

15.13 Major Depression in Adults in Primary Care Clinical Practice Guideline

This guideline is intended to assist the practitioner in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances. The treating practitioner should make the ultimate decision regarding the care of a particular patient.

Scope and Target Population

All adults greater than 18 years of age.

Goals of Treatment

A reasonable way to evaluate whether a system is successfully functioning in its diagnosis, treatment plan and follow-up of major depression is to:

- Recognize and diagnose depression;
- Educate patients about depression, assessing treatment preferences, engaging their participation and explaining the process of care;
- Use evidence-based guidelines and management tools for treating depression; and
- Monitor the patient's response to treatment.

Clinical Highlights and Recommendations

I. Recognition

- The primary care physician (PCP) suspects that a patient may be depressed.
- The patient may present with somatic complaints.
- Patient surveys utilized as an aid in self-reporting symptoms of depression.

II. Diagnosis

- The PCP may use screening tools followed by formal assessment to confirm diagnosis.

III. Patient Education

- If diagnosis is confirmed, the PCP and staff educate the patient about depression and the care process.
- Engage the patient and determine his/her preference for treatment.

IV. Treatment

- The PCP and patient select a management approach for treating depression:
 - 1) Watchful waiting, with supportive counseling
 - 2) Antidepressant medications
 - 3) Mental health referral for psychological counseling

V. Monitoring

- The PCP and support staff monitor for compliance with the plan and improvements in symptoms/function
- Modify treatment plan as appropriate

Annotations and Algorithms

1. Recognition

Presentations for major depression include:

- Multiple (>5/year) medical visits
- Multiple unexplained symptoms
- Work or relationship problems
- Dampened affect
- Poor behavioral follow-through with activities of daily living or prior treatment

- recommendations
- Weight gain/loss
- Sleep disturbance
- Fatigue
- Dementia
- Irritable bowel syndrome
- Volunteered complaints of stress or mood disturbance

Risk Factors for Major Depression Include:

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Dysthymia
- Stressful life events that include loss (death of a loved one, divorce)
- Domestic abuse/violence
- Traumatic events (car accident)
- Major life change (job change)
- Emotional and behavioral reactions to these social stressors can include symptoms of major depression

Two Question Screen

Over the past month, have you been bothered by:

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

If the patients' response to both questions is "no", the screen is negative.

If the patient responded "yes" to either question, consider asking more detailed questions or using the Hamilton Rating Scale for Depression.

Interview Questions

Using open-ended questions, addressing emotional issues in some way at each visit (how are things at home?), and having a high index of suspicion for depression when patients present with certain complaints (headache, fatigue, nonspecific aches) are all effective. Consider also asking these questions during your interview with patients whom you suspect are depressed.

- **Depressed Mood**
How's your mood been lately?
- **Anhedonia**
What have you enjoyed doing lately?
- **Physical Symptoms**
How have you been sleeping?
What about your appetite?
- **Effects of Symptoms on Function**
How are things at home/work?
How's your energy?
How have (the symptoms) affected your home or work life?
- **Psychological Symptoms/Suicidal Ideations**
How's your concentration?
Do you feel like life is not worth living?
Have you been feeling down on yourself?
Do you have any plans to hurt yourself?
How does the future look to you?

2. *Diagnosis*

Diagnostic Tools - Appendix I

- **Hamilton Rating Scale for Depression (HAM-D)** is used to assess the severity of depression in patients already diagnosed with an affective disorder. There are two versions of the scale using either 21 or 17 items (HAM-D21 and HAM-D17); the 17-item scale uses the first 17 questions on the full scale. Items are scored from 0 to 4, the higher the score, the more severe the depression. Questions are related to symptoms such as depressed mood, guilty feelings, suicide, sleep disturbances, anxiety levels and weight loss.
- **Geriatric Depression Scale** is ideal for evaluating the clinical severity of depression in the elderly, can be used at initial and follow-up visits, and therefore for monitoring treatment.

DSM-IV Diagnostic Criteria

For major depressive disorder, at least five of the following symptoms must be present most of the day, nearly every day, for at least two weeks. At least two bolded symptoms must be present.

