Prevention in Practice

Screening for Mood Disorders

Robert C. Rinaldi, PhD
Chicago, Illinois

Depression is the most common psychiatric diagnosis made. It has been estimated that the lifetime prevalence of depression in the United States is between 9% and 20%.[1–3]

The *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition-Revised (DSM-III-R), classifies depression under the general rubric of Mood Disorders. Mood disorders, defined as "significant disturbances in affect," are divided generally into depressive disorders and bipolar disorders. The two categories of depressive disorders are: (1) major depression, and (2) dysthymia. In addition, two categories of bipolar disorder are described: (1) bipolar disorder with manic episodes (may include major depressive episodes), and (2) cyclothymia.[4]

The National Institute of Mental Health Epidemiologic Catchment Area (ECA) Program is the largest of recent epidemiologic studies that have documented the scope of depressive disorders among individuals in this country. More than 20,000 adults from five demographically diverse areas of the United States were interviewed.[3]

The ECA study determined that the prevalence of bipolar disorder (one or more manic episodes followed by major depressive episodes) affected 0.5% of the population during a 6-month period. This rate increased to 0.8% when subjects were asked about lifetime recall. When a similar inquiry was made asking about hypomanic symptoms, the rate increased to 1.2% of the population.[5]

Major depression occurred in 3% of the population in a 6-month period. This rate nearly doubled (5.8%) for the lifetime period.[6] Dysthymia was diagnosed in 3.3% of the population on a lifetime basis.

Among ECA respondents, the 6-month prevalence rate for any affective disorder (bipolar disorder, cyclothymia, major depression, and dysthymia) was 5.8% with a lifetime rate for these combined disorders of 8.3%.[6] If extrapolated to the entire noninstitutionalized population of the United States, the total number of individuals with a lifetime history of any depressive disorder is 13.7 million. An estimated 9.6 million people have bipolar disorder, cyclothymia, major depression, or dysthymia during any 6-month period.[6]

Other ECA results support previous research findings that the rate of mood disorders among women is approximately twice that for men. In addition, it was found that persons between the ages of 25 years and 44 years are at highest risk for depression and that individuals who are separated or divorced are more likely to suffer from a depressive disorder than those who are married. No significant differences were found across racial, ethnic, or socioeconomic groups.[6]

Correlational studies between depression and suicide attempts were also conducted. Among those with no history of mental disorder, the rate of suicide attempts was 1%. In comparison, the rate of suicide attempts was 24% for those with a lifetime history of bipolar disorder, 18% for those with a lifetime history of major depression, and 17% for those with a lifetime history of dysthymia.[6,7]

The total direct and indirect annual costs of depression are quite high. Total direct costs (ie, hospitalization, provider visit expenses, medication costs) are estimated to be more than $2 billion annually; the total morbidity costs as a result of lost productivity are estimated to be $10 billion; and total mortality costs (based on the assumption that 60% of suicides are primarily the result of depression) because of lost productivity are estimated at more than $4 billion. These costs total approximately $16 billion per year.[8]

Given its prevalence, associated morbidity and mortality, and the array of effective clinical interventions available for this disorder, it would be reasonable to expect the level of appropriate care rendered to be quite high. Unfortunately, only about one person in three who suffers from a depressive illness ever proactively seeks

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Robert C. Rinaldi, PhD, is a psychologist and Director of the American Medical Association's Division of Health Science. Inquiries should be directed to Robert C. Rinaldi, PhD, American Medical Association, 515 North State St, Chicago, IL 60610.

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treatment in the general medical or mental health specialty sectors.[6] Further, current evidence suggests that depression is generally underdiagnosed, undertreated, or inappropriately treated by health care providers.[9]

Depression in the general medical setting is often seen at an earlier and more unorganized stage of illness, thus making it more difficult to diagnose. Depression may be masked by another medical or psychiatric disorder, and may present as vague physical complaints.

Several reliable screening tools are available for office use. A simple mental status examination may be used along with either the Hamilton Rating Scale for Depression (HRSD) or the Beck Depression Inventory (BDI). The HRSD is a 17-item symptom checklist that may be administered either by the physician or by ancillary staff. The BDI is a 22-item, self-administered instrument. Both examinations are easy to use, require only a few minutes to administer, and are considered reliable and valid.

Mood disorders affect millions of Americans at any given time. Depression is the most common psychiatric diagnosis made in primary care, mental health, and community settings. Because mood disorders are very prevalent and responsive to treatment, and because a great number of affected individuals never proactively seek treatment, primary care physicians should consider routinely screening for depressive and bipolar symptoms and treat or refer patients as appropriate.

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