Depression in the Community: Physician and Patient Perspective

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Depression and anxiety are the most common mental disorders seen by primary care physicians. The conditions often coexist. It has been reported that about half the psychiatric comorbidity in patients visiting their primary care physician goes unrecognized. Consequently, there is widespread agreement that an improvement in recognition of mental illnesses is required. This review examines how patient characteristics and patient presentation affect the acknowledgment of depression. Furthermore, the role of the physician will be discussed, with relation to the importance of acquiring specific consulting and prescribing skills for dealing with patients with depression. It is hoped that, with increasing awareness of depression and the development of training schemes for primary care physicians that focus specifically on the recognition and management of the condition in this setting, underrecognition and undertreatment of the disorder will improve.

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A substantial part of the daily work of the primary care physician or general practitioner (GP) concerns the care of people with mental health problems.[1] The most common psychiatric conditions are depression and anxiety. These conditions often coexist. The average English GP, with a list of 2000 patients, would be likely to have 60 to 100 patients with depression, 70 to 80 patients with anxiety and other neuroses, 50 to 60 patients with situational disturbances, 6 to 7 patients with affective psychosis, 4 to 12 patients with schizophrenia, 4 to 5 patients with organic dementia, and 5 to 6 patients with drug or alcohol disorder.[2]

Most studies concerning the recognition of mental illness in primary care have focused on psychiatric disorders in general,[3–8] or depression in particular.[9–11] These studies have shown that around half of the psychiatric morbidity present in individuals attending their GP, as judged by external psychiatric interview, goes unrecognized, whether the patient is consulting for a new problem,[5] or not.[4,6,9] However, these studies were cross-sectional in nature. The nature of general practice is longitudinal. Longitudinal studies have shown that more mental illness is recognized with time,[12] but that much recognized mental illness persists and is severe.[13,14]

Recognition has been shown to confer positive patient outcome when it leads to an appropriate intervention[6,15]; however, more recent studies indicate that disclosure to GPs and recognition alone may not improve patient outcome.[8,11] Another study found high recognition rates but low acknowledgment (i.e., management) in the elderly.[16] Generalists need sophisticated consulting skills, when presented with a wide range of physical, psychological, and social symptoms, to be able in the short time available to recognize psychiatric conditions. Most patients present with somatic symptoms, and there is often pressure not to miss life-threatening organic disorders, such as heart disease and cancer, although it needs to be remembered that mental illness is also often life-threatening.

Recognition, as the first step in the process toward recovery, is of such fundamental importance that we need to understand the many barriers that exist in the physician/patient process and how they may be overcome. These barriers can be patient-related or physician-related. Broadly speaking, depression may be missed because of patient characteristics or how they present or because of physician characteristics or the way physicians consult. This article will look at the physician/patient process in depression and how it can be improved.

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PATIENT CHARACTERISTICS

Marks and colleagues found that male doctors were more likely to perceive females as psychiatrically disturbed than males.[4] Males were rated more accurately by both male and female doctors. The doctors were most accurate with middle-aged patients and least accurate with those aged 15 to 24 years. Widowed patients were more likely to be wrongly perceived as mentally ill. Students were least likely to have mental illness recognized and those educated to the age of 23 years and over were less likely to have their illness recognized than those who left education earlier. The unemployed were least likely to have their illness go unrecognized. Freeling and colleagues did not control for doctor characteristics during their study, but found that patients in whom major depression went unrecognized were, on average, less depressed, appeared less depressed, had less insight into their depression, were more likely to have physical illness contributing to their depression, and were more likely to have been ill for more than a year.[9] Bridges and Goldberg described how patients who went unrecognized were more likely to be somatizing their distress; around half of their sample were seeking help for the physical manifestations of their psychiatric disorder.[5] Nearly half of the remainder had a concomitant physical disorder.

Davenport and colleagues found that patients who were more disturbed were more likely to be recognized because they give verbal, vocal (e.g., sighing), and postural cues in their consultation.[17] Similar results to those reported by Marks and colleagues[4] were found during a study by Bucholz and Robin: females, rather than males, were more willing to discuss their symptoms.[18] Individuals willing to discuss their symptoms were more likely to have experienced hopelessness, appetite reduction, weight loss, and cognitive difficulties than those who would not. Patients who abused drugs or alcohol were also less likely to discuss their depressive symptoms.