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

Assessment Check List

- Quantify Severity of Depression
- Assess and Document Impairment of Function
- Evaluate Pertinent History/Comorbid Conditions
 - Past history of depression
 - Past history of other mental health problems
 - Past history of mental health treatment
 - History of suicide attempt (Patient or Family)
 - Family history of depression and other mental health problems (especially bipolar)
 - Stressful life events
 - Substance abuse
 - Bipolar illness
 - Current medications
- Evaluate Suicide Risk
 - High Risk/Suicide Risk Assessment Guidelines (Appendix II) identifies risk levels, description and actions to consider for the suicidal patient.

Suicide Screening Questions

- Have these symptoms/feelings we've been talking about led you to think you might be better off dead?
- This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?
- What about thoughts about hurting or even killing yourself? If YES, what have you thought about? Have you actually done anything to hurt yourself?

Assessing Alternative Sources

- **Concurrent Medications** (Appendix II)
Idiosyncratic reactions to other medications can occur and if possible, a medication should be stopped or changed if depression develops after beginning its use. If symptoms persist after stopping or changing medication, re-evaluate for a primary mood or anxiety disorder.
- **Alcohol** Asking a few questions that can be easily integrated into a clinical interview serves as a screening of current alcohol or other drug problems. A common screening tool is the CAGE screen. (Appendix II)
- **Mania (R/O Bipolar Disorder)** Some patients presenting with a major depressive episode have a bipolar disorder, for which effective treatment may differ significantly from other depressed patients. When assessing a patient, consider asking about manic or hypomanic episode. (Appendix II)
- **Grief reaction** is a normal and natural consequence of personal or collective loss. Grief might last up to 12 weeks or less depending upon the severity and scale of the tragic event. However, if such grief reaction persists beyond three months it is called depression. (Appendix II)
- Always consider the possibility of a differential diagnosis such as; bipolar disorder (and Bipolar Type II), psychotic depression, and chronic depression as being important diagnosis which lead to different types of treatment selection.

3. *Depression & Mental Health Education Material*

External Resources

Several agencies provide information on depression, its causes, symptoms, methods for screening, treatment options, professionals who treat the disease, and how antidepressants are selected and common side effects. Information can be found at the following websites.

- Agency for Health Care Policy and Research <http://www.AHRQ.gov/consumer>
- American Academy of Family Physicians <http://familydoctor.org/handouts/587.html>
- American Psychiatric Association http://www.psych.org/public_info/depression.cfm
- National Alliance on Mental Illness <http://www.nami.org/index.html>
- Mental Health America <http://www.nmha.org>

Tools for Patient Education

Patients' compliance depends on physician's support. Several resources are available to provide guidance for discussing patient lifestyle issues that impact treatment of depression including exercise, psychotherapy, pregnancy, age, and over-the-counter treatments.

- U.S. Department of Health and Human Services Public Health Service. Depression in Primary Care, Volume 2. Treatment of Major Depression. Pp. 43-44, 1993 (Class R).
- U.S. Department of Health and Human Services Public Health Service. Quick Reference Guide for Clinicians. Depression in Primary Care: Detection, Diagnosis and Treatment. P. 10, 1993 (Class R).
- Artal M, Sherman C. "Exercise Against Depression." The Physician and Sports Med available at: <http://www.physsportsmed.com/issues/1998/10Oct/aratl.htm>

4. *Special Populations and Considerations*

Pregnancy

Because depression during pregnancy entails a risk to the newborn, the risk-benefit ratio of continuing SSRI treatment should be assessed. Maternal depression and other stress states have been associated with lower birth weight and gestational age of infant offspring, delivery by cesarean section, and admittance to neonatal care units. The use of selective serotonin reuptake inhibitors (SSRIs) during pregnancy has been associated with an increased risk of

neonatal abstinence syndrome, a type of withdrawal with symptoms that include high-pitched crying, tremors, and disturbed sleep. It is suggested that SSRI-exposed infants be monitored for at least 48 hours after birth. Also note that the long-term effects of in utero exposure to SSRIs have not been determined. Patients with a history of mood disorders are at increased risk of postpartum depression. Several depressive conditions may follow childbirth. “Postpartum Blues” affects 50%-85% of mothers in the first two weeks after delivery. If the patient remains significantly depressed 3-4 weeks following delivery, it should be considered serious and treated including eliminating medical causes of depressive symptoms such as postpartum thyroid disorders or anemia. The first two to three months postpartum is the period of greatest risk for the development of major depression.

Elderly

Major depression is also seen in elderly patients with comorbid illnesses, such as CVA, cancer, dementia or disabilities.

