

BASIC GUIDELINES FOR MAJOR DEPRESSION IN ADULTS IN PRIMARY CARE

*Suspect Major Depression:

- A. Presentations (in addition to obvious sadness)
- Multiple somatic complaints and visits (i.e. > 5 visits; more than 1 organ system with the absence of physical findings); weight gain/loss, cognitive deficits (impaired attention, concentration and ST memory)
 - Fatigue/sleep disturbances
- B. Risk Factors
- History of major depression and/or substance abuse
 - Dysthymia (see Annotation Appendix A)
 - Changes in work and/or interpersonal relationships

1 Diagnose and characterize major depression with clinical interview to include:

- A. DSM-IV TR criteria.
- B. History of present illness. (Onset and severity of symptoms, functional impairment, past episodes and psychosocial stressors.) Assess prior effective/failed treatments.
- C. Pertinent medical history, especially illness that can cause depression.
- D. Assess for current substance abuse, withdrawal or medications that can cause depression.
- E. Psychiatric co-morbidity.

> 5 DSM-IV TR
criteria present?

no

Consider other mood and anxiety
disorders or somatoform disorders

Emergency? Assess for suicidality,
psychosis and risk of harm to self
and others including ideation,
plan, intent, means to carry out
act and history of such.

yes

3
Involve behavioral/chemical
health clinician

2
Substance abuse or specific comor-
bidity, especially bipolar disorder?

yes

3
Involve behavioral/chemical
health clinician

Secondary causes?

yes

Address secondary causes
and re-evaluate

no

- Educate and engage patient in discussion about depression, treatment and self care options.
- Treat for current or most recent episode using medication and/or psychotherapy at appropriate level of care (if a subtype** exists, specific therapy may be indicated).
- Consider medications previously effective for patient or first degree relative.
- Monitor every 1-2 weeks until stable.

6
Continuation and maintenance
for 6-12 months

yes

Is patient responding adequately?

no

5
Evaluate dose, duration, type and adherence
with medication and/or psychotherapy.
Reconsider accuracy of diagnosis or impact
of comorbidities. If trial adequate, proceed
to other single agent approach in other
antidepressant category. Post two failed
trials refer to psychiatrist.

DSM-IV TR Criteria for Major Depressive Episode

Must have a total of 5 symptoms for at least 2 weeks.
One of the symptoms must be depressed mood or
loss of interest.

1. Depressed mood.
2. Markedly diminished interest or pleasure in all or almost all activities.
3. Significant (>5% body weight) weight loss or gain, or increase or decrease in appetite.
4. Insomnia or hypersomnia.
5. Psychomotor agitation or retardation.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or inappropriate guilt.
8. Diminished concentration or indecisiveness.
9. Recurrent thoughts of death or suicide.

* The two-question screen:

Over the past month have you been bothered by:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?

**Subtypes

- Major depression disorder with psychotic features
- Seasonal affective disorder
- Melancholic
- Catatonic
- Postpartum

Patient Questionnaire – Prime-M.D

NINE SYMPTOM CHECKLIST

Patient Name _____ Date _____

1. Over the *last two weeks*, how often have you been bothered by any of the following problems?

Not at all Several days More than half the days Nearly every day

- a. Little interest or pleasure in doing things.
- b. Feeling down, depressed, or hopeless.
- c. Trouble falling asleep, sleeping too much.
- d. Feeling tired or having little energy.
- e. Poor appetite or overeating.
- f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.
- g. Trouble concentrating on things, such as reading the newspaper or watching television.
- h. 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.
- i. Thoughts that you would be better off dead or of hurting yourself in some way.

2. If you checked off any problem on this questionnaire so far, 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

Major depression is suggested, if, of the nine items, five or more are checked as at least "more than half the days" and either item "a" or "b" is positive, that is, "more than half the days."

