Session 3:  
Outpatient Management of the Depressed Patient

Learning Objectives

1. Describe 3 signs/symptoms that suggest clinical depression in an otherwise healthy young patient.

2. Identify 3 ways to address barriers in practice to the timely diagnosis of clinical depression in the perimenopausal patient.
Session 3

Outpatient Management of the Depressed Patient

Faculty

Mark Zimmerman, MD
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Warren Alpert Medical School of Brown University
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Providence, Rhode Island

Dr Mark Zimmerman is associate professor of psychiatry and human behavior at the Warren Alpert Medical School of Brown University and director of outpatient psychiatry at Rhode Island Hospital. Dr Zimmerman is also director of the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, whose goal has been to integrate research methodology into routine clinical practice to examine issues related to diagnostic comorbidity and treatment outcome. The MIDAS project is the largest clinical epidemiological study using standardized measures ever to have been conducted in clinical practice.

Dr Zimmerman’s research interests during the past 20 years have been in the area of assessment, diagnosis, and treatment of mood disorders. He is the author of more than 300 articles published in peer-reviewed journals, and is on the editorial board of 7 journals.

In the 1980s, Dr Zimmerman developed a self-report questionnaire to diagnose the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III), major depressive disorders, and was one of the authors of the first semi-structured interview to assess the DSM-III personality disorders. More recently, he developed the Psychiatric Diagnostic Screening Questionnaire (PDSQ), the Diagnostic Inventory for Depression (DID), the Rhode Island Gambling Outcome Rating Scale (RIGORS), the Clinically Useful Depression Outcome Scale (CUDOS), and the Clinically Useful Anxiety Outcome Scale (CUXOS). The CUDOS and CUXOS are included in the first web-based outcome evaluation system (www.outcometracker.org).

Faculty Financial Disclosure Statement
The presenting faculty reports the following:
Dr Zimmerman has no financial relationships to disclose.
Outpatient Management of the Depressed Patient

Mark Zimmerman, MD

Session 3:
11:00 AM - 12:00 PM

Learning Objectives

• Describe 3 signs/symptoms that suggest clinical depression in an otherwise healthy young patient

• Identify 3 ways to address barriers in practice to the timely diagnosis of clinical depression in the perimenopausal patient

Q1. Pre-Activity Audience Response Question

Which of the following has been studied extensively in adolescents and young adults and therefore should be considered first when treating a 22-year-old depressed patient?

1. Fluoxetine
2. Trazodone
3. Escitalopram
4. None of the above
5. 1 and 3 only

Q2. Pre-Activity Audience Response Question

Which of the following is less likely to cause sexual side effects compared to SSRIs?

1. Trazodone
2. Bupropion
3. Mirtazapine
4. All of the above
5. 1 and 2 only

Q3. Pre-Activity Audience Response Question

Which of the following regarding vascular depression in the elderly is TRUE?

1. Vascular depression is associated with greater agitation compared to non-vascular depression
2. Vascular depression occurs in older patients compared to non-vascular depression
3. Psychotherapy is the treatment of choice
4. All of the above

Faculty Disclosures

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Patient Case 1

David is a 23-year-old man

- Parents worried, arranged office visit, and accompanied him to ensure he came
- He has returned to live at home after graduating from college 1 year ago and not finding employment in computer science
  - He has a part-time job bussing tables in a local restaurant at night
  - He is sleeping much of the day and is eating only one meal daily
  - He has little interest in anything, rarely sees friends, and avoids his parents by staying in his room in the basement
  - His parents complain he is irritable

What would be your next step?

