

Depression In Primary Care—More Like Asthma Than Appendicitis: The Michigan Depression Project

Michael S Klinkman, MD, MS¹, Thomas L Schwenk, MD², James C Coyne, PhD³

Objective: To explore the relationships between detection, treatment, and outcome of depression in the primary care setting, based upon results from the Michigan Depression Project (MDP).

Methods: A weighted sample of 425 adult family practice patients completed a comprehensive battery of questionnaires exploring stress, social support, overall health, health care utilization, treatment attitudes, self-rated levels of stress and depression, along with the Center for Epidemiologic Studies Depression Scale (CES-D), the Hamilton Rating Scale for Depression (HAM-D), and the Structured Clinical Interview for DSM-III (SCID), which served as the criterion standard for diagnosis. A comparison sample of 123 depressed psychiatric outpatients received the same assessment battery. Family practice patients received repeated assessment of depressive symptoms, stress, social support, and health care utilization over a period of up to 60 months of longitudinal follow-up.

Results: The central MDP findings confirm that significant differences in past history, severity, and impairment exist between depressed psychiatric and family practice patients, that detection rates are significantly higher for severely depressed primary care patients, and that clinicians use clinical cues such as past history, distress, and severity of symptoms to “detect” depression in patients at intermediate and mild levels of severity. As well, there is a lack of association between detection and improved outcome in primary care patients.

Conclusion: These results call into question the assumption that “depression is depression” irrespective of the setting and physician, and they are consistent with a model of depressive disorder as a subacute or chronic condition characterized by clinical parameters of severity, staging, and comorbidity, similar to asthma. This new model can guide further investigation into the epidemiology and management of mood disorders in the primary care setting.

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Epidemiologic and clinical research over the past 2 decades has shown depression to be a common and highly debilitating condition. Weissman and others (1) documented the high prevalence of depression in the community, and Kessler and others (2) found that 10% to 20% of the general

population consults a primary care physician for mental illness in a one-year period. Several epidemiologic studies in primary care settings have also documented the high prevalence (estimates ranging from roughly 5% to 25%) of depression in routine primary care practice (3–6). In the recent PRIME-MD 1000 study (7), 26% of adult primary care patients were assigned a criterion-based psychiatric diagnosis, with an additional 13% of patients assigned a subsyndromal diagnosis; of this total, 90% were mood, anxiety, substance abuse and somatiform disorders.

The clinical significance of these epidemiologic data has been confirmed by other studies examining the detection and treatment of depression in routine primary care practice. These studies have repeatedly documented that 50% to 70% of patients with criterion-based diagnoses are missed by

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¹Assistant Professor, Department of Family Medicine, University of Michigan, Ann Arbor, Michigan.

²Professor, Department of Family Medicine, University of Michigan, Ann Arbor, Michigan.

³Departments of Family Medicine and Psychiatry, University of Michigan, Ann Arbor, Michigan.

Address for correspondence: Dr MS Klinkman, 1018 Fuller Street, Ann Arbor, MI 48109 USA

primary care physicians and that, even when initiated, treatment is often "inadequate" by psychiatric standards (8). The combination of high prevalence, low detection rate, and inadequate treatment provided a compelling rationale for the Agency for Health Care Policy and Research (AHCPR) to develop and disseminate a clinical practice guideline for the detection and treatment of depression in primary care (9,10).

Although the guideline provides a concise series of steps to enhance accurate detection and treatment of major depression, its usefulness for primary care clinicians remains in doubt (11). The critical links among detection, treatment, and improvement in patient outcome have not yet been confirmed in the primary care setting. Recent prospective studies demonstrate a higher rate of relapse in primary care patients receiving guideline-concordant antidepressant therapy than in those receiving no therapy (Rost and others, unpublished observations). As well, an equal clinical response in patients receiving either placebo or active intervention in mild to moderately severe major depressive disorder (MDD) was apparent (12). Clinical trials of staged screening protocols and directed feedback of screening results have shown increased detection rates, but no improvement in patient outcomes (13–15). Clinical trials of collaborative care arrangements have shown improvement in treatment "adequacy," but improved patient outcomes for only a small subgroup of MDD patients (16,17).