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Algorithm Annotations

1. Diagnose and Characterize Major Depression With Clinical Interview

A. Depressed mood or anhedonia (diminished interest or pleasure in activities) is necessary to diagnose major depression. If depression is suspected on the basis of risk factors of common presentations, consider using a standardized instrument to document depressive symptoms. More importantly, document baseline symptoms and severity to assist in evaluating future progress. Useful initial questions include:

Over the past two months, have you been bothered by:

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

If the patient answers to either one of the above questions, consider using a quantitative questionnaire to further assess whether the patient has sufficient symptoms to warrant a diagnosis of clinical major depression and a full clinical interview. An example of such a questionnaire is the Patient Health Questionnaire (PHQ-9). **The primary objective is to use a standardized instrument that will quantify and document future progress, including response and remission**

B. Determine history of present illness including:

- Onset may be gradual over months or years, or may be abrupt.
- Severity of symptoms and degree of functional impairment.
- Number and severity of previous episodes, treatment responses and suicide attempts.
- Ask about concurrent psychiatric conditions. Obtaining a past psychiatric history is important in terms of understanding prognosis and risk factors. For example, knowledge of past episodes of major depression, past co-occurring mental/behavioral health conditions and past self-harm attempts is important for establishing risk and need to involve other mental health professionals.
- Psychosocial stressors (significant loss, conflict, financial difficulties, life change, abuse).

People diagnosed with major depression have a heterogeneous course from self-limiting to life-threatening. Predictors of poor outcome include severity at initial assessment, lack of reduction of social difficulties at follow-up and low educational level. Categorize severity of symptoms and degree of functional impairment as follows:

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

Moderate: Symptoms or functional impairment between mild and severe

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

C. Pertinent medical history that may complicate treatment (e.g. prostatism, cardiac conduction abnormalities, and impaired hepatic function).

D. Determine past history of substance abuse.

Medications and Withdrawal From Medications

- Reserpine, steroids, alpha-methyl dopa, propranolol and hormonal therapy may be associated with major depression.
- **Active abuse** or withdrawal from alcohol, cocaine, sedatives, *opiates*, *cannabis*, anxiolytics, hypnotics and amphetamines may be associated with depression.
- Idiosyncratic reactions to other medications can occur and if possible, a medication should be stopped or changed if depression develops after beginning its use. If symptoms persist after stopping or changing medication, reevaluate for a primary mood or anxiety disorder.

2. Substance Abuse or Specific Comorbidity, Especially Bipolar Disorder?

Before treating a patient with depression, it is important to know if the patient has a history of Bipolar Disorder or substance abuse. Patients who are depressed and actively abusing drugs or alcohol should be referred immediately to a psychiatrist or addictionologist for detoxification and rehabilitation. These patients should be informed that substance abuse can cause intensification and prolongation of their depressive symptoms as well as a significant decrease in the efficacy of antidepressant therapy.

The CAGE(AID) Screen

CAGE (AID) Screen

Have you ever:

- C Felt you ought to **cut** down on your drinking or drug use?
- A Had people **annoy** you by criticizing your drinking or *drug use*?
- G Felt bad or **guilty** about your drinking (*or drug use*)?
- E Had a drink (*or used drugs*) as an **eye opener** ifrst thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

Bipolar affective disorder

Some patients presenting with a depressive episode have a bipolar disorder, for which effective treatment may differ significantly from other depressed patients. When assessing a patient, consider asking about manic or hypomanic episodes.

- Has there been a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week?
- During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 1. Inflated self-esteem or grandiosity
 2. Decreased need for sleep
 3. More talkative than usual or pressure to keep talking
 4. Flight of ideas or subjective experience that thoughts are racing
 5. Distractibility
 6. Increase in goal-directed activity or psychomotor agitation
 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (*reckless spending, promiscuity*)

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

Ask patients with depression about a history of manic symptoms (abnormally elevated, expansive or irritable mood). Patients with a history of manic (bipolar) symptoms now presenting with depression may develop manic *or mixed state* symptoms with antidepressant drugs. Involve behavioral health professionals with these patients. If other psychiatric problems such as psychosis or eating disorders are suspected or present, involve behavioral health professionals.

3. Involve Behavioral/Chemical Health

Consider involving same-day Behavioral Health for:

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

Involvement could include:

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

4. Psychiatric Emergency

Assessing suicidal tendencies is a critical but often difficult process with a depressed patient. Consider asking and documenting the following progression of questions:

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

Many patients will not answer #4 directly or will add "but I'd never do it." Give them positive feedback (e.g., "I'm glad to hear that"), but do not drop the subject until she/he has told you the specific methods considered (e.g., gun, medication overdose, motor vehicle accident, etc.).

