Clinical Decisions About Diagnosis and Treatment for Depression Identified by Screening

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Many patients (from 6 to 48 percent in various studies) seen in outpatient medical settings are experiencing symptoms of depression when they present for medical care.[1-6] Most studies of depression in these settings focus on recognition vs nonrecognition of depressive symptoms by clinicians, finding that few of these patients are diagnosed as depressed in routine practice. Recognition is increased by use of a screening instrument.[7,8] However, such a simple dichotomy (recognition, nonrecognition) is not likely to reflect the true range of decisions made by family physicians about patients with depressive symptoms. This report is a preliminary description of the variety of decisions actually made by clinicians about such patients.

Methods

Patients with depressive symptoms were identified by use of the Zung Self-Rating Depression Scale (SDS).[9] The SDS is a diagnostic tool assessing 20 commonly agreed upon symptoms of depression, which has been extensively applied and validated.[10-14] It was administered to all eligible patients seen on two of the four patient care modules of the Duke-Watts Family Medicine Center during three full days per week (Monday through Wednesday) for four months (October 20, 1980, through February 18, 1981). Patients were eligible for the study if they were at least 20 years of age, not pregnant, not currently or recently identified as depressed, able to understand and complete the written SDS, and gave written informed consent. An SDS score of greater than or equal to 55 was used as criterion for entry into the study. This score is in the midportion of the mildly depressed range for the SDS.

Before they saw the patients, physicians were told of results of the SDS and were asked to evaluate the patients for depression and initiate treatment, if indicated. The clinicians were subsequently asked in nondirective interviews to review their decision-making process. Patients were classified into subgroups based on the clinicians' assessment and treatment.

Results

Thirty-nine patients were identified to their clinicians as having elevated SDS scores. The patients' ages ranged from 22 to 87 years, with a mean of 41 years. Ten patients were male (4 black and 6 white) and 29 were female (12 black and 17 white). Patients were seen by 22 clinicians, including 5 faculty and fellows; 5 third-, 4 second-, and 7 first-year residents; and 1 nurse practitioner. The clinical decisions fell into five categories:

1. *Depressed, treat with antidepressant medication.* Placed in this category were the 12 patients the clinicians believed had definite depressive illness requiring treatment with antidepressant medication. Most clinicians reported clear vegetative symptoms of depression as a factor in their decision to begin medication. Clinicians' comments about these patients included "she didn't seem insightful, therefore I would be unable to do psychotherapy," "she had no situational problems which I could expect to resolve."

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2. *Probably depressed, provide counseling, referral, or follow-up for further evaluation.* Eight patients fell in this category. A typical comment was, "situational depression secondary to death in the family. My philosophy is not to treat with medication at first, but try support and counseling; if this does not work or there is a prolonged depression, then treat with medication."

3. *Possibly depressed, further evaluation or treatment for depression deferred.* For two patients, one with angina and another with uncontrolled diabetes, the clinicians treated the more urgent medical problems prior to specific management of the depression.

4. *Possibly depressed, not amenable to therapy.* For 10 patients, the clinicians felt the patients' symptoms were not accessible to therapeutic intervention. Typical among these was the patient who was "not interested in treatment for depression, she said she didn't need it." Another patient was thought to have a "character disorder, not an acute depressive episode." A third was noted to be a "dry alcoholic, chronically anxious, had resolved previous depressions spontaneously."

5. *Not depressed.* There were seven patients whom the clinicians felt were clearly not depressed. For three of these, social problems were identified. One further patient was felt to be "hypochondriacal."

The SDS scores for the two patients in group 3, treated first for a medical problem, were 70 and 64. The mean score for the remaining four groups decreased from a high of 65 for the group which was treated with antidepressant medication, to a low of 57 in the group judged clinically not depressed. The differences among the four groups are statistically significant ($P = 4.279$, $P < .05$). There was a statistically nonsignificant tendency for faculty and fellows to treat fewer patients with medication than did the residents ($\chi^2 = 1.225$, $P > .05$).

Comment

Interpretation of the result of a test screening for depression was not a simple "yes-no" decision about presence or absence of depression. Clinicians subdivided the patients into different categories based on type of depression and the clinicians' degree of certainty about diagnosis. They used presence or absence of vegetative signs of depression as a key variable in deciding whether to treat with antidepressant medication. Beyond this, the clinicians also placed importance on other aspects of the clinical situation: quality of the physician-patient relationship, patient motivation and ability to benefit from treatment, priorities among multiple medical and psychiatric problems, and use of time to re-evaluate symptoms or for a trial of supportive therapy. This spectrum of decisions is not surprising in view of clinical experience in family practice. It has not been addressed, however, in previous studies of depression in outpatient medical settings. It is clear that assessment of screening and treatment of depression in family medicine must go beyond simple dichotomous decisions and consider the range of decisions that more accurately reflect those made in clinical practice.

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