Chapter 16: Depressive Disorders

Gin S. Malhi

Academic Department of Psychiatry, Kolling Institute, Northern Clinical School, Faculty of Medicine and Health, The University of Sydney, Australia, CADE Clinic and Mood-T, Royal North Shore Hospital, Northern Sydney Local Health District, Australia, Visiting Professor, Department of Psychiatry, The University of Oxford, UK, and Oxford Uehiro Centre for Practical Ethics, Faculty of Philosophy, The University of Oxford, Oxford, UK.

Erica Bell

Academic Department of Psychiatry, Kolling Institute, Northern Clinical School, Faculty of Medicine and Health, The University of Sydney, Australia, and CADE Clinic and Mood-T, Royal North Shore Hospital, Northern Sydney Local Health District, Australia.

and

Philip Boyce

Specialty of Psychiatry, Westmead Clinical School, The University of Sydney, Australia, Westmead Institute of Medical Research, Australia, and Faculty of Health, Charles Darwin University, Australia.

Introduction

Depression is a normal human emotion; we can all feel depressed or experience a low mood when confronted with adverse experiences, such as the loss of a relationship or an occupation. Generally, such low mood is transient and is not considered to be a 'disorder' per se. However, when a low mood is accompanied by other symptoms, is persistent (lasting over 2 weeks) and leads to some functional impairment, a clinically significant depressive disorder can be diagnosed.

DSM-5-TR refers to clinically significant depression as major depressive disorder (American Psychiatric Association, 2022). It is one of the most common psychiatric disorders (see *Epidemiology*) and is treatable. However, depression is often not identified or recognised, and effective treatments are delayed or missed altogether. This is especially problematic, as depression has widespread and significant impacts on the individual affected, their family, relationships and the wider community (see Table 16.1).

Table 16.1. Impact of depression.

Individual	Suffering, distress, and poor quality of life
	Increased risk of suicide
	Impaired work performance
	Lower income
	Poor academic achievement
	Adverse impact on medical problems (worsened illness course, increased disability, and increased mortality)
	Increased all-cause mortality
Social network	Reduced wellbeing of families and friends
	Disturbed inter-personal relationships
Community	Absenteeism and reduced work productivity
	Increased medical care costs

Epidemiology

Depression is one of the leading causes of disease burden worldwide because of prolonged morbidity and functional impairment, as such it is an important public health issue (Vos et al., 2020). There have been considerable efforts globally to raise awareness about depression and to destigmatise both the diagnosis and its treatment. However, globally, the 12-month prevalence of major depressive disorder (MDD), remains high (7.2%) and the prevalence of MDD over a lifetime is approximately double this (7.5-13.6%) (McGrath et al., 2023; Lim et al., 2018). Depression is found in all cultures, across all countries, and is twice as common in women as men - in contrast to bipolar disorder (Kuehner, 2017; McGrath et al., 2023). In Australia, approximately one in five people will suffer from an episode of depression in their lifetime (Australian Institute of Health and Welfare, 2023) and many will attempt suicide (Australian Institute of Health and Welfare, 2022).

Aetiology

The aetiology of depression is multifactorial. Both societal and environmental factors play a significant role in the development of depression, as well as contributions from biological and genetic factors. These influences interact via epigenetic mechanisms and therefore while the illness is familial, its incidence in a particular individual is difficult to predict.

One explanation for depression has been the serotonin hypothesis (Moncrieff et al., 2022). This emerged from the serendipitous discovery the monoamine oxidase inhibitors (MAOIs) lead to remission of depressive symptoms in the 1950s, and the subsequent finding that the tricyclic antidepressants are effective (Malhi and Mann, 2018). The drugs have an effect on transmission of monoamines (serotonin and noradrenaline) in the brain. The subsequent development of drugs that target serotonin receptors (the SSRIs) lead to the serotonin hypothesis; that depression was the result of defective central serotonin transmission. This hypothesis has been used as an explanation to patients as a rationale for the prescription of an antidepressant. However, this model has now been superseded by a number of other hypotheses that relate to stress (the HPA axis), genetic and epigenetic phenomena, immunological causes, and the role of trauma.

The development of depression is perhaps best understood using a stress diathesis model; a depressive episode is triggered by an adverse life event (stress) in those that have a vulnerability (diathesis) to developing depression. As mentioned above, the vulnerability may be biological (genetic), social (here social inequality is a key factor) or a variety of psychological vulnerabilities (such as low self-esteem or having experienced adverse childhood experiences).

Onset

Most commonly depression presents in primary care, manifesting initially from mid-adolescence through to the fourth and fifth decade of life. The illness is therefore not uncommon in the third decade of life (twenties), but a significant number of individuals will experience their first episode of depression before they turn 20 (Solmi et al., 2022). The onset of depression can be insidious but can also be sudden when triggered by significant life events.