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

- There are four male suicide completions for every female completion.
- Elderly Caucasian and Asian men over the age of 65 years and Asian women over 80 years are at disproportionate risk.
- Substance abuse is often a contributing factor, especially in younger people.
- The presence of firearms in the home is believed to greatly increase the danger if other risk factors are present.
- 75 percent of elderly suicide completers were seen by their doctor within one month of death.
- Across all age groups, one in seven suicide completers had contact with their doctor within a week of death.
- When a patient has high levels of all of the following, risk is very high and hospitalization may be needed immediately:
 - Internal emotional pain (e.g., feelings of shame, guilt, humiliation)
 - External stress (e.g., loss of spouse, job, legal troubles)
 - Agitation (e.g., from sleep loss, drug use, or *excessive anger*)
 - Hopelessness

There are no good predictors of suicide. The clinician should consider previous history of suicide attempts; chemical dependency; personality disorder and/or physical illness; family history of suicide; single status; recent loss by death, divorce or separation; insomnia; panic attacks and/or severe psychic anxiety; diminished concentration; anhedonia; hopelessness or suicidal ideation.

5. Evaluate Dose, Duration, Type, and Adherence With Medication and/or Psychotherapy

Consider Accuracy of Diagnosis or Impact of Comorbidities

A. The key objectives of treatment are:

1. Acute phase goal for treatment of major depression is remission of symptoms. Evidence shows that 40 percent *may* not be able to achieve remission. For those patients, the goal is to reduce symptoms to manageable levels.
2. Reduction of relapse and recurrence of major depression.
3. Return to previous level of occupational and psychosocial function.

B. Treatment Considerations

Optimal Practitioner contacts (at least three follow-up contacts by medical or mental health practitioner during 12-week acute phase of treatment)

Acute Phase (treatment period at least 12 weeks)

When considering treatment options, the primary goal is to achieve remission or get the patient to be virtually symptom-free (i.e., a Patient Health Questionnaire PHQ-9 score of <4).

1. Pharmacotherapy vs. Psychotherapy

- Pharmacologic and/or non-pharmacologic interventions (psychotherapy) are effective in treating depressions. Factors to consider in making treatment recommendations are symptom severity, presence of psychosocial stressors, presence of comorbid conditions, and patient preferences.
- Depression treatment should take health beliefs into account. Patients who perceive more self-control of their health experienced greater reduction in depressive symptoms, whether treated with psychotherapy or an antidepressant. Therefore, it is important to adequately assess a patient's expectations and beliefs in the controllability of depressive symptoms and functioning in order to treat major depression effectively and to minimize the risk of relapse and recurrence. (See Annotation #10 "Educate and Engage Patient Institute Treatment Plan Establish Follow-Up Plan" for details.)

2. Pharmacologic Therapy

- Treatment of choice for major depression may include pharmacology and psychotherapy. For patients with mild to moderate depression, psychotherapy and/or pharmacology is indicated. For severe depression, a combination of therapy is indicated.
- If there is less than 25 percent reduction of symptoms after six weeks at therapeutic dose (i.e., partial positive response to medication), add or substitute another treatment modality.
- When considering how long to continue medication after remission of acute symptoms, two issues need to be considered: continuation and maintenance treatment.

C. Continuation and Maintenance Treatment (6 to 12 Months)

Acute treatment (usually the first three months of treatment) refers to treating with antidepressant medication in order to achieve remission of major depressive symptoms. Remission is defined as having minimal residual symptoms (PHQ-9 score of four or less). However, consider that in elderly populations it may take longer to respond to acute treatment. Continuation therapy is the phase where one continues to treat with antidepressants in order to keep the patient free of symptoms for the duration of the current episode. By definition this is considered to be at least six months long, but lately the evidence supports viewing the duration as 6 to 12 months long. Maintenance therapy is designed to prevent recurrence of new or future episodes of major depression.

Recommended Guidelines for Pharmacologic Treatment of Depression

First Episode – Treatment duration 6 to 12 months

Second Episode – Treatment duration 3 years

Second Episode with Complicating Factors (*dysthymia, suicidality, psychosis*) – Lifetime treatment duration

Third Episode – Lifetime treatment duration

Institute Treatment Plan

Psychotherapy

- Outcome studies support the efficacy of several psychotherapeutic approaches (cognitive-behavioral, interpersonal, structured educational group therapy).
- Consider early referral for psychotherapy if psychological and psychosocial issues are prominent and/or patient requests it. Referral for psychotherapy may have maximum benefit as symptom severity diminishes.
- Supportive therapy by the physician in the primary care setting is not the same as a course of psychotherapy with a mental health professional. However, education, support and reassurance by the physician are critical. Support/reassurance includes asking the patient for his/her ideas regarding the cause of the depression and about their expectations of recovery. Inform patients with depression that they have a good chance of improving.

