The diagnosis and management of depression and anxiety in primary care: the need for a different framework

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The reality of primary care argues for a separate approach in the diagnosis and management of depression and distress

There has been increased debate related to depression and common mental disorders over the past few decades. The high prevalence of depression in primary care, and the low recognition and treatment rates have inspired primary care psychiatry. Educating general practitioners, preparing practice guidelines and conducting courses to improve their clinical skills have been attempted. These efforts have resulted in the expectation that depression would be managed in primary care. However, despite piloting, field studies and acceptance by academic general practitioners, the watered-down psychiatric approach, when used in primary care, has few takers in actual practice.^{1,2} The culture of primary care psychiatry borrows heavily from academic psychiatry and attempts to adapt it to the reality of primary care. The compromise is uneasy, unstable and difficult to apply in general practice. This paper highlights the issues related to the diagnosis and treatment of common mental disorders, the issues related to their presentation and management in primary care and suggests alternative strategies.

Recent trends in medicine

Two trends have markedly affected the diagnosis and management of psychiatric presentations in primary care. Firstly, the growth of medicine over the past century has seen the decline of family medicine and general practice, and the meteoric rise of specialist approaches. Many problems presenting to primary care are now viewed from a specialist perspective. This is true across all medical disciplines and particularly true of psychiatric disorders in primary care. Secondly, the progressive medicalisation of distress has lowered thresholds for the tolerance of mild symptoms and for seeking medical attention for such symptoms.³ Patients visit general practitioners when they are disturbed or

distressed, when they are in pain or are worried about the implications of their symptoms.⁴ However, the provision of support currently demands medical models, labels and treatments to justify medical input.

Psychiatric diagnosis, classification and treatment

Psychiatry has seen a revolution in diagnosis and classification. The medical model has increasingly influenced psychiatric thought. The lack of laboratory diagnosis, the absence of pathognomonic symptoms for specific categories and the problems in eliciting individual symptoms have resulted in the use of a collection of symptoms (syndrome) for diagnosis.⁵ However, clinical syndromes are often heterogeneous on aetiology, pathology, clinical features, response to treatment, prognosis, course and outcome. For example, symptoms of depression are a part of normal mood, a reaction to stress, habitual patterns of coping in people overwhelmed by the demands of life and due to diseases of the brain. They can completely remit, or have a relapsing or a chronic course. The many operational criteria and the numerous revisions of the classification systems often give psychiatric diagnoses an aura and equate the many categories with physical diseases. However, psychiatric categories can convey little information about aetiology, treatment and prognosis, and often create a spurious impression of understanding.

Nevertheless, diseases are essentially professional conceptualisations.⁶ They often assume biological dysfunction and disadvantage. Many psychiatric categories are also based on a social concept of agreed undesirability. Such conceptualisations are preferred to viewpoints, which argue for sin (from a religious point of view), crime (from a legal viewpoint) or social problem (from a social work perspective).

Illness, on the other hand, is a socio-cultural construction of sickness as perceived and experienced by a patient. Recent psychiatric classifications have used the term "disorder" as a compromise, as it side-steps the disease-illness controversy.

Psychiatric treatments, on the other hand, are essentially symptomatic.⁵ For example, tricyclic and serotonin-specific reuptake inhibitors are used for depression secondary to medical and organic conditions, and for depression in schizophrenia, affective disorders, stress-related conditions and personality disorders. They are also used in a variety of anxiety disorders including panic, phobia, obsessive-compulsive disorder, generalised anxiety and post-traumatic stress. This is also true for psychological treatment concepts and techniques, which are also used across psychiatric categories.

The different reality of primary care

The reality of primary care is not adequately understood by academic psychiatrists working in tertiary referral centres. The issues are briefly mentioned as follows:

- (a) There are differences between patients attending a psychiatric hospital and those who present to primary care. Patients who visit psychiatric facilities often have severe, complex and chronic illness, and are highly motivated to receive specialist treatment. On the other hand, those who visit general practitioners have milder and less distinct forms of illness, with concomitant psychosocial stress.
- (b) Differing conceptual models and perceptions are used in different settings. Psychiatrists use medical models, whereas general practitioners focus on the psychosocial context, stress, personality and coping.
- (c) Symptom scores in patients attending primary care, on standardised interview schedules (eg, the Revised Clinical Interview Schedule⁶) are distributed continuously with no point of rarity between cases and non-cases, making dichotomous clinical decision making difficult.
- (d) Mixed presentations of anxiety and depression are common in primary care.
- (e) Many patients who cross the case threshold do not have the complete syndrome attributes of depression or of anxiety.⁷

