

Clinician Guide to Depression Assessment and Management in Collaborative Care



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Preface

Community Partners in Care is a partnership of community and academic members to compare two ways of improving depression care. This partnership is funded by the National Institutes of Health. The two models, the Community Engagement Model and the Technical Assistance Model, both provide resources about programs that have already been proven to work well in improving depression care in other settings. This *Clinician Guide to Depression Assessment and Management in Primary Care*, is based on materials from the study *Partners in Care*. *Partners in Care* was a Patient Outcomes Research Team (PORT) II study, funded by the Agency for Healthcare Research and Quality, formerly the Agency for Health Care Policy and Research (AHCPR). It was a randomized trial to evaluate whether externally designed, evidence-based interventions for improving care for depression can be locally implemented in managed care organizations. The study took place in 46 primary care clinics within six diverse, nonacademic managed care plans in various locations across the United States. It involved 181 primary care providers and 1,356 patients with current depressive symptoms and either 12-month, lifetime, or no depressive disorder.

The original materials designed for clinicians, nurse specialists, and psychotherapists to use for the interventions were developed at RAND in collaboration with researchers and clinicians at many institutions, including the VA Greater Los Angeles Healthcare System, Los Angeles, California; the University of California, Los Angeles; Georgetown University; and the University of California, San Francisco. They are published in 7 volumes, along with the patient-education videotape and brochure developed for the *Partners in Care* study.

The interventions for which these materials were developed took place in 1995-2000. The authors recognize that clinics implementing the interventions today would want to update some of the manuals to take into account subsequent advances - for example, in psychotropic medications and in informatics support for documenting case management. However, the approach remains current, and is the basis for a variety of ongoing interventions for depression for adults, adolescents, and older adults.

This document, *Clinician Guide to Depression Assessment and Management in Primary Care*, provides an algorithm for evaluating people with symptoms of depression that takes account of the wide variety of comorbidities and diagnoses in individuals presenting to general clinicians with symptoms of depression. The algorithm helps clinicians to manage depressed patients efficiently while staying focused on the main therapeutic problems of treating major depression and dysthymia. The approach is guided by rigorous review of scientific evidence to identify cost-effective strategies for depression care.

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Introduction

How to Use the Clinician Guide

The *Clinician Guide* is intended to increase skills, confidence, and adherence to national guidelines for depression among primary care clinicians, including physicians, nurse practitioners, physician assistants, and nurses. It is also intended as a foundation for collaboration between mental health specialists and primary care clinicians. The *Guide* represents the application of mental health knowledge and evidence to the management of the population of patients seen in primary care settings.

Each of the Guide's two chapters—one on evaluation and one on management—is preceded by an organizing algorithm. The Algorithms are written from the point of view of a clinician who has newly identified symptoms of depression in his or her patient. The seven steps in each Algorithm deal with sub-populations of primary care patients and the clinical decisions they require for achieving guideline-concordant care. Each step has a corresponding section in the body of the text.

Figure 1.S (Brief) summarizes the evaluation algorithm, Figure 1.L (Long) includes the full algorithm, and Figure 1.K (Key) provides a key for the symbols used in the algorithm. Figures 2.S, 2.L, and 2.K provide analogous information for the management algorithm.

The algorithms can be used as a table of contents for the body of the *Clinician Guide*. For example, you may wish to get an overview of the evaluation or management material by reading through Figures 1.L or 2.L, then refer as needed to the relevant step in the body of the chapter. Or, you may want to spend an hour or so reading through the entire document, referring to the algorithm as a graphical summary.

Algorithm steps are ordered to reflect an efficient method for triaging and implementing care for patients walking in to primary care settings with symptoms of depression. The steps represent a way of thinking that is familiar to primary care clinicians. For example, assessment of suicidality comes into the evaluation algorithm early, in Step 3. If a patient is actively suicidal, it is important to direct attention immediately to this problem. If the clinician does a comprehensive assessment of other issues first, the issue of suicidality may be omitted, or may arise at the very end of the visit when it will be most difficult to deal with.

We have suggested medications and medication dosages as they apply to most people most of the time. Please consult a drug reference guide, such as the Physicians' Desk Reference (PDR), or your pharmacist if you have any questions. New developments relevant to depression care occur regularly, particularly in the area of medications, and we suggest initial and periodic re-review of the manual by your pharmacists and mental health specialists.

The information contained in the *Clinician Guide* can, in most cases, be confirmed in textbooks of psychiatry or in the Agency for Healthcare Research and Quality (AHRQ) guidelines for major depression. We have also added a reference section (Appendix J) composed of key articles about depression and its management, divided by topics. We hope you will consult these references for detailed discussion of many of the topics you find in the guide.

Summary of Key Treatment Challenges

Depression affects 5 to 10% of primary care patients. The *Partners in Care* treatment program has been designed to help clinicians overcome the most common reasons for treatment failure. These key treatment challenges are listed below.

1. Recognize and diagnose depression

Up to 50% of all cases of current major depression or dysthymia (acute or chronic depression) go undetected in primary care visits.

2. Educate the patient

Clear up misconceptions about the stigma and treatability of depression.

3. Reach agreement with patients on diagnosis and treatment

Patients and physicians often have different explanatory models for what is wrong and different expectations for treatment.

4. Start with the most effective treatment

Use antidepressant medication or psychotherapy. Avoid long-term use of minor tranquilizers.

5. If you use antidepressants:

- *Use an adequate dosage level.* Primary care physicians often 'undertreat' depression with subtherapeutic doses.
- *Continue medications for 6 to 9 months after recovery to ensure long-term success.* About 35% of patients stop taking their antidepressants in the first month of treatment.

6. If you use psychotherapy:

- Use a type known to be successful for depression.
- Continue monitoring psychotherapy patients for relapse during the 6 to 9 months after treatment

7. Follow outcomes closely and adjust treatment as needed.

Many patients do not respond to the initial treatment chosen, and require a change at week 6 - 10. In some cases, patients' symptoms improve, but they continue to function poorly. If patients are not significantly improved at 8 – 10 weeks, consider increasing, augmenting, or changing the medication, adding psychotherapy, and/or get a psychiatric consultation.

8. Prevent relapse and recurrence among patients with prior episodes of depression

- The risk of recurrence is 50% if the patient has had one prior episode of depression, and up to 90% if there have been three or more prior episodes.
- In the patients who are at high risk for recurrence, continue antidepressants for 2 years or more.

More appropriate care for depression often means **more cost-effective care**. If depressed patients do not receive appropriate care, they will still tend to make costly visits, but they will not improve in functioning outcomes. Addressing the challenges above will make care more efficient and effective.

Figure 1.S - BRIEF ALGORITHM FOR EVALUATION

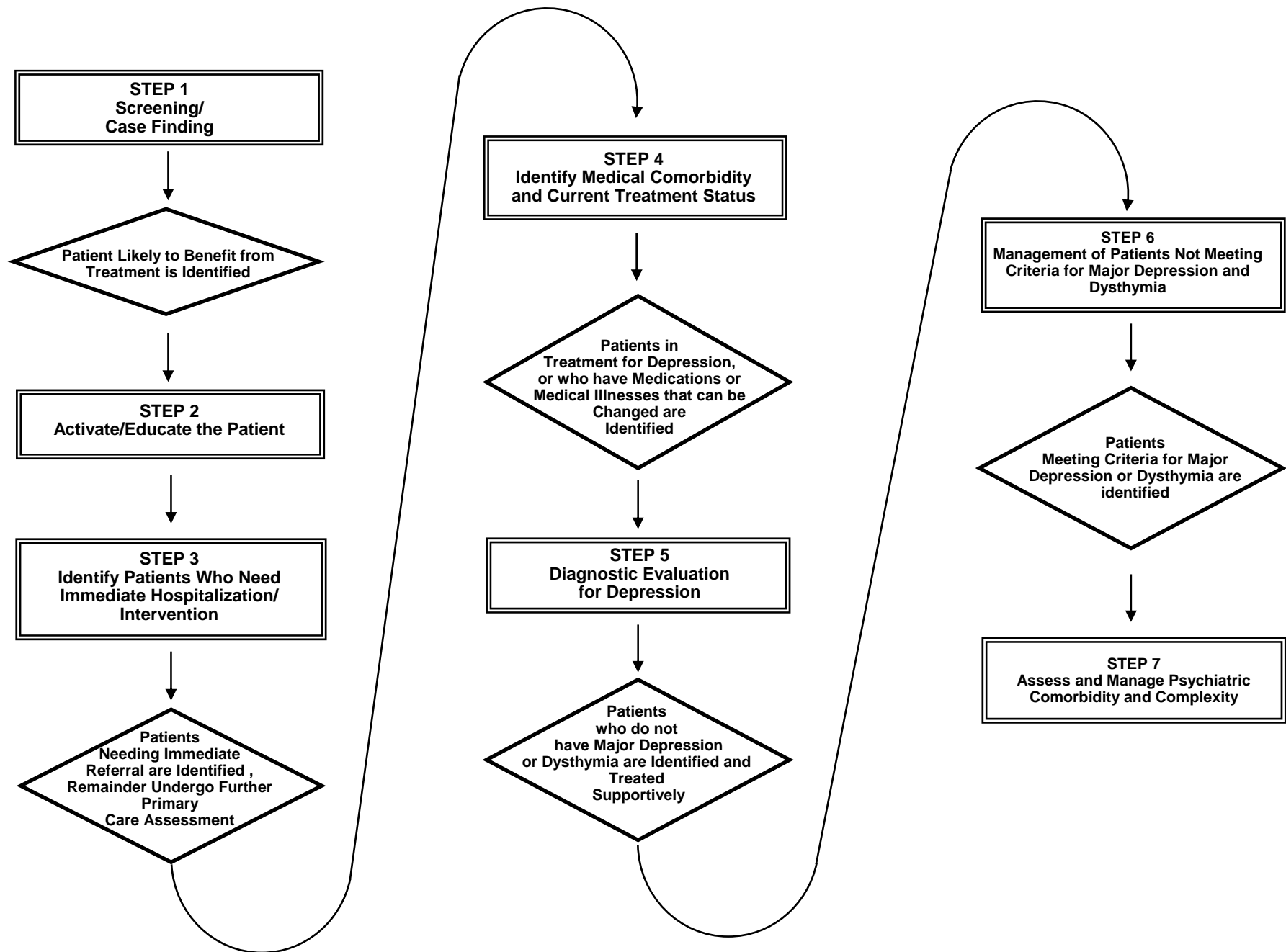
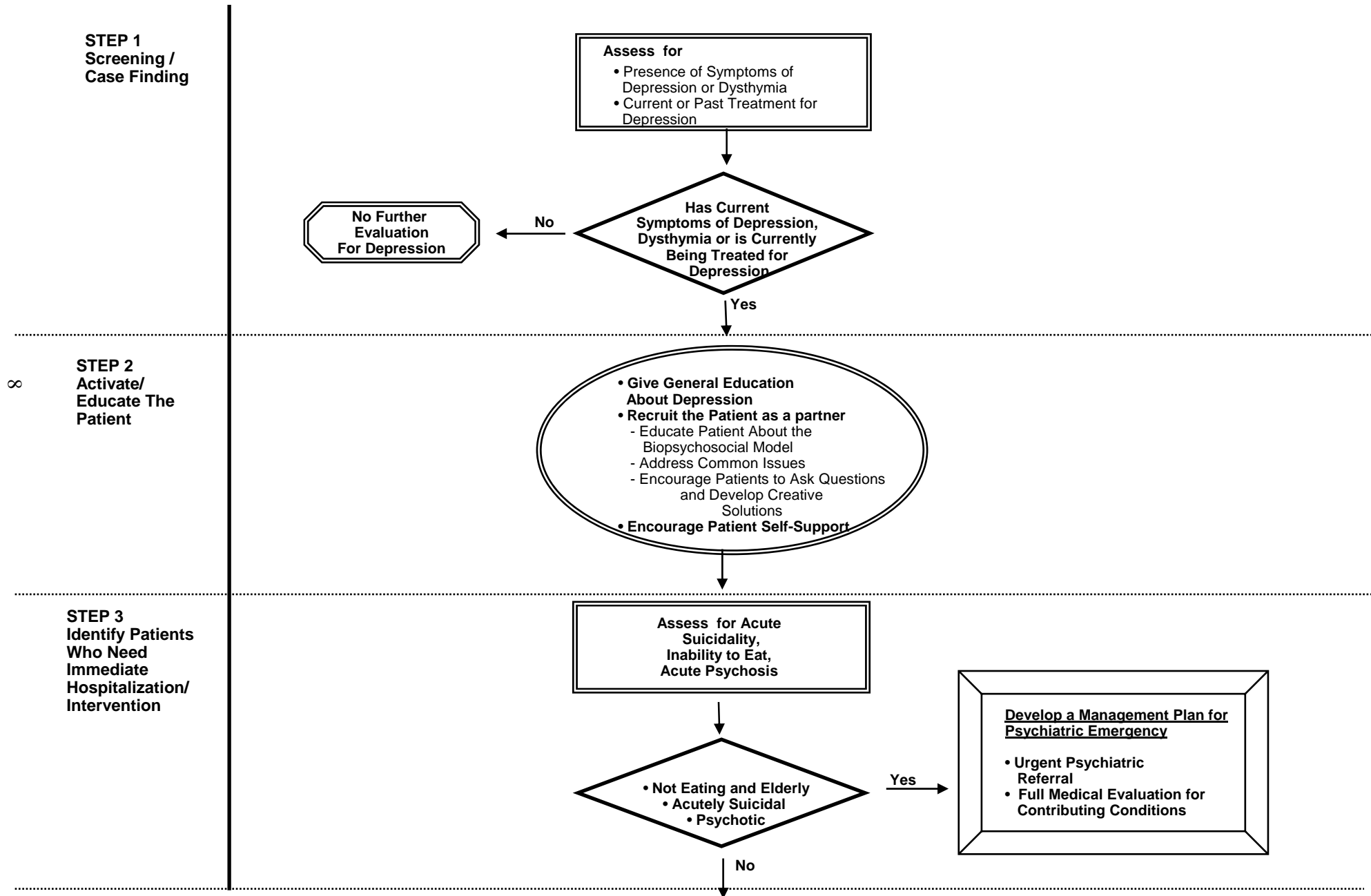


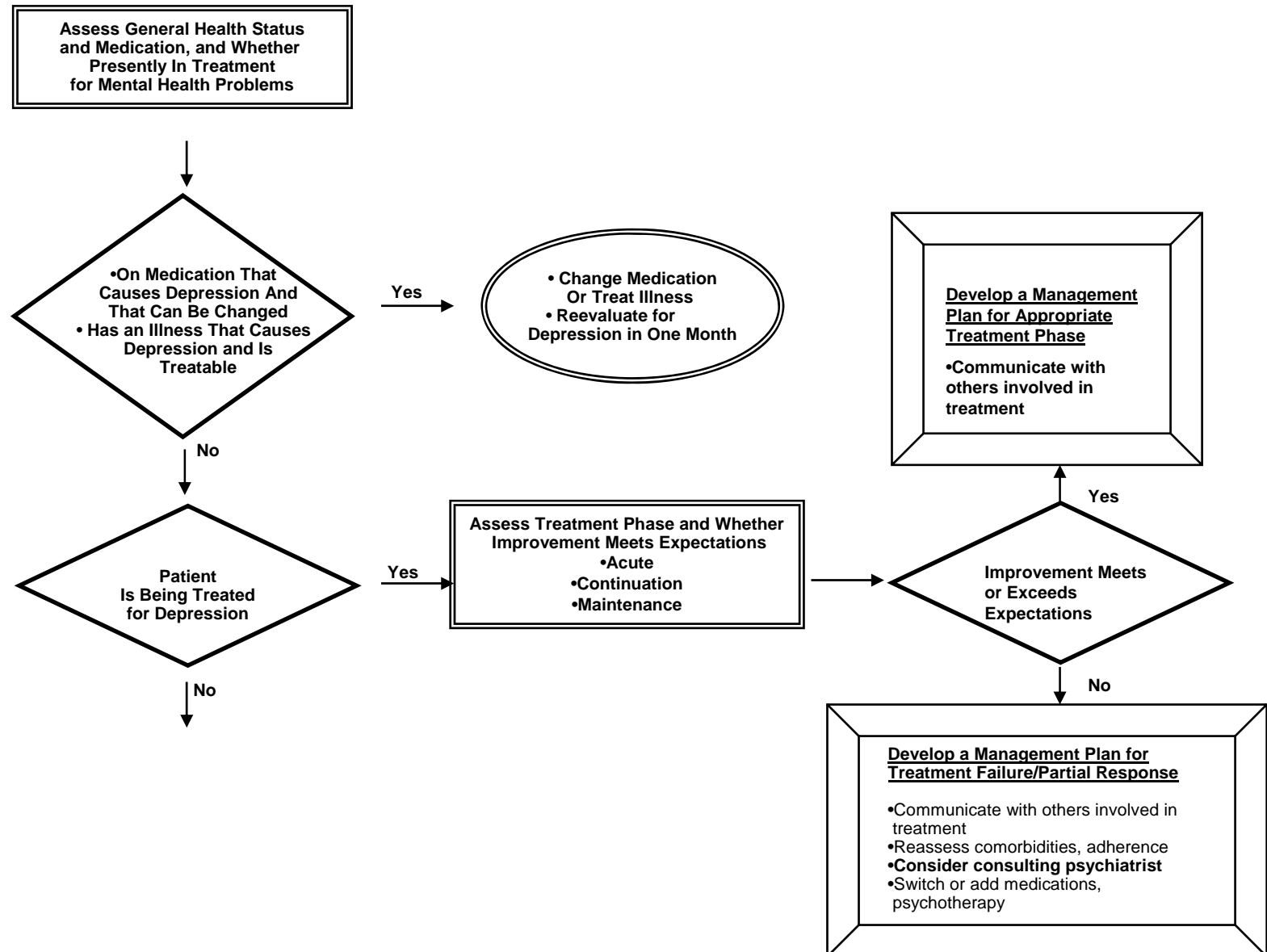
Figure 1.L - LONG ALGORITHM FOR EVALUATION

SEVEN STEPS FOR EVALUATING PEOPLE WITH SYMPTOMS OF DEPRESSION IN PRIMARY CARE



Evaluating People With Symptoms of Depression

STEP 4 Identify Medical Comorbidity and Current Treatment Status



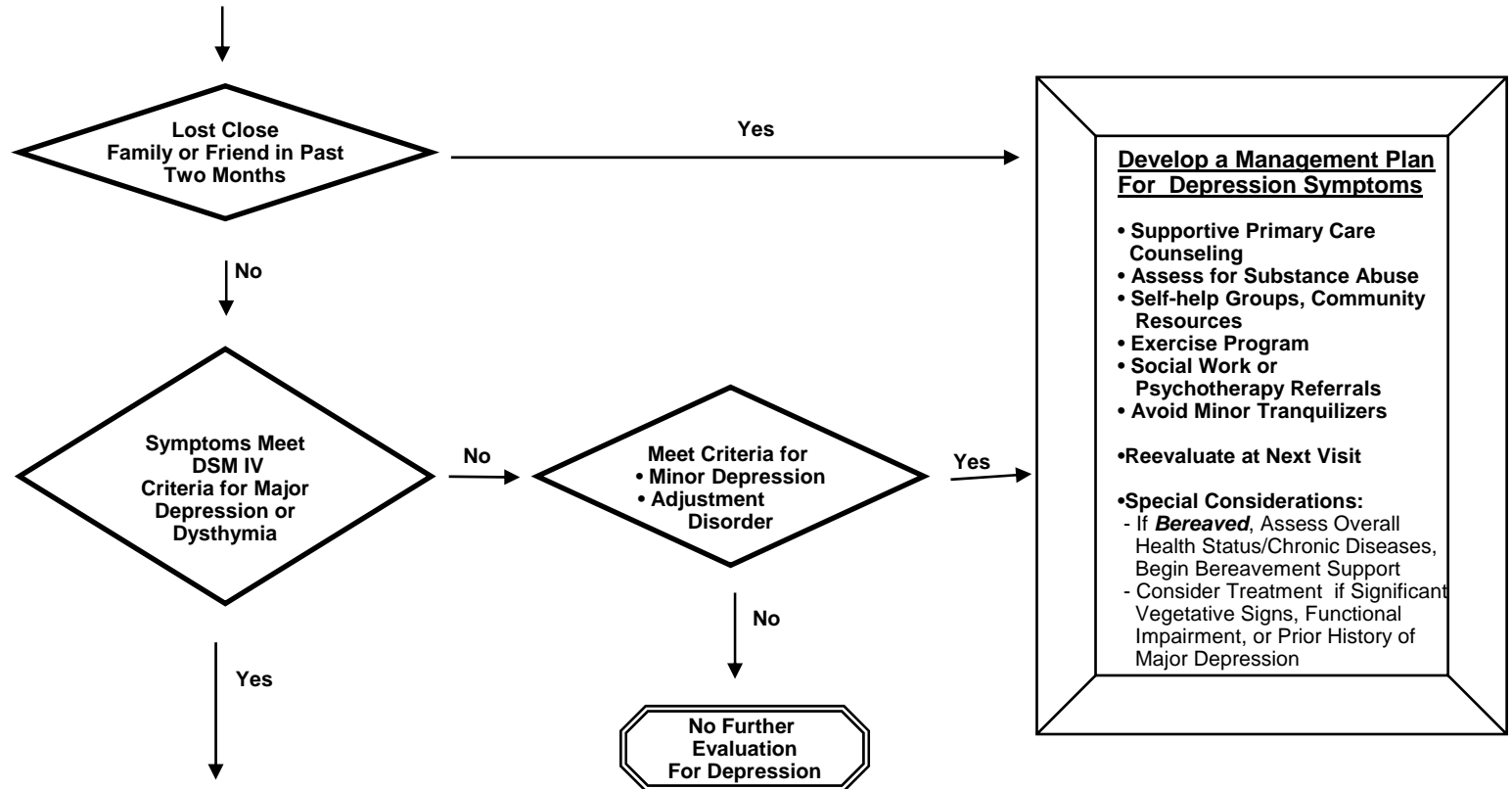
Evaluating People With Symptoms of Depression

STEP 5 Diagnostic Evaluation for Depression

Assess for:

- Diagnosis of Major Depression or Chronic Depression (Dysthymia)
- Bereavement
- Minor Depression
- Adjustment Disorder

STEP 6 Management of Patients Not Meeting Criteria for Major Depression and Dysthymia



Evaluating People With Symptoms of Depression

STEP 7 Assess and Manage Psychiatric Comorbidity and Complexity

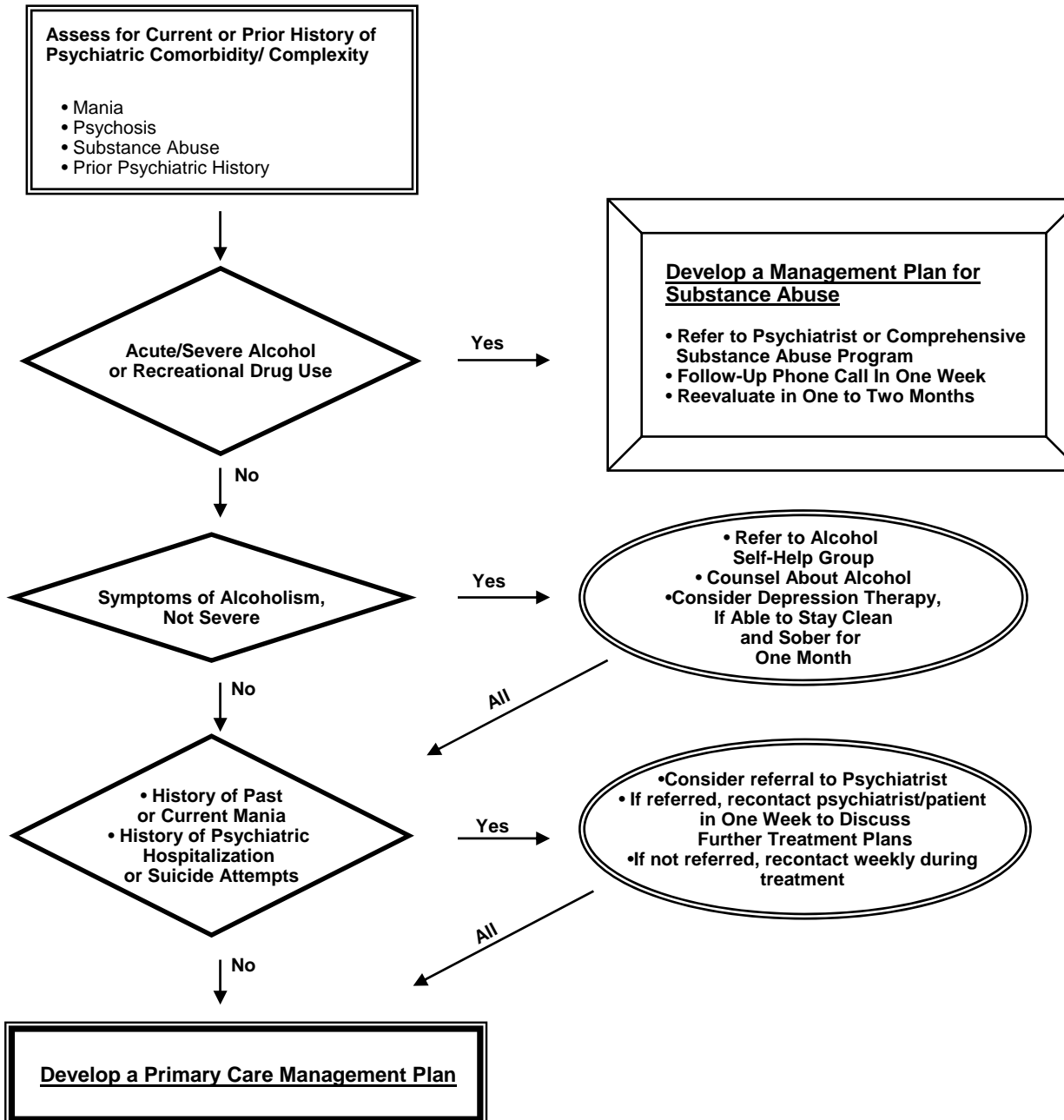


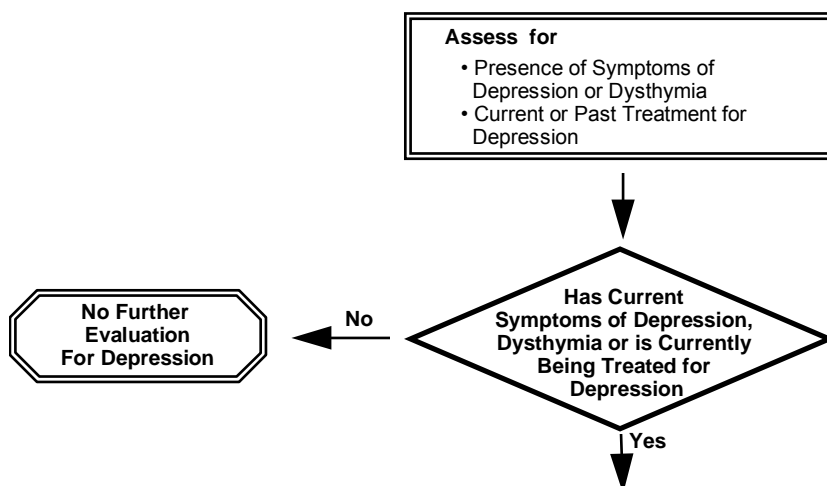
Figure 1.K
KEY FOR DEPRESSION SYMPTOMS ALGORITHM

<u>Symbols</u>	<u>What the Symbols Indicate</u>
<div> Assess for <ul style="list-style-type: none"> • Presence of symptoms of Depression or Dysthymia • Current or Past Treatment for Depression </div>	An assessment to be carried out
<div> No Further Evaluation For Depression </div>	An ending point . This type of patient requires no further assessment or management for depression
<div> Has Current Symptoms of Depression, Dysthymia or is Currently Being Treated for Depression </div>	A decision point . Look for the “yes” and “no” arrows directing you to the appropriate next action
<div> <u>Develop a Management Plan for Appropriate Treatment Phase</u> <ul style="list-style-type: none"> •Communicate with others involved in treatment </div>	A management planning step that exits the depression symptoms algorithm
<div> <ul style="list-style-type: none"> • Give General Education About Depression • Recruit the Patient as a partner <ul style="list-style-type: none"> - Educate Patient About the Biopsychosocial Model - Address Common Issues - Encourage Patients to Ask Questions and Develop Creative Solutions - Encourage Patient Self-Support </div>	An action to be carried out
<div> <u>Develop a Primary Care Management Plan</u> </div>	A management planning step that continues the depression symptoms algorithm

CHAPTER ONE

Seven Steps for Evaluating People with Symptoms of Depression in Primary Care

Step 1 SCREENING/CASE FINDING



Why Search for Depression?

