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Evidence-based practice guideline for the treatment of adult patients with depressive disorders. Part I: Psychiatric management

Oparte na dowodach wytyczne leczenia dorosłych pacjentów z zaburzeniami depresyjnymi. Część I: postępowanie psychiatryczne

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Abstract

The high prevalence of depression globally and the severe burden of this life-threatening mental illness necessitate an evidence-based approach to its treatment, in order to offer best-possible relief to those suffering from it. The present best-practice guideline was originally developed by a team of psychiatrists, psychologists, and other mental health professionals at a large psychiatric teaching hospital and outpatient clinic network in Michigan, USA. The document draws from several current major guidelines for the treatment of adult patients with depressive disorders published by national and international health organisations, such as the American Psychiatric Association (USA), Canadian Network for Mood and Anxiety Treatments (Canada), National Institute for Health and Care Excellence (UK) and World Health Organization (EU). The present document emphasizes the areas of broad consensus across these guidelines and, as such, the treatment recommendations contained herein represent the current "gold standard" in the field of psychiatry in the West. Part I of this two-part series covers a range of relevant psychiatric treatment aspects, from general patient management to treatment-stage-specific and population-specific recommendations. Special attention is given to pharmacotherapy, somatic therapies, treatment strategies for non-response and management of perinatal depression. Additional resources, including clinician- and patient-oriented websites and links to the full-text major published guidelines, where available, are provided. Psychiatric clinicians are encouraged to utilise the evidence-based practice recommendations for best-possible patient outcomes.

Keywords: guideline, depression, evaluation, treatment, pharmacotherapy

Streszczenie

Ze względu na wysoką zapadalność na depresję na całym świecie i ogromny ciężar tej zagrażającej życiu choroby psychicznej w jej leczeniu konieczne jest postępowanie oparte na dowodach (*evidence-based approach*), oferujące chorym możliwie największą poprawę samopoczucia. Niniejsze wytyczne w zakresie najlepszych praktyk stosowanych w leczeniu depresji zostały opracowane przez zespół psychiatrów, psychologów i innych specjalistów zajmujących się zdrowiem psychicznym w dużym psychiatrycznym szpitalu klinicznym oraz w sieci poradni zdrowia psychicznego w stanie Michigan w Stanach Zjednoczonych. Dokument ten bazuje na aktualnych zaleceniach dotyczących leczenia dorosłych pacjentów z zaburzeniami depresyjnymi wydanych przez uznane krajowe i międzynarodowe instytucje zdrowotne, takie jak Amerykańskie Towarzystwo Psychiatryczne (American Psychiatric Association) (USA), Kanadyjska Sieć Leczenia Zaburzeń Nastroju i Lękowych (Canadian Network for Mood and Anxiety Treatments) (Kanada), Narodowy Instytut Zdrowia i Doskonałości Klinicznej (National Institute for Health and Care Excellence) (UK) oraz Światowa Organizacja Zdrowia (World Health Organization) (UE). Niniejsza praca kładzie nacisk na obszary, w których wytyczne wyżej wymienionych instytucji pokrywają się ze sobą. Tym samym zawarte w niej zalecenia odzwierciedlają przyjęte obecnie złote standardy w dziedzinie psychiatrii w krajach zachodnich. Część I dwuczęściowej serii artykułów dotyczy całego szeregu aspektów leczenia psychiatrycznego, począwszy od postępowania ogólnego, poprzez leczenie specyficzne dla danej fazy choroby, a skończywszy na zaleceniach dotyczących konkretnych grup pacjentów. Specjalną uwagę poświęcono farmakoterapii, terapiom

somatycznym, strategiom stosowanym w przypadku braku odpowiedzi na leczenie oraz leczeniu depresji okołoporodowej. W pracy – tam, gdzie było to możliwe – podano również linki do dodatkowych zasobów zewnętrznych, takich jak strony internetowe dla pacjentów i klinicystów, oraz linki do pełnych tekstów wytycznych wydanych przez wspomniane instytucje. Klinicystów zachęca się do postępowania zgodnego z zaleceniami opartymi na dowodach w celu osiągania optymalnych wyników leczenia pacjentów z zaburzeniami depresyjnymi.

