DEPRESSION 1

The severity of depression in patients treated in general practice

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SUMMARY. The severity of depression, the presence and intensity of suicidal feelings, and the outcome of depressive illness treated in general practice were studied. The results suggest that a consideration of the relatively good outcome at 16 to 18 weeks alone is misleading. At least one in six new patients is suffering from a depression of moderately severe intensity and a similar proportion experience suicidal ideas that are persistent and require active rejection. A sample of patients with chronic depression had only a slightly smaller morbidity. The presence of moderately severe symptoms of depression in both groups of patients has important implications for treatment.

Introduction

DESPITE the known high prevalence of affective illness among the general population (Shepherd *et al.*, 1966), there is still little published clinical information about those patients who receive the whole of their treatment from their family doctor. It is all too often assumed that only mild depressive illnesses of short duration, usually responding to treatments prescribed in a lower dose range than in hospital practice, and sometimes not requiring any specific treatment, are treated in general practice.

Aim

This study investigates the severity of depression treated in several general practices, with special attention to the presence of suicidal feelings and the outcome of the illness.

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Method

Two separate groups of patients were investigated. Each patient was initially diagnosed as depressed by the family doctor and included in the study if the diagnosis was confirmed by the psychiatrist and the patient scored more than 11 on the Beck depression inventory.

Group A

Group A consisted of 119 consecutive patients diagnosed as suffering from a new episode of depressive illness—that is, those who had been free of all symptoms and had had no treatment for at least one year—and attending one of five practices (14 doctors).

Group B

Group B consisted of 88 consecutive patients who had been attending their general practitioner's surgery for treatment for a continuous period of more than three months. The patients were attending one of six practices (17 doctors).

All Group A patients were interviewed at home within seven days of the initial general-practitioner consultation; Group B patients were interviewed within seven days of inclusion in the study. Severity of depression was measured by the Beck inventory and a clinical four-point scale. Suicidal feelings were assessed on a four-point scale (Table 1). The first 73 patients in Group A were revisited at 16 to 18 weeks for reassessment of their mental state, and patients judged as fully recovered completed the Maudsley personality inventory.

A detailed analysis of treatments prescribed, the use of drugs by both doctors and patients, the correlation of

Table 1. Scale of suicidal feelings.

	Score
No suicidal ideas	0
Ideas present but immediately rejected	1
Passive feelings (e.g. I wish I were dead; Life is not worth living)	1
Ideas that require active rejection	2
Fears that ideas may provoke a response	2
Persistent ideas (serious consideration to act)	3
Attempted response	3

the psychiatrist's clinical rating with the Beck depression inventory score, and the sensitivity of this inventory to mood change in a general-practice environment have already been published for many of these patients (Johnson, 1973, 1974; Johnson and Heather, 1974).

Results

The age range was 15 to 81 years with a mean age of 34·5 years, 76 per cent of all cases were aged between 24 and 50 years. Depressive illness was reported in 3·5 per cent of all patients seen with a ratio of 2·5 to one of chronic patients to new patients.

A separate analysis suggested the optimum scores on the Beck depression inventory as "cut-off points" as: depression absent zero to ten; mild depression 11 to 18 (mean 14·5, SD 6·4); moderate depression more than 19 (mean 22·4, SD 5·6; Johnson and Heather, 1974). The validation in general practice by Salkind (1969) agrees with the cut-off point no depression to mild depression at 11, but two other studies (Beck *et al.*, 1961; Metcalfe and Goldman, 1965) suggest a higher score for the separation of mild to moderate depression at 24·2 to 25·4, so moderate depression has been subdivided at scores 19 to 25 and over 25 to allow comparison with other studies.

Table 2. Severity of depression.

Clinical rating	*Beck depression inventory*	*% Group A* N = 119	*% Group B* N = 88
Mild	11-18	*41*	*56*
Moderate	19-25	*43*	*33*
Moderate	>25	*16*	*11*
Severe		*0*	*0*

Mild = no significant change in function or lifestyle.
Moderate = significant reduction of function and change in behaviour.
Severe = psychotic, suicidal behaviour; extreme retardation or agitation.

Table 3. Rating of suicidal feelings.

