First, Do No Harm: Effective Strategies for Positive Long Term Outcomes in Depression

Conventional wisdom holds that a writer's greatest enemy is an empty sheet of paper. As a psychiatrist trained in allopathic medicine to practice healthcare justified by scientific evidence, I find the opposite is more likely the case—some days, I feel no escape from the onslaught of papers published in an ever-increasing number of peer-reviewed formats. I attend Grand Rounds at the university in my city when my schedule allows. The prescribing software I use lists new articles almost daily. My PDA has an application that downloads psychiatric news for me to read while I'm waiting for the dentist. I get four journals and two psychiatric newspapers every month. I still get weekly emails from my training program advising me of the four or five most relevant articles of the week. Some days I even read them.

Most days, though, my schedule runs behind because I listen, then seek to explain treatment options in language my patients can understand. Most days, I have to coordinate care with Primary Care Providers, other specialists, inpatient units, residential facilities, informal caregivers, therapists and case managers. Most days, a nearly bottomless stack of refill requests, urgent phone calls and administrative duties eat into my lunch and make me late for supper. Most days I work hard to maintain boundaries so that being a community psychiatrist doesn't keep me from being a son, uncle, lover and friend. Most days I work hard to balance productivity with quality. Most days, I challenge myself to provide the best rational care I know how to provide. Most days, I feel I succeed.

Nearly every day, the most straightforward of my cases progresses like that of the woman I will call Jane. Though she recently entered her fifth decade of life and this is her first visit with a psychiatrist, Jane has had intermittent depression for more than two decades. Growing up was difficult, it seems. Before she entered gradeschool, her parents separated due to dad's violence. After that, mom would come home drunk and beat her. She did well in highschool, until part-way through when her symptoms started. She's not sure if she started drinking then to help with anxiety, or if her drinking preceded her anxiety. She was arrested in highschool on substance related charges, and several times since. She took an unrecalled anxiolytic for awhile in he twenties. She went through rehab a decade ago. Running proved effective treatment for her until her symptoms flared a couple of years ago, She saw a counselor then, and took an unrecalled antidepressant for about six months. The antidepressant helped, but after she stopped it she started getting depressed again. She stayed sober until four months ago, when she once again resumed “self-medicating” with alcohol. Though she's always been impulsive and seldom felt herself to be on an emotional middle ground, she does not provide convincing history for any mania or hypomania. She has never had a head injury or seizure.

Despite seeing a therapist for a couple of months, Jane now feels depressed, unmotivated, and irritable. She's anxious, and startles easily. She's apathetic, and she can't concentrate. She feels guilty for not being a better wife and mother. She's easily overwhelmed, and though she has no plans to hurt herself, she has begun to think people would be better off if she got into an accident. She's not sleeping well, because her thoughts get in the way. She's exhausted. She's drinking 12 cups of coffee a day to help maintain her energy. She's eating more and can't seem to motivate herself to run. She's gained five pounds in the last month. She's overweight, and occasionally uses an Albuterol inhaler for her asthma. She's been sober for a few days, in part because money is too tight to pay for beer. She came today because she really wants to start a medication to help with her depression.

After much discussion during our hour and a half together, Jane and I agree on a plan. We will do

blood tests to screen for anemia, basic organ function, thyroid function, and nutritional deficiencies. She will read about fish oil, and sleep hygeine. She will exercise even though she doesn't feel like it. She will abstain from caffeine after supper, and work toward having none after lunch. She will abstain from alcohol, and re-engage in Alcoholics Anonymous. She will see her Primary Care Provider. She will keep working with her therapist. And even though the combination of depression, alcoholism, possible post-traumatic stress disorder and other symptoms most accurately described in DSM-IV's Cluster B personality disorders does not fit well into any treatment algorithms or FDA-approved indications, she will take a low-dose SSRI antidepressant. She will come back to see me in three weeks.