Słowa kluczowe: wytyczne, depresja, ocena, leczenie, farmakoterapia

INTRODUCTION

Depression is by far the most common, costly, and life-threatening mental illness. According to the most recent World Health Organization data, the total number of people living with depression in the world is 322 million or 4.4% of the global population (World Health Organization, 2017). Fewer than 50% of those who suffer receive diagnosis or care, and only 10–25% receive evidence-based care. In light of a recent expansion of treatment options for patients with depression, mental health providers are presented with a challenge: to offer up-to-date, consistent, evidence-based care to every patient in the communities they serve. This evidence-based practice guideline was originally developed by a multidisciplinary work group comprised of psychiatrists, psychologists, social workers, and professional counsellors affiliated with a psychiatric teaching hospital and network of outpatient clinics – Pine Rest Christian Mental Health Services – located in the state of Michigan, USA. The document draws from recently published major best practice guidelines for the treatment of depression: American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 3rd Edition (American Psychiatric Association, 2010), Canadian Network for Mood and Anxiety Treatments' (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder (Lam et al., 2016a), the National Institute for Health and Care Excellence's (NICE) Clinical Guideline [CG90] Depression in Adults: Recognition and Management (National Institute for Health and Care Excellence, 2009), and the World Health Organization's (Europe) report What are the most effective diagnostic and therapeutic strategies for the management of depression in specialist care? (Möller and Henkel, 2005). In addition, Part II of this guideline is adapted from the American Psychological Association's Report of the 2005 Presidential Task Force on Evidence-Based Practice (American Psychological Association, 2005). The authors of this article are indebted to the authors of the aforementioned documents and encourage the reader to consult the full-text versions of these documents for more detailed recommendations. Where freely available on the internet, links to such full-text versions have been included in the References section. The present English-language version of this two-part guideline is published in parallel with a Ukrainian-language version appearing in the official peer-reviewed journal of the Ukrainian Psychiatric Association (Voytenko et al., 2018b; 2018a).

It should be noted that the majority of the sources referenced in this document focus specifically on treating major depressive disorder (MDD) rather than persistent depressive disorder (dysthymia) or subclinical depression. Also, the recommendations provided in this guideline address treatment, rather than prevention, of depression, and focus on the adult population. The unique aspects of treating child and adolescent patients with depression are not addressed here. It should also be noted that the current document is based on the published guidelines developed in specific Western contexts (e.g., the United States of America, the United Kingdom, etc.); as such, some of the recommendations contained herein may not be directly applicable to the reader's cultural context. Finally, this document is not meant to be a comprehensive treatment manual; each clinician should exercise clinical judgment in the treatment he or she provides, based on the characteristics and needs of the specific patient and locally-available treatment options.

PATIENT MANAGEMENT

Completing a comprehensive evaluation

The clinician should establish a specific depressive disorder diagnosis, identify other psychiatric conditions or general medical conditions that may require further assessment and develop a collaborative, comprehensive treatment plan (American Psychiatric Association, 2010).

A thorough evaluation includes: understanding relevant predisposing, precipitating, and perpetuating factors; identifying impediments to treatment; assessing substance use and suicide potential; assessing scope of the patient's support system (National Institute for Health and Care Excellence, 2009) and obtaining collateral information. Because depressive symptoms may be triggered or exacerbated by use of illicit drugs and other substances, a thorough substance abuse history should be gathered (American Psychiatric Association, 2010). A concerted effort should be made over the first several visits to establish a precise diagnosis, recognizing that appropriate diagnosis can lead to the most targeted and effective treatment.