Patient Education

1. Successful care of major depression as an illness requires active engagement of each patient and their family and on-going patient education, beginning at the time of diagnosis. It is important for the patient to consider and adopt some self-care responsibilities, which may range from simply demonstrating reliable behavior in taking medications and calling the provider with side effects to agreeing to participate in sessions, journaling and completing homework, which is necessary for some cognitive behavioral therapies. Written materials are helpful to reinforce information shared during the discussion. Patients who commit to some self-care responsibilities and receive this education compared with those who do not are more likely to continue, rather than prematurely abandon treatment, and are more likely to attain better outcomes.
2. When antidepressant therapy is prescribed, the following key messages should be highlighted to support medication adherence and completion:
 - Most people need to remain on medication at least 6 to 12 months after they experience an adequate response to *treatment*. It usually takes from 2 to 6 weeks before *significant* improvement is seen.
 - Take the medication as prescribed, even after one feels better.
 - Do not stop taking the medication without calling your provider. Side effects can be managed by changes in the dosage or dosage schedule.
 - Most of the side effects from medication, *including nausea, diarrhea, headaches and dizziness are transitory*.

Medications

For antidepressant medications, adherence to a therapeutic dose and meeting clinical goals are more important than the specific drug selected. The educational messages in Annotation Appendix A may increase adherence.

Selection of an Antidepressant Medication

Antidepressant drug selection should be based on:

- The patient's (or first degree relatives') history of response to previous antidepressant medications (if any)
- The patient's comorbid psychiatric or medical conditions
- Clinician familiarity with specific antidepressants

Selective Serotonin Reuptake Inhibitor (SSRI), Serotonin-Norepinephrine Reuptake Inhibitors, Dopamine-Norepinephrine Reuptake Inhibitors and Norepinephrine-Serotonin Receptor Modulators:

SSRIs, venlafaxine, *duloxetine*, mirtazepine and bupropion are frequently chosen as first-line therapy because of simplicity, side effect profiles and community standards.

Secondary Amine Tricyclics

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

Secondary amine tricyclics cause less orthostatic hypotension and sedation than tertiary amine tricyclics.

Monoamine Oxidase Inhibitor (MAOI)

MAOIs, in general, should be restricted for patients who do not respond to other treatments. *They are rarely used by primary care physicians* because of their potential for serious life threatening side effects and the necessity of dietary and medication restrictions. Patients with major depressive disorders with atypical features are one group for whom several studies suggest MAOIs may be particularly effective. However, in clinical practice, many psychiatrists start with SSRIs in such patients because of the more favorable adverse effect profile.

Medication interactions with antidepressant agents: Many antidepressant agents have clinically significant drug interactions, particularly those agents which undergo cytochrome P450 enzymatic metabolism in the liver. A complete discussion of this topic is beyond the scope of this guideline. Practitioners are advised to consult references such as the Physician's Desk Reference, American Hospital Formulary Service, Epocrates or Micromedex for more information about drug interactions with specific agents, and to assess the significance of the interaction prior to prescribing antidepressants.

Elderly patients: Because of the potential for decreased renal and hepatic function, concomitant diseases and medications, the elderly are at higher risk of significant side effects or drug interactions with antidepressant medications. Consider starting at the lowest possible dose and increasing slowly to effective dose or until side effects appear. Tertiary amine tricyclics should generally be avoided in elderly patients because of the high incidence of orthostatic hypotension, sedation and cardiac effects with these agents.

Pregnancy

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

U.S. FDA Pregnancy Risk Categories: (B) No evidence of risk in humans. Either animal findings show risk, but human findings do not; or if no adequate human studies have been done, animal findings are negative. Bupropion and maprotiline are rated **B**. (C) Risk cannot be ruled out. Human studies are lacking, and animal studies are either positive for fetal risk or lacking. However, potential benefits may justify the potential risks. Amitriptyline, amoxapine, protriptyline, sertraline, trazodone, trimipramine, venlafaxine are rated **C**. (D) Positive evidence of risk. Investigational or post-marketing data show risk to the fetus. Nevertheless, potential benefits may outweigh the potential risks. If needed in a life-threatening situation or a serious disease, the drug may be acceptable if safer drugs cannot be used or are ineffective. Imipramine and nortriptyline are rated **D**.

