The Management of Depression

Robert K. Schneider MD, Robert N. Glenn Ph.D., James L Levenson MD

The management of depression first centers on whether or not to prescribe medications, psychotherapy, or both. When viewed more broadly there are additional important aspects in the management of depression. This chapter will cover: General Considerations in the Management of Depression; Management of the Suicidal Patient; When to Refer to a Mental Health Specialist; Ethical and Risk Management Issues; and Adjunctive Interventions.

General Considerations in the Management of Depression

Primary care physicians often carry long-term responsibility for the management of depression. Other professionals may be involved at various times in the course of treatment, but many patients return to their primary care physicians for treatment of both medical problems and symptoms of depression. Primary care physicians manage depressed patients without the involvement of mental health professionals in many circumstances.

The management of depression in the primary care setting is a complex and dynamic process requiring the physician’s attention to recognition, diagnosis, treatment and follow up. Each of these elements is covered in depth elsewhere in this book. This chapter will present an overview, integrating these elements with other aspects of management. For the purposes of this chapter we will assume that the symptoms of depression have been accurately recognized and properly diagnosed as Major Depression. Treatment for depression is potentially multimodal. The physician and patient have the task of choosing which treatments are appropriate and acceptable to both.

After the diagnosis is made in the physician’s mind, the task of “giving” the diagnosis to the patient is next. At this juncture the use of the very word “depression” is tricky. Informing the patient that he/she is depressed may create problems in acceptance and compliance. Many patients do not understand what depression really is, and may interpret the term in highly negative or self-critical ways. It is important to use the patient’s own words in describing depressive symptoms by restating the most troubling symptoms. These symptoms will become the target of treatment and will be tracked by the patient and the physician. The physician should also ask about other symptoms the patient might not have mentioned, particularly neurovegetative symptoms and thoughts about death or dying. (see Management of the Suicidal Patient below). Efficacy of treatment will be determined by tracking the course of the target symptoms over time, the more specifically described the better. “He’s depressed and feels helpless” is much less helpful than “His sleep is reduced to 4 hours, he has stopped going to church and his back pain has increased.” The latter better enables the patient and physician to track the patient’s response to treatment in terms
understandable, observable and specific to the patient.

After the target symptoms are identified, they should be tracked carefully over time. Dr. Pelonero reviews these terms in more depth as part of the AHCPR practice guidelines in Chapter 12. The terms used to follow the target symptoms over time can be remembered as the 5 Rs and the 3 phases. These terms allow the physician and the patient to conceptualize the course of depression longitudinally. A response is a point in time where symptoms have decreased to the point where the criteria for Major Depression are no longer met. A remission refers to a period in time and can be either partial or full. A partial remission is the period during which an improvement of sufficient magnitude exists that criteria for Major Depression are no longer met. A full remission is the period after partial remission when the patient becomes asymptomatic. A relapse is the return of symptoms after a full remission that satisfy full diagnostic criteria before recovery has occurred. A recovery is a prolonged full remission for at least six months during which the patient is asymptomatic. A recurrence is the appearance of a new episode of depression with symptoms that meet full criteria and thus can only occur after recovery. These terms have been precisely defined for research purposes (1), but also serve to remind us that depression is often a chronic disease, with many patients suffering multiple episodes and some never achieving complete recovery.

The “5 Rs” occur in the context of the “3 phases” of depression The treatment of depression is divided into three phases: acute, continuation and maintenance. The Acute phase begins when treatment is initiated and ends with full remission. The Continuation phase begins with full remission and lasts until the chance of relapse significantly diminishes (or relapse occurs). The goal during the continuation phase is to prevent relapse. The continuation phase typically lasts 6-9 months in the first episode of depression. The Maintenance phase follows the continuation phase, during which the goal is to prevent recurrence. The maintenance phase ends if a new recurrent episode of depression begins.

When it comes to intervention, the choice is complex between continued observation, psychotherapy, medication, nonmedication-nonpsychotherapy (“adjunctive”) interventions, or some combination of these. The relative efficacy of medication vs. psychotherapy vs. combination of both in the treatment of depression remains a topic of active study, without clear consensus emergent from the data. Chapter authors in this volume vary in their views regarding the choice of first-line treatment. However one interprets the research to date, treatment should be individualized to the particular patient. The choice should be directed by two organizing principles: severity of the depression and patient preference. The principles also relate to each other in that the more severe the depression the more treatment options become circumscribed. When the patient is actively suicidal, psychotic, manic or rapidly deteriorating, an emergent referral to a mental health specialist is indicated irrespective of patient preference and somatic treatments (medication, ECT) and usually hospitalization are indicated. Fortunately these cases are atypical in the primary care setting. Far more common are depressions that are subsyndromal, mild, or
moderate in severity. In these cases patient preference should direct treatment choice. The major reason for treatment failure is noncompliance or noncompletion of treatment. Patient preference is paramount in obtaining compliance with the treatment selected (see also Chapter 5 and 6).

