



City Health Information

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DETECTING AND TREATING DEPRESSION IN ADULTS

- **Primary care physicians can effectively detect and manage depression.**
- **Routinely screen for depression using a simple 2-question tool (PHQ-2).**
- **Depression can be treated. Medication and psychotherapy, alone or in combination, can help most patients.**

Depression is one of the most commonly seen conditions in primary care.¹ One in 4 women and 1 in 10 men will suffer from a major depressive episode during their lifetime.^{2,3} Postpartum depression affects 10% to 20% of women in the United States and has a negative impact on maternal, infant, and family health.⁴

Primary care physicians and other non-psychiatrists can effectively screen for and manage depression. Between 5% and 10% of patients screened for depression will meet diagnostic criteria for a current episode of depression, more in certain high-risk populations.⁵ There are barriers, however, to providing effective care, including lack of adequate education and training, time constraints, limited coordination with mental health programs, and inadequate reimbursement. These barriers result in too few patients being screened, identified, and adequately managed. Among older patients who committed suicide, 20% visited their primary care physician on the same day as their suicide, 40% within 1 week, and 70% within 1 month.⁶

DIAGNOSIS OF DEPRESSION

Screening for Depression

Observation and active listening during an office visit are powerful screening tools. Many depressed patients, especially the elderly, do not realize that they are suffering from depression. Thus, physicians should be alert to the possibility of depression in patients who present with unexplained physical symptoms. A patient's risk of having some type of mood disorder is directly related to the number of somatic symptoms with which they present.⁷ In a recent study, 69% of diagnosed, depressed patients reported unexplained physical symptoms as their chief complaint.⁸ Chronic anxiety or substance abuse may be associated with underlying depression.¹ Providers should be alert to clues indicating depression while performing the review of systems and taking a social history. Asking questions in an open-ended manner about a patient's level of functioning,

PHQ-2 – Screen for depression by asking the following 2 questions:⁹

Over the past 2 weeks, have you been bothered by:

- **little interest or pleasure in doing things?**
- **feeling down, depressed, or hopeless?**

A "yes" to either question requires further evaluation.

energy, motivation, and any work or social difficulties can reveal depression while avoiding stigmatization.

A physician can simply and quickly screen for depression by using a 2-question tool, the Patient Health Questionnaire-2, or PHQ-2 (see **Box**).⁹ If the patient's response to both questions is "no," then the screen is negative. If the patient responds "yes" to either question, or if you are still concerned about the possibility of depression, then consider asking more detailed questions or using the Patient Health Questionnaire (PHQ-9).⁹ This 9-item, self-administered questionnaire, available in many languages, can be completed by the patient before or during the office visit and can reliably detect and quantify the severity of depression (**Table 1**).⁹ Criteria for the diagnosis of a major depressive episode are provided in **Table 2**.¹⁰

Certain risk factors for depression should raise your index of suspicion that a patient should be screened: family history of depression, medical comorbidity (such as diabetes, heart failure, post-MI, HIV/AIDS, cancer, chronic pain), pregnancy and recent childbirth, and prior episodes of attempted suicide. In cases where patients are depressed, you should inquire about recent bereavement, medications, or drugs that can cause depressive symptoms. You should also ask if they have a history of bipolar illness or manic episodes; treating patients with an antidepressant alone may cause a mixed/manic episode in those with an undiagnosed bipolar disorder.¹⁰



TABLE 1. PATIENT HEALTH QUESTIONNAIRE (PHQ-9)*

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

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

add columns: + +

(Health care professional: For interpretation of TOTAL please refer to scoring card below)

TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
 Not difficult at all _____ Somewhat difficult _____
 Very difficult _____ Extremely difficult _____

***PHQ-9 QUICK DEPRESSION ASSESSMENT**

For initial diagnosis:

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

Consider Other Depressive Disorder if there are 2–4 ✓s in the shaded section (1 of which corresponds to Question #1 or #2).

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician. A definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of major depressive disorder or other depressive disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling

out normal bereavement, a history of a manic episode (bipolar disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

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

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

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for health professional use only

Scoring — add up all checked boxes on PHQ-9

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

Interpretation of Total Score

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

This PHQ-9 questionnaire is also available at www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

*Reprinted with permission from Spitzer RL, Kroenke K, Williams JBW, and the Patient Health Questionnaire Primary Care Study Group. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. JAMA. 1999;282:1737-1744. PRIME-MD PHQ-9. Copyright © 1999 Pfizer Inc.