Exercise

Evidence suggests that physical activity might be a useful *adjunctive* tool for easing major depression symptoms. Among individuals with major depression, exercise therapy is feasible and is associated with significant therapeutic benefit, especially if exercise is continued over time. When prescribing exercise as an adjunct to medication and psychotherapy, the complexity and the individual circumstances of each patient must be considered.

6. Chronic Pain

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

Key clinical practice recommendations include:

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

7. Culturally Diverse Populations

Minority populations are often underserved when it comes to treatment for depression. Having quality improvement (QI) interventions that have modest accommodations for minorities can reduce health disparities and improve quality of care. Some strategies to improve care can include:

- Offer a range of treatment choices with modifications suggested by experts in treating ethnic minorities.
- Allow for patient and/or family preferences for treatment.
- Provide culturally and linguistically appropriate educational and intervention materials.
- Have cultural training for staff.
- Develop “depression specialists” who can act as case managers and coordinate treatment between providers (utilize bilingual providers if possible).
- Look into day care and transportation needs.

COMMONLY USED ANTIDEPRESSANT MEDICATIONS:

| Generic Name | Brand Name | Blue Book Status ^b | Starting Dose | Usual Dose |
|---|--|-------------------------------|-----------------------|-------------------------|
| | | | (mg/day) ^c | (mg/day) ^d |
| Selective Serotonin Reuptake Inhibitors | | | | |
| Citalopram | Celexa [®] | F | 20 | 20-60 ^d |
| Escitalopram | Lexapro [®] | NF | 1 | 10-20 ^d |
| Fluoxetine | Prozac [®] | F | 10-20 | 20-60 ^d |
| Fluvoxamine | Luvox [®] | F | 50 | 50-300 ^d |
| Paroxetine | Paxil [®] | F | 10-20 | 20-50 ^d |
| Sertraline | Zoloft [®] | NF | 25-50 | 50-200 ^d |
| Serotonin/Norepinephrine Reuptake Inhibitors | | | | |
| Venlafaxine | Effexor [®] | NF | 37.5-75 | 75-375 ^d |
| Venlafaxine, extended release | Effexor | F | 37.5-75 | 75-225 ^d |
| Duloxetine | Cymbalta [®] | NF | 40 | 40-60 ^d |
| Dopamine-Norepinephrine Reuptake Inhibitors | | | | |
| Bupropion | Wellbutrin [®] | F | 50-150 | 150-450 ^d |
| Bupropion, sustained release | Wellbutrin SR ^{®e} | F | 100-150 | 150-400 ^d |
| Bupropion extended release | Wellbutrin | F | 150 ^f | 150-450 ^{d, f} |
| Norepinephrine-Serotonin Modulator | | | | |
| Mirtazapine | Remeron [®] | F | 1 | 15-45 |
| Tertiary Amine Tricyclics | | | | |
| Amitriptyline | Elavil [®] | F | 10-150 | 25-300 ^d |
| Doxepin | Sinequan [®] /Adapin [®] | F | 25-150 | 25-300 ^d |
| Imipramine | Tofranil [®] | F | 10-100 | 50-300 ^d |
| Trimipramine | Surmontil [®] | NF | 50-150 | 100-300 |
| Secondary Amine Tricyclics | | | | |
| Desipramine | Norpramin [®] | F | 10-75 | 75-300 ^d |
| Nortriptyline | Pamelor [®] /Aventyl | F | 10-100 | 75-150 ^d |
| Protriptyline | Vivactil [®] | F | 1 | 15-60 |
| Amoxapine | Asendin [®] | F | 25-75 | 50-400 |
| Tetracyclic | | | | |
| Maprotiline | Ludiomil [®] | F | 25-75 | 50-150 |
| Serotonin Reuptake Inhibitor/Antagonist | | | | |
| Trazodone (for sleep primarily ^g) | Desyrel | F | 25-150 | 75-600 |
| Monoamine Oxidase Inhibitors | | | | |
| Phenelzine | Nardil [®] | F | 7.5-45 | 15-90 ^d |
| Tranylcypromine | Parnate [®] | F | 20 | 30-60 |

a These medications are likely to be optimal medications in terms of the patient's acceptance of side effects, safety, and quantity and quality clinical trial data.

b F = Formulary, NF = Non-Formulary.

c Lower doses are recommended for elderly patients and for patients with hepatic impairment or renal impairment.

d Dose varies with diagnosis; see text for specific guidelines.

e Dosing frequency of Wellbutrin SR[®] is twice daily; dosing frequency of Wellbutrin XR[®] is daily.

f Patients with hepatic impairment, maximum dose = 150mg every other day.

g Trazodone's sedation/hypnotic dose = 25-50mg at bedtime; may increase up to 200mg at bedtime.

