Recognition and management of depression in general practice: consensus statement

E S Paykel, R G Priest, on behalf of conference participants

Depression is a frequently occurring psychiatric disorder, and most depressed patients in the United Kingdom are treated in general practice. The Royal College of Psychiatrists, in association with the Royal College of General Practitioners, has embarked on a "defeat depression" campaign.[1] Anticipating that an increased proportion of the large numbers of the general population who do not at present receive treatment for depressive illness will present to helping agencies, the two colleges are preparing professional educational materials and guidelines.

In recent years there has been a great deal of new knowledge regarding diagnosis, recognition, and effects of treatment. Two consensus meetings in which participants were mainly representatives of the two colleges, together with other experts, were therefore held in 1991 to consider, firstly, diagnosis and recognition (21 October 1991) and, secondly, management (15 November 1991). Specific questions were addressed by a presenter with a prepared paper, and a discussant, followed by extensive general discussion to reach an agreed consensus, which was circulated to participants for further approval. We present views that reflect the agreed conclusions. We emphasise, however, that they do not necessarily reflect the official policy of either of the two colleges. They are intended to form guidelines which we hope will be useful in practice and also in audit.

Diagnosis and recognition of depression

WHAT IS DEPRESSION?

The term depression describes a continuum of phenomena from a normal mood which is common and affects almost everyone from time to time to a severe disorder. A central feature of all depressive conditions is the lowering of mood, which when more severe may be accompanied by tearfulness and lack of ability to take interest in or pleasure from one's usual activities.

As depressions become more pronounced and pathological to reach the level of a psychiatric disorder the disturbance becomes more pervasive and a range of other symptoms develops.[2] In almost all cases there is a characteristic way of thinking, with persistent negative views, which may include thoughts of personal worthlessness and incapacity, guilt about past actions, and pessimism about the future. Ideas of being better off dead develop and thoughts of suicide with the possibility of suicide or attempted suicide. Depression probably precedes the large majority of all completed suicides. Disturbances of sleep and appetite are common, usually in the form of a reduction, sometimes of an increase. Other physical symptoms include diurnal variation of mood, loss of energy, psychomotor retardation (slowing of movement and speech), and fears or beliefs of bodily illness. There is impaired concentration, impaired ability to function in work and in a range of other roles, and impaired personal relationships. Anxiety is common. The boundary between depressive and anxiety disorders is not precise, and mixed states are common.

Modern classifications isolate a syndrome of "major depression."[3,4] An example of a definition (modified from published criteria) is presence of depressed mood or loss of interest and pleasure; four or more of seven concomitant symptoms—namely, feelings of worthlessness or guilt, impaired concentration, loss of energy and fatigue, thoughts of suicide, loss or increase of appetite and weight, insomnia or hypersomnia, retardation or agitation; a minimum duration of two weeks; and no evidence of other primary disorder. This syndrome is particularly useful when considering treatment with antidepressants.

Other forms of depression are also important in general practice, including (*a*) depressive episodes which do not reach the thresholds for major depression; (*b*) lifelong mild fluctuating depression (dysthymia)[3,4] on which major depressive episodes may be superimposed; (*c*) mixed subclinical states below the level of either of these. Manic depressive disorder (bipolar illness) with periods of elevated mood in addition to depression forms only a small proportion of all depression in general practice but tends to be more severe and recurrent.

Depressive disorders have a range of causes, including major stressful life events and losses, lack of social support, physical illness, and predisposing familial and genetic factors.[2] Multiaxial dimensions incorporating independent physical, psychological, and social elements can be useful in general practice. Aetiological distinctions such as reactive and endogenous and whether the depression can be explained by stress are no longer regarded as important in defining the presence of the disorder and need for treatment. What matters is presence of the syndrome.

Depression may present with somewhat different features in ethnic minorities within the United Kingdom. There is evidence of less guilt but more feelings of shame in patients from the Indian subcontinent, and expression of mood disorder by somatic symptoms is common in some cultures.

HOW COMMON IS IT IN DIFFERENT SETTINGS?

