Case Presentation: Eric

This case presentation is not based on an actual patient and does not include images of or references to any actual patient history or experience.

This resource is intended for educational purposes only and is intended for US healthcare professionals. Healthcare professionals should use independent medical judgment. All decisions regarding patient care must be handled by a healthcare professional and be made based on the unique needs of each patient.

History of Present Illness:

Eric is a 60-year-old man who presents to his primary care nurse practitioner, Jon, with irritability, excessive sleeping, and a lack of interest in his usual hobbies, such as attending baseball games and going to the movies with his wife. He also has been spending much time at home alone, watching television, rather than spending time with his friends or wife, as he usually does. Eric recently retired from his job as a general contractor remodeling people's kitchens and bathrooms. He enjoyed his job very much and felt a sense of pride in helping people make their homes more functional and attractive. However, his job was very physical, and at times stressful, so Eric felt it was time to retire and find something new with which to occupy his time.

History and Examination:

Medical history—Eric was diagnosed with hypothyroidism 5 years ago and has been on medication ever since. Annual lab tests indicate his thyroid levels have remained within the normal range for the past few years. He also has mild hypertension, which is well-controlled at an adequate dose.

Psychosocial history—Eric reports that he has several close friends and that he got along well with people at work. He denies a history of substance misuse and reports that he occasionally drinks a glass of wine with dinner. He does not smoke. Eric describes his marriage as "very good." He is also close with his adult daughter and enjoys spending time with his 2 grandchildren.

At age 33, Eric experienced a period of depressed mood after losing his job. During that time, he had problems getting out of bed in the morning because he felt hopeless and sad, stopped socializing with friends, and lost about 4 lbs of body weight in 4 weeks without intentionally dieting. He sought treatment from his primary care physician, who referred him to a psychiatrist for medication and a psychologist for outpatient cognitive-behavioral therapy (CBT). Eric worked with his psychiatrist and tried 4 different selective serotonin reuptake inhibitors (SSRIs) before he ultimately found one that seemed to work for him. He and his psychiatrist decided together that he could stop taking the medication after 1 year because his mood had improved and stabilized. He saw his therapist once weekly for approximately 2.5 years and reports that CBT also helped improve his mood and functioning.

Family history—Eric reports that, throughout his life, his mother had "very low periods" when she seemed extremely sad and had trouble functioning. However, she never sought treatment for these episodes.

Examination—Eric's physical examination indicates he is generally healthy for his age. His vital signs are all within the normal range, and the mental status examination indicates he is fully oriented and alert. Eric's appearance is that of an older man. His affect is flat, and he has trouble making eye contact, often staring at the floor instead.

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Storyboard 1

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NP Psych Navigator Video Storyboard for Depressive Symptoms Patient Case: Eric Initial Presentation and Diagnosis			
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 0/ Welcome	Tina: Welcome to the Patient Case Navigator interactive learning series. I'm Tina Matthews-Hayes, a dual-certified family and psychiatric nurse practitioner working in the psychiatric setting. Today's hypothetical case is focused on identifying and treating depressive symptoms. In this case, we will review: 1. How to perform a structured psychiatric interview 2. Standardized psychiatric rating scales appropriate for patients with depressive symptoms 3. Common barriers to adequate treatment response 4. How to assess and monitor patients for treatment side effects and adequate treatment response This case features Jon, a primary care nurse	Focus on Tina speaking. As Tina is reviewing the learning objectives, show on-screen text. When Tina introduces Jon and Eric, show their pictures on the screen.	 Learning objectives: 🕐 How to perform a structured psychiatric interview 🕐 Standardized psychiatric rating scales appropriate for patients with depressive symptoms 🕐 Common barriers to adequate treatment response 🕐 How to assess and monitor patients for treatment side effects and adequate treatment response  This image was purchased from Shutterstock. It includes stock

	practitioner, and his patient Eric. You will read and hear about depressive symptoms, screening and diagnosis, and treatment response, as well as watch a series of video vignettes of conversations between Jon and Eric. In addition, you will take some brief quizzes to test your knowledge as you progress through the case. I hope you find this case study informative and useful in better understanding how to identify and treat depressive symptoms.		photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.
Scene 1	***Assessing Symptoms and Taking the Patient's History***		
Scene 1a	Jon: Hi, Eric, I'm Jon. I'm a nurse practitioner here at the clinic. Eric, I looked at your paperwork, and your score on the patient health questionnaire (PHQ-9) measure that you completed indicates you have a moderately severe level of depression. Can we talk about this a little more? Eric (*staring at the floor*): Sure, I guess. Jon: I understand that there have been some changes in your life and you're feeling depressed. Can you tell me how that feels for you specifically? Every patient is different, so there is no 'wrong' or 'right' answer here. Eric: I am just not feeling motivated. My 'get up and go' seems to have gotten up and left. I used to be up every day and ready to get things done; now I just watch the History channel all day.	Scene opens to show Jon reviewing Eric's Patient Health Questionnaire-2 (PHQ-2) and Patient Health Questionnaire-9 (PHQ-9) while talking with Eric, who is sitting on an exam table. Focus on Jon and Eric as each of them speak. Eric generally looks at the floor or at his hands folded in his lap, rather than making eye contact with Jon.	 This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.   This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

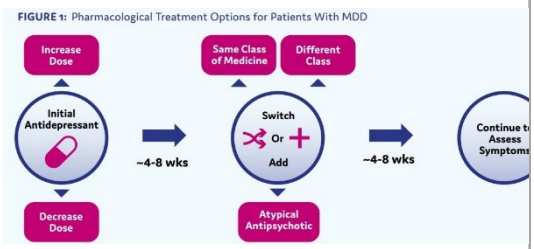
	Jon: Do you have any feelings of hopelessness or worthlessness now that you've retired and your role has changed? Eric: I'm not sure what to do with my time. What is the point of even taking a shower if I don't go to work? Jon: I can understand you feeling that way. Retirement is a big transition that many people struggle with. Your paperwork suggests that you are no longer enjoying things that you previously did. Can you tell me more about that or give me an example? Eric: Well, I haven't been to a movie in months, and my wife and I used to go just about every weekend. Also, I've stopped returning calls and texts from my friends. I just don't feel like seeing or talking to anyone right now. Jon: I see. Do you remember if there was a specific trigger to this change or any reason why you don't seem to want to engage in these activities anymore? Eric: It's hard to describe. I think I just don't care anymore. I don't care about which movie is playing or what it's about. I am flat out uninterested in seeing my friends or grandchildren. It wasn't like this while I was still working, so I'd say somewhere around my retirement is when things started to change.		

	Jon: I understand. I also noticed on your paperwork that you have experienced a change in your appetite. Can you tell me about that? Eric: I'm definitely a lot less hungry. That's probably why I've lost a few pounds in the last couple of weeks. Jon: Okay. Have you noticed any changes in your sleep—getting a lot more sleep or perhaps getting a lot less? Eric: I am sleeping much more than I usually do, including taking naps during the day. Sometimes I think it's because I don't feel like doing anything else. Jon: Can you give me a better idea of what your sleep routine is like? In other words, what time do you get to sleep? How long does it take to fall asleep? Those sorts of things. Eric: I used to stay up until about 10:30 or 11 PM, but now I am in bed around 9 PM. I usually sleep throughout the night, so I'm not having trouble sleeping. In fact, since I go to bed earlier, I'm getting 10 or 11 hours of sleep instead of my usual 7 or 8. Jon: Okay, so you are sleeping a lot more than what's normal for you as opposed to experiencing sleeplessness. Am I understanding correctly? Eric: Yes, that's right. Jon: Let me ask about a few other symptoms. Have you or others noticed that you have		

	been so fidgety or restless that you could not sit still? Or maybe you or others have noticed the opposite—that you have been talking or moving more slowly than usual? Eric: I noticed that I am moving more slowly, and my wife has commented on that as well. Jon: Okay. You marked here on the PHQ-9 that you often feel tired or have little energy. Can you tell me more about that? Do you have a hard time getting yourself to do your normal daily activities, like taking a shower and eating regular meals? Eric: Yes. I feel very rundown, like I don't have enough energy even though I am sleeping so much. Everything feels like it takes so much more effort, even simple things like brushing my teeth. I don't understand why I can't muster the energy or interest to do anything. Jon: I know that's a tough feeling, but you're not alone. It's actually very common in people who are depressed; that's why it's good that you're here today and talking about this. Can you tell me more about this period when you have been feeling down? Is there anything that makes you feel sadder or more depressed? Have you ever felt like you were less deserving than other people? Or have you felt guilty lately, maybe about		

	mistakes you made or maybe even for no reason at all? Eric: I can't say I have felt guilty about anything in particular, but I definitely don't feel as worthy as I used to, not since retiring. I look at other men my age going off to work in the morning, and that definitely makes me feel more depressed. I feel like I'm not as valuable to society and to my family as they are to theirs. Jon: I think that's an understandable feeling. For so many of us, our work is a very important part of who we are and how we feel about ourselves. I can promise you, though, Eric, that there is a lot you can still contribute to society and to the lives of the people who love you. Eric: Thank you. Jon: You indicated here that you sometimes have trouble concentrating. Can you tell me a little bit more about your struggles to concentrate or focus? Eric: Yes, I've been having maybe a little bit of a problem concentrating. I have noticed that I have a hard time paying attention when my wife is talking to me or when I'm reading something.		
Scene 1b	Jon: You indicated on your questionnaire and also said a moment ago that during this period when you've been feeling very sad and uninterested in your normal activities, you also felt like you had less energy and that	Focus on Jon and Eric as each of them speak.	

	you were moving more slowly. However, was there ever a time in your life when you experienced the opposite—that is, feeling so excited, energized, or “high” that you didn’t feel like or act like your normal self? Eric: No, that does not sound familiar. I have not experienced anything like that. Jon: Great. Have you ever had any periods where you were so irritable or angry that you felt that way for days on end, and you just weren’t feeling or acting like your normal self? Eric: I have been feeling more irritable lately, but it does not last for days on end. It lasts for maybe a few hours, and then I get over whatever it was I was upset about. It’s not like me to feel that way; I am usually a “glass half-full” kind of person. That’s why I am here today. Jon: That’s a great way to be, and we are going to do our best to get you back to feeling that way.		 This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.
Scene 1c	Jon: Now that we have gone over your responses on the paperwork you completed earlier, I’d like to ask you a little about your past. Has there ever been another time in your life when you felt as down and depressed as you feel currently? Eric: Yes, many years ago, when I was in my early 30s. I had just lost my job. I couldn’t	Focus on Jon and Eric as each of them speak.	

