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Primary Care Doctors: Treat or Refer Depressed Patients?

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Introduction

Primary care doctors are encouraged to screen patients for depression. But when they identify depressed patients, then what?

The National Institute of Mental Health estimates that about 12% of patients seen in primary care practices have major depression. Yet, a large proportion of these are undiagnosed, according to Ruth Shim, MD, MPH, Assistant Professor, Department of Psychiatry and Behavioral Sciences, and Associate Director of Behavioral Health, National Center for Primary Care, Morehouse School of Medicine, Atlanta, Georgia.

"Primary care doctors can and do effectively treat mild to moderate depression," says Shim.

In fact, once identified, most patients are treated in general medical offices rather than mental health centers. Studies indicate that patients, particularly members of racial or ethnic minorities, prefer it this way.

Part of the problem is lingering stigma -- nobody knows that you are seeking treatment for a psychiatric illness when you enter a primary care office, Shim notes. Care is also more accessible; it can be harder to get into the mental healthcare system, especially if you're underinsured or uninsured.

Many psychiatrists also prefer that primary care physicians oversee treatment of mild-to-moderate depression -- and anxiety, for that matter. "We need primary care physicians to treat people with less severe illness so we can focus on people who have more complex conditions," Shim remarks. "That improves access for everybody, because right now, you have to wait a long time to see a psychiatrist, particularly in public settings."

According to Shim, screening is best accomplished with the brief 9-item Patient Health Questionnaire (PHQ-9). Patients are asked how often they experience certain problems, such as lack of interest in activities, trouble sleeping, loss of appetite, inability to concentrate, and thoughts about death. Easy to use and score, this tool allows you to determine the severity of the illness, Shim explains.

Which Mental Health Professional?

Patients with severe depression should be referred immediately to a psychiatrist, says Shim. For others, discuss treatment options before writing a prescription. While some people prefer medication, others may want to try a course of therapy first; others might choose to do both.

"A psychiatrist can treat patients who don't have an adequate response to standard SSRI treatments, and can use various targeted psychopharmacological medication treatments," says Eric Hollander, MD, Clinical Professor of Psychiatry and Behavioral Sciences. Albert Einstein College of Medicine, Montefiore Medical Center, New York, NY. "They can also provide specific types of psychotherapy, and can understand the effects of medical problems on behavior or emotions.

"A psychologist or social worker can both provide psychotherapy, and either might be trained in specific forms of therapy, such as cognitive behavior therapy," says Hollander. "A psychologist can do psychological testing."

Patients who opt for medication alone should come back at 1- and 2-month intervals so that you can evaluate whether their symptoms have improved. The PHQ-9 is useful for this, too. If you see no progress, make a referral to a psychologist, psychiatrist, or clinical social worker, she notes.

Marian R. Stuart, PhD, Professor Emeritus, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School, Piscataway, NJ, believes medication, without therapy, is generally a temporary solution. "When you're depressed, just taking medication is not going to fix it. About one-third of patients totally improve on medication, and then most of those who stop taking it have a relapse," she says. "If you have psychotherapy and learn to think about your problems in a different way, the depression goes away, and you don't relapse. The psychological literature is really clear on this."

Learn to Think Differently

Physicians should direct patients to mental health practitioners who are well-versed in cognitive behavioral therapy (CBT) or interpersonal therapy (short-term therapy that focuses on current problem areas). Evidence-based studies indicate these routes are most useful in the treatment of depression, both experts agree.

"I would stay away from analytical therapy because there's not a whole lot of evidence supporting its usefulness in depressed patients," Stuart cautions. "It also requires a lot of time and resources."

Both CBT and interpersonal therapy are time-limited. CBT teaches patients to examine how their thoughts influence their behavior. The psychologist may assign homework, such as keeping a journal or tracking daily activities.

"Depressed people tend to have cognitive distortions where they think about things incorrectly, so CBT retrains the brain to think more effectively," Shim says. "Then there is behavior. When you're depressed, you don't want to get out of bed, so planning a daily activity log and sticking to it is important. When you have to show activities to a therapist, it makes you want to do more, because you don't want to have a blank page."

Stuart adds, "When you're depressed, you tell yourself horror stories about all the things that are going to happen; CBT really helps you edit your stories." Interpersonal therapy focuses on the patient's role in relationships and transitions in those roles -- for example, the loss of a partner or a job.

Know Who You Are Referring To

Ideally, primary care physicians should have several psychotherapists that they can refer patients to -- just as they have cardiologists or neurologists on file, Stuart says. Again, Shim stresses that patients should see someone who is certified to offer CBT or interpersonal therapy; a psychiatrist, psychologist, or licensed clinical social worker. "The brand name -- whether it's a clinical social worker or a psychologist -- is less important than the relationship the practitioner has with the patient," Stuart notes.

If you do refer to a psychiatrist, make sure the physician offers psychotherapy because some mainly provide medication management.

If you don't know who in your community is trained in these treatments call the local psychological or psychiatric associations. "All psychological associations will give you at least 3 referrals," Stuart says. "Then the doctor could call these people and chat for a few minutes, asking about the kinds of patients they see and what kind of therapy they do."

Some patients recover completely for a time and subsequently relapse. "After 3 episodes, you have a 90% chance of having another," Shim says. "These patients would probably be treated with antidepressants even when they're feeling perfectly fine to avert another occurrence. Long-term therapy might also be used to avoid another onset."

Providing Moral Support

Physicians are pressed for time. "With managed care, what used to be a 15-minute visit is now much shorter," Stuart acknowledges. "But I feel very strongly that doctors can, in 2 or 3 minutes, do an awful lot in terms of supportive psychotherapy."

In *The Fifteen Minute Hour: Therapeutic Talk in Primary Care*, Stuart and her co-author, Joseph A. Lieberman III, MD, MPH, describe the BATHE technique, which uncovers patients' pressing psychosocial issues.

Stuart explains: Start with **B**ackground; what's going on in the patient's life? Without exploring the patient's response, go on to **A**ffect; discuss how the patient feels about the issue. Move on to **T**rouble; what most distresses the patient about the current situation? How is the patient **H**andling these events? Finally, express **E**mpathy. "You connect with the patient by saying you understand how difficult things are," she says.

Every time the patient returns, repeat the process, though approaching issues from a positive vantage point. What's the **B**est thing that's happened since we last met? How do you **A**ccount for that? For what are you most grateful (ie, ask about **T**hankfulness)? How can you make these positive things **H**appen more often? Again, convey **E**mpathy or **E**mpowerment; for example, note how terrific the news is or how you believe the patient can keep achieving goals.

"It gets people to think in a different way," Stuart says. "If patients know the doctor is going to ask these questions, they start to think about some of the good things in their lives."

When doctors ask interested questions, depressed patients are much more likely to go for therapy. "There's a tremendous amount of literature that indicates doctors refer but patients don't go," Stuart says.

But, she points out, if patients get a chance to talk things over even briefly with the primary care physician, they begin to see that therapy could help them figure out what it is troubling them -- and possibly, to fix it. "The most important thing is for the primary care physician to help the patient have hope," Stuart emphasizes. "The doctor basically says, 'This is something we can treat. You are going to get better. I will work with you on this, and it's going to be okay.' "

Depression is the leading cause of disability worldwide, Shim says. It exacerbates physical problems and prevents patients from adhering to prescribed treatments.