

Original articles

Depression, anxiety, and somatoform disorders: Vague or distinct categories in primary care? Results from a large cross-sectional study[☆]

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Abstract

Objective: Depression, anxiety, and somatization are the most frequently observed mental disorders in primary health care. Our main objective was to draw on the often neglected general practitioners' (GPs) perspective to investigate what characterizes these three common mental diagnoses with regard to creating more suitable categories in the *DSM-V* and *ICD-II*. **Methods:** We collected independent data from 1751 primary care patients (participation rate=77%) and their 32 treating GPs in Germany. Patients filled out validated patient self-report measures for depression (PHQ-9), somatic symptom severity (PHQ-15), and illness anxiety (Whiteley-7), and questions regarding coping and attribution of illness. GPs' clinical diagnoses and associated features were assessed. **Results:** Patients diagnosed by their GPs with depression, anxiety, and/or somatoform disorders were significantly older, less educated, and more often female than the reference group not diagnosed with a mental disorder. They had visited the GP more often, had a longer duration of symptoms, and

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were more often under social or financial stress. Among the mental disorders diagnosed by the GPs, depression (OR=4.4; 95% CI=2.6 to 7.5) and comorbidity of somatoform, depressive, and anxiety disorders (OR=9.5; 95% CI=4.6 to 19.4) were associated with the largest degrees of impairment compared to the reference group. Patients diagnosed as having a somatoform/functional disorder only had mildly elevated impairment on all dimensions (OR=2.0; 95% CI=1.4 to 2.7). Similar results were found for the physicians' attribution of psychosocial factors for cause and maintenance of the disease, difficult patient–doctor relationship, and self-assessed mental disorder. **Conclusion:** In order to make the *DSM-V* and *ICD-II* more suitable for primary care, we propose providing appropriate diagnostic categories for (1) the many mild forms of mental syndromes typically seen in primary care; and (2) the severe forms of comorbidity between somatoform, depressive, and/or anxiety disorder, e.g., with a dimensional approach.

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Introduction

Depression, anxiety, and somatization are the most common mental disorders in primary care [1]. General practitioners (GPs) are usually the first contact person for patients suffering from psychological and physical problems and therefore play a central role in the detection, prevention, and management of mental disorders. Adequate detection and management of these disorders pose a challenge to the

health care system [2–5]. Not only do these disorders have a high prevalence [6,7], but patients suffering from them make up a disproportionately large portion of GPs' workloads and are often considered difficult and draining to treat [8].

Different groups often come to think about mental disorders from different viewpoints: patients based on life problems, GPs based on irregularities in management, and specialists based on preset nosological classifications [9]. This difference in perspective results in low rates of agreement between GPs' diagnoses and those derived from standard psychiatric classification systems [10,11]. The use of standardized psychiatric instruments in primary care is uncommon because GPs usually consider the patients' history and social and family background information for diagnosis and treatment [12]. The categories of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* [13] and the *International Classification of Disease (ICD-10)* [14] have also been deemed inadequate for general practice usage [15,16]. These facts lead to the question of what information and which associated features determine the diagnosis of a specific mental disorder in general practice.

Given the impending revisions of *DSM-IV* and *ICD-10*, it would be beneficial to consider how to make the new presentation more accessible and user friendly for GPs and other nonspecialists [17,18]. The *DSM-V* and *ICD-11* would be more broadly relied upon if they addressed themselves also to GPs and other health care workers who do not have the same understanding of mental disorders as specialists do.

Hence, the main aim of this study was to analyze clinically relevant features when GPs diagnose the three most common psychiatric syndromes in primary care: depression, anxiety, and somatization. Therefore, we used data from a large primary care study. In order to obtain more knowledge about how GPs think about mental disorders, we first compared the demographic and clinical characteristics of patient groups with different mental disorders as diagnosed by the GPs. Second, the agreement between GPs' diagnoses and patient self-report measures of depression, anxiety, and somatization was assessed. Third, we investigated which clinical characteristics, explanatory models, and patient self-report measures were associated with GPs' diagnoses.

Methods

Study design and subjects

This study was part of "FUNKTIONAL," a cluster randomized controlled trial conducted to evaluate a guideline-based curriculum for early diagnosis and treatment of functional/somatoform complaints in general practice (trial registration: Current Controlled Trials, ISRCTN27782834) [19,20]. The study was approved by the Ethics Committee of the University of Heidelberg.

For patient recruitment, 78 GPs in the Rhein-Neckar region in Germany were invited to participate in our study. Of those, 32 GPs (41%) working in 29 practices agreed to participate. For this study, we analyzed screening data from patients from all 32 GPs.

The patient inclusion criteria were age 18 to 65 years, a scheduled appointment, and a face-to-face contact with the GP. The patient exclusion criteria were insufficient German language skills, illiteracy, psychosis, substance addiction, or severe cognitive or physical impairment limiting the ability to participate in the study. Ongoing treatment was not among the exclusion criteria. Consecutive patients in the participating general practices were recruited and informed about the study by trained student assistants, on randomly selected days. The consenting patients filled out an informed consent form and completed the screening questionnaire directly on-site. The GPs were blinded to the results of the screening and completed an independent medical assessment after the consultation. For the following analysis, seven patient groups were created according to the GPs' diagnoses of mental disorders. Patients without any mental diagnosis constituted the reference group. Patients with mental diagnoses were divided into six groups: depressive disorder only; anxiety disorder only; somatoform/functional disorder only; comorbidity of somatoform, depressive, or anxiety disorder (two disorders); comorbidity of somatoform, depressive, and anxiety disorders (three disorders); and other mental disorder(s). Due to its diagnostic heterogeneity, the "other mental disorder(s)" group was not considered except in the description of demographic characteristics.

Measures

Patient self-report measures

Patients completed a self-report questionnaire including demographic characteristics and questions about physical and mental illness, and validated self-report questionnaires for somatization, depression, health anxiety, and symptom-related functional impairment.

Somatic symptom severity was assessed with the 15-item Patient Health Questionnaire somatic symptom severity scale (PHQ-15) [21,22]. Subjects rate the severity of each symptom during the past 4 weeks on a three-point Likert scale. The 15 somatic symptoms in this questionnaire cover more than 90% of all bodily complaints in outpatient care [23]. The PHQ-15 further includes 14 of the 15 most prevalent *DSM-IV* somatization disorder somatic symptoms [22]. The PHQ-15 also has high internal reliability and construct validity in assessing somatic symptom severity associated with health care utilization, work incapacity, and functional impairment [22,24]. Studies in general practice have shown that an increased number of somatic symptoms is a strong predictor of somatization [25–27].

Depression was assessed using the nine-item depression scale from the Patient Health Questionnaire (PHQ-9) [11,28,29]. Each of the PHQ-9 depression items describes

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