A Bird’s Eye View of depression and unexplained somatic symptoms in primary care

Wanchai, Hong Kong
2nd March 2005

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Six parts to the lecture:

1) How common is depression, and how likely is it to be detected, and how it presents in primary care?

2) What kinds of depression should you recognise?

3) How should depression best be detected?

4) How is it best assessed?

5) How is it best treated?

6) How are unexplained somatic symptoms best treated?
1. How common is depression, and how likely it is to be detected, and how it presents in primary care?
### Mental disorders in primary care

**WHO study: South Manchester 1991**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>male</th>
<th>female</th>
<th>both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>13.9</td>
<td>18.3</td>
<td>17.0</td>
</tr>
<tr>
<td>General fatigue</td>
<td>6.1</td>
<td>11.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>4.9</td>
<td>8.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>2.1</td>
<td>4.6</td>
<td>3.8</td>
</tr>
<tr>
<td>Alcohol problems</td>
<td>9.4</td>
<td>0.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>3.4</td>
<td>3.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Any mental Dx</td>
<td>23.5</td>
<td>27.5</td>
<td>26.2</td>
</tr>
</tbody>
</table>

rates / 100 consultations
# Mental disorders in primary care

**WHO study: Manchester & Shanghai**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Manchester</th>
<th>Shanghai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>17.0</td>
<td>4.0</td>
</tr>
<tr>
<td>General fatigue</td>
<td>9.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>7.1</td>
<td>1.9</td>
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<td>0.1</td>
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<tr>
<td>Any mental Dx</td>
<td>26.2</td>
<td>9.7</td>
</tr>
</tbody>
</table>

**rates / 100 consultations**
## Detection of Mental disorders by GP

*Manchester & Shanghai*

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Manchester Rates (%)</th>
<th>Shanghai Rates (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>17.0 (70.0%)</td>
<td>4.0 (21.0%)</td>
</tr>
<tr>
<td>General fatigue</td>
<td>9.7 (49.8%)</td>
<td>2.0 (21.7%)</td>
</tr>
<tr>
<td>Generalised anxiety</td>
<td>7.1 (72.3%)</td>
<td>1.9 (19.9%)</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>3.8 (69.6%)</td>
<td>0.1 (0.0%)</td>
</tr>
<tr>
<td>Alcohol problems</td>
<td>3.6 (63.0%)</td>
<td>2.7 (38.7%)</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>3.5 (70.6%)</td>
<td>0.2 (0.0%)</td>
</tr>
<tr>
<td>Any mental Dx</td>
<td>26.2 (62.9%)</td>
<td>9.7 (15.9%)</td>
</tr>
</tbody>
</table>

*rates / 100 consultations*
<table>
<thead>
<tr>
<th>Health Rating</th>
<th>Manchester</th>
<th>Shanghai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>3.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very good</td>
<td>19.0%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Good</td>
<td>27.1%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Fair</td>
<td>39.3%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Poor</td>
<td>22.4%</td>
<td>55.9%</td>
</tr>
</tbody>
</table>
### Presenting complaints of mental disorders: Manchester & Shanghai

<table>
<thead>
<tr>
<th>Category</th>
<th>Manchester</th>
<th>Shanghai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>29.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Both psych. &amp; physical</td>
<td>69.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Pain</td>
<td>23.2%</td>
<td>34.0%</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>24.3%</td>
<td>44.0%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>14.3%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Size of group: 222 (Manchester) 102 (Shanghai)

ICD-10 mental disorders only
## Treatment of recognised cases of depression

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Manchester</th>
<th>Shanghai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any drug treatment</td>
<td>55%</td>
<td>21.4%</td>
</tr>
<tr>
<td>sedatives</td>
<td>13%</td>
<td>14.3%</td>
</tr>
<tr>
<td>antidepressants</td>
<td>39%</td>
<td>0.0%</td>
</tr>
<tr>
<td>other</td>
<td>18.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Any non-drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td>discussion</td>
<td></td>
<td>78%</td>
</tr>
<tr>
<td>referral</td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>physical tests</td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>No treatment prescribed</td>
<td>5%</td>
<td>78.6%</td>
</tr>
</tbody>
</table>
In summary:

- Depression appears to be much less common in Shanghai than in Manchester
- It is even more likely to present as somatic symptoms in Shanghai
- Shanghai doctors are not very good at detecting depression
- Shanghai doctors are much less likely to treat depression
- Depressed patients in Shanghai are much more likely to rate themselves in poor health than those in Manchester
2: What kinds of depression should you recognise in primary care?
Classification of depression for primary care

DEPRESSION

i. presenting as unexplained somatic symptoms

ii. with physical disease

iii. presenting psychological symptoms

iv. CHRONIC ANXIOUS DEPRESSION
i. Depression presenting with unexplained somatic symptoms

Easily the commonest presentation (57%!)

