Difficult-to-treat depression

What can GPs do when a patient with depression does not get better?

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Depression remains a leading cause of distress and disability worldwide. In the 1997 Australian National Survey of Health and Wellbeing, 7.2% of people surveyed had experienced a mood (affective) disorder in the previous 12 months.[1] Those affected reported a mean of 11.7 disability days (when they were "completely unable to carry out or had to cut down on their usual activities owing to their health") in the previous 4 weeks. There was also evidence of substantial undertreatment: only 35% of people with a mental health problem had a mental health consultation during the previous 12 months. Of those with a mental health problem, 27% (ie, three-quarters of those seeking help) saw a general practitioner. In the 2007–08 Australian National Health Survey, not much had changed: 12-month prevalence rates were 4.1% for depression, 1.3% for dysthymia and 1.8% for bipolar disorder.[2] These disorders were associated with significant disability, role impairment, and mental health and substance use comorbidity. Again, there was evidence of substantial unmet need, and again GPs were the health professionals most likely to be providing care. However, one change in the intervening period was a reduction in treatment with antidepressants.

While GPs have many skills in the assessment and treatment of depression, they are often faced with people with depression who simply do not get better, despite the use of proven therapies, be they psychological or pharmacological. This supplement aims to address some of the issues that GPs face in this context.

To set the scene, Shadow Minister for Finance Andrew Robb (*page 3*) has provided an "insider's view" of depression. We are grateful to Mr Robb for his eloquent exposition of what it actually feels like to have a depressive illness. His account should serve as an ongoing reminder that depression happens to a wide cross-section of people, that those people suffer, and that our therapeutic endeavours should always be delivered in the context of the individual. GPs are well placed in this regard, as they often have a longitudinal knowledge of the patient, understand his or her circumstances, stressors and supports, and can marshal this knowledge into a coherent and comprehensive management plan. Of course, GPs should not soldier on alone if they feel the patient is not getting better. The rest of this supplement outlines strategies that they might adopt in such cases.

In trying to understand what happens when GPs feel "stuck" while treating someone with depression, Jones and colleagues (*page 6*) report a qualitative study that aimed to gauge the response of GPs to the term "difficult-to-treat depression". They found that, while there was confusion around the exact meaning of the term, GPs could relate to it as broadly encompassing a range of individuals and presentations. Thus, the term has face validity, if not specificity. More specific terms such as "treatment-resistant depression" are generally reserved for a subgroup of people with difficult-to-treat depression that has failed to respond to treatment, with particular management implications.

A set of articles then tackles one scenario in which depression can be difficult to treat — in the context of physical illness. Depression is often expressed via physical symptoms, but the obverse is that people with chronic physical ailments are at high risk of depression, as outlined by Olver and Hopwood (*page 9*). Pain syndromes, as discussed by Holmes and colleagues (*page 17*), are particularly tricky, as complaints of pain require the clinician to accept them as "legitimate", even if there is no obvious physical cause. The use of analgesics can create its own problems, including dependence. Patients with comorbid chronic pain and depression require careful and sensitive management and a long-term commitment from the GP to ensure consistency of care and support.

Depression (and anxiety) can also be seen in the context of cancer. This is in many ways understandable, given the existential issues raised by a cancer diagnosis, along with the pain and discomfort associated with the cancer and, often, its treatment. Couper and colleagues (*page 13*) provide useful strategies to assist in assessing mood in people with cancer (eg, how to distinguish depression from demoralisation), as well as articulating treatment options.

Interest in the role of lifestyle factors in the development and persistence of mental illnesses is gaining momentum. Jacka and Berk (*page 21*) detail the literature that supports an important role for exercise and diet in the management of depression, and provide useful practical tips to assist GPs in educating their patients about these issues. This should be an integral part of the comprehensive care of people with depression and can also help overcome associated physical health issues, such as obesity.

