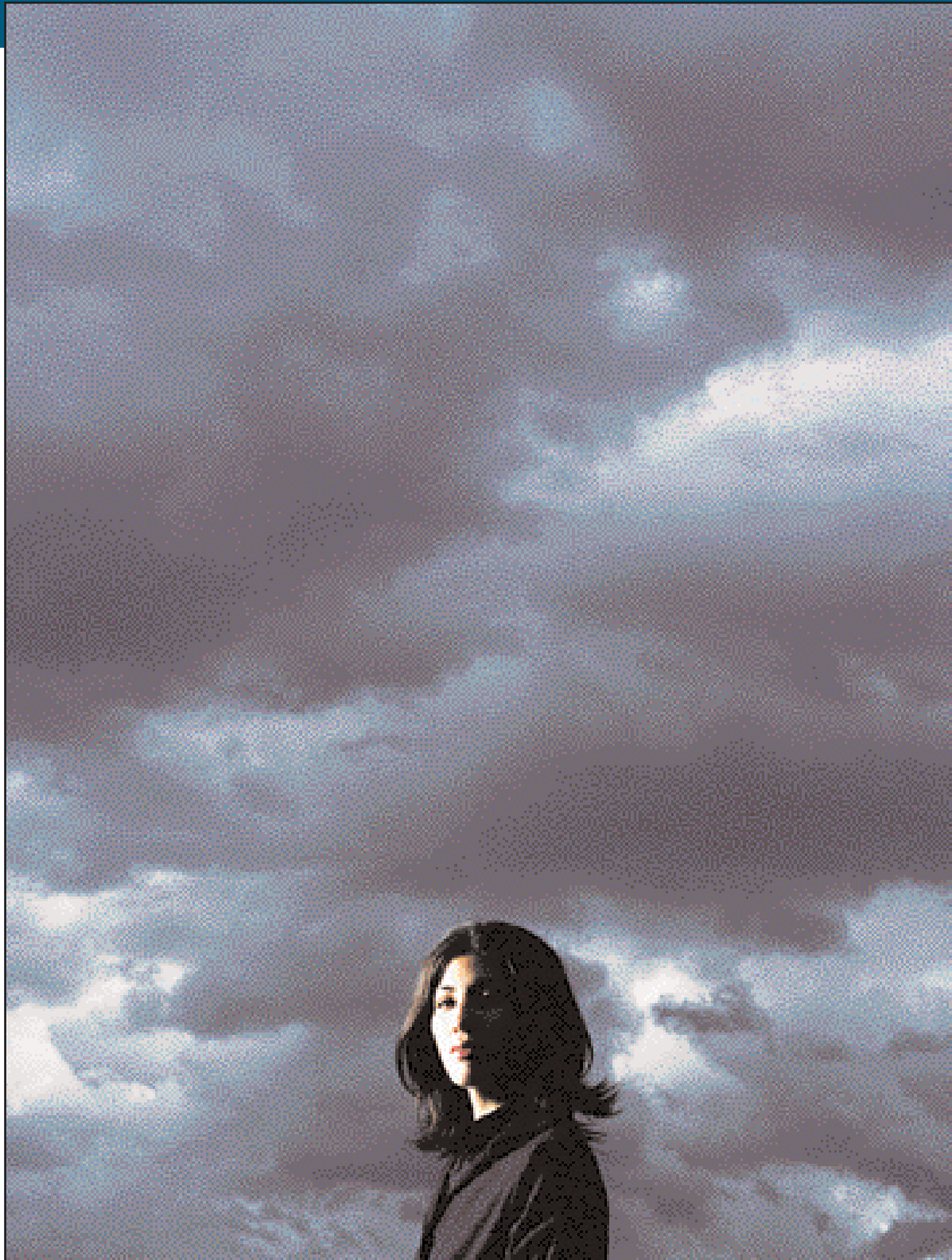


HOW TO TREAT

Inside

- The international and Australian contexts
- Sub-types of clinical depression and their response to therapy
- General management strategies
- Antidepressant medication
- Case study



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The depressions

The international context

DEPRESSION has long been recognised as the most common psychiatric disorder in general practice, but only recently has it attracted attention matching its prevalence and public health impact.

Two important factors have increased attention on depression. First, the introduction and widespread use of SSRIs led many patients to report feeling “better than ever”. Such benefits from a psychotropic drug, and acknowledgment by patients of their depression, was seminal to depression emerging from its own shadows.

Second, a Global Burden of Disease study, auspiced by WHO, Harvard University and the World Bank, established that the depressive disorders were highly disabling.

The study is commonly misinterpreted as indicat-

ing that depression was the fourth most disabling condition in 1990 and would rise to second position by 2020. However, the key projection referred to a composite of both mortality and disability. When disability was separated from mortality, unipolar depression was already the most disabling — and bipolar disorder the sixth most disabling — in 1990. A 2001 WHO replication study has now reported identical disability rankings for these two depression subtypes.

The Australian context

A 1997 study by the Australian Bureau of Statistics found that 5.8% of Australian adults (4.2% of women and 7.4% of men) experienced a clinical depressive episode in the previous year.

Data on the burden of depression and awareness

of the associated suicide rate (particularly in adolescents, rural and marginalised groups) contributed to depression being included in the mental health program in 1999, joining with cancer control, injury prevention and control, cardiovascular health and diabetes mellitus as one of the five National Health Priority Areas.

In 2000 the Commonwealth then developed a national action plan to improve understanding, early intervention, prevention, assessment and treatment.

In October 2000 beyondblue was launched as the public company under which a national depression initiative was to be advanced. In February 2002 the NSW Premier, Bob Carr, allocated funds to establish the Black Dog Institute to support research, educa-

cont'd page 11

from page 1

tion, training and clinical service developments for depressive disorders.

Is depression increasing in Australia?