5. *Treatment Options*

Supportive Counseling Clinical Approach

- Active Listening
- Advice giving
- Add perspective
- Confirm appropriateness of patient concerns

Process for Developing/Monitoring Coping Strategies

- Identify two or three coping strategies that may be helpful for the patient and clarify if the strategies will be consistent with their personality and lifestyle.
- Create a list of these coping strategies, giving one to the patient and the other to keep in the medical record.
- Have the patient keep track of both the problems and coping strategies that occur over the next week/couple of weeks. Have patient bring a summary to the next office visit.
- Assess coping strategies that patient used, reinforcing strategies that are effective and making suggestions when improvements are needed.

Focus on Coping Strategies

Problem Focused

- Identify situations that can be changed
- Gather facts
- Use problem-solving techniques
- Replace negative thoughts

Emotion Focused

- Identify situations that cannot be changed
- Discuss participation in Pleasurable activities
- Encourage activities that boost self-esteem
- Encourage activities that relax

Focus on Solutions

- Empathize with the patient
- Construct clear, simple, specific behavioral change plans:
 - Work
 - Home
 - Finances
 - Health

Antidepressant Treatment

Recommended Guidelines for Treatment of Depression

EPISODE	PHARMACOLOGIC TREATMENT DURATION
First	6-12 months
Second	3 years
Second with complicating factors*	Lifetime
Third	Lifetime

*Complicating factors are those situations where evidence either shows or suggests higher rates of recurrence after stopping antidepressants and include:

- Pre-existing dysthymia
- Inability to achieve remission
- Recurrence of symptoms in response to previously attempted lowering dose or discontinuation

Continuation/Maintenance Treatment – Preventing Relapse/Recurrence

Type of Patient	Continuation Treatment	Maintenance Treatment
Initial Episode	4 to 9 months after return to well state	Discuss with patient the Pros/Cons of continuing antidepressant therapy based on severity of episode
Recurrent Episode (2 or more episodes of depression in a 5 year period)	At least 9 months	Continue long-term maintenance therapy. Consult AHCPR (AHRQ) guidelines for details about maintenance treatment.

Herbal and Dietary Supplements

Caution: Many drugs interact with St. John's wort, including other antidepressants, warfarin, oral contraceptives, antiviral, anti-cancer, and anti-rejection drugs. Care should be taken to ask all patients what medications they are taking, including over-the-counter and supplements, to avoid these interactions. Other herbal remedies and dietary supplements, such as kava-kava, Omega-3 fatty acid (docosahexaenoic acid) and valerian root, have not been proven effective for the treatment of depression and may or may not be safe. Herbal products and nutritional supplements are not evaluated or regulated by the U.S. Food and Drug Administration for safety, efficacy, or bioavailability.

Psychiatric Emergency and Referral

Sequence in Referral Process

1. Once the PCP determines the diagnosis of depression, he/she should also discuss the need for mental health referral and emphasize the importance of utilizing individual therapy.
 - Psychological counseling may be used alone (if the patient prefers this to medication) in cases of mild to moderate depression. Initiate referral as soon as the patient agrees to counseling.
 - In more severe depression, psychological counseling should be used in conjunction with antidepressants.
 - Consideration for inpatient psychiatric admission process should be initiated with the help of a behavioral health specialist, if the patient is:
 - Suicidal with a plan
 - Homicidal with intent
 - Gravely psychotic
2. PCP explains reasons for mental health referral and recommends appropriate level of care and type of psychological counseling services (i.e., counselor, psychologist, psychiatrist).

3. Patient may not agree to seek help from a mental health specialist. If patient resists, PCP and/or office staff provides education, support and counseling, and reinforce need for mental health referral.
4. Referral is completed once the mental health specialist is selected. The PCP includes his/her office information, such as address, phone and fax numbers on the form, to facilitate communication.
5. Mental health specialist begins treating the patient and communicates response and recommendations back to the PCP.
6. PCP and mental health specialist should continue to communicate and coordinate patient treatment, until problems are resolved.

