

Gender differences in depression in primary care

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OBJECTIVES: To determine gender differences in the frequency and manifestation of depression in primary care.

STUDY DESIGN: PRIME-MD[®], a new assessment tool, was tested in 1000 patients as an aid to diagnose depression in primary care patients. Answers to a self-assessment questionnaire completed by patients determined whether physicians administered the mood module in the Clinician Evaluation Guide to diagnose depression. Functional status was assessed with the Medical Outcomes Study Short Form (SF-20).

RESULTS: More women than men were diagnosed as having a mood disorder (31% vs 19%; $p < 0.01$), and an antidepressant was newly prescribed only for women ($p < 0.001$). There were no gender differences in physician ratings of patients' health, but women rated their health significantly more poorly than did men. Similarly, functional impairment scores were significantly lower in women than in men.

CONCLUSIONS: Women are much more likely than men to have depressive disorders, and when these disorders are diagnosed, to receive a prescription for antidepressant medication. Further research is needed to determine why women seem to suffer disproportionately from symptoms of depression and signs of functional impairment. (AM J OBSTET GYNECOL 1995;173:654-9.)

Key words: Depression, gender differences, mood disorder, PRIME-MD, treatment, women

Numerous studies have shed light on the biologic, social, and psychological differences between men and women. However, little research has focused on the characteristics and needs of women. A separate focus is necessary because the expression and treatment of mental disorders in women can be affected by the reproductive cycle, pregnancy, menopause, infertility, and current as well as past sexual history. Decreased libido and sexual dysfunction have been associated with depression.¹ Depression also forms a part of both the immediate and long-term sequelae of symptoms associated with sexual assault^{2, 3} and childhood sexual abuse.⁴ Often depression and other emotional problems manifest as physical disorders such as chronic pelvic pain,⁵⁻⁷ and the inclusion of antidepressant therapy in the treatment regimen of such women has been recommended.⁸

Depression is the most common mental disorder found in patients seeking care from primary care physicians. Studies estimate that up to 20% of primary care outpatients have clinically significant depression.⁹⁻¹³ In fact most patients with depression are treated in the primary care setting rather than in the mental health sector.¹⁴⁻¹⁶ However, a number of studies have shown that primary care physicians in office settings fail to recognize at least 50% and perhaps as many as 75% of patients in their practices who suffer from a mental disorder.¹⁷⁻²¹ Because the obstetrician/gynecologist is the primary care physician for a large proportion of women, many gynecologic patients may have unrecognized depression. This can result in extensive patient suffering and increased health care costs.

Several obstacles to the recognition of mental disorders by primary care physicians have been identified. Patients who seek care from a primary care physician commonly complain of physical but not emotional symptoms. For example, a patient with major depression may complain of insomnia, anorexia, and fatigue, but she may not identify what she is feeling as depression. Therefore the physician must identify the mental disorder. Patients may also be reluctant to admit emotional or psychological problems because of the social stigma that unfortunately is still associated with mental disorders. Many primary care physicians are not familiar with the diagnostic criteria specified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.²² Those familiar with the criteria may not know the best questions to ask to determine

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whether the symptoms experienced by the patient meet the diagnostic criteria. Finally, time constraints may interfere with inquiry about depressive symptoms in a busy primary care setting.

Development and description of PRIME-MD

In recognition of these problems, we developed PRIME-MD (Primary Care Evaluation of Mental Disorders) to help primary care physicians screen their patients, evaluate their symptoms, and diagnose their mental disorders. PRIME-MD was developed based on many years of experience with the DSM-III,²³ DSM-III-R,²⁴ and DSM-IV,²² as well as numerous diagnostic interview guides that are used by mental health professionals. PRIME-MD was designed to meet the specific needs of primary care physicians by combining brevity and efficiency with accuracy.

