

# **Guideline on Management of Depression in Primary Care**

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# **1. Introduction**

- 1.1 Depression is a common disorder. The World Health Organization speculates that as many as 121 million people worldwide suffer from depression.<sup>1</sup> Estimates further suggest that the number is set to rise significantly over the next two decades and depression alone will constitute one of the largest health problems worldwide by the year 2020.<sup>2</sup> In Hong Kong, based on the information from the Department of Health and Hospital Authority 2003/04, the prevalence of depression (age 15 and above) is 0.6 % in males and 2.1 % in females.<sup>3</sup>
- 1.2 Many people feeling depressed with some somatic symptoms will present to general practitioners first and most treatments can be provided in the primary care setting. However, there is considerable evidence that depressive disorders are often not recognized in people presenting to primary healthcare workers (Goldberg 1984). It is estimated that 30-50% of cases of depression in primary care and medical settings are not detected.<sup>4</sup>
- 1.3 The most serious complication of depression is suicide. In 2003, there were 1 103 registered deaths due to suicide in Hong Kong, giving crude death rates of 16.2 per 100 000 population.<sup>5</sup> Self harm (including suicidal attempts and deaths) accounted for 1 433 episodes of in-patient discharges and deaths in Hospital Authority hospitals.<sup>6</sup>
- 1.4 This guideline is for primary healthcare workers especially general practitioners in particular. It is intended to describe good clinical practice in management of depression and to encourage a unified approach to the management of depression among clinics of PDQA. The guideline will cover the detection and treatment of mild to moderate depression in adult. Management of severe depression with high suicidal risk, depression in children, bipolar disorder, depression with psychotic features, postnatal depression are not included in this guideline.
- 1.5 This is only a guideline to clinical practice without restricting physician's individual clinical judgment. Each physician is ultimately responsible for the management of his/her unique patient based on the clinical information presented by the patient and the diagnostic and treatment options available.
- 1.6 This guideline has been prepared by a group of family physicians. They developed the guideline by reviewing relevant literatures, by adapting overseas evidence-based

guidelines including (1) Guidelines for the treatment and management of depression by primary healthcare professionals developed by the New Zealand Guideline Group (2) Management of depression developed by the National Institute of Clinical Excellence (3) Clinical Practice Guideline on depression by Singapore Ministry of Health March 2004, and by consensus with consideration of local practice. The guideline will be reviewed two years later or if new evidence appears that requires substantive changes to the recommendations.

## **2. Diagnosis**

- 2.1 The term “depression” is used to describe a normal emotional experience as well as a disorder. Normal sadness or unhappiness is however, different from the nature, experience and severity of depressive symptoms in a disorder. Depressive disorder involves other emotional changes such as anxiety, irritability or apathy. There are also cognitive, behavioral and somatic symptoms. In cases where agitation or slowing is present, it is observable by others and is not just subjective feelings only. The symptoms associated with depression cause clinically significant distress and/or impairment in social, occupational and other areas of functioning.
- 2.2 The diagnostic criteria of Major Depressive Disorder, Single Episode<sup>7</sup> are as follows:
- a. Presence of a single Major Depressive Episode (Appendix 1)
  - b. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified.
  - c. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.
- 2.3 Conditions that present with less severe depressive symptoms are:
- a. Dysthymia- the depressive symptoms are chronic and long-term but symptoms are less severe than major depressive disorder.
  - b. Adjustment disorder- there is distinct stressors that cause distress and give rise to mild symptoms. The symptoms of depression develop within 3 months of an identifiable stressor(s).

### **3. Assessment**

- 3.1 The basic assessment of depression includes the history, the mental state examination and physical examination<sup>8</sup>:
- a. Take a detailed history of the presenting symptoms and determine the severity (mild, moderate, severe with or without psychotic features by Appendix 2) and duration (chronic by Appendix 3) of the depressive episode.
  - b. Establish history of prior episodes, prior manic or hypomanic episodes, substance abuse and other psychiatric illnesses.
  - c. Look out for co-existing medical conditions, family history of mental illness, available supports. Evaluate functional impairment and determine life events and stressors.
  - d. Do a mental state examination including evaluation of severity of depression. An assessment of the risk of suicide, self-harm and risk of harm to others must be included in the assessment. (Appendix 4)
  - e. Do a physical examination to exclude medical condition. (Appendix 5)
  - f. Laboratory testing may be indicated if there is a need to rule out medical conditions that may cause similar symptoms.
- 3.2 Some questionnaires are available for the evaluation of depression. Although they are sensitive instruments, they are not very specific and this limits their usefulness. They are most useful when a depressive disorder is suspected and to monitor symptom change.<sup>8</sup> Hospital Anxiety and Depression (HAD) scale questionnaire is a sensitive screening tool. This is a quick and simple questionnaire that the patient completes. Although designed for hospital General Medical Outpatients, it has been extensively used in Primary Care. (Appendix 6)
- 3.3 Psychiatric referral is indicated when:
- a. Depression is associated with high suicidal risk
  - b. Severe depression with/without psychotic features
  - c. Severe postnatal depression
  - d. Bipolar disorder
  - e. There are co-morbid medical conditions for which expertise is required regarding drug-drug interactions.
  - f. There is diagnostic difficulty.
  - g. One or two trials of medication have failed.
  - h. If augmentation or combination therapy is needed.
  - i. Those with co-morbid substance abuse or severe psychosocial problems.
  - j. The patient is pregnant or plans to become pregnant.

## **4. Treatment**

4.1 Once the depressive disorder has been diagnosed and the duration, severity and presence of any melancholic features assessed, Treatment for mild and moderate depression include (1) Education and guided self-help (2) Psychotherapy (3) Pharmacotherapy (4) Combination of psychotherapy and pharmacotherapy. The key objectives of treatment are:

- a. Symptomatic remission of all the signs and symptoms of depression
- b. Restore occupational and psychosocial function
- c. Reduce the likelihood of relapse and recurrence

### **4.2 Patient education and guided self-help**

- a. Patients with mild depression may benefit from advice on sleep hygiene and anxiety management. (C) (Appendix 7)
- b. Patients of all ages with mild depression should be advised of the benefits of following a structured and supervised exercise programme of typically up to 3 sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. (C)
- c. For patients with mild depression, a guided self-help programme based on cognitive behavioral therapy (CBT) should be considered. (Appendix 7) It should consist of the provision of appropriate written materials and limited support from a healthcare professional, who introduces the self-help programme and review progress and outcome. This intervention should normally take place over 6 to 9 weeks, including follow-up. (B)
- d. Where indicated and with patients agreement, involve family members or friends in their care so that there is adequate support. This involvement is particularly important when there is a risk of suicide.

