Emotional Disorders in Primary Care

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Individuals with emotional disorders are more likely to use primary medical care than specialty mental health services, but these disorders are likely to be undetected or inadequately treated. Recognition of the importance of primary medical care for the treatment of mental disorder has resulted in pressing new research priorities. One set of issues concerns the adequacy of existing nosological systems for conceptualizing emotional disorder in primary care and identifying need for treatment. Another concerns the difficulties translating efficacious treatment into effective strategies that can be integrated into the competing demands of primary medical care. Psychologists have played only a limited role in defining and addressing emerging questions. Irreversible changes in mental health services have created the need for the development of a psychosocial perspective for what would otherwise be defined as narrowly biomedical issues.

There are dramatic shifts occurring in the settings in which emotional disorders are treated, how they are treated, and by whom. The present discussion must be placed in the context of these sweeping changes to fully appreciate the significance of emotional disorders in primary care. Pressing new research priorities are being defined by policymakers who need an empirical foundation for the key decisions they face. Yet with relatively few exceptions (Arean & Miranda, 1996; Coyne & Schwenk, 1995; Munoz, Hollon, McGrath, Rehm, & VandenBos, 1994; Schulberg & Rush, 1994), psychologists have taken almost no role in defining the relevant research questions, generating the requisite findings, and posing empirically based solutions to the problem of emotional disorders in primary care, where such disorders are increasingly most likely to be treated. Aside from psychologists not looking after their self-interests, they have failed to articulate a perspective that could serve as a needed balance to what have come to be a narrowly defined set of biomedical issues. The absence of a clearly articulated psychosocial perspective is to the detriment of all concerned and, most importantly, to those who must pay for, deliver, or receive treatment for emotional disorders in primary care. Like Rip Van Winkle, psychologists have slept through a revolution, and as they awaken, they must grasp how their world has changed.

Beginning in the 1970s, a number of important developments rapidly advanced our understanding of the nature of emotional disorders outside of mental health settings. First, there were increasing refinements in diagnostic criteria as seen in the Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978), followed by the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980), a revised DSM-III (DSM-III-R; American Psychiatric Association, 1987), and a successor (DSM-IV; American Psychiatric Association, 1994).

Second, interview schedules including the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978), the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratchliff, 1981), the Structured Clinical Interview for DSM-III (SCID; Spitzer & Williams, 1985), and the Composite International Diagnostic Interview (CIDI; World Health Organization, 1990) incorporated these refined diagnostic criteria into readily applicable assessment tools. No longer were researchers forced to choose between defining emotional disorder in terms of patients in mental health treatment or relying on some arbitrary cutpoints on frustratingly nonspecific self-report scales. It also became possible to begin to make cautious comparisons of emotional disorders across populations (Henderson, 1998).

Third, using these refined research diagnostic criteria, a number of ambitious research projects examined the nature, prevalence, and correlates of emotional disorder in the community. The most notable of these projects were the Epidemiologic Catchment Area (ECA) study (Regier, Myers, & Kramer, 1985; Robins et al., 1981), the National Co-Morbidity Survey (NCS; R. C. Kessler et al., 1994), and the Depression Research in European Society (DEPRES) study (Lepine, Gastpar, Mendlewicz, & Tylee, 1997). Such projects added to a wealth of accumulating data indicating that emotional disorders were highly prevalent in the community and personally and socially impairing.

In addition to prevalence rates, the ECA study yielded estimates of the proportion of individuals with each disorder who received treatment and of the type of treatment services received. It was
found that most persons with emotional disorders did not get treatment and that only a minority of the treatment received came from specialized mental health services (Regier et al., 1993; Shapiro et al., 1984). The de facto mental health system in the United States was found to consist not only of formal mental health services but of general medical care, social services, and various self-help efforts (Regier et al., 1993). Most people in the community with an emotional disorder visited a general medical provider in the course of a year, and more persons with emotional disorders were treated in this sector than by mental health professionals. Yet most emotional disorders in people visiting a general medical provider were undetected and untreated (Regier et al., 1993).

Similar results were obtained in the NCS (R. C. Kessler et al., 1999) and DEPRES study (Lepine et al., 1997). Furthermore, even when detected, emotional disorders were found likely to be inadequately treated or not treated at all (Katon, Von Korff, Lin, Bush, & Ormel, 1992; Schulberg et al., 1997).

