Mental Health Problems Within Primary Care: Shooting First and Then Asking Questions?

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... the estimated rates of failure to detect psychiatric disorders have ranged from 45 to 90 percent. The evidence is clear that the diagnostic skills of many generalists are inadequate to the task.[1]
—Eisenberg, 1992

Physician recognition of mental disorders, as defined from various perspectives, has occupied researchers for two decades. While a sizable literature consistently indicates underrecognition to be the prevailing pattern, little is known about the clinician's decisionmaking process and even less about whether and how diagnosis formulations influence treatment decisions. . . . Vitally significant, but equally lacking, are outcome data for primary care patients treated for a mental disorder.[2]
—Schulberg, 1990

Are generalists' skills in managing patients with mental health problems inadequate? Or as Schulberg notes, is our understanding of mental health in primary care so rudimentary that it is impossible to know? Depending on one's perspective, what has emerged is either an indictment of our competence or a recognition of the barriers, competing demands, and unclear nature of mental health disorders in primary care.

Mental health problems are common. Data from the Epidemiologic Catchment Area Study[3,4] suggest a high prevalence of major and minor depressive disorder. The annual cost of caring for patients with depression has been estimated at $16 billion.[5] Most patients with mental disorders, particularly those in rural areas,[6] are cared for solely within the primary care setting.

In 1978, Regier and colleagues[7] first systematically described psychologic services within primary care calling this sector the "de facto mental health services system." The National Ambulatory Medical Care Survey[8] (NAMCS) data demonstrate that almost 50% of all outpatient mental illness visits are provided by primary care physicians.

Within the primary care setting, the prevalence of mental health and other psychologic problems is up to 50%.[1,2,7,9-13] Rowe and colleagues[14] documented an 18% prevalence of depression during *the 1 month preceding* a patient's office visit in a community-based population! Given this high prevalence of psychological problems, how do primary care physicians perform?

At first blush, not so well. For example, among 1450 new patients screened with the General Health Questionnaire (GHQ), Ormel and colleagues[15] found that 557 patients had psychiatric disease, yet only 47% were recognized by their general physician as having anxiety, depression, or other psychiatric disorders. In an investigation of 302 ambulatory patients undertaken by Froom and associates[16], 25 of 41 (61%) patients with major depressive disorder were undiagnosed. Likewise, in the study of 266 family practice outpatients by Coyne et al,[10] there was only a modest association between physician rating of depression and the patient's actual depressive symptoms. Recent reviews summarize the consistent finding of a gap between screening prevalence and physician diagnosis of mental disorders.[1,2,17]

Some investigators have sought to explain this presumed performance gap. In this issue of *The Journal of Family Practice*, Olfson and colleagues[18] have added yet another small part to this complex puzzle. In evaluating the psychiatric interventions of seven family physicians within three university-affiliated practices, they demonstrated that two thirds of patients who reported poor emotional health received at least one psychologic intervention from their physician. Furthermore, the physicians undertook at least one psychologic intervention in over one half of patients with a diagnosis of alcohol abuse or dependence, major depressive disorder, obsessive compulsive disorder, or panic disorder,

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and in over 51% of patients with a positive treatment history of mental health problems. The authors conclude that primary care physicians may be far more extensively involved in *providing* psychologic interventions than in formally diagnosing psychiatric disease. What factors account for discrepancies among these studies and how can we improve the management of mental disorders in primary care?

Many patients with mental disorders present to physicians with somatic complaints.[19–21] Some researchers have suggested that screening all patients for these problems would improve recognition and outcomes of care.[1,2,17,22] One of the newest of these instruments is a two-stage screen, the SDDS-PC, designed to uncover alcohol abuse or dependence, generalized anxiety disorder, major depression and suicidal ideation, obsessive-compulsive disorder, and panic disorder.[23]

While the operating characteristics of these instruments appear sound,[24] and the SDDS-PC has a predictive value rivaling other common screening tests,[24] results of feedback have been disappointing and a clinically relevant effect on outcomes is lacking.[1,2,17,22] Rowe et al[14] suggest targeting screening to individuals with defined risk factors, but Mulrow's analysis[24] suggests that doing so would only marginally increase the predictive value of screening. Simon and Von Korff[25] suggest that a focus on case finding might be misplaced. Given the high prevalence of psychologic disorders, the ecology of office practice with its associated time constraints, and unproven effectiveness, it is unclear whether physicians would widely adopt such screening. The impact of recognition on patient outcomes also remains unclear.[15,26]

Moreover, many physicians report a difference between the recognition of psychologic disturbance and a diagnosis of a specific mental disorder, and express reluctance to label a patient.[13,27,28] Patient satisfaction may be enhanced by acknowledging the presence of a psychologic problem; however, the process by which a diagnostic label is attached to this problem takes time and negotiation.[28] Furthermore, some patients feel that care for psychologic problems does not legitimately fall into the realm of primary care, and, hence, fail to mention to their primary care physician the difficulties posed by these problems.[29]

Some have recommended improved educational interventions for primary care physicians.[1,2,17,22] Using case vignettes, Andersen and Harthorn[30] explored diagnoses of primary care physicians and found underrecognition of such problems as mood disorders, personality disorders, and somatic disorders. Main[31] found that clinician training in depression was associated with their perception of the prevalence and importance of depression. Yet, it remains unsubstantiated that a gap in primary care physician knowledge is responsible for deficiencies in performance. Even if educational deficits exist, and are responsible for performance deficits, Greco and Eisenberg[32] note the challenges of changing physician behavior through traditional educational interventions.

