Depression

# DEPRESSIVE DISORDERS: DEPRESSION

## Clinical Overview: Depressive Disorders

- Depressed patients are likely to complain about symptoms of depression to their PCPs first.
- The United States Preventive Task Force recommends that physicians use the following two questions to screen for depression:
  1. Over the past two weeks, have you felt down, depressed or hopeless?
  2. Over the past two weeks, have you felt little interest or pleasure in doing things?
- If a patient answers positively to one or both of these questions, further evaluation is indicated before a diagnosis of major depression can be made.
- To make a diagnosis of depression, organic and medical factors must be ruled out.
- Two other mood disorders mimic symptoms of depression:
  - Dysthymia: a mild chronic depression that lasts for at least two years.
  - Bipolar: dramatic mood swings from overly high and/or irritable (manic) to sad and hopeless (depressed) and back again.
- Education is a critical component of depression treatment.
- Medication, psychotherapy and a combination of both have been shown effective in treating depression.
- SSRI or Venlafaxine are commonly prescribed in the primary care setting due to their low level of toxicity and ease of administration (please see *Prescribing Antidepressant Medication* which is HIP's companion guide to this book).
- No one antidepressant medication has been shown to be clearly more effective than another.
- The FDA issued a public health warning about the increased risk of suicidal thought and behavior in children and adolescents treated with antidepressant medications (please see page 1-6).

## Clinical Snapshot: Depression

- Brief "snapshot" of a depressed patient's presentation:
  - Tearfulness.
  - Loss of interest.
  - Difficulty sleeping/sleeping too much.
  - Somatic complaints.
  - Anger.
  - Isolates self from social support.
  - Sadness.
  - Decrease in occupational functioning.
  - "Can't concentrate or focus."
  - Moves slowly or is fidgety.
  - Poor self-care (e.g., disheveled, unkempt).

## Facts about Depression

- Approximately 19 million people have a depressive disorder.
- Screening for depression and providing feedback reduces the risk for persistent depression and improves patients' compliance.
- Less than 25 percent of patients treated with antidepressant medications are given an actual diagnosis of depression.
- Patients with medically unexplained symptoms have higher rates of depression.
- Depression is associated with poorer medication regime compliance.
- Depression is associated with more functional impairment than most chronic medical illnesses.
- PCPs, as opposed to behavioral health specialists, now provide most of the treatment for depression.
- More than 40 percent of mental health care is for depression.

## How to Identify and Diagnose Depressive Disorders

- ***Screening Tools***

  - The United States Preventive Task Force recommends that physicians use the following two questions to screen for depression:
    1. Over the past two weeks, have you felt down, depressed or hopeless?
    2. Over the past two weeks, have you felt little interest or pleasure in doing things?

  - If the patient answers "yes" to one or both of the above questions, further evaluation is indicated and physicians should proceed with the following questions.
    3. During the past two weeks, have you had any of the following problems or concerns nearly every day?
       - Have you had trouble falling asleep or staying asleep?
       - Have you felt tired or with little energy?
       - Have you had a poor appetite or have you been overeating?
       - Have you felt badly about yourself? Have you felt like you were a failure or that you've let yourself or your family down?
       - Have you had trouble concentrating on things such as reading the newspaper or watching television?
       - Have you been moving so slowly that other people have noticed? Or, the opposite, have you been so fidgety or restless that you were moving around much more than usual?
       - During the past two weeks, have you had thoughts of hurting yourself in some way? Or have you had thoughts that you would be better off dead?
  - If the patient answers "yes" to one or both of the first two questions and answers "yes" to at least five of the next nine questions, then a diagnosis of major depression is likely indicated.

### ***DSM-IV Diagnostic Criteria for Major Depression***

- At least five symptoms must be present for at least a two-week period. Symptom #1 or #2 must be present.
  1. Depressed mood.
  2. Diminished interest or pleasure in all or almost all activities.
  3. Significant change in weight (> 5 percent of body weight) or appetite.
  4. Insomnia or hypersomnia.
  5. Psychomotor agitation or retardation.
  6. Fatigue or loss of energy.
  7. Feelings of worthlessness or excessive guilt.
  8. Diminished ability to concentrate.
  9. Recurrent thoughts of death, recurrent suicidal ideation or suicide attempt.