An executive committee consisting of the two senior authors (J. Williams and R. Spitzer) and five primary care physicians developed PRIME-MD. Four of the primary care physicians (M. Linzer, F. deGruy, S. Hahn, and K. Kroenke) headed a clinical test site in a field trial of 1000 primary care patients. The average amount of time to apply the PRIME-MD system in the field trial was approximately 8½ minutes, indicating that the system could be integrated into a busy office practice. A detailed description of PRIME-MD and its initial field trial has been published elsewhere.²⁵ A brief review of the PRIME-MD system is presented in this article, which focuses on the results of the field test of the PRIME-MD mood module and gender differences in mood disorders.

PRIME-MD system. There are two principal parts to the PRIME-MD system, which are explained in an instruction manual included in the system: a patient questionnaire (PQ) and a clinician evaluation guide (CEG). The PRIME-MD system is designed to be flexible; that is, physicians may use it with all patients or only with those suspected of having a mental disorder. The CEG can be used in its entirety, or evaluations may be restricted to specific disease modules that are most relevant to a particular patient.

The PQ is a single-page, easy-to-complete self-assessment questionnaire that is filled in by the patient in the waiting room before seeing the physician. The PQ includes 26 yes/no questions about symptoms and signs present during the past month, one question related to overall general health, and basic demographic questions. The 26 yes/no questions are divided into five diagnostic areas that represent the mental disorders most commonly encountered in primary care: mood, anxiety, alcohol, eating, and somatoform disorders. The answers to the questions in the PQ determine which if any of the modules in the CEG should be administered by the primary care physician for further evaluation and to make a diagnosis.

Table I. Disorders in the mood module of PRIME-MD

<ul style="list-style-type: none">• Major depressive disorder• Partial remission or recurrence of major depressive disorder• Dysthymia• Minor depressive disorder• Rule out bipolar disorder• Possible secondary depressive disorder caused by physical disorder, medication, or other drug
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The CEG presents standardized questions to encourage a brief and focused interview. These questions are arranged according to an algorithmic model that facilitates differential diagnosis. The model involves the use of broad questions at the beginning of most sections to screen for major areas of psychopathology; if no symptoms are present, the physician is instructed to skip that section. At the end of the CEG is a summary sheet for the physician to check any diagnoses that were made during the evaluation. The CEG summary sheet and PQ may be placed in the patient's chart.

If during the administration of the CEG the patient becomes upset or gives an answer that requires a response, the physician should stop and respond to the patient's distress. For example, the patient may express extreme guilt feelings, necessitating some response on the part of the physician during the interview. The physician might respond by saying, "That must be a terrible feeling. Tell me about it." This allows the physician to empathize with the patient's distress and gives the patient an opportunity to elaborate on it.

Mood module. Two questions on the PQ serve to screen for the presence of depression. They ask the patient to indicate if, in the past month, he or she has often been bothered by "little interest or pleasure in doing things" or "feeling down, depressed, or hopeless." If the response to either is yes, the physician administers the mood module from the CEG.

Table I lists the disorders that are included in the mood module of PRIME-MD. A *major depressive disorder* requires depressed mood or loss of interest or pleasure nearly every day during the past 2 weeks in conjunction with at least four other characteristic symptoms of depression. A diagnosis of *partial remission of a major depressive disorder* requires patients to have had some symptoms of depression during the past month but not the five symptoms necessary for a diagnosis of a major depressive disorder; such patients probably had an episode in the past that did meet the full diagnostic criteria for a major depressive disorder.

A diagnosis of *dysthymia* requires depressed mood for at least 2 years that has interfered with work or social functioning more days than not. *Minor depressive disorder*, which is not an official DSM-IV diagnosis, is a useful concept in primary care because it is associated with

considerable functional impairment. This disorder requires a 2-week period with depressed mood or loss of interest or pleasure with only two of the characteristic symptoms of major depressive disorder.

There is a single question in the mood module to help rule out a diagnosis of *bipolar disorder*. A full evaluation of bipolar disorder is not included in PRIME-MD, because most patients with bipolar disorder who are evaluated in primary care settings have been diagnosed and are being treated by mental health professionals. Therefore the CEG merely suggests that primary care physicians ask patients if they have been told that they were "manic-depressive" or have been treated with lithium. Finally, there is a category for diagnosis of *secondary depression* that is due to the biologic effects of a physical disorder, medication, or other drug. Although this may not always be clear-cut, it is useful for physicians to be able to indicate such conditions because of their treatment implications.

