Short Reports

Perceptions about anxiety, depression and somatization in general medical settings: A qualitative study

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ABSTRACT

Background. The recognition rates of anxiety and depression in general medical settings, despite the significant prevalence of such presentations, are low. Psychiatrists argue that the recognition and management of these conditions by physicians is less than optimal in primary care and general practice. We did this study to gain insights into physicians' perspectives on anxiety, depression and somatization, the conceptual models they employ and the practical problems they face in managing such patients in general medical settings.

Methods. Focus group discussions (FGDs) were conducted with family and primary care physicians. The FGDs for physicians were tape recorded and transcribed, verbatim. The views of psychiatrists working in liaison clinics were also ascertained.

Results. Family and primary physicians admitted to a high prevalence of patients who present with medically unexplained symptoms. They noted the co-occurrence of psychosocial stress. All physicians working in general medical settings admitted to difficulty in separating anxiety, depression and somatic presentations because of milder, less distinct syndromes and overlapping symptoms. They argued that it was difficult to use the current three-category division and that a more complex classification would be time-consuming and impractical in primary care.

Conclusion. Psychiatric classifications for use in primary care should consider the different context and employ physicians' perspectives rather than push specialist concepts and criteria.

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INTRODUCTION

Common mental disorders (CMDs), described by the labels anxiety, depression and somatization, are among the most frequent causes of morbidity and disability worldwide.[1] They have also been documented in primary healthcare in India.[2–9] The data from these studies suggest that 17%–46% of patients attending primary healthcare facilities suffer from CMDs. The settings, recruitment procedures, assessment instruments, time frames, concepts of illness used and help-seeking behaviour of populations may explain the differences in recorded prevalence. Female gender, older age, physical illness, poverty, unemployment and consultation with traditional healers are significantly related to CMDs.[7–9] However, the recognition rates of these conditions by physicians remain poor and their management is considered less than optimal in primary healthcare and general hospital settings.[1,8]

We conducted a qualitative study to obtain an insight into physicians' perspectives on CMDs, including presentations, prevalence, clinical features, diagnosis and management.

METHODS

Setting

Family physicians, working in the 40-bedded low-cost urban health centre that caters to people living in slums in Vellore, Tamil Nadu, were invited to participate in the study. Primary care physicians working in a comprehensive rural community healthcare programme with its weekly mobile clinics and daily outpatient clinics in an 80-bedded base hospital were also recruited. Liaison psychiatrists, working in a general hospital psychiatry unit in a medical school, were also contacted for their opinions on the issues.

Discussion guide

The focus group guide was developed on the basis of findings of previous studies.[8–13] The key themes of discussions were: Do you see patients with anxiety and depression? What is the common presentation? How common are such presentations? How do you diagnose these conditions? Do you use International Classification of Diseases (ICD) 10?[11] Are you comfortable in making a specific diagnosis? How do you separate these conditions? Will you use the new scheme being proposed for ICD 11 primary care? Do you think your colleagues will use it? What prevents you from using this approach? What alternatives do you suggest? A similar guide was used for medically unexplained symptoms/somatization.

The proposed ICD 11 scheme for the diagnosis of anxiety, depression, anxious–depression and dysphoric disorders was introduced during the session.[14] The 10-question symptom list, which formed the basis of anxiety–depression diagnosis, was presented. The severity specifier based on symptom counts was discussed. The concept and subcategories of body distress syndrome with its four proposed subtypes, based on a specific constellation of symptoms (e.g. gastrointestinal, cardiac) were also elaborated.[14]

Data collection

The participants were invited to attend the focus group discussions (FGDs) which were held in their respective hospitals. These sites were chosen according to ease of access for the participants. We conducted three groups, one focus group each with family physicians, primary care physicians and liaison psychiatrists.

The aim of the study and implications of participation were explained to the groups before the FGDs. The same two researchers (AK and KSJ), who ensured that each item on the agenda was fully discussed and that all respondents had sufficient opportunity to air their views, moderated each discussion group. Discussions lasted for 45–60 minutes. At the end of the session, time was spent in informal conversation about issues related to their practice.