However, these findings may have become outdated in the face of accelerating trends that place even more emphasis on primary care as the site in which emotional disorders are treated. Both the lay public and primary care physicians are more likely to accept newer antidepressants, such as selective serotonin reuptake inhibitors (SSRIs), venlafaxine, and nefazodone, than the antidepressants previously available. Patients are increasingly more likely to seek and receive an antidepressant from a primary care physician than from a psychiatrist. From 1991 to 1997, the annual number of antidepressant prescriptions written by primary care providers in the United States increased from nearly 25 million antidepressant prescriptions to over 50 million, compared with an increase from 15 to 33 million for psychiatrists (Hirschfeld, 1998).

Although the depressed elderly are presumed to be less likely to be treated than younger depressed patients, a recent population-based study in Ontario, Canada, found large and growing rates of antidepressant prescriptions for the elderly, with over 17% of the oldest women in the province receiving antidepressants in 1997 (Mamdani, Herrmann, & Austin, 1999). In a similar manner, 14.3% of elderly White individuals (but only 5.0% of African Americans) in the Piedmont region of North Carolina were found to be receiving an antidepressant (Blazer, Hybels, Simonsick, & Hanlon, 2000). In France, between 5% and 7% of the general population and 17% of the elderly were found to be chronic users of anxiolytics and hypnotics (Pelissolo, Boyer, Lepine, & Bisserbe, 1996). These high rates of prescription cannot be presumed to represent adequate treatment. Indeed, we will review literature below suggesting that under conditions of routine care, primary care patients do not obtain the anticipated benefits when treated with antidepressants. However, these figures do suggest that the assumption that most depression in primary care will go untreated needs to be reexamined with contemporary data. Furthermore, these rates of treatment exceed the presumed prevalence of depression among the elderly and raise the issue of specificity of treatment with antidepressants: Patients may be receiving treatment who do not meet criteria for a condition for which the efficacy of treatment with antidepressants has been established.

A considerable gap may still exist between the large number of depressed patients being seen by general medical providers and the smaller number obtaining effective treatment. The growing body of research refining and evaluating solutions to these problems includes investigations of integrating mental health profession-
define depression. Yet it was subsequently recognized that most patients who have elevated scores on screening instruments do not meet criteria for a depressive disorder and that, by themselves, such instruments provide distorted estimates of the need for treatment and the performance of providers. Still, attention has remained focused on how screening for psychological distress might still serve as a tool in improving the detection and outcome of depression. It was also noted that a considerable pool of patients had significant depressive symptoms but did not meet criteria for major depression. This raised questions about the adequacy of conventional DSM-IV criteria for use in primary care, an issue that has yet to be satisfactorily resolved. In particular, concerns remain about whether minor depression should be given greater recognition as a diagnostic entity and therefore as a suitable target for detection and treatment. More recently, attention has been turned to anxiety disorders. This is justified not only by arguments about their prevalence and associated impairment but also by findings that newer antidepressants are efficacious for anxiety disorders.

**Psychological Distress**

A variety of self-report measures of distress have been used with primary care populations, including the Center for Epidemiologic Studies Depression scale (CES-D; Radloff, 1977), the Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the General Health Questionnaire (GHQ; Goldberg & Hillier, 1979), as well as the Beck Depression Inventory, Primary Care edition (BDI-PC; Beck, Guth, Steer, & Ball, 1997), a measure specifically designed for use in primary care settings. With adjustments in cutpoints, such instruments are equivalent in providing moderate efficiency in first-stage screening for depression (see Coyne, Thompson, Palmer, Kagee, & Maunsell, 2000, for a review). In general, these instruments have relatively high sensitivity but limited specificity (Mulrow et al., 1995). They may identify a pool of patients who may have depression, but they do not provide a reliable diagnosis.

Consistent with other studies (e.g., Coulehan, Schulberg, Block, Janosky, & Arena, 1990), Fechner-Bates, Coyne, and Schwenk (1994) found that the CES-D had a sensitivity of 79.5% and a specificity of 71.1% but a modest positive predictive value of 28.5%, using a SCID-based diagnosis of major depression as the comparison. Practically speaking, the CES-D identified more than one third of these were actually depressed, and 1 in 5 depressed patients would have been missed if a physician had relied exclusively on the screening to detect depression. Efforts to improve the performance of the CES-D and similar instruments by raising cutpoints, by modifying scoring, or by eliminating poor-performing items inevitably involve some trade-off between sensitivity and specificity (Santor & Coyne, 1997). There are inherent limitations to self-report instruments as indicators of major depression.

