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Faces of Depression in Primary Care

Depression Symptomatology and Functional Outcomes from Early to Late Adulthood

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Objectives

Learn about the role of the primary care provider in identifying, evaluating, and managing MDD across the lifespan

1

Discuss the complexities of identifying MDD in the primary care setting

2

Showcase the burden of functional impairment and unresolved symptoms in MDD

3

Review clinical considerations for management of MDD, including the impact of treatment on patient functioning

4

MDD=major depressive disorder.

Polling Question

In your clinical experience, what proportion of your patients seen in primary care have major depressive disorder?

A. Very few (<20%)

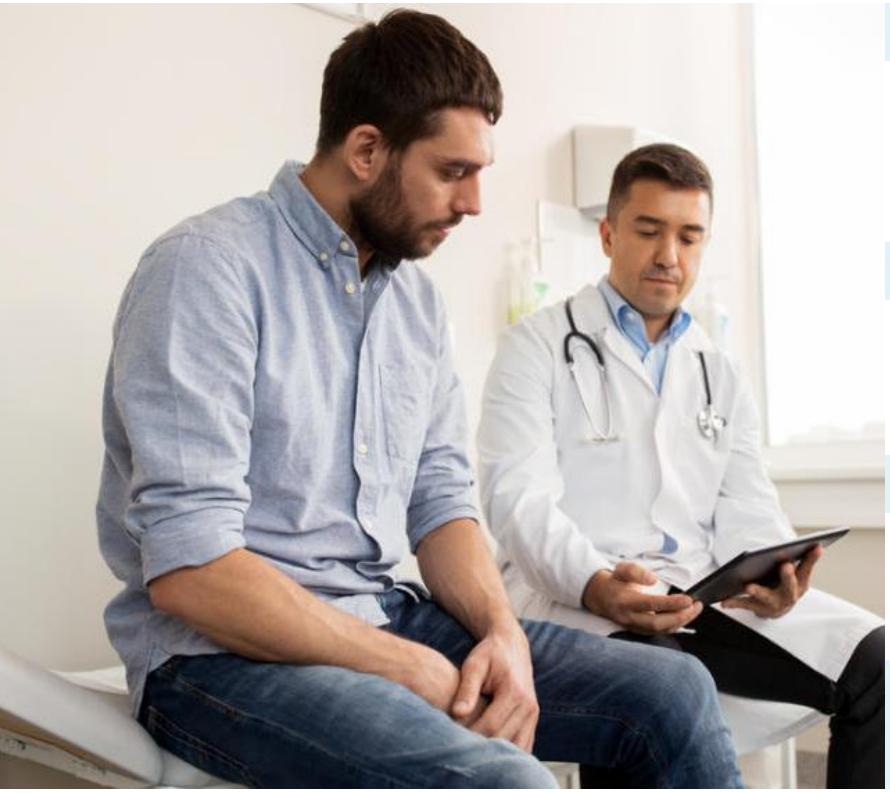
B. Some (~20-40%)

C. About half (~40-60%)

D. Most (~60-80%)

E. Almost all (>80%)

A High Proportion of Individuals with Depression are Treated by Their Primary Care Provider



MDD is common and often debilitating[1]

- One of the most common mental disorders in the US
- Can result in severe impairments that interfere with/limit one's ability to carry out major life activities

Depression is highly prevalent in the primary care setting[2]

- In a large international study, among primary care patients seeking general health services were screened for psychological symptoms, ~30% received an ICD-10 diagnosis of current depression

Depression is one of the most common conditions treated in primary care[3]

- ~50% of depression-related visits occur in the primary care setting[4]
- ~10% of all primary care visits are related to depression[3]

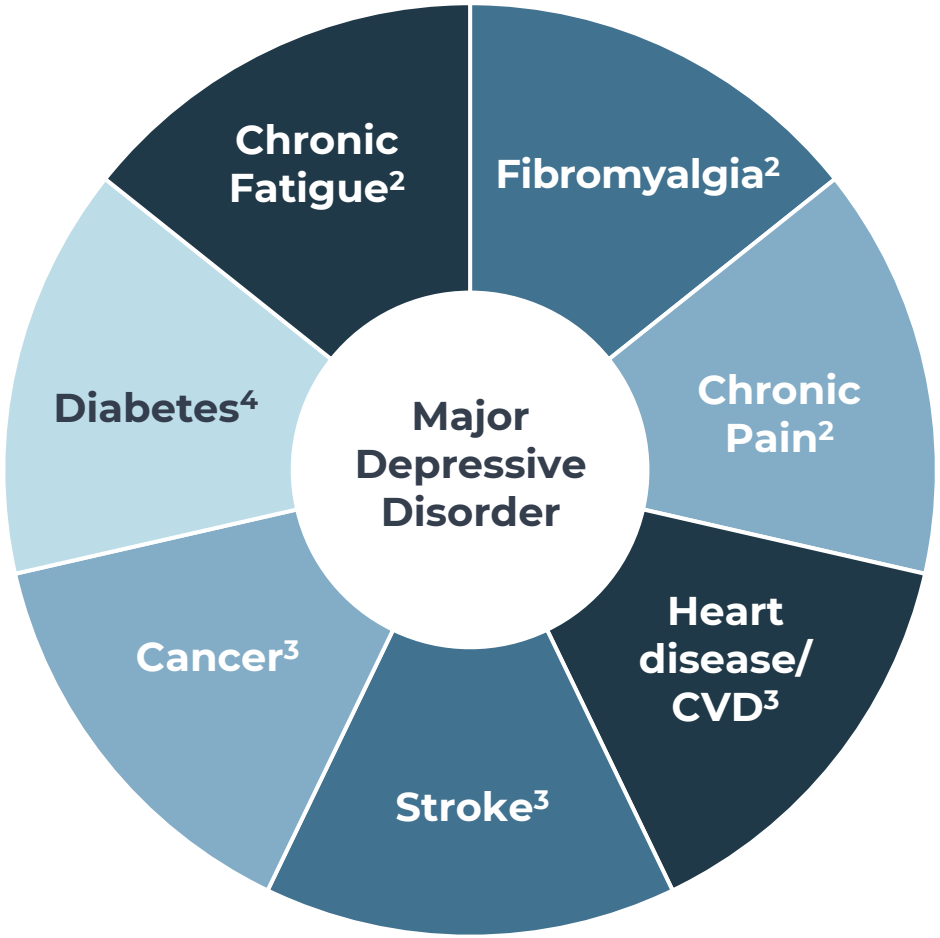
PCPs may feel that they lack the time or training to adequately address their patients' depressive disorders[5]

ICD-10=International Classification of Diseases, version 10. PCP=primary care provider. US=United States.

