Physicians should help patients with depression name their problem

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Because people with depression often do not recognize they have a problem or are unable to describe their distress, many do not seek treatment. About a quarter of those with major depression are undiagnosed, according to several studies, and fewer than half receive treatment.

To improve recognition and treatment of depression, primary care physicians should do three things: help their patients name their distress, provide explanations for the depression that conform to patients' experiences and reduce blame and stigma.

The recommendations for physicians, published in the Journal of General Internal Medicine, stem from research led by Ronald M. Epstein, M.D., professor of Family Medicine and Psychiatry at the University of Rochester Medical Center and director of the Rochester Center to Improve Communication in Health Care.

The researchers propose several steps to enhance patient-physician communication and to develop clinical, public health, and media interventions to improve depression care. These include:

- People experience depression in many different ways. Physicians should adjust their view to a patient's experience and not maintain a one-dimensional concept of depression.

- Physicians should not rely on symptom checklists exclusively to detect depression.

- Discussions of depression-related concerns with primary care physicians should not require that the patient endorse a self-diagnosis of depression.

- Physicians should explain that personality, social and genetic factors make some people more vulnerable to depression, but that does not mean the patient is to blame.

- Many patients doubt that depression can be treated. Physicians should emphasize that depression responds to treatment.

In conducting the study, the researchers recruited 116 people in Rochester, N.Y, Austin, Texas, and Sacramento, Calif., who were English-speaking men and women, aged 25 to 64, and who reported a personal history of depression or experience with a close friend or relative. The participants filled out a detailed questionnaire and participated in focus group discussions. The researchers conducted line-by-line reviews of transcripts of the focus group discussions, coding remarks according to cognitive and communicative processes that hindered or enabled discussion of depression-related symptoms.

Many participants reported not knowing something was wrong, sometimes for years. Some who described themselves as "always dark," "introspective", and "always in a bad mood" had been so acclimated to being "gloomy" that it was difficult for them to appreciate their descent into depression. In the study, "naming" refers to how people find words to describe their distress.

"Naming is often a precondition for the contemplation phase of behavior change; conversely, not naming one's distress as depression can

contribute to "illness delay," the temporal gap between deciding one is ill and seeking care," the researchers state. "Many participants had difficulty naming their distress as depression because their experiences did not comport with their "common-sense" models of depression. Nor were many of these experiences likely to have been considered depression symptoms by their physicians, who held different but narrow models that did not encompass the protean ways in which people experience depression."

Finding meaningful causal explanations for their distress allowed participants to organize their experiences and helped them discuss their problem with a physician or other health care professionals.

"Physicians, families, friends, and the media can prompt people who have depressive symptoms to seek care by adopting a multi-faceted understanding of the experience of depression from the patient's perspective—and helping them find the words to bring their experiences and concerns to the attention of physician," the researchers conclude. "In that way, a shared vision of the cause and treatment of depression can facilitate follow-through with a mutually-endorsed plan."

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