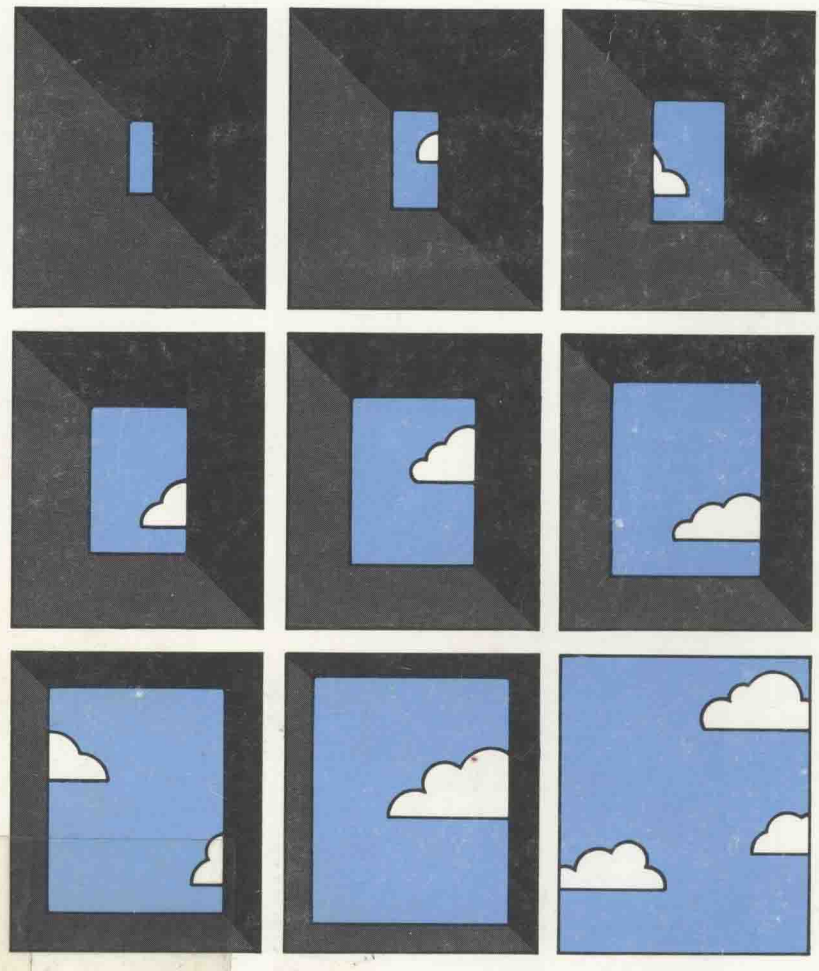
Clinical Practice Guideline
Number 5

Depression in Primary Care:
Volume 1.
Detection and Diagnosis



U.S. Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research

Clinical Practice Guideline
in Primary Care

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Depression in Primary Care:
Volume 1.
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Depression Guideline Panel

U.S. Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research
Rockville, Maryland

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Guideline Development and Use

Guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical conditions. This guideline was developed by an independent, multidisciplinary panel of private sector clinicians and other experts convened by the Agency for Health Care Policy and Research (AHCPR). The panel employed an explicit, science-based methodology and expert clinical judgment to develop specific statements on patient assessment and management for the clinical condition selected.

Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review and field review were undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice. The panel's recommendations are primarily based on the published scientific literature. When the scientific literature was incomplete or inconsistent in a particular area, the recommendations reflect the professional judgment of panel members and consultants.

The guideline reflects the state of knowledge, current at the time of publication, on effective and appropriate care. Given the inevitable changes in the state of scientific information and technology, periodic review, updating, and revision will be done.

We believe that the AHCPR-assisted clinical guideline development process will make positive contributions to the quality of care in the United States. We encourage practitioners and patients to use the information provided in this *Clinical Practice Guideline*. The recommendations may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by the practitioner in light of available resources and circumstances presented by individual patients.

J. Jarrett Clinton, MD
Administrator
Agency for Health Care Policy and Research

Foreword

This *Clinical Practice Guideline* (*Depression in Primary Care: Volume 1. Detection and Diagnosis*; and *Volume 2. Treatment of Major Depression*) was developed with support from the Agency for Health Care Policy and Research (AHCPR) by the Depression Guideline Panel to assist primary care providers (e.g., general practitioners, family practitioners, internists, nurse practitioners, registered nurses, mental health nurse specialists, physician assistants, and others) in the diagnosis of depressive conditions and the treatment of major depressive disorder. The panel hopes that the general principles embodied in these guidelines will also provide a framework for other medical and nonmedical practitioners who assume responsibilities for the recognition and care of depressed persons.

