Depression is one of the most common reasons patients visit their family physician. According to Alberta Health and Wellness, depression anxiety and stress accounted for 30% of all doctor visits in the province for the 1999/2000 year. This disorder, with a one-year prevalence rate in Canada of 3.2% to 4.6%, is expected to be the second leading cause of disability worldwide by the year 2020. Depressed patients use more health resources than patients with other medical conditions, and depression causes more than a twentyfold

Depression is a common debilitating disorder that causes significant patient distress and reduced quality of life. Once diagnosed, the condition usually can be treated successfully with patients regaining their previous level of functioning.

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increased risk of social disability.\textsuperscript{6-9} Evidence suggests depression may be accelerating the progression of medical illnesses and raising mortality rates.\textsuperscript{10-12} This article is directed towards family physicians, who treat more than 75\% of the patients suffering from depression in Canada.\textsuperscript{13} The goal of this article is to provide a framework for the clinician to implement a pragmatic approach towards the treatment of this frequently overlooked condition.

With each interaction the physician has with a patient, there are three factors that form the basis for decision making—the doctor-patient relationship, the disorder itself and the treatment that is to be implemented. By dividing the treatment of depression into four different phases (\textit{i.e.}, engagement, acute, prophylaxis and discontinuation), both the patient and the doctor can establish a defined path towards achieving a goal of complete symptom resolution and improved quality of life.

The treatment phases cited in this article are a synthesis of what has already been described in the literature and clinical experience. The framework addresses the use of the three factors in the decision-making process at each treatment phase of depression.

### Treatment Factors

Three factors play a role in every patient visit, regardless of the phase of treatment (Table 1). Consideration will be given first to the doctor-patient relationship or therapeutic alliance. A strong therapeutic alliance between the doctor and patient has been found to improve the outcome of psychotherapies and enhance medication compliance.\textsuperscript{14-16} An interpretive model of the doctor-patient interaction, rather than the traditional paternalistic model, is suggested. In an interpretive model, the aim is for the physician

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and patient to share responsibility for decisions. The physician uses his/her knowledge to help the patient choose a treatment. The physician contributes the medical information while the patient adds the history. Respecting the patient’s value system, together they decide on the most suitable treatment. A compassionate and non-judgmental doctor-patient relationship is paramount when treating depression.

On each visit, the physician will ask questions about the disorder, such as the frequency and severity of symptoms. The patient’s level of functioning and his/her quality of life also will be determined, and the role of psychosocial factors will be reviewed.

An evaluation of the treatment is addressed by using both patient descriptions and objective findings. Treatment evaluation will depend on the patient’s satisfaction with the advantages and disadvantages of the treatment.

### Treatment Phases

**Definitions.** When treating depression, consider the presence of four treatment phases — the engagement phase, the acute phase, the prophylaxis phase and the discontinuation phase (Table 2).

During the engagement phase, the physician develops a rapport with the patient and gathers information. Diagnostic issues are addressed, etiological factors are identified and a mutually agreed upon plan is established.

The acute phase is the active phase of treatment, in which there is an emphasis on symptom resolution and evaluation of information.

The prophylaxis phase begins once full symptom remission has been achieved. The goal is to keep the patient well by continuing and maintaining treatment.

The purpose of the discontinuation phase is to close a treatment plan in such a manner that no harm comes to the patient.

### Engagement Phase

**Doctor-Patient.** When communicating with a depressed patient, it is important to enhance the therapeutic alliance by listening to concerns, using simple language and checking for good comprehension. One should be sensitive to gender and culture issues in addition to the patient’s level of education. Be careful of exhibiting a bias towards long-term patients or fellow professionals. You may want to believe they should not be depressed, and you may believe they understand more about depression than they actually do.

Much of the communication between the patient and the doctor is non-verbal. While being interviewed, the patient sends the physician non-verbal signs, which need to be interpreted and addressed to the same degree as their verbal communication. Be cognizant of the fact that your demeanor with the last patient may carry over to the current depressed patient and may be misinterpreted in a negative manner. Adopt a communication style that suits the patient and gives him/her permission to speak with you about uncomfortable topics.
When informing patients about their diagnosis, check their level of knowledge and how they feel about the disorder. How do they want you to manage confidentiality issues? Who should they tell? Who should you tell?

Be clear that you take the patient’s thoughts of suicide seriously. Let him/her know his/her safety and the safety of others takes priority over all other considerations. Have a discussion about this topic at the onset of treatment, regardless of the severity of their condition. Ask depressed mothers who have a newborn about infanticide. Do not wait for the patient to initiate a conversation about suicide, infanticide or homicide. It is not easy for patients to discuss these thoughts during a visit.

