



INSTITUTE FOR CLINICAL
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Health Care Guideline for Patients and Families

The information contained in this document is a translation of an ICSI health care guideline from medical terminology to commonly used and easily understood English. It is intended for patients, their families and/or caregivers, and other individuals who have little or no health care training. The medical terms used in this document are followed by italicized statements in parentheses that explain the meaning of the term.

The *Major Depression in Adults in Primary Care for Patients and Families* should not be construed as medical advice or medical opinion related to any specific facts or circumstances. If you are seeking medical advice, you are urged to consult a health care professional regarding your own situation and any specific medical questions you may have. In addition, you should seek assistance from a health care professional in interpreting any *ICSI Health Care Guideline for Patients and Families* and applying it in your individual case.

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The next scheduled revision will occur within 24 months.

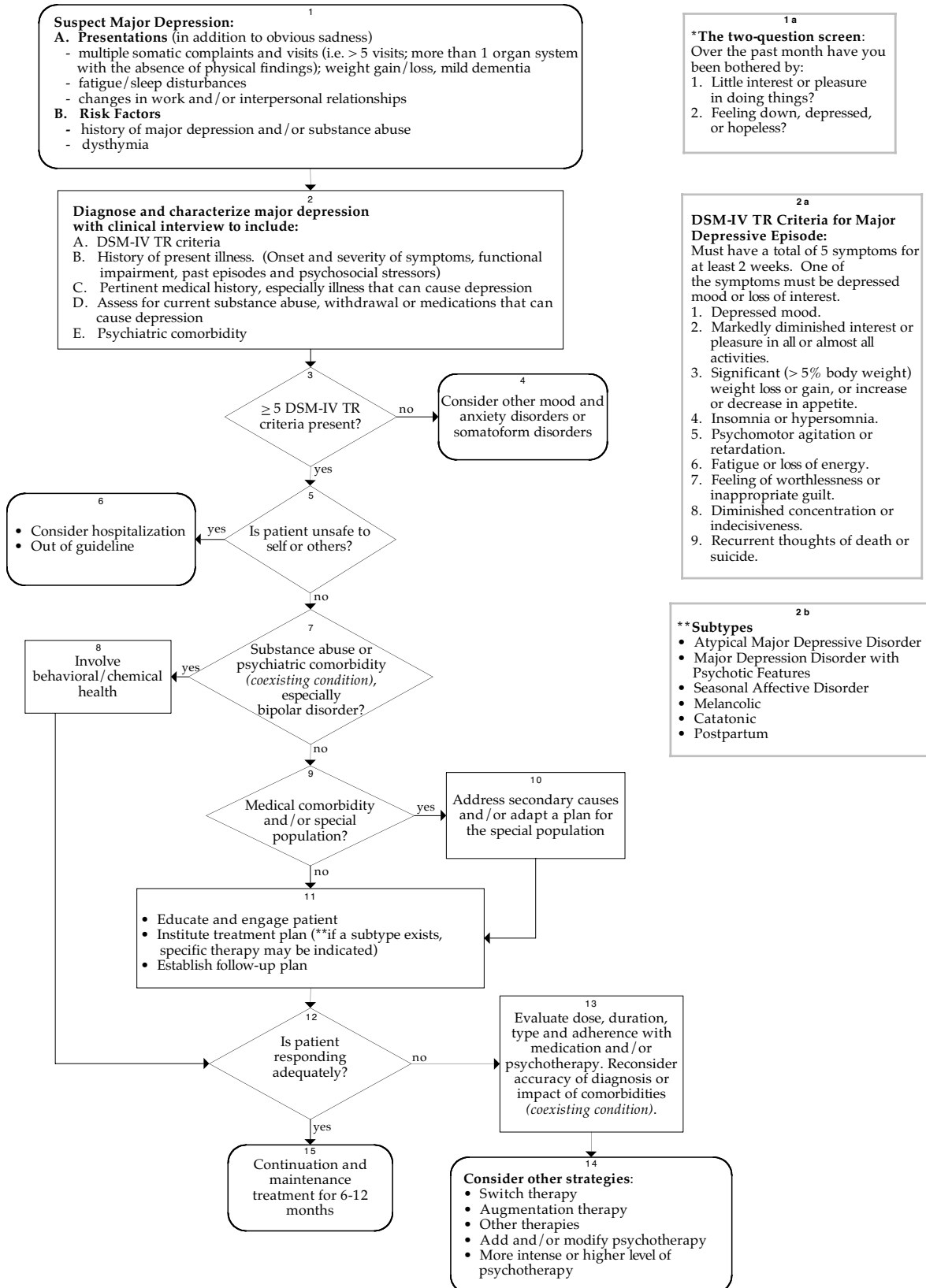


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Flowchart Notes

1. Suspect Major Depression

Major depression can be a primary disorder or secondary to substance abuse, withdrawal from substance abuse, other psychiatric illnesses, certain medical illnesses, and/or certain medications. Many patients with major depression do not initially complain of depressed mood. Therefore, providers need to suspect this diagnosis based on a profile of common presentations and risk factors.

Presentations for major depression include:

- Multiple medical visits (more than 5 a year)
- Multiple unexplained symptoms
- Work or relationship dysfunction
- Changes in interpersonal relationships
- Weight gain or loss
- Sleep disturbance
- Fatigue
- Dementia
- Irritable bowel syndrome
- Poor follow-through with daily living activities or prior treatment recommendations

Risk factors for major depression include:

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Dysthymia (*chronic feelings of sadness*)
- Stressful life events that include loss (death of a loved one, divorce)
- Domestic abuse/violence
- Traumatic events (for example, a car accident)
- Major life change (for example, a job change)

Major depression is also seen in the elderly with coexisting illnesses such as stroke, cancer, dementia or disabilities.

Patients with a history of mood disorders are at increased risk for postpartum depression. Several depressive conditions may follow childbirth. "Postpartum Blues" affects 50-85% of mothers in the first two weeks after delivery. It is characterized by mood lability (*changing mood*), tearfulness, anxiety and sleep disturbance but usually does not result in functional impairment. No specific treatment is required. If the patient remains significantly depressed 3-4 weeks following delivery, it should be considered serious and treated including eliminating medical causes of depressive symptoms such as postpartum thyroid disorders or anemia. The first 2-3 months postpartum is the period of greatest risk for the development of major depression.

The close relationship of mind and body may result in the presentation of medical illness along with major depression. For example:

- Medical illness may have a biological cause (for example, thyroid disorder, stroke).
- Medical illness or patient's perception of his or her clinical condition and health-related quality of life may trigger a psychological reaction to prognosis (*prospect of recovery*), pain, or disability (for example, depression in a patient with cancer).
- Medical illness may exist coincidentally in a patient with primary mood or anxiety disorder.

2. Diagnose and Characterize Major Depression with Clinical Interview

- A. If you suspect depression on the basis of common presentations or risk factors, ask about depressed mood and anhedonia (*diminished interest or pleasure in activities*). At least one of these symptoms is necessary for diagnosing major depression. Useful questions include:

Over the past month, have you been bothered by:

- Little interest or pleasure in doing things?
- Feeling down, depressed, or hopeless?

