



Depression Toolkit for Primary Care Clinicians

The Patient Health Questionnaire
(PHQ-9) Adult Toolkit

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This toolkit is intended to provide educational guidance for clinicians on the subject of depression and should not be relied upon other than for informational purposes. The document is not intended to provide medical advice to either individuals or members. The information provided in the document is not member-specific and clinicians should verify both the accuracy of any statement in the document and the applicability before relying upon such statement. Any steps in the management of depression should include the discussion of risks and benefits as well as member preference.

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Introduction

At AmeriHealth Caritas District of Columbia we recognize the earliest and best opportunities to identify depression are in the offices of primary care providers since depressive disorders are commonly seen in primary care settings. Depression is a potentially life-threatening disorder that affects approximately 14.8 million Americans 18 years of age and older in a given year. Depression also affects many people younger than age 18. The STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study found that nearly 40 percent of youth had their first depressive episode before the age of 18.¹

Unfortunately, depression is associated with substantial morbidity and disability for individuals. Yet, depression is a highly treatable condition. AmeriHealth Caritas District of Columbia believes that primary care providers should be equipped to screen for depression and provide immediate treatment either in their own practices or by referring to a mental health professional. Toward this end, AmeriHealth Caritas District of Columbia is seeking your assistance in the identification and treatment of depression.

This Depression Toolkit is intended to help primary care clinicians effectively assess, treat and monitor depression in adults with this condition. The kit will provide you with easy-to-use tools to engage the member in the process of treatment and to educate and empower members to participate in their own treatment plans. As a clinician you can effectively select an appropriate management approach for treating depression by using the evidence-based guidelines and management tools for treating depression that were adopted by the American Psychiatric Association. These guidelines cannot replace good clinical judgment, and they should not be the sole source of guidance for adult depression management.

The screening process starts with the Patient Health Questionnaire (PHQ-9), a well-known and valid tool. You may already have this depression tool in your electronic health records system. If not, the PHQ-9 is included in this manual. The PHQ-9 is a nine-item self-report depression scale that guides the clinician in making criteria-based diagnoses of depression and assessing the severity of depressive disorders. Additionally, the measure's sensitivity to severity makes it useful in monitoring response to treatment.

The PHQ-9 is based on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual 5th Edition (DSM-5) and has excellent psychometric properties. Additional benefits in using the PHQ-9 are the short administration time and the easy score tabulation and interpretation.

AmeriHealth Caritas District of Columbia will support your screening process by providing available staff who can guide your process and, if necessary, provide member outreach and interventions. Thank you in advance for your participation in this crucial program.

Recognition and Diagnosis of Depression in Adults

Recognizing depression and safety tools

AmeriHealth Caritas District of Columbia has adopted the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition. You can find this guideline online at the link below. The original guidelines are from 2010, with an update in December 2011, but no changes were noted and the current guidelines were re-adopted.

<http://psychiatryonline.org/guidelines.aspx>

Additionally, Up to Date at <http://www.uptodate.com/home> is an excellent source for clinicians, with current research, evidence-based treatment and recommendations to improve patient outcomes.



Recognizing depression tools

Through interviewing or examining a member, the clinician may observe signs of depression. Being diagnosed with a chronic condition is a common trigger for depression, so you may want to consider screening all members with a chronic condition. Some members may also self-identify or present with multiple somatic complaints. These tools may aid in forming a preliminary diagnosis.

DSM-5 diagnostic criteria for depression

For major depressive disorders, at least five of the following symptoms must be present most of the day for at least two weeks. Also, at least one of the first two symptoms must be present.

- Depressed mood
- Marked diminished interest in usual activities
- Significant increase or loss in appetite or weight
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Difficulty with thinking, concentrating or making decisions
- Recurrent thoughts of death or suicide

Source: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition 2013. (2)

Addressing risk

- Presence, history, lethality of suicidal ideation, intent or plans
- Access to means for suicide and the lethality of those means, such as access to a firearm
- Lifetime history, nature, seriousness and number of previous suicide attempts and aborted attempts
- Presence of hopelessness, psychic pain, decreased self-esteem or narcissistic vulnerability
- Presence of severe anxiety, panic attacks, agitation or impulsivity
- Presence and history of aggression and violence
- Presence of alcohol or other substances
- Presence of psychotic symptoms, such as command hallucinations or poor reality testing
- Presence of acute or chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties, or changes in socioeconomic status, family discord, domestic partner violence, and past or current sexual or physical abuse or neglect
- Absence of psychosocial support, such as poor relationships with family, unemployment, living alone, unstable or poor therapeutic relationship, or recent loss of a relationship
- History of childhood traumas, particularly sexual and physical abuse
- Family history of or recent exposure to suicide



Source: Adapted from APA's Practice Guideline for Assessment and Treatment of Patients with Suicidal Behaviors (3)

Suicide screening questions

1. In the past month, have you made any plans or considered a method that you might use to harm yourself? If yes, what?
2. There is a big difference between having a thought and acting on a thought. Do you think you might actually make an attempt to hurt yourself in the near future? If so, what is the plan?
3. Do you think there is any risk that you might hurt yourself before your next visit (with your doctor)?

Action steps	
No current thoughts with or without risk factors.	Continue to monitor the member and schedule follow-up appointments.
Current thoughts with no plan, or intent with or without risk factors.	Contract with the member for safety. Monitor him or her with each visit. Monitor his or her response to medication. Educate the member and his or her family. Provide a local crisis intervention number. Consider behavioral health referral if the member's thoughts continue despite support and treatment.
Current thoughts with a plan.	Immediate response: direct the member to a crisis center or local emergency room.

When initially assessing the member, the clinician should consider other conditions that may appear with depressive-like symptoms, such as medication side effects. Antihypertensive drugs, cardiovascular drugs, sedatives, analgesics, narcotics, anti-inflammatory agents and hormones can influence a member's mood. Additionally, the use of alcohol and street drugs can influence presentation.

Use of the Adult Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9) can be self administered before or during the office visit. The PHQ-9 can be found on the next page with scoring and further explanations to follow. The English and Spanish versions are available for you to use and reproduce as needed. Translations into other languages are available by going to www.phqscreeners.com. Many of the translations have been developed by the MAPI Research Institute using an internally accepted translation methodology.



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Adult Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

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

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
Little interest or pleasure in doing things.				
Feeling down, depressed or hopeless.				
Trouble falling or staying asleep, or sleeping too much.				
Feeling tired or having little energy.				
Poor appetite or eating.				
Feeling bad about yourself — or that you are a failure or have let yourself or your family down.				
Trouble concentrating on things like reading the newspaper or watching television.				
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.				
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.				
Total:				

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

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Cuestionario Sobre La Salud Del Paciente-9 (PHQ-9)

Nombre: _____ Dia: _____

Durante las últimas **2 semanas**, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

	(0) Ningún día	(1) Varios días	(2) Más de la mitad de los días	(3) Casi todos los días
Poco interés o placer en hacer cosas.				
Se ha sentido decaído(a), deprimido(a) o sin esperanzas.				
Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado.				
Se ha sentido cansado(a) o con poca energía.				
Sin apetito o ha comido en exceso.				
Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia.				
Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión.				
¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que.				
Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera.				
Total:				

Si marcó cualquiera de los problemas, ¿qué tanta dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar o llevarse bien con otras personas?

☐ No ha sido difícil
☐ Un poco difícil

☐ Muy difícil
☐ Extremadamente difícil

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Directions

1. The member should complete the PHQ-9 by circling the number that most closely reflects his or her thinking for the past **two weeks**
2. Add up each column and place the score at the end of column in the box
3. Add together column scores to get a total score. The PHQ-9 score for the nine items ranges from 0 – 27.
4. Interpret the total score by using the below box

PHQ-9 proposed treatment actions

PHQ-9 score	Depression severity	Proposed treatment actions
0 – 4	None to minimal	None
5 – 9	Mild	Watchful waiting. Repeat PHQ-9.*
10 – 14	Moderate	Treatment plan, and consider counseling, follow-up and/or pharmacotherapy.
15 – 19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy.
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if the member shows severe impairment or poor response to therapy, initiate an expedited referral to a mental health specialist for psychotherapy and/or collaborative management.