### **4.3 Psychotherapy**

- a. Psychotherapy alone is as efficacious as antidepressant medication in patients with mild to moderate major depression and can be used as first-line treatment.<sup>24</sup> (Ia, A)

- b. Psychological treatment especially focused on depression such as problem-solving therapy (Appendix 8), brief cognitive behavioral therapy (Appendix 9) and counseling (Appendix 10) of 6 to 8 sessions over 10 to 12 weeks should be considered for mild to moderate depression. (B)
- c. Healthcare professionals providing psychological treatment should be experienced and competent in the delivery of the treatment. (GPP)
- d. Besides primary care physicians who are experienced and competent in conducting psychotherapy, patients could be referred to other local resources including various counseling services, hotlines, seminars and workshops for psychotherapy. (GPP) (Appendix 11)
- e. In all psychological interventions, healthcare professionals should develop and maintain an appropriate therapeutic alliance, because this is associated with a positive outcome independent of the type of therapy provided. (C)
- f. Among the specific psychotherapeutic interventions, Cognitive Behavior Therapy (CBT) has the best documented efficacy for the treatment of depression.<sup>9</sup> CBT is recommended when the patient has distorted negative thoughts.<sup>9</sup> (1a, A) CBT is also an effective maintenance treatment and is recommended for patients with recurrent depression who are no longer on medication.<sup>10</sup>(1b, A)
- g. Problem-solving Therapy is as effective as antidepressant for primary care patients with mild depression.<sup>11</sup> It is recommended for primary care patients with mild depression. (1b, A)
- h. If after several sessions of psychotherapy and improvement is not observed, it is recommended that a thorough review of the diagnosis, complicating conditions and issues, and treatment plan should be conducted. (GPP)

#### 4.4 **Pharmacotherapy**

There is no clinically significant difference in effectiveness between selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs). Treatment decisions need to be based on considerations of relative patient acceptability, toxicity and cost.(A)

- b. For moderate and severe depressive disorders with melancholic features, TCAs are still

the initial drug of choice providing they are prescribed at an adequate dose and the patient can tolerate the side effects.(GPP)

- c. When TCA is used in treatment of depression in adults, low dose tricyclics (typically 75-100mg) is justified.(A)
- d. In general practice, a starting dose less than 75mg could be tried and stepped up according to the clinical effect and tolerance of individual patients. (GPP)
- e. Medication should be maintained at the full dosage required to attain symptom remission in the acute treatment phase. Patients should be reviewed every 1–2 weeks at the start of antidepressant treatment. (C)
- f. Continuation of treatment for further 3-6 months for first episode and for up to 3 years for recurrent episodes of depression are recommended.(C)
- g. Treatment should be continued for at least 4 weeks (6 weeks in the elderly) before considering whether to switch antidepressant due to lack of efficacy. (C)
- h. In cases of partial response, continue for a further 2 weeks (elderly patients may take longer to respond). (C)
- i. The use of fluoxetine, sertraline and paroxetine should be considered in patients with depression with concomitant anxiety symptoms. (A)
- i. In general all medications should be tailed off over a four week period.(C) This is probably not necessary for fluoxetine due to its extended half-life.(C)
- j. The use of benzodiazepine may be considered for short term use for anxiety features coexists with depression when balanced judiciously against possible harm after discussion with patient.(C)
- k. The SSRIs and related antidepressants venlafaxine are contraindicated in those aged under 18 years because there is insufficient information on safety and efficacy. (C)

#### 4.4.1 ***Introduction***

- a. Antidepressant drugs are effective in the treatment of major depression of moderate and severe degree including major depression associated with physical illness and that

following childbirth; they are also effective for dysthymia (lower grade chronic depression).<sup>12</sup> Antidepressant drugs are not generally effective in milder forms of acute depression but a trial may be considered in cases refractory to psychological treatments.<sup>12</sup> With all major groups of antidepressants, benefit is rarely seen in less than 10-14 days.<sup>13</sup>

- b. For most patients, antidepressant medications including tricyclic antidepressant (TCA), tetracyclic antidepressant, serotonin selective reuptake inhibitor (SSRI), monoamine oxidase inhibitor (MAOI) and other newer antidepressant medications are generally considered equally effective, with response rates in clinical trials ranging from 50% to 75% of patients.<sup>14</sup> Antidepressant medications have been grouped as follows: 1) tricyclic antidepressant (TCA) medications, which for the purposes of this review also include the tetracyclic antidepressant medication maprotiline; 2) Serotonin Selective Reuptake Inhibitor (SSRIs), which include fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram; 3) other antidepressant medications, including bupropion, nefazodone, trazodone, venlafaxine, mirtazapine, and reboxetine; and 4) MAOIs, which include phenelzine, tranylcypromine, and isocarboxazid.<sup>14</sup> (Appendix 12)

#### 4.4.2 *Factors in selecting a specific antidepressant*<sup>15</sup>

A recent Cochrane systematic review of ninety-eight randomised controlled trials concludes that there are no clinically significant differences in effectiveness between selective serotonin reuptake inhibitors and tricyclic antidepressants (1a). Treatment decisions need to be based on considerations of relative patient acceptability, toxicity and cost.<sup>16</sup> (Appendix 13) (A)

#### 4.4.3 *Continuation of treatment*

In general, it is important that treatment continue after initial relief from the acute symptoms. The general rule is that the treatment which was effective during the acute treatment phase should be continued. Medication should be maintained at the full dosage required to attain symptom remission in the acute treatment phase. Patients should be reviewed every 1–2 weeks at the start of antidepressant treatment.<sup>12</sup>

(C) Continuation of treatment for further 3-6 months for first episode and for up to 3 years for recurrent episodes of depression are recommended.<sup>15</sup> (C) Treatment should be continued for at least 4 weeks (6 weeks in the elderly) before considering whether to switch antidepressant due to lack of efficacy.<sup>12</sup> (C) In cases of partial response, continue for a further 2 weeks (elderly patients may take longer to respond).<sup>12</sup> (C)

#### 4.4.4 *Discontinuation of medication*

- a. There is growing evidence that rapid cessation of any antidepressant can cause a

withdrawal syndrome with onset after a few days and resolving within about four weeks. In general all medications should be tailed off over a four week period Patients should be reviewed every 1–2 weeks at the start of antidepressant treatment.<sup>15</sup> (C)

- b. A useful strategy is to try and determine how low a dose is required to “keep you well”. Patients should be informed of this and advised not to suddenly cease treatment.<sup>15</sup>

