

3 Assessing anxiety and depression in primary care

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A general practitioner who sees 40 patients a day can expect that eight will require support or treatment for anxiety or depression — and that's not counting those whose disorders go unrecognised.

Depressive and anxiety disorders are common, occurring in up to 25% of primary care patients,¹ and are more disabling, both socially and in terms of physical functioning, than many chronic physical illnesses, such as diabetes, hypertension, arthritis and back pain.^{2,3} The economic impact is immense, both in direct costs to health care systems and in indirect costs to the community.⁴ Despite this, there is considerable evidence that the medical profession deals poorly with these disorders. In up to half of patients presenting with anxiety or depression, the diagnosis is missed, and in those who are recognised a significant proportion are not treated.^{1,5}

Most patients with these disorders present and are managed in primary care settings.^{6,7} This article reviews the prevalence, recognition and assessment of depressive and anxiety disorders in primary care.

Prevalence of depression and anxiety in primary care

The most thorough large-scale study is the World Health Organization [WHO] study on psychological disorders in primary care.¹ Over 25 000 consecutive adults were screened at 15 sites in 14 countries. Over 5 000 were further assessed with detailed psychiatric interviews. A quarter had a recognisable mental disorder, the commonest being a depressive disorder (11.7%) or an anxiety disorder (10.5%), with 4.6% having both. Only half of the mental disorders were recognised by the primary care physician; among those patients with a recognised mental disorder, half were offered drug treatment.

A similar study in Australia of 4867 patients of 117 general practitioners found that 35.6% had elevated scores on a screening test for mental illness, while 20.6% had been treated for anxiety or depression in the previous 12 months. Treatments included medications (52%), referral to a specialist (24%) and non-drug advice (70%), with 91% of patients reporting their treatment or advice as reasonably good or very good.

The high prevalence rates in primary care patients are not sur-



A fully rigged ship running onto the rocks — a common theme in anxiety. This painting was shown at the 1950 International Exhibition of Psychiatric Art, and is now in the Cunningham Dax Collection of Psychiatric Art in the Mental Health Research Institute of Victoria. Reproduced with permission.

Synopsis

Depressive and anxiety disorders are common in primary care settings, yet up to half the patients who present with these disorders may not be diagnosed and others may not be treated.

- The cornerstone of detection is an understanding of the common presenting symptoms and syndromes.
- Patients with depression or anxiety frequently present complaining of physical symptoms, which may obscure the psychiatric diagnosis.
- The doctor's consultation technique is important: an empathic style, open questions and a willingness to hear the patient out will help reveal the diagnosis.
- Clinical depression is diagnosed when there are at least three or four symptoms (low mood, loss of interest, sleep disturbance, lost concentration, fatigue, disturbed appetite, agitation or retardation, feelings of worthlessness or guilt, suicidal thoughts) present every day for at least two weeks.
- Anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder and generalised anxiety disorder.
- Screening tools (simple questionnaires designed to identify signs and symptoms of anxiety and depression) can be effective.
- Once a depressive or anxiety disorder is detected, possible causes to be explored include underlying medical conditions, psychiatric conditions, and drug or alcohol use.

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prising in view of large community surveys, such as the National Comorbidity Study in the United States,⁸ which reported a 12-month prevalence of 11.3% for depressive disorders and 17.2% for anxiety disorders.

Barriers to recognising depression and anxiety

The reasons behind the non-recognition of many cases of anxiety and depressive disorders in primary care are complex and poorly understood, despite a number of studies and reviews addressing this issue.^{4,6,9,10}

One way of viewing the problem is to consider the various “hurdles” that must be overcome on the path from being ill to receiving treatment. These include:

1. *The patient recognising that he or she is unwell.* Often patients consider their psychiatric problems as “their lot in life”, and something that cannot change.
2. *The patient recognising that a doctor can help.* Often patients will present with problems associated with anxiety or depression, without thinking the doctor can help with the anxiety or depression itself. This is especially common with depression, where the sufferer may feel hopeless and beyond help.
3. *The doctor recognising the mental illness.*
4. *The doctor recognising the need to treat and enlist specialist services where necessary.*

The barriers at the third hurdle have been best studied and are generally divided into those related to the doctor, the patient, or the consultation.