* This may not be necessary until member is further in treatment. Source: Kroenke K, Spitzer, Psychiatric Annals (4).

Please note the final question of the PHQ-9 asks the member to report “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?” This single member-rated difficulty item is not used in calculating the PHQ-9 score or in diagnosis, but rather provides an impression of how the symptoms impair the member and can be useful in deciding or adjusting treatment options.

Treatment of depression

The Texas Algorithm is one approach the clinician may want to review when treating depression. It can be viewed at: <http://www.pbhcare.org/pubdocs/upload/documents/TMAP%20Depression%202010.pdf>.

The first line of treatment for the member with mild depression may only be counseling in the clinician's office, in which supportive strategies and coping skills are discussed. Counseling efforts should focus on solutions. Sharing educational materials with the member and answering questions as needed may by itself decrease depressive symptoms. The member may want to set goals he or she would like to meet between doctor appointments. Always schedule a follow-up appointment to monitor if the symptoms have been eliminated or changed. Organized support groups in the community are another source of support and resources.

If the member's **depression is moderate**, counseling and an antidepressant may be warranted. The decision for medication, counseling and/or both should be a joint decision based on the advantages and disadvantages. The use of combined treatment with psychological counseling and antidepressants is often recommended for members who have partial response to either type of treatment alone or have complex psychological problems, including members with borderline personality disorder. Clearly, members who have severe depression and/or chronic illness or poor inter-episode recovery would also benefit from combined treatment.

Factors in considering an antidepressant may include patient preference, prior response to antidepressant, safety, tolerability and anticipated side effects. Co-occurring psychiatric or general medical conditions — and their potential drug interactions — may also influence which medication category to choose. When selecting a counselor, the member may want to consider past personal experience, the location of the facility, gender preference, religious perspective and if the

agency is an in-network AmeriHealth Caritas District of Columbia provider. A customer service representative at AmeriHealth Caritas District of Columbia is available to assist in finding a provider who meets the needs of the member.

Members should be informed that antidepressant medication is not a cure for depression, but the medication is effective in alleviating some symptoms. Antidepressants work to balance some of the natural chemicals in our brains. You may want to explain to the member that these chemicals are called neurotransmitters and they affect our moods and emotional responses. Encourage the member to be patient since the full effect may not occur for four to eight weeks. Additionally, the member may experience side effects, but many are alleviated over time.

Approximately 60 percent to 70 percent of patients respond to the first antidepressant prescribed or to an increased dosage of that drug, but unfortunately 30 percent to 40 percent do not. National Institute of Mental Health-funded research has shown that patients who did not get well after taking the first medication increased their chances of becoming symptom-free after they switched to a different medication or added another medication to their existing one.⁶

There are different types of medication for the treatment of depression, such as selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), atypical antidepressants, tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). The most widely prescribed antidepressants are the SSRIs. The SSRIs include well-known antidepressants such as Prozac, Zoloft and Paxil. Research suggests there is little difference in the effectiveness of these newer antidepressants, but there may be differences in side effects, costs and how long the medication takes to work.

SNRIs are used for depression, but sometimes used to treat other conditions such as anxiety and nerve pain. SNRIs include Cymbalta, Effexor XR and Pristiq. Atypical antidepressants are those that do not fit into any other categories. Wellbutrin, Trazadone, Remeron and Nefazodone fall into this group. Generally, these medications have fewer sexual dysfunction symptoms and may be considered for this reason.

Tricyclics and older antidepressants are effective, but are usually not a first-choice treatment for depression because of numerous side effects. This category includes Anafranil, Tofranil, Surmontil, Pamelor and Norpramin, to name a few. Similarly, the MAOIs are used as a last resort because of numerous bothersome and potentially dangerous serious side effects and the need for a special diet. These medications are Nardil, Parnate and Marplan.

The most common side effects associated with SSRIs and SNRIs include:

- Headache, which usually goes away within a few days
- Nausea, which also usually goes away within a few days
- Sleeplessness or drowsiness, which may go away, but not for some individuals. Sometimes the dose may need reduction or the time of day to take the medication may need adjustment.
- Agitation, a feeling of jitteriness
- Sexual dysfunction, reducing sex drive and possibly enjoyment of sex

Tricyclic medications can also cause side effects, including:

- Dry mouth
- Constipation
- Bladder issues, such as difficulty emptying or the stream being not as strong
- Sexual dysfunction, reducing sex drive and potentially enjoyment

Serious risks

In October 2004, the Food and Drug Administration (FDA) directed manufacturers to add a boxed warning to the labeling of all antidepressant medications to alert the public about the increased risk of suicidal thinking or suicide attempts by children and adolescents taking antidepressants. In May 2007, the FDA directed that the warning should be extended to include young adults up through age 24. The warning also says patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment, for possible side effects, suicidal thinking or unusual changes in behavior such as agitation, social withdrawal and difficulty sleeping. The latest information from the FDA can be found at <http://www.fda.gov/>.

Additionally, some members may respond to antidepressants by becoming overly talkative and overactive, and sleeping less than normal. These individuals may be in a manic state and should be seen by a clinician for an evaluation to rule out bipolar disorder. For this reason, after completing the PHQ-9, a brief bipolar screener should be completed on any member you are considering for an antidepressant. Antidepressants are augmented with mood stabilizers for individuals with bipolar symptoms. It is also important to consider family history of bipolar disorder. A positive family history would increase the likelihood of bipolarity in the member. Below is a brief screener for manic symptoms, followed by a table of typical antidepressants and their available doses.

Mania

Has there ever been a period of at least four to seven days when you felt very happy, excited and full of energy, or really agitated, or have your family, friends or a therapist said you were manic?

A “yes” response indicates the potential for bipolar disorder. The member should be assessed further for mania.

DSM-5 diagnostic criteria for bipolar disorder

For bipolar disorder, at least four of the following symptoms must be present most of the day for at least four to seven days. Also, one of the symptoms must be the first symptom listed.

- A period of persistent elevated, expansive or irritable mood
- Marked diminishment in sleep
- Pressured speech
- Flight of ideas or racing thoughts
- Distractibility
- Increased goal-directed activity or psychomotor agitation
- Excessive involvement in activities that have high potential for consequences (spending sprees or risky ventures)
- Inflated self-esteem or grandiosity

Source: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition 2013.(7)

Antidepressants

This table is provided for your use with permission from MDwise Inc., Indianapolis, Indiana. Each medication plan may be different: to ensure these medications are approved through the member’s plan, please contact AmeriHealth Caritas District of Columbia directly.