Assessing patient safety

Include risk assessment for potential harm to self using a validated self-rated or clinician-administered risk assessment questionnaire, such as the Columbia-Suicide Severity

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Rating Scale (C-SSRS) (Posner et al., 2008). Risk assessment should be conducted before starting treatment and during treatment (Lam et al., 2016b). As part of the risk assessment, evaluate the often-neglected factors of patient's level of self care, hydration and nutrition, because these can be compromised by severe depressive symptoms (American Psychiatric Association, 2010). In addition to assessing the potential for self harm, evaluate the patient's potential for harm to others; inquire about any history of violence, homicidal ideation/intent/plan and access to means. "Duty to warn" (i.e. to inform the local authorities and the potential victim of violence) may apply where there is a real threat to an identifiable person(s). Finally, it is important to assess the extent to which the patient's depression is affecting the patient's ability to care for dependents (American Psychiatric Association, 2010).

Top risk factors: extreme anxiety, agitation or panic, global insomnia, anhedonia, hopelessness or helplessness, impulsivity, active substance use, previous suicide attempts, and family history of suicide. Identified risk groups: Caucasian men 20–30 or over 50 years of age, women 40–60 years of age, older adults, individuals with no religious affiliation or unmarried family status, transgender and gender-non-conforming individuals (Culpepper, 2010; Haas et al., 2014). In addition, access to lethal means (e.g., firearms, stockpiles of prescription medications, etc.) significantly increases risk of suicide; the clinician should take every reasonable step to limit the patient's access to such means (e.g., requesting that the patient or family remove firearms from the home, dispose of excess medications, etc.).

Development of a collaborative, comprehensive Safety Plan is essential for patients at "moderate" to "severe" risk, up to and including inpatient hospitalisation. "No-suicide contracts" have been shown to be highly unreliable and should not be used.

Determining appropriate setting for treatment

The optimal level of treatment should be based on symptom severity, patient safety concerns, least restrictive setting, and setting most likely to improve the patient's condition (American Psychiatric Association, 2010). The optimal level of care should be re-evaluated on an ongoing basis throughout the course of treatment (American Psychiatric Association, 2010).

Integrating outcome measurements

In order to systematically assess the type, frequency and severity of depressive symptoms as well as the response to treatment including the side effects and therapeutic benefits (National Institute for Health and Care Excellence, 2009) integrate clinician and/or patient administered rating scale measurements into all treatment phases (American Psychiatric Association, 2010). Some suggested standardised, validated measurements include Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001), Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960) and others.

Enhancing treatment adherence

Evaluate adherence to recommended treatment and presence of side effects throughout the course of treatment. Assess and acknowledge potential barriers to treatment adherence (e.g., side effects of medications, lack of motivation or hopelessness due to depression, breach/rupture in the therapeutic alliance, financial, logistical, or cultural barriers to treatment) and collaborate with the patient (and if possible, the patient's family or other social supports) to minimise the impact of these potential barriers (American Psychiatric Association, 2010). Giving the patient an opportunity to verbalise any hesitations or concerns about treatment or side effects may help improve treatment adherence (American Psychiatric Association, 2010). Use psychoeducation to help the patient form realistic expectations for each stage of treatment and emphasise the importance of compliance with treatment for its ultimate outcome.

Additional recommendations

Throughout all phases of treatment it is important to maintain a strong therapeutic alliance, provide psychoeducation and support, and coordinate care with other care providers and family members, where appropriate (American Psychiatric Association, 2010). As part of treatment, consider improving the patient's social supports, sleep hygiene (National Institute for Health and Care Excellence, 2009) and other mood-enhancing self-care (e.g., regular exercise, appropriate nutrition, meaningful/purposeful activity), and discourage use of tobacco, alcohol and other deleterious substances (American Psychiatric Association, 2010). Printed patient-oriented materials and trusted websites (such as depressiontoolkit.org, available in English only) on depression and the patient's role in treatment can serve as a helpful addition to the face-to-face education provided by the clinician (American Psychiatric Association, 2010).