Increasing attention on depression has raised the question of whether the prevalence of the illness is also increasing. The issue is unresolved but any true increase is likely to be small.

It has been suggested that changes in the age structure of the population have increased the preva-

lence, that younger people are more prepared to acknowledge and remember depression, and that social factors such as material-istic expectations and illicit drug use have led to more depression.

In addition, depression has progressively been defined more broadly and with a lower threshold for diagnosis. When the first antidepressant (imipramine) was developed in the late 1950s, the manufacturers were reluctant to take it to market because they thought there were insufficient depressed people to generate a profit. At the time,

depression was viewed as a condition that often required admission to an institution.

Appreciation of the impact of depression on the onset and outcome of many major medical illnesses is progressing rapidly. For example, clinical depression and the presence of depressive symptoms substantially increase the chance of subsequent cardiac events such as re-infarction or heart failure after an initial cardiovascular event, while post-infarct depression triples the chance of death over the next year.

Classification of depression

CURRENT classification systems for depression are largely based on a "dimensional" concept, in which various aspects of the illness can be described on a scale, for example, from mild to severe.

The North American *DSM* system proposes major and minor expressions of depression, with additional dimensional descriptions of duration, persistence and recurrence.

In effect, major depression is severe and present for more than two weeks, and dysthymia indicates moderate depression present for more than two years.

This is an unhelpful approach, both theoretically and in practice, and is rarely used in other disciplines. For example, if I present to a dermatologist with a brown blotch on my skin, I will not be informed that it is either a major or a minor blotch. I want to know its categorical status (eg, freckle, melanoma) because that will guide rational treatment options.

In general, classification systems view depression as a single entity, varying merely by severity. This is equivalent to our medical ancestors failing to distinguish between components of "the pox" (smallpox and chicken pox) or dropsy, which can have renal or cardiac causes.

The current dimensional model also confuses research findings.

For example, studies on the efficacy of treatments for major depression have generated the largest database in psychiatry and dictate treatment guidelines and algorithms.

However, such studies quantify all antidepressant drugs (old and new classes, differing drugs within each class, St John's wort), psychotherapies (cognitive behaviour therapy, interpersonal psychotherapy), counselling and even bibliotherapy (reading books about depression) as having similar efficacy rates of 55-60%. This is not consistent with our clinical observations.

A diagnosis of major depression in clinical trials fails to distinguish real differences in patients' illnesses, and encourages the conclusion that every treatment is a "winner" and "one size fits all". It also leads to treatments being judged more by their appeal to the practitioner rather than by their utility, leading to the choice being dictated by the practitioner's discipline.

Irrespective of the type of depression, a patient is likely to receive an antidepressant drug from a GP or psychiatrist, psychotherapy from a psychotherapist, CBT from a clinical psychologist, counselling from a counsellor and crystal therapy from a crystal therapist.

This article offers a contrasting model, based largely on research and clinical observation at the mood disorders unit at Sydney's Prince of Wales Hospital (now the Black Dog Institute), and fleshed out in a recent book for patients and health professionals (Parker G. *Dealing with Depression: A Commonsense Guide to the Mood Disorders*. Allen and Unwin, Sydney, 2002).

The model is presented in black and white terms, ignoring some of the grey realities. In brief, we propose that there are distinctive depressive disorders and they respond differently to differing treatments.

Defining depression

The word depression is used widely in everyday language, but it is important to define its meaning in the context of medicine. Distinctions between depressed mood and clinical depression are vital.

Depressed mood

Depressed mood is very common, falling within the range of normal emotions. Four probe questions



In many cases GPs have the advantage of knowing the patient and being able to observe changes from normal, such as preoccupation or the loss of the "light in the eyes"

assist establishing whether a person has a depressed mood:

- Are you depressed?
- Has your self-esteem or sense of self-worth dropped?
- Are you feeling more self-critical than usual?
- Are you getting less pleasure from things?

A drop in self-esteem is the most common component, with the extent of the decline indicating the severity of the mood. Self-esteem tends to be preserved in grief, while fear, insecurity or sensations of "going mad" tend to dominate in anxiety. Overlap between these states and depression is common in practice but identifying (sequentially or on severity grounds) the primary condition may well shape management plans.

Clinical depression

Clinical depression can be distinguished from a depressed mood on the basis of:

- Severity (the features are distinct, and the individual may judge that life is not worth living, lack motivation and be asocial) and the presence of accessory features such as disturbances of appetite, sleep and libido, lack of energy, and poor concentration.
- Disability (eg, preventing or compromising usual role function).
- Persistence (being present for at least two weeks).

Detecting depression in a general practice setting

Many studies have criticised GPs for failing to detect depression. The studies usually asked patients to complete a self-report screening measure and then checked whether the GPs detected "cases" at consultation.

Apart from limitations of the methodology, including an arbitrary definition of "cases" by cut-offs on symptom scores, the studies generally failed to acknowledge the way that patients interpret physical and emotional changes — their attributional style — and the way this influences their presentation to the GP.

People interpret changes such as sleep disturbance or fatigue in different ways, perhaps as a distinct psychological disorder, or a transient stress in response to the vicissitudes of life, or just as incon-

sequential signals. When the attributional style of patients is taken into account, GPs are quite able to detect "true" clinical depression in most instances.

A diagnosis of clinical depression can be made on the basis of the symptoms described earlier. Denial of symptoms is rare. Even people failing to acknowledge their depression, perhaps for cultural reasons or because it is dominated by somatic symptoms such as insomnia and fatigue, usually will admit to central symptoms.

In many cases GPs have the advantage of knowing the patient and being able to observe changes from normal, such as preoccupation or the loss of the "light in the eyes".

Many screening tools have been proposed to assist the detection of depression in general practice.

One tool we have developed for use in the medically ill is shown in the box below.