Depression in Primary Care

As noted above, people first present with depression in primary care. Indeed, depression is one of the most common reasons for which people seek a GP appointment. However, sometimes the person presents with another illness or with somatic symptoms associated with depression as their primary complaint. It is estimated that over 50% of people with depression presenting in primary care do not have the illness recognised by their GP, thereby delaying or missing out on appropriate treatment. Furthermore, of those that have their depression identified, only 50% will be adequately treated (Marx et al., 2023).

Diagnosis

A depressed mood is a normal human experience, something that can happen to all people when an adverse experience happens such as the breakup of a relationship, the loss of a job, or a bereavement. What differentiates this normal human emotion from a depressive illness is the presence of additional symptoms, the persistence of the low mood and the duration it has been present for. The incidence and severity of depressive symptoms varies. The key symptoms that are used to define depression are shown in Table 16.2 (see also, Figure 17.1 within Chapter 17: Bipolar Disorder), 5 symptoms are required to be present to qualify for the diagnosis. When present concurrently these symptoms constitute a depressive syndrome, and if present on most days (persistence) for a period of at least two weeks (duration) they then qualify for designation as a depressive episode. Depressive episodes are the basis of major depressive disorder which is often a lifelong recurrent disorder.

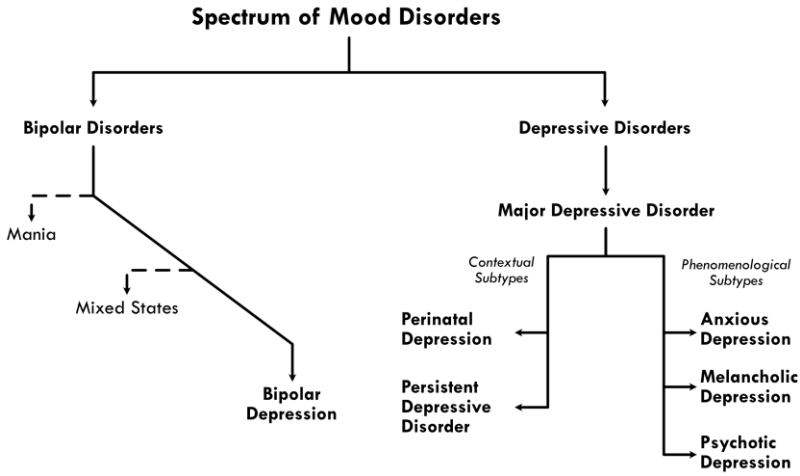

Figure 16.1. Putative types of depressive disorders. This schematic organises some of the various 'types' of depression. It is important to note that this is not comprehensive and that only recognised examples of depressive disorders that are commonly encountered in clinical practice are shown.

It is important to note that major depressive disorder is an umbrella term that encompasses different 'types' of depression. That is to say, depressive syndromes that vary in terms of their prevailing symptoms or distinguishing features such as context within which the depression has manifested. In the past, depression was subdivided into 2 types; one with a 'biological underpinning' called endogenous depression (or melancholia) and the other, arising from psychosocial factors. The validity of this binary distinction has not been confirmed, and currently it is recognised that depression is a heterogeneous disorder. The key types of depression are listed within Figure 16.1, but it is important to note that these types are purely based on phenomenology and are not discrete, separate kinds of depression.

Clinically and in research, the diagnosis of depression is therefore regarded categorically even though individual symptoms are dimensional, and the illness (major depressive disorder) exists on a spectrum of mood disorders. Therefore, in practice, qualification for a diagnosis of major depressive disorder also requires a degree of distress and functional impairment that distinguishes it from normalcy. Further specification of depressive disorders is based on severity (mild, moderate, and severe) and syndromal subtypes (e.g., melancholic, psychotic) – and both specifiers may be used to refine management.

In this context, the Activity, Cognition and Emotion (ACE) model (Malhi et al., 2018) is useful as it underscores both the dimensional nature of depressive symptoms and the need for adopting a longitudinal perspective when assessing mood disorders (see Bipolar chapter for further detail). In practice, an emphasis on careful assessment is critical as there are no biomarkers that can supplant clinical acumen.

Diagnostic criteria for major depressive disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood*.
2. Markedly diminished interest or pleasure in all, or almost all, activities (anhedonia)*.
3. Significant changes in weight or appetite (either increased or decreased).
4. Significant changes in sleep (insomnia or hypersomnia).
5. Psychomotor agitation or retardation (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional).
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thoughts of death (not just fear of dying); recurrent suicidal ideation without a specific plan; a specific suicide plan; or a suicide attempt.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or another medical condition.
D. At least one major depressive episode is not better explained by a psychotic disorder.
E. There has never been a manic episode or a hypomanic episode.

* Key symptoms, either depressed mood or anhedonia must be present.

Course and Impact

The course of depression is equally varied as is its diagnosis, but, by and large, it is an episodic disorder and patients tend to feel reasonably well between episodes. However, it is important to note once depression has manifested it is never cured *per se* and that an underlying vulnerability for depression remains lifelong.