Like hypertension and other chronic diseases, clinical depression (major depression or dysthymia) is very treatable, but without treatment it is often a silent cause of major disability. Research has shown that, while untreated depression is not a frequent cause of death, it causes more severe disability than any of the common chronic diseases other than heart disease. Clinical depression is common in primary care patients (5 - 10%), and is often unrecognized by patients, family, or physicians. All of us have some depressive symptoms, like sadness or hopelessness, from time to time, but we usually experience them in relationship to life events such as problems with work or relationships, losses, or even positive changes such as promotions or the birth of a child. Temporary distress and suffering due to realistic life pressures and losses is expected, and in psychiatric terms, can be called an adjustment reaction or altered mood. When you think about patients you have cared for in practice, some will have surmounted major stresses with a return to optimism and an energetic life style over weeks to months; these individuals have successfully dealt with their "adjustment." But others will have been downhearted and fatigued for no apparent reason; and some will have suffered a loss or stress from which they just don't seem to have bounced back even months later. When depressive symptoms are pervasive or long-lasting, and particularly when the symptoms include bodily dysfunction such as sleep disturbance or physical dysfunction such as difficulty concentrating or carrying on usual daily activities, the individual may be suffering from clinical depression rather than from a temporarily altered mood state.

Clinical literature documents that **successful treatment shortens the course of depression and prevents recurrence**. Depression is the most common cause of work disability, and is undoubtedly a factor in many divorces and other social disruptions. People are differently predisposed by genetics or, for example, by a history of childhood trauma to experience clinical depression. Those who are predisposed often experience a vicious cycle whenever a major life setback occurs--just when they require extra

reserves of energy and enthusiasm to surmount obstacles, they are overcome by fatigue, poor concentration, and hopelessness. Typically, even when clinically depressed people realize that their inability to function is due to their state of mind and that life really is not hopeless, they remain trapped by the biologic state in which they find themselves.

The *Partners in Care* approach aims to find, evaluate, and treat patients with current clinical depression. Clinical depression includes patients with major depression, dysthymia, and bipolar or manic-depressive disorder. Because the *Partners in Care* approach is directed toward the primary care setting, we do not deal with bipolar disorders except in terms of identifying these patients and suggesting that they be referred to a psychiatrist.

General Definitions for Conditions Characterized by Depressive Symptoms

The following definitions describe the conditions dealt with by our algorithm:

People with Bad Moods that Pass

People often feel downhearted, blue, irritable, or anxious. “Bad moods” lasting a few days at most do not indicate long-lasting changes in brain chemicals, and do not require treatment for depression. The symptoms are often brought on by frustrating and difficult life experiences. People usually recover quickly and their symptoms do not seriously affect their lives.

Grief Reactions

Symptoms in grief reactions can be as severe as major depression, but happen during the two months following a loss. These early symptoms of grief do not require treatment for depression. Symptoms following a loss that persist for more than two months or that occur more than two months after the loss may require treatment for major depression.

Adjustment Reactions

In an adjustment reaction, people experience feelings of depression, but these feelings are not severe or long-lasting enough to indicate clinical depression. The feelings occur in response to a particularly stressful life event, or circumstance such as the loss of a job, marital conflict, etc. The feelings usually go away as the event or circumstance gets better or farther in the past. Even if the circumstance doesn't substantially improve, the adjustment reaction usually resolves within six months. Also, the feelings are usually not so severe that they interfere with daily activities and responsibilities.

Minor Depression

In minor depression, it may be difficult to pinpoint a particular event or cause. Depressive symptoms are experienced daily for two weeks or more, but are not severe enough to be classified as clinical depression. It is often accompanied by the additional symptoms of difficulty concentrating and loss of interest in daily activities. Some people with minor depression have increased risk for full clinical depression.

Major Depression

Major Depression seriously impacts a person's ability to function both at home and in the workplace. As in minor depression, depressive symptoms are experienced daily for two weeks or more, but the symptoms are more severe.

Dysthymia

Dysthymia is also called chronic depression. In this illness, symptoms of depression last for two years or more, though they are not severe enough to be classified as major depression. There may be periods of feeling better, but the good moods don't last. The length of time that symptoms last is the hallmark of dysthymia. Some people with dysthymia are at risk for developing major depression on top of dysthymia, if they are not treated.



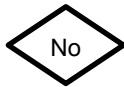
Assess for Presence of Symptoms of Depression and Current or Past Treatment for Depression

At this point in our algorithm, we are searching for a population of patients who are likely to have clinical depression. We are not making a diagnosis of, for example, major depression or dysthymia, but we are screening for these illnesses.

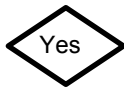
Detecting depression in primary care practices requires a high index of suspicion. Even the most experienced clinician will miss depression in patients if he or she does not routinely assess patients for key symptoms such as depressed mood or loss of pleasure. The presence of symptoms of depression does not indicate a diagnosis of clinical depression, but indicates the group of people in whom further evaluation for depression is indicated.

Brief screening questionnaires that indicate how the person feels are a good start for detecting depression. These aids identify patients with altered mood states as well as major depression, but select the portion of the population most at risk for having major depression. The PHQ-9 (Patient Health Questionnaire – 9), the Medical Outcome Study 5-Item Mental Health Index, the Beck Depression Inventory, and the Composite International Diagnostic Interview (CIDI) screen for major depression and dysthymia, and are examples of the kinds of tools that can be used for finding patients in a practice who are at high risk for depression.

Partners in Care searches for patients who have had symptoms consistent with a major depression or dysthymia over the past year, and then asks whether these patients have at least some current symptoms of depression. We define “current” as over the past month. Dysthymic patients typically have symptom-free periods but virtually always relapse in a short period of time, so a preventive approach toward these patients is indicated if they have had even a few symptoms over the past month. Patients who appear to have experienced a major depression over the past year but have not had at least a week of symptoms over the past month probably do not require intervention at this time.



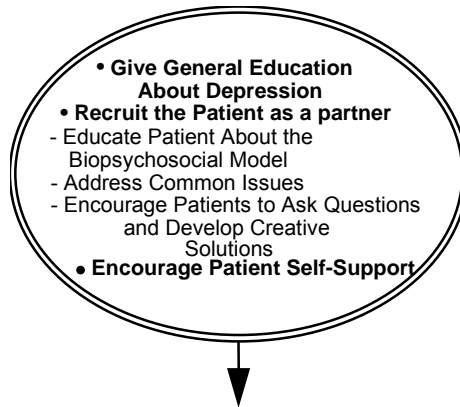
If the patient does *not* have current symptoms of depression or dysthymia, or is not currently being treated for depression, the patient does not require intervention for depressive symptoms, and there is no need for further evaluation at this time. The only exception is individuals who have had multiple (≥ 3) prior episodes of documented major depression. These individuals have a >90% change or relapse, and prophylactic antidepressant therapy should be considered.



If the patient has current signs or symptoms of depression or dysthymia, or is currently in treatment for depression, the patient requires education about depressive symptoms and encouragement to participate in assessment and management of these symptoms.

Step 2

ACTIVATE/EDUCATE THE PATIENT



People with significant recent (past year) or current symptoms of depression or dysthymia, or a significant past history of depression, will benefit from education about depression and from encouragement to become active participants in monitoring and intervening to improve their health. *Partners in Care* provides patients with a general brochure about depressive symptoms and a videotape to accompany it. These materials reflect the philosophy described below.



Recruit the Patient as a Partner

- ***Understand the patient's perspective***

Creating a good fit between the physician's and the patient's understanding of depression is essential for treatment success. Try to listen and talk with the patient in uncomplicated and non-judgmental terms. This will allow the patient to feel part of the team and increase his or her likelihood of compliance.
- ***Educate patients about the biopsychosocial model***

Many patients focus on somatic symptoms or stress and do not think they have depression. The biopsychosocial model and the 'cycle of depression' provide a useful framework for discussing the diagnosis of depression with patients. This model is illustrated in Figure 1.1.
- ***Encourage patients to ask questions and develop creative solutions***
- ***Encourage patient self-support***
 - teach the patient the symptoms of depression that he/she should monitor
 - show the patient written records of his/her symptoms
 - identify and encourage pleasurable activities.

TEACHING PATIENTS:

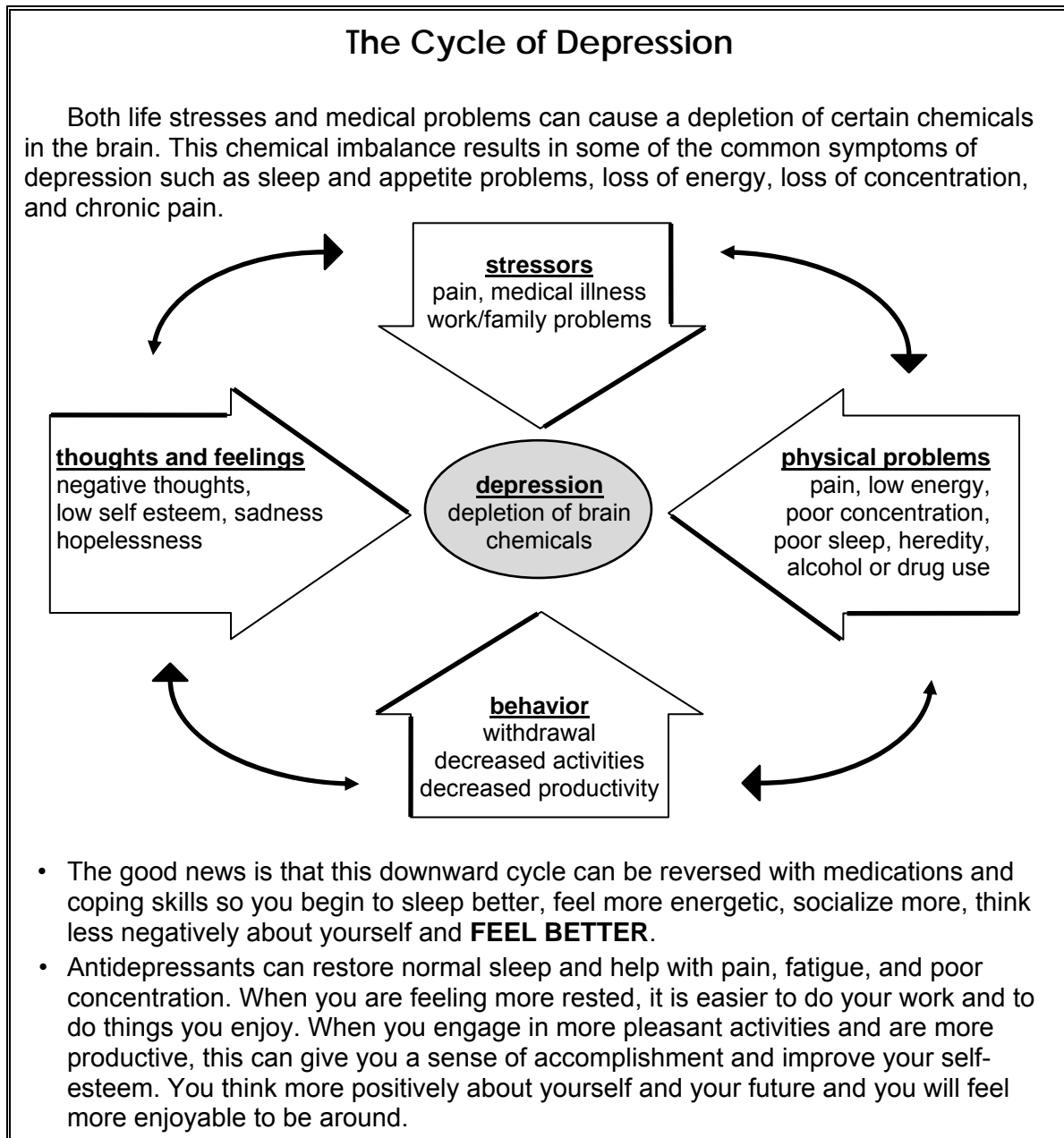
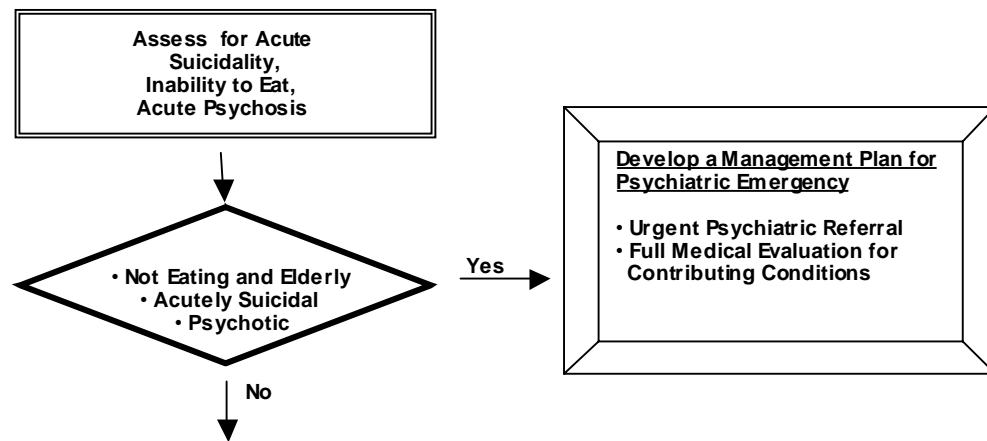


Figure 1.1 - The Cycle of Depression

- ***Emphasize the points that most commonly cause patients concerns***
 1. *Depression is common:* One in 15 people who see a primary care physician meet diagnostic criteria for depression.
 2. *Depression can cause a wide spectrum of symptoms:* depressed mood, sadness, irritability, pain (headache, stomach pain, back pain), sleeping or eating problems, fatigue or loss of energy, difficulty concentrating, remembering, or making decisions, loss of interest in activities one used to enjoy, nervousness or tension, anxiety attacks, and/or worry about one's health.
 3. *Depression affects the body, behavior, and thinking, including:*
 - changes in sleep and appetite, fatigue, aches and pains,
 - decreased social interaction, negative thoughts.
 4. *Depression is a medical illness, not a character defect or weakness. Symptoms are real, not imagined. Discuss stigma.*
 People become depressed for different reasons, including
 - Biology (no apparent reason)
 - Stress
 - Life changes or losses (loss of a loved one, a relationship, a job, one's health)
 - Physical problems (chronic pain, medical illness)
 5. *Minor tranquilizers, drugs, and alcohol make depression worse, not better.*
 6. *Recovery is the rule, not the exception.*
 7. *Depression can almost always be treated.*
 8. *The aim of treatment is complete remission of symptoms and improvement in functioning.*
 9. There is a high risk of recurrence: 50% after one episode, 70% after two episodes, and 90% after three episodes. These recurrences can be avoided or minimized with good care.
 10. Increasing pleasurable activities among people with depression will improve mood and is a goal of therapy.

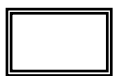
Step 3

IDENTIFY PATIENTS WHO NEED IMMEDIATE HOSPITALIZATION/INTERVENTION



Among primary care patients with symptoms of depression or dysthymia, a small minority will require immediate intervention for serious acute symptoms. These include people who are acutely suicidal, have difficulty eating (especially if elderly) or are psychotic. Rather than trying to assess these individuals in detail in primary care, it is probably most efficient to identify these serious symptoms and refer immediately. Prior to referral, also consider possible medical causes of the patient's symptoms such as medications (e.g., prednisone), underlying diseases such as cancer or thyroid disease, and alcohol or drug abuse. The presence of one of these causes will not obviate the need for referral, but may change the ultimate management.

Patients who have been referred may return to your care, either because the psychiatrist assessed them to be at lower risk or because the patient refused to continue in mental health. In this case, involving both the consulting psychiatrist and the primary care physician through telephone or in person discussions may be very helpful.



Assess for Inadequate Nutrition

While patients with depression commonly suffer depressed appetites and slow weight loss, some individuals simply stop eating or drinking. Elderly individuals may be at risk even with milder appetite suppression, because of the severe consequences of malnutrition in this age group. Assess whether the individual is eating and drinking normally, whether they have undergone rapid weight loss, and their overall nutritional state (e.g., weight to height ratio). Severely malnourished individuals, and those who are unable to eat or drink, will usually require hospitalization.



Assess the Potential for Suicide

Depression is one of the strongest risk factors for suicide, and patients should be carefully evaluated for the potential of suicide. Figure 1.2 suggests a screening process and reviews the risk factors for suicide.

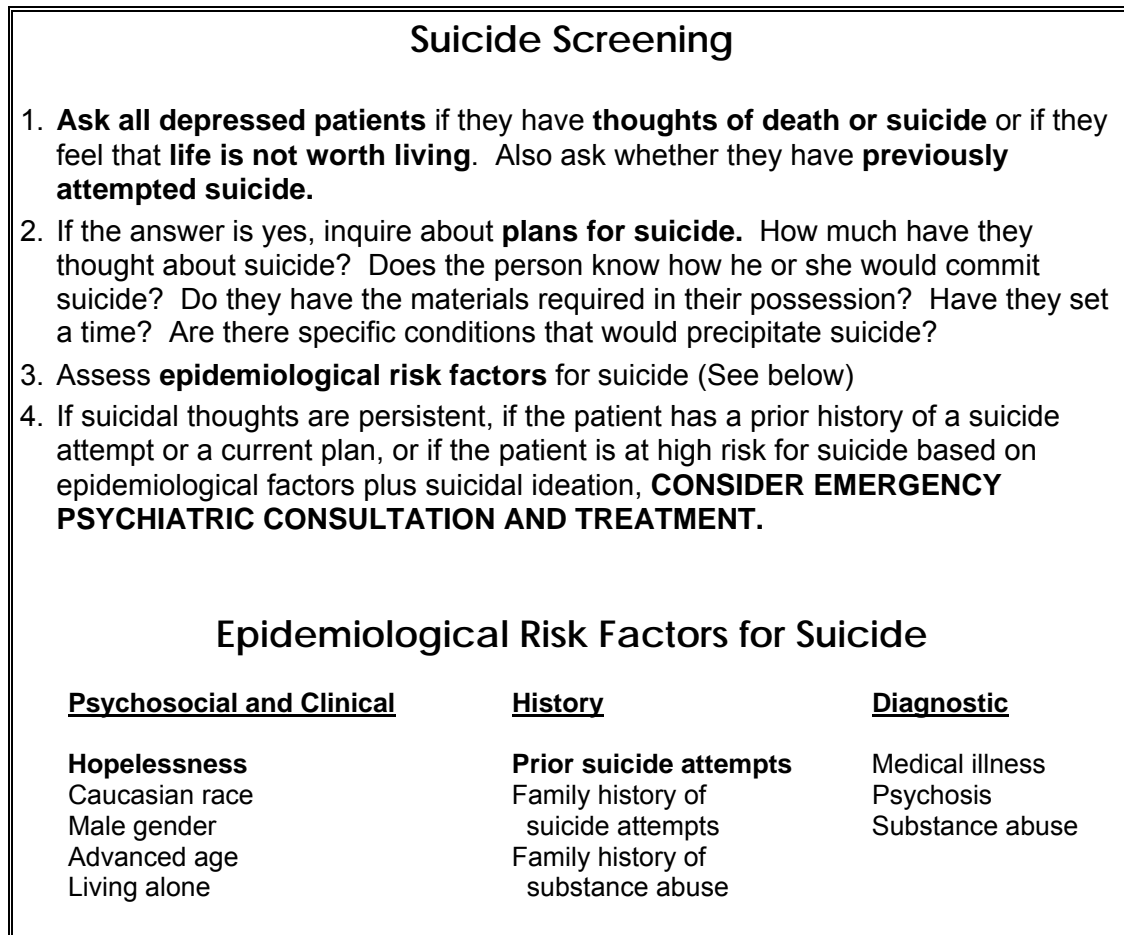


Figure 1.2 - Evaluating the Risk of Suicide

If you are called upon to manage a patient with suicidal potential, these guidelines may help:

- Brief, frequent and supportive visits.
- If medications are used, supply only one or two weeks of medication at a time.
- Use newer antidepressants (SSRIs), which are much safer. The tricyclic antidepressants (TCAs) have a narrow window of safety. Even a two-week supply of a TCA can be fatal in overdose.



Assess Patients for Psychotic Symptoms

Psychotic symptoms occur in 1 or 2% of the population and 5 to 15% of depressed patients. Some patients with depression or other psychiatric disorders may have psychotic symptoms. These are unusual experiences such as:

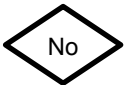
- Hearing voices or receiving special information that other people don't hear (auditory hallucinations)
- Seeing things that people don't see (visual hallucinations)
- Feeling that someone might be interfering with or controlling his or her thoughts
- Feeling that other people are out to hurt them (paranoid thoughts)
- Having other unusual thoughts that others don't understand (delusions)

These kinds of experiences may be symptoms of a psychotic disorder, and psychiatric consultation should be strongly considered, particularly if the symptoms interfere with the patients' ability to function or with their treatment. Treatment of such patients may involve antipsychotic medications and, at times, hospitalization and Electroconvulsive Therapy (ECT).

Psychotic symptoms may be mood congruent (depressive content), suggesting a severe, psychotic depression. Or they may be bizarre or mood incongruent, suggesting another underlying diagnosis (schizophrenia, bipolar disorder, organic brain syndrome).



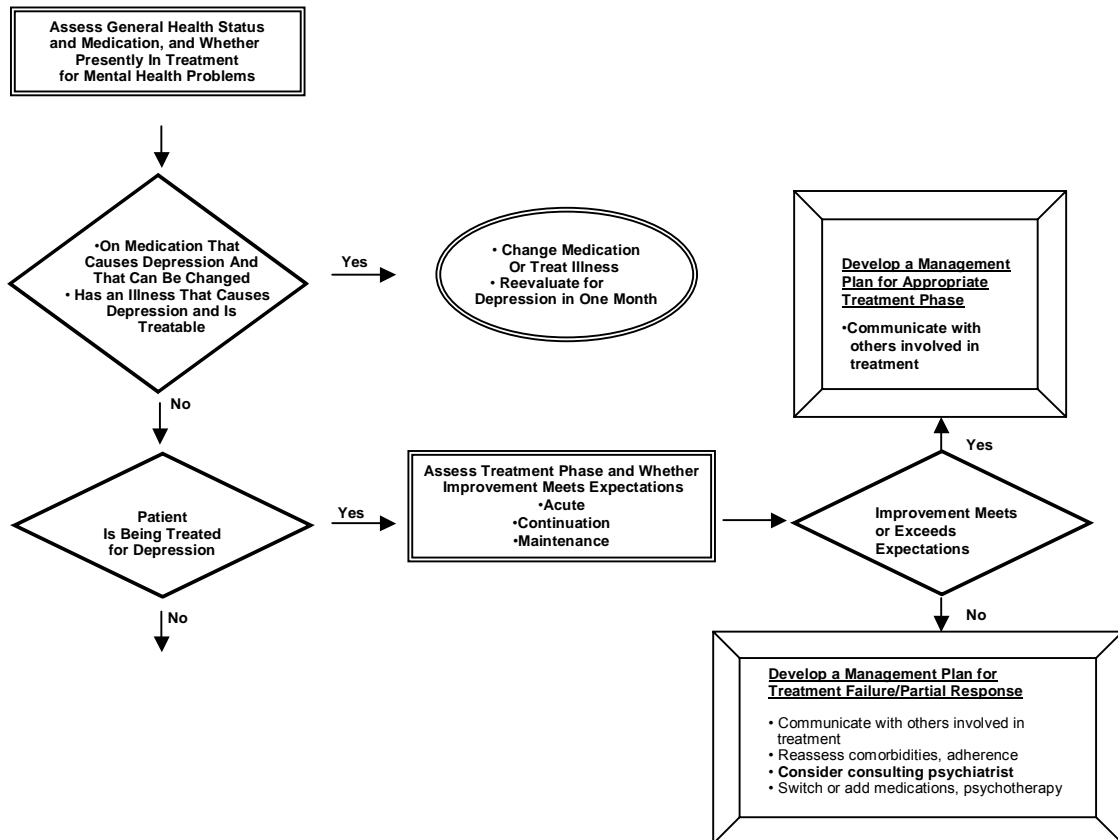
Patients who are *not eating* and *elderly*, *acutely suicidal* or *psychotic* require immediate psychiatric referral, and may require hospitalization. **Remember: all of these problems can have medical causes (e.g., drugs, infections, autoimmune diseases, thyrotoxicosis). So evaluate for relevant medical conditions as well.**



Continue assessment.

Step 4

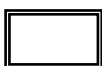
IDENTIFY MEDICAL COMORBIDITY AND CURRENT TREATMENT STATUS



Assess Patients for Current Treatment Status

To assess medical comorbidity and current medical and psychological treatments, ask the patient to:

- **List all current medications**
- **Ask whether the patient is currently in psychotherapy**
- **Review the patient's current medical problem list**



Assess for Medical Illnesses that Can Cause Depression

Often, depression requires treatment even in the face of a medical illness that could be causing it. Some medical illnesses, such as stroke and arthritis, are associated with higher than usual rates of depression, but treating the underlying medical illness is often not enough to cure the depression. Fibromyalgia sometimes responds to low-dose antidepressants, but can be accompanied by full-blown depression. Other illnesses, such as cancer, may not be treatable. In these cases, treating depression is essential in order to maintain the patient's ability to cope, even if the depression is caused all or in part by the underlying disease. When the patient complains of physical symptoms that could be caused either by depression or by medical illness, a dual approach is often appropriate, whereby the depression is treated and the physical symptoms are re-evaluated to see if they improve as other depressive symptoms improve. Remember that if the patient does not have a combination of symptoms that can indicate depression (e.g., if they only have pain and fatigue and do not feel sadness, loss of interest and other depressive symptoms) it is unlikely that major depression is the cause.

Thyroid disease, hypercalcemia, Vitamin B-12 deficiency, autoimmune diseases, debilitating viral and bacterial illnesses, and other treatable illnesses can cause depression, or symptoms that mimic it (see Figure 1.3). If one of these illnesses is discovered, it is often better to see if the depression remits as the disease improves, although at times the depression, if severe or interfering with recovery, may require aggressive management.

