Depression Treatment Guidelines

Depression is a prevalent and serious mental health condition that affects millions of people worldwide. Effective treatment is essential for managing symptoms and improving quality of life.

Depression Treatment Guidelines provide healthcare providers with evidence-based recommendations on the best approaches for treating and supporting individuals with depression. These guidelines emphasize a combination of therapies, including psychotherapy, medication, and lifestyle interventions, tailored to the severity of the condition and the individual's specific needs.

The American Psychological Association (APA) provides detailed recommendations for managing depression across three age cohorts: children, adolescents, and adults, including older adults. These recommendations are outlined in the following tables:

Table 1

Recommendations for the child population from the APA Guideline Development Panel for the treatment of depression

Recommendation	Strength of recommendation	Justification
Initial treatment		
For the initial treatment of child patients with depressive disorders, there was insufficient evidence to make a recommendation regarding any of the following psychotherapies/interventions: • Behavioral therapy • Cognitive therapy • Cognitive-behavioral therapy • Family therapy • Play therapy • Problem-solving therapy • Psychodynamic therapy • Supportive therapy There was insufficient evidence to make a recommendation regarding pharmacotherapy for child patients with depressive disorders.	Insufficient evidence for a recommendation	Based on the literature reviewed that met the AMSTAR requirements, there was insufficient evidence to either recommend or not recommend the use of the listed psychotherapies/ interventions in children with depressive disorders. Based on the literature reviewed that met the AMSTAR requirements, there was insufficient evidence to either recommend or not recommend pharmacotherapy for child patients with depressive disorders. The panel noted safety concerns with using pharmacotherapy with children and recommends shared decision-making regarding medication options with a child psychiatrist in addition to the clinician, patient, and their parents/guardians or family members actively involved in their care.

Table 2

Recommendations for the adolescent population from the APA Guideline Development Panel for the treatment of depression

Recommendation	Strength of recommendation	Justification
Initial treatment		
For the initial treatment of adolescent patients with depressive disorders, the panel recommends that clinicians offer one of the following psychotherapies/interventions: • Cognitive-behavioral therapy • Interpersonal psychotherapy adapted for adolescents (IPT-A) The panel recommends fluoxetine as a first-line medication compared to other medications for adolescent patients with major depressive disorder, specifically when considering medication options. There was insufficient evidence to recommend either treatment (psychotherapy or fluoxetine) over the other for major depressive disorder.	Recommendation for use	Based on the literature reviewed that met the AMSTAR requirements, cognitive-behavioral therapy, and interpersonal psychotherapy adapted for adolescents (IPT-A) were the only psychotherapy intervention with evidence of efficacy.
Additional psychotherapy recommendations for initial treatment		
If neither recommended psychotherapy is available or acceptable to the patient and their parent/guardian, the panel suggests an alternative model. However, the following interventions have not yet been evaluated in adolescents. There is insufficient evidence to recommend for or against clinicians offering any one of the following psychotherapies/interventions over the others: • Behavioral therapy • Cognitive therapy • Family therapy • Problem-solving therapy • Psychodynamic therapy • Supportive therapy	Insufficient evidence for a recommendation	Based on the literature reviewed that met the AMSTAR requirements for all interventions except for cognitive-behavioral therapy and interpersonal psychotherapy adapted for adolescents (IPT-A), evidence was not strong enough to determine that any one therapy was superior to another. Decisions should be based on shared decision-making with youth patients, their parents/guardians, or family members actively involved in their care.

