

The 15-minute



ILLUSTRATION/WHITNEY SHERMAN

Depression is one of the most common conditions in a primary-care office. Incorporate simple behavioral therapy techniques into your patient's appointment and dramatically improve the outcomes.

Hour

IT'S *five o'clock and you have 15 minutes to evaluate Mrs. Smith's recurrent headache. You review the laboratory tests; all are negative. As you check her vital signs, Mrs. Smith tells you about her recent troubles with her daughter. While she expertly reads the eye chart, she adds that worries over her daughter's school truancy have kept her up at night. With a few well-chosen questions, you discover Mrs. Smith cries often and has lost interest in her friends and hobbies. Aha! You are now certain that Mrs. Smith's headaches are a symptom of depression. Unfortunately, you have two minutes left for the appointment, and begin to sweat over how find the time to explain this to Mrs. Smith and prescribe a course of treatment.*

*This scenario is all too common in the medical office. According to Patricia Robinson, Ph.D., a psychologist and the co-author of *Treating Depression in Primary Care*, as many as 26 percent of primary-care patients are suffering from some type of depressive disorder at the time of a medical encounter. "That means seven patients in a 28-patient contact day will present with symptoms of depression," she says.*

Recent estimates suggest that primary-care physicians provide 53 percent of mental health services in the United States. Before the advent of managed care, patients and physicians had an array of treatment resources paid for by insurance plans, such as inpatient hospital treatment programs and long-term outpatient psychotherapy. However, as more and more physicians practice under managed-care plans, they are faced with the dual pressures of increasingly limited inpatient and outpatient psychiatric benefits, as well as contractual arrangements that may place them financially at risk for referrals to specialty mental health care. This means that more and more physicians face the challenge of diagnosing and managing psychiatric disorders, like depression, in their offices.

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When is a headache just a headache?

Recognizing depression may be harder in the primary-care office than in mental health settings. Experts have identified three reasons why depression is often underdiagnosed by primary-care physicians. First, some physicians may be uncomfortable talking about psychological problems. Second, physicians may not be familiar with diagnostic criteria for clinical depression. Finally, the standard 10- to 15-minute office visit leaves little time for the traditional comprehensive evaluation associated with making a psychiatric diagnosis. Robinson says "primary-care physicians are responsible for diagnosing dozens of medical conditions on a daily basis. Their primary training is medical rather than psychological. Predictably, they focus most on physical symptoms of depression."

Additionally, patients in the primary-care office more often list physical symptoms, such as pain, as the focus for treatment, rather than emotional or social problems. "Getting patients past the stigma of depression and helping them accept treatment is the biggest challenge with this disorder," says Joseph Brock MD, a family physician in Muskegon, Michigan. Patients may avoid discussing the psychological symptoms of depression because they worry they may be going crazy.

So how do you separate patients suffering from strictly medical diagnoses from those with clinical depression? Robinson says "physicians can improve their depression detection rate by focusing on the psychological symptoms of depression." Asking patients about how much they join in social activities, or how much they feel hopeless about the future, may increase the chances of diagnosing depression. Other symptoms of depression include sadness or irritability, as well as

Thoughts that Harm



Ask your patients the following questions to identify patterns of negative thinking that you can help them to overcome through behavioral therapy.

1. Setting achievement standards so high you are bound to fail
2. Viewing life events as all bad
3. Assuming other people are critical of you
4. Predicting that future life events will turn out badly
5. Labeling yourself stupid, lazy, ugly, etc.
6. Seeing one bad event as a pattern of failure that will never end
7. Insisting that your positive accomplishments or qualities don't count, or ignoring positive life events
8. Blaming yourself for others' problems

changes in sleep and eating patterns.

Robinson cautions that co-morbid psychiatric disorders pose a second challenge to identifying depression. That is, many patients meet criteria for more than one psychiatric diagnosis. For example, the co-morbidity rate for depressive and anxiety disorders among primary-care patients is greater than 50 percent. Robinson suggests that physicians want-

ing to identify anxiety disorders ask their patients if they worry too much. Patients with chronic pain conditions also have a high rate of depression, and are often frequent users of primary-care medical services. Studies have shown that depression can increase pain perception, and medications useful for treating depression are also beneficial for chronic pain conditions. Other co-morbid disorders that present with depression include substance abuse and eating disorders.