DMI-10 screening measure for depression

1. Are you stewing over things?
2. Do you feel more vulnerable than usual?
3. Are you being self-critical and hard on yourself?
4. Are you feeling guilty about things in your life?
5. Do you find that nothing seems able to cheer you up?
6. Do you feel as if you have lost your core and essence?
7. Are you feeling depressed?
8. Do you feel less worthwhile?
9. Do you feel hopeless or helpless?
10. Do you feel more distant from other people?

For each item a "very true" response scores 3; "moderately true" = 2; "slightly true" = 1; and "not true at all" = 0.

A cut-off total score of 9 or more indicates a depressed mood. In Australian general practice studies, one in three patients will score above cut-off, with two subsequent questions assessing duration of mood state and any associated impairment clarifying the likelihood of clinical depression.

Sub-types of 'clinical depression' and their response to therapy

WE suggest that when clinical depression has been diagnosed, it can be classified into one of three broad types: psychotic depression, melancholic depression, and non-melancholic depression. For those attending a GP's surgery, the first would be very rare, while melancholic depression would comprise up to 10% of the depressed subjects, so that non-melancholic depression dominates.

Psychotic and melancholic depression have specific features, while non-melancholic depression is a residual group without specific clinical features.

The figure at right shows that all three classes share a mood disorder component which, in general, increases in severity from non-melancholic through the melancholic and psychotic categories.

The latter two are more biological in the sense of having stronger genetic and other biological contributions such as sub-cortical pathology. The non-melancholic disorders usually reflect interaction between a life event stressor and the individual's predisposing personality.

Melancholic and psychotic depression can be distinguished from non-melancholic depression by the presence of psychomotor disturbance. Psychotic depression is defined by the presence of psychotic features such as hallucinations and delusions.

The natural outcome and the response to treatment varies between the three types of depression. The spontaneous remission and placebo response rates for psychotic and melancholic depression are minimal (5-10%) but substantial in non-melancholic depression (40-60%).

In psychotic depression an antidepressant alone achieves a 25% response rate, compared with 33% for an antipsychotic alone and 80% for combination of the two drugs or the use of ECT.

In melancholic depression, antidepressants alone have a response rate of 40-80%, with the rates varying between antidepressant classes. Atypical antipsychotics are being used increasingly as brief augmentors of antidepressant response in melancholic depression.

ECT assists most types of depression but, because of difficulties with acceptability and side effects, it is generally reserved for psychotic and melancholic depression after failed response to antidepressants.

Psychotherapies, including counselling, have similar efficacy to that of antidepressants in non-melancholic depression, but have no clear primary impact on melancholic and psychotic depression.

Diagnosis of clinical depression should also consider the possibility that a patient has bipolar disorder (manic depression), which can occur with or without psychotic features.

The interval between an individual developing the "high" of the manic phase and being diagnosed with bipolar disorder averages about a decade, reflecting the fact that the illness often has subtle expressions and is under-recognised.

Psychotic depression

Delusions are more common than hallucinations in psychotic depression. Delusions may be mood congruent (being plausibly linked with a severely depressed mood, such as feeling so worthless or guilty as to deserve being put to death or jailed) or mood incongruent (eg, believing there are drug dealers under the floor boards, with no conceptual link to a depressed mood).

Mood-congruent delusions can be expressed as disproportionate beliefs, such as an individual presenting to a police station for cheating \$20 on their tax 30 years ago. Hallucinations are most commonly auditory (eg, hearing derogatory statements) but can include distorted tastes and smells.

If not volunteered by the patient (or more commonly by the family), check for the presence of psychotic symptoms if a patient shows distinct psychomotor disturbance, pseudo-dementia features, or has a bipolar history or guilt preoccupations.

Two questions help: "Are you feeling guilty?" (requiring the guilt to be distinct from the "normal guilt" experienced by most depressed people), and "Do you have any sense that you deserve to be punished or are being punished?"

Melancholic depression

In melancholic depression the mood disturbance is generally severe, with the patient commonly reporting

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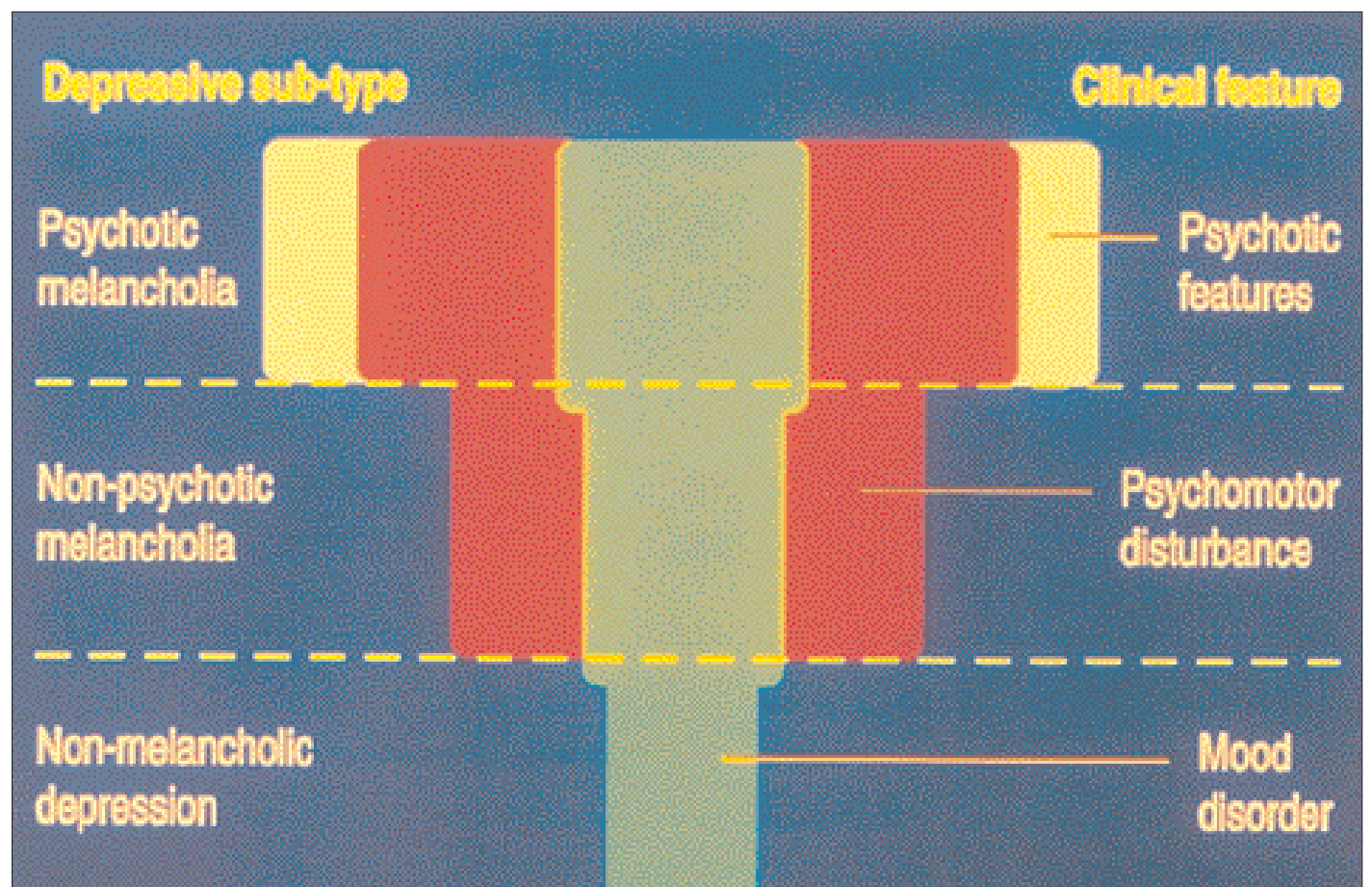