TABLE 2. SUMMARY OF DSM-IV CRITERIA FOR MAJOR DEPRESSIVE EPISODE

- Five (or more) of the following symptoms have been present during the same 2-week period, nearly every day, and represent a change from previous functioning; at least 1 of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:
 - depressed mood most of the day
 - markedly diminished interest or pleasure in all, or almost all, activities most of the day
 - significant weight loss when not dieting, or weight gain, or decrease or increase in appetite
 - insomnia or hypersomnia
 - psychomotor agitation or retardation
 - fatigue or loss of energy
 - feelings of worthlessness or excessive or inappropriate guilt
 - diminished ability to think or concentrate, or indecisiveness
 - recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms do not meet criteria for a mixed episode (both depression and mania during the same episode), are not due to the direct physiological effects of a substance or a general medical condition, or are not better accounted for by bereavement.

Adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. text rev. Washington, DC: American Psychiatric Association; 2000.

Assessing Suicide Risk

Patients with depression may be at increased risk for suicide. For depressed patients, detecting suicidal risk can be life-saving. Asking a patient about suicidal thoughts or plans does not initiate such ideas or foster action. On the contrary, patients may be relieved if they are asked directly about their thoughts and feel that you are interested in their situation.¹¹

When the response to Question 9 on the PHQ-9 is positive, you must evaluate the patient's risk for suicide by further assessing the patient's thoughts and plans (Table 3), and by considering other risk factors:¹²

- Prior suicide attempts (best indicator of future suicide)
- Significant comorbid anxiety or psychotic symptoms and active substance use
- Access to firearms
- Living alone or poor social supports
- Male and elderly
- Recent loss or separation
- Hopelessness
- Preparatory acts (procuring means, putting affairs in order, warning statements, giving away personal belongings, suicide notes)

- Family history of affective disorder, suicide, alcoholism

Elicit the presence or absence of suicidal ideation

The physician should begin by asking depressed patients questions to elicit feelings about being alive, such as, "Have you ever felt that life is not worth living?" or, "Did you ever wish you could go to sleep and just not wake up?" Based on the response, the physician can proceed to more specific questions about suicide, such as, "Are you imagining that others would be better off without you?" and, "Are you having thoughts about killing yourself?"

Elicit the presence or absence of a suicide plan

If suicidal ideation is present, the physician should ask if the patient has a suicide plan. This includes asking how, where, and when suicide would be attempted. If the patient is actively thinking of suicide or has made attempts in the past – and particularly if he or she has a plan for committing suicide – the primary care physician should arrange a mental health consultation with a psychiatrist or other qualified mental health professional *as soon as possible*. This constitutes a medical emergency that may necessitate calling 911. The primary care physician and psychiatrist can decide which safety measures and treatments, including hospitalization, are needed. (See Table 4 for further information on management of the suicidal patient.)

When to Refer to a Psychiatrist

Referral to a mental health specialist should be considered for depressed patients who have a history of any of the following:

- Psychotic or manic symptoms
- Suicidal ideation or attempts
- Substance abuse or dependence
- Severe psychosocial problems
- Severe personality disorder
- Poor response to antidepressant medication

MANAGEMENT OF DEPRESSION BY THE NON-PSYCHIATRIST

Treatment Approaches

Once a diagnosis has been made, effective management may include patient education, supporting the patient's self-management efforts, treatment, and ongoing monitoring. Self-management goals could include:

- Taking medications regularly
- Spending time with people who are supportive
- Getting regular exercise
- Making time for enjoyable or relaxing activities

Depression may be treated with psychotherapy, pharmacotherapy, or both (see Algorithm, page 5). Either modality alone appears to be equally effective in treating mild depression, but there is less evidence that psychotherapy alone is effective for severely depressed patients.¹³

Some patients may be reluctant to see a specialist for psychotherapy, or may prefer not to take medication. It is important for the primary care physician to remain engaged with these patients, to approach them in a supportive manner, and to offer additional treatment or referral as

TABLE 3. SUICIDE RISK ASSESSMENT AND ACTION PLAN¹²

Risk assessment	Risk level	Action
No current thoughts of hurting or harming self, and no other major risk factors	Low risk	Continue follow-up visits and monitoring as per treatment algorithm
Current thoughts of harming or killing self, but no plans, previous attempts, or other major risk factors	Intermediate risk	Refer for urgent mental health assessment Assess suicide risk carefully at each subsequent visit and contract with patient to call you if suicide thoughts become more prominent
Current thoughts of harming or killing self, with plans	High risk	Emergency management by a mental health specialist Arrange a safe means for transport to the nearest emergency room

Reproduced with permission from Intermountain Health Care's Management of Depression Care Process Model - 2004 Update, p.11. Copyright 2004, Intermountain Health Care.