1. Ask David about his social life
2. Have David and his parents tell each other what is bothering them
3. Ask the parents to step out so you can get additional information from David
4. Ask David to step out so you can get additional information from his parents

After his parents leave the exam room, he confirms low energy, difficulty thinking/concentrating (he is worried he has ADHD), amotivation, and feeling badly about himself due to his lack of adequate employment

- On questioning, he admits to drinking alcohol daily, and smoking marijuana much of the time he is awake. He explains it is the only thing that helps him feel better
- He feels hopeless and can’t see his situation changing anytime soon. He denies thoughts of death, but asks, “What is the point?”
- He denies history of self-harm

Management should focus on:

1. Lack of skills for finding employment
2. Adjustment disorder due to graduating college without a job
3. Major depression
4. Substance-induced mood disorder
5. Sleep disorder

Major Depressive Disorder (MDD)

DSM-IV-TR Criteria

5 symptoms nearly every day during 2-week period that includes depressed mood and/or pervasive loss of interest/pleasure:

- Unintentional weight loss/gain or decreased/increased appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Difficulty concentrating
- Excessive guilt or worthlessness
- Recurrent thoughts of death or suicidal ideation or attempt

From Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association 2010.
Major Depressive Disorder (MDD)
DSM-IV-TR Criteria (Cont.)

Symptoms
✓ cause significant distress or impaired function
✓ not due to a substance or medical condition
✓ not due to bereavement, or last > 2 mos
  • are characterized by functional impairment, preoccupation with worthlessess, suicidal ideation, psychosomatic symptoms, or psychomotor retardation

Mood Disorders are Common and Undertreated

• Prevalence of mood disorders in American adults ~ 9.5%
• National Comorbidity Study (NCS)
  – Only 20% of individuals with a 12-month history of a psychiatric disorder obtained treatment
  – Only 40% of individuals with a lifetime disorder obtained treatment
• Major depression affects 1 in 20 (~15 million) annually
  – The risk of recurrence:
    >50% after 1 episode
    >70% after 2 episodes
    >90% after 3 episodes

DSM-IV Depression Severity Measures

• Quick Inventory for Depressive Symptomatology (QIDS)
  – Used in STAR*D
  – Takes longer to complete
• Patient Health Questionnaire (PHQ-9)
  – 9 items correspond to DSM-IV criteria
  – Widely used in primary care
  – Combined items sacrifice information
• Clinically Useful Depression Outcome Scale (CUDOS)
  – Brief, like PHQ-9, but without sacrificing information
  – Web-based administration (www.outcometracker.org)

Measuring Outcome When Treating Depression

- Using a depression scale is like using a scale to measure weight (or a thermometer to measure fever)
- Outcome is improved when treating depression in primary care

David

At this point, you:
1. Recommend discontinuation of all alcohol and illicit drugs
2. Recommend family therapy
3. Start David on an antidepressant
4. Provide referral for cognitive behavioral therapy
5. Recommend he begin a structured exercise program

David

You recommended he stop all alcohol and illicit substance use. David skips the next appointment but returns in 6 weeks. He says he has cut back significantly on the drinking and marijuana use but none of his symptoms have changed.

At this point you:
1. Initiate antidepressant therapy
2. Initiate stimulant therapy for concentration problems and oversleeping
3. Refer to a therapist for cognitive behavioral therapy

Prevalence of Severity Subtypes According to Different Measures of Depression

<table>
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<tr>
<th>Scale</th>
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<th>Moderate</th>
<th>Severe</th>
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<tr>
<td>HAMD</td>
<td>30.2</td>
<td>43.3</td>
<td>24.9</td>
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<tr>
<td>CUDOS</td>
<td>33.1</td>
<td>45.9</td>
<td>19.0</td>
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<tr>
<td>PHQ-9</td>
<td>7.4</td>
<td>21.3</td>
<td>69.3</td>
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<tr>
<td>QIDS</td>
<td>12.8</td>
<td>33.5</td>
<td>52.9</td>
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</tbody>
</table>


