

**VALUEOPTIONS TREATMENT GUIDELINE FOR THE DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSIVE DISORDERS**

*Adopted, augmented and summarized from the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder(2<sup>nd</sup> Ed)*

ValueOptions has adopted and recommends the use of the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder. The APA published the Second Edition of this guideline in 2000. The APA also publishes A Quick Reference Guide for Treating Major Depressive Disorder which is based on the longer, more comprehensive Practice Guideline. Both documents can be found on the APA's website at: [http://www.psych.org/psych\\_pract/treatg/pg/prac\\_guide.cfm](http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm)

It should be reiterated from these publications that the guidelines should not be construed as standards of medical care. Nor should it be expected that adherence to the guidelines will automatically ensure successful treatment outcomes. Rather, the documents should be seen as representing parameters of practice supported by both professional consensus and evidence basis. The clinician needs to be the final judge of whether a particular procedure or treatment plan should be used for his or her patient based on the clinical presentation of the patient and the totality of treatment and diagnostic options available. Furthermore, ValueOptions advises that the guidelines be considered and rendered within the context of the patient's cultural, ethnic, and spiritual values in order to maximize the accuracy of the diagnosis, the effectiveness of the treatment, and the best possible outcomes for the patient and the family.

ValueOptions has prepared the following general summary of some, but not all, of the major points from the APA Major Depression Guideline for reference and use by our providers. ValueOptions has also incorporated by reference other research conducted on various topics contained within the APA Guideline. ValueOptions refers readers of this guideline to the APA documents for a more comprehensive and thorough consideration of the diagnostic and treatment issues summarized herein.

Periodically, ValueOptions reviews treatment records of providers in order to monitor adherence to treatment guidelines. It is recommended that providers reflect their application of this guideline in their patients' record documentation.

This treatment guideline covers the Major Depressive Disorder diagnoses found in DSM-IV-TR: 296.20 – 296.36

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### Additional References

- (1) American Psychiatric Association's Practice Guideline: Psychiatric Evaluation of Adults
- (2) American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition, Text Revision, esp. pp. 349-356
- (3) American Psychiatric Association's Practice Guideline: Suicidal Behaviors
- (4) Cognitive Therapy of Depression. Beck, Aaron T., Rush, A. John, Shaw, Brian F., and Emery, Gary. Guilford Press, 1979.
- (5) Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide. Hawton, Keith, Salkovskis, Paul M., Kirk, Joan and Clark, David M. Oxford, 1998.
- (6) *Relapse in Depression: Risks and Rates*. Harvard Mental Health Newsletter, March 1992.
- (7) *Recovery From Depression*. Harvard Mental Health Newsletter, June 1993.
- (8) Johnson-Powell, G. & Yamoamoto, J. (Eds) (1997) Transcultural Child Development: Psychological Assessment and Treatment. New York, NY: John Wiley & Sons, Inc. Comprehensive update of the 1983 classic The Psychosocial Development of Minority Group Children

**A. Psychiatric Management** - (a broad array of provider activities and interventions for all patients with major depressive disorder)

1. Perform a diagnostic evaluation <sup>(1), (2)</sup>
  - Consider both psychiatric and general medical co-morbidity
  - Common co-morbid conditions: alcohol/substance abuse/dependence; panic or other anxiety d/o; OCD; pseudo-dementia; personality disorders
2. Evaluate the safety of the patient and others. Assessment of suicide risk <sup>(3)</sup>primary:
  - Suicidal ideation, intent, or plans
  - Access to means and lethality of means
  - Psychotic symptoms, command hallucinations, severe anxiety
  - Alcohol or substance abuse
  - History and seriousness of prior attempts
  - Family history of or recent exposure to suicide
3. Evaluate and address functional impairments
4. Determine the treatment setting. Consider hospitalization if patient:
  - Poses serious threat of harm to self or others
  - Is severely ill and lacks adequate social supports
  - Has certain co-morbid psychiatric or medical conditions
  - Has not adequately responded to outpatient treatment
5. Establish and maintain a therapeutic alliance
6. Monitor psychiatric status and safety
  - Monitor patient for changes in destructive impulses
  - Monitor changes in symptoms of depression and co-morbid conditions
  - Consider diagnostic re-evaluation if significant change in symptoms
7. Provide education to the patient and, when appropriate, to family
8. Enhance treatment adherence, especially emphasizing:
  - Concerns regarding adherence, and the importance of adherence for successful tx
  - How to take medications and possible side effects
  - The typical 2-4 week lag for beneficial effects to be noticed
  - The need to continue meds even after feeling better and to consult with MD before discontinuing
9. Address early signs of relapse
  - Inform patient and family about significant risk of relapse
  - Educate patient/family re: how to identify early signs/symptoms of new episodes

**B. Acute Phase Treatment** (focus is on target symptom reduction, choice of initial treatment modality, and preliminary education about the illness and its treatment)