Typically, untreated episodes of depression last several months but can extend to years, and even with successful treatment complete recovery can take up to a year. Even so, following recovery, the likelihood of recurrence remains high, and up to 50% of patients with depression will experience further episodes of

depression during their lifetime. The likelihood of a favourable outcome reduces with age and with older age of onset. Further, with each episode the probability of further recurrences increases. Thus, overall, roughly 50% of those experiencing a major depressive episode will recover within 6 months but more than a quarter will remain unwell and develop a chronic depressive disorder (Angst et al., 2009; Boschloo et al., 2014; Hengartner, 2020). This is partly why depression confers a high global burden of disease, and why by 2030 it will be the leading cause of burden of disease worldwide (World Health Organization, 2011).

Management of Depression

Diagnosis and Formulation

Taking a thorough history, ideally over a period of time, which allows the observation of symptoms, and the gathering of collateral history is the key to making an accurate diagnosis and fully understanding depression. To make sense of the illness, a complete picture of the person's life is needed. So, after assessing the current symptoms (*presenting complaint*) and how these have emerged (*history of presenting complaint*) and reviewing the course of the illness (*past psychiatric history*), it is important to put this in context, with respect to the development of the individual, their relationships, and roles. The components of taking a clinical history are shown in Figure 16.2.

Understanding the nature of depression, how it has emerged, and how it can be best treated, is essential for patient engagement and for ensuring optimal outcomes. It helps develop a comprehensive and effective management plan. Once a clinical picture of the current depressive episode and its clinical context is formed, it is possible to consider the degree to which its aetiology and pathogenesis is driven by biological and/or psychological factors in combination with personal, social and lifestyle determinants. This informs treatment.

In most cases, and especially where there are many psychosocial contributory factors to the depressive illness, the initial steps of management should involve *Actions* (see Figure 16.3). Note, treatment with medications is not always necessary and is considered later under *Choices* and *Alternatives* (Malhi et al., 2021).

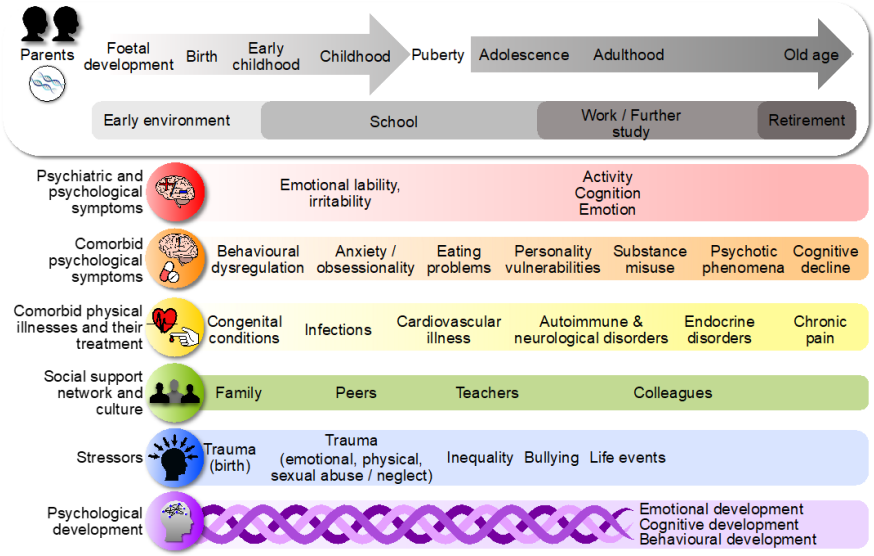

Figure 16.2. Framework for assessing clinical factors that contribute to depression, adapted from Malhi et al. (2020). The growth and development of an individual is depicted at the top of the figure and this 'life-line' provides a timeframe for changes across several domains. The domains are shown on the left and the key aspects that should be considered and assessed are depicted according to stage of life.

In many cases of depression, changes to lifestyle, the removal of stressors and the use of evidence-based psychological interventions alongside psychoeducation, are sufficient to manage uncomplicated depressive symptoms. In patients where pharmacotherapy is needed from the outset, because of symptom severity or patient preference, it is important to ensure that *Actions* have been undertaken (Malhi et al., 2021). This is because psychological therapies alongside pharmacotherapy enhance outcome, and adverse social and lifestyle factors often maintain depression. Furthermore, many of the *Actions* are likely to optimise the pharmacotherapeutic response and therefore it is essential that they are given full consideration at the outset of management and subsequently maintained throughout.

