Family Practice
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Vol. 19, No. 6
Printed in Great Britain

Managing depression in primary care: another example of the inverse care law?

Carolyn A Chew-Graham[a], Sean Mullin[b], Carl R May[c], Scott Hedley[b] and Hannah Cole[b]

Chew-Graham CA, Mullin S, May CR, Hedley S and Cole H. Managing depression in primary care: another example of the inverse care law? *Family Practice* 2002; **19:** 632–637.

Background. Depression is a common problem, often being recurrent or becoming chronic. The National Service Framework for Mental Health (published by the Department of Health, 1999) states that people with depression should continue to be predominantly managed in primary care. There is much evidence that the detection and management of depression by GPs could be improved, but little work has focused on GPs' views of their work with depressed patients.

Objectives. This was a qualitative study exploring GP attitudes to the management of patients with depression. Views of GPs in socio-economically deprived areas are compared with those serving more affluent populations.

Methods. Semi-structured interviews were conducted with two groups of GPs in north-west England. One group of GPs (22) were practising in inner-city areas, and a second group (13) in suburban and semi-rural practices. All were Principals in practices that participated in undergraduate teaching. The interviews were audio-taped and subsequently transcribed verbatim. Analysis was by constant comparison until category saturation of each theme was achieved.

Results. Subjects conceptualized depression as an everyday problem of practice, rather than as an objective diagnostic category. Thematic coding of their accounts suggests a tension between three kinds of views of depressed people: (i) That depression is a common and normal response to life events or change and that it reflects the medicalization of these conditions; (ii) That the label or diagnosis of depression offers a degree of secondary gain to *both* patients and doctors, particularly to those GPs practising in inner-city areas and (iii) That inner-city GPs experienced on-going management of depressed people as an *interactional* problem, in contrast to those GPs serving a less deprived population who saw depression as a treatable illness and as rewarding work for the GP.

Conclusion. Depression is commonly presented to GPs who feel that the diagnosis often involves the separation of a normal reaction to environment and true illness. For those patients living in socio-economically deprived environments, the problems, and therefore the depression, are seen to be insoluble. This has an important implication for the construction of educational interventions around improving the recognition and treatment of depression in primary care: some doctors may be reluctant to recognize and respond to such patients *in depth* because of the much wider structural and social factors that we have suggested in this paper. That it is the doctors working with deprived populations who express these views, means that the 'Inverse care law' [Tudor Hart J. The inverse care Law. *Lancet* 1971; **1(7696):** 405–412] operates in the management of depression.

Keywords. Depression, inverse care law, primary care, sick role.

Received 5 April 2002; Revised 26 July 2002; Accepted 26 July 2002.

[a]School of Primary Care, University of Manchester M14 5NP, [b]Y4 student, University of Manchester, [c]Centre for Health Services Research, University of Newcastle, Correspondence to Carolyn A Chew-Graham, School of Primary Care, Rusholme Health Centre, Walmer St, Manchester M14 5NP; E-mail: cchew@man.ac.uk

Introduction

Depression is the most common of the psychiatric disorders encountered in primary care[3] with an estimated 17% of the British population suffering major depression at some point during their lives.[4,5] A quarter of these will suffer from recurrent or chronic depression.[4] Perhaps 70% of these will seek help from their GP.[5] Even so,

community epidemiological studies suggest that depression is often under-diagnosed and poorly managed.[5,6,7] It is suggested that the prevalence of depression is linked to poverty and social disadvantage.[8]

The frequently intractable nature of chronic depression is a problem for doctors in several ways. Existing treatment modalities (either pharmacological or psychotherapeutic) fail to resolve the disorder in a significant proportion of cases.[9] Regular review and monitoring of patients is time-consuming, and often unproductive since recurrence and recovery are often linked to changes or improvements in sufferers' social and economic circumstances.[10] In the UK there has been an increasing emphasis on the recognition and diagnosis of depression,[6,9] but at the same time it has been suggested that GPs may be reluctant to explore and pursue psychosocial issues with patients because of the pressure of other work, and the consequent emotional burden that they themselves experience.[11,12]

In the case of depression it has been assumed that improving training for GPs would lead to improved diagnosis, management and clinical outcomes.[13,14] This is consistent with a view that responding to depression is a technical problem of clinical practice, open to modification through improving clinical *skills.* However, educational interventions for GPs in this field have had disappointing results.[13,14] In relation to this it is important to understand that although sufferers' social and economic contexts are often the crucial variable in understanding recurrence and recovery, the ways that GPs conceptualize people with depression are equally important in understanding their stance on diagnosis and management.[11,15]

This paper reports results of two qualitative studies intended to explore the ways that GPs framed their ideas about depression and depressed people. The objective of the studies was to identify the ways in which medical and moral judgements about depression are woven together in primary care. We also intended to explore differences in experiences and attitudes of GPs practising in different environments.