- To make a diagnosis of depression, organic factors or other known causes of mood disorders should be ruled out. These include:
  - General medical disorders.
  - Medication side effects.
  - Substance abuse.
  - Other non-mood psychiatric disorders and grief reactions.

- Mnemonic device to help remember the diagnostic criteria for depression: **SIGECAPS**

  **S**leep

  **I**nterest

  **G**uilt

  **E**nergy

  **C**oncentration

  **A**ppetite

  **P**sychomotor agitation/retardation

  **S**uicidal ideation

## Other Mood Disorders: Dysthymic Disorder and Bipolar Disorder

- When screening for depression, keep the following in mind:
  - **Dysthymic disorder** is a milder form of depression that lasts for at least two years. People with dysthymia may have periods of normal mood that last up to two months. Many cannot tell when they first became depressed.
  - **Bipolar disorder** involves dramatic mood swings – from overly "high" and/or irritable (i.e., manic) to sad and hopeless (i.e., depressed) and back again. Severe changes in energy and behavior go along with these changes in mood. A **manic episode** involves an expansive mood (excessively high or euphoric) that lasts at least one week and is different from usual functioning. Antidepressant medication may trigger a manic episode in patients with bipolar disorder. If, during this time, the patient experiences three or more of the following symptoms, he or she may have experienced a manic episode:
    1. Inflated self-esteem or grandiosity.
    2. Decreased need for sleep (e.g., feels rested after only three hours of sleep).
    3. More talkative than usual or pressure to keep talking.
    4. Flight of ideas or subjective experience that thoughts are racing.
    5. Distractibility.
    6. Increase in goal-directed activity or psychomotor agitation.
    7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., spending sprees, abuse of drugs, aggressive or provocative behavior, increased sexual drive).

    **If you suspect that your patient has experienced a manic episode or may have bipolar disorder, refer him or her to a specialized behavioral health provider (see page i for phone numbers).**

## Treatment of Depression

- ***Education***
  - Education is a critical component to depression treatment. The better patients understand depression, the more likely they will adhere to treatment.

> Physicians Should Provide the Following Information:
> 1. Depression is a medical illness.
> 2. There are effective treatments available for depression.
> 3. When treatment is followed properly, symptoms typically improve.

  - A discussion with patients pertaining to expected treatment length (at least six to eight months) and side effects of medication should be routinely conducted. Patients are often better able to adhere to treatment protocols when they are provided with detailed information.
  - Treatment modalities for depression include medication, psychotherapy or a combination of the two.
  - Review the patient education handout, "Depression is Treatable," in the Appendix on page 14-2.

### *Medication*

- Review the patient education handout, "Depression Is Treatable," in the Appendix on page14-2.

- A follow-up appointment to discuss side effects and review treatment gains made on medication should occur typically within two weeks, as this represents a time when side effects may occur, which can, in turn decrease adherence to the medication.

- The monitoring of response over time is quite important. It is suggested that patients be seen a minimum of three times during the initial three months of treatment. This is measured and reported to NCQA. The first follow-up visit should be within two weeks of beginning medication. It is then recommended that the patient be seen once a month for the following two months.

- If a patient does not respond to the initial medication within four weeks, or is intolerant of side effects, a reappraisal of the treatment regimen should take place, with a possible referral to a psychiatrist.

- If you find that the patient is not compliant with recommended follow-up visits or treatment protocol, please contact the Case Management program at **1-800-447-0769**.

- Medication should be continued for four to six months after full remission of symptoms. Maintenance therapy should be considered for recurrent episodes.

- For a more detailed description of prescribing medication to treat depression, see the *Prescribing Antidepressant Medication* companion guide to this book.