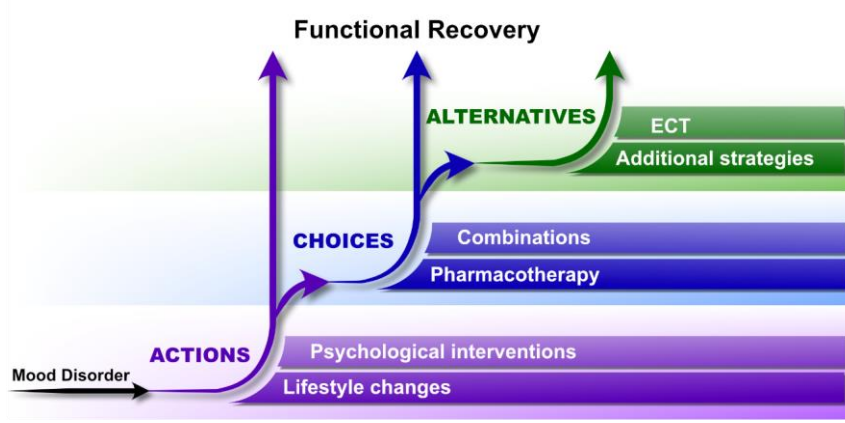

Figure 16.3. Actions, Choices, and Alternatives framework for managing mood disorders, adapted from Malhi et al. (2020). This framework includes 3 components. 1) *Actions* – form the basic foundation of management and should be instituted whenever possible. They include lifestyle changes and psychological interventions. 2) *Choices* – involve those pharmacotherapeutic options that are recommended and should be trialled initially. 3) *Alternatives* – include complex medication strategies and physical treatments such as ECT. Functional recovery can be achieved at any point, and the aim should be to achieve this as quickly and effectively as possible.

Actions

In the management of depression, *Actions* involve the development of good habits, gaining knowledge, and measuring and facilitating the development of new coping skills. These are outlined in Figure 16.4, and amongst these, note that evidence-based psychological interventions require delivery by trained clinicians, typically psychiatrists, psychologists, and primary care physicians (general practitioners) with an interest in psychological therapies.

Figure 16.4. Actions for managing depression, adapted from Malhi et al. (2020). There are three groups of Actions that can facilitate functional recovery. The first are those the patient needs to institute, such as lifestyle changes. These include sleep hygiene, maintaining a healthy diet and taking regular exercise. The second are those the patient needs to address as a priority – although they may require assistance – such as limiting drinking and the cessation of smoking. The third are those that need to be implemented. These include psychoeducation and psychological treatment. In addition, it is important to consider the social needs of the individual, and how these are impacting their depressive illness, and assist with these if possible (e.g., referring to social worker). Finally, the assessment (measurement) of clinical symptoms, and especially those related to any risks, and an appraisal of overall outcome are important.

Psychological Treatments

Several evidence-based psychological treatments have substantive support for acute major depressive episodes, with emerging evidence of longer-term benefits. Therapies, such as cognitive behavioural therapy (CBT), Interpersonal Therapy (IPT), Problem-solving therapy (PST), Behavioural activation therapy (BAT), Nondirective supportive therapy, and Short-term psychodynamic psychotherapy (STPP) have been found to be effective. The UK NICE guideline that considered cost and access alongside effectiveness ranked interventions for major depressive disorder having divided the depressive spectrum into less and more severe (NICE, 2022) (see Figure 16.5). Notably, it ranked group interventions as being better for less severe depression and counselling (individual supportive therapy) as being better than STPP (Malhi et al., 2022). But overall, CBT is the primary recommended approach for acute MDD.