Methods

The PRIME-MD system was tested in 1000 primary care patients by 25 primary care physicians at four sites. The main objectives of this field test were to assess the frequencies of the PRIME-MD diagnoses and to test the validity of the PRIME-MD system. The functional level in patients with a PRIME-MD diagnosis was assessed with the Medical Outcomes Study Short Form (SF-20)^{26, 27} and compared with the functional level in patients without the diagnosis. Patient and physician perceptions of the patient's health were compared, and the results of PRIME-MD evaluations were compared with those of mental health professionals who conducted independent telephone interviews with participating patients.

The PRIME-MD 1000 Study provided an opportunity to examine gender differences in depression among primary care patients and the relative characteristics of female primary care patients with depression. The current study asked the following questions: Are there gender differences in the frequencies of mood disorders among primary care patients? Are there gender differences in symptoms among patients with a mood disorder? Are there gender differences in functional impairment, health status, and health care use? If there are gender differences, what are their possible determinants?

Results

The overall results of the PRIME-MD 1000 Study are reported elsewhere.²⁵ The study population was 57% white, 30% black, and 8% Hispanic. Sixty percent of patients in the study were women (67% among black or Hispanic patients compared with 54% among white patients). There was no significant difference in age between men and women (average age, 55 years), but men had a significantly higher level of education (39%

of men were college graduates versus 20% of women). Overall, 26% of patients had one or more PRIME-MD diagnoses; another 13% had a subthreshold or probable diagnosis (such as partial remission of major depressive disorder or probable alcohol abuse/dependence). A diagnosis of any mood disorder (including the subthreshold diagnosis of major depression) was made in 26% (249) of patients. In comparison, 18% of patients had an anxiety disorder, 14% a somatoform disorder, 5% alcohol abuse/dependence, and 3% an eating disorder. It should be noted that some patients had diagnoses in more than one diagnostic module.

Women were more likely than men to be diagnosed as having a mood disorder. Of the total population, 31% of women and 19% of men had a mood disorder (odds ratio = 1.9, $p < 0.01$). A major depressive disorder was diagnosed in 15% of women and 6% of men (odds ratio = 2.6, $p < 0.01$), and 11% of women and 4% of men had dysthymia (odds ratio = 3.0, $p < 0.01$). Gender differences remained significant after adjustment for other demographic and health variables (age, minority status, level of education, and number of types of physical disorders). These findings replicate those of a recent large World Health Organization field trial, which found that women were twice as likely as men to have a diagnosis of depression.²⁸

The frequencies of the nine symptoms that constitute the diagnostic criteria for major depressive disorder were compared between men and women. Two symptoms were endorsed significantly more frequently by depressed women than men: poor appetite or overeating, 43% versus 29% ($p < 0.01$, χ^2 with Yates' correction); and feeling bad about oneself/failure/having let oneself or family down, 40% versus 22% ($p < 0.01$, χ^2 with Yates' correction).

The PRIME-MD 1000 Study found no significant differences between depressed women and men in the numbers of visits to a physician within the past 3 months. However, depressed women reported significantly more visits to emergency rooms in the past 3 months ($p < 0.05$); this difference remained significant after adjustment for other demographic variables but not when the means were adjusted for the number of mental disorders. Although there was a large difference between depressed men and women in the reported number of days of not feeling well that interfered with usual activities, the difference was accounted for by demographic variables.