The doctor

Most general practitioners have had little formal psychiatric training and have practised in an environment where excluding physical illness is the primary focus of attention. Anxiety and depression become diagnoses of exclusion and, as such, are considered late. Perceptions about mental illness are often negative, with fears of alienating patients if such diagnoses are made. Practitioners sometimes justify depression and anxiety as understandable responses to the vicissitudes of life. Yet, although depression and anxiety are often understandable, they are disabling and treatable, and should not be passed over.

Falsely negative perceptions about treatment may also lead to reluctance in diagnosing mental illness.

Finally, personal issues for the doctor may also hinder recognition: some feel uncomfortable dealing with emotions and the interpersonal issues that are associated with anxiety and depression.

The consultation

Most general practice consultations last 10–15 minutes, and many patients present with more than one problem. The presenting symptoms of mental illness are rarely the classical descriptions seen in text books, which are written with psychiatric settings in mind.

Studies of interview characteristics suggest that the recognition rates of mental illness improve if the doctor adopts an empathic style (i.e., demonstrated ability to take the patient’s viewpoint), lets the patient lead the interview,

Case history 1: A man anxious about his health

Presenting complaint

Bill was a 28-year-old unemployed man living with his girlfriend. He presented complaining of fatigue and “light spots” in front of his eyes. He reported having seen an optometrist who could find no cause and suggested he attend his general practitioner.

Past history

Bill had attended a number of doctors, and was vague regarding details. He reported having been referred to a neurologist three years ago to investigate numbness in his feet, but no cause was found. He also reported attending casualty once for a suspected heart attack, but tests were clear.

Further questioning

Bill reported his fatigue had fluctuated over two years, and his “light spots” were also variable, describing them as “spots in my sight where it seems brighter”.

Further questioning revealed Bill was worried he might have multiple sclerosis, which he had read about, but also feared he was “going crazy”, like an uncle who had been admitted to a “mental institution” many years ago.

Bill also reported episodes of palpitations of sudden onset, with sweating, racing pulse, nausea and a feeling that he was going to collapse. These lasted between 10 minutes and two hours. He experienced about two attacks every three weeks, for over six months. Bill had been reluctant to mention them, fearing it was further evidence he was going crazy.

Mental state examination

Bill presented as neat and tidy. He was keen to give as many details as possible. His speech was slightly fast and his affect anxious. He did not appear depressed. Thought content revealed a mild preoccupation with the belief he had a serious medical condition or was going crazy. There were no psychotic features and cognitive function was intact.

Physical examination and investigations

Physical examination was unremarkable. Investigations (full blood examination, electrolytes, urea and creatinine, liver function tests, thyroid function tests, a random blood sugar test, B₁₂ and folate levels and a urine drug screen) gave normal results. A discharge summary from his casualty attendance revealed a work-up for acute myocardial infarction had been unremarkable.

Diagnostic assessment

Bill was diagnosed as suffering panic disorder, without agoraphobia, any associated depression or underlying medical conditions. He was given information about the condition, including a suitable self-help book on anxiety reduction, and treated with a combination of pharmacotherapy (a selective serotonin reuptake inhibitor) and supportive psychotherapy with cognitive-behavioural techniques to deal with panic attacks.

Bill’s condition improved dramatically over the next six weeks and maintained a slower improvement over six months, with only one episode of relapse associated with a temporary break up in a relationship.

asks direct psychologically oriented questions early in the interview, responds to non-verbal cues, listens attentively, tolerates silences, maintains eye contact, avoids closed-ended questions about physical symptoms (i.e., Yes/No questions), and avoids interrupting the patient.^{6,9}

The patient

Some studies suggest that most patients with anxiety or depressive disorders initially present with somatic complaints (see the Case history).⁴ Many patients are not aware of the emotional origin of their symptoms. They may fear stigmatisation, or fear that they are “going crazy”.