### *Psychotherapy*

Psychotherapy alone may be considered as an initial treatment modality for patients with mild to moderate Major Depressive Disorder.  If this option is chosen, patients should be referred for behavioral health services. Services are available at the HIP Mental Health Centers, or by calling the Mental Behavioral Service Line for a referral to a network provider **(1-888-447-2526)**.

### *Medication and Psychotherapy*

- The combination of medication and psychotherapy may be a useful initial treatment choice for patients with moderate to severe Major Depressive Disorder. In addition, patients with a poor response or poor compliance with a single modality may benefit from combined treatments.

- The choice of mode of treatment should be made based on clinical picture. Therapy and medication are both effective. Patient preference should be taken into account. Medication should be used in adult cases of severe depression.

## Special Populations

### *Depression in Children and Adolescents*

- Depression can present somewhat differently in children and adolescents. The following is a list of symptoms that may indicate depression in this population:
  - Frequent vague, nonspecific physical complaints such as headaches, muscle aches, stomachaches or feeling tired.
  - Frequent absences from school or poor school performance.
  - Talk of running away from home or past attempts to run away.
  - Outbursts – shouting, complaining, crying, irritability.
  - Boredom.
  - Lack of interest in playing with friends.
  - Alcohol or substance abuse.
  - Social isolation.
  - Poor communication.
  - Fear of death.
  - Extreme sensitivity to rejection or failure.
  - Increased anger or hostility.
  - Reckless behavior.
  - Difficulty with relationships.

- Talking With Parents
  - It is very important for parents to understand their child's depression and the treatments that may be prescribed.
  - Physicians can help by talking with parents about their questions or concerns, reinforcing that depression in youth is not uncommon and reassuring them that appropriate treatment with psychotherapy, medication or a combination can lead to improved functioning at school, with peers and at home with family.
  - Referring the youth and family to a behavioral health professional can help to enhance recovery.

- Treating children and adolescents with antidepressant medications:
  - The Food and Drug Administration (FDA) issued a Public Health Advisory about the increased risk of suicidal thoughts and behavior in children and adolescents treated with antidepressant medications: The FDA warns: "Pediatric patients being treated with antidepressants for an indication should be closely observed for clinical worsening, as well as agitation, irritability, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. This monitoring should include daily observation by families and caregivers and frequent contact with the physician. It is also recommended that prescriptions for antidepressants be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose."
  - For more information, see **www.fda.gov**.

### *Postpartum Depression*

**Postpartum Depression** – a depressive episode (see criteria for Major Depression at beginning of chapter) that is temporarily associated with childbirth. The episode begins in the first days or weeks after delivery and lasts at least two weeks.

- The DSM-IV criteria requires onset by the fourth postpartum week, however, many clinicians consider symptom onset within six to 12 months after delivery as temporarily related to childbirth.
  - Prevalence: 10-15 percent of women develop postpartum depression. This rate is similar across races and countries of origin.

**Postpartum or Maternity Blues** – mild mood problems of short duration. The symptoms usually begin three to four days after the delivery and worsen by day five to seven and tend to go away by day 12.

  - Prevalence: 39-85 percent of new mothers experience "postpartum blues."

**Postpartum Psychosis** – a very small percentage of women may experience psychotic symptoms such as hallucinations or delusions during postpartum period.

  - Prevalence: One to two women in 1,000 will experience postpartum psychosis.

**Antepartum Depression** – a depressive episode during pregnancy, prior to childbirth.

  - Prevalence: Approximately 10 percent of women experience antepartum depression.

- Important Facts About Postpartum Depression:
  - Eighty percent of women experience mood fluctuations in the antepartum or postpartum period.
  - Three-fourths of postnatal depression cases are unidentified.
  - Common reasons why postpartum depression is not often identified:
    - Mothers may not realize that their experience is not the norm.
    - Society pressures mothers to be "happy."
    - Mothers may fear "going crazy" and having children taken away.
    - Mothers may not be receiving care from their family physician and may not be sure who to turn to for help.
    - Physician may delay detection by minimizing a woman's distress in an effort to be reassuring.
- Psychosocial Risk Factors for Postpartum Depression:
  - A history of postpartum depression after previous pregnancies.
  - Antepartum depression.
  - Recent life stressors.
  - Lack of social support.
  - Marital problems or any type of abuse of the mother.
  - History of maternal psychiatric disorder.
  - Women experiencing "highs" (mild euphoria, increased energy) within the first few days of delivery are more likely to experience depression several months later.

