‘You’re depressed’; ‘No I’m not’: GPs’ and patients’ different models of depression

UMDS MSc IN GENERAL PRACTICE TEACHING GROUP

SUMMARY

Questionnaires concerning models of depression were completed by 90 general practitioners (GPs) and 681 patients. GPs and patients held similar beliefs about the role of mood-related symptoms, psychological causes, and non-medical treatments. However, the GPs reported greater support for somatic symptoms, medical causes, and medical treatments. Therefore, GPs and patients report different models of depression, with GPs favouring a more medical perspective. In addition, the results illustrated a role for personal experience of depression. The implications for diagnosis, adherence, and a ‘you are depressed; no I’m not’ style of interaction are discussed.

Keywords: depression, personal models, diagnosis, concordance.

Introduction

DEPRESSION raises issues both of under-diagnosis by GPs[1] and of patients’ non-adherence to treatment.[2] As possible explanations, research has examined the role of doctor and patient characteristics.[3] It is possible, however, that diagnosis and adherence are not related to either of these factors independently but to their interaction. Such a notion concurs with an emphasis on shared understanding and on the use of models within the consultation.[4,5] The present study therefore aimed to contrast GPs’ and patients’ models of depression. In addition, the study aimed to assess the effect of personal experience of depression on any differences.

Method

Subjects

Nine GPs distributed questionnaires to 900 consecutive patients aged over 16 years who spoke fluent English and attended their practices (six in London and one each in Brighton, Swindon, and Shrewsbury), and to 135 GPs in and around these practices.

Measurements

The questionnaires asked for profile characteristics — age in years, sex, and personal experience of depression (yes/no) — and for information that would enable a model of depression to be built up for each subject. Subjects were asked to rate on a scale of 1 (totally disagree) to 5 (totally agree) the extent to which they believed certain items to be symptoms of depression, causes of depression, or treatments for depression.

Symptoms of depression were categorized as follows:

- Mood symptoms, such as difficulty coping, crying, and loss of self-esteem
- Somatic symptoms, such as aches and pains, lack of appetite, and decreased sex drive.

Causes of depression were categorized as follows:

- Psychological causes, such as stress, life events, unhappy childhood
- Medical causes, such as hormones, chemical imbalances in the brain, and tendencies within the family
- External causes, such as things that ‘just happen’ and time of year.

Treatments for depression were categorized as follows:

- Medical treatments, such as medication, talking to a GP, or talking to a psychiatrist
- Non-medical treatments, such as talking to a friend, talking to a counsellor, or the passage of time.

Results

Questionnaires were returned by 681 patients (response rate = 75.7%; mean age (SD) = 44.81 ± 16.52; male: *n* = 182 [27.5%], female: *n* = 481 [72.5%]), and by 90 GPs (response rate = 66.7%, mean age (SD) = 41.92 ± 9.97; male: *n* = 56 [62.9%]; female: *n* = 33 [37.1%]).

Models of depression

The means (and SDs) for beliefs about the symptoms, causes, and treatments of depression are shown in Table 1.

The results indicate that the GPs and patients gave comparable ratings for mood-related symptoms, the role of psychological causes, and the helpfulness of non-medical treatments. However, the GPs attached greater importance to somatic symptoms, the role of medical and external causes, and the helpfulness of medical treatments.

Impact of personal experience of depression

Thirty-eight (42.7%) of the GPs and 402 (60.5%) of the patients reported having personal experience of depression. The results for the impact of personal experience on models of depression are shown in Table 2.

The results show no interaction between personal experience of depression (yes/no) and group (GP versus patient) for mood-related symptoms, for psychological or external causes, or for medical or non-medical treatments. However, the results show significant depression by group interactions for somatic symptoms and medical causes. Post hoc tests indicate that patients who had been depressed attached significantly greater importance to somatic symptoms and medical causes than patients who had not been depressed ($P<0.001$) and also than GPs who had been depressed ($P<0.001$). They also show that the GPs’ ratings are similar regardless of their personal experience.