1. National Institute of Mental Health (NIMH) website. Updated July 2023. Available at: https://www.nimh.nih.gov/health/statistics/major-depression.shtml. Accessed 29 April 2025.
2. Üstün TB. Mental Illness in General Health Care: An International Study. John Wiley & Sons; 1995.
3. Unützer J, et al. *Prim Care*. 2012; 39(2): 415-431.
4. Narrow WE, et al. *Arch Gen Psychiatry*. 1993; 50: 95-107.
5. Brody DS, et al. *Gen Hosp Psychiatry*. 1995;17(2):93-107.

Depression May Interact 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
  - Increased healthcare costs
  - Delayed recovery, negative prognosis, and elevated premature mortality among those with comorbid medical illness



CVD=cardiovascular disease.

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 HJ, et al. *Chonnam Med J*. 2015;51:8-18.
4. Mezuk B, et al. *Diabetes Care*. 2008;31:2383-2390.

Depression in Older Adults[a] May Be Particularly Difficult to Recognize

Approximately 5-10% of older adults seen in primary care settings have clinically significant depression[1]

Depressive symptoms may be dismissed or underreported due to[2]

- Comorbid medical conditions
- Concomitant medications
- Cognitive problems associated with normal aging

Late-life depression is often accompanied by

- Cognitive impairment[3]
- Functional decline[4]

Compared to early-onset, depression in older adults has[5]

- Specific depressive syndromes
- Worse prognosis
- More chronic course
- Higher relapse rates

On the HAM-D, older adults were more likely than younger adults to have[6]

- Agitation
- Somatic symptoms
- Hypochondriasis
- Less guilt
- Less loss of sexual interest

[a]Older adults = adults 60 years and older.
HAM-D=Hamilton depression rating scale.

1. Lyness JM, et al. *J Gen Intern Med*. 1999;14:249-254.
2. Alexopoulos GS. *Lancet*. 2005;365(9475):1961-70.
3. Steffens DC. et al. *Arch Gen Psychiatry*. 2006;63:130-138.
4. Beekman AT, et al. *Acta Psychiatr Scand*. 2002;105:20-27.
5. MacQueen GM, et al. *Can J Psychiatry*. 2016;61(9):588-603.
6. Hegeman JM, et al. *Br J Psychiatry*. 2012;200:275-281.

Depression Can Have a Serious Impact on an Individual's Ability to Function

Functional impairments associated with depression may disrupt work, school, leisure, family life activities and family responsibilities[1]

Overall, **~80%** of US adults with depression reported **at least some difficulty** managing work, home, or social activities due to their symptoms

~30% reported **moderate or extreme difficulty**[2]

Screening tools for functional impairment may include[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-SR)

Functional recovery often lags behind symptomatic improvement[1]

Impaired functioning is a predictor of subsequent depression relapse[3]

Functional recovery is critical for individuals to achieve and remain in remission of MDD and return to productive and fulfilling lives[1,a]

[a]Functional remission defined as SDS score of ≤6.
MDD=major depressive disorder. US=United States. YLD=years lived with disability.

1. Sheehan DV, et al. *J Affect Disord*. 2017;215:299-313.
2. Brody DJ, et al. NCHS Data Brief. Accessed November 11, 2022. https://www.cdc.gov/nchs/data/databriefs/db303.pdf.
3. IsHak W, et al. *J Affect Disord*. 2013;151(1):59-65.

Management Considerations for MDD

Polling Question

In your clinical practice, which of the following do you use most often to assess for depression in the primary care setting?

A. Use of screening tools (e.g., PHQ-2/-9)

B. Clinical interview

C. Wait for patient to report

D. Defer to care team

E. None of the above

PHQ=Patient Health Questionnaire.

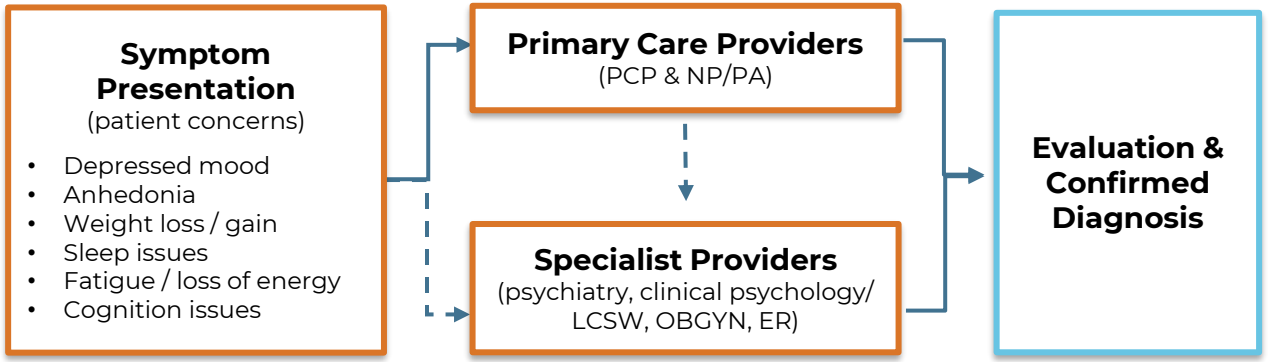
Opportunities to Improve Recognition of Depression in Primary Care

Interventions to improve detection[1]

- ***Guideline implementation***
- ***Clinician education***
- ***Screening*** with feedback and disclosure of results
- ***Case management***
- ***Collaborative / stepped care*** with PCPs and MH specialists
- ***Chronic disease management***

Screening tools for depression may include[1]

- Hamilton Depression Rating Scale (HAM-D)
- Montgomery-Åsberg Depression Rating Scale (MADRS)
- Clinical Global Impression Scale (CGI)
- Patient Health Questionnaire (PHQ)-2 and PHQ-9
- Beck Depression Inventory (BDI)
- Inventory of Depressive Symptomatology (IDS-SR)



ER=emergency room. LCSW=licensed clinical social worker. MH=mental health. NP=nurse practitioner. OBGYN=obstetrics and gynecology. PA=physician assistant. PCP=primary care provider.