If the patient answers "yes" to either one of the above questions, consider using a questionnaire to further assess whether the patient has sufficient symptoms to warrant a diagnosis of major depression and a full clinical interview. An example of such a questionnaire is the PHQ-9, a Patient Health Questionnaire used to diagnose and rate severity of depression.

- B. Determine the patient's history of present illness, including:

- When it started, which may be gradual over months or may be abrupt
- Severity of symptoms and degree of functional impairment:

People diagnosed with major depression have a heterogeneous (*diverse*) course ranging from self-limiting to life-threatening. Predictors of poor outcome include higher severity at initial assessment, lack of reduction of social difficulties at follow-up, and low educational level.

Categorize severity of symptoms and degree of functional impairment as follows:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis of major depression and only minor impairment in occupational and/or social functioning.

Moderate: Symptoms or functional impairment ranging between mild and severe.

Severe: Several symptoms in excess of those necessary to make the diagnosis, and marked interference with occupational and/or social functioning.

- Number and severity of previous episodes, responses to treatment, and suicide attempts.
- Coexisting conditions. Obtaining a past psychiatric history is important for understanding prognosis (*outcome*). For example, knowledge of past episodes of major depression, past co-occurring behavioral health conditions, and past self-harm attempts is important for establishing risk and need to involve other mental health professionals.

- Psychosocial (*involving both psychological and social aspects*) stressors (significant loss, conflict, financial difficulties, life change, abuse).
- C. Determine pertinent medical history that may complicate treatment [for example, prostatism (*enlargement of the prostate gland*), cardiac conduction abnormalities (*irregular heart rhythms*), impaired hepatic (*liver*) function].

Perform a focused physical examination and laboratory testing as indicated by the clinic's system. The benefit of screening tests, including thyroid tests, to evaluate major depression has not been established.

Reliance on laboratory tests should be greater if:

- The medical review detects symptoms that are rarely encountered in mood or anxiety disorders.
 - The patient is older.
 - The first major depressive episode occurs after the age of 40.
 - The depression does not respond fully to routine treatment.
- D. Determine past history of substance abuse.

Medications

The following may be associated with major depression: steroids (*to treat conditions such as asthma and arthritis*), alpha-methyldopa (*to treat high blood pressure*), and hormonal therapy.

Withdrawal from reserpine (*to treat psychotic states*) and propranolol (*to treat heart disease*) may be associated with major depression. Use of alcohol and hypnotics might be mimicking depression.

Withdrawal from cocaine, anxiolytics (*anti-anxiety medication*), and amphetamines (*psychostimulants*) may be mimicking depression.

Idiosyncratic (*abnormal*) reactions to other medications can occur and if possible, a medication should be stopped or changed if depression develops after beginning its use. If symptoms persist after stopping or changing medication, re-evaluate the patient for a primary mood or anxiety disorder.

3. Five or More DSM-IV TR* Criteria Present?

- A. Five or more of the following symptoms must be present and documented during the same 2-week period and represent a change from previous functioning. At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure in activities.

**Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, used as a primary diagnostic reference for mental health professionals in the U.S.)*

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-congruent delusions (*false beliefs consistent with person's prevailing mood*), or hallucinations (*seeing or hearing things that are not there*).

- 1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (for example, patient feels sad or empty) or observation made by others (for example, patient appears tearful).
- 2) Marked loss of interest or pleasure in all, or almost all, activities most of the day, nearly every day (indicated by either subjective report or observation made by others).

- 3) Significant weight loss when not dieting, or weight gain (for example, a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
 - 4) Insomnia or hypersomnia (*excessive sleeping*) nearly every day.
 - 5) Psychomotor agitation (*mentally-induced overactivity*) or retardation (*underactivity*) nearly every day (must be observable by others; should be more than merely subjective feelings of restlessness or slowing down).
 - 6) Fatigue or loss of energy nearly every day.
 - 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional [*false psychotic beliefs*]) nearly every day (more than merely self-reproach or guilt about being sick).
 - 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (indicated by either subjective report or observation made by others).
 - 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation (*entertaining the idea*) without a specific plan, a suicide attempt or a specific plan for committing suicide.
- B. The symptoms do not meet criteria for a Mixed Episode (*alternating moods: some symptoms of depression along with some symptoms of mania*) (such as increased energy, rapid speech, decreased need for sleep, increased impulsivity.)
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (for example, illegal drugs or prescription medications) or a general medical condition (for example, hypothyroidism [*underactive thyroid*]).
- E. The symptoms are not accounted for by bereavement, that is, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation (*entertaining the idea*), psychotic symptoms (*mental derangement characterized by loss of contact with reality*), or psychomotor retardation (*mentally-induced underactivity*).

**Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, used as a primary diagnostic reference for mental health professionals in the U.S.)*

4. Consider Other Mood and Anxiety Disorders or Somatoform Disorders (*Disorder with Symptoms That Cannot be Explained by a Physical Condition*)

Patients with some depressive symptoms who do not meet full DSM-IV TR* criteria for major depression often respond positively to antidepressant medication and/or psychotherapy. Emerging evidence also supports the use of bright light therapy in some of the cases of milder depression.

Presentations particularly suggestive of an anxiety disorder include:

- Medically unexplained symptoms of autonomic excitation (*involuntary physical reactions*) such as:
 - Cardiac (chest pain, palpitations, shortness of breath, hyperventilation).
 - Gastrointestinal (epigastric distress [*pain around the stomach or abdomen*], irritable bowel syndrome).

- Neurologic (headache, dizziness, paresthesias [*abnormal skin sensation such as tingling or itching*]).
- Panic attacks.
- Emergency room visit for medically unexplained physical symptoms, particularly chest pain.

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These depressive symptoms can cause significant impairment, suffering, and disability. Antidepressants should be considered, though the evidence for their efficacy (*effectiveness*) is less well established with these disorders than with major depression. Other depression categories include Dysthymic Disorder (*chronic feelings of sadness*) and Depressive Disorder Not Otherwise Specified (NOS) (*a depressive disorder that fits no other category*). (See Appendix A.)

5. Is Patient Unsafe to Self or Others?

Assessing suicidal tendencies in a depressed patient is a critical but often difficult process. Consider asking the following progression of questions and document the responses.

1. Do you feel that life is worth living?
2. Do you wish you were dead?
3. Have you thought about ending your life?
4. If yes, have you gone so far as to think about how you would do so?
5. Do you have access to a way to carry out your plan?
6. What keeps you from harming yourself?

Many patients will not answer question No. 4 directly or will add "but I'd never do it." Give them positive feedback (for example, "I'm glad to hear that"), but do not drop the subject until she/he has told you the specific methods considered (for example, gun, medication overdose, motor vehicle accident, etc.).