Depression is very common in the general population and in patients consulting in general practice. Exact estimates depend on the thresholds taken on the continuum. In the general population at any time the prevalence of major depression is around 5%.[5,6] Three per cent of the general population are diagnosed by general practitioners in a year as suffering from depression, with a roughly equal number who may be unrecognised on consultation.[7] Rates for referral to psychiatrists are much lower—around three per 1000 or 10% of those diagnosed in general practice—and only one per 1000 is admitted to hospital.[7] Lifetime rates for depression also depend on criteria and

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thresholds, with some estimates that at least one third of the population experience an episode of the milder clinical forms during their lives.[8]

The above figures indicate that most depression is treated in general practice. Studies of patients consulting general practitioners confirm this.[9-12] Roughly 5% of consulters show major depression, another 5% milder episodes, and a further 10% some depressive symptoms. Therefore, at least one patient with mild depression or worse is likely to present at each surgery session.

Depression can occur at any age from childhood to old age and is more frequent in young adults than previously thought. It occurs twice as frequently in women as in men, and particularly in women with babies and young children. It is common in those who are physically ill, and is also common with alcoholism. At least half those who experience an episode have a further attack, and about 12% of cases evolve to a more chronic course.

WHY IS DEPRESSION MISSED?

General practitioners have a difficult task requiring considerable skill, often with several presenting problems and cues, to distinguish among a wide range of possibilities, including potentially life threatening physical disorders, less severe physical disorders, mild or no disorder, and psychological disorders. Although general practitioners recognise and manage efficiently a large number of depressed patients, at any consultation about half the patients consulting with depression are not recognised.[13] A further 10% are recognised at subsequent consultations, and 20% remit during this time, but the remaining 20% may remain unrecognised even after six months.

Recognising depression is also made difficult by the frequency in general practice of presentations with somatic symptoms and of depression related to physical disorders.[14 15] The best method for the general practitioner to overcome these problems is by using a relatively direct interview for the main specific symptoms of depression.

There is also an important message for patients. Patients may be reluctant to disclose depressive symptoms because of feelings of shame and also fear that the doctor will not have time to listen. In some consultations in which depression is missed the patient may give no hint of this underlying problem or only a small and easily missed cue to test the doctor's response. A consultation which focuses on physical symptoms and on eliminating serious physical disorder may be satisfying for the worried patient but may fail to get to the root of the problem. It is important for recognition and treatment that patients feel able to acknowledge depressive symptoms and life problems when consulting their doctor. Public education in this regard would be valuable.

There has now been a large body of general practice research which indicates the specific circumstances under which depression and other psychiatric disorders are more or less likely to be missed. These include factors in the patient, in the general practitioner, and in the consultation process. In the patients depressions associated with true physical illness and those presenting as somatic complaints are particularly likely to be missed.[16] Other risk factors for nonrecognition are depressions of less recent origin and those presenting with less overt and less typical symptoms, particularly less prominent depressed mood and appearance, and less insight by the patient.[16] Overt depressed mood is less common as a symptom in ethnic minorities and elderly people.[17] For the general practitioner two symptoms may be particularly valuable in pointing to depression: depression of mood which is persistent and pervasive; and loss of motivation, interest, and drive. Other pointers are fatigue, insomnia, low self opinion, loss of concentration, and hopelessness.[18] Being able to explain a persisting depression in terms of recent stresses should not preclude it from specific treatment.

There are certain doctors who are more accurate in recognising depression.[13 19-22] These tend to make more eye contact with the patient, to be less likely to interrupt the patient or show signs of being in a hurry, and to be good listeners. They are also more likely to ask direct questions with a psychological and social content. These behaviours are likely to encourage the patient to reveal depressive cues. Some behaviours of the doctor will make it more difficult to detect depression because they will have the effect of inhibiting a distressed patient—for example, asking many "closed" questions (those that can readily be answered with a simple "yes" or "no") and asking questions derived from theory rather than from what the patient has just said.

Studies of the consultation interaction itself show that better recognition occurs in those consultations in which patients mention psychological symptoms early and mention more symptoms; where the consultation is longer; and where the general practitioner shows high empathy, tolerates and uses silence, uses the patient's answers in further discussion, and notices non-verbal behaviour.[20-23]

IMPROVING RECOGNITION, AND THE BENEFITS

Accurate recognition of depression in general practice depends primarily on the skill of the doctor as interviewer, and training is most usefully directed at improving these skills. Interview skills training, using video feedback, provided in a one to one or group setting is the method which has been shown most to improve recognition.[24-28] Skills taught have been shown to be maintained over time and to have an impact on satisfaction and outcome. General practitioner trainers can be further trained to teach the skills to their own trainees. Some training has focused on somatic presentations. Two other interventions—direct factual lectures to general practitioners by psychiatrics, and work by psychiatrists seeing patients in general practice surgeries—do not seem to improve this process,[7] although they produce other kinds of benefits.