A series of articles then discusses the topic of psychiatric comorbidity in depression. In clinical practice, this is more common than not, and underappreciation of such issues can lead to suboptimal treatment outcomes. Beatson and Rao (*page 24*) tackle the difficult topic of depression co-occurring with borderline personality disorder (BPD). People with BPD have, as part of the core disorder, a perturbation of affect associated with marked variability of mood. This can be very difficult for the patient to deal with, and can feed self-injurious and other harmful behaviour. The key to management is the provision of a therapeutic "holding environment" and therapeutic consistency. Use of mentalisation-based techniques is gaining support, and psychological treatments such as dialectical behaviour therapy form the cornerstone of care. Use of medications tends to be secondary, and prescription needs to be judicious and carefully targeted at particular symptoms. GPs can play a very important role in helping people with

BPD, but should not "go it alone", instead ensuring sufficient support for themselves as well as the patient.

Tiller (*page 28*) provides an overview of anxiety in the context of depression. This is a very common comorbidity, can be associated with poor clinical outcomes and carries particular therapeutic challenges. A careful balancing of psychological and pharmacological interventions is required for optimal success. Another particularly problematic form of depression is that which occurs in the context of bipolar disorder. As Berk and colleagues (*page 32*) show, firm data on how best to manage bipolar depression are surprisingly lacking. It is clear that treatments such as unopposed antidepressants can make matters a lot worse, with the potential for induction of mania and mood cycle acceleration. However, certain medications (notably, some mood stabilisers and atypical antipsychotics) can alleviate much of the suffering associated with bipolar depression. Specialist psychiatric input is often required to achieve the best pharmacological approach. For people with bipolar disorder, psychological techniques and long-term planning can help prevent relapse. Family education and support is also an important consideration.

Schizophrenia is an often disabling condition associated with a broad lack of integration in society, low levels of income, lack of gainful employment, and high rates of physical health problems (notably cardiovascular disease) and substance use. It is hardly surprising that people with schizophrenia are at high risk of depression, but this is often missed clinically or the symptoms are simply attributed to the core illness. Bosanac and Castle (*page 36*) provide clinical clues to assessing mood in people with schizophrenia, and outline potential therapeutic strategies. GPs play a crucial role in the comprehensive care of people with schizophrenia, and a high index of suspicion for depression should be part of this.

Curran and colleagues (*page 40*) address what is likely to become a more common scenario with an ageing population — depression in the context of dementia. This is a complex clinical presentation, and requires vigilance, careful monitoring, and appropriate liaison with other members of the care team and the patient's family. The treatment of depression in people with dementia requires particular care, and attention must be given to avoiding any deleterious effects of prescribed antidepressants or other agents.

The final three articles in this supplement cover treatment strategies for patients with depression that does not respond adequately to usual first-line and second-line treatments. Chan and colleagues (*page 44*) provide a succinct account of potential pharmacological interventions for treatment-resistant depression, which has failed to respond to an adequate course of an antidepressant, although they point out the paucity of definitive evidence-based research in this area. This is a scenario in which GPs should consider specialist psychiatric review for their patients. Fitzgerald (*page 48*) details non-pharmacological biological approaches to difficult-to-treat depression. Electroconvulsive therapy has a long history in this regard and still holds an important place in the management of severe depression. However, the emerging technology of magnetic seizure therapy shows promise as an alternative application with fewer cognitive side effects. Other emerging treatments, such as repetitive transcranial magnetic stimulation and transcranial direct current stimulation, have the potential to alleviate depression in some people, with relatively few side effects. For a very select group of patients with depression, vagus nerve stimulation and deep brain stimulation have provisional evidence of effectiveness.

Psychological therapies such as cognitive behaviour therapy and interpersonal therapy have strong support in research and clinical practice as effective treatments for depression, either alone or in conjunction with antidepressant medications. Casey and colleagues (*page 52*) show how such therapies can be adapted for use in people with severe depression, and also outline broader psychosocial aspects of care.

The range of articles in this supplement highlight that a broad and individually focused plan of care, tailored to the person's needs and clinical profile, is the cornerstone of quality care. We thank all contributing authors and hope that this supplement assists clinicians generally, and GPs in particular, to enhance the health outcomes of patients with difficult-to-treat depression.

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