The FGDs were conducted in English, the language routinely used at work; one researcher facilitated the group while the other recorded the proceedings, noting key themes and monitoring

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verbal and non-verbal interactions. The sessions with family and primary healthcare physicians were audiotaped, with the consent of participants, and transcribed verbatim. Details of demographic characteristics such as age, gender and clinical experience were collected from the participants.

Analysis

We used a framework approach to data collection and analysis.[15,16] The analysis was designed so that it could be viewed and assessed by people other than the primary analyst. Notes and open codes were generated and organized manually, and similar codes were grouped into categories. The team read the transcripts and notes several times and reached consensus regarding the categories and 'higher codes'. Though rigour was not enhanced by multiple coding, the analysis was improved by constant comparison with the transcripts as advocated by Glaser and Strauss.[17] The team identified and discussed a hierarchical scheme of specific themes, issues and problems that emerged from the data.

RESULTS

Twenty-three people attended the discussion sessions (Table I). The majority were men, family and primary healthcare physicians with a mean age of 32 years and 7 years of clinical experience.

The major themes in primary healthcare and in family practice included the fact that patients with anxiety, depression and somatization were commonly seen (25%–60%) in clinical practice. The physicians agreed that all such patients present with somatic symptoms and that it was difficult to separate anxiety, depression and somatization as separate diagnoses because of mixed presentations. They also mentioned that they commonly used other medical labels for such presentations including irritable bowel syndrome, dyspepsia, atypical chest pain, tension headache, etc. Most practitioners said that they were comfortable with a diagnosis of depression and symptomatic labels but not with anxiety. They admitted to not using the mental and behavioural disorder classification of ICD 10 for primary care.

There was unanimous agreement that it was difficult to use the proposed ICD 11 primary care symptom list in routine clinical practice to subcategorize patients because of mild, mixed presentations with overlap of symptoms. The current diagnoses of anxiety, depression and medically unexplained symptoms were not being routinely used, and the further subdivisions of anxiety and depression and bodily distress syndrome would be even more difficult to use in primary care. The heavy patient load and lack of time precluded such use in routine clinical care. There was also unanimous agreement that subcategorization does not make a difference to clinical management as most physicians used general protocols for managing such patients with symptomatic treatment, understanding explanatory models, exploring psychosocial stress, suggesting alternative coping, etc. The physicians were confident of managing mild-to-moderate depression, but preferred to refer severe disorders, which were rare in their practice. Examples of the verbatim transcripts are shown in Box 1.

TABLE I. Sociodemographic details and clinical experience of participants

Variable	Family medicine (*n*=4)	Primary care (*n*=8)	Liaison psychiatry (*n*=11)	Total (*n*=23)
Gender				
Men	2	5	9	16
Women	2	3	3	7
Age (years)*	35.8 (5.1)	32.8 (7.9)	29.8 (6.4)	32.2 (7.12)
Clinical experience (years)*	11.8 (5.7)	8.1 (7.9)	5.7 (6.7)	7.6 (7.03)

* mean (SD)

Box 1. Verbatim accounts about perception about anxiety, depression and somatic presentations

Family physician, man, aged 35 years: 'We see quite a bit of anxiety and depression. However, they are mixed with medical problems. It is rare to see anxiety and depression alone. These symptoms are components of a musculoskeletal problem or a chronic medical disease. Most of them are mild-to-moderate depression or anxiety. It is difficult to classify them into any one category. Severe depression with psychotic symptoms is very rare, less than 5%.'

Family physician, woman, aged 33 years: 'It will not be the anxiety or depression symptoms which stand out. It will be the aches, pains, backache, which are not due to medical conditions; 6–7 of every 10 (patients) present with such aches and pains.'

Family physician, woman, aged 45 years: 'I cannot apply psychiatric protocols in primary care. To be frank, I don't know how to separate the two. We are more comfortable making a diagnosis of depression than anxiety.'

Family physician, man, aged 30 years: 'We are more comfortable looking at it as a compound syndrome rather than specifically categorizing them.'