TREATMENT STAGE-SPECIFIC RECOMMENDATIONS

Acute stage

Selecting an initial treatment modality

Treatment should aim for complete remission (a score within the normal range on an identified outcome measure such as the HAM-D, PHQ-9, etc.) of the current depressive episode and a full return to the baseline level of functioning, as this reduces the risk of relapse (American Psychiatric

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Association, 2010). The initial choice of treatment modality will depend on the severity of the patient's depressive symptoms, as well as presence of comorbid disorders and patient treatment history and preferences (American Psychiatric Association, 2010).

Subclinical or mild depression. Recommend depression-focused psychotherapy and physical exercise. Medication as a first-line treatment modality should only be considered for patients with past history of MDD, failed psychotherapy trials, or in cases where the depressive symptoms have lasted for more than 2 years (National Institute for Health and Care Excellence, 2009).

Moderate depression. The optimal initial treatment strategy is a combination of antidepressant pharmacotherapy and psychotherapy (American Psychiatric Association, 2010; National Institute for Health and Care Excellence, 2009).

Severe depression. Consider whether inpatient or partial hospitalisation is needed. Best outcomes are achieved with a combination of pharmacotherapy and psychotherapy and/or neuromodulation procedures (American Psychiatric Association, 2010; Möller and Henkel, 2005; National Institute for Health and Care Excellence, 2009). It is essential to develop a crisis plan and to coordinate care with other providers (National Institute for Health and Care Excellence, 2009).

Psychotherapy

Cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) are the most-studied and therefore preferred modes of psychotherapy for acute mild to moderate depression (American Psychiatric Association, 2010; Möller and Henkel, 2005; Parikh et al., 2016). Other empirically-supported psychotherapies for depression include psychodynamic therapy, problem-solving therapy and acceptance and commitment therapy in individual and group formats (American Psychiatric Association, 2010). An initial course of psychotherapy should encompass 16–20 sessions over 3–6 months and include systematic monitoring of symptoms to assess for safety and response to treatment (Parikh et al., 2016). Determination of the mode of therapy will also depend on past treatment response, patient preferences and clinician availability. For a more detailed discussion of psychotherapy for the treatment disorders, see Part II of this guideline.

Pharmacotherapy

For most patients, selective serotonin-reuptake inhibitor (SSRIs), serotonin–norepinephrine reuptake inhibitors (SNRIs), mirtazapine, and bupropion are the optimal first-line monotherapy agents (American Psychiatric Association, 2010). A generic SSRI is typically a preferred option for patients with no previous history of antidepressant treatment, or those who responded well to an SSRI in the past (National Institute for Health and Care Excellence, 2009). A meta-analysis published in 2009 that included 117 antidepressant trials and second-generation antidepressants found the most efficacious to be mirtazapine, escitalopram, venlafaxine, and sertraline with escitalopram and sertraline, showing the best profile of patient acceptability (Cipriani et al., 2009). Tricyclic antidepressants (TCAs) are generally comparable in effectiveness to the antidepressants mentioned above, but have a broader, more pronounced side effect profile including risk of cardiac arrhythmia and death in overdose (National Institute for Health and Care Excellence, 2009). Use of monoamine oxidase inhibitors (MAOIs) imposes special tyramine-free dietary restrictions and therefore should be reserved for cases where other less restrictive treatments have proven ineffective (American Psychiatric Association, 2010; Möller and Henkel, 2005; National Institute for Health and Care Excellence, 2009). Detailed medication algorithms are available, including the widely-used Texas Medication Algorithm Project (TMAP) (Suehs et al., 2008). Look for at least a 20% reduction in symptoms within the first 4 weeks; maximum symptom reduction at a given dose will be observed within 6–8 weeks. It is important to monitor for treatment-emergent suicidality while on antidepressant therapy until at least the age of 25. In cases where psychotic features are present, an antidepressant treatment should be augmented with an antipsychotic agent or electroconvulsive therapy (ECT) (National Institute for Health and Care Excellence, 2009).