#### 4.4.5 *Specific Drug Classes*

##### a. Selective Serotonin Reuptake Inhibitors (SSRIs)

- i. A large body of literature containing approximately 50 randomized, placebo-controlled trials supports the premise that SSRIs are superior to placebo in the treatment of major depressive disorder.<sup>14</sup> In general, significant differences in efficacy between individual SSRIs have not been observed.<sup>14</sup> SSRIs should be used with caution in patients with epilepsy (avoid if poorly controlled, discontinue if convulsions develop), concurrent electroconvulsive therapy (prolonged seizures reported with fluoxetine), history of mania, cardiac disease, diabetes mellitus, angle-closure glaucoma, concomitant use of drugs that increase risk of bleeding, history of bleeding disorders (especially gastro-intestinal bleeding), hepatic impairment, renal impairment, pregnancy, and breast-feeding. The risk of suicidal behaviour is higher in young adults, calling for close monitoring of those receiving SSRIs. SSRIs may also impair performance of skilled tasks (e.g. driving).<sup>12</sup> Abrupt withdrawal of SSRIs should be avoided (associated with headache, nausea, paraesthesia, dizziness and anxiety).<sup>12</sup>
- ii. SSRIs are less sedating and have fewer antimuscarinic and cardiotoxic effects than tricyclic antidepressants. Side-effects of the SSRIs include gastro-intestinal effects (dose-related and fairly common—include nausea, vomiting, dyspepsia, abdominal pain, diarrhoea, constipation), anorexia with weight loss (increased appetite and weight gain also reported) and hypersensitivity reactions including rash (consider discontinuation—may be sign of impending serious systemic reaction, possibly associated with vasculitis), urticaria, angioedema, anaphylaxis, arthralgia, myalgia and photosensitivity; other side-effects include dry mouth, nervousness, anxiety, headache, insomnia, tremor, dizziness, asthenia, hallucinations, drowsiness, convulsions, galactorrhoea, sexual dysfunction, urinary retention, sweating, hypomania or mania, movement disorders and dyskinesias, visual disturbances, hyponatraemia, and cutaneous bleeding disorders including ecchymoses and purpura. Suicidal ideation has been linked with SSRIs but causality has not been established.<sup>12</sup> The SSRIs and related antidepressants venlafaxine are contraindicated in those aged under 18 years because there is insufficient information on safety and efficacy.<sup>12</sup> (C)

b. Contraindications to SSRI<sup>13</sup>

- i. Hypersensitivity to SSRIs or any other component
- ii. Escitalopram is contraindicated in patients hypersensitive to citalopram
- iii. Manic phase
- iv. Concomitant use with MAOIs

c. Dosage of SSRI<sup>13</sup>

- i. Dose should be started low and adjusted according to patient's response and serum level. Maintain at minimum effective dose
- ii. Dose should be gradually reduced before ceasing therapy; do not stop treatment abruptly; risk of seizures or withdrawal syndrome
- iii. For details of individual drugs, refer to appendix 14.

d. Tricyclic Antidepressants (TCAs)

- i. These drugs are most effective for treating moderate to severe endogenous depression associated with psychomotor and physiological changes such as loss of appetite and sleep disturbances; improvement in sleep is usually the first benefit of therapy<sup>12</sup>. About 10 to 20% of patients fail to respond to tricyclic and related antidepressant drugs and inadequate dosage may account for some of these failures. It is important to use doses that are sufficiently high for effective treatment but not so high as to cause toxic effects<sup>12</sup>. In most patients the long half-life of tricyclic antidepressant drugs allows once-daily administration, usually at night; the use of modified-release preparations is therefore unnecessary<sup>12</sup>.
- ii. A recent Cochrane systematic review concludes that whilst selective serotonin reuptake inhibitors do appear to show an advantage over tricyclic drugs in terms of total drop-outs, this advantage is relatively modest<sup>18</sup>. (1a) This has implications for pharmaco-economic models, some of which may have overestimated the difference of drop-out rates between selective serotonin reuptake inhibitors and tricyclic antidepressants<sup>18</sup>. (1a) For moderate and severe depressive disorders with melancholic features, TCAs are still the initial drug of choice providing they are prescribed at an adequate dose and the patient can tolerate the side effects<sup>15</sup>. (GPP)

- iii. When TCA is used, low dose (<100mg/day) was frequently used in PDQA. Another Cochrane systematic review investigate the use of low dose TCA(mostly between 75 and 100 mg/day) in 35 studies (2013 participants) compared low dosage tricyclics with placebo, and six studies (551 participants) compared low dosage tricyclics with standard dosage tricyclics concluded that treatment of depression in adults with low dose tricyclics is justified<sup>19</sup>.(1a, A)

Another systematic review and meta-analysis shows that low dosage tricyclic antidepressants between 75 and 100 mg/day and possibly below this range brings about more reduction in depression at 4-8 weeks of treatment and beyond, as well as more dropouts due to side effects and more people with at least one side effect than placebo in both primary care and psychiatric settings.<sup>26</sup> (1a, A) When the investigators limited the included studies to patients taking less than 75mg/day of tricyclics they

- iv. were still more likely to show response than those taking placebo at 4 weeks (relative risk 1.63, 1.29 to 2.07). Patients receiving this minimal dosage were still more likely to drop out due to side effects (relative risk 2.17, 1.05 to 4.50) or to experience at least one side effect (relative risk 2.18, 1.28 to 3.73) than those taking placebo.<sup>26</sup> The minimum effective dosage and ranges for antidepressants has not been established.<sup>26</sup> In general practice, a starting dose less than 75mg could be tried and stepped up according to the clinical effect and tolerance of individual patients. (GPP)
- v. Arrhythmias and heart block occasionally follow the use of tricyclic antidepressants, particularly amitriptyline, and may be a factor in the sudden death of patients with cardiac disease<sup>12</sup>. They are also sometimes associated with convulsions (and should be prescribed with special caution in epilepsy as they lower the convulsive threshold); maprotiline has particularly been associated with convulsions<sup>12</sup>. Hepatic and haematological reactions may occur and have been particularly associated with mianserin<sup>12</sup>.
- vi. Other side-effects of tricyclic and related antidepressants include drowsiness, dry mouth, blurred vision, constipation, and urinary retention (all attributed to antimuscarinic activity), and sweating<sup>12</sup>.
- vii. Neuroleptic malignant syndrome may, very rarely, arise in the course of antidepressant treatment<sup>12</sup>.
- viii. Limited quantities of tricyclic antidepressants should be prescribed at any one time because they are dangerous in overdose<sup>12</sup>.

- e. Dose<sup>13</sup>
  - i. Dose should be started low and adjusted according to patient's response and serum level. Maintain at minimum effective dose
  - ii. Dose should be gradually reduced before ceasing therapy; do not stop treatment abruptly; risk of seizures or withdrawal syndrome
  - iii. Refer to appendix 14 for dosage of individual TCAs
  
- f. Contraindications to TCAs<sup>13</sup>
  - i. Hypersensitivity to tricyclic antidepressants, or any other component
  - ii. Do not prescribe an MAOI within at least 2 weeks of discontinuing TCA; 3 weeks if clomipramine or imipramine
  - iii. Acute recovery phase post myocardial infarction
  - iv. Arrhythmias
  - v. Narrow-angle glaucoma

