# TREATING DEPRESSION IN THE PRIMARY CARE SETTING

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Interview with J. Sloan Manning, MD

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*An* **Advanced Studies *in* Medicine (ASiM)** *Senior Clinical Editor interviewed Dr Manning regarding the challenges faced by PCPs in treating depressed patients. Dr Manning also addresses the important issue of undertreatment.*



**ASiM: You have a lot of experience in teaching family physicians about mood disorders. Why is it important for family physicians and primary care practitioners (PCPs) to be able to recognize and treat depression, when this has traditionally been in the realm of psychiatry?**

*Dr Manning*: This emphasis on treating depression in primary care has been occurring since the late 1980s, when the National Institutes of Mental Health had their Depression Awareness and Recognition Treatment (DART) program. That's really when it began, along with the introduction of fluoxetine in the late 1980s. It was then that psychiatrists discovered that most depressed patients were actually being seen in primary care settings. So, the introduction of safer antidepressants along with the knowledge that patients could, for the most part, be effectively treated in primary care has driven this. This phenomenon is still broadening as the complexity of depression is better understood and the diagnostic specificity improves.

The role of managed care in this shift to primary care has made the situation worse, rather than better. Managed care has made reimbursement for the cost of treating depression in primary care nonexistent. Mental health carveouts to managed care have essentially separated the practice of medicine from the practice of psychiatry (you treat the mind, I'll treat the body). However, it's not that easy. There's a unity between the mind and body that cannot be easily separated.

**ASiM: You have developed a resident training program for family physicians to be able to recognize and treat mood disorders.[1] For those physicians already practicing, where can they gain the skills to have more confidence in identifying and managing mood disorders?**

*Dr Manning*: Our training program also includes pharmacy students and nurse practitioner students and takes place in a mood disorders center. The more difficult patients (those with diagnostic dilemmas, treatment refractory patients, or other complex cases) are used as teaching cases. This program is a kind of consultation service within the residency program, where we do team assessments and team treatments with a therapist, a family physician, and a learner (a family practice resident, pharmacy student, or nurse practitioner). It gives the learner a chance to see a family physician and another healthcare professional, such as a counselor, therapist, or social worker, assess these individuals. We have the chance to evaluate the resident and his or her interview style. The resident has the opportunity to hear how I would ask the questions, what I picked out as important, what the therapist picked out as important. It is a chance to allow the resident or learner to see the breadth and depth of mental illness and how psychological stress affects patients' lives and patients' other illnesses. It is immersion into mental health in primary care.

In clinicians who are already practicing, it's difficult to obtain this type of training. A physician can't just take time off from his or her practice to do this. The way I learned was to locate several skilled psychiatrists in my community and essentially be mentored. It wasn't one-on-one mentoring; I spoke with them and they directed me to pertinent places in the psychiatric literature. My interest and skill level increased through mentoring, looking through the scientific literature, completing CME [continuing medical education] programs, and the blood, sweat, and tears of practice—seeing what actually happens.

My interest in this area developed because I found in my practice that depressed and anxious patients are extraordinarily prevalent. When I got to private practice, one of the first things I recognized was that many people seeking treatment in primary care are depressed and anxious, and I had not received adequate training to care for them. The inadequacy does not lie with my teachers. The whole field was in its infancy when I was in training in the 1980s. It wasn't emphasized because in internal medicine programs, there is no requirement for courses in mental health treatment. In family practice residencies, a couple of months of training in this area are required, but the training is typically directed by nonphysicians, such as psychologists and licensed therapists. So, one has this perpetual sense that treating depression is something that "other people" do rather than something that PCPs should learn how to do. Residencies have turned to nonphysicians for psychosocial or behavioral medicine emphasis in their curricula. That's been very useful, but, again, it continues to reinforce the idea that mental health is something that other people do. When physicians get out of their training programs, they realize that mental healthcare is a huge part of their practice—in private practice or in other primary care settings—and the training is not up to speed. That was my experience.

**ASiM: What are the most common physical symptoms of depression (pain and others) that your depressed patients report?**

*Dr Manning*: They have nonspecific, vague complaints—gastrointestinal complaints, headache. In fact, any kind of chronic pain can be a presenting symptom. It is important to separate chronic pain associated with depression from any neuropathic pain, such as diabetic neuropathy, although they may be comorbid. Many people with depression present with only physical symptoms, be it pain, upset stomach, dyspepsia, constipation, irritable bowel syndrome. Again, the brain is connected to every place in the body. If the brain is not working well, in terms of mood, other parts of the body—in fact, several parts of the body—are often affected. Most people think "if my stomach hurts, I must have a stomach problem." What we find is that the stomach (or back, or head) is just a voice for the mood.