Bridges and Goldberg described the widespread presentation of patients with somatic symptoms that were attributable to their psychiatric disorder.[5] Somatic presentation is also likely when the patient also has significant chronic physical illness.[19] Ormel and colleagues found that patients who presented with a psychiatric or social reason for their encounter were more likely to be recognized.[6] Individuals whose symptoms were of more recent origin, who had more than one psychiatric diagnosis, or had more severe mental illness also had higher rates of recognition. Unpublished findings from the Hampshire Depression Project also indicate that GP recognition is associated with greater severity of illness (C. Thompson, oral communication).

During a study by my own group, we controlled for doctor characteristics by videotaping consultations in everyday general practice.[10] We found that women with major depression were less likely to be acknowledged as depressed if they had a physical illness. The unacknowledged group complained of more fatigue. Patients judged to have moderate-to-severe physical illness were 5 times less likely to have their major depression recognized than those without. In addition, patients with mild illness (e.g., colds or sore throats) were nearly 3 times less likely to have their depression recognized. Content analysis of the consultations found that women with major depression were up to 10 times more likely to be acknowledged as depressed if they mentioned the depression at the very beginning of the consultation instead of late, or not mentioning it at all.[20] From this study it appears that the recognition and acknowledgment of major depression are patient driven. It largely depends on the willingness of the patient to mention it to the doctor.

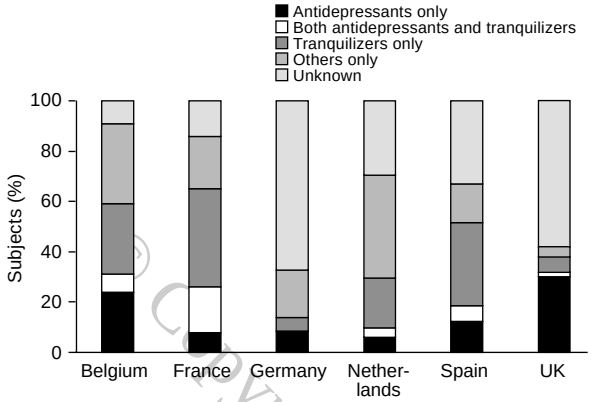
PATIENT PRESENTATION

Most consultations in primary care are patient initiated. Help-seeking behavior varies. Lay respondents to an opinion poll commissioned for the Defeat Depression Campaign conducted by the Royal College of Psychiatrists and the Royal College of General Practitioners described a widespread reluctance to consult and receive medication.[21] Over 90% would want counseling if they became depressed. A similar unpublished poll conducted at the end of the 5-year campaign showed a slight improvement, but emphasized the need for further public awareness campaigns (D. Baldwin, oral communication).

DEPRES (Depression Research in European Society) was the first large pan-European community survey of depression.[22] The study was conducted by Professors Lépine, Gastpar, Mendlewicz, and me and involved more than 78,000 adults in 6 countries. During Phase I of DEPRES, respondents were recruited into the study via door-to-door interviews in which individuals were asked to complete the depression section of the Mini-Neuropsychiatric Interview (MINI).[23] A total of 13,359 of the 78,463 adults who participated in screening interviews suffered with depression: a 6-month prevalence of 17%. A large proportion of the depressed individuals (43%) had never sought treatment for their condition. Of those who had sought help (57%), most had visited a primary care physician. Individuals with more severe depression had made consultations more frequently. Interestingly, more than two thirds of depressed subjects (69%) had been prescribed no treatment. Only 25% of individuals prescribed drug therapy had been given antidepressants, although this proportion varied across the participating countries (Figure 1).