Therapeutic class/ brand name	Dosage forms	Recommended starting dose	FDA maximum daily dose	Monthly cost*
Selective serotonin reuptake inhibitors				
CELEXA (generic) citalopram	10, 20, 40 mg tablet 10 mg/5ml solution	20mg qD	40mg	\$6.50
LUVOX (generic) fluvoxamine	25, 50, 100 mg tablet	100mg qD	300mg	\$13 – 30
PAXIL/PAXIL CR (generic)paroxetine	10, 20, 30, 40 mg tablet 12.5, 25, 37.5 mg ER tablet	20mg qD (tablet) 25mg qD (ER tablet)	60mg (tablet) 75mg (ER tablet)	\$8 – \$200

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Therapeutic class/ brand name	Dosage forms	Recommended starting dose	FDA maximum daily dose	Monthly cost*
PROZAC (generic) fluoxetine	10, 20 mg tablet 10, 20, 40 mg capsule 20mg/5ml solution	20mg qD	80mg qD	\$5 – 25
ZOLOFT (generic) sertraline	25, 50, 100 mg tablet 20mg/ml concentrate	50mg qD	200mg qD	\$7 – 10
LEXAPRO escitalopram	5, 10, 20 mg tablet 5mg/5ml solution	10mg qD	20mg qD	\$90 – 95
LUVOX CR fluvoxamine	100, 150 mg capsule	100mg qD	300mg	\$180 – 195
VIIBRYD Vilazodone	10, 20, 40 mg tablet	10mg qD	Not available	\$104
PROZAC WEEKLY fluoxetine	90mg delayed release capsule	90mg q Wk	90mg q Wk	\$110

Therapeutic class/ brand name	Dosage forms	Recommended starting dose	FDA maximum daily dose	Monthly cost*
Serotonin and norepinephrine reuptake inhibitors				
EFFEXOR/EFFEXOR XR (generic) venlafaxine	25, 37.5, 50, 75, 100 mg tablet 37.5, 75, 150 225 mg ER tablet 37.5, 75, 150 mg ER capsule	25mg TID (tablet) 75mg qD (ER tablet) 75mg qD (ER capsule)	375mg (tablet) 225mg (ER tablet) 225mg (ER capsule)	\$29 – 44
PRISTIQ desvenlafaxine	50, 100 mg ER tablet	50mg qD	Not available. Doses up to 400mg/day have been used.	\$110 – 220
CYMBALTA duloxetine	20, 30, 60 mg capsule	20mg BID	60mg	\$110 – 230
SAVELLA Milnacipran	12.5, 25, 50, 100 mg tablet	12.5mg qD	200mg	\$65 – 122

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Therapeutic class/ brand name	Dosage forms	Recommended starting dose	FDA maximum daily dose	Monthly cost*
Atypical antidepressants				
WELLBUTRIN/ WELLBUTRIN SR, WELLBUTRIN XL (generic) bupropione	75, 100 mg tablet 100, 150, 200 mg 12hr tablet 150, 300 mg 24hr tablet	75mg BID (tablet) 150mg qD (12hr/24hr tab)	450mg (tablet) 400mg (12hr) 450mg (24hr)	\$35 – 63
trazodone HCl (generic)	50, 100, 150, 300 mg tablet 150, 300 mg ER tablet	75mg BID (tablet) 150mg qD (ER tablet)	400mg (tablet) 375mg (ER tablet)	\$6 – 11
REMERON/ REMERON SOLUTAB (generic) mirtazapine	7.5, 15, 30, 45 mg tablet	15mg qD	45mg	\$8.50 – 45
nefazodone HCl (generic)	50, 100, 150, 200, 250 mg tablet	50mg BID	Not available. Doses up to 600mg have been used.	\$30 – 38

*Estimated costs include the use of the State Medical Advisor Committee.

Sources

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – TR (2000). American Psychiatric Association. American Psychiatric Association (2010). Practice guideline for major depressive disorder in adults. American Journal of Psychiatry, 167 (suppl. 4), 1 – 52.

VHA/DOD (2000), Clinical practice guideline for the management of major depressive disorder in adults Version 2.0 (Contract number: V101 (93)P-1633), Washington, DC. HEDIS 2012, Volume 2.

Monitoring and follow-up

The goal of the acute phase is remission of symptoms, which should lower the PHQ-9 score. The clinician may repeat the PHQ-9 to measure the initial response after four weeks of an adequate dose of antidepressant or six weeks of counseling; however, the clinician may choose to repeat the PHQ-9 after true stability occurs, which could be several months into treatment. Below is a table that can guide treatment planning decisions.

Antidepressant only		
PHQ-9 score	Treatment response	Treatment plan
Drop of 5 points from baseline	Adequate	No change needed. Follow up in four weeks.
Drop of 2 – 4 points	Possibly adequate	May warrant an increase in antidepressant dose.
Drop of 1 point or no change or increase	Inadequate	Increase dose, augment, switch, and/or add psychiatric consultation or counseling.

Counseling only		
PHQ-9 score	Treatment response	Treatment plan
Drop of 5 points from baseline	Adequate	No change needed. Follow up in four weeks.
Drop of 2 – 4 points	Possibly adequate	Probably no treatment change needed. Share PHQ-9 with psychiatrist or psychologist.
Drop of 1 point or no change or increase	Inadequate	<p>If depression-specific psychological counseling (CBT, PST, IPT*), discuss with therapist and consider adding an antidepressant.</p> <ul style="list-style-type: none"> • Members satisfied in their other type of therapy consider antidepressant • Members dissatisfied in other psychological counseling, review other treatment options and preferences

*CBT — Cognitive Behavioral Therapy; PST — Problem Solving Treatment; IPT — Interpersonal Therapy

Source: Depression Management Tool Kit, MacArthur Initiative. (8)

To reduce the risk of relapse, ongoing medication treatment may be necessary for four to nine months, especially if there are additional risk factors for likelihood of recurrence, such as family history, co-occurring disorders or continued residual symptoms. Ongoing collaboration and communication are encouraged between clinician and psychiatrist or therapist. A release of information is necessary and should be completed at the time of referral.

A referral to behavioral health treatment may be necessary if the member is voicing:

- Threat of harm to self or others
- Significant change in emotions or behavior with no obvious precipitants
- A loss of function at home, school or work
- Poor response to current medication regimen
- Current or past trauma issues
- Chronic medical issues compounding behavioral health symptoms
- Recent psychiatric admission
- Poor response to current counseling offered by PCP
- Suggestion or knowledge of drug and alcohol issues
- Signs of changing to “manic” behaviors
- Perinatal and postpartum depression

Perinatal and postpartum depression

Major depression disorders during pregnancy and the postpartum period pose unique challenges. About 10 percent of women develop depression during pregnancy. Half will remit with delivery but half continue to have symptoms postpartum. Other women who were not depressed during pregnancy may become depressed afterwards. The term “perinatal depression” covers depression during and after pregnancy.

It is critically important to differentiate depression in the postpartum period from the much rarer, but more dangerous, condition of postpartum psychosis. Identifying psychosis is both easier and harder than identifying other perinatal conditions. Psychosis may begin very early, within three days of delivery. Women with psychosis may be sleepless, irrational or markedly different from their normal selves. However, some conceal their symptoms for fear they will be institutionalized or lose their infants. History from the woman’s partner or another observing adult may be needed. An observer’s request to have a newly delivered mother screened for severe depression or psychosis should always be taken very seriously.

Postpartum women are also at increased risk for obsessive compulsive disorder (OCD) and severe anxiety of other kinds. Screening instruments other than the PHQ-9 are available to identify OCD and anxiety disorders. The Edinburgh Postnatal Depression Scale (EPDS) uncovers symptoms of anxiety as well as depression. A referral should be made to the member’s behavioral health plan so a complete evaluation can be completed.

Women who have experienced depression in the past, including during or after previous pregnancies, are at higher risk for perinatal episodes. For this reason, prenatal screening should always include questions about prior episodes of mood disorder.⁹ Other risk factors include stressors, such as if the mother doesn't want the pregnancy, has a poor relationship with her partner or mother, or has severe psychosocial stress. Stress may include poverty or problems negotiating accommodation for pregnancy with an employer. Vomiting that persists beyond the usual period of morning sickness may also be a sign of depression in pregnancy. Many of the normal symptoms of pregnancy, such as changes in weight, sleep problems and fatigue, overlap with those of depression. Nevertheless, the PHQ-9 still offers clinicians a valid way to screen women during pregnancy. The EPDS, which was designed to take the overlapping symptoms into account, may also be used to screen pregnant women. The EPDS can be found at this website: http://www2.aap.org/sections/sc/practicingsafety/Toolkit_Resources/Module2/EPDS.pdf.