	even get out of bed because I was so down. Jon: At that time, did you seek treatment for how you were feeling? Eric: Yes. My doctor recommended I see a psychiatrist, who gave me some medication. It did not do anything at first, and then we had to try a few other medications. It was really frustrating. Jon: I can imagine. That's actually very common, though. Antidepressants can be very effective, but it's not unusual at all for your depressive symptoms to not respond fully to the medication. What often happens is we might need to increase the dose slowly over the course of a month or 2. If the medication is still not working for you at that point, there are other options we can consider, like adding another antidepressant, switching antidepressants, or even adding a completely different class of medication to the antidepressant. Eric: I guess that explains why my doctor switched me to another pill. We tried 4 different drugs before we found one that finally seemed to work for me. I hope I don't have to go through all of that again. Jon: I know that's a lot to deal with, having to try so many medications before finding something that worked for you. However, I'm glad you finally found an	When Jon discusses MDD treatment response, show figure. Return to showing Eric and Jon.	 This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.    This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

	antidepressant your symptoms responded to. I think that bodes well for us finding something that could help again. Did your doctor provide any other treatments that helped? Eric: Yes. I also saw a therapist every week. That was tough at first; I'm not used to talking about my thoughts and feelings. After a while, though, I realized it was helping. I even started looking forward to going. Jon: That's excellent. I'm glad you found a combination of treatments that worked well for you. How long did you see your therapist and take the medication? Eric: I took the medication for about a year, and I saw the therapist for 2½ years. Jon: I see. Has anyone in your family ever had a mental illness or been treated for a mental health problem? Eric: I'm not sure. I don't think so. However, my mother had many times in her life when she was very sad. She would cry nonstop, and she wouldn't get out of bed, make breakfast for us kids, or go about her normal day. Jon: Did she seek treatment during those times? Eric: No. She would just snap out of it eventually, I guess. As a family, we never talked about it. It was just one of those things—"Mom is having one of her 'sad spells' again…"		

	Jon: I see. Did you ever see her experience periods where, instead of feeling down and staying in bed, she had excess energy or seemed very hyper or talkative? Eric: No, nothing like that. She just periodically had these down periods.		
Scene 1d	Jon: Got it. I have one more question about how you have been feeling lately, and I ask every single patient this question. I don't want you to be afraid to answer how you feel. If we can't talk about it, it's hard for me to help. Do you currently have any thoughts of hurting yourself? Eric: (*Pauses for a moment*) You're not going to lock me up, are you? Jon: Sending someone to the hospital is never my first choice, but if you are having these thoughts, then I need to make sure you can remain safe. Eric: (*Pauses again*) I do think about dying—kind of a lot, to be honest. I don't think about actually hurting myself. I could never do that. However, I feel as if my wife and everyone I know would be better off if I were not here anymore. I feel so useless to everyone, including to myself. Jon: It's got to be tough feeling that way, but we are going to work together to figure out what is going on and what we can do about it.	Focus on Jon and Eric as each of them speak. While Jon is explaining a	  This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

	Do you have any weapons in the home? Eric: No, not really. I mean, we have knives in the kitchen. I guess that's a weapon. But we don't have guns or anything like that, and I would never use them on myself or do anything to actually hurt myself. Jon: I really appreciate you trusting me enough to share that with me, Eric. I know these aren't easy feelings to talk about. We know that having a relative who has attempted or died by suicide can increase a person's risk of attempting or completing suicide themselves. Has anyone in your family ever attempted suicide or died by suicide? Eric: Thankfully no. Jon: That's good to hear. When people are feeling depressed, it's not uncommon for them to have thoughts about dying. My main concern is making sure you are safe. I want to talk to you about making a safety plan. Are you familiar with those? Eric: (*Shakes his head no*) Jon: A safety plan is a written list of warning signs that a crisis might be on the verge of occurring, what you can do when that starts to happen, and people you can ask for help and how to contact them, including professionals. I have one with me here. I'd like to take a few minutes to	safety plan, show an image of an example safety plan.	 Safety Plan Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing: 1. 2. 3. Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity): 1. 2. 3. 4. Step 3: People and/or social settings that provide distraction: 1. 2. 3. 4. Step 4: People whom I can ask for help: 1. Name Phone 2. Name Phone 3. Name Phone Step 5: Professionals or agencies I can contact during a crisis: 1. Clinician/Agency Name Phone 2. Clinician/Agency Name Phone 3. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255) 4. Crisis Text Line: Text TWT to 741741 Step 6: Making the environment safe: 1. 2. 3. Safety Plans Work There is hope. 1. Write 3 warning signs that a crisis may be developing. 2. Write 3 internal coping strategies that can take your mind off your problems. 3. Who/What are 3 people or places that provide distraction? (Write name/place and phone numbers) Phone Phone Phone 4. Who can you ask for help? (Write names and phone numbers) Phone Phone Phone 5. Professionals or agencies you can contact during a crisis: Clinician: Phone Local Urgent Care or Emergency Department: Address Phone Call or text 988 or chat 988lifeline.org 6. Write out a plan to make your environment safer. (Write 2 things) 988 SUICIDE & CRISIS LIFELINE Modified from Stanley & Brown (2021) PEP22-08-03-007

	fill this out with you, so when you leave here today, you'll have a plan in place. I'm really glad that you're not thinking about harming yourself, but if you do ever start to feel that way, this plan ensures you will know what to do and how to reach out for help. How does that sound to you? Eric: That makes sense. Thank you. I appreciate you helping me. Jon: Eric, I just want to thank you again for trusting me and being open about how you've been feeling and giving me a chance to help you. Before we move on, if your thoughts of dying get worse or you ever make a plan to hurt yourself, can you promise me you will call a crisis hotline or 9-1-1 and tell your wife so she can get help? Eric: Yes, I promise. Jon: Thank you. I'm going to give you this wallet card with some crisis phone numbers on it, so you have them in case you ever need them.		
Scene 2a	Tina: We will now test your understanding of the case presented above.	Show Tina speaking. Then show the question on the screen.	
	Tina: Here is our first quiz question. After Jon has begun to develop a strong basis for a therapeutic alliance with his new patient, he asks Eric about wanting to hurt himself. True or false, Jon should assess for suicidality at this first		**QUESTION**: After Jon has begun to develop a strong basis for a therapeutic alliance with his new patient, he asks Eric about wanting to hurt himself. True or false, Jon should assess for suicidality at this first meeting, but he does not need to bring it up at subsequent visits. a. True

	meeting, but he does not need to bring it up at subsequent visits. a. True b. False		b. False
2b	Tina: The correct answer is false. The American Psychiatric Association recommends that a careful and ongoing evaluation of suicide risk is needed for all patients diagnosed with MDD. Just as Jon did in this case, patients should be asked about suicidal thoughts, intent, plans, means, and behaviors. The patient's risk of harming themself or others should be monitored throughout treatment. **[APA2010,p15,col2,para2]**	Show Tina speaking. Then show the answer on the screen.	**ANSWER**: False. The APA recommends a careful and ongoing evaluation of suicide risk for all patients diagnosed with MDD. Patients should be asked about suicidal thoughts, intent, plans, means, and behaviors.
2c	Tina: We will now proceed with our second quiz question: Which of the following laboratory tests might Jon consider ordering to assess for underlying causes of Eric's depressive symptoms? a. Complete blood count (CBC) b. Serum thyroid-stimulating hormone (TSH) c. Serum total testosterone d. All of the above	Show Tina speaking. Then show the question on the screen.	**QUESTION**: Which of the following laboratory tests might Jon consider ordering to assess for underlying causes of Eric's depressive symptoms? a. Complete blood count (CBC) b. Serum thyroid-stimulating hormone (TSH) c. Serum total testosterone d. All of the above

2d	**Tina: All of the above are correct answers. Let's review the utility of each of these tests in certain situations.** Laboratory tests can help you assess for underlying medical causes of depressive symptoms. Some of the conditions included on the differential are vitamin B12 deficiency and folate (vitamin B9) deficiency. These can be tested for in a CBC to assess for macrocytic anemia. Hypothyroidism, or as in Eric's case, subtherapeutic treatment of hypothyroidism, can also be an underlying cause of depressive symptoms and can be initially screened for with a serum TSH. Hypogonadism may underlie some cases of depressive symptoms and can be initially tested for in men with a serum testosterone. In addition to ordering these laboratory tests, Jon might consider ordering a urine toxicology screen to screen for substances of abuse that could be causing Eric's depressive symptoms.	Show Tina speaking. Then show the answer on the screen.	**ANSWER**: All of the above. 🕐 Laboratory tests can help assess for underlying medical causes of depressive symptoms. 🕐 Some of the conditions included on the differential are **vitamin B12 deficiency and folate (vitamin B9) deficiency.** o These can be tested for in a CBC to assess for macrocytic anemia. 🕐 **Hypothyroidism** can be an underlying cause of depressive symptoms. o It can be initially screened for with a serum TSH. 🕐 **Hypogonadism** may underlie some cases of depressive symptoms. o Men can be initially screened with a serum testosterone. 🕐 Other considerations may include a urine toxicology screen to screen for substances of **abuse**.
2e	Tina: For our final question of this video segment, let's recall the conversation between Jon and Eric toward the end of the vignette we just saw where Jon discusses creating a safety plan with Eric. A safety plan is:	Show Tina speaking. Then show the question on the screen.	**QUESTION**: Recall the conversation between Jon and Eric toward the end of the vignette where John discusses creating a safety plan with Eric. A safety plan is: A. A written list of coping strategies and sources of support. B. A list of phone numbers a person can call in an emergency.

	A. A written list of coping strategies and sources of support. B. A list of phone numbers a person can call in an emergency. C. Your personal cell phone for patients to contact when they feel it is urgent. D. A written list of positive life experiences that the patient creates.		C. Your personal cell phone for patients to contact when they feel it is urgent. D. A written list of positive life experiences that the patient creates.
2f	Tina: The correct answer is that a safety plan is a written list of coping strategies and sources of support. A safety plan may also contain a written list of warning signs that a crisis might be on the verge of occurring, what a patient can do if that starts to happen, and people the patient can ask for help and how to contact them, including professionals (sources of support). Jon uses a template to fill one out with Eric during their appointment, which is an excellent practice.	Show Tina speaking. Then show the answer on the screen.	**ANSWER**: A safety plan is a written list of coping strategies and sources of support. A safety plan may also contain: o A written list of **warning signs** that a crisis might be on the verge of occurring. o What a patient can do if that starts to happen. o People the patient can ask for help and how to contact them, including professionals (sources of support). **Answer: A written list of coping strategies and sources of support.** A safety plan is a written list of warning signs that a crisis might be on the verge of occurring, what you can do when that starts to happen (coping strategies), people you can ask for help and how to contact them, and professionals you can ask for help (sources of support). Jon uses a template to fill one out with Eric during their appointment, which is an excellent practice.