#### 4.4.6 ***Antidepressant-benzodiazepine combination therapy***

Anxiety frequently coexists with depression. Adding benzodiazepines to antidepressants is commonly used to treat people with depression. A latest Cochrane database of systematic review on aggregating nine studies with a total of 679 patients, the combination therapy group was less likely to drop out than the antidepressant alone group<sup>20</sup>. (1a) The review concluded that the potential benefits of adding a benzodiazepine to an antidepressant must be balanced judiciously against possible harms including development of dependence and accident proneness, on the one hand, and against continued suffering following no response and drop-out, on the other<sup>20</sup>. (1a) The use of benzodiazepine may be considered for short term use for anxiety features coexists with depression when balanced judiciously against possible harm after discussion with patient. (C)

#### 4.4.7 ***SSRIs-TCAs combination therapy***

The evidence supporting SSRI-TCA combination therapy is not conclusive (Thase & Rush 1995). Caution is needed when using SSRI and TCA in combination because SSRIs inhibit metabolism of several TCAs, resulting in a substantial increase in blood levels and toxicity or other adverse side effects from TCAs (Preskorn & Burke 1992). Since SSRI-TCA combination therapy is still a controversial subject, this is not recommended for use in primary care setting. (GPP)

#### 4.4.8 ***SSRIs for major depressive disorder in children and adolescents***

The Food and Drug Administration (FDA) directed manufacturers of all antidepressant

drugs to revise the labeling for their products to include a boxed warning and expanded warning statements that alert health care providers to an increased risk of suicidality (suicidal thinking and behavior) in children and adolescents being treated with these agents, and to include additional information about the results of pediatric studies.<sup>29</sup> The SSRIs and related antidepressants venlafaxine are contraindicated in those aged under 18 years because there is insufficient information on safety and efficacy.<sup>12</sup> (C)

#### 4.4.9 ***Major depression with high levels of anxiety (anxious depression)***

Major depression with high levels of anxiety (anxious depression) is a common subtype of depression associated with greater psychosocial impairment and poorer response to antidepressant treatment. It is unclear whether in this population there are differences in efficacy or tolerability across selective serotonin reuptake inhibitors. A RCT showed no significant differences in efficacy and tolerability of fluoxetine, sertraline, and paroxetine in patients with high levels of baseline anxiety symptoms during the acute treatment of major depression. Each treatment was similarly effective in improving depression in this subtype of patients with anxious depression.<sup>27</sup> In a RCT, Fluoxetine was comparably efficacious to amitriptyline in the treatment of major depression with associated anxiety.<sup>28</sup> The use of fluoxetine, sertraline and paroxetine should be considered in patients with depression with concomitant anxiety symptoms. (A)

#### 4.5 **Combined psychotherapy and pharmacotherapy**

- a. Concurrent combined psychotherapy and pharmacotherapy is recommended in severe depression<sup>21</sup> and chronic depression<sup>22</sup> as it is more effective than either alone in these conditions. (1b, A)
- b. Adding CBT for patients with residual depressive symptoms after acute treatment with pharmacotherapy is recommended as it has been shown to improve remission rates and reduce relapse rates<sup>23</sup>. (1b, A)

## **Summary of Recommendations**

### **5.1 Psychotherapy**

- a. Psychotherapy alone is as efficacious as antidepressant medication in patients with mild to moderate major depression and can be used as first-line treatment.<sup>24</sup> (A)
- b. Psychological treatment especially focused on depression such as problem-solving therapy, brief cognitive behavioral therapy and counseling of 6 to 8 sessions over 10 to 12 weeks should be considered for mild to moderate depression. (B)
- c. Healthcare professionals providing psychological treatment should be experienced and competent in the delivery of the treatment. (GPP)
- d. Besides primary care physicians who are experienced and competent in conducting psychotherapy, patients could be referred to other local resources including various counseling services, hotlines, seminars and workshops for psychotherapy. (GPP)
- e. In all psychological interventions, healthcare professionals should develop and maintain an appropriate therapeutic alliance, because this is associated with a positive outcome independent of the type of therapy provided. (C)
- f. Among the specific psychotherapeutic interventions, Cognitive Behavior Therapy (CBT) has the best documented efficacy for the treatment of depression.<sup>9</sup> CBT is recommended when the patient has distorted negative thoughts.<sup>9</sup> CBT is also an effective maintenance treatment and is recommended for patients with recurrent depression who are no longer on medication.<sup>10</sup>(A)
- g. Problem-solving Therapy is as effective as antidepressant for primary care patients with mild depression.<sup>11</sup> It is recommended for primary care patients with mild depression. (A)
- h. If after several sessions of psychotherapy and improvement is not observed, it is recommended that a thorough review of the diagnosis, complicating conditions and issues, and treatment plan should be conducted. (GPP)

### **5.2 Pharmacotherapy**

- a. There is no clinically significant difference in effectiveness between selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs). Treatment decisions need to be based on considerations of relative patient acceptability, toxicity and cost.(A)
- b. For moderate and severe depressive disorders with melancholic features, TCAs are still

the initial drug of choice providing they are prescribed at an adequate dose and the patient can tolerate the side effects.(GPP)

- c. When TCA is used in treatment of depression in adults, low dose tricyclics (typically 75-100mg) is justified.(A)
- d. In general practice, a starting dose less than 75mg could be tried and stepped up according to the clinical effect and tolerance of individual patients. (GPP)
- e. Medication should be maintained at the full dosage required to attain symptom remission in the acute treatment phase. Patients should be reviewed every 1–2 weeks at the start of antidepressant treatment. (C)
- f. Continuation of treatment for further 3-6 months for first episode and for up to 3 years for recurrent episodes of depression are recommended.(C)
- g. Treatment should be continued for at least 4 weeks (6 weeks in the elderly) before considering whether to switch antidepressant due to lack of efficacy. (C)
- h. In cases of partial response, continue for a further 2 weeks (elderly patients may take longer to respond). (C)
- i. The use of fluoxetine, sertraline and paroxetine should be considered in patients with depression with concomitant anxiety symptoms. (A)
- i. In general all medications should be tailed off over a four week period.(C) This is probably not necessary for fluoxetine due to its extended half-life.(C)
- j. The use of benzodiazepine may be considered for short term use for anxiety features coexists with depression when balanced judiciously against possible harm after discussion with patient.(C)
- k. The SSRIs and related antidepressants venlafaxine are contraindicated in those aged under 18 years because there is insufficient information on safety and efficacy. (C)

6. **Ranking of evidence and grade of recommendation**

Adapted from the US Agency of Health Care Policy and Research

<b>Level</b>	<b>Type of Evidence</b>
Ia	Evidence obtained from meta-analysis of randomized controlled trials
Ib	Evidence obtained from at least one randomized controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomization
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities
<b>Grading</b>	<b>Recommendation</b>
A	Requires at least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (Evidence levels Ia, Ib)
B	Requires the availability of well-conducted clinical studies but no randomized clinical trials on the topic of recommendation. (Evidence levels IIa, IIb, III)
C	Requires evidence obtained from expert committee reports or opinion and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (Evidence level IV)
GPP	Recommended best practice based on clinical experience of Guideline Development Group.

