Variations in Approaching the Diagnosis of Depression: A Guided Focus Group Study

Patricia A. Carney, PhD; Lorna A. Rhodes, PhD; M. Scottie Eliassen, MS; Lee W. Badger, PhD; Elizabeth H. Rand, MD; Carolyn Neiswender, MSW; Mary Owen, MD; and Allen J. Dietrich, MD
Hanover, New Hampshire; Seattle, Washington; and Tuscaloosa, Alabama

BACKGROUND. Primary care physicians are often held to the same standard of performance as mental health specialists, yet they face special challenges in recognizing and treating depression. The purpose of this study was to explore the range of approaches to diagnose depression.

METHODS. A purposeful sample of 21 primary care physicians in three US cities participated. A semistructured series of questions and clinical cases stimulated discussions about recognizing and managing major and minor depression. The focus groups were videotaped, and data were analyzed by two independent reviewers using the classic method of content analysis.

RESULTS. Primary care providers have three major ways of approaching the diagnosis of depression: a biomedical exclusionary approach, where investigation of all physical complaints occurs first; a mental health approach, where psychosocial aspects of a presentation are pursued first; and a synergistic approach, where physical and mental health complaints are addressed simultaneously. Physicians move freely across all approaches depending on patient cues.

CONCLUSIONS. Physicians' approaches to depression vary depending on patient characteristics and cues. Through a better understanding of current practices, future researchers can identify the optimal clinical approaches to match the characteristics and cues of specific patients. This study informed the development of a larger objective study of primary care physician performance.

KEY WORDS. Family practice; primary health care; depressive disorders; diagnosis; mental disorders. *(J Fam Pract 1998; 46:73-82)*

Patients with depressive disorders are common in primary care practice, yet the disorder may go unrecognized or receive suboptimal management. Some authorities believe that 40% to 50% of patients with depression are not recognized in general medical settings.[1-4] Interventions intended to improve physicians' approaches to depression have included a screening and feedback approach, in which patients complete a questionnaire about depression to give the provider clues for recognition and to activate subsequent treatment.[5-11] The impact of these studies has been mixed.[3,11] The value of screening for mental health problems in primary care is likely to be as equivocal as it was 10 years ago.[12,13]

Goldberg[14] points out that depression in medical populations may be different from depression in mental health settings, yet studies in mental health populations typically set standards for recognition and treatment of depression in primary care. Recent studies on depression in primary care reveal that an interviewing style using affective questioning in the pursuit of certain symptoms in the patient presentation is more likely to result in recognition of depression.[15,16] Clearly, more studies are needed to understand the complicated factors that affect primary care physicians' current practices, including their comfort level and ability to identify and treat

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From the Department of Community and Family Medicine, Dartmouth Medical School, Hanover, New Hampshire (P.A.C., M.S.E., A.J.D.); the Department of Anthropology, University of Washington, Seattle (L.A.R.); the Department of Medicine, University of Washington, Seattle (M.O.); the School of Social Work, University of Alabama, Tuscaloosa (L.W.B., C.N.); and the Department of Psychiatry and Neurology, University of Alabama School of Medicine, Tuscaloosa (E.H.R.). Requests for reprints should be addressed to Patricia A. Carney, PhD, Dartmouth Medical School, 1 Medical Center Drive, HB 7920, Lebanon, NH 03756. E-mail:Patricia.Carney@dartmouth.edu

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TABLE 1

Two Patient Cases Used to Stimulate Dialogue About Physicians' Attitudes and Practice Patterns Toward Depression

Case Components	Case 1 Minor Depression	Case 2 Major Depression
Case presentation	• 26-year-old woman with tension headaches and irritable bowel syndrome	• 45-year-old man with difficulty concentrating and sleeping
Depressive symptom	• 10-lb weight gain • Hypersomnia (10 hours per night) • Anhedonia	• 10-lb weight loss • Insomnia with early morning awakening • Anhedonia • Impaired concentration • Depressed mood • Psychomotor retardation
Family history of mental illness	• None	• Hospitalization for depression (sister) • Possible suicide (father)
Stressful life events	• Recent divorce, job transition, and relocation	• Job transfer with poor performance review • Isolation from family (geographically separated due to job transition) • Marriage difficulties

depression. Through a better understanding of their current practices, we can describe how physicians currently alter their diagnostic approaches to typical patient presentations and develop interventions to improve recognition skills.