Exercise

Evidence suggests that physical activity might be a useful tool for easing major depression symptoms. When prescribing exercise as an adjunct to medication and psychotherapy, the complexity and the individual circumstances of each patient must be considered. Several caveats apply:

- Anticipate barriers – hopelessness and fatigue can make physical exertion difficult.
- Keep expectations realistic – some patients are vulnerable to guilt and self blame if they fail to carry out the regime.
- Introduce a feasible plan – walking, alone or in a group, is often a good option.
- Accentuate pleasurable aspects – the specific choice of exercise should be guided by the patient’s preferences, and must be pleasurable.
- State specifics – a goal of 30 minutes of moderate-intense exercise, 3-5 days a week is reasonable for otherwise healthy adults.
- Encourage adherence – greater antidepressant effects are seen when training continues beyond 16 weeks.

Referral and Follow Up with Behavioral Health

- If possible an appointment with a behavioral health specialist should be made prior to the patient leaving the PCP’s office.
- The patient should always be given the name, address and phone number of the behavioral health specialist.
- The PCP should follow up with the behavioral health specialist in 6-8 weeks.

6. Monitoring

Once treatment is initiated, the patient should be contacted by phone or office visit within 1-2 weeks of diagnosis as a first step, regardless of severity.

Scheduling Follow-up Appointments after Initial Treatment

Minor	Watchful waiting, with a re-evaluation in 4-8 weeks
Mild	Visit or phone contact <u>every month</u>
Moderate	Visit or phone contact <u>every 2 weeks</u> . Initiate referral to behavioral health specialist at first visit/contact.
Severe	Visit or phone contact at least <u>every week</u> . Immediate referral to behavioral health specialist.

Monitoring tools could include but are not limited to:

- A. Depression Monitoring Flow Sheet**
- B. Processing Referrals for Psychological Services**
- C. Referral to Mental Health Services Form**
- D. Model Communication Form**

(Mental Health Specialist – PCP)

Available from: *The MacArthur Initiative on Depression & Primary Care* www.depressionprimarycare.org

Based on The MacArthur Initiative on Depression & Primary Care at Dartmouth & Duke, Depression Management Tool Kit, Version 9.11, May 2006 and the Institute for Clinical Systems Improvement Health Care Guideline: Major Depression in Adults in Primary Care, Eleventh Edition, May 2008.

Approved and adopted by the Quality Medical Management Committee (QMMC) June 2007.
Reviewed and revised by QMMC June 2009.

Appendix I

Diagnostic Tools

- 1. *Hamilton Rating Scale***
- 2. *Geriatric Depression Scale***

Hamilton Rating Scale for Depression

Patient Name: _____

Rater Name: _____

Date: _____

- 1. Depressed mood** _____
Sad, hopeless, helpless, worthless
0 = Absent
1 = Gloomy attitude, pessimism, hopelessness
2 = Occasional weeping
3 = Frequent weeping
4 = Patient reports highlight these feelings states in his/her spontaneous verbal and non-verbal communication.
- 2. Feelings of Guilt** _____
0 = Absent
1 = Self-reproach, feels he she has let people down
2 = Ideas of guilt or rumination over past errors or sinful deeds
3 = Present illness is punishment
4 = Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations. Delusions of guilt.
- 3. Suicide** _____
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead, or any thoughts of possible death to self
3 = Suicide, ideas or half-hearted attempt
4 = Attempts at suicide (any serious attempt rates 4)
- 4. Insomnia, early** _____
0 = No difficulty
1 = Complaints of occasional difficulty in falling asleep i.e. more than half-hour
2 = Complaints of nightly difficulty falling asleep
- 5. Insomnia, middle** _____
0 = No difficulty
1 = Patient complains of being restless and disturbed during the night
2 = Walking during the night – any getting out of bed rates 2
(Except voiding bladder)
- 6. Insomnia, late** _____
0 = No difficulty
1 = Waking in the early hours of the morning but goes back to sleep
2 = Unable to fall asleep again if he/she gets out of bed

Page 1 Score _____

7. **Work and activities** _____
- 0 = No difficulty
- 1 = Thoughts and feelings of incapacity related to activities:
work or hobbies
- 2 = Loss of interest in activity – hobbies or work – either directly
reported by patient or indirectly seen in listlessness, in
decisions and vacillation (feels he/she has to push self to
work or activities)
- 3 = Decrease in actual time spent in activities or decrease in productivity.
In hospital, rate 3 if patient does not spend at least three hours a day
In activities.
- 4 = Stopped working because of present illness. In hospital rate 4 if
patient engages in no activities except supervised ward chores.
8. **Retardation** _____
- Slowness of thought and speech; impaired ability to concentrate;
Decreased motor activity
- 0 = Normal speech and thoughts
- 1 = Slight retardation at interview
- 2 = Obvious retardation at interview
- 3 = Interview difficult
- 4 = Interview impossible
9. **Agitation** _____
- 0 = None
- 1 = Fidgetiness
- 2 = Playing with hands, hair, obvious restlessness
- 3 = Moving about; can't sit still
- 4 = Hand wringing, nail biting, hair pulling, biting of lips, patient is on the run
10. **Anxiety, psychic** _____
- Demonstrated by:
- Subjective tension and irritability, loss of concentration
 - Worrying about minor matters
 - Apprehension
 - Fears expressed without questioning
 - Feelings of panic
 - Feeling jumpy
- 0 = Absent
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = incapacitating