Table 1: Personality-style influences on managing non-melancholic depression

Personality style	Management
<p>Anxious worriers Most common style observed in general practice settings. A key risk for anxiety and early onset and persistent depression. Under stress, such individuals usually go quiet, keep to themselves, cry and "stew". When depressed they are most likely to have anxious depression (a mixture of such symptoms)</p> <p>High-trait anxiety externalisers Patients externalise under stress, becoming more irritable and quick tempered. When presenting with depression they will usually interact pleasantly but describe their irritability ("I'm snapping at my husband/wife/kids")</p>	<p>The two most common styles: essentially an emotional dysregulation temperamental style. SSRIs and some other new antidepressants are "enabling" drugs, effectively modulating and muting worry and irritability and also reducing the chance of future episodes. For patients rejecting an antidepressant, an anxiety management strategy and possibly a psychotherapy, such as CBT or interpersonal psychotherapy, may be of assistance</p>
<p>Avoidant Shy, inhibited and introverted</p>	<p>Patients may receive some benefit from an antidepressant but generally require behavioural intervention</p>
<p>Hostile Low frustration tolerance. Volatile and often impulsive, evidenced generally by failing to maintain relationships and, when depressed, being even more volatile (eg, yelling, breaking things). Alcohol and substance use is particularly common. In "getting the pus out", their depressed states often remit rapidly although others around them may be recipients of the collateral damage</p>	<p>Patients do poorly with most formal treatments (including antidepressants) and generally are non-compliant with most interventions. If motivated, they may obtain benefit from anger management and other behavioural strategies</p>
<p>Perfectionist All work has to be perfect; near enough is never good enough; uncompromising standards; serious and obsessional</p>	<p>Patients are generally pleasant and attentive to advice, but their depression is resistant to most interventions, including antidepressant drugs. As soon as they are minimally improved, they return to worrying about the situation causing their depression. Management tip: Play to their strengths, eg "box" their mingled problems into structured sets and get them to deal with the easiest one first</p>
<p>Ongoing low self-esteem Sometimes called "characterological depression", to capture its early expression and persistence. Self-defeating and ineffective self-concepts. Often recipients of childhood neglect and/or abuse</p>	<p>Response to treatment is generally low or transient. Multiple medications, psychotherapeutic and social interventions are likely to be needed</p>

HOW TO TREAT The depressions

from page III

distinct anhedonia (lack of pleasure) and a non-reactive mood or one that brightens only temporarily or marginally.

Other so-called endogeneity symptoms, such as appetite or weight loss and early-morning waking, have weak specificity to melancholia.

Psychomotor disturbance (a key specific marker in melancholic depression) has several components:

- Cognitive processing difficulties, with slowed thoughts and impaired capacity to work or study.
- A motor disorder (retardation and/or agitation) that should be observable (as most depressed patients will report feeling “slowed down”, irrespective of depressive sub-type).

Retardation may be evident in profound amotivation, such as lying in bed or ignoring bathing. Observationally, retardation is more consistently expressed as a non-reactive mood, reduced and less spontaneous speech, and moving slowly.

Agitation should be distinguished from anxiety, although all agitated patients will also feel anxious. Agitation has both motor aspects (writhing movements of the limbs, stereotypic picking movements, needing to pace up and down) and cognitive elements (eg, being tortured by minor worries blown out of all proportion). It is often associated with a characteristic statement (“What is going to become of me?”) that resists reassurance.

Manic or hypomanic episodes

Open or closed questions should be used to check whether patients have experienced episodes where they:

- Are excessively energised or “wired”.

- Talk a lot more than usual.
- Need less sleep and do not feel tired.
- Spend more money, often inconsequentially.
- Feel unusually self-confident and grandiose.
- Are more impatient and irritable.
- Are more distractible.
- Dress more colourfully.
- Are more verbally or socially indiscreet and impulsive.
- Have increased libido.
- Find natural settings (eg, beaches, parks) more beautiful or colourful.