Depression and anxiety are particularly likely to be missed when they are associated with physical illness or another psychiatric illness (especially dementia, schizophrenia and drug and alcohol disorders), when symptoms are of less recent origin, and when there are cultural differences between the patient and doctor.^{4,10}

Recognising depressive and anxiety disorders

Before depressive and anxiety disorders can be adequately assessed, they must be recognised. Goldberg⁶ has outlined three fundamental approaches to the problem:

1. improving the interview technique of primary carers
2. the use of screening tools, and
3. bringing mental health services into primary care settings.

Suggestions to improve interviewing have included the use of video feedback techniques,¹⁰ restructuring consultations to allow extended and repeated interviews, and education about situations in which to be particularly vigilant (e.g., women in the postnatal period).

Other authors have suggested educational efforts need to be broadened to decrease the burden on doctors.⁹ Community campaigns to raise awareness about mental illness are under way in Australia and elsewhere. Information in surgeries, such as posters and videos, can help patients recognise their problems and help them feel comfortable discussing these issues with their doctor. Finally, other staff members, such as nurses, can be better trained to recognise mental illness.

Assessing depression

Although severe depression is generally readily recognised, milder forms are often difficult to distinguish from emotional changes associated with everyday life. Bereavement, job loss, divorce, and other life events can result in a depressive reaction of short duration. As a general rule, clinical depression is diagnosed when there are at least three or four core symptoms (Box 1) present every day for a minimum of two weeks.

Recently published clinical practice guidelines (freely available from the National Health and Medical Research Council) discuss the assessment of depression in young people.^{11,12}

Mental state examination

The mental state examination can be quite variable depending on the severity of the depression. Generalised psychomotor retardation is the commonest sign, although agitation can also occur. Lack of attention to personal grooming and hygiene may also be evident. The speech may be slow and monoto-

1 SAD-A FACES: a mnemonic for the core symptoms of depression⁴

- S** = Sleep — insomnia/hypersomnia; often the earliest symptom; may be overlooked if the patient has been given sleeping tablets
- A** = Appetite or weight change (increase or decrease)
- D** = Dysphoria — “bad mood”, irritability, sadness; the essential abnormality; few complain of it spontaneously
- A** = Anhedonia — loss of interest in work, hobbies, sex
- F** = Fatigue — affects almost all; often manifests as difficulty completing tasks
- A** = Agitation/retardation — especially in the elderly
- C** = Concentration — diminished; difficulty with simple tasks, conversation, decision-making; may lead to a misdiagnosis of dementia in the elderly
- E** = Esteem — low; guilt; events from the past may assume new significance
- S** = Suicidal thoughts — present in two-thirds of depressed patients; 10%–15% will commit suicide.

nous. The affect is usually, but not always, depressed, and often anxious or irritable, with the patient easily moved to tears (although in more severe depression the patient often describes being emotionally blunted and “beyond tears”). The thought content reveals themes of hopelessness and helplessness, with a negative view of the self, world and future. Suicidal ideas and plans may be evident. In severe depression delusions may occur, and these are usually mood-congruent, with themes such as poverty, failure, guilt, or terminal somatic illnesses (such as “rotting” internal organs). Perceptual disturbances such as hallucinations are less common, but can occur in severe depression.

Cognitive function is intact, although in severe depression the patient may not have the interest or energy to answer, making cognitive assessment difficult.

The depressive syndromes

The *Diagnostic and statistical manual of mental disorders*, fourth edition (DSM-IV)¹³ classifies the mood disorders into the depressive disorders and the bipolar disorders (previously called manic-depressive illness).

The depressive disorders are:

Major depressive disorder: Five or more symptoms present for at least two weeks, with a significant impairment in occupational or social functioning.

Dysthymic disorder: Chronic but mild depression. There are more than two (but fewer than five) symptoms present most of the time for at least two years. The symptoms must cause significant distress or impairment.