If the responses to the screen suggest depression, the clinician should discuss treatment. Many milder forms of depression in pregnancy respond to time-limited counseling, ranging from acknowledgement and monitoring by the care provider to various forms of brief psychotherapy, including interpersonal psychotherapy and cognitive behavioral therapy.

After delivery, more than 50 percent of all women experience affective symptoms, especially tearfulness, in the first two weeks. These "blues" are, by definition, self-limiting. They may begin within 48 hours of delivery and should not last more than 10 days. The blues require only assurance.

However, between 10 percent and 20 percent of women have or develop diagnosable postpartum depression. About half of these will have been depressed during pregnancy and half develop symptoms only after delivery. Postpartum depression ranges from mild to life-threatening. Women's risk for suicide falls during pregnancy, but the postpartum period is the time of women's highest risk for psychiatric hospitalization. Risks for both suicide and infanticide must be considered during this time. (Note, many lay people assume that a woman with postpartum depression wants to hurt her baby. Knowing others think this can prevent a woman from disclosing her distress. In fact, most women with postpartum depression are excessively concerned about the health and well-being of their infants.)

If medication is needed, discuss the risks and benefits of antidepressants during pregnancy and breast-feeding. The discussion should cover both the risks of untreated mood disorders in pregnancy and the postpartum period, and current research on the safety of antidepressants during pregnancy or while nursing. Women can be reassured that, although the risks of treatment are not completely known, the available information is relatively reassuring. Not treating a serious condition like depression also involves significant risk.

Untreated depression during pregnancy will make it difficult for the woman to function at home or work. Depression contributes to discord in marriages and raises the risk of suicide (though suicide during pregnancy is somewhat rarer than at other times). Untreated depression in pregnancy also poses risk to the fetus, being associated with low birth weight and prematurity risk.

Because medical ethics make it difficult to do well-designed research on pregnant women, all that we know about the risk of medication comes from animal studies and retrospective reviews of large numbers of women who take medication during pregnancy without being involved in research. The longer a medication has been available, the more data we have about its effects in pregnancy. If an antidepressant is needed for a pregnant woman, it is advisable to use an older rather than a newer drug, unless there is a specific reason not to. Such reasons include allergy or a woman's prior history with response or nonresponse to a particular drug.

The risks of any medication in pregnancy vary over time. Because the fetal body is fully formed by 14 weeks' gestation, the risk for so-called "birth defects" or malformations is only an issue in the first trimester. Malformations occur in 2 percent to 4 percent of all pregnancies. No increase in any specific malformation has been associated with the use of antidepressants early in pregnancy. Benzodiazepines given late in the first trimester have been weakly associated with facial cleft deformities (cleft lip/palate).

Antidepressants in the second trimester are not associated with any known risk. In the third trimester, the use of SSRIs may contribute to a slight risk for premature delivery, but only by a week.¹⁰ The possibility that SSRIs, especially Paxil, may contribute to a rare condition called "persistent pulmonary hypertension of the newborn" may need to be considered. The condition is often minor, but occasionally it is lethal. Around 10 percent of infants exposed to SSRIs in utero may show signs of distress postpartum, the "neonatal abstinence syndrome." This syndrome may require an extra day or two in special care nursery, but is not life threatening.

As described earlier, postpartum blues is not a major depressive disorder and does not require medication. However, women who develop postpartum depression typically also describe having had the blues. If the woman's history or the duration or severity of her postpartum symptoms suggest major depression, she should be screened for hypothyroidism, with a TSH level. If that is normal, antidepressants may be used. The available data do not indicate any particular evident risk of damage to a nursing infant from maternal use of an antidepressant. However, absence of evident risk is not proof of safety. In general, after the child is three months old, when his or her liver is fully mature, the risks from medication taken by a nursing mother are extremely low. Before that, unless there is a specific reason to use a particular antidepressant in a nursing mother (allergies, prior response or nonresponse), it is advisable to use older drugs with published studies on breast milk excretions. Nortriptyline (a tricyclic antidepressant) allows for measurement of blood levels in both the mother and the infant. Sertraline (Zoloft) has also been studied. It has a short half-life and relatively low excretion into breast milk. No effects on the infant have been found.

Clinicians should discuss with members the risks of medicating compared with the risks of untreated depression. For additional information on the risks of antidepressants during pregnancy or while nursing, go to the Massachusetts General Women's Mental Health site at <http://womensmentalhealth.org> or to <http://jama.jamanetwork.com/article.aspx?articleid=191970>.

Member resources

Materials are in the public domain and can be reproduced by clinicians. Member tools are located in the appendix.

Support and how to refer for behavioral health services

AmeriHealth Caritas District of Columbia can provide support to members during their treatment phases. If you feel barriers are present that prevent our member from achieving his or her behavioral health care goals, such as medication noncompliance, not showing up for appointments, inappropriate use of the emergency room or limited knowledge concerning his or her behavioral needs, please call our Rapid Response and Outreach Team (RROT). A Member Intervention Request Form can also be completed and faxed directly to the RROT in lieu of calling. Both numbers are available on your contact list.

Reimbursement

The behavioral health screening code recommended for your state and based on the 2013 AMA CPT Manual will be reviewed by your AmeriHealth Caritas District of Columbia trainer.

Payment for completion of a PHQ-9 can occur at initiation of treatment (baseline) and one additional time during treatment to establish adequacy of treatment.

Continuing medical education (CME) opportunities for the clinician

The Agency for Healthcare Research and Quality offers CME opportunities on various topics, including mental health.

<http://www.effectivehealthcare.ahrq.gov/index.cfm/tools-and-resources/cmece-activities/#mental/>

Additional resources for physicians

Depression and Bipolar Support Alliance

<http://www.dbsalliance.org/site/PageServer?pagename=home>

National Alliance of Mental Illness

<http://www.nami.org/>

Mental Health America

<http://www.mentalhealthamerica.net/>

American Psychiatric Association

<http://www.psychiatry.org/mental-health/>

American Academy of Family Physicians/FamilyDoctor.org

<http://familydoctor.org/familydoctor/en/diseases-conditions/depression.html>

National Institute of Mental Health

<http://www.nimh.nih.gov/health/index.shtml>



To refer a member for behavioral health treatment, please call the behavioral health managed care number provided on the member's card.

Depression Toolkit for Primary Care Clinicians

The Patient Health Questionnaire (PHQ-9) Adult Toolkit

Citations

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Rapid Response and Outreach Team Numbers

State	Phone number	Fax number
Pennsylvania, Indiana, Nebraska	1-800-573-4100	1-800-647-5627
South Carolina	1-866-899-5406	1-866-279-6377
Louisiana	1-888-643-0005	1-877-724-4838
Florida	1-866-935-6686	1-855-894-6888
Washington, D.C.	1-877-759-6222	1-888-607-6405
Michigan	1-888-288-1722	1-855-851-0433

Appendix

What is Depression?

Everyone occasionally feels blue or sad. But these feelings are usually short-lived and pass within a couple of days. When you have depression, it interferes with daily life and causes pain for both you and those who care about you. Depression is a common but serious illness.

Many people with a depressive illness never seek treatment. But most, even those with the most severe depression, can get better with treatment. Medications, psychotherapies and other methods can treat people with depression.

There are several forms of depressive disorders.

- Major depressive disorder, or major depression, is a mixture of symptoms that interfere with a person's ability to work, sleep, study, eat and enjoy once-enjoyable activities. Major depression can be disabling if not treated and stops a person from doing his or her usual activities. Some people may have only a single episode within their lifetimes, but more often a person may have many episodes.
- Dysthymic disorder, or dysthymia, is when a person has a long-term (2 years or longer) depression but it may not be severe enough to disable a person. Still, it can stop the person from doing usual activities or from feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.
- Minor depression is characterized by having symptoms for 2 weeks or longer that do not meet the definition for major depression. Without treatment, people with minor depression are at high risk for changing to major depressive disorder.

