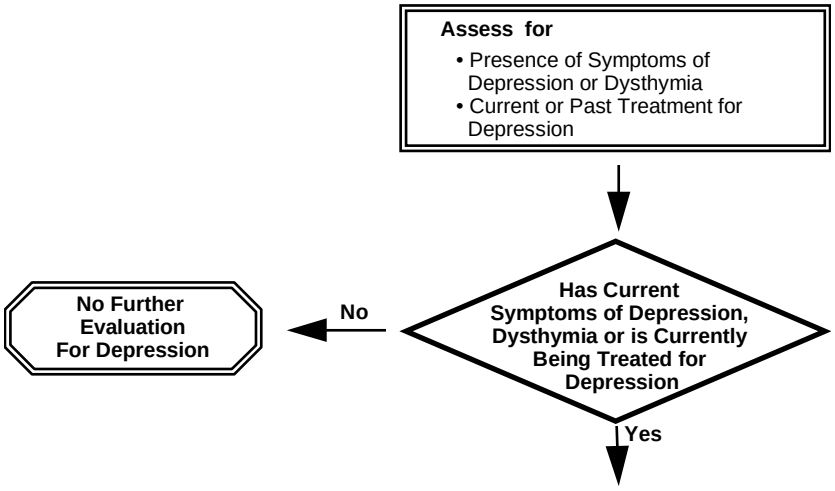
Seven Steps for Evaluating People with Symptoms of Depression in Primary Care

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.

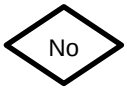
Assess for Presence of Symptoms of Depression and Current or Past Treatment for Depression

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.

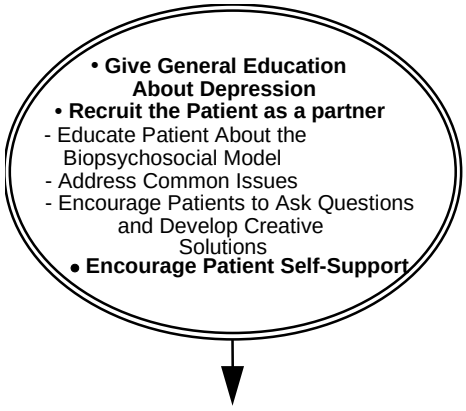
Partners in Care searches for patients who have had symptoms consistent with a major depression or dysthymia over the past year, and then asks whether these patients have at least some current symptoms of depression. We define "current" as over the past month. Dysthymic patients typically have symptom-free 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

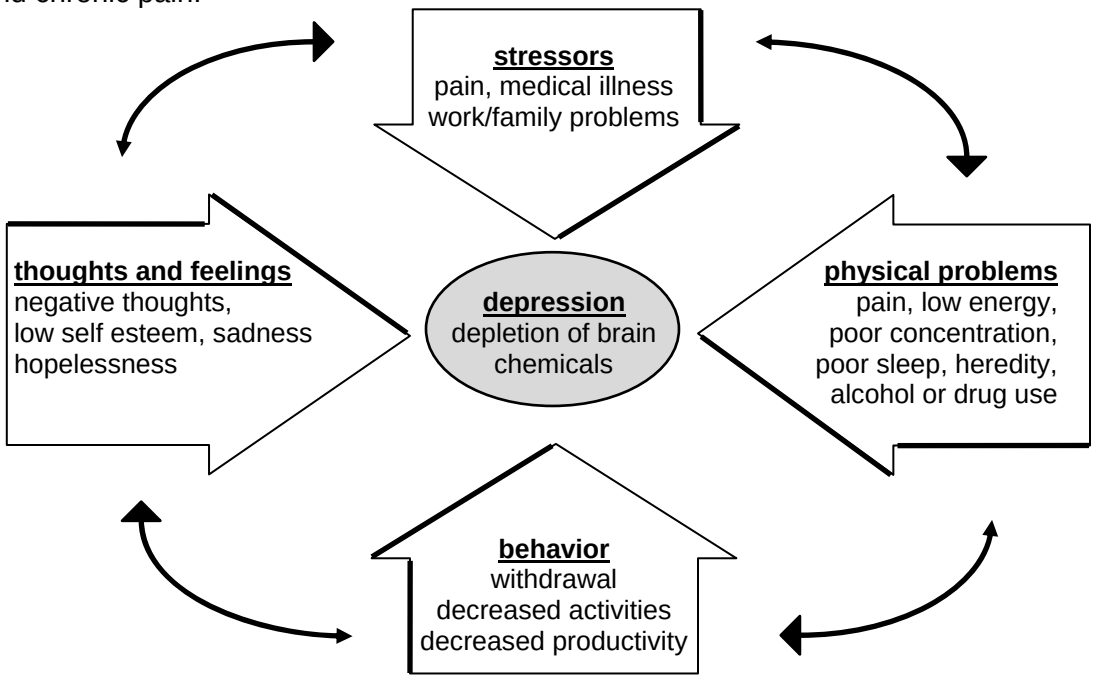
  - show the patient written records of his/her symptoms

