Introduction

Optimizing Treatment Outcome in Depression

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Many effective therapies, including pharmacotherapy, psychotherapy, and electroconvulsive treatment, are available for patients suffering from unipolar depressive disorders. Antidepressant drugs have become first-line treatment for depression in both primary and specialty care settings. Despite the improved safety and tolerability of newer antidepressants compared with tricyclic antidepressants and monoamine oxidase inhibitors, many patients do not adhere to antidepressant treatment. What are the most important contributing factors to noncompliance with drug treatment in depression, and how can we approach this issue with our patients?

In this supplement, based on a symposium held at the 1999 annual meeting of the American Psychiatric Association, Pedro L. Delgado, M.D., reviews some of these factors, focusing particularly on widely held misconceptions about depressive illness and antidepressants, misconceptions that may compromise treatment compliance. Steps for enhancing treatment adherence by improving patient and family education and communication between patients and clinicians are also presented. Additionally, Dr. Delgado discusses some of the more practical aspects of patient management leading to the development of a collaborative treatment environment.

Unfortunately, even when patients adhere fully to antidepressant treatment, the robust efficacy of antidepressants fails to translate to universal response. Patients may improve minimally or not at all, despite adequate doses of antidepressants prescribed for an adequate period of time. Other patients may improve significantly, but their response may be only partial, with some symptoms persisting. In both scenarios, clinicians face the dilemma of what to do next. Several treatment strategies are available to help partial and nonresponders gain full therapeutic response.

As my contribution to this supplement, I review the switching strategy, which is very widely used among clinicians for the management of nonresponse in depression.[1] This strategy, in which the patient's antidepressant is discontinued and a different one is started, is also frequently used in the management of intolerance. Although studies have shown that intolerance to one antidepressant does not predict intolerance to another antidepressant of the same class, many clinicians favor the switch to an antidepressant of a different class owing to concerns about possible cross-reactivity. As I point out in my review of the literature, switching antidepressants appears to be a relatively well-tolerated and effective strategy. More studies, however, are needed to guide clinicians in decisions concerning the type of switches (switch within the same class versus switch to a different class) and the specific agents involved.

J. Craig Nelson, M.D., examines the efficacy of another widely used strategy, augmentation. This approach typically targets nonresponders and, in particular, partial responders to antidepressant treatment. A number of augmenting agents, such as lithium, have been used over the past few decades with relative success. However, the introduction of newer agents

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has made some of the older studies obsolete. Dr. Nelson discusses the relative advantages and disadvantages of augmentation strategies and provides the rationale for some of the treatment combinations that are available, such as the use of a relatively noradrenergic drug added to a relatively serotonergic drug. Finally, he reviews the practical issues concerning the administration of these strategies.

Once patients have responded to their antidepressant medication, clinicians face a number of decisions related to reducing the risk for relapse and recurrence, primarily the duration of the treatment and how to improve treatment response while minimizing side effects. John M. Zajecka, M.D., reviews the main approaches to enhancing compliance with long-term antidepressant treatment and to optimizing treatment response and outcome. He discusses some of the factors that increase the risk for relapses and recurrences, creating in turn the need for extended periods of treatment. He also discusses the most common side effects to emerge in the context of long-term treatment, such as sleep disturbances, weight gain, sexual dysfunction, and asthenia, and provides recommendations for managing these side effects, with the underlying goal of improving patients' quality of life. Finally, Dr. Zajecka provides suggestions for early and ongoing educational messages that can improve the long-term management of depression.

I am very pleased to present this series of articles on a topic that is of great significance to both patients and practicing clinicians. I hope that these discussions will be useful to those who face the challenge of improving the delivery of antidepressant treatment and reducing the burden on the patients and their families and that they will also inspire future research on this topic.

REFERENCE

1. Fredman SJ, Rosenbaum JF, Fava M, et al. How often do psychiatrists raise the dose when SSRIs do not work? In: New Research Program and Abstracts of the 152nd Annual Meeting of the American Psychiatric Association; May 17, 1999; Washington, DC. Abstract NR128:97.