Diagnosis often missed - GP distracted by possible physical causes of symptoms

Physical symptom may be part of the depression; maybe a pre-existing minor symptom; maybe quite new

Most of these patients do not think of themselves as depressed, but are aware of their physical symptoms, and want you to deal with them
ii: Depression accompanying definite physical disorders

About 10% of depression in general medical practice

GP often misses it, since the presence of real physical disorder demands attention

However, depression often exacerbates pains and other physically caused discomforts - and treatment of this often very rewarding in terms of symptom relief.

Response to treatment proportional to severity of the depression - not to whether there is an understandable cause for the depression [eg cancer]
In steady state....

Pre-existing physical illness

Body

Mind

PAIN
STRESSFUL LIFE EVENT

Mind

Body

Pre-existing physical illness

PAIN
gets
worse
STRESSFUL LIFE EVENT

DEPRESSION

Mind

Body

Pre-existing physical illness

Much worse

PAIN!
STRESSFUL LIFE EVENT

Depression gets even worse

Mind

Body

Much worse

PAIN!

Pre-existing physical illness

Body

Mind

Depression
iii. Depression presenting psychologically

Only 5% of cases in Manchester
95% detected by their GP
Not really a problem
Detection most likely if psychological symptoms are mentioned early in the interview
iv: Chronic mixed anxious depression

100% detected by the GP in Manchester

Management different from a discrete episode of depression
3: How should depression best be detected?
3: How should mental disorders be detected in general medical practice?

First, by the doctor modifying his/her interview techniques to make it more likely that the patient displays CUES suggesting distress.

Second, by routinely using two screening questions when a CUE is detected, or in three other circumstances.
Sensitive doctors:

- Make eye contact with the patient
- Make empathic comments
- Pick up verbal cues
- Pick up non-verbal cues
- Do not read notes while patient is speaking
- Deal with over-talkativeness
- Ask fewer questions about the past
Making eye contact

Make it at the beginning, and when the patient is telling you something

Don’t look in the notes, or at your computer, unless you stop the patient:

“Excuse me a moment, I need to look something up in your record”
Draw attention to both verbal and non-verbal cues:

**Verbal:**

“You mentioned that you felt quite low after your mother died. Tell me about that”

**Non-verbal:**

“You look quite sad”

“You sound very upset about this”

“You’ve got quite a tremor when you talk about this”
Make supportive comments when needed:

“You’ve been going through a bad time”

“Things have been very difficult for you”

“That must have been really frightening”
Deal with emotion by drawing attention to it:

OBVIOUS DISTRESS:

“You still seem very upset by your mother’s death”

ANGER:

“You seem very angry about this. Tell me about it”

EMBARRASSMENT:

“This is something that is difficult for you to talk about”
How should depression be detected if there are cues?

Screening with 2 routine questions.

In the past week:

- have you been feeling in low spirits or depressed?
- have had less pleasure from your usual activities?

ALSO, in certain high risk groups. do they have:

- a past history of depression
- a significant physical illness causing disability
- some other mental health problems (e.g. dementia)
3: Detection Skills

IN SUMMARY:

- Sensitive doctors are good communicators, and good detectors of depression.
- Especially important to detect depression with unexplained somatic symptoms, and when depression accompanies definite physical disease.
- Use screening questions routinely in 3 other high risk groups.
4: Assessment of Severity
Today, we will deal only with

- Assessing severity of depression

- Making the link between somatic symptoms and emotional arousal
Today, we will deal first with

- Assessing severity of depression

**Why does this matter?**

- because different degrees of depression should be treated differently
Today, we will deal first with

Assessing severity of depression

If either of your screening questions is positive, routinely go on to ask the following additional questions:
Assessing Severity of Depression

Must be present:

- Persistent sadness or low mood; and/or
- Loss of interests or pleasure

Plus at least four of:

- Disturbed sleep
- Poor concentration
- Low self confidence
- Fatigue or low energy
- Pessimism or hopelessness about the future
- Poor appetite
- Low libido
- Suicidal thoughts or acts
- Agitation or slowing of movements
- Guilt or self-blame
- May be diurnal variation of mood
5: Treatment of depression in primary care
4. Management Skills....