Although there are no good predictors of suicide in specific cases, a number of factors point to heightened risk:

- There are four male suicide completions for every female completion.
- Elderly Caucasian and Asian men over the age of 65 and Asian women over 80 years are at disproportionate risk.
- Two-thirds of elderly suicide completers are in relatively good health.
- Substance abuse is often a contributing factor, especially in younger people.
- The presence of firearms in the home is believed to greatly increase the danger if other risk factors are present.
- 75% of elderly suicide completers were seen by their doctor within one month of death.
- Across all age groups, one in seven suicide completers had contact with their doctor within a week of death.
- When a patient has high levels of all of the following, risk is very high and immediate hospitalization may be needed:

- Internal emotional pain (for example, feelings of shame, guilt, humiliation).
- External stress (for example, loss of spouse or job, legal troubles).
- Agitation (for example, caused by sleep loss or drug use).
- Feelings of hopelessness.

Suicide remains a rare occurrence relative to the frequency of depression in the general population; between one and five suicides occur per one thousand patient years of follow-up.

Emerging literature suggests that a past history of self harm attempts, in combination with a history of well developed suicide plans, place the patient at a greater eventual risk of completing a suicide attempt. Circumstances such as clear past examples of a sense of competence to execute an attempt, a sense of courage to make the attempt, behaviors that ensure the availability of means and opportunity to complete, concrete preparations to enact the suicide plan, and a current episode of severe depression combine to pose a greater danger of eventual completed suicide. The clinician should consider previous history of suicide attempts; chemical dependency; personality disorder and/or physical illness; family history of suicide; single status; recent loss by death, divorce or separation; insomnia; panic attacks and/or severe psychic anxiety; diminished concentration; anhedonia; hopelessness; or suicidal ideation.

7. Substance Abuse or Specific Comorbidity (Concurrent Condition), Especially Bipolar Disorder?

The medical literature does not support definitive statements about the best way(s) to treat patients who are diagnosed with both major depression and substance abuse/dependence. The majority of reviewed studies indicate that success in treating dependency on alcohol, cocaine, and other abused substances is more likely if accompanying depression is addressed. Fewer investigators have looked at whether treating substance abuse is helpful in reducing depression.

There is some evidence that patients with major depression that is secondary to their substance abuse may have remission of their depressed mood once the substance abuse is treated. However, it is difficult to separate secondary depression from primary depression that predates or is separate from the substance use.

Studies to assess the efficacy (*effectiveness*) of concurrent treatment of major depression and substance abuse are limited in number and are of variable quality. Although results are not fully consistent, the majority of available evidence suggests that medication can be of benefit in treating substance abuse and depression in patients who have both disorders. Medications studied include amantadine (*a dopamine agonist*), desipramine (*a tricyclic antidepressant*), and fluoxetine (*an SSRI – selective serotonin reuptake inhibitor*).

CAGE is a screening tool to determine alcohol and other drug use problems. The CAGE(AID) Screen broadens the CAGE to include other drug use.

Some patients presenting with a major depressive episode have a bipolar disorder (*characterized by unusual shifts in mood, also called manic-depressive disease*). For these individuals, effective treatment may differ significantly from that used in other depressed patients. When assessing a patient, consider asking about manic or hypomanic (*less severe mania*) episodes:

- Has there been a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week?
- During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 1. Inflated self-esteem or grandiosity

2. Decreased need for sleep
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility
6. Increase in goal-directed activity or psychomotor agitation (*mentally-induced overactivity*)
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

If these criteria are met, the patient may have bipolar disorder. Treatment for this falls out of the scope of this guideline.

Ask patients with major depression about a history of manic symptoms (abnormally elevated, expansive, or irritable mood). Patients with a history of manic (bipolar) symptoms now presenting with major depression may be destabilized if only treated with antidepressant drugs. Behavioral health involvement is advised with these patients if there was not a prior history of successful primary care management.

8. Involve Behavioral/Chemical Health

Consider involving same day behavioral health for:

- Suicidal thoughts and/or plans that make the clinician uncertain of the patient's safety.
- Violent or homicidal thoughts and/or plans that make the clinician uncertain about the safety of the patient or others.
- Recent loss of touch with reality (*psychosis*).
- Inability to care for self/family.

Involvement could include:

- Appointment with psychiatrist and/or psychotherapist
- Phone consultation, with psychiatrist and/or psychotherapist
- Referral to the Emergency Department

9. Medical Comorbidity (*co-existence*) and/or Special Population?

Medical Comorbidities (*concurrent health conditions*)

Be aware of the increased incidence of depression in chronic comorbid (*concurrent*) conditions such as chronic pain, diabetes, cancer, Parkinson's disease, and cardiovascular disease. Depression may increase in frequency with acute conditions such as fractured leg, back pain with disability, acute MI, stroke, etc. Difficulties coping with a medical condition may also play a role.

The following conditions are particularly important for screening, given the findings.

Cardiovascular Disease

Major depression is associated with an increased risk of developing coronary artery disease, and has also been shown to increase the risk of mortality (*death*) in patients after myocardial infarction (*heart attack*) by as much as four-fold. Moderate to severe depression before CABG (Coronary Artery Bypass Graft) surgery, and or persistent depression after surgery increases the risk of death after CABG more than two-fold higher than non-depressed patients.

Several possible mechanisms are proposed to explain why depression increases the risk of developing cardiovascular disease including behavioral issues such as increased smoking, obesity, sedentary lifestyle, and lack of adherence to medication. Biologic explanations associated with depression such as increased inflammatory processes (*cells that line internal body cavities*), and abnormalities in endothelial function may also explain possible mechanisms for an increased risk.

Consensus medical opinion is to treat depressed cardiac patients with a safe drug rather than watchful waiting since they would benefit from symptomatic relief of their depressive symptoms and there is a potential improvement in their cardiovascular risk profile.

Diabetes

Major depression is associated with an increased number of known cardiac risk factors in patients with diabetes and a higher incidence of coronary heart disease, therefore screening and treatment of depression in this patient group should be emphasized.

Individuals with diabetes have a two-fold higher odds of depression than those without diabetes. Depression earlier in life increases the risk of developing diabetes by two-fold. Depressive symptom severity is associated with poorer diet, medication compliance, and self care plus functional impairment and higher health care costs.

Chronic Pain

Depression and pain symptoms commonly coexist, exacerbate or attenuate one another, and appear to share biological pathways and neurotransmitters.

A recent study has shown that 22% of all patients in primary care suffer from persistent debilitating pain and that these patients are four times more likely to develop depression.

Key clinical practice recommendations include:

- In those patients presenting with either pain or depressive symptoms, assess both domains. If comorbidity is found, treat both conditions for optimal outcomes.
- Given that depression and pain symptoms appear to follow the same descending pathways of the central nervous system involving a functional deficiency of the neurotransmitters serotonin, norepinephrine, and dopamine, antidepressant medication is warranted.
- Combining pharmacologic (*medication*) treatment and cognitive-behavioral therapy appears to produce the most favorable treatment outcomes.

Special Populations

Geriatrics

Depression in the elderly is widespread, often undiagnosed and usually untreated. It is not a part of normal aging. Losses that older patients experience can contribute to depression.