Another challenge to primary care physician diagnosis is that the overwhelming majority of patients with problems such as depression will have "subthreshold disorders" that do not fit classic criteria for psychiatric diagnoses.[3,4,25] Most mental disorders in primary care are less severe and more likely to spontaneously remit.[9,20,33] The natural history of the spectrum of treated and untreated mental health disorders in primary care settings is not well understood. How should physicians handle psychologic stress and mental disorders that are subthreshold in nature? Only recently have studies demonstrated effective interventions for threshold disorders, and it remains unknown which problems benefit most from which treatments.[34] Recognition, watchful waiting, informal counseling, and negotiation may be appropriate strategies for some patients[28]; however, given the limitations of time and resources and of effective interventions, we should attempt to target those most in need of treatment and most likely to benefit from it.

One of the most promising areas of exploration encompasses issues related to patient-physician interaction. Setting an agenda, asking open-ended questions, and being alert to patient cues have been associated with enhanced diagnosis of mental disorders.[35,36] In previous studies, self-confident, outgoing physicians with high academic ability tended to make more accurate psychologic diagnoses.[37,38]

There is also a discrepancy between treatment efficacy and effectiveness. Despite the known efficacy of antidepressant therapy, Schulberg showed that only 33% of 91 primary care patients were able to complete recommended treatment.[39] Limited support for primary care practice, including a maldistribution of mental health providers, financial and insurance disincentives, and other structural barriers, probably exacerbate this gap.[1,2,17,22,26,27] Thus, while clearly treatable under ideal conditions, the management of psychologic problems remains challenging in community practice. Without improvements in generalists' care, Sturm and Wells[40] suggest that it would be more cost-effective to transfer a larger part of mental health treatment to the subspecialty sector. Investigators have explored alternative models of care involving collaborative management[41] and onsite mental health providers,[42] but it is unknown how patients feel about such psychiatric arrangements. It is likely that many primary care patients with psychologic distress would resist referral and the resulting psychiatric labeling. Sturm and Wells[40] conclude that quality improvement in the general medical sector might be more effective than shifting the balance of care.

Where do we go from here? We should begin by calling a moratorium on blaming primary care physicians for poor performance. The process of primary care is complex, and the challenges of negotiating and providing mental health treatment within the competing demands of primary care practice[43] remain daunting. The patient's reason for encounter, expectations, perception of stigma, and preferences may greatly influence the physician's behavior or apparent ability to meet "expert" standards of management. In the case of mental health care by primary care physicians, let us make sure we are not guilty of shooting first and then asking questions.

