Northeast Behavioral Health Partnership, LLC

Depressive Disorders Clinical Guidelines

Developed in Collaboration with Northeast Behavioral Health Partnership, Centennial Mental Health, North Range Behavioral Health, and Touchstone Health Partners

DSM-IV-TR Diagnostic Codes: 296.2x; 296.3x; 300.4; 311

Diagnostic Considerations:

1. **Review diagnostic criteria** in DSM-IV-TR. Use diagnostic decision tree for Differential Diagnosis of Mood Disorders (Appendix A) particularly when presentation is complex and may lead to a different treatment approach, e.g. bipolar disorders, schizoaffective disorder.
2. Utilize **standardized rating scale instruments** to assist in diagnosis and as a baseline for treatment outcomes. See the Appendix C for a list of public domain instruments.
3. **Consider age** as a factor in how symptoms of depression are manifested. In children, somatic symptoms, social withdrawal and decline in school performance are common. Among adolescents, depression is often associated with substance abuse, impulsive or reckless behavior, hypersomnia and increased irritability. In older adults, depression may manifest as cognitive impairment and increased somatic complaints.
4. **Refer to the client's medical provider** to rule out physical conditions that may mimic depression, e.g., hypothyroidism, sleep disorders, chronic fatigue syndrome, stroke, dementia, Parkinson's Disease, as well as medications with side effects similar to symptoms of depression, e.g., heart and blood pressure medications, steroids, and narcotics prescribed for pain relief.
5. **Assess for post-partum depression** if the client has given birth, miscarried or aborted a pregnancy within the previous 12 months, using an appropriate screening tool. If present, ensure mother and child are receiving medical follow-up.
6. **Consider co-morbid conditions**, such as substance abuse, as this can greatly complicate treatment. Evaluate for the presence of other psychiatric conditions, including anxiety, eating disorders, and disruptive behavior disorders.
7. **Assess for precipitating events**, including recent loss, interpersonal conflict, or recent changes in health or level of functioning. Significant psychosocial events may suggest grief or an Adjustment Disorder.
8. Carefully evaluate **suicidal risk**. Static factors that increase risk for self-harm include age, race, family history of mood disorders, past attempts to harm self, and multiple episodes of depression. Dynamic factors include psychosocial stress and support, substance abuse, and recent suicidal

ideation and/or attempts. See related guideline "Suicidal Behavior Clinical Guideline" on Assessing Suicidal Behaviors.

Treatment Guidelines:

1. Primary goals during initial treatment are to **ensure the client's safety and achieve symptom relief,** as early relief of symptoms is associated with continued engagement in treatment and superior long-term outcomes. Additionally, the client should be encouraged to resume and maintain normal daily activities with adequate symptom relief.
2. **Initiate a safety plan and assess suicide risk regularly**, particularly with a history of self-injury or suicide attempt, verbal statements regarding suicide or not wanting to live, or other risk factors (e.g., substance abuse, chronic pain, or recent loss). Suicide risk may increase as the client begins feeling better and experiences more energy. See related guideline "Suicidal Behavior Clinical Guideline" on Treating Suicidal Behaviors.
3. **Include family members** or other key supports in the treatment process; encourage participation, with the client, in safety planning or education about the illness and treatment process. See "Depression Tips" for education materials to use with families and clients.
4. Strongly consider a **referral for medication evaluation**, especially if the client is experiencing psychotic symptoms, suicidal ideation or behavior, or severe vegetative symptoms or when there is family history of mood disorders, recurrent episodes of depression, or past response to medications. If the client is prescribed medication for depression, support medication adherence and coordinate care with the prescriber.
5. The attached **medication algorithms** provide guidelines for the selection of medical therapies. Deviation from the algorithms should be documented in detail. Non-prescriber clinicians should provide information to the prescriber regarding medication effectiveness.
6. Initiate **evidence-based psychological treatment** for depression, e.g. Cognitive-Behavioral Treatment (CBT), Inter-personal Therapy (IPT), Problem-Solving therapy (PST). Psychotherapy is most productive with symptom relief and establishing sufficient emotional stability to address underlying issues, e.g. past trauma, marital conflict. See Appendix C for treatment manuals.
7. **Coordinate care with medical providers** as there is a significant body of research indicating that the relationship between depression and other health conditions is bidirectional. See Appendix A "Medical Illness and Major Depressive Disorder."
8. **Evaluate the effectiveness of treatment at regular intervals** using a self-report depression assessment instrument. If the client is not on medication and is not improving, consider referral

for medication evaluation. In addition reassess diagnosis, to ensure the correct treatment is in place and co-morbid conditions are addressed. Adjust treatment intensity as symptom severity improves or worsens.