Depression was selected as a topic for guideline development because:

- Depressive disorders are commonly encountered in primary care, as well as in other treatment settings.
- Most depressed patients seek care from primary care practitioners.
- A range of effective treatments are available and commonly provided for these conditions.
- There is a large body of scientific evidence on which to base these guidelines.
- Practice surveys indicate that improvements are needed in primary care practitioners' ability to recognize and treat depressive disorders.
- Depressive disorders result in significant morbidity and mortality.
- Depressive disorders have a high prevalence in the general population.

These guidelines are not aimed at rendering selected procedures reimbursable or not reimbursable; that decision logically falls to third-party payors. Nor do they specify which professionals should conduct which procedures, an issue addressed by licensing/privileging bodies. Should the recommended steps in the diagnosis or treatment of depression fall outside the expertise of the practitioner, he or she should seek a consultation with, or a referral to, someone knowledgeable in these matters.

The Depression Guideline Panel is composed of experts from diverse disciplines, as well as a consumer representative. The guidelines are based on systematic literature reviews commissioned by the panel and conducted by experts in numerous areas relevant to depression, with special attention to the clinical issues most pertinent to the diagnosis and treatment of depression in primary care. Guideline development also included input from a broad range of professional and consumer organizations and individuals. The guidelines have undergone peer review and field review with intended users in clinical sites to evaluate the document both conceptually and operationally. For practitioners, patients, and their families, we hope these guidelines provide a richer understanding of depression. For researchers, we hope we have identified key areas of uncertainty for further investigation.

Research develops knowledge. The synthesis and specification of current knowledge do not mitigate (in fact increase) the need for careful translation and application of this knowledge. Practitioners translate and apply that knowledge. However, in many cases they have to act without sufficient scientifically based data.

The panel's inferences as to what is optimal patient care are not expected to apply to all patients or situations. Knowledge developed through research can only provide a starting point for approaching a particular patient. Algorithms are not applicable in every case, and often provide only coarse road maps for managing patients. Adaptation of guidelines to particular patients requires practitioners to have skill, training, knowledge, and experience, and patients and families to have patience, understanding, trust, and knowledge.

This is the first edition of the *Clinical Practice Guideline*. We plan to revise the guidelines based on new knowledge, empirical evaluation of their impact on patient outcome, and critiques from users. The panel welcomes comments and suggestions for use in the next edition. Please send written comments to Director, Office of the Forum for Quality and Effectiveness in Health Care, AHCPR, Executive Office Center, Suite 401, 2101 East Jefferson Street, Rockville, MD 20852.

Depression Guideline Panel

Abstract

Despite the high prevalence of depressive symptoms and full major depressive episodes in patients of all ages, depression is underdiagnosed and undertreated by primary care and other nonpsychiatric practitioners, who are, paradoxically, the providers most likely to see these patients initially. Primary mood disorders include both depressive (unipolar) and manic-depressive (bipolar) conditions. Major depressive disorder (sometimes called unipolar depression) is characterized by one or more episodes of mild, moderate, or severe clinical depression without episodes of mania or hypomania (i.e., low-level mania).

Depression may co-occur with nonpsychiatric medical disorders or with other psychiatric disorders; it may also be brought on by the use of certain medications. Major risk factors for depression include a personal or family history of depressive disorder, prior suicide attempts, female gender, lack of social supports, stressful life events, and current substance abuse. The social stigma surrounding depression is substantial and often prevents the optimal use of current knowledge and treatments. The cost of the illness in pain, suffering, disability, and death is high. Given the strong evidence that treatments are effective, third-party coverage for the diagnosis and treatment of depression should be equal to that available for other medical disorders.

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Dedication

Depression in Primary Care is dedicated to the memory of Gerald L. Klerman, MD, who passed away while serving as one of our scientific reviewers. Dr. Klerman, in his lifetime of research, teaching, and clinical work, and in his years of government service as the administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Washington, DC (1977–80), worked diligently to develop scientifically based information to help clinicians better serve their patients. We remain indebted to him for his contribution to our panel and to the field of psychiatry in general.

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Acknowledgments

These guidelines were developed with the help of many dedicated contributors. The reviewing consultants for treatment issues searched and compiled a vast literature. The scientific reviewers critiqued the reviews and several drafts of the guideline document. A variety of professional organizations, patient groups, and individuals provided peer review and pilot-tested the guidelines. Finally, critical administrative, scientific, technical, and secretarial support made the entire effort feasible. A full listing of all those involved in this effort appears in the lists of contributors at the end of this document.

Special recognition goes to David Schriger, MD, MPH, UCLA School of Medicine, Los Angeles, California, panel methodologist, who critiqued all reviews and drafts of the guidelines and helped to conceptualize the overall approach, specify clinical issues, and organize the relevant data. Extraordinary credit also goes to Madhukar Trivedi, MD, Instructor, Department of Psychiatry, University of Texas Southwestern Medical Center, Dallas, Texas, scientific assistant to the chair, who helped to conceptualize the overall approach, conduct all meta-analyses, and review most studies of medication efficacy. Without him, this project would not have been possible.

