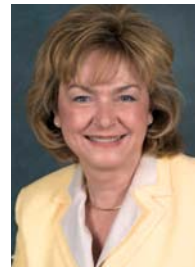


He's Not That Into This: Recognizing Depression in Men And Other Atypical Patients

A clinical discussion with Valerie A. Hart, EdD, APRN, CS, and Nancy Balkon, PhD, ANP-C, APRN



Dr. Hart



Dr. Balkon
Host for CE-TODAY

Women are twice as likely as men to be diagnosed with depression; hormonal factors and the responsibilities at work and home are cited as reasons for the disparity. However, even though 3 to 4 million men in the United States are affected by the illness, they are less likely to admit to the disease and healthcare professionals are less likely to suspect it. The same is true for other patient groups, including African Americans and Hispanics. In this interview, the faculty will discuss how men and other atypical patients might manifest signs and symptoms of depression and how healthcare professionals can recognize this debilitating disease in all patients.

Dr. Balkon: Let me ask the first question; we know that women experience depression twice as often as men; how do you account for that disparity that we see in our clinical practices?

Dr. Hart: A couple of large categories exist in terms of biological factors, psychosocial factors, and genetic factors that account for this disparity (Table 1).

Dr. Balkon: Would you explain the biological factors?

Dr. Hart: The biological factors are linked to the various reproductive events in a woman's life, which really begin with the child-bearing years, beginning in adolescence and continuing until about age 45 years, and then another peak during perimenopause and menopause. The mood changes that are related to hormonal fluctuation during menstruation and pregnancy are really somewhat new in terms of identifying them in primary practice—clinicians highlighting these fluctua-

tions and perhaps even asking women where they may be in their cycle during a typical visit. But the research is very clear about the connection between mood and hormone, specifically estrogen, fluctuation.

The second biological factor is thyroid function; clearly differences exist between men and women concerning thyroid function. I believe the specific issue is not clear, but we know that thyroid function is more of an issue for women in depression.

The third factor is the Circadian rhythm, and this pattern is different for women in that women who are depressed sleep more and report being more hypersomnolent. So clearly, the biology, the issues related to depression, and the mood issues related to the various kinds of depression differ for women and these are connected with physiology.

Dr. Balkon: That is a very interesting point. You mentioned some subtle distinctions that occur during the trajectory

Learning Objectives

Upon completion of this course, you should be able to:

- ▶ Identify patient groups that are often overlooked when diagnosing depression
- ▶ Cite various patient presentations of depression and appropriate treatment strategies
- ▶ Describe barriers to effective patient care in the primary care setting and myths about depression

For information on how to earn CE contact hours, see inside front cover. To view disclosure information, see page 5. Participation in this self-study activity should be completed in about 1 hour.

Course ID: AB0435



To listen to the audio interview with Dr. Hart as she discusses issues related to depression, please insert the companion CD into your CD player or visit www.np.ce-today.com.

from a young adult female on through perimenopause and menopause and later in life; would you care to comment further about that, specifically regarding the differences that you have seen in your clinical practice?

Dr. Hart: Again, within the biologic category, partly what makes it very difficult for women to separate whether this mood fluctuation—sadness, irritability, feelings of being fragile—is connected to something hormonally. The difficulty women have in coping during perimenopause, which is a 10-year period, is such fluctuations. Women cannot track in any consistent way where they are hormonally during perimenopause as they could during regularly cycled menstruation. When cycles are more predictable, women could be more

consistent about when they might be premenstrual. It is a really difficult time, not even considering all of the psychosocial factors that I hope we can discuss.

Dr. Balkon: What a wonderful segue; would you please comment on the psychosocial point of view? Maybe a little later in our discussion we can link the biological, the psychosocial, and the genetic factors.

Dr. Hart: For a long time, those who have tried to determine why the population that is being treated for and experiencing depression is twice as large for women than men have described many variables and these variables include role stress or role strain, which is this issue of the working woman today. Recently, I heard some-

one comment that there is no such term as a “working father,” and yet “working mother” is a term that many people understand and conceptualize. Research shows us that the responsibilities of working mothers indicate that women are responsible for the majority of child care and the majority of the household responsibilities and role strain is a problem. Sexual discrimination and sexual harassment are issues that have been well documented—women are still not earning equal pay for equal work. And the lack of social support in terms of parenting, again, may contribute to the role strain. In addition, violence against women in any form, whether it is abuse or rape, these areas are really stacked against women more than men. Typically some of the symptoms of depression that clients talk about in terms of feeling helpless and hopeless really refer to the way that women may feel at times concerning society's view of them in their situation.

Regarding the issue of poverty, women and children represent 75% of the poor in this country, which is an additional factor for role strain. And overarching all of these issues is the reality that from very early on, culturally, females are given permission to express feelings, to identify feelings, to share them, and to talk about them. Women really are encouraged to have a connection with that inner self. So, it makes more sense that women are able to identify when they feel sad and perhaps to seek treatment or to talk to someone when they feel that way.