These findings suggest that identification and treatment of depression in primary care is a far more complex process than can be accounted for in the structured psychiatric epidemiologic model employed in the AHCPR guideline. A partial list of the factors contributing to this complexity in primary care includes patient resistance, the protean somatic manifestations of psychic distress, the fact that few patients present with depression as a chief complaint, the short length of most office visits, the presence of multiple competing demands for clinician attention during routine visits, the lack of physician skill and knowledge, the biological orientation of both psychiatry and medicine, inappropriate diagnostic classifications for mental health problems in primary care, insurance systems that may not reimburse primary care physicians for certain psychiatric diagnoses, and rapid changes in consultation and referral support for psychiatric care in managed care systems (8). These factors remain largely unaddressed in empirical work in this area and present a major challenge to investigators seeking to understand the clinical epidemiology, detection, and treatment of depression in primary care.

Research in this area also suffers from several other methodological limitations. First, it fails to distinguish incident cases (new episodes) from prevalent cases (ongoing episodes), resulting in a heterogeneous sample of subjects at different stages of a depressive episode. Second, it fails to account for medical or psychiatric comorbidity, which affects more than half of all depressed primary care patients. Third, it fails to account for long "blackout periods" between assessment points in a relatively short study period, with many

studies reduced to comparing outcomes at a single assessment 12 months after initial enrollment. Fourth, it fails to account for parallel mental health treatment occurring outside the primary care setting. Finally, it fails to examine patient factors that may contribute to the success of detection and treatment.

We have encountered most of these issues and problems in the course of analyzing and interpreting incoming data from the Michigan Depression Project (MDP), a longitudinal study of depressed patients in primary care settings across southeastern Michigan. The pattern of results seen in this project has stimulated an internal critical reappraisal of the "clinical ecology" of depression in primary care and has led us to propose a new conceptual model for depression. In this paper, we describe the MDP, some of its key findings, and the clinical, research, and policy implications of those findings.

The MDP, which has run since 1987 with both internal and National Institute of Mental Health funding, arose from concerns about the apparent poor performance by primary care physicians in detecting and treating depression, as well as from studies suggesting that typical detection and treatment protocols derived from psychiatric practice seemed to be unsuccessful when employed in primary care. The MDP was designed to overcome some of the major methodological limitations of other primary care studies, particularly the twin assumptions that depressed primary care patients are the same as depressed psychiatric patients and that treatment of depressed patients in psychiatric and primary care is or should be identical.

The MDP started with a simple pilot study exploring the medical and psychosocial correlates of self-reported depressive symptoms in patients of community-based family physicians (18). As part of this study, a network of collaborating community-based physicians and group practices was developed and 293 adult patients were screened in waiting rooms with the CES-D questionnaire (19). A weighted sample of 57 patients with a "positive" score (16 or higher) on the CES-D and a control group of 39 patients received a formal diagnostic assessment by structured telephone interview. Comparisons between the 2 groups revealed a strong association between self-reported depressive symptoms and high rates of physical symptoms, chronic health problems, recent life events, and a lack of supportive relationships. Stress, health status, and support accounted for up to 30% of the variance in self-reported "depression."

The next pilot study (20) developed a 2-stage assessment methodology for major depression, using the same group of community practices as the previous study. Two hundred and sixty-six patients were screened with the CES-D followed by a structured diagnostic interview using traditional DSM-III-R diagnostic criteria; 22.6% scored "positive" on the CES-D, and 8% of the original sample met diagnostic criteria for MDD. Independent physician ratings of "depression" completed at the office visit were discrepant from both questionnaire scores and the results of a structured diagnostic

interview. Physician ratings were as closely associated with patient-rated levels of "stress," physical health, and measures of distress as they were with depression. The CES-D also performed poorly in its ability to predict patients who met formal diagnostic criteria for MDD.