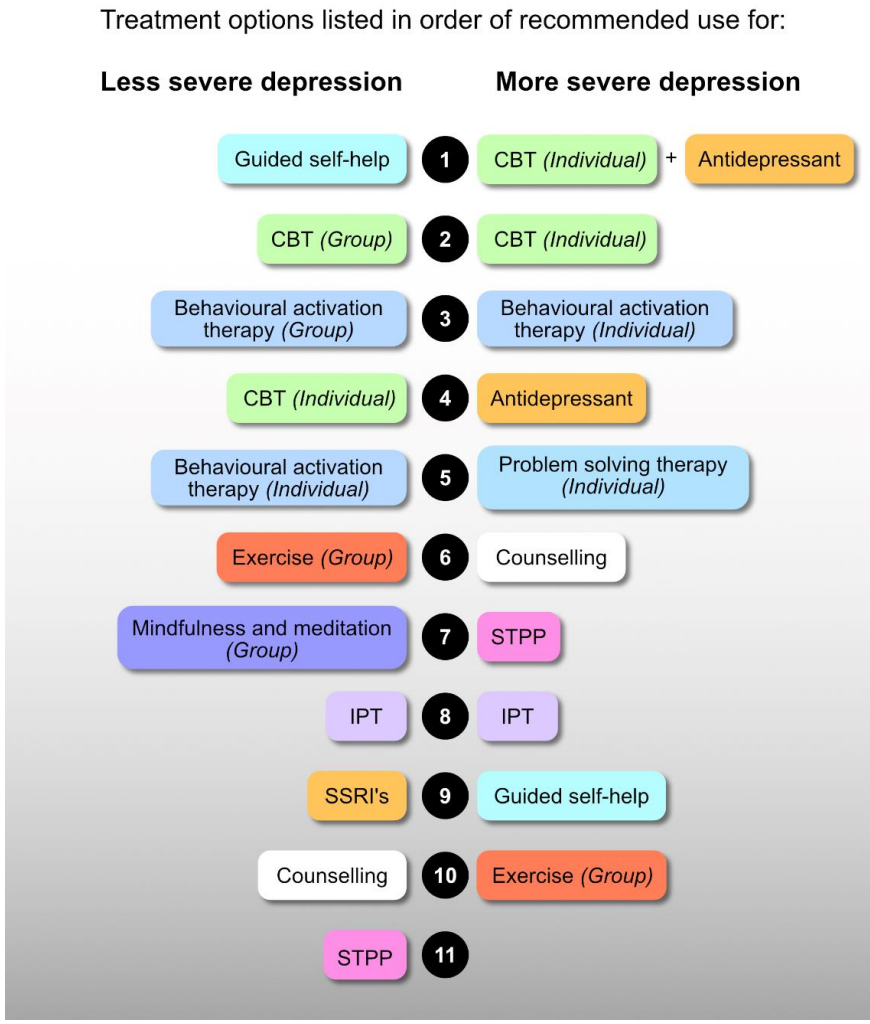

Figure 16.5. Schematic illustrating treatments ordered by recommended use according to the 2022 NICE guidelines, adapted from Malhi et al. (2023). Treatments are identified by separate colours, with mode of delivery shown in italics. In addition, SSRIs and the broader category of antidepressants are shown in the same colours. CBT = cognitive behavioural therapy; IPT = Interpersonal therapy; SSRI's = selective serotonin reuptake inhibitors.

Reflecting the rapidly changing delivery landscape (e.g., during and post-pandemic), the 2020 RANZCP guidelines include detailed consideration of the digital delivery of psychological therapies (interventions offered on computer,

tablet, or smart phone). Extant evidence suggests that digitally delivered interventions may have equivalent efficacy to in-person treatment for major depressive disorder but with significant cost benefits. This is particularly important in remote areas where there is limited access to mental health professionals. Even so, clinically, in-person treatment remains essential and is often preferred by both patients and clinicians, highlighting the relative strengths and weaknesses of in-person versus digital delivery for different patients and across various phases of management.

Choices

If the above *Actions* are insufficient and are unable to produce remission, and the patient is willing to consider medication, then an antidepressant should be prescribed. In some cases, an antidepressant may be prescribed from the outset, especially if this has been necessary in the past and this should be combined with actions. Hence, it is important to determine whether the patient has had previous treatment. When selecting an antidepressant, there are two main considerations: *efficacy* and *tolerability*[1].

Efficacy

All antidepressants have been shown to be better than placebo[2], but clinically there is a range of effects. The differential activity of antidepressants is evident both clinically and in research studies. Generally, medications with a broader spectrum of actions, such as the tricyclics (e.g., amitriptyline), appear to be more efficacious than those that are selective. However, agents with a broad mechanism of action are also more likely to have side effects that reduce compliance and effectiveness.

The efficacy of antidepressants is also dependent on depression severity, subtype, and the clinical profile of symptoms the person is experiencing. Therefore, efficacy should not be the only consideration when selecting an antidepressant.

The most commonly prescribed classes of antidepressants in Australia are the serotonin reuptake inhibitors (SSRIs), followed by the dual acting serotonin and noradrenaline reuptake inhibitors (SNRIs).

[1] Note: *effectiveness* is a combination of the two, and it is *not* synonymous with efficacy.
[2] Note: superiority over placebo is required for regulatory approval.

Table 16.2. Pharmacological treatment based on clinical profile. Considerations must also include efficacy and tolerability, depressive subtype and severity, past treatment history and responsivity, and patient preference.

Key/Prominent Symptom(s)	Antidepressant
Anxiety	Escitalopram Venlafaxine
Cognitive difficulties (e.g., learning, memory, decision-making)	Vortioxetine
Fatigue	Bupropion
Melancholia (e.g., psychomotor slowing, diurnal mood variation)	Amitriptyline Venlafaxine
Pain	Amitriptyline
Sleep disturbances (e.g., Insomnia)	Agomelatine Mirtazapine

Tolerability

Tolerability is equally important as efficacy, and adherence to medication is a critical factor in treatment success. While antidepressants are frequently prescribed, up to 50% of people do not continue them (Sansone and Sansone, 2012). When commencing antidepressant therapy, patients should be advised of potential side-effects and asked to be vigilant and monitor not only their symptoms, but also how they react to their medication. The key side effects of the major classes of antidepressants are shown in Table 16.3. It is imperative that patients are informed of the time needed for an antidepressant to work (at least 2 weeks) and that they need to be taken regularly. They should be encouraged to report side effects promptly but not necessarily stop medication – unless the side effects are intolerable. Instead, they should seek prompt assistance and review by their doctor.

In practice, once antidepressant therapy has been initiated, it is useful to schedule a follow-up appointment within 2 weeks. Most side effects occur within the first week of treatment by which time steady state serum levels of most antidepressants will have been reached. A 'start low' and 'go slow' approach to dosing can be adopted for patients of advanced age, or those who have a history of poor medication tolerance or are anxious about taking medication.