TABLE 1. DEPRESSION: DIFFERENCES IN WOMEN COMPARED WITH MEN

Parameters	Differences in Women (Compared with Men)
Lifetime prevalence rate	20% (10% in men)
Age of onset	May be earlier
Duration of episodes	May be longer
Course of illness	May more often be recurrent
Seasonal effect on mood	Greater
Association with stressful life events	More frequent
Atypical symptoms of depression (eg, hypersomnia, hyperphagia)	Experienced more often
Severity of depression	May be greater if self-rated by the patient
Guilt feelings	May be experienced more often
Suicidal behavior	Suicide attempted more often but much less often successfully
Association of anxiety disorders, especially panic and phobic symptoms	Greater
Association of eating disorders	Greater
Association of alcoholism and substance use disorder	Usually less
Association of thyroid disease	Greater
Association of migraine headaches	Greater
Association of antisocial, narcissistic, and obsessive-compulsive personalities	Less
Effect of exogenous and endogenous gonadal steroids on mood	Greater

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 Pajcar K. New strategies in the treatment of depression in women. *J Clin Psychiatry* 1995;56 (suppl 2):30-7.
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 Available at: www.aafp.org/afp/990700ap/225.html

Exercise 1

Which statement is true?

- a. Men and women have the same issues regarding depression and thyroid function
- b. Women experience depression and commit suicide twice as often as men
- c. The biology, the issues related to depression, and the mood issues related to the various kinds of depression differ for women and these are connected with physiology
- d. The difficulty women have in coping during perimenopause, which is a 10-year period, is not having a consistent cycle

Answer on page 16.

Dr. Balkon: That is an absolutely appropriate observation and with all of the points that you have just mentioned, there is one point that we definitely see in our practices and that is women who are single and the head of the household who assume an additional burden without support systems in place; sometimes they get caught up in life-living and the pursuit of caring for their children and keeping a roof over their heads, that they often can neglect themselves and not even realize that they are depressed.

What are some of the subtle symptoms that you see in practice and which symptoms should clinicians focus on that people do not equate with depression? I am referring to the abnormalities because the tendency is to think that those who are depressed exhibit the characteristics such as a lack of interest in the activity of daily living and lying around like a couch potato watching TV every day when in fact the trajectory prior to that may have characteristics of irritability along with other symptoms. Do you care to comment on that a little further?

Dr. Hart: I would like to discuss some of the issues related to men and depression. But first, I want to address this point that you mentioned regarding women and role strain. Balance is extremely important and I know that women seek help in psychotherapy and sometimes they really talk about what is wrong with them and they may ask for antidepressant medication. In fact when we discuss their life and talk about what they are trying to accomplish, it becomes clear that they may need help—help with child care and help at home—but they may not necessarily need antidepressant medication. It is about balance, and achieving balance can be very tricky today; having all of the balls in the air is particularly difficult. To answer your question about a person feeling depressed, some of the more subtle manifestations include patients having vague physical complaints. For example, if a patient feels out of sorts, not able to concentrate at work, or a lack of interest in things that ordinarily brought pleasure and difficulty making decisions. Of course, one of the more obvious manifestations is significant weight loss.

Dr. Balkon: Or significant weight gain?

TABLE 2. DSM-IV DIAGNOSTIC CRITERIA AND SUGGESTED QUESTIONS

Symptom	DSM-IV Diagnostic Criteria	Suggested Questions
Depressed mood	Depressed mood most of the day, nearly every day	<ul style="list-style-type: none"> How has your mood been lately? How often does this happen? How long does it last?
Anhedonia	Markedly diminished interest or pleasure in almost all activities most of the day, nearly every day	<ul style="list-style-type: none"> Have you lost interest in your usual activities? Do you get less pleasure in things you used to enjoy?
Sleep disturbance	Insomnia or hypersomnia nearly every day	<ul style="list-style-type: none"> How have you been sleeping? How does that compare with your normal sleep?
Appetite or weight change	Substantial change in appetite nearly every day or unintentional weight loss or gain ($\geq 5\%$ of body weight in a month)	<ul style="list-style-type: none"> Has there been any change in your appetite or weight?
Decreased energy	Fatigue or loss of energy nearly every day	<ul style="list-style-type: none"> Have you noticed a decrease in your energy level?
Increased or decreased psychomotor activity	Psychomotor agitation or retardation nearly every day	<ul style="list-style-type: none"> Have you been feeling fidgety or had problems sitting still? Have you slowed down, like you were moving in slow motion or stuck in mud?
Decreased concentration	Diminished ability to think or concentrate, or indecisiveness, nearly every day	<ul style="list-style-type: none"> Have you been having trouble concentrating? Is it harder to make decisions than before?
Guilt or feelings of worthlessness	Feelings of worthlessness or excessive guilt nearly every day	<ul style="list-style-type: none"> Are you feeling guilty or blaming yourself for things? How would you describe yourself to someone who had never met you before?
Suicidal ideation	Recurrent thoughts of death or suicide	<ul style="list-style-type: none"> Have you felt that life is not worth living or that you'd be better off dead? Sometimes when a person feels down or depressed they might think about dying. Have you been having any thoughts like that?

Available at: www.jr2.ox.ac.uk/bandolier/band99/b99-6.html

Depression: Guidelines for Diagnosis. Adapted from DSM-IV. Available at: <http://pdf.osfhealthcare.org/depression.pdf>.

Dr. Hart: Sure. Another manifestation is patients having thoughts of death or suicide.

Dr. Balkon: Exactly.

Dr. Hart: But patients who are restless or irritable will not necessarily use the word “depressed,” but they will say, “I do not feel well” or “I do not feel right,”

and I believe that rather than focusing on symptoms, clinicians should be encouraged to listen to what is going on and hopefully talk with the client about the client's life. Clinicians must listen to the narrative to uncover the story.