While a low threshold for screening for these illnesses should be maintained if other coexisting symptoms suggest them, it is usually unnecessary to embark on a medical work-up of depressive symptoms themselves.

DIAGNOSIS	CRITERIA	ACTION
Depression secondary to general medical disorders or medications. (Consider psychiatric or medical specialty consultation)	<ul style="list-style-type: none">steroids, reserpine, antineoplastic agents (see Figure 1.4 for others)autoimmune diseasesneurologic diseases (stroke, Parkinson's, multiple sclerosis, epilepsy, brain tumor, dementia)sleep apneacancercardiac disease: CHFmetabolic (B12 deficiency)endocrine (thyroid or parathyroid disorders, Cushing's, Addison's)	<ul style="list-style-type: none">stop medication if possible and treat depression if it persiststreat illness and depression if it persiststreat depression and neurological illness (in case of epilepsy, consider EEG)consider sleep studytreat depression and cancertreat depression and CHFreplace vitamins and treat depression if it persistscorrect abnormalities and treat depression if it persists.

Figure 1.3 - Medical Conditions Contributing to Depression



Assess for Medications Associated with Depressive Symptoms

Although none of the medications in the box below are absolutely contraindicated in patients with depression, we do recommend that they be suspected if a patient's depressive symptoms worsen as they are started on one of these medications. If it is possible to change them, it is likely to be worth the effort.

Below (Figure 1.4) is a list of medications for which there is fairly good evidence of an association with depressive symptoms. (However, the literature on these associations is not particularly strong.)

Antihypertensive and cardiovascular drugs:

methyldopa, reserpine, diuretics (usually associated with hypokalemia or hyponatremia).

Sedative/hypnotic agents

alcohol, benzodiazepines, barbiturates, chloral hydrate, meprobamate

Anti-inflammatory agents and analgesics

indomethacin, opioid (narcotic) analgesics

Hormones

corticosteroids, oral contraceptives, estrogen withdrawal

Miscellaneous

levodopa, cimetidine, antineoplastic agents, stimulant withdrawal

Figure 1.4 - Medications Associated with Depression



Patient is on medication that causes depression

If a medication is suspect, one of two actions is recommended:

- Lower the dosage level
- Try an alternative medication.

The next steps:

- Wait two to four weeks
- Reevaluate depression

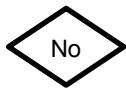
If a treatable illness is present:

- Treat and re-assess for depression in one month



Is the patient being treated for depression?

- If the patient is **currently being treated for depression** with either antidepressants or psychotherapy, it is important to assess at what point in treatment the patient is presenting to you, and then to monitor progress over time.
- If the patient **is within the first twelve weeks of therapy, and is improving significantly**, treatment is probably going reasonably well and the primary care MD can simply call the treating MD or therapists and re-evaluate in one month to see how things are going. Patients whose symptoms resolve completely should be monitored as recommended for continuation phase therapy (see Step 5, Management) or maintenance therapy (see Step 7, Management).
- If the patient is beyond 12 weeks of therapy, and is not symptom-free, or is past the first 6 weeks of therapy without showing significant improvement, the patient may be failing to respond or only partially responding to treatment. The treating MD or therapist should be called and the case should be discussed with the *Partners in Care* Psychiatrist (see the “Reassessment of Depressive Symptoms Using the PHQ-9” section and Figure 2.14).



Continue evaluation

Step 5

DIAGNOSTIC EVALUATION FOR DEPRESSION

Assess for:

- Diagnosis of Major Depression or Chronic Depression (Dysthymia)
- Bereavement
- Minor Depression
- Adjustment Disorder

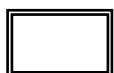


All patients who have been found to have symptoms of depression or dysthymia, are not currently being treated for depression, are not acutely in need of psychiatric referral, and are not being further evaluated for medical conditions that can cause depression should be evaluated for the diagnosis of clinical depression. Individuals who do have depressive symptoms but do not meet criteria for clinical depression are managed differently than those who do. Typically, about 20 to 25% of patients who have any significant symptoms of depression in primary care practices, and about half of those who screen positively on instruments like the PHQ-9, will have clinical depression on further evaluation.

A variety of diagnoses can be made among patients who have symptoms of depression or dysthymia. These include:

- **No diagnosis (a passing altered mood)**
- **Adjustment Reaction**
- **Minor Depression**
- **Bereavement**
- **Major Depression**
- **Dysthymia**
- **Bipolar Disorder**
- **Depression plus another psychological disorder**

The clinician's first diagnostic job is to assess whether the patient meets DSM -IV criteria for major depression or dysthymia. Conditions marked by depressive symptoms that are not treated as major depression include **bereavement, minor depression, and adjustment disorder**. These conditions require monitoring, patient education, and sometimes counseling, but do not require therapy for major depression and dysthymia. A management plan can be developed without further detailed assessment except assessment for substance abuse. Of these conditions, bereavement is the only one that can meet criteria for major depression, being excluded from that diagnosis only on the basis of the proximity of the loss of a significant other.



Assess for Major Depression

The diagnosis of major depression is based on DSM-IV criteria for depression. These are listed below in Figure 1.5. For each of the criteria, you will need to develop some probes--e.g., for "Depressed Mood," you may want to ask how much of the time during the past month the individual has felt depressed, downhearted or blue. Take a look at the questions on the PHQ-9 for example descriptors of a depressed mood, loss of interest or pleasure, and feelings of worthlessness or guilt. You can then ask whether these symptoms have been present for as much as two weeks at a time or more over the past year. A person who has met diagnostic criteria for major depression at some time over the past year, and who has continued to have at least some symptoms over the past month, requires treatment for depression.

Primary care patients with depression can present themselves to you in a number of ways and still meet criteria for major depression or dysthymia. These different presentations are one of the reasons depression is difficult to diagnose if not specifically looked for.

1. Those who emphasize mood or emotional complaints: low or depressed mood, low self-esteem, worthlessness, or feelings of guilt, anxiety, irritability, apathy, loss of interest.
2. Those who have physical/somatic complaints: insomnia, fatigue, decreased energy, headache or other pain symptoms, weight changes. This kind of presentation is quite common in primary care.
3. Those who complain of poor memory or concentration.
4. Those who complain of stress or problems at home or at work.

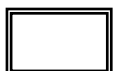
Diagnostic Criteria

Below are the criteria that are used to make a diagnosis of depression.

Major depression is more than just "low mood." It is a **syndrome** defined by at least **five of the following nine symptoms**. The symptoms have to be present **nearly every day for 2 weeks** or longer. One of the symptoms has to be #1 or #2 below.

- 1. Depressed mood**
- 2. Loss of interest or pleasure**
3. Significant change in weight or appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or guilt
8. Impaired concentration or indecisiveness
9. Thoughts of death or suicide

Figure 1.5 - DSM-IV Criteria for Depression



Assess for Dysthymia

In dysthymia, depressive symptoms are present much of the time for at least two years. Dysthymia patients either meet DSM-IV criteria for major depression (and thus have major depression plus dysthymia), or meet minor depression symptom criteria but have symptoms that are present much of the time for at least two years.

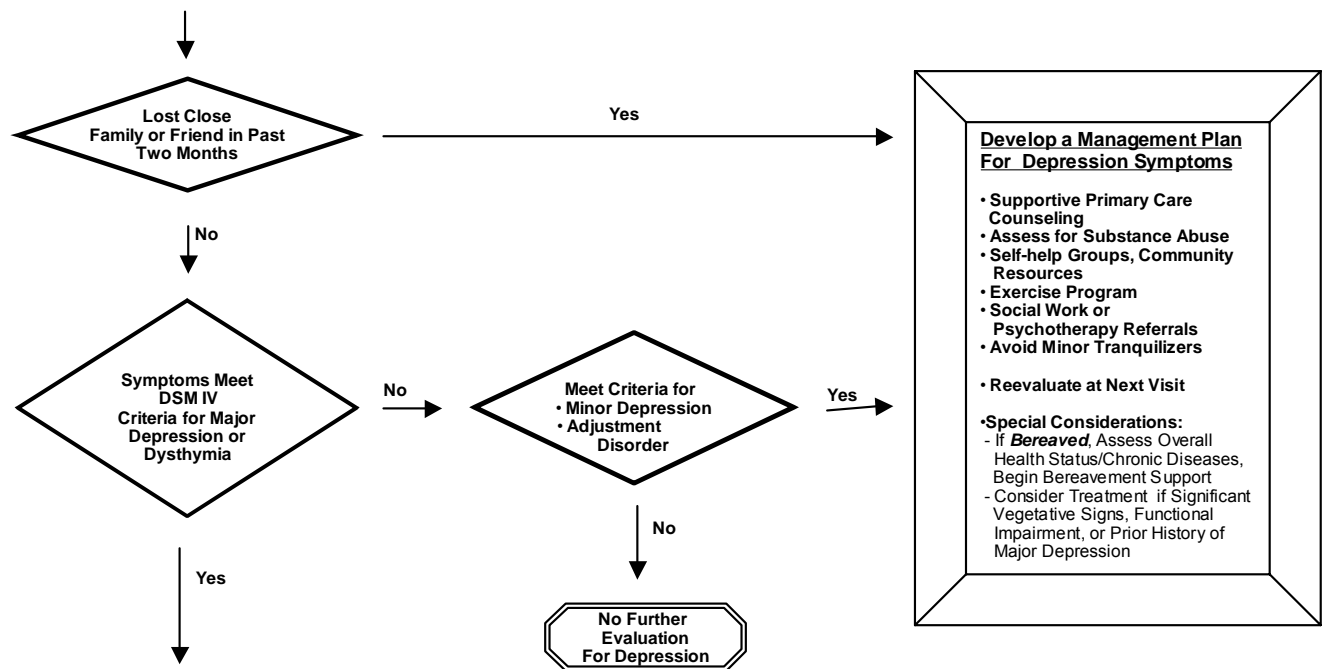


Assess for Bereavement (losing a close family member or friend)

Ask the individual whether he or she has lost a close family member or friend during the preceding two months, indicating acute bereavement.

Step 6

MANAGEMENT OF PATIENTS NOT MEETING CRITERIA FOR MAJOR DEPRESSION AND DYSTHYMIA



Yes If the patient has lost a close friend or family member during the past two months, he or she does not need immediate depression treatment

During the initial months after a death, it is normal for individuals to experience symptoms of depression. Sometimes these are very severe, but unless the patient is a danger to themselves or others, they should be allowed to experience their grief and require only monitoring and supportive counseling. Occasional use of short-acting benzodiazapines for sleep may be indicated, but excessive or prolonged use should be avoided at all costs. It is important to remember that bereaved individuals are at a much greater risk of death from all causes than other individuals, particularly during the first six weeks after the loss, and to ensure that any chronic conditions are monitored and controlled.

If significant symptoms persist after two months or the patient has significant functional impairment, consider treatment for major depression.

Yes If the patient does not meet criteria for major depression or dysthymia:

- **Assess for Adjustment Disorder:**

An adjustment disorder indicates a poor adaptation or response to a stressful life event or circumstance. In adjustment disorder, the feelings occur almost every day, but are usually not so severe that they interfere with basic daily activities and responsibilities.

• **Assess for Minor Depression:**

In minor depression, there is often no particular event or cause for the symptoms. Depressive symptoms are experienced daily for one to several weeks or more, but are not severe enough to be classified as clinical depression, nor long enough to be classified as dysthymia. Some people with minor depression are at higher risk of developing major depression.



Develop a Management Plan for Individuals Who Do Not Meet Criteria for Major Depression: Watchful Waiting and Prevention

A significant number of these patients will develop major depression. These individuals require monitoring and a treatment approach oriented to prevention. The key primary care management tool for this group, in addition to the recommended preventive actions, is watchful waiting. We recommend the following management strategy, outlined in Figure 1.6:

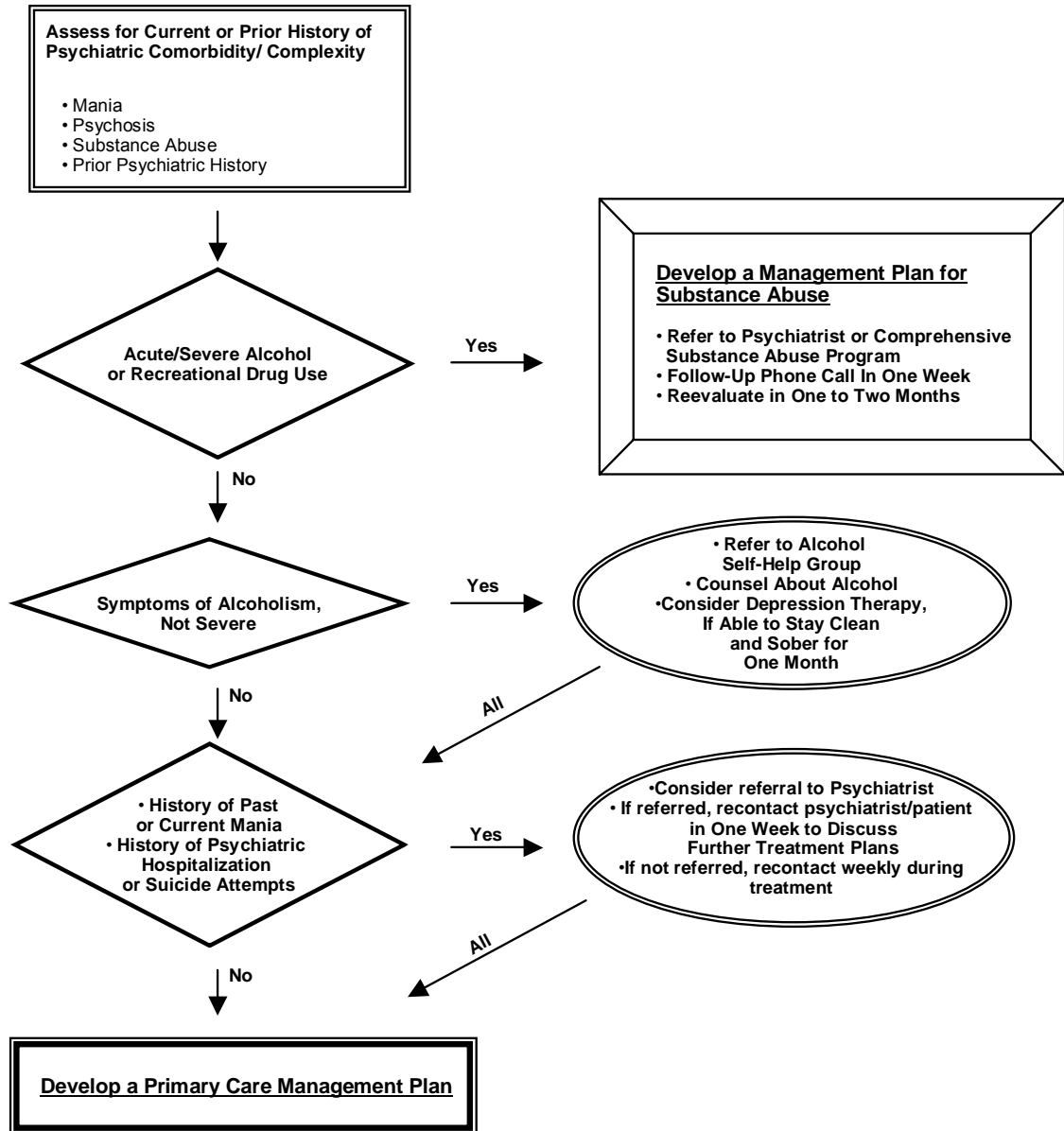
- Give the patient the “Your Personal Plan: Watchful Waiting” (see Appendix H)
- Reevaluate in one month; if still symptomatic, but no major depression, continue primary care management with visits every 1-3 months.

DIAGNOSIS	CRITERIA	ACTION
Dysthymia	<ul style="list-style-type: none"> • At least 2 depressive symptoms persist uninterruptedly for 2 years or more with no more than 2 months that are asymptomatic 	<ul style="list-style-type: none"> • treat like major depression, with antidepressants or psychotherapy • consider maintenance treatment for 2 years or more
Bereavement	<ul style="list-style-type: none"> • Recent loss of a loved one 	Develop a management plan for watchful waiting and take some or all of the following preventive actions: <ul style="list-style-type: none"> • provide supportive primary care counseling, including encouraging pleasurable activities • assess for substance abuse • consider referral to self-help groups, community resources • consider exercise program • consider social work referral • avoid minor tranquilizers • Special considerations <ul style="list-style-type: none"> - if bereaved, assess overall health status, chronic diseases - consider treatment if significant vegetative signs, functional impairment, or prior history of major depression
Minor depression	<ul style="list-style-type: none"> • 2-4 symptoms for > 2 weeks including depressed mood or loss of interest/pleasure • Depression affects functioning 	
Adjustment Disorder	<ul style="list-style-type: none"> • Symptoms arise within 3 months of a stressor • Does not meet criteria for major depression, dysthymia, bereavement, or other major affective disorder • Symptoms out of proportion to event or has worsened function 	

Figure 1.6 - Other Diagnoses Often Associated with Major Depression That Require Watchful Waiting

Step 7

ASSESS AND MANAGE PSYCHIATRIC COMORBIDITY AND COMPLEXITY



Assess for Current or Past Substance Abuse

Ask patients how much alcohol they currently drink and how often. Ask about a history of alcoholism. The 4-item CAGE questionnaire and the more recent 3-item Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) questionnaire are brief screens for symptoms of alcoholism. One or more positive responses on the CAGE questionnaire suggest that the patient likely has an alcohol abuse problem.

Do you ever feel the need to cut down on your drinking?

Do you ever feel annoyed by criticism of your drinking?

Do you ever have guilty feelings about your drinking?

Do you ever take a morning eye-opener?

The AUDIT-C is a 3-item screen for symptoms of alcoholism that is increasingly being used instead of the CAGE questionnaire. A score of 3 or more for women and 4 or more for men suggests that the patient likely has an alcohol abuse problem, and a score of 8 or more suggests that the patient likely has alcohol dependence. An individual who has only one drink a day, which is within recommended limits, will screen positive (i.e., all points are from question #1 alone and questions #2 & #3 score are zero). In this situation, we recommend that the provider review the patient's alcohol intake over the past few months to confirm accuracy (e.g. "Has this been your consistent pattern over the past 2-3 months?"), review the problem list to ensure there are no medical contraindications due to drinking (e.g. hepatitis C, prior alcohol treatment), and advise the patient to stay below recommended limits.

AUDIT-C Questions

1. How often do you have a drink containing alcohol?

0 = Never

1 = Monthly or less

2 = 2-4 times a month

3 = 2-3 times a week

4 = 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day?

0 = 1 or 2

1 = 3 or 4

2 = 5 or 6

3 = 7 to 9

4 = 10 or more

3. How often do you have six or more drinks on one occasion?

0 = Never

1 = Less than monthly

2 = Monthly

3 = Weekly

4 = Daily or almost daily

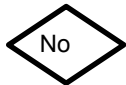


If the patient has symptoms of alcohol or drug abuse:

- Antidepressant treatment should not be started until the patient has been able to abstain from alcohol or drugs for at least four weeks.
- Most depression related to alcohol or drug abuse will remit spontaneously within a few weeks once the substance abuse stops. This is particularly true if depressive symptoms are part of the acute substance intoxication (e.g., alcohol or sedatives) or withdrawal (e.g., cocaine and other CNS stimulants).
- Recommend self-help groups such as Alcoholics Anonymous (AA) and inpatient or outpatient treatment for substance abuse, unless you are familiar and feel comfortable with such treatment yourself. Patients meeting criteria for major depression who have significant alcohol or drug abuse should preferably be referred to a program that has mental health professionals available, such as a comprehensive substance abuse program. If such a program is not available, the patient should be seen by a psychiatrist.



Patients who are less severe alcoholics may respond simply to being told to go to AA and not to drink, and that depression therapy can begin after a month of staying clean and sober.



Continue evaluation



Assess for Current or Past Mania

Bipolar disorder occurs in about 1% of the population and in about 5-10% of depressed patients. It is much less common than major depression in primary care settings. You need to consider the possibility of bipolar disorder in all patients who present with depression, however, because it is treated very differently.

Antidepressants can make a person with bipolar disorder more manic.

Begin by asking whether the patient has ever been told of mania or been treated with lithium. Then look for symptoms of mania. If such symptoms are present currently, or ever occurred for a week or more in the past, consider the diagnosis of bipolar disorder.

Bipolar disorder is characterized by episodes of **euphoric or irritable mood**. During these periods, patients may also have **excessive levels of energy** and a **decreased need for sleep**. Self-esteem is often inflated, and patients may believe that they have special powers or knowledge. Speech is often loud and hard to interrupt. Thought processes may be highly distracted, moving rapidly from one subject to another. These patients may get involved in excessive or risky activities such as spending lots of money or engaging in inappropriate sexual behavior.

Such patients often require treatment with a mood stabilizer such as lithium, carbamazepine, or valproic acid. They may even require hospitalization. Antidepressants alone may precipitate or worsen a manic episode. These patients should be considered candidates for **psychiatric referral**, for diagnostic assessment, and for pharmacotherapy recommendations.



If the patient has current or history of mania, referral to a psychiatrist is indicated; the patient can be returned to the primary care physician if treatment is not expected to be complicated.



Assess History of Psychiatric Hospitalization or Suicide Attempts

Patients with a past history of psychiatric hospitalization or suicide attempts may or may not be appropriate for management in a primary care setting. These historical factors suggest that the patient may be at increased risk for another suicide attempt or hospitalization, even if they are not in imminent danger. (Note: Criteria for imminent danger are addressed in Step 3.) Such patients may benefit from psychiatric consultation to clarify diagnosis and treatment plans and to assist with monitoring their progress in case they become more ill.



- **Inquire about and document level of current thoughts or plans for suicide.**
- **Monitor closely.**
- **Consider psychiatric consultation for clarification of diagnosis or treatment plan.**

Figure 1.7 summarizes three categories of psychiatric comorbidity and complexity (e.g., bipolar disorder, substance abuse, and prior psychiatric hospitalization or suicide attempts), that are related to major depression.

Recognizing Common Psychiatric Comorbid Conditions

DIAGNOSIS	CRITERIA	ACTION
Substance abuse	<ul style="list-style-type: none"> • alcohol • illicit drugs (cocaine or amphetamine withdrawal) • prescription drugs (narcotics, sedatives) 	<ul style="list-style-type: none"> • treat substance abuse first; then treat depression. • consider consultation for mental health or substance abuse.
Bipolar Disorder (current or past history of manic symptoms)	<ul style="list-style-type: none"> • elevated/expansive/irritable mood for at least one week • decreased sleep • increased energy, talking, or activity • distractibility • inflated self-esteem or grandiosity 	<ul style="list-style-type: none"> • obtain psychiatric consultation. • treatment requires a mood stabilizer (Lithium, valproic acid, or carbamazepine) and possibly other medications. • treatment with antidepressants alone is risky (may cause manic episode).
History of psychiatric hospitalization or suicide attempts	Same as diagnosis	<ul style="list-style-type: none"> • inquire about current thoughts or plans for suicide. • monitor closely. • consider referral to a psychiatrist.

Figure 1.7 - Common Differential Diagnoses

Figure 2.S - BRIEF ALGORITHM FOR MANAGEMENT

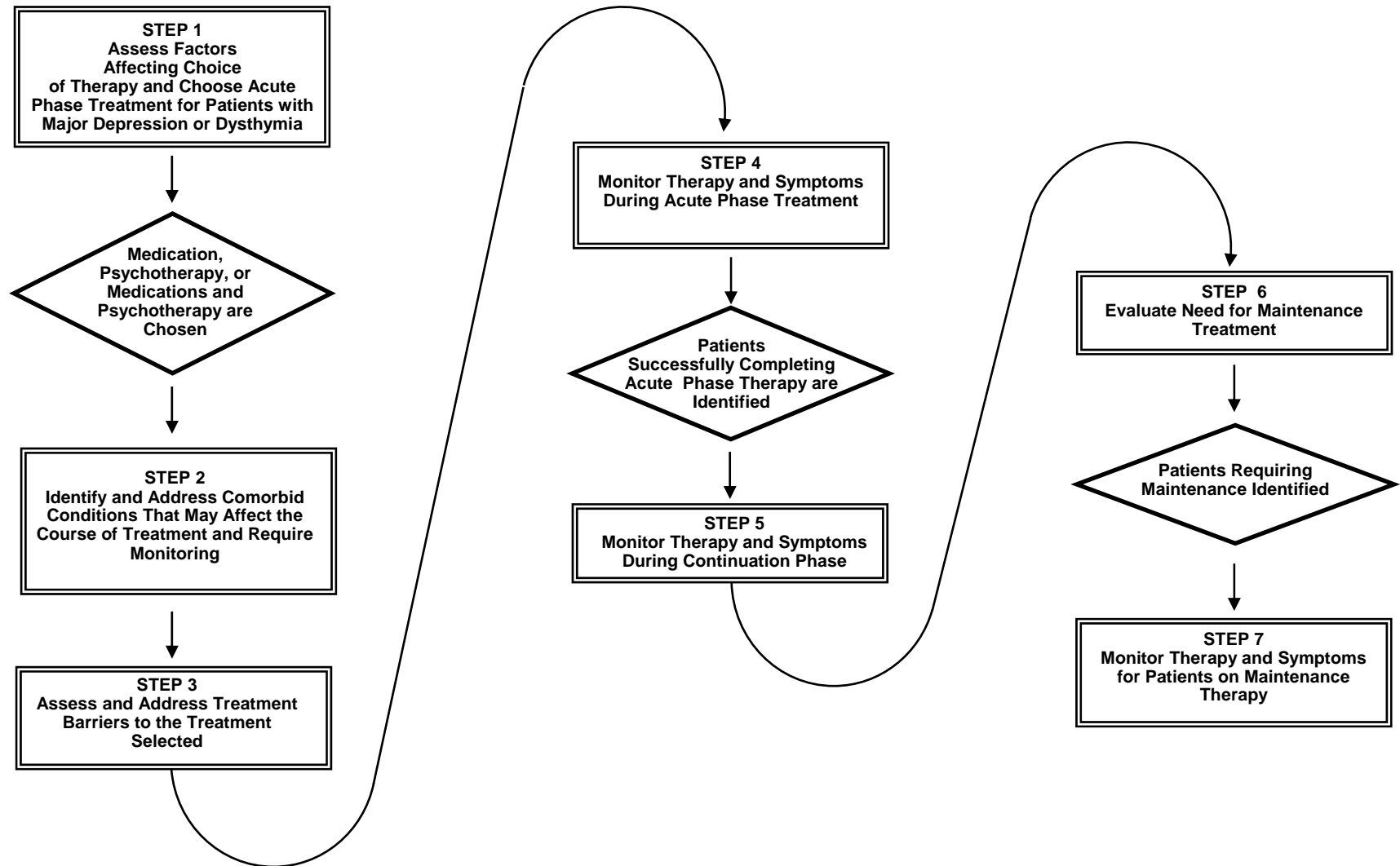
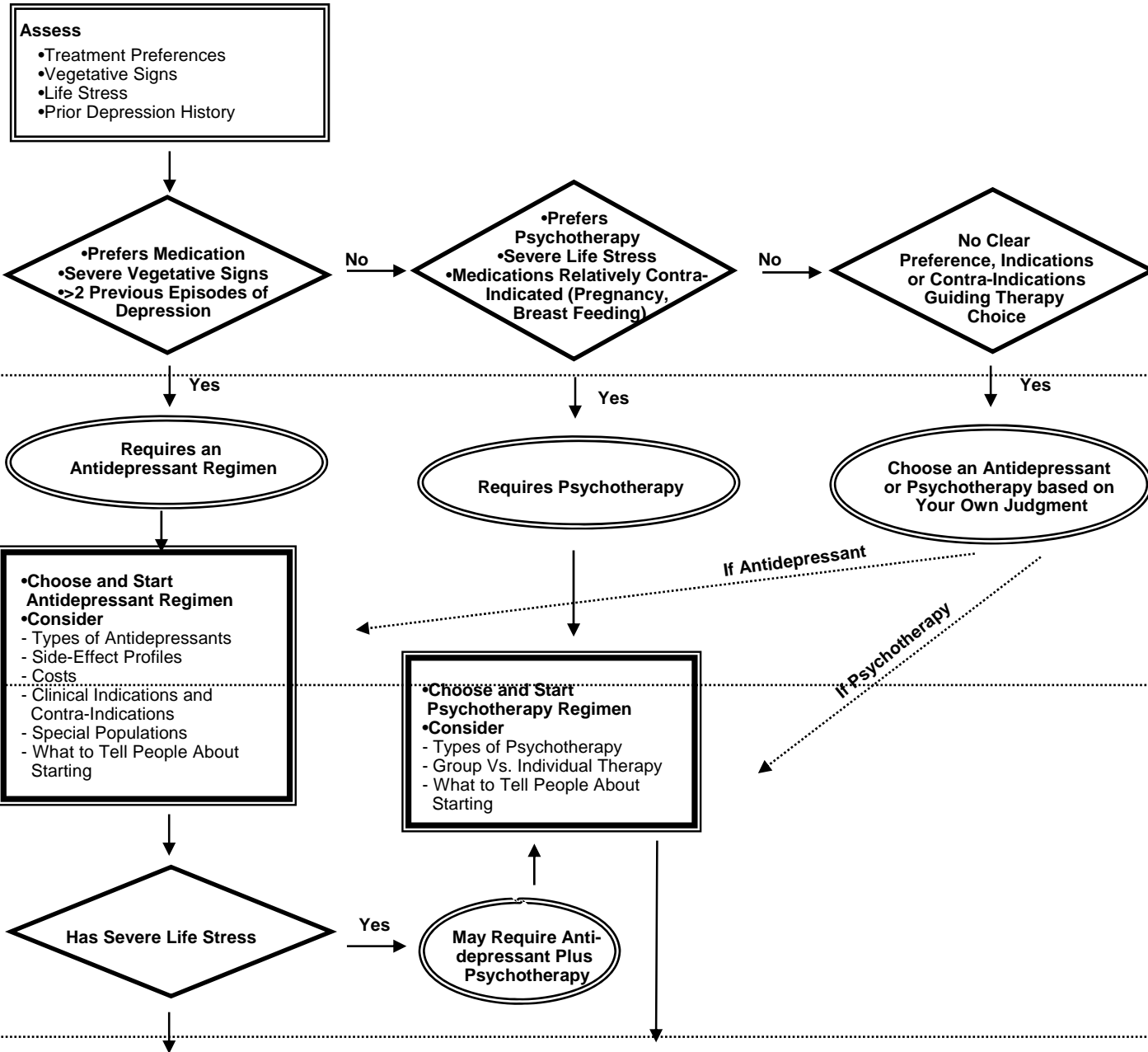