1. Habtamu K, et al. *Syst Rev.* 2023;12:25.
2. Ebell MH, et al. *Am Fam Physician.* 2008;78(2):244-246

United States Preventive Services Task Force (USPSTF) Recommends Screening All Adults for Depression in the Primary Care Setting

Recommendation: *Screen for MDD in all adults regardless of risk factors*

- Consider screening adults who have not been screened previously, and re-screen adults at increased risk based on risk factors, comorbid conditions, and life events
- Risk factors include family history of depression or other mental health conditions, prior MDE, or history of trauma or adverse life events

Implementation: *Collaborative care is key*

- Clinicians should be aware of the risk factors, signs, and symptoms of depression and suicide; listen to any patient concerns; and make sure that persons who need help get it
- Collaborative care is a multicomponent, health care system–level intervention that uses care managers to link primary care clinicians, patients, and mental health specialists to ensure patients receive the best care
- To achieve the benefit of depression screening and reduce disparities in depression-associated morbidity, persons who screen positive should be evaluated further for potential diagnosis and, if appropriate, provided or referred for evidence-based care

Benefits: *Depression screening programs in primary care result in improved health outcomes*

MDD=major depressive disorder. MDE=major depressive episode.

1. Barry MJ, et al. *JAMA*. 2023;329(23):2057-2067.

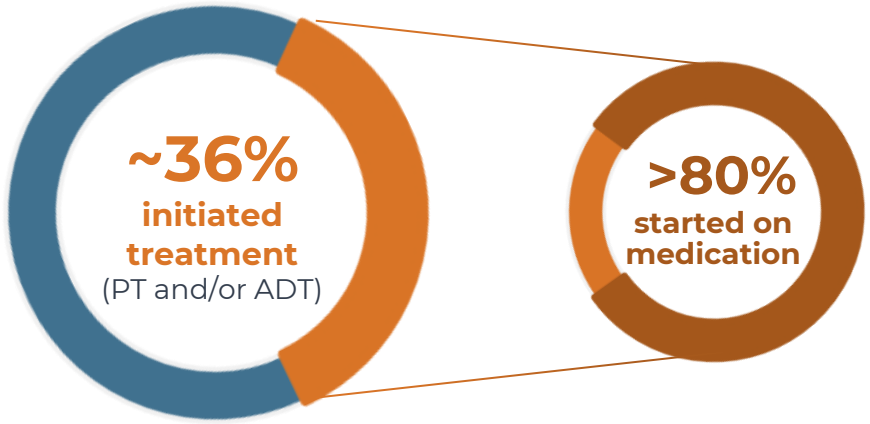
Current and Investigational MDD Treatments Span Multiple Modalities[1-4]

MDD=major depressive disorder.

1. Murri MB, et al. *Front Psychiatry*. 2019;9:762.
2. American Psychiatric Association. Practice Guideline for the Treatment of Patients With Major Depressive Disorder. 3rd ed. 2010.
3. Müller HHO, et al. *Front Neurosci*. 2018;12:239.
4. Iacoviello BM, Charney DS. *Eur Psychiatry*. 2015;30(1):75-81..

In the US, the Primary Care Setting Presents an Important Opportunity to Detect and Treat Depression[1]

Among ~240,000 adults diagnosed with depression in primary care settings from 2010 to 2013[1,a]



The strongest predictors for initiating psychotherapy rather than medication were

- Younger age
- Racial/ethnic minority
- No prior medication for depression
- Prior use of specialty mental health care

[a]Electronic health record data for this retrospective observational study were obtained from 5 US healthcare systems with diversity in size, geographic location, and patient populations.
ADT=antidepressant therapy. PT=psychotherapy. US=United States.