Methods

Two study groups of GPs working in a conurbation in north-west England were recruited by letter in May 2000 (22 GPs) and May 2001 (13 GPs). Group one were practising in inner-city areas, and group two in suburban and semi-rural practices. The samples were purposive to ensure that the sample included single-handed GPs and GPs from a variety of sizes of practice. The response rate was 66% and 65% respectively. Subjects consented to take part in a single semi-structured interview lasting around 45 minutes. The questions focused on the presentation of mild to moderate depression in their practice, the diagnosis and management of depression in primary care, and the difficulties GPs may encounter in any of these areas.

Interviews were audio-taped with consent, and transcribed verbatim. Transcripts formed the material subject to formal 'constant comparative' qualitative analysis[16] in which thematic categories were identified in subjects' accounts. The themes were pursued on a developmental basis through the course of the study, with the interview schedules being modified in the light of the emerging themes. Interpretation and coding of qualitative data was undertaken by all authors: the transcripts were coded individually, then through discussion to achieve agreement on interpretation of the data.

Results

Our analysis focused on the ways that subjects conceptualized depression as an everyday problem of practice, rather than as an objective diagnostic category. Thematic coding of their accounts suggests a tension between three kinds of views of depressed people: (i) that depression is a common and normal response to life events and change, and that it reflects the medicalization of these conditions; (ii) that the diagnosis of depression offers a degree of secondary gain to *both* patients and doctors; and (iii) inner-city GPs experienced depressed people and consultations with them as an *interactional* problem.

Depression is a 'normal' response to life events

Subjects who practised in urban/inner-city areas (group one) framed their accounts of depression in relation to a variety of aetiological factors; they relied on notions of 'stress' following family breakdown, un- and underemployment, crime and poor housing as the principal causal factors of the syndrome labelled as depression. These explained both the epidemiology and the phenomenology of depression:

> "Here? We see loads. It's very common because of the area we work in. Because—you know—of the social factors, it's a deprived area. And that brings with it lots of stress, a lot of depression." [GP13 (group 1)]

There was nothing unexpected or surprising for doctors about the level of depression to be found in such circumstances. One subject put it very plainly, saying that "living in crap surroundings . . . is a potent cause of depression"[GP1 (1)]. The kinds of social networks and resources that might sustain sufferers in other contexts were non-existent for many of their patients:

> "Especially in an area like this, there is a lot of poor family support, lots of people who have very hard lives, a lot of loneliness. And yes, I think a lot of depression is circumstantial." [GP10 (1)]

If depression is conceptualized as a normal response to disadvantage, in which existential *despair* is the principal component, then the question of an appropriate diagnostic and management strategy could become as intractable as the illness itself for GPs in these environments.[17]

Respondents practising in more affluent, suburban and semi-rural areas (group 2), however, also conceptualized depression as a reaction to external factors:

> " . . . obviously you've got lots of different factors . . . often just life events, I suppose . . . maybe it's a death or job stress, or someone made redundant . . . there is lots and lots of pressure on people at work at the moment." [GP1 (group 2)]

The role of workplace 'stress' was alluded to in all interviews with GPs practising in suburban areas, and "occupational distress" [GP3 (2)] formed a significant theme in the interviews. It seemed to be of as much importance as socio-economic deprivation as a cause of depression in GPs working in the inner-city.

The potential for secondary gain?

The problem of the 'appropriateness' of diagnosing depression hinges on the extent to which it involves a gain of some kind for both patient and doctor. Subjects framed these needs in two ways. First, as an instance of patient 'demand', for example:

> "Society often generates this need for medical treatment of [its] problems. Patients actually a lot of the time want a medical answer, they want a quick fix, they want to have something done." [GP9 (1)]

This notion of patients actively seeing the medicalization of their personal problems was constructed either in terms of a social aetiology; patients' expectations and demands were derived from their knowledge that there *is* an illness called depression, that it is widespread, and that doctors are there to treat it.[18] But there was also a sense in which some subjects construed patients as seeking a more explicit personal gain.