Storyboard 2

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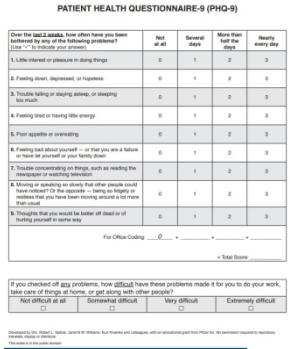
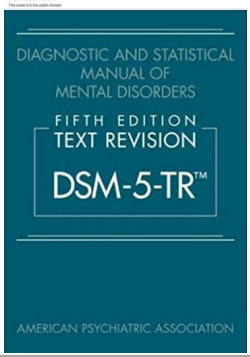
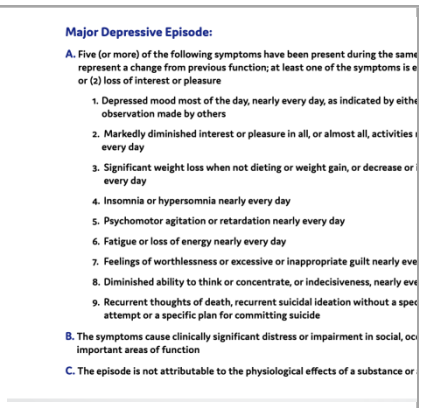
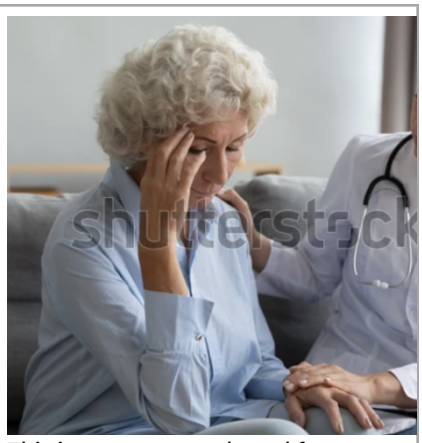
NP Psych Navigator Video Storyboard for MDD Patient Case: Eric DSM-5 Diagnostic Criteria for MDD			
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 0	Standardized psychiatric rating scales for major depressive disorder (MDD) like the Patient Health Questionnaire (PHQ-9) can help aid your clinical evaluation. However, to make the correct diagnosis, you must perform a structured psychiatric interview and determine whether your patient meets all of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria for MDD. We'll now review these criteria and discuss how clinical probes can be helpful in assessing your patients' symptoms.	Tina speaking Include a "picture-in-picture" of the PHQ-9 and *DSM-5-TR* while Tina is talking. First the PHQ-9 will appear over Tina's shoulder, then the *DSM-5-TR* will appear over that.	  PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)  DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FIFTH EDITION TEXT REVISION DSM-5-TR™ AMERICAN PSYCHIATRIC ASSOCIATION
Scene 1			

Scene 1a	According to the *DSM-5*, a patient with MDD must exhibit 5 or more of the 9 depressive symptoms listed in criterion A. At least 1 of these 5 symptoms must include depressed mood or loss of interest or pleasure. **[DSM-5 APA 2013/pg160/Diagnostic Criteria for MDD A1-2; pg161/A3-9]** The patient's symptoms must be present for at least 2 weeks and cause significant functional impairment related to social, occupational, or other relevant areas of functioning. For patients, this functional impairment may include significant factors, such as the ability to perform activities of daily living or experience their usual productivity at work. Symptoms that may be attributable to medical conditions, medications, other substances, or other psychiatric conditions must be ruled out. **[DSM-5 APA 2013/pg160/Diagnostic Criteria for MDD A; pg161/B-E]**	*DSM-5* criteria for a depressive episode **[DSM-5 APA 2013/pg160/Diagnostic Criteria for MDD A1-2; pg161/A3-9; B-E]**	 **Major Depressive Episode:** **A.** Five (or more) of the following symptoms have been present during the same represent a change from previous function; at least one of the symptoms is e or (2) loss of interest or pleasure 1. Depressed mood most of the day, nearly every day, as indicated by eithe observation made by others 2. Markedly diminished interest or pleasure in all, or almost all, activities every day 3. Significant weight loss when not dieting or weight gain, or decrease or every day 4. Insomnia or hypersomnia nearly every day 5. Psychomotor agitation or retardation nearly every day 6. Fatigue or loss of energy nearly every day 7. Feelings of worthlessness or excessive or inappropriate guilt nearly eve 8. Diminished ability to think or concentrate, or indecisiveness, nearly eve 9. Recurrent thoughts of death, recurrent suicidal ideation without a spec attempt or a specific plan for committing suicide **B.** The symptoms cause clinically significant distress or impairment in social, oc important areas of function **C.** The episode is not attributable to the physiological effects of a substance or
Scene 1b	Let's review each of the possible 9 symptoms that are part of the diagnostic criteria for MDD: The first symptom is having a depressed mood most of the day, nearly every day. It's important to remember that depressed mood may present as emptiness or hopelessness and not just sadness. You may hear patients state that they are just going through the	Patient and provider: https://www.shutterstock.com/image-photo/young-caring-female-caregiver-nurse-doctor-1562123143	**MDD symptoms:** 🕐 **Depressed mood** 🕐 **Loss of interest or pleasure** in most activities

	motions every day or that they don't see any point in doing things that used to bring them joy. The patient may report that they have not noticed this symptom, but others in their life have mentioned it to them. **[DSM-5 APA 2013/pg160/Diagnostic Criteria for MDD A1]** Patients who report greatly reduced interest or pleasure in all or almost all activities most of the day, nearly every day, exhibit another symptom of MDD. This symptom may not present as sadness or withdrawal. Instead, patients may continue their usual daily routines but lose motivation to pursue fulfilling life activities. **[DSM-5 APA 2013/pg160/Diagnostic Criteria for MDD A2]**		 This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.
Scene 1c	The next symptom is a physical change that often occurs in people with MDD. An unintentional loss or gain of more than 5% of one's body weight within a month can be indicative of MDD. Significant weight loss or gain can occur with a decrease or increase in appetite when experienced nearly every day. So, be sure to ask your patients about their meals and any changes in their eating habits. **[DSM-5 APA 2013/pg161/Diagnostic Criteria for MDD A3]** Not being able to sleep or sleeping too much nearly every day is another symptom of MDD. **[DSM-5**	Tina speaking Insomnia: https://www.shutterstock.com/image-photo/depressed-young-asian-woman-sitting-bed-1841485552	 **MDD symptoms:** • **Unintentional weight loss or gain** (>5% in 1 month) • **Sleep disturbance** (insomnia or hypersomnia)

	APA 2013/pg161/Diagnostic Criteria for MDD A4] I find it important to carefully characterize changes in a patient's sleep patterns and amount of sleep and to probe for any new onset medical conditions that could affect sleep. I ask about previous testing for sleep apnea, if patients are using any devices during sleep, and if they are getting up more than twice a night to urinate. Changes in appetite and sleep can be characterized as somatic symptoms. [Kapfhammer2006,pg229,col1,para1] Some patients with MDD may complain of other somatic symptoms, like general aches and pains and gastrointestinal upset. These complaints are commonly seen in patients with MDD and its associated conditions, such as irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, and chronic pain.[Kapfhammer2006,pg229,col1,para1]		 This image was purchased from Shutterstock. It includes a stock photography model. It does not include an affiliate of AbbVie Inc., nor does it include an actual patient.
Scene 1d	Patients with MDD may also exhibit psychomotor agitation or slowing nearly every day. Patients may not be aware of this symptomatic change in their behavior, so it's important to ask if anyone in their lives has noticed this change. **[DSM-5 APA 2013/pg161/Diagnostic Criteria for MDD A5]** The next symptom is fatigue or loss of energy	Tina speaking Show graphic https://www.shutterstock.com/image-photo/depressed-woman-awake-night-she-touching-1285836277	

	nearly every day. It is common for people with MDD to feel tired and lethargic. This could be related to a lack of sleep or oversleeping. **[DSM-5 APA 2013/pg161/Diagnostic Criteria for MDD A6]**		 This image was purchased from Shutterstock. It includes a stock photography model. It does not include an affiliate of AbbVie Inc., nor does it include an actual patient. **MDD symptoms:** 🕐 **Psychomotor changes** (agitation or retardation) severe enough to be observable by others. 🕐 **Tiredness, fatigue, or low energy**, or decreased efficiency with which routine tasks are completed.
Scene 1e	A depressed mood is often associated with negative thinking. Patients with MDD might report feeling guilty or worthless nearly every day. It's important to ask patients about these thoughts and feelings specifically, as some patients may believe their negative thoughts to be accurate and may not realize they are a symptom of MDD. **[DSM-5 APA 2013/pg161/Diagnostic Criteria for MDD A7]** Additionally, I ask patients questions regarding any triggers to these thoughts and assess if they seem to	Trouble with negative thinking, feelings of guilt, and concentrating: https://www.shutterstock.com/image-photo/young-indian-eastern-tired-exhausted-business-1979913266	**MDD symptoms:** 🕐 A sense of **worthlessness or excessive, inappropriate, or delusional guilt**. 🕐 **Impaired ability to think, concentrate, or make decisions**—indicated by subjective report or observation by others.

	be repeated in a loop. Such thoughts may include considering yourself unworthy of love or success, believing others hate you, or blaming yourself for things outside of your control. In addition to negative thinking, MDD can also affect cognition and interfere with a patient's ability to concentrate or make decisions nearly every day. This symptom of MDD can lead to significant functional impairments, such as at work or in school. **[DSM-5 APA 2013/pg161/Diagnostic Criteria for MDD A8]**		 This image was purchased from Shutterstock. It includes a stock photography model. It does not include an affiliate of AbbVie Inc., nor does it include an actual patient.
Scene 1f	Finally, a symptom of MDD that is very important to discuss with your patients is recurrent thoughts of death and suicidality. This can be a difficult topic to broach and must be handled with care. If a patient expresses suicidal ideation, reports previous suicide attempts, or discloses a specific plan for committing suicide, you must discuss a safety plan with them. **[DSM-5 APA 2013/pg161/Diagnostic Criteria for MDD A9]**	Tina speaking Show graphic from art: https://www.shutterstock.com/image-photo/depression-woman-hug-her-knee-cry-1718414866	  This image was purchased from Shutterstock. It includes a stock photography model. It does not include an affiliate of AbbVie Inc., nor does it include an actual patient. **MDD symptoms:**

			◔ **Recurrent thoughts of death** (not just fear of dying), suicidal ideation, or suicide attempts.
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 2			
Scene 2a	The list of MDD symptoms that we just reviewed is quite lengthy. However, it is important to thoroughly review each of these 9 symptoms with your patients when assessing them for MDD. The presentation can seem overwhelming. We must be careful not to jump to a diagnosis based off of a screening tool. After a patient screens positive on a clinical rating scale, we want to use open-ended questions to give the patient an opportunity to describe their symptoms and experiences in their own words.	Patient and provider: https://www.shutterstock.com/image-photo/doctor-comforting-her-depressed-patient-medicine-1533439505	**Key Points:** ◔ It is important to thoroughly review each of these 9 symptoms with your patients when assessing them for MDD. ◔ Clinical rating scales can help identify which patients require more in-depth screening for depression.  This image was purchased from Shutterstock. It includes stock photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.
Scene 2b	Recall that in Jon's assessment of Eric, Jon used open-ended questions to get a more holistic view of what Eric was thinking and feeling. Clinical probes of this nature can provide more comprehensive information about the patient. **[Bobo Mayo Clin**	Tina speaking Show graphic to be developed by art.	