Dr. Balkon: Along that thought, as a clinician I like to ask questions that are open-ended that might not necessarily

directly focus on the question, “Are you depressed?” For example, with regard to women and men, I ask questions that look at relationships. For example, if parents find themselves unusually or uncharacteristically irritable with their children and they express concerns about being short-tempered with regard to the child's behavior, realizing that they typically would not lose their temper over such behavior and would instead redirect the child, that might be a subtle clue to explore regarding the possibility that these parents might have the initial trappings of a depression or definitely an acute depression.

Let's focus on men. We believe that men experience depression less frequently than women, and that men represent an underdiagnosed group with regard to this disorder. What are some of the atypical ways that men might manifest signs or symptoms of depression?

Dr. Hart: If we take away the biologic components that we discussed with regard to women, we return to talking about the psychosocial cultural issues. Clearly the cultural expectations for men are that tough guy who only deals with things rather than feels them or admits feeling them. In our culture, being depressed may be viewed as somewhat unmanly, so the thought is that a man just grins and bears it and is strong. This perpetuates that men display depression more often as a problem with work performance, irritability, anger, aggression, vague physical complaints of being tired or less interested in eating, or just withdrawing and being quiet at home or at work, or they may act directly opposite and manifest risk-taking behavior. Using alcohol and drugs is more common with men. In general, usually women feel the feelings and men act them out. As research has shown, the acting out might start with young boys, into adolescence, and through to adulthood that men may be involved in a brawl and will act out the feelings that are inside rather than feel them. Therefore, during times of grief or at other pressure points in a man's life, clinicians may have to uncover what is happening in a man's life to get to these issues. I do not believe that men will talk about being or feeling depressed.

Exercise 2

When men are depressed, they will exhibit signs of:

- a. Sadness and hypersomnolence
- b. Anger and irritability
- c. Fear of taking risks
- d. Overeating and increased alcohol and drug use

Answer on page 16.

Dr. Balkon: That is an excellent point. Coupled with that, we should always be cognizant of these behaviors in our clinical practices; for example, dialogues patients have with us regarding how they interact with others or how they feel at any given point in time. In my experience, clinicians immediately label patients as angry and will encourage patients to participate in an anger management class or in a substance abuse program. While these programs allow patients to be introspective and to identify their personal behaviors and ways to change them, health professionals have an obligation to consider ruling out an underlying depression, and if it this underlying depression exists, possibly treating it not only with counseling but with medication for a short time. What are your thoughts about that issue?

Dr. Hart: I agree with you and I think, again, specifically in primary care, if clinicians can tune into the patient's life and look at issues such as:

- Are there pressure points in this person's life?
- Are people entering and leaving this person's system in terms of births or deaths?
- Has this person just become a new parent?
- Has someone died in the family?
- Has this person become unemployed or changed jobs?
- Has this person retired?
- Is this person someone who is newly out as a gay teen or a young adult?

These factors ring bells in the research that men specifically are at a greater risk for depression. Interestingly enough, going through divorce and not being married are other risk factors for men. Of course, being diagnosed with a physical illness is a risk

factor, which may be an attack on a man's self-image—one's identity as a man. The clinician must tune in to these issues—which is larger than just the symptom the person walking into the office is experiencing; spread it out to what is going on in that person's life and what has occurred in the past weeks and months because in this breaking-off of mind/body, we artificially separate the two entities.

Dr. Balkon: I would like to reflect on the past few minutes of our conversation. It seems that for clinicians as well as for significant others and people in one's environment that it is very easy to stereotype and to form assumptions and then just initiate treatment or initiate an interactive approach for that individual. Would you care to speak a little bit about the role of men and women and some of the possible stereotyping that you may have seen in clinical practice? For example, do clinicians stereotype men in a certain way and alter their treatment plan in a specific way to reflect that stereotyping?

Dr. Hart: I think we are all creatures of the culture in which we are brought up, and as providers, we have to look quite closely at our assumptions about men and women. However, research also exists regarding this issue, and it is very hard to separate the psychosocial cultural influences and the patient. But we know that clinicians need to be careful about making assumptions and rather than accepting what patients reveal specifically about a symptom, clinicians need to listen to what is occurring in their patients' lives. And research proves that, although it may be a stereotype, men have a more difficult time with telling a narrative.

Research also notes the differences between women and men. For example, women, in fact, have an earlier onset of depression, and again, that probably relates to the biologic factor. The changing of seasons has a greater effect on mood for women, which means we may be talking more biology. However, regarding gender, an important factor shows that 80% of people who commit suicide are men because men cope differently than women. If men experience a less-serious depression, they may cope by diverting their attention, they may work more or they may use alcohol, but men are an

important underdiagnosed group because when they do fall into serious depression on that continuum and become suicidal, their efforts are more lethal.

Dr. Balkon: That point is excellent because it really does fit into stereotyping. One has to ask why so many men have committed suicide successfully. Are we as clinicians missing important clues or are we not doing something correctly? Or it may be the way that we perceive men in our own lives as being strong, able to cope, and handling it all, and the fact is that men are putting up the boundaries and not revealing what is really going on in their heart and in their soul.

The next topic is something that we all face in our clinical practices; working with patients, both young and old, who have been diagnosed with chronic illness. How do clinicians differentiate between normal feelings of sadness and a clinical diagnosis of depression? Chronic illness itself takes on trappings of depression. Twenty or 30 years ago, cancer was “a death sentence.” Today, cancer is a chronic illness. What are your feelings about that?