The most common side-effects reported by patients include gastrointestinal symptoms (nausea and diarrhoea), sexual dysfunction, sedation, weight gain, anxiety, over-stimulation, and agitation (see Table 17.3). It is important to consider

potential interactions with other medications and sometimes the risk of suicide needs to be factored into prescription choice as some antidepressants are potentially more dangerous than others in high doses – as occurs in an overdose (e.g., tricyclic antidepressants).

Table 16.3. Side effects associated with common antidepressant classes, adapted from Malhi et al. (2015).

	Weight gain	Sexual dysfunction	CNS effect (e.g. sedation, fatigue, agitation)	Anticholinergic effect (e.g. tremor, dry mouth)	GI distress
SSRI	+	+++	++	++	++
NARI	++	+	+	+	++
NaSSA	++	++	+++	++	+
Melatonergic agonist	+	+	+	+	+
NDRI	++	+	++	++	+
SNRI	+	+++	++	++	++
TCA	++	+	+++	+++	+
MAOI*	+	+	+	+	+
SARI	+	+	+++	+	++

Note: + < 10%, ++ = 10-30%, +++ > 30%. SSRI = Selective Serotonin Reuptake Inhibitor; NARI = Norepinephrine and Dopamine Reuptake Inhibitor; NaSSA = Noradrenergic and Specific Serotonergic Antidepressant; Melatonergic agonist = Melatonergic Agonist; NDRI = Norepinephrine-Dopamine Reuptake Inhibitor; SNRI = Serotonin-Norepinephrine Reuptake Inhibitor; TCA = Tricyclic Antidepressant; MAOI = Monoamine Oxidase Inhibitor; SARI = Serotonin Antagonist and Reuptake Inhibitor.*Some combinations of MAOIs with other medications can cause serious side effects and on occasion be fatal. Therefore, contraindications and dietary restrictions must be reviewed and adhered to. See 'Further reading' section at the end of this chapter for additional details.

Selecting an Antidepressant

The actions of antidepressants should be tailored to the clinical profile of the patient. This requires an understanding of the pharmacological actions of different medications (see Table 16.3). Figure 16.6 illustrates the seven drugs recommended as *Choice* agents. Each of these has a slightly different pharmacological profile, which means they each have a unique effect as regards efficacy and tolerability. Together, the seven antidepressants provide a range of mechanisms of action. It is important to note that monoaminoxidase inhibition is *not* represented by these 7 agents. Inhibitors of this enzyme provide a broad spectrum of efficacy, but

because antidepressants in this class have many interactions, they are regarded as an *Alternative*, rather than a *Choice* antidepressant.

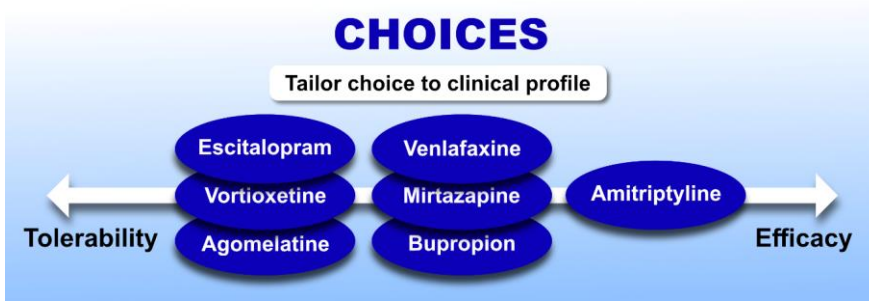

Figure 16.6. Pharmacotherapy Choices for the management of depression, adapted from Malhi et al. (2020). The *Choice* antidepressants each have different mechanisms of action. Broadly, all of them have actions on monoaminergic systems, with some medications having additional effects. The different receptor-binding profile of each antidepressant means that there is some separation in terms of clinical effects – both efficacy and tolerability. Knowledge of the different mechanisms of action is important as it provides a basis for understanding the different clinical effects and profiles of these medications. The seven *Choice* antidepressants are depicted according to their relative efficacy and tolerability, but selection should also consider clinical profile, depressive subtype, illness severity, past treatment history, prior responsivity, and patient preference.

Alternatives

There are now nearly 30 medications that have antidepressant properties and have an indication for the treatment of depression. Therefore, there are multiple choices and options available. However, in many cases, these interventions are either ineffective or insufficient on their own, and this means that additional, *Alternative* strategies have to be employed.

Chief amongst these alternatives is the combination of the various types of treatment that have been discussed. As has already been emphasised, the combination of psychological interventions with medications is most effective and preferable where possible. And ideally, this should occur in the context of lifestyle and habit-transforming *Actions*.

In some cases of depression these steps do not produce a satisfactory response, and the patient is unable to achieve remission and recovery. In these

instances, *Alternatives* are necessary. These are summarised in Figure 16.7 and can be remembered using the acronym *MIDAS*.