Educate patients about their condition. Psychoeducation and supportive care are seen as cornerstones of treatment. Patients will benefit from understanding the etiology of their disorder using a biopsychosocial model. The epidemiology, the course of the condition, treatment options and the prognosis, should be explained. Help the patient evaluate the advantages and disadvantages of psychotherapy and pharmacotherapy.

In a depressed person’s world, there is the healthcare world, consisting of the doctor’s office, and the real, world referring to the patient’s life outside the office. The information obtained in the office may be limited and needs to be interpreted in the context of the patient’s life. The real world holds the key to determining the relevance of psychosocial factors. These factors may play a predisposing, precipitating or perpetuating role. The patient-doctor relationship is the entry point for the physician to access this information. By attending to these issues, the physician can understand the significance and dynamics of family, work, social life, physical health, spiritual factors and intrapsychic issues.

By considering the expectations of others, in addition to the patient and physician expectations, one may be able to enlist the support of third parties and prevent them from sabotaging a treatment plan. The family, the workplace, insurance compa-

<table>
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<th>Phase</th>
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<tr>
<td>Engagement</td>
<td>Develop doctor-patient relationship, gather information, address diagnostic issues, identify etiological factors, review treatment options and set treatment goals.</td>
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<tr>
<td>Acute</td>
<td>Active treatment, process information, achieve symptom relief.</td>
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<tr>
<td>Prophylaxis</td>
<td>Prevent return of symptoms.</td>
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<tr>
<td>Discontinuation</td>
<td>Review and stop treatment, address antidepressant discontinuation syndrome, highlight the role of coping mechanisms and develop an early detection plan for the future.</td>
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nies, licensing bodies for vehicles and planes, along with the judicial system, are all interested in the treatment outcome.

Obtaining collateral information, especially from family members, can be invaluable because it allows physicians to obtain more objective information, identify support systems and gain a better comprehension of how the disorder is impacting the patient and others.

**Disorder.** As a first step, the physician should make the diagnosis of the condition using the criteria put forward by the American Psychiatric Association’s Diagnostic Statistical Manual (Table 3).19

Diagnostic considerations would include the presence or absence of other psychiatric or medical conditions and the history of medication use. Patients sometimes neglect to tell physicians about the use of over-the-counter medications, herbal treatments, high-dose vitamins, steroid precursors or fad diets.

A diagnosis of depression is not excluded in the presence of a personality disorder. Patients who are depressed can appear to have a personality disorder. If in doubt, treat the depression because it has a better prognosis.

In an outpatient primary-care setting, patients often do not appear depressed and they may minimize their emotional symptoms. It is possible for patients to have very good coping mechanisms and still be depressed. In such cases, it may be the untreated disorder that leads to the psychosocial dilemmas.

**Treatment.** Obtaining informed consent for treatment has grown in importance over the last several years. For consent to be valid, the patient must, at least, be informed of the pros and cons of the intended treatment and why it has been chosen.20 Document this in the patient’s chart and add what responsibilities you have assigned to the patient. In a shared model, one can gain therapeutic value from a patient taking responsibility for managing his/her condition. Patients learn to recognize that improvement depends on their motivation to actively participate in the treatment process.

Patients should be encouraged and shown how to monitor their symptoms. They can use diaries, complete self-rating scales, write down questions, read about their illness or fill out mood charts. If you tell them to be on time and attend their appointments regularly, you need to adhere to the same rules, or compliance will diminish. If the physician cannot hold to his/her side of the contract, then an explanation should be provided at

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**Table 3**

**Diagnosis of Major Depression**

- Depression is indicated by the presence of five of the following symptoms for two weeks or longer, where social or occupational functioning is affected.

- The patient has either a depressed mood or loss of interest in most activities.

**Symptoms**

- Low mood
- Diminished interest
- Increase or decrease in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Diminished energy
- Excessive guilt/feelings of worthlessness
- Diminished concentration or indecisiveness
- Recurrent thoughts of death

Depression

Educate patients as you would a diabetic or someone with hypertension. The more they know about their condition, the more they will regain a sense of control. 

the onset. If you address this problem early, most patients will appreciate your honesty, but expect the same level of understanding.

Review the role of psychotherapy and pharmacotherapy. Clinical management includes psycho education and supportive care. This should be a standard component of treating depression. If this is as much as you can offer, explain this to the patient. This will give him/her the opportunity to advise you if he/she feels the need to access more resources.