Training in these detection skills with use of video feedback methods can be widely disseminated through the general practitioner vocational training structure. Particularly helpful contributions can come from training practices, from links between trainers and course organisers, and from links between these and local departments of psychiatry. There is also potential for extending this approach to other members of the primary care team—for example, practice nurses. Training of health visitors in the recognition and management of postnatal depression is already taking place in some areas.[29]

Recognition of depression can be achieved accurately within routine consultations, but there is value in setting aside additional time when necessary—for instance, by another, more convenient appointment. The additional time may not necessarily be spent in detection but may be spent in negotiating what is to be done about treating the depression. It is also valuable to organise practices in such a way as to achieve continuity of contact between the patient and the same doctor. Repeated consultations over a period, even when brief, can help considerably in the task of recognition.

A further procedure that improves recognition under research conditions is screening using questionnaires or computer administered interviews such as the general health questionnaire or Beck depression inventory.[30] It may be particularly of value in high risk

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groups. Additional attention is needed to what the general practitioner does with the information: widespread use of screening without associated training in interview skills would be unlikely to be successful in improving recognition. A British study found that improved recognition, brought about by screening with the general health questionnaire, improved outcome for patients whose illness would not otherwise have been detected.[31] This was replicated in the United States in two studies.[32,33] Two other studies, in which it seemed general practitioners did nothing specifically different as a result of the information, did not replicate the original study.[34,35] Screening can be useful when employed by a skilled practitioner who possesses the interviewing skills necessary to discuss social and psychological problems with the patient.

Recognition seems to improve outcome. In addition to the above screening studies, two naturalistic studies that used independent research assessment of depressive illness found that cases of depression which had been recognised spontaneously by the general practitioner had a better outcome than those that had not been so recognised.[21,36]

Many of the issues in improving recognition of depression are educational. These include not only education of general practitioners but undergraduate medical education and training of doctors in the preregistration and senior house officer years. Public education is also important to reduce stigma, encourage acknowledgment of depression to the doctor, and allow self recognition and recognition by families.

Management of depression

ROLE OF ANTIDEPRESSANTS

At doses of 125-150 mg daily tricyclic antidepressants are effective in patients in general practice with depressive illness.[37-39] In contrast, there is no evidence from controlled trials that doses of 75 mg daily or lower are effective, although individual patients may respond to and remain well on such doses and relapse on withdrawal.[40]

Antidepressants are effective in depressive disorders satisfying the criteria for major depressive episodes,[37,40] and in episodes a little below this threshold, but have not been found effective in clinical trials in the very mild end of the clinical range. Antidepressants are effective even in the presence of life stress and should not be withheld because the depression seems understandable. It is therefore recommended that antidepressant medication should be used for moderate and severe depressions where, irrespective of cause, there is a persistent picture of the depressive syndrome —that is, symptoms additional to the depressed mood itself, such as pessimistic thoughts; suicidal feelings; sleep and appetite disturbance; severe impairment of energy, interest, motivation, drive, or concentration; and impaired capacity to function. In general the dose of antidepressant drugs should be low at the start to minimise side effects and then be increased subsequently over a week or two to the standard psychiatric range.

A wide choice of antidepressant compounds is available for use in general practice. The advantages of the traditional tricyclic antidepressants are that they are cheap and physicians are familiar with their long term effects, including both their efficacy and their adverse reaction profiles. Many newer compounds are less toxic in overdose and have fewer side effects. They are therefore particularly useful where there is a clear suicidal risk or when side effects are likely to be a problem. It may be that fewer side effects will lead to an improved take up of effective treatment. The vast majority of antidepressant compounds available have been shown to be superior to placebo, but no difference in efficacy among drugs has been shown.[41]

Antidepressant drugs should not be used in isolation in treatment. In particular the aims and intentions of treatment should be clarified with the patient, including the actions and side effects of the drugs themselves. Patients' lack of knowledge plays a part in the high rate at which they abandon drug therapy. Patients should be warned that there is likely to be a delay of two or three weeks before substantial improvement will occur. The use of antidepressants should be only part of the general therapeutic approach. A programme of treatment should be negotiated with the patient, whose choice is thus taken into account in the therapeutic contract.

PREVENTING RELAPSE

After successful treatment of the acute episode of depression with antidepressants management may be divided into two phases—the first or continuation phase lasting four to six months, and the second or prophylactic phase progressing thereafter. Further episodes of illness during the first phase are often termed relapses and any during the second phase are termed recurrences.