### Initial Management Steps for Depression

1. Restate the most troubling symptoms
2. Ask about other symptoms (e.g., lack of pleasure, concentration difficulties, low energy, preoccupation with death, suicide etc.)
3. State the target symptoms of treatment and the expectation of change
4. Establish where the patient is in the longitudinal course of the disease (e.g. relapse vs. recurrence)
5. Determine severity of depression
6. Discuss patient preferences and expectations

### Management of the Suicidal Patient

Assessment of suicide is an essential component in evaluating and treating depression. An evaluation of the patient’s suicidal potential should be performed whenever the diagnosis of depression is considered and especially if an antidepressant is prescribed (2). Identification of depression and suicidal ideation is particularly important in the medical setting, as physicians are likely to have contact with people who soon thereafter commit suicide. About 80% of people who end their lives talk about suicide before taking action. Some evidence indicates that half of people (and 75% of elderly) who kill themselves have seen their physicians within a month before they died. Suicide ranks as the ninth leading cause of death each year, with over 30,000 suicides annually. There are at least 10 suicide attempts for each completed suicide. Physicians have the potential to help prevent morbidity and mortality from suicide. Their skill in identifying, evaluating, and interviewing for suicidal ideation/intent can make a crucial difference. Key risk factors for suicide can be identified in the patient’s demographics (table 1), history (table 2), and current state (table 3) (2) (4).

#### Table 1: Demographic Risk Factors for Suicide

| **Age** | The highest risk is in adolescence, and in the elderly |
| **Gender** | Women make 10 times more attempts than men, but men succeed at suicide three times more often because they use more lethal methods (four times more likely to die). |
| **Marital Status:** | Separated, widowed, or divorced |
| **Race:** | Caucasian men and women account for a disproportionate 90% of all suicides. |
| **Sexual identity:** | Homosexuals are at higher risk |
Gun ownership: People who live in homes with firearms are five times more likely to die by suicide than those in gun free homes.

Relationships: Persons are at higher risk when living alone and have no social supports.

Employment: Unemployed or have lost status in their jobs.

**Table 2: Patient History Risk Factors for Suicide**

- Prior suicide attempts, even if minor
- Family history of suicide or attempts
- Suicide of a close friend, particularly if an adolescent
- Psychotic or bipolar depression
- Poor coping ability
- Substance abuse
- Personality disorder
- Anniversary of a loss
- Chronic pain
- Chronic debilitating illness (e.g., AIDS, ESRD)

**Table 3: Current State Risk Factors for Suicide**

- A direct or indirect expression of intent to harm self
- A plan that is well developed
- Poor judgment or impulse control
- Use of alcohol or other substances
- Giving away of possessions
- A significant deterioration in functioning and appearance
- A rapid elevation in mood. The patient may have decided upon a plan and feels a sense of relief.
- More energy may also help a patient follow through with a plan
- A fantasy of reuniting with deceased loved one.
Case 1:
Mr. L’s wife died of breast cancer 6 months ago. He now comes for his “yearly check-up.” Though Mr. L denies “depression,” he has stopped hunting and fishing with his friends, which are long-time interests. He is Caucasian, 63 years old, recently retired with COPD and rheumatoid arthritis.

Many patients with Major Depression deny feeling depressed, though they usually endorse specific symptoms if asked. Mr. L’s withdrawal from pleasurable activities is suggestive. Mr. L has many risk factors for suicide (older white male, widowed, not working, chronic illness, chronic pain, and access to guns). His physician should evaluate for depression, and directly ask about any alcohol use and suicidal thoughts. The next section reviews how to discuss suicidal ideation with patients.

**Discussing Suicidal Ideation and Plans With the Patient**
Patients’ anxiety or shame and physicians’ discomfort may lead to skirting the topic of suicide. The best approach is to ask the patient directly. A good, empathic initial question is “Have you felt so bad that life did not seem worth living?” If answered affirmatively (or not answered), the next question would be “Was it bad enough that you thought of ending your life?”

Further steps are:
1. Ask about the frequency of the thoughts (pervasive, intermittent)
2. Are the thoughts directly related to a recent or upcoming situation?
3. Does the patient have a plan? If so, how well developed is the plan?
4. How lethal is the method described?
5. What is the patient’s access to the method? Is there a gun or drugs in the home?
6. Does the patient have any thoughts or impulses of hurting someone else? It is not uncommon for suicidal and homicidal thoughts to occur together, particularly if domestic violence is involved.

**Suicidal Ideation and Planning: Immediate Safety**
Prevention of suicide requires specific and immediate interventions to increase patients’ safety. Emergent referral to a mental health practitioner is always indicated with acute suicidal thoughts or plans, or recent attempts. An inpatient admission may also be needed if the patient’s or others’ safety cannot be protected. Depending upon the severity of the crisis, the physician should consider the actions below in the interim before evaluation, admission or treatment by a mental health provider. If the patient has expressed suicidal ideation or intent, the physician has to determine the extent to which

- the patient will cooperate around safety issues (e.g. giving up guns)
- the availability of friends and family to ensure safety or to follow through with more restrictive options
- the risk to another person if violence is also threatened
The range of alternatives for the physician will depend upon the degree to which the patient’s safety can be assured. Assessment will be contingent upon:

1. The patient’s willingness to engage in a plan with the physician to not harm himself/herself. This plan can be verbal or written. It can be as simple as the patient’s clear agreement to call the practice if they are feeling unable to control thoughts or impulses to harm themselves (3).

2. The availability of family or friends to provide a “suicide watch” (if needed) for a defined period of time or to help in the removal of lethal items from the home. They should also be familiar with the procedures if more restrictive intervention is required (i.e. psychiatric emergency room, involuntary hospitalization).

3. Increased contact with the physician or medical practice until the patient can see a mental health practitioner.

4. The physician will need to implement more restrictive options for the patient’s safety if prevention of self-harm cannot be negotiated. The patient can be given the opportunity for a voluntary admission to a hospital. Refusal to agree to this alternative requires an involuntary process. Procedures vary by state or province.

