Barriers to the Diagnosis of Depression in Primary Care

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Approximately 50% of people treated for depression receive treatment in primary care settings. However, studies have demonstrated that specific factors interfere with recognition of this disorder in the primary care setting and decrease the likelihood of an accurate diagnosis. Variables that relate to the patient include lack of awareness and understanding of the nature of the disease and its symptoms so that they can be accurately reported to the physician. Variability in clinical presentation and the presence of comorbid medical disorders also make detection difficult. Complaints of physical symptoms confuse the clinical picture. In addition, patients are ashamed to admit to psychological symptoms of depression and fear the stigma attached to it. Interfering factors that relate to the physician include a lack of knowledge about the disease and lack of training in its management that reduce the physician's ability to render a diagnosis and undermine confidence in the capacity to treat the illness successfully. Reluctance on the part of the physician to inquire frankly about depression also plays a role. Barriers that stem from the system include financing of care under capitated systems, other reimbursement issues, time available to care for patients, and continuity of the physician/patient relationship. A variety of tools are available to assist primary care physicians in the recognition and accurate diagnosis of depression. Use of these tools would increase the recognition and effective management of depression.
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Depressive illness is common in the U.S. population. The recent National Comorbidity Study,[1] a large-scale epidemiologic survey of mental illness prevalence, indicated that the lifetime prevalence of major depression is 17% (Table 1). In any given year, 10% of individuals aged 18 to 54 years are suffering with a depressive disorder. Morbidity and mortality associated with depressive illness are quite high.[2–8] In a study in more than 11,000 adults, Wells and colleagues[9,10] found that depression was associated with impairment equivalent to or greater than that associated with such chronic or recurrent disorders as diabetes, hypertension, arthritis, gastrointestinal disturbances, lung disturbances, bronchitis, emphysema, and back problems; only advanced coronary artery disease and some aspects of angina were associated with greater impairment. Major depression is associated with a 15% mortality rate in association with suicide alone for those patients whose depression is severe enough to require hospitalization.[11]

Table 1. Lifetime and 12-Month Prevalence Rates for Major Depression and Dysthymia*

Disorder	Time Frame	Male (%)	Female (%)	Total (%)
Major depression	Lifetime	13	21	17
	12-month	8	13	10
Dysthymia	Lifetime	5	13	6
	12-month	2	3	3

*From reference 1, with permission.

The significant morbidity and mortality associated with major depression are in large part preventable. With appropriate treatment, response can be achieved in more than 70% of depressed individuals.[12,13] However, the proportion of individuals who receive treatment for depression is quite small, and the proportion who receive appropriate treatment is smaller still. Data from the National Comorbidity Study indicate that only half of individuals with three or more mental disorders receive care in any setting over their lifetime, and 40% receive mental health specialty care (Figure 1).[1] For those with one or two disorders, 40% receive care in any setting, and one quarter receive mental health specialty care. It is estimated that 5% to 10% of patients with depression are effectively treated over the course of their lifetime.[14,15]

Most patients with depression have their initial contact with the health care system in the primary care setting, of-

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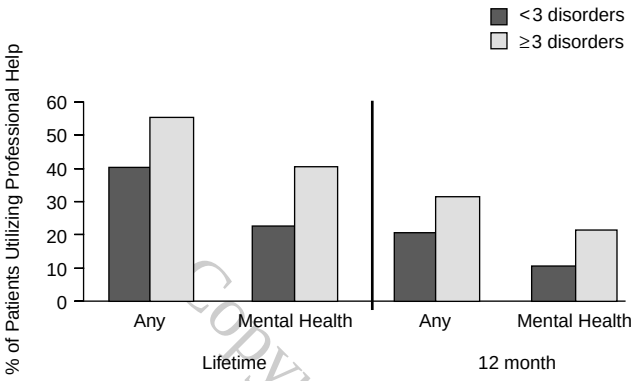
Figure 1. Proportion of Patients With Mental Disorders Receiving Any Care or Mental Health Specialty Care by Number of Disorders in the National Comorbidity Survey*



*From reference 1, with permission. Proportion of patients with mental disorders receiving care in any setting or receiving mental health specialty care. Data are shown according to number of mental disorders present and as lifetime and 12-month percentages.