9. **Consider cultural differences** in treatment planning by gaining comfort in asking about these differences (See Appendix B "Considering Culture When Treating Depression").
10. **Encourage healthy behaviors** such as regular exercise, alcohol use only in moderation, social support. Refer to wellness programs such as stress management and/or support groups.
11. Facilitate relapse prevention by helping the client/family **develop an action plan to** identify how the client will address early symptoms of depression.

References

Adapted from Gelenberg, A.J., Freeman, M.P., Markowitz, J.C., Rosenbaum, J.F., Thase, M.E., Trivedi, M.H., et al. Practice guideline for the treatment of patients with major depressive disorder [Internet]. 3rd ed. Arlington (VA): American Psychiatric Association; 2010 Oct [cited 2011, April 4]. Available from: http://www.psych.org/guidelines/mdd2010

Appendix A

Issue of Medical Illness and Major Depression Disorder (MDD)

A growing body of evidence describes the relationship between medical illness and Major Depression Disorder (MDD) as bidirectional. This phenomenon has been most extensively studied in cardiovascular disease, and recent evidence points to a bidirectional relationship between MDD and diabetes and obesity.

- MDD increases an individual's risk for developing a medical illness and worsens the prognosis of comorbid medical illnesses. Individuals, with MDD, are 2 to 3 times more likely to develop type 2 diabetes, congestive heart failure, and hypertension as well as 2-3 times more likely to have a heart attack (myocardial infarction) or stroke (cerebral vascular accident). In addition individuals with MDD, who have hypertension, a heart attack, or congestive heart failure, are at increased risk of mortality as a result of these disorders.
- Having a medical illness puts individuals at increased risk for developing MDD or worsening depression outcomes, including developing chronic depression, incomplete recovery of depressive symptoms, and more depressive relapses. One major study suggested that obesity increased the risk of onset of depression by 55%.

These studies suggest that interventions aimed at modifying factors associated with one illness will positively affect comorbid illnesses as well. This information supports the following for behavioral health staff treating an individual with MDD:

- The importance of ensuring coordination of care with the medical provider so that the medical provider knows that the individual is being treated for MDD
- Referral to psychiatry when there is a history of major medical problems, even if self-reported, in particular a heart attack (MI), congestive heart failure, hypertension, diabetes, or stroke, so that the psychiatrist can confirm and help monitor their medical history.

References

Katon, W.J. (2003). Clinical and health services relationship between major depression, depressive symptoms and general medical illness. Biological Psychiatry, 54 (8), 216-226.

Golden, S.H., Lazo, M., & Carnethon, M. (2008). Examining a bidirectional association between depressive symptoms and diabetes. JAMA, 299 (23), 2751-2759.

Luppino, F.S. , de Wit, I.M., & Bouvey, P.E. (2010). Overall weight, obesity, and depression: A systematic review and meta-analysis of longitudinal studies. Archives General Psychiatry, 67, (3), 220-229.

Golden, S.H., Williams, J.E., & Ford, D.E. (2004). Depressive symptoms and the risk of type 2 diabetes: ; The Atherosclerosis Risk in Communities study. Diabetes Care, 27, 429-435.

Hays, J.C., Krishnan, K.R., & George, L.K. (1997). Psychosocial and physical correlates of chronic depression. Psychiatry Res., 72, (3),149-159.

Koike, A.K., Unutzer, J., & Wells, K.b. (2002). Improving the care for depression in patients with comorbid medical illness. American Journal Psychiatry, 159, (10), 1738-1745.