Recommendation	Strength of recommendation	Justification
Additional pharmacotherapy guidance for initial treatment		
Information regarding other medication options for adolescents is lacking. Thus, if fluoxetine is not a treatment option or is not acceptable, the panel recommends shared decision-making regarding medication options with a child psychiatrist in addition to the clinician, patient, and their parents/guardians or family members actively involved in their care.	Conditional recommendation for use	The recommendation is due to safety concerns such as increased suicide risk for adolescents when using other medications.
In general, the panel recommends against using the following medications for adolescent patients with major depressive disorder. However, when other options are not available, effective, and or acceptable to the patient, the panel recommends shared decision-making between the patient and clinician. • Clomipramine • Imipramine • Mirtazapine • Paroxetine • Venlafaxine If these medications are being considered, the panel recommends: • Paroxetine over clomipramine when both are being considered. • Paroxetine over imipramine when both are being considered. • There was no information available for other comparisons between the listed medications.	Recommend against use	Based on the literature reviewed that met the AMSTAR requirements the panel recommends against the medications as noted due to safety concerns with using these medications on adolescents. Further, the panel recommends only choosing between the medications as noted when other options have been exhausted or are unavailable. This is due to safety concerns with using these medications on children.

Table 3

Recommendations for the General Adult Population from the APA Guideline Development Panel for the treatment of depression

Recommendation	Strength of recommendation	Justification
Initial treatment		
Psychotherapy and pharmacotherapy For the initial treatment of adult patients with depression, the panel recommends the following in the context of sharing decision-making with the patient when considering options: 1. That clinicians offer either psychotherapy or second-generation antidepressants. When selecting between treatments, the panel recommends considering the following options: • Second-generation antidepressants • The panel found that effectiveness studies demonstrated similar effects across psychotherapy. Thus, the panel cannot recommend specific monotherapies for the initial • treatment. General models that appear to have comparable effects include: • Behavioral therapy • Cognitive, cognitive-behavioral, and mindfulness-based • cognitive-therapy • Interpersonal psychotherapy • Psychodynamic therapies • Supportive therapy 2. If considering combined treatment, the panel recommends cognitive-behavioral therapy or interpersonal psychotherapy plus a second-generation antidepressant.	Recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, comparative effectiveness research finds either similar effects between treatments or insufficient evidence to determine that one treatment can be offered over another.

Recommendation	Strength of recommendation	Justification
Initial treatment		
For adult patients with depression who are also experiencing relationship distress, if a recommended treatment is not acceptable or available, the panel suggests that clinicians offer problem-focused couples' therapy. When selecting between treatments, the panel suggests considering the following options: • Suggest behavioral therapy rather than antidepressant medication alone. • If considering combined treatment, the panel suggests cognitive therapy plus antidepressant medication to improve the likelihood of full recovery in treatment.	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, if a recommended treatment is not available or acceptable, the panel suggests the listed interventions, which demonstrated efficacy when compared with no treatment(i.e., waitlist) or control.
For adult patients with depression, there is insufficient evidence to recommend for or against clinicians offering: • Cognitive behavioral analysis system of psychotherapy (CBASP) • Brief problem-solving therapy (10 or fewer sessions) vs. treatment as usual.	Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements the evidence was insufficient to be able to recommend for or against the listed interventions or treatment comparisons. Decisions should be based on shared decision-making with the patient.

Recommendation	Strength of recommendation	Justification
Initial treatment		
Complementary and alternative treatments For adults with depression for whom psychotherapy or pharmacotherapy is either ineffective or unacceptable, the panel suggests the following options: • Exercise monotherapy • St. John's wort monotherapy If neither is acceptable or available, the panel suggests consideration of: • Bright light therapy • Yoga • If considering adjunctive treatments, the panel suggests adding acupuncture to antidepressant medication. There is insufficient evidence to recommend: • Tai chi • Acupuncture monotherapy • Combination of second-generation antidepressants and acupuncture • Omega-3 fatty acids monotherapy • Combination of second-generation antidepressants and Omega-3 fatty acids • S-Adenosyl methionine monotherapy • Combination of second-generation antidepressants and exercise	Conditional recommendation for use Conditional recommendation for use Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements, evidence indicates no difference in effects between St. John's Wort and second-generation antidepressants and indicates some small to medium benefits of the other suggested complementary and alternative treatments. Evidence is insufficient to recommend the last list of complementary and alternative treatments, as noted.
For adult patients with subclinical depression, the panel suggests that clinicians offer psychotherapy (psychotherapy in general, including both cognitive-behavioral therapy and noncognitive-behavioral therapy psychotherapies [e.g., interpersonal counseling, problem-solving therapy, life review therapy]).	Conditional recommendation for use	When subclinical depression is the focus of treatment, based on the literature reviewed that met the IOM or AMSTAR requirements, the panel suggests the listed interventions, which demonstrated efficacy when compared with control.