Here we describe our use of focus group methodology to explore physicians' attitudes toward depression and their self-reported practice patterns with the aim of providing a preliminary sense of their responses and concerns. The results and our discussion suggest a typology for understanding how depression relates to other diagnostic possibilities and how particular approaches to depression create specific dilemmas for the provider. We anticipated that through the focus group discussions, physicians would identify a variety of approaches to depression, which could then guide the development of more effective approaches to patient care.

METHODS

Focus groups were conducted in three US cities: Seattle (Washington), Tuscaloosa (Alabama), and Manchester (New Hampshire). Participants were identified by physician recruiters in each city. Each group constituted a purposeful sample that included a mix of both family physicians and internists, and male and female representatives. The target number of participants for each focus group was eight. The study was approved by the committees for the protection of human subjects at each authors' academic institution.

Two trained facilitators (MD or PhD) conducted each videotaped session. Two patient cases were used to apply a standardized "clinical" stimulus to generate dialogue about practice (Table 1). We anticipated that physicians would discuss illustrative patient examples from their own practices, and we wanted to begin the sessions by generating open responses to two typical patient cases to explore recognition and to some extent management of depression in primary care. Thus, case 1 was designed to address recognition using minor depressive symptoms with two comorbid conditions, and case 2 was designed to address management using major depressive symptoms with two somatic complaints. The cases were based in part on actual patients' histories and were reviewed by two independent psychiatrists and one primary care physician to ensure that they represented typical patient presentations.

Participants were instructed that the objective of the focus group was to explore clinical experiences and beliefs rather than come to any consensus. In Seattle and Manchester, the cases were presented first; in Tuscaloosa the semistructured interview was conducted first. For all sessions, case 1 was handed out first to participants. When appropriate, facilitators asked participants for clarification or probed to

explore relationships among concepts. As a group they could query the facilitator for additional history, much as a physician might interview an actual patient. Once case components reached saturation, a semistructured interview schedule was administered to explore general approaches to actual patients (Table 2). The time devoted to the discussion of cases and the semistructured series of questions was evenly balanced (45 minutes each). Total time for each focus group was approximately 90 minutes.

The videotapes of the focus group discussions were analyzed using the classic method of content analysis[16] with an emphasis on the discovery of dominant themes. Two authors (L.A.R. and P.A.C.), working independently, examined one session in detail using verbatim transcripts. Detailed field notes on conversations were taken on the second session. The emerging themes and typology were confirmed when the two reviewers compared their analyses. There was complete agreement on the dominant theme and on the typology between the two analysts. A draft typology was generated prior to the focus group in Manchester, and this was shared with participants at the end of that session to validate our preliminary findings. Identification of the other emerging themes was a compilation of independent and joint perspectives between the two analysts. Field notes and videotapes from the final session were analyzed using the same method as the first two sessions. This last analysis yielded confirmation and completion of the themes independently and jointly derived by the analysts. Analyses of the slightly differing formats (cases presented first compared with semistructured interviews first) did not alter the emerging themes. Examples presented here were taken directly from the transcripts or field notes derived from the videotapes made of all three focus groups; words in brackets have been added by the authors for clarification.

TABLE 2

Structured Questions for the Focus Group to Explore General Approaches to Actual Patients, with Thematic Summary of Results

Structured Questions	Emerging Themes
About Recognition	
1. What comes to mind when you think about diagnosing depression?	• Uncertainty of diagnosis; patient resistance
2. When diagnosing a patient's condition what makes you consider depression?	• Patient behavior and appearance; family history
a. Are there specific clues that you find most reliable?	• Depends on the patient
3. What makes you feel confident or not of the diagnosis of depression?	• Relationship with patient; patient's openness to diagnosis
4. What prevents you from pursuing depression as a possible diagnosis?	• Not knowing patient well; uncertainty of diagnosis
5. When diagnosing depression, would you attempt to distinguish between different depression?	• Depends on patient cues; depends on presenting of forms of symptoms
6. How do you approach the issue of suicide?	• Ask about family history; ask if patient feels like hurting himself
About Management	
1. When you are confident that the patient is depressed, how do you proceed?	• Depends on patient cues
a. What influences you to choose drug therapy?	• Previous experience
b. What influences you to choose psychotherapy?	• Possible suicide; drugs don't work
c. Are there other treatment options that you sometimes recommend?	• Relaxation; exercise
d. Do the patient's age or sex influence your approach?	• Depends on patient
2. What would make you refer the patient to a mental health professional for treatment?	• Patient is possibly suicidal; drugs do not work

RESULTS

Twenty-one physicians took part in the focus group sessions. Two physicians who were expected to attend the Alabama focus group never arrived and one did not attend the Seattle focus group. Table 3 outlines the participants' demographic and practice characteristics. Clinical experience ranged from 2 to more than 30 years. The majority of participants were in group practice (89%).