Family physician, man, aged 35 years: 'It might be possible to identify (subcategories of anxiety, depression, somatization) but it will be easier for me to put it under (physician labels) irritable bowel syndrome, non-cardiac chest pain, peptic ulcer, fibromyalgia, chronic fatigue syndrome, etc. Finally, these are often associated with stress, marital disharmony and sexual dysfunction. So we use the underlying cause (as the diagnostic label). Maybe (the psychiatric classification) can be used for research purposes but not for routine clinical work.'

The psychiatrists practising in liaison clinics recognized anxiety, depression and somatization as common clinical presentations. They agreed that they routinely attempted to categorize and diagnose such presentations, but that it was difficult in medical settings due to mixed and sub-threshold presentations and the shortage of time due to busy medical outpatient settings. They felt that subcategorization was not often attempted by physicians and that the proposed scheme with its many subcategories will be difficult to implement in routine medical practice.

DISCUSSION

Our study is a qualitative investigation of physicians' perceptions about anxiety, depression and somatization. Focus group research has disadvantages. By the very nature of the FGD methodology, it is likely that the views of those individuals who are more vocal are most prominent, although we made every effort to ensure that everyone participated actively. Another issue is the limited generalizability due to recruitment of small, convenience samples.

Family and primary healthcare physicians admitted to seeing a large numbers of patients who present with medically unexplained symptoms. They noted the co-occurrence of psychosocial stress. They argued that it was difficult to separate anxiety, depression and somatic presentations in general healthcare settings. They acknowledged that it was difficult to use the present three-category division (anxiety, depression, somatization) itself, and it would be impossible to use the proposed complex classification

(four subcategories of anxiety and depression and four categories of bodily distress syndrome).

The widespread acknowledgement of the prevalence of anxiety, depression and medically unexplained symptoms in primary healthcare, educational programmes for general practitioners (GPs), diagnostic algorithms, practice guidelines and management protocols[18] for large-scale application at a primary level have not resulted in improved recognition and management of these disorders in the past. Despite piloting, field studies and acceptance by academic GPs, the watered-down psychiatric approach, when used in primary healthcare, has few takers in actual practice in the West[19,20] and in India. The cumbersome case-finding instruments, the complex diagnostic criteria and the elaborate treatment guidelines have not helped the cause nor gained in popularity and usage. The culture of psychiatry in primary healthcare borrows heavily from academic and tertiary healthcare psychiatry and attempts to adapt it to the reality of primary healthcare.[21] The compromise is uneasy, unstable and difficult to apply in general practice.

The findings of this study and the context of primary care (Box 2) require that anxiety, depression and somatization in general medical practice and tertiary care need to be understood as being different.[22] Current attempts to apply tertiary care approaches in primary care are difficult to implement and may not be effective. GPs use symptomatic management and approaches to relieve distress; patients find this useful. However, mainstream psychiatry, with its focus on disease, finds this difficult to accept.

The growth of tertiary care medicine over the past century has resulted in the increased importance of specialists and the decline of family medicine and general practice.[23] Specialty medicine protocols and guidelines have steadily expanded and now define their respective fields. Many problems of patients presenting to primary care are, therefore, treated through approaches developed in tertiary care. This is true across all medical disciplines and is particularly true of psychiatric disorders in primary care. There is a progressive medicalization of all personal and social distress. Among patients, this has lowered thresholds for tolerance of mild symptoms and for seeking medical attention for such complaints. Patients visit GPs when they are disturbed or distressed, when they are in pain or are worried about the implication of their symptoms.[19] These forms of distress largely require psychological and social support. However, normative practice currently mandates Diagnostic and Statistical Manual of Mental Disorders (DSM)/ICD labelling and standardized treatments to justify medical input.[22] The differences in settings, type of patients, time, expertise and perspectives between physicians and psychiatrists are rarely acknowledged. Consequently, psychiatric specialist perspectives dominate the discourse and are often praised but seldom practised in primary care.