  - identify and encourage pleasurable activities.

TEACHING PATIENTS:

The Cycle of Depression

Both life stresses and medical problems can cause a depletion of certain chemicals in the brain. 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 chronic pain.



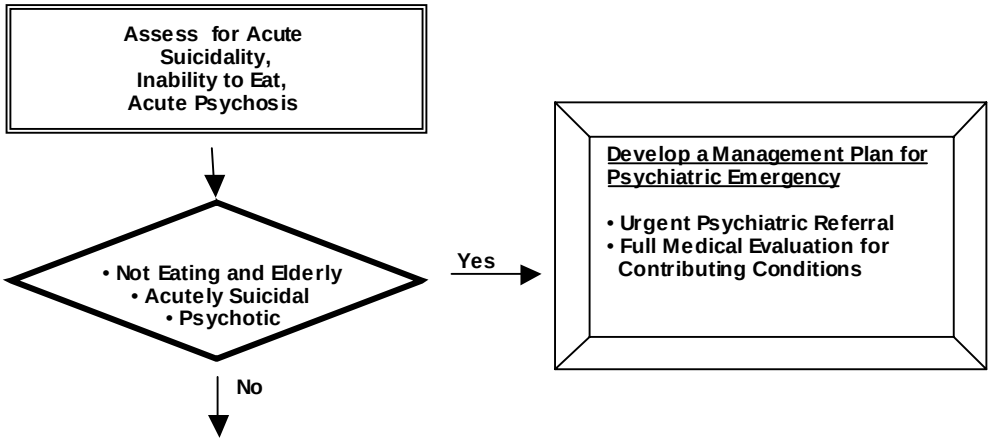
- The good news is that this downward cycle can be reversed with medications and coping skills so you begin to sleep better, feel more energetic, socialize more, think less negatively about yourself and **FEEL BETTER**.
- Antidepressants can restore normal sleep and help with pain, fatigue, and poor concentration. When you are feeling more rested, it is easier to do your work and to do things you enjoy. When you engage in more pleasant activities and are more productive, this can give you a sense of accomplishment and improve your self-esteem. You think more positively about yourself and your future and you will feel more enjoyable to be around.

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.

Suicide Screening

1. **Ask all depressed patients** if they have **thoughts of death or suicide** or if they feel that **life is not worth living**. Also ask whether they have **previously attempted suicide.**
2. If the answer is yes, inquire about **plans for suicide.** How much have they thought about suicide? Does the person know how he or she would commit suicide? Do they have the materials required in their possession? Have they set a time? Are there specific conditions that would precipitate suicide?
3. Assess **epidemiological risk factors** for suicide (See below)
4. If suicidal thoughts are persistent, if the patient has a prior history of a suicide attempt or a current plan, or if the patient is at high risk for suicide based on epidemiological factors plus suicidal ideation, **CONSIDER EMERGENCY PSYCHIATRIC CONSULTATION AND TREATMENT.**

Epidemiological Risk Factors for Suicide

Psychosocial and Clinical	History	Diagnostic
Hopelessness	**Prior suicide attempts**	Medical illness
Caucasian race	Family history of suicide attempts	Psychosis
Male gender	Family history of substance abuse	Substance abuse
Advanced age		
Living alone		

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).