Antidepressant Classes

- **Selective serotonin reuptake inhibitors (SSRIs)**
  - fluoxetine
  - paroxetine
  - citalopram, escitalopram
  - sertraline
- **Serotonin norepinephrine reuptake inhibitors (SNRIs)**
  - venlafaxine, desvenlafaxine
duloxetine
  - milnacipran*
- **Dopamine norepinephrine RI**
  - bupropion
- **Serotonin modulators**
  - trazodone, nefazodone, vilazodone
- **Norepinephrine-serotonin modulators**
  - mirtazapine
- **Tricyclics/tetracyclics (TCAs)**
  - amitriptyline, nortriptyline
desipramine, doxepin, others
- **Monoamine oxidase inhibitors (MAOIs)**
  - selegiline, phenelzine, tranylcypromine, isocarboxazid

* Not FDA approved for depression
Choosing an Antidepressant

- Are there patient characteristics that should be considered in selecting an antidepressant because these factors predict differential response to antidepressant medications?
- APA Practice Guideline for the Treatment of Patients with MDD (Revised, 2010):
  - “Because the effectiveness of antidepressant medications is generally comparable between classes and within classes of medications, the initial selection of an antidepressant medication will largely be based on the anticipated side effects, the safety or tolerability of these side effects for the individual patient, pharmacological properties of the medication (e.g., half-life, actions on cytochrome P450 enzymes, other drug interactions), and additional factors such as medication response in prior episodes, cost, and patient preference.” (p. 15)


Why So Little Differential Treatment Predictive Power?

4 groups of depressed patients:
1. Placebo responders
2. Treatment nonresponders
3. Pan responders (respond to any active treatment)
4. Drug specific responders

Antidepressants and Suicide Risk

- Fluoxetine and escitalopram approved for MDD in adolescents (12-17 years); most data available
- 2004 FDA advisory linking a 4% absolute rate and 2-fold increase in risk of suicidality (suicidal thinking or behavior) with SSRI used for MDD in children and adolescents
  - based on post-hoc analysis of placebo-controlled trials in which no suicides occurred
  - In 2006, warning extended to young adults <25 years of age

Antidepressants and Suicide Risk (Cont.)

- Comprehensive review of pediatric trials suggests benefits of AD likely outweigh risks for those <18 years with MDD and anxiety disorders
- History of non-suicidal self-injury prior to treatment is a clinical marker for subsequent suicide attempts

When do antidepressants begin to work?

When initiating antidepressant medication what do you tell patients regarding how long it usually takes antidepressant medication to begin to work?
1. Within the first 2 weeks
2. After about a month
3. After about 6-8 weeks
4. After 12 weeks

Onset of Action of Antidepressants: A Meta-analysis

- 47 placebo-controlled studies with weekly ratings
  - 74 cohorts on active medication (>5,000 patients)
  - 47 cohorts on placebo (>3,400 patients)
- All studies used same outcome measure (Ham-D)
Weekly Reduction in Ham-D Scores on Medication (n=5,158) and Placebo (n=3,418)

<table>
<thead>
<tr>
<th>Week #</th>
<th>Medication</th>
<th>Placebo</th>
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<tr>
<td>1</td>
<td>4.5</td>
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<tr>
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<td>3</td>
<td>2.1</td>
<td>1.6</td>
</tr>
<tr>
<td>4</td>
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<tr>
<td>5</td>
<td>0.9</td>
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<tr>
<td>6</td>
<td>0.7</td>
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</tr>
<tr>
<td>Total change</td>
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Drug-Placebo Separation on the Ham-D Over the Course of a 6-Week Trial

Second Meta-analysis

Taylor et al. (2006) Early Onset of Selective Serotonin Reuptake Inhibitor Antidepressant Action
Archives of General Psychiatry, 63, 1217-1223

28 placebo-control trials (5,872 patients)

Conclusion: “Treatment with SSRIs is associated with symptomatic improvement in depression by the end of the first week of use, and the improvement continues at a decreasing rate for at least 6 weeks.”

When do you see patients back?

For the typical non-suicidal depressed patient, after initiating an antidepressant during your first visit with the patient when do you usually schedule the first follow-up visit?

