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Faces of Depression in Primary Care

Depression Symptomology and Functional Outcomes from Early to Late Adulthood

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Our Featured Speaker

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Objectives

Discuss the role of the primary care provider in identifying, assessing, and managing major depressive disorder across the lifespan

Describe the complexities of identifying major depressive disorder in the primary care setting

Highlight the burden of functional impairment in major depressive disorder and review the role that depression treatment has on functional improvements

A High Proportion of Individuals with Depression are Treated by their Primary Care Physician

- Depression is common and often debilitating[1,2]
  - Affects ~8.4% of American adults in a given year
  - Projected to be the 2nd leading contributor to the global burden of diseases worldwide by 2030
- Depression is highly prevalent in the primary care setting[3]
  - In a large international study, primary care patients seeking general health services were screened for psychological symptoms and 10% received an ICD-10 diagnosis of current depression
- ~ 50% of the depression-related provider visits that occur yearly in the US are in the primary care setting[4]
- Depression is one of the most common conditions treated in primary care[5]
  - ~10% of all primary care visits are depression related
  - PCPs tend to rate patients with depression as more difficult to evaluate and treat compared to those without depression

1. National Institute of Mental Health (NIMH) website accessed Feb 7, 2022 at: https://www.nimh.nih.gov/health/statistics/major-depression.shtml
2. Mathers, C. D., et al. *PLoS Med*, 2006; 3(11): e442.
3. Üstün, T.B. Mental Illness in general health care: an international study: John Wiley & Sons; 1995.
4. Narrow, W. E., et al. *Arch Gen Psychiatry*, 1993; 50: 95-107.
5. Unützer, J., et al. *Prim Care*, 2012; 39(2): 415-431.

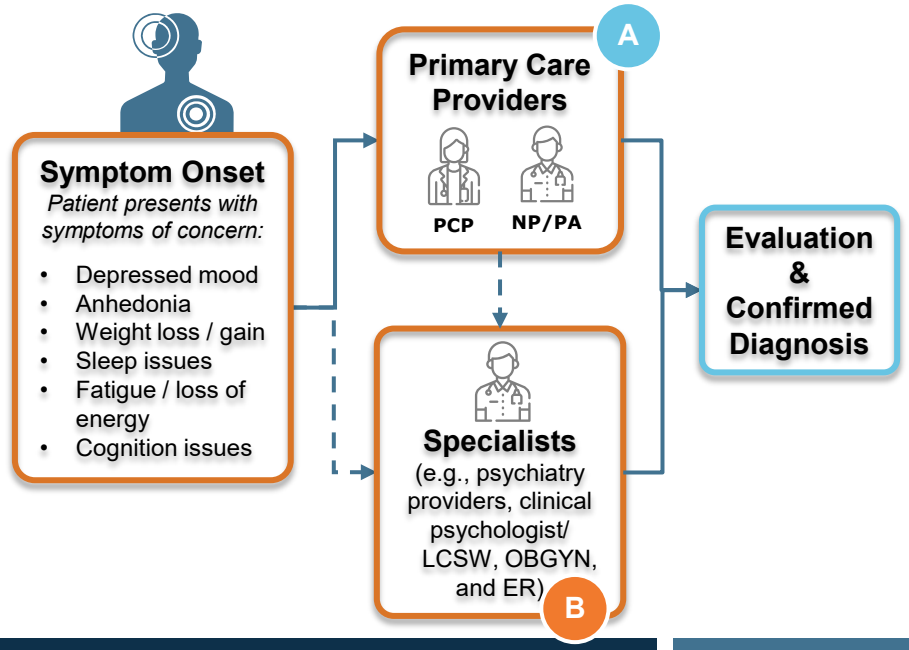
Recognition of Depression in Primary Care is Suboptimal

Interventions to Improve Detection[1]

- Implementation of guidelines
  - US Preventative Services Task Force recommends depression screening for all adults during PCP visits
- Clinician education
- Screening with feedback and disclosure of results
- Case management
- Collaborative care/Stepped care (primary care providers with mental health specialist)
- Chronic disease management

Screening Instruments for Depression[2]

- Patient Health Questionnaire (PHQ)-2 and PHQ-9
- World Health Organization Well-Being Index (WBI-5)
- Beck Depression Inventory (BDI)
- Hamilton Depression Rating Scale (HAM-D)



1. Habtamu, K., et al. *Systematic Reviews*, 2023; 12: 25.
2. Ebell, M. H., et al. *Am Fam Physician*, 2008; 78(2): 244-246.