The mood state should be observable to others and not merely reported, with more than a few such symptoms suggesting a diagnosis of bipolar disorder. (Depressive episodes alone over time indicate unipolar depression.)

Non-melancholic depression

Non-melancholic depression is a residual class with no positive defining features. It is a diagnosis of exclusion, identified by the absence of melancholic or psychotic depression features (ie, no psychotic symptoms or observable psychomotor disturbance, and mood is substantially reactive). The old terminology of reactive/neurotic depression recognised two main elements of non-melancholic depression — contributions of stressful life events and of personality style.

Contribution of stress

Acute stress such as the break-up of a relationship can lead to an acute reactive or adjustment depressive disorder, particularly when the individual’s self-esteem was invested in what is now lost.

Chronic unresolvable stressors (eg, a dysfunctional marriage) may lead an individual to feel that nothing will have any impact on the situation (a type of learned helplessness), and hence to depression.

Because of the high spontaneous remission rate in the acute stress group and because such patients tend to present when improving (reflecting revived motivation), the GP might need to do little more than listen to the patient’s dilemmas, offer common-sense advice, and review in a week. If there is no distinct improvement by then, other strategies, including antidepressant medication, would generally be warranted.

For patients depressed by chronic and/or unresolvable stressors, “social engineering” to redress those stressors is logical but, in practice, solutions are difficult. Use of problem-solving strategies by the GP or a clinical psychologist can assist.

SSRI medication can be very helpful, providing patients with some emotional distance from the distressing events.

Contribution of personality

Personality (or temperament) style is a key factor predisposing to the non-melancholic disorders. Table 1, see page III) describes the most commonly observed styles. The first five have a strong genetic or “hard wiring” component, while the sixth has a strong environmental contribution.

Personality is dimensional, varying in “severity”, and so we seek patterns at best, rather than distinct classes. Assessing and understanding patients’ personality patterns can help to interpret their likely treatment preference, adherence and responsiveness.

General management strategies

THE depressive disorders are a variable group of illnesses and it is not useful to determine treatment solely on the basis of severity or duration. There are several key components to management.

Recognise the need for an initial interview that is both empathic and time consuming

Between 30 and 60 minutes are generally required. The aims of the interview are to:

- Determine why this patient (personality) is depressed (what type) at this time (considering biological factors, including prescribed and illicit drugs and alcohol excess, medical illness and social factors).
- Provide immediate counselling, whether primary or adjunctive.
- Build treatment compliance and address concerns about “loss of control”.
- Ensure the patient’s safety.

Decide on specific and adjunctive treatments

Clinical judgments should heed the individual patient’s preference but may require extensive negotiation, most commonly in regard to antidepressants.

Mental health literacy studies have shown that general-practice patients have a much stronger preference for counselling than for antidepressants, viewing the latter as not particularly effective and as addictive. Thus, a brief interview terminating with a prescription is unlikely to have much impact on a patient’s motivation to comply with therapy.

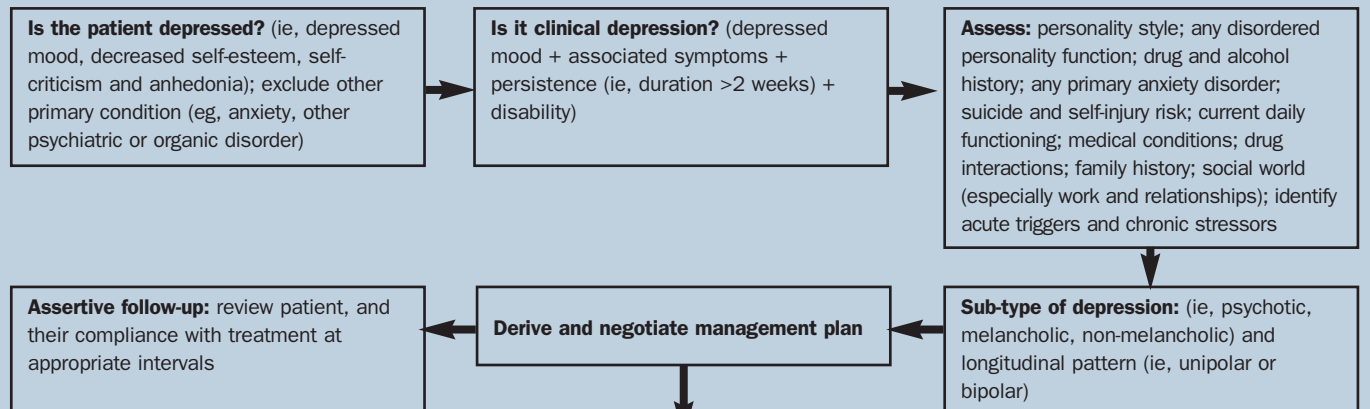
Implement or co-ordinate a set of commonsense components of treatment

These include counselling (eg, identifying depression triggers and determining the extent to which they can be corrected or negotiated), and reducing the risk of impulsiveness and recklessness that may lead to “Russian roulette” strategies, or the tendency for depressed individuals to lower themselves further in the social hierarchy (eg, by inappropriately leaving their job).

Active steps may be required to protect against suicidal acts (eg, removing weapons) and even homicidal acts (eg, in a woman with a puerperal psychosis). If safety cannot be assured, hospitalisation may be required or, alternatively, a protective system in the home requiring a family member or friend to be at close hand.

Because depressed patients are often without hope, the patient and, more importantly, the family need to be reminded (repeatedly) that recovery, not mere improvement, is to be expected.

