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# 'I mean what is depression?' A qualitative exploration of UK general practitioners' perceptions of distinctions between emotional distress and depressive disorder

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## ABSTRACT

**Objective** Detection of depression is a key part of primary mental healthcare. However, determining whether depressive disorder is or is not present in primary care patients is complex. The aim of this qualitative study was to explore general practitioners' (GPs) perceptions of distinctions between emotional distress and depressive disorder.

**Design** Qualitative interview study.

**Setting** Face-to-face and telephone interviews with GPs from the South of England.

**Participants** GPs working in UK primary care practices (n=21).

**Method** Interviews followed a semi-structured interview guide, were audio recorded and transcribed. Data were analysed thematically.

**Results** Views were divergent when directly considering whether emotional distress could be distinguished from depressive disorder. Some GPs suggested a distinction was not possible as symptoms lay on a continuum, with severity as a proxy for disorder. Others focused on the difficulty of the distinction and were uncertain. Some GPs perceived a distinction and referred to emotional distress as more likely in the presence of a stressor with the absence of biological symptoms. It was also common for GPs to refer to endogenous and reactive depression when considering possible distinctions between distress and depressive disorder.

**Conclusions** GPs' perceptions of when emotional symptoms reflect disorder varied greatly, with a broad range of views presented. Further research is needed to develop more consistent frameworks for understanding emotional symptoms in primary care.

## Strengths and limitations of this study

- Focusing specifically on general practitioners' (GPs) perceptions of distinctions between distress and disorder enabled a novel analysis in this complex area.
- Our sampling strategy resulted in a well-balanced sample of GPs on characteristics including gender, years practicing, age, practice size, deprivation in practice area.
- A limitation is that our sample of GPs were drawn from a relatively small geographical area in the South of England.

## INTRODUCTION

In the UK, depression is primarily managed by general practitioners (GPs).[1] A GP's role involves detection,[2] sharing understandings of symptoms,[3] and providing appropriate evidence-based care.[4] Recent 'state of the art' guidance on the detection and diagnosis of depression in primary care recommends using brief screening tools based on diagnostic criteria, provided there are appropriate services in place.[1] Despite such guidance, the detection of depression remains a complex issue: there are long-standing debates regarding the nature of depressive disorder itself and how/whether it may differ from non-disordered stress processes.[5–8] There is continuing discussion regarding the appropriateness of categorical diagnostic approaches,[9] and some caution against labelling, instead favouring individual approaches based on assessing thoughts, feelings and behaviours in the context of the presenting patients' lives.[10] Nonetheless, 37%–44% of presenting primary care patients report heightened distress symptoms,[11] and detection of depression remains an important part of national guidelines.[12]

The dominant conceptualisations of depression are based on criteria contained within the diagnostic and statistical manual of mental disorders (DSM-5)[13] and international classification of diseases (ICD 11).[14] These feed into general practice through both guidelines[12] and popular screening

tools such as the Patient Health Questionnaire-9 (PHQ-9), which is directly based on the DSM criteria.[15] The resulting conceptualisation of depressive disorder is one primarily based on symptoms, duration and functioning.[16] However, the DSM-5 clearly states that: "an expectable or culturally approved response to a common stressor or loss such as the death of a loved one is not a mental disorder." (p20).[13] This introduces notions of boundaries; what is, and what is not depressive disorder? Importantly, the DSM-5 highlights the centrality of clinical judgement in determining the presence of disorder: "[this] requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss" (p161).[13] Thus, how GPs understand and interpret ideas regarding distress and whether it is distinct from disorder will play a critical role when patients consult with emotional symptoms. These understandings will impact through the effects of diagnostic explanations on patients' identities (eg, adjusting to the presence of a mental health condition) and through treatment decisions such as whether to initiate antidepressants or not.[17]

In previous qualitative research, GPs often report difficulty when considering differences between 'disorder' or expected responses to life stressors.[17–19] GPs also report a range of different ways of thinking about the nature of depression itself, from a normal response to life events (p4) to various biomedical understandings.[18] Previous research has tended to acknowledge these complexities, then move on to discuss depression management more broadly.[19] Our aim in the present paper was to directly focus on how GPs view possible distinctions between emotional distress and depressive disorder.