Dr. Hart: The research indicates that approximately one-third of individuals who develop a serious medical condition experience, among possible other feelings, symptoms of depression, and a variety of explanations exists. Physical changes that may be associated with a chronic illness, including one's own psychological reaction to the illness or the hardships that may occur or be posed by that illness, the fact that patients may be in pain, and a patient's life may be disrupted, perhaps permanently, that mobility can be affected, independence, and most importantly perhaps, that view of oneself. A person's identity can shift in addition to the fact that many medications produce side effects of depression and that many patients with chronic illness take multiple medications. Therefore, a typical scenario in which patients with a chronic illness or a serious medical illness present with depressive symptoms and clinicians are required to tease out what is the rate of depression and is it connected or is it separate? Clinicians have a dilemma about whether depression should it be treated separately.

Dr. Balkon: How do you approach a patient who has a chronic illness? What types of questions do you ask or cues do you listen for to help tease out whether someone is actually depressed or is just having momentary sadness?

Dr. Hart: Some of the statistics show that the rates of depression for certain illnesses are very high; with heart attack, the rate is 40%, for multiple sclerosis it is 65%, the rate of depression for cancer is about 40%, and for diabetes mellitus the rate is about 25%. Part of the problem is that clinicians can erroneously view depression as an expected by-product of chronic illness. The patients and their families can certainly view it that way, which is normal. Of course these patients are depressed, and therefore they are not treated for their depression. But, I think clinicians must begin to understand from the patient's point of view the meaning of the illness and the meaning of the diagnosis. Then clinicians must walk through the various symptoms and line them up with the DSM and seeing if those patients fit the diagnostic criterion for a depression. If they do, then the depression must be treated separately. It should not be assumed that these patients are depressed as a result of their chronic condition and that nothing should be done. The same idea is often held true for the elderly; that a very large number of elderly in our population with chronic illness are depressed. And the assumption is, of course, they are old, they have a chronic illness, so they are at the end of their life. This kind of thinking should be reexamined because the depression can be successfully treated. However, clinicians must then help the patient toward accepting, which may be a strong word, but moving toward acceptance of dealing with a chronic illness.

Dr. Balkon: What are some of the tricks that you use? You mentioned elders, and doesn't that revert to the stereotype issue?

Dr. Hart: With elders, for example patients their mid-70s or 80s who may have expressed suicidal ideation but do not have plans or actual intentions, and I could visualize a clinician saying, “Well, given the life that they have and they are living alone, their spouse has died, they have no support systems, no family in the area, I don't blame them.”

Dr. Balkon: So, when clinicians think these thoughts, how do they refocus and work with patients to empower them to move in a direction of reengaging with their environment in the hopes that possibly the depression will lift and the feelings can pass?

Dr. Hart: Clinicians always have to check their biases, and in our society, ageism exists. So that when people are not working, not producing, they may have less value. However, depression is not a normal part of aging, and yet aging puts someone at risk for depression and for suicide. Erik Erikson, while in his 90s, co-wrote a book titled *Vital Involvement* and he talked about successful aging and those two components. He spoke about how our culture “will encourage you, in your final chapter, to withdraw from life. They will want you to retreat to the rocking chair and to really disappear. And you will want to also,” and he was really campaigning the fact that the elderly must not disappear. They must stay involved with people, with causes that are important to them, and with activities that they enjoy. And, I think to ensure that clinicians do not bypass the individual who has given up on life, whether because of chronic illness or aging, they must check their own biases and ensure that they are not contributing to this misperception in our culture.

Dr. Balkon: Exactly. With elders and with some of the other chronic illness populations, as a pharmacologist I look at patients from the viewpoint of medication history and the combination of physiologic and psychological morbidities with regard to diagnoses; we as clinicians do a lot of things with patients in which they develop depressive symptoms, but they are actually iatrogenically induced, that is, induced by clinicians through our prescribing. In addition, clinicians have to look at what the patients are doing, for example, self-medicating. The literature frequently notes that elders self-medicate with alcohol, and when the baby-boomers begin entering the nursing homes, routine drug screenings will also be necessary because baby-boomers medicate with drugs, too. There is a fine line; these patients have accessibility and the wherewithal to end their lives by overdosing. Polypharmacy exists in the elderly and in the chronic illness populations who have an upset in their normal homeo-

static mechanisms to manage drugs. These drugs have longer half-lives and longer elimination half-lives and patients can present with symptoms of lethargy and cognitive disturbances and clinicians have to tease out those issues. With regard to pain management, if patients are undermanaged for pain and chronic illness, fatigue is a real factor and fatigue can manifest as a depression to a clinician who is not looking for chronic fatigue. Therefore, a sleep history is very important. Patients must be asked how much they sleep, how many hours they sleep, and how they sleep. Patients will say that they sleep all night but in reality, it is a restless sleep. They complain of waking up fatigued in the morning, or at the end of whatever their normal Circadian cycle is for sleep, and that fatigue can cause individuals to be less tolerant of others in their environment or less apt to participate in activity of daily living or start seeing themselves as hopeless and helpless. With regard to pharmacology, clinicians need to take an excellent drug history, including the drugs that patients take other than prescribed medications. Over-the-counter drug use must be considered, which may indicate that patients are

self-managing side effects or that they are noncompliant with their pharmacologic therapy for personal, cultural, or social reasons. Drugs may be prescribed that these patients cannot afford so they self-manage and self-medicate, which might not be the right thing to do and then they manifest symptoms that might be considered as a depression.