1. Waitzfelder B, et al. *J Gen Intern Med*. 2018;33(8):1283-1291.

Significant Challenges Exist Surrounding the Treatment of MDD

1. Under-treatment due to misdiagnosis or underdiagnosis[1,2]

2. Low rates of adherence and persistence to first-line pharmacotherapy[3]

Potentially influenced by

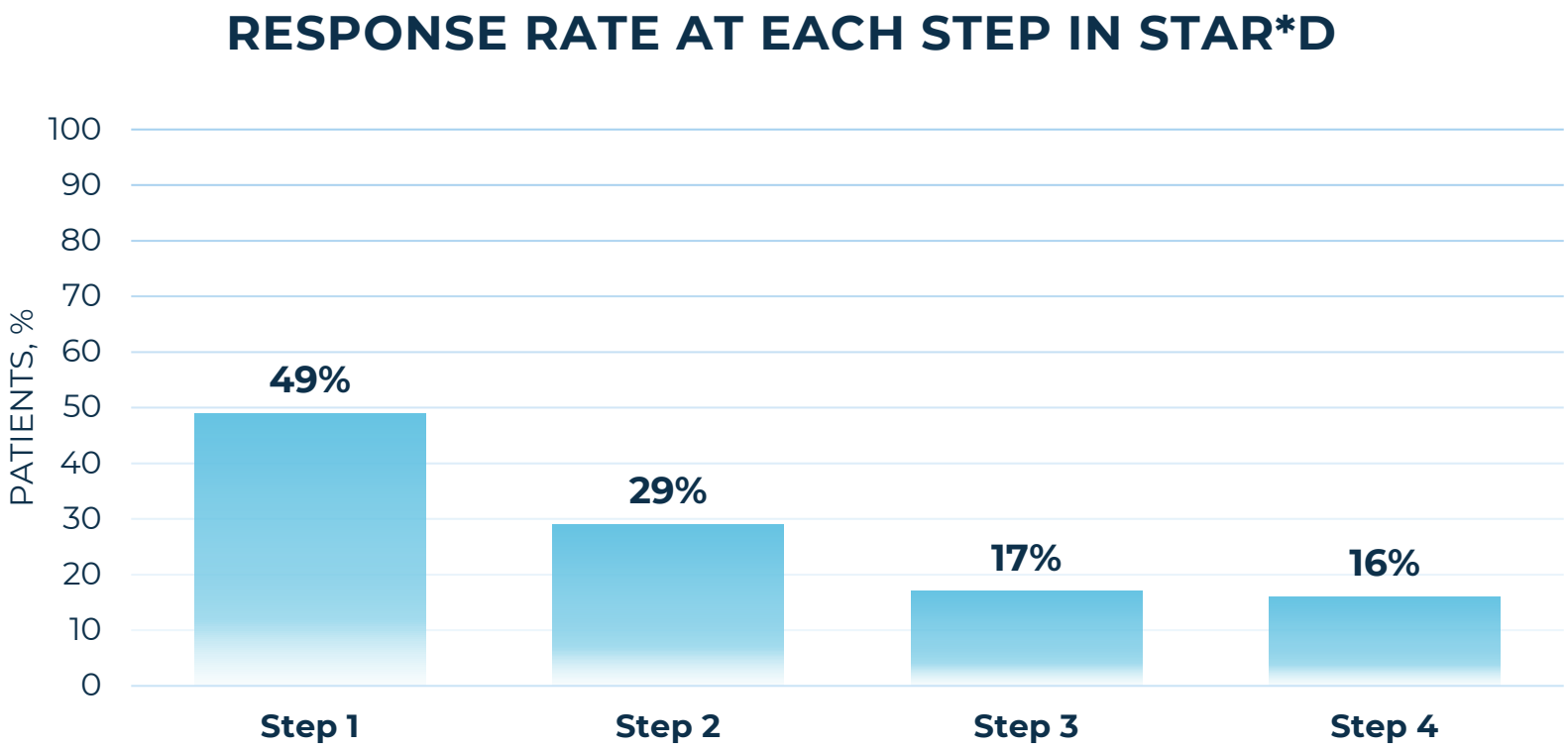
- **Relatively slow onset of action**: antidepressants require 4–8 weeks to achieve full therapeutic effect[4]
- **Limited efficacy**: a significant proportion of patients fail to remit or only partially remit despite adequate therapy[5,6]
  - The modest positive predictive value of early improvement is overshadowed by the robust negative predictive value of lack of symptomatic improvement within the first 2 weeks[1]
- **Failure to achieve PROs**: most individuals with MDD do not achieve full functional recovery[1]
- **Side effects / tolerability issues**: adverse events associated with pharmacologic agents may reduce adherence and persistence[4] and result in polypharmacy[1]

3. Need for complex multidisciplinary approach[7]

MDD=major depressive disorder. PRO=patient-reported outcome.

1. McIntyre RS. *Curr Psychiatry Suppl*. 2019;18(9):S1-S4.
2. Nierenberg. *Am J Manag Care*. 2001(suppl 11):353-66.
3. Cantrell, et al. *Med Care*. 2006;44(4):300-303.
4. American Psychiatric Association. *Practice guideline for the treatment of patients with major depressive disorder*. 2010.
5. Olchanski, et al. *Clin Ther*. 2013;35(4):512-22.
6. Nierenberg, et al. *Psychol Med*. 2010;40(1):41-50.
7. Paganin W, et al. *Clin Neuropsychiatry*. 2023;20[3]:173-182.

Less Than Half of Patients With MDD May Respond to Initial ADT



When more treatment steps are required, lower remission rates and higher relapse rates may be expected

In the STAR*D study, response was defined as a 50% or greater reduction in QIDS-SR_{16} score from entry score at each step.

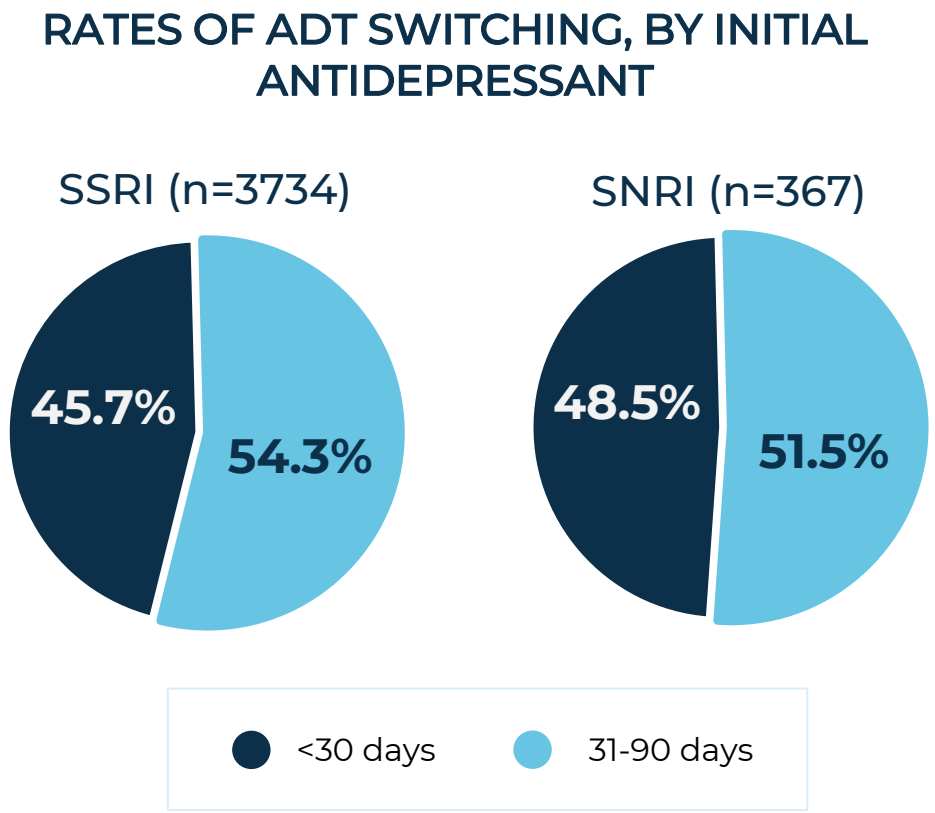
ADT=antidepressant treatment. MDD=major depressive disorder. QIDS-SR_{16}=Quick Inventory of Depressive Symptomatology–Self-Report. STAR*D=Sequenced Treatment Alternatives to Relieve Depression.