Recommendation	Strength of recommendation	Justification
Partial or nonresponders to initial antidepressant treatment		
For adult patients with depression who have either not responded or only partially responded to initial antidepressant medication treatment, the panel recommends the following options: 1. Switch from antidepressant medication alone to cognitive therapy alone or, 2. Switch from antidepressant medication alone to another antidepressant medication	Recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, the panel equally recommends the listed interventions, and there is evidence demonstrating no difference in effect.
For adult patients with depression who have either not responded or only partially responded to initial antidepressant medication treatment, the panel suggests that clinicians offer one of the following psychotherapies/interventions and select between treatments as follows: 1. Add psychotherapy (interpersonal psychotherapy, cognitive-behavioral therapy, or psychodynamic psychotherapy) to the antidepressant medication treatment 2. Augment with another antidepressant medication	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, the panel suggests adding one of the psychotherapies listed or augmenting with another antidepressant medication the treatment of adult patients who have not responded or only partially responded to initial antidepressant medication treatment. However, the panel does not suggest adding cognitive-behavioral analysis system of psychotherapy or brief supportive therapy to antidepressant medication treatment.
For adult patients with major depressive disorder who have either not responded or only partially responded to initial adequate second-generation antidepressant treatment attempts, there is insufficient evidence to determine differences in treatment effect for the following: • Switching to another second-generation antidepressant • Switching to a nonpharmacologic (i.e., cognitive therapy) monotherapy • Augmenting with guided cognitive-behavioral therapy self-help	Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements, the evidence was insufficient to be able to recommend for or against adding guided cognitive-behavioral therapy self-help to antidepressant medication treatment or switching or augmenting among other second-generation antidepressants or nonpharmacologic (i.e., cognitive therapy) modalities.

Recommendation	Strength of recommendation	Justification
Relapse prevention		
For adult patients with depression who have achieved remission the panel suggests clinicians offer psychotherapy (cognitive-behavioral therapy, mindfulness-based cognitive therapy, or interpersonal psychotherapy) rather than antidepressant medication or treatment as usual to prevent relapse. There is insufficient evidence to recommend one form of the three psychotherapies listed.	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, the panel suggests psychotherapy in general (cognitive-behavioral therapy, mindfulness-based cognitive therapy, or interpersonal psychotherapy), which demonstrated comparative effectiveness when compared with treatment as usual and antidepressant medication to prevent relapse. However, there was insufficient evidence to be able to recommend a specific form of psychotherapy to prevent relapse.

Table 4

Recommendations for the older adult population from the APA Guideline Development Panel for the treatment of depression

Recommendation	Strength of recommendation	Justification
Initial treatment—Major depressive disorder		
For the initial treatment of older adult patients with depression, the panel recommends the following in the context of shared decision-making with the patient: 1. Either group life review treatment or Group Cognitive Behavioral Therapy (either alone or added to usual care) over no treatment 2. Combined pharmacotherapy and IPT over IPT alone. Of note, while the study upon which this is based used nortriptyline, the panel recommends a second-generation antidepressant due to the reduced risk of side effects.	Recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, cognitive-behavioral therapy (group) and life review (group) based interventions were the only interventions with adequate efficacy evidence. However, comparative effectiveness research either finds sufficient evidence to recommend between some treatment comparisons or find similar effects between treatments. While nortriptyline was used in the past due to its efficacy and safety, practices have changed significantly, and nortriptyline is now viewed as a second- or third-line pharmacotherapy strategy for major depression. It is generally reserved for patients who have not done well with a selective serotonin reuptake inhibitor or a serotonin-norepinephrine reuptake inhibitor, which are generally considered to be safer for older adults than nortriptyline. There is some efficacy data from systematic reviews/meta-analyses showing efficacy of second-generation antidepressants over placebo.