Source: <http://csi.micromedex>; Lexi-Comp's Drug Information Handbook 12th edition.

For further prescribing information, the following drug references may be used:

- The Physicians Desk Reference
- The American Hospital Formulary Service (AHFS)
- Micromedex
- Epocrates

Follow-up

Initial Follow-up Contact Intervals (office, phone, other)

If symptoms are severe, weekly contacts are appropriate. Contact should be every 2 to 4 weeks if mild or moderate symptoms are present. This protocol should be in place until remission or best possible response is achieved, then treatment should be spaced out as clinically warranted.

Office visits for maintenance medication can occur every 3 to 12 months if everything else is stable.

Referral

Consider involvement of a mental health provider for the following:

- Patient request for psychotherapy
- Presence of severe symptoms and impairment
- Diagnostic question
- Presence of other psychiatric condition (e.g., personality disorder, history of mania)
- Chemical dependency questions
- Clinician discomfort with the case
- Initial treatment does not result in a successful outcome
- Patient's request for more specialized treatment

GENERALIZED ANXIETY DISORDER DSM-IV TR CRITERIA:

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

USEFUL INTERVIEW QUESTIONS FOR ANXIETY:

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

PANIC ATTACK DSM-IV TR CRITERIA:

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

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

DIAGNOSIS SUGGESTIVE OF AN ANXIETY DISORDER:

- Atypical chest pain
- Hyperventilation
- Irritable bowel syndrome

TREATMENT AND EDUCATION:

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

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

Annotation Appendix A

EXAMPLES OF ANXIETY DISORDERS:

In many of these circumstances referral to mental health is appropriate.

| Disorder | Description | Useful Questions |
|---|---|--|
| Social phobia | Marked and persistent fear of potentially embarrassing social or performance situations. Marked and persistent fear of a specific object or situation. | Do you worry that you might embarrass yourself in a social or performance situation? |
| Specific phobia | Marked and persistent fear of a specific object or situation. | Do you have excessive or unreasonable fears about specific objects or situations? |
| Obsessive compulsive disorder | Persistent and intrusive thoughts, ideas, impulses or images associated with repetitive behaviors to reduce distress. | Are you bothered by recurrent thoughts and/or repetitive behaviors? |
| Post-traumatic stress disorder | Exposure to a traumatic event which is persistently re-experienced with anxiety symptoms lasting more than one month. | Do you have distressing anxiety caused by re-experiencing some past traumatic event? |
| Acute stress disorder | Exposure to a traumatic event which is persistently re-experienced with anxiety symptoms lasting two days to four weeks, and occurring within four weeks of the event. | Do you have distressing anxiety caused by re-experiencing some past traumatic event? |
| Anxiety disorder NOS (not otherwise specified) | Prominent anxiety of phobic avoidance not meeting criteria for another specific anxiety disorder which, for example, may be episodic, a reaction to a medical condition, or a combination of symptoms from several anxiety disorders. | Do you have episodes of nervousness or excessive worry? |

Annotation Appendix A

EXAMPLES OF ANXIETY DISORDERS:

In many of these circumstances referral to mental health is appropriate.

| <u>Disorder</u> | <u>Description</u> | <u>Useful Questions</u> |
|--------------------------------|---|--|
| Dysthymia | Chronic (> 2 years) and frequent low mood, often experienced as emptiness or sadness, often accompanied with lethargy and self-criticism, and requiring at least two other symptoms of MDD. | Do you often feel sad, empty or unmotivated? |
| Depressive disorder NOS | Depressive symptoms not meeting criteria for another mood disorder. | Do you experience periods where you feel down or depressed? |
| Bipolar disorder | History of at least one episode of mania (e.g., high energy, irritability, grandiosity, minimal sleep, pleasure seeking) and commonly severe depression. | Do you experience periods where you feel down or depressed? Have either you or your family members noticed you've experienced periods of at least a week where you have: <ul style="list-style-type: none">• Talked or thought more and/or faster than usual?• Needed significantly less sleep?• Felt happier, and/or more irritable than usual?• Initiated and engaged more than usual in activities such as spending money, sexual activities, travel? |