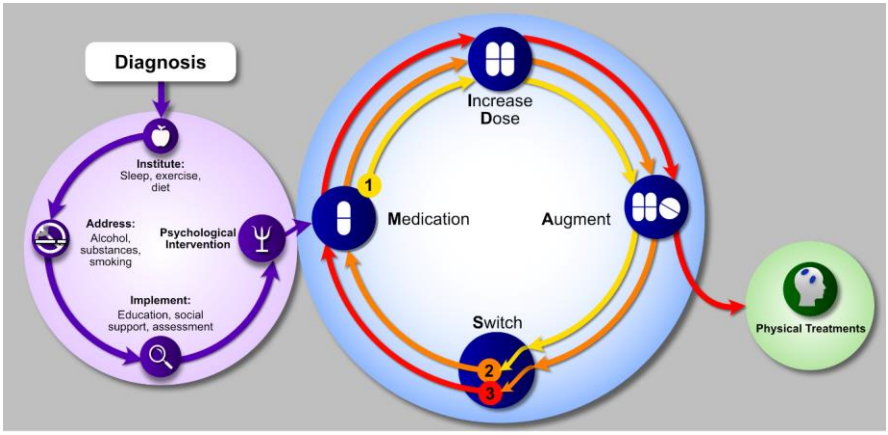

Figure 16.7. MIDAS approach, adapted from Malhi et al. (2020). This figure provides an overview of the management of depression. Following accurate diagnosis and clinical formulation, *Actions* are instituted, and psychological interventions are administered on their own or alongside pharmacotherapy. ***M**edication* if needed is selected to suit the clinical profile of the depressive presentation as per the Choices available and according to effectiveness. The first antidepressant (1) is then prescribed and the dose of this can be increased (*Increase Dose,* ***ID***) if necessary. If this is insufficient, then ***A**ugmentation* can be considered. This involves the addition of an agent such as lithium, which augments the actions of the antidepressant. If this strategy is ineffective, then the antidepressant needs to be substituted. ***S**witching* the antidepressant should ideally involve shifting to another class altogether (e.g., a different *Choice* antidepressant medication), but switching within class is acceptable if the main reason for doing so is that the initial medication was not taken as prescribed (e.g., because of side effects or poor adherence). The MIDAS cycle should be repeated for as many of the Choice antidepressants as possible (and at least 3) before considering ECT. However, ECT may be administered much earlier in some cases, for example where depression is marked by psychotic symptoms or during pregnancy.

Physical Treatments

Many kinds of physical treatments have been developed and trialled for the treatment of depression. Most are still experimental, and none are as effective as electroconvulsive therapy (ECT; see Chapter 36). Figure 16.8 shows progression through several variations of ECT, in which the stimulus intensity and electrode

placement is altered. Note, with increasing efficacy, there is the increasing likelihood of transient cognitive side-effects. Therefore, in practice, whenever possible, brief, or ultra-brief pulse unilateral ECT should be trialled initially. ECT is especially useful in psychotic depression, and depression with melancholic features. ECT can also be administered as a matter of urgency where a patient is refusing oral medication and there is an urgent need for treatment because of inanition and dehydration. Importantly, ECT is safe in pregnancy, and may sometimes be the preferred choice.

Patients will need to give informed consent for ECT. If they do not have the capacity to provide this, or if they are an involuntary patient, then an order for involuntary treatment with ECT can be made under the appropriate Mental Health Act. Patients will need to have an anaesthetic review prior to the administration of ECT to ensure their fitness for an anaesthetic.

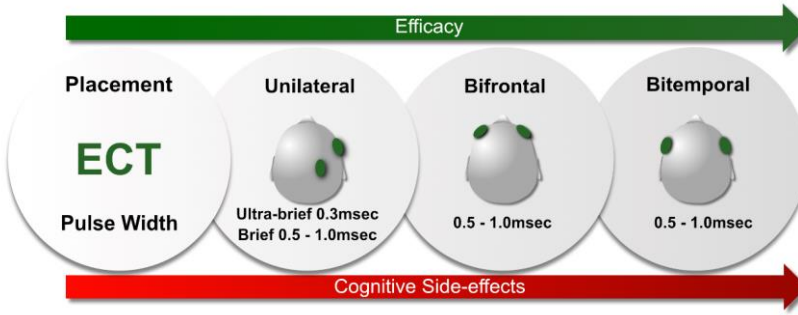

Figure 16.8. ECT in depression, adapted from Malhi et al. (2020). ECT can be applied unilaterally or bilaterally, over frontal and temporal regions (bifrontal and bitemporal, respectively). The pulse-width can be varied from 0.3- 1.0 msec, allowing different amounts of stimulation to be applied. Efficacy increases from unilateral to bilateral ECT and with an increase in pulse-width from ultra-brief to brief. With increasing efficacy there is an increased likelihood of cognitive side-effects, which are usually transient.

Maintenance Treatment

For most episodes of depression, one or other of the many treatments available (lifestyle, psychological, pharmacological, and physical) is likely to be effective. It is also important to remember however, that episodes of depression are intrinsically recurrent, and therefore periods of acute illness will often remit spontaneously. But even in these instances persisting with treatment is important as it ensures continuing engagement of the individual and allows for the ongoing provision of care. In this regard, it is important not to limit the focus of management to the treatment of an acute episode of depression. The disorder's recurrent course,

the persistence of subsyndromal symptoms, and increased suicide risk suggest that continued monitoring is warranted. Indeed, it is during the maintenance phase of management that the focus of clinicians can fully shift to building resilience against future episodes and moving towards quality-of-life enhancement.