While these precautions are usually not difficult to implement, they are not always effective. Patients who become unambivalently and persistently intent on killing themselves may succeed despite others’ best efforts.

**When to Refer to a Mental Health Specialist**

**Emergent Referral**

The first consideration is whether mental health referral is emergent i.e. the patient’s safety is in question now. All depressed patients with active psychosis (hallucinations or delusions), acute suicidal risk, or dehydration-malnutrition, should be emergently referred to a psychiatrist. An emergent referral can be voluntary or involuntary. In a voluntary emergent referral, the patient agrees to the evaluation and is escorted to the place of evaluation, which is usually a general hospital’s emergency room or a psychiatric crisis evaluation service. In the event that the patient does not agree to emergency evaluation, involuntary psychiatric hospitalization should be considered. Criteria for involuntary hospitalization, who can file, and legal procedures vary by state or province. Generally a crisis service or magistrate is contacted and a law enforcement officer is sent if necessary to escort the patient to a facility for emergency evaluation. While some patients may be initially very distressed or angry about being coerced into psychiatric care, most are ultimately grateful, recognizing their physicians and families acted out of concern for them.
Non-Emergent, Urgent Referrals

The non-emergent, urgent referral is for the unstable patient that needs evaluation in the next 24-72 hours. The patient is considered to be relatively safe and can wait because the patient is cooperative with a plan for safety, there is a good supportive environment to observe the patient, there is no access to means for suicide (e.g. removal of guns), and the patient accepts the need for referral. Urgent, non-emergent referral should also be attempted for patients without any acute risk whose depressive symptoms are severely distressing to them. For both emergent and urgent referrals, physicians should have established knowledge of available mental health resources in their community and how to access them.

Routine Referrals

Routine referrals will occur much more frequently than the emergent or urgent referrals. Referral patterns vary within physician groups. The three major variables affecting routine referral are, the physician’s comfort and aptitude in handling depression, the system of health care in which the physician practices, and the patient’s condition (and preferences). In systems where mental health services are integrated with primary care, referral indications and pathways are much clearer. Since most physicians and mental health professionals in the United States are not currently in such systems, the primary care physician must take more responsibility for referral. Reasons for referral include: a patient who wants or could benefit from psychotherapy (please see the Psychotherapy chapter for referring a patient for psychotherapy), patients who have not responded to therapeutic trials of antidepressants, comorbid substance abuse, bipolar illness, a history of psychotic or severe depression. Some patients are not open to referral to a mental health specialist and openly refuse, or accept the referral in the office and then do not keep the appointment. These situations are challenging and difficult and can isolate the primary physician. In these circumstances a telephone call to a mental health colleague should be made to discuss options. The one thing all referrals have in common is forethought on the referring physicians part, being aware of laws, referral procedures, and ones own skills allows for efficient and timely referrals to mental health professionals and ultimately the best outcomes for our patients.

Ethical and Risk Management Issues

Boundaries

Maintenance of professional boundaries is appropriate in all doctor-patient relationships, but a physician’s wish to aid a distressed, depressed patient may lead to crossing boundaries. Depressed patients are more vulnerable, more likely to be dependent, lonely, and unhappy in their primary relationships. In most cases, physicians should remain neutral regarding patients’ major life decisions (e.g., quitting job, divorce). It is often appropriate to encourage an acutely depressed patient to postpone a major decision until feeling better, but physicians should refrain from urging a particular decision. While it can be very tempting, for example, to tell a depressed patient to leave an unhappy marriage, the
physician seldom has sufficient knowledge of both sides, and the consequences of such advice. To take such a position undermines the physician’s objectivity, and erodes the patient’s autonomy and capacity for independence. Excessive self-disclosure by physicians is also to be avoided. While it is said, “misery loves company,” depressed patients do not want or benefit from having depressed physicians. Doing special favors for patients (e.g., loaning money, supporting unjustified sick leave) is also ill advised, as it fosters increased dependency and unrealistic expectations about the physician. For similar reasons, physicians should not have sessions with depressed patients that are unbilled, unusually long, or outside regular office hours. Hugging and kissing patients are usually inappropriate; a lonely depressed patient is especially likely to misinterpret what the physician intended as an innocent expression of affection and concern. Sexual misconduct by physicians who become involved with patients typically starts with their rationalizing less serious boundary violations with patients who are depressed and hungry for a benevolent, caring parental figure (6).

Confidentiality
Confidentiality is a vital ethical principle throughout medical care, but especially important in the treatment of psychiatric disorders. While stigma associated with depression has fallen in recent years, many people are still reluctant to accept a diagnosis of and treatment for depression. Others are willing but wish to keep it a secret. Family members, employers, schools, and other third parties may ask the physician for information about a depressed patient, but this requires the patient’s permission. Some employers may discriminate against depressed employees. Concern that a history of depression may interfere with obtaining personal health, disability, or life insurance is not unwarranted. This does not apply to group policies, but many insurers do charge more or decline to insure individuals currently or previously treated for depression. Confidentiality, like other ethical principles, is not an absolute and sometimes must give way to an overriding moral imperative. Physicians may break confidentiality with suicidal patients if it is to prevent self-harm (e.g., asking the spouse to remove firearms from the home). Physicians are legally mandated to report child abuse or neglect, both of which are more frequent with a seriously depressed parent.

