General practitioners and psychiatrists: comparison of attitudes to depression using the depression attitude questionnaire

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SUMMARY

Background. *Variation in the management of depression may be linked to doctors' attitudes to depression.*

Aim. *A study was undertaken comparing the attitudes to depression between general practitioners and psychiatrists.*

Method. *A sample of 74 general practitioners and 65 psychiatrists in Wales was surveyed by postal questionnaire. Attitudes were assessed by the depression attitude questionnaire and patient management was assessed by a questionnaire on prescribing practice.*

Results. *General practitioners differed significantly from psychiatrists in attitudes, particularly in areas covering professional ease in dealing with patients with depression and identification of depression. Those general practitioners who reported use of low antidepressant doses were significantly more likely than general practitioners prescribing standard doses to believe in psychotherapeutic treatments. Users of short-term continuation therapy expressed a lack of therapeutic optimism and comfort in dealing with depressed patients.*

Conclusion. *General practitioners and psychiatrists differ significantly in their attitudes to depression. The attitudes which vary among general practitioners reflect practice. The depression attitude questionnaire may prove useful in indicating how educational initiatives to improve primary care detection and management should be directed.*

Keywords: depression; management of disease; doctors' attitude; general practitioners; psychiatrists; comparative studies.

Introduction

DEPRESSIVE illness is a common reason for consultations in general practice.[1,2] Researchers have repeatedly identified possible deficiencies in both the identification and management of depressive illness in general practice.[3-6] However, this work has largely been carried out by psychiatrists who tend to use psychiatric criteria for depression, derived from research in psychiatric patients. There is evidence that psychiatrists and general practitioners differ in their ratings of psychiatric symptoms and the importance attached to them.[7] It cannot be assumed that the psychiatrist's approach is most appropriate to primary care. The development of better management of depression will, for the majority of sufferers, of necessity be in primary care and will have to be mediated through general practitioners' activities. A clear picture of general practitioners' views about depression is thus necessary and some understanding of how they differ from those of psychiatrists would be useful, so that initiatives reflect the general practitioners' own perspectives.

The depression attitude questionnaire[8] provides researchers with a useful tool with which to measure doctors' attitudes to depressive illness. The questionnaire was initially used to survey general practitioners drawn randomly from the Medical Research Council general practice research framework. The initial results identified four principal components related to attitudes: attitudes towards treatment; professional ease in dealing with depressed patients; belief in the malleability of depressive syndromes; and identification of depression. This research suggested that the depression attitude questionnaire may prove to be a useful instrument to orientate educational effort and measure change over time.[8]

The management of depression involves a combination of identification, communication, pharmacotherapy and psychotherapy. For this study, reported antidepressant prescribing was used as a way of identifying variation in doctors' management. Good prescribing habits, as suggested by the consensus statement of the defeat depression campaign, include a treatment dose of 125–150 mg of amitriptyline or equivalent daily and continuation therapy lasting between four and six months.[9]

A study was undertaken to compare and contrast attitudes to and prescribing habits for depression among a sample of general practitioners and psychiatrists in Wales.

Method

The method used has been described elsewhere.[10] In brief, a postal questionnaire consisting of the depression attitude questionnaire and a prescribing questionnaire was sent to a sample of general practitioners and psychiatrists in 1992. The depression attitude questionnaire consists of 20 questions, and answers to each are marked on a visual analogue scale, where strongly disagree is marked at 0 mm through to strongly agree, marked at 100 mm. The questionnaire on prescribing habits was devised to gather data so that respondents could be classified into standard prescribers who reported usually giving treatment doses of 125 mg or greater of amitriptyline or equivalent, and continuation therapy for four months or longer, and low prescribers who did not reach these criteria. The general practitioner sample comprises all those in a defined area in South Glamorgan east of the river Taff, while the psychiatrist sample was drawn from the same and neighbouring counties. Non-respondents were sent a reminder one month after the first mailing.

Data were analysed using the *SPSSPC+* statistical package. The chi square test and *t*-test were used on ordinal and continuous variables, respectively. The Mann Whitney *U* test was also used, where appropriate.

Results

Responses were received from 74 out of 123 general practitioners (60%) and 65 out of 97 psychiatrists (67%). There were no significant differences between respondents and non-respondents among psychiatrists or general practitioners in age, sex and

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whether or not engaged in full-time practice. General practitioner respondents were more likely to have been qualified longer than psychiatrist respondents (Mann Whitney U test = 4174, $P<0.01$).

Depression attitude questionnaire responses

There were significant differences in mean scores between general practitioners and psychiatrists on the depression attitude questionnaire for 13 of the 20 statements (Table 1). General practitioners were less comfortable than psychiatrists in dealing with patients with depression and found the work harder and less rewarding than did psychiatrists. While both general practitioners and psychiatrists tended to disagree with the statements that depression is a natural part of being old and is a response of people with poor stamina, psychiatrists disagreed more strongly.