To finish this topic, you had talked about myocardial infarction and the research that links it to depression. Were you referring to patients who have already had myocardial infarctions or were you also commenting on the fact that the literature leans toward an increased preponderance of individuals who are diagnosed with cardiac disease who have an undercurrent of depression because of the increased catecholamines over time, the metabolic syndrome that develops?

Dr. Hart: I was referring to both because a lot of interesting research exists about the connection, and as a psychotherapist, I love the symbolism in terms of the heart and depression. I do not believe that it is a coincidence that the heart is the organ that might fail.

Dr. Balkon: Let's move to another topic; do you have any suggestions for identifying depression in patients who may present in atypical ways?

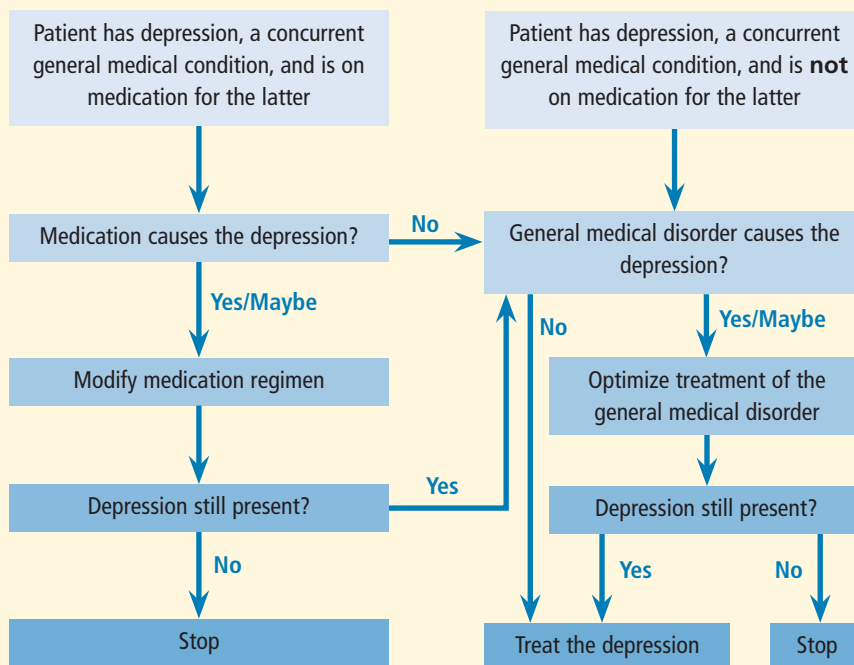
Dr. Hart: Again, to address the primary care provider, encourage a focused interview, and within the confines of a 15-minute office visit, this might mean taking the first 5 minutes and asking a fairly open-ended, tell-me-what-has-been-going-on question. And again, clinicians really need to delve into the client's life to understand if major changes have occurred. For example, major additions or subtractions in their lives or have there been any pressure points? Has there been loss? Has there been conflict? Has there been some change? Is there some event that might have triggered the visit today that may perhaps be a physical symptom or complaint? But in fact is the client going to tell a story of other stressors or just general isolation? If clinicians can learn the art of truly listening to the patients by giving them full attention, not checking off a list, not looking at the chart, but making eye contact and leaning forward, clinicians will uncover why the patients may really be there, therefore allowing for a diagnosis. Perhaps a patient is presenting multiple visits, but you cannot put your finger on what is going on and really a more efficient and effective way, and never mind developing the kind of relationship between patients and primary care providers that most clinicians aim for.

Dr. Balkon: In mentioning that time restriction, the majority of our audience is practicing nurse practitioners in primary care and, Valerie, your expertise is in psychiatry and you mention roughly a 15-minute interaction with a patient. I know in primary care, clinicians try to maneuver their busy schedules to give time to patients where time is due. And I imagine the time that you take with a patient per visit probably goes how long, 50 minutes possibly?

Dr. Hart: Sure. Conducting psychotherapy is really quite separate from what we are discussing today.

Dr. Balkon: Within that context that we are speaking to an audience of primary care providers and your expertise is in psychiatry, do you have any specific

FIGURE 1. ALGORITHM FOR DIFFERENTIATING AMONG DEPRESSION, GENERAL MEDICAL CONDITIONS, AND MEDICATION EFFECTS



Adapted from the Agency for Health Care Policy and Research: Depression in Primary Care: Vol. 1: Detection and Diagnosis [AHCPR publ no. 93-0550].

The HANDS® depression screening tool (© 1998 Screening for Mental Health, Inc. and President and Fellows of Harvard College) is a 10-item, validated self-report scale that was developed by a team of researchers affiliated with Harvard Medical School, including Lee Baer, MD and Douglas Jacobs, MD. It is available to nurse practitioners and other primary care clinicians who register to participate in the National Depression Screening Day (NDS) program. To register online for the primary care component of NDS 2005, go to www.mentalhealthscreening.org/register.

guidelines to conduct a mini-mental status interview for depression? What types of questions should be asked? Initially you begin with the question, “How are things going in your life” and expanding on that, but are there any specific cognitive parameters that should be looked at? I know a psychiatric history; I perform them every day and they are pretty extensive but, which essential points do you think our audience needs to ask in addition to that open-ended question?