- Health Risks Associated with Maternal Depression:
  - Maternal depression can affect infant cognitive skills, expressive language development, and attention.
  - Infants of mothers with post-partum depression have increased risk of epidural analgesia, increased operative deliveries and increased rates of admission to neonatal care units.
  - Pregnant women with depression are at increased risk for poor nutrition, substance abuse and non-compliance with prenatal care.
  - Children of mothers with postpartum depression are predisposed to depression.

- Treatment:
  - Due to the health risks of antepartum depression and the fact that depression during pregnancy is a strong predictor of postpartum depression, the antepartum period is an optimum time for screening, diagnosis and treatment.
  - Inform pregnant women of the prevalence of antepartum and postpartum depression. Let them know that depression during and after pregnancy is not uncommon should be discussed with the doctor.
  - Explain that there is effective treatment available if needed.
  - Due to maternal concerns about taking medication while breastfeeding, therapy is often the treatment of choice for postpartum depression.

### *Grieving Patients*

- Grief, a process experienced after the death of a loved one, impacts the manner in which one thinks, behaves and reacts.
- The grieving process continues throughout a person's lifetime and is commonly re-experienced at the anniversary of a loved one's death, during special occasions and life cycle events.
- Symptoms of grief are quite similar to those of Major Depression and include:
  - Shock.
  - Confusion.
  - Lack of interest in the "outside" world.
  - Anxiety, fear.
  - Anger.
  - Tearfulness.
  - Agitation, moodiness.
  - Numbness.
  - Disbelief.
  - Social isolation.
  - Guilt.
  - Change in sleep, appetite or weight.
  - Restlessness.
- Grieving patients are often distressed by friends/family memebers telling them that they "should be over it by now." Explaining that it is not uncommon to experience symptoms for a long time while grieving can be very reassuring.
- If symptoms of grief persist for more than two months, a diagnosis of depression should be considered.

- If patients present with the following symptoms, a referral to a behavioral health professional should be considered, as the patient may be experiencing atypical grief reaction:
  - Excessive feelings of guilt about actions taken or not taken.
  - Recurrent thoughts of death.
  - Preoccupation with worthlessness.
  - Psychomotor retardation.
  - Prolonged functional impairment.
  - Hallucinations (with possible exception of thinking he or she hears the deceased loved one).

- Grieving patients should be assessed for suicide risk.

- Physicians should tell grieving patients:
  1. Everyone experiences grief in his or her own way.
  2. There is no set time when you "should be over it."
  3. Your symptoms are common after a loss.
  4. You are not "going crazy."
- Discuss possible mental health referral.

### *Depression in the Medically Ill*

- The symptoms of depression can be both produced and obscured by physical illness. Therefore, when assessing this population, keep in mind the following:
  - Depression in the medically ill exacerbates morbidity and mortality.
  - Depression increases financial burdens.
  - Depression increases the risk of poor self-care.
  - Depression increases the risk of poor prognosis regarding coping with the medical illness.

### *Depression in the Elderly*

- Depression can present somewhat differently in the elderly. The following is a list of symptoms that may indicate depression in this population:
  - Symptoms of anxiety.
  - Slowing of thought and activity level.
  - Bodily symptoms: weakness, headaches, palpitations, decreased interest in sex, abdominal or back pain, shortness of breath and constipation.
  - Imaginary illnesses.
  - Hallucinations.

## Depression and Substance Abuse

Depression commonly co-occurs with alcohol and substance abuse disorders. The CAGE and the CAGE-AID are brief and effective screening tools to assess for alcohol and substance abuse respectively. They can be found in the Substance Abuse chapter that begins on 7-1.