Depression in adults older than 65 years of age ranges from 7 to 36 percent in medical outpatient clinics and increases to 40 percent in the hospitalized elderly. Unlike younger people with depression, the elderly will have a medical comorbidity. The highest rates of depression are found in those with strokes (30 to 60 percent), coronary artery disease (up to 44 percent), cancer (up to 40 percent), Parkinson's disease (40 percent), and Alzheimer's disease (20 to 40 percent). The recurrence rate is also extremely high at 40 percent.

Similar to other groups, the elderly present with nonspecific complaints, such as insomnia, anorexia, and fatigue.

Treatment and prognosis for recovery is the same as for younger patients, however, special considerations must be made in the elderly. It usually takes them longer to achieve a remission, and they should be treated for longer periods than younger patients. When using pharmacotherapy, the physician must carefully consider how the metabolism of the drug may be affected by physiologic changes in the elderly, their comorbid illnesses and the medications used for them. Psychotherapy is also appropriate, being limited only by cognitive impairments.

Recurrent depression is common in the elderly. Maintenance therapy with an SSRI (selective serotonin reuptake inhibitor) for two years was shown to be effective in preventing recurrent depression after a first time major depression in the elderly over seventy years of age, Interpersonal psychotherapy alone was ineffective.

Pregnancy

Depression poses risk for pregnancy. Maternal depression and other stress states have been associated with lower birth weight and gestational age of infant offspring, delivery by cesarean section, and admittance to neonatal care units. Other potential consequences of depression during pregnancy include: poor maternal weight gain or frank weight loss and malnutrition (puts infants at risk for low birth weight), long-term hospitalization, marital discord and divorce, poor prenatal care compliance, difficulty caring for other children, loss of employment, increased harmful behaviors such as nicotine, alcohol or drug use and suicide. The challenge is to minimize unnecessary medication exposure to the developing fetus while maintaining the health of the mother. Studies are sparse, specifically regarding the efficacy of psychotherapy and psychotropic treatments. Medication should be used when the risk to the mother and fetus from depression outweighs risks of pharmacotherapy. Maternal illness severity is an important factor in the risk benefit decision-making process. Mild to moderate depressive symptoms may respond to interpersonal psychotherapy which has been modified for pregnancy. More severe depression requires psychopharmacological interventions. It is very possible that antidepressant treatment for depression during pregnancy could reduce or avert some of the potential adverse effects of depression on the mother and her developing fetus. Safety of antidepressants during pregnancy has not been clearly established.

Consideration should be used for bright light therapy as an option for depressed pregnant women.

Cultural Considerations

The concept of depression varies across cultures. In many cultures, for depression to become a problem for which a person seeks medical treatment, symptoms may include psychosis, conversion disorders (*a psychological disorder in which paralysis of the limbs occurs without physical basis*), or significant physical ailments.

- Be aware that psychosocial stressors may be more prevalent with special populations and the health care team may want to take these issues into consideration as a treatment plan is made. Examples of possible stressors include:
 - Housing
 - Daycare
 - Employment
 - Financial stability
 - Food
 - Transportation
 - Immigration status
- Assess for other resources the client may have used such as elders, native or spiritual advisors/healers, or whomever is within their frame of reference. Acknowledge their role and collaborate if possible/appropriate.

- Many assessment tools may not be useful for certain populations. Screening instruments are validated in certain groups. Use caution when using because a tool may not be applicable to all groups.
- Cost implications for patients often affect adherence, including insurance coverage or generic versus brand name medications. Adherence factors are important for providers to discuss with the patient.
- Symptoms of depression may be perceived differently by various cultures. This may lead to under-recognition or misidentification of psychological distress. In some cultures mood, affect and anxiety symptoms are considered social, moral, or spiritual problems.
- The most common somatic symptoms of depression and anxiety are musculoskeletal pain and fatigue. A provider might consider starting the conversation with the patient on physical symptoms since this is a common presentation of depression in some cultures.
- Ten to 75 percent of patients are noncompliant with medication use and rates are higher in inter-cultural settings because of cultural expectations and communication problems.
- Most therapies based on research have been evaluated with white, middle class, English-speaking populations.
- Recent research on depression in low-income minority women in the United States documents significant improvement of symptoms and social functioning regardless of whether treatment was medication or psychotherapy when treatment was sufficiently accessible (availability of child care and transportation).
- Health care providers can create a more comfortable environment for a patient of another culture by acknowledging the impact of culture and cultural differences on physical and mental health.
- A discrepancy between aspiration and achievement may be a better predictor of psychiatric illness than socioeconomic status. The larger the discrepancy between aspiration and achievement, the greater risk of emotional disturbance.

10. Address Secondary Causes

People with secondary causes for major depression may also have an underlying primary mood or anxiety disorder. Understanding and addressing the needs of special populations may enhance treatment outcomes.

11. Treatment Plan

Depression is diagnosed on the basis of specific DSM-IV TR* criteria obtained through a clinical interview.

Successful treatment programs include:

- Organized treatment protocols (*a detailed plan*).
- Structured follow-up programs.
- Systematic monitoring of treatment adherence.

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Patient Education

1. Successful treatment of patients with major depression requires active engagement of the patient and his/her family and on-going patient education, beginning at the time of diagnosis. It is important for the patient to consider and adopt some self-care responsibilities, which may range from simply demonstrating reliable behavior in taking medications and calling the provider with side effects to agreeing to participate in psychotherapy sessions, journaling, and homework [necessary for some cognitive behavioral therapies (CBT)].

Written materials are helpful to reinforce information shared during the discussion. Patients who commit to some self-care responsibilities and receive education are more likely to continue treatment and are more likely to attain better outcomes compared to patients who are not committed.

Education topics should include:

- The cause, symptoms, and natural history of major depression.
 - Treatment options (trial-and-error approach).
 - Information on what to expect during the course of treatment.
 - How to monitor symptoms and side effects.
 - Follow-up schedule (office visits and/or telephone contacts).
 - Early warning signs of relapse or recurrences.
 - Length of treatment.
2. When antidepressant medication is prescribed, the following key messages should be used to support medication adherence and completion:
 - Side effects from medication often precede therapeutic benefit and typically recede over time. It is important to expect some discomfort prior to benefit.
 - Successful treatment often involves dosage adjustments and/or trial of a different medication at some point, to maximize response and minimize side effects.
 - Most people need to be on medication at least 6-12 months after adequate response to symptoms.
 - It usually takes 2-6 weeks before improvement is seen.
 - Patients should take the medication as prescribed, even after feeling better.
 - Patients should not stop taking the medication without calling the provider. Side effects can be managed by changes in the dosage or dosage schedule.

Exercise

Among individuals with major depression, exercise therapy is feasible and associated with significant therapeutic benefit, especially if exercise is continued over time. When prescribing exercise either alone or as a supplement to medication and psychotherapy, the complexity and the individual circumstances of each patient must be considered. When prescribing an exercise prescription, consider the following:

- Anticipate barriers – hopelessness and fatigue can make physical exertion difficult.
- Keep expectations realistic – some patients are vulnerable to guilt and self-blame if they fail to carry out the regime.
- Introduce a feasible plan – walking, alone or in a group, is often a good option.