Other therapies

ECT is a safe and effective therapy (60–80% remission rate) for patients with severe MDD that is not responsive to psychotherapy or pharmacotherapy (American Psychiatric Association, 2010; Milev et al., 2016; Möller and Henkel, 2005; National Institute for Health and Care Excellence, 2009). It is also considered to be a first-line therapy for patients with MDD in the following situations: 1) psychotic or catatonic features are present, 2) urgent response is needed due to life-threatening factors (e.g., extreme suicidality, prolonged refusal of food or fluids), and 3) the patient has a strong preference for ECT or an established history of response (American Psychiatric Association, 2010; Milev et al., 2016; National Institute for Health and Care Excellence, 2009). ECT can be used safely for pregnant patients until the third trimester.

Bright light therapy may be used to treat MDD with seasonal onset, aka seasonal affective disorder (SAD) as well as non-seasonal depression (American Psychiatric Association, 2010). For specific recommendations related to optimum dosing, treatment time of day and other factors, see Terman's *Light therapy for seasonal and nonseasonal depression: efficacy, protocol, safety, and side effects* (Terman and Terman, 2005).

Repetitive transcranial magnetic stimulation (rTMS) is Food and Drug Administration-approved for treatment of select patients with MDD. Current major published guidelines diverge in their recommendations regarding rTMS, from "insufficient evidence for use in initial treatment

of MDD," (American Psychiatric Association, 2010) or "use in a research setting only" (National Institute for Health and Care Excellence, 2009) to "a first-line recommendation for patients with MDD who have failed at least 1 antidepressant" (Milev et al., 2016).

Strategies for non-response

If a patient is not responding to treatment, prior to augmenting or changing treatment, consider the following: misdiagnosis, undiagnosed and/or untreated comorbidities, reassessment of underlying medical conditions, dose and length of medication trial, adherence to treatment and side effects, presence of adverse life events, personality/identity issues and cultural/ethnic factors, inadequate fit with or skill set of the therapist (American Psychiatric Association, 2010).

For patients treated with psychotherapy alone, consider increasing the intensity of treatment or changing the type of therapy (American Psychiatric Association, 2010). If sufficient response is still not achieved, consider introducing pharmacotherapy in addition to or in lieu of psychotherapy. A concurrent treatment with medication and psychotherapy may prove especially beneficial for patients who have shown incomplete response to pharmacotherapy or talk therapy alone or have a history of treatment non-compliance (American Psychiatric Association, 2010; Parikh et al., 2016).

From the standpoint of psychopharmacological treatment, the general strategy is as follows: in case of partial response, increase dose or augment treatment; in case of no response but tolerable side effects, increase the dose; in case of no response at maximal doses or intolerable side effects, switch to a different medication (American Psychiatric Association, 2010; Kennedy et al., 2016). More specifically, for patients who have not responded to a trial of an SSRI, a switch to another antidepressant (within-class or out-of-class, e.g. SNRI, TCA) may be helpful; augmentation of antidepressant medications can utilise another non-MAOI antidepressant (e.g. bupropion), generally from a different pharmacological class, or a non-antidepressant medication such as lithium, thyroid hormone, or a second-generation antipsychotic (American Psychiatric Association, 2010; Suehs et al., 2008). In patients capable of adhering to a tyramine-free diet and medication restrictions, it is possible to switch to a nonselective MAOI after taking necessary precautions to avoid drug-drug interactions (American Psychiatric Association, 2010). For patients with multiple failed medication trials, consider referring for a second opinion or possibly referral for a somatic therapy (e.g., ECT, rTMS).

Insomnia and fatigue are among the most common residual symptoms in patients with MDD. In addressing insomnia, an initial focus should be on improving sleep hygiene. If insomnia persists, consider short-term use at low doses of a non-controlled sedating antidepressant medication (e.g., trazodone, mirtazapine, doxepin), melatonin, ramelteon or an antihistamine (e.g., hydroxyzine, diphenhydramine). If insufficient efficacy or tolerability results, consider short-term use of benzodiazepines or selective gamma-aminobutyric acid (GABA) agonist hypnotics (e.g., zolpidem, eszopiclone) (American Psychiatric Association, 2010). Insomnia may be an independent co-occurring disorder and is a risk factor for depression relapse, recurrence, and treatment resistance. Consider referral for sleep evaluation and alternative sleep therapies (e.g., CBT for insomnia, CBT-I).