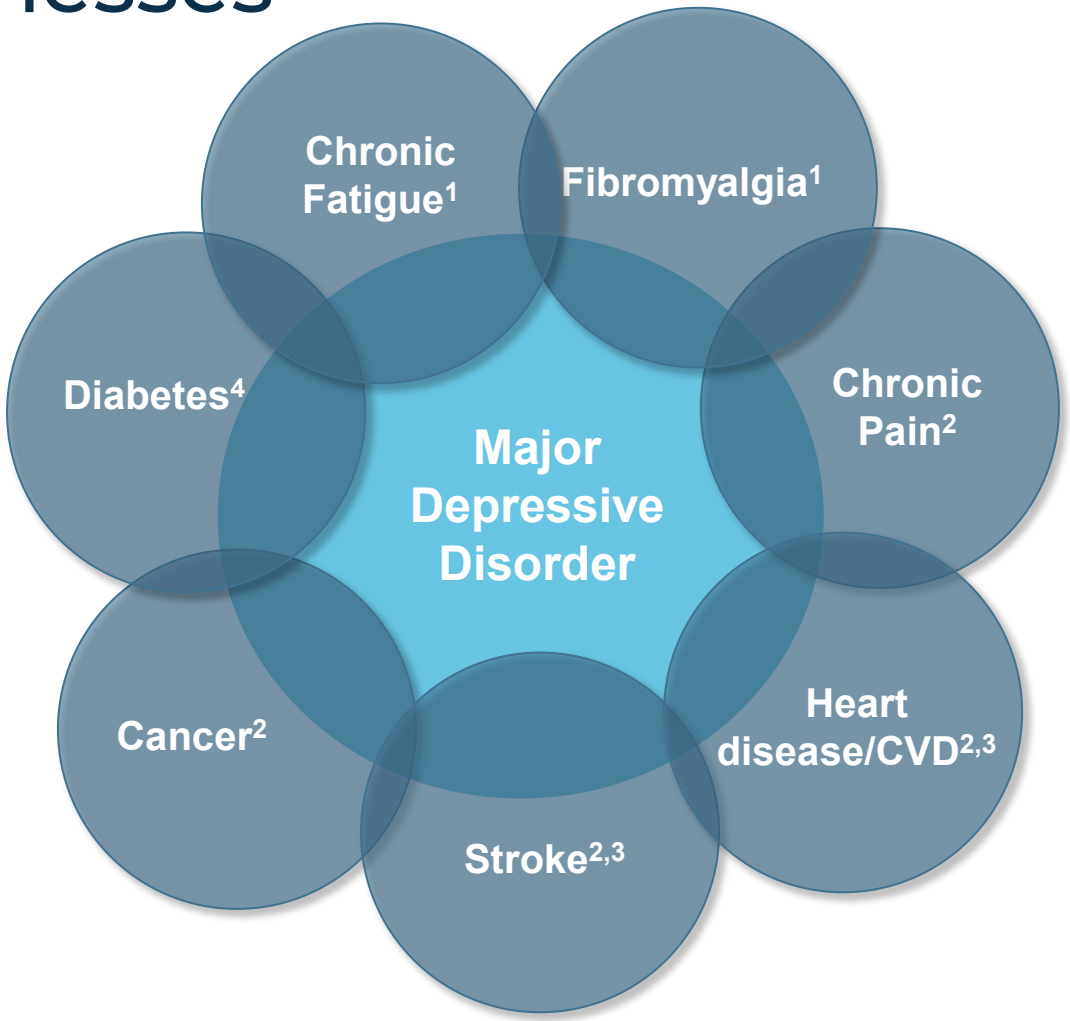
Interaction of Depression with other Chronic Physical Illnesses