1. 1 week
2. 2 weeks
3. 3 weeks
4. 1 month
5. More than 1 month

David: Take Home Points

- Screen for alcohol and illicit drug use
- Other co-morbidities may affect response to treatment: anxiety, ADHD, substance abuse/dependence
- Black box warning should not deter treatment
- Measure outcome to monitor course of treatment
- Patients should be seen no later than 2 weeks after initiating treatment

Patient Case 2
Susan is a 49-year-old woman with fatigue, anxiety, decreased libido, and menstrual irregularities

- In for routine annual exam – you have known her for years
- She is normally very pleasant, busy and successful, married and mother of 2 teenagers, but over the last 6 months she has not been herself:
  - Problems with concentration and memory, especially word-finding problems that interfere with work and social interactions
  - Fatigue and low energy, so she has reduced exercise frequency
  - Wonders if she is perimenopausal as she is having night sweats that awaken her from sleep, decreased libido, weight gain, and shorter menstrual cycles (21 days instead of 28) so menstrual migraines are more frequent

Susan

At this point, you perform routine exam, mammogram, and labs including TSH, which are all normal.

What might best explain Susan’s complaints?

1. Perimenopause
2. Generalized anxiety disorder
3. Major depression
4. Early dementia
5. Normal aging

Susan

What would be your next step?

1. Start antidepressant therapy
2. Start a prn benzodiazepine to help with feeling overwhelmed
3. Recommend complementary/alternative interventions for her symptoms (e.g., soy, ginkgo, St John’s wort)
4. Further testing to rule out dementia, other serious medical conditions

Menopause and Depression

- Women are at greater risk of depression in menopausal transition with or without prior depression history
- MDD is underdiagnosed and undertreated since symptoms often attributed to menopausal causes
- Co-morbidities (medical and psychiatric) and depression have a bidirectional relationship that may complicate diagnosis and treatment

Depression or Menopause?

- Overlapping symptoms: low energy, poor concentration, sleep problems, weight changes, and decreased libido
- Important co-morbidities include migraine, chronic pain, DM, cancer, fibromyalgia, IBS, obstructive sleep apnea
- Routine screening for MDD in perimenopause: If meet DSM criteria, diagnose depression even if somatic symptoms or life stressors evident
- Generally, hormone therapy (HT) alone will not treat MDD, but some antidepressants can reduce menopausal symptoms
- SNRIs may be more effective than SSRIs for MDD through the menopausal transition
- HT plus antidepressant therapy can improve both sets of symptoms, but should be limited to the perimenopausal period

### Depression Rates in Patients with Chronic Medical Conditions

<table>
<thead>
<tr>
<th>Medical Illness</th>
<th>Depression (%)</th>
<th>Medical Illness</th>
<th>Depression (%)</th>
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<tbody>
<tr>
<td>Cardiac disease</td>
<td>17-27</td>
<td>Diabetes (self-reported)</td>
<td>26</td>
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<tr>
<td>Cerebrovascular</td>
<td>14-19</td>
<td>Diabetes (diag. interview)</td>
<td>9</td>
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<tr>
<td>Alzheimer's</td>
<td>30-50</td>
<td>Cancer</td>
<td>22-29</td>
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<tr>
<td>Parkinson's</td>
<td>4-75</td>
<td>HIV/AIDS</td>
<td>5-20</td>
</tr>
<tr>
<td>Epilepsy (recurrent)</td>
<td>20-55</td>
<td>Pain</td>
<td>30-54</td>
</tr>
<tr>
<td>Epilepsy (controlled)</td>
<td>3-9</td>
<td>Obesity</td>
<td>20-30</td>
</tr>
<tr>
<td>Migraine</td>
<td>18</td>
<td>General population</td>
<td>10.3</td>
</tr>
</tbody>
</table>


### Susan

You prescribe an SNRI and counsel Susan with regard to her migraine medicine:

1. Triptans can reduce antidepressant effectiveness
2. SRIs can reduce triptan effectiveness
3. A potentially life-threatening interaction can occur with a triptan and an SRI
4. SRI and triptan side effects are similar and can be more pronounced when taken together

### Susan

Susan returns in 4 weeks and is feeling better overall, however she is concerned that she has lost all interest in sex.