1. Rush AJ, et al. *Am J Psychiatry*. 2006;163(11):1905-1917.

Many Non-Responders May Remain On Ineffective Therapy For Longer Than Recommended

In a study of ~57,000 treatment-adherent adults diagnosed with depression on an ADT, **8.6% switched their ADT** and **2.4% added another ADT** during the first 90 days of treatment[1]

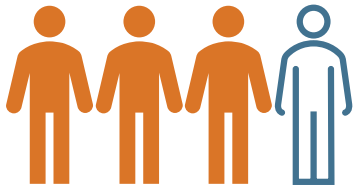
Prolonging the time to effective antidepressant therapy may have a **negative effect** on the doctor-patient relationship which may ultimately lead to **poor adherence** rates[2]



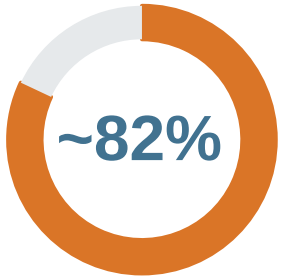
ADT=antidepressant treatment. SNRI=serotonin and norepinephrine reuptake inhibitor. SSRI= selective serotonin reuptake inhibitor.

1. Marcus S, et al. *Psychiatr Serv*. 2009;60:617-623.
2. Moller HJ, et al. *Medicographia*. 2010;32:139-144.

Unresolved Symptoms of Depression Are Common, Even in Patients Who Have Responded or Remitted From Their ADT[1]



3 out of 4 of patients with depression who **respond** to SSRI treatment but do not reach remission experience **5+ unresolved symptoms**



~82% of patients who achieve **remission** after 8 weeks of SSRI treatment experience **at least 1 unresolved symptom**

The presence of **unresolved symptoms** in patients with MDD, even in those who achieve remission, often leads to **poor outcomes**

MDD=major depressive disorder. SSRI= selective serotonin reuptake inhibitor.

1. Zajecka J, et al. *J Clin Psychiatry*. 2013;74(4):407-414.

Unresolved Symptoms May Lead to Poor Outcomes

Patient self-reports frequently identify fatigue, low energy, and concentration/ memory problems as especially disruptive to occupational and global functioning[1]

Patients with unresolved symptoms versus those without are more likely to experience:

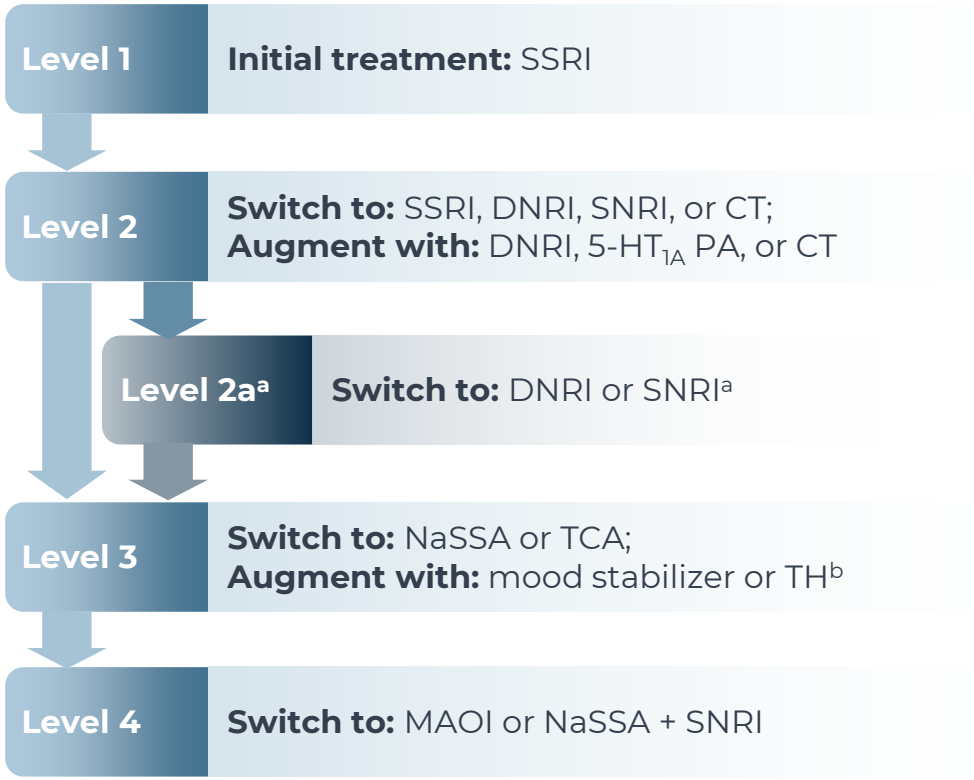
- Chronic depressive episodes[2]
- Decreased likelihood of recovery over time[3]
- Greater risk of relapse and recurrence[2]
- Shorter duration between episodes[2]
- Continued impairment in work and relationships[2,3]

MDD=major depressive disorder.

1. Saltiel PF, et al. *Neuropsychiatr Dis Treat*. 2015;11:875-888.
2. Papakostas GI. *J Clin Psychiatry*. 2009;70 (suppl 6):16-25..
3. Jackson WC, et al. *J Clin Psychiatry*. 2020;81(3):OT19037BR2.

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

STAR*D ALGORITHM[1]



Data from the STAR*D trial was analyzed to assess functional outcomes of patients with MDD[2]

- After 12-weeks of treatment, 2,876 patients were classified based on responder status
  - Remitters[c]: n=943 (33%)
  - Partial responders[d]: n=1069 (37%)
  - Non-responders[e]: n=854 (30%)
- Change in all functional measures[f] from baseline to end of Level 1 treatment was significantly different across the three groups
- Compared to patients who achieved remission, those who achieved partial response demonstrated significantly lower **quality of life** and **work productivity**, and impairment in **functioning** and **social adjustment**