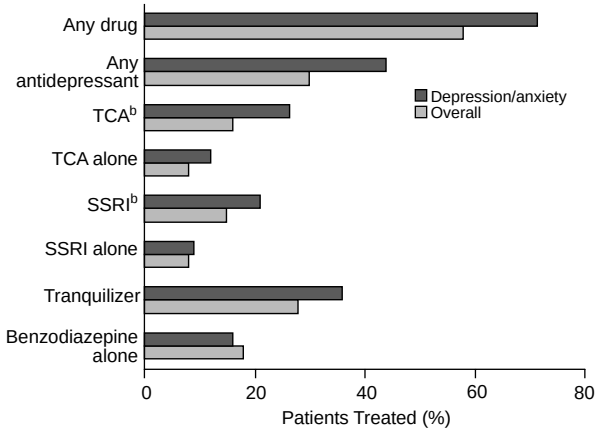
In Phase II of DEPRES, in-depth interviews were conducted with a subgroup of depressed individuals from Phase I who had consulted a health care specialist about their symptoms during the past 6 months and were willing to participate. More than 1800 individuals completed Phase II. On the basis of cluster analyses, individuals were

Figure 1. Management of Depressed Patients Seeking Treatment[a]



[a]From reference 22, with permission.

Figure 2. Prescribed Treatment for Patients With Severe Depression Associated With Anxiety[a]



[a]From reference 24. Abbreviations: SSRI = selective serotonin reuptake inhibitor, TCA = tricyclic antidepressant.
[b]TCA and SSRI could be administered in conjunction with another drug, such as a tranquilizer.

categorized into 6 patient types: moderately impaired depression, depression associated with chronic physical problems, severe depression associated with anxiety, depression associated with social problems, depression associated with sleep problems, and depression associated with tiredness or fatigue.[24]

From a GP's perspective, it is important to identify patients with severe depression associated with anxiety. Results from Phase II of DEPRES showed that these patients were associated with the greatest amount of comorbidity, disability, and impairment of the 6 groups. Consequently, these patients are a heavy burden on society in terms of health care utilization and lost productivity. Furthermore, an analysis of management strategies revealed that more than half of these patients had been prescribed inadequate treatment for their condition (Figure 2). Over 50% of patients had not been prescribed an antidepressant, and almost 20% had been given a benzodiazepine alone, which would have no effect on the treatment of their depression.

PHYSICIANS

Marks and colleagues demonstrated that "age and experience" did not show strong associations with accuracy, although the academically more able doctors who possessed an appropriate concept of minor psychiatric illness were more likely to rate the patient's psychiatric illness more congruently.[4] They found that doctors with longer consultation times were no better at recognizing mental illness, although another study found that relevant psychological problems are more likely to be dealt with in longer consultations with greater patient satisfaction.[25] Marks and colleagues found that "interest and concern," characterized by being very empathic, interested in psychiatry, and asking about the family and problems at home, are associated with being a high and accurate recognizer of mental illness.[4] They found a 9-fold variation in accuracy among their 91 GPs. GPs classified on the dimension "conservatism" because of their resistance to change, extroversion, use of hypnotics, and a tendency to make "contentless" statements during the consultation were least congruent in rating psychiatric disorder. Schulberg and McClelland postulated that a doctor's inability to recognize depression may be due to a lack of knowledge of the symptoms of depression and their management, a failure to consider the diagnosis of depression because of a preoccupation with organic illness, underrating its severity or treatability having considered the possibility, and a failure to elicit the symptoms needed to make the diagnosis, which relates to their consulting skills or lack of them.[26]

General Practitioner Consulting Skills

Generalists need to have a high index of suspicion for mental illness whenever they see someone for physical or social problems and vice versa. Unfortunately, patients with mental illness mainly present with somatic symptoms in primary care[27] and leave mentioning the psychosocial problems until late in the consultation.[28] Problems mentioned late are as important as problems mentioned early.[29] Some GPs are more accurate than others in recognizing depression.[4,27,30] The better recognizers tend to make more eye contact with the patient, are less likely to interrupt the patient, are less likely to appear to be in a hurry, and appear to be good listeners. They are able to ask appropriate directive questions about psychosocial issues at the right time in the consultation, i.e., they apply this form of questioning after using open questioning perhaps several times in a consultation. By contrast, doctors who are low recognizers ask many closed questions that leave the patient with little option but to give "yes/no" type responses. Davenport and colleagues[17] found that certain doctors en-

courage patients to present verbal, vocal, and nonverbal cues, whereas other doctors inhibit cue emission. In primary care settings, the diagnostic process may not follow the time-honored tradition of history taking, diagnosis, and management. It has long been known that GPs arrive at a treatment decision and then seek to justify it by providing a suitable diagnostic label.[31]

Physicians' Prescribing Skills

The problem with adequate treatment of depression does not simply lie with underrecognition. As the results of Phases I and II of the DEPRES study have shown, undertreatment or prescription of inappropriate treatment is also a problem in patients whom the physician has recognized as depressed. Consensus has been achieved about how depression should be treated in primary care, and guidelines have been issued by the Royal Colleges of General Practitioners and Psychiatrists[32] and by the British Association for Psychopharmacology.[33] One of the principal recommendations is to prescribe antidepressants at effective doses.