## 7. Reference

1. The Mental health Context: Mental health policy and service guidance package. Geneva: World health organization; 2003
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### **Disclaimer**

Every effort has been made to ensure the accuracy and completeness of this version of guideline. However, we make no warranties regarding errors or omissions and assume no responsibility or liability for loss or damage resulting from the use of information contained within.

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**Criteria for Major Depressive Episode**

A1.1 Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucination.

- a. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful).  
**Note:** In children and adolescents, can be irritable mood.
- b. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- c. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.  
**Note:** In children, consider failure to make expected weight gains.
- d. Insomnia or hypersomnia nearly every day
- e. Psychomotor agitation or retardation nearly every day (observable by other, not merely subjective feelings of restlessness or being slowed down)
- f. Fatigue or loss of energy nearly every day
- g. Feelings of worthlessness or excessive or inappropriate guilt (with may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- h. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- i. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

- A1.2 The symptoms do not meet criteria for a Mixed Episode<sup>7</sup>
- A1.3 The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- A1.4 The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism)
- A1.5 The symptoms are not better accounted for by Bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

**Criteria for Severity/Psychotic/Remission Specifiers for current (or most recent) Major Depressive Episode**

- A2.1 **Note:** Code in fifth digit. Mild, Moderate, Severe Without Psychotic Features, and Severe With Psychotic Features can be applied only if the criteria are currently met for a Major Depressive Episode. In Partial Remission and In Full Remission can be applied to the most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode.
- A2.2 **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with other.
- A2.3 **Moderate:** Symptoms or functional impairment between “mild” and “severe.”
- A2.4 **Severe Without Psychotic Features:** Several symptoms in excess of those required to make the diagnosis, **and** symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.
- A2.5 **Severe With Psychotic Features:** Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:
- a. **Mood-Congruent Psychotic Features:** Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment.
  - b. **Mood-Incongruent Psychotic Features:** Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Included are such symptoms as persecutory delusions (not directly related to depressive themes), thought insertion, thought broadcasting, and delusions of control.
- A2.6 **In Partial Remission:** Symptoms of a Major Depressive Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Major Depressive Episode lasting less than 2 months following the end of the Major Depressive Episode. (If the Major Depressive Episode was superimposed on Dysthymic Disorder, the diagnosis of Dysthymic Disorder alone is given once the full

criteria for a Major Depressive Episode are no longer met.)

A2.7 **In Full Remission:** During the past 2 months, no significant signs or symptoms of the disturbance were present.

A2.8 **Unspecified**

Criteria for Chronic Specifier

A3.1 *Specify if:*

**Chronic** (can be applied to the current or most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I and II Disorder only if it is the most recent type of mood episode)

A3.2 Full criteria for a Major Depressive Episode have been met continuously for at least the past 2 year

**Assessment of suicidal risk**

**A4.1 Demographic factors**

- a. Social isolation (living alone, single) and lack family support
- b. Older male
- c. Recent loss

**A4.2 Check the history**

- a. History of prior suicidal attempts especially if multiple/severe attempts
- b. Family history of suicide
- c. Substance abuse/ dependency
- d. Presence of physical illness

**A4.3 Assess for**

- a. Severe depression
- b. Anxiety
- c. Hopelessness
- d. Psychosis especially with command hallucinations

**A4.4 Ask about suicidal thinking**

- a. Presence of a specific plan
- b. Means available to carry out the suicidal plan
- c. Absence of factors that would keep the patient from completing the plan
- d. Rehearsal of the plan including preparations such as letters, will

A4.5 Asking about suicidal thoughts and plans will not prompt a suicidal attempt. It may be appropriate to ask a series of questions about how the individual views the future and whether there are feeling of hopelessness and helpless and thoughts about death before going on to directly asking about actual thoughts and plans.

*(Adapted from Clinical Practice Guidelines on Depression, Ministry of Health Singapore March 2004)*

- (1) Book on suicidal counseling: Suicide Counseling in the Satir Model-Reflection on Clinical practice by Dr Grace Cheung (Editor).
- (2) Practical Guidelines for Doctors *Assessing and Managing Potentially Suicidal Patients* Centre for Suicide Research and Prevention, The University of Hong Kong

**Factors associated with depression**

**A5.1 Medical conditions associated with depression**

- a. Hypothyroidism
- b. Malignancy
- c. Parkinson's disease
- d. Myocardial infarction
- e. Stroke
- f. Endocrinopathies (Cushing's syndrome, adrenal insufficiency, carcinoid, hyperparathyroidism)
- g. Infections (hepatitis, mononucleosis, influenza or other viral illnesses)
- h. Chronic disease (congestive heart failure, diabetes, systemic lupus erythematosus, rheumatoid arthritis)
- i. Alcoholism or other substance abuse/ dependence
- j. Fibromyalgia/ chronic fatigue syndrome
- k. B12 or folate deficiency
- l. Sleep disorders

**A5.2 Medications associated with depression**

- a. Drugs of abuse (alcohol, amphetamines, cocaine, marijuana)
- b. Anti-hypertensives (reserpine, methyldopa, beta blockers)
- c. Psychoactive drugs (analgesics, sedative-hypnotics, anxiolytics)
- d. Steroid hormones (prednisone, oral contraceptives)
- e. Chemotherapy agents
- f. Levodopa
- g. Cholesterol lowering agents

**A5.3 Psychiatric disorders associated with depression**

- a. Bipolar disorder
- b. Dysthymia
- c. Grief, bereavement
- d. Anxiety disorder
- e. Post-traumatic stress disorder
- f. Somatoform disorders
- g. Eating disorders
- h. Sleep disorders
- i. Substance abuse

**A5.4 Life situations associated with depression**

- a. Coping with illness
- b. Marital discord
- c. Child rearing difficulties
- d. Work stress
- e. Abuse ( domestic violence, physical or sexual abuse)

*Adapted from:*

- *Depression: A Guide to Diagnosis and Treatment, Brigham and Women's Hospital.*
- *University of Michigan health system depression Guidelines, June 1998.*

**Questionnaires for depressive Disorders**

**Hospital Anxiety and Depression Scale (HADS)**

This scale covers depression and anxiety and was developed for use in general medical patients. The validated Chinese version is enclosed for reference. Copyright has to be sought for use of this scale.