What else do elevated scores on measures of distress indicate? Fechner-Bates et al. (1994) found that taking into account any DSM-III-R diagnosis of a depressive disorder only marginally improved the performance of the CES-D as a screening instrument and that most adjustment disorders were missed. It is readily possible for patients to score in the distressed range without a single depressive symptom, and less than half of distressed patients have had 2 weeks of mood disturbance (Coyne & Schwenk, 1997).

Our experience with screening for distress in elderly primary care patients is that over 40% of positively screening patients will not be distressed 2 weeks later (J. Streim, personal communication, March 6, 2000). Yet can nondepressed patients who screen positive, but who do not meet criteria for major depression, be viewed as an at-risk population? With cases of major depression excluded, an elevated score on the CES-D is so inefficient in identifying patients at risk for subsequent depression (Munoz et al., 1995) that an effect for any preventive intervention cannot be demonstrated without a prohibitively large sample (see Coyne et al., 2000, for an extended analysis of this problem). Undoubtedly, much of the self-reported distress assessed in primary care samples reflects psychosocial problems, physical symptoms including pain, and unhappiness, which are not appropriately construed as emotional disorders (Coyne & Kagee, 2000).

**Major Depression**

The first wave of primary care office-based studies found that major depression was highly prevalent among primary care patients but was often undetected and untreated by primary care physicians. Estimates of prevalence ranged from 4.8% to 13% (Barrett, Barrett, Oxman, & Gerber, 1988; Coyne, Fechner-Bates, & Schwenk, 1994; Katon, 1987; L. G. Kessler, Cleary, & Burke, 1985; Schulberg et al., 1985), and even the lowest estimate may still make major depression the most common condition in primary care, perhaps exceeding hypertension (Katon & Schulberg, 1992). Studies that use results of semistructured interviews as the criterion for diagnosis and formally solicit diagnoses from the primary care physicians find as many as 50%–70% of patients with a current major depression are missed (Coyne, Schwenk, & Fechner-Bates, 1995; Gerber et al., 1989; Perez-Stable, Miranda, Munoz, & Ying, 1990; Von Korff et al., 1987). Taken together, this body of research has been widely interpreted as upholding the view that undetected depression among primary care patients is a major public health problem.

However, interpretation of such prevalence data is more complex. Many depressed patients have few or no symptoms beyond what is needed to meet criteria for a diagnosis and are not substantially impaired (Coyne et al., 1994). The cases missed by physicians are disproportionately milder cases (Coyne et al., 1995). Furthermore, the symptoms of many depressed primary care patients, and particularly the symptoms of those patients who are not detected as having depression by their physicians, are in a range of severity in which antidepressants have not been shown to have a decided advantage over placebos (Elkin et al., 1989; Paykel, Hollyman, Freeling, & Sedgwick, 1988). Furthermore, patients’ willingness to accept an antidepressant is a strong predictor of whether they will be detected (Rost et al., 2000), suggesting a role for patient preference in the process of detection. In addition, patients with less severe depression are also less likely to accept treatment (Grembowski, Martin, & Patrick, 2001). On the other hand, primary care patients who present with mild major depression and remain undetected may suffer later exacerbation of symptoms when they no longer are in contact with their physician (Rost, Zhang, Fortney, Smith, & Coyne, 1998).
Minor Depression

Estimates of the rates of minor and intermittent depression insufficient to meet criteria for current major depression range from 2% to 9% among primary care patients (Barrett et al., 1988; Hoepner, Nyce, Cleary, Regier, & Goldberg, 1979; Ormel, Van Den Brink, Koeter, & Giel, 1990), but there is ambiguity as to the clinical significance of these conditions. It has been suggested that minor depression represents a source of considerable impairment and a risk for major depression such that early intervention could reduce unnecessary suffering and disability (Broadhead, Blazer, George, & Tse, 1990; Horwarth, Johnson, Klerman & Weissman, 1992; Wells et al., 1989). However, controlled studies of intervention for minor depression in primary care have produced quite modest and even null effects, in part due to the improvement in symptoms among these patients regardless of intervention (Barrett et al., 1999; Katon et al., 1995; Williams et al., 2000). In general, although minor depression may entail severe functional impairment (Callahan et al., 1994), few treatments have been shown to be effective with this disorder (Coyne et al., 1995). There appears to be an emerging paradox concerning depressive symptoms and conditions that are not sufficient to meet full criteria for major depression. Namely, although such conditions are less severe than major depression, it may be more difficult to demonstrate that they benefit from treatment (Callahan, 2001).