Brief screening questionnaires are a tool that physicians can use to increase recognition of depression and other psychiatric problems. Many of them are simple checklists that can be completed by patients in the waiting room. The Beck Depression Inventory has a primary-care version specifically tailored to assess depression symptoms. Other brief questionnaires include the Beck Anxiety Inventory and the BASIS-32 questionnaire. Checklists and similar screening tools can save time during office visits and help facilitate a conversation between physicians and patients about psychological problems.

Clinical management:
The pill or the couch?

The job of diagnosing depression may seem easy compared to the challenge of treating depressed patients in 10- to 15-minute office visits. However, both medication and counseling interventions can be tailored to fit a busy practice schedule. Advances in the safety and effectiveness of antidepressant medications have made it easier to manage them in the primary-care office. Surveys indicate about 80 percent of the antidepressant prescriptions in the U.S. are written by primary-care doctors. Unfortunately, many patients have trouble taking the medications as prescribed, as well as taking them long

Signs of Suicide



Studies show that 32 to 69 percent of persons who attempted suicide see their primary-care physician within one week of the attempt. Among all the psychiatric disorders, the highest risk for suicide is associated with depression. Other risk factors for depression include:

- Previous suicide attempts
- A plan, especially one that involves a lethal weapon
- Feelings of hopelessness
- Persons who are divorced, widowed, or single
- Presence of life stress such as a job loss or relationship problems
- Early stages of recovery from depression

Experts recommend that a physician who suspects a patient is thinking about suicide ask direct questions. Asking about suicide does not increase the risk for suicide. The following is a list of questions useful in evaluating suicide risk:

- Have you thought about killing yourself?
- Have you ever tried to kill yourself in the past?
- Have you made any plans to kill yourself?
- Do you have the means to carry out your plan?

Patients who are psychotic or have plans to kill themselves need to be hospitalized. If hospitalization is not indicated, suicide prevention measures include:

1. Establishing and maintaining a no-suicide contract with your patient
2. Providing your patient with 24-hour backup through emergency phone numbers
3. Using strategies to increase adherence to a treatment plan, such as follow-up phone calls and/or frequent return office visits
4. Making sure firearms and other lethal weapons have been removed from your patient's home

enough to effectively treat their depression. For example, as many as 50 percent of primary-care patients stop taking their medication within the first month of an initial prescription for antidepressant medication. Poor symptom resolution related to skipping doses or early discontinuation of a medicine may lead to unproductive and repetitive office visits. In *Treating Depression in Primary Care*, Robinson and her colleagues recommend that physicians can improve patient adherence by providing written instructions about how to take medication correctly, when to expect improvements, and how to handle side effects. If antidepressant medication is taken properly, most patients can expect to see improvements in their symptoms within three to four weeks.

Studies of depression suggest that, at least for mild depression, certain types of counseling are as effective as medication. However, physicians may shy away from psychotherapy techniques either from discomfort in discussing psychological problems or concerns that a talking cure requires a fifty-minute hour on the couch. Experts like Robinson disagree. Brief and specific interventions that focus on changing a patient's behaviors and beliefs are effective in treating depression and work well in the primary-care visit.

"Just Do It"

Behavior therapy for depression involves changing how a patient copes with life problems. Ways to facilitate change include improving a patient's problem-solving

strategies or encouraging the patient to participate in activities that are pleasurable or raise self-confidence. With behavior therapy, the physician can use the trust established in the relationship with a patient to get her to try new behaviors. The most important component in a behavior change plan is to get the patients to choose small, specific goals that will improve their life situation or mood. Becoming a happy person is an unspecific goal; going out to the movies with a friend is one small and specific step toward improving a depressed mood.

Robinson suggests that physicians can present patients with brief workbook-like pamphlets that describe behavior change strategies. "Most physicians are comfortable with asking patients what types of activities help them feel better," she says. "Patients can choose one or more strategies with the physician, and develop a treatment plan that is supported by a patient education pamphlet." For example, physicians can list out these key activities (seeing a friend, reading a magazine, going for a walk) on a prescription pad. Follow-up visits can track how often a patient is trying a new behavior, and identify any problems in achieving the goal. Failure to achieve a goal suggests that the patient and physician have chosen a goal that is too large or unspecific.