**HOSPITAL ANXIETY AND DEPRESSION SCALE 廣東話譯本**

以下嘅問題，係問你最近幾日內嘅情緒健康，啲問題好簡單，你唔需要諗好耐先至答到。

**Q1. 呢個禮拜內，你有冇試過覺得緊張，好難放鬆自己？R**

1. 大多數嘅時候有
2. 經常有
3. 間中 / 有時有
4. 從未試過

**Q2. 以前你鍾意嘅嘢(如嗜好、工作、飲食、玩意)而家重鍾唔鍾意？**

1. 重好鍾意
2. 冇以前咁鍾意
3. 少咗好多興趣
4. 冇晒興趣

**Q3. 你有冇試過好驚，覺得好似就嚟有啲好得人驚嘅嘢就快發生咁樣？R**

1. 好明顯試過，而且好緊要添
2. 有試過，但唔係好緊要
3. 試過少少，好輕微
4. 從未試過

**Q4. 你覺得自己有冇幽默感/識唔識得笑/睇唔睇到生活小節中好笑或得意嘢？**

1. 有，同以前一樣
2. 有，但冇以前咁容易
3. 比以前少好多
4. 完全冇

Q5. 最近你有冇啲擔心嘅嘢？R

1. 好多時都有
2. 經常有
3. 有時有,但不是很多時
4. 間中有/完全冇

Q6. 最近你多唔多時候覺得開心？R

1. 完全唔覺得
2. 好少覺得
3. 有時覺得
4. 多數時間都覺得

Q7. 你可唔可以定落嚟(或安靜咁坐喺度)，同埋放鬆自己？

1. 肯定可以
2. 多數都可以
3. 唔係時時可以
4. 完全唔可以

Q8. 你有冇覺得你做任何嘢都比以前慢咗？R

1. 差不多時時都有
2. 經常有
3. 間中有
4. 完全冇

Q9. 你有冇試過驚到(或嚇到)幾乎暈倒/好似個心要跳出嚟？

1. 完全冇
2. 間中有
3. 經常有
4. 時時都有

Q10. 你有冇對自己嘅外表/衣著/打扮冇啲興趣？R

1. 肯定完全冇啲興趣
2. 比以前少咗好多興趣
3. 可能比以前少咗一啲興趣
4. 同以前一樣，從冇少過

Q11. 你有冇覺得坐立不安，唔啱就好唔自然咁？R

1. 多數時間都覺得

2. 經常有
3. 唔係太多
4. 完全冇

Q12. 你有冇很興奮地期待一啲好嘅嘢發生？

1. 一直都有
2. 比以前少咗一啲
3. 比以前少咗好多
4. 完全冇

Q13. 你有冇試過突然之間無緣無故好驚，或者好怕一啲嘢？**R**

1. 好多時都有
2. 經常有
3. 間中有
4. 完全冇

Q14. 你可唔可以開心地睇一本好書、報紙雜誌，睇電視或聽收音機節目？

1. 經常都可以
2. 有時唔可以
3. 唔係很多時可以
4. 好少可以

### Total HAD Score

AS

DS

Subscales:

Depression: Items 2, 4, 6, 8, 10, 12, 14 (even numbered items)

Anxiety: Items 1, 3, 5, 7, 9, 11, 13 (odd numbered items)

Scoring:

Score items 1 through 4 with values of 0 through 3. Those items followed by an **R** should be reversed when scoring (i.e., scored 3 through 0)

**Patient education and guided self-help**

- The book : 回到開心時 情緒管理 DIY  
作者：李靜慧 湯國鈞 何敏賢 李智群
- The book : 我選擇快樂 快樂心理學  
作者：劉遠章 陶兆輝
- The VCD: Stress management
- Relaxation exercise (Pamphlet enclosed)

**Problem-solving therapy**

- A8.1 A discrete, time limited, structured psychological intervention, that focuses on learning to cope with specific problem areas.
- A8.2 Problem solving interventions teach the person to use their own skills and resources to cope with both present and future problems. It has several stages: (1) Identifying and clarifying the problem (2) Setting clear achievable goals (3) Brainstorming to generate solutions (4) Selecting the preferred solution (5) Evaluating progress.
- A8.3 Both appropriately trained GPs and practice nurses can deliver this treatment effectively.

## Cognitive-behavioral Therapy Techniques 25

### A9.1 Cognitive Techniques

#### A9.1.1 **Teach ABC Model**

- a. Automatic thoughts (AT) and underlying beliefs
- b. Teach the distinction and relationship between AT and beliefs
- c. Cultivate more positive and meaningful beliefs and values

#### A9.1.2 **Encourage a problem-solving mindset**

- a. Think about alternatives and solutions

#### A9.1.3 **Encourage a self-reflective mindset**

- a. What are my views and perceptions?
- b. What are my blind spots or distorted thinking?
- c. Labeling of cognitive distortions

#### A9.1.4 **Self-questioning techniques**

- a. *Evidence question*
  - i. What are the evidences for my belief?
  - ii. What are the evidences against my belief?
- b. *Alternative question*
  - i. What are the alternative thinking and solutions?
- c. *Impact question*
  - i. What are the effects of my thinking and behavior?
  - ii. What if I change my thinking and behavior?
- d. *Action question*
  - i. What should I do now?
  - ii. What is the first step to achieve my goal?

#### A9.1.5 **Reattribution**

- a. Avoid placing all the blame on self
- b. The pie chart technique

#### A9.1.6 **Decatastrophizing**

- a. Avoid focusing on the most extreme negative outcome
- b. Ask self: “So what is the worst thing that might happen? And if so, would this be really horrible? How can I survive it?”

#### A9.1.7 **Paradox or exaggeration**

- a. Inverse of decatastrophizing
- b. Take an issue or idea to the extreme, leading the patient to see the absurdity of an overinflated viewpoint

#### A9.1.8 **Cost-benefit analysis**

- a. Avoid all-or-none dichotomous thinking
- b. List pros and cons, costs and benefits of a situation or alternative

#### A9.1.9 **Downward arrow**

- a. Help patients understand the logic and sequencing of their reasoning. Ask patient, “If so, then what?”, leading to a sequence of thoughts and uncovering the patient’s underlying beliefs and assumptions

#### A9.1.10 **Idiosyncratic meaning**

- a. Clarifying a term or statement made by the patient in order to have a deeper understanding of the patient’s perceived reality

#### A9.1.11 **Mental rehearsal**

- a. Visualizing in the mind the desired outcome and procedures to achieve the outcome
- b. Assertiveness and social skill training

#### A9.1.12 **Reframing**

- a. Help patient see the problem from a more positive or meaningful perspective
- b. Turning adversity to advantage
- c. Dimensions that can create a more positive view
- d. Time – from past or present to future
- e. Self-evaluation – from self blame to self-appreciation, e.g. attitude or effort
- f. Learning – from misfortune to personal growth and learning
- g. Value – from narrow, materialistic to broad and psychospiritual

#### A9.1.13 **Appreciation and self-contentment**

- a. From blame or guilt to appreciation and compassion

- b. Teach appreciation of daily trivial matters
- c. Count what patient has possessed already

**A9.1.14 Cultivate a positive mindset**

- a. The power of positive thinking
- b. Meaning making and value forming – life philosophy
- c. Not indulge in the regrets and pains in the past, nor the worries of the future

**A9.2 Behavioral Techniques**

**A9.2.1 Assertiveness and social skill training**

- a. Teaching or modeling for desired behavior in social situations
- b. Teach conflict management skills