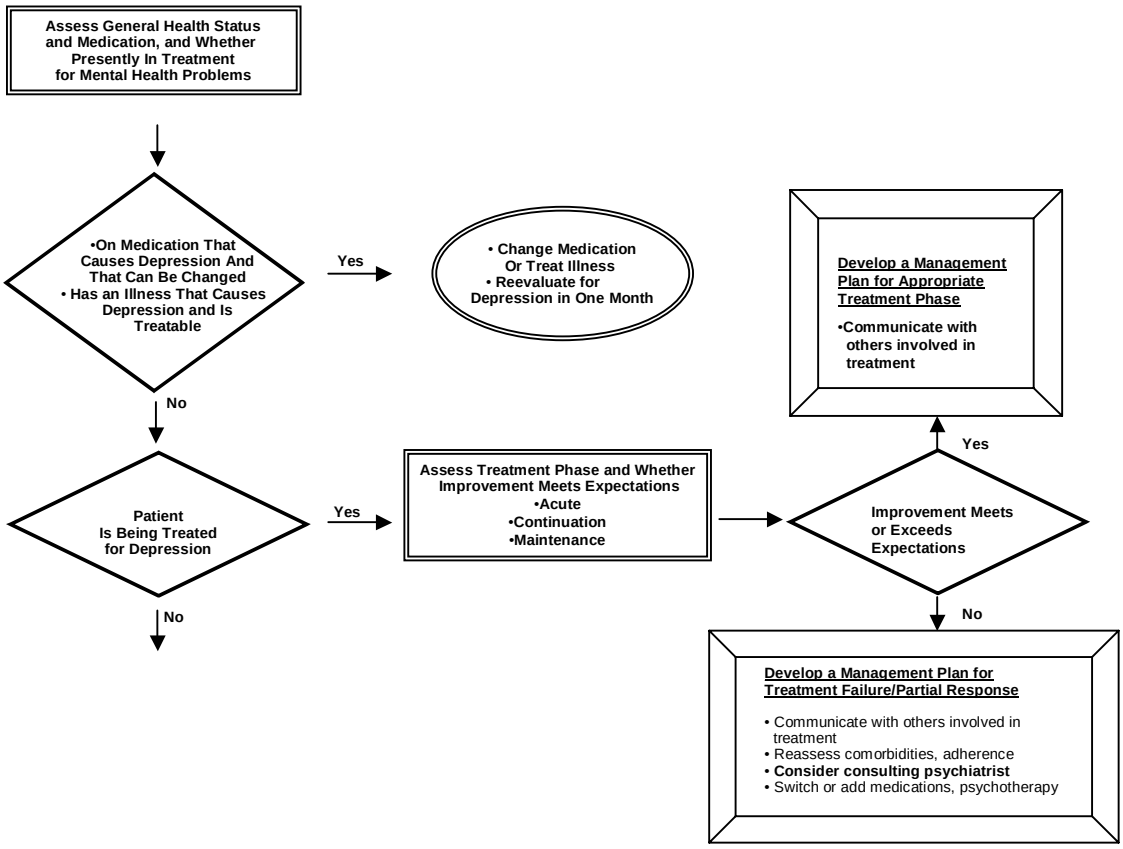
Yes

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.

No

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)**	• steroids, reserpine, antineoplastic agents (see Figure 1.4 for others) • autoimmune diseases • neurologic diseases (stroke, Parkinson's, multiple sclerosis, epilepsy, brain tumor, dementia) • sleep apnea • cancer • cardiac disease: CHF • metabolic (B12 deficiency) • endocrine (**thyroid** or parathyroid disorders, Cushing's, Addison's)	• stop medication if possible and treat depression if it persists • treat illness and depression if it persists • treat depression and neurological illness (in case of epilepsy, consider EEG) • consider sleep study • treat depression and cancer • treat depression and CHF • replace vitamins and treat depression if it persists • correct 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

Yes

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:

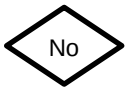
- Wait two to four weeks
- Reevaluate depression

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 or 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 of loss of energy
7. Feelings of worthlessness or guilt
8. Impaired concentration or indecisiveness
9. Thoughts or death or suicide