	Proc 2017/pg 1546/col2/para2/ln10-17] For example, instead of asking questions with “yes” or “no” answers, Jon used open-ended questions to discover that Eric is no longer engaging with his friends or going out to the movies. Jon also learned that Eric is feeling less valuable to society as he struggles to adjust to his retirement.		 (to be adapted by art)
Scene 2c	Because MDD is a complex condition and is often misdiagnosed, the more information you can obtain from your patient interview, the better equipped you will be to make an accurate diagnosis and appropriate treatment plan. Open-ended questions can also help you better establish a rapport with your patients, which is essential in diagnosing and treating patients effectively. **[Bobo Mayo Clin Proc 2017/pg 1534/Table1]**	Tina speaking	
Scene 2d	In addition to using open-ended questions to discuss diagnostic criteria, you can also use them to review the patient’s past medical history and obtain sensitive health information. For example, Jon used open-ended questions to discover that Eric had	Tina speaking	

	experienced a similar depressive episode when he was younger and that he had responded well to previous medication and therapy. Furthermore, Jon's sensitive broaching of the topic of suicidality helped him discover that Eric had experienced recurrent thoughts of death and that he needed to work with Eric to develop a safety plan. It is important to remember as mental health care providers that we can work toward reducing the stigma of psychiatric illness, and we should approach these discussions in much the same way as we do a discussion of smoking history. As a reminder, for any patient with suicidal ideation, it is important to create a safety plan and to identify any protective factors that are in place.		
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 3			
Scene 3a	Now, let's put everything we've reviewed together by testing your knowledge of the *DSM-5* diagnostic criteria for MDD.	Tina speaking	

3b	Tina: Which of the following indicates that Eric might have MDD? Choose all that apply. a. Depressed mood b. Fatigue c. Unintentional weight loss of more than 5% of his body weight in the past month d. **Increased irritability**	Focus on Tina speaking. Then show the graphic on screen.	**QUESTION**: Which of the following indicates that Eric might have MDD? Choose all that apply. a. Depressed mood b. Fatigue c. Unintentional weight loss of more than 5% of his body weight in the past month d. Increased irritability
3c	**Tina: Options a through c can all point to a diagnosis of MDD.** According to the *DSM-5*, a patient with MDD must exhibit 5 or more of the 9 depressive symptoms listed in criterion A for most of the day, nearly every day. These 5 symptoms must include depressed mood or loss of interest or pleasure. The other symptoms included in the diagnostic criteria for MDD include unintentional loss or gain of more than 5% of one's body weight within a month or a decrease or increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of	Focus on Tina speaking. Then show the graphic on screen.	**ANSWER: a,b, and c.** 🕐 A patient with MDD must exhibit 5 or more of the 9 depressive symptoms listed in criterion A for most of the day, nearly every day. 🕐 These 5 symptoms must include depressed mood or loss of interest or pleasure. 🕐 The patient's symptoms must be present for at least 2 weeks and cause significant functional impairment related to social, occupational, or other relevant areas of functioning. 🕐 Symptoms that may be attributable to medical conditions, medications, other substances, or other psychiatric conditions must be ruled out. 🕐 Increased irritability can be a sign in children or adolescents of depressed mood.

	excessive guilt or worthlessness; difficulty concentrating or making decisions; and recurrent thoughts of death, suicidal ideation with or without a specific plan, or a suicide attempt. Lastly, the patient's symptoms must be present for at least 2 weeks and cause significant functional impairment related to social, occupational, or other relevant areas of functioning. Symptoms that may be attributable to medical conditions, medications, other substances, or other psychiatric conditions must be ruled out. **[DSM-5 APA 2013/pg 125/para A-C/Notes; pg 126/para 1]** Increased irritability can be a sign of depressed mood in children or adolescents, but it is not included in the *DSM-5* criteria for MDD diagnosis in adults.		
3d	Tina: Is there anything else you think Jon should ask Eric about his medical history? a. If he is taking any herbal supplements b. How many hours a night he is sleeping	Focus on Tina speaking. Then show the graphic on screen.	**QUESTION**: Is there anything else you think Jon should ask Eric about his medical history? a. If he is taking any herbal supplements b. How many hours a night he is sleeping c. If he has a history of a cancer diagnosis d. **Both a and b**

	c. If he has a history of a cancer diagnosis **d. Both a and b**		
3e	**Tina: Both a and b are correct.** Although Jon covered many aspects of Eric's life and his depressive symptoms, it's important that he gathers as much information as possible to inform his diagnosis and treatment plan. For example, Jon could ask Eric if he is taking any herbal supplements because patients often do not remember to bring those up. Additionally, herbal supplements can cause mood symptoms and interact with mood disorder medications. Lastly, specifics about the number of hours of sleep Eric is getting nightly could also be helpful to know when later assessing his response to treatment. **[APA DSM-5/pg163/para5-6] [APA Clinical Guidelines/pg15/col1/para5/b; col2/para1; pg37-38/Table7]**	Focus on Tina speaking. Then show the graphic on screen.	**ANSWER: Both a and b are correct.** 🕐 It is important to gather as much information as possible to inform a diagnosis and treatment plan. 🕐 For example, Jon could ask Eric if he is taking any herbal supplements because patients often do not remember to bring those up. Additionally, herbal supplements can cause mood symptoms and interact with mood disorder medications. Lastly, specifics about the number of hours of sleep Eric is getting nightly could also be helpful to know when later assessing his response to treatment. **[APA DSM-5/pg163/para5-6] [APA Clinical Guidelines/pg15/col1/para5/b; col2/para1; pg37-38/Table7]**

3f	Tina: Which of the following is an example of an open-ended question? 1. Have you used antidepressant medications in the past year? 2. Do you have a family history of depression? **3. Can you tell me more about when these symptoms started?** 4. How many nights a week do you drink alcohol?	Focus on Tina speaking. Then show the graphic on screen.	**QUESTION**: Which of the following is an example of an open-ended question? 1. Have you used antidepressant medications in the past year? 2. Do you have a family history of depression? 3. **Can you tell me more about when these symptoms started?** 4. How many nights a week do you drink alcohol?
3g	**Tina: "Can you tell me more about when these symptoms started?" is an example of an open-ended question.** Like standardized psychiatric rating scales, open-ended clinical questions can be helpful in screening patients for mood disorders. Open-ended questions invite patients to share, in their own words, more about their experiences with us. They can also help providers in making a diagnosis by facilitating a thorough yet conversational review of the *DSM-5* criteria. Additionally, open-ended questions can give providers more	Focus on Tina speaking. Then show the graphic on screen.	**ANSWER**: 🕐 Open-ended questions invite patients to share more about their experiences with us. 🕐 They can also help providers in making a diagnosis by facilitating a thorough yet conversational review of the *DSM-5* criteria. 🕐 Open-ended questions can give providers more information on the impact of a patient's symptoms on their overall function and quality of life.

	information on the impact of a patient's symptoms on their daily life in terms of their overall function and quality of life, which can be helpful to know when later assessing the patient's response to treatment.**[APA DSM-5/pg163/para5-6] [APA/pg15/col1/para5/b ; col2/para1; pg23/col1/para 1; pg24/col1/para2; pg37-38/Table7]** Closed-ended questions, on the other hand, have a limited number of answers.		
Closing			
Closing Graphic		NP Psych Navigator branded graphic that plays at the end of the video	(To be developed)

Storyboard 3

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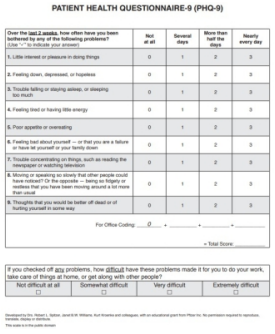
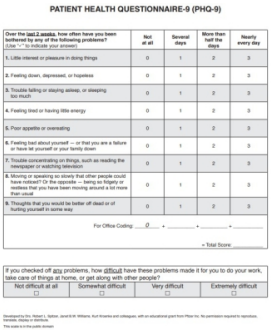
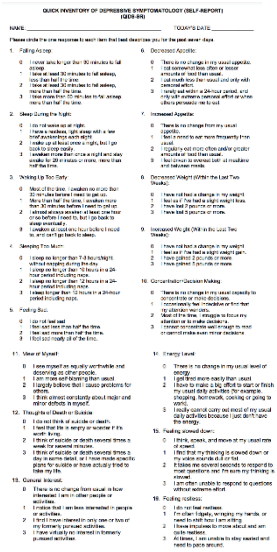
NP Psych Navigator Video Storyboard for MDD Patient Case: Eric Scales for MDD			
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 0	We will now review some of the standardized psychiatric rating scales available to Jon to help him assess the nature of Eric's depressive symptoms.	Tina speaking	
Scene 1			
Scene 1a	After performing a full clinical evaluation and workup, Jon ruled out several other potential causes of Eric's depressed mood, including medical conditions, medications, and other substances. Because major depressive disorder (MDD) often presents with symptoms similar to those of other psychiatric conditions, standardized psychiatric rating scales can help in making a diagnosis. **[DSM-5 APA 2013/pg 123/para 7;**	Image of Jon https://www.shutterstock.com/image-photo/portrait-friendly-male-doctor-nurse-wearing-1666399057	 **KEY POINT**: 🕐 Psychiatric rating scales can help in identifying patients with depressive symptoms.