Back in my office five weeks later, Jane reports marked improvement. She attributes her recovery to being on an antidepressant, which she feels is “helping something connect” in her brain. She has cut out most of her alcohol, no longer drinks soda, and limits her caffeine intake to 24oz of coffee each morning. She re-injured her knee running, but can already move around without crutches. She's lost a couple of pounds. She no longer panics, and can now keep her thoughts from overwhelming her. She keeps up with her housework, and daily makes it a point to get out of the house with her children. She works parts of three days each week. She never rejoined her 12-Step group. She regularly attends therapy, where she and her therapist focus on anger management and taking responsibility for her own situation. She has not yet started the Vitamin D and Vitamin B12 prescribed in response to her lab tests, but agrees she will do that. She remains ambivalent about fish oil. She agrees to keep working with her therapist, and eagerly agrees to a tentative plan to taper off her antidepressant in the late spring. She feels confident that she is on the path to recovery, and will not need to see me about medications for a couple of months.

Two months later, Jane frets that her medications no longer work, and may need to be increased or discontinued in favor of something more potent. She's not sure why her depression seems to be “just starting to start all over again.” She did not go back to her therapist after our last visit. She quit her job. She over-thinks. She trusts people less, and her irritability seems to be making a comeback. She drinks soda again and has gained five pounds in the last two months. She stopped exercising. She never started B12, though Vitamin D helps her energy and pain levels. She again has problems falling asleep that she suspects are due to resuming her evening caffeine use. She has not used any alcohol or illicit substances since our last visit, and there is no chance she could be pregnant. After much discussion, she agrees to resume exercise, remain off alcohol, continue with her current antidepressant dose, continue Vitamin D supplementation, start Vitamin B12 as prescribed, start fish oil, remain off alcohol, again limit caffeine to mornings, and resume therapy.

As Jane walks out of my office, I ask myself once again whether my educated attention actually helps—after all, despite her earlier assertions of benefit, being on an SSRI clearly did not keep her on the path to recovery. Perhaps that success in most cases is moderate at best could be attributed to patients not following all my recommendations. Perhaps the most easily treated cases of depression are handled without a psychiatrist's attention, and so I only see the difficult-to-treat cases. Perhaps the reason it seems most of my patients have a chronic course is that the ones who get better don't come back. Perhaps I'd get better outcomes if more helpful treatment algorithms existed, or if I could find studies done on the kinds of patients I see rather than folks carefully selected for a single variable. Perhaps if I chose to work with patients who had better insurance, more resources, less medical illness, more stability, better parents...

Why didn't an SSRI result in sustained improvement for Jane? Why did another of my most-chronically-depressed patients get no better after she got a vagal nerve stimulator, but then improve

after she weaned herself from most of her medications and placed herself on an over-the-counter adrenal supplement? How much can I trust the various kinds of evidence that come my way? Why does the American Psychiatric Association's *Practice Guideline for the Treatment of Patients With Major Depressive Disorder* confidently recommend antidepressant medications as "an initial treatment choice" for all levels of depression severity, even when the serotonin theory of depression remains unsubstantiated?[i,ii] Why were combination therapies with multiple medications so common at that last psychopharmacology conference I attended? What does it mean that the majority of psychotropic medications are prescribed by non-psychiatric providers?[iii] Why are antidepressants the most commonly prescribed medications for adults in the United States of America?[iv] How helpful can antidepressants be when one half of patients stop them within three months?[v] What treatments result in the best long term outcomes for depression? How do antidepressants work? Do antidepressants work?

---

i Gelenberg AJ, et al. Practice Guideline for the Treatment of Patients With Major Depressive Disorder. Third Edition. American Psychiatric Association. October 2010. p17.

ii Krishnan V and Nestler EJ. Linking Molecules to Mood: New Insight Into the Biology of Depression. Am J Psychiatry 2010; 167: 1305-1320.

iii Goodwin R, Gould MS, Blanco C, Olfson M: Prescription of Psychotropic Medications to Youths in Office-Based Practice. Psychiatric Services 2001; 52:1081-1087.

iv Gu Q, Dillon C, and Burt V. Prescription Drug Use Continues to Increase: U.S. Prescription Drug Data for 2007-2008. NCHS Data Brief, No. 42, September 2010.

v Osterberg L and Blaschke T. Drug Therapy: Adherence to Medication. N Engl J Med 2005; 353:487-497.