Recommendation	Strength of recommendation	Justification
Initial treatment—Major depressive disorder		
For older adult patients with depression, if a recommended treatment is not acceptable or available, the panel suggests that clinicians offer one of the following psychotherapies/interventions: Cognitive-behavioral therapy (individual) (either standalone or in combination with usual care), which was found to be superior to: • No treatment • A nonspecific talk therapy control • Usual care • Desipramine • Combination of cognitive-behavioral therapy and nonspecific therapeutic techniques (individual) with pharmacotherapy, which was superior to pharmacotherapy alone. Of note, while a specific study upon which this is based used desipramine, the panel recommends a second-generation antidepressant due to the reduced risk of side effects. Interpersonal psychotherapy and pharmacotherapy, which was conditionally superior for preventing recurrence to either: • Supportive care • IPT and supportive care • Of note, while the study on which this is based used nortriptyline, the panel recommends a second-generation antidepressant due to the reduced risk of side effects • Problem-solving therapy (group), which was superior to reminiscence therapy (group) • Interpersonal psychotherapy (individual), which was superior to supportive care	Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements, there is insufficient evidence available to determine differences in treatment effect for the listed treatment comparisons for older adult patients with depression. Thus, the panel makes no recommendations of one treatment over the other for the treatments in each pair comparison. Decision should be based on shared decision-making with the patient.

Recommendation	Strength of recommendation	Justification
Initial treatment—Major depressive disorder		
The panel suggests considering one of the following options for subthreshold or minor depression • Cognitive-behavioral therapy (internet) for subthreshold depression • Cognitive-behavioral therapy (individual) and usual care for minor depressive disorder • Cognitive-behavioral therapy (group) and usual care for treating minor depressive disorder • Combination cognitive-behavioral therapy and treatment as usual rather than combination of talking control30 (individual) and usual care for older adults with minor or major depressive disorder • Life review course (group) rather than an educational video for older adults with subclinical depression • Problem-solving therapy (individual) • Paroxetine • Of note, while the study on which this is based used paroxetine, some argue that paroxetine is contraindicated in older adults due to its anticholinergic side effects, and many geriatric psychiatrists would prefer another SSRI (i.e., escitalopram or sertraline). The panel encourages shared decision-making with patients ofthe benefits versus harms of treatment.	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements for subthreshold depression, there was no efficacy data sufficient to recommend treatment. Thus, the panel makes the listed suggestions. While paroxetine was used in the past, currently many geriatric psychiatrists would prefer another SSRI (like escitalopram or sertraline) to paroxetine due to the anticholinergic side effects of paroxetine.

Recommendation	Strength of recommendation	Justification
Initial treatment—Major depressive disorder		
The panel had insufficient evidence to recommend the following treatments: • Behavioral bibliotherapy (self-guided) vs. treatment as usual for subthreshold depression. • Life review therapy (individual) vs. treatment as usual for subclinical depression.	Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements there is insufficient evidence available to determine differences in treatment effect for the listed treatment comparisons for older adult patients with subthreshold or minor depression. Thus, the panel makes no recommendations of one treatment over the other for the treatments in each pair comparison. Decision should be based on shared decision-making with the patient.
MDD or minor depression + cognitive impairment/dementia		
The panel suggests considering one of the following options for MDD or minor depression in the context of cognitive impairment or dementia: • Problem-solving therapy (individual): For older adult patients with major depressive disorder and executive dysfunction. • Problem-solving behavioral therapy (individual) or pleasant events behavioral therapy (individual): For minor or major depressive disorder in older adults with dementia.	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements for MDD or minor depression plus cognitive impairment/dementia, there was no efficacy data sufficient to recommend treatment. Thus, the panel makes the listed suggestions.