THE DOMINANT THEME: EXPLORATION

The dominant theme of our focus groups was exploration. Participants emphasized that

TABLE 3

Characteristics of Focus Group Participants

Characteristic	Location of Focus Group: Manchester, NH (n=8)	Seattle, WA (n=7)	Tuscaloosa, AL (n=6)
Age			
Range, years	35-70	28-75	40-65
Mean, years	47	46	52
Sex			
Men, %	62	29	83
Women, %	38	71	17
Specialty			
Family practice, %	75	14	64
Internal medicine, %	25	86	33

depression requires investigating, pursuing, uncovering, and probing. Participants used spatial metaphors suggesting that depression and other illnesses are "under" or "covered" by more superficial problems or by unintentional masking on the part of the patient. The goal for the physician is to explore until they find the "ultimate" symptom or clarify what is meant by the patient's words:

> If they come back and they're worse we need to escalate our concern and move out into wider pastures and look for things that are less superf . . . apparent.

This participant's self-correction, from "superficial" to "apparent," suggests that he recognized both that the initial problem turns out to be less important than it first seemed, and that his own prior perception is what needs to be corrected. Regardless, the "wider pastures" are beyond the ini-

TABLE 4

Three Approaches to Diagnosing Depression and the Factors that Determine Each Approach

Factors	Typology of Approaches: Biomedical Exclusionary	Focused Psychosocial	Synergistic
Physician index of suspicion	Most concerned with excluding all non-emotional causes of depression	Depression is real reason for visit, can be recognized immediately	Mutually complex relationship between depression and other illnesses
Investigative attitude	Depression may be real problem, but physical complaints require investigation first	Underlying physical problem may or may not emerge	Explore depression along with other symptoms
Belief about underlying cause of depression	Physical problem seen as possible cause	Social and psychological causation emphasized	Multicausal model
Physician's aim in treatment	Concern about complete, thorough testing	Concern about using time optimally, and not wasting money	Concern about making patient feel better quickly
Confidence with diagnosis	Any underlying depression will emerge if trust is established	Patient needs to recognize depression	Patient needs to recognize depression along with other problems
Use of medication	Medication given later, if depression an issue	Medication for depression given first	Medication for depression given along with other treatments

tial impression.

Another physician's phrasing of the issue of "exploration" points to an important related theme: The patient often contributes to the difficulty in making a depression diagnosis, either consciously or subconsciously.

> I think the bowel situation is just a smoke screen for something else . . . [later in the same discussion] The bowel business isn't as bad as it's cracked up to be. . . .

Conscious or unconscious masking by the patient can occur in any aspect of the presentation, including the purely affective:

> This lady . . . it took more discussion, it began to dawn on me, she fooled me because she had a smile on her face.

> Some [patients] invest all their energy to make sure [they look] OK, but [it] may be a mask, a mask that hides the difficulties.

A Typology of Approaches to Depression

Our sessions suggest that participants approach depression in three different ways: two require specific modes of uncovering and the third is a composite position that also assumes a gradual clarification of the depressive disorder (Table 4). When the results from the first two sessions were presented to the third focus group, there was overwhelming agreement with both the typology and the analysis of dilemmas related to the treatment of depression. This typology describes ways of thinking and speaking about depression but does not necessarily differentiate individuals or groups of physicians. A particular physician might approach depression in all three of the following ways:

Biomedical Exclusionary Approach. Depression here is assumed to lie "under" possible physicalproblems and can only be uncovered by specifically testing for or pursuing these problems.

A dominant concern that emerged repeatedly was the need to rule out "physical" or "organic" causes of the presenting symptoms. Participants responded to both patient cases by asking questions about the patients' physical condition, and many described their initial reaction in terms of the tests and questions necessary to gather information about or rule out serious disease.