- Emphasize pleasurable aspects – the choice of exercise should be guided by the patient's preferences, and must be pleasurable.
- A goal of 30 minutes of moderate-intensity aerobic exercise, 3-5 days a week, is recommended for otherwise healthy adults.
- Encourage adherence – greater antidepressant effects are seen when training continues beyond 16 weeks.

Psychotherapy

- Offer a referral for psychotherapy whenever psychological or psychosocial issues are prominent, or if the patient requests it. Individuals perceiving more self-control of their health experience greater depressive symptom reduction.
- Support and education in the primary care setting are critical and contribute to the likelihood of good follow through on treatment. It may help patients understand their options and resources if the primary care clinician explains that this is not the same as a course of psychotherapy.

Medications

For antidepressant medications, the patient's adherence to a therapeutic dose and meeting clinical goals are more important than the specific drug selected. The educational messages in Appendix A (Treatment and Education box) may increase adherence.

Health care providers should carefully evaluate their patient in whom depression persistently worsens, or emergent suicidality is severe, abrupt in onset, or was not part of the presenting symptoms to determine what intervention, including discontinuing or modifying the current drug therapy is indicated.

The provider should instruct their patient, and their patient's caregiver to be alert for the emergence of agitation, irritability, and the other symptoms. The emergence of suicidality and worsening depression should be closely monitored and reported immediately to the health care provider.

Selection of antidepressant medication should be based on:

- The patient's history of response to previous antidepressant medication, if any.
- The patient's other psychiatric or medical conditions, if any.
- Clinician familiarity with specific antidepressants.

There is no evidence regarding choice of brand versus generic based on adverse clinical outcomes.

Consider discussing with the patient the specific side effect profiles, costs, and benefits of different antidepressants, including generics. Cost implications for patients needs to be discussed between provider and patient.

Selection of an Antidepressant Medication

1. SSRIs (selective serotonin reuptake inhibitor), venlafaxine, duloxetine, mirtazepine, and bupropion

SSRIs, venlafaxine, duloxetine, mirtazepine, and bupropion are frequently chosen as first-line therapy medications because of their simplicity and low side effect profiles.

They generally lack the common adverse reactions (dry mouth, constipation, dizziness upon standing or sedative effects) of tricyclics and cause fewer problems when taken in overdose. However, they

may cause headaches, nervousness, insomnia, and sexual side effects. They also may be more expensive, as some may not yet be available as generics.

Care must be taken to remain with either the brand name product or the same general product.

2. *Tricyclics*

The literature clearly supports the effectiveness of tricyclics. Because of associated side effects, they are used as first-line medications less frequently.

Secondary amine tricyclics cause less orthostatic hypotension (*low blood pressure when standing*) and sedation than tertiary amine tricyclics.

These medications should be monitored cautiously in patients with heart problems, or in patients with potential drug interactions. Monitoring blood levels and EKG may be advised.

3. *MAOIs (monoamine oxidase inhibitors)*

In general, because of their potential for serious side effects and the need for dietary restrictions, **MAOIs** should be restricted to patients who do not respond to other treatments. Patients with major depressive disorder with atypical features are one group for whom several studies suggest MAOIs may be particularly effective. However, in clinical practice, many psychiatrists start with SSRIs in such patients because of their more favorable side effect profiles.

Interactions with other medications: Many antidepressant medications have clinically significant drug interactions. A complete discussion of this topic is beyond the scope of this guideline. Health care providers are advised to consult references for more information about drug interactions with specific medications, and to assess the significance of the interaction before prescribing antidepressants.

Elderly patients: Because of the potential for decreased renal (*kidney*) and hepatic (*liver*) function, concurrent diseases and medications, the elderly are at higher risk of significant side effects or drug interactions with antidepressant medications. Consider starting at the lowest possible dose and increasing slowly to an effective dose or until side effects appear. Tertiary amine tricyclics generally should be avoided in elderly patients because of the high incidence of orthostatic hypotension (*low blood pressure when standing*), sedation, cognitive problems, and cardiac (*heart*) effects with these medications.

Pregnancy: Approximately 5 to 10% of women experience significant mood or anxiety symptoms during pregnancy. Physicians must help patients weigh the risk of prenatal exposure to psychotropic medications against the risks of untreated psychiatric illness. The first line of treatment for mild to moderate depression includes increased social supports and psychotherapy. When these non-medication options have failed or if patients have severe major depression or other conditions that may be a focus of clinical attention, then the risks of untreated illness may outweigh the potential detrimental effects of certain psychotropic medications.

Patients commonly underestimate the risks of untreated maternal psychiatric illness while overemphasizing the risks of their psychotropic medications. Misperception about risk can lead both physicians and patients to terminate otherwise wanted pregnancies or avoid needed pharmacotherapy. By informing patients about the nature and magnitude of medication risks as well as the risks of untreated illness, psychiatrists can help patients reach their own decisions.

Lactation: Antidepressants may appear in breast milk in low concentrations. Because of the long half-life of these medications, nursing infants may have measurable amounts in their plasma (*blood*) and tissues, including the brain. This is particularly important during the first few months of life, with immature hepatic (*liver*) and renal (*kidney*) function. Because antidepressant medications affect neurotransmitter function in the developing central nervous system, it may not be possible to predict long-term neurodevelopmental

effects. Therefore, use of antidepressants in mothers who are nursing should only be used when clearly needed and potential benefits outweigh the risks to the nursing infant.

Herbals

Caution: Many drugs interact with St. John's wort, including other antidepressants, warfarin (*blood thinner*), oral contraceptives, antiretroviral (*drugs that fight retroviruses*), anti-cancer, and anti-rejection drugs. Care should be taken to ask all patients what medications they are taking, including over-the-counter drugs and supplements, to avoid these interactions.

Hypericum perforatum (St. John's wort) is popularly thought to be an herbal remedy for depression. The Hypericum Depression Trial Study Group concluded that the data do not support the use of hypericum instead of antidepressants or psychotherapy nor have they proven effective in standard clinical care of patients with major depression.

SAM-e is a natural compound that has been studied as a treatment option for depression. Essentially these studies show that SAM-e is superior to placebo and comparable to tricyclics in the treatment of outpatients with major depression. Effective oral doses seem to be in the 400-1600 mg a day range as compared to doses of 400 mg a day of tricyclics. Side effects are less common than with tricyclics and include mild insomnia, lack of appetite, constipation, nausea, dry mouth, diaphoresis (*excessive sweating*), dizziness and nervousness. Increased anxiety and hypomania (*less severe mania*) have been reported in patients with bipolar disorder. Interactions with other medications have not been studied and are unknown. Comparisons to newer antidepressants have not been done yet.

Other herbal remedies and dietary supplements, such as kava-kava, omega-3 fatty acid, or valerian root, have not been proven effective treating depression and may or may not be safe.

Herbal products and nutritional supplements are not evaluated or regulated by the FDA (U.S. Food and Drug Administration) for safety, efficacy, or bioavailability (*ability of substance to be absorbed into the bloodstream*).

Follow-up

Follow-up methods (office, phone, other) and their frequency should be determined.