Recommendation	Strength of recommendation	Justification
MDD or minor depression + cognitive impairment/dementia		
The panel had insufficient evidence to recommend the combination of behavioral activation therapy (individual) and treatment as usual over treatment as usual for depressive symptoms in older adults with mild to moderate cognitive impairment.	Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements, there is insufficient evidence available to determine differences in treatment effects for the listed treatment comparisons for older adult patients with MDD or minor depression plus cognitive impairment/dementia. Thus, the panel makes no recommendations of one treatment over the other for the treatments in each pair comparison. Decisions should be based on shared decision-making with the patient.
Persistent depressive disorder		
The panel suggests considering one of the following options for MDD or minor depression in the context of cognitive impairment or dementia: • Problem-solving therapy (individual) or paroxetine for persistent depressive disorder. • Of note: While the study on which this is based used paroxetine, some argue that paroxetine is contraindicated in older adults due to its anticholinergic side effects. Many geriatric psychiatrists would prefer another SSRI, such as escitalopram or sertraline.	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements for persistent depressive disorder in older adults, there was no efficacy data sufficient to recommend treatment. Thus, the panel makes the listed suggestions. Of note, while some evidence supported problem-solving therapy, it was not significantly superior to attentional control conditions using either phone or video contact. While paroxetine was used in the past, currently many geriatric psychiatrists would prefer another SSRI (like escitalopram or sertraline) to paroxetine due to the anticholinergic side effects of paroxetine.

Recommendation	Strength of recommendation	Justification
MDD with medical or other complications		
The panel suggests considering the following options for patients with depression and the indicated complicating factors: • Combination of cognitive-behavioral therapy (individual) and usual care: For minor or major depressive disorder with type II diabetes mellitus or chronic obstructive pulmonary disease (COPD). • Multicomponent intervention (individual): For treating symptoms of depression in temporarily homebound African American adults. • Coping improvement (group) rather than psychotherapy on request (individual): For older adults with mild to severe depressive symptoms and HIV.	Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements for MDD with medical or other complications, there was no efficacy data sufficient to recommend treatment. Thus, the panel makes the listed suggestions.

Recommendation	Strength of recommendation	Justification
Prevention of recurrence-MDD		
For older adult patients with a history of depression, the panel recommends clinicians offer any of the following options: Either: • Combination interpersonal psychotherapy and pharmacotherapy • Combination supportive care and pharmacotherapy • Of note: While the study on which this is based used nortriptyline, the panel recommends a second-generation antidepressant due to the reduced risk of side effects. If the prior options are not acceptable or available, the panel suggests considering the following option: • Interpersonal psychotherapy (individual) alone	Recommendation for use Conditional recommendation for use	Based on the literature reviewed that met the IOM or AMSTAR requirements, comparative effectiveness research demonstrated sufficient evidence for the panel to recommend some combinations of treatments over others due to differences in treatment effect for prevention of recurrence. Other treatments or combinations of treatments were equally recommended by the panel based on comparative effectiveness research evidence showing no difference in effect for the prevention of recurrence. While nortriptyline was used in the past due to its efficacy and safety, clinical practices have changed significantly. Nortriptyline is now viewed as a second or third-line pharmacotherapy strategy for major depression. It is generally reserved for patients who have not responded well to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI), which are generally considered safer for older adults than nortriptyline. There is efficacy data from systematic reviews and meta-analyses demonstrating the efficacy of second-generation antidepressants over placebo.

Recommendation	Strength of recommendation	Justification
Prevention of recurrence-MDD		
For older adult patients with a history of depression, there is insufficient evidence to recommend between: • Cognitive-behavioral therapy (group) plus pharmacotherapy, and • Pharmacotherapy alone, for preventing recurrence. Thus, the panel makes no recommendations for one treatment over the other.	Insufficient evidence for a recommendation	Based on the literature reviewed that met the IOM or AMSTAR requirements, there is insufficient evidence available to determine differences in treatment effect. Thus, the panel makes no recommendations of one treatment over the other. Decision should be based on shared decision-making with the patient.

Mcquaid, J., Lin, E., Washington, K., Jones, V., Kessler, M., York, N., & Mufson, L. (2019). *Clinical practice guidelines for the treatment of depression across three age cohorts*. https://www.apa.org/depression-guideline/guideline.pdf