Major depression is associated with high numbers of medically unexplained symptoms:[1]

- Pain
- Fatigue
- Poor general health outcomes

Untreated depression is independently associated with:[1]

- Morbidity
- Delayed recovery and negative prognosis among those with medical illness
- Elevated premature mortality associated with comorbid medical illness
- Increased healthcare costs



1. Unützer, J., et al. *Prim Care*, 2012; 39(2): 415-431
2. Goodwin G., et al. *Dial Clin Neuro*, 2006; 8(2): 259-265.
3. Kang, H. J., et al. *Chonnam Med J*, 2015; 51: 8-18.
4. Mezuk, B., et al. *Diabetes Care*, 2008; 31: 2383-2390.

Depression in Older Adults may be Particularly Difficult to Recognize

- Global prevalence of depression in older adults is 28.4%[1,2]
  - Late-onset depression: ~5%
- 5-10% of older adults seen in primary care settings have clinically significant depression[3]
- Depressive symptoms may be dismissed or underreported due to[4]:
  - Comorbid medical conditions
  - Concomitant medications
  - Cognitive problems associated with normal aging
- Late-life depression is often accompanied by:
  - Cognitive impairment[5]
  - Functional decline[6]

1. Hu, T., et al. *Psychiatry Research*, 2022; 311:114511. doi.10.1016/j.psychres.2022.11.4511.
2. Lozupone, M., et al. *European Psychiatry*, 2014; 29(1):
3. Lyness, J. M., et al. *J Gen Intern Med*, 1999; 14: 249-254.
4. Alexopoulos, G. S. *Lancet*, 2005; 365(9475): 1961-70.

Functional Impairment is a Core Feature of Depression

- Functional impairments associated with depression result in social and occupational impairments that disrupt work, school, leisure, family life activities and family responsibilities[1]
- Among survey of respondents with 12-month MDD[2]
  - 97% reported some level of functional impairment
  - 60% reported severe or very severe impairment based on the Sheehan Disability Scale (SDS)
- Psychosocial functioning ↔ Depressive symptoms[1]
  - Neuropsychological mechanisms[3]
- Impaired functioning is a predictor of subsequent depression relapse[4]