Algorithm for treating depressive disorders



For physical treatments of depression sub-type, consider these broad, stepped recommendations:

Psychotic:

1. Antidepressant + antipsychotic drug
2. ECT

Melancholic:

1. SSRI or dual-action antidepressant drug
2. Dual-action antidepressant drug if SSRI at Step 1
3. TCA
4. MAOI
5. ECT
6. (Augmentation with atypical antipsychotic [briefly] or with lithium or thyroxine may be appropriate at steps 2-4)

Non-melancholic:

All antidepressants (intra-class, inter-class) have the same chance of being effective, but SSRIs are likely to have the best cost-benefit ratio (in terms of antidepressant effect and side effects) as well as prophylactic effect in those personality styles marked by “emotional dysregulation”

Non-physical treatments (psychotherapy, etc) are best viewed as adjunctive for psychotic and melancholic depression, and potentially primary treatments for non-melancholic depression

Counselling and commonsense advice should be provided to depressed patients (and often their families), irrespective of depressive sub-type

Recognise that if the depressive disorder is to be managed well over a period of years, an assertive management plan is necessary

An individual experiencing a first episode of depression has a 50% chance of recurrence, but the rate rises to 80% and 90% after the second and third episodes, respectively.

For most patients experiencing recurrent clinical depression, an antidepressant is likely to be the most effective maintenance strategy in terms of cost, practitioner’s time and efficacy. However, use of an antidepressant alone is only effective in a small proportion of cases.

Patients feel unsatisfied and disenfranchised if their therapist (GP or psychiatrist) merely prescribes a drug. They do not wish to take antidepressants after their depression has remitted and they need considerable education about depression and its management.

Whether provided through counselling, problem-solving skills, avuncular listening or a psychotherapy, there is an add-on value to such a humanising role.

Kay Jamison, a US psychiatrist who has written extensively about her own bipolar disorder, observed that a drug diminished her depression but adjunctive psychotherapy healed.

Active follow-up (or even pursuit) of depressed patients has been shown to be necessary in any maintenance program.

Simply providing education improves the medium- and long-term course of depression minimally.

Although detection of depression has improved, and many more patients have been prescribed antidepressant drugs, the course of depression has been modified minimally overall because, without assertive follow-up, patients stop their drugs and other maintenance strategies.

Antidepressant medication

IN contrast to general mythology and the efficacy database from clinical trials, not all antidepressants have equal clinical effectiveness. Just as there are narrow-spectrum and broad-spectrum antibiotics, there are also narrow-action and broad-action antidepressant classes, so that there is no best antidepressant.

The SSRIs are primarily narrow-action antidepressants, influencing serotonergic neurotransmission. The dual-action serotonin-noradrenaline reuptake inhibitors venlafaxine, mirtazapine and duloxetine also affect noradrenergic neurotransmission. Tricyclics and monoamine oxidase inhibitors are very-broad-action antidepressants, influencing a range of neurotransmitters.

For psychotic depression, an antipsychotic is required in addition to an antidepressant. There is not yet any information on whether newer antidepressants or the atypical antipsychotics have greater efficacy over their predecessors. Psychotic depression is almost always best handled by referral to a psychiatrist, especially when ECT may be required.

For melancholic depression we have demonstrated an effect of age on the response to antidepressant treatment. The chance of response to an SSRI is similar to that for a tricyclic in patients younger than 40 years, but tricyclics have a fourfold higher success rate over SSRIs in those older than 60.

Psychomotor disturbance becomes more evident with advancing age, suggesting involvement of different neurotransmitter systems and a decreased chance of responding to a narrow-action antidepressant.

Thus, I recommend starting with either an SSRI or a dual-action drug. If an SSRI is chosen and fails, trial a dual-action drug, then, if necessary, a tricyclic. If those approaches fail, referral to a psychiatrist would be indicated.

The psychiatrist might pursue alternate single medications (eg, MAOIs) or primary drug augmentation (with an atypical antipsychotic, lithium or thyroxine).

For non-melancholic depression, if an antidepressant drug is to be chosen then the first choice is probably an SSRI. These agents have similar overall group efficacy but individual patients vary, often responding to one when another has failed, and the individual drugs certainly differ in their side-effect profiles.

The dual-action drugs have comparable efficacy to the SSRIs but, because of their broader-spectrum action, may be more problematic in terms of side effects, and reaching the optimal dose may take longer with an SNRI.

The broad-spectrum tricyclics and MAOIs have no specific advantages over either the SSRIs or SNRIs (although the sedation from tricyclics may assist sleep) and commonly cause distinct side effects.

If two SSRIs, or one SSRI and another "new" antidepressant fail, prescribing another antidepressant is unlikely to be effective for non-melancholic depression. Pursuing non-drug approaches or referral to a psychiatrist is likely to be more helpful.

Herbal therapies

In controlled studies, St John's wort has achieved similar efficacy to SSRIs. S-adenosylmethionine (SAME) also has some support for its efficacy, but in less formalised studies. However, it is likely that such drugs are relevant only in milder, non-melancholic depression.

They are not innocuous, causing some significant side effects alone and in combination with other drugs, including alteration of the pharmacokinetics of many drugs, including conventional antidepressants. Like older antidepressants, they can induce manic states.

Psychotherapies

Psychotherapies, particularly cognitive behaviour therapy and interpersonal psychotherapy, are generally viewed as highly efficacious for depression but are associated with some myths. Unfortunately, like other treatments, they have generally been tested as "universal" interventions, disregarding the type of depression to which they have been applied.

CBT has strong credibility and is highly regarded by many patients and professionals but essentially is not proven for the acute management of a depressive syndrome. CBT is likely to be useful in some subgroups of patients, but numerous attempts to determine predictors of CBT response (eg, personality style) have failed.

Formalised psychotherapies require sophisticated training, high-level skills and practitioners with excellent interpersonal skills.

A common myth is that a combination of a psychotherapy and an antidepressant medication is superior to either alone. However, although adding an antidepressant to a psychotherapy increases the efficacy, adding psychotherapy to antidepressant therapy has only rarely produced extra efficacy in controlled studies.