> Her colon is going to need a consult. If she continues to have headaches [after taking simple headache medication] I would think about getting a CT scan.

> I'd be concerned about his liver function, alcohol use. First we have to assure we don't see a medical diagnosis, [we] collect information and data.

A number of participants expressed anxiety about missing something, to which other members of the session responded with empathy and agreement.

> I think organic disease is always in everyone's mind . . . [talks about how, in the absence of physical findings the problem may appear to be psychological, but despite this reasoning] he turns out to have cancer!

One person clearly stated the nature of such anxiety:

> If you miss a circumstance such as a thyroid condition, or anemia, or diabetes, liver cancer, pancreatic cancer (a major situation there, difficult to diagnose) these are things you have to show that you have engaged in a systematic [investigative] process, you have not just had tunnel vision even if you [do] have tunnel vision.

Participants also mentioned that many patients expect a physical diagnosis and that only a physical treatment will ensure that the patient comes back for a second visit.

When participants discussed the cases with this emphasis on "real," "medical," "organic" or "physical" disease (all terms they used with some hesitation), they described a diagnosis of depression coming after all other possibilities have been explored.

> I'm not sure there's a good way to diagnose depression. We sort of run out of ideas and say, maybe it's depression.

In this case, the exploration involves the assumption that the apparent organic problems cover or conceal the underlying depression, which is the ultimate symptom.

> You recognize the fact that organic disease can mask . . . this [depression] can masquerade as organic disease.

> You do these things [tests, etc] to solidify your think-

ing just the way you [would] if you have a person with pneumonia.

Focused Psychosocial Approach. In this approach, depression is assumed to be the most immediate and apparent problem; other physical symptoms may become clear after the depression has been treated. Some other problem may be the ultimate symptom, or depression could be the only correct diagnosis.

Although this perspective is similar to the first, it can be more complex. In the simplest version, depression is the first and obvious symptom, which probably does not reflect underlying physical disease.

> [There's] no specific focus for his pain, I wouldn't have to wait for too much to initiate treatment. There are very safe drugs out there [for depression].

Participants taking this approach mentioned the waste involved in futile pursuit of physical causes.

> [The patient] comes in and could go on for years and years and receive no attention for this [depression], could have an MRI, million dollar workups.

> I like to start fairly early [with treatment for depression] because after being waylaid for several years, working people up, it gets to be really complicated and expensive. . . .

The complication here is that, although depression may be the most obvious diagnosis, and may lie on top of a physical disease, it may need exploration to emerge clearly. The exploration may be to assess the patient's resistance to psychological probing or to a final diagnosis. Exploration may also help patients recognize that somatic symptoms may be psychological.

> Very few people come in and say "I'm sad," or "I'm depressed."

> There's people who just react. They need relief. . . we're looking at getting to those things that brought them there to begin with, chronic things they've not been able to cope with.

> [We] need to get to underlying issues [psychological issues], not just pile on diagnostic procedures.

Some participants stressed that the exploration required to reveal depression needed to be approached carefully, and several mentioned the reality of patients' concerns.

> When we say somatize, it sounds pejorative — "I can't cope so I'll just somatize" — but you begin to wonder if these people aren't just glued together differently.

> You can start from the body and say [to the patient], your body is telling you these things; I would not be hesitant to prescribe [antidepressant] medication on the first visit.

> Some people, you can't tell when they walk in cause they're gonna mask that [depression], and I think you have to probe a lot, you really have to dig for it.

In general, when participants talked about this perspective they spoke of themselves as already knowing or suspecting that the patient is depressed, but having to explore further to be sure of their diagnosis, and to gather enough evidence to persuade the patient of it. They mentioned that patients fear the potential stigma associated with a psychological diagnosis and they discussed various ways to approach the subject with the patient. Several people said that they use brief questionnaires to help them, and their patients, see the psychological nature or true dimensions of the problem.

Synergistic Approach. Here depression and physical problems are considered synergistically, pursued and treated simultaneously. Participants spoke of the necessity to explore patients' responses to the possibility of a diagnosis of depression, while they attempt to treat depression and other illnesses at the same time. When speaking from this perspective, participants emphasized depression as a part of other illnesses, and other illnesses as markers of depression.

> There are people who have heart attacks, and they're depressed.