**A9.2.2 Behavioral rehearsal**

- a. Rehearse or role play desired social behavior

**A9.2.3 Graded task assignment**

- a. Establish a hierarchy of events that involve the target behavior
- b. Task arranged in steps from least anxiety producing to most anxiety producing

**A9.2.4 Relaxation and meditation**

- a. Deep breathing relaxation
- b. Mental imagery relaxation
- c. Meditation

**A9.2.5 Problem-solving training**

- a. Teach problem solving techniques
- b. Induce successful experience in problem-solving

**A9.2.6 Goal setting and implementation**

- a. Help patient set realistic and beneficial goals
- b. Design procedures or steps to achieve the goal
- c. Divide goal into sub-goals and target the first action

**A9.2.7 Activity scheduling**

- a. Design daily activity schedule together with the patient

- b. Structure can reduce anxiety

#### A9.2.8 **Homework**

- a. Design homework together with patient in session which serves as a continuation of what discussed in the session
- b. Feasible and practical with a high chance of success

#### A9.2.9 **Bibliotherapy**

- a. Prescription of reading assignments or internet searching

**Counseling**

A10.1 Counseling and psychotherapy is primarily the *use of self* to help another person *solve a problem* in order to *cope more effectively* with their life. Therapists use all the *resources* available to them to establish *trust* and help clients work toward a *solution*. The goal is to *alleviate* human suffering, solve problems and help people live *more satisfying lives*<sup>25</sup>.

A10.2 There is evidence for the efficacy of counseling for depression in primary care for patients with mild to moderate depression of recent onset when it is compared with antidepressant and GP care.

A10.3 **Basic Counseling skills**<sup>25</sup>

A10.3.1 Rapport Building Skills

- a. Caring and respectful attitude
- b. Supportive and empathetic stance
- c. Verbal and non-verbal communication

A10.3.2 Engagement and Induction Skills

- a. Inquiry Questions:
  - i. Have you been under stress recently?
  - ii. Anything special happened to you recently?
  - iii. How is your mood recently? Why?
- b. If problems are identified, then ask patient:
  - i. Do you want to talk more about it?
  - ii. May I know more about what happened to you? I think it may be important to your general health.
  - iii. Sometimes I will also do some counseling or talking about problems with patients, do you want to tell me more?
- c. If patient is reluctant to talk, you may suggest:
  - i. Many people found sharing their problems with others helps relieve distressed emotions. Why don't you try?
  - ii. You may not feel comfortable to talk about your problem. Usually to start talking is difficult, but I encourage you to consider trying.

- iii. I think your health problems are probably related to stress and emotions. I need to know more about your problems if you want me to help you to get healthy.
- iv. You may want to talk to a family member or a bosom friend. I can also give you some counseling service information, so that you can seek professional counseling for your problems.

#### A10.3.3 Understanding skills

- i. *Problem understanding*: the predisposing factors, precipitating factors and perpetuating factors of the problem.
  - ii. *Person understanding*: personal history, personality, coping style, etc.
  - iii. *Context understanding*: individual, social, cultural.
  - iv. *Interaction* between person, problem and context.
- a. *Attending skills*
    - i. Verbal and non-verbal aspects
  - b. *Listening skills*
    - i. Listen to the surface contents and the underlying themes- patterns, self-concept, psychological needs.
    - ii. Listen to the non-verbal communication and self-presentation.
  - c. *Empathy skills*
    - i. Imagine you are your patient-put yourself in his/her shoes
    - ii. Cognitive empathy
    - iii. Emotive empathy
    - iv. Balance between empathy and objectivity

#### A10.3.4 Questioning skills (Exploration skills)

- a. *Storyline Questions*: relevant details, sequence and patterns
- b. *Person-centered questions*: personality, coping, inner feelings and thoughts, motivation for change
- c. *Possibility or Solution Questions*: exploring possible solutions and envisioning future.

#### A10.3.5 Summarizing and Reflecting Skills

- a. Summarize the pattern and important points.
- b. Reflect patient's intrapsychic, interpersonal, and contextual reality.

#### A10.3.6 Guiding and Educating Skills

- a. Two kinds of education: instructional learning (psychoeducation) and self-discovered learning
- b. Use of questions, metaphors and examples
- c. Clear and convincing tone

#### A10.3.7 Experiential Skills

- a. Allowing ventilation of feelings
- b. Focusing and relaxing training
- c. Use of mental imagery

#### A10.3.8 Empowerment Skills

- a. Amplify patient's strengths and resources
- b. Validate patient's feelings and self-esteem

**Local resources**A11.1 **Counseling services** (public/ non-government organization)

- a. 明愛向晴軒 (pamphlet enclosed)
- b. RESOURCE The Counseling Centre Ltd : <http://www.resourcecounseling.org>
- c. 香港基督教服務處 - 輔導服務 (pamphlet enclosed)

A11.2 **Hotlines for suicide and depression**

- a. 社會福利署熱線 2343 2255
- b. 撒瑪利亞防止自殺會 2389 2221-3
- c. 醫院管理局精神科熱線 2466 7350
- d. 生命熱線 2382 0000
- e. 香港心理衛生會 – 心理健康資訊電話 2772 0047
- f. 浸會愛群社會服務處精神康復者家屬資源及服務中心 2560 0651

A11.3 **Seminars and Workshops for personal growth and development**

- a. HK Psychological Society  
[http:// www.hkps.org.hk](http://www.hkps.org.hk)
- b. HK Professional Counseling Association  
[http:// www.hkpca.org.hk](http://www.hkpca.org.hk)
- c. Centre on behavioral Health HKU  
[http:// www.cbh.hku.hk](http://www.cbh.hku.hk)
- d. HKU Family Institute  
[http:// www.hkufi.hku.hk](http://www.hkufi.hku.hk)
- e. HK Satir Centre for Human Development  
[http:// www.hksatir.org](http://www.hksatir.org)
- f. Green Pastures Whole Person Development Centre  
[http:// www.greenpastures.com.hk](http://www.greenpastures.com.hk)
- g. HK Institute for Children’s Mental Health  
[http:// www.icmh.com.hk](http://www.icmh.com.hk)
- h. Asian Professional Counselling Association  
[http:// www.apca-counselling.com](http://www.apca-counselling.com)
- i. United Centre of Emotional Health and Positive Living (UCEP)  
<http://www.ucep.org.hk>
- j. Hong Kong Family Welfare Society
- k. 香港基督教服務處  
天倫綜合家庭服務中心

