

Treatment resistant depression: ten things NOT to do

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This is intended to be read as a companion piece to an earlier article on principles of treating resistant depression. On the principle of *primum non nocere*, it occurred to me that it might be at least as helpful to come up with a list of ten things NOT to do, so here goes:

1. **Change antidepressant too early.** While there is some evidence that a pharmacological response can sometimes be seen within a few days, some patients will need two weeks or more at an effective dose.
2. **Change medication too late.** Don't persist beyond six weeks if there has been no benefit.
3. **Undermedicate.** Ensure your patient is receiving an effective dose of medication for an effective period.
4. **Overmedicate.** Benefits are rarely seen at doses more than twice the usual treatment dose. Venlafaxine is an exception, with a small group of patients appearing to need doses of more than 300mg. On the other hand, high doses are almost guaranteed to cause problematic side-effects.
5. **Polymedicate.** As a rule, antidepressant combination should be avoided. As a liaison psychiatrist in a large hospital, I have seen people come in with fulminant serotonergic syndromes, fitting, even with symptoms of cardiomyopathy. Combining antidepressants is a hazardous option that, if entertained, should be directed by a consultant psychiatrist, with a full discussion of potential risks to the patient.
6. **Prescribe unfamiliar drugs.** If you are considering using high dose tricyclics, or MAO inhibitors, ensure you are aware of the precautions and risks associated with their use.
7. **Overuse sedatives.** Benzodiazepines have a place in the short-term management of severe agitation or insomnia in patients judged to be at low risk of abuse. Second generation antipsychotics like quetiapine can also be helpful, but should only be used if there are significant clinical dividends. They have significant risks including hypotension, metabolic disturbances, precipitation of biliary disease etc.
8. **Understate risk.** While there is not a linear relationship between depression severity and suicide risk, this should be monitored in all patients with treatment-refractory depression, especially in patients with other risk factors such as past self-harm, family history of suicide, male sex, substance use, chronic pain, isolation etc.
9. **Soldier on alone.** Enlist help in managing these complex and often functionally impaired patients. This might include their partner or a friend or family member, a clinical psychologist or other health worker, or formal referral for a second opinion or management advice.
10. **Despair.** Repeated failure to improve angers doctors, and we have to be aware of our own transference issues in dealing with persistently or recurrently depressed patients. A positive, non-judgemental and empathic approach remains the cornerstone of treatment.

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