Treatment Responsivity

Not all patients will respond to their initial treatment (about 40-50% will respond to an initial antidepressant) with a further 20% responding to a second round of antidepressant (Rush et al., 2006). Many patients coming into hospital may not have responded to a number of rounds of treatments.

The lack of response to treatments in depression has traditionally been described as 'treatment-resistant depression' (TRD), and more recently as 'difficult-to-treat depression' (DTD). However, these concepts are problematic as they emphasize lack of response and focus management on poor outcomes and failure to respond. This negative approach blames the individual and raises the complex and largely insurmountable role of personality factors. An alternative framing – the *responsivity paradigm* – addresses these problems.

An unsatisfactory response is often the result of poor adherence to treatment as prescribed. This applies to lifestyle advice, psychological interventions, and medications. Many of the Actions, such as diet and exercise, are challenging and are difficult for everyone irrespective of whether they are suffering from depression. Psychological interventions often require motivation, structure, and organisation. Medications are often seen as stigmatising and may also be regarded as unnecessary or dependence-inducing, and so patients fail to take their medications as prescribed – changing doses for example and stopping and starting treatment as they deem appropriate. Side effects and a lack of understanding about the need to continue treatment, may often lead to non-adherence, underscoring the importance of psychoeducation when prescribing medication.

The *responsivity paradigm* advises that these issues should be acknowledged at the outset, and that it should be accepted that there are several different *channels* (pathways) of treatment that can be pursued. Further, that no one knows at the start of treatment which of the various treatments is most likely to work. Hence, it is understood that several different strategies will have to be trialled until the appropriate strategy is found.

Having this discussion at the beginning of management allows the provision of a series of strategies that encompass different kinds of treatments. The discussion makes it clear from the outset that successful treatment may take time, and that

management requires regular review and revision of the treatment strategy being employed.

Further, reviewing the diagnosis and formulation regularly will open many channels of responsivity, and as treatment progresses, different strategies can be trialled.

The examples shown in Figure 16.9 make it clear that in some instances, more than one kind of therapy may be needed, and that in some cases, initial treatment may 'prime' the effects of later treatments, thus facilitating overall efficacy. The key advantage of this approach is that it provides a positive mindset, both for the patient and clinician, and avoids repeated disappointments and discussions regarding lack of response. Instead, clinical improvement is monitored and discussed, and versatility is introduced into management from the outset.

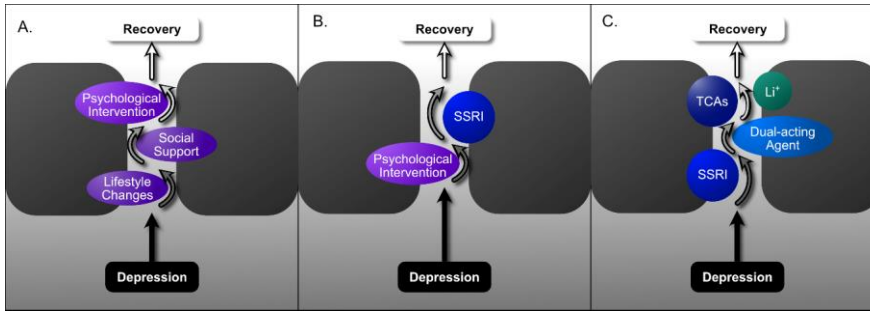

Figure 16.9. Responsivity Paradigm. The schematic above shows three channels that represent typical examples of pathways from depression to recovery. Each of the figures depicts different sets of treatments being used individually in sequence or in combination to achieve change. (A) Combination of lifestyle changes, social support, and psychological interventions (such as CBT) to facilitate recovery from depression. (B) Combination of psychological intervention and an SSRI to achieve recovery. (C) Sequencing of agents. First, an SSRI may be prescribed, but this only achieves a partial response and therefore it is suited to a dual-acting agent and then further supplanted by a broad-spectrum antidepressant such as a tricyclic (TCA). However, in this instance further treatment is necessary and an augmentation strategy (addition of lithium) is implemented to achieve recovery.

Conclusion

This chapter has outlined the foundational knowledge needed to address the most prototypical presentations of depression. However, in real-world practice, treating depression is rarely straightforward and often complicated by other factors such as atypical presentations, prior treatment history and psychological or

physiological comorbidities. For more detailed information regarding the nuances of treatment and the management of depression in clinical practice, see the 'Further reading' list at the end of this chapter.

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Cite as:

Malhi, G.S., Bell, E., Boyce, P. (2024). Depressive disorders. In Boyce, P., Harris, A., and Malhi, G.S. (Eds.), *The Sydney textbook of psychiatry* (pp. 200–220). The University of Sydney.

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