These 2 pilot studies highlighted the complex interweaving of distress and depressive symptoms seen in primary care practice and served to develop and refine a community-based practice "laboratory" capable of identifying and tracking routine primary care patients with depressive symptoms over time. This laboratory was expanded to provide the research platform for the subsequent MDP studies.

Methods Employed in the MDP

During the first phase of the formal MDP, patients aged 17 to 80 were recruited from the practices of 50 family physicians in southeast Michigan between September 1990 and December 1991. The participating family physicians, all board certified, included clinicians in full-time practice in rural and suburban communities, members of the Michigan Research Network (a practice-based research network administered by the Michigan Academy of Family Physicians), and a small number of full-time faculty members of the University of Michigan Department of Family Practice. Research assistants rotated between participating sites and approached patients waiting for a routine visit with their physician.

A total of 1928 patients completed the initial office-based screening, which included the CES-D and a separate questionnaire assessing self-rated levels of depression, perceived stress, general health, and primary reason(s) for the office visit. Patients scoring above the standard cut point of 15 on the CES-D were oversampled for diagnostic interview (described below) with the goal of increasing the yield of depressed patients for study. To ensure the accuracy of our estimates of the prevalence of depressive disorders and the rates of detection of depression by physicians, the resulting data were weighted according to the probability of a patient having been selected for an interview. This 2-stage sampling strategy with compensatory data weighting combined efficiency in identifying cases of depression with accuracy in the resulting clinical data for epidemiologic analyses.

A total of 425 family practice patients received the Structured Interview for the DSM-III-R (SCID) (21), which was administered by trained mental health professionals. The SCID served as the criterion standard to identify depressed patients and to evaluate the performance of the physicians in detecting and treating depression. The version used in this phase of the MDP assessed current (defined as within the preceding month) and lifetime psychiatric status for major Axis I disorders using DSM-III-R criteria, a rating of the severity of MDD, basic demographic and psychiatric treatment history information, and the DSM-III-R Axis IV, the Global Assessment of Functioning Scale (GAF).

These 425 patients also completed a series of 3 assessments (at the time of the SCID interview and at 4.5 and 9

months), which included the HAM-D (22) and the Michigan Inventory of Live Events (MILE), a comprehensive clinical interview assessing stress, social support, overall health, and health care utilization. The structured version of the HAM-D employed in the study was, at the time, the most frequently used measure of initial depressive symptomatology and improvement in depression treatment outcome studies. It also facilitated comparisons between this sample and those obtained in other studies.

A comparison sample of 123 depressed psychiatric patients was obtained from those presenting at the outpatient Depression Program of the University of Michigan Department of Psychiatry during the same time period as the recruitment of primary care patients. At the time of this study, it was a routine part of the intake procedure for all psychiatric outpatients to complete the CES-D and to be administered the SCID and HAM-D. Patients in this sample also completed the same series of MILE interviews as the family practice patients.

Results of Studies Published to Date

The Utility of the CES-D as a Screening Instrument for Depression

The first published study from MDP data examined the usefulness of the CES-D scale as a screening instrument for depression (23), and the study showed that most patients who scored high on the CES-D were not depressed, that one-fifth of depressed patients scored low on the CES-D, and that the CES-D performed about as well in detecting anxiety and substance abuse disorders as in detecting major depression. Although there was a significant relationship between the CES-D score and SCID diagnosis of current MDD (sensitivity 79.5%, specificity 71.1%), the association between high CES-D and MDD of mild severity was weak. At the calculated prevalence rate of MDD of 13.5% in this sample, the positive predictive value of a high CES-D was only 27.9%. The strength of the relationship between CES-D scores and depression did not increase when the full range of depressive disorders was incorporated in the analysis, with the positive predictive value of a high CES-D score a modest 46.3% under the most inclusive possible definition of "depression." Significant associations were also noted between high CES-D scores and other psychiatric disorders such as anxiety disorder (sensitivity 53.4%, specificity 89.5%) and eating disorder (sensitivity 47.8%, specificity 99.3%).