	pg 124/para A-D/Notes; pg 125/para A-C/Notes; pg 126/para 1]		
Scene 1b	The scales we will review now include the Patient Health Questionnaire (PHQ-9) and the Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR_{16}). Both of these scales can be completed by the patient at the start of their visit, as was the case with Eric's visit where he filled out the PHQ-9 before Jon entered the room.	Tina speaking Show PHQ-9 graphic https://www.nppsychnavigator.com/Clinical-Tools/Psychiatric-Scales/Patient-Health-Questionnaire-Depression-Scale-(PHQ	 **The Patient Health Questionnaire-9 (PHQ-9)**  PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Scene	Script	Description	Onscreen Images/Footage
Scene 2			
Scene 2a	The PHQ-9 is a brief 9-item scale that evaluates depressive symptoms over the past 2 weeks. It is completed by the patient and can be finished in less than 5 minutes. This scale has been validated for use as a screening and diagnostic tool for MDD. It can also be	Image of table with scores https://www.uptodate.com/contents/calculator-depression-screening-by-a-nine-item-patient-health-questionnaire-phq-9-in-adults	**PHQ-9 Scale Calculation** **0 to 4 points:** No depression **5 to 9 points:** Mild depression **10 to 14 points:** Moderate depressio **15 to 19 points:** Moderately severe d **20 to 27 points:** Severe depression **[Kroenke 2001/pg611/Table5]**

	used to monitor treatment response and determine symptom severity in MDD. **[Kroenke 2001/pg606/col2/para2/ln1-7; pg607/col1/para1-2; pg611/col1/para3; pg612/col2/para3] [Smarr/pgS463/col1/para2]** Each item corresponds to 1 of the 9 depressive symptoms included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria for MDD. Scores range from 0 to 27, with items rated based on the number of days the patient has experienced each item. MDD can be diagnosed if a patient has experienced 5 or more of the 9 items for at least more than half of the days within the past 2 weeks. One of these symptoms must be depressed mood or a loss of interest or pleasure. The PHQ-9 also includes 1 global item to assess functional impairment. This item reflects the criterion in the *DSM-5* that the patient's depressive symptoms must cause significant functional impairment related to	Show Tina talking. Show PHQ-9 again; we will have art highlight the global item used to assess functional impairment. Source: https://www.nppsychnavigator.com/Clinical-Tools/Psychiatric-Scales/Patient-Health-Questionnaire-Depression-Scale-(PHQ)	 **The PHQ-9**  PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9) Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "+" to indicate your answer) Not at all / Several days / More than half the days / Nearly every day 1. Little interest or pleasure in doing things 2. Feeling down, depressed, or hopeless 3. Trouble falling or staying asleep, or sleeping too much 4. Feeling tired or having little energy 5. Poor appetite or overeating 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down 7. Trouble concentrating on things, such as reading the newspaper or watching television 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual 9. Thoughts that you would be better off dead or of hurting yourself in some way For Office Coding: 0 + ... + ... = ... = Total Score ... If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not difficult at all / Somewhat difficult / Very difficult / Extremely difficult

	social, occupational, or other relevant areas of functioning.**[Kroenke 2001/pg607/ col1/para2; pg611/Table5] [Smarr/pg462/col2/p ara2]**		
Scene 2c	The QIDS-SR$_{16}$ is a 16-item scale that evaluates depressive symptoms over the past week. It is self-administered and can be completed within 5 to 7 minutes. It has been validated for use as a screening and diagnostic tool for MDD and to monitor treatment response and symptom severity in MDD. **[Rush/pg579/col2/pa ra3-4; pg581/Appendix 1] [Brown/pg7/para3]**	Image of QIDS-SR$_{16}$ https://med-fom-ubcsad.sites.olt.ubc.ca/files/2013/11/QIDS-SR.pdf	**The QIDS-SR$_{16}$** 
Scene 2d	Each item corresponds to 1 of the 9 depressive symptoms included in the *DSM-5* criteria for MDD. Scores range from 0 to 27, with items rated based on severity. **[Rush/pg574/col1/pa ra2] [Liu/pg4/col2/para2] [Bernstein 2009/pg140/col1/par a1; pg144/col1/para2] [Bernstein 2010/pg8/para6]**	Image of table with scores https://med-fom-ubcsad.sites.olt.ubc.ca/files/2013/11/QIDS-SR.pdf	**QIDS-SR$_{16}$ Score Calculation** **Scoring Criteria** 0–5 Normal 6–10 Mild 11–15 Moderate 16–20 Severe ≥21 Very Severe **[Bernstein 2009/pg140/col1/para1]**

Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 3			
Scene 3a	In addition to asking Eric to complete the PHQ-9, Jon used open-ended questions to evaluate Eric's depressive symptoms in a thorough yet conversational way. Eric's answers to these open-ended questions also helped Jon get a better idea of how Eric's symptoms impact his overall function and quality of life. Now let's see how much of this presented content on clinical scales in MDD you have processed with some questions.	Image of Jon Focus on Tina speaking.	 
3b	Tina: Which of the following changes in scores on the PHQ-9, administered before and 6 weeks after antidepressant initiation, would indicate a clinically significant response?	Then show graphic on screen.	**QUESTION**: Which of the following changes in scores on the PHQ-9, administered before and 6 weeks after antidepressant initiation, would indicate a clinically significant response? a. A 2-point change in score

	a. A 2-point change in score b. A 3-point change in score c. A 4-point change in score **d. A 5-point change in score**		b. A 3-point change in score c. A 4-point change in score d. A 5-point change in score
3c	Tina: A 5-point change in score would indicate a clinically significant response. Scores of 5, 10, 15, and 20 on the PHQ-9 represent thresholds of mild, moderate, moderately severe, and severe depression, respectively. When patients take the PHQ-9 on a follow-up visit after starting therapy, a 5-point change is considered clinically significant. According to the developers of the PHQ-9, a score of less than 10 suggests a partial response to antidepressant treatment. **[Kroenke 2012/p281/col2/para 1/ln9-12]**	Focus on Tina speaking. Then show graphic on screen.	**ANSWER**: A 5-point change in score would indicate a clinically significant response. 🕐 Scores of 5, 10, 15 and 20 on the PHQ-9 represent thresholds of mild, moderate, moderately severe, and severe depression, respectively. 🕐 A 5-point change is considered clinically significant. 🕐 A score of less than 10 suggests a **partial response** to antidepressant treatment.
3d	Tina: Why are clinical scales useful in diagnosing MDD?	Focus on Tina speaking. Then show graphic on screen.	**QUESTION**: Why are clinical scales useful in diagnosing MDD? a. Because MDD is known as the silent killer.

	a. Because MDD is known as the silent killer. b. **Because MDD often presents with symptoms similar to those of other psychiatric conditions.** c. Because MDD often presents in patients with no family history of psychiatric illness. d. Because MDD is often unrecognized by patients afflicted with it.		b. Because MDD often presents with symptoms similar to those of other psychiatric conditions. c. Because MDD often presents in patients with no family history of psychiatric illness. d. Because MDD is often unrecognized by patients afflicted with it.
3e	Tina: Because MDD often presents with symptoms similar to those of other psychiatric conditions, standardized psychiatric rating scales can help in making a diagnosis. **[DSM-5 APA 2013/pg 123/para 7; pg 124/para A-D/Notes; pg 125/para A-C/Notes; pg 126/para 1]** Hypertension is often referred to as the silent killer. MDD often presents in patients with a positive family history of depressive	Focus on Tina speaking. Then show graphic on screen.	**ANSWER:** Because MDD often presents with symptoms similar to those of other psychiatric conditions, standardized psychiatric rating scales can help in making a diagnosis. 🕐 Hypertension may be referred to as the silent killer. 🕐 MDD often presents in patients with a positive family history of depressive disorders or other psychiatric disorders. 🕐 The symptoms of MDD are serious and pervasive and can affect patients in all aspects of their lives.

	disorders or other psychiatric disorders. In fact, family histories of MDD and bipolar disorder are common in patients with diagnoses of MDD. **[APA2010,p25,col1,para2]** While patients may not have diagnosed themselves with a depressive disorder, the symptoms of MDD, as we see in Eric's case, are serious and pervasive and can affect patients in all aspects of their lives.		
3f	Tina: And now, our third and final quiz question for this section—when using the PHQ-9 in clinical practice, MDD can be diagnosed if a patient has experienced: **a. 5 or more of the 9 items for at least more than half of the days within the past 2 weeks.** b. 5 or fewer of the 9 items for at least more than half of the days within the past 2 weeks. c. 5 or more of the 9 items for at	Focus on Tina speaking. Then show graphic on screen.	**QUESTION**: When using the PHQ-9 in clinical practice, MDD can be diagnosed if a patient has experienced: a. 5 or more of the 9 items for at least more than half of the days within the past 2 weeks. b. 5 or fewer of the 9 items for at least more than half of the days within the past 2 weeks. c. 5 or more of the 9 items for at least more than half of the days within the past 1 week. d. 5 or fewer of the 9 items for at least more than half of the days within the past 1 week.

	least more than half of the days within the past 1 week. d. 5 or fewer of the 9 items for at least more than half of the days within the past 1 week.		
3g	Tina: Patients must experience 5 or more of the 9 items for at least more than half of the days within the past 2 weeks. The PHQ-9 is a brief 9-item clinical rating scale that evaluates depressive symptoms over the past 2 weeks. It is completed by the patient and can be finished in less than 5 minutes. This scale has been validated for use as a screening and diagnostic tool for MDD. It can also be used to monitor treatment response and determine symptom severity in MDD. **[Kroenke 2001/pg606/col2/para2/ln1-7; pg607/col1/para1-2; pg611/col1/para3; pg612/col2/para3] [Smarr/pgS463/col1/para2]**	Focus on Tina speaking. Then show graphic on screen.	**ANSWER**: 5 or more of the 9 items for at least more than half of the days within the past 2 weeks. - The PHQ-9 is a brief 9-item **clinical rating scale** that evaluates depressive symptoms over the past 2 weeks. - It can be completed by a patient in **less than 5 minutes**. - This scale has been **validated** for use as a screening and diagnostic tool for MDD. - It can also be used to monitor treatment response and determine symptom severity in MDD. - Each item corresponds to 1 of 9 **depressive symptoms included in the *DSM-5* criteria for MDD**. - This scale also includes **1 global item to assess functional impairment**.