Contents

Tables

Figures

Executive Summary

Up to one in eight individuals may require treatment for depression during their lifetimes. The direct costs of treatment for major depressive disorder combined with the indirect costs from lost productivity are significant, accounting for approximately $16 billion per year in 1980 dollars. Regrettably, only one-third to one-half of those with major depressive disorder are properly recognized by practitioners. Fewer than one-third of patients with bipolar disorder are in treatment.

Despite the high prevalence of depressive symptoms and major depressive episodes in patients of all ages, depression is underdiagnosed and undertreated by primary care and other nonpsychiatric practitioners, who are, paradoxically, the providers most likely to see these patients initially. Depression may occur concurrently with other nonpsychiatric general medical disorders or with other psychiatric disorders; it may also be brought on by the use of certain medications. Major risk factors for depression include a personal or family history of depressive disorder, prior suicide attempts, female gender, lack of social supports, stressful life events, and current substance abuse. The social stigma surrounding depression is substantial and often prevents the optimal use of current knowledge and treatments. The cost of the illness in pain, suffering, disability, and death is high.

Once identified, depression can almost always be treated successfully, either with medication, psychotherapy, or a combination of both. Not all patients respond to the same therapy, but a patient who fails to respond to the first treatment attempted is highly likely to respond to a different treatment.

This *Clinical Practice Guideline* focuses on the diagnosis of depressive disorders, particularly in outpatients. Depression is defined according to the current U.S. standard diagnostic system in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (*DSM-III-R*), published by the American Psychiatric Association.

A clinical depression or a mood disorder is a syndrome (i.e., a constellation of signs and symptoms) that is *not* a normal reaction to life's difficulties. Depressive and other mood disorders involve disturbances in emotional, cognitive, behavioral, and somatic regulation. Depressive disorders should not be confused with the depressed or sad mood that is a normal response to specific life experiences—particularly losses or disappointments. These responses are transient and are not associated with significant functional impairment. A sad or depressed mood is only one of the many signs and symptoms of clinical depression. In fact, the mood disturbance may include apathy, anxiety, or irritability rather than or in addition to sadness; further, the patient's interest or capacity for pleasure or enjoyment may be markedly reduced.

Primary mood disorders include both depressive (unipolar) and manic-depressive (bipolar) conditions. Major depressive disorder (sometimes called unipolar depression) is characterized by one or more episodes of mild, moderate, or severe clinical depression without episodes of mania or hypomania (i.e., low-level mania). By definition, major depressive episodes last at least 2 weeks (typically much longer) in both major depressive and bipolar disorders. A sad mood or a significant loss of interest is required, along with several associated signs and symptoms, to warrant a diagnosis of a major depressive episode. A major depressive episode can occur as part of a primary mood disorder (e.g., major depressive or bipolar disorder), as part of other nonmood psychiatric conditions (e.g., eating, panic, or obsessive-compulsive disorders), in association with drug or alcohol intoxication or withdrawal, as a biologic consequence of various general medical conditions (secondary mood disorders), or as a consequence of selected prescribed medications.

Unipolar forms of primary mood disorders are divided into three groups:

- Major depressive disorder consists of one or more episodes of major depression with or without full recovery between episodes.
- Dysthymic disorder features a low-grade, more persistent depressed mood and associated symptoms for at least 2 years, during which a major depressive episode has not occurred. Over extended followup, many patients with this disorder develop episodes of major depression.
- Depression not otherwise specified (DNOS) is a residual category for patients with symptoms and signs of depression that do not meet the formal diagnostic criteria for either major depressive or dysthymic disorder.

Bipolar disorders are recurrent, episodic conditions characterized by a history of at least one manic or hypomanic episode. Bipolar disorders have been grouped into three types:

- Bipolar I disorder features at least one manic episode along with (nearly always) major depressive episodes.
- Bipolar disorder not otherwise specified is a residual category that includes bipolar II disorder, a condition characterized by recurrent episodes of major depression along with hypomanic (but not full-blown manic) episodes, as well as other forms that do not meet formal criteria for bipolar I or cyclothymic disorder.
- Cyclothymic disorder is characterized by numerous periods of mild depressive symptoms insufficient in duration or severity to meet the criteria for major depressive episodes interspersed with hypomanic episodes; it lasts at least 2 years by definition. Patients with this condition are rarely free of mood symptoms.

Major depressive disorder may begin at any age, but it most commonly begins in the 20s to 30s. Symptoms develop over days to weeks. Some persons have only a single episode, with a full return to premorbid

functioning. However, more than 50 percent of those who initially suffer a single major depressive episode eventually develop another. In these cases, the diagnosis is revised to recurrent major depressive disorder.