Figure 2.L - LONG ALGORITHM FOR MANAGEMENT

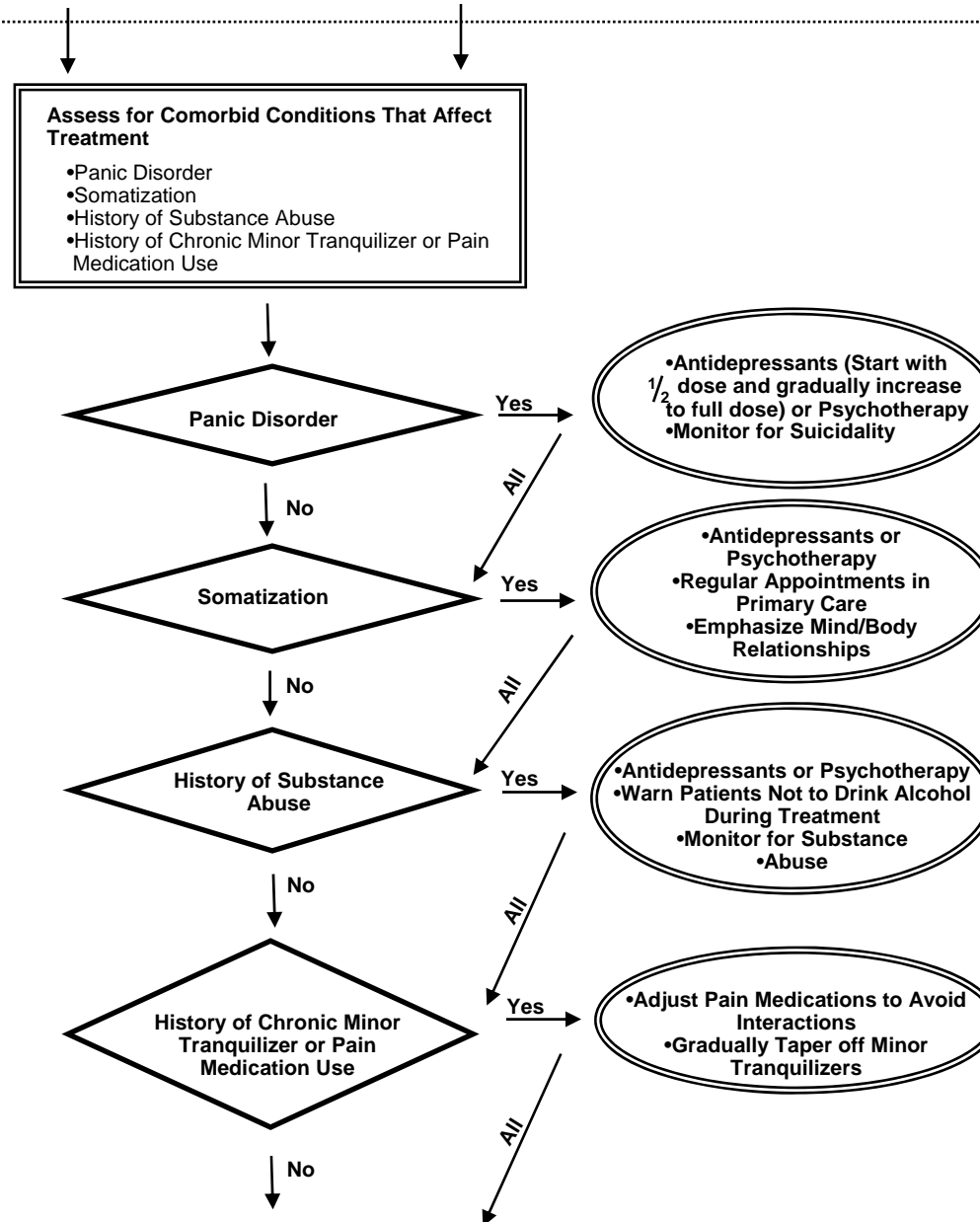
SEVEN STEPS FOR DEVELOPING A MANAGEMENT PLAN FOR MAJOR DEPRESSION OR DYSTHYMIA DURING ACUTE, CONTINUATION, AND MAINTENANCE PHASES

STEP 1
Assess Factors
Affecting Choice
of Therapy and
Choose Acute
Phase Treatment



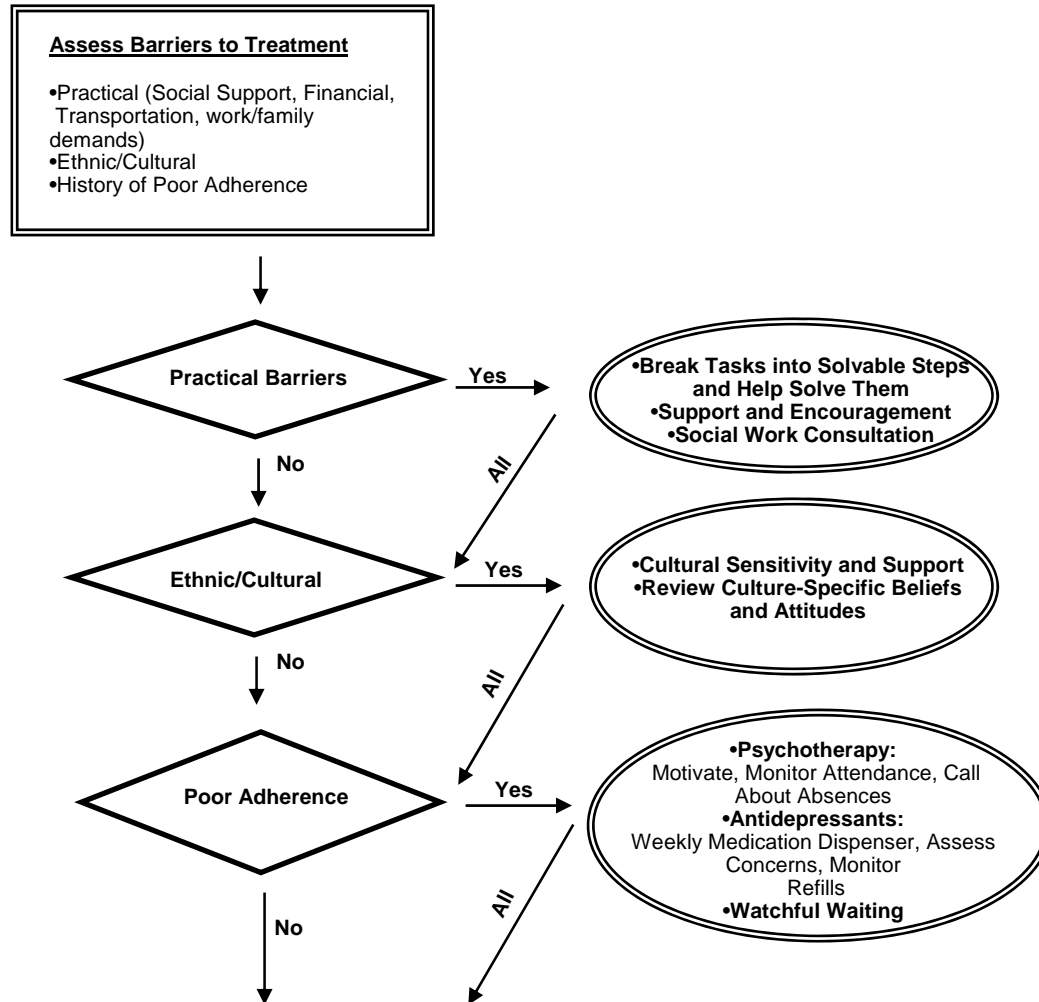
Developing a Management Plan for Depression

STEP 2 Identifying and Addressing Comorbid Conditions That May Affect the Course of Treatment and Require Monitoring



Developing a Management Plan for Depression

STEP 3 Assess and Address Treatment Barriers to the Treatment Selected



Developing a Management Plan for Depression

STEP 4 Monitor Therapy and Symptoms During the Acute Phase Treatment

Set up a Monitoring Plan Including:

- Follow-up Telephone calls/ Visits
- Reassessment of Depressive Symptoms, Functional Status, Treatment Adherence, Side Effects of Medications

Depressive
Symptoms and Functional
Disability Have Resolved
Completely by 8-12
Weeks

No

Develop a Management Plan for Treatment Failure/Partial Response

- Communicate with others involved in treatment
- Reassess comorbidities, adherence
- Consider consulting psychiatrist**
- Switch or add medications, psychotherapy

Yes

STEP 5 Monitor Therapy and Symptoms During Continuation Phase

**Begin Continuation Phase Treatment
(6-9 Weeks)**

Stays Symptom Free
for 9 mos

No

Develop a Management Plan for Treatment Failure/Partial Response

- Communicate with others involved in treatment
- Reassess comorbidities, adherence
- Consider consulting psychiatrist**
- Switch or add medications, psychotherapy

Yes

STEP 6 Evaluate Need for Maintenance Therapy

•>2 Prior Episodes of
Depression
•Dysthymia

No

**Discontinue antidepressants for
patients on antidepressants**

**Reduce frequency of monitoring for
patients treated with psychotherapy.**

Yes

Developing a Management Plan for Depression

STEP 7 Monitor Therapy and Symptoms for Patients on Maintenance Therapy

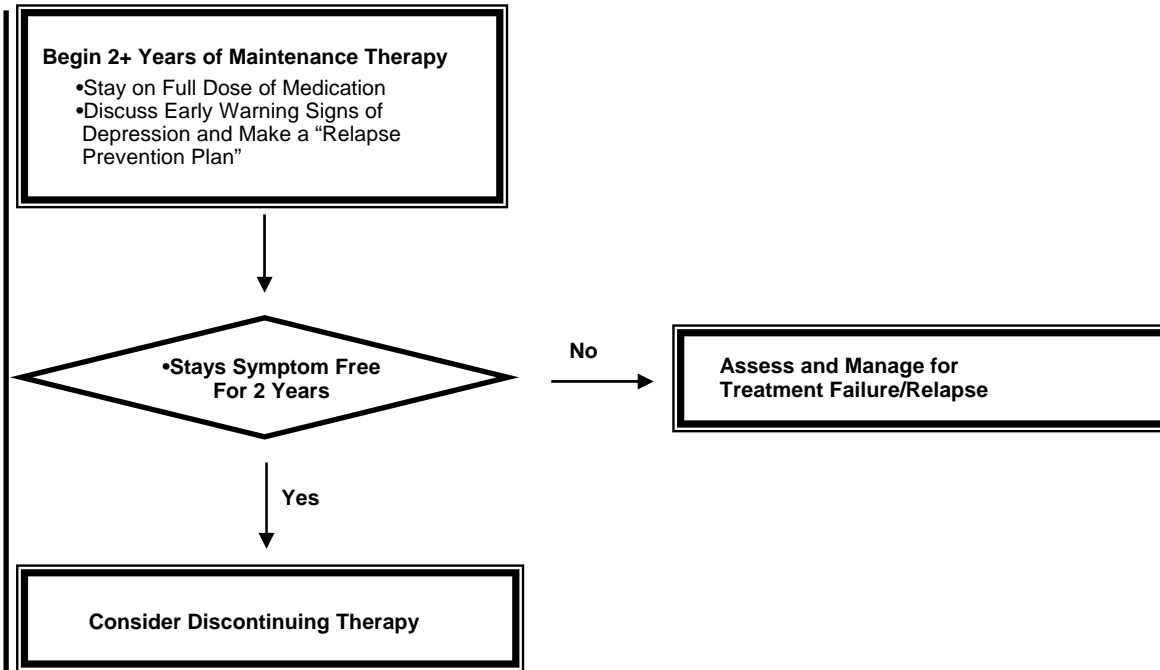
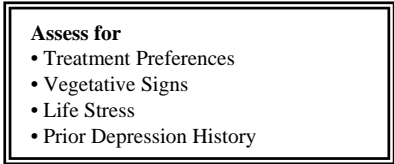

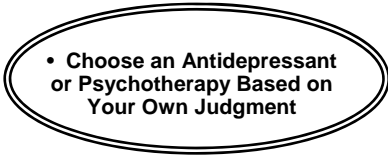
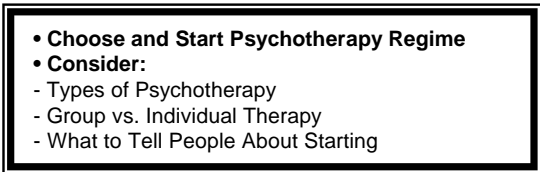
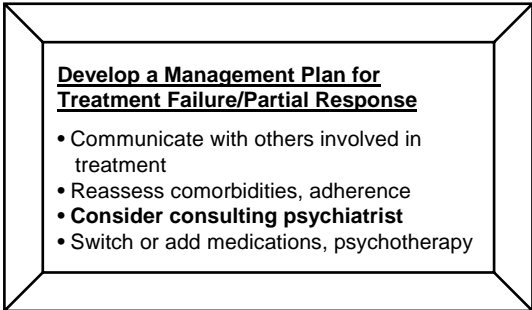


Figure 2.K
KEY FOR MANAGEMENT ALGORITHM

<u>Symbols</u>	<u>What the Symbols Indicate</u>
	An assessment to be carried out
	A decision point . Look for the “yes” and “no” arrows directing you to the appropriate next action
	An action to be carried out
	A management planning step that continues the management algorithm
	A management planning step that exits the management algorithm

CHAPTER TWO

Seven Steps for Developing a Management Plan for Major Depression and Dysthymia During Acute, Continuation, and Maintenance Phases

Whichever types of therapy a patient ultimately receives, treatment should be viewed as having three phases—**acute**, **continuation**, and **maintenance**. The goals and tasks required for each phase are different. Figure 2.1 below indicates each phase, its goals, and approximately how long a typical patient spends in each phase. Patients who follow more complicated courses may require more time to complete each phase.

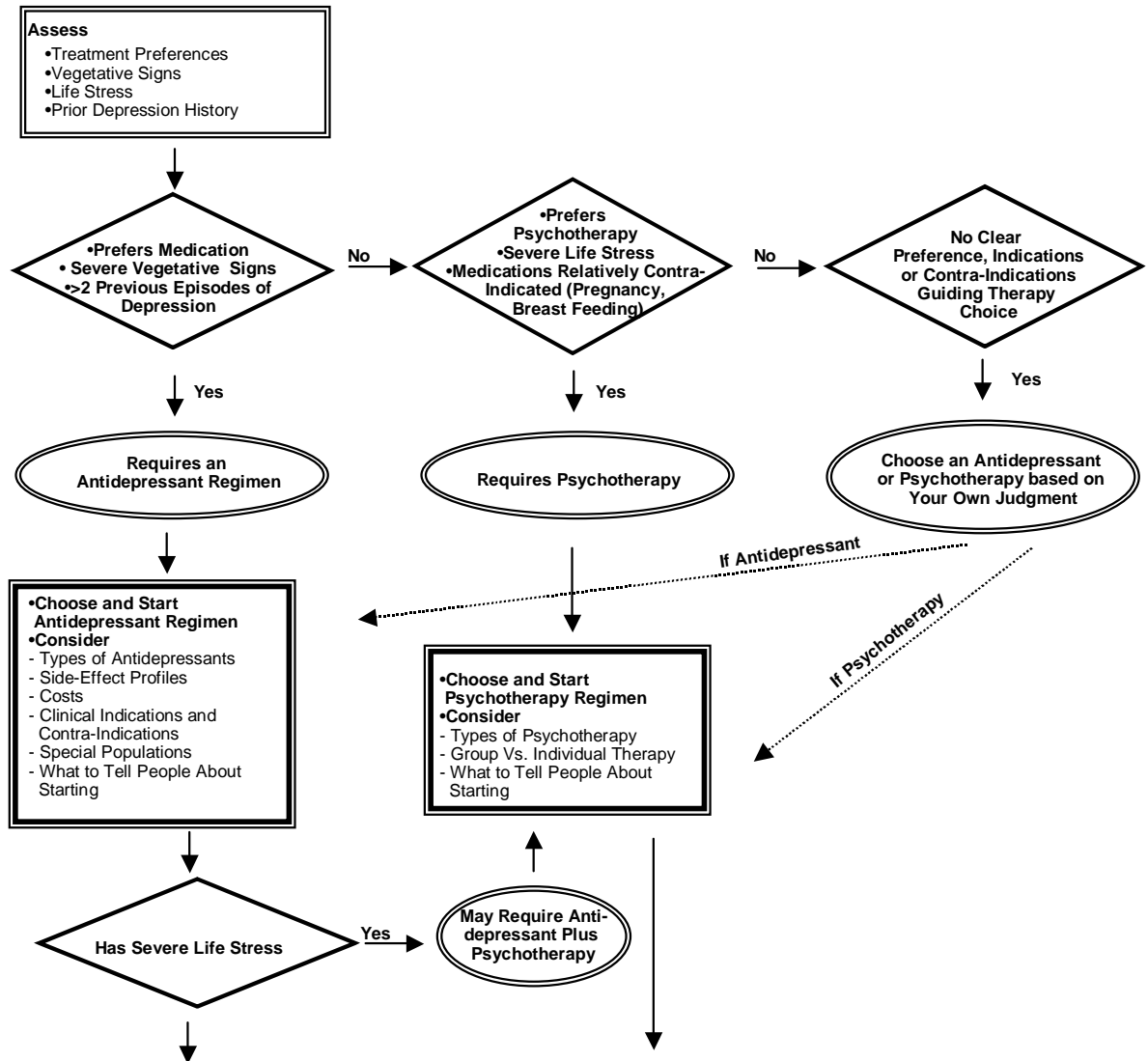
Stage	Treatment	Goal	# of Months
1	Acute	<ul style="list-style-type: none">• Initiate treatment• Fully relieve depressive symptoms• Educate the patient	0 - 4
2	Continuation	<ul style="list-style-type: none">• Monitor depressive symptoms and functional status• For patients on medications, continue medication treatment until the end of this phase, then stop (total months of Rx about 9)• Maintain acute phase gains• Prevent relapse	4 - 9
3	Maintenance	<ul style="list-style-type: none">• Monitor for relapse• Reinforce education• Continue medications at the usual dosage (not lower) in individuals at high risk of relapse• Discuss early warning signs of depression	9 - ?

Figure 2.1 - Three Stages of Treatment for Managing Depression

Remember, patients may come to you already in therapy (see Assessment, Step 4). For these patients, assess whether treatment should be directed toward acute, chronic, or maintenance phases, and manage or monitor progress accordingly.

Step 1

ASSESS FACTORS AFFECTING CHOICE OF THERAPY AND CHOOSE ACUTE PHASE TREATMENT



General Considerations Regarding Treatment Choice

You are now ready to choose between the two main recommended types of treatment for depression--**medications or psychotherapy**. Some patients, based on their clinical states, may require antidepressants, some may require psychotherapy, and some may require both. Scientific studies have shown that for most patients, however, **either medications or psychotherapy will be equally effective**. For these patients, it is most appropriate for the patient's preferences to guide treatment choice. Recent studies of antidepressant efficacy that include unpublished studies find that

antidepressant effect sizes are less than previously reported. These findings suggest that providers should be circumspect regarding the benefits of antidepressants.

We want to promote **cost-effective decision-making** and care that provides **good value**, which means good patient outcomes for each treatment dollar spent. That means that patients who are receiving care for depression should receive **appropriate** care in an **efficient** manner. Discuss the costs and benefits of psychotherapy and medication with your patients so that you and they can make a decision that ensures the active participation in treatment which in turn leads to long-term success.

Both antidepressant medications and psychotherapy have a high likelihood of curing depression over a period of 8 to 12 weeks. Antidepressant medications may work somewhat faster, but psychotherapy may help the patient learn to deal more effectively with the types of problems that led to and could perpetuate the depression. Patients will have to take antidepressant medications daily for 9 months or longer in order for them to be fully effective, and may experience unwanted side effects. On the other hand, psychotherapy requires a longer time commitment during the 8 to 12 weeks of therapy.

Advantages of psychotherapy/disadvantages of medications for treatment of depression

1. Psychotherapy does not involve any physiologic side effects, such as those found with antidepressant medications.
2. Psychotherapy should teach patients coping skills to help them to deal more effectively with their current and future life situation, while medication therapy alone does not.
3. Many patients are looking for help with current, real life problems, which is a major focus of therapy. To the extent that these problems are not caused entirely by the depression, they may not be susceptible to “just a pill.”
4. Teaching patients skills for coping with, avoiding, and improving their depression may have more enduring benefits in some patients than medication therapy alone, and accomplishing this may require psychotherapy.

Disadvantages of psychotherapy/advantages of medication for treatment of depression

1. Psychotherapy has not been tested with psychotic or severe types of depression that are typically seen in psychiatric practice but less frequently in primary care settings.
2. Many patients fail to follow through with treatment. Encouragement from their physician may aid patients to stay in treatment.
3. Therapy sessions are time-consuming and can be inconvenient.
4. Therapy outcome is related to how skilled the therapist is.
5. Medication therapy may resolve symptoms quicker than does psychotherapy.
6. Medications require less of a time commitment in patients who may have realistic problems with time off from work, childcare, transportation, etc.



Assess Factors Affecting Treatment Choice

a) Assess Patient Preferences

For some patients, identifying a preference may be no more difficult than asking them which type of therapy they prefer. For others, particularly those who have not had previous contact with mental health care, more time and effort will be required.

Patients and physicians may have different perceptions of what the problem is and what treatments would be helpful. For example, many patients may not think that they are depressed at all, and may have strong preferences about treatments that differ from what you as the physician would ordinarily recommend.

It is therefore essential to find common ground between our own clinical perspective and that of the patient (see Figure 2.2). It is also important to review available treatment alternatives with patients and elicit their preferences so that they can make as much of an informed decision as possible. With the appropriate support and education, even patients who are initially resistant to treatment often change their minds. Providers may even be able to select treatments that patients prefer, thereby enhancing compliance.

Key Discussion Points

1. Ask patients to describe how they view their illness.
2. Share your own view of their illness.
3. Identify key differences between these two views.
4. Explain alternative treatments, including costs and benefits, advantages and disadvantages in their particular situation.
 - Indications/contraindications they have for particular therapies.
 - Number of visits required? (More with psychotherapy)
 - Providers used? (Psychotherapist vs. primary care physician and depression nurse specialist).
 - Costs and side effects of medications.
 - Restrictions imposed by insurance plan.
5. Review the key points of your discussion, especially information on alternative treatments.
6. After reviewing the options, ask patients to identify the treatment they prefer.

Figure 2.2 - Assessing Patient Treatment Preferences

- b) Assess clinical features affecting appropriateness of using medications or psychotherapy:
- Vegetative signs
 - Prior depression history, especially number of previous episodes of depression
 - Life stress
 - Contraindications to medications, including pregnancy or breastfeeding
- c) Make a final choice based on preferences and clinical features

Figure 2.3 summarizes the key issues that should shape the choice of therapy. Patient preference is at the top of the list, because unless there are major indications or contraindications for one type of therapy or the other, treatment will be most successful if the patient is fully in alliance with it. **For both psychotherapy and antidepressants, the most common reason for failure to completely recover is that the full course of therapy was not followed.** In studies, only a relatively small proportion of primary care patients complete a full course of psychotherapy (8 to 12 weeks) or a full course of medications (about 9 months).

Antidepressants	Psychotherapy
<ul style="list-style-type: none"> • Patient preference • Severe symptoms that are vegetative (sleeplessness, trouble concentrating, poor oral intake, obstipation, psychomotor retardation, psychomotor agitation, disheveled appearance) • Prior history of multiple (>3) episodes of depression • Family history of multiple depressions • Prior positive response to antidepressants 	<ul style="list-style-type: none"> • Patient preference • Severe life stress: e.g., significant psychological or social problems, functional disability problems that have causes other than depression itself • Marked cognitive symptoms (negative thoughts) • Medications relatively contraindicated (pregnancy, breast feeding) • Prior positive response to psychotherapy

Figure 2.3 - Indications for Types of Treatment

Pregnant or breast feeding women, or women who want to become pregnant:

- Should strongly consider psychotherapy and avoid antidepressants because of potential risks to the fetus, particularly during the first trimester.
- If depression is severe and there is concern about the well-being of the mother or baby, the risk of not treating with antidepressants may be greater than any potential harm to the baby.
- In such complex cases, primary care physicians should consider consultation with a psychiatrist.