	Each item corresponds to 1 of 9 depressive symptoms included in the *DSM-5* criteria for MDD. Possible scores range from 0 to 27, with items rated based on the number of days the patient has experienced each item. MDD can be diagnosed if a patient has experienced 5 or more of the 9 items for at least more than half of the days within the past 2 weeks. One of these symptoms must be depressed mood or a loss of interest or pleasure. The PHQ-9 also includes 1 global item to assess functional impairment. This item reflects the criterion in the *DSM-5* that the patient's depressive symptoms must cause significant functional impairment related to social, occupational, or other relevant areas of functioning.**[Kroenke 2001/pg607/ col1/para2; pg611/Table5] [Smarr/pg462/col2/p ara2]**		

Closing Graphic		NP Psych Navigator branded graphic that plays at the end the video.	(To be developed)

Storyboard 4

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NP Psych Navigator Video Storyboard for Depressive Symptoms Patient Case: Eric Treatment Initiation and Monitoring			
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 0/ Welcome	Tina: In this last section, we will review how to initiate treatment in cases where a patient's depressive symptoms are not fully responding to medication and engage in treatment monitoring for major depressive disorder (MDD). In the previous scenes, you learned that Eric's symptoms meet the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria for MDD. At the end of their first appointment, Jon started Eric on a selective serotonin reuptake inhibitor (SSRI), the same one that Eric eventually responded to when treated for depression in the past. He also provided Eric with a referral to a psychologist who works in the same clinic as Jon and who specializes in cognitive-behavioral therapy (CBT) for adults with depressive disorders. Eric began CBT shortly thereafter.	Focus on Tina speaking.	

	In this scene, Eric and Jon are meeting 8 weeks after their initial visit. They continued to meet every 2 weeks after the initial visit to assess Eric's response to the SSRI. Thus, this visit represents the fifth time they have seen each other. The American Psychiatric Association (APA) recommends generally needing 4 to 8 weeks of treatment to determine antidepressant response, so you certainly want to follow up with your patient. **[APA 2010/p18/col2/para2/ln5-9]** If you're not able to see the patient in person within 2 to 4 weeks of initiating an antidepressant, consider using telehealth options, if available at your clinic, or otherwise consider scheduling a time to speak with your patient by telephone.		
Scene 1	***Follow-Up Visit 4: 8 Weeks After Initiating Antidepressant Therapy***		
Scene 1a	Jon: It's good to see you again, Eric. How are you? Eric: I'm getting by. Jon: I know it's only been 2 weeks since we last met, but it's important that we touch base regularly so we can see how your medication is working and whether your symptoms are getting better, worse, or staying the same. I know when you first came back 2 weeks after our initial visit, you did not	Scene opens to show Jon talking with Eric, who is sitting on an exam table. Focus on Jon and Eric as each of them speak. Eric generally looks at the floor or at his hands folded in his lap rather than making eye contact with Jon.	 

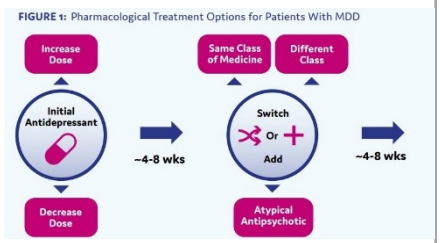
	notice the SSRI making much of a difference. When you came back at 4 weeks, you generally felt the same, and at 6 weeks, you noticed maybe a slight improvement. Am I summarizing this correctly? Eric: That's right. I really don't feel much better. I am worried this medication isn't working. Jon: That's completely understandable, but try not to worry too much; this is very common. Sometimes we just have to try different strategies before we find one that works. I am optimistic that we will find something given that the last time you felt this way, you eventually did experience an improvement with the right medication and therapy. Eric: Okay. Being optimistic is tough right now, but I will try. Jon: I know it's tough, but I appreciate that. Each time you've come in, you have completed that same Patient Health Questionnaire (PHQ-9) measure that you did the first time. Eric: That's right. How did I do today? Jon: Well, over the past 8 weeks, your score has improved a little but not as much as we would like. Your initial score 8 weeks ago was a 19, which suggests moderately severe		 This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

	depression. Your score was an 18 when you returned 2 weeks later, and a 16 after 4 weeks on the medication. At 6 weeks on the medication, your score dipped down to a 13, which is suggestive of more moderate depression. Today, it is a 13 again. We've seen some downward movement in your score, which is something, but I'd like to see your symptoms improve even more. Eric: Me too! Jon: Why don't you catch me up on how you have been the last 2 weeks? How would you describe your depression since we last met? Eric: I guess I feel about the same. My wife said that lately, I seem to be smiling a little more, but I was hoping I would feel more like my old self by now. However, I remember from the last time I was taking these pills that it took a couple of months for them to start working. Jon: You're right. It often takes at least 2 to 4 weeks to start noticing beneficial effects from an antidepressant. However, on average, it takes a total of 4 to 8 weeks to determine if you're responding to treatment. **[APA 2010/p29/col1/para2/ln17-19;p18/col2/para2/ln5-9]** What's important right now is that you are tolerating the		

	medication well and don't feel any worse than you did before you began taking it. Eric: No, I definitely don't feel worse than when I saw you last. Jon: That's excellent. What about your sleep? Are you still sleeping more than usual but feeling tired? Eric: That hasn't changed. I am still sleeping about 10 hours a night, but everything feels like it takes every ounce of energy—even if it's just walking out to the mailbox or driving to pick up a pizza. Jon: I see. And what about the thoughts of dying that you shared with me last time? Eric: I still have those, although they aren't anything specific, like a plan. As sad as I have been lately, I don't think I could ever resort to something like suicide. I'm glad you helped me create that safety plan at our last visit, so if I do start to have these thoughts, I will know what to do. However, I still wonder from time to time how things might be better if I just wasn't here any longer. Talking to my therapist about that seems to help. Jon: I'm sorry you're still feeling that way, and I'm glad you've found talking with your therapist to be helpful. Let's see if maybe		

	we need to adjust your medication and whether that might help with these symptoms. Remind me, how are you taking your medication? Eric: I take 1 pill each night before bed, and that's it. I even keep it on my nightstand so that I don't forget to take it.		
Scene 1b	Jon: Perfect. Let's revisit the side effects of SSRIs. SSRIs can sometimes cause side effects that patients find unpleasant, and in some cases, these effects can lead to them stopping the medication altogether. For example, some patients might not adhere to antidepressants that cause weight gain. **[APA 2010/p75/col1/para1/ln1-3]** It's important that we discuss any side effects you're experiencing over time because we might be able to change the dose or find another antidepressant that doesn't have those same effects—or maybe has them to a lesser degree. Eric: That makes sense. I know we discussed the headache I experienced over the first week on the medication that seemed to go away by our second visit. Remind me, what are the other side effects I should be looking out for? Jon: In addition to headache, some of the more common side effects of SSRIs are changes in sleep, such as insomnia; weight gain; sexual	Focus on Jon and Eric as each of them speak. As Jon is discussing common side effects of SSRIs, show text on screen. Along with the text, show various images depicting some of the side effects.	  This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient. Common side effects of SSRIs include **[APA 2010/p36/col2/para4/ln 1-2; para 5/ln1-3; para6/ln1-4 and p38/col1/para2/ln1-2; col2/para1/ln1-3 and p39/col1/para2/ln1-2]**: 🕐 Headache 🕐 Sleep changes (eg, insomnia) 🕐 Weight gain 🕐 Sexual dysfunction 🕐 Risk of falls 🕐 Gastrointestinal disturbance

	dysfunction; risk of falls; and upset stomach. **[APA 2010/p36/col2/para4/ln 1-2; para 5/ln1-3; para6/ln1-4 and p38/col1/para2/ln1-2; col2/para1/ln1-3 and p39/col1/para2/ln1-2]** (*Jon looking at tablet*) I see that they weighed you when you arrived today, and it looks like your weight is still the same as it was when we first met, so that's good. Any concerns about your sexual health? It's not unusual for men taking SSRIs to experience a decrease in their sexual desire, difficulty achieving erection, or problems with ejaculation or orgasm. **[APA 2010/p36/col2/para6/ln1-4]** Have you noticed any of those types of issues since you started the medication? Eric: No; thankfully everything seems fine there. In fact, other than the headache I had initially, I haven't experienced any of the other side effects that you mentioned. Jon: That's great to hear. Are there any side effects I didn't mention that you have experienced since you started the medication? Eric: No, none at all. I guess I'm not completely surprised about that since I was on this medication before. Jon: Well, I will touch base with you about any treatment-related side effects as we continue to	Focus on Jon and Eric as each of them speak.	    This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.   This image was purchased from Shutterstock. It includes photography models. It does not include affiliates

	meet. **[APA 2010/p27/col2/para3/ln11-14]** If you do start experiencing these side effects or any others, please give our office a call right away. Even if it's embarrassing, like sexual side effects, it's important to let us know. Eric: Thank you. I will definitely let you know.		of AbbVie Inc., nor does it include an actual patient.
1c	Jon: Eric, given that you have been taking this SSRI and have gone to therapy for 8 weeks now, and your PHQ-9 score has only improved somewhat, I think it's time we look at what we can do about your medication. Eric: Maybe I need to stay on this SSRI a little longer? Jon: Well, SSRIs are not like taking an NSAID for a headache, where you take it and a few hours later the pain resolves. We often need to increase the dose of an SSRI gradually, which is what we have been doing over the past 8 weeks. It can take 6 to 8 weeks to see a full benefit from the medication. However, it's now been 8 weeks since you started the SSRI. We have slowly increased your dose, but you are still feeling depressed, have low energy and motivation, are sleeping excessively, and are experiencing passive suicidal ideation. I suggest you keep taking this SSRI since you are currently tolerating it well, and have experienced some benefit	Show Jon and Eric. When Jon talks about augmenting treatment, show Figure 1 showing steps for adding an atypical antipsychotic.	  This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient. 

	from it, but that we add another medication to it—an atypical antipsychotic. Eric: An antipsychotic? I'm not psychotic, I'm depressed. I just need an antidepressant. Jon: That's a very common and understandable reaction, and I agree that you don't have symptoms of psychosis. This class of medications can be used as an adjunct treatment for MDD for patients who, like yourself, are experiencing a partial response to their antidepressant therapy. Jon: Guidelines for the treatment of depression recommend considering adding another medication, such as an atypical antipsychotic, if a patient's depression has not improved on an SSRI after 4 to 8 weeks at a maximum tolerated dose. **[APA 2010/p29/col1/para2/ln17-19; p18/col2/para2/ln5-9; p55/col1/para5 and col2/para1]** There is research suggesting that some atypical antipsychotics can be given in combination with SSRIs to help with your depressive symptoms. **[APA 2010/p55/col1/para5 and col2/para1]** What do you think of this plan? Eric: Well, if there's some research showing this might work and this is something you typically do with patients like me, I guess I am all for it.	Return to showing Eric and Jon.	  This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