- Ventilation of feelings
- Provision of information/education
- Making links - how symptoms relate to social & interpersonal problems
- Negotiation
- Motivating change in behaviour
- Problem solving
- Restoring sleep rhythms
- Negotiating acceptable treatment
Today, we will deal only with

- Management of Depression

- Making links - how symptoms relate to social & interpersonal problems
MILD DEPRESSION
5 or 6 symptoms on ICD-10

Many treatments are equally effective:
- Hypericum (St John’s Wort)
- Problem solving from GP or nurse
- Restoration of sleep
- Moderate exercise
- Self help materials, bibliotherapy
- Computerised CBT
- and, of course, case management + PBO
MODERATE & SEVERE DEPRESSION
(7 - 12 symptoms on ICD-10)

- Find an AD drug that suits the individual patient, and/or
- Problem solving, IPT or CBT if available
- Computerised CBT also effective
- + Regular follow up - can be carried out by practice nurse.
Anti-depressants in primary care

- All the drugs are EQUALLY effective (or ineffective)
- Studies claiming to show differences between them are usually NOT carried out with primary care patients
- Some are more toxic than others
- Some are more likely to be taken regularly
- The costs are very different, use generic drugs when you can!
First line anti-depressants in primary care

- fluoxetine and citalopram are both cheap, not that toxic, as effective as any others, and well tolerated.
- sertraline is best in heart disease.
- Lofepramine, mirtazepine & reboxetine are safer in overdose.
- Avoid paroxetine as 1st line treatment.
- Avoid dothiepin in ischaemic heart disease.
- Do not use venlafaxine as 1st line Rx.
Drug treatments in PC

The patient fails to respond...

- check drug taken regularly & in prescribed dose
- increase dose within permitted range, only modest, incremental increases
- if poorly tolerated switch to another drug
- switch to 2\textsuperscript{nd} AD if no response in 1/12
Drug treatments in PC

Second line treatments

- Try another SSRI
  - Mirtazepine acceptable (but sedation & weight gain)
  - Moclobemide acceptable (but wash out previous AD)

- Combined treatments (lithium augmentation and AD combinations), also phenelzine, and venlafaxine should not be initiated in PC
Chronic anxious depression
(mainly seen in primary care)

Remember social & I-P causes
Combined AD and CBT
Consider befriending
Telephone support
Enhanced care
A simple management for chronic anxious depression

Regular structured visits; plan activities - relaxing or distracting; problem-solving; avoid negative thoughts

Exercise may be helpful, also sleep management

Keep referrals and investigations to a minimum

Poly-pharmacy to be avoided; so simplify medication

Sick role may be unhelpful; encourage self-help & confidence building
TREATMENT RESISTANT DEPRESSION

- Try a different drug, from a different group
- Problem solving, IPT or CBT if available
- Consider referral to a psychiatrist for other treatments
- (Try venlafaxine if patient won’t go?)
What doesn’t seem to work?

Lots of things.

Supportive counselling; aroma therapy; avoiding coffee and chocolate; Colour therapy; dance therapy; fish oils; ginkgo; ginseng; glutamine; homoeopathy; lemon balm; meditation; music; painkillers; keeping a pet; selenium; avoiding sugar; tyrosine; vervain.

Many of these are harmless, but there is no evidence that they are effective.
WHO NEEDS PSYCHOTHERAPY?

- those who won’t take drugs at all
- those who won’t persist with drugs
- those who relapse despite drugs
- those who don’t respond to drugs
- effects may be additive
Psychotherapy for depression in primary care

- Special training needed for IPT & CBT
- GPs find CBT unfamiliar & difficult
- Usually no-one else to do the treatments
- But both GPs and nurses can be trained to do problem solving
How to decide in each case? (Patient-based Evidence)

- What is time course of the disorder?
- Is there a family history of depression?
- Is there a past history of depression?
- Is there social support?
- How severe is the depression now?
- Is severity increasing?
How to decide in each case? (Patient-based Evidence)

What is time course of the disorder?

- Less than 2 weeks, or
- Symptoms intermittent
  - general advice, watch & wait
How to decide in each case?

- What is time course of the disorder?
- Is there a family history of depression?

If YES, favours active treatment
How to decide in each case?

- What is time course of the disorder?
- Is there a family history of depression?
- Is there a past history of depression?

If YES, favours active treatment
How to decide in each case?

- What is time course of the disorder?
- Is there a family history of depression?
- Is there a past history of depression?
- Is there good social support?

NO - active treatment

YES, and MILD: favours advice, watch & wait
How to decide in each case?