Score	*% Group A* N = 119	*% Group B* N = 88
0	*57*	*61*
1	*25*	*27*
2	*17*	*11*
3	*1*	*1*

Group A (new patients)

An analysis of severity of depression shows 59 per cent of patients classified as moderate with a score on the Beck inventory of more than 19 (Table 2); 16 per cent had a score of more than 25. A separate rating of suicidal feelings (definitions in Table 1) shows that 43 per cent of patients had experienced some suicidal ideas during their present illness, with 18 per cent having persistent or troublesome impulses (Table 3). A significant positive correlation ($r = 0{\cdot}520$; $p < 0{\cdot}01$) existed between the severity of depression and a high score on the rating of suicidal feelings (Table 3). At the follow-up visit, 16 to 18 weeks after the initial contact, 51 patients (69 per cent) were fully recovered, seven patients (ten per cent) much improved, and only 15 patients (21 per cent) were either unchanged or worse.

An analysis of the scores on the Maudsley personality inventory completed by the 51 recovered patients showed that the neuroticism score (N) had a positive correlation with the severity of suicidal feelings ($r = 0{\cdot}278$; $p < 0{\cdot}01$). No significant correlation was found for the extraversion score; any trend present suggested a negative relationship.

Group B (follow-up patients)

The proportion with a Beck inventory score of more than 19 was 44 per cent, with 11 per cent scoring more than 25 (Table 2). Again a separate analysis of suicidal feelings demonstrated that 39 per cent of patients experienced some suicidal ideas with 12 per cent having troublesome or persistent thoughts. A significant correlation ($r = 0{\cdot}660$; $p < 0{\cdot}01$) existed between the severity of depression and a high score on the rating of suicidal feelings (Table 3).

In both groups of patients the intensity of suicidal feelings had no significant association with age, sex, or duration of illness.

Discussion

The most significant results are clearly the analyses of severity of depression and its relationship to the presence of suicidal feelings. Even when the most restricted interpretation of the category "moderate depression" is taken (Beck inventory less than 25), 16 per cent of Group A patients and 11 per cent of Group

B patients fall within this classification. If a wider definition using the level of psychological and social function is used (Beck score of more than 19), then 59 per cent of Group A patients and 44 per cent of Group B patients are included. All these patients were unable to continue with their normal lives and required some major change in lifestyle such as discontinuing their normal work. This proportion, therefore, is likely to cause a significant disruption within their family environment.

The importance of the severity of depression reported is confirmed by the analyses of suicidal feelings experienced by these patients. The proportion who had such impulses at some time during their illness was surprisingly high: 43 per cent of Group A and 39 per cent of Group B. Perhaps this result should have been anticipated since the one-year prevalence rate for the general population has been shown to be nine per cent (Paykel *et al.,* 1974). It is not suggested that all these patients were seriously at risk, since those scoring only one on the rating scale (Table 1) were experiencing only passive or transient impulses. Nevertheless, this high prevalence must reinforce the need to discuss these symptoms with every patient. Discussion and reassurance on this point will be beneficial to many patients.

However, the 18 per cent of Group A and 12 per cent of Group B who scored higher on the scale were all experiencing quite definite impulses that required active rejection. This proportion agrees with Fahy (1974) who identified suicidal ideas in 14 to 16 per cent of patients with depression in both a hospital and a general-practice population. In both Group A and Group B patients the severity of depression had a positive correlation with the presence and intensity of suicidal feelings ($p > 0{\cdot}01$).

The principal risk in depressive illness is death or permanent damage due to a suicide attempt. Before specific treatments the risk of suicide in manic depressive illness was 14 to 16 per cent (Slater and Roth, 1969). It has been repeatedly shown that as many as 70 per cent of successful suicides have declared their intent within a few weeks of their death (Robins *et al.,* 1959). The idea that patients who talk about suicide do not commit the act is fallacious.

However, the frequency of suicidal feelings creates a common clinical dilemma. What is the actual risk associated with the presence of such ideas in a particular patient? This study shows that suicidal ideas have a strong positive correlation with severity of depression and the presence of premorbid neuroticism, but no correlation with age, sex, or duration of illness. The presence of suicidal feelings must, therefore, always be assumed in the presence of moderate depression, but this does not give any clues as to the danger of acting out the impulse. The serious suicide attempt is often determined by a complex interaction of environment, personality and illness and can only be assessed in the setting of a full medical and social history of the original patient, but any signs or symptoms indicating increasing severity must alert the clinician to an increasing potential risk.