Depressive disorder not otherwise specified: Depression is the central feature, but the pattern does not fit the above disorders, or adjustment disorder (see below). It includes pre-

menstrual depression, recurrent brief depression and other, less established, syndromes.

Adjustment disorders: These are classified separately to depressive disorders, and refer to clinically significant emotional or behavioural symptoms related to depression, anxiety, or both, occurring in response to identifiable psychosocial stressors. They develop within three months of the stressor, and resolve within six months, and are not severe enough to meet criteria for major depressive disorder.

Assessment of anxiety

Anxiety is an emotion experienced by all to varying degrees, but it is difficult to define. It is similar to fear and apprehension, which serve adaptive functions in preparing people for danger, but occurs in the absence of a specific danger and usually in response to anticipated problems or hazards. In anxiety disorders, symptoms are out of proportion to the perceived threat, restrict activity, do not dissipate with reassurance and may be linked to thoughts or actions which seem excessive or ridiculous.¹⁴

General anxiety symptoms can be classified broadly into cognitive, somatic and psychological symptoms (Box 2).

If patients report significant anxiety symptoms, specific questions about the various syndromes should follow.

The anxiety syndromes

DSM-IV¹³ classifies the anxiety disorders as follows:

Panic disorder is characterised by recurrent, unexpected panic attacks, at least one of which has been followed by one or more months of persistent concern about having additional attacks, worry about the implication of the attack (e.g., fear of going crazy or having a heart attack), or a significant change in behaviour. Panic attacks are sudden, unexpected attacks of anxiety that are not necessarily linked to any cue. Agoraphobia often develops, which is essentially a fear of being in places

or situations from which escape may be difficult should a panic attack occur, leading to avoidance of many activities.

Phobias are more circumscribed forms of anxiety. *Simple phobia* involves persistent, excessive or unreasonable fear of specific objects or situations, with subsequent avoidance of such objects or situations. *Social phobia* is the fear of any situation where public scrutiny may be possible, usually with the fear of having a panic attack, or behaving in a way that is embarrassing or humiliating.

Obsessive-compulsive disorder (OCD) involves specific cognitive and behavioural symptoms accompanying the feelings of anxiety. These include obsessional thoughts (recurrent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety), and compulsions (repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession in order to reduce anxiety).

OCD is usually a chronic lifelong illness, with a waxing-and-waning course. The most frequent presenting obsessions are those related to contamination, pathological doubt (e.g., "Did I turn off the stove?"), somatisation and a need for symmetry. Frequent compulsions include the need to wash, check and count. The diagnosis of OCD should be made when the symptoms are severe, persistent and distressing.

Post-traumatic stress disorder (PTSD) occurs after an acutely distressing or catastrophic event. Symptoms include re-experiencing the trauma (e.g., recurrent dreams of the event, flashbacks), persistent avoidance of stimuli associated with the event, and persistent symptoms of increased arousal (hypervigilance, irritability, exaggerated startle response). A diagnosis of PTSD is made if the symptoms are present for at least one month and cause clinically significant distress or impairment in functioning.

Generalised anxiety disorder is excessive anxiety and worry, occurring most days for more than six months. It refers to excessive anxiety in a range of situations that does not fit into any of the more common syndromes.

2 Signs and symptoms of anxiety

Cognitive

Fear of dying or going mad
Decreased attention and concentration

Somatic

Cardiovascular: palpitations, chest pain, tachycardia, flushing
Respiratory: hyperventilation, shortness of breath
Neurological: dizziness, headache, paraesthesia, vertigo
Gastrointestinal: choking, dry mouth, nausea, vomiting, diarrhoea
Musculoskeletal: muscle ache and tension, restlessness

Psychological

Derealisation, depersonalisation, speeding or slowing of thoughts, distractibility, irritability, insomnia, vivid dreams.

Common presentations

In clinical situations, patients rarely present with such classical symptoms and signs. Studies in primary care settings suggest that 50%–95% of psychiatric patients initially present with somatic complaints,⁶ or "somatisation". In practice, these presentations are characterised by physical symptoms (often more than one) that are vague and difficult to explain in terms of organic disease.