Improving attitudes towards antidepressant medications along with the patient's ability to handle medication side effects are key factors in promoting greater adherence to maintenance treatment and thus greater likelihood of preventing relapse. Interventions toward this end may include patient visits with a depression prevention specialist (PhD, MSN, MSW who has received special training) and follow-up phone calls. Interventions are critical to educating the patient regarding the importance of preventing relapse, safety and efficacy of medications and management of potential side effects.

If symptoms are severe: Weekly contacts may be needed.

If mild or moderate symptoms are present: Contact should be every 2-4 weeks.

For maintenance medication: Office visits can occur every 3-12 months if everything else is stable.

Referral

Consider involvement of a behavioral health care provider for the following:

- Patient request for psychotherapy.
- Presence of severe symptoms and impairment.
- Diagnostic question.

- Presence of other psychiatric condition (for example, personality disorder, history of mania).
- Substance abuse questions.
- Clinician discomfort with the case.
- Initial treatment does not result in a successful outcome.
- Patient's request for more specialized treatment.

12. Is Patient Responding Adequately?

The goal of treatment should be to achieve remission. Remission is defined as the absence of depressive symptoms, or the presence of minimal depressive symptoms. Response is defined as a 50% or greater reduction in symptoms (as measured on a standardized rating scale) and partial response is defined as a 25-50% reduction in symptoms. There are different definitions of these issues in the research, and the time at which one measures is also debated.

13. Evaluate Dose, Duration, Type, and Adherence with Medication and/or Psychotherapy; Reconsider Accuracy of Diagnosis or Impact of Comorbidities (*Concurrent Health Problems*)

The key objectives for treatment are:

- Remission of symptoms in the acute phase. Remission may be expected in up to 40% of patients with single treatment. Remaining patients will need to be re-evaluated for reasons for lack of remission and decisions made about next steps. Evidence shows that for these patients, at best, 40% will not be able to achieve remission. For those patients, the goal is to reduce symptoms to manageable levels.
- Reduction of relapse and recurrence of major depression.
- Return to previous level of occupational and psychosocial (*involving both psychological and social aspects*) function.

Treatment considerations

When considering treatment options, the primary goal is to achieve remission or get the patient to be virtually symptom-free (that is, a PHQ-9* score of 4 or less or a HAM-D** score of less than 7).

A. Medication vs. Psychotherapy

If the presenting symptoms of depression are severe, the initial recommendation is to treat with antidepressants and psychotherapy. If the initial presentation is mild to moderate then either an antidepressant or psychotherapy (or both) is indicated. Psychotherapy, especially focused psychotherapy can significantly reduce symptoms, restore psychosocial and occupational functioning, and prevent relapse in patients with major depression.

It is useful to take into consideration cultural beliefs and sufficiency of (or lack of) resources such as transportation, finances, and child care when making a decision whether to treat with medication and/or psychotherapy.

- Medication and/or (psychotherapy) are effective in treating depression. Factors to consider in making treatment recommendations are:
 - Symptom severity

- Presence of psychosocial (*involving both psychological and social aspects*) stressors
- Presence of comorbidities (*concurrent health problems*)
- Patient preferences

*Patient Health Questionnaire, used to diagnose and rate severity of depression

**Hamilton Depression Rating Scale, used to measure severity of depression

- In order to treat major depression effectively and to minimize the risk of recurrence, it is important to adequately assess a patient's expectations and beliefs regarding ability to control depressive symptoms and increase functioning. Patients who perceive more self-control of their health experience a greater reduction in depressive symptoms, whether treated with psychotherapy or medication.
- A switch from an antidepressant to psychotherapy or vice versa appears useful for nonresponders to initial treatment.
- Psychotherapy may provide better outcomes on adjustment/functional measures such as mood, suicidal ideation, work, and interests; medication treatment may be superior on vegetative symptoms such as sleep and appetite.

B. Medication

- If there is less than 25% reduction of symptoms after 6 weeks at the therapeutic dose (that is, only a partial positive response to medication), add or substitute another treatment.
- When considering how long to continue medication after remission of acute symptoms, two issues need to be considered: continuation and maintenance.

Without long-term antidepressant treatment major depressive relapses and recurrences occur in 50-80% of patients.

It has been estimated that patients recovering from primary major depression have a relapse rate of 40-50%. Data also shows that patients who have three or more episodes of depression actually have a 90% risk of relapse.

The best candidates for maintenance therapy are patients who have two previous episodes of major depression, or who have two episodes of major depression but have also had rapid recurrence of episodes, or are older in age at the onset of major depression (more than 60 years of age), have had severe episodes of major depression or a family history of a mood disorder. Maintenance therapy should also be considered for at risk patients with double depression, patients with comorbid anxiety disorder, or substance abuse. Patients whose major depression has a seasonal pattern are also at risk for recurrence.

It is suggested that the dose of antidepressant medication that leads to satisfactory acute therapeutic response should be maintained during long-term treatment to prevent relapse and recurrence of depression.

Patients experiencing the first episode of major depression should be withdrawn gradually, (six to 12 months, including acute and continuation therapy). Patients undergoing treatment for the second episode of major depression should continue treatment through a two episode cycle, perhaps four to five years. Patients who have three or more episodes of major depression or who have two episodes with complicating factors (such as rapid recurrence of episodes, more than 60 years at age of onset of major depression, severe episodes or family history), should continue treatment indefinitely.

Premature treatment discontinuation can be triggered by a number of factors including lack of adequate education about the disease, failure on the part of either physician or the patient to establish goals for follow-up, psychosocial factors and adverse side effects. Early drug discontinuation contributes to probability of relapse and recurrence.

14. Consider Other Strategies

If patient is newly involved in psychotherapy:

- Return visit in 8-10 weeks to evaluate progress
- Contact with patient in 4-6 weeks
- Communicate with therapist in 4-6 weeks
- Therapy can take 8-10 weeks to show improvement

If there is less than a 25% reduction in symptoms when the patient is evaluated after 4-6 weeks of a medication, switch to a different medication. If there is a partial response and side effects are not prohibitive, increase the dose.

If this has not achieved remission 4-6 weeks later, consider:

- Switching to a different antidepressant medication; augmentation (*additional*) strategies containing initial antidepressant and adding another agent (such as lithium or low-dose thyroid) or other biological treatments (adding a second antidepressant medication).
- Referral to a psychiatrist for possible MAOI (monoamine oxidase inhibitor, used to treat depression), or treatment with electroconvulsive therapy (ECT).
- Looking for comorbidities (concurrent health problems), such as substance abuse issues and involve addiction specialists as needed.
- Consider the possibility of a bipolar diathesis (*predisposition*). Bipolar patients require a different treatment approach and may not consistently come forward with their hypomanic, mixed, or manic histories.
- Referrals to a behavioral health provider if there are personality disorders present.
- If the patient is only on medication, add psychotherapy.
- Whether adequate engagement of patient/family is present and whether treatment recommendations are being followed.
- Obtaining a consultation or referral to behavioral health specialists.

Supplemental Therapy is used for those situations where the patient's depression is either treatment-resistant or only partially responsive to treatment.

