

EDITORIALS

The Many Faces of Depression in Primary Care

One of the difficulties facing primary care physicians in accurately diagnosing patients with depression is that these patients present more than two thirds of the time with one or more physical symptoms and worry about their physical health.¹ Recent studies also have shown that depressed primary care patients have significantly more medical comorbidity,² adverse health behaviors such as obesity, sedentary lifestyle, and smoking,³ nonadherence to medical regimens,^{4,5} and social stressors⁶ compared to patients who are not depressed. Depressed patients also have a higher likelihood of having had experiences of childhood adversity (i.e., physical and sexual abuse)⁷ and adult domestic violence.⁸ This multitude of problems certainly leads to many “competing priorities” for both the physician and the patient during a brief primary care visit.⁹ It also probably explains why cross-sectional primary care studies show worse accuracy of diagnoses of depression compared to studies that measure accuracy of diagnosis over a 6-month period.¹⁰ The longer time period allows the physician to “sift” through the multiple problems that many depressed patients have in order to make an accurate diagnosis. Three articles in this month’s *Journal of General Internal Medicine* address several of these competing issues primary care physicians face in diagnosing and treating patients with depression.

The article by Greco et al. entitled “The Outcome of Physical Symptoms with Treatment of Depression” provides important new information about the association of depression with physical symptoms.¹¹ This study randomized 573 primary care patients with depression to one of three serotonin reuptake inhibitors and followed patients with computer-assisted interviews at 1, 3, 6, and 9 months. There are several important findings to emphasize. First, patients with depression have an extraordinarily high number of physical symptoms. Based on the threshold of the physical symptom causing at least a “little bother,” over 80% of patients had headache, 71% nausea or indigestion, 70% limb and back pain, 60% stomach pain and bowel problems, and 55% palpitations and dyspnea. Twenty to thirty percent were “bothered a lot” by these same symptoms. Over a decade of research has also described a linear relationship between the number of physically unexplained symptoms patients experience and the percentage of patients with one or more anxiety or depressive disorders.^{12,13} High rates of recurrent major depression are seen in patients with syndromes such as chronic fatigue, fibromyalgia, and irritable bowel that by definition have multiple unexplained physical symptoms.¹⁴ This evidence suggests that the American Psychiatric Association’s Diagnostic and Statistical

Manual Version IV (DSM) committees that developed criteria for major depression missed an important physical symptom component of the major depressive syndrome. Indeed headache, gastrointestinal, and musculoskeletal complaints are all more likely to be problems for patients with depression than the DSM IV symptom of decreased sexual drive.

There are likely to be bidirectional interactions between physical symptoms and depression: depression probably causes many physical symptoms due to dysregulation of the autonomic nervous system, sleep cycles, and hypothalamic pituitary axis; aversive symptoms such as pain also likely cause depression.¹⁵ The Greco study provides evidence that greater improvement of depression is associated with more marked improvement in physical symptoms.¹¹ Patients who had either partial recovery (at least a 50% drop in depressive symptoms) or remission from depression had evidence of a greater degree of decrease in somatic symptom severity (effect sizes of 0.6 to 1.0) compared to patients who had persistent depression symptoms (effect sizes of 0.3 to 0.5). These data emphasize the importance of effective treatment of depression in primary care. A recent study also showed that effective treatment of depression in patients with osteoarthritis and major depression and/or dysthymia was associated with more relief from both pain severity and bothersomeness of pain.¹⁶ It is also likely in patients with depression and chronic medical illness that palliative treatment of pain and other aversive symptoms will improve depression.¹⁷

Unfortunately, over a decade of research has shown that recovery rates (based on at least 50% decrease in symptoms) from depression in “usual primary care” practice are only approximately 40% at 4 to 6 months.¹⁸ These rates of recovery have been shown to markedly improve with disease management interventions that integrate either allied health professionals such as nurses or mental health professionals into the care of patients with depression.^{18,19} The disease management programs that have been shown to be effective have many similar components including integrating an allied health professional or mental health professional into primary care to provide: (1) more time for education and activation of the patient to become a knowledgeable collaborator in care; (2) more frequent patient contacts (either by telephone or in person); (3) tracking of depression symptoms with a standard scale such as the Patient Health Questionnaire (PHQ-9)²⁰; (4) tracking and encouraging adherence to antidepressants or psychotherapy referral; (5) facilitating return visits to the primary care physician or mental health

specialist for patients who are not improving; and (6) decision support for the primary care physician in terms of antidepressant treatment.^{18,19} These interventions have improved recovery rates from 40% in usual care to 55% to 75% depending on the intensity of intervention.¹⁸

The article by Nicolaidis et al. in this month's journal emphasized that depression and physical symptom burden are often associated with childhood abuse, physical and/or sexual intimate partner violence (IPV), and community violence.²¹ Moreover, there were dose-response relationships between the number of forms of violence experienced and the odds of having both depressive symptoms and chronic physical symptoms.²¹ This study was completed in university-affiliated primary care clinics with a high percentage of patients living in poverty (i.e., almost half of patients' household incomes were below the U.S. poverty level). Clinics that have a high percentage of patients living in poverty have been found to have extremely high rates of patients exposed to childhood and adult abuse, more than 50% of patients meeting DSM IV criteria for one or more anxiety and depressive disorders, and high rates of chronic medical disorder and functional impairment.^{22,23} Other research has also shown an association between childhood abuse and vulnerability to depression⁷ and chronic somatization as adults.²⁴ Patients who experience childhood and/or adult violence may also develop problems with trusting key authority figures due to experiences of being hurt by people they loved and relied upon.²⁵ They also often understandably feel humiliation and shame based upon these experiences of violence and betrayal. Faced, like all people with depression, with a combination of multiple depressive and physical symptoms, they may selectively focus on the physical when seeking medical care to unconsciously avoid having to face their psychological pain and to avoid feeling a sense of shame with the physician.²⁶ Because both childhood abuse and physical abuse is often associated with higher likelihood of environments where alcohol and drugs are problems for the victims of violence and with family members, there is also a risk for these patients to inadvertently develop problems with prescription abuse when they present with aversive physical symptoms.²⁷ Medications such as opiates and benzodiazepines are strong palliative medications for both the chronic psychological and physical pain that these patients experience.²⁷

A final article, by Cox et al., in this month's journal found in a large double-blind randomized relapse prevention trial of bupropion versus placebo among 429 patients who had been abstinent from smoking after 7 weeks of open-label bupropion treatment (300 mg) that bupropion was more effective than placebo in preventing relapse in both patients with and without lifetime episodes of major depression.²⁸ This is an important study because cross-sectional data have shown that patients with major depression are more likely to be current smokers.²⁹ Our research group recently found that 16% of primary care patients with type 2 diabetes and depression were current

smokers versus 7% of patients with diabetes who were not depressed.³⁰ Longitudinal data have also found that over a 9-year period patients with depression were 40% less likely to quit smoking than patients without depression.³¹ A recent study by Dierker et al. also found that patients with a history of major depression who were smokers often had a relapse of depression when they tried to quit.³² The study by Cox et al. did not find a differential effect of bupropion versus placebo on change from baseline in depressive symptoms but the small sample size in the major depression group may have limited the power to detect differences. Moreover, eligibility criteria that excluded patients with an "unstable" psychiatric disorder may have screened out patients with current major depression. It is plausible that treatment with a medication like bupropion may not only decrease craving for nicotine when patients attempt to quit but also suppresses relapse into a depressive episode for those with a history of major depression.—

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