**ASiM: Do depressed patients discuss these associated symptoms spontaneously or is further questioning necessary?**

*Dr Manning*: Simon et al showed that of the more than 25 000 patients in primary care in their study, 1145 met the criteria for major depression. Of those 1145 patients, 69% reported only somatic symptoms.[2] The patients did not say "I'm sad, I'm lonely, I'm tired, I'm depressed." It was a physical complaint that brought them to the doctor's office. In my own practice, I've found that a significant percentage of patients present with a physical symptom. When I teach residents, I have always told them that pain is a major presenting complaint for depression, even before the Simon study came out. These patients are not typically talking about their mood, although they may be. For most people, their bodies are voicing their mood

and they're framing the presenting complaint not in terms of their emotions but in terms of what their body is telling them.

**ASiM: As you are aware, one of the most significant obstacles to PCPs taking on the challenge of mood disorders is the time constraint in an office practice setting. Many do not look for mood disorders, such as anxiety or depression, or recognize the painful physical symptoms as a sign of depression, despite the fact that depression and anxiety are very treatable. PCPs may fear initiating a long, drawn-out dialog for depression in an examination for which only 10 to 15 minutes have been allocated. How can PCPs overcome this challenge?**

*Dr Manning*: We routinely find that complaints about limits of time are complaints about limited familiarity and a lack of training. So, as training and comfort levels improve, people will tend to complain less about the time because they know exactly what they are going to be doing.

However, I have been in private practice long enough to know that there are days when you only have 4 or 5 minutes, maybe 10 minutes maximum. The entire assessment and evaluation cannot be done in one visit, and it doesn't have to be. Often, the assessment and evaluation is done in a series of brief visits. If a patient presents with a complaint of back pain or headache, the patient can be sent home that day with some educational material, or the physical examination and some laboratory analyses can be done, with the patient returning in a few days. This gives the physician a chance to go over the test results and, in the next visit, begin to ask questions such as "By the way, how have you been resting lately? Have you been sleeping lately? How has your mood been? Is your energy low in general?" It's a longitudinal process. It's a journey that the physician and the patient take, and we don't have to get there in 1 day.

**ASiM: For those PCPs who manage depressed patients, another common problem is undertreatment (prescribing too little or the wrong type of medication). This is particularly true when painful physical or anxiety symptoms first present with depressive symptoms, such as insomnia, headache, extremity pain, and during treatment, increasing the risk of relapse. How can the PCP distinguish earlier in the diagnostic process whether the somatic symptoms are depression related?**

*Dr Manning*: For any type of patient, physical symptoms can always be due to one of several causes, so it's always a differential diagnosis. The clinician should recognize that depression and mood disturbances can present with pain symptoms, so depression and anxiety should simply be included in the differential diagnosis in patients who present with these complaints. A herniated disk might be causing the back pain, but the clinician should also ask questions about sleep, energy, and mood. Anxiety or depression should be included as a possibility in the diagnosis from the start, to be excluded when appropriate, rather than stumbling on depression after several thousand dollars have been spent for complicated and intrusive investigations.

**ASiM: How do you tailor treatments for depression when painful physical symptoms are present?**

*Dr Manning*: The clinician should first frame the connection between the mood and the somatic symptoms for the patient. The patient needs to understand the connection between the way they feel in their emotions and they way they feel in their bodies. The clinician needs to normalize the idea that these illnesses are related, that the mood centers in the brain connect with pain perception and pain interpretation centers. Once that is established in the patient's mind, the patient should be reassured that as their mood improves, many of these physical complaints will go away.

However, some patients want to know that the clinician really does appreciate that their back hurts and will attend to it, that the necessary steps will be taken to properly investigate the nature of their complaints. This is reasonable, but the clinician should ensure that a strong suspicion of a mood disorder as the source of their complaint is on the agenda.