**What do you do now?**

1. Reduce the SNRI dose
2. Prescribe a PDE-5 inhibitor
3. Switch antidepressant to bupropion
4. Add nefazodone

### Triptans and Antidepressants

- Migraine and depression are common co-morbidities
- Patients should be cautioned that co-administration of a triptan and an SSRI, SNRI, MAOI, or TCA can rarely precipitate serotonin syndrome
  - symptoms may include confusion, agitation, high blood pressure, increased HR, muscle twitches, uncoordination, diarrhea, sweating, shivering, high fever, seizures
  - onset of symptoms can occur within minutes to hours of taking a new or a greater dose of a serotonergic medication
  - seek medical attention immediately if symptoms occur

### Side Effects of Antidepressant Drugs

**Side Effect**  | **Drugs/Drug Classes**
--- | ---
Anticholinergic | TCAs, SNRIs, bupropion
Sexual (ED, libido, orgasm) | SSRIs, SNRIs, MAOIs
Activation (esp. insomnia) | SSRIs, SNRIs, bupropion
Weight gain | SSRIs, mirtazapine, TCAs, MAOIs
Sedation, fatigue | TCAs, bupropion, mirtazapine, SSRIs, SNRIs
GI, reduced appetite | SSRIs, SNRIs, bupropion
Seizure | Bupropion, TCAs
Arrhythmias | TCAs, SSRIs
Hypertensive crisis | MAOIs

**Drug interactions:** additive/synergistic side effects with concomitant medications; cytochrome P450 enzyme inhibition

### Antidepressants Least Likely to Cause Sexual Dysfunction

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

**Serotonin norepinephrine reuptake inhibitors (SNRIs)**
- Venlafaxine, desvenlafaxine
- duloxetine
- milnacipran*

**Dopamine norepinephrine RI**
- bupropion

**Serotonin modulators**
- trazodone, nefazodone, vilazodone

**Norepinephrine-serotonin modulators**
- mirtazapine

**Tricyclics/tetracyclics (TCAs)**
- amitriptyline, nortriptyline, desipramine, doxepin, others

**Monoamine oxidase inhibitors (MAOIs)**
- selegiline, phenelzine, tranylcypromine, isocarboxazid
Strategies for Managing AISD

<table>
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<tr>
<th>STRATEGIES</th>
<th>PROS</th>
<th>CONS</th>
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<td>Tolerance</td>
<td>Simple</td>
<td>Low success rate</td>
</tr>
<tr>
<td>Lower dose</td>
<td>Simple</td>
<td>Relapse</td>
</tr>
<tr>
<td>Drug holiday</td>
<td>No additional medications</td>
<td>Potential discontinuation symptoms; relapse</td>
</tr>
<tr>
<td>Substitution</td>
<td>Single agent successful</td>
<td>Fear of therapeutic failure</td>
</tr>
<tr>
<td>Antidotes</td>
<td>Good success rate</td>
<td>Increased side effects; cost</td>
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Strategies for Managing AISD

- Substitute antidepressants with agents least associated with AISD
- Add antidotes*
  - Bupropion, buspirone, testosterone, sildenafil, mirtazapine, DHEA
  - Case reports suggest amantadine, cyproheptadine, yohimbine, dopaminergic agents, psychostimulants, ropinirole
  - Peripheral stimulation of the sympathetic nervous system (e.g., exercise) may affect SD from certain SSRIs

*Not FDA approved for AISD; strength of evidence-based data varies with agents

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*Not FDA approved for AISD; strength of evidence-based data varies with agents

Continuation of Antidepressants After Depression Remits

- Typically, treatment should continue for at least 6-9 months after substantial improvement
- Patients who have had ≥2 depressive episodes or who have chronic depression have a high probability of recurrence after drug discontinuation
- These patients may require ongoing maintenance treatment