However, the clinical significance of minor depression may vary according to whether such symptomatology reflects a general vulnerability to major depression (Coyne & Katz, 2001). Given the recurrent nature of major depression, prior depression is an excellent marker for this vulnerability (Coyne, Pepper, & Flynn, 1999). Yet, in contrast to the DSM-IV, which makes past major depression an exclusion criteria, studies of minor depression typically do not take history of depression into account. Individuals with a history of major depression actually spend more time with subsyndromal depressive symptoms than in full episodes of major depression (Judd et al., 1998b). However, most individuals experiencing mild symptoms do not progress to a full episode of depression, with only 9%–21% of women and 4%–13% of men becoming clinically depressed in their lifetime (R. C. Kessler et al., 1994). The finding that subsyndromal symptoms in recovered depressed persons are an important predictor of rapid relapse (Judd et al., 1998a) adds to the weight of evidence that both recent and more distant history of depression should be routinely assessed and taken into account in the interpretation of depressive symptoms.

Anxiety Disorders

Although anxiety disorders are believed to be the most common psychiatric disorder in primary care (Sherbourne, Jackson, Meredith, Camp, & Wells, 1996), they have only begun to be given attention other than as a comorbidity of depression. Panic disorder and general anxiety disorder can be highly impairing, but the common phobias, which contribute to the high prevalence of anxiety disorders, are not (Nisenson, Pepper, Schwenk, & Coyne, 1998). Although comorbid anxiety disorders facilitate the detection of depression, there has been a concern in the past that this contributed to the inappropriate treatment of depression with benzodiazepines (Depression Guidelines Panel, 1993). However, newer antidepressants, including the SSRIs, can also be effective for anxiety disorders, potentially reducing this problem (Uhlenhuth, Balter, Ban, & Yang, 1999). The availability of these newer antidepressants will give rise to simplified treatment algorithms that do not require primary care providers to make complex diagnostic distinctions or treatment choices. The apparent efficiency of such algorithms may make it more difficult for consumers and nonphysician mental health professionals to argue for the necessity of offering psychosocial interventions in primary care as alternatives to these algorithms.

Mixed Anxiety–Depression

Katon and Roy-Byrne (1991) have provided a comprehensive review concerning evidence for a mixed anxiety–depressive disorder among primary care patients. The DSM-IV includes such a condition, requiring 1-month mood disorder and other affective symptoms, but only as a set of criteria for further study rather than an accepted diagnosis. Such mixed states are highly prevalent (Barrett et al., 1988). There is evidence that primary care providers take into account both anxious and depressive symptoms in deciding caseness for major depression (Nisenson et al., 1998) and that a substantial proportion of patients receiving antidepressants have mixed anxiety and depressive symptoms without meeting full criteria for major depression (Sireling, Paykel, Freeing, Rao, & Patel, 1985). Some anxious–depressed patients suffer substantial impairment and may be at risk for subsequently full criteria major depression. However, other such patients are not impaired and recover without formal treatment. Nease, Volk, and Cass (1999) used cluster analysis to examine mood and anxiety symptoms in primary care patients and found that patients clustered into four groups, all of which displayed some mixture of mood and anxiety symptoms at varying levels of severity, rather than into groups of mostly pure mood, mostly pure anxiety, and mixed mood and anxiety symptoms. Patients with mood and anxiety disorders were distributed throughout all the groups, suggesting that coexisting mood and anxiety symptoms are the rule rather than the exception. Katon and Roy-Byrne suggested that further research is needed to resolve the apparent heterogeneity of mixed anxiety–depressive disorder and its relation to major depression. They note that the bulk of available studies are limited by the absence of data concerning lifetime psychiatric disorder or a longitudinal perspective.

Controversy Over Diagnostic Criteria

The controversy over the adequacy of psychiatric diagnostic criteria for primary care patients (Barrett et al., 1988; Nease et al., 1999) is rather different from the disputes familiar to psychologists concerning the suitability of self-reported distress as an equivalent to diagnosis (Coyne, 1994; Vredenburg, Flett, & Krames, 1993). The key issues in primary care are how to best identify patients who are both significantly impaired by emotional distress and likely to benefit from specific treatments while minimizing unnecessary treatment. The prevailing view has emphasized treatment of any patients who currently meet diagnostic criteria. However, this approach leaves out a number of intermediate steps that are important in primary care: namely, assessment and interpretation of the severity of current symptoms in light of prior history, as well as the negotiation toward the patient’s acceptance of the diagnosis and treatment plan. In other words, determining whether patients
currently fit into traditional diagnostic categories is only one step in identifying those who will accept and benefit from treatment.