Both Antidepressants and Psychotherapy

Patients who have indications for both antidepressants and psychotherapy, or who have responded significantly but not fully to one modality or the other, may require combination therapy with both antidepressants and psychotherapy. The combination *should not* be required in most cases. It is not cost-effective to use both therapies when one alone is sufficient, and it adds unnecessarily to patient burden.

Summary of Indications for Treatment Choice:



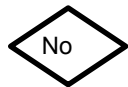
If the patient prefers medications, has severe vegetative signs, incomplete response to psychotherapy, or greater than 3 episodes of prior depression, **he or she requires an antidepressant medication.**



If the patient prefers psychotherapy, is under severe life stress, has contraindications to medications, or has an incomplete response to medication, **he or she requires psychotherapy.**



If the patient has major indications for both antidepressants and psychotherapy, **he or she requires both medications and psychotherapy.**



If the patient does not have compelling indications for either psychotherapy or antidepressants, and does not have strong preferences, **choose either medications or psychotherapy based on practical considerations.**

Watchful Waiting:

If patients with major depression or dysthymia refuse treatment, a course of watchful waiting is indicated. This entails **counseling by the primary care clinician**, continued **patient education**, and **follow-up visits**. Key activities are:

- Identify and encourage pleasurable activities
- Assess treatment barriers and encourage treatment
- Give patient the “Your Personal Plan: Watchful Waiting” (see Appendix H)
- Reassess the patient again at one month
- Continue reassessments monthly if necessary

Starting Treatment with Psychotherapy or Medications



Starting Psychotherapy



Choose and start a psychotherapy regimen

- Choose a psychotherapy approach

Psychotherapy has been shown to be as effective as antidepressant medication in treating depression, particularly the mild to moderate depression typically seen in primary care medical settings. The types of therapy most useful for treating depression are active/directive therapies that focus on current problems. Those that have proven to be effective in treating major depression in randomized trials include: cognitive therapy, behavioral therapy, combined cognitive-behavioral therapy, and interpersonal psychotherapy.

Cognitive therapy treats depression by identifying and correcting thinking patterns that are negatively biased and distorted in such a manner as to keep patients depressed. For example, a patient who believes that she is worthless if she's not successful in her career is likely to become depressed and stay depressed as long as she is having career problems. Cognitive therapy would help her examine her belief and learn to feel worthwhile, even in the face of career problems.

Behavioral therapy works to help patients engage in pleasant activities in order to overcome depression. Many persons who are depressed have suffered a recent loss. For example, a patient may have lost his spouse. As a result, he may no longer engage in any pleasant activities, because he doesn't know what to do alone. Treatment would focus on helping the patient learn to spend a substantial portion of time engaging in enjoyable activities.

Cognitive-behavioral therapy. Both cognitive therapy and behavioral therapy have been shown to be effective in treating acute depression. Cognitive-behavioral therapy combines those two treatments to alleviate current symptoms of depression, get the patient functioning again, and provide the patient with strategies to prevent relapse.

Combined cognitive and behavioral treatment also helps people learn to interact with others more appropriately. Persons who are vulnerable to depression tend to lack assertiveness skills; that is, they don't know how to ask others for what they want in a relationship. The treatment helps people learn to be assertive with others, setting limits on others' behaviors and having their own needs met.

Interpersonal psychotherapy. Interpersonal therapy is based on the assumption that depression occurs in an interpersonal context. Interpersonal difficulties are viewed as possible cause and/or consequence of depression. The therapy consists of strategies that are designed to help the patient deal more effectively with current interpersonal problems and to improve social functioning. Examples of techniques include clarification (restructuring and feeding back patient's communication), encouragement of affect (helping the patient to recognize and accept painful feelings

and to express suppressed feelings), and communication analysis (identifying problems in talking with others).

Group Versus Individual Treatment

Cognitive-behavioral group treatment for depression has been found to be equally as effective as individual therapy for treating depression. Group treatment has certain advantages over individual treatment. First, group treatment for depression has cost savings over individual treatment. Second, group treatment allows one well-trained therapist to be helpful to more depressed patients at one time than does individual treatment. Third, socially isolated depressed patients can benefit from the social support that they receive from other group members.

Deciding whether to treat a patient with group or individual treatment should be a decision based on both clinical and practical considerations. Clinical considerations should be: 1) Is the patient likely to be someone that other group members will like and support? Our experience has been that the group members can tolerate many differences and still like each other and give each other support. However, we have treated abrasive patients who are disliked by the group, and in those cases, group treatment is not indicated. 2) Is the patient likely to be able to participate actively in a group? Some patients are truly too shy to discuss their problems in a group, and these individuals probably should not be made part of a group. Practical considerations have to do with whether wait time for group is too extended, whether the patient can come to a scheduled group time, and whether a group is likely to be available to the patient that is convenient for him/her

Group Treatment Models

Cognitive-behavioral group treatment for depression can be given as closed groups or open-ended groups that allow new members in at the beginning of each module. The advantages and disadvantages of each model will be considered below.

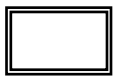
Closed groups are conducted by organizing a group of 10-12 patients (allowing for drop out) who begin and end treatment together, with no other patients entering treatment after the initial group. A major advantage of this group format is that excellent group cohesion can be established among the members. This group cohesion can aid in retention of members in treatment. In addition, in closed groups, the leader can spend a major portion of time discussing termination during the final four sessions. During these sessions, each member can be encouraged to finalize gains and consolidate the treatment.

Closed groups also have some disadvantages. They don't accommodate patient flow well in sites where small numbers of patients are being treated. If only one group is being conducted, a patient may have to wait nearly three months to begin group. Patients are highly unlikely to remain motivated for treatment following a long wait. Another disadvantage of closed groups is that patients are all very depressed at the beginning, often bogging down the group and making it difficult to summon the energy for progress.

Open groups that allow patients to enter at the beginning of each month (or module) also have a number of advantages. Open groups provide excellent ability to adapt to patient flow, as no patient has to wait longer than four weeks to enter a group. Open groups also have the advantage of pairing new patients with those who have made excellent progress in treatment. The recovering depressives are often extremely helpful in instilling hope in those who are just entering treatment.

Open groups have two major disadvantages. First, building group cohesion is much more difficult in a group where members are coming and going throughout the group. This can be overcome somewhat by spending time at the beginning of each module introducing the concept of depression, recognizing the similarity in depression across patients in the group, and conceptualizing the “depression” as the common enemy to be worked on by the group. Second, open groups have the disadvantage of providing less opportunity to deal with termination. Because members are leaving each month, it is not feasible to focus on termination throughout the entire group. This disadvantage can be lessened by making sure that termination is dealt with for those members who are leaving within the structure of the group treatment.

- Give the patient the “Your Personal Plan: Psychotherapy” (see Appendix G).



Starting Medications



Choose and start an antidepressant regimen

- Select an antidepressant

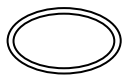
The information shown in Figure 2.4 will help you to select an antidepressant. You may wish to look up the specific antidepressant you select in the appendix material on antidepressant medication at the end of this document (Appendices A through C). In general, you should consider two types of well-studied antidepressants for treating depression. These include the selective serotonin reuptake inhibitors (SSRIs), and other types of antidepressants such as tricyclic antidepressants (TCAs). The figure summarizes some key factors to consider in choosing an antidepressant.

- Give the patient the “Your Personal Plan: Medications” (see Appendix F).

Factors to Consider When Choosing and Starting an Antidepressant

- **Side effect** profile (see Figures 2.5 through 2.7)
- Clinical indications and contraindications
- **Age:** Elderly patients are at higher risk for side effects and drug interactions. In these patients, the newer antidepressants (SSRIs) are generally better tolerated.
- **Suicidality:** In patients who have made suicide attempts or who are considered at significant risk for making a suicide attempt, **SSRIs are recommended** because they are **much safer in the case of overdose**.
- **Drug interactions** with concurrent medications - e.g., avoid a combination of antidepressants and monoamine oxidase inhibitors (MAOIs). Be aware that tricyclic antidepressants (TCAs) can potentiate the effects of quinidine, leading to a complete heart block. SSRIs can raise serum levels of such medications as digoxin, anticonvulsants, and warfarin (see Tables B.1 and B.2 in Appendix B).
- **TCAs** are contraindicated in patients with certain coordination defects or narrow-angle glaucoma (see Figure 2.6).
- **Cost** - Many SSRIs are now generic.

Figure 2.4 - Factors to Consider When Choosing and Starting an Antidepressant



Special patient populations: elderly, medically ill, pregnant or breast feeding

For all special populations, start slow (lower initial dose) and go slow (slower rise in dose). Monitor more frequently for side effects. Consider psychiatric consultation.

Elderly

- Often more sensitive to side effects.
- Often on multiple medications (beware of drug interactions!).
- Try to use SSRIs or secondary amine tricyclics (nortriptyline or desipramine).
- Pay attention to contributing factors such as medical illness, losses, social support, the stress of being a caregiver, and the psychological effects of declining physical health or of disability.

Acutely Medically Ill

- May be more sensitive to side effects.
- May be using multiple medications (beware of drug interactions!).
- Cardiac conduction defects and narrow-angle glaucoma are contraindications to tricyclic antidepressants.
- Severe liver and kidney disease can reduce the metabolism/elimination of antidepressants.

Pregnant/Breast feeding Women, or Women who Want to Become Pregnant

- Should strongly consider psychotherapy and avoid antidepressants because of potential risks to the fetus, particularly during the first trimester.
- If depression is severe and there is concern about the well-being of mother or baby, the risk of not treating may be greater than any potential harm to the baby.
- In such complex cases, primary care physicians should consider consultation with a psychiatrist.



Other Considerations for Antidepressant Choice (see Figure 2.8)

- Side Effect Profiles
- Costs
- Clinical Indications
- Drug Interactions (refer to Appendix B for details)

Selective serotonin reuptake inhibitors (SSRIs):
fluoxetine, sertraline, paroxetine, citalopram, escitalopram

No absolute contraindications

Common side effects (> 10 %):

- Insomnia, restlessness, agitation, sedation, fine tremor, GI distress, headache, dizziness, sexual dysfunction (difficulty reaching orgasm).
- Fluoxetine may be the most activating, and paroxetine the most sedating, choice. Paroxetine also has the most anticholinergic side effects such as dry mouth and constipation (sertraline may cause diarrhea more commonly). Citalopram tends to have lower side effect profiles than the other SSRIs.
- Because of their side-effect profile, SSRIs are recommended as 'first line' in patients, particularly in elderly patients and in patients who are at risk for suicide attempts by overdose.

Cost:

These medications are nearly all generic and cost approximately \$1.00 per day. Some pharmacies may offer these as \$4 prescriptions. Whether the costs are borne by the plan or patient varies with payment arrangements.

Figure 2.5 - Side Effects, Costs and Clinical Indications for Selective Serotonin Reuptake Inhibitors (SSRIs)

Secondary Amine TCAs : Nortriptyline or Desipramine

Contraindications:

- A bundle branch block or other significant conduction defect (1st or 2nd degree block)
- Recent myocardial infarction (< 6 weeks)
- Urinary retention
- Narrow-angle glaucoma

Common side effects (> 10 %):

Arrhythmias, tachycardia, dry mouth, constipation, fine tremor, fatigue or insomnia (desipramine)

Costs:

These medications cost about \$1.00 per day, which is similar to the cost of generic SSRIs but cheaper than other newer antidepressants. Patient costs may be more similar depending on payment arrangements

Other points:

- Consider nortriptyline if patient has anxiety, psychomotor agitation, and problems with sleep
- Consider desipramine if patient has decreased energy and psychomotor retardation
- Not recommended for people with significant risk for suicide--even a two week supply of TCAs can be fatal in the case of an overdose

Figure 2.6 - Side Effects, Costs and Clinical Indications for Secondary Amine Tricyclics (TCAs)

Other Antidepressants: Bupropion, Duloxetine, Mirtazapine, Venlafaxine

Contraindications:

- Do not use bupropion for patients with seizures or bulimia
- Do not use duloxetine for patients with liver failure

Common side effects:

Bupropion has less sexual side effects than the SSRIs. Bupropion and venlafaxine tend to be activating, and mirtazapine tends to be sedating. Mirtazapine may increase weight gain more than the SSRIs. Duloxetine and venlafaxine have similar side effects as the SSRIs.

Costs:

These medications are more expensive than SSRIs and TCAs. Even when generic they may cost approximately \$2.00 to \$4.00 per day. Whether the costs are borne by the plan or patient varies with payment arrangements. This cost concern may affect patient preferences and treatment adherence.

Figure 2.7 - Side Effects, Costs and Clinical Indications for Other Antidepressants

Guidelines for Choosing Antidepressants

First and Second Line Antidepressants

- SSRI** Drug treatment may begin with a selective serotonin reuptake inhibitor (SSRI) such as **citalopram**, **fluoxetine**, **sertraline**, or **paroxetine** (see Table 2.1).
The patient should be able to make an informed choice, considering such factors as prior response to antidepressants, side effects (side effect profiles of drugs are described in Tables 2.1 and 2.3), other medications and medical conditions, and cost of the medications.
- Other** If a patient has failed a six-week trial of an antidepressant at a therapeutic dose or cannot tolerate the side effects of a particular antidepressant even after attempting to lower the dose or treating the side effect, a trial of a **different medication or switching/adding psychotherapy** is recommended. (Example: if a patient's initial drug was a citalopram, the second trial may be with an sertraline, and vice versa.)

Patients may not respond to a particular medication in a group (SSRIs, TCAs), but may respond to another. Response is hard to predict and can be idiosyncratic. Response may be better with a medication from another class. Side effect profiles may help guide choice of a second trial of medication. The underlying depression should not be untreated during the switch.
- 2nd line** If patients have 'failed' trials of different types of antidepressants (SSRIs and others), or if there are reasons to use another antidepressant (such as a prior response to another type of antidepressant), primary care physicians can **substitute another antidepressant** or **consider a consultation with a psychiatrist** for advice in further antidepressant management (such as augmentation).

Figure 2.8 - General Algorithm for Selecting an Antidepressant

Table 2.1 - SSRI and Other Antidepressants: Dose, Price, and Side Effects**I. Serotonin Reuptake Inhibitors (SSRIs)**

Common side effects (> 10 %) include: *insomnia, restlessness, agitation, sedation, fine tremor, GI distress, headache, dizziness, sexual dysfunction.*

<i>Drug Name</i>	<i>Unit doses available (in mg)</i>	<i>Therapeutic dosage range (mg)</i>	<i>Usual dose (mg)</i>	<i>Cost/day for usual dose</i>	<i>Starting dose in young patients (mg)</i>	<i>Starting dose in elderly patients (mg)</i>	<i>Comments</i>
<i>Fluoxetine (Prozac)</i>	10, 20	10-60	20	\$1.00	20	10	Long half-life
<i>Paroxetine (Paxil)</i>	10, 20, 30, 40	10-50	20-30	\$1.00	20	10	Dry mouth, constipation,
<i>Citalopram (Celexa)</i>	20, 40	10-40	20	\$ 1.00	20	10	
<i>Escitalopram (Lexapro)</i>	5, 10, 20	10-20	10	\$3.00	10	5	Not generic
<i>Sertraline (Zoloft)</i>	50, 100	25-200	50-100	\$1.00	50	25	

***The side effects listed are in addition to side effects listed for all drugs in a class**

II. Secondary Amine Tricyclics (TCAs)

Common side effects (> 10 %) include: *arrhythmias (particularly with preexisting conduction defects), dry mouth*

<i>Drug Name</i>	<i>Unit doses available (in mg)</i>	<i>Therapeutic dosage range (mg)</i>	<i>Usual dose (mg)</i>	<i>Cost/day for usual dose</i>	<i>Starting dose in young patients (mg)</i>	<i>Starting dose in elderly patients (mg)</i>	<i>Comments</i>
<i>Nortriptyline (e.g., Pamelor)</i>	10, 25, 50, 75	40-150 qhs	50-100 qhs	\$1.00	25 qhs	10 qhs	<i>Weakness/fatigue, confusion, fine tremor, sedation</i>
<i>Desipramine (e.g, Norpramin)</i>	10, 25, 50, 75, 100, 150	75-300 qday	150-200 qday	\$1.00	50 qday	25 qday	<i>Tachycardia, insomnia, agitation</i>

***The side effects listed are in addition to side effects listed for all drugs in a class**

Table 2.1 - (cont.)

III. Other Antidepressants

<i>Drug Name</i>	<i>Unit doses available (in mg)</i>	<i>Therapeutic dosage range (mg)</i>	<i>Usual dose (mg)</i>	<i>Cost/day for usual dose</i>	<i>Starting dose in young patients (mg)</i>	<i>Starting dose in elderly patients (mg)</i>	<i>Some common side effects</i>
<i>Bupropion (Wellbutrin)</i>	75,100 SR: 100, 150, 200 XL: 150, 300	75-150 bid-tid SR: 100-200 bid XL: 150-300 qday	75-150 bid-tid SR: 100-200 bid XL: 150-300 qday	\$2.00 SR: \$2.00 XL: \$4.00	150 qd	37.5 bid SR: 100 qday XL: 150 qday	Insomnia, agitation, tremors, headache. Avoid in patients at risk for seizures and patients with bulimia. Minimal sexual side effects
<i>Venlafaxine (Effexor)</i>	25, 37.5, 50, 75, 100 XR: 37.5, 75, 150	12.5-150 bid XR: 37.5 – 225 qday	25-100 bid XR: 75-225 qday	\$2.00 XR: \$4.00	25 bid-tid XR: 75 qday	25 qday XR: 37.5 qday	Nausea, activation, sweating, headache hypertension at high doses
<i>Duloxetine (Cymbalta)</i>	20, 30, 60	40-60 qday	40-60 qday	\$4.00	40 qday	30 qday	Nausea, dry mouth, constipation, decreased appetite, fatigue, sweating, sexual dysfunction Enteric coated – DO NOT break tablets! Not generic
<i>Mirtazapine (Remeron)</i>	15, 30	15-45 qhs	15-30 qhs	\$2.00	15 qhs	7.5 qhs	Sedation, weight gain, minimal sexual side effects Not generic

Table 2.2 - Second Line Antidepressants: Not Recommended for Routine Care

These medications are recommended if:

- Patients have not responded to SSRIs or TCAs or other antidepressants.
- Patients or a close blood relative have responded to one of these medications in the past and have not had significant side effects.
- A consultant recommends one of these medications because of side effects from one of the other antidepressants (such as sexual dysfunction with SSRIs).

Generic Names	Brand Names	Usual Doses (in mg/day)*	Price**	Comments***
<i>Amitriptyline</i>	Elavil Endep	100 - 300	\$2.00/day \$0.30/day for generic version.	Significant side effects (TCA****)
<i>Clomipramine</i>	Anafranil	125 - 300	\$3.00/day	Significant side effects (TCA-****). 2 % risk of seizures. (Used in OCD)
<i>Trimipramine</i>	Surmontil	150 - 300	\$1.00/day	Significant side effects (TCA).
<i>Protriptyline</i>	Vivactil	30 - 60	\$1.50/day	Significant side effects (TCA). Activating.
<i>Amoxapine</i>	Asendin	200 - 400	\$3.00/day	Significant side effects (TCA). Contains a neuroleptic - risk of EPS/tardive dyskinesia.
<i>Maprotiline</i>	Ludiomil	150 - 225	\$1.50/day	Significant side effects. > 3 % risk of seizures
<i>Tranlycypromine</i>	Parnate	20 - 40	\$1.00/day	Monoamine Oxidase Inhibitor (MAOI) *****
<i>Isocarboxazid</i>	Marplan	10 - 30	*****	MAOI***** Sedating Orthostasis
<i>Phenelzine</i>	Nardil	30 - 60	\$1.00/day	MAOI***** Sedating Orthostasis
<i>Trazodone</i>	Desyrel	200 - 600	\$1.50/day	Significant side effects: sedation, orthostatic hypotension. Priapism in 1/2,000 men.
<i>Imipramine</i>	<i>Tofranil,</i> <i>Janimine</i>	150-200	\$0.20	Significant side effects (TCA).
<i>Doxepin</i>	<i>Sinequan</i>	150-200	\$0.20	Significant side effects (TCA).

* Use lower doses in geriatric or medically ill patients.

** Estimates based on average doses and prices.

*** See PDR or package inserts for full list of side effects/precautions.

**** Has most of the common side effects of TCAs: dry mouth, constipation, urinary hesitancy, orthostatic hypotension/dizziness, sedation. Potentially serious side effects include cardiac arrhythmias and lethality in overdose.

***** MAOIs require a special diet low on tyramine. Do not co-administer with meperidine, tryptophan, 5 hydroxymethorphan, or other antidepressants. You must wait 5 weeks after the last dose of fluoxetine until starting an MAOI. Consult a psychiatrist if you are not familiar with the use of these medications.

***** Discontinued by manufacturer in 1994

Table 2.3 - Side Effects at Therapeutic Doses (%)

CARDIOVASCULAR

SIDE EFFECTS	Citalopram	Fluoxetine	Paroxetine	Sertraline	Nortriptyline	Desipramine	Bupropion
Postural hypotension	1	< 1	1	< 1	6	6	3
Dizziness	<1	6	13	12	6	6	11
Tachycardia	1	1	> 1	< 1	6	6	11
ECG changes	<1	< 2	< 1	-	6	6	5
Arrhythmias	1	1.5	< 1	-	6	6	5

GASTROINTESTINAL

SIDE EFFECTS	Citalopram	Fluoxetine	Paroxetine	Sertraline	Nortriptyline	Desipramine	Bupropion
Dry mouth	20	10	18	16	20	20	26
Nausea, vomiting	21	21	26	26	2	6	18
Diarrhea	8	12	12	18	-	-	7
Constipation	-	5	14	8	9	6	10
Weight gain/loss	+6	-13	+> 1	+< 1	+6	+6	-23

URINARY AND SEXUAL

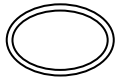
SIDE EFFECTS	Citalopram	Fluoxetine	Paroxetine	Sertraline	Nortriptyline	Desipramine	Bupropion
Urinary retention	<1	1. 5	> 1	< 0.5	< 2	-	< 1
Sexual dysfunction	6	15	15	15	< 2	7	3

EYES AND SKIN

SIDE EFFECTS	Citalopram	Fluoxetine	Paroxetine	Sertraline	Nortriptyline	Desipramine	Bupropion
Blurred vision	1	3	4	> 1	6	7	3
Skin rash	1	3	2	< 2	< 2	12	5
Sweating	11	8	11	1	3	-	6

CENTRAL NERVOUS SYSTEM

SIDE EFFECTS	Citalopram	Fluoxetine	Paroxetine	Sertraline	Nortriptyline	Desipramine	Bupropion
Weakness, fatigue	5	4	15	8	20	6	4
Seizures	<1	< 0.5	-	< 0.5	< 0.5	< 0.5	< 1
Headache	1	20	18	20	< 2	< 0.5	34
Tremor	8	14	8	11	11	6	6
Drowsiness, sedation	18	12	23	13	7	6	3
Insomnia	15	17	13	16	<2	6	20
Confusion, disorientation	<1	1.5	1	> 1	11	-	8
Anxiety, nervousness	4	15	5	6	-	-	7
Agitation, motor restlessness	3	11	2	6	-	-	2



What To Tell Patients About Antidepressants

Once you have “negotiated” a treatment plan, complete a personal plan form (see Appendices F – I) with the patient. Address any questions/concerns he/she may have about the medication. The questions below represent common concerns.

- Antidepressants help restore a chemical imbalance in the brain.
- They are not addictive.
- The response is gradual, and the medication will take 2 to 6 weeks to work.
- Sleep and appetite may improve first. Mood, energy, and negative thinking may take a few weeks to start improving.
- Take the medications daily.
- Keep track of side effects and discuss these with your physician.
- Keep taking the medication even if you feel better.
- Don't stop the medication before talking to your physician.
- Call your physician if you have a question.
- Keep medications away from children.

Questions most commonly asked and answered about antidepressants

1. I have a problem with pain. How can an antidepressant help with this?

- Antidepressants have been shown successful (even in the absence of major depression) in a number of pain conditions such as diabetic neuropathy, post-herpetic neuralgia, and phantom limb pain.
- See the “Cycle of Depression” chart, Figure 1.1. Antidepressants may help restore normal sleep and ‘reverse’ this cycle.

2. I have a lot of stress in my life. How can an antidepressant help with this?

- Life stress can cause or worsen the symptoms of depression. The depression can then worsen the impact of such stressors and your ability to cope with them. Treating the depression can help some patients break out of this vicious circle.

3. Are antidepressants addictive?

- **No.** Antidepressants are not habit-forming or addictive. They do not produce a ‘high’ feeling, but slowly increase the amount of certain chemicals in the brain over a number of weeks.
- Some people have been taking antidepressants continually for up to 30 years without any significant (physical or psychological) adverse effects.

4. My problem is anxiety or panic attacks, not depression. How can antidepressants help?

- In many cases, anxiety is a by-product of depression. Once the depression lifts, the anxiety improves as well.

- Antidepressant medications are the most effective medical treatments for many anxiety disorders, including panic disorder and generalized anxiety disorder.

5. My problem is inability to sleep. How can an antidepressant help with this?

- In many cases, poor sleep is a by-product of a major depression. Once the depression lifts, the sleep improves as well.
- Antidepressants can help restore normal sleep, even in people who do not have major depression. When compared to other sleeping pills, they have the advantage that they are not habit-forming, and they usually do not impair concentration or motor performance.

6. How long will it take the medications to work?

- It usually takes from one to six weeks for patients to start feeling better. In many cases, sleep and appetite improve first. It may take a little longer for your mood and energy to improve, and for your negative thinking to decrease.
- If the depression has not improved after 4 to 6 weeks, you may need an increase in the dose or a change to another antidepressant.

7. How long will I have to take the medication?

- Once you are completely recovered from your depressive episode, you should stay on the medication for another 6 months to prevent a relapse.
- Some patients who have had previous depressive episodes or are otherwise at high risk for a recurrence should be kept on 'maintenance' antidepressants for longer periods of time.

8. Are there any dangerous side effects?

- Side effects from antidepressants are usually mild. You should ask your doctor what to expect and what to do if you have a problem.
- In many cases, your body will get used to the medication and you won't be bothered with the side effect for long. In other cases, your doctor may suggest that you lower the dose, add another medication, or change to another antidepressant. If used properly, there are no dangerous or life-threatening side effects.

9. Is it safe to take antidepressants together with alcohol or other medications?

- In general, antidepressants can safely be taken with other medications. You should let your doctor know exactly which other medications (including over the counter medications) you are taking so that he/she can make sure that there are no problems.
- Antidepressants can increase the sedating effects of alcohol. Be careful to avoid excessive alcohol intake while on these medications.

10. What should I do if I miss the medication one day?

- Don't 'double up' and take the dose you forgot. Just keep taking your medication as prescribed each day.