Patients in the study completed three self-report symptom severity scales: the Zung Depression Scale,²⁹ the Zung Anxiety Scale,³⁰ and the Somatic Symptom Inventory.³¹ As Table II illustrates, women reported higher rates of symptoms than men on all scales. Although the differences were not large clinically, they were statistically significant. However, all of the differences were attenuated by the difference in the number

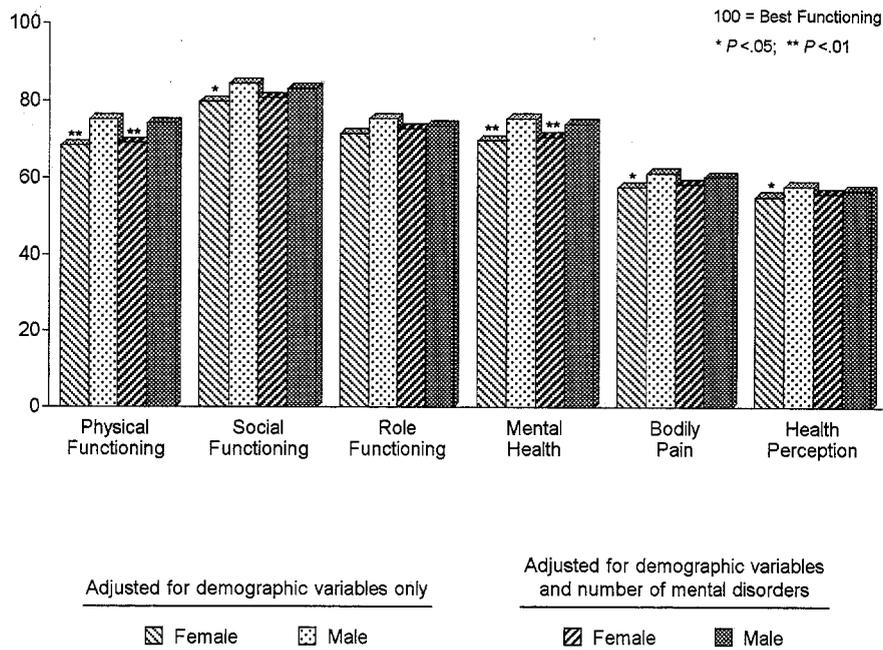


Fig. 1. Summary of results from the Medical Outcomes Study Short Form (SF-20) completed by PRIME-MD subjects. Statistically significant gender differences were found for physical functioning and mental health subscales after adjusting for demographics and number of mental disorders.

Table II. Gender differences in symptom severity scale ratings for 249 depressed patients in the PRIME-MD 1000 Study

	Rating		Gender differences (p value)		
			Unadjusted value	Adjusted for	
	Women	Men		Demographics	Mental disorders
Zung Depression Scale*	37.1	34.0	<0.001	<0.01	<0.05
Zung Anxiety Scale†	35.4	32.2	<0.001	<0.001	<0.01
Somatic Symptom Inventory‡	23.2	21.1	<0.001	<0.001	NS

NS, Not significant.

*Range = 20-71, 20 = no symptoms.

†Range = 20-69, 20 = no symptoms.

‡Range = 13-62, 13 = no symptoms.

of mental disorders; the Zung Depression Scale symptoms were attenuated slightly by demographic variables.

Patients also completed the Medical Outcomes Study Short Form (SF-20), a measure of health status and overall functioning.^{25, 26} The measure has six subscales, with scores on each subscale ranging from 0 (complete impairment) to 100 (no impairment or perfect health). Fig. 1 summarizes the findings from the SF-20. Initial differences in the scales for social functioning, bodily pain, and health perception appeared to be accounted for by the number of mental disorders. However, for the physical functioning and mental health subscales, there were statistically significant gender differences that remained even after adjustments for demographic variables and the number of mental disorders.

There were no significant gender differences in the numbers of physical disorders recorded by physicians or in physician ratings of patients' health. However, women rated their own health significantly more poorly compared with self-ratings by men (e.g., 35% of women rated their health as poor or only fair compared with 24% of men).

Of the 249 patients diagnosed as having a mood disorder, 128 (93 women and 35 men) were not receiving antidepressant therapy at the time of their diagnosis. Diagnoses in these patients included major depressive disorder, dysthymia, or both. An antidepressant was newly prescribed by primary care physicians in 15% (19/128) of patients who had not received antidepressant therapy. All 19 patients newly prescribed an antidepressant were women ($p < 0.001$). There was no

interaction between gender of the physician and gender of the patient.