If significant co-occurring anxiety is present, consideration can be given to co-administration of an anxiolytic medication, starting with non-addictive, non-controlled medications such as buspirone or hydroxyzine, beta blockers (e.g., propranolol, atenolol), progressing if needed to limited and carefully monitored use of benzodiazepines. If controlled substances are to be utilised, the provider should screen for and avoid any overlapping use of benzodiazepine medications with opiate medications.

Treatment should aim at complete remission, as the presence of residual symptoms increases the likelihood of relapse, and is a negative predictor of a long-term positive outcome (Lam et al., 2016b).

Continuation stage

Patients who respond to an antidepressant treatment should be continued on medication for a period of 6–12 months beyond acute symptom resolution in order to mitigate the risk of relapse and recurrence (American Psychiatric Association, 2010; Möller and Henkel, 2005). The general rule is to maintain the same dose of medication as the one used in the acute phase (American Psychiatric Association, 2010). Depression-focused psychotherapy should be utilized during the continuation phase to help prevent relapse; to date, CBT has the best evidence available for use during this treatment stage (American Psychiatric Association, 2010).

Maintenance stage

The objective of maintenance therapy is to prevent the occurrence of a new episode of depression after full recovery from a previous episode. Maintenance therapy should be strongly considered for all patients at risk of recurrence, (American Psychiatric Association, 2010; Lam et al., 2016b; Möller and Henkel, 2005; National Institute for Health and Care Excellence, 2009).

Risk factors for recurrence include but are not limited to: a history of three or more prior episodes of major depression, the presence of residual symptoms, a familial history of mood disorders, seasonal patterns, early age of onset, ongoing psychosocial stressors, comorbid diagnosis or substance abuse (American Psychiatric Association, 2010; Lam et al., 2016b).

The time frame for maintenance therapy is variable based on the patient's functioning, psychosocial stressors,

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history and symptoms. Some patients may require ongoing treatment (American Psychiatric Association, 2010; Möller and Henkel, 2005).

Discontinuation of treatment

Prior to terminating active treatment, patients should be made aware of the risk of relapse and have a plan in place for accessing treatment in the event of symptom recurrence (American Psychiatric Association, 2010). Antidepressant treatment should be tapered off in order to avoid withdrawal symptoms or relapse (American Psychiatric Association, 2010; Kennedy et al., 2016). Patients may need to be monitored by the prescribing provider for several months following the discontinuation of pharmacotherapy (American Psychiatric Association, 2010).

SPECIAL POPULATIONS AND COMORBIDITIES

Substance use

Management of comorbid conditions should include treatment of comorbid substance use (American Psychiatric Association, 2010).

MDD associated catatonic features

The first line treatment of catatonic features of MDD is a benzodiazepine or barbiturate, typically along with an antidepressant (American Psychiatric Association, 2010). ECT is recommended where pharmacotherapy for the catatonic features proves ineffective (American Psychiatric Association, 2010).

Co-occurring anxiety

Antidepressant treatment may be augmented with a benzodiazepine in individuals with comorbid anxiety (American Psychiatric Association, 2010).

Smoking

Depressed patients who smoke may benefit from bupropion or nortriptyline as these medications have demonstrated efficacy in both treatment of depression and smoking cessation (American Psychiatric Association, 2010). Clinicians should be aware that varenicline can have a negative impact on the patient's mood.