Nonpharmacologic Treatments

- Cognitive behavioral therapy (CBT) may be as effective as drug therapy for acute outpatient treatment; can reduce relapse risk even after treatment is terminated
- Exercise may be helpful as adjunctive therapy for mild to moderate depression
- Sleep deprivation can have immediate but short-lived effects, but it can trigger mania in bipolar disease. Relapse usually occurs after sleep recovery
- Phototherapy (10,000 lux/30-60 min/day) may be effective as monotherapy for seasonal affective disorder and as adjunctive treatment in nonseasonal depression. Excessive exposure may trigger mania. Dawn simulators may also be effective adjuncts.
- Yoga and mindfulness-based therapies are promising but more research needed.

Susan: Take Home Points

- Women are at greater risk of depression in menopausal transition with or without prior depression history.
- Don’t just attribute symptoms to perimenopause if she meets criteria for MDD: underdiagnosed and undertreated.
- Co-morbidities (medical and psychiatric) and depression have a bidirectional relationship that may complicate diagnosis and treatment.
- Management of antidepressant side effects, treatment to remission, and adjunctive therapy rather than serial monotherapy should be standard of care.

Patient Case 3
Sylvia is a 78-year-old woman with incontinence episodes, gait disturbance, and social withdrawal

- Husband makes an appointment for her
- She is normally loving and involved in community, but she has not been herself for the last several weeks
  - Blank and vacant stare, even with grandchildren
  - Difficulty with cooking and seems disinterested
  - Remembers people but responses are slow
  - Gait is off and she takes small steps
  - Has had several urinary incontinence episodes

Sylvia

PMH

- TIA 4 years ago, some "white" areas on MRI that were dismissed as non-specific and commonly seen
- No history of murmurs, atrial fibrillation, valve disease, carotid stenosis

Interview

- Blank and limited facial expression
- Sits quietly in her chair, responds monosyllabically
- Responses to questions are slow, often begin with "I don't know," but is able to answer most questions accurately
- When asked to describe her mood, she says fine
- No evidence of psychosis; denies visual hallucinations

Sylvia

Exam

- Mini-mental state exam reveals that she has difficulty with short-term recall, multi-stage commands and figure drawings
- Wide-based and small-stepped gait
- Deep tendon reflexes seem normal to slightly slow in the relaxation phase
- Vitals are unremarkable; no fever, no bacteriuria
- There is no family or personal history of depression
- B12, folate levels, and TSH WNL

What is the most likely diagnosis?

1. Parkinson’s disease
2. Alzheimer’s disease
3. Minimal cognitive impairment
4. Vascular dementia
5. Vascular depression

Clinically Defined Vascular Depression

- Two groups of consecutively recruited patients ≥60 years with major depression
- Defined as vascular versus nonvascular depression based on age at first onset of depression (> or < age 60) and score on Cumulative Illness Rating Scale – Geriatrics
- Patients with vascular depression
  - greater overall cognitive impairment and disability
  - fluency and naming were more impaired
  - had more psychomotor retardation
  - less agitation and guilt
  - greater lack of insight

Sylvia

Vascular Depression Studies

- Elderly depressed patients vs. elderly controls:
  - Those with late onset depression had significantly more neurologic findings, e.g., abnormal complex motor sequencing, frontal lobe abnormalities
  - More ischemic lesions in deep white matter with hyperintensities on MRI; ischemic lesions more in dorsolateral prefrontal cortex
- Depressed patients with vascular changes were older and had more late-onset depression compared to depressed patients with nonvascular changes (patients with cognitive conditions were excluded)
Sylvia: Additional Points

- A helpful screening tool in elderly, especially this population, is the Geriatric Depression Scale (GDS) as it may be completed by caregiver, family, etc. and measures symptoms that elderly may report more than depressed mood.
- Dementia with depression may be difficult to discriminate from the pseudodementia of depression except by temporal onset.
- If not responsive to medication trial(s), ECT might be indicated; is a reason for referral.
- Psychotherapy may be useful, but amotivation and stigma in this population may limit success.
- Depression after age 60-70 requires ongoing, indefinite duration of treatment.