Dr. Hart: I think the clinician must not interrupt for 5 minutes—and 5 minutes is a long time to let the client talk. That will be the challenge for the primary care provider. If providers listen to and allow for some silence, they will hear issues of loss, isolation, change, conflict, or stress. And then questions can be more specific about sleep changes, weight loss or gain, appetite, interest, mood, or thought processes. And again, our audience probably knows how to contend with the DSM in terms of identifying the disorder as a bipolar disorder or a major mood disorder. However, it is important to identify these more subtle issues of listening to a narrative and picking up clues; are clients telling a story of being restless, irritable, angry, and anxious, in conflict, or feeling a loss? Has an anniversary of a traumatic event occurred? These are really important triggers that are very often missed. After hearing that narrative, which will be a very different technique, clinicians can delve into the more typical issues related to diagnosis in terms of the physical side of depression and mood. But, frankly, I believe that the important piece is for clinicians not to talk during the beginning first 5 minutes.

Dr. Balkon: Next, let's discuss treatment. What about treatment? In your experi-

ence, should depression in men and women be treated differently?

Dr. Hart: Again, after all that we have said about cultural expectations, clearly we have to separate issues. Are we talking about a mild, a moderate, or a serious depression? It is important to note that if the depression is in the mild and moderate range, then patients have an option about taking an antidepressant as opposed to a mandate, but if the depression is considered to be in a more serious category, such as major depression or bipolar disorder, then the combination of psychotherapy and medication is important. In the first category of mild-to-moderate depression, psychotherapy, whether it is interpersonal or cognitive, very well may be the treatment of choice. Therefore, do clinicians approach these therapies differently with men and women? Of course, because therapies are a venue that women are more comfortable with. Although I see plenty of men in my practice—some come in voluntarily and some are nudged in by significant people in their life—learning to get in touch with and identify the patterns that may relate to the pain that they are feeling is, in some way, not gender-specific in terms of psychotherapy. Yes, there are some specific differences, but I am not sure that medication has any gender differences, other than if women are pregnant or breastfeeding.

Dr. Balkon: I am curious; I really enjoy speaking with people from different areas of the country and the world, and I would like to hear what your impression is in your area of the country, which is the Northeast and Maine. I know, too, that you travel extensively also. What is your perception about the way clinicians approach patients with depression? Is

the tendency to medicate? Or is the tendency to do the traditional talk therapy or refer patients out? When should clinicians decide to actually implement pharmacotherapy? How does this present in the areas that you are exposed to?

Dr. Hart: I teach a course on family theory and communication theory to family and adult nurse practitioners, and they tell me that it does not take too many tears for the prescription pad to come out in most of the primary care offices. Therefore, medicating is more common because the SSRIs are medications that do not have very many side effects and many primary care providers are relatively comfortable with the side effects the SSRIs do have; they take less time, patients do not need close monitoring, and I believe that clinicians may feel that they do not have the skills to delve into the psychological issues verbally. While the patients are in the office, we try to encourage them to discuss issues, but SSRIs are at the top of the list of the most prescribed drugs in this country. So yes, it is very easy to get a prescription for antidepressants. It is much more difficult for a primary care provider to tune in and really relate to patients in a therapeutic way.

Dr. Balkon: I am smiling to myself because I can see different trends—pharmacologically and psychiatrically. For example, look at smoking cessation; the great wave is to provide a patient with a prescription of bupropion and I have noted that patients historically say, “Gee, I feel so much better,” which gets back to smiling because the self-medication with chain-smoking cigarettes that brings patients to a primary care setting can be a subtle manifestation of anxiety and cult depression. Then suddenly they have this

“If clinicians have identified depression of any sort on the continuum—mild, moderate, or severe—they need to specifically ask patients openly about suicidal thoughts.”

drug that has antidepressant properties, but they do not know that it is an antidepressant, they are getting more bang for the buck. Do you see happening that in your area of the country?

Dr. Hart: I have not heard that, but that makes perfect sense.

Dr. Balkon: And patients do not realize that two issues are being taken care of at the same time, that is, their substance abuse for nicotine and their depression. I propose to the primary care clinicians to look past that; peel that onion back a little bit and try to get a sense of who the patients are who come to your office for that type of management. The other interesting piece that you mentioned is that patients are concerned about seeking counseling because of the stereotype; they say, “Am I nuts, I am seeing somebody for psychiatric problems, am I mentally ill?” Can you comment about that? How can our audience approach the sensitive topic of referral for counseling to make patients feel more comfortable?

Dr. Hart: Something creative was done locally and it was actually done at a very large, huge actually, OB/GYN practice. An advanced practice psychiatric nurse initiated this; she was responsible for gathering a cadre of psychotherapists interested in working with individuals and couples experiencing infertility and attending during an infertility process and work-up, which can be quite lengthy. She brought the psychotherapists together and for about 3 months, brought everyone up to speed on the latest technology so that we would really know what we were talking about. Remember that advanced practice psychiatric nurses are very equipped to be clinicians in this situation, understanding the physiology. Then they began working

with their clients by giving them a list of psychotherapists interested in and who had experience in working with individuals and couples experiencing infertility; this would help normalize the process so that patients had a great referral list and the psychotherapists normalized the infertility process at the outset. The idea is that the primary care providers introduce the topic; rather than waiting until patients were in trouble, the clinicians could explain to their patients that this process is very stressful, and most people find it to be so, and that if this process evolves into something unmanageable that they may consider talking with someone about it rather than waiting for a crisis occur. The primary care providers mention to their patients that they have referrals. I have some primary care providers who send me great referrals because they understand that they cannot do psychotherapy, they do not have the training, they do not want to do psychotherapy, so they are very clear about introducing the idea to their patients and separating out the issues. These primary care providers have a strong enough relationship with their patients that they can, say, ask them to return in 2 weeks, 3 weeks, or 1 month, and they give a referral to the patients. I believe that personal touch makes all of the difference in the world rather than saying “I think you should talk to someone,” and then not have a name to give to the patients. Therefore, my suggestion is that if you get referrals that have a personal touch it is not just sending patients off to some clinic, I think makes a huge difference.