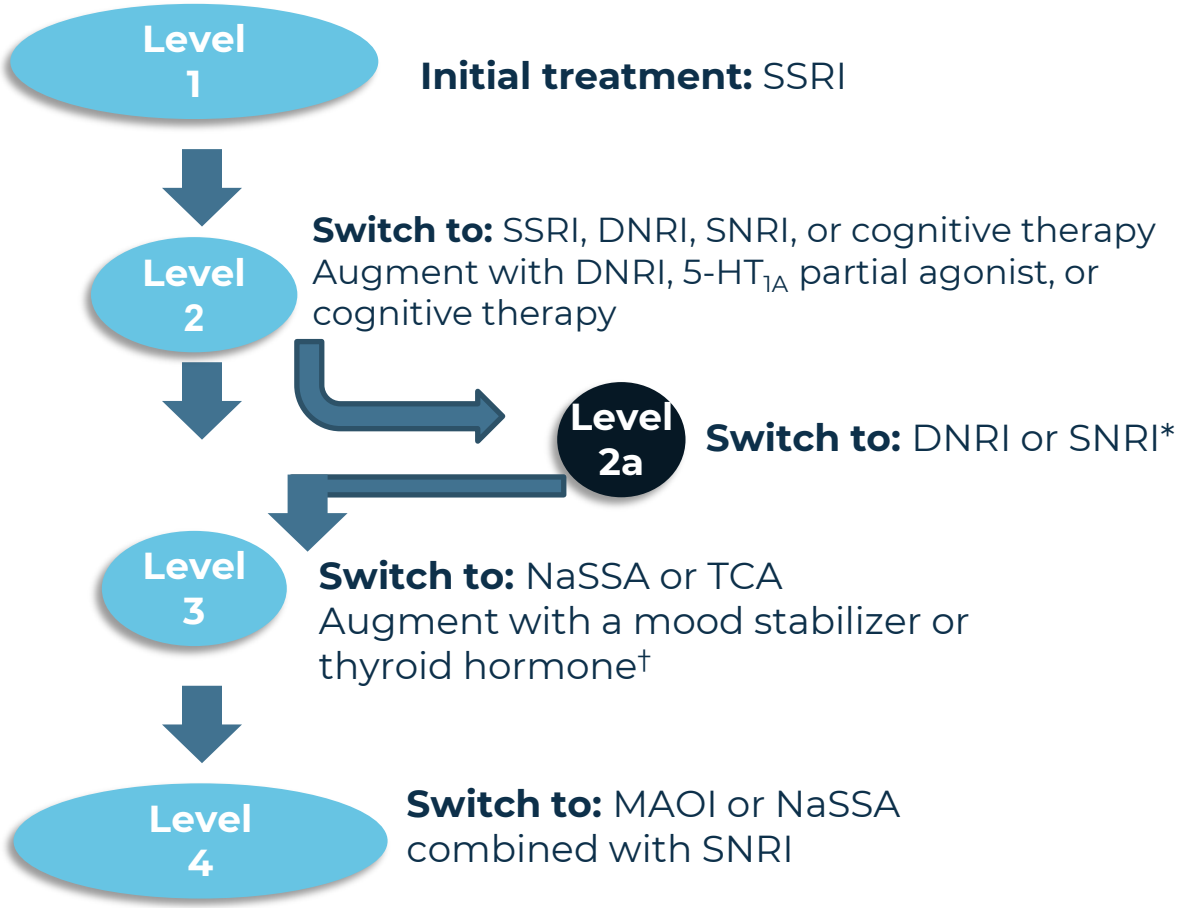
Assessment of Functional Impairment[1]

- Sheehan Disability Scale (SDS)
- Global Assessment of Functioning (GAF)
- WHO Disability Assessment Schedule (DAS 2.0)
- Short-Form Health Survey (SF)
- Social Adjustment Scale Self-Report (SAS-SF)

- **Functional recovery is critical for individuals to achieve and remain in remission of MDD and return to productive and fulfilling lives[1]**
  - Functional remission is SDS ≤6
- Functional recovery often lags behind symptomatic improvement[1]

1. Sheehan, D. V. , et al. *Journal of Affective Disorders*, 2017; 215: 299-313.
2. Kessler, R. C., et al. *JAMA*, 2003; 289: 3095-3105.
3. Yang, H., et al. *Frontiers in Psychiatry*, 2022; 13:915689. doi: 10.3389/fpsyt.2022.915689.
4. IsHak, W., et al. *J Affect Disord.* 2013; 151(1): 59-65.

Partial Response with First-line Antidepressants is Associated with Lower Levels of Functionality



- After 12-weeks of treatment, patients were classified as[1,2]:
  - Remitters: QIDS-SR ≤ 5; n=943 (33%)
  - Partial responders: QIDS-SR > 5 and ≥ 25% reduction from baseline; n=1069 (37%)
  - Non-responders: QIDS-SR > 5 and < 25% reduction from baseline; n=854 (30%)
- All functional measures (SF-12, Q-LES-Q, WSAS, and WPAI) were significantly different across the three response groups at baseline and end of Level 1 treatment[2]
- **Compared to those who achieved remission, partial responders had different levels of response on measures of**[2]:
  - Quality of life
  - Work productivity
  - Social adjustment

*Only for those who failed cognitive therapy; †Only with DNRI, SSRI, or SNRI.