Figure 1.5 - DSM-IV Criteria for Depression

Assess for Dysthymia

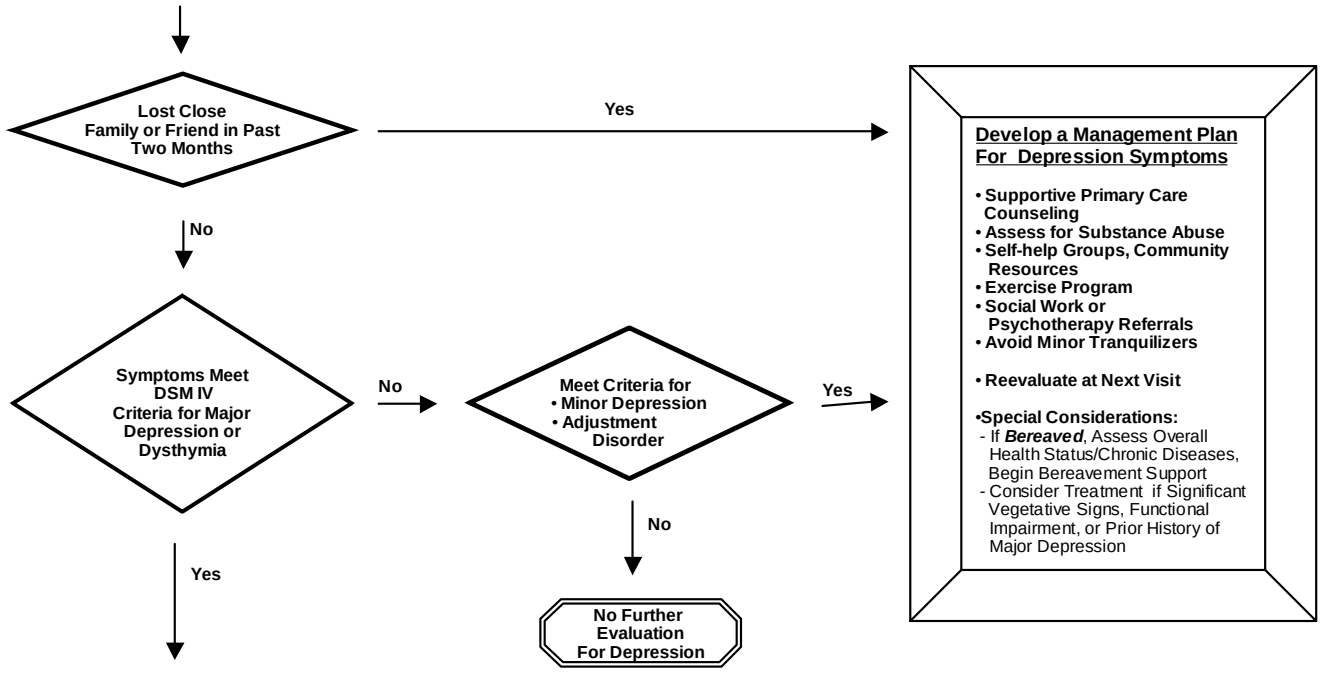
In dysthymia, depressive symptoms are present much of the time for at least two years. Dysthymia patients either meet DSM-IV criteria for major depression (and thus have major depression plus dysthymia), or meet minor depression symptom criteria but have symptoms that are present much of the time for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