11. Can I stop the medication once I am feeling better?

- No. You would be at high risk for a relapse and may experience some temporary withdrawal symptoms. After one episode of depression, there is a 50% risk of recurrence. After two episodes, the risk goes to 70%; and after three episodes, the chances are 90% that you will have a recurrence if you stop using the medication. In most cases, you should continue the medication for at least 6 months after you and your doctor agree that your recovery is complete.
- **DON'T STOP THE MEDICATION BEFORE DISCUSSING IT WITH YOUR PHYSICIAN.**

12. How do antidepressants work?

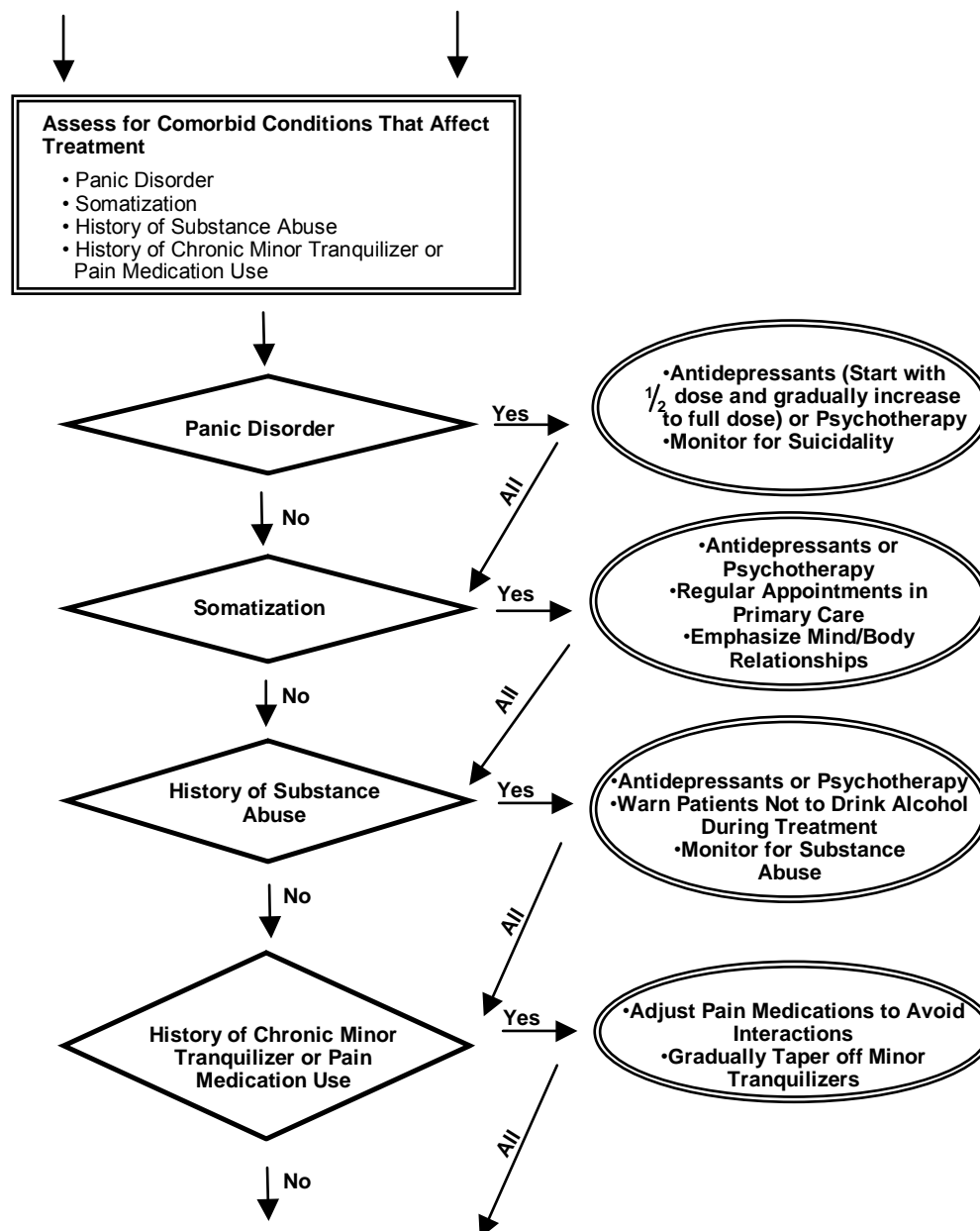
- Antidepressants help restore the correct balance of certain chemicals called **neurotransmitters** in critical regions of the brain.

13. Will I get better?

- With adequate treatment, between 50 and 80% of patients will have a complete recovery.
- Should you not respond to the first antidepressant treatment you try, there is an excellent chance that you will respond favorably to another antidepressant.

Step 2

IDENTIFY AND ADDRESS COMORBID CONDITIONS THAT MAY AFFECT THE COURSE OF TREATMENT AND REQUIRE MONITORING



There are some comorbid psychological conditions that do not dictate choice of therapy (i.e., they can respond to either medication or psychotherapy) and that do not necessarily require management by a mental health professional. However, these conditions do affect both prognosis and the optimal approach to the patient. Depending upon the severity of the disorder, psychiatric consultation may be desirable. The most common of these are panic disorder, somatization disorder, a history of substance abuse, and a history of chronic minor tranquilizer or pain medication use. These will be discussed in the paragraphs that follow. Others include eating disorders, obsessive-compulsive disorders, personality disorders, and dementia.



Assess Patients for Panic and Anxiety

Anxiety and depression are often comorbid, particularly in medical patients. The presence of anxiety does not necessarily mean that the patient will respond more poorly to treatment, but if not identified and addressed, it may worsen adherence and hence treatment success. In one treatment trial, depressed medical patients comorbid for panic who were not treated for the panic did significantly worse than those without panic. Usually, if the patient's panic or anxiety is addressed, as the patient's depression improves, so does the anxiety.

Patients with panic disorder have recurrent panic attacks, sometimes followed by intense fear of having another attack. These attacks are distinct periods of heightened anxiety during which patients experience a number of physical symptoms of anxiety such as palpitations, shortness of breath, dizziness, lump in the throat, sweating, tingling in the extremities, flushing, and a sense of extreme anxiety or impending doom. A significant number of patients with the disorder do not relate their symptoms to the fact that they are anxious, however.



If the patient has significant panic or anxiety, these symptoms may make treatment somewhat more difficult or complicated, particularly early in treatment.

- These patients may appear more distressed, anxious, or demanding at first, but they have an excellent prognosis if treated correctly.
- Patients with anxiety or panic are at higher risk of suicide, and therefore should be carefully assessed for suicidality.
- Antidepressants and psychotherapy are both effective in the treatment of panic disorder, with or without depression. One of the hallmarks of behavioral therapy is to help the patient to understand the **relationship between their anxiety and their physical symptoms** by explaining the physiology involved and by encouraging the patient to re-experience some of their symptoms by hyperventilating. Primary care clinicians can successfully use behavioral methods to improve panic in some cases.
- Both selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) have been successfully used to treat panic disorder and are the drugs of first choice for this condition.

- Patients with panic disorder who receive antidepressants should **be started on one-half the usual starting dose** of an antidepressant and titrated upwards more slowly than patients without panic disorder, to avoid a transient worsening of anxiety symptoms (see Figure 2.9). **After a few weeks, the patient should be moved to full antidepressant dosage levels.**
- In some cases, a short term (4-8 weeks) course of a benzodiazepine (such as Clonazepam) is helpful until the antidepressant becomes effective. Whenever possible, however, benzodiazepines should be avoided in the long-term treatment of depression and anxiety.
- Before treating anxiety symptoms and panic attacks, consider other causes of anxiety such as hyperthyroidism, hypoglycemia, caffeine abuse, stimulant abuse (cocaine, amphetamines), excessive use of sympathomimetics, or withdrawal from alcohol or minor tranquilizers.

Antidepressant Medication	Starting Dose in mg/day
<i>Fluoxetine</i>	5-10 mg
<i>Sertraline</i>	12.5-25 mg
<i>Paroxetine</i>	5-10 mg
<i>Citalopram</i>	10 mg

Figure 2.9 – Example Antidepressant Starting Doses for People with Panic Disorder



Assess Somatization

Some patients express psychological and social distress in the form of medical/physical symptoms and make frequent visits to their physicians without a clear medical cause. This process is called **somatization**, and it can be quite frustrating for both patients and physicians. Somatizers, or persons who focus their symptoms of depression on somatic rather than psychological concerns, may be particularly difficult to engage in treatment for depression. In particular, they may believe that the only reason they are feeling down is because of their physical health. In addition, they may feel that the only thing that will make them feel better is to “cure” their physical problems.



If a depressed patient somatizes his/her complaints (i.e., focuses on multiple unexplained physical symptoms), you may need to take account of the somatization.

Engaging somatizers in treatment of depression may take more time than engaging non-somatizers in treatment. You may need to bring up the depression with them on several occasions before they agree to treatment. Each psychotherapy session or week of successful antidepressant therapy may bring them closer to agreeing to treatment. Be patient; it may take extended time for them to try treating their depression.

- Somatization behavior can be minimized by arranging regularly scheduled appointments, so that the patient does not need a 'symptom' to see the doctor. Rather than focusing on curing symptoms, physicians should focus on reducing a patient's disability and maximizing the ability to function. Use office visits to support and encourage behaviors that minimize the "sick" role.
- Antidepressants have been shown to be effective in many chronic pain conditions, even those that exclude depression (diabetic neuropathy, migraine headaches, post-herpetic neuralgia, tension headache, rheumatoid arthritis, and fibromyalgia). Antidepressants should be used at usual dosage levels to preserve their full effect.
- Antidepressant therapy can help restore sleep and coping behaviors. They can also decrease symptoms such as insomnia, lack of energy, demoralization, and anhedonia.
- Antidepressants may also increase the pain threshold.
- Psychotherapy can also be successful for somatizers.

When **making a referral to psychotherapy** for a somatizer, focus on their concerns. You may want to agree with them that their physical health and concerns are extremely overwhelming and burdensome. This may segue into suggesting that anyone dealing with such serious problems could use some support or treatment. This may help them agree to seek treatment.

With somatizers, it is extremely important to say to them that in making a mental health referral you are not saying that all of their problems are in their head nor are you sending them away for treatment. You may want to assure them that you plan to continue treating them. However, in your experience, people with as many problems as they have are probably highly stressed and can benefit from mental health treatment.

One step in moving somatizers toward accepting a referral for mental health services can be helping them to **stop separating mind from body**. Remind them that physical health affects mental health; many people with medical problems become depressed. Also, mental health affects physical health. Persons who are depressed, for example, rate higher levels of pain and disability than those who are not depressed but with similar medical problems. Therefore, treating both the medical and mental health problems makes sense.



Assess Substance Abuse History

By this point in the algorithm, we have already referred patients who are current substance abusers to special programs or to the psychiatrist. But we still include patients who have abused substances in the past.



Individuals with a history of alcohol abuse can be treated similarly to other patients using either psychotherapy or antidepressants.

They should be warned about the ineffectiveness of treatment in the face of continued substance abuse, and the dangers of combining antidepressants with drugs or alcohol. They should also be monitored for recurrent substance abuse. Re-enforcement for continuing AA or other self-help group participation is also indicated.



Assess History of Chronic Use of Minor Tranquilizers or Pain Medications

Chronic use of tranquilizing and pain medications is a frequent and difficult problem in primary care practices. These medications tend to worsen depression and they interact, sometimes dangerously, with other medications including antidepressants.

Chronic use of narcotic pain medications is too complex a subject to explore in detail here. Depression can be treated while narcotics are continued, but extra vigilance about possible drug interactions is necessary. In general, chronic use of pain medications is not very effective in eliminating pain. In some cases, however, patients with painful illnesses are able to successfully use these medications in titrated doses to control their pain and increase functioning. A key indicator of successful use of pain medications for chronic disease is that the individual uses the medication to function better, and is able to reduce the dose or get off the medication when the disease improves.



If patients are on chronic pain medications or minor tranquilizers, every effort should be made to reduce the medications as depression improves.

Minor tranquilizers were initially introduced as non-toxic and non-addictive. However, it has since been determined that the psychological and physical addiction they engender can be among the most difficult to cure of any. The fact that genuine pain and anxiety often underlie their use does not, unfortunately, make chronic treatment with them any less harmful. They worsen depression and reduce functioning.

**NOTE: Long-term use of minor tranquilizers
IS NOT RECOMMENDED
in the treatment of depression.**

Minor tranquilizers are **NOT** effective in the long-term treatment of depression. They also pose a number of risks including **physical dependence, cognitive impairment/confusion**, and a risk of **accidents/falls**, particularly in elderly patients. In addition, these medications contribute significantly to the **cost** of treating depression without offering a clear benefit.

Minor tranquilizers include all sedative hypnotic drugs such as **benzodiazepines** (Valium, Librium, Ativan, etc.), and **barbiturates** (phenobarbital, etc.). A list of commonly prescribed minor tranquilizers is presented in Figure 2.10.

List of Commonly Prescribed Minor Tranquilizers	
1. <u>Benzodiazepines</u>	<u>Trade Name</u>
Alprazolam	Xanax
Chlordiazepoxide	Librium
Clonazepam	Klonopin
Clorazepate	Tranxene
Diazepam	Valium
Estazolam	ProSom
Flurazepam	Dalmane
Halazepam	Praxipam
Lorazepam	Ativan
Midazolam	Versed
Oxazepam	Serax
Prazepam	Centrax
Quazepam	Doral
Temazepam	Restoril
Triazolam	Halcion
2. <u>Barbiturates</u>	<u>Trade Name</u>
Pentobarbital	Nembutal
Secobarbital	Seconal
Phenobarbital	---
3. <u>Other agents with sedating/hypnotic action</u>	<u>Trade Name</u>
Zolpidem	Ambien
Zaleplon	Sonata
Eszopiclone	Lunesta
Ramelteon	Rozerem
Chloral Hydrate	---
Ethchlorvynol	Placidyl
Meprobamate	Equanil, Miltown
Diphenhydramine	Benadryl
Hydroxyzine	Atarax, Vistaril

Figure 2.10 - Commonly Prescribed Minor Tranquilizers

These drugs may alleviate some of the symptoms associated with depression such as **anxiety** or **insomnia**, but they are generally **not effective in treating a major depression**.

Occasionally, minor tranquilizers are needed for a short period of time in the treatment of depression to reduce extreme anxiety.

Rules for Short-Term Use of Minor Tranquilizers

Do not start treatment with a minor tranquilizer alone.

Consider benzodiazepines (such as Clonazepam) only for short-term use (less than 6 weeks) to help manage insomnia or anxiety in addition to treatment with an antidepressant.

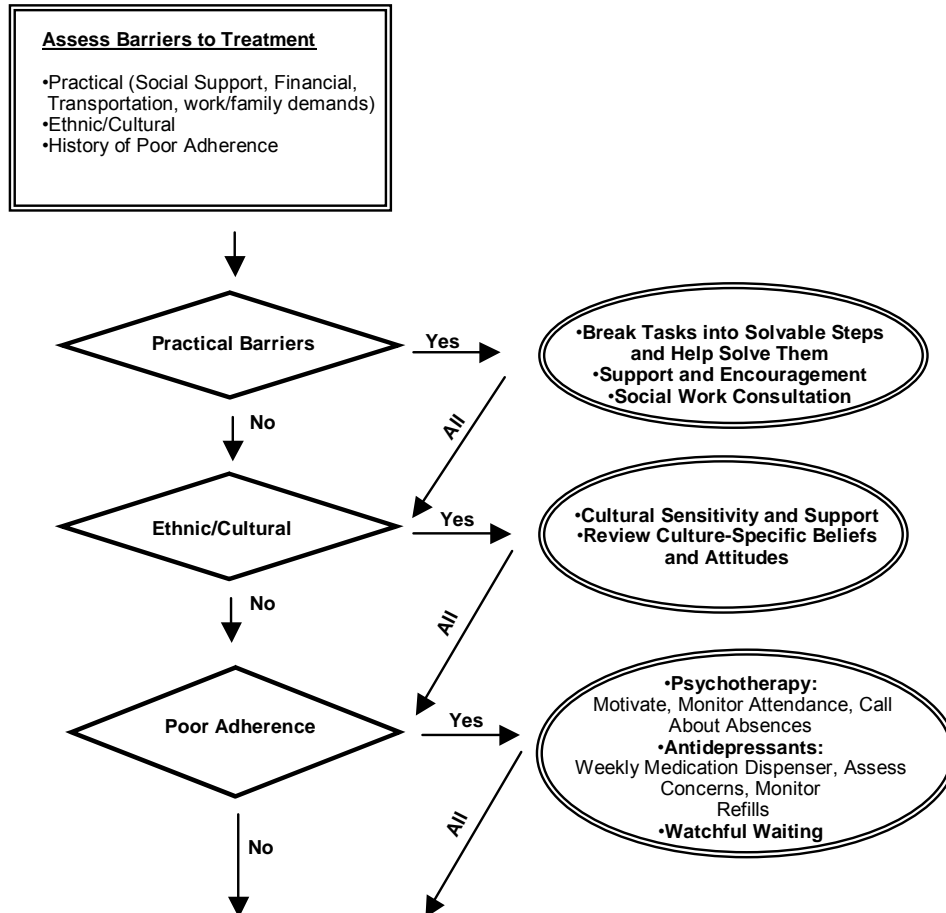
Ramelteon (Rozerem) is contraindicated with use of fluvoxamine (Luvox)

Anyone who has tried to wean people off minor tranquilizers (especially those who use them chronically), knows that the process can be difficult and frustrating. The medication must be tapered gradually to avoid withdrawal symptoms including heightened anxiety and seizures. The patient's habituation addiction to the medications must be recognized and dealt with.

DIAGNOSIS	CRITERIA	ACTION
<ul style="list-style-type: none">• Comorbid psychiatric disorders	<ul style="list-style-type: none">• somatization disorders• anxiety/ panic disorders• history of substance abuse• history of chronic minor tranquilizer or pain medication use• eating disorders• personality disorders• obsessive-compulsive disorder• dementia	<ul style="list-style-type: none">• treat the depression• consider psychiatric consultation• adapt treatment as recommended above

Step 3

ASSESS AND ADDRESS TREATMENT BARRIERS TO THE TREATMENT SELECTED



Assess Barriers to Treatment

While barriers to treatment often manifest themselves later, when the patient is not adhering to therapy or coming to visits, it is worth thinking at least briefly about potential barriers before therapy has even started. You can then revisit this list later, if therapy is not going smoothly. Common barriers discussed here include practical barriers, such as transportation, ethnic/cultural barriers, and a history of poor adherence to medications.



If the patient experiences practical barriers to treatment, such as transportation, these often need to be addressed.

Practical barriers are often magnified by depressed individuals. People with little social support, financial constraints, or excessive work or family demands often feel overwhelmed by the need to make extra medical or psychotherapy visits, as if such visits

may be the “straw that breaks the camel’s back.” Of course, these individuals are just the ones that most need extra counseling and monitoring if therapy is to be successful. **Breaking the problems into solvable steps** and providing **encouragement** can often resolve these problems. **A visit to a social worker** may help in solving practical problems if they are not amenable to supportive encouragement alone.



All patients are candidates for experiencing cultural barriers to depression treatment. If the patient is a member of a minority group, however, particular sensitivity may be necessary. A review of culture-specific beliefs is helpful.

Latinos

Several aspects of Latino culture affect the willingness of Latino patients to engage in treatment. By attending to these cultural aspects, you will find that Latinos are more likely to agree to treatment for depression. The first cultural factor to consider is that of *respeto*, that is, the expectation that males and older Latinos will be treated with respect, particularly by younger persons. This cultural characteristic suggests that it is particularly important to use titles of respect when speaking with Latinos in general, but older Latinos in particular. Using the formal *Usted* to connote respect is particularly useful if a younger interviewer is working with a patient.

Latinos are also generally taught to respect powerful others, such as physicians and nurses. As a result, it may be necessary to work particularly hard with Latino patients to make sure that they have indicated any concerns that they may have about getting treatment for depression. They are more likely than majority patients to say “Yes, Doctor” without clearly stating reservations unless they are given clear permission by the physician or nurse to state any concerns. If these concerns are not elicited, the patient has a much higher likelihood for failing to show up for treatment.

Latinos, particularly those who are less acculturated, may be influenced by the cultural concepts of *machismo* and *marianismo*. *Machismo* refers to the general dominance of the male in the family, with both the responsibility for providing for and protecting others in the family. When dealing with more traditional Latino families, it may be necessary to obtain the consent of the male head of the household for a Latina to obtain treatment. If this is the case, bringing the husband/father in to discuss treatment options and planning may facilitate getting the wife or daughter in for treatment. The cultural concept of *marianismo* refers to the belief that suffering for women is directly related to spirituality, such that the “long suffering” woman may be revered. Because of this concept, traditional Latinas may need extra encouragement that they should not be suffering and don’t deserve to feel so bad. Often they are not as motivated to help themselves as they might be to help others. Therefore, reminding a traditional Latina that she needs to take care of herself in order to take care of others may be particularly useful.

Latinos may be used to “warmer” interactions with others than are non-Latinos. In this regard, the concept of *simpatia* is particularly important. That is, traditional Latinos tend to like warm relationships, where others are showing clear concern for them and their family members. In order to best help Latinos enter treatment, several important steps should be undertaken. First, an effort to remember the names of important family members of the patients can be extremely helpful. Remembering to ask about the patient and others in his/her family is helpful. Making sure that you ask the patient if s/he

is comfortable or needs anything can be extremely useful, as can providing a beverage during a long interview.

Finally, Latinos may have more barriers to overcome in order to come to treatment. For example, many Latinas may not have access to baby-sitting in order to come to treatment, or others may be unable to ask for time away from work in order to come to treatment. Working with patients to help them overcome these barriers is an essential component to offering culturally sensitive treatment.

African-Americans

The key to understanding how to evaluate African-Americans is to understand that they are a diverse and heterogeneous group. Stereotypes are inaccurate and harmful. There are vast socio-economic, regional, and sub-group ethnic identity differences (Creole, Cajun, Caribbean, etc.). Although, it is not necessary for a provider to have knowledge of specific differences among these groups, it is important that the provider make an effort to understand his or her patient's particular cultural beliefs about illness and treatment.

Because of the unique history of African-Americans, and long-standing struggles with prejudice and discrimination, it is also important for providers to realize that many come to the medical encounter with fears about mistreatment and/or poor treatment. These fears have been exacerbated by recent media reports of sub-standard care for African-American patients with renal and cardiac disease.

Surveys of African-American patients reveal a preference for providers who are open, engaging, and direct in style. They are less likely to trust clinicians who appear to be distant, or indifferent. They also prefer providers who are careful to elicit personal values and preferences with regard to both diagnosis and treatment.

Studies of help-seeking behavior have shown that many African-Americans are more likely to seek help from spiritual advisors (ministers, religious counselors) for emotional problems. Queries about emotional health should, therefore, include questions about previous history and experience with spiritual counseling.

Because a higher percentage of African-American patients have low socio-economic status, it is also essential that providers remember to elicit information about financial barriers to recommend care.



Adherence can be the main determinant of treatment success with either medications or therapy.

- **Adherence to any regimen** is increased by educating the patient, making the patient a full partner in therapy, writing down instructions, and addressing barriers to adherence.
- **It is an excellent idea to spend a few minutes talking about such barriers at the time when you first prescribe a treatment.** Many patients can anticipate what some of the barriers might be for them, and this leaves you an opportunity to tackle such potential problems ahead of time.

Adherence to Psychotherapy

An important issue in treating depressed patients is keeping the patient in treatment. Although one philosophy of psychotherapy is that patients need to be **motivated** and willing to make great sacrifices in order to make gains in psychotherapy, this approach does not make sense with depressed medical patients. Symptoms of depression include lack of motivation and energy, as well as hopelessness about the possibility of change. Given these symptoms, along with the often times difficult and demanding lives that patients lead, many patients are likely to have trouble attending therapy.

Several approaches can be helpful to minimize attrition from treatment. First, predicting for the patient that s/he may have trouble going to treatment is useful. This can be done by suggesting that for many depressed people it can be hard to attend treatment. Suggest to them that on the morning of their next appointment they may think, "Oh what's the use, this isn't going to help. I don't have the energy to go through with this. I should solve my own problems. Maybe if I stay home and rest I will get better." When you are dealing with depressed patients, it is an error to try to move them from their hopeless position to optimism - it is too far of a leap. Therefore, rather than pointing out to them that most patients respond rapidly to therapy (they will be sure that they are one of the few who won't), it may be better to ask them what they think the chance is of getting better by doing exactly what they have been doing, i.e., staying home, resting, trying to get over this on their own. They are likely to admit that these things haven't helped and aren't likely to help in the near future. Then, ask them what the likelihood is that they will get better if they do something different - like go to treatment. They will probably say that it slightly improves their odds of getting better. Point out that since continuing doing nothing is not likely to help and going to therapy, as they agree, increases the chances of their getting better a bit, that going to treatment is useful. Encourage them to talk with themselves in a similar way if they don't feel like going to the next appointment. They can remind themselves that even though I may not want to go to treatment, it is likely to be more helpful than doing nothing.

Next, **stay on top of the patient's attendance**. If the patient **misses a session**, they should be telephoned immediately to explore why they have missed the appointment and to reinstate with them a plan to return to treatment. Discuss real barriers to care and help the patient problem solve any barriers. Many times depressed patients lack assertiveness skills and, therefore, are unable to ask partners, bosses, etc. to give them the time and support they need to get into treatment. Reassuring them that they are worth the time and energy to get into treatment is very important. Practicing assertiveness skills in asking for help is particularly useful. Ask them to take the part of the unsupportive boss and you take their role and help them assertively ask for time off for treatment.

Finally, the relationship with the provider is an essential ingredient in keeping people in treatment. Ask about the relationship throughout treatment, assessing how the patient is feeling about you and the treatment. Make it clear to them that you are willing to discuss any problems that may arise regarding treatment.

Adherence to a medication schedule

As a primary care or mental health specialty clinician, you may know how difficult it is to get patients to complete even a simple course of antibiotics, let alone take medication for a chronic illness such as depression every single day. Figure 2.11 presents some of the more common reasons for poor patient adherence to a medication schedule and suggestions for improving adherence.

Strategies for Coping with Poor Adherence

- Try to be open to the patient's perspective and concerns.
- Examine possible barriers to adherence.
- For patients on medications, weekly pill boxes (i.e., those with spaces for each dose labeled by day of the week) are the best practical aid for patients in monitoring and ensuring their own compliance.
- Work with the patient to find a reasonable solution.

Reasons for Stopping or Not Taking Medication	Treatment Strategies
Patient does not feel understood or supported.	<ol style="list-style-type: none"> 1. Improve the therapeutic alliance: <ul style="list-style-type: none"> • express interest, empathy, and support • frame the treatment as a cooperative effort • maintain continuity of providers • try to understand the patient's perspective on the problem • address the patient's concerns and fears directly
Lack of team effort: Patient takes a passive role.	<ol style="list-style-type: none"> 1. Describe treatment as a team effort: <ul style="list-style-type: none"> • the physician brings experience with depression and its treatment • the patient brings experience with his/her own body and case of depression • the patient and the physician work together to reduce the patient's depression and improve functioning 2. The physician will help, but the patient must take an active role in getting better.
The patient does not accept the diagnosis of depression and/or has a different explanatory model.	<ol style="list-style-type: none"> 1. Explore and appreciate the patient's perspective on the problem. 2. Postpone treatment if necessary; raise possibility of treatment at a later date.