The general practitioners' and psychiatrists' mean scores on the depression attitude questionnaire were compared using the four principal components identified in previous research[8] — attitudes towards treatment, professional ease in dealing with depressed patients, belief in the malleability of depressive syndromes, and identification of depression — and significant differences analysed by the t-test (Table 2). General practitioners had a significantly higher mean score than psychiatrists on the component reflecting professional ease, implying less comfort in dealing with depressed patients. General practitioners also had a significantly higher mean score than psychiatrists on the identification of depression component, reflecting the attitudes that it is difficult to distinguish treatable depression in practice, that most depression results from a person's misfortunes and that there is little help for patients beyond the general practitioner's treatment.

Attitudes to depression and reported prescribing habits

Responses to the questionnaire on prescribing habits showed that 35 of 68 responding general practitioners (51%) could be classed

Table 1. Depression attitude questionnaire statements for which mean scores between general practitioners and psychiatrists were significantly different.

Statement	Mean score (95% CI) among[a] General practitioners (n = 74)	Psychiatrists (n = 65)
Biochemical abnormality is basis of severe depression	66.8 (61.9 to 71.7)	75.8 (70.0 to 81.6)*
Difficult to know if patients are unhappy or have clinical depressive disorder needing treatment	46.2 (40.4 to 52.0)	34.7 (27.7 to 41.7)*
People with poor stamina deal with life problems by becoming depressed	35.4 (29.5 to 41.3)	22.1 (16.1 to 28.1)*
I feel comfortable dealing with depressed patients' needs	60.7 (55.3 to 66.1)	78.0 (73.6 to 82.4)***
Depression is a patient response which cannot be changed	30.2 (25.7 to 34.5)	14.1 (10.1 to 16.1)***
Becoming depressed is part of being old	21.9 (16.9 to 26.9)	13.5 (8.9 to 18.1)*
Working with depressed patients is heavy going	71.4 (67.8 to 75.0)	45.2 (38.0 to 52.4)***
Little to offer depressed patients who do not respond to what GPs do	30.4 (24.6 to 36.2)	9.2 (6.0 to 12.4)***
Rewarding to look after depressed patients	56.3 (50.7 to 61.9)	82.0 (77.7 to 86.3)***
Psychotherapy tends to be unsuccessful with depressed patients	43.8 (38.2 to 49.4)	27.2 (21.4 to 33.0)***
Depressed patients needing antidepressants are better off with a psychiatrist than GP	17.4 (14.0 to 20.8)	35.6 (28.4 to 42.8)***
Antidepressant treatment in general practice usually produces a satisfactory result	69.5 (64.9 to 74.1)	60.1 (53.9 to 66.3)*
If psychotherapy freely available, would be more beneficial than antidepressants for most patients	51.8 (46.0 to 57.6)	22.3 (17.4 to 27.2)***

n = number of respondents in group. [a]0 = strongly disagree through to 100 = strongly agree. t-test of general practitioners versus psychiatrists: *$P<0.05$, ***$P<0.001$.

Table 2. Mean scores on the depression attitude questionnaire among general practitioners and psychiatrists and four principal components related to attitudes.

Component	Mean score (95% CI) among GPs (n = 74)	Psychiatrists (n = 65)
Treatment attitude		
High score = biochemical basis of severe depression, antidepressants useful, psychotherapy unsuccessful	52.1 (49.4 to 54.8)	52.3 (49.8 to 54.8)
Professional ease		
Low score = comfortable managing depression, such work is not heavy going, such work is rewarding, psychotherapy should be left to a specialist	51.0 (47.5 to 54.3)	32.0*** (28.3 to 35.8)
Depression malleability		
High score = pessimism towards depression, depression caused by deprivation in early life, depression not amenable to change, is a natural part of being old, patients are better off with psychiatrist than GP	29.9 (27.2 to 31.7)	30.1 (27.1 to 33.0)
Depression identification		
High score = difficulty distinguishing depression from unhappiness, depression comes from people's misfortunes, little help beyond GP	45.5 (42.1 to 48.9)	33.4*** (29.8 to 37.1)

n = number of respondents in group. t-test of general practitioners versus psychiatrists. ***$P<0.001$.

as low dose prescribers of antidepressants and 27 (40%) as short-term users of continuation therapy. Among 60 responding psychiatrists 10 (17%) were classed as low dose prescribers of antidepressants and 6% of 62 were classed at short-term users of continuation therapy.

Depression attitude questionnaire responses were then compared between general practitioners prescribing low or short doses of antidepressants and those prescribing standard doses (the number of psychiatrists who were low or short-term presribers was insufficient to allow analysis). General practitioners who were low dose prescribers disagreed more strongly than those who were standard prescribers with the statement that psychotherapy tends to be unsuccessful with depressed patients, (mean score 37.2 versus 49.7, respectively, $t = -2.15$, $P<0.05$). They also had a significantly lower mean score on the component relating to treatment attitudes (mean score 48.7 versus 54.6, respectively, $t = -2.1$, $P<0.05$), reflecting less of a belief in the biochemical basis of depression and the usefulness of antidepressants and more of a belief in the use of psychotherapy.