> "What else is going on? That's the question that springs to mind. *Depression is the new back pain, you know.* I don't think people look hard enough at the secondary gains of illness. I think particularly now the government is willing us back towards full employment, the only way out of working for your living is to be ill." [GP17 (1)]

Similarly:

> "And you have to weed out the miserable ones, obviously, 'cos it's become common currency that misery is the same as depression." [GP19 (1)]

Whilst this theme of secondary gain may not be perceived as surprising when the GPs were working in deprived areas, those GPs from more affluent areas, also described this phenomenon:

> " . . . because [town] has got a lot of 20 and 30 somethings, quite affluent people who kind of say, I've got it all, I've got this job, I've got a beautiful wife, I've got a good car, but I just don't feel happy . . ." [GP1 (2)]

This kind of response is consistent with a position adopted by GPs towards other chronic problems, notably low back pain, and which we have discussed elsewhere.[19] But such explicit attributions of a manipulative relationship between reported symptoms and secondary gains were rare. More common was the notion that, "people feel conditions are being imposed upon them . . . and having a mental health problem is a way out of that" [GP13, (1)]. The 'gain' that this involves is a more conventional one, conceptualized in terms strongly reminiscent of the notion of a 'sick role'. It is important to note that the notion of 'gain' does not simply extend to the patient. Subjects also found a gain in applying the diagnosis of depression:

> "When we feel powerless to help the patient in any other way, or we can see that they have no other resources to turn to, then sometimes it is easy to read into the situation a diagnosis of depression." [GP6 (1)]

In this context, the 'gain' for the doctor is a diagnostic move that accommodates and acknowledges the reality of existential despair that is framed as a key component of depression by subjects. This gain also allows the GP to follow a pre-determined treatment plan:

> "With the good sides of anti-depressants, it helps us to stagger the consultations, being able to prescribe and review somebody 2 to 3 weeks later, and again 2 to 3 weeks later, is a good way of breaking up those consultations we don't have time for, it makes us feel good because it feels as if we are doing something, it makes us feel good because we know that the patient will improve if we have got the diagnosis right and they take the tablets." [GP2 (2)]

Applying a label of depression to the patient provides security to the GP in their work.[11]

Interactional difficulties with depressed people

Seligman[20] has described depression as "The common cold of psychopathology, at once familiar and mysterious". This reflects the fact that depression is the most common diagnosis designated in psychiatry and general practice, but also that the term 'depression' belongs to the technical vocabulary of the mental health professional and GP and also, like the common cold, to ordinary language.[21] The NSF[1] dictates that management for patients with depression must be located in primary care.

GPs commonly reported that, having made the diagnosis of depression, their preferential mode of treatment was unavailable:

> "We don't have sufficient resources available. Psychology is something that has a long, long waiting list . . . em, counselling we have had ready access to, but because of the changes, that's going to be diluted, back to the lowest common denominator, and that's a shame." [GP9 (2)]

GPs reported, therefore, that the limited resources available in both primary and secondary care forced them to prescribe anti-depressants rather than psychological therapies:

> "It takes forever to get patients to be seen. If you refer someone who is depressed it could take 4–6months before they get an appointment . . . Erm, nothing much happens when they get there, funnily enough . . . they change the antidepressant and see how they feel in a few months—well, I could have done that, you know." [GP9 (1)]

Those GPs working in more affluent areas (group 2) were more positive about the availability and likely success of 'talking therapies':

> "It's no point stuffing people full of antidepressants, when they are still left with the problem . . . sometimes it helps to have a counsellor who puts, kind of, strategies out and enables them to move on." [GP4 (2)]

It was, however, apparent that some patients in these areas accessed such care privately:

> ". . . it's very much a gold standard treatment, but you don't get that on the NHS." [GP5 (2)]

Previous work[22] suggests that GPs' emotional responses affect referral patterns in such patients. This study provides similar evidence:

> (reporting what a patient told him) . . . "I went to see a doctor a few years ago and sat down and said 'I'm depressed' and the doctor turned and said 'well, how do you think I'm feeling?'." [GP8 (2)]

Against this background, subjects stressed the importance of developing a therapeutic interaction in which they 'listened' to patients, and enabled them to talk. But they tempered this with the difficulties of accommodating such work within the practical exigencies of their workload:

> "The more you listen, the more people come and talk to you, and the longer your surgeries run over, and the more people complain because they can't get in to see you." [GP14 (1)]

