Commentary

How practice-based research changed the way I manage depression

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"For Depression, the Family Doctor May Be the First Choice but Not the Best."

—*New York Times*, June 24, 2003
(review of Kessler RC, Berglund P, Demler O, et al, "The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication [NCS-R]." JAMA 2003; 289:3095–3105)

A psychiatrist colleague once remarked that I did a better-than-average job diagnosing depression. Maybe so, but I was never quite sure if my patients really met established diagnostic criteria, since I usually "gestalted" the diagnosis. I would talk to my patients about depression so they would understand and accept it as a treatable medical condition, not a moral failing.

Recommending appropriate therapy was fairly easy, since information on pharmacotherapy is so prevalent. But I rarely learned how well my depressed patients were doing, since I practiced the "no news is good news" model of chronic disease management.

Then I was invited to participate in a practice-based study of depression.[1] I learned a better way to manage depression, which was more effective, satisfying, and—believe it or not—more efficient than the old way. I learned that successful management also saved time and money by reducing fruitless diagnostic testing and return visits for unmet needs.

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THE 5 LINKED TASKS OF SUCCESSFUL MANAGEMENT

Successful management of depression requires completion of 5 linked tasks: recognition, diagnosis, treatment, systematic follow-up, and outcome assessment. Most important for the busy practitioner, these tasks can be completed without disrupting "usual" patient care.

What specific tools did I acquire? I'll describe them according to tasks; the first task—*recognition*—deserves special emphasis and is discussed last.

Diagnosis: 9 simple questions

Whenever I suspect the possibility of depression in a patient, I ask the 9 simple questions in the PRIME-MD Patient Health Questionnaire (PHQ-9).[2,3] The PHQ-9 instrument is the best available depression screening tool for primary

FIGURE 1

PRIME-MD Patient Health Questionnaire (PHQ-9)

Patient Name:_____

Date:_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

How to score PHQ-9

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are checked as at least "More than half the days"
- Either item #1 or #2 is positive, that is, at least "More than half the days"

Other Depressive Syndrome is suggested if:

- Of the 9 items, 2, 3, or 4 are checked as at least "More than half the days"
- Either item #1 or #2 is positive, that is, at least "More than half the days"

Guide for Interpreting PHQ-9 Scores

Score	Action
≤4	The score suggests the patient may not need depression treatment.
≥5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥15	Warrants treatment for depression, using antidepressant, psychotherapy, or a combination of treatment.

FIGURE 2

Depression Scoring System

Date of Measurement	Initial	Follow-up	Follow-up	Follow-up
	Score	*Score*	*Score*	*Score*
1. Depressed or sad mood				
2. Fatigue, decreased energy, lack of motivation				
3. Change in appetite and/or weight				
4. Disinterest in usual activities				
5. Decreased libido				
6. Difficulty concentrating, remembering				
7. Restlessness, irritability				
8. Reduced self-esteem, increased self-consciousness				
9. Feelings of guilt, worthlessness, helplessness				
10. Persistent physical symptoms (headaches, other pains) that don't respond to treatment				
11. Recurring thoughts of death and/or suicide				
Total score*				

*Use the initial score as the benchmark for monitoring improvement.

care.[4] An affirmative answer to either question A or B plus a total of 5 positive "nearly every day" replies indicates a diagnosis of major depression. Fewer symptoms indicate minor depression, for which therapy is individualized (**Figure 1**).

It takes about 1 or 2 minutes to make a PHQ-9 diagnosis of depression; listening to the patient's story fleshes out the diagnosis and may reveal underlying comorbidities (such as alcohol use or physical abuse) that guide the next task.

I minimize diagnostic testing. In 16 months, 1 of 95 patients in my practice with major depression turned out to have a significant underlying medical illness responsible for his symptoms. I diagnosed a lymphoma during systematic follow-up when treatment failed.