Primary care providers must make diagnostic judgments in a context in which most patients are suffering some physical and emotional discomfort, and therefore, the risk of a lowered threshold for diagnosis is that a large number of patients will be inappropriately labeled as having an emotional disorder. Many depressed patients have only the minimum number of symptoms required for a diagnosis, meaning that interpretation of one or two symptoms makes the difference between an accurate diagnosis or a false positive or a false negative diagnosis. Symptoms may not be numerous or severe enough to warrant a formal diagnosis at an index visit, yet these symptoms may intensify when the patients are no longer in contact with their physician (Rost et al., 1998). A history of prior depression can be crucial in interpreting current presentation. Issues in assessing anxiety disorders are more complex, in that it is more difficult to reliably establish a prior history, and the revised criteria presented in the DSM-IV may not be clinically valid (Bienvenu, Nestadt, & Eaton, 1998). Although intended to distinguish generalized anxiety from normal worrying, the increase in the required duration of symptoms from 1 month to 6 months may not be an acceptable means of drawing this distinction in primary care. Finally, unlike patients seeking treatment in specialized mental health settings, patients identified as having emotional disorders in primary care may not be ready to accept and benefit from treatment (Rost et al., 2000; T. L. Thompson, Mitchell, & House, 1989).

These factors may help to explain evidence that primary care providers often reject formal psychiatric nosology and instead rely on their own assessment of current symptoms and their knowledge of the patient (Klinkman, Coyne, Gallo, & Schwenk, 1998; Va- lenstein et al., 1997). Primary care providers are widely criticized for missing major depression (Depression Guidelines Panel, 1993). Yet when compared with formal diagnostic criteria, they make more false positive diagnoses than false negatives (Klinkman et al., 1998). Many false positive patients have a mix of affective symptoms and a history of depression, and it is not clear that the primary care providers’ judgments are clinically invalid.

A diagnostic system that was more clinically useful and acceptable in primary care would better accommodate the number and severity of a full range of affective symptoms and, importantly, incorporate more of a temporal perspective. Prior history would be given weight in interpreting ambiguous presentations of symptoms, but some diagnoses would still be best resolved only with extended observation or “watchful waiting” (Freedman, 1989).

Improving the Outcome of Depression in Primary Care

**Dominant View: Screen, Detect, Medicate, and Observe Improvement**

As we have noted, most efforts to improve the outcome of emotional disorders in primary care have centered on depression. Identification of depression as highly prevalent, but largely untreated in primary care, was the impetus for development (by the U.S. Public Health Service Agency for Health Care Policy and Research [AHPCPR]) of practice guidelines for the management of depression (Depression Guidelines Panel, 1993). These guidelines advocated front-loading strategies to improve the outcome of depression: increased case finding with routine screening as a key means of facilitating physician detection of depression. Although they acknowledged the efficacy of psychotherapy for mild and moderate depression, they put greater emphasis on medication as the first line of treatment (Munoz et al., 1994).

Initial clinical trials confirmed that screening led to increased detection and treatment of major depression (Magruder-Habib, Zung, & Feussner, 1990; Rand, Badger, & Coggins, 1988; Shapiro et al., 1987). Yet enthusiasm for the routine screening for depression (Depression Guidelines Panel, 1993) has been dampened by repeated findings that screening and feedback to providers do not improve the outcome or adequacy of treatment of depressed patients in primary care (Callahan et al., 1994; Dowrick & Buchan, 1995; Moore, Silimperi, & Bobula, 1978; Reifler, Kessler, Bernhard, Leon, & Martin, 1996; Scott & Freeman, 1992; Shapiro et al., 1987).