Primary care physicians' narratives of their context, reality, presentations and problems are rarely highlighted, nor do they find a place in the diagnosis and management of the conditions. Their narratives are trivialized while the theory and psychiatric models are considered universal and transcendental. Their singularity and incommensurability are dismissed when universal theoretical formations are applied to primary care practice. The evaluation of physicians' concerns, within a patronized relationship with psychiatry and psychiatrists, poses problems. Yet, it is not recognized. Psychiatrists rarely acknowledge philosophical difficulties inherent in the separation of disease from distress.

The family and general practice perspective supports the contention that the presentations currently labelled anxiety, depression or common mental disorders in primary care are illness experiences, which do not require disease labels.[22] It makes a case for the provision of support without medicalizing these issues. The focus on clinical presentations without diagnosis and the symptomatic management of people with emotional distress who present to primary care, as currently practised by family and primary care physicians, are complementary. Psychiatric concepts and interventions, based on specialist perspectives, have not only complicated matters but have disempowered GPs with psychiatric terminology and techniques, which are impractical and counterproductive in primary care settings. These arguments suggest that the standards for medical practice should be based on the issues as seen in primary care rather than those employed in tertiary and specialist settings.[23]

Box 2. Differences between primary care and specialist settings, which explain the divergence in perspectives[22]

1. Patients attending a psychiatric hospital have severe, chronic and complex problems. Milder and less distinct forms of illness with concomitant psychosocial stress are seen in primary care. Mixed presentations—of anxiety, depression and somatization—are common in primary care and many patients who cross the case threshold do not exhibit the full syndrome attributes of depression or of anxiety. General practitioners (GPs) also see sub-syndromal presentations with marked distress and disability.
2. Psychiatrists use medical models while GPs focus on the psychosocial context, stress, personality and coping.
3. Symptom scores in patients attending primary care on standardized interview schedules are distributed continuously with no point of rarity between cases and non-cases, making clinical distinctions difficult. Studies using statistical techniques have failed to show superiority of the two-factor anxiety–depression models over the one-factor solution. In addition, the anxiety and depression factors of the two-factor model have always been highly correlated.
4. The commonest presentation of psychiatric problems in primary care is with medically unexplained somatic symptoms. However, a significant number of such patients also mention the presence of simultaneous psychological stress or distress.
5. The aetiology of medically unexplained somatic symptoms is unclear. The general tendency is to assume psychogenesis. However, the label 'somatization' often marks medical failure to diagnose rather than an understanding of the phenomenon.
6. The numerous categories of depression in the International Classification of Disease 10 (ICD 10) for use in psychiatric settings have been clubbed into a single category of depression in the ICD 10 for primary care. The result is that patients with features of biological depression are clubbed with normal people with adjustment reactions due to stress and with those who cannot cope with the demands of life because of poor coping skills.
7. Many studies have shown a high rate of spontaneous remission of depression and common mental disorders in primary care. The literature on major depression also supports the argument that there is a high rate of spontaneous remission.
8. Many authors have highlighted the high rate of improvement in the placebo arms of randomized trials employed to test the efficacy of antidepressant medication.
9. Despite efforts at simplification, the guidelines for managing common mental disorders in primary care have proposed elaborate and separate protocols for each of the traditional psychiatric categories, making them impractical for routine use.

The reality of primary care, its problems and opportunities demand unique solutions. Transplanting knowledge structure, formations and practices developed and employed in tertiary care and specialist facilities results in a lack of goodness of fit. Context and local knowledge are critical to understanding illness in primary care. Universal abstractions may not fit local reality and artificial structures. Primary care needs to be understood and theorized independently of tertiary care perspectives.[23] Contexts should not only change medical practice but contexts should be able to change medical perspectives.

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Obituaries

Many doctors in India practise medicine in difficult areas under trying circumstances and resist the attraction of better prospects in western countries and in the Middle East. They die without their contributions to our country being acknowledged.

The National Medical Journal of India wishes to recognize the efforts of these doctors. We invite short accounts of the life and work of a recently deceased colleague by a friend, student or relative. The account in about 500 to 1000 words should describe his or her education and training and highlight the achievements as well as disappointments. A photograph should accompany the obituary.

—Editor