This situation should sound warning bells for depression or anxiety. In one study, patients were divided according to whether their presenting complaints were related to a medical diagnosis or not. In those with no medical diagnosis, 38%–45% were found to have a psychiatric disorder (mostly anxiety or depression), compared with 15% in the group with a medical disorder.¹⁵ Typical symptoms were fatigue, gastrointestinal complaints, dizziness, joint pain, weight loss, chest pain and headache.

Other situations in which to be particularly vigilant for depressive and anxiety disorders are:

► patients with chronic physical illness, especially involving the

- neurological system (e.g., Parkinson's disease, strokes, multiple sclerosis)
- patients with chronic pain
- the elderly, especially the bereaved and those living alone or in nursing homes
- women in the postnatal period
- adolescents with behaviour problems.

Screening tests for depression and anxiety

Screening tests for depression and anxiety are simply questionnaires with a score that predicts the diagnosis. They may be rated by the doctor or patient and are helpful in improving recognition rates.^{5,16,17}

Various screening tests have been studied in primary care settings. These include PRIME-MD,¹⁸ the General Health Questionnaire,¹⁹ the Beck Depression Inventory,²⁰ and the Zung Self-Rated Depression Scale.²¹

Doctor-rated screening tests are a more structured way of interviewing and rating the severity of the illness. Patient-rated screening tests have the advantage of being completed in the patient's own time, and hence allowing more widespread and time-efficient screening. PRIME-MD (primary care evaluation of mental disorders) combines a patient questionnaire to screen for common mental disorders and a clinician evaluation guide to gain further diagnostic information in areas which drew affirmative responses from the patient.

A more simple doctor-rated screening test, developed using latent trait analysis by Goldberg et al.,²² is shown in Box 3.

Screening questionnaires can be used routinely in all new patients, or used selectively in high risk groups. Disadvantages include the time needed for training, concerns about their usefulness, and the time taken for completion.

Exploring the causes of depression and anxiety

Depression and anxiety may occur as primary disorders or secondary to a range of medical conditions, drug use or other psychiatric disorders. The causes of primary depression and anxiety are beyond the scope of this review, but include biological factors such as genetics, neurotransmitter abnormalities, neuroendocrine abnormalities and psychosocial factors (life events, environmental stress, and premorbid personality).

In the primary care setting it is the secondary causes that need to be excluded.

Medical conditions

A range of medical conditions are associated with depression and/or anxiety, highlighting the importance of thorough physical examinations and basic investigations. Most standard textbooks include long lists for both anxiety and depression. The more common conditions associated with depression include endocrine disorders (hypothyroidism, hyperthyroidism, Cushing's disease and Addison's disease), infections (infectious mononucleosis, influenza, tertiary syphilis and AIDS), neurological disorders (multiple sclerosis, Parkinson's disease) and cerebrovascular disorders. Underlying malignancies should also be considered.

For anxiety disorders, consider endocrine disorders such as thyroid, parathyroid, and adrenal dysfunction (phaeochromocytoma), seizure disorders and cardiac conditions such as

3 A screening test for anxiety and depression²²

Anxiety scale

Score one point for each "Yes".

1. Have you felt keyed up, on edge?
2. Have you been worrying a lot?
3. Have you been irritable?
4. Have you had any difficulty relaxing?

If "Yes" to two of the above, go on to ask:

5. Have you been sleeping poorly?
6. Have you had headaches or neck aches?
7. Have you had any of the following: trembling, tingling, dizzy spells, sweating, urinary frequency, diarrhoea?
8. Have you been worried about your health?
9. Have you had difficulty falling asleep?

Depression scale

Score one point for each "Yes".

1. Have you had low energy?
2. Have you had loss of interests?
3. Have you lost confidence in yourself?
4. Have you felt hopeless?