Figure 2.11 - Treatment Strategies for Adherence to Medication Schedule

Reasons for Stopping or Not Taking Medication	Treatment Strategies
<p>The patient does not understand the rationale for antidepressant treatment.</p>	<ol style="list-style-type: none"> 1. Explore the patient's 'explanatory model.' 2. Give further information about antidepressant treatment. 3. Give written materials and instructions. 4. Address concerns about antidepressants. 5. Explain the target symptoms and the mechanism of antidepressants.
<p>Patient still has concerns about the medication/is ambivalent or resistant.</p>	<ol style="list-style-type: none"> 1. Explore reasons for ambivalence or resistance. 2. Address common fears related to antidepressant medications: <ul style="list-style-type: none"> • <i>addiction</i> - antidepressants are not addicting • <i>change in personality</i> - antidepressants do not cause lasting changes in personality. • <i>stigma</i> - rehearse things a patient can say to explain the diagnosis to family, friends, employers, and others. • <i>change in weight</i> - tricyclic antidepressants can cause mild weight gain. Keep an eye open for this or consider SSRIs if the patient is very concerned about this. • <i>dependence on antidepressants or the physician</i> - patients will not become dependent on the treatment. 3. Identify and address 'psychological barriers': <ul style="list-style-type: none"> • <i>negative thinking</i> ('I'll never get better'). • <i>paranoia</i> (the patient may be afraid the physician is trying to harm or take advantage of him or her) • <i>low self-esteem/guilt</i> ('I deserve this'). • <i>loss of sick role</i> may be threatening to the patient. 4. Outline expected improvements: sleep and appetite, concentration, energy, attitude/outlook, level of functioning

Figure 2.11 - Treatment Strategies for Adherence to Medication Schedule (cont.)

Reasons for Stopping or Not Taking Medication	Treatment Strategies
Patient has side effects.	<ol style="list-style-type: none"> 1. Anticipate common or serious side effects. 2. Side effects are not a disaster - they tell us that the drug is in the body and having an effect. 3. Educate the patient about side effects and their management. 4. Encourage patient to wait - many side effects will resolve by themselves. The body adapts with time. 5. Reduce dose. It may be a matter of finding the right dose. 6. Treat side effects. 7. Consider checking medication levels and think about possible drug interactions. 8. Consider changing medication/treatment.
Patient forgets to take the medication.	<ol style="list-style-type: none"> 1. Frequent telephone check-ins or clinic visits. 2. Enlist help of family members (to remind the patient or administer the medications). 3. Mechanical aids.
Patient 'runs out of pills.'	<ol style="list-style-type: none"> 1. Track medication use with pharmacy records and pill counts. 2. More frequent clinic and telephone follow-ups.
Treatment regimen is too complex.	<ol style="list-style-type: none"> 1. Simplify treatment regimen. 2. Also consider other medications the patient is taking. 3. Match the timing of medications to the patient's daily schedule. 4. Use large, clear labels, and provide instructions. 5. Use mechanical aids such as charts, pill boxes.
Patient is concerned about high cost of medication.	<ol style="list-style-type: none"> 1. Discuss the 'costs' of not treating depression. 2. Compare the cost of other treatments. 3. Consider changing to a cheaper medication.

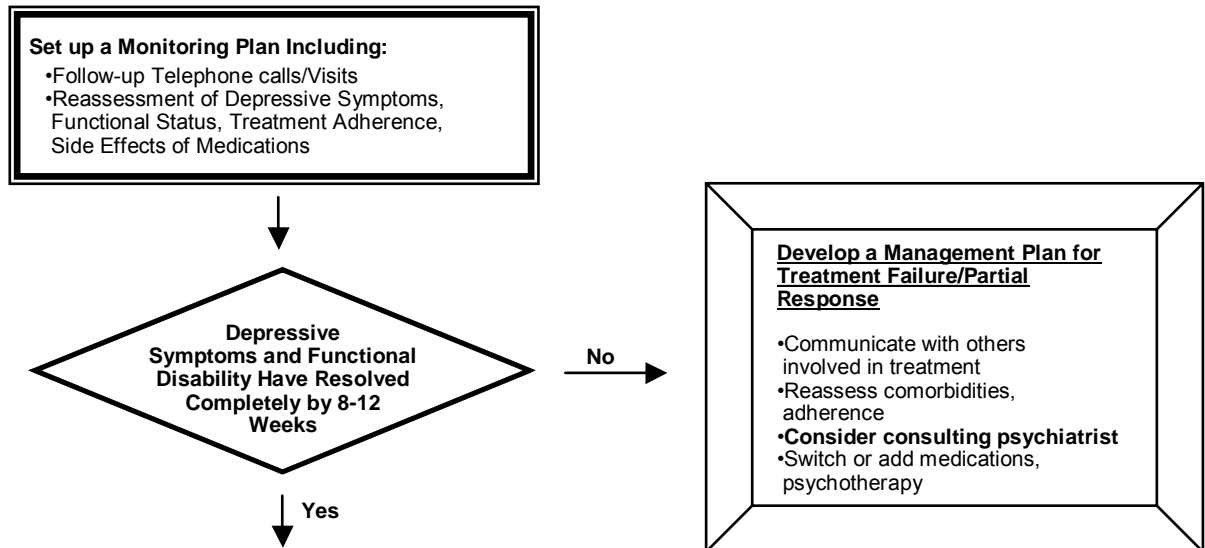
Figure 2.11 - Treatment Strategies for Adherence to Medication Schedule (*cont.*)

Reasons for Stopping or Not Taking Medication	Treatment Strategies
<p>Friends or family recommend stopping treatment or are not supportive.</p>	<ol style="list-style-type: none"> 1. Explore reasons, including personal or friends' prior exposure to antidepressants or psychiatric treatment. 2. Educate family members and enlist their support. 3. Help the patient deal with the stigma associated with depression and antidepressant treatment. 4. Offer non-stigmatizing analogies to other diseases (e.g., diabetes, arthritis, hypertension).
<p>Patient feels that the treatment is not working.</p>	<ol style="list-style-type: none"> 1. Explore medication compliance (make sure they are taking the medication correctly). Consider drug levels. 2. Reevaluate diagnosis. Are there other complicating factors such as substance abuse or personality disorder? 3. Address resistance to treatment or to getting better (see above). 4. Consider increasing dose, changing the medication, increasing frequency of follow-ups, switching to or adding psychotherapy. 5. Consider psychiatric consultation.
<p>Patient is 'feeling better' and wants to stop medications.</p>	<ol style="list-style-type: none"> 1. Educate about the risk of relapse and importance of maintenance treatment. REMEMBER: There is a high rate of relapse if patients discontinue the medication immediately after they are better. 2. Use the 'therapeutic leverage' from an initial positive response to an antidepressant: explain that the improvement is due to the medication and that it must continue to maintain the improvement.

Figure 2.11 - Treatment Strategies for Adherence to Medication Schedule (*cont.*)

Step 4

MONITOR THERAPY AND SYMPTOMS DURING THE ACUTE PHASE



Whether the patient is started on antidepressants or psychotherapy, it is important that the primary care clinician set up a monitoring plan for acute phase treatment. For patients in psychotherapy, this may only require a telephone check after two weeks of therapy and after completion of therapy. For patients being followed in primary care on antidepressants, regular follow-up is necessary.



Follow-up Visits: Keeping Track of Depression

REMEMBER: Between 20 and 50% of patients started on antidepressants **STOP TAKING** their medication during the first month of treatment. It is therefore important to closely monitor the patient's clinical status and side effects, and to address barriers to effective treatment (see Figure 2.12).

Recommended Schedule for Follow-up Visits

Patients should be seen according to the following schedule, or more often, as needed. They should be assessed at the end of the eight-week period.

<u>Interval</u>	<u>Action</u>
1 week	Telephone follow-up
2 weeks	Clinic visit
3 weeks	Telephone follow-up
4 weeks	Clinic visit
6 weeks	Clinic visit or telephone follow-up
8 weeks	Clinic visit

Figure 2.12 - Follow-up Visit Schedule

Structured Telephone Visits

If patients do not come to scheduled follow-up visits, they should receive a 'telephone visit' that follows the same format as the follow-up visit.

Format for Follow-up Visits

During follow-up visits, physicians should assess changes in symptoms, functioning, side effects, and other problems (Figure 2.13). Here's a suggested protocol for making your assessment.

1. Review Depressive Symptoms

Review DSM IV checklist from 'Personal Plan.'

- Ask the patient to complete the PHQ-9 to determine severity of symptoms (include questions on sleep and weight change).

Patient Outcomes (after 8-week follow-up period)

Patient is Doing Well (in remission)

- See patient every 3 months

Patient Still Has Significant Symptoms

- Change treatment
- Change or augment medication
- Add psychotherapy
- Obtain psychiatric consultation

Figure 2.13 - Patient Outcomes After 8-Week Follow-up Visit

2. Review Level of Functioning

- Ask about physical, social, and role functioning.
- De-emphasize symptoms, illness behavior, and disability. Encourage patients to return to their previous levels of functioning.

3. Review Medication Compliance

- Ask if patient is taking the medication regularly.
 - a. Are you taking the medication?
 - b. Do you ever forget to take the medication?
 - c. When you feel better, do you forget to take the medication?
- Ask for reasons of noncompliance.
 - a. What makes it difficult for you to take the medication?
 - b. When do you forget to take the medication?

4. Review Side Effects

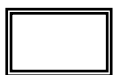
- Review common and serious side effects (use the 'Your Personal Plan').
- Ask about other problems or side effects that patients may attribute to the medication.
- Encourage the patient to continue taking medications, since many side effects will resolve with time. If side effects are serious or hard to tolerate, consider lowering the dose of the medication, changing the medication, or using specific treatments for side effects.

5. Ask About Other Patient Concerns and Encourage Continued Treatment

- Address concerns about depression or its treatment.
- Help patients 'problem-solve' around difficult issues.
- Express confidence that the treatment will work.
- Praise patients for any improvements or efforts of successful problem-solving.
- Address concerns about the therapeutic (doctor-patient) relationship.

6. Make Necessary Changes in the Treatment Plan

- Consider changes in the dose, the timing, or the type of antidepressant.
- Consider adding psychotherapy.
- Consider increasing the number of follow-up appointments.
- Consider getting a psychiatric consultation.



Reassessment of Depressive Symptoms Using the PHQ-9 (Patient Health Questionnaire)

This is a 9-item self-rating scale that can be easily administered in the primary care setting. It can help you track the patient's depressive symptoms over time.

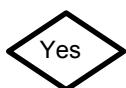
The following range of scores was taken from a study of depressed patients in family practice:

<u>Scores</u>	<u>Degree of Depression</u>
0-4	None or minimal
5-9	Mild
10-19	Moderate
20-27	Severe

1. A reasonable goal for treating a depressed patient would be to have the score on the PHQ-9 **decrease by at least half and below a score of 5**.
2. If a patient's PHQ-9 scores are not improving or are worsening, this should be a clear indication that:
 - The patient may not be responding to treatment
 - There may be additional stressors or problems in the patient's life.
3. Poor PHQ-9 scores should lead you to one or more of the following actions:
 - Reconsider the diagnosis
 - Change the treatment
 - Discuss the case with a psychiatric consultant



If depressive symptoms have completely resolved by the 8-week reassessment, the patient can begin continuation therapy.



If depressive symptoms persist after 4-8 weeks, consider that the patients may have a partial response to therapy or be a treatment failure.

If the patient is on medication, consider that:

- the dose may be too low
- a different medication may be needed
- adherence may be a problem
- there may be complicating psychosocial factors
 - Review possible causes for the poor treatment response (Figure 2.14)
 - Consider a psychiatric consultation and referral to psychotherapy

Be aggressive about changing medications that do not result in some improvement after 4 weeks or major improvement after 8 weeks. In general, switching to a medication with a different mechanism of action (e.g., a different SSRI or a different antidepressant such as a tricyclic) is indicated.

Troubleshooting: What to do if your patients don't get better

Common problems	Possible Solutions
1. Wrong diagnosis	<ol style="list-style-type: none"> 1. Reconsider diagnosis and differential diagnosis. 2. Consider psychiatric consultation.
2. Insufficient dose	Increase dose.
3. Insufficient length of treatment (Remember: it may take 6-8 weeks for patients to respond to treatment.)	Support and encourage patient to stay on medication for a full trial (6 to 8 weeks) at a therapeutic dose.
4. Problems with adherence	<ol style="list-style-type: none"> 1. Try to understand the patient's perspective and concerns. 2. Address barriers to adherence and problem-solve together. 3. Consider serum drug levels (only useful with tricyclic antidepressants [see Figure 2.15]).
5. Side effects. (Remember: side effects may be physiological or psychological)	<ol style="list-style-type: none"> 1. Encourage patient to give medications time to work. 2. Reassure patient that the body often gets used to medications with time. 3. Reduce dose. 4. Treat side effect. 5. Change medication.
6. Other complicating factors <ol style="list-style-type: none"> a. Psychosocial stressors/barriers b. Medical problems/medications c. Psychological barriers (low self-esteem, guilt, loss of sick role is threatening) d. Active substance abuse e. Other psychiatric problems 	<ol style="list-style-type: none"> 1. Address problems directly. 2. Consider psychiatric consultation. 3. Consider adding psychotherapy.
7. Treatment is not effective (despite adequate trial of medication at adequate dose)	<ol style="list-style-type: none"> 1. Change medication 2. Psychiatric consultation for difficult-to-treat depression.

Figure 2.14 - Troubleshooting for Patients Who Continue to Be Symptomatic

When to Check Serum Antidepressant Level

Drug level checks should **not** be on a routine basis.

- There are no suggested blood levels for selective serotonin reuptake inhibitors.

Good reasons to check serum antidepressant levels are:

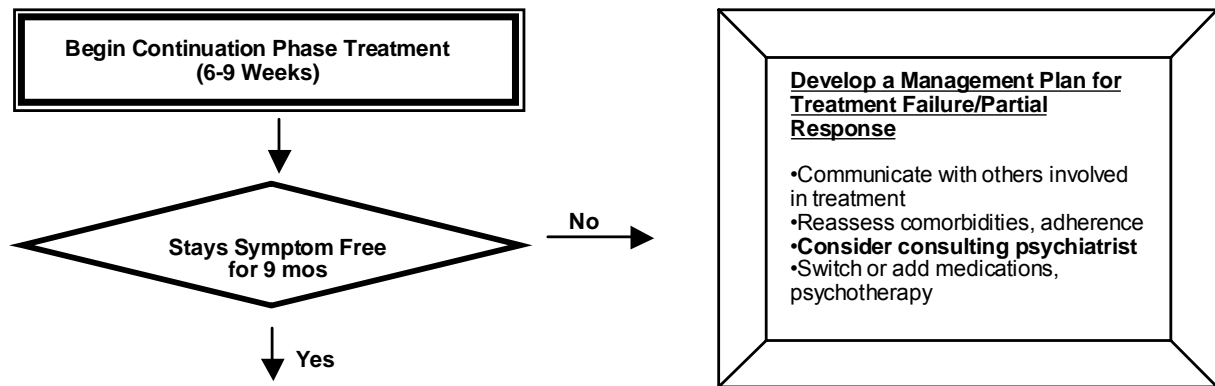
- No results after 4 weeks on a therapeutic dose: 100 mg of nortriptyline or 250 mg of desipramine.
- Significant side effects on low doses (<75 mg of nortriptyline, <150 mg of other TCAs).
- Suggested blood levels for tricyclic antidepressants (ng/ml) are:

Nortriptyline	Desipramine
50-150	150-300

Figure 2.15 - Serum Antidepressant Levels

Step 5

MONITOR THERAPY AND SYMPTOMS DURING CONTINUATION PHASE



Whether the patient is on medication or psychotherapy, it is important to continue to monitor the patient during the continuation phase of therapy. Patients who have begun on medications should stay on them through the continuation phase (approximately 9 months).

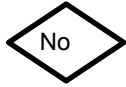
STRONG RECOMMENDATION

Continue the medication for 6 to 9 months after the patient is free of symptoms.



If patient stays *symptom free* for six months through the continuation phase and if there is no history of prior depressions and the patient is in complete remission, taper the medication off

- All antidepressants except for fluoxetine (Prozac) should be tapered off over 2 weeks. Prozac can be stopped abruptly because of its long half-life.
- Schedule a follow-up visit within 4 to 8 weeks after stopping antidepressants to spot early recurrences.
- Educate patients and significant others about early signs of recurrence and encourage them to talk to their physicians when they notice such early signs of depression
- Make a relapse prevention plan with the patient (see Relapse Prevention Form).
- Patients who meet the criteria for maintenance treatment should be continued on the full dose of the medication that was effective, for at least 2 years (see Step 6)



If Patient Relapses

Even with appropriate treatment, patients with major depression may experience a relapse. Below are some pointers on how to help a patient who is experiencing a return of symptoms.

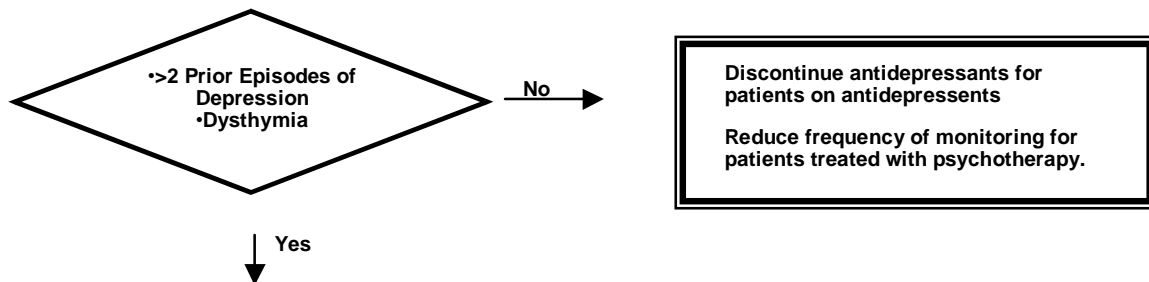
- Assess compliance with maintenance treatment. Consider serum tricyclic level if patient is on TCAs.
- Examine for new stressors (including psychosocial stressors).
- Restart treatment at the last effective dose of antidepressant or consider an increase in dose.
- Consider adding psychotherapy.
- Refer for psychiatric consultation if patient looks 'treatment resistant.'

Length of Treatment/Preventing of Relapse

REMEMBER: Patients who have had two or more prior episodes of depression or who have concurrent dysthymia (chronic low-grade depression) are at high risk for recurrence of depression. **They should be encouraged to stay on maintenance medication for at least 2 years after making a complete recovery.** If such patients stop treatment, they should be followed closely for an early detection of recurrence (see Step 6).

Step 6

EVALUATE NEED FOR MAINTENANCE THERAPY



Maintenance Treatment Indications For Medication:

REMEMBER: Patients who have had two or more prior episodes of depression or who have concurrent dysthymia (chronic low grade depression plus major depression) are at high risk for recurrence. They should be encouraged to stay on **maintenance medication for at least 2 years after making a complete recovery**. If patients stop treatment, follow them closely to quickly detect recurrence.

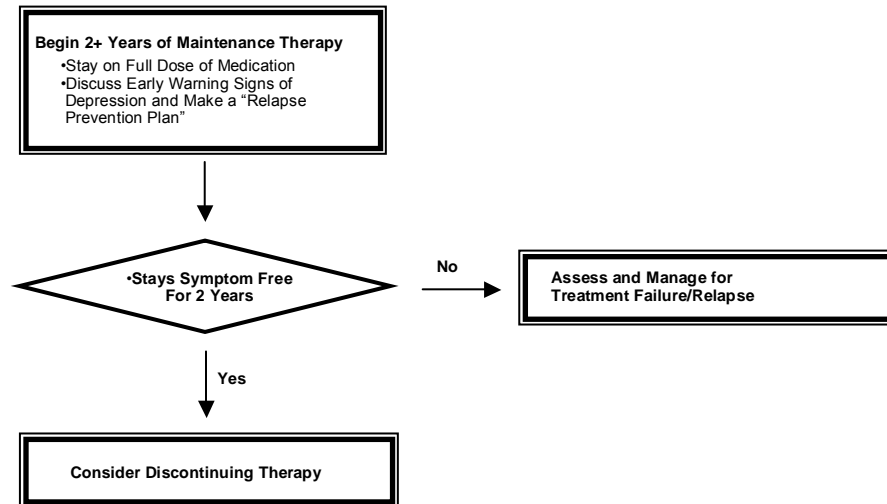
Maintain Treatment for More Than 9 Months, IF:

- 2 or more prior episodes of depression
- 1 prior episode of major depression and a strong family history of depression
- 1 prior episode of major depression before age 20
- Concurrent dysthymia with major depression (chronic low-grade depression for greater than two years) with major depression

Review the "Your Personal Plan: Relapse Prevention" (Appendix I) with the patient.

Step 7

MONITOR THERAPY AND SYMPTOMS FOR PATIENTS ON MAINTENANCE THERAPY



Patients at Risk for Recurrence Should:

- Receive relapse prevention education to help them learn more about ways to prevent recurrence of depression.
- Continue on the **full dose of antidepressants for at least 2 years** after they have made a complete recovery
- Be **followed every 3 months** to monitor for compliance with maintenance medication and recurrence of depressive symptoms.
- Be asked to think about '**early warning signs**' of depression that may help them or family members recognize a recurrence of depression.
- Have a '**relapse prevention plan**' that will help them and their family members know what to do if such symptoms recur (see "Your Personal Plan: Relapse Prevention," Appendix I).

APPENDICES

- A. Dosage Levels for COMMONLY USED Antidepressants
- B. Drug Interactions
- C. Individual Medication Profiles
- D. PHQ-9
- E. Your Personal Plan: Medications
- F. Your Personal Plan: Psychotherapy
- G. Your Personal Plan: Watchful Waiting
- H. Your Personal Plan: Relapse Prevention
- I. References

Appendix A

Dosage Levels for COMMONLY USED Antidepressants

Serotonin reuptake inhibitors (SSRIs)

(doses are in mg)

1. Starting dose *Fluoxetine* **20** (10 in elderly and patients with panic disorder)
 Sertraline **50** (25 in elderly and in patients with panic disorder)
 Paroxetine **20** (10 in elderly and in patients with panic disorder)
 ParoxetineCR **25** (12.5 in elderly and in patients with panic disorder)
 Citalopram **20** (10 in elderly and in patients with panic disorder)
 Escitalopram **10** (10 in elderly and in patients with panic disorder)
2. After 1 week If patient is having significant problems/side effects:
 Temporarily decrease dose or change to a secondary amine tricyclic if lower dose is not tolerated.
3. After 2-3 weeks If patient has only a partial or no response:
 Fluoxetine: continue at **20** mg or increase to 20 mg if patient was started at a lower dose.
 Sertraline: continue at **50** mg, or consider increase to **100** mg (50 mg in elderly and patients with panic disorder)
 Paroxetine: continue at **20** mg, or consider increase to 30 mg (20 mg in elderly and in patients with panic disorder)
 ParoxetineCR: continue at **25** mg, or consider increase to 37.5 mg (25 mg in elderly and in patients with panic disorder)
 Citalopram: continue at **20** mg, or consider increase to 30 mg (20 mg in elderly and in patients with panic disorder)
 Escitalopram: continue at **20** mg, or consider increase to 30 mg (20 mg in elderly and in patients with panic disorder)
4. After 4-6 weeks If patient has a partial or no response:
 Fluoxetine: consider increase to **40** mg
 Sertraline: consider increase to **150** mg
 Paroxetine: consider increase to **40** mg
 Citalopram: consider increase to **40** mg
 Escitalopram: consider increase to **40** mg
5. After 6-8 weeks If patient has no response:
 Discontinue and start another antidepressant or get consultation.

Tricyclic Antidepressants (TCAs)

(doses are in mg)

1. Starting dose *Nortriptyline* **25** (10 in elderly and in patients with panic disorder)
Desipramine **50** (25 in elderly and in patients with panic disorder)
2. First 2 - 3 weeks Increase dose every 4 days (or week in elderly), as tolerated. Target doses are:
Nortriptyline **50 -100**
Desipramine **100 – 200**

If patient does not tolerate side effects after one to two weeks at sub-therapeutic doses, taper drug over 4 days and change to an SSRI.

3. After 4-6 weeks Only **partial or no response**:
Check serum drug level and adjust dose accordingly.
4. After 6-8 weeks **No response at therapeutic serum level**:
Taper TCA over 4 days and start another antidepressant or get a psychiatric consultation.

Other Antidepressants

(doses are in mg)

1. Starting dose *Bupropion* **100** twice daily for three days, then increase to three times daily (75 in elderly)
BupropionSR **150** for three days, then increase to twice daily (100 in elderly)
BupropionXL **150** for three days, then increase to 300
Venlafaxine **75** (25 in elderly, increase to 25 twice daily after four days)
VenlafaxineXR **75** (37.5 in elderly, then 75 in one week)
Duloxetine **30** twice daily (30 in elderly)
Mirtazapine **15** (7.5 in elderly and in patients with panic disorder)
2. After 1 week If patient is having significant problems/side effects:
Temporarily decrease dose or change to another antidepressant if lower dose is not tolerated.
3. After 2-3 weeks If patient has only a partial or no response:
Bupropion (SR/XL) gradually increase to maximum of 450 mg/day
Venlafaxine: increase by 75 mg/day every four days to a maximum of 250 mg/day (25 mg twice a day every week in elderly)
VenlafaxineXR: increase by 75 mg/day every four days to a maximum of 225 mg/day (75 mg every two weeks in elderly)
Mirtazapine: increase 15 mg every one to two weeks (every three weeks in elderly)
5. After 6-8 weeks If patient has no response:
Discontinue and start another antidepressant or get consultation.

Appendix B

Drug Interactions

Below are **some** of the more common or troublesome drug-drug interactions involving antidepressant medications. This list is not complete, however, and if you have questions about drug interactions, you should consult other references or a clinical pharmacist. **Particularly with SSRIs, a good rule of thumb is to follow levels of those drugs with a narrow therapeutic window (e.g., digoxin, anticonvulsants, warfarin, TCAs) as you increase the dose of antidepressants.**

Table B.1 - Selective Serotonin Reuptake Inhibitors

Selective Serotonin Reuptake Inhibitors (SSRIs)

(fluoxetine, sertraline, paroxetine, citalopram, escitalopram)

SSRIs can raise the plasma concentrations of

- Drugs *metabolized* by the P450 liver isoenzymes (see table on next page)
- Tricyclic antidepressants (TCAs) and trazodone
- Bupropion (risk of seizures)
- Ketobenzodiazepines (i.e. diazepam)
- Some triazolobenzodiazepines (i.e., alprazolam)
- Antipsychotics: increased risk for EPS -(tremor, stiffness, restlessness)
- **Anticonvulsants**
- **Antiarrhythmics (propafenone, flecainide, encainide)**
- **Digoxin, digitoxin**
- **Diuretics – may contribute to hyponatremia (via SIADH)**
- **Beta blockers** (metoprolol, propranolol): may cause bradycardia and heart block. Consider atenolol instead.
- **Warfarin: may cause increased bleeding time**
- **theophylline**

Cimetidine can raise the plasma levels of SSRIs. Consider using ranitidine or famotidine instead.