Page 2 Score _____

- 11. Anxiety, somatic** _____
- Physiological concomitants of anxiety such as:
- Gastrointestinal: dry mouth, wind, indigestion, diarrhea, cramps, belching
 - Cardiovascular: palpitations, headaches
 - Respiratory: hyperventilation, sighing
 - Urinary frequency
 - Sweating
 - Giddiness, blurred vision
 - Tinnitus
- 0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating
- 12. Somatic symptoms: gastrointestinal** _____
- 0 = None
1 = Loss of appetite but eating without encouragement
2 = Difficulty eating without urging. Requests or requires laxatives or medication for GI symptoms
- 13. Somatic symptoms: general** _____
- 0 = None
1 = Heaviness in limbs, back or head; backaches, headaches, muscle aches, loss of energy, fatigability
2 = Any clear symptom rates 2
- 14. Genital Symptoms** _____
- Symptoms such as: loss of libido, menstrual disturbances
- 0 = Absent
1 = Mild
2 = Severe
- 15. Hypochondriasis** _____
- 0 – Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Strong conviction of some bodily illness
4 = Hypochondrial delusions
- 16. Loss of Weight** _____
- Rate either 'A' or 'B':
- A** When rating by History:
- 0 = No weight loss
1 = Probably weigh loss associated with present illness
2 = Definite (according to patient) weigh loss
- B** Actual Weigh changes (weekly):
- 0 = Less than 1 lb. (0.5 kg) weigh loss in one week
1 = 1-2 lb. (0.5-1.0 kg) weight loss in week
2 = Greater than 2 lb. (1 kg) weigh loss in week
3 = Not assessed

17. **Insight** _____
 0 = Acknowledges being depressed and ill
 1 = Acknowledges illness but attributes cause to bad food, overwork, virus, need for rest, etc.
 2 = Denies ill at all
18. **Diurnal Variation** _____
 A Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none.
 0 = No variation
 1 = Worse in A.M.
 2 = Worse in P.M.
 B When present, mark the severity of the variation. If NO variation, mark none.
 0 = None
 1 = Mild
 2 = Severe
19. **Depersonalization and Derealization**
(Such as: Feelings of unreality, Nihilistic ideas) _____
 0 = Absent
 1 = Mild
 2 = Moderate
 3 = Severe
 4 = Incapacitating
20. **Paranoid Symptoms** _____
 0 = None
 1 = Suspicious
 2 = Ideas of reference
 3 = Delusions of reference and persecution
21. **Obsessional and Compulsive Symptoms** _____
 0 = Absent
 1 = Mild
 2 = Severe

Page 4 Score _____

TOTAL Score _____

Score for level of depression: 10 - 13 mild; 14-17 mild to moderate; >17 moderate to severe.

Reference:

*Hamilton M. "Development of a rating scale for primary depressive illness."
 Br J Soc Clin Psycho. 1967; 6:278-296*

Geriatric Depression Scale

Patient _____

Examiner _____ Date _____

Directions to Patient: Please choose the best answer for how you have felt over the past week.

Directions to Examiner: Present questions VERBALLY. Circle answer given by patient. Do not show to patient.