THE HAMILTON RATING SCALE FOR DEPRESSION

(to be administered by a health care professional)

Patient's Name _____

Date of Assessment _____

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

1. DEPRESSED MOOD (Sadness, hopeless, helpless, worthless)

0= Absent

1= These feeling states indicated only on questioning

2= These feeling states spontaneously reported verbally

3= Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep

4= Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

2. FEELINGS OF GUILT

0= Absent

1= Self reproach, feels he has let people down

2= Ideas of guilt or rumination over past errors or sinful deeds

3= Present illness is a punishment. Delusions of guilt

4= Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. SUICID

0= Absent

1= Feels life is not worth living

2= Wishes he were dead or any thoughts of possible death to self

3= Suicidal ideas or gesture

4= Attempts at suicide (any serious attempt rates 4)

4. INSOMNIA EARLY

0= No difficulty falling asleep

1= Complains of occasional difficulty falling asleep ___i.e., more than 1/2 hour

2= Complains of nightly difficulty falling asleep

5. INSOMNIA MIDDLE

0= No difficulty

1= Patient complains of being restless and disturbed during the night

2= Waking during the night—any getting out of bed rates 2 (except for purposes of voiding)

6. INSOMNIA LATE

_____ **0=** No difficulty

in

hours of the morning but goes back to sleep

2=

1= Unable to fall asleep again if he gets out of bed

7. WORK AND ACTIVITIES

_____ **0=** No difficulty

1= Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbie

2= Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)

3= Decrease in actual time spent in activities or decrease in productivity

4= Stopped working because of present illness

8. RETARDATION: PSYCHOMOTOR (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)

_____ **0=** Normal speech and thought

1= Slight retardation at interview

2= Obvious retardation at interview

3= Interview difficult

4= Complete stupor

9. AGITATION

_____ **0=** None

1= Fidgetiness

2= Playing with hands, hair, etc.

3= Moving about, can't sit still

4= Hand wringing, nail biting, hair-pulling, biting of lips

10. ANXIETY (PSYCHOLOGICAL)

_____ **0=** No difficulty

1= Subjective tension and irritability

2= Worrying about minor matters

3= Apprehensive attitude apparent in face or speech

4= Fears expressed without questioning

11. ANXIETY SOMATIC: Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)

_____ **0=** Absent

1= Mild

2= Moderate

3= Severe

4= Incapacitating

12. SOMATIC SYMPTOMS (GASTROINTESTINAL)

0= None

1= Loss of appetite but eating without encouragement from others. Food intake about normal

2= Difficulty eating without urging from others. Marked reduction of appetite and food intake

13. SOMATIC SYMPTOMS GENERAL

0= None

1= Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability

2= Any clear-cut symptom rates 2

14. GENITAL SYMPTOMS (Sy) mptoms such as: loss of libido; impaired sexual performance; menstrual disturbance

0= Absent

1= Mild

2= Severe

15. HYPOCHONDRIASIS

0= Not present

1= Self-absorption (bodily)

2= Preoccupation with health

3= Frequent complaints, requests for help, etc.

4= Hypochondriacal delusions

16. LOSS OF WEIGHT

A. When rating by history:

0= No weight loss

1= Probably weight loss associated with present illness

2= Definite (according to patient) weight loss

3= Not assessed

17. INSIGHT

0= Acknowledges being depressed and ill

1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.

2= Denies being ill at all

18. DIURNAL VARIATION

A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none

0= No variation

1= Worse in A.M.

2= Worse in P.M.

B. When present, mark the severity of the variation. Mark "None" if NO variation

0= None

1= Mild

2= Severe

19. DEPERSONALIZATION AND DEREALIZATION (Such as: Feelings of unreality;
Nihilistic ideas)

_____ **0=** Absent

1= Mild

2= Moderate

3= Severe

4= Incapacitating

20. PARANOID SYMPTOMS

_____ **0=** None

1= Suspicious

2= Ideas of reference

3= Delusions of reference and persecution

21. OBSESSIVE AND COMPULSIVE SYMPTOMS

_____ **0=** Absent

1= Mild

2= Severe

Total Score _____