I Think I Can

Patient education is the key factor in changing beliefs and attitudes that are risk factors for depression. Physicians can use

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office visits to teach their patients about the different types of negative thinking that promote depression and help patients learn to identify negative thought patterns in their own lives. (See "Thoughts that Harm," page 40.) The doctor's job in using behavior modification to treat depression is to encourage patients to confront negative beliefs and replace them with optimistic thoughts. For example, patients who are highly critical of themselves can be encouraged to shift the focus away from their shortcomings and toward identifying and affirming personal strengths. Patients who are self-critical might be given a prescription to list 20 positive things about themselves and to review the list daily prior to the next office visit.

Primary care physicians are also in a position to confront myths that keep patients from accepting professional help. Beliefs that depression is a personal weakness and that people should be able to 'snap out of it' are common misconceptions about depression and are barriers to treatment. Moreover, many patients fear that having depression means they are crazy. Providing educational pamphlets on depression can empower patients to understand the illness and learn how to manage symptoms effectively.

Follow-up Care

How often should depressed patients be seen once a treatment plan is established? "I recommend that physicians see patients often enough to determine that the patient is following the treatment plan and responding well to it. The physician might book a phone call or appointment with a patient two weeks after setting up a behavioral treatment plan," says Robinson. For some patients, this might mean having the nurse or medical assistant phone

the patient the day after an initial antidepressant prescription is written. Robinson also suggests that physicians have patients call the office to report their progress. The key to treatment success is to communicate to the patient that they are to call the physician's office if there are problems with the treatment plan. Early identification of difficulties allows for quick changes that create a viable plan for the patient. Robinson also emphasizes that flexibility in follow-up schedules is important for both the physician and patient.

Family matters

The family practice model of primary-care medicine is a natural arena for helping family members understand a patient's depression and to learn ways to help a loved one recover from the illness. Brock recommends asking patients who they can talk to, or who really listens to them, and making sure to include those important support people in the patient's treatment plan. Primary care doctors can encourage patients to bring those persons to follow-up visits. During family visits, physicians can give information on common depression symptoms and how depression affects relationships. Explaining to a family, or other support persons, how the negative outlook and behavior changes associated with depression create strain and distance in relationships may provide relief and facilitate problem-solving. Family members or other support persons might be included in a prescription plan, such as taking a depressed patient out for walks or to the movies.

Continuing education

How can physicians increase their skills in recognizing and managing depres-

sion in the primary-care office? Michael Freeman MD is the president of the Institute for Behavioral Healthcare, a Tiburon, California-based company that provides continuing education on mental health issues. He suggests that physicians look for educational opportunities that focus on recognizing and treating depression as well as associated disorders such as anxiety and substance abuse. His organization co-sponsors an annual primary-care behavioral health conference. Family medicine training programs, national and state medical associations, as well as health-care companies, also organize seminars on treating depression in the primary-care setting.

Helping a patient through an episode of depression can have a pro-

Resource Rx

The Partnership for Behavioral Healthcare/Centralink annual Primary Care Behavioral Healthcare Summit. Call 415-435-9821 for details.

Treating Depression in Primary Care

(Context Press, 1996) by Patricia Robinson, Ph.D., Charles Wischman, MD, and Alison Del Vento, R.N.-C.

The Feeling Good Handbook

(Plume/Penguin Group, 1990) by David Burns, MD

Healthwise Handbook Twelfth Edition

(Healthwise Incorporated, 1995).

The Relaxation and Stress Reduction Workbook

Fourth Edition (New Harbinger Publications, Inc., 1995) by Martha Davis, Ph.D., Elizabeth Robbins Eshelman, M.S.W., and Matthew McKay, Ph.D.

Mind Over Mood: A Cognitive

Therapy Treatment Manual for Clients

(The Guildford Press, 1995) by Dennis Greenberger, Ph.D., and Christine A. Padesky Ph.D.

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found effect on the doctor-patient relationship. "Depression is a disorder where you can make as big an impact on a patient's life as delivering their baby," says Dr. Brock.

"I've created stronger relationships with my patients, and that is very rewarding to me." ■

*SOURCE: The Feeling Good Handbook
(Plume/Penguin Group, 1990) by David Burns, MD*

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