	Jon: Yes; this is a common approach for patients whose depression is not responding to an SSRI, and it is supported by evidence from many large-scale research studies called clinical trials. **[APA 2010/p98/col2/para2]** We will continue to meet periodically to see how your symptoms are responding to this second medication. Eric: How soon might this new approach work? Jon: It could take another 4 to 8 weeks to work, so hang in there with me. I know this has been a long journey, but think of it as a marathon, not a sprint. I believe we will figure out how to get across the finish line together, so to speak, and get you back to feeling more like your typical self. We just need some patience and persistence. How does that sound? Eric: Okay. I'm on board to give this a try. Jon: Sounds great. I appreciate you being willing to give this a chance.		
Transition	Tina: Antidepressant education and monitoring are critical parts of helping patients adhere to treatment, ensuring patients are safe and comfortable, and giving them the greatest opportunity to benefit from their medication. **[APA 2010/p29/col1/para2/ln1-25]**	Focus on Tina speaking. While Tina is talking about reasons for antidepressant	

	There are several reasons why patients may not respond to an antidepressant. First, the antidepressant itself may not be efficacious in improving the patient's symptoms. For instance, it might be the wrong medication for that particular patient, the dose might need to be increased, or the patient may need to stay on it longer. **[APA 2010/p52/col2/Table 9]** Each person is different. One antidepressant might work great for one patient and be ineffective for another. The biological mechanisms that lead to antidepressant nonresponse are not yet known, but one hypothesis proposes that individual differences in brain anatomy and neurocircuitry may play a role. **[Levinstein 2014/p8/col1/para2 and col2/para1]** Second, tolerability can be a problem given the potential side effects of antidepressants. Adverse effects like weight gain, insomnia, and sexual dysfunction can occur with antidepressant treatment. **[APA 2010/p37-38/Table 7]** Understandably, some patients may feel they cannot bear some of these unpleasant side effects. Like efficacy, tolerability can vary by patient; what one person finds unpleasant yet acceptable, another person might find intolerable. **[APA**	nonresponse, show text on screen. With text, show an image of a person looking upset/hopeless about their medication. https://www.shutterstock.com/image-photo/caucasian-patient-female-consult-mental-health-1789517291	 This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient. Challenges to getting a good response to antidepressant treatment: **1.** Suboptimal efficacy due to the wrong dose, inadequate length of time on the medication, or the person's individual biology not being responsive to the medication **[APA 2010/p52/col2/Table 9]** **2.** Unpleasant side effects of antidepressants can occur, such as weight gain, insomnia, and sexual dysfunction **[APA 2010/p37-38/Table 7]** **3.** Nonadherence to the antidepressant **[APA 2010/p52/col2/Table 9 and p75/col1/para1/ln1-3]**

	2010/p29/col1/para2/ln8-14] Intolerability to treatment side effects can lead to nonadherence, which is a third possible reason for treatment nonresponse. **[APA 2010/p52/col2/Table 9 and p75/col1/para1/ln1-3]** Patients might stop taking their medication as prescribed for a number of reasons, including side effects of treatment, logistical and cultural barriers, or feeling unmotivated due to their depression. **[APA 2010/p16/col2/para4]** You should ask patients about barriers to adherence as well as any fears or concerns they might have about their treatment and possible side effects. **[APA 2010/p16/col2/para4].** For instance, you could ask questions such as, “Do you ever have problems taking your medication as prescribed?” or “What concerns do you have about how this medication might affect you?” Be sure to discuss nonadherence with patients in a collaborative, nonjudgmental, patient-centered way; help them set realistic expectations for their outcome to treatment; and don’t forget to work on building a strong treatment alliance, which can help enhance treatment adherence. **[APA 2010/p16/col2/para4 and p23/col1/para2/ln4-7]**	Focus on Tina speaking.	

	In this final scene, we will learn how Eric is responding after 2 weeks on the atypical antipsychotic in combination with the SSRI.		
Scene 1d	Jon: Nice to see you again, Eric. It's now been 10 weeks since I first saw you and 2 weeks since you started taking the atypical antipsychotic in addition to your SSRI. How are you feeling? Eric: I feel like I am finally starting to feel better. It's interesting what a difference another medication can make. Jon: I'm really glad to hear that. Tell me what's going well for you. Eric: Well, for one thing, I can get out of bed at a normal time and get on with my day—and no napping. I'm able to stay busy, or at least keep my mind busy, so I don't feel the need to sleep out of boredom. Jon: That's excellent. What sorts of things are you doing to stay busy? Eric: This weekend, I did chores in the yard and small repairs around the house, which made me feel good—like I'm back at work again. I was also thinking of visiting with a few buddies of mine next week. Also, I think I mentioned to you before that my wife and I really enjoyed going to the movies regularly, but I hadn't felt up to it in months. Well, we went to the Saturday matinee last week. Afterwards, we usually get lunch at a nearby restaurant. I wasn't as hungry as I usually am, but I think I am starting to get my appetite back a bit.	Focus on Jon and Eric as each of them speak. Eric looks noticeably more upbeat.	  This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

	I know this probably doesn't sound very exciting to most people, but it's something my wife and I always enjoyed doing together. I have really missed that. I feel bad when I think of all the time I missed out on with her because I was feeling so sad. Jon: I understand you feeling that way, but try not to blame yourself, Eric. Depression is a medical condition. If you hadn't been able to go to the movies because you had a migraine, you wouldn't feel guilty. Right? Eric: No, I guess not. Jon: There's no reason to feel guilty about having depression. What's important is that we seem to have found something that's working for you. Speaking of which, how is your therapy going? Eric: Good. My therapist gives me homework each week, which seemed sort of silly at first, but I remembered doing the same thing the last time I talked with someone, and it really does help. I'm learning to monitor my thoughts and think more positively about myself and this new chapter of my life, that sort of thing. I guess I still need to work on that. Jon: I'm really glad to hear that you're benefitting from therapy. You should continue with therapy even though you're starting to feel better. Therapy can be a great place to talk about what to do if you notice yourself starting to feel down again in the future, which is possible given that you've had depressive episodes before.		

	Eric: Yes; my therapist and I have talked about recurrent depression and that continuing with therapy might help reduce my risk of relapse. **[APA 2010/p19/col1/para3/ln6-14]** I will definitely keep going to my appointments.		
Scene 1d	Jon: Let's look at your paperwork today to see how your depression scores might have changed. The last time you were here, your PHQ-9 score was a 13, and that was only slightly lower than what it had been over the previous 8 weeks. Eric: Yes, I remember. How is it today? Jon: Today, it's all the way down to an 8, which is suggestive of a milder depression, so that's excellent news. That indicates that your depressive symptoms are improving significantly. [Kroenke 2012/p281/col2/para1/ln6-12] I'm going to recommend that you continue taking both medications and continue with therapy, and we will keep meeting every 4 weeks to see how you're doing. I'll also have you continue to complete a PHQ-9 each time you come in so we will have a quantifiable way to measure and track how you're doing. This will let us see whether your scores change or remain steady. How does that sound? Eric: That makes sense. Jon: One last item before we finish. The last time you were here, we talked about side effects of SSRIs. You said you weren't experiencing any negative side	Focus on Jon and Eric as each of them speak.	  This image was purchased from Shutterstock. It includes photography models. It does not include affiliates of AbbVie Inc., nor does it include an actual patient.

	effects at that time. Now that you have been on the SSRI longer, and have added on another medication, are you noticing any new and unpleasant side effects? Eric: **I have been a little nauseous and sometimes have a headache, which isn't common for me. I may be feeling a bit hungrier than usual, too. I did notice that** my sleep and appetite are improving, and I'm feeling more like my old self. Jon: **Headache and nausea are common side effects associated with the use of atypical antipsychotics. Metabolic changes, including weight gain, can also happen with this class of medications. We will check your weight at our visit today, and we will continue to assess your weight and possibly some bloodwork at our follow-up visits as you progress on this medication.** I think it sounds like we are on the right track with your treatment plan. Keep up the good work, Eric. I will see you back in a month.		
Questions			
2a			
2b			
2c	Tina: Now let's review what we just learned about treatment and monitoring for patients with MDD with a few short questions. Jon should counsel Eric that short-term efficacy trials indicate		**QUESTION:** Jon should counsel Eric that, in general, patients are most likely to see results from initial antidepressant medication therapy after at least:

	that patients are most likely to see results from initial antidepressant medication therapy after at least: a. 1 to 2 weeks b. 2 to 4 weeks c. 4 to 6 weeks d. 12 weeks		a. 1 to 2 weeks b. 2 to 4 weeks c. 4 to 6 weeks d. 12 weeks
2d	Tina: The correct answer here is 4 to 6 weeks. Let's break this down, as it is important to understand how to appropriately counsel our patients and how to initiate treatment with cautious optimism, as well as to share realistic timelines with our patients. All antidepressant medications have been shown to require at least **4 to 6 weeks for patients to achieve maximum therapeutic effects**. **[APA2010,p43,col2,para2]** Improvement with antidepressant medications can be seen as early as 1 to 2 weeks into treatment, with other patients seeing improvement in symptoms in 2 to 4 weeks. **[APA2010,p43,col2,para2]** Some evidence suggests that patients continue to show benefits trialing medications for an additional 4 to 6 weeks, or up to 12 weeks total.		**ANSWER**: 4 to 6 weeks. 🕐 All antidepressant medications have been shown to require **at least 4 to 6 weeks for patients to achieve maximum therapeutic effects**. 🕐 Improvement with antidepressant medications can be seen as early as 1 to 2 weeks into treatment, with other patients seeing improvement in symptoms in 2 to 4 weeks. 🕐 Some evidence suggests that patients continue to show benefits trialing medications for an additional 4 to 6 weeks, or up to 12 weeks total.
2e	Tina: If Eric had shown no improvement in his depressive symptoms 3 weeks after starting the SSRI, but no worsening either, which of the following would	Focus on Tina speaking. Then show the graphic on screen.	**QUESTION**: If Eric had shown no improvement in his depressive symptoms 3 weeks after starting the SSRI, but no worsening either, which of the

	have been the most appropriate strategy for Jon to follow? a. Switch Eric to another antidepressant. b. Add an atypical antipsychotic. c. Titrate Eric's SSRI to a maximum tolerated dose and monitor his symptoms for at least another 3 weeks. d. Continue Eric on the same medication and dose.		following would have been the most appropriate strategy for Jon to follow? a. Switch Eric to another antidepressant. b. Add an atypical antipsychotic. c. Titrate Eric's SSRI to a maximum tolerated dose and monitor his symptoms for at least another 3 weeks. d. Continue Eric on the same medication and dose.
2f	Tina: The answer is to titrate Eric's SSRI to a maximum tolerated dose and monitor his symptoms for at least another 3 weeks. If Eric had shown no improvement but no worsening of his depressive symptoms after 3 weeks, the most appropriate strategy would be to titrate his SSRI to a maximum tolerated dose and monitor his symptoms for at least another 3 weeks. As we noted previously, many patients do not experience optimal response to an antidepressant until at least 4 to 6 weeks following antidepressant initiation and having increased their medication to a maximum tolerated dose. Moreover, the APA generally recommends waiting 4 to 8 weeks to determine antidepressant response. So, it is possible that Eric might still respond to the medication. [Levinstein	Focus on Tina speaking. Then show the graphic on screen.	**ANSWER**: Titrate Eric's SSRI to a maximum tolerated dose and monitor his symptoms for at least another 3 weeks. 🕐 If Eric had shown no improvement but no worsening of his depressive symptoms after 3 weeks, the most appropriate strategy would be to **titrate his SSRI to a maximum tolerated dose and monitor his symptoms for at least another 3 weeks.** 🕐 The APA generally recommends **waiting 4 to 8 weeks** to determine antidepressant response. So, it is possible that Eric might still respond to the medication.