Table 2. Patient and Physician Barriers to Recognition of Depression

Patient barriers
Absence of self-awareness
Clinical presentation
Comorbid medical illnesses
Physical symptoms
Degree of somatization
Subthreshold depression
Characteristics of the depression
Severity
Quality of mood
Shame/guilt/hopelessness
Physician barriers
Background training and knowledge
Beliefs
Effectiveness of treatment
Self-confidence to treat depression
Need for information
Attitudes
Comfort with psychological issues
Perceived time availability
Perceived role responsibility
Extent to which patient is to blame for the illness
Perception of physical illness as a "good reason" for depression
Skills
Systematic gathering of information
Direct inquiry
Assessment of nonverbal signs of emotional distress
Interviewing skills

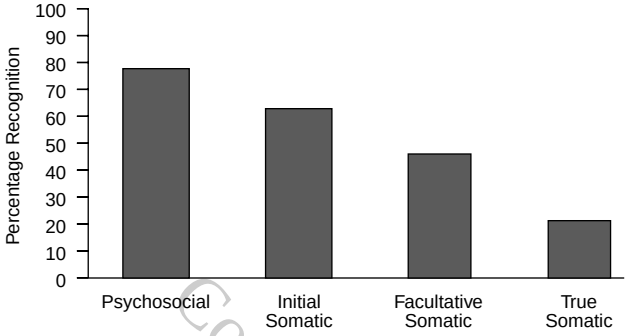
ten seeking help for another disorder or for somatic symptoms of depression. The primary care setting thus presents a special opportunity to increase the percentage of patients with depression who are accurately diagnosed and effectively helped.

BARRIERS TO EFFECTIVE TREATMENT IN PRIMARY CARE

Analysis of the usual processes of care for patients with depression shows that there are several points at which opportunities exist to intervene to improve quality and cost-effectiveness of care. These "key levers" can be identified as the following: (1) recognition and diagnosis; (2) appropriate specialty care referral; (3) acute treatment selection; (4) acute treatment implementation; (5) maintenance treatment; and (6) patient adherence. There are problems at each of these points in the primary care setting. A review of studies of recognition of depression in primary care[14,16–48] indicates that rates of accurate diagnosis have ranged from 7% to 70%, with rates in most studies falling in the 30% to 40% range. Approximately 5% to 10% of those diagnosed receive referral to specialty care.[41,49,50] In a study of referral criteria among primary care physicians who do refer patients,[51] retrospective analysis of referred cases showed that the physicians followed their own specified referral criteria in only 20% to 50% of cases. With regard to acute treatment selection, a survey of primary care physicians indicates that no clear criteria exist for employing psychosocial interventions, despite evidence from randomized controlled trials of efficacy of at least five major forms of psychosocial treatment.[52] Pharmacotherapy is beset with problems. With regard to selection of treatment, a recent study by Options Managed Care showed that benzodiazepines accounted for three of the top five medications prescribed for antidepressant treatment by primary care physicians.[53] In another study,[54] it was found that only 45% of patients needing antidepressant medication received it, and only 25% of them received adequate dosage or duration. Data from the Medical Outcomes Study[55,56] show that 60% of patients with major depression received no medication; of those receiving any medication, 20% received only a minor tranquilizer and 12% received an antidepressant alone. With inadequate management of side effects, treatment compliance in this setting is poor. Duration of treatment is also largely inadequate, and systematic trials of medication for more than 6 weeks were unusual.

In addition to diagnosis, treatment, and treatment adherence barriers, barriers to effective management also exist at the system and policy levels. Problems at the system level include limitations on time available for the primary care physician to spend with each patient, difficulties in transmitting information between specialty and primary care settings, and access to specialty care that is convenient in terms of waiting, geography, and hours of operation. Policy issues include reimbursement methodologies and their impact on the ability of physicians to provide the most appropriate and effective treatment. Some of these system and policy issues are discussed in other articles in this supplement.