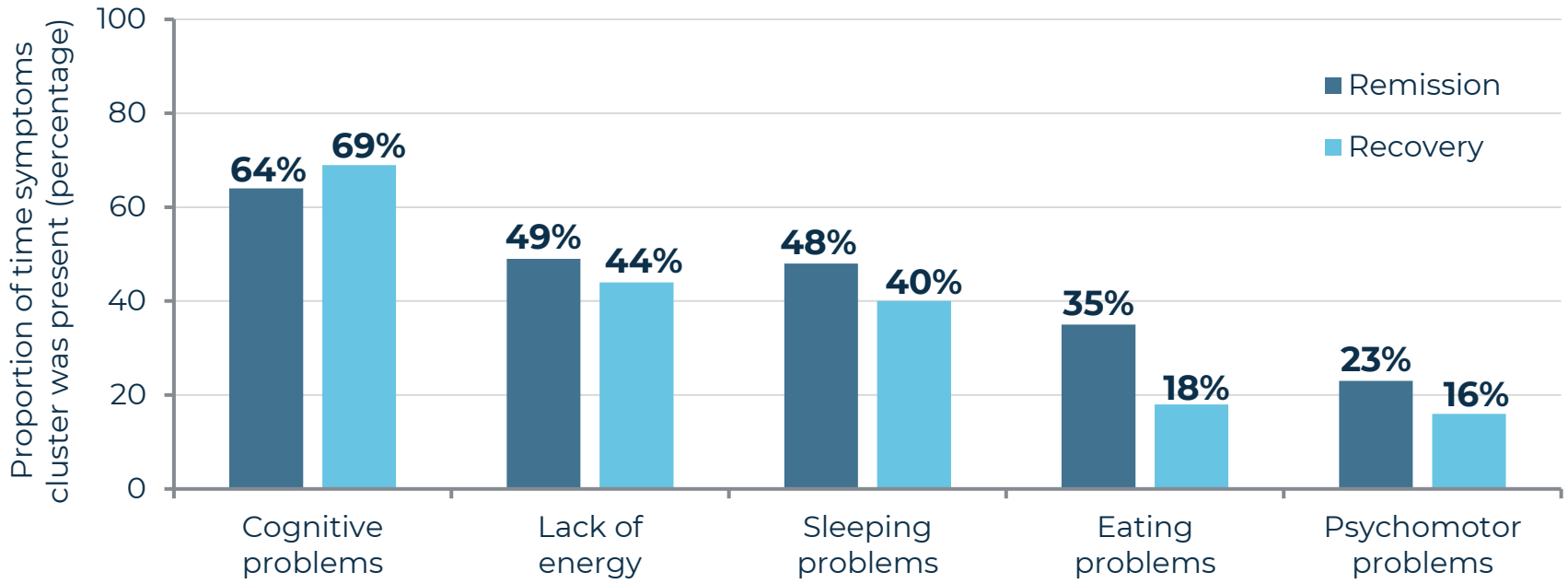
[a]Only for those who failed CT in Level 2. [b]Only with DNRI, SSRI, or SNRI. [c]QIDS-SR ≤ 5. [d]QIDS-SR > 5 and ≥ 25% reduction from BL. [e]QIDS-SR > 5 and < 25% reduction from BL. [f]SF-12, Q-LES-Q, WSAS, and WPAI.

BL=baseline. CT=-cognitive therapy. DNRI=dopamine norepinephrine reuptake inhibitor. MAOI=monoamine oxidase inhibitor. MDD=major depressive disorder. NaSSA=noradrenergic and specific serotonergic antidepressant. SNRI=serotonin norepinephrine reuptake inhibitor. SSRI= selective serotonin reuptake inhibitor. TCA=tricyclic antidepressant. TH=thyroid hormone. PA=partial agonist. Q-LES-Q=Quality of Life Enjoyment and Satisfaction Questionnaire. SF-12=Short-Form Health Survey. WPAI=Work Productivity and Activity Impairment. WSAS=Work and Social Adjustment Scale.

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

Functional Impairments May Persist Despite Symptomatic Remission or Recovery[1]

In a 3-year, prospective study of measuring presence or absence of depressive symptoms in primary care patients with MDD (n=267), many patients continued to experience functional symptoms during remission and recovery[1]



Depressed primary care patients (N=267) (74.2% of whom were receiving antidepressants at baseline) were monitored over 3 years for the presence or absence of depressive symptom clusters week by week during DSM-IV–defined remissions, recoveries, relapses, and recurrences. The mean proportion of time each symptom cluster was present during 'n' number of phases is shown.

DSM-IV=Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. MDD=major depressive disorder.

1. Conradi HJ, et al. *Depress Anxiety*. 2012;29:638–645.

US Practice Guidelines for the Treatment of Patients With MDD

INITIAL TREATMENT → INADEQUATE RESPONSE

APA (2010)[1]

Mild to moderate MDD

PT **OR** ADT (SSRI, SNRI, atypical ADT)

Moderate to severe MDD

PT **&** ADT (SSRI, SNRI, atypical ADT)

…TO PT

- Consider changing intensity or type of PT
- Consider adding ADT

…TO ADT

- Increase dose, switch ADT, or augment with PT or another pharmacologic agent
- For patients whose symptoms do not adequately respond to pharmacotherapy, consider other somatic therapies

APoA (2019)[2]

PT **AND/OR** ADT (SSRI, SNRI)

offered in the context of shared decision-making with patients

- Switch from ADT alone to cognitive therapy alone
- Switch to another ADT

ADT=antidepressant therapy. APA=American Psychiatric Association. APoA=American Psychological Association. MDD=major depressive disorder. PT=psychotherapy. SNRI=serotonin-norepinephrine reuptake inhibitor. SSRI=selective serotonin reuptake inhibitor.

1. American Psychiatric Association. *Practice Guideline for the Treatment of Patients With Major Depressive Disorder*. 3rd ed. 2010.
2. American Psychological Association. *APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts*. 2019.

Polling Question

In your clinical practice, what is your preferred strategy for second-line antidepressant treatment (ADT)?

A. Increase dose and optimize current ADT

B. Switch to a different ADT (SSRI or SNRI)

C. Switch to a DNRI

D. Stay on same ADT and combine with another ADT (SSRI or SNRI)

E. Stay on same ADT and augment with a DNRI

F. Stay on same ADT and augment with a non-ADT (AAP)

Some Clinical Evidence Supports Augmenting Reuptake Inhibitors With Different Drug Classes and Psychotherapy[1-5]

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

*Augmentation with antipsychotics is the most studied adjunct therapy in patients with MDD[6]

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. 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. Nuñez NA, et al. *J Affect Disord*. 2022;302:385-400.