## METHOD

### Participants

Primary care practices were recruited through the Wessex NIHR Clinical Research Network. We targeted practices with differing list sizes, deprivation indices and urban/rural locations. GPs from participating practices were invited to participate via email. GPs were purposively sampled to provide diversity across gender, age and years since qualification, GPs provided consent to take part and for their data to be used in this study.

### Interviews

Interviews were semi-structured (telephone or face-to-face), focusing closely on ideas about emotional distress and depressive disorder in primary care patients. The topic guide was developed by AG, MS, CB and TK with input from the broader team (see online supplementary file). Questions were developed based our on overarching research question/aim with reference to relevant literature. GPs were asked to describe a patient they had seen who was experiencing a depressive disorder (or 'clinical' depression), a patient who presented with emotional symptoms whom they did not believe was depressed, and then to describe differences between the two. GPs were also asked about factors that would affect treatment, diagnostic labelling and their thoughts on suggested definitions of distress and disorder. Interviews were carried out by CB, a medical student at the time the interviews were conducted (January to March 2015). CB was closely supervised by experienced researcher's AG and MS. CB did not have a prior relationship with the interviewees. Interviews were audio recorded.

### Analysis

Our team had a range of backgrounds including an academic psychologist (AG) academic GPs (MS, TK, BT, PL, MM), a health services researcher (SW) and a junior doctor (CB). Interviews were transcribed verbatim and checked for accuracy, and transcripts were read and reread by CB and AG. Analysis was carried out thematically and iteratively, drawing on aspects of the approach described by Braun and Clarke,[20] and Joffe and Yardley.[21] AG, MS and SW independently conducted an in-depth reading of three transcripts and discussed initial codes. AG then coded half the transcripts, developing a draft coding frame that was discussed, refined and agreed by MS, SW, CB and MM. AG coded the remainder of the transcripts and amended the coding frame where necessary. SW independently coded three transcripts using the final coding frame, AG and SW discussed and agreed any modifications based on discrepancies. Higher order themes were then developed by clustering codes, remaining vigilant for contradictions, inconsistencies and disconfirming cases where apparent. Developed themes and interpretations were discussed and agreed with MS, TK, BT, PL, MM, CB and SW. The sample was judged to provide sufficient information power[22]; it was diverse, clear and detailed, representing a range of experiences with the intervention. NVivo V.11 for mac was used to manage data, and pseudonyms have been used.

### Patient and public involvement

This study was part of a programme of research exploring conceptualisations of emotional distress and depression (including quantitative and qualitative studies with patients and healthcare professionals). Public involvement in this research programme, including discussion around how patients experience distress, led to the idea to conduct this study with GPs. There was no direct involvement of patients and the public in the execution of the study. As the study focused on interviewing GPs, the participant information sheet and interview schedule were developed and checked with GP colleagues (both internal and external to the study team).

## RESULTS

Twenty-one GPs took part from 19 practices (interviews ranged in length from 18 to 36 min). There was an issue with the recording for one additional GP and consequently their data were not included in the analysis.

Table 1 Characteristics of study participants

| Characteristic | Description |
|---|---|
| Age | 45 years (median, range 38–58) |
| Gender | 12 male; 9 female |
| Years practicing as a GP | 16 years (median, range 7–30) |
| List size of practice | 9998 (median, range 3400–17 829) |
| Deprivation index of practice | 14.1 (median, range 6–28.1) |
| GP's practice setting | 11 urban; 10 rural |

GPs, general practitioners.

Twenty-one interviews were transcribed verbatim. Participants were aged from 38 to 58 years old, with a median age of 45. Participant characteristics are shown in table 1.

## Findings

There is an existing literature on GPs' understandings and management of depression, consequently, the topic of identifying depression is covered only briefly here. Within the topic of emotional distress, we developed three themes: *The importance of context; the absence of biological/physical features*; and *rationality and coherence*. Within talk of distinguishing between distress and disorder, a further four themes were developed: *Considering severity; inherent difficulty of concepts; viewing a distinction* and*; chronic stressors* A final theme entitled *Considering a GP's role* encapsulated GPs discussion of their part in the management of emotional distress.