Similarly:

> " . . . we don't have enough time for any patient in general practice . . . just does not lend itself to a 7½ minute appointment, and it's extremely difficult to manage any patient in that time." [GP2 (2)]

Respondents described a tension between the intractable nature of the patient and the wider demands of primary medical care. To begin with, these patients are constituted as highly demanding 'burdens' on the doctors' own psychological and professional resources:

> "You have to have the emotional energy and stability to manage patients with depression. But a lot of GPs are stressed and a lot have mild depression, and when you have that combination, it's extremely difficult to look after patients who have got a depressive illness." [GP2 (2)]

In this context, subjects found themselves often deeply frustrated and drained by their encounters with depressed patients:

> "I suppose that people that are on long-term antidepressants are not particularly attractive people. That sounds an awful thing to say, doesn't it? But they are people that you generally find difficult to deal with anyway—people that bore you and make you tired or whatever—so it's hard to maintain an interest." [GP4 (1)]

Some doctors recognized their own reluctance to recognize and respond to such patients in depth because of the much wider structural and social factors.[11] Many GPs working with a less deprived population were, however, more positive about the majority of people who they had diagnosed as depression as having the potential to improve:

> "A lot of the GP's workload can be very mundane, matter of fact and routine, dealing with depression is always a bit more challenging and interesting." [GP3 (2)]

> ". . . then 4, 5, 6 weeks down the road you suddenly see you've got a person in front of you and that's really great . . . they look so much better, and that's very rewarding." [GP7 (2)]

They similarly, however, alluded to a hard core of people who frustrated them by their apparent resistance to treatment and continued incapacity:

> ". . . and you feel the depression which just sort of surrounds you, when they go out you think 'Bloody hell, I'm depressed as well', and you know it's not you 'cos you were alright when you got up this morning." [GP3 (2)]

Subjects practising in inner-city areas were frustrated by the intractability and time-consuming nature of

depression in their practice. They emphasized structural factors and workload as factors that inhibited the potential for therapeutic interactions with such patients, but woven through accounts of the practical difficulties that they encountered in this work was the sense that, for these GPs, it was an unrewarding domain of clinical practice.

Conclusion

Depression is a complex psychological problem, not just in Britain but across the western world,[21,23,24] with a variety of factors influencing its aetiology and phenomenology.[3] The subjects in this study were GPs working in a variety of practices and geographical areas in north-west England, some characterized by poverty and deprivation, others by affluence and excess. All GPs perceived depression as a reaction to life events or change whichever end of the socio-economic spectrum the patient resided. Conventional clinical interventions were seen to be of limited effectiveness in those areas of socio-economic deprivation. As with other conditions, mental health need often translates into whether a problem can be managed with available technology, treatment and resources.[11] In British general practice, management resources may be limited to an assessment or labelling of what is wrong and the prescription of an antidepressant, particularly in inner-city practices where the limited financial resources of patients means they cannot access private talking treatments.

Increased socio-economic deprivation is associated with higher prevalence of psychological distress[25] and shorter consultations[26] which, in the UK, remain short by international standards (UK mean 8.4 minutes[27], compared with 15 minutes in Canada[28] and 21 minutes in Sweden.[29]

In this context, GPs in this study serving inner-city populations in the UK construed treating and managing depression as a source of frustration and found the ongoing management of depressed people a burden. Implicitly, they well understood that they were responding to despair made manifest in illness.[18,22] One interpretation of these accounts might be that they wove moral and medical categories together in ways that shifted attention away from their own inability to offer more than palliative care for many such patients, focusing instead on the difficulties that such patients pose for them.

This kind of account has an important implication for the construction of educational interventions around improving the recognition and treatment of depression in primary care in the UK: doctors working in inner cities may be reluctant to recognize and respond to such patients in depth because of much wider structural and social factors, as well as their own emotional responses. These negative attributions mean that GPs exhibit a pessimistic view of the possible outcomes of individual consultations. Without understanding the framework which underpins GPs' views on 'depression' as a problem presented to them, educational interventions directed at GPs will not improve patient outcome.

In addition, these results suggest that the inverse care law operates in the primary care management of patients with depression: simply offering more training to GPs will do little to address the needs of GPs working in socio-economically deprived areas.

Acknowledgements

We are grateful to the GPs who took part in this project for their time and candour. We thank Thomas Hogg for his helpful comments on this work.

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