Note. DNRI=dopamine and norepinephrine reuptake inhibitor; MAOI=monoamine oxidase inhibitor; NaSSA=noradrenergic and specific serotonergic antidepressant; SNRI=serotonin norepinephrine reuptake inhibitor; SF-12, Short-Form Health Survey; SSRI=selective serotonin reuptake inhibitor; STAR*D=Sequenced Treatment Alternatives to Relieve Depression; TCA=tricyclic antidepressant; QIDS-SR, Quick Inventory of Depressive Symptomatology-Self Report; Q-LES-Q, Quality of Life Enjoyment and Satisfaction Questionnaire; WPAI, Work Productivity and Activity Impairment questionnaire; WSAS, Work and Social Adjustment Scale.

1. Rush AJ et al. *Am J Psychiatry*. 2003;160(2):237.
2. Dennehy, E. B., et al. *J. Psychiatr. Pr.* 2014; 20: 178-187.

Commonly Reported Unresolved Symptoms

Why Do They Matter?

- Some unresolved symptoms are identified as especially disruptive to global functioning[1-4]

Low energy

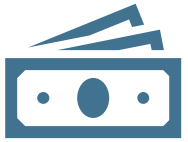
Insomnia

Concentration/ memory problems

- Patients with unresolved symptoms[5]:

More likely to experience a chronic course of illness

Less likely to recover over time



Experience increased psychosocial and socioeconomic impairment[2]

- Some unresolved symptoms are identified as independent predictors of MDD recurrence[2]

Insomnia

Sleep disturbances

Anxiety

Some Commonly Reported Unresolved Symptoms in patients achieving remission with an SSRI

Symptom	% reporting (n=943)
Anxiety[3,*]	78.2
Sleep disturbances[4]	71.7
Appetite/weight disturbances[4]	35.9
Sad mood[4]	27.1
Hypersomnia[4]	24.0
Energy[4]	22.5
Concentration/decision-making[4]	20.9

*Anxiety data originates from a different study (n=624).

1. Saltiel PF, et al. *Neuropsychiatr Dis Treat.* 2015;11:875-888. 2. Israel JA. *Pharmaceuticals (Basel).* 2010;3(8):2426-2440. 3. Romera I, et al. *BMC Psychiatry.* 2013;13:51. 4. Nierenberg AA, et al. *Psychol Med.* 2010;40(1):41-50.
5. Jackson WC, et al. *J Clin Psychiatry.* 2020;81(3):OT19037BR2.

Practice Guidelines and Recommendations Support Augmentation of ADTs[1-6]

SOME CLINICAL EVIDENCE SUPPORTS AUGMENTING REUPTAKE INHIBITORS WITH DIFFERENT DRUG CLASSES AND PSYCHOTHERAPY

Adjunctive Treatment	APA[1]	NICE[2]	BAP[3]	WFSBP[4]	CANMAT[5]
Antipsychotics	●	●	●	●	●
Mood stabilizers	●	●	●	●	●
Benzodiazepines	●	●		●	
Psychotherapy	●		●	●	●

Clinical confidence

● Substantial ● Moderate ● Low ● None

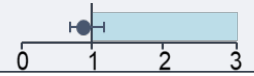
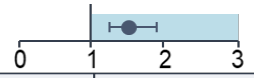
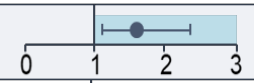
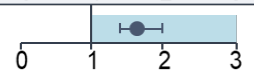
APA=American Psychiatric Association. BAP=British Association for Psychopharmacology. CANMAT=Canadian Network for Mood and Anxiety Treatments. NICE=National Institute for Health and Care Excellence. WFSBP=World Federation of Societies of Biological Psychiatry.

1. American Psychiatric Association. 3rd ed. American Psychiatric Association; 2010. 2. National Collaborating Centre for Mental Health (UK). British Psychological Society; 2010. 3. Cleare A, et al. *J Psychopharmacol.* 2015;29(5):459-525. 4. Bauer M, et al. *World J Biol Psychiatry.* 2013;14(5):334-385. 5. Kennedy SH, et al. *Can J Psychiatry*. 2016;61(9):540-560. 6. Parikh SV, et al. *Can J Psychiatry*. 2016;61(9):524-539.