TABLE 4. MANAGEMENT OF THE SUICIDAL PATIENT*¹⁴

The following recommendations have been developed to aid physicians in assisting potentially suicidal patients:

Be attentive. The patient needs to believe that someone understands his or her distress and takes it seriously. It is essential that patients not feel ignored or that their concerns are being dismissed or minimized. Listen carefully and offer empathic statements.

Remain calm and do not appear threatened. This helps the patient to feel secure and facilitates a productive doctor-patient conversation.

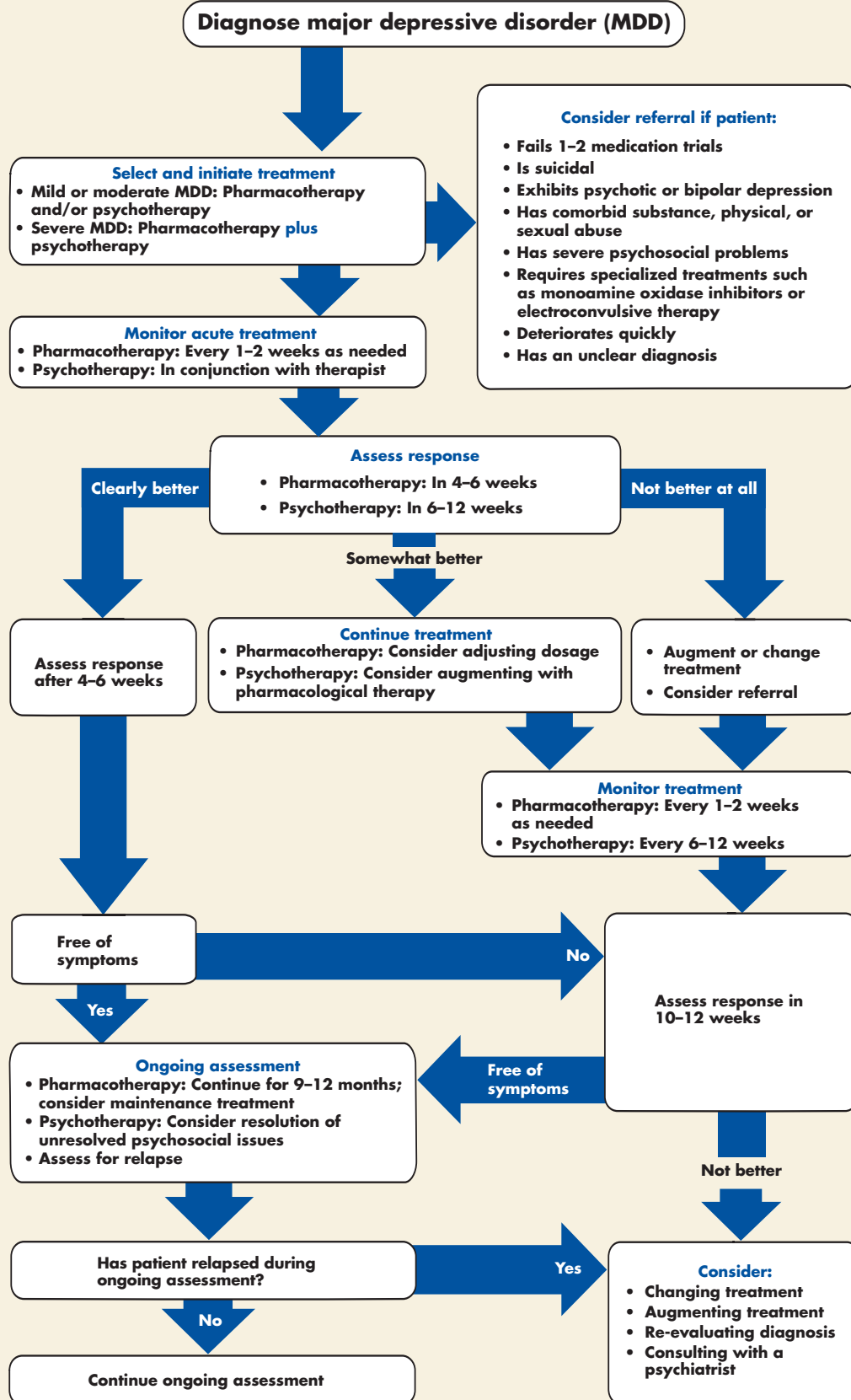
Stress a partnership approach. Let the patient know that he or she shares responsibility for choosing the treatment approach. Explain that the acute mental distress and hopelessness will subside with appropriate treatment.