These include:

- Lithium supplement with TCAs (*tricyclic antidepressants*).
- Lithium supplement with SSRI (*selective serotonin reuptake inhibitor, an antidepressant*; caution – monitor for serotonin syndrome).
- T₃ (*thyroid hormone*) supplement of TCA.
- Stimulant drugs as supplement to TCA/SSRI ("jump-start response").

- TCA-SSRI combination (caution – monitor for elevated TCA level).
- Bupropion (*antidepressant*) – SSRI combination.
- Mirtazapine (*antidepressant*) – SSRI combination.
- Buspirone (*antianxiety drug*) – SSRI combination.
- Carbamazepine/valproic acid (*anticonvulsive drugs*) – TCA combination (caution - monitor for decreased TCA level)
- Carbamazepine/valproic acid – SSRI combination.
- Atypical antipsychotic-antidepressant combination.

Other Therapies

Psychotherapy

Randomized, controlled studies support the efficacy of psychotherapy in the treatment of depression. Patient preference, the nature and severity of depressive symptoms, access to resources, affordability of services, and the presence of environmental stressors should be considered as treatment planning is completed. There are numerous types of psychotherapy, just as there are numerous types of medication. If a patient has received psychotherapy and not responded, evaluate the treatment they have received and consider another type. Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Short-Term Psychodynamic Psychotherapy (STPP) and Problem-Solving Therapy (PST) have documented efficacy. In mild to moderate levels of depression, psychotherapy can be equally as effective as medication. With severe depression, antidepressant medication may be more helpful in the acute phases. There is documentation to support lower relapse rates among patients receiving psychotherapy.

Hospitalization

Partial or full hospitalization may be indicated in patients who have failed outpatient management, particularly if safety issues are a concern.

Light Therapy

Use of bright light therapy for treatment of major depression with seasonal symptoms is well established. Additionally, there is preliminary evidence of the efficacy (*effectiveness*) of bright light therapy for some other types of depressive symptom patterns, including non-seasonal depression and milder variations of seasonal depressive patterns. Bright light therapy may also quicken and enhance the effects of antidepressant medication. Further research is needed to clearly establish safety and efficacy (*effectiveness*) during pregnancy. Although the light exposure dosage (typically 5,000-10,000 lux) and exposure length (typically 30-60 minutes) have been fairly standard for seasonal affective disorder treatment, research on bright light therapy for other types of depression has not necessarily utilized standard dosages and exposure times. It is important that any light therapy treatment utilize equipment that eliminates ultraviolet frequencies and produces bright light of known spectrum and intensity. For these reasons, use of client-constructed light therapy units are contraindicated (*not advised*).

Electroconvulsive Treatment (ECT)

Electroconvulsive treatment (*ECT*) is very effective and can sometimes be administered safely in an outpatient setting. ECT does not cure depression, and a successful ECT treatment should be followed by a plan to prevent relapse of the depression. A patient considering ECT would need to be able to tolerate anesthesia, and should consult with a psychiatrist about the risks and benefits.

Factors that may suggest a given patient may be a candidate for ECT include:

1. Agitated depression in elderly patients.
2. Antidepressant medications have not been tolerated or pose a significant medical risk.
3. Antidepressant medication trials have not been successful.
4. ECT has been successful in previous episodes.
5. Catatonia (*a type of schizophrenia marked by stupor or rigidity*) is present.
6. A rapid response is needed because of severe suicide risk or because the patient's health has been significantly compromised by the depression [for example, severe cachexia (*psychic attachment to an idea, object, or person*), inability to attend to the activities of everyday living].
7. Psychosis (*mental derangement marked by loss of contact with reality*) is present despite treatment.
8. Melancholic symptoms (*loss of interest in usually pleasurable activities*)
9. Symptoms of Parkinsons disease

Vagus Nerve Stimulation

Vagus Nerve Stimulation (VNS) generally refers to the use of an implantable device, which provides intermittent stimulation of the left vagus nerve (*a nerve composed of sensory fibers that carry information to the brain*) at the cervical (*neck*) level. It is used as an adjunctive (*supplemental*) treatment along with other modalities (*types*) such as use of psychotropic medications. It has only been studied in refractory (*unresponsive*) or treatment resistant depression.

Side effects include: voice alterations (generally just while one is receiving the 30 seconds of stimulation each 5 min), increased rate of neck pain, cough, dyspnea (*difficulty breathing*), and dysphagia (*difficulty swallowing*). At this point in time, VNS is approved by the FDA for treatment resistant depression. However, given the lack of double blind controlled studies this is a promising new therapy that remains to be fully proven.

Transcranial Magnetic Stimulation

Repetitive transcranial magnetic stimulation (rTMS) is a non-invasive technique that stimulates the brain internally by using high intensity, pulsed electron-magnetic fields. Recent research has examined the use of rTMS in the treatment of major depressive disorder. In the procedure, a hand-held stimulating coil is applied directly to the patient's head and delivers a magnetic pulse to the cortex. Results of research studies to date have been inconsistent and inconclusive. The FDA has not yet approved rTMS for general clinical use, and it must be considered, at this time, investigational.

Acupuncture

Although acupuncture is known to be an alternative therapy for the treatment of depression, it has shown mixed results. Acupuncture may be an alternative for those who reject traditional treatments, for those who do not show adequate response to traditional treatments or for those in whom antidepressants may be contraindicated (*not advised*) (frail, elderly or pregnant women). Electro-acupuncture may be a treatment of choice for those who are unable to comply with classic tricyclic antidepressants because of their anticholinergic (*blocking the effects of acetylcholine*) side effects. It is felt that additional studies need to be done for endorsement as a recommended treatment for depression.

15. Continuation and Maintenance Treatment for 6-12 Months

Acute treatment (usually the first 3 months of treatment) refers to treatment with antidepressant medication in order to achieve remission of major depressive symptoms. Remission is defined as having minimal residual symptoms (a HAM-D* score of less than 7 or a PHQ-9** score of 4 or less).

**Hamilton Depression Rate Scale, used to measure severity of depression*

***Patient Health Questionnaire, used to diagnose and rate severity of depression*

Continuation therapy is the phase where antidepressants are continued in order to keep the patient free of symptoms for the duration of the current episode. Continuation therapy is considered to be at least 6 months long, but lately the evidence supports viewing the duration as 6-12 months long. However, consider in elderly populations it may take longer to respond to acute treatment. Therefore, the maintenance period of treatment may need to be extended.

Maintenance therapy is designed to prevent recurrence of new or future episodes of major depression. Evidence suggests that treating depressed patients with adequate doses of antidepressants for longer periods is effective in preventing recurrence of depression. An adequate dose is generally considered to be the same as the dose required in the acute phase of treatment to achieve remission.

Complicating factors are those situations where evidence either shows or suggests higher rates of recurrence after stopping antidepressants and include:

- Pre-existing dysthymia (*chronic feelings of sadness*).
- Inability to achieve remission.
- Recurrence of symptoms in response to previous attempts at lowering the dose or discontinuing the medication.

With the wide array of half-lives (*the time needed for half the amount of a substance to be eliminated by natural processes*) and therapeutic dose ranges for the various existing antidepressants, it is beyond the scope of this guideline to discuss detailed discontinuation strategies.