Some forms of depression are slightly different, or they may happen for unusual reasons.

They include:

- Postpartum depression, which is much more serious than the “baby blues” that many women have after giving birth, when hormone fluctuations and physical changes occur and the new duties of caring for a newborn can be overwhelming. It is estimated that 10 percent to 15 percent of women have postpartum depression after giving birth.
- Seasonal affective disorder (SAD), which is when depression happens during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be treated with light therapy, but nearly half of those with SAD do not get better with light therapy alone. Antidepressant medication and psychotherapy can lower SAD symptoms, either by themselves or with light therapy.

Sometimes a person will report feelings of sadness to his or her doctor and the doctor will treat him or her for depression. Later, the person may report feeling very excited and overly happy. The doctor would change that person's diagnosis and treat him or her for **bipolar disorder**. Bipolar disorder is not as common as major depression or dysthymia and usually takes time for the doctor to identify. Bipolar disorder usually appears in the late teens or early adult years and the person has mood swings, feeling very good and then feeling sad. The doctor will treat this illness with a different medication than he or she would suggest for depression.

Causes

Most likely, depression is caused by a mix of your genes, your life situations, where you live and your emotions. Some types of depression tend to run in families. However, depression can occur in people without family histories of depression, too. Scientists are studying certain genes that may make some people more likely to get depressed. In addition, trauma, loss of a loved one, a difficult relationship or any stressful situation may trigger a depressive episode. Other depressive episodes may occur with or without an obvious trigger.

Signs and symptoms

The signs of depression are different for each person. Many people say it is hard to get out of bed in the morning or they just want to hide under the covers and not talk to anyone. Some say they don't feel like eating, and then they lose some weight. Some say that nothing seems fun anymore. Most people feel tired all the time and they don't sleep well at night. They may have to push themselves to take care of themselves or their children. Sometimes a person can feel hopeless, like nothing is going to change or get better.

People with depressive illnesses do not all have the same symptoms. How severe symptoms are, how often they occur and how long they last depend on the person and his or her illness.

Signs and symptoms include:

- Ongoing sadness, anxiousness or “empty” feelings
- Feelings of hopelessness or negativity
- Feelings of guilt, worthlessness or helplessness
- Irritability, restlessness
- Loss of interest in activities or hobbies that used to be fun
- Being tired and having low energy
- Finding it hard to concentrate, remember details and make decisions
- Poor sleep, early-morning waking or sleeping too much
- Eating too much, or not enough
- Thoughts of suicide, suicide attempts
- Aches and pains, headaches, cramps, or digestive problems that do not ease even with treatment

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<http://www.nimh.nih.gov/index.shtml>.

¿Qué Es la Depresión?

Todos nos sentimos melancólicos o tristes a veces. Pero estos sentimientos no suelen durar mucho y se pasan en un par de días. Cuando tenemos depresión, esta interfiere en nuestra vida cotidiana y le causa dolor a usted y a quienes se preocupan por usted. La depresión es una enfermedad frecuente pero grave.

Muchas personas con depresión nunca buscan tratamiento. Pero la mayoría, incluso quienes padecen la depresión más grave, pueden mejorar con tratamiento. La medicación, las psicoterapias y otros métodos se pueden utilizar para tratar a las personas con depresión.

Existen varias formas de trastornos depresivos.

- El trastorno depresivo mayor, o depresión mayor, es una mezcla de síntomas que interfieren con la capacidad de una persona para trabajar, dormir, estudiar, comer o disfrutar de actividades que antes disfrutaba. Si no se trata, la depresión mayor puede ser discapacitante e impedir que una persona realice sus actividades habituales. Algunas personas solo tendrán un episodio único en sus vidas, pero es más frecuente que una persona sufra de muchos episodios
- Se habla de trastorno distímico, or distimia, cuando una persona tiene una depresión prolongada (2 años o más), pero no lo suficientemente grave como para discapacitarla. Sin embargo, puede impedir que la persona haga sus actividades habituales o se sienta bien. También es posible que las personas con distimia experimenten uno o más episodios de depresión mayor en sus vidas
- La depresión menor se caracteriza por presentar síntomas que no responden a la definición de depresión mayor durante dos semanas. Sin tratamiento, las personas con depresión menor tiene un riesgo alto de pasar a un trastorno depresivo mayor

Algunas formas de depresión son levemente diferentes, o pueden suceder por razones no habituales. Las formas de depresión son:

- Depresión posparto, que es mucho más grave que la “baby blues” (tristeza después de tener un bebé) que muchas mujeres tienen después de dar a luz, cuando hay cambios hormonales y físicos, y los nuevos deberes de cuidar a un recién nacido pueden resultar excesivos. Se calcula que del 10 al 15 por ciento de las mujeres tienen depresión posparto después de dar a luz
- Trastorno afectivo estacional (SAD, del inglés seasonal affective disorder), que se llama así cuando la depresión se experimenta durante los meses de invierno, cuando hay menos luz solar natural. Por lo general, la depresión se va durante la primavera y el verano. El SAD se suele tratar con fototerapia (terapia con luz), pero casi la mitad de los pacientes con SAD no mejoran solo con fototerapia. La medicación antidepresiva y la psicoterapia pueden reducir los síntomas de la SAD, ya sea solas o acompañadas con fototerapia

A veces una persona manifestará síntomas de tristeza a su médico, quien la tratará por depresión. Más tarde, la persona puede manifestar que se siente muy entusiasmada o demasiado feliz. El médico cambiará el diagnóstico de esa persona y la tratará por **trastorno bipolar**. El trastorno bipolar no es tan frecuente como la depresión mayor o la distimia, y el médico suele tardar en identificarlo. El trastorno bipolar suele aparecer al final de la adolescencia o al principio de la adultez, y la persona tiene cambios de estado de ánimo, se siente muy bien y luego triste. El médico tratará esta enfermedad con otra medicación distinta a la que él indicaría para la depresión.

Causas

Lo más probable es que la causa de la depresión sea una mezcla de sus genes, sus situaciones de vida, el lugar donde vive y sus emociones. Algunos tipos de depresión tienden a darse en las familias. Sin embargo, también puede aparecer en personas sin antecedentes familiares de depresión. Los científicos están estudiando algunos genes que, probablemente, hagan a las personas más propensas a deprimirse. Además, una situación traumática, la pérdida de un ser querido, una relación difícil o cualquier situación estresante quizá disparen un episodio depresivo. Otros episodios depresivos pueden ocurrir con un disparador obvio o sin él.

Signos y síntomas

Los signos de depresión son diferentes en cada persona. Muchas personas dicen que les resulta difícil salir de la cama a la mañana o que solo quieren taparse y no hablar con nadie. Algunos dicen que no tienen ganas de comer y empiezan a bajar de peso. Otros dicen que ya nada les parece divertido. La mayoría se siente cansada todo el tiempo y no duerme bien de noche. Quizá tengan que presionarse para ocuparse de sí mismos o de sus hijos. A veces una persona puede sentirse desesperanzada, como si nada fuera a cambiar o a mejorar.

No todas las personas con enfermedades depresivas tienen los mismos síntomas. La gravedad y la frecuencia de la enfermedad, y la duración de los síntomas varían según la persona y su enfermedad.

Algunos signos y síntomas son:

- Sentimientos presentes de tristeza, ansiedad o “vacío”
- Sentimientos negativos o de desesperanza
- Sentimientos de culpa, desvalorización o impotencia
- Irritabilidad y desasosiego
- Pérdida de interés en actividades o hobbies que antes eran divertidos
- Cansancio o falta de energía
- Dificultad para concentrarse, recordar detalles y tomar decisiones
- Alteraciones del sueño, despertarse temprano a la mañana o dormir demasiado
- Consumo excesivo o deficiente de alimentos
- Pensamientos suicidas o intentos de suicidio
- Dolores generales, dolores de cabeza, calambres o problemas digestivos que no se alivian ni siquiera con tratamiento

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Managing Your Depression

Depression, even the most difficult cases, can be treated. The sooner that treatment can begin, the better treatment will work.