### Depressive disorder

There was a focus by many GPs on 'biological' symptoms when identifying depressive disorder, such as loss of appetite, poor sleep and fatigue. Suicidal ideation was also reported as an indicator. Beyond these more commonly reported indicators, even within discussion of depression specifically, variability between GPs was prominent. When discussing examples of depressive disorder, some GPs mentioned 'true' or 'proper' depression, and the idea that such depressions were accompanied by an all-pervading hopelessness.

> If there is no—if people can't see a way out, worthlessness, hopelessness and—can't see, you know, the light at the end of the tunnel—um—then that tends to make me think of depression.
>
> Sharon

Discussions of proper depression often included the idea that these depressions occurred independently of life events, as noted by Victor below:

> Proper depression is the clinical depression when actually—there's nothing outside that is making you depressed; there's nothing in your life circumstances that would lead you to feel miserable.
>
> Victor

Other GPs spoke more about impact on functioning as a determinant of diagnosing depressive disorder.

> Somebody who's depressed is, I feel, is non-functioning, erm, and um they…their low mood is having such an impact on their ability to function and to maintain the normal things they do in their life, um, that um, that you would then see it as depression.
>
> Harriet

### Emotional distress

When asked to describe patients with emotional symptoms that they would not identify as having a depressive disorder, GPs drew on a range of strategies to give an indication of 'non-disordered' distress.

#### *Importance of context*

The majority of GPs discussed the relationship of symptoms with a specific triggering context. Distress was often seen as part of a reaction to life events, for example, familial/occupational stress or bereavement.

> I saw a young chap today with anger management issues. I don't think he is depressed; I think there's probably also an element of drug abuse and the situation. He lives at home, … … stressful situation at home, not for any specific reason, I think just having growing children, … of them at home, is just quite stressful. So—but he is—I don't think he's depressed but I think there are anger management issues.
>
> Linda

#### *Absence of common biological/physical symptoms*

The absence of biological/physical symptoms was mentioned by some GPs as an indication of emotional distress rather than the presence of a depressive disorder. These GPs described understandings of depression as a condition with particular physical manifestations and a physical symptom profile that is likely to differ from distress. A small number of GPs also used the term 'adjustment disorder' when describing emotional symptoms in the absence of biological/physical symptoms, finding it to be 'a truer description rather than a—you know—profound depression' (Scott).

> Well we see a lot—yesterday I saw someone who—she is—oh yes, she's … boyfriend broke up with her last spring, her—it had been quite a long term relationship, about three years and she had not really got over it but it really is very much an adjustment disorder rather than depression and she gets upset every time she sees him or one of his friends, but when she's not thinking about it she actually functions perfectly well. She hasn't got any biological symptoms of depression.
>
> Scott

### *Rationality and coherence*

Some GPs discussed how patients experiencing emotional distress conceptualised their problems in a rational manner. GPs also often perceive these patients' responses as being 'quite rational', despite severity, suggesting proportionality[23] may be important for these GPs when considering the nature of patients' symptoms.

> I see many people who come in stressed, that have a lot of life events going on, and who burst into tears once they start talking to you, but once you explore their symptoms then, you know, they are not giving [features] of depression, they're giving features of stress and anxiety, you know, quite—quite rational with it; everything they are going through is quite… you know, a logical reaction to what's going on.
>
> Simon

## Distinguishing between emotional distress and depressive disorder

### *Considering severity*

Ideas varied regarding severity as a factor in distinguishing between emotional distress and depression. Some GPs said they considered severity to be central to diagnosis, tending to draw on continuum models of symptoms and therefore regarding a clear-cut distinction between distress and depression as irrelevant or impossible. It was common for these GPs to mention the use of brief severity scales such as the PHQ-9.[15]

> But, of course, it's … you know, it's a scale, it's degrees of depressive symptoms amounting, you know, the more—different—symptoms you get, the more it mounts up to being diagnosed as clinical depression. But with this patient, I did a PHQ on him and—a PHQ9 and it was 14/27 and it wasn't, you know, really worth treating him at this point, but that's subject to review.
>
> Roy

Others suggested they found severity less useful, causing them to look to other factors, such as duration, and the potential of distress to fluctuate to a greater degree than depressive disorder. Some also found severity scales unhelpful when considering the nature of their patients' symptoms.