For Unresolved Symptoms: Augmentation with Atypical Antipsychotics is More Effective than Monotherapies

- In a meta-analysis of 11 RCTs consisting of 3341 patients with MDD:[1]
  - AAP augmentation showed superior efficacy compared to monotherapy
  - Effect size positively correlated with severity of treatment-resistant depression

REMISSION RATES

	AAP n/N	Monotherapy n/N	Odds Ratio* (95% CI)	
Non-TRD	32/49	39/53		0.89 (0.69-1.14)
TRD 1	248/753	85/434		1.55 (1.25-1.92)
TRD 2	54/198	34/203		1.63 (1.11-2.38)
TRD 2-4	281/931	127/720		1.68 (1.40-2.03)

- With regards to quality of life and functioning, certain atypical antipsychotics have been shown to be significantly more beneficial than placebo[2]
  - With small to moderate effect sizes (g: .22-.49)[3]

*Odds ratio >1=superior to placebo.
CI=confidence interval; n/N, number of patients achieving remission/total number of patients. AAP=Atypical Antipsychotic. TRD=treatment-resistant depression (number after indicates number of antidepressant treatment failures within the current depressive episode). RCT=randomized controlled trial.

1. Wang, H. R. et al. *Int J Neuropsychopahrmacology*, 2015; 18(8):pyv023.
2. Zhou, X. et al. *Int J Neuropsychopharmacology*, 2015; 18(11):pyv060.
3. Spielmans, G. I. et al. *PLoS Med*. 2013; 10(3): e1001403.

Functional Recovery: A Framework For Treatment

- Acute phase
- Obtaining a response

Symptom Relief

Return to Normal Function

- Continuation phase
- Remission achievement

- Maintenance phase
- Institute new strategies &address vulnerabilities

Development of Resilience

Support for Personal Recovery & Quality of Life

Exploration of quality of life across a range of domains (general, illness-specific, etc.)

Aim of living well despite illness

- 2019-2020 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults emphasize full functional recovery and integration[1]
- Quality of Life as a patient-reported outcome serves as a compass for collaborative treatment planning[2]

1. 2019–2020 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults (2020). The University of South Florida, Florida Medicaid Drug Therapy Management Program sponsored by the Florida Agency for Health Care Administration.
2. Mahli et al. 2020 *Australian & New Zealand Journal of Psychiatry* 2021, Vol. 55(1) 7–117

Summary

- Major Depressive Disorder (MDD) is a chronic, heterogenous disorder often associated with multiple medical and/or psychiatric comorbidities, as well as lingering unresolved symptoms which may have significant impact to overall functioning and quality of life
- Depression, including MDD, may present differently based on a number of factors including age, and these factors may need to be considered with respect to treatment modalities
- A substantial proportion of patients experiencing depression symptoms or living with major depressive disorder are seen in the primary care setting
- Primary care clinicians are in a unique position to intervene for individuals with depression, perhaps at an earlier stage of their illness, to increase chances for remission, recovery, and enhance functional outcomes
- Moving forward, primary care clinicians should empower themselves with a strong working knowledge of the different presentations of depression, available treatment options (including augmentation strategies) and align with patients to identify unresolved symptoms as early as possible to increase remission and recovery levels, as well as improve functional outcomes long-term

Closing

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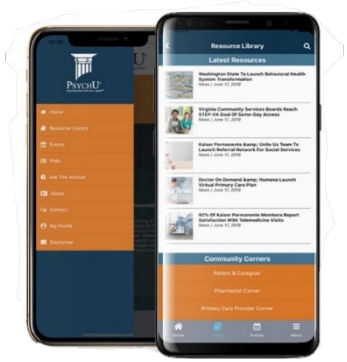

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