The first step is to visit a primary care provider, or doctor. Certain medications, and some medical problems such as viruses or a thyroid disorder, can cause the same signs as depression. A doctor will do a physical exam, talk to you and sometimes do blood work. If the doctor can find no medical reason that may be causing the depression, the next step is to complete a depression test.

The doctor may feel he or she can treat the depression by just talking with you or by ordering an antidepressant. Sometimes, the doctor will suggest you see a mental health professional, who would discuss with you any family history of depression or other mental disorder and get a complete history of your symptoms. You should talk about when your symptoms started, how long they have lasted, how severe they are and if you have had depression before. If you had depression before, they will ask how you were treated for the depression. The mental health professional may also ask if you are using alcohol or drugs, and if you are thinking about death or suicide.

Treatments

Once diagnosed, a person with depression can be treated in several ways. The most common treatments are medication and psychotherapy.

Medication

Antidepressants work on brain chemicals called neurotransmitters, especially serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists have found that these particular chemicals help keep your mood even, but they are unsure of exactly how they work.

Popular newer antidepressants

Some of the newest and most-used antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil) and citalopram (Celexa) are some of the most commonly used SSRI antidepressants. Most are available in generic versions.

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include medications such as venlafaxine (Effexor) and duloxetine (Cymbalta).

SSRIs and SNRIs tend to have fewer side effects than older antidepressants, but they sometimes cause headaches, nausea, jitters or difficulty sleeping when people first start to take them. These symptoms tend to fade with time. Some people also have sexual problems with SSRIs or SNRIs, which may be helped by changing the dose or trying another medication.

One popular antidepressant that works on dopamine is bupropion (Wellbutrin). Bupropion tends to have similar side effects to SSRIs and SNRIs, but it is less likely to cause sexual side effects. However, this medicine has been known to cause seizures in some people.

Tricyclics

Tricyclics are older antidepressants. Tricyclics are powerful, but they are not used as much today because their side effects are more serious.

MAOIs

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. They can be especially effective in cases of “atypical” depression, such as when a person experiences increased appetite and the need for more sleep rather than decreased appetite and sleep. They also may help with feelings of anxiety or panic.

However, people who take MAOIs must avoid certain foods and beverages (including cheese and red wine) that contain a substance called tyramine. Certain medications, including some types of birth control pills, prescription pain relievers, cold and allergy medications, and herbal supplements, also should be avoided while taking an MAOI. These substances can interact with MAOIs to cause dangerous increases in blood pressure. The development of a new MAOI skin patch may help reduce these risks. If you are taking an MAOI, your doctor should give you a complete list of foods, medicines and substances to avoid.

How should I take medication?

All antidepressants must be taken for at least 4 to 6 weeks before they have a full effect. You should continue to take the medication, even if you are feeling better, to prevent the depression from returning.

Medication should be stopped only under a doctor’s care. Some medications need to be lowered slowly before stopping completely so the body has time to react to the lesser dose. Antidepressants are not habit-forming but suddenly ending an antidepressant can cause withdrawal symptoms or lead to a relapse of the depression. Some people with chronic depression may need to stay on the medication most of their life.

Psychotherapy

Several types of psychotherapy — or “talk therapy” — can help people with depression.

Two main types of psychotherapies — cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) — are both helpful in treating depression. CBT helps the person look at their negative thinking. The therapist will help the person look at issues differently instead of always going to the negative side. By changing old thinking patterns, the person can look at his or her home, relationships and job in a positive and better way. It may also help the person look at what may be the actual cause of the depressive feelings and help the person make the right changes. Interpersonal therapy (IPT) helps people understand and work through troubled relationships that may be causing their depression or making it worse.

For mild to moderate depression, psychotherapy may be the best option. However, for severe depression and for certain people, psychotherapy may not be enough, and treatment through medication and psychotherapy together, for a longer period of time, may be needed.

How can I help myself if I am depressed?

If you have depression, you may feel tired, helpless and hopeless. It may be very hard to take any action to help yourself. But as you begin to understand your depression and begin treatment, you will start to feel better.

To help yourself

- Do not wait too long to get evaluated or treated. Try to see a professional as soon as possible.
- Try to be active and exercise. Go to a movie, a ballgame, or another event or activity you once enjoyed.
- Set goals for yourself that you can make and keep
- Break up large tasks into small ones and start on the important ones first. Do what you can as you can.
- Try to spend time with other people and confide in a trusted friend or relative. Try not to close yourself off from others who are trying to help you.
- Your mood will improve slowly; it will not be overnight. Do not think you will “snap out of” your depression.
- Don’t make big decisions, such as getting married or divorced or changing jobs, until you feel better. Talk about your decisions with others who know you well and have a clear view of your issues.
- Remember that positive thinking will replace negative thoughts as your depression reacts to treatment
- Continue to educate yourself about depression

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Cómo Manejar la Depresión

La depresión puede tratarse, aún en los casos más difíciles. Cuanto más pronto se pueda empezar el tratamiento, mejor va a funcionar.

El primer paso es visitar a un médico o proveedor médico primario. Algunos medicamentos, y algunos problemas médicos como los virus o un trastorno de la tiroides, pueden causar los mismos signos que la depresión. Un médico le hará un examen físico, hablará con usted y, algunas veces, le pedirá un análisis de sangre. Si el médico no puede encontrar una razón médica que pueda causarle la depresión, el paso siguiente es hacer un test de depresión.

El médico puede sentir que puede tratarle la depresión solo hablando con usted o indicándole un antidepresivo. Algunas veces, el médico le sugerirá que visite a un profesional de la salud mental, que hablará con usted sobre sus antecedentes familiares de depresión u otros trastornos mentales, y obtendrá un historial completo de sus síntomas. Usted debería hablar de cuándo empezaron sus síntomas, cuánto duran, cuán graves son y si tuvo depresión antes. Si tuvo depresión antes, el profesional de la salud mental le preguntará qué tratamiento recibió para la depresión. Puede preguntarle también si está consumiendo drogas o alcohol, y si piensa en la muerte o el suicidio.

Tratamientos

Una vez diagnosticada, una persona con depresión puede tratarse de diversas formas. Los tratamientos más frecuentes son la medicación y la psicoterapia.

Medicación

Los **antidepresivos** trabajan sobre las sustancias químicas cerebrales denominadas neurotransmisores, en especial la serotonina y la norepinefrina. Otros antidepresivos trabajan sobre la dopamina, otro neurotransmisor. Los científicos han descubierto que estas sustancias químicas particulares ayudan a mantener parejo el estado de ánimo, pero no están seguros de cómo trabajan exactamente.

Los antidepresivos populares más nuevos

Algunos de los antidepresivos más nuevos y más consumidos se llaman inhibidores selectivos de la recaptación de serotonina (ISRS). Algunos de los antidepresivos ISRS más usados son fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil) y citalopram (Celexa). La mayoría está disponible como medicamento genérico.

Los inhibidores de la recaptación de serotonina y norepinefrina (IRSN) son similares a los ISRS, y entre ellos se encuentran medicamentos como venlafaxine (Effexor) y duloxetine (Cymbalta).

Los ISRS y los IRSN tienden a tener menos efectos secundarios que los antidepresivos más antiguos, pero a veces causan dolores de cabeza, náuseas, nerviosismo o dificultad para dormir cuando las personas empiezan a tomarlos por primera vez. Estos síntomas tienden a irse con el tiempo. Algunas personas también tienen problemas sexuales con los ISRS o IRSN, y se las puede ayudar con un cambio en la dosis o probando otros medicamentos.