> A lot of the time these [real cases] are not isolated cases presenting like this [that is, in a clear-cut way like the examples], they [symptoms of depression] have to be kind of jumped on along with other things.

> I have a patient-centered approach — depression plays

> a role in a large number of illnesses, usually I see it as a concomitant problem in a lot of my patients — they may be acutely ill, chronically ill, but we only have one term for it, depression. In primary practice it's all depression. . . .

This physician went on to say that this is what distinguishes his experience from a "DSM [*Diagnostic and Statistical Manual*] approach," depression is "one of the physiological disturbances" to be expected in any illness. Here is another participant describing a synergistic approach:

> This [discussion so far] is either/or. I work in the model that it's all together. I sort of gather the psychological information at the same time as the physical. I think it [depression] has a metabolic origin as well, but I gather the psychosocial as I gather the medical. [The patient] has symptoms that fit major depression that need to be addressed; at the same time, there is something else going on. It's a problem to say either medical or depressed, it doesn't work.

From this perspective, attending to and treating obvious symptoms has the potential to build the patient's trust; trust, in turn, leads to the revelation of symptoms at a deeper level.

> They are reluctant to admit it [depression]. Once you begin to earn their trust, you find out what they are really feeling.

The synergistic approach seems most connected to participants' desire to see a larger picture in which depression is symptomatic of either severe illness or serious social problems.

> Depression [is the condition we diagnose in] normal people with overwhelming problems. It's mostly reactive, social.

> They have good reason to be depressed, families are falling apart, or they've been divorced. . . or they've got diabetes or high blood pressure, they're living with multiple stressors without any hope they can get out from under them and depression is on that list as well.

Other Important Themes

Three additional themes emerged that affected the physicians' approaches in diagnosing depression. These were illustrated especially in response to the structured series of questions outlined in Table 2. They are medication, the patient-driven nature of the diagnosis, and referrals to psychiatry or psychotherapy.

Medication. Participants spoke of the effect the new medications for depression (antidepressants) had on their willingness to diagnose depression because of the availability of treatment. The availability of antidepressants also affects the physicians' ability to diagnose depression because a patient's improvement on medication can confirm a suspicion of depression. Thus:

> The model of a biological basis has advanced; it's [now] more analogous to treating an infection.

> The thing I can thank the drug companies for is that now there are drugs that, once I can identify [depression], and they can accept it, I can help them to feel better.

Some participants spoke of the need to make the patient feel better quickly and the role of antidepressants have in doing this.

> You have to try it. If the patient's not feeling good and there's that possibility [of depression], you have to bark up that tree to see if you make them feel any better.

> One of the nice things about primary care these days [medication] is one of the things you can make people feel better with. Steroid injections make people better, getting diabetes under control makes people feel better, getting depressed people happier makes them feel better and the only reward in primary care is not filling out the forms. . . but making people feel better.

Some physicians marveled at the medication-driven aspect of the diagnoses and their ability to change patients' feelings about themselves with medication. On this theme, participants differed by age; the younger doctors expressed willingness to use medicine early in treatment, while some older physicians indicated that they do not think of antidepressants as an initial treatment.

The Patient-Driven Nature of the Diagnosis. Several group discussions indicated a belief that the patient's attitude drives the likelihood and timing of communication about a diagnosis of depression.

> It's hard to convince people they are depressed.

Participants spoke of using questionnaires, multiple visits, and symptom journals to get patients to realize they are depressed. This also allowed the relationship to develop until physicians felt comfortable addressing the topic. One doctor described depression as a "destination" at which you could arrive in various ways depending on the reactions of the patient.

Referral to Psychiatry or Psychotherapy. Participants agreed that they would refer any patient who is suicidal or for whom the antidepressants were not working to a psychiatrist. Except in such cases, they expressed mixed views about referrals. Some questioned the value of therapy, or pointed out that their patients might feel demeaned or stigmatized by a referral. Many expressed confidence in their ability to deal with simple depression and depression co-occurring with other diseases.

DISCUSSION

Our findings suggest that primary care physicians use three different approaches for patients who may be depressed: a biomedical exclusionary approach, a focused psychosocial approach, or a synergistic approach. These findings have at least two important implications.

First, these findings make explicit the challenge of dealing with undifferentiated complaints in primary care. When a cardiologist sees a patient, some differentiation of the presenting chief complaint has already occurred: Either the patient or a referring physician has determined that the problem concerns the cardiovascular system. Similarly, psychiatrists typically see patients for mental health problems. This differentiation may not always prove to be accurate, but a direction and an agenda for the physician-patient interaction has been set.