- (f) The labelling of patients with sub-syndromal presentations on the basis of distress and impairment essentially implies a lowering of the threshold for diagnosis.⁸
- (g) Studies using statistical techniques have failed to show the superiority of the two-factor anxiety–depression models over the one-factor solution.⁹ In addition, the anxiety and depression factors of the two-factor model have always been highly correlated.
- (h) The most common presentation of psychiatric problems in primary care is with medically unexplained somatic symptoms.¹⁰ However, a large number of such patients also mention the presence of simultaneous psychological stress or distress. The cultural background of the patient may determine the mode of presentation—that is, psychological or somatic symptoms.
- (i) The aetiology of medically unexplained somatic symptoms is unclear.¹¹ The general tendency is to assume psychogenesis. However, the label “somatisation” actually acknowledges medical ignorance rather than understanding.
- (j) The numerous categories of depression in the International Classification of Diseases (ICD 10)¹² for use in psychiatric settings have been clubbed into a single category of depression in the ICD 10 for primary care,¹³ resulting in patients with features of biological depression being grouped with normal people with adjustment reactions due to stress and with those who cannot cope with the demands of life because of poor coping skills.
- (k) Many studies have shown a high rate of spontaneous remission of depression and common mental disorders in primary care.¹⁴ Literature on major depression also supports the argument that there is a high rate of spontaneous remission.¹⁵
- (l) Many authors have highlighted the high rate of improvement in the placebo arms of randomised trials used to test the efficacy of antidepressant drugs.¹⁶
- (m) Despite efforts at simplification, the guidelines for managing common mental disorders in primary care have proposed elaborate and separate protocols for each of the traditional psychiatric categories,¹³ making them impractical for routine use.²

The need for a radically different approach

The different reality of primary care, the arbitrary categorisation inappropriate to the primary care setting and the symptomatic nature of all current psychiatric treatments demand a radically different approach for managing psychiatric problems in primary care. Two alternative and complementary approaches, rooted in primary care, are suggested.

A. Management of common mental disorders without formal diagnosis

The continuous distribution (non-bimodal) of symptom scores, the mixed presentations, the difficulty in the clinical and statistical separation of anxiety and depression, the high correlation between two traditional categories, the sub-syndromal yet distressing conditions, the difficulty of differentiating distress from disorder and the symptomatic nature of current psychiatric treatments argue strongly for the futility of subcategorisation of psychiatric presentations in primary care. The failure to recognise and label psychiatric disorders in primary care has often been blamed on poor education and skill among general practitioners. Psychiatrists who regularly work in primary care appreciate the complexity of the task. Psychiatrists would also misclassify patients, for the reasons mentioned, if their diagnostic skills were compared against standardised interview schedules in primary care settings. Finally, even the minority of patients who present to primary care with specific classic and identifiable psychiatric syndromes are treated with symptomatic treatments arguing against the usefulness of diagnostic subcategorisation.

The advantages of an approach which does not subcategorise psychiatric presentations in primary care are as follows:

- (a) It includes the use of neutral diagnostic labels, reducing the stigma associated with psychiatric terms. Terms such as “functional somatic symptoms” and “unexplained medical symptoms” more accurately describe such cases and should be preferred to “somatisation”, which re-words the same phenomenon in psychiatric jargon.
- (b) It avoids the distress/disease controversy.
- (c) It focuses on a holistic approach rather than a symptom checklist.
- (d) The identification of multiple diagnostic labels due to the high correlation between traditional categories will be avoided.

- (e) It avoids the threshold debate separating distress and disease.

The approach advocated argues that symptom presentation be treated without labels. However, such an approach would go against medical tradition. Nevertheless, the mixed emotional states and the arbitrary divisions make psychiatric classification, especially when applied in primary care, much less meaningful, making such an approach worthwhile.

B. The use of a single general protocol for management

The difficulty in the categorisation of psychiatric presentations is further compounded by the complex and separate protocols for each traditional psychiatric syndrome. They may not be necessary for patients who present to primary care, nor practical for use in such settings. The minor variations in presentations do not warrant major changes in the treatment approach. All common presentations of non-psychotic psychiatric morbidity have common themes in treatment. An amalgamation of these common issues specifically suited primary care has been attempted, and general principles have been enumerated.^{17, 18} Table 1 lists an example of a general protocol, which has identified the essence of treatment often useful in patients with common mental disorders who present to primary care.¹⁹ The steps do not follow specific theory, but are eclectic and consider specific concerns of patients who present to primary care and who often receive psychiatric labels. The 10 simple steps are practical and can be used in busy general medical settings.