To be of benefit, screening must be integrated with additional enhancements of routine care, and even then, the benefits are not assured (Callahan et al., 1994). Moreover, potential drawbacks of routine screening include the risk of encouraging providers to overdiagnose and treat patients who are distressed but not depressed (Klinkman, Coyne, Gallo, & Schwenk, 1997) and the commitment of considerable resources to interview assessments of patients who are not found to be depressed. Screening for distress is clearly not a panacea for the problem of depression in primary care (see Coyne et al., 2000, for a review). A recent meta-analysis failed to find that routine screening improved the outcome of depression in general medical care (Gilbody, House, & Sheldon, 2001), and a cost-effectiveness analysis concluded that screening was justified under only highly restricted conditions (Valenstein, Vijan, Zeber, Boehm, & Buttar, 2001). However, both of the analyses may still have been overly optimistic in their conclusions, because they made unrealistic assumptions about rates of treatment in the absence of screening and about the effectiveness of treatment under conditions of routine care (Coyne, Palmer, & Thompson, 2001).

One important limitation on the effectiveness of routine screening as a means of improving the outcome of depression is that it depends on the effectiveness of initiating treatment of patients who are found to be depressed. Ormel et al. (1990) reported that although detection of depression was associated with fewer patients meeting diagnostic criteria for depression at 1 year, treatment of depression was not associated. Brugha, Bebbington, McCarthy, Sturt, and Wykes (1992) noted equivalent outcomes for major depressive disorder patients not receiving antidepressant treatment and for those receiving treatment. A number of studies in both North America and Europe found either modest short-term benefits for detection and treatment or, more consistently, none at all (Coyne, Klinkman, Gallo, & Schwenk, 1997; Pini, Perkonigg, Tansella, Wittchen, & Psych, 1999; Rost et al., 1998; Simon et al., 1999; Tiemens, Ormel, & Simon, 1996). Indeed, Schulberg et al. (1996) found that the improvement rates of depressed patients provided antidepressant treatment by primary care physicians was only 48%, which is lower than the rates of improvement often found with placebos administered in the context of randomized clinical trials in specialty mental health settings.

**Next Wave of Physician- and Practice-Centered Strategies for Improving Outcome**

Renewed efforts to improve the outcome of depression in primary care tend to presume that the difficulty lies with primary care
physicians. Physician-centered interventions have included a variety of educational strategies, feedback and supervision, and academic detailing. In a review of the literature from 1966–1998 for all emotional disorders in primary care, Kroenke, Taylor-Vaisey, Dietrich, and Oxman (2000) reported changes in diagnosis and treatment for the majority of interventions but improvement in patient symptomatology for only 4 of 11 studies, with some of this improvement short-lived. For instance, Katon et al. (1995) examined the effect of a collaborative management protocol including training, conferences, and a review of each case by a psychiatrist. Although considered a successful trial, the intervention improved outcomes for only those patients with major depressive disorder who required adjustment of their medication regimen during the intervention period. Lin et al. (1997) later found that none of the short-term improvements in depression treatment persisted after the collaborative care intervention ended.

Several newer primary care interventions have also failed to improve outcomes. In a particularly ambitious study, Goldberg et al. (1998) randomized 15 practices with 95 practitioners and 1,177 depressed patients to either academic detailing, continuous quality improvement, or routine care but were unable to demonstrate improvement in patient outcomes for the active intervention groups. Katon and colleagues (Katon et al., 1999) have now reported a stepped collaborative care trial, which provided collaborative care intervention for only those patients whose depressive episodes had not resolved at 6–8 weeks. They found improved outcomes at 3 and 6 months, although differences in outcomes were of marginal statistical significance at the 6-month measure. Tiemens et al. (1999) implemented a 20-hr training program for primary care physicians on detection, diagnosis, and treatment, finding an initial improvement in short-term outcomes for depressed patients but no effect by 1 year. C. Thompson et al. (2000) carried out a randomized, controlled trial of a practice-based educational intervention based on clinical practice guidelines in 60 primary care practices in the United Kingdom and found no effect on either recognition or clinical outcome.

Results from recent studies examining both practice-level interventions and outcomes monitoring are just now becoming available. These studies show minimal short-term improvements in selected patient outcomes when compared with routine care (Rollman et al., 1999; Sherbourne et al., 1999), but even these minimal improvements may not be maintained (Lin et al., 1997, 1999) and are unlikely to result in improved quality of life or daily functioning (Revicki, Simon, Chan, Katon, & Heiligenstein, 1998; Simon et al., 1998). Trials with multiple outcome assessments showed narrowing of differences between intervention and control arms over time (Hunkeler, 1999). An important but often overlooked finding in this generation of clinical trials is that routine or usual care arms often show short-term improvements in outcome measures approaching that of intervention arms. It is clear that not all patients require intensive intervention, and better identification of those who do could provide a means of better allocating resources.