Appendix B

Considering Culture when Treating Depression

Prevalence Rates

The 2009 SAMHSA National Surveys on Drug Use and Health reported that episodes of and treatment for major depression (MDE) that occurred over the past year can vary by ethnicity:

Ethnicity	Percent Reporting a MDE within Past Year	Percent Reporting Receiving Treatment for a MDE
Two or more races	13.3%	65.2%
Native Hawaiian or Other Pacific Islander	11.6%	Not reported
American Indian or Alaskan Native	9.7%	Not reported
White	8.0%	69.6%
Black or African American	6.5%	57.4%
Latino	6.3%	53.4%
Asian	3.6%	48.0%

*Data collected from 2004-2007.

In addition Cochran (2001) reported that lesbian and gay youths reported higher levels of depression and that gay men exhibit higher rates of depression. And the CDC (2008) reports that depression occurs at twice the rate in women as in men (aged 20 to 29).

It is important to note that the prevalence rates may be influenced by cultural factors in the reporting of symptoms.

Treatment:

Try to avoid ethnocentrism when treating individuals with cultural backgrounds different than your own. Ethnocentrism refers to the tendency for all people to think about situations based upon their own cultural viewpoint and the belief that their own cultural viewpoint is superior.

It is important to cultivate the ability to be comfortable in asking about cultural differences. Client preferences for treatment may vary based on their ethnicity and culture; asking your clients about their treatment preferences is recommended (Kaiser, 2006).

Here are some things you can ask of your clients that may help you provide culturally appropriate treatment for depressive symptoms (adapted from the DSM-IV Cultural Formulation pp: 843-844):

- Assess your client's cultural identity—ethnicity, sexual orientation, age, sex/gender, etc.
- Assess your client's cultural explanation of illness—this may vary from a biological explanation (e.g., depression runs in my family) to a spiritual explanation (e.g., the weight of my sins makes me very sad).
- Assess cultural factors related to psychosocial functioning—these can represent areas of strength such as an extended support system (e.g., grandparents, spiritual leader) or represent challenging areas such as social stigma (e.g., family does not support mental health treatment and thinks the client should "just snap out of it").

Appendix C

Additional Resources

Public Domain Depression Rating Scales:

http://www.depression-primarycare.org/images/pdf/phq_9_eng.pdf (PHQ-9)

http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf (CES-DC; children)

http://www.chcr.brown.edu/pcoc/cesdscale.pdf (Center for Epidemiological Studies-Depression Scale)

http://healthnet.umassmed.edu/mhealth/ZungSelfRatedDepressionScale.pdf (Zung Self-Rating Depression Scale)

http://healthnet.umassmed.edu/mhealth/HAMD.pdf (Hamilton Rating Scale for Depression)

http://www.psy-world.com/madrs_print1.htm (Montgomery and Asburg Depression Rating Scale)

http://www.stanford.edu/~yesavage/GDS.html (Geriatric Depression Scale)

Cognitive-Behavioral Treatment Manuals:

CBT manual for treating adolescents with depression:
https://trialweb.dcri.duke.edu/tads/tad/manuals/TADS_CBT.pdf

A Brief Behavioral Activation Treatment for Depression: http://web.utk.edu/~dhopko/BATDmanual.pdf

Group Therapy manual for CBT Treatment of Depression:
http://epsy.tamu.edu/uploads/files/Elliott/CPSY%20633%20-%20Group%20Counseling/CBGT%20Depression.pdf

Treatment manuals for depressed youth by Clarke and Lewinsohn; includes group and individual treatment manuals:
http://www.kpchr.org/public/acwd/acwd.html

Klerman, G., Wisssman, M. & Rounsaville, B. (1984). *Interpersonal Psychotherapy of Depression*. New York: Basic Books.

Websites with Helpful Tips for Clients:

DBSA - Depression and Bipolar Support Alliance: http://www.dbsalliance.org

Mental Health America: http://www.nmha.org/

ValueOptions® Achieve Solutions: https://www.achievesolutions.net/achievesolutions

Books/Workbooks:

Mind Over Mood by Dennis Greenberger and Christine Padesky

Skills Training Manual for Diagnosing and Treating Chronic Depression by James McCullough.