1. Pharmacotherapy Alone
  - a. Mild symptoms: antidepressants (if preferred by patient)
  - b. Moderate-severe symptoms: antidepressants treatment of choice (unless ECT)
  - c. Psychotic features: antidepressants plus antipsychotics or ECT
  - d. NOTE: there is comparable efficacy between and within classes of medications; reference complete APA guideline for specific considerations and dosages
  - e. Initial selection based on
    - Anticipated side effects and tolerability by individual patient
    - Patient preference and history of previous usage and prior response
    - Cost
    - Presence of comorbid psychiatric or general medical conditions
2. Psychotherapy Alone
  - a. If severity of episode is mild to moderate and if preferred by patient
  - b. Cognitive behavior therapy<sup>(4),(5)</sup> and interpersonal therapy have best levels of evidence.
  - c. Psychodynamic therapy, oriented toward both symptoms and broader, long-term goals, is supported by broad clinical consensus
3. Combined Pharmacotherapy and Psychotherapy – consider if:
  - a. Mild to severe symptoms with clinically significant psychosocial issues, interpersonal problems, or comorbid personality disorder
  - b. History of partial response to only one modality
  - c. Poor adherence to treatments
4. Electroconvulsive Therapy - consider if
  - a. Episode includes high degree of symptom severity and functional impairment; psychotic symptoms or catatonia; urgent need for response
  - b. May be preferred treatment when presence of comorbid medical conditions precludes medications or prior history of positive response to ECT
5. Monitor response to initial treatment
  - a. If no response and clinical severity warrants, consider increased dosage of medication or increased intensity of psychotherapy; or trial of ECT
  - b. If partial or positive response, continue for 4-8 weeks
6. Re-assess adequacy of response after 4-8 weeks of acute treatment phase
  - a. Full response: go to Continuation Phase
  - b. Partial Response: consider changing dosage, augmenting or changing antidepressant, adding or changing type/intensity of psychotherapy, or trial of ECT
  - c. No response: consider adding or changing antidepressant, adding psychotherapy, or trial of ECT,

**C. Continuation Phase:** 16-20 week period after sustained & complete remission

- To prevent relapse,<sup>(6)</sup> continue medication at the same dose
- Continue or consider addition of psychotherapy

**D. Maintenance Phase** - Considerations for use of maintenance treatment:<sup>(7)</sup>

- Risk of recurrence: consider number of prior episodes; presence of comorbid conditions; residual symptoms between episodes
- Severity of episodes: consider suicidality, psychotic features; severe functional impairments
- Side effects experienced with continuous treatment
- Patient preferences

**E. Discontinuation of Active Treatment**

- Consider same factors addressed in the decision to initiate maintenance treatment, plus presence of an additional, non-affective psychiatric diagnosis, or presence of a chronic general medical condition
- To discontinue pharmacotherapy, taper the dose over at least several weeks
- Establish a plan to restart treatment in case of relapse

**F. Special Considerations****1. Major Psychosocial Stressors**

- An MDD episode that follows a serious adverse life event is no less likely than other depressive episodes to either require or benefit from antidepressant medication treatment.

**2. Bereavement**

- Commonly accompanied by the signs and symptoms of MDD
- Individuals with more prolonged MDD manifestations tend to be younger and to have a history of prior episodes.
- Antidepressant medications or psychotherapy should be used when the reaction to a loss is particularly prolonged and psychopathology and/or functional impairments persist.

**3. Cultural Factors<sup>(8)</sup>**

- Cultural variables may impact the accurate assessment of MDD.
- The expression of MDD symptoms may vary among cultures, especially the tendency to manifest somatic and psychomotor symptoms.
- Ethnic groups may differ in their responses to antidepressant medications.

**4. Children and Adolescents**

- The clinical presentation of depression can differ significantly from that of adults.
- Younger children may exhibit behavioral problems such as social withdrawal, aggressive behavior, apathy, sleep disruption, and weight loss.
- Adolescents may present with somatic complaints, self-esteem problems, rebelliousness, poor school performance, or a pattern of risky or aggressive behavior.
- Medications effective in adults have not always been found to be effective in children; and medications safe with adults have raised some serious safety concerns in children.

**5. The Elderly**

- Typically display more vegetative signs and cognitive disturbance; complain less of subjective dysphoria.
- MDD may be misattributed to physical illness, dementia, the aging process itself.
- MDD and general medical illness frequently coexist in this age group.
- Some medications commonly prescribed for the elderly (e.g., beta-blockers) are thought to be risk factors for the development of MDD.
- Enhance medication adherence by simplifying medication regimen and minimizing cost

**6. Pregnancy**

- Counsel women of childbearing age as to the risks of becoming pregnant while taking psychotropic medications.
- Consider antidepressant medications for pregnant women who have MDD, for those in remission, for those at high risk for a recurrence.
- Risks of untreated MDD in pregnancy: low birth weight, suicidality, potential for long-term hospitalization, marital discord, inability to engage in appropriate obstetrical care, difficulty caring for other children.

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