The advantages of a single protocol include:

- (a) Greater chance of mastery and consequent use in clinical practice
- (b) Encouragement of a holistic approach to care
- (c) Flexible format that allows incorporation of specific techniques
- (d) Provision for the treatment of the classic syndrome.

Although specialists will argue for the use of specific treatments, the limited applicability of such protocols in busy general practice settings argues against such approaches. The current psychiatric treatment strategies, despite their elaborate specifications, are essentially symptomatic. Simplifying protocols will ensure their use in routine clinical practice. There is a need to identify such optimal general protocols and to test their efficacy and effectiveness in

Table 1 The 10-step symptomatic approach to managing common psychiatric disorders¹⁹

1. *Acknowledge distress:* Acknowledging distress suggests that patients' symptoms have been carefully considered, and also reflects an empathetic attitude and contributes to establishing an effective rapport and the formation of a therapeutic alliance, which are essential in facilitating improvement
2. *Elicit patient's perspective on symptoms:* Providing appropriate reassurance is an important part of the medical consultation. It is most effective if based on the patient's actual concerns. Eliciting such explanations will also allow for focused examination, investigations and specific reassurance
3. *Focused history, physical examination and laboratory investigations:* This will go a long way in reassuring the patient that medical causes have not been overlooked
4. *Reassure patients about symptoms:* Reassurance is crucial in allaying the patient's concern and changing their help-seeking behaviour. Explanations that completely deny all disease often makes patients wonder if the doctor disbelieves their symptoms. Explanations that provide tangible mechanisms grounded in patients' concerns, often linking physical and psychological factors, are necessary as they have a greater chance of acceptance by patients and better psychosocial outcome²⁰
5. *Providing alternative explanation for symptoms:* A common expectation among patients is a better understanding of their symptoms. Worrying about their health is bound to recur if the symptoms persist, especially if the patients lack a satisfactory explanation that allows them to interpret their symptoms as benign. Consequently, it becomes necessary to manage the patient's beliefs, misconceptions and concerns about health. Altered bodily function (eg, irritable bowel syndrome) as an explanation is helpful for many patients. Alternative explanations for symptoms (ie, the individual's tendency to interpret innocuous bodily sensations as bodily dysfunctions or symptoms related to stress) are also useful. Simple explanations of possible links between anxiety and stress causing physical symptoms or how depression lowers the pain threshold are constructive. Patients often present their need for explanation by explicit questions, statements of concern about symptoms, suggestions that disease might be absent or tentative references to serious disease. Doctors should take the opportunities to work with patients in developing explanations that offer hope, and indicate ways forward or out of their current predicaments²¹
6. *Prescribe drugs:* Patients may expect drugs to be prescribed. Antidepressant drugs are useful and can be prescribed if depression, anxiety, panic, phobia or obsessive-compulsive symptoms are present, or when the pain is incapacitating (eg, headache, irritable bowel syndrome, atypical chest pain). Serotonin selective reuptake inhibitors are generally preferred as they have fewer side effects. However, tricyclic or newer sedative antidepressants are favoured in patients with insomnia. Nevertheless, the placebo response has been documented in trials for major depression. Patients who wish to avoid psychotropic drugs and those without such symptoms can be given vitamins, and the placebo response often helps them cope with their circumstances and reduces symptoms and distress²²
7. *Suggest general stress-reduction strategies:* Recommending regular physical exercise, involvement in religious activities, hobbies, leisure, yoga or meditation to improve coping are useful. Incorporating such activities into the patient's daily routine is cardinal for success
8. *Explore possible stress and specific measures to reduce tension:* Patients with specific problems will need help with problem solving. Often, life situations may be difficult to resolve and may require acceptance and change in coping strategies. Asking patients to look for specific solutions to their difficulties and giving them time to examine the issues is obligatory. Problem solving and simple cognitive behavioural techniques can be included in follow-up sessions
9. *Discussing patient's choices, alternatives and responsibility:* Some patients expect cures from doctors, whereas many have limited expectations and mainly expect emotional support and explanation.²³ The provision of emotional support and explanation are necessary, but there is also a need to discuss the patient's choices, alternatives and responsibility
10. *Give a specific appointment for review:* Agree on a treatment plan. Regular progress review is necessary for most patients with scheduled, brief appointments. Restoration of function and psychological support are the treatment goal rather than complete symptom elimination. Referral to specialists should be avoided as these patients are best managed in primary care settings. Psychiatric evaluation and specialist counselling may be necessary for persistent and incapacitating mental disorders, suicidal ideation, interpersonal difficulties, sexual dysfunction and substance dependence

clinical practice by using randomised controlled trials.