Inform patients psychotherapy is intended to address personal growth issues and social problems, while the medication is directed towards treating their symptoms and level of functioning. It is a valuable practice to inform patients in whom you have decided to use an antidepressant, that it is not being given to solve life problems.

Acute Phase

This is the active treatment phase when one is trying to gain control of the symptoms by producing a response followed by complete resolution of symptoms. Response is defined as an improvement in signs and symptoms by 50% or more. A partial response is less than a 50% improvement. Remission is defined as a complete response in which the person has achieved wellness. When patients have been in remission for four to nine months, they are considered to have recovered from their depressive episode (Table 4).

Patient-doctor. It is worthwhile to set up a schedule of appointments with the patient (Table 5). Physicians are often concerned that a depressed patient booked for a short appointment may take up more than the allotted period of time. These cases are time consuming, but there are solutions, such as the following:

• Alternate a long appointment with a short one;
• See the patient more frequently to avoid a build up of thought and emotions that may take up more of your time unexpectedly.

Disorder. Review the frequency and severity of symptoms while keeping in mind that improvement will take weeks. In addition to answering patients’ questions, go over their homework and self-rating assessments. Ask about the impact of the condition on their psyche, their social life, their family and their work. Ascertain their level of functioning and identify the barriers to improvement.

Treatment. If you feel pharmacotherapy is warranted but the patient is hesitant, do not force the
issue or give ultimatums. Explain the risks and, whenever clinically possible, let the patient decide for him/herself. One helpful technique is to set aside a period of time for the patient to try alternatives. At a scheduled date, meet with the patient again to reconsider the decision. In an outpatient setting, it is the patient who usually has the final say.

Milestones for improvement can be identified when an antidepressant is used. Remind the patient that positive changes will be gradual and may take weeks. Some patients will experience a good day/bad day phenomenon. Their improvement will be characterized by a progressive increase in the number of good days. During the first two weeks of treatment, tolerability of the antidepressant is the primary goal, and any improvement is considered extra beneficial. At the beginning of the third week, some patients may feel worse for a few days. It is worth warning them about this possibility, because it is not what they would expect after taking a medication for two weeks. By the fourth week they should feel about 50% of how they would normally feel. The majority of patients should have returned to their normal state by the eighth week of treatment.

Always check the patient’s compliance to treatment. If you have a good working relationship with the patient and you do not chastise him/her for not following directions, he/she is more likely to let you know about his/her indiscretions. Other factors that can encourage compliance include active patient participation, physician empathy, good communication, family support, well tolerated antidepressants and the patient believing that the therapy he/she is receiving is effective.

Try to reverse social isolation if it is present. Encourage the patient to exercise and eat healthy, depending on the severity of the condition. If spirituality or religion is a source of strength for the patient, encourage him/her to access it. Direct patients who want to be well informed to the appropriate resources. Educate patients as you would a diabetic or someone with hypertension. The more they know about their condition, the more they will regain a sense of control. Knowledge will enable them to help themselves in the future. They will become more adept at identifying the condition early and knowing what treatment works for them.

It is worth asking the patient if he/she wants you to meet their spouse or partner. The partner

### Table 4

**Depression Reference Terms**

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<th>Term</th>
<th>Description</th>
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<td><strong>Response:</strong></td>
<td>Greater than 50% reduction of symptoms, but 100% reduction not achieved.</td>
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<tr>
<td><strong>Remission:</strong></td>
<td>Complete response, wellness achieved.</td>
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<tr>
<td><strong>Recovery:</strong></td>
<td>Four to nine months of remission or wellness.</td>
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<tr>
<td><strong>Relapse:</strong></td>
<td>(a) Worsening before wellness is achieved.</td>
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<td></td>
<td>(b) Deterioration before four to nine months of wellness.</td>
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<tr>
<td><strong>Recurrence:</strong></td>
<td>Worsening after four to nine months of wellness.</td>
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or loved one sees the effect of the condition and often feels helpless. They usually want to know what to do and what not to do.

**Prophylaxis Phase**

This phase begins once the patient has achieved remission. Some physicians divide this phase into two parts, with continuation referring to the first four to nine months after remission, and maintenance referring to the period after this. Prophylaxis is equivalent to the term maintenance as defined in the Canadian Psychiatric Association Guidelines for Treatment of Depressive Disorders. Regardless of the term used, the goal is to keep the patient stable.