Treatment: What to discuss

I use most of the office visit to discuss the diagnosis, patient preferences for treatment (or no treatment), and pharmacotherapy indications, expectations, and side effects. In my experience, this discussion is usually completed within the allotted time of the appointment.

Follow-up: Make 3 appointments

I ask patients to make 3 follow-up appointments: at 1 week (to assess medication side effects, if medication is prescribed), at 4 weeks

(to assess early response), and at 8 weeks (to assess maintenance of response). After the week-8 visit, I ask patients to return every 3 months, or sooner if not at goal.

If the patient declines pharmacologic treatment, or if referral for counseling is the sole treatment decision, the schedule of follow-up visits may vary. Visits would then be spent assessing whether the patient is improving or in need of additional treatment.

Outcome assessment: Take "emotional temperature"

I obtain a quantitative "depression score" (**Figure 2**) at the initial diagnostic visit and at each follow-up visit. This ad hoc scoring system, developed by my psychiatrist partners, complements a patient's report of progress. Scores collected from individual patients can also be used to assess overall improvement in the practice population of depressed patients.

I have found that patients understand and support having their "emotional temperature" taken at each visit. The PHQ-9 can be used to quantitate improvement during follow-up visits.[3]

Recognition: Pandora's box?

No matter how efficient, practical, and "user-friendly," a protocol is of no value if unused. I suspect that, consciously or unconsciously, many physicians avoid opening the "Pandora's box" of depression, because they fear disrupting the office schedule.

In my practice, recognizing and managing depression—and other unexpected patient issues—necessitated, I now realize, a complete re-engineering of the way I practiced medicine. Suppose you went to a shoe store on Friday to buy a pair of hiking boots for a weekend outing and were told, "Sorry, you'll have to come back next week: we sell hiking boots only on Tuesdays and Thursdays." Think how absurd that would be, and then realize it is exactly how most doctors schedule patient visits—on the "quota system," despite good evidence that patients' primary care needs cannot be conveniently categorized and scheduled.

> In my practice, one third of depressed patients complain only of a variety of somatic complaints

All I know about my schedule at the start of a day is that I will encounter 25 to 30 patients, and that I will leave the office when it closes. I will not know in advance the complaints, treatments, and time I should spend with each patient. This flexible scheduling works well and liberates me to address patients' spontaneous needs as they arise during the office encounter.

CASE FINDING: DON'T TRUST APPEARANCES

For depression, the case-finding approach is preferable to screening the entire practice.[5] I no longer trust appearances to recognize depression. While participating in the practice-based study of depression,[1] I encountered a hard-working, cheerful female executive who had undergone many diagnostic procedures and who did not at all appear depressed—but she was. She got better after treatment and expressed profound gratitude. Not all severely affected patients present saying, "I'm depressed, please treat me."

Unexplained somatic complaints

In my practice, one third of depressed patients complain only of a variety of somatic symptoms. I tell medical students, "If you can't figure out what's going on in an office encounter within minutes (1 to 3 minutes, depending on the level of training), think depression or alcohol abuse." This clinical pearl is memorable and mostly accurate; the differential diagnosis can be expanded throughout training.

Stress? Suspect depression

Two thirds of my patients with diagnosed depression allude to "stress," but often only in

a very roundabout manner. So, whenever a patient utters the word "stress" during an office encounter, out comes the PHQ-9. I cannot think of a simpler technique for recognizing depression. In general, it is also well to remember that patients suffering from chronic diseases will have a higher-than-average likelihood of associated depression.

MANAGING DEPRESSION SHOULD BE SIMPLE

The management of depression should resemble the management of diabetes: astute case finding (mass screening for diabetes is not recommended), clearly defined diagnosis (blood sugar level), effective treatment (both behavioral and pharmacologic), systematic follow-up, and a quantitative outcome (glycosylated hemoglobin level). Diabetes was formerly managed as an acute illness, since once upon a time it was acceptable just to keep patients out of ketoacidosis. Today we treat diabetes better, and patients do better. Now it is time to do better with depression.

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