Un antidepresivo popular que trabaja sobre la dopamina es el bupropion (Wellbutrin). Tiende a tener efectos secundarios similares a los de los ISRS o IRSN, pero es menos probable que cause efectos secundarios sexuales. Sin embargo, se sabe que estos medicamentos pueden causar convulsiones en algunas personas.

Tricíclicos

Los tricíclicos son antidepresivos más antiguos. Son poderosos, pero no se usan mucho hoy porque sus efectos secundarios son más graves.

Los IMAO

Los inhibidores de la monoaminoxidasa (IMAO) son la clase más antigua de antidepresivos. Pueden ser especialmente efectivos en casos de depresión “atípica”, como cuando una persona no tiene disminución del apetito y del sueño sino que experimenta aumento del apetito y la necesidad de dormir más. También pueden ayudar con los sentimientos de ansiedad o pánico.

Sin embargo, las personas que toman IMAO deben evitar determinados alimentos y bebidas (como el queso y el vino tinto) que contienen una sustancia llamada tiramina. También deberían evitarse algunos medicamentos, como algunos tipos de píldoras anticonceptivas, analgésicos recetados, antialérgicos y medicamentos para el resfrío, y suplementos herbarios, cuando se toma un IMAO. Estas sustancias pueden interactuar con los IMAO y causar aumentos peligrosos de la presión arterial. El desarrollo de un nuevo parche cutáneo de IMAO puede ayudar a reducir estos riesgos. Si está tomando un IMAO, su médico debería darle una lista completa de alimentos, medicamentos y sustancias que debe evitar.

¿Cómo tomo el medicamento?

Todos los antidepresivos deben tomarse por lo menos de 4 a 6 semanas antes de que tengan un efecto total. Debe seguir tomando el medicamento, incluso si se siente mejor, para evitar que vuelva la depresión.

El medicamento debería suspenderse solo con control médico. Algunos medicamentos tienen que reducirse lentamente antes de dejarlos completamente para que el cuerpo tenga tiempo de reaccionar a una dosis menor. Los antidepresivos no crean dependencia, pero interrumpir un antidepresivo de repente puede provocar síntomas de abstinencia o producir una recaída de la depresión. Algunas personas con depresión crónica quizás tengan que estar medicadas la mayor parte de su vida.

Psicoterapia

Varios tipos de psicoterapia, u “orientación psicológica”, pueden ayudar a las personas con depresión.

Para tratar la depresión, son útiles dos tipos principales de psicoterapia: terapia conductual cognitiva (TCC) y la terapia interpersonal (TIP). La TCC ayuda a la persona a observar su pensamiento negativo. El terapeuta le ayudará a ver los problemas desde diferentes puntos de vista en lugar de hacerlo siempre del lado negativo. Al cambiar viejos patrones de pensamiento, la persona puede mirar su hogar, relaciones y trabajo de una forma positiva y mejor. También es posible que le ayude a ver cuál puede ser la causa real de los sentimientos depresivos y a hacer los cambios correctos. La terapia interpersonal (TIP) ayuda a las personas a entender y trabajar las relaciones conflictivas que puedan estar causando su depresión o empeorándola.

En el caso de depresión leve o moderada, la mejor opción es la psicoterapia. Sin embargo, en caso de depresión grave y para algunas personas, es posible que la psicoterapia no alcance y se necesite un tratamiento combinado de medicación y TIP, durante un período más largo.

¿Qué puedo hacer por mi mismo si estoy deprimido?

Si tiene depresión, tal vez se sienta cansado, impotente y desesperanzado. Puede que le resulte muy difícil actuar para ayudarse. Pero a medida que empieza a entender su depresión y comience un tratamiento, empezará a sentirse mejor.

Cómo ayudarse

- No espere mucho tiempo para llegar a una evaluación o tratamiento. Trate de ver a un profesional lo más pronto posible.
- Trate de estar activo y de hacer ejercicio. Vaya al cine, a un partido de pelota u otro evento o actividad que antes disfrutaba.
- Fije metas que pueda alcanzar y mantener
- Divida las tareas grandes en pequeñas, y comience por las más importantes. Haga lo que pueda en la medida que pueda.
- Trate de pasar tiempo con otras personas y confiar en un amigo o familiar de confianza. Trate de no aislarse de otros que tratan de ayudarlo.
- Su estado de ánimo mejorará lentamente; no será de la noche a la mañana. No piense que “saldrá de golpe” de su depresión.
- No tome grandes decisiones, como casarse o divorciarse, o cambiar de trabajo, hasta que se sienta mejor. Hable de sus decisiones con otros que lo conozcan bien y tengan una visión clara de sus problemas.
- Recuerde que, a medida que su depresión reaccione al tratamiento, el pensamiento positivo reemplazará a los pensamientos negativos
- Siga informándose sobre la depresión

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Recovering from Depression

Treatment for depression may start with just talking — or maybe taking an antidepressant — but there is more you can do to help yourself recover. Recovery may take weeks, and learning how to help yourself get well and stay well is very important. You may want to make a recovery plan that focuses on the action steps you need to take to stay well. Your plan is whatever you want it to be, and it should be simple so you can follow it daily. Get a notebook and write a few steps down. For example, you may include the following action steps:

- Eating three healthy meals a day
- Drinking plenty of water
- Going to bed at a good regular time for you
- Doing something you enjoy — like playing a musical instrument, watching a favorite TV show, knitting or reading a good book
- Exercising
- Doing a relaxation exercise
- Writing in your journal
- Talking to a friend
- Taking medications

There may be problems or situations causing your depression. You may want to look at the problems and break them down into small steps to work on at your pace. The goal is to solve the problem so you are less stressed.

Be kind to yourself! Recovery takes time. Don't forget to include your family and friends in your recovery plan. They can help support your plan or offer new suggestions.

You will know you are in remission when you are meeting your goals of eating well, sleeping well and enjoying your usual activities. Sometimes people relapse and start to feel like they are not in control of their depressive symptoms. Early warning signs may include:

- Anxiety
- Forgetfulness
- Lack of motivation
- Feeling slowed down or sped up
- Avoiding others and isolating yourself
- Increased irritability and restlessness
- Not keeping appointments
- Changes in appetite

You may want to ask your family and friends if they are seeing early warning signs.

If you feel you may be relapsing, call your physician or therapist for an appointment. Keep working on your recovery plan and call your friends and family for support. You may want to add a few new activities to help reduce your depression, such as joining a support group, watching comedies or reading a good book. By using your new skills and seeking support from professionals and family and friends, you can be back on the road to recovery.

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Recuperarse de la Depresión

El tratamiento para la depresión empieza solo hablando, o quizás con la toma de un antidepresivo, pero hay más que puede hacer por usted para recuperarse. La recuperación tal vez lleve semanas, y es muy importante aprender a ayudarse a mejorar y a estar bien. Tal vez quiera hacer un plan de recuperación enfocado en los pasos que debe dar para estar bien. Su plan es lo que usted quiera que sea y debería ser sencillo para que pueda seguirlo a diario. Consiga un cuaderno y anote algunos pasos. Por ejemplo, puede incluir los siguientes pasos:

- Comer tres comidas saludables al día
- Tomar mucha agua
- Ir a la cama a una hora regular que le resulte adecuada a usted
- Hacer algo que disfrute, como tocar un instrumento musical, mirar el show de TV que prefiera, tejer o leer un buen libro
- Hacer ejercicios
- Hacer ejercicios de relajación
- Escribir en su diario
- Hablar con un amigo
- Tomar medicamentos

Hay problemas o situaciones que pueden ser la causa de su depresión. Quizás quiera ver los problemas y dividirlos en pequeños pasos para trabajarlos a su ritmo. El objetivo es resolver el problema para disminuir el estrés.