Whither Psychotherapy in Primary Care?

The AHCPR Depression Guidelines are widely interpreted as emphasizing medication, and most efforts to improve the outcome of depression in primary care have a similar bias. Collaborative mental health care has generally come to mean psychiatrists or nurse specialists providing enhanced management of medication. Some ongoing multisite trials for which results are not yet available prescribe psychotherapy as a second line of treatment for patients who refuse medication or who are inadequately responsive to it (Schulberg et al., 2001; Unützer et al., 2001). All of this reflects the profound medicalization of the issue of emotional disorders in primary care. On the other hand, data demonstrating the effectiveness of psychotherapy provided to depressed primary care patients within the constraints of that setting are quite limited.

Schulberg et al. (1996) showed in intent-to-treat analyses that interpersonal psychotherapy (IPT) was equivalent to enhanced management of antidepressants, and both were superior to routine care, despite that only 42% of the patients receiving IPT and 33% receiving antidepressants completed the trial. Secondary analyses showed that this effect also held for severely as well as mildly and moderately depressed patients (Schulberg, Pilkonis, & Houck, 1998). Two studies have failed to show a benefit for cognitive therapy over routine care by primary care physicians (Scott & Freeman, 1992; Teasdale, Fennell, Hibbert, & Amies, 1984), but another study showed a benefit (Ross & Scott, 1985). Reviewing the outcome studies available through 2000, Schulberg, Raue, and Rollman (in press) concluded that, overall, manualized psychotherapies were superior to routine care for depressed primary care patients.

Yet there remains the practical issue of skilled therapists willing to adhere to manualized treatment being readily available in primary care. Both IPT and cognitive therapy require highly skilled therapists, and their efficacy may depend on the degree to which therapists adhere to the manualized treatment manuals (Frank, Kupfer, Wagner, McEachran, & Cornes, 1991). Mynors-Wallis and colleagues (Mynors-Wallis, 1996; Mynors-Wallis, Davies, Gray, Barbour, & Gath, 1997; Mynors-Wallis & Gath, 1997; Mynors-Wallis, Gath, Day, & Baker, 2000) have tested a problem-solving treatment (PST) for depression that is specifically designed to be feasible for clinicians who are not highly trained in providing therapy. The most recent trial using PST randomized patients to one of four treatment groups: PST administered by a nurse, PST administered by a general practitioner, antidepressant medication, or combination treatment with PST and medication (Mynors-Wallis et al., 2000). No differences in outcomes were seen at 6, 12, or 52 weeks, although all groups showed significant levels of improvement. The authors concluded that their results demonstrate the effectiveness of PST at levels equal to that of antidepressants, although it is unclear whether the study was sufficiently powered to detect differences between the groups.

What effectiveness can be expected for routinely referring depressed primary care patients to psychotherapists? Phrased in this way, effectiveness depends not only on the efficacy of treatment but on uptake—patients accepting the referral and adequately completing the course of treatment. Psychotherapy may appeal to the substantial numbers of primary care patients who reject antidepressants (Rost et al., 2000). Schulberg et al. (1996) and others have demonstrated that treatment effects are found even when depressed primary care patients with substantial physical comorbidity are not excluded from a clinical trial. Yet, however encouraging such data may be, policymakers may remain unconvinced of the benefits of referral of depressed primary care patients until effectiveness can be demonstrated under conditions of routine care. Aside from issues of patient uptake, there are unanswered ques-
tions about psychotherapists’ performance outside of clinical trials in which treatment fidelity is monitored and enforced. Practicing clinicians tend to express reservations about adherence to manu-
ialized treatment as being too rigid (Addis & Krisnow, 2000). Moreover, some data are not reassuring that the concern the effective-
ness of routinely provided psychotherapy. Lambert, Hansen, and Finch (2001) examined effectiveness data for over 10,000 patients receiving psychotherapy in a health maintenance organization. At least 21 sessions were required for 50% of the patients to show clinically significant improvement, and it was estimated that at least 40 sessions and sometimes the addition of medication would be required for 75% of patients to show clinically significant improvement. Effectiveness of psychotherapy in this study was undoubtedly limited by the nonspecificity of the treatment pro-
vided, as well as the nonspecificity of the conditions being treated. Lambert et al. (2001) noted that a substantial percentage (10%–
20%) of the patients were already highly functioning and therefore could not be expected to show substantial gains from treatment. These data are thus not decisive, even if they suggest that routine psychotherapy may require more sessions to be effective than many patients and third party payers are willing to accept. How-
ever, it is likely that policymakers will require compelling effect-
iveness data as well as efficacy data if they are to be convinced of the benefits of referring depressed patients to psychotherapy. Such demonstrations should be seen as an important research agenda.