Figure 2. Effect of Type of Patient Presentation on Recognition of Depression in Primary Care*



*From reference 57, with permission. Proportion of patients in whom depression was correctly recognized according to whether patients had psychosocial, initial somatic, facultative somatic, or true somatic presentation in the primary care setting.

BARRIERS TO RECOGNITION AND DIAGNOSIS

Patient Barriers

Barriers to recognition of depression in primary care can be categorized as patient-related or physician-related (Table 2). Patient barriers to recognition and diagnosis include absence of awareness of the character of depression and of its status as a medical illness that is eminently treatable. On the most basic level, overall diagnostic yield for depression would be markedly improved if patients presented to primary care physicians to be evaluated for depression on the basis of their awareness of the illness and its symptoms. Programs to increase awareness of depression in the general population are important in this regard. Valuable initiatives include programs developed by the National Institute of Mental Health Depression Awareness, Recognition, and Treatment Initiative.

Other barriers on the patient side include the nature of the clinical presentation. Patients presenting with comorbid medical illness are less likely to receive a diagnosis of depression. Tylee et al.[42] found that recognition of depression on the part of primary care physicians occurred significantly more frequently for patients with no other physical illness (67%) than for those with comorbidity (29%). Similarly, the presence of physical symptoms is associated with a reduced likelihood of correct diagnosis of depression. Kirmayer et al.[57] have shown that correct recognition of depression is related to degree of somatization in patient presentation (Figure 2). In a primary care setting, depression was recognized in 77% of patients spontaneously presenting with at least one psychosocial symptom or problem (psychosocial presentation), 52% of patients spontaneously presenting with somatic symptoms but affirming a psychosocial problem when asked (initial somatic presentation), 45% of those presenting with only somatic symptoms but admitting the possibility of psychosocial problems (facultative somatic presentation), and 20% of those presenting with somatic symptoms and denying all psychosocial problems (true somatic presentation). Other factors that influence recognition include characteristics of the depression, including severity, quality of mood, and feelings that are part of depressive illness. Patients able to complain of a distinct quality of mood are more likely to be recognized as having depressive illness. Finally, feelings of shame, guilt, or hopelessness, ubiquitous in depression, present barriers to diagnosis because the patient may feel unworthy of seeking or receiving help, feel that there is no help that will do any good, or simply lack the strength, energy, and clear-mindedness to seek help.

Physician Barriers

Physician barriers to recognition of depression can be grouped under the general headings of beliefs, attitudes, knowledge, and skills.

Belief and Attitudinal Barriers.[14,22,35,47–49,58–61] With regard to beliefs, an increased likelihood of recognition of depression is associated with stronger belief in the effectiveness of treatment for depression and greater self-confidence on the part of the physician regarding his or her ability to treat depression. The belief that information gathering is necessary to recognition and the willingness to gather information are also both related to likelihood of recognition.

With regard to attitudes, correct diagnosis is more likely if the physician is comfortable with psychological issues, if the physician has the perception that he or she has time available to deal with psychological issues, and if the physician perceives treating mental illness as part of his or her responsibility as health care provider. Correct diagnosis is less likely if physicians think that patients are to be blamed in some respect for their illness; recognition is also less likely if physicians believe that a "good reason" for the depression exists in the form of, for example, a concomitant medical illness or a serious problem in the patient's life.

Knowledge and Skills.[16,27,32,34,39,62–69] Review of the literature reveals that knowledge of depression and its treatment and particular skills are associated with successful diagnosis,[16] including the ability to directly and systematically inquire about mood disturbance and to accurately assess nonverbal signs of emotional distress and good interviewing skills. In one study, primary care physicians were asked to assess how well they believed they could recognize depression and whether they believed they needed to ask questions of the patient in order to diagnose depression or confirm the diagnosis.[60] It was found that those physicians who believed that they could render a diagnosis on the basis of their ability to read hidden emotions were less likely to recognize depression. Those physicians who

Table 3. Tools for Assisting Primary Care Physicians in Recognizing and Treating Depression

Zung Scale[75,76]
AHCPR[a] Depression in Primary Care Guideline[12,77]
Prime-MD[78,79]
Symptom Driven Diagnostic System[80–83] (SDDS)
Rhythms
Pro-Partners
Pfizer/Value Health Science computerized disease management program

[a]Abbreviation: AHCPR = Agency for Health Care Policy and Research.

believed that they could recognize depression only if they asked a set of systematic questions were much more accurate in recognizing depression.