Dr. Balkon: That is an incredible recommendation, and I applaud you for it, using the GYN/infertility illustration as an example. I can think of several other disease processes or psychosocial issues that combined with diagnoses that our

primary care nurse practitioners are seeing in which a dyad or a family presents for management and your suggestion of having a referral list is really important. But, I want to mention one more thought and this fits into what you had been saying about getting to know the patients and getting them to express themselves; I think in a dyad or even within a family structure, individuals might not be able to speak freely in front of their partner or their family members. So let's use fertility as an issue; I would also suggest that the primary care provider be attuned to the dynamics between the couple. With fertility, usually one person really beats up on himself or herself. We are talking about either a low sperm count on a part of the man, or on the feminine side the issues that we see in GYN, and perhaps the primary care provider can take a minute to speak with each partner separately, which is something that is appropriate and perhaps empowering by giving themselves permission to seek counseling, either as a couple or individually. This can enable them to go through that emotional trajectory and possibly even through the grief process so that they can move forward to make decisions that are well thought out so and they can be true to themselves. This also applies to families.

As we go through the list, I feel this is an incredible and appropriate time to ask you a very loaded question: When should a nurse practitioner in primary care treat depression, and when is it best to refer patients to a mental health professional? If possible, could you mention the distinctions between the different types of mental health professionals available and how to make an appropriate referral?

Dr. Hart: In terms of the continuum, if we are talking about a mild or moderate symptom and clinicians have a long-standing relationship with the patients, they may be in the very best position to make the recommendation for psychotherapy; they may certainly be in the position to talk about it. If the depression has moved along the continuum into a more serious depression that needs to be treated with medication, long-term research has shown that medication together with psychotherapy are most effective. So clearly, I am not happy when patient therapy consists only of an antidepressant. Yet, sometimes

that will be the patient's choice, but the patients should be offered the option to talk with someone. Often many issues must be dealt with, and again, that issue of differentiating is extremely important, and one of the issues to consider is when not to refer and when it is not depression, meaning, is it healthy bereavement? Is this a normal grief reaction? Should the person be crying and not be given an antidepressant? Because when people have experienced great loss, they do not sleep, they do not eat, and they can look pretty bad for a period of time. They need to receive the message, which must be that "you are grieving and this is a normal event as a human being." And yes, they may need support and care, but that needs to be normalized as well. They may want to talk to someone, but I see many, many people after the fact that have had an unresolved grief reaction that was buried and stuck because they pushed to hurry up and get over it. Years later, a grief that was never dealt with will at some point become problematic.

Dr. Balkon: I suppose that every nurse practitioner, or the majority of those who are listening to us today, can probably tap into that with regard to their own professional career and burying things. If you have been a nurse long enough, you think to yourself, "I am dealing with it. I am dealing with it. I am dealing with it." There is that patient who touches you in a very special way, and then years later, somewhere down the line, a trigger brings it all back, and if you didn't have the support to deal with it in the very beginning...

Dr. Hart: I want to make sure that we cover the important issue of suicide. This is a problematic way to begin this discussion, unfortunately, but we have been hinting at it all along; the statistic that 2 of 3 people who successfully kill themselves have seen a care provider in the month prior to suicide and almost 1 in 2 will have done so in the week before. Therefore, we as clinicians are in fact missing something. That is the first important fact. Men, almost 4 to 1, more often complete suicide as opposed to women who more often attempt suicide, and that includes a variety of risk factors. However, suicide screening is almost everything that we have talked about in terms of these

current stressors. Slight gender-risk factor differences exist in that the highest risk category for suicide is men over age 65 with a chronic illness and who live alone. These are the patients we should be most concerned about. However, there are a couple of peaks or spikes if we look at men overall; men between 16 and 24 years and between 39 and 54 years. Again, times of transition, times of heavy pressure, and whether these individuals are an adolescent, a young adult, or in midlife crisis, these are important transitional times. Alcoholism is another risk factor, specifically for men. For women the peaks or spikes we should look at are those under age 30 years, loss of an intimate relationship, living alone, substance abuse, and something along the same axis—a personality disorder. Therefore, the most important point is that if clinicians have identified depression of any sort on the continuum—mild, moderate, or severe—they really need to specifically ask patients openly about suicidal thoughts. Clinicians must open the topic and ask about it. Patients who have depression or a mood disorder must be asked very directly, "have you had thoughts of harming yourself," and then ask specifically what thoughts, and then the issue of access: "Do you have a plan? Do you have access?" But the most important thing is to not believe the myth that talking about suicide makes people do it. In fact, just the opposite is true.