**ASiM: Although the SSRIs [selective serotonin reuptake inhibitors] have a much better side-effect profile than the TCAs [tricyclic antidepressants], their onset of action may take as long as 4 weeks. For the depressed patient, this can seem like an eternity. Not surprisingly, therefore, the patient may discontinue treatment early. How do you prevent early discontinuation with your patients? Do antidepressants with both norepinephrine and serotonin reuptake inhibition, such as bupropion,**

**venlafaxine, duloxetine, and mirtazapine, have a faster onset of action? How do their dosing and tolerability profiles compare to SSRIs or TCAs?**

*Dr Manning*: For the last couple of years, since the meta-analysis on venlafaxine efficacy by Thase et al was published, I more often choose SNRI [selective serotonin-norepinephrine reuptake inhibitor] drugs as first-line therapy.[3] SSRIs are very effective medications, but with SNRIs, the more mechanisms of action you can hit with a single drug, the better your chance of improved remission rates. And many of these chronic painful symptoms might be better addressed by multimodal mechanisms of action. The TCAs have always been the drug of choice in chronic pain syndromes. It's not for historical reasons; it's because they are more effective. So if you want to achieve better remission rates in chronic pain symptoms, the SNRIs make a lot of sense. It's very easy to get someone partially well (50% or 75% better) and think you've done a good job. But in reality, those residual symptoms are just predicting dysfunction and relapse rates. Unless there is complete remission of symptoms, there is not normal social functioning. So, it's really important to push all of the way to "well." That can be challenging for many patients.

The data that we have on SNRIs show about 45% remission rates in controlled studies. That leaves 55% of people needing some other medicine or medicines in combination. This is not a new concept in medicine. You don't treat diabetes or hypertension with one medicine. Physicians need to be aware that in the treatment of mood disorders—particularly depression—rational polypharmacy and achieving incremental improvement with adding medicines is becoming standard. PCPs are treating diseases this way all of the time.

The faster onset of action with SNRIs has been a secondary measure in these studies. Studies have shown that patients taking SSRIs or SNRIs begin to show improvement within 1 to 2 weeks, but there's nothing conclusive on that right now. There are some people who believe that dual-mode activity might get faster onset of action, but if we are going to be scientifically rigid about asking the question, there has been no study that has proved it. One of the studies with duloxetine and pain symptoms showed that duloxetine worked very quickly, but it was not a primary measure. We'll know more as time goes on.

All antidepressants have some side effects. Most of the side effects are mild and go away quickly. SSRIs were so attractive 15 years ago because of their safety in overdose. These medicines, when they are used well, are often very tolerable. I don't see a difference between the SSRIs and the SNRIs in terms of their tolerability profile. Most of the newer non-TCAs tend to be safer than TCAs and certainly have better tolerability profiles.

**ASiM: In your experience, what is the role of psychotherapy for treating depression in primary care?**

*Dr Manning*: Patients do best when they receive both medicine and psychotherapy, with their complementary modes of action. You'll find people who, when the medicine is working well, don't need psychotherapy because to them it's perfectly obvious what they need to be doing. For other people, because depression can be chronic and triggered by significant psychosocial contexts like bereavement or divorce, psychotherapy may be a necessary part of the solution because pills don't teach you anything. Some people have been depressed early enough in life that the depression may have actually prevented them from gaining some areas of mastery and competency in their own functioning. So, medication is not automatically going to add maturity. Even people who are mature may not know how best to handle a specific situation and need advice; psychotherapy is a wonderful component to add to treatment in those scenarios.

For mild to moderate depression, there are people who prefer psychotherapy, and that may be the only treatment they want to pursue. For more significant, severe depression, medication will almost always be necessary, and the combination of medicine and psychotherapy is going to provide the best result.

**ASiM: If a PCP wants to establish a relationship with a psychotherapist in their area, can you offer any advice on how to go about it and what the physician should look for?**

*Dr Manning*: Having a relationship with a psychotherapist is very, very important, and most clinicians identify whom they are comfortable with in their area. You get to know them informally over a period of time. You meet people at CME gatherings and in-hospital at consultations, or you have heard through other practitioners or other patients that one person is very good at handling a certain type of mood disorder. One of the sad things about managed care is the people you'd like to refer to, the ones that you feel most comfortable with, are often not available. They are not on

somebody's managed care plan. It's just as challenging to find a psychotherapist as it is to find a psychiatrist, because they are either not available or are busy, or quality of treatment may be variable.

Ideally, psychotherapy should live in primary care, because I'd rather walk out of the door and introduce somebody to a psychotherapist while they are at my office than have to refer them anywhere. That way, the patient would begin to see mental illness as part of primary care, which it really is. And the resources that are needed would not require referral and leave the clinician wondering whether the patient is going to make the call or be able to get there or whether it will be paid for. Mental health is health. If you're not mentally healthy, you're not healthy in most other ways either. I would rather just include mental healthcare as part of what you would think of as primary care, but right now, most of the obstacles to that are financial.

## REFERENCES


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