If "Yes" to ANY question, go on to ask:

5. Have you had difficulty concentrating?
6. Have you lost weight (due to poor appetite)?
7. Have you been waking early?
8. Have you felt slowed up?
9. Have you tended to feel worse in the morning?

Interpretation

Add anxiety score, add depression score. Patients with anxiety scores of five, or depression scores of two have a 50% chance of having clinically important disturbance; above these scores the probability of illness rises sharply.

arrhythmias, supraventricular tachycardia, and mitral-valve prolapse.

Depression may arise as a psychological response to physical illness, especially if the illness is life-threatening, chronic, or associated with pain. As many as one-fifth of general medical inpatients show some evidence of depression.²³ Alternatively, depression may be a direct consequence of the physical illness. Both Cushing's disease and hypothyroidism are well known examples of endocrinopathies for which depression may be the first manifestation. The same is true for anxiety, where hyperthyroidism and vitamin B₁₂ deficiency are frequently associated with anxiety symptoms.

Pharmacological agents

The list of drugs suspected of causing depression or anxiety is long.²⁴ While for some of the drugs the evidence is strong (e.g., sympathomimetics and anxiety; high dose reserpine and depression), for most drugs the evidence is weak, often consisting only of case reports.

Drugs commonly associated with depression are antihypertensive agents, corticosteroids, oral contraceptives and anti-neoplastic agents.²⁴ Recreational drugs such as alcohol and amphetamines can cause depression either during intoxication or withdrawal.

Drugs commonly associated with anxiety are sympathomimetics such as amphetamines, cocaine and caffeine. Drugs that increase serotonin release, such as LSD and MDMA ("ecstasy"), can cause acute and chronic anxiety. Prescription medications to consider include sympathomimetics, antihypertensives (especially captopril), and non-steroidal anti-inflammatory drugs.²⁵

Careful questioning about the timing of the drug dose in relation to the symptoms is important. If suspected, the drug should be withdrawn and the patient monitored for a correlation between relief of symptoms and washout (about five half-lives) to confirm or refute the diagnosis.

Psychiatric disorders

Depressive disorders and anxiety disorders often coexist and are often secondary to other psychiatric disorders.

The comorbidity between depression and anxiety is so high that debate continues as to whether they are categorically separate disorders or part of a continuum.^{26,27} For example, studies suggest that 30%–40% of patients with panic disorder or OCD also have depression.^{28,29}

Comorbidity between anxiety disorders is common (e.g., 30% of patients with OCD report simple or social phobias, and 15% report panic disorder).²⁹

Comorbidity with other psychiatric disorders is also common. Depression can be a feature of virtually any psychiatric disorder. Particularly high rates of depression are found in alcohol-related disorders, eating disorders, schizophrenia and somatoform disorders.³⁰

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The key comorbid psychiatric disorders to explore in anxiety disorders (apart from depression) are substance-related disorders (especially alcohol), schizophrenia and dementia.

Determining which disorder is primary and which secondary is difficult. For example, an anxious patient may become alcohol dependent through years of self-medication, or alcohol dependence may result in chronic anxiety. Finally, some independent factor, such as a genetic predisposition or tumultuous life events, may have led to both. Careful history-taking to determine the temporal relationship, with corroborative information from friends or relatives, helps in some cases. In others, unravelling which disorder came first is impossible.

When to refer to specialist services

The main difficulty in referring to specialist psychiatric services is discussing the referral with the patient. The stigma attached to mental illness continues despite medical and community education programs. As a consequence, referral needs to be handled tactfully. Discussing emotional factors in illness, explaining and demystifying psychiatric services and addressing patient fears and beliefs about psychiatrists are key elements in the process.

Situations in which referral should be considered include:

- ▶ severe depression or anxiety
- ▶ high suicide risk
- ▶ failure to respond to treatment
- ▶ uncertainty about the diagnosis
- ▶ possible organic brain disease or dementia
- ▶ the need for greater resources
- ▶ adolescent patients
- ▶ comorbidity with drugs or alcohol
- ▶ patients not accepting recommended advice or treatment.