A Guide To Selection Of Antidepressants

Drug	Recommended outpatient dose for a depressive episode <sup>1</sup>	Cost for 30 days treatment <sup>2</sup>	Side effect profile			Other adverse effects	Contraindications	Precautions
			sedative	anticholinergic	postural			
<b>Tricyclic antidepressants (TCAs)</b>								
Amitriptyline	150 mg	\$28.98	+++	+++	++	(Apply to all TCAs) Excessive sweating, carbohydrate craving, weight gain, insomnia, dizziness, sexual dysfunction, ECG changes	Acute MI	(Apply to all TCAs) Cardiovascular disorders, hepatic impairment, hyperthyroidism, epilepsy, suicidal tendencies, prostatic hypertrophy, narrow angle glaucoma or increased intraocular pressure, schizophrenia, bipolar affective disorder (mania), MAOis, alcohol withdrawal
Clomipramine	100 mg	\$68.88 SR	++	++	+			
Desipramine	150 mg	\$160.23	+	+	+++			
Dothiepin	150 mg	\$16.04	+++	+++	++			
Doxepin	150 mg	\$15.17	+++	+++	++			
Imipramine	150 mg	\$25.77	++	++	++			
Nortriptyline	150 mg	\$23.27	+	+++	+/-			
Trimipramine	150 mg	\$19.67	+++	++	++			
<b>Selective serotonin re-uptake inhibitors (SSRIs)</b>								
Fluoxetine	20 mg	\$64.30 <sup>3</sup>	+/-	+/-	+/-	Insomnia, nausea, weight loss, rash, sexual dysfunction, hyponatraemia	MAOis Hypersensitivity to Paroxetine	Significant agitation, severe hepatic or renal impairment, mania, cardiac disease
Paroxetine	20 mg	\$69.85 <sup>3</sup> SR	+/-	+/-	+/-			
<b>Atypical cyclic agents</b>								
Amoxapine	300 mg	\$60.80	+	+	+	Gynecomastia, cardiacity, anticholinergic effects	Acute MI	Similar to the tricyclic antidepressants
Mianserin	150 mg	\$78.55 SR	++	+/-	+	Sedation, cardiacity, rash	Epilepsy, acute MI, conduction disorders, narrow angle glaucoma, urine retention, MAOis	Similar to the tricyclic antidepressants
Mirtazapine	60 mg	\$80.73 SA	++	+/-	+	Hepatic dysfunction, blood dyscrasias	Mania, MAOis	Bipolar depressive illness, narrow angle glaucoma, prostatic hypertrophy
<b>Reversible MAO-A inhibitor (RMA)</b>								
Moclobemide	450 mg	\$99.36 SR	+/-	+/-	+	Anxiety, headache, nausea, rash	Hypersensitivity to Moclobemide, acute confusional states, children	Large quantities of tyramine-rich foods, hydralazine, phaeochromocytoma, agitation or agitation, bipolar affective disorder, clonidine, pethidine
<b>Monooamine oxidase inhibitors<sup>4</sup></b>								
Phenelzine	60 mg	\$45.55	+/-	+/-	++	Insomnia, sexual dysfunction, agitation, hepatic dysfunction	Phaeochromocytoma, cardiovascular or cerebrovascular disease, sympathomimetics, pethidine, SSRIs, TCAs	Require low tyramine diets; epilepsy, liver disease, ability surgery interactions with other medications; bipolar affective disorder (mania)
Tranylcypromine	30 mg	\$66.07	+/-	+/-	++			

Footnotes

- 1 Due to wide variation in metabolism and clinical responses, doses need to be individually titrated
- 2 Cost to person (and any subsidy) using the recommended dose rates in the previous column.
- 3 The difference in the price between Moclobemide and Doxepin is because there is a generic price per dose (rather than per mg). Prices quoted reflect the higher (on average) dose of Fluoxetine prescribed in New Zealand, as it is also indicated for other disorders at a higher dose.
- 4 MAOis may cause constipation, dry mouth, urinary difficulty by other than an anticholinergic mechanism.

SA = available on special authority

Appendix 12: Antidepressant Drugs. A Guide to Selection New Zealand, 2004.

**Cost of Antidepressants**

**Recommended Outpatient dose for a depressive episode  
Cost for 30days treatment (HK \$)**

**Tricyclic antidepressants**

amitriptyline

150mg

17.82\*

clomipramine

100mg

377.22§

desipramine

150mg

864.93§

dothiepin

150mg

38.7\*

doxepin

150mg

81.88§

imipramine

150mg

139.10§

nortriptyline

150mg

125.61§

trimipramine

150mg

106.18§

**Selective serotonin re-uptake inhibitors**

fluxetine

20mg

11.37\*

paroxetine

20mg

377.05§

### **Atypical cyclic agents**

amoxapine

300mg

328.20§

maprotiline

150mg

424.02§

mianserin

60mg

435.78§

### **Reversible MOA-A inhibitor (RIMA)**

moclobemide

450mg

536.35§

### **Monoamine oxidase inhibitors**

phenelzine

60mg

266.39§

tranylcypromine

30mg

307.53§

§ cost estimate based on currency exchange from New Zealand Guideline

\* cost estimate based on DH dispensary price as at Aug 05

**Details of individual drugs**A14.1 **SSRI**a. **Fluoxetine:**

- i. Adult oral: initially 20mg once daily; increased to 20mg twice daily after several weeks, if required
- ii. Maximum dose: 80mg/day

b. **Paroxetine:**

- i. Adult oral: initially 10mg once daily (or 12.5mg of controlled-release form); increased by increments of 10mg/day at intervals of at least one week, if required
- ii. Maximum dose: 50mg/day
- iii. A meta-analysis examined efficacy and tolerability data from 39 randomized, double-blind, parallel-group studies comparing paroxetine (n = 1924) with clomipramine (n = 141) or other tricyclic antidepressants (TCAs; n = 1693) in the treatment of major depression, demonstrate that paroxetine has comparable efficacy to and better tolerability than TCAs, including clomipramine, and is therefore an appropriate treatment strategy for depression, particularly in the common clinical situation where concomitant anxiety symptoms are present.<sup>17</sup> **(1a)**  
The use of paroxetine in patients may be considered in patients with depression with concomitant anxiety symptoms when patients are intolerable to other alternative treatment. **(GPP)**

c. **Sertraline:**

- i. Adult oral: initially 25mg once daily for first week; increased to 50mg once daily at intervals of at least one week, if required
- ii. Maximum dose: 200mg/day

d. **Citalopram:**

- i. Adult oral: initially 20mg once daily; increased after at least one week to 40mg/day, if required

e. **Escitalopram:**

- i. Adult oral: initially 10mg once daily; increased after at least one week to 20mg once daily, if required

## A14.2 **TCA**

a. **Amitriptyline:**

- i. Adult oral: initially 50-75mg/day; increased to 100-200mg/day, if required

b. **Imipramine:**

- i. Adult oral: initially 75mg/day; increased to 150-200mg/day, if required

c. **Clomipramine:**

- i. Adult oral: initially 25mg/day; increased to approximately 100mg during the first 2 weeks, if required

d. **Desipramine:**

- i. Adult oral: 100-200mg/day; increased to 300mg/day, if required

e. **Doxepin:**

- i. Adult oral: 75mg-150mg/day in divided doses or as a single dose in the evening

f. **Maprotiline:**

- i. Adult oral: initially 75mg/day, increased after 2 weeks in 25mg increments, if required
- ii. Maximum dose: 50mg/day