Documentation
Non-psychiatric physicians frequently treat depression in their patients without explicitly documenting diagnosis or treatment. While this may be an understandable response to concerns regarding confidentiality (see preceding section), failure to document is a mistake with potentially serious consequences. Written details permit the physician (or a subsequent physician) to accurately track treatment response, recall side effects or compliance problems, and note any referrals made to mental health professionals. Predictably, as more non-psychiatric physicians prescribe antidepressants, there are more malpractice suits brought against them following poor depression outcomes (especially suicide).
While sketchy documentation may be frequent, it is difficult to claim it represents the standard of care. If the physician did not document a diagnosis of depression, evaluation of suicide risk, treatment and referrals, the plaintiff’s attorney is likely to assert there is no evidence the physician ever did what he/she claims.

**Shared Treatment**

Shared treatment arrangements, where a primary care physician provides pharmacotherapy and a non-medical therapist provides psychotherapy have become common, raising a number of potential concerns. It is clearly negligent for a physician to prescribe an antidepressant “recommended” by a psychotherapist, without seeing the patient. The physician should not prescribe any psychiatric drug about which he/she is not knowledgeable. Since psychologists, social workers, and counselors are not licensed to prescribe, the physician will be the one bearing liability risk if there is an adverse outcome related to antidepressant medication.

Are physicians in shared treatment relationships responsible only for the part of treatment they provide (typically, medication), or are they responsible for the overall treatment of the patient? The answer is likely to vary with the specifics of the case, but in general, the courts have regarded physicians as having broad authority and responsibility. Furthermore, plaintiffs’ attorneys usually try to cast their nets widely, attracted toward deeper pockets. Better patient care and lower malpractice risk can be achieved by clear communication between the physician and non-medical psychotherapist, with explicit understanding of their relative responsibilities and expectations. In a shared treatment arrangement, the psychotherapist and physician must be free to discuss the patient. Neither should agree to a patient’s insistence that there be no communication. Certainly psychotherapists must still exercise discretion in whether to withhold sensitive information (e.g., the patient having had an extramarital affair). Failure to communicate may deprive either clinician of essential information (e.g., occult substance abuse), and it may also undermine allocation of responsibility, leading to failure to intervene when the patient is deteriorating.

**Case 2**

A psychologist treating Mr. J advised him to consult his primary care doctor for antidepressant medication after Mr. J’s depression had worsened despite 8 weeks of psychotherapy. The PCP prescribed fluoxetine. There was no communication by phone or letter between the psychologist and PCP. On a follow-up visit to the PCP, the patient complained his depression was no better, even worse. After careful questioning, Mr. J acknowledged he had stopped taking fluoxetine after a few days because he did not wish to be on any psychiatric drug. The PCP assumed the psychologist would decide what to do next, for without medication, there was no need for his involvement. The
psychologist assumed the PCP was proceeding with pharmacotherapy, since psychotherapy alone had not worked. Mr. J’s condition worsened. His wife became alarmed. She called the offices of both the PCP and psychologist; each suggested she call the other. If Mr. J commits suicide, both the PCP and the psychologist may be held liable.

The physician may bear some responsibility even for aspects of treatment outside his/her domain, especially if the collaborating therapist is grossly unethical, incompetent or impaired, as the next case illustrates:

Case 3
Ms. K told her PCP (who was treating her with an antidepressant) that she “loved” the counselor recommended by the PCP’s nurse. At subsequent visits, Ms. K spoke so affectionately about her therapist, that the PCP grew uneasy about their relationship (Ms. K and the therapist). It later emerged that the therapist had become sexually involved with Ms. K, was unlicensed, and had no malpractice insurance. If a lawsuit arises, the search for a way to compensate the patient may focus liability on the PCP.

In shared treatment arrangements, the physician has some accountability for knowing the qualifications and competence of the collaborating psychotherapist (and vice versa). Responsibility for having such knowledge is increased when one has referred the patient to the other, and more so if they regularly collaborate in shared cases.

Disability and Its Evaluation
Depression causes as much or more disability (e.g. missed work, days in bed) than chronic medical conditions like diabetes or arthritis (7). Even minor depressive illness results in days lost from work, and because of its greater prevalence, accounts for more total disability days in the community than major depression (8). Consequently, physicians are frequently asked by patients, employers, or insurers (private or Social Security) to complete disability evaluations for depressed patients. Some physicians reflexively release patients with depression from work and support their receipt of disability regardless of whether they meet disability criteria (which vary by occupation and insurance policy). While such physicians feel they are acting out of loyalty to their patients, uncritical support for disability promotes invalidism and chronicity of illness. The employer, insurer, and patient each have their own interests; physicians cannot serve all three simultaneously and equally. The same problems arise in school and work release evaluations (9). If the depressed patient’s physician decides to play this role, he/she should be truthful, and inform the patient that filling out disability forms will breach confidentiality. If the provision of accurate information to employer or insurer will potentially harm the doctor-patient relationship, the physician can decline to perform the disability evaluation, and recommend an
independent examination. In any case, all patients who are unable to work (or attend school) because of depression should be aggressively treated. Depression only very rarely should be a cause of permanent disability, as long as the patient has received adequate treatment.

**Adjunctive Interventions**

In addition to antidepressants and/or psychotherapy, there are a number of other interventions that may improve outcomes in depression. Some patients are eager for ways to speed recovery, while others require encouragement to take an active role in treatment. Some adjunctive interventions have been demonstrated as beneficial, while others remain unproven but potentially helpful.