> Int: What do you think are the key differences between those two examples?
>
> P: I think—the main differences, for me, are the duration of the symptoms … the … struggling to say intensity because I think they can be equally intense but often they are more fluctuating with distress, so you go through periods of feeling very unhappy and then that—and then you are able to function normally.
>
> Nick

> You can try and objectify these things by doing GAD 7s and PHQs and all these sorts of things—but of course they are very, very, very subjective and—you might get somebody with maximum points on a depression score and you're not wholly convinced in your own mind that they are actually depressed, that they are more sort of—experiencing some brief emotional distress.
>
> Daisy

### *Inherent difficulty of concepts*

For other GPs, questions about distinctions led to reflections on difficulty surrounding the issue. These GPs represented more of a middle ground and tended to have less formed ideas regarding the complexities of the distress versus disorder question.

> I mean what is depression? Okay, if you look at the guidelines for what depression is, that's normally something acute that happens in your life but it's not really depression whereas, you know—I don't know would call what I call true depression—I mean—it's very difficult to define in this sort of way. Okay, it can have different presentations.
>
> Victor

## Conceptualising a distinction

Rather than referring to a continuum, some GPs discussed distress and depressive disorder as likely to have related aspects (eg, emotional experience) but differ in key ways.

> I don't think it's an emotional difference, but I suppose the prognosis is different for the two of them: one is more of a—I think it's more important to get a diagnosis of some sort of label on the person who's not got any reactive element…They are not able to reverse their sort of entrenched feelings and behaviours. The other one seems a bit more reactive, there's a natural process to that, you'd expect that to resolve after 6–12 months with just time and support.
>
> Govinder

Above, Govinder describes distress as likely to be 'reactive'. This terminology was drawn on by some GPs, using endogenous and reactive depression as descriptors. In particular cases, GPs apparently interpreted distress as akin to reactive depression, and depressive disorder to endogenous depression. (This interpretation offered by GPs, differs from the psychiatric notion of endogenous and reactive depression where both are considered subtypes of major depressive disorder.[24])

> I think—I guess I do take into account, you know, what they see as—factors—contributing to it and I do think there is a clear distinction between—you know—an endogenous and a reactive type of depression; so I don't think—you know—and I suppose the situation that really—often is presented, that people, you know: well two groups, you get people who say I've got all of this going on. So you can talk them through that, but others who say, you know, really – everything seems to be perfectly good in my life but I don't know why I feel this way.
>
> Debbie

When discussing what one GP believed was a clear distinction, the issue of overtreatment was brought up.

> I think the danger is probably the more of the classified people with 'shit life syndrome' is being depressed when they're not; they just have difficult, very difficult lives and—they pitch up in General Practice and there's not much you can do for them—but there's no one else to help them, either… I mean I think there are people who are unhappy for long periods of time and distressed, who aren't depressed.
>
> Nick

Within the complexity of the issues described when considering distinctions, some GPs referred to transitions from emotional distress to depressive disorder.

> Bereavement is a better example because obviously we wouldn't treat people for depression very close to bereavement because it's impossible to do that, generally—because bereavement is bereavement—and until such time as it's ingrained and out of proportion, it's an ongoing—then it becomes depression—do you see what I mean?
>
> Linda

> If somebody's distressed for long enough—it may be that they will develop a depressive illness; if you put enough stress and distress on somebody for—any length of time, they may crack—potentially.
>
> Sharon

When talking in this way GPs appeared to be drawing on a process narrative, rather than identifying whether particular symptoms were present or not, or how best to classify them.

### *Chronic stressors*

The presence of chronic life stressors was discussed by some GPs in our sample when considering emotional distress and depressive disorder.