**Competing Demands on Primary Care as a Treatment Setting for Emotional Disorder**

There is a certain Willie Suttonism to the focus on emotional disorders in primary care.¹ A large number of individuals with emotional disorders are to be found there, and many of them will not have consulted a mental health professional. Primary care providers are prepared to dispense medications that have proven efficacious in clinical trials. Yet the results obtained with this treatment do not match what is obtained in clinical trials, and a variety of interventions to improve patient outcomes have not had marked success. In light of this, greater attention needs to be given to some of the difficulties posed by primary care as a treatment setting.

During routine clinical encounters, primary care physicians deal with multiple health problems and multiple priorities encompassing multiple domains, biomedical as well as social and emotional. This complex balancing act must take place over 12–15 min under usual circumstances (6 min in the United Kingdom), setting limits on what can be accomplished and placing negotiation at the center of every primary care encounter (Klinkman, 1997). The various practice- and physician-centered efforts to improve the outcome of emotional disorders have minimized the role of the patients in this negotiation. The assumption seems to be that they are passive, open to discussion of their problems in terms of emotional disor-
der, and willing to accept treatment with an emphasis on medica-

...
inated by a biomedical perspective, to which psychologists have as yet contributed little. We can point to the largely disappointing results of efforts to improve the outcome of emotional disorders in primary care and call for a greater role for psychologists. However, it may be unrealistic to expect that primary care will be de-emphasized as a key context for the treatment of emotional disorders or to expect a wholesale integration into primary care of psychologists providing conventional psychotherapy. Nonetheless, there are key ways in which psychologists can have a crucial role in redefining a research agenda for emotional disorders in primary care, and in doing so, they can identify a place for the discipline's unique expertise. There are a number of pressing needs:

1. Develop a nosological system for emotional disorders in primary care that takes into account that many patients will not present with clearly defined symptom patterns. Such a system would undoubtedly require a temporal perspective to explicate patients' presentation and will need to be validated in terms of its ability to predict benefit from treatment.

2. Address accelerating rates of the prescription of psychotropic medication, particularly among the elderly. Efforts to increase the detection and treatment of emotional disorder need to be tempered with greater attention to when medication is inappropriate and when it can be terminated. Reduction in the inappropriate prescription of antidepressants and anxiolytics should be identified as an important mental health outcome.

3. Explicate the relevant patient variables and social processes affecting problem definition, acceptability of treatments, and preferred providers and settings. This would involve attention to the trade-offs and commitment of resources patients are willing to accept and an underlying conceptualization of patients as decision-making consumers, not simply passive recipients of treatment.

4. Explore the relationship between symptom relief and the associated personal and social problems patients seek to have addressed in primary care. This involves attention not only to functional outcomes but to the interpersonal circumstances that give rise to emotional disorder and leave patients vulnerable to relapse. Indeed, the potential for this role in relapse prevention is validated by a recent meta-analysis of cognitive-behavioral treatment outcomes (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). The value of psychotherapeutic intervention should be defined in part by a rehabilitative function not served by medication alone.

5. Explicate the relevant provider and practice variables that affect how treatments are delivered. The lack of acceptance of psychiatric nosology by primary care providers, the ineffectiveness of screening-based feedback in improving outcomes, and the disappoiting effects of educational strategies and practice guidelines on provider behavior all point to the need for a better understanding of providers.

6. Develop brief, structured psychological treatments compatible with the competing demands and staffing of primary care. Just as SSRIs allow simplified treatment algorithms for treating emotional disorders, it should be possible to develop algorithms for psychological treatments that exploit common elements or mechanisms. For instance, there has been lively debate as to whether similarities between behavioral activation for depression and exposure for anxiety might allow for simplified strategies for treating anxiety and depression (Arean & Coyne, 2000).

7. Identify what bundling of skills and services might make integration of psychologists into primary care more cost-effective and acceptable. For instance, roles in the diagnosis and treatment of emotional disorder might be supplemented with activities such as health promotion and pain management. The opportunities related to health psychology and behavioral medicine in primary care may be complementary to those related to a role in the management of emotional disorders.

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