Discuss suicide in a calm, reasoned manner. Emphasize that suicidal feelings are a symptom of a treatable condition, worsen when patients are under stress, and are often temporary. Avoid judgmental statements.

Emphasize that suicide causes a great deal of pain to family members. Explain that this pain may last for many years.

*This approach may be utilized when evaluating a patient for active suicidal intent or managing a patient with a history of suicidal ideation who is also under the care of a mental health professional.

DEPRESSION TREATMENT ALGORITHM



Adapted with permission from Schwenk TL, Terrell LB, Harrison RV, Shadigian EM, Valenstein MA. Depression (Update): UMHS Guidelines for Clinical Care. Ann Arbor, Mich: GUIDES, Office of the Executive Vice President for Medical Affairs, University of Michigan Health System; 2004.

the opportunity arises. When psychosis, suicidal ideation, or severe dysfunction is present, medication will be needed and hospitalization may be necessary. Electroconvulsive therapy may be useful for some of these patients, especially those with psychosis or failure to respond to treatment.

Educating the Patient

Patients often experience confusion and shame when given a diagnosis of depression. It is essential to try to dispel negative perceptions of the disorder with an explanation of the causes, mechanisms, and impact. Comparing depression to other treatable medical illnesses will help patients feel less stigmatized. For example, the physician can explain that depression is a physical illness just like hypertension, but that the brain is affected rather than the heart and blood vessels. Inform patients that antidepressant medication helps correct imbalances in brain chemicals.

The physician should provide information about available treatment options including effectiveness, and, if medication is prescribed, onset of action and potential adverse effects. Inform patients that they may need to take antidepressants for as long as 6 weeks before they experience any benefits and often weeks longer before maximum benefits are evident. Although some patients may respond quickly, all patients should be cautioned not to expect immediate symptom relief, especially of depressed mood (sleep and appetite may improve before mood). If patients know what to expect concerning the usual pharmacologic responses, they will be less likely to discontinue treatment prematurely before the medication takes effect.

Nonpharmacological Approaches

Selection of nonpharmacologic treatment options is influenced by the severity of depression, the preferences of the patient, and the experience of the physician. These can include psychotherapy, increased physical activity and other self-management techniques. Cognitive-behavioral and interpersonal psychotherapy alone have the best documented efficacy in the literature and can be considered an initial treatment in patients with mild to moderate major depressive disorders. Care and acceptance of the patient is in itself therapeutic. Listen for and explore beliefs about depression or treatment methods that could interfere with treatment and recovery. The BATHE mnemonic (see **Box, page 7**) summarizes a brief technique that is often useful to elicit and address mental health concerns in a busy practice.¹⁵ The technique can be employed in initial assessment and subsequent visits.

Pharmacotherapy

Selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and other agents, such as bupropion (Wellbutrin®), mirtazapine (Remeron®), and venlafaxine (Effexor®), are all effective in treating depression. Most

antidepressants are equally effective, therefore, a physician should consider the adverse effect profile of the medication, safety, and the patient's specific complaints. For example, a patient who complains of insomnia might benefit most from taking a more sedating antidepressant such as paroxetine or mirtazapine. Duration and dosage of an antidepressant are critical in determining the effectiveness of a therapeutic trial. Patients must take an adequate dosage of the medication for a sufficient period of time, otherwise it cannot be determined that the trial of medication has failed. When available, always try to choose generics first, lowering the cost for both the patient and the health care system. **Table 5** lists some individual agents with dosage ranges and information on cost. Monoamine oxidase inhibitors are not listed; they are now rarely used for depression because of potentially serious adverse effects, and they should be prescribed only by physicians experienced in their use.