Relapse takes on two forms. In the first form, there is a worsening of the condition before symptom remission is achieved. In the second form, remission is achieved, but the person deteriorates within a year. Recurrence refers to a new episode of depression.

**Patient-doctor.** This stage emphasizes trust. The physician has to trust the patient will follow treatment, inform the doctor if the condition returns or if he/she decides to stop taking the antidepressant. Appointments become less frequent and prescriptions are for larger doses. At this point, the efforts by the doctor and patient to secure a positive alliance pay off.

Patients need to be reminded of their treatment responsibilities and the need to repair their social fabric, which may have been torn as a result of depression. Symptom remission was only one part of the treatment.

Discuss the risk of recurrence along with the role of psychotherapy and antidepressants in preventing this from occurring.

Highlight the necessity to continue treatment, even though the patient may feel better. Patients should understand how to distinguish normal emotional turmoil from symptoms of depression.

**Disorder.** An untreated depression usually lasts from six to 24 months. The chance of relapse in the first six months is 35% to 60% if the antidepressant is discontinued. The chance of recurrence after one episode is 50%, after two episodes it is 70% and after three episodes it is 90%. The risks for recurrence include multiple prior episodes, a chronic course, severe episodes and a history of partial responses to treatment. Both psychotherapy and antidepressants, whether used alone or in combination, have been found to be useful in preventing relapse. The evidence may be strongest for a combination of both.

**Treatment.** If an antidepressant was used, stay with the same dose that helped the patient get well. Have the patient continue taking the antidepressant for a minimum of six months. Treating patients for one complete year is preferable so they can make changes to their lives without worrying about relapse.

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**Table 5**

**Scheduling Visits**

- Once per week for the first month.
- Once every two weeks for two months.
- Once per month for three months.
- Patient and physician mutually agree on scheduling thereafter, but treatment should be re-evaluated at least once per year.
- Short visits: Patient and physician understand their purpose beforehand.
- Longer visits: Mixed with short visits to address psychosocial and intrapsychic issues.

* This schedule is a guide for the family physician. Each case should be addressed on its own merit.
workplace are sometimes less understanding and forgiving of a quick relapse.

Psychotherapies and lifestyle changes can be valuable in this stage to target precipitating and perpetuating factors. It is easier for the patient to incorporate new thought patterns and change behaviors when he/she is well, because most of his/her energy is not being directed towards crisis management or surviving the day.

With the recognition that many patients may need long-term treatment with antidepressants, clinicians need to be vigilant for unwanted side effects to these drugs. Weight gain, sexual dysfunction, over-sedation or insomnia can create significant problems, which can have a deleterious effect on compliance and quality of life.

Discontinuation Phase

Patient-Doctor. This process often occurs when the patient decides to stop taking the antidepressant. Indicate to patients at the onset that stopping medication should be done only with the physician’s knowledge. An explanation of the risks associated with recurrence and relapse can help them understand the consequences of their actions.

While it should be explained when patients start a treatment that antidepressants are not addictive, they should be cautioned about the possibility of a discontinuation syndrome, which can occur if they stop taking their medication abruptly. They should be instructed on how to manage the condition should it recur.

Patients should be taught how to recognize the early manifestations of depressive symptoms and what to do when they return.

Disorder. Depression appears to be a life-long condition that follows the model of other medical disorders, in which there are periods of remission and exacerbation. A total of 50% of patients will achieve complete recovery after one year of treatment. As many as 85% of patients will experience a recurrence of their depression within 15 years.

Treatment. When discontinuing an antidepressant, consider tapering the dose by 25% per week. The taper should be individualized to each patient, depending on the clinical circumstance.

Be aware of which antidepressants carry the greatest risk of discontinuation syndrome.

Before discontinuing treatment, ask the patient if there are any major stresses in his/her life. If there are, you may want to reconsider your decision. Holidays and anniversary dates are generally periods of increased stress for patients, and are not a good time to stop treatment.

Conclusion

Depression is a common debilitating disorder that causes significant patient distress and reduced quality of life. Once diagnosed, the condition usually can be treated successfully with patients regaining their previous level of functioning.

Treatment responses can be enhanced if the physician sets up a treatment plan that includes the patient as an active participant. An understanding of the doctor-patient relationship, the role of the disorder and the intended treatment will facilitate improvement. Knowledge of the treatment phases can provide both the patient and the doctor with a sense of direction.

References
2. Alberta Health and Wellness: Alberta’s Health System
Some Performance Indicators November 2000.