Case 4:

Ms. Q is a nurse and single mother who complains of persistent depression. She has not responded to an initial trial of an antidepressant. She works the late shift and “cat naps” during the day, smokes 2 packs of cigarettes per day, drinks 5 cups of coffee and 3 “cokes” per day to “keep going.” She eats primarily fast food and has not seen her friends or attended church anymore because “there’s no time left after my job and my children.”

Successful treatment for her depressive symptoms requires lifestyle changes. Poor sleep habits, smoking, over consumption of coffee, and social isolation all are interfering with recovery.

**Exercise**

Depression rates are lower in the physically active (10), and generally depressed patients are more physically inactive as a result of the depression itself. Exercise in almost any form (aerobic and less intense forms) is an effective adjunct in the treatment of depression improving energy, mood, appetite, sleep, and self-esteem. It has been found to be an effective treatment when compared to no treatment (11). Also, exercise’s antidepressant qualities continue after depressive symptoms abate (12) making it valuable as part of long-term management and relapse prevention. In general, exercise is safe and effective in the treatment of mild to moderate depression. Severely depressed patients are usually unable to exercise until partly recovered. Prematurely urging them to exercise adds to their feeling of failure and inadequacy. Prescribing exercise may be contraindicated for depressed bulimic patients, who already may be compulsively over-exercising.
Nutrition and Hydration

Though eating correctly and maintaining adequate hydration may seem obvious; they are frequently overlooked in the management of the depressed patient. Reduction in intake of food and fluids, or overconsumption of “junk” food, are often symptoms of depression. If sustained or if the patient was already in a vulnerable state (e.g. chronically ill, elderly), secondary problems can occur including alteration of medication metabolism and orthostasis secondary to dehydration. If prolonged, electrolyte derangement and vitamin deficiencies may occur. Some depressed patients may benefit from oral nutritional supplements (13). B vitamin supplementation has been studied in treatment-resistant depression with mixed results; a daily multivitamin cannot hurt and may help (14).

Sleep Hygiene

A disrupted sleep cycle is a major symptom of depression and sleep deprivation is a recognized precipitant of depression. Poor sleep quality or quantity contributes to the higher incidence of depression postpartum, in rotating shift workers, chronic pain, and substance abuse. Some patients have lifestyles entailing chronic poor sleep habits. A review of the patient’s sleep pattern and instruction on proper sleep hygiene is often very helpful. Simple information sheets can be provided including reminders to only be in bed when ready for sleep, don’t read or watch television in bed for prolonged periods, avoid drinking fluids before bed that may cause nocturnal urination, and avoid stimulating substances in the late afternoon or evening. While treatment of depression may be necessary to improve sleep quality and quantity, improved sleep may also be necessary for remission of depression. Failure to change poor sleep habits will undermine the effectiveness of therapies for depression and promote relapse.

Hypnotic medication can be a valuable adjunct to treatment when depression includes insomnia. This is especially true in the agitated or anxious depressed patient. Typically a low dose of a short-or-intermediate acting benzodiazepine or zolpidem is prescribed during the first weeks of therapy until the normalizing effect of the antidepressant on sleep starts. Chronic use of hypnotic drugs should be avoided because they are CNS depressants, and may lead to dependency and withdrawal making them particularly risky in patients with current or prior substance abuse. If chronic therapy for insomnia is needed, then trazodone is often used (15).

Reduction of Psychoactive Substances

Patients frequently consume substances that may adversely affect treatment of depression, in some cases as a form of self-treatment, and some substances interfere with antidepressant treatment (16, 17).

Caffeine is probably the most widely used psychoactive substance. Many patients with depressive symptoms, particularly fatigue and decreased concentration may self-medicate with caffeine. In addition to coffee, tea, caffeinated soda, and herbal beverages (e.g. Herba Mate), caffeine may be consumed in
over the counter (OTC) preparations for weight loss, headache, and staying awake. A few patients are especially sensitive to caffeine and experience side effects even at lower doses (1-2 cafffeinated drinks). When taken in regular high quantities (greater than 4 caffeinated drinks per day), caffeine may produce anxiety and interfere with sleep. Also a withdrawal syndrome characterized by irritability, depression, lethargy, headache and decreased concentration may occur particularly in the late afternoon. Excessive consumption of caffeine interferes with the normalization of sleep that marks antidepressants’ efficacy. Too much caffeine may aggravate side effects of antidepressants, especially SSRIs and bupropion, such as jitteriness, diarrhea, and insomnia.

OTC decongestants may cause side effects including jitteriness and sleeplessness on their own account or they may interact with antidepressants causing side effects as well. Because OTC sympathomimetics are nonspecific adrenergic agonists, tachyphylaxis is common; some patients are addicted and using large quantities (e.g. nasal decongestant spray). Sedating antihistamines may aggravate the mental slowing of depression or sedation side effect of antidepressants. The preferred treatment for allergic upper respiratory symptoms in depressed patients is nonsedating antihistamines. Patients who come in during cold or allergy season with new side effects on a stable antidepressant regimen suggests a possible OTC drug action or interaction.

A wide variety of herbal preparations contain sympathomimetic compounds, primarily “natural” ephedrine (often identified as ephedra or Ma Huang). Like OTC sympathomimetics, such herbal supplements may cause poor sleep and jitteriness by interacting with medications or in their own right.

