Don't Stress About Conceptualizing Depressive Symptoms: Just Address Them

By Daniel Cukor, PhD, and Steven Weisbord, MD

Major depression is a complicating comorbid diagnosis in a variety of chronic medical conditions, but may be a particular diagnostic and treatment challenge to the patient with end stage renal disease (ESRD). New Medicare guidelines mandate that dialysis providers must screen for depression, and soon they will be required to document a treatment plan. This new requirement is forcing kidney care providers to seriously consider the best approaches to accurately diagnose and treat patients on dialysis once they have been identified as having depression. There are a variety of diagnostic tools used to screen for depression, each with their own psychometric properties. Some of these instruments are designed to cast a wide net, with few missed diagnoses but tolerant of more false positives. Others are designed to be more discriminating, allowing for fewer false positives; however, these frequently have a higher test burden.

Beyond measurement issues, there is also the issue of the interpretation of the particular sympom as etiologically related to depression (Table 1). For example, if a patient exhibited recent weight gain, which is quite common in patients on chronic dialysis, how would the clinician definitively determine if this is indicative of the increased appetite and lethargy often seen in clinical depression, or associated with edema or a consequence of diet or fluid non-compliance? One way of conceptualizing this challenge is through the context of "lumping versus splitting." "Lumping" involves looking for underlying commonalities across diagnostic entities, seeking to describe the difficulties in the most parsimonious way. "Splitting" seeks to identify each diagnostic category that each symptom could be applied to. As an example, in a patient in the midst of a depressive episode who demonstrates an inability to remain asleep, insomnia could be conceptualized to be attributable to depression or could be viewed as an independent sleep disorder.

The most recent version of the Diagnostic and Statistical Manual for Mental Disorders (DSM 5) has undergone a conceptual shift away from "comorbid" or "secondary" specifiers, commonly used in the DSM IV, and toward the diagnosis of the additional disorder independent of the presence or absence of other psychiatric or medical conditions. The rationale for this approach is the improved detection and management of the individual, without regard to overlapping co-morbidities, as this will ultimately lead to a faster and more substantive improvement in the patient's quality of life. In essence, the new DSM advocates for "etiological blindess," with the clinician not charged with making the determination as to which complex is the primary driving force for this symptom, rather for the clinician to note the symptom in as many domains as relevant.

Table 1. Overlap of depression symptoms

Uremic symptoms	DSM 5 symptoms of major depression	Other possible diagnosic categories
	Depressed mood	
	Anhedonia	
Anorexia/edema	Weight change	Non-adherence
Neuropathy/arthropathy	Insomnia/hypersomnia	Insomnia, sleep apnea, restless leg
Encephalopathy	Psychomotor agitation/retardation	Anxiety
Anemia/volume overload/ congestive heart failure	Fatigue	Exhaustion/frailty
	Worthlessness/guilt	
Encephalopathy	Diminished ability to think	Cognitive impairment
	Thoughts of death	

In our example, the clinician does not have to make a discretionary judgment as to whether the weight gain is due to depression or dietary non-compliance, but rather should include the weight gain as being possibly related to both. A further advantage of this approach is that it does not mandate a dualistic approach, as the weight gain may indeed be due to both depression and non-compliance. Similarly, patients may receive superior care if the symptoms shared between depression and sleep disorders, pain disorders, sexual dysfunction, and anxiety disorders are recorded as being part of each diagnostic entitity, because the symptom can simultaneously be both a sign of depression and an indication of another problem.

We believe ultimately that this "splitting" approach will lead to more targeted interventions and that once the patients' interest in treatment is verified, their distress can be adressesed more directly. Although it is possible that the successful treatment of depression could eventually impact the patient's insomnia, targeting the insomnia specifically from the outset may allow for a quicker resolution of that particular symptom and may have other positive consequences on the treatment of depression. As the new Medicare screening requirements are being implemented, we have heard many clinicians question their meaningfulness. However, we believe that increased identification of depression and engagement with patients about their symptoms and interest in treatment will lead to improved management and enhanced quality of life, even if the true etiology of the symptom remains unclear.

Suggested Reading

1. Weisbord SD, et al. Prevalence, severity, and importance of physical and emotional symptoms in chronic hemodialysis patients. *Journal of the American Society of Nephrology* 2005; 16:2487–94.
2. Cukor D, Cohen SD, Peterson RA, Kimmel PL. Psychosocial aspects of chronic disease: ESRD as a paradigmatic illness. *Journal of the American Society of Nephrology* 2007; 18:3042–55.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub; 22 May 2013.

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