The course of recurrent major depressive disorder is variable. In some patients, the episodes are separated by many years of normal functioning without symptoms. For others, the episodes become increasingly frequent with greater age. Major depressive episodes nearly always reduce social, occupational, and interpersonal functioning to some degree, but functioning usually returns to the premorbid level between episodes if they remit completely. Major depressive episodes may end completely or only partially. If the latter occurs:

- The likelihood of a subsequent episode is higher.
- The need for longer term treatment is increased.
- The prognosis following subsequent episodes is for continuing poor or partial interepisode recovery.
- The need for treatment with both medication and psychotherapy may be greater.

The point prevalence for major depressive disorder in the Western industrialized nations is 2.3 to 3.2 percent for men and 4.5 to 9.3 percent for women. The lifetime risk for major depressive disorder is 7 to 12 percent for men and 20 to 25 percent for women. Prevalence rates are unrelated to race, education, income, or civil status. Risk factors for major depressive disorder include female gender, a history of depressive illness in first-degree relatives, and prior episodes of major depression. The point prevalence of major depressive disorder seen in primary care outpatient settings ranges from 4.8 to 8.6 percent.

Three subgroups of major depressive disorder based on cross-sectional symptom features—psychotic (with delusions or hallucinations), melancholic, and atypical—may have implications for treatment selection. Two subgroups based on course features—seasonal pattern and postpartum onset—have prognostic utility; the seasonal type may also suggest the specific therapeutic option of light therapy.

The essential feature of dysthymic disorder is a chronic mood disturbance (sadness in adults; sadness and, possibly, irritability in children and adolescents) present most of the time for at least 2 consecutive years (1 year for children and adolescents). The differentiation between dysthymic disorder and major depressive disorder can be difficult. Their symptoms are similar, differing only in duration and severity. Data from the large, multisite Epidemiologic Catchment Area (ECA) Study indicate a lifetime rate of dysthymic disorder of 4.1 percent for women and 2.2 percent for men.

Depression not otherwise specified identifies mood conditions with depressive symptoms that do not meet either the severity or the duration criteria for dysthymic, major depressive, or bipolar disorders. An analysis of the ECA Study data showed that 11.0 percent of subjects met the

criteria for DNOS. The point prevalence of DNOS in primary care outpatients is 8.4 to 9.7 percent.

Bipolar disorders classically feature episodes of major depression interspersed with episodes of mania and/or hypomania. Manic episodes are distinct periods of persistently elevated, abnormally expansive, or irritable mood with other associated symptoms, such as inflated self-esteem and decreased need for sleep. Manic episodes markedly impair occupational, social, and interpersonal function and often require hospitalization to prevent harm to self or others. Hypomanic episodes are similar to, but milder than, manic episodes. Some patients with bipolar I (with mania) or bipolar II (with hypomania) disorder exhibit a "rapid cycling" pattern, in which they experience four or more mood episodes per year. The prognosis is poorer for these rapid cyclers.

The mean age at onset of the bipolar disorders is in the early 20s. The sexes do not differ in age at onset. The morbidity and mortality associated with bipolar I disorders are high. Ten to 15 percent of untreated patients commit suicide, which is 15 to 20 times the suicide rate in the general population. Bipolar I disorder affects men and women equally. It has a lifetime prevalence of 0.8 to 1.2 percent. Bipolar I disorder occurs at much higher rates in first-degree relatives of people with this condition than in the general population.

Psychoactive substances, such as cocaine and amphetamines; head trauma; multiple sclerosis and other neurologic diseases; endocrinopathies; and some other general medical disorders can produce secondary manic and hypomanic episodes similar to those in primary bipolar disorder. Antidepressant medications in persons with a genetic disposition to bipolar disorder can precipitate manic or hypomanic episodes as well.

Cyclothymic disorder features numerous, alternating hypomanic and mild depressive periods, which last days to weeks and are nearly continuous. There are few truly symptom-free periods. The symptoms fluctuate, but never reach the severity/duration criteria for the diagnosis of major depressive or manic episodes. The lifetime prevalence of cyclothymic disorder is 0.4 to 1.0 percent.

The signs and symptoms of major depressive disorder are more similar than different in children, adolescents, and geriatric patients; in men and women; and in all ethnic groups.

Patients with depressive symptoms or in a major depressive episode may also be suffering from another, nonmood psychiatric disorder. When the formal major depressive syndrome is associated with another psychiatric condition, the decision of which to treat first rests on the nature of the nonmood disorder. If the nonmood disorder is causing the mood symptoms, then it should usually be treated first. If it is an eating or obsessive-compulsive disorder, that is usually the initial treatment target. If the nonmood disorder is generalized anxiety or personality disorder, the major depressive disorder is the first treatment target, because patients with one of these two nonmood conditions are not typically excluded from