Primary care physicians, on the other hand, typically see patients for whom the chief complaint has not been sorted by organ system, diagnosis, or by a likely therapeutic approach. The different approaches characterized by focus group participants demonstrate the complexity of addressing undifferentiated complaints. Identification of these approaches provides insight into the difficulties faced by primary care providers in recognizing depression. Clearly, it is inappropriate to hold primary care physicians to the gold standard of an exhaustive psychiatric interview when asked to address chief complaints such as fatigue or backache in a 15-minute visit.

Second, the identification of the three different approaches will allow further studies to explore when each of these strategies is most useful, depending on patients' presenting symptoms and their individual characteristics. Also, these findings will allow the development of tools to make each of these strategies more efficient. Although physicians will move freely among the approaches, perhaps those who find themselves typically taking the biomedical exclusionary approach to patients complaining of fatigue would do well to use a depression screening instrument in addition to ordering thyroid function tests at the first visit.

By examining the theme of exploration, we discovered that physicians' attitudes and their motives for their investigative approach change depending on the patients' physical and mental health complaints. Other factors that affect physicians' approaches include beliefs about the underlying causes of depression, the physicians' aims in treatment, confidence in their diagnoses, and comfort with use of medications (Table 2). Our findings support those of Susman et al[18] who discovered in a qualitative study of six family physicians that depression is easily recognizable, but difficult to diagnose because of uncertainty about perceived stigma, desire to preserve the physician-patient relationship, and lack of supporting resources, as well as time and financial pressures. Interventions to address these issues must include education for both patients and physicians and flexibility to embrace situational factors.

Some physicians in our groups leaned toward one approach or another, but in general all of them recognized and could speak from all of the approaches. In telling us that their diagnoses are patient-driven, they may, in part, be telling us that complex situational factors push them toward one or another approach. Highly pragmatic and practice-oriented, they pick the approach that works at the moment. There was no point in any of our discussions at which a response was greeted with confusion or even surprise by another participant, suggesting a great deal of agreement about the basic features of the approaches as outlined.

We also noted a lack of categorizing in how physicians speak about depression. We found that they did not often speak of DSM criteria and they seem to resist the categorization of their approaches. There

was overall agreement that case 2 was an example of a more severe depression than case 1. In addition, descriptions such as "dysthymic disorder" or "atypical depression" were rarely used, and there appeared to be no specific changes to the typology based on the severity of symptoms. We also noted that even when all the symptoms and issues were brought forth during the focus group sessions, no single approach dominated the discussion. Additional research would need to be conducted to specifically identify how the severity of symptoms might alter the approach.

The focus group study has generated several interesting questions, including: how these approaches differ with experience or training; which approaches are more effective or efficient; how the presenting complaint drives the approach; and what specific factors in the doctor-patient relationship lead to better patient outcomes? We are currently conducting a study using unannounced standardized patients (lay individuals trained to replicate a clinical encounter for purposes of evaluation) whose case presentations are based on the cases used in this focus group study. The standardized patient methodology will allow us to control the patient characteristics while exploring physicians' approaches. We believe this follow-up study will identify more successful interventions to enhance physicians' approaches to the recognition and management of depression.

Finally, we would like to point out the strengths and weaknesses of our methodology. Qualitative methods are increasingly popular in primary care research.[19-21] They allow for the gathering and understanding of data that are not easily obtained through highly structured methods. Often the data are too preliminary for hypothesis testing and thus more appropriate for hypothesis generation. We found focus groups to be an efficient way to gather information on the attitudes of moderate numbers of people and to bring different perspectives into our analysis.[22] This suited our purpose by revealing those aspects of diagnosis most likely to emerge within a group of peers. An advantage specific to our study is that the geographic spread of our groups suggests similarities in provider attitudes in different parts of the United States.

Despite the strengths of focus group methodologies, limitations do exist. Focus groups do not allow for comparison among individuals' attitudes, since attitudes might be influenced by the focus group process, nor do they necessarily represent the full range and complexity of the participants' opinions[23]. In addition, although our study involved an analysis of physicians' perspectives, we do not intend to imply that patients are passive in the process of recognizing and managing depression. Indeed, we feel that an effective treatment of depression must be a collaborative process between physicians and patients. Our findings are intended to assist this process by increasing physicians' understanding of how their approaches to patients may vary. Geographic differences may also have effected attitudes and this variable is impossible to detect from our limited sample. We also acknowledge that participants may have been influenced by social desirability generated either by the group dynamics or by the focus group questions themselves.