Selective Serotonin Reuptake Inhibitors

SSRIs are the usual treatment of choice for depressed patients with or without anxiety symptoms when medications are indicated. SSRIs help normalize serotonergic imbalances, which may contribute to both depression and anxiety. All SSRIs have similar effectiveness. Their efficacy is comparable to that of tricyclic antidepressants,¹² but without the latter's anti-cholinergic and sedative effects. SSRIs are easier to administer, better tolerated, and less likely to result in fatality from an overdose.

Physicians who prescribe SSRIs for treatment of depression should be aware of the possible adverse effects. Patients should be informed that although the antidepressant effect is delayed, transient adverse effects can occur immediately. During treatment with an SSRI, patients may complain of feeling jittery or experience an increase in anxiety. Other adverse effects include nausea, headache, insomnia or sedation, delayed ejaculation in men, and anorgasmia in women.

Adverse Effects

Adverse effects are common with most, if not all, antidepressant medications, and patients should be aware of which symptoms to expect and how to cope with them. The newer antidepressant medications (SSRIs, bupropion, mirtazapine, and venlafaxine) are easier to dose and have more tolerable side effects, allowing for a quicker response, better adherence, fewer office visits, and lower cost.¹¹ Early adverse effects may cause patients to question the appropriateness of the medication or discontinue it before a therapeutic effect is achieved. Physicians should caution patients about early side effects and reassure them that these will usually diminish in less than 2 weeks or can be managed by adjusting or changing medications. Patients should be encouraged to discuss questions of dosage and side effects with their physician or pharmacist. Some of the common side effects that patients may experience with

THE BATHE MNEMONIC

The BATHE mnemonic is often useful in eliciting information from patients and addressing mental health concerns in a busy practice.¹⁵ The technique allows the physician to reinforce effective coping strategies and provide general support and ideas for the patient to use. The sequence is as follows:

- **Background** Ask open-ended questions such as “What is going on in your life?” to encourage open dialogue about issues that may be troubling the patient.
- **Affect** Questions such as “How do you feel about that?” or “What is your mood like lately?” make it possible for the patient to talk about the state of his or her feelings.
- **Trouble** Asking “What about the situation troubles you the most?” helps the physician elicit the meaning to the patient of a specific situation.
- **Handling** Asking “How are you handling that?” will help the physician assess the patient’s coping skills and level of functioning.
- **Empathy** Comments such as “That must be very difficult for you” or “I understand that is a difficult situation” legitimize the patient’s reaction to a situation.

TABLE 5. DRUGS FOR DEPRESSION^{16,17}

Drug	Usual Daily Dosage	Cost ^a
SSRIs		
Escitalopram – <i>Lexapro</i> ^{®*}	10–20 mg once/day	\$ 65.10
Citalopram – <i>Celexa</i> ^{®*}	40 mg once/day	79.50
Duloxetine – <i>Cymbalta</i> ^{®*}	20–30 mg b.i.d.	101.10
Fluoxetine – average generic price	20 mg once/day	72.45
<i>Prozac</i> ^{®*}		117.30
<i>Prozac Weekly</i> ^{®*}	90 mg once/week	92.88
Paroxetine – <i>Paxil</i> ^{®*}	20 mg once/day	85.20
<i>Paxil CR</i> ^{®*}	25 mg once/day	85.50
Sertraline – <i>Zoloft</i> ^{®*}	100–150 mg once/day	80.70
Tricyclic Antidepressants		
Amitriptyline – average generic price	150 mg once/day	26.40
Desipramine – average generic price	150 mg once/day	49.80
<i>Norpramin</i> ^{®*}		109.80
Imipramine – average generic price	150 mg once/day	79.20
<i>Tofranil</i> ^{®*}		226.80
<i>Tofranil PM</i> ^{®*}		122.10
Nortriptyline – average generic price	75–125 mg once/day	60.00
<i>Pamelor</i> ^{®*}		269.70
Other Antidepressants		
Bupropion – average generic price	100 mg t.i.d.	65.70
<i>Wellbutrin</i> ^{®*}		121.50
<i>Wellbutrin SR</i> ^{®*}	150 mg b.i.d.	112.80
Mirtazapine – average generic price	45–60 mg once/day	149.70
<i>Remeron</i> ^{®*}		88.20
<i>Remeron SolTab</i> ^{®*b}		76.80
Trazodone – average generic price	300 mg in divided doses	65.40
<i>Desyrel</i> ^{®*}		183.00
<i>Desyrel Dividose</i> ^{®*}		173.95 ^c
Venlafaxine – <i>Effexor</i> ^{®*}	75 mg b.i.d.	93.60
<i>Effexor XR</i> ^{®*}	150 mg once/day	86.70

^a Cost for 30 days’ treatment with the lowest usual dosage according to data from retail pharmacies nationwide provided by NDCHealth, a health care information services company, April 2003 and August 2004.