References

1. Eisenberg L. Treating depression and anxiety in primary care. N Engl J Med 1992; 326:1080–4.
2. Schulberg HC. Mental disorders in the primary care setting: research priorities for the 1990s. In: Mayfield J, Grady ML, eds. Primary care research: an agenda for the 90s. US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. PHS publication no. 90–3460; AHCPR publication no. 90–17. Washington, DC: US Government Printing Office, 1990:71–80.
3. Broadhead WE, Blazer DG, George LK, et al. Depression, disability days, and days lost from work in a prospective epidemiologic survey. JAMA 1990; 264:2524–8.
4. Johnson J, Weissman MM, Klerman G. Service utilization and social morbidity associated with depressive symptoms in the community. JAMA 1992; 267:1478–83.
5. Depression Guideline Panel. Depression in primary care: volume 1. Detection and diagnosis. Clinical Practice Guideline, No. 5. Rockville, Md: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, April 1993. AHCPR publication no. 93-0550.
6. Wagenfeld MO. Mental health and rural America: a decade review. J Rural Health 1990; 6:507–22.
7. Regier DA, Goldberg ID, Taube CA. The de facto US mental health services system: a public health perspective. Arch Gen Psychiatry 1978; 35:685–93.
8. Schurman RA, Kramer PD, Mitchell JB. The hidden mental health network. Arch Gen Psychiatry 1985; 42:89–94.
9. Ormel J, Koeter MWJ, van den Brink W, van de Willige G. Recognition, management, and course of anxiety and depression in general practice. Arch Gen Psychiatry 1991; 48:700–6.
10. Coyne JC, Schwenk TL, Smolinski M. Recognizing depression: a comparison of family physician ratings, self-report, and interview measures. J Am Board Fam Pract 1991; 4:207–15.
11. Salmon P, Stanley B, Milne D. Psychological problems in general practice patients: two assumptions explored. Br J Clin Psychol 1988; 27:371–9.
12. Simon GE, Von Korff M. Recognition, management, and outcomes of depression in primary care. Arch Fam Med 1995; 4:99–112.
13. May S. Patient satisfaction and the detection of psychiatric morbidity in general practice. Fam Pract 1992; 9(1):76–81.
14. Rowe MG, Fleming MF, Barry KL, et al. Correlates of depression in primary care. J Fam Pract 1995; 41:551–8.
15. Ormel J, Koeter MW, van den Brink W, et al. Recognition, management, and course of anxiety and depression in general practice. Arch Gen Psychiatry 1991; 48:700–06.
16. Froom J, Schlager DS, Steneker S, et al. Detection of major depressive disorder in primary care patients. J Am Board Fam Pract 1993; 6:5–11.
17. Brody DS, Larson DB. The role of primary care physicians in managing depression. J Gen Intern Med 1992; 7:243–7.
18. Olfson M, Weissman MM, Leon AC, et al. Psychological management by family physicians. J Fam Pract 1995; 41:543–50.
19. Kirmayer LJ, Robbins JM, Dworkind M, et al. Somatization and the recognition of depression and anxiety in primary care. Am J Psychiatry 1993; 150(5):734–41.
20. Gerber PD, Barrett JE, Barett JA, et al. The relationship of presenting physical complaints to depressive symptoms in primary care patients. J Gen Intern Med 1992; 7:170–4.
21. Kroenke K, Spitzer RL, Williams JB, et al. Physical symptoms in primary care. Arch Fam Med 1994; 3:774–9.
22. Schulberg HC, McClelland M. A conceptual model for educating primary care providers in the diagnosis and treatment of depression. Gen Hosp Psychiatry 1987; 9:1–10.
23. Weissman MM, Olfson M, Leon AC, et al. Brief diagnostic interviews (SDDS-PC) for multiple mental disorders in primary care. Arch Fam Med 1995; 4:220–7.
24. Mulrow CD, Williams J, Garotte M. Case-finding instruments for depression in primary care settings. Ann Intern Med 1995; 122: 913–21.
25. Simon GE, Von Korff M. Recognition, management, and outcomes of depression in primary care. Arch Fam Med 1995; 4:99–112.
26. Ormel J, Oldehinkel T, Brilman E, et al. Outcome of depression and anxiety in primary care. Arch Gen Psychiatry 1993; 50:759–66.
27. Rost K, Smith R, Matthews DB, et al. The deliberate misdiagnosis of major depression in primary care. Arch Fam Med 1994; 3:333–7.
28. Susman JF, Crabtree BF, Essink G. Depression in rural family practice, easy to recognize, difficult to diagnose. Arch Fam Med 1995; 4:427–31.
29. Good MJD, Good BJ, Cleary PD. Do patient attitudes influence physician recognition of psychosocial problems in primary care? J Fam Pract 1987; 25:53–9.
30. Andersen SM, Harthorn BH. The recognition, diagnosis, and treatment of mental disorders by primary care physicians. Med Care 1989; 27:869–86.
31. Main DS, Lutz LJ, Barrett JE, et al. The role of primary care clinician attitudes, beliefs, and training in the diagnosis and treatment of depression. Arch Fam Med 1993; 2:1061–6.
32. Greco PJ, Eisenberg JM. Changing physicians' practices. N Engl J Med 1993; 329:1271–4.
33. Katon W, Lin E, Von Korff M, et al. The predictors of persistence of depression in primary care. J Affect Disord 1994; 31:81–90.
34. Miranda J, Munoz R. Intervention for minor depression in primary care patients. Psychosom Med 1994; 56:136–42.
35. Goldberg DP, Jenkins L, Millar T, et al. The ability of trainee general practitioners to identify psychological distress among their patients. Psychol Med 1993; 23:185–93.
36. Davenport S, Goldberg D, Millar T. How psychiatric disorders are missed during medical consultations. Lancet 1987; 1:439–41.
37. Goldberg D. The recognition of psychiatric illness by non-psychiatrists. Aust N Z J Psychiatry 1984; 18:128–33.
38. Goldberg D, Steele JJ, Johnson A, et al. Ability of primary care physicians to make accurate ratings of psychiatric symptoms. Arch Gen Psychiatry 1982; 39:829–33.
39. Shulberg HC, Block MR, Madonia MJ, et al. Applicability of clinical pharmacotherapy guidelines for major depression in primary care settings. Arch Fam Med 1995; 4:106–12.
40. Sturm R, Wells KB. How can care for depression become more cost-effective? JAMA 1995; 273:51–8.
41. Katon W, Von Korff M, Lin E, et al. Collaborative management to achieve treatment guidelines. Impact on depression in primary care. JAMA 1995; 273:1026–31.
42. Burns BJ, Burke JD, Ozarin LD. Linking health and mental health services in rural areas. Int J Mental Health 1983; 12(1–2):130–43.
43. Jaén CR, Stange KC, Nutting PA. Competing demands of primary care: a model for the delivery of clinical preventive services. J Fam Pract 1994; 38:166–71.