SSRIs can interact with several other classes of drugs, causing potentially fatal SEROTONIN SYNDROME. DO NOT CO-ADMINISTER THESE DRUGS: MAOIs, tryptophan, sumatriptan, dihydroergotamine, meperidine, dextromethorphan

Table B.2 - Tricyclic and Other Antidepressants

Tricyclic Antidepressants (TCAs)

(nortriptyline, desipramine)

Pharmacodynamic Interactions

- TCAs can potentiate **anticholinergic side effects** of benztropine, neuroleptics, digitalis and cause confusion
- TCAs can potentiate antihistaminic side effects of diphenhydramine and other antihistamines and cause sedation and weight gain.
- TCAs can potentiate **anti-alpha-1 adrenergic** effects of prazosin and cause hypotension.
- TCAs can potentiate **anti-arrhythmic effects** of quinidine, procainamide, disopyramide, and cause heart block.
- TCAs can potentiate the sedating side effects of alcohol and other sedatives.
- TCAs can inhibit the **antihypertensive action** of clonidine.
- TCAs can potentiate sulfonylureas and cause hypoglycemia
- TCAs can increase bleeding time with warfarin
- TCAs in combination with MAOIs (monoamine oxidase inhibitors) can cause a potentially fatal serotonin syndrome. **DO NOT CO-ADMINISTER TCAs with MAOIs**

Pharmacokinetic Interactions

- TCAs can induce the metabolism of valproic acid
- TCAs can have their metabolism induced/concentration lowered by
 - barbiturates
 - carbamazepine
 - valproic acid
 - rifampin
 - cholestyramine
- TCAs can have their metabolism inhibited/concentration increased by:
 - cimetidine (consider using famotidine or ranitidine instead)
 - antipsychotics
 - SSRIs
 - imidazole antifungals such as ketoconazole

Other Antidepressants

(bupropion, venlafaxine, duloxetine, mirtazapine)

Bupropion

- Antipsychotics – may increase the likelihood of EPS
- Levodopa and other dopaminergic Parkinson's agents – may increase agitation, confusion, hallucinations, nausea and vomiting
- TCAs – may increase the risk of seizures

Duloxetine

- Antipsychotics – may increase the likelihood of EPS
- Bupropion – may increase the risk of seizures
- TCAs – may increase the likelihood of arrhythmias and anticholinergic symptoms

Mirtazapine

- May potentiate effect of benzodiazepines

Venlafaxine

- Similar to SSRIs

Table B.3 P450 Drug Interactions

P450 Isoenzyme System	Common Substrates (may be increased by inhibitors)		Antidepressant Major inhibitors
	Antidepressant Medications	Other Medications	
1A2	Duloxetine, fluvoxamine, mianserin, mirtazapine, modafinil, tertiary tricyclic antidepressants (TCAs).	Propranolol, R-warfarin, tacrine, theophylline	Fluoxetine, fluvoxamine
2B6	Bupropion	Cyclophosphamide, efavirenz, ifosfamide, methadone	Fluoxetine, fluvoxamine
2C9/19	Citalopram, fluoxetine, mirtazapine, tertiary TCAs	Diazepam, NSAIDs, omeprazole, phenytoin, propranolol, S-warfarin, torsemide	Fluoxetine, fluvoxamine, modafinil, paroxetine, venlafaxine
2D6	Citalopram, duloxetine, escitalopram, fluoxetine, fluvoxamine, mianserin, mirtazapine, nefazodone, paroxetine, trazadone, venlafaxine, secondary and tertiary TCAs	Antipsychotics: haloperidol, perphenazine, risperidone, thioridazine Beta blockers: metoprolol, penbutolol, propranolol, timolol Narcotics: codeine, tramadol	Bupropion, duloxetine, fluoxetine, paroxetine
3A4	Citalopram, escitalopram, fluvoxamine, mianserin, mirtazapine, modafinil, nefazodone, sertraline, trazodone, venlafaxine, tertiary TCAs	Benzodiazepines, calcium channel blockers, carbamazepine, dexamethasone, erythromycin, ethinyl estradiol, glyburide, ketoconazole, lovastatin, testosterone, protease inhibitors	Fluoxetine, fluvoxamine, nefazodone,

Secondary TCAs include desipramine and nortriptyline, tertiary TCAs include amitriptyline and imipramine.

Appendix C

Individual Medication Profiles

Suicidality and Antidepressant Drugs

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (and other psychiatric disorders). Any use of antidepressants in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

Fluoxetine (Prozac)

1. Start at 20 mg po qam (10 mg po qam in patients with panic disorder or patients > 60)
2. If patient has significant side effects, consider lowering the dose to 5 or 10 mg po qam or treating side effects (see below).
3. Continue 20 mg dose for 4 weeks. If no response, increase dose by 20 mg every 4 weeks.
4. If no response after 4 weeks at 80 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

WHAT TO DO IF PATIENTS DEVELOP SIDE EFFECTS?

1. WAIT - many side effects will resolve with time.
2. Reduce dose
3. Consider specific treatments as suggested below
4. Consider changing to a TCA

SIDE EFFECTS	TREATMENT
Nausea, diarrhea	<ol style="list-style-type: none">1. Take medication with meals2. Try antacids3. This often subsides after a few days
Anxiety, agitation, jitteriness	<ol style="list-style-type: none">1. Support and wait2. Consider the short term use of a benzodiazepine (i.e., lorazepam 0.5 - 1 mg po tid prn – do not use for longer than 6 weeks)3. Consider propranolol 10-20 mg po tid
Insomnia	<ol style="list-style-type: none">1. Make sure medication is taken in the morning2. Consider low dose trazodone (50-100 mg po qhs)
Sexual dysfunction (delayed ejaculation in men, anorgasmia in women)	<ol style="list-style-type: none">1. Try cyproheptadine 4-8 mg po 0.5-2 hours before intercourse2. If this is a significant problem, consider specialty consultation - recommendation may be to change to bupropion or nefazodone.
Fine tremor	<ol style="list-style-type: none">1. Try a temporary dose reduction2. Try a low dose beta blocker (i.e., propranolol 10-20 mg po tid)

Paroxetine (Paxil, Paxil CR)

1. Start at 20 mg po qam (25 mg for Paxil CR). For patients with panic disorder or patients > 60, 10 mg po qam (12.5 mg for Paxil CR)
2. If patient has significant side effects, consider lowering the dose to 10 mg po qam or treating side effects (see below).
3. Continue 20 (25 for Paxil CR) mg dose for 2 weeks. If no response, increase dose by 10 (12.5 for Paxil CR) mg every 2 weeks. Go slower (i.e., stay at 20, 30, or 40 mg) if side effects are bothersome.
4. If no response after 4 weeks at 50 (62.5 for Paxil CR) mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Nausea, diarrhea	1. Take medication with meals 2. Try antacids 3. This often subsides after a few days
Anxiety, agitation, jitteriness	1. Support and wait 2. Consider the short term use of a benzodiazepine (i.e., lorazepam 0.5 - 1 mg po tid prn - do not use for longer than 6 weeks) 3. Consider propranolol 10-20 mg po tid
Insomnia	1. Make sure medication is taken in the morning 2. Consider low dose trazodone (50-100 mg po qhs)
Sexual dysfunction (delayed ejaculation in men, anorgasmia in women)	1. Try cyproheptadine 4-8 mg po 0.5-2 hours before intercourse 2. If this is a significant problem, consider specialty consultation - recommendation may be to change to bupropion or nefazadone .
Fine tremor	1. Try a temporary dose reduction 2. Try a low dose beta blocker (i.e., propranolol 10-20 mg po tid)
Sedation	Change medication to qhs dosing

Sertraline (Zoloft)

1. Start at 50 mg po qam (25 mg po qam in patients with panic disorder or patients > 60)
2. If patient has significant side effects, consider lowering the dose to 25 mg po qam or treating side effects (see below).
3. Continue 50 (25) mg dose for 2 weeks. If no response, increase dose by 50 mg every 1-2 weeks up to 150 mg. Go slower (i.e., stay at 50 or 100 mg) if side effects are bothersome.
4. If no response after 4 weeks at 150 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Nausea, diarrhea	<ol style="list-style-type: none">1. Take medication with meals2. Try antacids3. This often subsides after a few days
Anxiety, agitation, jitteriness	<ol style="list-style-type: none">1. Support and wait2. Consider the short term use of a benzodiazepine (i.e., lorazepam 0.5 - 1 mg po tid prn - do not use for longer than 6 weeks)3. Consider propranolol 10-20 mg po tid
Insomnia	<ol style="list-style-type: none">1. Make sure medication is taken in the morning2. Consider low dose trazodone (50-100 mg po qhs)
Sexual dysfunction (delayed ejaculation in men, anorgasmia in women)	<ol style="list-style-type: none">1. Try cyproheptadine 4-8 mg po 0.5-2 hours before intercourse.2. If this is a significant problem, consider specialty consultation - recommendation may be to change to bupropion or nefazadone.
Fine tremor	<ol style="list-style-type: none">1. Try a temporary dose reduction2. Try a low dose beta blocker (i.e., propranolol 10-20 mg po tid)

Citalopram (Celexa)

1. Start at 20 mg po qam (10 mg po qam in patients with panic disorder or patients > 60)
2. If patient has significant side effects, consider lowering the dose to 10 mg po qam or treating side effects (see below).
3. Continue 20 (10) mg dose for 2 weeks. If no response, increase dose by 10 mg every 2 weeks up to 60 mg. Go slower (i.e., stay at 20 or 30 mg) if side effects are bothersome.
4. If no response after 4 weeks at 60 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Nausea, diarrhea	1. Take medication with meals 2. Try antacids 3. This often subsides after a few days
Insomnia	1. Make sure medication is taken in the morning 2. Consider low dose trazodone (50-100 mg po qhs)
Sedation	Change medication to qhs dosing
Sexual dysfunction (delayed ejaculation in men, anorgasmia in women)	1. Try cyproheptadine 4-8 mg po 0.5-2 hours before intercourse. 2. If this is a significant problem, consider specialty consultation - recommendation may be to change to bupropion or nefazadone .

Escitalopram (Lexapro)

1. Start at 10 mg po qam (10 mg po qam in patients with panic disorder or patients > 60)
2. If patient has significant side effects, consider lowering the dose to 5 mg po qam or treating side effects (see below).
3. Continue 10 mg dose for 2 weeks. If no response, increase dose by 10 mg every 2 weeks up to 40 mg. Go slower (i.e., stay at 10 or 20 mg) if side effects are bothersome.
4. If no response after 4 weeks at 40 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Nausea, diarrhea	1. Take medication with meals 2. Try antacids 3. This often subsides after a few days
Insomnia	1. Make sure medication is taken in the morning 2. Consider low dose trazodone (50-100 mg po qhs)
Sedation	Change medication to qhs dosing

Nortriptyline (Pamelor, Aventyl)

Relative contraindications:

1st or 2nd degree heart block, bundle branch block, recent myocardial infarction « 6 weeks), urinary retention, narrow-angle glaucoma.

1. Obtain EKG in patients with heart disease or in patients > 50 to rule out serious conduction deficit.
2. Start at 25mg po qhs.
3. Increase dose by 25 mg every 4 days (10 mg every 4 days in patients > 60) until bothersome side effects, good response, or dose reaches 100 mg po qhs. Go slower in older patients or if patient has side effects. If patient has persistent side effects, reduce dose until the medication is relatively well tolerated.
4. Consider serum level if patient is not improved at 100 mg po qhs or if patient has severe side effects at doses below 75 mg po qhs. Target level is 50 - 150 ng/ml.
5. Treat side effects or change to an SSRI if patient cannot tolerate side effects at the minimal effective dose or if there is no response after 6 weeks at a therapeutic dose.

WHAT TO DO IF PATIENTS DEVELOP SIDE EFFECTS?

1. WAIT - many side effects will resolve with time.
2. Reduce dose
3. Consider specific treatments as suggested below
4. Consider changing to an SSRI

SIDE EFFECTS	SPECIFIC TREATMENTS
Dry mouth	Try sugarless gum or candy
Dry eyes	Try artificial tears
Blurred vision	Try pilocarpine eye drops (1 % soln.) tid - qid
Constipation	1. Exercise 2. Increase fluid and fiber intake 3. Stool softeners 4. Bulk laxatives: Metamucil, psyllium
Urinary retention (especially in men with enlarged prostate glands)	Consider a trial of bethanechol 10-30 mg tid
Agitation, jitteriness	1. Short term use of Lorazepam 0.5 mg po tid (do not use for longer than 6 weeks) 2. Consider propranolol 10-20 mg po tid
Insomnia	1. Consider low dose trazodone (50mg po qhs) 2. Consider short term use of lorazepam 0.5 to 1 mg po qhs (do not use for longer than 4 weeks)
Sedation	1. Make sure patient takes medication at bedtime 2. Consider caffeine prn
Orthostatic hypotension/dizziness	1. Arise slowly from a lying or sitting position 2. Consider support hose
Palpitations/conduction delays/arrhythmias	1. Check EKG 2. Stop TCA if significant arrhythmias develop
Weight gain	1. Rule out edema 2. Encourage regular exercise 3. Consider change to an SSRI

Desipramine (Norpramin)

Relative contraindications:

1st and 2nd degree heart block, bundle branch block, recent myocardial infarction (< 6 weeks), urinary retention, narrow-angle glaucoma

1. Obtain EKG in patients with heart disease or in patients > 50: rule out serious conduction deficit
2. Start at 50 mg po qam (25mg po qhs in patients > 60)
3. Increase dose by 25 mg every 4 days until bothersome side effects, good response, or dose reaches 300 (150 in elderly) mg po qhs. Go slower if patient has side effects. Switch dose to bedtime if the patient has trouble with daytime sedation.
4. Consider serum level if patient not improved at 300 (150 in elderly) mg po qhs or if patient develops severe side effects at low doses. Consider drug interactions. Target level is 115 - 300 ng/ml.
5. Treat side effects or change to SSRI if patient cannot tolerate side effects at the minimal effective dose or if no response after 6 weeks at a therapeutic dose.

WHAT TO DO IF PATIENTS DEVELOP SIDE EFFECTS?

1. WAIT - many side effects will resolve with time.
2. Reduce dose
3. Consider specific treatments as suggested below
4. Consider changing to an SSRI

SIDE EFFECTS	SPECIFIC TREATMENTS
Dry mouth	Try sugarless gum or candy
Dry eyes	Try artificial tears
Blurred vision	Try pilocarpine eye drops (1 % soln.) tid - qid
Constipation	1. Exercise 2. Increase fluid and fiber intake 3. Stool softeners 4. Bulk laxatives: Metamucil, psyllium
Urinary retention (especially in men with enlarged prostate glands)	Consider a trial of bethanechol 10-30 mg tid
Agitation, jitteriness	1. Short term use of lorazepam 0.5 mg po tid (do not use for longer than 6 weeks) 2. Consider propranolol 10-20 mg po tid
Insomnia	1. Consider low dose trazodone (50mg po qhs) 2. Consider short term use of lorazepam 0.5 to 1 mg po qhs (do not use for longer than 4 weeks)
Sedation	1. Make sure patient takes medication at bedtime 2. Consider caffeine prn
Orthostatic hypotension/dizziness	1. Arise slowly from a lying or sitting position 2. Consider support hose
Palpitations/conduction delays/arrhythmias	1. Check EKG 2. Stop TCA if significant arrhythmias develop
Weight gain	1. Rule out edema 2. Encourage regular exercise 3. Consider change to an SSRI

Bupropion (Wellbutrin)

1. Start at 100 mg po twice daily (150 mg po once daily for SR and XL) for three days, then increase to three times daily (twice daily for SR and 300 mg once daily for XL). For elderly patients, start at 75 mg (100 for SR) in elderly.
2. If patient has significant side effects, consider treating side effects (see below).
3. Continue 300 mg dose for 2 weeks. If no response, gradually increase dose to 450 mg. Go slower (i.e., stay at 300) if side effects are bothersome.
4. If no response after 4 weeks at 450 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Headache	1. Try NSAIDs 2. This often subsides after a few days
Nausea	1. Take medication with meals 2. Try antacids 3. This often subsides after a few days
Dry mouth	Try sugarless gum or candy
Insomnia	1. Make sure medication is taken in the morning 2. Consider low dose trazodone (50-100 mg po qhs)

Venlafaxine (Effexor)

1. Start at 75 mg po qam (25 or 37.5 for XR mg po qam in patients > 60)
2. If patient has significant side effects, consider lowering the dose to 25 mg po qam or treating side effects (see below).
3. Continue 75 (25 or 37.5) mg dose for 2 weeks. If no response, increase dose by 75 mg every 4 days (every 1 to 2 weeks in elderly) up to 375 (225 for XL) mg. Go slower (i.e., stay at 150 or 112.5 mg for XR) if side effects are bothersome.
4. If no response after 4 weeks at 250 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Nausea	1. Take medication with meals 2. Try antacids 3. This often subsides after a few days
Sedation	Change medication to qhs dosing
Insomnia	1. Make sure medication is taken in the morning 2. Consider low dose trazodone (50-100 mg po qhs)
Sexual dysfunction (delayed ejaculation in men, anorgasmia in women)	1. Try cyproheptadine 4-8 mg po 0.5-2 hours before intercourse. 2. If this is a significant problem, consider specialty consultation - recommendation may be to change to bupropion or nefazadone .
Dry mouth	Try sugarless gum or candy
Anxiety, agitation, jitteriness	1. Support and wait 2. Consider the short term use of a benzodiazepine (i.e., lorazepam 0.5 - 1 mg po tid prn - do not use for longer than 6 weeks) 3. Consider propranolol 10-20 mg po tid

Duloxetine (Cymbalta)

1. Start at 50 mg po qam (25 mg po qam in patients with panic disorder or patients > 60)
2. If patient has significant side effects, consider lowering the dose to 25 mg po qam or treating side effects (see below).
3. Continue 50 (25) mg dose for 2 weeks. If no response, increase dose by 50 mg every 2 weeks up to 150 mg. Go slower (i.e., stay at 50 or 100 mg) if side effects are bothersome.
4. If no response after 4 weeks at 150 mg po qam, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Nausea, diarrhea	1. Take medication with meals 2. Try antacids 3. This often subsides after a few days
Sedation	Change medication to qhs dosing
Insomnia	1. Make sure medication is taken in the morning 2. Consider low dose trazodone (50-100 mg po qhs)
Dry mouth	Try sugarless gum or candy

Mirtazapine (Remeron)

1. Start at 15 mg po qhs (7.5 mg po qam in patients with panic disorder or patients > 60)
2. If patient has significant side effects, consider lowering the dose, increasing the dose if sedation is the side effect or treating side effects (see below).
3. Continue 15 (7.5) mg dose for 2 weeks. If no response, increase dose by 15 mg every 2 weeks up to 45 mg. Go slower (i.e., stay at 15 or 30 mg) if side effects are bothersome.
4. If no response after 4 weeks at 45 mg po qhs, or if patient cannot tolerate minimal effective dose, consider changing to another antidepressant.

SIDE EFFECTS	TREATMENT
Sedation	Increase the dose
Dry mouth	Try sugarless gum or candy
Constipation	1. Exercise 2. Increase fluid and fiber intake 3. Stool softeners 4. Bulk laxatives: Metamucil, psyllium
Weight gain	1. Calorie reduction 2. Exercise

Appendix D

PHQ-9 (Patient Health Questionnaire)

©

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. **Consider Major Depressive Disorder**
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)
Consider Other Depressive Disorder
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Appendix E

Your Personal Plan: Medications

YOUR PERSONAL PLAN: Medications

Patient Name: _____ Study ID#: _____

CONTACT/APPOINTMENT INFORMATION

Primary Care Clinician: _____ Tel. No: (____) _____

Depression Nurse Specialist: _____ Tel. No: (____) _____

➤Next appointment: Date ____/____/____ Time: ____:____ ^(circle one) am / pm

YOUR MEDICATION SCHEDULE

Name of medication: _____	From: _____	To: _____
1 st Take ____ tablet(s) of ____ mg every morning/evening for ____ days	____/____	____/____
THEN 2 nd Take ____ tablet(s) of ____ mg every morning/evening for ____ days	____/____	____/____
THEN 3 rd Take ____ tablet(s) of ____ mg every morning/evening for ____ days	____/____	____/____
THEN 4 th Take ____ tablet(s) of ____ mg every morning/evening for ____ days	____/____	____/____

NOTE: The medication is started at a low dose to give your body time to adapt. If you are having side effects, you can stay at a lower dose for a little longer and then increase the amount. **Remember: It may take a few weeks before you experience the medication's full effect, so don't get discouraged.**

Ω IMPORTANT!!! Ω
DON'T STOP THE MEDICATION BEFORE CALLING YOUR DOCTOR

SYMPTOMS TO MONITOR

4 if you are having this symptom:

<input type="checkbox"/> Anxiety attacks	<input type="checkbox"/> Decreased or increased appetite	<input type="checkbox"/> Feeling depressed or sad
<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Feeling slowed down or sped up/jittery	<input type="checkbox"/> Loss of interest or pleasure
<input type="checkbox"/> Problems with sleep	<input type="checkbox"/> Feelings of worthlessness or guilt	<input type="checkbox"/> Nervousness or tension
<input type="checkbox"/> Trouble thinking, concentrating, or deciding	<input type="checkbox"/> Wishing you were dead or thinking about suicide	<input type="checkbox"/> Fatigue or loss of energy
		<input type="checkbox"/> Others: _____

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. _____
2. _____
3. _____

INFORMATION ABOUT ANTIDEPRESSANT MEDICATIONS

How do antidepressants work?

Both life stresses and medical problems can deplete the amount of chemical messengers in the nervous system that maintains the balance in how you feel emotionally and physically. This chemical imbalance results in some of the common symptoms of depression such as sleep and appetite problems, loss of energy, loss of concentration, and increased sensitivity to pain. Antidepressant medications help restore a normal balance of these chemical messengers, which helps to relieve emotional and physical symptoms.

Antidepressants can take up to 6 weeks to work. It usually takes one to four weeks until people start feeling better emotionally and physically. The improvement may be gradual, and oftentimes family members or friends may notice a difference in how you are doing before you do. Your sleep and appetite may improve first, then your mood and energy. Negative thinking may take some more time to decrease.

Once you are feeling better, do not stop the medication right away. Your doctor may recommend taking the medication for six to nine months or longer to prevent a relapse of the depression.

How to find an antidepressant that works for you?

Scientific studies show that antidepressant medications do not differ in the percentage of patients that get better. However, different medications are effective for different people, and the side effects of the medications differ. Some medications also cost more than others. Your doctor can help you decide which medication may be best for you.

About 70% of patients will get better after 4 to 6 weeks on an antidepressant medication. By working together, you and your doctor can decide during that six-week period whether the medication you started is the right one for you. If you need to switch to another antidepressant because of side effects or because you are not significantly improved after six weeks, chances are still excellent that you will improve on this second medication.

What about side effects?

Some people may experience side effects when taking antidepressant medications. While these side effects can be annoying, they are rarely dangerous to your health. They usually occur in the first few weeks and then gradually decrease as your body adapts to the medication. Because of these early side effects, patients sometimes feel a little worse before they start getting better and may give up too soon. If you have side effects that are bothering you, discuss these with your doctor. Your doctor will help you determine if these side effects will decrease over time or if you should decrease or switch your medication.

Some of the side effects that can occur with antidepressants:

- | | | | |
|---------------|---------------------|--------------------------------------------|------------------|
| • nausea | • diarrhea | • dizziness | • blurred vision |
| • headaches | • insomnia | • rapid heart rate | • dry mouth |
| • jitteriness | • sedation | • temporary difficulty in achieving orgasm | • constipation |
| • weight gain | • urinary hesitancy | | • other: _____ |

Remember:

- Antidepressants are not addicting or habit forming. They do not make people 'high', and they do not lead to serious withdrawal symptoms once you stop them.
- Take the medications daily.
- Keep track of side effects and problems and discuss them with your physician.
- **Do not stop the medication before talking with your doctor.**

Appendix F

Your Personal Plan: Psychotherapy

YOUR PERSONAL PLAN: Psychotherapy

Patient Name: _____ Study ID: _____

CONTACT INFORMATION

Primary Care Clinician: _____ Tel. No: (____) _____

Depression Nurse Specialist: _____ Tel. No: (____) _____

Psychotherapist: _____ Tel. No: (____) _____

YOUR NEXT APPOINTMENTS

With Primary Care Physician: Date ____/____/____ Time: ____:____ ^(circle one) am / pm

With Psychotherapist: Date ____/____/____ Time: ____:____ ^(circle one) am / pm

SYMPTOMS TO MONITOR

4 if you are having this symptom:

- | | |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Anxiety attacks | <input type="checkbox"/> Wishing you were dead or thinking about suicide |
| <input type="checkbox"/> Aches and pains | <input type="checkbox"/> Feeling depressed or sad |
| <input type="checkbox"/> Problems with sleep | <input type="checkbox"/> Loss of interest or pleasure |
| <input type="checkbox"/> Trouble thinking, concentrating, or deciding | <input type="checkbox"/> Nervousness or tension |
| <input type="checkbox"/> Decreased or increased appetite | <input type="checkbox"/> Fatigue or loss of energy |
| <input type="checkbox"/> Feeling slowed down or sped up/jittery | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Feelings of worthlessness or guilt | _____ |

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. _____
2. _____
3. _____

Appendix G

Your Personal Plan: Watchful Waiting

YOUR PERSONAL PLAN: Watchful Waiting

(For patients not started on medication or psychotherapy treatment plan)

Patient Name: _____ **Study ID:** _____

CONTACT INFORMATION

Primary Care Physician: _____ **Tel. No:** (____) _____

Depression Nurse Specialist: _____ **Tel. No:** (____) _____

Psychotherapist: _____ **Tel. No:** (____) _____

YOUR NEXT APPOINTMENTS

With Primary Care Physician:	Date ____/____/____	Time: ____:____ <small>(circle one)</small> am / pm
With Depression Nurse Specialist:	Date ____/____/____	Time: ____:____ am / pm
With: _____	Date ____/____/____	Time: ____:____ am / pm

SYMPTOMS TO MONITOR

4 if you are having this symptom:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Anxiety attacks
<input type="checkbox"/> Aches and Pains
<input type="checkbox"/> Problems with sleep
<input type="checkbox"/> Trouble thinking, concentrating, or deciding
<input type="checkbox"/> Decreased or increased appetite
<input type="checkbox"/> Feeling slowed down or sped up/jittery
<input type="checkbox"/> Feelings of worthlessness or guilt | <input type="checkbox"/> Wishing you were dead or thinking about suicide
<input type="checkbox"/> Feeling depressed or sad
<input type="checkbox"/> Loss of interest or pleasure
<input type="checkbox"/> Nervousness or tension
<input type="checkbox"/> Fatigue or loss of energy
<input type="checkbox"/> Others: _____
_____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

YOUR QUESTIONS/CONCERNS

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. _____
2. _____
3. _____

Appendix H

Your Personal Plan: Relapse Prevention

YOUR PERSONAL PLAN: Relapse Prevention

Patient Name: _____ Study ID: _____

CONTACT INFORMATION

Primary Care Physician: _____ Tel. Nº: (____) _____

Depression Nurse Specialist: _____ Tel. Nº: (____) _____

Psychotherapist: _____ Tel. Nº: (____) _____

PERSONAL WARNING SIGNS

1. _____
2. _____
3. _____

STRESSFUL LIFE EVENTS AND HOW TO MINIMIZE THEM

Event: _____ How to minimize: _____

Event: _____ How to minimize: _____

Event: _____ How to minimize: _____

MEDICATIONS

Name of antidepressant: _____ Dose: _____

Take medication until: ____/____/____

Questions: Call your **primary care clinician** or your **depression nurse specialist**.

(See Contact Information, above)

WHAT YOU SHOULD DO IF SYMPTOMS OF DEPRESSION RECUR

1. _____
2. _____
3. _____

Reviewed by: _____ (Signature of MD/Primary Care Clinician)

Appendix I

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CHANGING PROVIDER BEHAVIOR

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Cognitive Behavioral Therapy and Interpersonal Therapy

For Primary Care CBT:

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