Exceptions are partial responders to antidepressant medication (a group at high risk of recurrent episodes); when certain psychotherapies provide a distinct augmentation benefit and possibly assist prophylaxis; and for patients who wish to cease an antidepressant after a period of time, when a move to a formal psychotherapy may be particularly useful.

There is likely to be benefit for patients with non-melancholic depression if some form of psychotherapy addresses their predisposing temperament or personality characteristics. Patients lacking a complete remission and having ongoing residual symptoms are highly likely to relapse, arguing for a form of psychotherapy.

Nuances in prescribing antidepressants

Key issues in the use of antidepressants include the time to onset of action, drug interactions, initiation and withdrawal reactions, and the total duration of medication.

A common myth is that antidepressants take weeks to work, which can risk GPs and psychiatrists leaving a patient on ineffective treatment for weeks or months. In reality, if an antidepressant is going to be effective it should be expected to provide some benefit in the first 5-10 days, irrespective of its class. This interval can perhaps be extended by another week for patients with melancholia.

It is important to review a patient in the next two weeks, looking for a return of a "light in the eyes" or greater reactivity, or any symptomatic improvement. If there is no improvement after two weeks, increase the dose of the drug (if relevant), or begin tapering off in order to trial another antidepressant, and/or consider referral.

The pattern of improvement can be important. Rapid response after starting an antidepressant is common and occurs in both true responders and placebo responders (especially for the non-melancholic disorders).

True responders generally maintain their improvement trajectory to full response, while placebo responders slide back, with relapse generally detectable by the second week. A slower but sustained improvement pattern is most common in melancholic subjects.

Non-responders fail to report any improvement other than from secondary drug effects (eg, sleep assisted by a sedating drug), and relapse is to be expected.

I recommend starting most new antidepressants at half the recommended starting dose to reduce the risk of common side effects and rare but distressing agitation states. If the patient has not had any serious side effects I increase to the recommended starting dose by 2-7 days and consider further increases (depending on response) weekly.

It is important to ensure that the antidepressant will not interact adversely with other psychotropic or non-psychotropic drugs. Ask patients directly whether they are taking St John's wort, SAME or other such agents, as these are rarely nominated when patients are asked what drugs they are taking.

In negotiating with a patient to take an antidepressant, discuss discontinuation reactions at the outset. If a patient abruptly stops taking an antidepressant or forgets to take it for a day or more, profoundly distressing symptoms can be experienced. Tapering usually takes days and, for some drugs, months.

How long should an antidepressant be prescribed? Generalisations are difficult. In a non-melancholic disorder I usually suggest a course of 3-6 months. Stopping after that period risks relapse but I usually respect the patient's preference.

Some people with chronic illness often need to "fail" several times before becoming genuinely committed to ongoing treatment. Alternatively, I may suggest a non-drug strategy (eg, anxiety management course, CBT) to increase resilience before stopping medication.

For patients with melancholic depression, I generally recommend a longer period (one year minimum, often foreshadowing continuation over several years), particularly if a patient has experienced a severe and protracted episode.

Prolonged antidepressant treatment is usually required after psychotic depression, although I will

generally try to withdraw the antipsychotic medication after psychotic symptoms have settled, as maintenance therapy can be unduly sedative.

The more assertive recommendations for melancholic and psychotic depression reflect their higher morbidity over time, and the associated higher risk of suicide.

Management expectations and referral

Most patients with depressive disorders prefer to be managed by their GP and not see a psychiatrist, so there is wisdom in GPs knowing how to prescribe antidepressants for non-melancholic depression and for straightforward melancholic depression.

For more complex cases, when a patient has not benefited from two antidepressants (from different classes) or when there is a psychotic depression, referral to a psychiatrist should be considered.

Immediate access to specialist services should be considered in urgent situations, particularly when there are safety concerns, using the local mental health crisis service if needed. It is useful to become acquainted with one or more clinical psychologists and counsellors in the region who "get results", the services provided by the local mental health service (eg, anxiety management programs), and tertiary services for patients with severe and persisting depression.

Our facility, the Black Dog Institute, now provides a telepsychiatry service to those within NSW in such circumstances, while other states have a range of local strategies.

Should GPs practise psychotherapy? Of course, in the sense of offering at least the non-specific ingredients that underpin all psychotherapies, including empathy, support and time, as well as a logical model.

More specific non-drug interventions (eg, counselling, problem solving, anxiety management, psychotherapies) all have ingredients that can be learned and implemented by GPs with considerable utility.

Conclusions

MOST treatment models and practice guidelines for depression are based on limited and simplistic evidence. As Haynes et al recently pointed out in a *BMJ* editorial, "Evidence does not make decisions, people do".

Depression management requires the practitioner to review the patient's state, consider which treatment options are relevant, factor in the research evidence, respect the patient's preferences with each option and then use clinical expertise to bring such considerations to a treatment option.

Despite the complexities of such an approach, it is a superior objective to the prevailing simplistic models for both depression classification and management.

How the Black Dog Institute may help GPs

- Development of non-derivative interview and management guidelines for GPs
- Development of assessment (eg, semi-structured interview) and monitoring tools (antidepressant drug response and mood-monitoring charts) to assist detection and clinical recording of relevant intake and monitoring data
- Staging training and educational programs, particularly ones designed to assist practitioners to obtain access to Medicare incentive payments

We will progressively roll out such material on our web site (currently www.mdu.unsw.edu.au but shortly to become www.blackdoginstitute.asn.au). Our current program — Identifying your Priorities — Better Prescribing for Mental Health — aims to provide GPs with basic information about the different types of depression, as well as other psychiatric disorders commonly seen in general practice. For further information, contact the administrator at the Black Dog Institute on (02) 9382 4523.



GP's contribution



Dr Marcela Cox
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GP's case study

ALISON, 32, is a real estate agent who lives with her husband, Paul, who works in information technology.