Considerations From the Literature In Forming an Augmentation Strategy for Inadequate Responders

1

Avoid contraindications

Avoid medications that would be relatively contraindicated

2

Target symptoms

Choose a medication that targets a cumbersome symptom to produce rapid relief before full antidepressant response is achieved

3

Assess comorbidities

Choose a strategy that treats comorbidities to minimize the number of prescribed medications

4

Consider compliance

Factor in cost, side effects, dosing regimen, and other properties of medications that could impact compliance

5

Evaluate evidence

Consider the weight of clinical evidence for effectiveness of a given strategy

1. Blier P. *Int J Neuropsychopharm*. 2014;17:997-1008.

Adjunctive Antipsychotics Are Commonly Prescribed to Patients With Severe MDD and High Functional Impairment[1]

Most common reasons for prescribing adjunctive antipsychotic

- Better efficacy/symptom control
- Specific drug features
- Familiarity with product
- Patient's level of functioning
  - **Greater functional impairment**
- Patient's history of MDD
  - **Longer current MDE**
  - **More prior MDEs**
  - **More prior treatment changes**
  - **Higher CGI-S score**
- Change in clinical presentation

Most common reasons for not prescribing adjunctive antipsychotic

- Preference to wait and see if symptoms improve
- Preference to reserve antipsychotic for specific symptoms
  - Psychotic symptoms, 66.4%
  - Psychomotor agitation, 35.3%
  - Hostility, 32.9%
  - Irritability, 28.8%
  - Impulsivity, 28.1%
  - Bursts of anger, 27.1%
- Symptoms not considered severe enough
- Tolerability/safety concerns

*Otsuka-sponsored case review study to determine which patients with MDD and an inadequate response to antidepressant treatment are prescribed an adjunctive antipsychotic and the key factors that influence this decision. Psychiatrists or primary care physicians (n = 411) based in the USA and Europe completed an online survey for 10 consecutive adults with MDD and inadequate response to antidepressant treatments for whom a treatment change was considered.

MDD=major depressive disorder. MDE=major depressive episode.

1. McIntyre RS, et al. *Adv Ther*. 2015;32:429-444.

Augmenting ADT Monotherapy With AAPs[1]

RESPONSE

In a meta-analysis of nine studies (n=3391) examining efficacy of ADT augmentation with an AAP in patients with MDD and incomplete response to ADT monotherapy[1]

- AAP augmentation was superior to placebo in
  - Response rate
  - Remission rate
  - Montgomery Åsberg Depression Rating Scale (MADRS) score
  - Sheehan Disability Scale (SDS) score
  - Clinical Global Impression (CGI) scores

REMISSION

FUNCTION

- Augmentation with an AAP was associated with higher rates of:
  - Discontinuation
  - Akathisia, insomnia, restlessness, somnolence, and weight increase

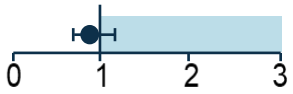
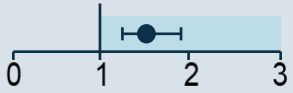
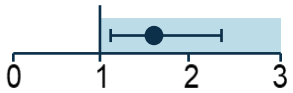
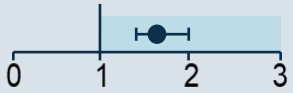
AAP=atypical antipsychotic. ADT=antidepressant treatment. MDD=major depressive disorder.

1. Kishi T, et al. *Int J Neuropsychopharmacol*. 2019;22(11):698-709.

Remission Rates Are Higher With AAP Augmentation Versus Monotherapy[1]

In a meta-analysis of 11 RCTs consisting of 3341 patients with MDD, AAP augmentation showed superior efficacy compared to monotherapy, and effect size positively correlated with severity of TRD[1]

Remission Rates

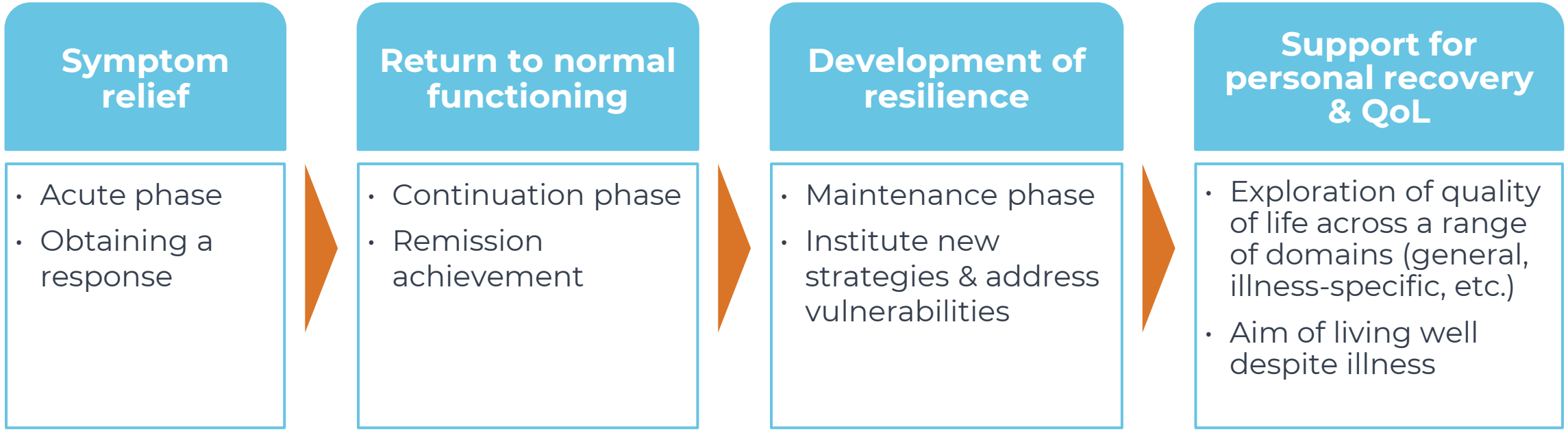
	AAP n/N	Monotherapy n/N	Odds Ratio[a] (95% CI)	
Non-TRD	32/49	39/53		0.89 (0.69-1.14)
TRD 1	248/753	85/434		1.55 (1.25-1.92)
TRD 2	54/198	34/203		1.63 (1.11-2.38)
TRD 2-4	281/931	127/720		1.68 (1.40-2.03)

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]

[a]Odds ratio >1=superior to placebo.
AAP=atypical antipsychotic. CI=confidence interval. MDD=major depressive disorder. n/N, number of patients achieving remission/total number of patients. TRD=treatment-resistant depression (number after indicates number of antidepressant treatment failures within the current depressive episode). RCT=randomized controlled trial..