Dr. Balkon: Exactly. That has been my experience. The population that I work with and I see is in an evaluation center for a 207-bed psychiatric facility that is associated with a large medical center and patients come to us either from other emergency departments or clinical environments for direct admission, but we do have a component of individuals who come in because something is just not right. They want a referral. Part of our screening process point-blank on triage is asking, "Are you depressed? Are you suicidal? And if you are suicidal, do you have a plan? Can you contract with me right now for your safety?" And then continue on with the psychiatric evaluation. But invariably if patients are thinking about suicide and they actually present to a clinician's office, they will admit it. And when they do admit contemplating suicide, they most certainly and definitely have to be triaged to an appropriate place

for intervention and a decision must be made regarding whether they should be admitted and closely supervised for a very short time until the medications are titrated and the initial crisis is over, or whether some other alternatives can be implemented to provide for their safety.

We are coming close to the end of our discussion and to summarize, is there anything else that you feel that we have not discussed that you would like to add? Any points that you might want to emphasize and summarize about all the information we have presented, because we have talked about a lot of different issues at this point in time.

Dr. Hart: I want to mention that a National Depression Screening Day occurs in the fall every year, and this past October some 6000 primary care sites were involved so that screening for depression is something that more and more has become not only a primary care issue but the public is also aware. People can go online; there is perhaps some movement in the destigmatizing of this as an entire area and I hope we

TABLE 3.
WHY SCREEN FOR DEPRESSION?

- Clinical depression is a serious medical illness
- Clinical depression can lead to suicide
- Sometimes people with depression mistakenly believe that the symptoms of depression are a "normal part of life"
- Clinical depression affects men and women of all ages, races, and socioeconomic groups
- One in 4 women and 1 in 10 men will experience depression at some point during their lifetime
- Two-thirds of those suffering from the illness do not seek the necessary treatment.
- Depression can co-occur and complicate other medical conditions.
- More than 80% of all cases of clinical depression can be effectively treated with medication, psychotherapy, or a combination of both
- Screenings are often the first step in getting help

Available at: www.nmha.org/ccd/support/screening.cfm

have encouraged clinicians to develop the rapport, the relationship necessary to discover these more subtle symptoms in their patients.

Exercise 3

When patients present to primary care providers with depressive symptoms, it is most important for the providers to:

- a. Take a thorough patient history
- b. Take a thorough sleep history
- c. Determine if the patients are self-medicating
- d. Listen to verbal and observe nonverbal cues

Answer on page 16.

Dr. Balkon: I totally concur with you and I applaud nurse practitioners. I had

the ability in my role as a clinical associate professor to teach a distributed program online with nurse practitioners all over the country and people also out of country and what I find is that we have to celebrate the title of nurse practitioner because we do keep “nurse” in nurse practitioner and we can tap into what we have just talked about today with regard to focusing on patients, encouraging them to talk, and the sum total of our discussion today is really to give ourselves permission and to celebrate the fact that we can and do keep “nurse” in nurse practitioner in our daily practices. The other piece that I wanted to emphasize for the audience is that the primary care conferences that I attend, not only locally here on Long Island but across the country, regardless of whether we are talking about nurse practitioners or clinicians who do similar work, the cur-

rent thrust is for primary care to manage and assess patients and follow-up for common psychiatric disorders, among which are depression, anxiety, post-traumatic stress, and attention deficit. And I think that you have been an absolutely incredible resource with regard to guiding people and empowering them into making an intelligent decision about how to start the initial assessment and how to feel comfortable with admitting that a particular patient needs a little more help than primary care clinicians can provide, and seeking out those psychiatric professionals and their locales so that they can collaborate with and share treatment.

Dr. Hart: Thank you, Nancy.

Dr. Balkon: I really want to thank you. It has been an absolute pleasure. ■

For More Information, Visit These Web Sites

American Psychiatric Association
www.psych.org

Depression and Bipolar Support Alliance
www.dbsalliance.org

Expert Consensus Guidelines
www.psychguides.com

National Alliance for the Mentally Ill
www.nami.org

National Depression Screening Day
www.mentalhealthscreening.org

National Institute of Mental Health
www.nimh.nih.gov

National Mental Health Association
www.nmha.org

Answers

Exercise 1

Which statement is true?

- a. Men and women have the same issues regarding depression and thyroid function
- b. Women experience depression and commit suicide twice as often as men
- c. The biology, the issues related to depression, and the mood issues related to the various kinds of depression differ for women and these are connected with physiology
- d. The difficulty women have in coping during perimenopause, which is a 10-year period, is not having a consistent cycle

Answer: c. The biological factors are linked to the various reproductive events in a woman's life. Research is very clear about the connection between mood and hormone, specifically estrogen, fluctuation. The second biological factor is thyroid function, and the third factor is the circadian rhythm.

Exercise 2

When men are depressed, they will exhibit signs of:

- a. Sadness and hypersomnolence
- b. Anger and irritability
- c. Fear of taking risks
- d. Overeating and increased alcohol and drug use

Answer: b. Being depressed may be viewed as somewhat unmanly, so men are expected to grin and bear it and be strong. This perpetuates that men display depression more often as a problem with work performance, irritability, anger, aggression, vague physical complaints of being tired or less interested in eating, or just withdrawing and being quiet at home or at work, or they may act directly opposite and manifest risk-taking behavior.

Exercise 3

When patients present to primary care providers with depressive symptoms, it is most important for the providers to:

- a. Take a thorough patient history
- b. Take a thorough sleep history
- c. Determine if the patients are self-medicating
- d. Listen to verbal and observe nonverbal cues

Answer: d. If clinicians can truly listen to the patients by giving them full attention, not checking off a list, not looking at the chart, but making eye contact and leaning forward, clinicians will uncover why the patients may really be there and therefore allowing for a diagnosis.

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