	2014/p1/col2/para1/ln2-6] [APA 2010/p43/col2/para2/ln6-8;p18/col2/para1/ln4-6]		
2g	Tina: According to the APA guidelines, monitoring for adverse effects of antidepressant treatment should occur: a. Every 2 weeks. b. Every 4 weeks. c. Based on whether the patient has a history of antidepressant nonresponse. d. Based on the frequency and severity of side effects of the particular medication.	Focus on Tina speaking. Then show the graphic on screen.	**QUESTION**: According to the APA guidelines, monitoring for adverse effects of antidepressant treatment should occur: a. Every 2 weeks. b. Every 4 weeks. c. Based on whether the patient has a history of antidepressant nonresponse. d. Based on the frequency and severity of side effects of the particular medication.
2h	Tina: Monitoring for adverse effects of antidepressant treatment should occur based on the frequency and severity of side effects of the particular medication. The APA practice guideline for the treatment of MDD does not recommend monitoring for adverse events using a set time limit, such as 2 weeks or 4 weeks. Instead, it recommends monitoring patients on pharmacotherapy; the frequency of this monitoring is determined by the frequency and severity of side effects associated with the chosen medication. [APA 2010/p17/col2/para2/ln12-18]	Focus on Tina speaking. Then show the graphic on screen.	**ANSWER**: Monitoring for adverse effects of antidepressant treatment should occur based on the frequency and severity of side effects of the particular medication. 🕐 The APA practice guideline for the treatment of MDD does not recommend monitoring for adverse events using a set time limit. 🕐 The frequency of monitoring should be determined by the frequency and severity of side effects associated with the chosen medication.

Closing	Tina: Thank you so much for joining us for this interactive learning experience. We hope you feel you have improved your knowledge base as well as your comfort in caring for patients with MDD.	Show closing graphic.	To be created.

Storyboard 5 – Conclusion

The page which hosts this content will include the following disclaimer immediately below the video player:

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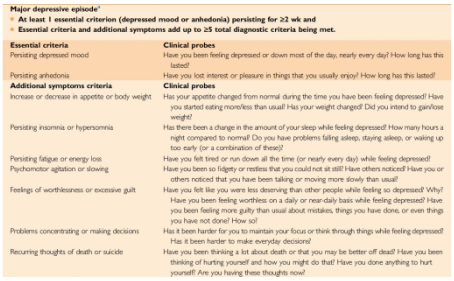
NP Psych Navigator Video Storyboard for Depressive Symptoms Patient Case: Eric			
Scene	**Script**	**Description**	**Onscreen Images/Footage**
Scene 0/ Welcome	Tina: I hope this has been a useful case for helping you to better understand the complexities of major depressive disorder (MDD), including screening, diagnosis, treatment initiation, and monitoring treatment response. Let's review some of the key takeaways from today's case.	Focus on Tina speaking.	

Scene 1	First, we learned about the importance of making an accurate MDD diagnosis, including what to consider when making a differential diagnosis. It is especially important to differentiate MDD from bipolar disorder, as bipolar disorder is often mistaken for MDD and has different treatments. **[Haddad 2015/p185/col2/para2/ln1-11]** To make the correct differential, explore the patient's history for previous depressive episodes and symptoms, previous manic and hypomanic episodes, and a family history of depression and bipolar disorder. Also, explore the patient's medical history for comorbidities that could explain or exacerbate their symptoms. Asking about suicidality is critical but should be done with sensitivity and empathy. If the patient has a positive history for suicidality or otherwise has symptoms that cause concern, help them create a suicide safety plan and ensure they understand how to use it.	While Tina is talking, show text on screen. While Tina is talking, show a screenshot of the start of *DSM-5* criteria for MDD and show a screenshot of example clinical probes for a major depressive episode. Focus on Tina speaking. While Tina is speaking, show text on screen.	**Making an accurate major depressive disorder (MDD) diagnosis:** 🕐 Take a thorough patient history. o Previous or current depressive episodes o Previous or current manic or hypomanic episodes o Family history of MDD, bipolar disorder o Medical comorbidities o Consider a broad differential diagnosis. **Major Depressive Disorder** Diagnostic Criteria A. 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 attributable to another medical condition. 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **(Note:** In children and adolescents, can be irritable mood.) 2. 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). **[APA 2013/p162/MDD Criteria A1–A2]**  **Major depressive episode**[1] • **At least 1 essential criterion (depressed mood or anhedonia) persisting for ≥2 wk and** • **Essential criteria and additional symptoms add up to ≥5 total diagnostic criteria being met.** **Essential criteria** / **Clinical probes** Persisting depressed mood — Have you been feeling depressed or down most of the day, nearly every day? How long has this lasted? Persisting anhedonia — Have you lost interest or pleasure in things that you usually enjoy? How long has this lasted? **Additional symptoms criteria** / **Clinical probes** Increase or decrease in appetite or body weight — Has your appetite changed from normal during the time you have been feeling depressed? Have you started eating more/less than usual? Has your weight changed? Did you intend to gain/lose weight? Persisting insomnia or hypersomnia — Has there been a change in the amount of your sleep while feeling depressed? How many hours a night compared to normal? Do you have problems falling asleep, staying asleep, or waking up too early (or a combination of these)? Persisting fatigue or energy loss — Have you felt tired or run down all the time (or nearly every day) while feeling depressed? Psychomotor agitation or slowing — Have you been so fidgety or restless that you could not sit still? Have others noticed? Have you or others noticed that you have been talking or moving more slowly than usual? Feelings of worthlessness or excessive guilt — Have you felt like you were less deserving than other people while feeling so depressed? Why? Have you been feeling worthless on a daily or near-daily basis while feeling depressed? Have you been feeling more guilty than usual about mistakes, things you have done, or even things you have not done? How so? Problems concentrating or making decisions — Has it been harder for you to maintain your focus or think through things while feeling depressed? Has it been harder to make everyday decisions? Recurring thoughts of death or suicide — Have you been thinking a lot about death or that you may be better off dead? Have you been thinking of hurting yourself and how you might do that? Have you done anything to hurt yourself? Are you having these thoughts now? **[Bobo Mayo Clin Proc 2017/pg 1534/Table 1]**  **Treatment Assessment:** 🕐 Clinical scales can be used for monitoring symptom severity and treatment response. 🕐 Medication side effects should be assessed. 🕐 Always address the possible risk of self-harm.

	Second, knowing the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria for both MDD and bipolar disorder is crucial to making the right diagnosis. As you interview the patient, make sure to ask about each diagnostic criterion. Clinical probes are an effective way to address *DSM-5* criteria in a manner that is more conversational, which can help with building rapport and patient trust. **[Bobo Mayo Clin Proc 2017/pg 1546/col2/para2/ln10-17]** Validated depression rating scales such as the Patient Health Questionnaire-9 (PHQ-9) can also aid in assessing symptoms. While screening tools are important in providing thorough, measurement-based care, they do not replace a provider's nuanced assessment. Rather, they help to focus attention on those patients who are most likely to benefit from a more in-depth clinical interview. Screening tools should be used routinely for monitoring symptom severity and treatment response. **[Kroenke 2012/p281/col1/para3/ln1-3 and col2/para1/ln1-6]**	While Tina is speaking, show text on screen. While Tina is speaking, show text on screen. While Tina is speaking, show text on screen.	 **Key point**: - Treatment nonresponse can be caused by multiple factors. **APA Practice Guidelines**: - Wait 4 to 8 weeks to assess treatment response to antidepressants. - In patients without adequate response, clinicians can consider changing or augmenting with a second medication. - Changes to treatment plans, such as augmenting with a second-generation antipsychotic medication, are reasonable if a patient does not have adequate improvement in 6 weeks. - Consistently follow-up with patients to assess treatment effects, adverse medication effects, and risk of self-harm. **Frequency of monitoring**: - Symptom severity (including suicidal ideation) - Co-occurring disorders (including general medical conditions) - Treatment adherence - Availability of social supports - Frequency and severity of side effects with medication

	Lastly, you need to monitor patients for medication side effects and risk of self-harm. **[APA 2010/p17/col2/para2/ln6-13]** Certain adverse events can affect patients' adherence and, thus, their treatment response. Patients also could require medical intervention, which is another reason to monitor them. Understand that treatment nonresponse can be caused by multiple factors—not just nonadherence—and it can take time to determine whether a patient is responding to antidepressant treatment. **[Haddad 2015/p186/Table 1]** The American Psychiatric Association (APA) advises generally waiting 4 to 8 weeks before deciding whether the patient is responding to antidepressant treatment fully or even partially. **[APA 2010/p18/col2/para1/ln4-6]** However, providers can review other treatment options with their patient, such as augmentation with an atypical antipsychotic, if their patient has experienced some improvement within 6 weeks of adequate antidepressant therapy. **[APA 2010/p52/col2/para1]** Reasons beyond nonresponse or partial response that may prompt a provider to consider changing treatment course may include adverse events related to initial or current therapy.		

	Lastly, continue to meet with patients throughout treatment to assess how they are responding, and be sure to administer rating scales at each visit so that you have a documented, measurement-based approach to assessing treatment response. The APA recommends meeting with patients at a frequency that is based on their symptom severity (including suicidal ideation), co-occurring disorders (including general medical conditions), treatment adherence, availability of social supports, and the frequency and severity of side effects with their medication. **[APA 2010/p17/col2/para2 /ln12-18]**		
Scene 2	I hope the lessons from this case help inform your care of patients with MDD going forward by clarifying the important steps in providing appropriate diagnosis and treatment. Thank you for participating in our interactive patient case study and questions. Please remember you can find additional information about MDD that can be beneficial to your practice on NPPsychNavigator.com.	Focus on Tina speaking.	
Closing Graphic		NP Psych Navigator branded graphic that plays at the end of the video.	[Needs to be developed]

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