^b Disintegrating tablets.

^c Cost for 30 days’ treatment based on AWP listings in *Drug Topics Red Book* 2002.

Adapted with special permission from The Medical Letter, Inc. Treatment guidelines from The Medical Letter: Drugs for psychiatric disorders. *The Medical Letter*. 2003;1:69-76 and *The Medical Letter*. 2004;46(1193):81-83.

*Use of brand names is for informational purposes only and does not imply endorsement by the New York City Department of Health and Mental Hygiene.

antidepressants include gastrointestinal upset, sleep disturbance, sexual dysfunction, weight change, headaches, dry mouth, and sedation. Finally, patients should be counseled to avoid alcohol while taking an antidepressant because alcohol may reduce the medication's therapeutic effects, can depress mood, and because some antidepressants may potentiate the effects of alcohol.

Antidepressants can sometimes increase a patient's level of energy and activity before improving mood. While this can enable a person to act on suicidal ideas, the risk is far lower than the risk of suicide with untreated depression. Patients with suicidal thoughts should be counseled to call the physician immediately if such thoughts become more specific, frequent, or intense after initiation of an antidepressant. When antidepressant medication is reduced or stopped, patients can occasionally experience mild and fleeting symptoms (dizziness, nausea, lethargy, headaches) that can easily be avoided by gradually tapering the medication.

Prognosis

Untreated major depressive episodes typically last

6 months or longer and are a frequent cause of suicide. However, improvement is seen in approximately 70% to 80% of properly treated patients.¹⁸ To avoid relapse, patients should remain in psychotherapy, and continue medication at the same dosage for 9–12 months for the first episode of depression; longer for a second episode. Lifelong maintenance therapy should be considered for patients who have a history of psychotic depression or who have experienced 3 or more depressive episodes.

Most depressed patients will respond well to psychotherapy, pharmacotherapy, and supportive care in the primary care setting. Referral resources for formal psychotherapy or management of severe or complicated cases can be obtained by calling (800) LIFENET/ (800) 543-3638, or 311. Managing depression can be rewarding because treatments are available that can save lives and significantly improve daily functioning and quality of life. With screening, patient education, treatment, and careful monitoring, physicians can provide effective care for their depressed patients.

RESOURCES

Referrals

LIFENET TELEPHONE NUMBERS AND WEB SITE
24 Hours a Day and 7 Days a Week

In English: (800) LIFENET – (800) 543-3638 or 311

In Spanish: (800) AYUDESE – (877) 298-3373

In Chinese: (800) ASIAN LIFENET – (877) 990-8585

For other languages, call (800) LIFENET or 311 and ask for an interpreter.

TTY hard of hearing, call (212) 982-5284

Web site: www.mhaofnyc.org/

American Psychiatric Association Answer Center:
Locate a psychiatrist apa@psych.org or (888) 35-PSYCH

National Mental Health Association: Find a mental health professional for counseling www.nmha.org

Physician Resources

MacArthur Toolkit on Depression in Primary Care
www.depression-primarycare.org/clinicians/toolkits/

HSTAT: Guide to Clinical Preventative Services, 3rd Edition: Recommendations and Systematic Evidence Reviews, Guide to Community Preventative Services.
www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat3.chapter.1996

National Guideline Clearinghouse: Adult Primary Care Depression Guidelines. Kaiser Permanente Care Management Institute.
www.guideline.gov/summary/summary.aspx?view_id=&doc_id=6007

University of Michigan Depression Center
www.med.umich.edu/depression/

Intermountain Health Care: Management of Depression
www.ihc.com/xp/ihc/documents/clinical/103/8/5/cpmdepression.pdf

American Psychiatric Association
www.psych.org

Patient Resources

National Institute for Mental Health
www.nimh.nih.gov/publicat/depression.cfm

American Psychiatric Association
www.healthyminds.org/

References Online: To view references for this publication, visit www.nyc.gov/html/doh/downloads/pdf/chi/chi25-1-ref.pdf.