¡Sea bueno con usted mismo! La recuperación lleva tiempo. No se olvide de incorporar a su familia y amigos en su plan de recuperación. Pueden ayudarle a sostener su plan o a ofrecer sugerencias nuevas.

Usted sabrá que se está recuperando cuando cumpla con sus objetivos de comer bien, dormir bien y disfrutar de sus actividades habituales. Algunas personas tienen recaídas y comienzan a sentir que no están controlando sus síntomas depresivos. Los primeros signos de alarma son:

- Ansiedad
- Falta de memoria
- Falta de motivación
- Sentimiento de lentitud o aceleración
- Aislamiento y rechazo de la compañía
- Aumento de la irritabilidad y el desasosiego
- No mantener las citas
- Cambios en el apetito

Tal vez quiera preguntarle a su familia y sus amigos si están viendo los primeros signos de alarma.

Si siente que está recayendo, llame a su médico o terapeuta para conseguir una cita. Siga trabajando en su plan de recuperación y llame a sus amigos y familia para pedir apoyo. Tal vez quiera agregar actividades nuevas para ayudar a reducir la depresión, como unirse a un grupo de apoyo, mirar comedias o leer un buen libro. Usar nuevas habilidades y buscar apoyo de profesionales y de la familia y amigos le permite volver al camino hacia la recuperación.

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Antidepressants and Their Side Effects

Antidepressants help balance the chemicals in your brain that affect your mood. People taking antidepressants need to follow their doctors' directions. The medication should be taken in the right dose for the right amount of time. It can take three or four weeks until the medicine takes effect. Some people take the medications for a short time, and some people take them for much longer periods. People with long-term or severe depression may need to take medication for a long time.

Once a person is taking antidepressants, it is important not to stop taking them without the help of a doctor. Sometimes people taking antidepressants feel better and stop taking the medication too soon, and the depression may return. When it is time to stop the medication, the doctor will help the person slowly and safely decrease the dose.

It's important to give the body time to adjust to the change. People don't get addicted, or "hooked," on the medications, but stopping them suddenly can cause withdrawal symptoms.

If a medication does not work, it is helpful to be open to trying another one. A study funded by the National Institute of Mental Health found that if a person with difficult-to-treat depression did not get better with a first medication, chances of getting better increased when the person tried a new one or added a second medication to his or her treatment.

Do not take a double dose if you forgot your medication. Take your next dose at the regular time. Antidepressants may cause mild side effects that usually do not last long. **Any unusual reactions or side effects should be reported to a doctor immediately.**

The most common side effects associated with newer antidepressants include:

- Headache, which usually goes away within a few days
- Nausea (feeling sick to your stomach), which usually goes away within a few days
- Sleeplessness or drowsiness, which may happen during the first few weeks, but then goes away. Sometimes the medication dose needs to be reduced or the time of day it is taken needs to be adjusted to help lessen these side effects.
- Agitation (feeling jittery)
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex

Older antidepressants can cause other side effects, including:

- Dry mouth
- Constipation
- Bladder problems. It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected.
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex
- Blurred vision, which usually goes away quickly
- Drowsiness. Usually, antidepressants that make you drowsy are taken at bedtime.

Helpful hints

- If your medicine upsets your stomach, ask your doctor if you should take it with a meal or if the risk may be less with a brand rather than a generic form of a drug
- If your depression medicine makes you sleepy during the day or keeps you awake at night, ask your doctor what time of day you should take it. By taking your medicine first thing in the morning or right before bed, you might diminish some of the unwanted effects.
- Don't take depression medicine with alcohol. Alcohol can affect how well the medicine works, cause you to sleep and possibly worsen depression.
- If you have dry mouth, chew gum or sip water throughout the day
- Using over-the-counter medications for diarrhea or constipation may eliminate some symptoms

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Los Antidepresivos y Sus Efectos Secundarios

Los antidepresivos ayudan a equilibrar las sustancias químicas del cerebro que afectan a su estado de ánimo. Las personas que toman antidepresivos tienen que seguir las instrucciones de sus médicos. La medicación debe tomarse en la dosis correcta durante la cantidad correcta de tiempo. Puede tardar tres o cuatro semanas hasta que el medicamento haga efecto. Algunas personas toman la medicación durante poco tiempo y otras la toman durante períodos más prolongados. Las personas con depresión prolongada o grave quizás necesiten medicación durante más tiempo.

Una vez que una persona está tomando antidepresivos, es importante no dejar de hacerlo sin ayuda de un médico. A veces las personas que toman antidepresivos se sienten mejor y dejan de tomar la medicación demasiado pronto, y la depresión puede volver. Cuando llega el momento de dejar la medicación, el médico ayudará a la persona de manera lenta y segura a disminuir la dosis. Es importante dar tiempo al cuerpo de ajustarse al cambio. Las personas no se hacen adictas, o “quedan enganchadas” a los medicamentos, pero dejarlos de forma abrupta puede provocar síntomas de abstinencia.

Si un medicamento no funciona, es útil estar abierto a probar otro. Un estudio financiado por el Instituto Nacional de la Salud Mental descubrió que si una persona que padece una depresión difícil de tratar no mejora con un primer medicamento, aumentan las posibilidades de que mejore cuando la persona prueba un medicamento nuevo o agrega un segundo medicamento al tratamiento.

No tome una dosis doble si se olvidó de tomar su medicamento. Tome su dosis siguiente a la hora habitual.

Es probable que los antidepresivos causen efectos secundarios leves que no suelen durar mucho. **Debe informar a su médico de inmediato toda reacción o efecto secundario inusual.**

Los efectos secundarios más frecuentes asociados a los antidepresivos más nuevos son:

- Dolor de cabeza, que suele irse en unos días
- Náuseas (malestar en el estómago), que suelen irse en unos días
- Insomnio o somnolencia, probables durante las primeras semanas, pero que después se van. A veces es preciso reducir la dosis de medicamento o ajustar el momento del día en que se toma para ayudar a disminuir estos efectos secundarios
- Agitación (sentirse nervioso)
- Problemas sexuales, que pueden afectar tanto a hombres como a mujeres, como reducción del impulso sexual, y problemas para tener relaciones sexuales y sentir goce

Los antidepresivos más antiguos pueden causar otros efectos secundarios, como:

- Boca seca
- Estreñimiento
- Problemas de vejiga. Tal vez sea difícil vaciar la vejiga, o el chorro de orina no sea tan fuerte como siempre. Es posible que resulten más afectados los hombres mayores con agrandamiento de la próstata.
- Problemas sexuales, que pueden afectar tanto a hombres como a mujeres, como reducción del impulso sexual, y problemas para tener relaciones sexuales y sentir goce
- Visión borrosa, que suele irse rápidamente
- Somnolencia. Por lo general, los antidepresivos que producen somnolencia se toman en el momento de ir la cama.

Sugerencias útiles

- Si su medicamento le produce malestar estomacal, pregunte a su médico si debería tomarlo con una comida o si el riesgo es menor con una marca comercial que con un genérico de un medicamento
- Si su antidepresivo le da sueño durante el día o lo mantiene despierto a la noche, pregunte a su médico en qué momento del día debería tomarlo. Al tomarlo a primera hora de la mañana o justo antes de ir a la cama, podría disminuir algunos de los efectos indeseados.
- No tome antidepresivos con alcohol. El alcohol puede afectar el funcionamiento del medicamento, provocar sueño y, posiblemente, empeorar la depresión.
- Si tiene la boca seca, mastique goma de mascar o beba sorbos de agua durante todo el día
- Puede eliminar algunos síntomas con medicamentos de venta libre para la diarrea o el estreñimiento

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This is to help you learn about your medical condition. It is not to take the place of your doctor. If you have questions, talk with your doctor. If you think you need to see your doctor because of something you have read in this information, please contact your doctor. Never stop or wait to get medical attention because of something you have read in this material.

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