In this study, the CES-D appeared to be more closely related to generalized distress than to criterion-based diagnosis of MDD and was unhelpful in daily practice. Its strong association with other psychiatric diseases confused rather than simplified the diagnostic process, and it could not be recommended for use as a primary care depression screening instrument.

Subsequent work (24) examined whether the performance of the CES-D could be improved by adjusting cut points, eliminating items, or revising item scoring. Although some

improvement in screening efficiency for depression could be achieved using half the items and a simplified scoring scheme, the optimized instrument remained less than adequate as a screening tool.

The Prevalence and Nature of Depression in Primary Care

The next study, which examined the prevalence and nature of depression in routine primary care practice (6), was one of the first studies to use the SCID to determine the full range of criterion-based depressive disorders in a community-based primary care population. A high prevalence of depression was found, with 22% of all patients meeting criteria for at least one depressive disorder and 13.5% meeting criteria for major depression. Over 40% of those meeting criteria for MDD, however, barely met diagnostic criteria and had little or no impairment based on GAF scores. Confirming an unexpected finding in our pilot work (20), the likelihood of a man being depressed was equal to that of a woman among those patients actually seen by a family physician. Substantial psychiatric comorbidity was also found in depressed patients, particularly current or lifetime anxiety disorders (44%) and lifetime substance abuse (42%).

The 3 central findings of this study were that 1) criterion-based diagnosis of major depression in primary care includes many patients with mild depression and little to no related impairment, 2) self-ratings, but not demographic variables, distinguish depressed patients from nondepressed patients, and 3) depressed patients are likely to have significant psychiatric comorbidity. These findings strongly suggested that MDD in this primary care setting was a heterogeneous, complex problem crossing diagnostic boundaries and raised questions about the validity of the DSM-III-R in defining depression in primary care patients.

Detection of Depression by Family Physicians

The diagnostic issues raised by the previous study led to an examination of the detection behaviour of family physicians, focusing on the differences between detected and undetected patients with MDD (25). Initial analyses confirmed that family physicians performed relatively poorly in detecting depression, identifying only 35% of patients with MDD and 28% of patients with any depressive disorder. Detection was strongly related to severity, however: 73% of severely depressed patients were detected, as compared with 18.4% of mildly depressed patients. The low rate of "detection" may have been in part an artifact of the study methodology. DSM-III-R, on which the SCID was based, lacked an impairment criterion for diagnosis of MDD. Using the subsequent DSM-IV definition of MDD, which includes an impairment criterion, would have eliminated many of the undetected mild MDD cases included in this study and improved clinician detection rates.

These results confirmed that primary care physicians were quite sensitive in detecting depressed patients who were overtly psychologically distressed, had more symptoms of greater intensity, and displayed their psychological distress

as anxiety. The results also suggested that family physicians miss significant numbers of depressed patients because they are very different from the overtly depressed patients in psychiatric settings (who provide the basis of their medical training). This issue was explored in the next study.

Differences Between Depressed Patients Seen in Primary Care and Psychiatric Settings

In this study, 153 primary care patients were compared with 123 patients enrolled in the psychiatric mood disorders clinic on a number of demographic and clinical variables. Depressed psychiatric patients were more likely to meet criteria for MDD (not unexpected since the patients had been referred for that purpose), were more severely depressed, more likely male, more highly educated, and younger (26). Depressed primary care patients were less likely to have received prior treatment for depression and were more likely to have past and current psychiatric comorbidity. The observed differences in severity and functional status were even greater for those patients who went undetected by the family physicians. Undetected depressed primary care patients had milder depression and functioned at a higher level than those who were detected, who were in turn more mildly depressed and more functional than psychiatric patients.

These results provided strong evidence that the type of depression encountered in routine primary care—even for criteria-defined MDD—is substantially different from that seen in psychiatric practice, confirming the findings emerging from other studies in primary care settings (27–30).