When feasible (for example, the starting dose is not the same as the therapeutic doses), it is recommended that the dose be tapered over a period of weeks to several months when discontinuing an antidepressant.

Appendix A – Other Mood Disorders

Generalized Anxiety Disorder (GAD) DSM-IV TR* Criteria:

- A. Excessive anxiety and worry about a number of events (which cause clinically significant distress or impairment in functioning) occurring more days than not for at least six months.
- B. The person finds it difficult to control the worry.
- C. Associated with at least three of the following:
 1. Restlessness, feeling "on edge."
 2. Fatigue.
 3. Difficulty concentrating.
 4. Irritability.
 5. Muscle tension.
 6. Sleep disturbance.

Panic Attack

DSM-IV TR* Criteria:

Discrete period of intense fear or discomfort in which at least four of the following symptoms develop abruptly and reach a peak within 10 minutes:

1. Palpitations, pounding or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feeling of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, lightheaded, or faint.
9. Feelings of unreality or being detached from oneself.
10. Fear of losing control or going crazy.
11. Fear of dying.
12. Paresthesias (numbness or tingling).
13. Chills or hot flashes.

Useful interview questions for anxiety:

- Are you often worried or anxious?
- Do you have repetitive behaviors or thoughts that are difficult for you to control?
- Do you ever experience sudden attack or fear of losing control, dying, fainting, going crazy, or severe embarrassment?
- Are you particularly anxious when meeting new people, or in groups?
- Are there places, things, or situations that you go out of your way to avoid due to an unusual fear level?

Diagnosis suggestive of any anxiety disorder:

- Atypical chest pain
- Hyperventilation
- Irritable bowel syndrome

Treatment and Education:

Both pharmacologic and non-pharmacologic interventions may be effective depending on the severity of symptoms. For antidepressant medications, adherence with a therapeutic dose is more important than the specific drug selected. The following educational messages may increase adherence:

1. Take the medication daily.
2. Antidepressants must be taken for two to four weeks for a noticeable effect.
3. Continue to take medicine for at least 6-12 months even if feeling better.
4. Do not stop taking antidepressant without checking with your provider.
5. Contact your provider if you have questions about your medication.

Examples of Other Mood Disorders:		
In many of these circumstances, a referral to mental health is appropriate.		
Disorder	Description	Useful Questions
Dysthymia	Chronic (> 2 years) and frequent low mood, often experienced as emptiness or sadness, often accompanied with lethargy and self-criticism, and requiring at least 2 other symptoms of MDD (Major Depressive Disorder).	Do you often feel sad, empty, or unmotivated?
Depressive disorder NOS (not otherwise specified)	Depressive symptoms not meeting criteria for another mood disorder.	Do you experience periods where you feel down or depressed?
Bipolar disorder	History of at least one episode of mania (e.g., high energy, irritability, grandiosity, minimal sleep, pleasure seeking) and commonly severe depression.	Have either you or your family members noticed you've experienced periods of at least a week where you have: <ul style="list-style-type: none"> • talked or thought more and/or faster than usual? • needed significantly less sleep? • felt happier, and/or more irritable than usual? • initiated and engaged more than usual in activities such as spending money, sexual activities, travel?
Examples of Anxiety Disorders:		
Social phobia	Marked and persistent fear of potentially embarrassing social or performance situations.	Do you worry that you might embarrass yourself in a social or performance situation?
Specific phobia	Marked and persistent fear of a specific object or situation.	Do you have excessive or unreasonable fears about specific objects or situations?
Obsessive compulsive disorder	Persistent and intrusive thoughts, ideas, impulses or images associated with repetitive behaviors to reduce distress.	Are you bothered by recurrent thoughts and/or repetitive behaviors?
Post traumatic stress disorder	Exposure to a traumatic event which is persistently re-experienced with anxiety symptoms lasting more than one month.	Do you have distressing anxiety caused by re-experiencing some past traumatic event?
Acute stress disorder	Exposure to a traumatic event which is persistently re-experienced with anxiety symptoms lasting two days to four weeks, and occurring within four weeks of the event.	Do you have distressing anxiety caused by re-experiencing some past traumatic event?
Anxiety disorder NOS (not otherwise specified)	Prominent anxiety of phobic avoidance not meeting criteria for another specific anxiety disorder which, for example, may be episodic, a reaction to a medical condition, or a combination of symptoms from several anxiety disorders.	Do you have episodes of nervousness or excessive worry?
Social phobia	Marked and persistent fear of potentially embarrassing social or performance situations.	Do you worry that you might embarrass yourself in a social or performance situation?

Website Resources

A number of websites provide more in-depth information on depression. The table below includes details.

Author/Organization	Description	Website Address/Order Information
American Psychiatric Association	Provides mental health news, on-line CME programs and legislation. Links to MEDEM for patient information.	http://www.psych.org
Health Disparities Collaboratives	Training manuals and tools to download.	http://www.healthdisparities.net
National Alliance for the Mentally Ill	Advocacy, links to Minnesota chapter support groups.	http://www.nami.org
National Institute of Mental Health	This government-sponsored site provides comprehensive information on the following topics: clinical trials, research and funding opportunities, and patient education materials for adults and children. Links to PubMed, MedlinePlus and other relevant sites are available.	http://www.nimh.nih.gov
National Library of Medicine MedlinePlus	This government-sponsored comprehensive site provides information on medications, diagnosis, treatments, clinical trials and links to other relevant sites. Spanish versions of some patient education materials are also provided.	http://www.nlm.nih.gov/medlineplus
National Mental Health Association	Provides patient information, depression screening tool, community resources and discussion board.	http://www.nmha.org
American Psychiatric Association/American Academy of Child and Adolescent Psychiatry	Provides parents of children and adolescents information about pediatric depression, treatment alternatives and the latest science and research findings.	http://www.parentsmedguide.org
Weekes	204-page book.	Bookstores; \$4.99
Department of Health and Human Services	23-page booklet.	Dept. of HHS (301)443-4140 or (800)421-4211 NIH Pub #00-3561; Limited quantities available at no cost. Information in the public domain and can be reprinted without permission.
National Institutes of Health	24-page booklet.	Dept. of HHS (301)443-4140 or (800)421-4211 NIH Pub; Limited quantities available at no cost.
Park Nicollet Institute	3-fold brochure.	PDF available at http://icsi.org/knowledge/detail.asp?catID=240&itemID=2030

Website Resources

Author/Organization	Description	Website Address/Order Information
American Psychiatric Association	8-page booklet written above the average reading level.	American Psychiatric Press, Inc. (800)368-5777 #2351; \$22.00/50
Dr. David Burns	book	Bookstores
Channing Bete	31-page booklet	Channing Bete 1-800-628-7733
Dennis Greenburger and Christine Padesky	215-page workbook	Bookstores
American Academy of Family Physicians	Handout	http://familydoctor.org/058.xml
American Psychiatric Association	Handout	http://ps.psychiatryonline.org Psychiatry Serv 52:1145-1146, September 2001