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Managing Depression in General Practice in Pakistan: Do We Need to Re-Invent the Wheel?

Pages with reference to book, From 130 To 131

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Depressive illnesses constitute a major portion of workload of a family physician in the UK (16%)¹ and North America (23.5%)². Major depressive disorder has been found to be present in nearly 13% of patients aged over 15 attending general practitioners (GPs) for a new inception of illness³ Comparative data is not available for Pakistan. However⁴ two studies that looked into pathways to care in Rawalpindi and Lahore⁵ suggest that around 25% of patients seen in a psychiatric service are first seen by a primary health care physician. Other studies done at general practice level⁶ and a hospital based non-speciality clinic⁷ report a widely varying prevalence figure of 5.4-38.4% for anxiety and depressive syndromes. These syndromes, which form the bulk of psychiatric morbidity in general practice, had a prevalence figure of more than 30% in two recent community surveys, one in Chitral, a remote rural area in North Pakistan⁸ and the other in Azam Basti, a Katchi Abadi in Karachi (Unpublished data). Epidemiological studies from the UK and USA show that the prevalence of major depression in general population is around 5%^{9,10}. Extrapolation of this data would suggest that there are more than 42 million anxious and depressed patients amongst Pakistan's projected population of 140 million¹¹. At least 7 million of these suffer from major depressive disorder. This is further corroborated by the data on consumption of benzodiazepines and antidepressants in Pakistan. Approximately, 11 million units of benzodiazepine compounds and over 2 million units of antidepressants were dispensed in the year upto June 1996. Considering that many depressed patients are inappropriately treated with benzodiazepines, this suggests a large number of patients already recognized and being treated with medication. With the total number of psychiatrists estimated at 200, a vast majority of these patients inevitably will be seen and treated by the GPs. It is therefore, important that initiatives being taken to enhance GPs' skills to manage depressive illness must get maximum support.

In the UK, GPs and psychiatrists have developed considerable expertise in this area over the past 50 years. There are many lessons that can be learnt from their success. Firstly, 90% of the depressed patients are diagnosed and treated by a GP with only 10% being referred to a psychiatrist¹². This implies dissimilarities in the nature of clinical syndromes that present to these different groups of doctors. Secondly, processes have been developed which GPs can follow to identify depression and decide upon its management^{13,14}. Skills taught to GPs have been shown to be maintained overtime and to have an impact on satisfaction and outcome of patient care. However, two interventions, didactic lectures to GPs by psychiatrists and psychiatrists seeing patients in general practice, do not seem to improve this process, although they produce other kinds of benefits¹². Thirdly, a number of studies have shown that Research Diagnostic Criteria (RDC)¹⁵ are helpful in predicting outcome of treatment in primary health care setting. Patients respond to antidepressive medication, irrespective of any precipitating factor, when their symptoms fulfill criteria for RDC probable or definite major depressive episode. And lastly, a tricyclic dose of 150-175 mg daily, or equivalent, is needed for a favourable response to treatment¹². In a recent study set in 41 general practices in London¹⁶ benefits from amitriptyline followed a schedule of drug administration aimed at achieving an intake of 75 mg daily by the end of the first week, 100 mg daily for the second week and 125 mg or 175 mg daily, if judged clinically necessary for the last four weeks of the study. At four weeks, the mean daily dose was 119mg

and the median 125 mg. Other research work suggests that therapeutic doses of medication need to continue for at least 4 months¹⁷, preferably six months¹⁸ after recovery to avoid an early relapse. Attempts have been made to replace the need for GPs to have a high degree of sensitivity to cues of emotional disturbance by providing them with the results of screening questionnaires applied in the waiting room¹⁹. A number of validated screening instruments in Urdu language have become available over the past few years. These include the Hospital Anxiety and Depression Scale (HADS)²⁰, Bradford Somatic Inventory (BSI)²¹, Self Report Questionnaire (SRQ)²², the Aga Khan University Anxiety and Depression Scale (AKUADS) (Unpublished data) and the General Health Questionnaire (GHQ) 28-item version (Unpublished data). The AKUADS is particularly unique among these for having been based entirely on presenting complaints of indigenous patients in Urdu language. The use of screening instruments, which rely upon the presence or absence of a selection from a constellation of symptoms, reduces the problems of 'caseness' and supplies the GP with a response set of suitable questions to be triggered by a depression 'cue' in exactly the same manner as the cue word 'pain' triggers a response set in all medically-trained people. On the other hand, such screening instruments cannot replace the skills of a good physician. A good GP has sensitive 'antennae' for various problems he deals with and ought to have similar sensitivity towards depressive illness. The skill cannot be replaced by a questionnaire. The focus of GP training therefore, must be his skill to pick up and identify any available 'cue' to depression which may appear anywhere in a consultation. Once a cue has been identified, assessment is necessary to establish as soon as is feasible the probability of the patient suffering from a depressive illness. This entails not only exploring the sufferer's experience but also excluding, or identifying and treating, any of a range of physical conditions which may be linked to the depression. If a depressive illness is recognized, the GP needs to acknowledge it to the patient in a non-threatening manner which conveys some hope. This should be followed by an explanation of depression as a syndrome rather than a single symptom or normal mood which might be treated by the sufferer showing 'strong will power'. 'Only after this sequence has been implemented should management be decided upon. Perhaps because of its difficulty, depressive illness is among the most rewarding diagnoses which a GP can make. Much of general practice consists of conditions which are self-limiting, though acute, or conditions with an inevitable downhill progression towards chronic handicap and disability. The successful management of depressive disorder can produce relief which can be dramatic and rewarding because the patient's return to reasonable cognitive function and emotional drive allows the taking and implementation of decisions which can improve social performance as well as family and working life²³.