There is a strong and complicated relationship between smoking and depression. People who have ever smoked are 50% more likely to have depression, and the incidence of depression in smokers is more than twice that in nonsmokers (18). Patients may be smoking for the antidepressant effects of nicotine or to counteract a particular symptom of depression (lack of concentration, fatigue, constipation etc). It has also been observed that depressive symptoms appear during smoking cessation in people with a history of depression (19) and smokers whose withdrawal syndrome includes depressive symptoms are less likely to achieve abstinence. Smoking may interfere with treatment in some patients by inducing hepatic metabolism of some psychiatric drugs.
The strong association of cigarette smoking and depression has led to the use of antidepressants to assist in smoking cessation. If depression is present all antidepressants may be effective. However, if depression is not present, not all antidepressants are equally efficacious. When accompanied by smoking cessation counseling, bupropion has been demonstrated in controlled trials to double one year quit rates compared to placebo (12-16% to 24-35%) (20). Similar results have been found with nortriptyline (21), and in small studies with doxepin (22). Trials of fluoxetine, sertraline, and other antidepressants have generally been unsuccessful.

Alcohol is the quintessential form of self-treatment. In the short term, for some it causes a feeling of well being, relaxation, and helps initiate sleep. Yet because it is a CNS depressant, it eventuates in worsening depression. It ultimately erodes sleep by disrupting REM sleep, decreases motivation and self-esteem, and contributes to poor nutrition. It is appropriate to urge cessation of all alcohol during the initial phases of treatment of depression. When the symptoms of depression have abated, cautious limited resumption of alcohol can be considered. Advising no more than one drink per day is prudent. Patients should be instructed that their sensitivity to alcohol, especially psychomotor skills has been significantly increased by antidepressant medication. Also alcohol may make patients more sensitive to the adverse effects of antidepressants. In some patients even small amounts of alcohol will exacerbate depressive symptoms; in these cases total abstinence from alcohol should be prescribed to achieve and maintain full remission.

Patients should be asked about any other psychoactive substance use. Chronic daily use of marijuana may cause associated with depression, apathy, and decreased ability to concentrate. Even occasional usage should be discouraged in actively depressed patients. Cocaine and amphetamines cause the release of brain catecholamines. Repeated usage leads to a vicious cycle of catecholamine depletion with intense feelings of depression, resulting in increased abuse, and then ultimately a “crash.” Following cessation of regular use of cocaine or amphetamines, there are often depressive withdrawal symptoms.

**Relaxation Techniques**

Meditation, yoga, tai chi, and other mind-body therapies may be helpful in managing some of the anxiety symptoms associated with depression, and there are easy-to-learn forms adapted for general use, relaxation techniques. These techniques become particularly important if the patient doesn’t wish to or shouldn’t be prescribed a benzodiazepine. These practices, though simple, require effort and motivation on the patient’s part. Depressed patients often lack energy and motivation making relaxation techniques usually impractical in the moderately to severely depressed patient. However, in the mildly depressed patient with anxiety or in long-term treatment, relaxation techniques can be an important adjunct. Many psychotherapists, and physical and occupational therapists are familiar with and can teach relaxation techniques to patients, and there are increasing numbers of non-medical sources for them as well.
Religious Involvement

Isolation and disconnection from social support are often seen in depression. Depression occurs less often in people with religious involvement as opposed to those with no religious involvement. Recent studies have shown a decreased likelihood of depression in frequent church attendees (23). It is unclear what provides the protective value. Social support, instillation of hope, a sense of life’s meaning, acceptance of suffering or other spiritual values are some of the possibilities that could explain religion’s protective value. It appears that the cognition of an ordered world (faith and trust in God) offers some protective value for the psychological symptoms of depression, but less for the somatic symptoms of depression (24). While, a physician cannot “prescribe” religion, a careful review of past religious involvement may uncover a potential avenue for support that could be reinvigorated with the physician’s encouragement. Sometimes depression is precipitated by a loss that challenges the patient’s faith, and/or causes spiritual alienation. Clergy or pastoral counsellors can add meaningful help for depressed patients with these “psychoreligious” conflicts.

Support Groups and other Social Involvement

Social isolation is a risk factor, a symptom, and a cause of depression. Steps taken to counter social isolation directly are helpful. This may be as simple as the physician encouraging the depressed patient to have more contact with family, friends, and community. For patients with chronic or recurrent depression, as with other chronic medical illnesses, support groups can be helpful, providing an opportunity to share experiences with others with the same condition. Physicians should learn what resources are locally available; Table 4 lists national sources of information regarding mental health referral, support groups, and depression in general.

Table 4: National Organizations and Access Information

D/(ART) Program
Depression Awareness, Recognition and Treatment (D/ART) Program
National Institute of Mental Health
1-800-421-4211
301-443-4140

Depression and Related Affective Disorders Association (DRADA)
Meyer 3-181, 600 North Wolfe Street
Baltimore, MD 21287-7381
(410) 955-4647 - Baltimore, MD
(202-955-5800 - Washington, D.C.
drada@jhmi.edu
Depressives Anonymous: Recovery from Depression
329 E. 62nd St.
New York, NY 10021
212-689-2600

National Depressive and Manic-Depressive Association
730 North Franklin Street, Suite 501
Chicago, IL 60610
1-800-82-NDMDA6
(312) 642-0049
FAX: (312) 642-7243

National Foundation for Depressive Illness
P.O. Box 2257
New York, NY 10116
800-239-1265
800-248-4344

National Institute of Mental Health
5600 Fishers Lane, Rm 15C05
Rockville, MD 20857
301-443-4513