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CME Activity Detecting and Treating Depression in Adults

1. Factors that can increase a person's risk for depression include all of the following EXCEPT:

- A. Chronic medical conditions
- B. Prior suicide attempt
- C. Family history of sick sinus syndrome
- D. Family history of depression

2. All of the following statements about diagnosing major depressive disorder are correct EXCEPT:

- A. It is possible to simply and quickly screen for depression by asking 2 questions.
- B. DSM-IV criteria require that depressive symptoms be present for at least 2 months.
- C. At least one of the DSM-IV symptoms must be either depressed mood or loss of interest or pleasure.
- D. The PHQ-9 is a 9-item, self-administered questionnaire that can reliably detect and quantify the severity of depression.

3. All of the following statements about treating depression are true EXCEPT:

- A. Electroconvulsive therapy is a useful treatment for some severely depressed patients.
- B. Some patients may experience a transient increase in anxiety when they start taking an antidepressant medication.
- C. It may take 4–6 weeks before a patient begins to experience an adequate response to an antidepressant medication.
- D. SSRIs are not an effective treatment for severely depressed patients.

4. Self management goals for patients can include all of these EXCEPT:

- A. Drinking herbal teas
- B. Medication adherence
- C. Regular exercise
- D. Going to the movies with family/friends

5. All of the following statements about suicidal ideation are correct EXCEPT:

- A. Asking about suicidal ideation does NOT plant the idea in a patient's mind.
- B. If suicidal ideation is present, a patient should be asked if they have a plan.
- C. It is important to emphasize that suicide causes a great deal of pain to family members.
- D. It is not necessary to ask every depressed patient about suicidal ideation.

6. How well did this continuing education activity achieve its educational objectives?

- A. Very well
- B. Adequately
- C. Poorly

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Address _____

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CME Activity

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Instructions

Read this issue of *City Health Information* for the correct answers to questions.

To receive continuing education credit, you must answer 4 of the first 5 questions correctly.

If you would like to participate in this activity by submitting the response card:

1. Complete all information on the response card, including your name, degree, mailing address, telephone number, and e-mail address. PLEASE WRITE CLEARLY.
2. Select your answers to the questions and check the corresponding boxes on the response card.
3. Return the response card or a photocopy of the card postmarked no later than January 31, 2007. Mail to CME Administrator; NYC Department of Health and Mental Hygiene; 125 Worth Street, CN-29C; New York, NY, 10013.

Continuing Medical Education Detecting and Treating Depression in Adults

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JANUARY 2006 VOL. 25 NO. 1

Objectives

At the conclusion of this CME, participants should be able to:

1. Screen for major depressive disorder
2. Diagnose major depressive disorder
3. Assess suicidal ideation
4. Treat major depressive disorder

Accreditation

This continuing medical education (CME) activity is open to physicians (MDs, DOs) and physician assistants. The NYC DOHMH is accredited by the Medical Society of the State of New York to sponsor continuing medical education for physicians. The NYC DOHMH designates this continuing medical education activity for a maximum of 1.5 hours in Category One credit toward the AMA/PRA (Physician's Recognition Award). Each physician should claim only those hours of credit that he/she actually spent on the educational activity.

Participants in CME activities sponsored by the NYC DOHMH are required to submit their name, address, and professional degree. Such information will be maintained in the Department's CME program database. If participants in CME activities so request, the information will be used by the CME Program to verify whether a professional participated in an activity and, if the activity was associated with an exam, passed the exam.

The Department will not share information in the CME database with other organizations without permission from persons included in the database, except in certain emergencies or disasters where public health agencies deem communication with all health care providers to be essential or where required by law.

Participants who provide e-mail addresses upon registration for an activity may receive electronic announcements from the Department about future CME activities as well as other public health information.

Participants must submit the accompanying exam by January 31, 2007.

CME Activity Faculty:

Jorge Petit, MD, Lloyd I. Sederer, MD. All faculty are with the Division of Mental Hygiene, NYC DOHMH.

The faculty have no financial arrangement or affiliation with any commercial entities whose products, research, or services may be discussed in these materials.



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