Continuation phase

As far as drug treatment is concerned inadequate treatment in the first six months in controlled trials resulted in relapse rates as high as 50% (compared with 20% when treatment was continued).[42] Therefore, four to six months of antidepressant therapy after the initial treatment phase is advocated to prevent relapse. There is no reason for a steep reduction to a "maintenance" dose, and drugs should be continued close to the dose at which a clinical response was achieved, unless side effects make this unacceptable. This advice must be balanced against the observation that compliance with such a regimen is poor and up to two thirds of patients fail to take the drugs as prescribed during the first four weeks of treatment.

Some patients are more likely to relapse than others.[43] They include patients with a history of previous episodes of depressive illness, patients who have a severe illness and who have residual symptoms at the end of the acute treatment phase, patients who lack social support, and patients with continuing social difficulties (such as unemployment or dysharmony in interpersonal relationships). The patient clearly should be given as much information and help as possible in deciding whether to continue. Advice should include the facts that antidepressants are not habit forming or addictive and that a minimum of four months' treatment is advised for classic depression to prevent relapse. This will enable the patient better to make an informed choice about continuation with treatment.

Prophylactic phase

The decision regarding long term prophylaxis should be a joint one with the patient, the risks and advantages being balanced against the benefit. Prophylaxis should be seriously considered when there have been recurrent episodes of severe depression (unipolar affective disorder) or recurrent episodes of manic depressive illness (bipolar affective disorder).[44] Antidepressants are effective in the former and lithium in the latter. The total duration of prophylaxis to recommend remains a matter of clinical judgment. The value of prophylactic drug treatment for less severe degrees of depression is more debatable, although there is evidence of an effect of antidepressants in the prevention of depression for up to three years. The appropriate dosage of antidepressants for long term therapy has not been established.

Education of the patient (and when appropriate

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family or friends) about relapse and recurrence is important, particularly in such vulnerable cases. They should be warned to be alert for the possibility of a recurrence and advised what action to take if it occurs. They may be invited to obtain the help of other members of the family or social group in this process.

There is also evidence of a protective effect of cognitive therapy on prevention of relapse[45] (see below). When available, non-drug methods of prophylaxis should be explained to the patient in order to indicate the range of options. The patient should be made aware of facilities for group support and of self help schemes in the locality. The doctor will be expected to advise on how appropriate the various treatments (or combinations of them) are to the individual consulting, and the process of decision is clearly an interactive one.

PSYCHOSOCIAL MANAGEMENT

Counselling and social work treatment can be valuable for patients with less severe forms of chronic or acute on chronic depression, particularly those with chronic practical difficulties and those who are socially isolated or have a poor relationship with their partner. Forms of psychotherapy, particularly interpersonal psychotherapy, may also benefit depression associated problems and, to a lesser degree, symptoms in patients under psychiatric care.[46-50] Psychosocial and medication approaches combine well and should often be used together. To some extent their targets are different.[45]

Patients who have been shown to improve with counselling are depressed people with marital problems —for example, when treated by social workers attached to general practices[51 52]—and women with non-psychotic postnatal depression—for example, when treated by health visitors[29] given minimal training in Rogerian counselling. Studies of brief counselling conducted by general practitioners have tended to concentrate on anxiety reduction rather than depression,[53] and further studies are necessary to evaluate the latter.

General practitioners should consider:

- Seeing other members of the family or friends
- Advising environmental change
- Recommending self help groups
- When appropriate, contacting a range of statutory and voluntary agencies on behalf of the patient, including people of influence such as housing managers and building society or bank managers. Alternatively, an advocate from the local citizen's advice bureau or voluntary agency could be encouraged to do this on the patient's behalf
- Helping the patient set an agenda determined by his or her own priorities, listing the problems being faced. Alternatives to medication should be reviewed and if medication is prescribed the patient should be encouraged to state frankly if it is later abandoned. The patient's role should be as active as possible within the limits imposed by the depression
- Discussing chronic social difficulties with the patient, even if the general practitioner feels powerless to change them, since talking about them may bring relief to the patient. Social work involvement may be helpful here also
- Facilitating the establishment of support groups run by suitably trained health visitors, counsellors, community psychiatric nurses, social workers, or psychologists.