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
Phone 703/684-7722
Fax 703/684-5968
Mental Health Information Center 800/969-NMHA
TY Line 800/433-5959
www.nmha.org

The Mental Health Foundation
www.mentalhealth.org.uk

American Psychiatric Association
1400 K St. NW
Washington, DC 20005
202-682-6220
www.psych.org

American Psychological Association
750 1st St. NE
Washington, DC 20002-4242
(202) 336-5500
www.apa.org

**Patient Educational Material**

Many patients and their families can benefit from educational material, and the organizations listed in the table above are good sources for printed and web-based information. For those who wish more in depth information, there are a number of good books (see Table 5). Educational materials are useful adjuncts to
treatment, but are primarily effective in reinforcing information provided by the physician, his staff and mental health professionals. Clinical research suggests that if the educational material is not supported by the health care staff, then there is little impact on patient behavior (25). Patient educational material should not replace patient-physician dialogue, which remains one of the most powerful means of behavior change in patients.

**Table 5: Self-help Books on Depression**

Feeling Good: the New Mood Therapy and The Feeling Good Handbook by David D. Burns, Signet, 1980

Free Yourself from Depression by Michael D. Yapko, Rodale Press, 1992

The Pain Behind the Mask: Overcoming Masculine Depression By John Lynch and Christopher Kilmartin

**Light Therapy**

Seasonal Affective Disorder (SAD) is a mood disorder consisting of recurrent episodes of major depression that occur with a seasonal pattern, most commonly with depressive episodes during the fall and winter, with full remission to normal mood (or switching to hypomania or mania) during the spring and summer. Randomized controlled trials with light therapy have demonstrated short-term improvement in SAD, but little is known regarding light therapy's long-term benefits (26). A variety of modalities have been tested, including light boxes, light visors, and dawn simulators. The therapeutic effects are mediated via the eyes, not the skin. The spectrum of light appears unimportant, but intensity probably is a requirement to achieve benefits, on the order of 10,000 lux. The ideal timing remains controversial; although most controlled trials have shown morning light to be superior to evening light (30). The optimal dose has not determined. Side effects include minor visual complaints, headache, insomnia, and over-activation (including rarely mania) (29). Most light therapy modalities screen out UV rays, so adverse cutaneous reactions are limited to patients with photosensitivity. There have been no reports of basal cell cancer or cataracts with light therapy. No ocular changes have been detected even after years of treatment, and there are no defined ocular contraindications (27). There is no evidence of similar benefit from tanning salons (eyes usually covered; high UV light exposure does carry risks). There is no evidence that replacing home or office light bulbs with bulbs of different spectra provides any benefit. There is some evidence of modest acute benefits of light therapy in nonseasonal depression (28), but no evidence that it can be used instead of standard therapies. Even in SAD, light therapy is not adequate as sole treatment if symptoms are severe.

**St. John’s Wort and other alternative medicine therapies**

St. John’s wort, a common flowering plant (Hypericum perforatum), is widely sold in the United States as a dietary supplement. The FDA does not evaluate it and does not monitor its purity or safety. St. John’s wort is licensed in Germany for the treatment of anxiety, depression and insomnia. Many Americans now
take this preparation for depressive symptoms. Hypericin, a naphthodiathrone, is considered the active ingredient. It is not known if hypericum crosses the blood brain barrier, but in vitro it inhibits the uptake of the neurotransmitters serotonin, norepinephrine and dopamine and binds to GABA receptors. How the body metabolizes and excretes hypericum is unknown at this time (31). Most of the studies (32) using hypericum for the treatment of depression come from Europe and use different definitions for depression, making it difficult to interpret the results. However, it does appear that hypericum is safe and may be effective in the treatment of mild depression. Most experienced physicians consider it ineffective for severe depression. St. John’s wort should not be combined with SSRIs because of the risk of serotonin syndrome.

Patients may turn to a wide variety of other herbal or nutritional remedies purported to have antidepressant effects, such as gingko, kava kava, melatonin, megavitamin doses, DHEA, chromium, inositol, and S-adenosyl methionine. Some other herbal agents include ginseng, royal jelly, wild oats, lemon balm, wood betony, and basil (33, 34). Full discussion is beyond the scope of this book, but physicians are urged to carefully ask patients what they may be taking.

**Key Points**

- An assessment of suicidality should be performed on every patient suspected of having depression.
- While physicians vary in experience and comfort in managing depression, mental health referral should be made if the patient is acutely suicidal, psychotic, severely depressed or has not responded to antidepressants.
- Appropriate boundaries in the doctor-patient relationship should be maintained with depressed patients.
- Patient confidentiality may be broken when dealing with a suicidal patient.
- Explicit documentation of symptoms, diagnosis, and treatment is very important for clinical and medical-legal reasons.
- Lifestyle interventions (i.e. exercise, nutrition, sleep hygiene, relaxation techniques, religious involvement, social contact, psychoeducation) can play important roles as treatment for minor depression and as adjuncts to treatment in moderate and severe depression.
- Overuse of psychoactive substances including caffeine, nicotine, over-the-counter medications, herbal remedies, alcohol, and other substances of abuse may aggravate depression and interfere with recovery.
- There is much interest but fewer data regarding alternative remedies such as St. John’s wort and light therapy.
References:

General

Suicide

Boundaries

Disability

Exercise

Nutrition


**Sleep Hygiene**


**Psychoactive Substances**


18. Regier et al. *Arch Gen Psychiatry* 41:949-958.


**Religious Involvement**


**Psychoeducational Material**

Light Therapy

St. John’s Wort and other alternative medicine therapies

Key References
1. Harris EC, Barraclough B. Suicide as an outcome for mental illness. *(A large meta-analysis of 249 reports of suicide risk of all mental disorders. It illustrates that an assessment of suicidality should be performed on not only patients with depression but all patients with a mental illness)*. *British Journal of Psychiatry* 1997, 170, 205-228.
2. Gabbard GO, Nadelson C. Professional boundaries in the physician-patient relationship. *(Gabbard & Nadelson are two of the most respected psychiatrists in the field. Their discussion on boundaries is readable and applicable to all)*. *JAMA* 1995 May 10; 273(18): 1445-9.
3. Wells KB et al. The functioning and well-being of depressed patients. *(The Medical Outcome Study is the seminal study demonstrating similar functional impairment in medical and psychiatric illnesses)*. *JAMA* 1989 August 18; 262 (7): 914-9.
4. Edzard E, Rand JI, Stevinson C. Complementary therapies for depression. *(The authors offer the most complete review to date on complementary and alternative therapies for depression)*. *Arch Gen Psychiatry* November 1998; 55:1026-1032.
Key Case: A colleague with depression and alcohol abuse.

A 56 year-old male physician, who is on staff at the same community hospital as the treating physician, presents for a “yearly check-up.” His last contact with the treating physician was 6 years ago for a similar visit. He reports displeasure with his work and dissatisfaction with the changes in medical care that have occurred in his career. He goes on to note a recent 12 pound weight loss, a decrease in energy, problems paying attention to his tasks, a feeling of being “too busy” for any fun, and difficulty sleeping. He says that he helps his insomnia with “a cognac.” He is evasive with further questioning about his alcohol consumption, though he admits that his father was an alcoholic. He also reports that his paternal uncle committed suicide. The remainder of his history and physical are negative.

When you call to report the results of his lab work (slightly elevated AST and ALT) over the phone the next evening, you find that his speech is slurred. You briefly, awkwardly approach the topic of drinking, but he is evasive. Feeling uncomfortable, you stop questioning him on the issue and the conversation ends.

Two months pass, and several of your other patients have reported dissatisfaction with your colleague (patient) because he erratically cancelled and rescheduled appointments. You also notice that he is absent at committee and hospital staff meetings which is unusual for him. He approaches you in the hall and says that he needs to talk to you after hours that day. In your office he reports that his wife has asked him for a separation and he has “had enough” and wants a “break from all this.” He inquires if you would like to take over his practice. He appears tired, speaks softly, shows signs of psychomotor retardation and has poor eye contact. You inquire further about his drinking. He says that it is the only thing that helps. When asked directly about “hurting himself,” he does not answer. After an awkward silence he stands up and asks you to consider his offer. He leaves before you can respond.

Question: What are the risk factors for suicide in this case?

□ Comments: At this juncture you, the treating physician, are in a difficult situation. First, the patient has escalating symptoms of depression (e.g. decreased energy, decreased concentration, poor sleep, isolation, hopeless, weight loss, cessation of pleasurable activities and psychomotor retardation). Second, he has indications of significant substance abuse (e.g. erratic work schedule, self-medicating with alcohol, evasiveness when discussing alcohol, elevated hepatic enzymes and positive family history). Third, the patient has significant risk factors for suicide (e.g. escalating symptoms, alcohol abuse, male, pending divorce, positive family history, giving away his practice). You have adequate information to believe that your patient has major depression, alcohol abuse and is at significant risk to commit suicide.

□ Question: When should a treating physician break confidentiality?
Comment: The next step in treating this patient would involve breaking your confidential relationship with him to access other resources on his behalf. However, you feel uncomfortable doing so because he is your colleague and professional peer. Despite your discomfort, it is appropriate and indicated to break confidentiality to get further information.

You call the patient’s wife and she confirms that he drinks nightly to intoxication. She says she is leaving him because he has repeatedly either denied “the problem” or flatly refused treatment and she “can’t take it anymore.” She also says that she is worried because he has been acting “very strangely.” She describes that he has been in the garage late at night the last few nights and does not seem like “himself anymore.” He has not come home tonight, she says, and this is unusual. You inform her of your concerns, and that you are going to activate emergency measures to find him and have him emergently evaluated and treated.

How is an emergent referral made?

Comment: You contact the mental health crisis service in your area and they explain to you the steps you need to take to have him located and brought in for evaluation. Two hours later, the psychiatrist in the emergency room calls and reports that the Sheriff found him in a rest area, intoxicated, with a gun on the seat next to him. He still refuses treatment. The psychiatrist reports that the patient is going to be involuntarily admitted for treatment. After being hospitalized, and completing an outpatient alcohol treatment program, the patient returns to work three months later with the help of the impaired physicians’ program in your state.

Conclusion: This case illustrates the complex mixture of escalating depression and alcohol abuse in an impaired colleague. Like any patient suspected of imminent danger due to suicidality, the treating physician may break confidentiality to further assess and treat the patient. In this case the information received from the patient’s wife confirmed the treating physician’s suspicion. Who then appropriately activated an emergent referral to mental health services and the patient was found and treated before any harm occurred.

Harris EC, Barraclough B. Suicide as an outcome for mental illness. *Br J of Psychiatry* 1997, 170, 205-228.

