Screening for Depression in the Primary Care Population

D. Edward Deneke, MD[a,*], Heather E. Schultz, MD, MPH[b], Thomas E. Fluent, MD[a]

KEYWORDS

• Depression • Screening • Suicide • Primary care

KEY POINTS

- Depression is common in the primary care population, and imposes social, financial, and medical costs on patients on families.
- Screening for depression can be useful in the primary care setting if reliable systems of care are in place to ensure adequate treatment and follow-up.
- Use of collaborative care models for depression in the primary care setting have been shown to be a cost-effective means for providing depression-related care, but economic and cultural barriers continue to slow widespread adoption.
- Screening for suicide risk in the primary care population is generally not recommended. However, clinicians should familiarize themselves with the common risk factors for suicide and remain vigilant for patients at increased risk for self-harm.

INTRODUCTION

The *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) defines major depressive disorder (MDD) as a mental health condition characterized by 5 or more of the following symptoms lasting for at least 2 weeks: depressed mood, diminished interest in activities (anhedonia), disordered sleep, fatigue, changes in appetite or changes in weight, persistent feelings of guilt or hopelessness, decreased concentration, psychomotor slowing, and thoughts of suicide; the 2 symptoms of depressed mood and anhedonia are cardinal, and at least 1 must be present for the diagnosis to be made (**Box 1**).[1] When assessing a patient for MDD, these symptoms need to

This article first appeared in Prim Care Clin Office Pract 2014;41(2):399–420.
Conflicts of Interest: None.
[a] Department of Psychiatry, University of Michigan Health System, University of Michigan, 4250 Plymouth Road, Ann Arbor, MI 48109-2700, USA; [b] Inpatient Psychiatry, University of Michigan Hospital and Health Systems, University of Michigan University Hospital, 9C 9150, 1500 East Medical Center Drive, SPC 5120, Ann Arbor MI 48109, USA
* Corresponding author.
E-mail address: edwardde@med.umich.edu

Psychiatr Clin N Am 38 (2015) 23–43
http://dx.doi.org/10.1016/j.psc.2014.11.006 **psych.theclinics.com**
0193-953X/15/$ – see front matter

Box 1
Diagnosing major depressive disorder

Five or more of the following symptoms are present during a 2-week period:

Note: Of the 5 symptoms, at least 1 must be depressed mood or anhedonia; symptoms need to represent a change from the patient's baseline, and be accompanied by an impairment in social or occupational functioning.

- Feeling depressed, sad, or hopeless most of the time (depressed mood)
- Decreased interest in pleasurable activities (anhedonia)
- Change in appetite (increase or decrease) and/or 5% or more change in weight
- Sleeping more or less often than usual
- Frequent feelings of worthlessness or excessive/inappropriate guilt
- Frequent fatigue
- Physical restlessness (psychomotor agitation) or slowed movements (psychomotor retardation)
- Indecisiveness or decreased concentration
- Recurrent thoughts of death or thoughts of suicide

From American Psychiatric Association, American Psychiatric Association DSM-5 Task Force. Diagnostic and statistical manual of mental disorders: DSM-5. 5th edition. Washington, DC: American Psychiatric Association; 2013.

represent a change from the patient's baseline, and must be accompanied by impairment in social or occupational functioning.

Depressive disorders are highly prevalent in the general population and can be found across the age spectrum.[2] The estimated lifetime prevalence of MDD in the United States is approximately 13.2%,[3] with a 12-month prevalence of 6% to 7%.[2] Evidence suggests that upward of three-quarters of those who experience a major depressive episode will experience a subsequent episode,[4] with the mean number of episodes among adults with lifetime MDD being 4.7.[3] Approximately one-third of nonelderly patients[5] and two-thirds of elderly patients[6] are treated in the primary care setting.

Somatic symptoms (eg, headache, back pain, fatigue, and other physical complaints) are frequently found alongside symptoms of depression, often dominating the clinical picture and masking the underlying depressive disorder. This masking can sometimes make an accurate diagnosis more difficult. A 2005 literature review reported that approximately two-thirds of patients with depression present to primary care with primarily somatic complaints, and the presence of somatic complaints correlated with a decrease in the clinician's ability to recognize the depression.[7] Somatic symptoms comorbid with depression have been shown to be more prevalent in certain populations, including those who are pregnant, elderly, poor, incarcerated, and those suffering from other medical issues.[7]

Depression has a significant impact on the lives of the affected population. Given the symptoms of the disorder it should not be surprising that people suffering from depression often experience a decreased quality of life, as well as decreased productivity both at work and at home.[8,9] Depression can also have a negative impact on a person's self-reported global heath rating, whether taken alone or in combination with common chronic health conditions (**Table 1**).[10] In addition to depression's negative impact on health, people with depression have also been shown to have increased mortality rates.[11]