- | | | |
|---------------------------------------------------------------------|---------|--------|
| 1. Are you basically satisfied with your life? | Yes | No (1) |
| 2. Have you dropped many of your activities and interests? | Yes (1) | No |
| 3. Do you feel that your life is empty? | Yes (1) | No |
| 4. Do you often get bored? | Yes (1) | No |
| 5. Are you hopeful about the future? | Yes | No (1) |
| 6. Are you bothered by thoughts you can't get out of your head? | Yes (1) | No |
| 7. Are you in good spirits most of the time? | Yes | No (1) |
| 8. Are you afraid that something bad is going to happen to you? | Yes (1) | No |
| 9. Do you feel happy most of the time? | Yes | No (1) |
| 10. Do you often feel helpless? | Yes (1) | No |
| 11. Do you often get restless and fidgety? | Yes (1) | No |
| 12. Do you prefer to stay at home rather than go out and do things? | Yes (1) | No |
| 13. Do you frequently worry about the future? | Yes (1) | No |
| 14. Do you feel you have more problems with memory than most? | Yes (1) | No |
| 15. Do you think it is wonderful to be alive now? | Yes | No (1) |
| 16. Do you feel downhearted and blue? | Yes (1) | No |
| 17. Do you feel pretty worthless the way you are now? | Yes (1) | No |
| 18. Do you worry a lot about the past? | Yes (1) | No |
| 19. Do you find life very exciting? | Yes | No (1) |
| 20. Is it hard for you to get started on new projects? | Yes (1) | No |
| 21. Do you feel full of energy | Yes | No (1) |

22. Do you feel that your situation is hopeless?	Yes (1)	No
23. Do you think that most people are better off than you are?	Yes (1)	No
24. Do you frequently get upset over little things?	Yes (1)	No
25. Do you frequently feel like crying?	Yes (1)	No
26. Do you have trouble concentrating?	Yes (1)	No
27. Do you enjoy getting up in the morning?	Yes	No (1)
28. Do you prefer to avoid social occasions?	Yes (1)	No
29. Is it easy for you to make decisions?	Yes	No (1)
30. Is your mind as clear as it used to be?	Yes	No (1)

TOTAL:

Please sum all bolded answers that are circled (worth one point) for a total score. _____

Scores: 0 - 9 Normal 10 - 19 Mild Depressive 20 - 30 Severe Depressive

Source: www.stanford.edu/yesavage

A series provided by The Hartford Institute for Geriatric Nursing (hartford.ign@nyu.edu)

www.hartfordign.org

Appendix II

Assessment Tools

1. Suicide Risk Assessment
2. Medications and Depression
3. Alcohol CAGE Score
4. Bipolar Disorder Symptomatology
5. Grief Reaction Identification

1. Suicide Risk Assessment

Risk	Description	Action
Low	No current thoughts, no major risk factors.	Continue follow-up visits and monitor.
Intermediate	Current thoughts, but no plans, with or without risk factors	Assess suicide risk carefully at each visit and contract with patient to call you if suicidal thoughts become more prominent; consult with an expert if needed.
High	Current thoughts with plan	Emergency management by qualified expert.

2. Concurrent Medications

The drugs listed below have been implicated in the development of depression.

Antihypertensive and cardiovascular drugs	Methyldopa, reserpine, clonidine, beta-blockers, digoxin, diuretics (hypokalemia or hyponatremia)
Sedative-hypnotic agents	Alcohol, benzodiazepines, barbiturates, chloral hydrate, meprobamate
Anti-inflammatory agents and analgesics	Opioid (narcotic) agents
Hormones	Corticosteroids, oral contraceptives, estrogen withdrawal, anabolic steroids

3. CAGE Questionnaire

Have you ever felt you ought to **C**ut down on your drinking?

Have people **A**nnoyed you by criticizing your drinking?

Have you ever-felt bad or **G**uilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

Two or more “Yes” responses yield a positive screen test for alcohol.

4. Mania or Bipolar Symptomology

Has there ever been a period of at least four days when you were so happy or excited that you got into trouble, or your family or friends worried about you, or a clinician said you were manic?

A “Yes” response indicates potential bipolar disorder. Assess further for mania. Diagnostic criteria for mania include the concurrent presence of at least four of the following symptoms, one of which must be the first symptom listed (bolded).

- **A distinct period of abnormal, persistently elevated, expansive, or irritable mood.**
- Less need for sleep.
- Inflated self-esteem/grandiosity.
- More talkative (pressured speech) than usual.

- Distractibility.
- Increased goal-directed activity or psychomotor agitation.
- Excessive involvement in pleasurable activities without regard for negative consequences (e.g., buying sprees, sexual indiscretions, foolish ventures).

5. Grief Reaction?

Did your most recent period of feeling depressed or sad begin just after someone close to you died?

If YES TO QUESTION 1, ASK: Did the death occur more than two months ago?

If 'No' to first question, or if 'Yes' to both questions, treat the patient for depression.