Other approaches to treatment

Two other approaches to the treatment of depression are worth mentioning. Firstly, Dowrick²⁴ has argued that depression is an explanation promoted by the pharmaceutical industry (which wants to increase the sale and profits from antidepressants), by psychiatrists (who subscribe to the medical model of disease), by general practitioners (who are looking for simple solutions to complex problems) and by society's need for relieving all forms of personal and social distress. He argues for alternative approaches of understanding the thoughts and feelings that we currently describe as depression, drawing on a wide variety of non-medical sources. He suggests that we move beyond depression as a medical concept and as a personal problem.

The other approach is case management for major depression in primary care as practised in the US. Deficits in the care of depression lead to poor drug

compliance, which increases the risk of unfavourable outcomes. Systematic reviews have concluded that case management improves outcomes of major depression in primary healthcare settings.²⁵ However, this approach examines an intervention for a specific and severe category of depression in a particular context. Its application and usefulness for all presentations of anxiety and depression in primary care has not been shown.

The practice-theory gap

It is generally believed that theory drives practice. This is a simplistic interpretation of realities on the ground. In fact, it is practice that defines theory. The distinction between justice and law is an example. Justice is an agreed concept of value which is implemented through law. However, the laws often fall short of delivering justice, and need to be constantly interpreted and rewritten to provide justice. Similarly, the relief of distress among patients who attend primary care is an agreed aim. It is implemented through the different

practice guidelines. Many of these recommendations fall short of the ideal and need to be re-examined and re-worked. This is particularly true of the diagnosis and management of common mental disorders in primary care.

The challenge of relieving emotional distress is currently dealt with by practice guidelines based on the medical model. The many issues raised suggest that the current medical diagnostic and therapeutic approaches, which demand subcategorisation and the use of specific treatment protocols, do not meet the challenge and are inappropriate for the task. There is a need to re-work the details keeping in mind the complex nature of the issues.

The approaches suggested need to be evaluated, as all interventions need an evidence base before implementation in clinical practice. The framework suggested does not currently have an evidence base that supports its use in primary care. However, competent clinicians working in primary care already use similar approaches, which provide for face and content validity.

Nevertheless, randomised controlled trials should be used to prove the efficacy and effectiveness of these approaches. The current medical model places an ideological bar on the discussion of alternative approaches. There is a need for an alternate framework, and an urgency to narrow the practice–theory gap.

CONCLUSION

The two strategies suggested are based on the argument that it is difficult to subcategorise clinical presentations of common mental disorders in primary care. It maintains that diagnostic labels are not necessary for management, as the current psychiatric treatments are essentially symptomatic and are delivered across diagnostic categories. It supports the contention that the presentations currently labelled as anxiety, depression or common mental disorders in primary care are illness experiences that do not require disease labels. It makes a case for the provision of support without medicalising the issues. It also suggests that the standards for medical practice should be based on the issues as seen in primary care rather than those used in tertiary and specialist settings.

The focus on clinical presentations without diagnosis and the symptomatic management of people with emotional distress who present to primary care are complementary. In fact, these approaches are not new and describe the current practice among competent doctors in primary care. Recent concepts and interventions, based on specialist perspectives, have not only complicated the issues but have also disempowered general practitioners with psychiatric jargon and techniques which are impractical and counterproductive in primary care settings.

The reality of primary care, its problems and opportunities demand unique solutions. Transplanting knowledge structure, formations and practices developed and used in tertiary care and specialist facilities results in a lack of goodness of fit. Context and local knowledge are critical to understand the illness in primary care. Universal abstractions may not fit local reality and artificially force the structures. Primary care should be able to choose a different framework for the management of psychiatric and emotional problems. Contexts can not only change medical practice but should also be able to change medical perspectives.

Summary points

- The diagnosis and management of depression and distress in primary care is controversial.
- The different reality of primary care argues for a separate approach that should be rooted in primary care.
- Management without subcategorisation and the use of a simple general protocol are suggested as the way forward in managing common mental disorders in primary care.

The complexity of the issues related to the diagnosis and management of such presentations demand a re-evaluation of the issues. The alternative approaches have to be rooted in primary care so that they are useful and can be successfully employed.

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