They always present as a very well groomed and attractive couple, both of whom have a lot of their self-esteem invested in physical appearance. Both work out at the gym regularly.

Alison presented last year with weight loss (10kg in six months) without dieting, but she had been training frequently at the gym. She had been seeing another GP in the area and had been investigated to exclude organic causes.

On further discussion it became apparent that Alison had features of non-melancholic depression, with lowered mood, irritability, feeling anxious and teary and not coping well with her stressful job. Her BMI was 19.5 and she had no features of an eating disorder.

Alison was treated with supportive counselling and was started on an SSRI and improved rapidly. After only two months' treatment, she became pregnant and stopped the SSRI herself.

Because of her recent depression and her issues with body image and perfectionism, Alison was felt to be at high risk of further depression during the pregnancy and postnatal period. She was therefore also seen by a child and family psychiatrist for personal and couple counselling during this time.

Non-pharmacological therapy was adequate, with her depression continuing to improve and completely resolving by about six months into the pregnancy.

Now six months postnatally, Alison remains well, is not depressed and enjoys motherhood. However, she mentions that Paul has become depressed in the last few months, manifest by increased alcohol use, anger and volatility. He sees his own GP and has been started on an SSRI.

Questions for the author

Given Alison's situation, how likely is she to suffer further depression?

The prognosis is largely dependent on determining factors that caused Alison's initial depression. For example, was there any organic disorder? Was the depression a reflection of her temperament?

Descriptors suggest a pneumatic couple, with Alison having some narcissistic and obsessional traits, and



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it may be that the depression followed failure to have her multiple needs met and a lack of flexibility on her part. How is the marital relationship? Is Alison investing too much in the baby, and excluding her husband? Without knowing the predisposing and precipitating factors, the prognosis remains speculative.

What risk does Alison's and Paul's baby daughter have of developing depression in later life?

Assuming that both Alison and Paul have a non-melancholic depressive disorder, then there is no necessary direct hereditary risk of depression in the daughter. However, if either of the parents carry a personality style predisposing to depression (particularly "anxious worrying") then that temperament may well be inherited and increase the risk of subsequent depression.

If one parent had melancholic depression, the daughter's chance is 10%; if both had a melancholic

depression, the daughter's chance is 40%.

Alison chose to stop her medication when she discovered she was pregnant. Please comment on the best choice of antidepressant in pregnancy.

No antidepressant medication has been established as safe during pregnancy, largely because extraordinarily large databases are required to exclude the possibility, and current absence of proof does not allow us to say that there is proof of absence of any risk. Given that reality and that attempts should be made to manage the pregnancy without antidepressants, there are times when this course cannot be sustained.

If required to choose, the SSRIs are seemingly the safest antidepressant (and again a half-dose may be sufficient). If the patient has a melancholic depression that is not responding to an SSRI, then a tricyclic antidepressant is probably the next choice.

More questions for the author

Given the widely variable response to drug therapy in non-melancholic depression, to what extent would you suggest increasing the dose of a medication before trialling another?

Most responders to an antidepressant drug (whether true responders or placebo responders) will tend to show some improvement irrespective of dose in the first week (although placebo responders will fall back fairly quickly). Thus, increasing the antidepressant drug dose does not generally create a categorical change (ie, non-responder to responder) but is more likely to be associated with either greater improvement or greater rapidity of improvement.

Are tricyclic antidepressants more effective than SSRIs in elderly patients with non-melancholic depression, as they are in the melancholic subtype?

No, and, as the risks of TCAs in elderly patients are considerably higher than for the SSRIs, there is little to argue for their use in elderly patients with non-melancholic depression.

With the greater community awareness of depression and treatment for it, some patients now seem to have a lower tolerance to feeling "sad", even when this would be considered normal, such as following a recent bereavement. What do you see as the role of antidepressant medications in such situations?

It would be hard to argue a case for prescribing an antidepressant for individuals merely feeling sad and experiencing normal grief. When grief is severe and/or protracted, and in such instances it is usually associated with a depressed mood, then a case for a trial could be made – but not at the expense of having first tried some form of counselling. Importantly, when the SSRIs are prescribed at the right dose, they do not interfere with normal emotions, including sadness and grief, and this argues against their general use in such circumstances.

GPs are often warned about the considerable side effects and risks of discontinuing antidepressant medication too rapidly. However, many patients do stop medication themselves without obvious side effects, and SSRIs are now used intermittently for symptoms of premenstrual syndrome. How is it that this does not cause problems?

SSRIs can again be used intermittently for PMS symptoms without high risk of discontinuation symptoms, but the chance can be further reduced if the dose is halved for the short-acting SSRIs (eg, 50mg Zoloft, 10mg Cipramil). For slow-release SSRIs such as fluoxetine, discontinuation syndromes are quite rare.

Some patients feel so good on SSRIs that once their depression has cleared they are reluctant to

stop medication. Some even express the desire to stay on medication "forever", despite the initial severity of their depression not warranting this. Is there any significant harm in continuing these drugs long term and how should the GP approach this situation?

I have long been impressed by the SSRIs in terms of their "anti-worry" properties, which are as impressive as their antidepressant ones. By normalising the level of worry in many individuals, they enhance quality of life while also preventing new episodes.

It is important to recognise that they can sometimes over-correct the level of worry, turning some anxious worriers into "average Australians" (ie, "no worries"). Thus, the house-proud housewife may leave the dishes in the sink for a week or the concert pianist may cut his practice hours from 12 hours a day to 30 minutes. Thus, there is often a need to tweak the dose of an SSRI to ensure that the patient is not "blah'd out".

In general terms, there is no long-term harm. However, particular side effects may appear (hyponatraemia), and their safety (as for other antidepressants) during pregnancy remains to be clarified. Because the SSRIs have been in use for almost 20 years without substantive long-term concerns, and because of their propensity to modulate worry and assist with anxiety and depression, they have presented a major advance.