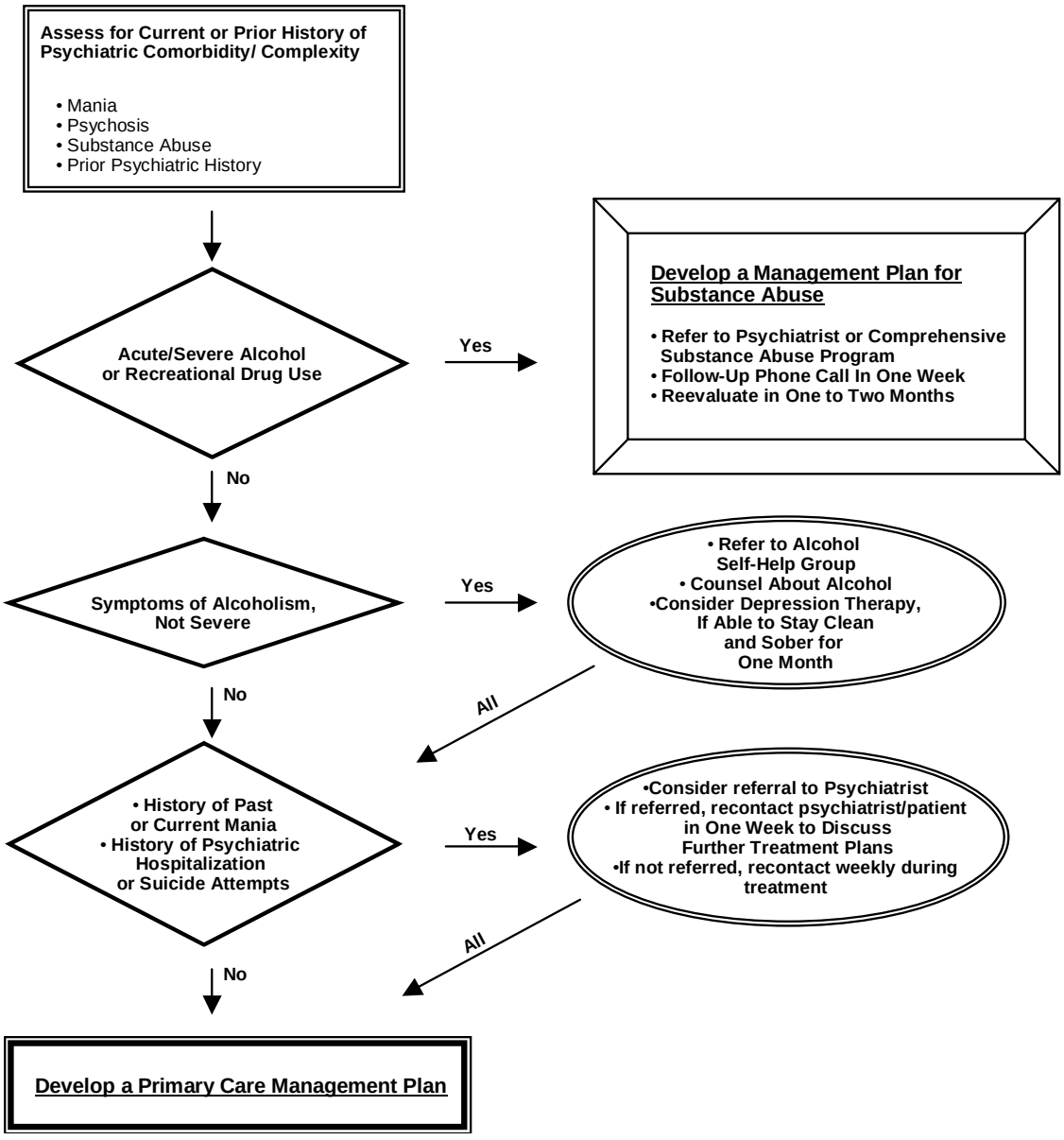
- Give the patient the "Your Personal Plan: Watchful Waiting" (see Appendix H)
- Reevaluate in one month; if still symptomatic, but no major depression, continue primary care management with visits every 1-3 months.

DIAGNOSIS	CRITERIA	ACTION
Dysthymia	• At least 2 depressive symptoms persist uninterruptedly for 2 years or more with no more than 2 months that are asymptomatic	• treat like major depression, with antidepressants or psychotherapy • consider maintenance treatment for 2 years or more
Bereavement	• Recent loss of a loved one	Develop a management plan for watchful waiting and take some or all of the following preventive actions: • 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 - if bereaved, assess overall health status, chronic diseases - consider treatment if significant vegetative signs, functional impairment, or prior history of major depression
Minor depression	• 2-4 symptoms for > 2 weeks including depressed mood or loss of interest/pleasure • Depression affects functioning	
Adjustment Disorder	• 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.

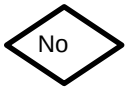
AUDIT-C Questions

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 <u>symptoms of alcohol or drug abuse</u>:

- 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 pharmocotherapy 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	• alcohol • illicit drugs (cocaine or amphetamine withdrawal) • prescription drugs (narcotics, sedatives)	• treat substance abuse first; then treat depression. • **consider consultation for mental health or substance abuse.**
Bipolar Disorder (current or past history of manic symptoms)	• elevated/expansive/irritable mood for at least one week • decreased sleep • increased energy, talking, or activity • distractibility • inflated self-esteem or grandiosity	• **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	• inquire about current thoughts or plans for suicide. • monitor closely. • **consider referral to a psychiatrist.**

Figure 1.7 - Common Differential Diagnoses