Discussion

General practitioners and patients held similar views about the importance of mood-related symptoms, the role of psychological causes, and the helpfulness of non-medical treatments. The GPs, however, attached greater importance to somatic symptoms, medical and external causes, and the helpfulness of medical

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Table 1. GPs' and patients' models of depression.

	GPs' mean (SD) rating	Patients' mean (SD) rating	F-value	P-value
Symptoms				
Mood symptoms	4.15 (0.71)	4.04 (0.74)	1.79	0.18
Somatic symptoms[a]	4.19 (0.59)	3.66 (0.79)	38.19	0.0001
Causes				
Psychological causes	3.79 (0.71)	3.77 (0.69)	0.14	0.7
Medical causes[a]	3.67 (0.77)	3.36 (0.76)	12.7	0.0001
External causes[a]	3.19 (1.02)	2.46 (1.04)	37.61	0.0001
Treatments				
Medical treatments[a]	4.1 (0.58)	3.53 (0.86)	36.08	0.0001
Non-medical treatments	3.87 (7.2)	3.72 (0.82)	2.58	0.11

[a]Significant main effect of group.

Table 2. The role of depression and group on models of depression.

	Not been depressed (n = 313)		Been depressed (n = 440)		Main effect by group F (P)	Main effect by depression F (P)	Group by depression F (P)
	GPs (n = 51)	Patients (n = 262)	GPs (n = 38)	Patients (n = 402)			
Symptoms							
Mood related[b]	4.08 (0.53)	3.96 (0.73)	4.24 (0.67)	4.17 (0.67)	1.82 (0.18)	3.83 (0.05)	0.05 (0.82)
Somatic[abc]	4.18 (0.53)	3.45 (0.79)	4.21 (0.07)	3.81 (0.74)	40.67 (0.0001)	4.91 (0.05)	3.73 (0.05)
Causes							
Psychological	3.86 (0.78)	3.68 (0.69)	3.7 (0.63)	3.82 (0.68)	0.05 (0.83)	0.14 (0.71)	2.45 (0.19)
Medical[ac]	3.76 (0.75)	3.25 (0.74)	3.53 (0.75)	3.47 (0.73)	9.06 (0.01)	0.24 (0.63)	3.7 (0.05)
External[a]	3.28 (1.13)	2.38 (1.04)	3.03 (0.83)	2.53 (1.01)	31.05 (0.0001)	0.32 (0.57)	2.97 (0.09)
Treatments							
Medical[a]	4.09 (0.55)	3.56 (0.83)	4.12 (0.66)	3.55 (0.85)	33.6 (0.0001)	0.007 (0.94)	0.09 (0.75)
Non-medical	3.95 (0.69)	3.77 (0.75)	3.76 (0.77)	3.69 (0.8)	1.16 (0.28)	1.29 (0.26)	0.64 (0.43)

[a]Significant main effect of group (GPs versus pts). [b]Significant main effect of depression (yes/no). [c]Signficant group by depression interaction.

treatments. This suggests that GPs have beliefs about depression that do not agree with those of patients, with the GPs favouring a more medical model. However, whereas the GPs reported beliefs that were unaffected by their personal experience, patients who had been depressed reported a medical model of depression similar to that of the GPs.

Could such discordance and concordance help to explain under-diagnosis[1] or non-adherence to treatment?[2] If a patient presents with somatic symptoms only, a diagnosis of depression by the GP could be deemed unacceptable by the patient, leading to a 'you're depressed; no I'm not' style of interaction. Under-diagnosis may therefore be a result of disagreement between GPs and patients over the nature of depression. Furthermore, such discordance could explain non-adherence since patients may not take their medication if they do not believe they are depressed or if they consider medical treatment to be inappropriate.

Why then do patients who have been depressed have models of depression similar to those of GPs? Perhaps having depression changes an individual's model of depression. Alternatively, if a patient presents with mood-related symptoms, both the patient and the GP may agree that such symptoms indicate depression; a diagnosis would be made by the GP and accepted by the patient. In such cases, perhaps acceptance of a diagnosis of depression does not change a patient's model of depression but in itself indicates that the patient agreed with the GP in the first place. Such patients may also show greater adherence to treatment.

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