Current Work From the MDP

Life Events and the Onset of Depressive Episodes in Primary Care and Psychiatry

To explore the nature of the differences between primary care and psychiatric depression, we examined the role of life events in the onset of major depression among family practice and psychiatry patients (Coyne and Pepper, unpublished data). Drawing on the work of Brown and Harris (31), the severity of life events was rated on the basis of contextual information collected in a semistructured interview. For example, the birth of a child was a severe life event for a young woman with no job skills who had been planning to leave her alcoholic and abusive husband, but not for a woman who had planned the pregnancy and had the benefit of a supportive husband. When life events data were coded in this way, the onset of depression among family practice patients was often preceded by a severe life event. This was not the case for depressed psychiatric patients, who were actually more similar to nondepressed family practice patients in this regard. This difference remained even when significant health-related events were eliminated from consideration.

These results were consistent with the notion that much of the depression seen in primary care patients has a more complex set of determinants than depression seen in psychi-

atric patients, again suggesting that they may represent different clinical entities.

Short-Term Outcomes for Depressed Family Practice and Psychiatric Patients

The short-term implications of the differences between primary care and psychiatry in the process of care for depression were recently assessed by comparing outcomes for detected and undetected family practice and psychiatric patients at 4.5 and 9 months (32). There were no differences in outcome at 4.5 months between undetected and detected family practice patients, with the HAM-D score of detected family practice patients actually higher than that of undetected patients and psychiatric patients. The results were unchanged after adjusting HAM-D scores for age and the initial severity of depression and after excluding patients with mild MDD. By 9 months, most patients in all 3 groups had improved and no longer met MDD diagnostic criteria. The somewhat counterintuitive finding that detected depressed family practice patients showed the least improvement in their HAM-D scores over time might be interpreted as an anomaly, or as evidence that even when family physicians detect depression they fail to treat it adequately. In this study, however, it was most likely due to the presence of chronic medical problems and poor marital support in detected family practice patients, the 2 variables that most accurately predicted HAM-D scores at 9 months.

These results again highlight the complexity of depression in primary care, the diagnostic confusion in patients with multiple psychiatric and medical comorbidities, and the lack of a linear and positive relationship between screening, detection, diagnosis, treatment, and improvement.

False Positives, False Negatives, and the Diagnosis of Depression in Primary Care

The relationship between depressive symptoms, MDD, and detection and treatment by family physicians was further investigated in a comparison of false positive and false negative depressed cases from the MDP (Klinkman and others, unpublished observations). Primary care patients were assigned to 1 of 4 groups based on clinician identification and SCID diagnosis: true positives, identified as depressed by both physician and SCID; false positives, labeled as depressed by the physician, but not meeting SCID criteria for MDD; false negatives, labeled as not depressed by the physician but meeting SCID criteria; and true negatives, not depressed by either assessment method. Differences between the 4 groups in demographic characteristics, clinical presentation, scores on mental health instruments, and prior mental health history were explored. False positive patients displayed significantly higher levels of distress and impairment and were significantly more likely to have a history of mental health problems and treatment than were true negatives. Most importantly, the 2 “misidentified” groups, false positives and false negatives, were indistinguishable across all measured clinical characteristics: prior psychiatric care, CES-D scores, GAF scores, and patient self-rated level of depression. False

positive and false negative patients’ scores occupied the middle ground between true positives and true negatives on most clinical characteristics. Physicians appeared to discriminate between the false positive and false negative groups based upon their knowledge of the patient’s clinical history.

The central finding of this study was the striking similarity of the 2 misidentified groups—one meeting criteria for MDD, one not. In the absence of observable clinical differences between false positives and false negatives, family physicians appeared to employ historical cues in assigning the diagnosis of depression to these distressed and impaired patients. Misidentification in this study may have been introduced by the imposition of DSM diagnostic criteria to define “caseness” in these middle-ground patients.

Exploring Primary Care Physician Practices in Detecting and Treating Depression

The results described above are supported by a recent qualitative study linked to the MDP in which 3 focus groups of primary care physicians convened to explore their views of detection, treatment, and collaborative care of depression (Valenstein and Klinkman, unpublished data). The key themes that emerged from the focus groups were: 1) detection is based on functional rather than diagnostic criteria; 2) there is a high level of patient resistance to diagnosis and treatment, such that physicians have to consider carefully the diagnosis and its implications for the patient before the issue is broached; and 3) initiation and continuation of treatment require considerable time and negotiation. Consequently, clinicians only detect those patients they believe require treatment, using functional status as their guide.