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

Treatment Goals in MDD May Include Full Functional Recovery[1]



QoL as a patient-reported outcome serves as a compass for collaborative treatment planning[2]

MDD=major depressive disorder. QoL=quality of life.

1. The University of South Florida, Florida Center for Behavioral Health Improvements and Solutions. *2023–2024 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults*. 2023.
2. Mahli et al. *Aust N Z J Psychiatry*. 2021;55(1):7–117.

Summary

A substantial proportion of patients with MDD are seen in the primary care setting, and PCPs are uniquely positioned to intervene

1

Probing for impact on functionality, in addition to depression symptoms, is imperative for successful patient outcomes

2

Measurement-based tools can aid the PCP with assessing the severity of MDD and the impact on function and quality of life

3

Augmentation with AAPs may target several monoamine neurotransmitters and improve residual symptoms or impaired functioning

4

MDD=major depressive disorder. PCP=primary care provider.

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Faces of Depression in Primary Care

Depression Symptomatology and Functional Outcomes from Early to Late Adulthood

July 2025 US.PSY.D.25.00029

Appendix

Clinician-Administered Scales Can Be Used to Rate the Severity of Depression

HAM-D[1]

A **17-item** scale that rates the severity of depression

Each item is given a score of **0 to 4** based on severity level

A **total score of ≥20** is often required for inclusion in depression clinical trials

MADRS[2]

A **10-item** scale that rates the severity of depression

Each item is given a score of **0 to 6** based on severity level

A **total score** is rated as:

- *Normal/absent: 0 to 6*
- *Mild: 7 to 19*
- *Moderate: 20 to 34*
- *Severe: 35 to 60*

CGI[3]

A **1-item** scale that rates illness severity (CGI-S) or improvement since the start of treatment (CGI-I)

Each item is given a score of **1 to 7**

CGI-S: 1 = "not ill"; 7 = "extremely ill"

CGI-I: 1 = "very much improved"; 7 = "very much worse" since the start of treatment

CGI=Clinical Global Impression Scale. HAM-D=Hamilton Depression Rating Scale. MADRS=Montgomery-Åsberg Depression Rating Scale.

1. Hamilton Depression Rating Scale. Accessed March 1, 2021. https://dcf.psychiatry.ufl.edu/files/2011/05/HAMILTON-DEPRESSION.pdf.
2. Duarte-Guerra LS, et al. *BMC Psychiatry*. 2016;16:119.
3. Busner J, Targum SD. *Psychiatry (Edgmont)*. 2007;4(7):28-37.

Self-Administered Tools Can Be Used to Rate Depression Severity

PHQ-2 or PHQ-9[1-4]

A **2- or 9-item** tool that rates the severity of depression

Each item is given a score of **0 to 3** based on frequency of symptoms over the last 2 weeks

The **total score** is rated as:[a]

- *Normal: 0 to 4 (0 to 2 for PHQ-2)*
- *Mild: 5 to 9 (3 to 6 for PHQ-2)*
- *Moderate: 10 to 14*
- *Moderately severe: 15 to 19*
- *Severe: 20 to 27*

BDI[5,6]

A **21-item** scale that rates the severity of depression

Each item is given a score of **0 to 3** based on severity level

The **total score** is rated as:

- *Minimal: 0 to 13*
- *Mild: 14 to 19*
- *Moderate: 20 to 28*
- *Severe: 29 to 63*

IDS-SR[7,8]

A **30-item** tool that rates the severity of depression

Each item is given a score of **0 to 3** based on severity level

The **total score** is rated as:

- *Normal: 0 to 14*
- *Mild: 15 to 26*
- *Moderate: 27 to 37*
- *Severe: 38 to 48*
- *Very severe: 49 to 84*

[a]The PHQ-2 includes only the first 2 items of the PHQ-9, with total score ranges from 0-6.

BDI=Beck Depression Inventory. IDS-SR=Inventory of Depressive Symptomatology–Self Report. PHQ=Patient Health Questionnaire.

1. Levis B, et al. *JAMA*. 2020;323(22):2290-2300.
2. National Council for Mental Wellbeing. Accessed December 2022. https://www.thenationalcouncil.org/wp-content/uploads/2021/04/PHQ-9.pdf.
3. American Psychological Association. Accessed May 2025. https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.
4. Kroenke K, et al. *Gen Hosp Psychiatry*. 2010;32(4):345-59.
5. Jackson-Koku G. *Occup Med (Lond)*. 2016;66(2):174-175.
6. Lee EH, et al. *Psychiatry Investig*. 2017;14(1):30-36.
7. Rush AJ, et al. *Psychol Med*. 1996;26(3):477-486.
8. Trivedi MH, et al. *Psychol Med*. 2004;34(1):73-82.

Clinician-Administered Scales Can Be Used to Assess Overall Health and Rate Impact on Function

SF-36[1-3]

Tool that evaluates **overall health** across **8 domains,** and can be used with any age, disease, or treatment group

Each domain will score from **0 to 100**, with 100 indicating more favorable health

The SF-36 does not result in a total score representative of overall health[3]

GAF[4,5]

Designed to briefly measure **impact on functioning** across **3 dimensions** during the **past week**

The total score ranges from **1 to 100**, with low levels indicating poor functioning

Each 10-point score range is associated with a description of functioning

GAF=Global Assessment of Functioning. SF-36=36-Item Short-Form Health Survey.

1. Ware JE. *SPINE*. 2000;25(24)3130-3139.
2. RAND Health Care. Accessed May 2025. https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form/scoring.html.
3. Lins L, et al. *SAGE Open Medicine*. 2016;4:1-12.
4. Grootenboer EM, et al. *J Eval Clin Pract*. 2012;18(2)502-507.
5. International Association of Analytical Psychology. Accessed May 2025. https://iaap.org/wp-content/uploads/2023/04/GAF-Scale.pdf.