Comment

The PRIME-MD 1000 Study found significant gender differences in psychopathology that were not accounted for by differences in other demographic variables. Women reported higher levels of depression and anxiety compared with men, and women were nearly twice as likely to be diagnosed as having a mood disorder. This gender difference in psychopathology accounted for differences in the frequency of emergency room visits and disability days. Gender differences in self-reported levels of physical health, as well as levels of physical and mental health functioning, remained after controlling for demographic variables and numbers of mental disorders.

Two symptoms of depression were more common in depressed women than in men: loss of appetite/overeating (a compound item) and a sense of failure or guilt, which represents a cognitive component of depression. We know of no other studies that have evaluated whether these symptoms of depression are more common in women.

The finding that antidepressant medication was newly prescribed only for women and not men is intriguing. In the past several years there has been an increase in the treatment of depression by nonpsychiatric physicians. This change may reflect characteristics of some newer antidepressant agents, such as easier dose titration, improved side effect profiles, and ease of monitoring therapy (no blood level determinations necessary). However, the PRIME-MD 1000 Study findings suggest that there may be a general bias among physicians in prescribing medication for women. Alternatively, the findings may reflect that women more often request medication or verbalize more of their symptoms, thereby encouraging physicians to prescribe medication for relief of symptoms. Another explanation for the finding may be that men decline or defer the use of medication more often than do women. The gender differences in new antidepressant prescriptions in the PRIME-MD 1000 Study may also be attributable to the difference in frequency of visits; that is, women seek medical care more often than men, and physicians are more likely to prescribe medications for high users of medical care. This finding and recommendations for other types of treatment bear further investigation.

Women reported more symptoms of psychopathology and impairment in the PRIME-MD 1000 Study, but it is not clear why. Although it is conceivable that these symptoms represent gender differences in the threshold for reporting functional impairment, the possibility remains that depression indeed causes more impairment in women and thus is more likely to result in a physician prescribing medication to relieve symptoms.

In conclusion, the PRIME-MD 1000 Study found that women are far more likely to be diagnosed as having a mood disorder. However, the study did not provide insight regarding why women seem to suffer disproportionately from symptoms of depression and signs of functional impairment that are not accounted for by other demographic variables, such as age, ethnicity, level of education, and minority status. Future research is needed to address the important questions of causation. In the interim the obstetrician/gynecologist, as a caregiver for women, needs to be aware of the incidence, etiology, and physical manifestations of depression in this population and its possible implications in diagnoses and treatment.

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Advances in the management of depression: Implications for the obstetrician/gynecologist

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The selection of an appropriate medication is important for successfully treating depression in women. Although antidepressants do not differ in their efficacy for the treatment of major depression, they do differ in their side effect profiles, toxicity, and mechanisms of action. Tricyclics, heterocyclics, and newer agents such as bupropion, fluoxetine, paroxetine, sertraline, and venlafaxine are used most commonly to treat depression in women. The dosages, side effects, indications, and precautions for these antidepressants are reviewed. Factors affecting selection of a particular antidepressant, as well as the general management of depression in women, are discussed. (*Am J Obstet Gynecol* 1995;173:659-66.)

Key words: Depression, treatment, antidepressants, women

Approximately 65% to 80% of depressed outpatients treated with an antidepressant will show marked improvement.^{1, 2} There is little evidence that any one antidepressant or class of antidepressants is more efficacious or results in a more rapid response than any

other. However, antidepressants differ in their mechanisms of action, side effect profiles, and toxicity in overdose. This article will review currently available antidepressants used to treat women suffering from major depression (Table I).

Tricyclic antidepressants

Tricyclic antidepressants (TCAs) are one of the older classes of antidepressants. They act by blocking the reuptake of both norepinephrine and serotonin, but their primary effects are on the norepinephrine system. Unfortunately, the side effect profile of TCAs is subop-

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