Implications of MDP Findings for Detection and Treatment of Depression in Primary Care

We believe that the central findings of the MDP—the significant differences between depressed psychiatric and family practice patients, the higher rates of detection and treatment of severely depressed patients, the confounding effects of stress, anxiety, and other comorbidity, and the lack of association between detection and improved outcomes—are part of a growing body of work that has stimulated a critical reappraisal of the accepted wisdom regarding depression in primary care. Our results call into question one major assumption underlying previous mental health research in primary care, that “depression is depression” irrespective of the setting and physician. This assumption has allowed the extrapolation of diagnostic and treatment standards from the psychiatric setting to the primary care setting without full critical evaluation and has inappropriately framed the debate on “underdiagnosis,” “undertreatment,” and inadequate primary care physician performance. It also grossly oversimplifies the very complex diagnostic and therapeutic process in primary care.

This issue is particularly relevant in light of the growing influence of clinical practice guidelines. Published guidelines

for the diagnosis and treatment of depression in primary care are largely based on research conducted using the psychiatric model of care and share 3 questionable assumptions: that diagnostic criteria derived from the psychiatric research setting are valid for an unselected primary care population, that treatment recommendations for severely depressed psychiatric patients are appropriate for and will be accepted by mildly depressed primary care patients, and that routine surveillance for depression through questionnaires and a brief history will yield a significant population of patients for whom more intensive diagnostic and therapeutic measures will be cost-effective. Each of these assumptions has been strongly challenged (33–37).

The pattern of results seen in the MDP suggests that in failing to “detect” mild cases of MDD, physicians may be responding appropriately to the relatively mild major depression that is highly prevalent in primary care. Many patients who meet the diagnostic criteria listed in the guideline have minimal to no impairment and are not clearly in need of treatment. Some patients may be less responsive to usual treatment approaches because of psychiatric comorbidity and will not benefit from treatment. Finally, both physician and patient have multiple competing priorities for time during routine office visits, such that identification and treatment of mild depressive symptoms may not be a priority. The psychiatric model incorporated in existing guidelines cannot take into account these important influences on detection and treatment in primary care.

If the psychiatric model of depression is not right for primary care, what model might be more accurate? We believe the overall pattern of results from the MDP to be most consistent with a model of depressive disorder as a subacute or chronic condition marked by exacerbation and improvement over time, characterized by the core clinical parameters of severity, staging, and comorbidity (37; Klinkman and others, unpublished observations). In this model, depression behaves more like asthma than acute appendicitis, and its waxing and waning nature makes the accuracy of diagnosis and the adequacy of treatment difficult to assess. At higher levels of severity, depressive symptoms may be present all or most of the time, occur without provocation, and cause significant impairment. At moderate levels of severity, depression may become symptomatic only under certain conditions and may result in minimal or moderate impairment; individual episodes of depression may be of short duration. At minimal severity, depressive episodes may occur only rarely, cause minimal impairment, and be self-limited. Most primary care depressive episodes are of moderate or minimal severity, while most patients in psychiatric settings are at the highest level of severity.

The true positive patients from the MDP are those with severe exacerbations which require immediate attention and treatment: family physicians appear to detect and treat them at high rates. Distressed and possibly depressed patients with less severe symptoms—the false positive and false negative

patients—occupy the moderate level of severity in which detection appears to be far more complex. False positive patients may be in the waning stages of an exacerbation or responding to treatment, while false negative patients may be in the early stages of a depressive episode for which they meet criteria, but are functionally intact. In these circumstances, clinicians appear to respond primarily to psychological distress and functional impairment and may use a prior history of depression and change in symptoms over time as diagnostic clues, rather than screening for the presence of specific diagnostic criteria. Their decisions to detect and treat moderate and minimal severity patients, and the effectiveness of such treatment, are also likely to be influenced by the presence of competing demands, patient resistance, and the clinical ecosystem of insurance, consultation, and referral systems (37). Unmeasured differences in severity, staging, and comorbidity in this intermediate group may account for both unexpected treatment success and failure. These factors might partially explain the inconsistent results of recent clinical trials—improvement despite inadequate treatment (38), relapse in the presence of adequate treatment (Rost and others, unpublished observations), and no difference in outcome among patients receiving adequate, inadequate, or even no treatment (15,17).