It is encouraging to note that a national group of psychiatrists has been active for past few years in developing training packages for GPs in Pakistan. In a recent meeting of this group (One Day Workshop of the National Group on Awareness and Prevention of Depression, 4th October, 1996) material for continued medical education has been delineated. It is hoped that these efforts will be guided by many useful lessons learnt elsewhere in the world. There is a strong need to involve GPs in this process and review the education material from their perspective. In time general practice will generate its own criteria and response set for diagnosing and managing depressive disorders. After all, even the RDC definition of major depression includes key symptoms such as changes in appetite and sleep and easy fatigability which can just as well be produced by organic disease as by affective disorder. Many GPs do a superb job in the diagnosis and treatment of depression. If all performed at the level of the most accurate, a large number of people would function better and more happily²⁴.

References

1. Dunn, G. and Skuse, D. The natural history of depression in general practice: Stochastic models. *Psychol. Med.* 1981 ;11:755-764.

2. Justin, R.G. Incidence of depression in one family physician's practice. *3. Fam. Pract.*, 1976;3:438-439.
3. Bridges, K. and Goldberg, D. Somatic presentation of depressive- illness in primary care. In the *Presentation of depression: Current approaches* (eds P Freeling, P., Downey, L.J. and Malkin, J.C.), London. Royal College of General Practitioners, 1987.
4. Gater, R., Sousa, B.D.E., Barrientos, G. et al. The pathways to psychiatric care: A cross-cultural study. *Psychol. Med.*, 1991 ;2 1:761-774.
5. Javed.M.A. and Karamat, S. The pathways of psychiatric care in Lahore, Pakistan. *Pak. J. Clin.Psychiatry.* 1995,5:18-24.
6. Akhund, E,Khan, ME, Mohsin, A. et al. Psychiatric disorders in general practice. *J. Pak. Med. Assoc.*, 1987;37:2.4.
7. Ali, B., Saud, M., Mohammad, S.N. et al. Psychiatric morbidity: Prevalence, associated factors and significance. *J.Pak. Med. Assoc.*, 1993;43:69-70.
8. Mumford, D.B., Nazir, M., Jilani, F et al. Stress and psychiatric disorder in the Hindu Kush. A community survey of mountain villages in Chitral, Pakistan.*Br. 3. Psychiatry*, 1996;168:299-307.
9. Bebbington. P.,Hurry, J., Tennant, C. et al. Epidemiology of mental disorders in Camberwell. *Psychol. Med.*, 1981; 11:561-579.
10. Weissman, M.M., Leaf, P.3., Tischler, G.L. et al. Affective disorders in five United States communities. *Psychol. Med.*, 1988; 18:141-153.
11. Britannica World Data, Pakistan, In *Britannica Book of the Year* (ed. Edwards, G.M.). Chicago, Encyclopaedia Britannica, 1996.
12. Paykel, E. S. and Priest, R.G. Recognition and management of depression in general practice: Consensus statement.*Br. Med. J.*, 1992;305:1198.202.
13. Goldberg, E., Smith, C., Steele, J.J. et al. Training family doctors to recognise psychiatric illness with increased accuracy. *Lancet*, 1980;ii:521 -523.
14. Burton, RH. and Freeing, P. How general practitioners manage depressive illness: Developing a method of audit. *3. R. Coil. Gen. Pract.*, 1982;32:558-561.
15. Spitzer, R.L., Endicott, J. and Robins, E. Research Diagnostic Criteria: Rationale and reliability. *Arch.Gen. Psychiatry*, 1978;35:773-782.
16. Hollyman, J.A., freeling, P., Paykel, E. S. et al. Double-blind placebo-controlled trial of amitriptyline among depressed patients in general practice. *3. R. Coil. Gen. Pract.*, 1988;38:393-397.
17. Prim, RE and Kupfer, D.J. continuation drug therapy for major depressive episodes: How long should it be maintained? *Am. J. Psychiatry*, 1986; 143:18-23.
18. Frank, E., Kupfer, D.J., James, M et al. Three-year outcomes for maintenance therapies in recurrent depression. *Arch. Gen. Psychiatry*, 1990;47: 1093-1099.
19. Johnston, A. and Goldberg, D. Psychiatric screening in general practice: A controlled trial. *Lancet*, 1978;i:605-608.
20. Mumford, D.B., Tareen, I.A.K., Bajwa, M.A.Z. et al. The translation and evaluation of an Urdu version of the Hospital anxiety and depression scale. *Acts Psychiatr. Scand.*, 1991 (a);83 :81-85.
21. Mumford, D.B., Bavington, J.T., Bhatnagar, KS. et al. The Bradford somatic inventory.*Br. 3. Psychiatry*, 1991;1 58:379- 386.
22. Minhas, F.A., Iqbai, K. and Mubasshar, MH. Validation of self rating questionnaire in primary care settings in Pakistan. *Pak. J. Clin. Psychiatry*, 1995;5 :60-64.
23. Freeling, P.R. and Tylee, A. Depression in general practice. In *Handbook of affective disorders* (ed E S Paykel). Edinburgh, Churchill Livingstone, 1992.
24. Freeing, P. Diagnosis and treatment of depression in general practice. *Br. 3. Psychiatry*, 1993;163(suppl. 20):14-19.