PSYCHOLOGICAL TREATMENTS

Specific psychological treatments based on a recognised theoretical model can be useful in the type of depression found in general practice. In particular, cognitive and behavioural techniques are effective for symptom remission in milder clinical depressions.[54-59] Such specific psychological treatments have a key role in the management of depressed patients seen in primary care. These approaches may be used separately or as an adjunct to pharmacological treatment.

Psychological treatments are important in view of the fact that many patients prefer not to take drugs for their depression. Non-compliance is described above, and some patients given a prescription for antidepressants may not even have it dispensed.[60] Furthermore, some patients do not respond to drugs alone.

Disadvantages of cognitive therapy are that a typical course takes 15 hours and it is not readily available in all areas. Some patients require preliminary treatment with antidepressants before they can function well enough (coping, decision making) to make use of psychological measures. A combination of psychological and pharmacological treatments is sometimes advantageous. Cognitive treatment may reduce rates of relapse and recurrence.[45] If confirmed it would provide an important specific indication.

Short of a formal programme of cognitive therapy, primary care physicians have used some of the principles involved to good effect. These include giving written material to the patient; sharing the rationale and framework of the management plan with the patient; using diary keeping techniques to monitor and schedule daily activities; using simple thought-feeling records; setting "self help" tasks as homework. These principles can often be applied within routine appointments and do not necessarily demand more time for individual patients. An alternative problem solving approach with structured elements has also been shown to be effective.[61]

WHEN IS PSYCHIATRIC REFERRAL APPROPRIATE?

Only a minority of patients with depression are referred to a psychiatrist. The general practitioner has a key role both as advocate and gatekeeper with a prime responsibility to make appropriate referrals to specialists.[62-65] Patients should not be sent to "a specialist" without being told that it is to a psychiatric clinic that they are being referred. Their anxieties—for example, about stigma—and misconceptions should be dealt with appropriately when their agreement is sought for this course of action. The reasons for referral may be divided into those that are patient centred and those that are doctor centred.

Among the first group there is uncertainty about the diagnosis—for example, in a patient with definite depressive symptoms but with the possibility of a more severe underlying psychosis—and for consultation for management. Both may occur if the patient fails to respond to the initial treatment for depression, and the general practitioner may want advice on using higher doses of antidepressants, changing the class of drug, or using lithium and may wish to have supervision of both drug and non-drug interventions. Referral is occasionaly undertaken when hospital investigations are required to look for possible underlying organic brain disease—for example, dementia and tumours.

A further indication for referral occurs when the resources for management are available only through the specialist. This is probably the most frequent reason for referral to a psychiatrist of a patient with depression and is appropriate for all those occasions in which the patient requires management at the secondary care level—for example, outpatient, day patient, or inpatient. It particularly applies to the severely ill patient. This severity may be indicated not just by the number or intensity of the symptoms but also by such features as suicidal potential, violent behaviour, serious self neglect, or psychotic phenomena. Other patients in this category are those whose depression is associated with other psychiatric disorders such as

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anorexia or alcoholism. Failure to respond to simple forms of treatment also brings patients into this situation. It is crucial that there should be avenues for rapid referral including domiciliary consultations. In some parts of the NHS referral to a psychiatrist is the only access route to care by community psychiatric nurses or clinical psychologists.

Among general practitioner centred reasons for referral it is occasionally necessary for the patient to be referred merely as a result of pressure from the patient or others, or because the general practitioner has been offering correct advice that the patient had doubted.

Patients in severe psychological distress are often angry, and the general practitioner may not know how to deal alone and without help with what may appear to be unreasonable behaviour. Psychiatrists should be trained to deal sympathetically and therapeutically with patients whose actions are inappropriate, and the general practitioner should not feel inhibited from referring patients under these circumstances, especially if suicidal behaviour is possible.

ESP and RGP served as chairmen of the consensus conferences. Participants in the conferences are listed below.

"Diagnosis and recognition of depression in general practice": D Bhugra, C V R Blacker, T S Brugha, P E Bebbington, R France, P Freeling, L Gask, D Goldberg, C M Harris, S A Montgomery, T O'Dowd, D Pereira Gray, C Ronalds, J L Scott, D Sharp, P Smith, R Steel, P Surtees, C Thompson, A T Tylee, D G Wilkinson.

"Management of depression in general practice": G Ashcroft, C V R Blacker, R Corney, R France, P Freeling, C M Harris, T O'Dowd, C Ronalds, C Salisbury, J L Scott, D Sharp, R Steel, C Thompson, P Tyrer, A T Tylee, D G Wilkinson, A Wright.

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