Conclusion

The results of the MDP and the recent work of many other researchers suggest that we are badly in need of longer, incidence-based studies of depression so as to understand better how severity and time interact to characterize the disease, its impact on the patient, and the diagnostic and treatment process. We also recommend that clinicians pay more attention to patient-specific factors, which are important for detection and treatment, so that we can better understand the treatment alliance which must be created between physician and patient to address a disease which is chronic and potentially lifelong. Finally, we believe the field will soon be ready for intervention studies, in which subgroups of patients who appear most in need of treatment (based on functional impact) are compared with those who are more mildly depressed and barely meet diagnostic criteria. This type of study is needed to help primary care physicians focus their energies and therapies where they will have the most benefit in treating what is clearly a common and important, but still poorly understood, problem in primary care medical practice.

Clinical Implications

- Detection rates were much higher for severely depressed primary care patients.
- Detection in the primary care setting was not associated with improved outcomes.
- “Depression” in primary care may be very different from depression seen in psychiatric settings.

Limitations

- This was a prevalence-based study, and therefore all patients were not at the same stage of the depressive episode.
- Adequacy of treatment for detected patients was not measured.
- The extent of parallel treatment by mental health professionals is not known.

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Résumé

Objectif : Étudier les liens entre la détection, le traitement et l'issue de la dépression dans le secteur des soins primaires, à partir des résultats obtenus dans le cadre du projet sur la dépression au Michigan.

Méthode : Un échantillon pondéré de 425 patients adultes traités en cabinet de médecine familiale ont rempli une série exhaustive de questionnaires portant sur le stress, le soutien social, l'état de santé général, l'utilisation des soins de santé, les attitudes face au traitement et une auto-évaluation du niveau de stress et de dépression, en plus d'être évalués selon l'échelle d'évaluation de l'état dépressif du Center for Epidemiological Studies, l'échelle de dépression de Hamilton et l'interview clinique structurée pour le DSM-III qui a servi de critère type pour le diagnostic. Un échantillon de référence formé de 123 patients psychiatriques externes souffrant de dépression ont été soumis à la même batterie de tests. Les symptômes de dépression, le niveau de stress, le soutien social et l'utilisation des soins de santé chez les patients suivis en médecine familiale ont été réévalués durant une période de suivi longitudinal pouvant atteindre jusqu'à 60 mois.

Résultats : Les principales conclusions du Projet sur la dépression au Michigan confirment qu'il existe des différences significatives au niveau des antécédents, de la gravité des problèmes et du niveau de dysfonction entre les malades psychiatriques déprimés et les patients traités en médecine familiale, que le taux de détection est nettement plus élevé chez les patients de soins primaires gravement déprimés et que les cliniciens utilisent des indices cliniques, comme les antécédents, la détresse et la gravité des symptômes, pour «détecter» la dépression chez les patients dont la gravité des symptômes varie de légère à modérée. On note également une absence d'association entre la détection et l'amélioration de l'état chez les patients de soins primaires.

Conclusion : Ces résultats viennent mettre en doute l'hypothèse voulant qu'une dépression reste toujours une dépression, quel que soit le contexte et le médecin, mais viennent appuyer un modèle du trouble dépressif dans lequel ce trouble est défini comme un état subaigu ou chronique qui se caractérise par des paramètres cliniques de gravité, de stadification et de comorbidité, similaires à l'asthme. Ce nouveau modèle pourrait guider les études futures sur l'épidémiologie et le traitement des troubles de l'humeur par les médecins de soins primaires.