Professor Donoghue and I conducted a study to ascertain whether prescribing habits met suggested guidelines.[34] Prescription practices were analyzed using Prescribing Analysis and Cost (PACT) data; medical notes; and a large, computerized patient record database based on more than 1.5 million people and more than 80,000 prescriptions. All 3 data sources showed similar results: as many as 88% of prescriptions for tricyclic antidepressants (TCAs) were prescribed at doses below those recommended by the consensus guidelines. Prescribing skills for the newer antidepressants, such as the selective serotonin reuptake inhibitors (SSRIs), were better than for the TCAs. We concluded from the study that a more pragmatic approach to improve prescribing may be to recommend the newer antidepressants as first-line treatment for depression.

THE WAY FORWARD

If recognition is largely patient driven, perhaps the public are not yet ready for generalists to expose the true level of mental illness in our patients until the overall stigma of mental illness in society is reduced. When the media so regularly gives out inappropriate messages about "dangerous mad people," it is not surprising that many people hide psychiatric symptoms from their doctors or only mention them late in the consultation, when some trust has developed. When employers and insurers stigmatize mental illness, it is not surprising that general practitioners share this concern with their patients. Thankfully, the baton of the Defeat Depression Campaign in the United Kingdom is being carried forward by the leading patient association (the Depression Alliance) in an attempt to continue to build on the public education achievements of the last 5 years in reducing stigma. The Defeat Depression Campaign was organized jointly by the Royal College of Psychiatrists and the Royal College of General Practitioners between 1992 and 1997.[35] The Royal College of Psychiatrists is also launching a successor campaign on stigma.

There is widespread agreement that an improvement in the recognition of mental illness in primary care is needed.[35] Training for GPs has addressed this issue and achieved some change in GPs' recognition and management skills,[36,37] although training effects diminish over time.[38] While the Defeat Depression Campaign will have been instrumental in some of the prescribing changes that have occurred, Professor John Donoghue and I have shown that key consensus messages about TCA prescribing had not found their way into GP everyday practice at the beginning of the campaign.[34] As yet unpublished data (J. M. Donoghue, A.T.) show little change by the end of the campaign in the prescribing of TCAs, although there has been a huge increase in the prescribing of newer compounds. Disclosing the results of screening questionnaires to GPs about their patients' mental illness has little effect on GP behavior unless they know what to do with the result.[39] GPs are more likely to recognize conditions they feel confident in treating. A survey of the mental health training needs of randomly selected GPs in England and Wales found that around half had undertaken a psychiatric post in their training, but 39% had found it to be of uncertain or little value to life as a generalist.[40] Only 36% of GP respondents had undertaken any form of mental health training in the previous 3 years, yet all of the respondents considered they were already average or above average at recognizing depression.[40] From the evidence discussed earlier, there appears to be a gap between GP perceived training need and likely real training need, which largely concerns skills. This form of training is not generally provided for GPs by the current continuing medical education (CME) infrastructure, which is largely led by tutors who spend their limited resources on managing the bureaucracy of education and arranging for the provision of lectures by specialists rather than generalists.[41] Few GP tutors are able to provide skills-based training. Such training should preferably be to the whole primary care team in their own practice.

Several attempts have been made to improve the attitudes, knowledge, and skills of GP trainers, established GPs, and GP trainees.[27,37,42–50] Most of these programs have not been disseminated to other centers. Thompson and colleagues[49] attempted to replicate unsuccessfully the effects reported by Rutz and colleagues[36] on Gotland. Many of these approaches involve a standard training intervention, although a move to a more learner-centered approach has been widely advocated,[51] as has a multiprofessional approach.[52] The challenge is therefore to refine such teaching interventions and show their effect.

The Royal College of General Practitioners Unit for Mental Health Education at the Institute of Psychiatry, London, is developing such training and will be examin-

ing its potential in improving the recognition and management of mental illness in primary care.[53]

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