Perinatal depression

Depression during pregnancy is a major predictor for post partum depression. Untreated prenatal depression could lead to a number of negative consequences, such as suboptimal prenatal care, maternal substance use, premature delivery and low birth weight. For mild to moderate depression, psychotherapy is a first-line treatment (American Psychiatric Association, 2010). It is important to keep in mind that discontinuation of antidepressants during pregnancy increases the risk of relapse. For severe depression, medication is first-line. In considering psychopharmacological treatment options, the prescriber must use the evidence available on medication safety (Wisconsin Association for Perinatal Care, 2015). About 20% of women develop postpartum depression (Gavin et al., 2005). Untreated postpartum depression can affect the maternal-child relationship as well as child development (American Psychiatric Association, 2010). For mild to moderate postpartum depression, first-line treatment includes IPT and CBT psychotherapies, which are recommended for women who chose to treat their depression without medications. For severe postpartum depression, medication is recommended (American Psychiatric Association, 2010). As mentioned, ECT or transcranial magnetic stimulation can be used safely during pregnancy up to the third trimester of pregnancy. Women who elect to breast-feed and treat depression with psychopharmacological methods can present a challenge, since all antidepressants are excreted, to some degree, into breast milk. It is important to keep in mind that antidepressant levels in breast milk are much lower than those reaching the foetus in utero, and risks/benefits of untreated maternal depression for the mother and the foetus must be considered, along with the risks/benefits of formula feeding vs. breast feeding when creating an individualised treatment plan with the patient. SSRIs are the first medication treatment choice to treat post partum depression due to their ease of administration, low toxicity and greater tolerability (American Psychiatric Association, 2010; Gjerdingen, 2003; Horowitz and Goodman, 2005; Wisner et al., 2002). This class of antidepressants is the most studied in mother-infant pairs (Horowitz and Goodman, 2005). As part of a comprehensive risk/benefit analysis, the prescriber should consider the course of illness and the preferences of the mother/couple. Clinically-relevant updates and patient information can be found at www.womensmentalhealth.org.

Late-life depression

When working with depressed older adults, it is essential to identify comorbid somatic conditions, as certain medical illnesses may mimic depression and could influence the choice of medication and dosing (American Psychiatric Association, 2010). Possible sensitivity to medication side effects (such as anticholinergic effects and hypotension) should be closely monitored; medication dosages should always be adjusted for hepatic or renal dysfunction (American Psychiatric Association, 2010). Elderly patients generally do well with a low dose of an SSRI (Möller and Henkel, 2005). ECT can also be a very effective treatment for MDD in older adults.

Cognitive dysfunction

Cognitive dysfunction in the context of a major depressive episode can be a prodromal sign of future dementia. Therefore, it is essential to assess the patient's cognitive functioning at regular intervals throughout treatment (American Psychiatric Association, 2010).

Bereavement

Normal grief response to a recent loss may not require depression-focused treatment. Patients with uncomplicated grief may benefit from participation in bereavement support groups. However, in cases of complicated grief, accompanied by a significant functional impairment and severe psychological distress, psychotherapy or antidepressant treatment is recommended (American Psychiatric Association, 2010).

Chronic pain. Chronic pain is often comorbid with depression. People living with chronic pain may be able to manage their symptoms through lifestyle changes (National Institute of Mental Health, 2015). Best-practice first-line treatment for chronic pain is a multimodal approach that includes, but is not limited to, medication management, physical or restorative therapy, and CBT or supportive psychotherapy (American Society of Anesthesiologists Task Force on Chronic Pain Management; American Society of Regional Anesthesia and Pain Medicine, 2010). Select SNRIs (e.g., duloxetine) and TCAs (e.g., amitriptyline) have been found to be effective in treating both pain and depression.

CONCLUSIONS

The above recommendations represent the state-of-the-science of psychiatric treatment of depressive disorders in adult patients, based on the available evidence. The guideline covers a broad range of relevant topics, including evidence-supported pharmacological and somatic treatment options. The topic of evidence-based psychotherapy for depression is discussed in more detail in Part II of the guideline. Psychiatric providers are encouraged to utilise the treatment recommendations for best-possible patient outcomes.

Conflict of interest

The authors do not report any financial or personal links to other persons or organizations that might negatively affect the content of this publication and/or claim rights thereto.

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