PRIMARY CARE VERSUS SPECIALTY CARE

Available data indicate that in critical areas, quality of care in the psychiatric setting is superior to that in primary care, including higher rates of depression recognition, higher level of patient satisfaction, better clinical outcome, and more comprehensive and effective treatment of subthreshold depression.* The level of severity of depression is also greater in the specialty care setting. Although cost of treatment is greater in specialty care, current data indicate that cost-effectiveness of treatment is also greater. Although it may thus seem that one approach to improving overall quality of care of individuals diagnosed with depression is to refer them to specialty care, such an approach may be unrealistic for a number of reasons. One is that the current broad changes in health care financing serve to guide patients increasingly into the primary care setting. Another is that many patients prefer to receive treatment in the primary care setting. Data from the Epidemiologic Catchment Area (ECA) study indicate that 60% of depressed patients receive all of their care from primary care physicians.[74]

Methods to Improve Recognition of Depression

Given that the majority of patients with depression are likely to seek treatment initially in the primary care setting and that many are likely to continue treatment in that setting, efforts are clearly needed to improve diagnosis and treatment in primary care. A number of tools currently exist to assist the primary care physician in recognizing and managing the depressed patient (Table 3). Studies in Sweden[66,67] indicate that a 2-day educational session on depression repeated annually or every 2 years can substantially increase the rate of recognition of depression among primary care physicians. However, a number of more systematic approaches have been developed that, if followed in the primary care setting, would most likely result in an increase in both rate of recognition and rate of effective treatment. The Zung Self-Rating Depression Scale[75,76] (SDS) is a 20-item depression scale that has been shown to increase the depression recognition rate by 2.5-fold to 25-fold in several studies of systematic use in primary care offices, with degree of improvement being affected by baseline recognition rates and experience of the physicians in this area. A guideline for diagnosis and treatment of depression in primary care has been formulated by the U.S. Agency for Health Care Policy and Research (AHCPR)[12,77]; the AHCPR Guideline is the product of exhaustive and rigorous review of scientific literature in the area, comprising some 3500 studies. Prime-MD[78,79] is an instrument that screens for five major psychiatric disorders common in the primary care population: mood disorders, anxiety disorders, eating disorders, alcohol abuse, and somatization disorder. The instrument consists of a 26-item questionnaire completed by the patient and confirmatory modules administered by the physician. The Symptom Driven Diagnostic System for Primary Care[80–83] (SDDS-PC) is another instrument that screens for six disorders common in the primary care setting; the patient-administered questionnaire consists of 16 items and each of the confirmatory modules requires approximately 5 minutes to administer. Rhythms, a program sponsored by Pfizer, and Pro-Partners, sponsored by Eli Lilly, are well-designed and highly useful programs that assist in tracking the course of depressive illness and provide patient educational material in a sequenced and systematic fashion. A new program is a comprehensive computerized depression management program developed by Pfizer and Value Health Sciences. The program has been specifically designed to address the key levers in depression recognition and treatment discussed above. In particular, the program assists in the subtyping and severity rating of depression and provides recommendations for acute treatment, guidelines for referral, guidelines for acute treatment, recommendations for maintenance treatment, and a methodology for follow-up and monitoring of continuation care.

CONCLUSION

The bottom line of these efforts to improve recognition and management of depression in the primary care setting is the extension of effective care to a greater proportion of individuals with depressive disorder in this country. The psychiatric profession has a responsibility to initiate and support these efforts. Continued referral of patients with complicated illness, including illness of greater severity, drug therapy problems, or psychiatric comorbidity, to specialists will ensure that increasing numbers of those patients who will benefit most from specialized care will continue to have such care available to them.

*References 6, 14, 24, 29, 30, 38, 40, 41, 45, 54, 56, 70–73.

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