- What is time course of the disorder?
- Is there a family history of depression?
- Is there a past history of depression?
- Is there social support?
- How severe is the depression now?
- Is severity increasing?

≥7 symptoms or ≤6 deteriorating: treat
≤6, improving - advice, watch & wait
Problem Solving

1. Ask the patient to identify their MAIN problem
2. Ask them to think of possible solutions
3. Suggest any you can think of they haven’t mentioned
4. Prioritise the list; allow them to strike out impossible solutions
5. List advantages and disadvantages of each solution
6. Settle on their preferred solution: break it down into steps
7. They are to work on the first step of their preferred solution and report progress to you
Some relative costs....

For drugs, assume 4 sessions, 10 mins

- Amitryptyline 100mg .............. £67.10
- Prozac 20mg ....................... £114.00
- Venlafaxine 75mg ................. £159.50

Problem solving, 6 x 30 mins

- By GP ................................ £273.00
- By nurse .............................. £183.00
In Summary....

- People consulting us need to receive patient based evidence, which is more than “evidence based medicine”
- In mild depression, drugs are unnecessary provided you give good advice and follow-up the patient
- No drug is superior to another in primary care
- Differences between them are in tolerability, toxicity and costs
6: Treatment of Unexplained Somatic Symptoms
6. Treatment of USS:

Making links - how symptoms relate to social & interpersonal problems
Some characteristics of consultations which encourage somatisation

Bridges & Goldberg 1987

Somatisation seen as a feature of dyadic exchange between doctor & patient:

- Doctor confines consultation to physical causes
  (Patients collude with this)
- Doctor avoids dealing with embarrassing or difficult material
- Doctor may lack alternative strategies
STRESSFUL LIFE EVENT

What sort of symptoms?
STRESSFUL LIFE EVENT

ANXIETY

Mind

Body

Abdominal pain

tachycardia
dyspnoea

How?
STRESSFUL LIFE EVENT

ANXIETY

Mind

Body

Spasm in circular muscles of gut → Abdominal pain

Sympathetic stimulation → tachycardia

Bronchospasm → dyspnoea
STRESSFUL LIFE EVENT

Depression/
anxiety not
invariably
present

Mind

Body

PAIN
gets
worse
STRESSFUL LIFE EVENT

Vigilance,
catastrophising

ANXIETY

Autonomic
arousal

MEDICAL
ILLNESS

symptoms

Health care utilisation
How can depression cause physical symptoms?

Examples?
STRESSFUL LIFE EVENT

DEPRESSION

Rumination,
Lowered pain threshold
Depressive convictions about own health

Autonomic arousal

symptoms
A simple Management of Unexplained Somatic symptoms

GP needs to:

- make appointments to see the patient regularly,
- each time to *physically examine* patient; and
- NOT say “it’s your nerves”.

(It may help, if the patient is also depressed, to prescribe an anti-depressant).
A more complex management of Unexplained Somatic symptoms

**GP needs to** *physically examine* patient; carry out all *reasonable* investigations; then *reattribute* the physical symptom.

(It may also be necessary to prescribe an anti-depressant).
A more complex management: “reattribution”

Three stages:

1) Feeling understood: patient feels doctor has understood his symptoms

2) Changing the attribution: the patient must “re-frame” symptoms - see them in a different way

3) Making the link: how emotion can cause the symptoms
Feeling understood

- Take a full history, clarify complaint
- Elicit associated symptoms
- Respond to mood cues, probe mood state
- Explore social & family factors
- Clarify health beliefs
- Perform a focused physical examination
Changing the attribution

- Feedback the results of physical examination & investigations
- Acknowledge the reality of the patient’s symptoms
- Reframe the patients complaints: remind them of other symptoms and life events
Making the link

- **EXPLANATION**: linked to depression or anxiety
- **DEMONSTRATION**: Practical; “here and now”; linked to life events
- **IDENTIFICATION**: other family members
- **PROJECTION**: family member - learned behaviour
Negotiating Treatment

- Explore patient’s views
- Acknowledge patient’s worries and concerns
- Problem-solving and coping strategies
- Relaxation
- Appropriate treatment of depression
- Specific plans for follow-up
What do all effective treatments have in common?

A healer is prepared to see the patient and **support him or her** through the crisis.

The healer must believe in what he or she is doing, to produce and **expectancy** that improvement will occur, and some **hope** for the future.

**ALL successful healers do this!**

*(Remember - different approaches suit different people).*
That’s all today, but I’ll take questions