The follow-up interviews confirmed the results of other studies which report that the outcome of affective illness in general practice measured at six months suggests a good prognosis (Goldberg and Blackwell, 1970). In this survey 79 per cent of patients had either fully recovered or were much improved at 16 to 18 weeks. However, assessments made only at this time ignore the severity of depression with its full range of morbidity for patient and family alike, and also the risks associated with suicidal feelings which have occurred between presentation and recovery. Duration of illness showed no correlation with any of these factors. Despite this relatively good outcome of depression in new patients at four to six months, the more chronic group, who had persevered with treatment for a continuous period of three months or longer, still experienced a significant morbidity; 44 per cent were unable to resume their normal lifestyle. This must strongly suggest that of those new patients unchanged or worse at 16 to 18 weeks, a small but important proportion remain moderately depressed and often quite seriously restricted in their level of psychological or social function. As with all other psychiatric morbidity (Shepherd *et al.,* 1966) these cases accumulate so that eventually they make up the majority of patients under treatment.

On the basis of these results it would be quite wrong to dismiss the affective illness treated within general practice as of minor importance. It is true that affective illness in general practice includes a wider spectrum of non-specific neurotic reactions than hospital practice, with a much greater emphasis on the milder forms. It is also true that most of these syndromes are self-limiting and of short duration, or alternatively respond well to treatment. However, these facts can be misleading in the total assessment of the importance of depression treated within general practice.

Other studies have commented on the complex mechanisms determining the content of the ten per cent of patients referred to specialist services. Demographic, social, geographical, and attitudinal variables have long been recognized leading Kessel (1963) to observe that the process is often unrelated to the severity of the illness or the needs of the patient. More recently certain clinical variables have been identified as relevant (Fahy *et al.,* 1969; Fahy, 1974).

The present study confirms that a considerable proportion of moderately ill patients remain under the sole management of the general practitioner. The morbidity identified makes it important that the treatment of these patients should not be regarded with complacency, particularly among the chronic patients where the morbidity remains high and often therapeutic enthusiasm has begun to wane.

Enquiries about the Beck depression inventory and the Maudsley personality inventory should be addressed to Dr Johnson at the above address.

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The Comprehensive Medical Practice Act of 1976 (Congressional Record 122:E2719, 20 May, 1976)

Mr Maguire (New Jersey): "Mr Speaker, I am introducing the Comprehensive Medical Practice Act of 1976, a bill which provides a major opportunity to move health care in the United States in a direction which meets the needs of patients more adequately and at lower cost than is presently the case.

"In the bill that I am proposing, I wish to promote formation of practices of groups of physicians. Rates of hospitalization and rates of surgery are decreased in group practices. Group practices emphasize ambulatory care.

"Because of the integrated nature of group practices, quality programmes can be set up, time can be taken by the physicians for additional education, and an informal network of discussion and referral within the practice leads to high quality, up-to-date medical care. The size of the comprehensive medical practice allows for efficient management of patients and referrals within the organization. This leads to efficient, integrated, quality care, effective use of preventive medicine, patient education, and the use of less expensive physician extenders.

"I have concluded that the encouragement of the formation of comprehensive medical practices will lead to higher quality medical care at lower total cost.

"The bill defines a comprehensive medical practice as one which consists of several practitioners of whom half are in the primary specialties of family medicine, primary paediatrics, and primary internal medicine, while the others may represent the specialities needed to provide adequate overall care for the patients the practice serves. A comprehensive medical practice is one which offers a variety of medical services reasonably expected to meet the majority of medical needs of the local population.

"My bill requires that a readily identified individual be primarily responsible for each patient. This will lead to continuity of care and formation of a long-term relationship between the patient and the physician. The bill requires that a single medical record system be kept and that the equipment, facilities, and personnel be shared so that efficient use is made of these. It also requires that the comprehensive practices meet accreditation standards set up by the American Group Practice Association and the Joint Commission on Accreditation of Hospitals . . . I am requiring that the comprehensive medical practices have a unitary administrative structure which assures that the patient will have an individual to go to when he has complaints regarding either the cost of his medical care or its quality."

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