Patient Case 4

Beth is a 38-year-old woman with insomnia

- She presents with complaints of insomnia and fatigue x 6 weeks.
- Affect – anxious.
- At the end of the visit she breaks down crying.
- Husband of 8 years unexpectedly moved out of the house 6 weeks ago and she learned that he was having an affair.

Beth

PMH
- Noncontributory

Interview
- Reports daily difficulty falling asleep and feeling tired the next day.
- Cries nightly. Reports feeling hurt, betrayed, sad, and angry.
- Mood is down daily, about half the day (especially in pm).
- Appetite is normal.
- Denies feeling guilty or suicidal but wonders if she failed as a wife.
- Initially she had problems concentrating and missed 1 week of work after her husband left. Subsequently, she returned to work, and has been keeping up.
- Continues to care for children and last week enjoyed oldest child’s school play.

What is the most likely diagnosis?

1. Major depressive disorder
2. Depressive disorder not otherwise specified (mild depression)
3. Post-traumatic stress disorder
4. Adjustment disorder
5. No disorder

Beth

PMH
- Noncontributory

Interview
- Reports daily difficulty falling asleep and feeling tired the next day.
- Cries nightly. Reports feeling hurt, betrayed, sad, and angry.
- Mood is down daily, about half the day (especially in pm).
- Appetite is normal.
- Denies feeling guilty or suicidal but wonders if she failed as a wife.
- Initially she had problems concentrating and missed 1 week of work after her husband left. Subsequently, she returned to work, and has been keeping up.
- Continues to care for children and last week enjoyed oldest child’s school play.
Adjustment Disorder

- The development of emotional or behavioral symptoms in response to an identifiable stressor
- The symptoms are clinically significant as indicated by marked distress or impairment
- Criteria are not met for another specific psychiatric disorder
- No evidence that antidepressants are effective
- Psychotherapy is treatment of choice

From Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association 2010.

Applying Diagnostic Criteria for MDD

When diagnosing depression, how often do you determine whether patients meet DSM-IV diagnostic criteria for major depressive disorder?

1. Less than 25% of the time
2. 26-50% of the time
3. 51-75% of the time
4. More than 75% of the time

Psychiatrists’ Use of DSM-IV Criteria to Diagnose Major Depressive Disorder

When diagnosing depression, how often do you determine whether patients meet DSM-IV diagnostic criteria for major depressive disorder?

Nonpsychiatrist Physicians’ Use of DSM-IV Criteria to Diagnose MDD

When diagnosing depression, how often do you determine whether patients meet DSM-IV diagnostic criteria for major depressive disorder?

Overdiagnosis of Depression in Primary Care

- Meta-analysis of 41 studies of diagnostic accuracy
- For every 100 unselected cases seen in primary care
  - 15 false positive diagnoses of depression

Conclusion

- Psychiatric disorders are common in patients being managed for medical conditions by primary care clinicians
- Screening and identification of depression, anxiety, and substance use disorders can be done using office-based tools
- Treatment of depression should consider bidirectional relationship with psychiatric and medical co-morbidities
Q1. Post-Activity Audience Response Question

Which of the following has been studied extensively in adolescents and young adults and therefore should be considered first when treating a 22-year-old depressed patient?

1. Fluoxetine
2. Trazodone
3. Escitalopram
4. None of the above
5. 1 and 3 only

Q2. Post-Activity Audience Response Question

Which of the following is less likely to cause sexual side effects compared to SSRIs?

1. Trazodone
2. Bupropion
3. Mirtazapine
4. All of the above
5. 1 and 2 only

Q3. Post-Activity Audience Response Question

Which of the following regarding vascular depression in the elderly is TRUE?

1. Vascular depression is associated with greater agitation compared to nonvascular depression
2. Vascular depression occurs in older patients compared to nonvascular depression
3. Psychotherapy is the treatment of choice
4. All of the above