Should this study lead physicians to change their current practice patterns? The physicians in these focus groups currently choose their approach to recognizing depression intuitively. While this may work well most of the time, we believe that the identification of these three typical approaches can aid physicians in making explicit choices, which may be useful in increasing the efficiency of care, especially for patients with nonspecific complaints who are not progressing well. While future research will clarify the optimum match between patient presentation and recognition strategy, practicing family physicians can add the knowledge gained in this study to their diagnostic tools.

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REFERENCES

1. Perez-Stable E, Miranda J.Munoz RF, Ying YW, et al. Depression in medical outpatients: under recognition and misdiagnosis. Arch Intern Med 1990; 150:1083-88.
2. Katon W, Sullivan MD. Depression and chronic medical illness. J Clin Psychiatry 1990:12:3-14.
3. Gonzales JJ, Magruder KM, Keith SJ. Mental disorders in primary care services: an update. Public Health Rep 1994;109:251-8.
4. Simon GE, Vonkorff M. Recognition, management and outcomes of depression in primary care. Arch Fam Med 1995; 4:99-105.
5. Hoeper EW, Nycz GR, Kessler LG, et al. The usefullness of screening for mental illness. Lancet 1984; 1:33-5.
6. German PS, Shapiro S, Skinner EA, et al. Detection and management of mental health problems of older patients by primary care providers. JAMA 1987; 257:489-93.

7. Linn LS, Yager J. The effect of screening, sensitization, and feedback on notations of depression. J Med Educ 1980; 55:942-9.
8. Magill M, Zung W. Clinical decisions about diagnosis and treatment for depression identified by screening. J Fam Pract 1982; 14:1144-9.
9. Magruder-Habib K, Zung WW, Feussner JR. Improving physicians' recognition and treatment of depression in general medical care: results from a randomized clinical trial. Med Care 1990; 28:239-50.
10. Ford DE, Kamerow DB. Screening for psychiatric and substance abuse disorders in clinical practice. 1990; 5(Suppl 5):S37-S41.
11. Brown C, Schulberg HC. The efficacy of psychosocial treatments in primary care: a review of randomized clinical trials. Gen Hosp Psychiatry 1995; 17:414-24.
12. Kamerow DB. Is screening for mental health problems worthwhile in family practice? An affirmative view. J Fam Pract 1987; 25:181-4.
13. Campbell, TL. Is screening for mental health problems worthwhile in family practice? An opposing view. J Fam Pract 1987; 25:184-7.
14. Goldberg RJ. Depression in medical patients. RI Med 1993; 76:391-6.
15. Badger LW, deGruy FV, Hartman J, et al. Psychosocial interest, medical interviews and the recognition of depression. Arch Fam Med 1994; 3:899-907.
16. Badger LW, deGruy FV, Hartman J, et al. Patient presentation, interview content and the detection of depression by primary care physicians. Psychosom Med 1994; 56:128-35.
17. Berelson BR. Content Analysis. In: Lindsey G, ed. Handbook of social psychology. Vol. 1. Redding, Mass: Addison-Wesley; 1954. 448-522.
18. Susman JL, Crabtree BF, Essink G. Depression in rural family practice: easy to recognize, difficult to diagnose. Arch Fam Med 1995; 4:427-31.
19. Miller WL, Crabtree BF. Qualitative analysis: how to begin making sense. Fam Pract Res J 1994; 14:289-97.
20. Miller WL, Crabtree BF, Yanoshik MK. Expanding the boundaries of family medicine research [editorial]. Fam Med 1991; 23:425-6.
21. Crabtree BF, Miller WL. A qualitative approach to primary care research: the long interview. Fam Med 1991; 23:145-51.
22. Morgan D. Focus groups as qualitative research. New York, NY: Sage; 1988. 16-58.
23. Carey MA. The group effect in focus groups: planning, implementing, and interpreting focus group research. In: Morse JM, ed. Critical issues in qualitative research methods. New York, NY: Sage; 1993. 225-241.