Those general practitioners reporting prescribing shorter doses of continuation therapy disagreed less strongly than those prescribing for more standard lengths of time that there is little to be offered to those depressed patients who do not respond to what general practitioners do (mean score 36.7 versus 22.9, respectively, $t = 2.39$, $P<0.05$). They agreed less strongly than the standard users group that it is rewarding to spend time with depressed patients (mean score 49.3 versus 64.2, respectively, $t = -2.63$, $P<0.01$). They also had significantly higher scores than the standard users group on the professional ease component (mean score 55.6 versus 46.4, repectively, $t = 2.51$, $P<0.05$) reflecting a reduced ease in dealing with depressed people.

Discussion

The study is the first to compare general practitioners' and psychiatrists' attitudes to the treatment of depression. The depression attitude questionnaire responses identified some differences between general practitioners and psychiatrists, particularly in the key areas of professional ease in dealing with patients with depression and of difficulties in the identification of depression. A comparison of depression management by general practitioners (as reflected by use of reported continuation therapy and treatment dose of antidepressants) and attitudes showed differences between those classed as standard and low prescribers. However, the standards reflected a cut-off in a continuous variable of dosage and differences may reflect this artefact.

The general practitioners in the present study were compared with the 72 from the Medical Research Council research group.[8] No significant difference was found between the general practitioners in the present study and those from the Medical Research Council research framework in terms of age, sex, number of years qualified, time in practice and whether practising full or part-time. A comparison of depression attitude questionnaire results between the two general practitioner populations revealed a significant difference for one question only. The general practitioners in the present study disagreed less strongly than the Medical Research Council doctors with the proposition that there was little to be offered to those depressed patients who do not respond to what general practitioners do (mean scores and 21.4, 95% CI 17.3 to 25.5 and 30.4, 95% CI 24.6 to 36.2, repectively $P<0.01$). The difference between the two groups may be understandable as these attitudes are most likely to reflect experiences with local services, such as difficulties gaining access to secondary care.

Research into any professionals' attitudes must be interpreted carefully. The similarity both in demographic characteristics and depression attitude questionnaire responses between the general practitioners responding to the Medical Research Council survey[8] and the general practitioners in this study is important as it encourages a belief that the doctors in the present study were not untypical. However, both samples of general practitioners were respondents, so they may not necessarily be representative of the national general practitioner population. Attitudes expressed on a questionnaire may not reflect day to day practice and, as such, differing attitudes may have little practical importance. In particular, it is important to note that self-report measures may reflect idealized practice. Also, respondents may be more favourably inclined to psychiatry, or have more decided views than non-respondents.

The psychiatrists maintained a strong belief in the biochemical basis of depression and, as their career choice, gave responses that indicated their ease in dealing with patients with depression. The general practitioners, however, may have been reflecting their experience of practical problems in depression in primary care, in areas of its identification, the importance of life events in its initiation and a relative lack of therapeutic optimism.

Assessment of the interaction between general practitioners' attitudes and prescribing behaviour was less clear. It perhaps is important that a group characterized by use of low doses of antidepressants should believe less in the biochemical basis of depression and the usefulness of antidepressants while having a greater belief in psychotherapy. Similarly, doctors using short term continuation therapy tended to reflect a combination of lack of therapeutic optimism with reduced ease in dealing with depressed patients.

Do these results reflect a difference in the clinical experience of depression between general practitioners and psychiatrists? Major and minor depressive disorder both occur in general practice with a point prevalence of approximately 5%.[2] Fahy[11] discovered that general practitioners' patients differed quantitatively and qualitatively from psychiatrists' patients and Sireling and colleagues[12] concluded that there were differences in that the general practice patients had generally milder cases of depression, with shorter illnesses and lower severity scores. However, Sireling and colleagues concluded that most cases of depression treated by general practitioners satisfied criteria for psychiatric disorder. There is also adequate evidence that depression in general practice responds to antidepressant medication in standard regimens.[13,14] Differences between general practitioners and psychiatrists are not likely to be explained totally by patient differences.

What are the practical implications? First, the attitudes and the variations in them, of the general practitioners must be understood and accepted by psychiatrists if they wish to work with general practitioners to improve care for depressed patients. Secondly, as general practitioners' attitudes have been shown to vary, educational input in any general practice could and should be tailored to reflect the attitudes of the doctors in that practice. Some general practitioners may prefer a more psychotherapeutic approach, others a more medical one. There will not be a standard approach. Such variation may be a strength of general practice.

The clear unease of some general practitioners in dealing with depressed patients is an area with which psychiatrists should be able to help. Educational iniatitives such as the defeat depression campaign may be one approach, or more local personal collaboration by general practitioner attachment to psychiatric outpatient clinics or psychiatrist attachment to general practices may be more appropriate.

Further investigation into this area will need to reassess the validity of such self-report data on attitudes and prescribing. It will also be useful to compare general practitioners' attitudes

with those of other health care providers, such as clinical psychologists and community psychiatric nurses.

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