Research

Clinical Brief: Depression Screening and Treatment

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ABSTRACT

Depression is a condition seen frequently in primary care practice as well as by practitioners who treat patients with chronic pain. The U.S. Preventive Services Task Force recommends that all adults be screened for depression and those who screen positive for depression be appropriately referred for additional assessment and management. Cognitive behavioral therapy, pharmacotherapy, physical activity and mindful exercise are all accepted approaches to treatment of depression.

Epidemiology

Depression, formally referred to as *major depressive disorder* (MDD), has a lifetime prevalence of 13%. When screened at a primary care visit, about 43% of patients who suffer from MDD report suicidal ideation within the past week.[1]

Depression is ranked 1st for causes of years of life lived with a disability (YLD) and 3rd for quality-adjusted life years (QALY) in older adults. [2] Depression may increase the risk of physical disability, coronary heart disease and diabetes mellitus and mortality. It is also a major risk factor for suicide. Depression has a significant economic burden; direct and indirect costs were estimated to be $83 billion in 2000.[2]

Assessment of Depression in Primary Care

Although there are a number of screening tools available to assess depression, there is little evidence that one is superior to another.
The U. S. Preventive Services Task Force (USPSTF) recommends that these two questions are an effective screening tool:[3]

"Over the past 2 weeks, have you felt down, depressed, or hopeless?" and
"Over the past 2 weeks, have you felt little interest or pleasure in doing things?"

A positive answer to either question warrants further assessment.

Any positive screening test indicates the need for a full diagnostic interview using standard criteria to diagnose depression. Screening alone does not improve health outcomes; it must be followed up with case management.[1] Thus it is recommended that clinicians have available appropriate staff support, or a referral system in place, to enable such follow-up. Such support or referral system would be comprised of clinical staff trained to provide direct care of depressed patients, such as case management, support or coordination, or mental health treatment.[3] The optimal interval for depression screening has not been established.

Effective Interventions

Psychotherapy and Antidepression Medication

Both psychotherapy and antidepressant medications, alone or in combination, have been shown to be effective in treating depression, and have become the standard approach. The medications found to be effective are: selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), and more recently, other non-SSRI "second generation" antidepressants.

Adverse effects of antidepressant medications. The most important adverse effects documented in the most recent systematic review conducted for the USPSTF are: 1) increased risk for suicidal behavior (although not actual incidence of suicide) in young adults (ages 18-29); and 2) increased risk for upper gastrointestinal bleeding in older adults.[2, 3]

Physical Activity and Mindful Exercise

Physical activity. Physical activity, in general, is associated with improvements in depressive symptoms, as well as showing a consistent association with improved health, better cognitive function and psychological well-being.[4] A Cochrane review indicated that mixed aerobic and resistance exercise was more beneficial than aerobic alone.[5] It also suggested that more frequent exercise (30 minutes duration, 3-5 times per week) compared to less frequent (weekly exercise only) resulted in greater improvement in depressive symptoms.[5, 6] For mild depression, national guidelines recommend a structured, supervised program of physical activity 3 times weekly (45-60 minutes/session) for 10-14 weeks.[7]

"Mindful Exercise"—Hatha Yoga, Tai Chi, Qigong. A 2008 systematic review indicated beneficial effects on depressive symptoms of meditative/mindful exercises including Hatha yoga, tai chi and qigong.[6, 8]

Relationship to Manual Care Providers

The USPSTF recommends that primary care providers screen for depression.[3] Patients with chronic musculoskeletal pain may make primary contact with manual care providers as well. [9] Since depression is 3-4 times more common in people with chronic low back pain than it is in the general population,[10] chiropractors, physical therapists, massage therapists and other providers of manual therapies are most likely frequently seeing depressed patients, whether or not they are aware of it. For example, the *Practice Analysis of Chiropractic* survey does not specifically ask chiropractors about depression in their patients, and reports that chiropractors only rarely see patients with psychological disorders.[11] Providers of manual care should therefore be vigilant in identifying patients with depression and ensuring that they have access to effective treatment.

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