> The trouble that you've got is for 95% of our patient population, you won't be able to remove the stressor… if you took their work environment away, then they will probably function fine—but there are a few individuals that can actually make that change, unfortunately. So, you know, three or four months later—do you still say it's emotional distress—or do you say it's depression—because it's ingrained, because they can't change the stresses?
>
> Linda

Chronic stressors increased complexity for some GPs when considering patients' contexts. The presence of an overt long-term stressor appeared to some to indicate distress; however, duration was often considered a key factor in detecting disorder.

### Considering a GP's role

When discussion of a GP's role in emotional distress arose, responses again were varied. A small number felt that were 'far too busy' to manage distress.

> You could say if people are distressed—that, you know, we should be sat here dealing with … cancer patients and … you know, the primary prevention and diagnosing cancer and we're far too busy to—to deal with people that are "upset"
>
> Daisy

However, the majority of GPs discussed the importance of listening, diagnosis and signposting to appropriate services.

> I think it's supportive and—signposting agencies they can use—such as counselling, if necessary, or—citizen's advice or things like that, often predominantly supportive.
>
> Linda

> Listening and signposting to appropriate people that might be able to help them because I think a lot of people just don't know what other help is out there, so they use us as a kind of port of call, almost as a sounding board sometimes.
>
> Adele

One GP discussed how distinguishing between emotional distress and depressive disorder was a key part of primary care work:

> In General Practice-land we spend a lot of our time with patients who are—either one or the other or both and getting a feel for how you diagnose and what you do, whether it's something active or passive—for people who are going through such difficulties—is a critical skill. If you can't do that—or you're not interested in it or not prepared to learn, then General Practice is not for you.

Another highlighted the key role of determining what is 'normal', and being cautious not to pathologise symptoms.

> We are a neutral sounding board; sometimes people are coming along and they're—they're—the question behind what they're saying is—is this normal, is this what I should expect? And we have a role to point out what is normal, even though it's unpleasant and what will pass and what is—does not require medicines and—you know—it's not pathological. So we have a big role to do that and that's probably our most important role for this.
>
> Scott

## DISCUSSION

Our analysis identified variability in GPs' approaches to diagnosis and the importance of context when considering patients presenting with emotional symptoms. When directly considering whether emotional distress could be

distinguished from depressive disorder, opinions varied: some rejected the notion of a clear distinction, particularly those who thought severity was key. Some discussed the difficulty of making direct distinctions between distress and depression. Others thought distinctions were important, and notions of reactive vs endogenous depression were often drawn on. Broadly, the GPs interviewed drew on a range of different conceptualisations to determine when a patients' symptoms may be driven by stress or driven by depressive disorder. Finally, the majority of GPs viewed their role in managing distress of one of listening, diagnosing and signposting to services.

The variability of approaches reported by GPs around the constructs of distress and depression mirrors debate about the nature of disorder in the literature.[7 8 25 26] The atheoretical focus on symptoms, severity and function recommended in the DSM classification[13] was reflected by some interviewees, including the focus on persistent low mood. Other GPs' views echoed critiques of this approach in the literature by Mulder,[7] and Wakefield[8] suggesting that focusing on these factors alone may be over simplistic and lead to over-diagnosis and medicalisation. The aetiology of depression is not well understood and has many different interpretations, including developmental, cognitive and biological.[25 27] The atheoretical conceptualisation of depression with a focus on symptoms and severity, bypasses this complexity and increases reliability of detection of this specific symptom cluster. However, symptoms can be driven by many processes,[8 16] some of which may represent psychopathology, some may not; thus, this approach to simplifying depression may actually increase complexity for GPs.[18]

GPs often viewed context as key in how they conceptualised symptoms. This is despite a decontextualised focus on symptoms, duration and functioning being promoted by guidance on the classification of depression.[13] It could be argued that taking context into account may lead to increased variability and potentially missed cases.[2 13 28] However, in focusing on context, the view these GPs hold is consistent with developing theories of emotion regulation. 'Emotion context sensitivity' is described as the capacity for an individual to shift emotional responses according to changing contextual (social or environmental) demands.[29] Context insensitivity is thought to be a key aspect of depressive disorder.[30] In theories of emotion, an appropriate relationship to context is often seen as fundamental in distinguishing between adaptive, or pathological emotional responses.[29]

Our work highlights the ongoing complexity in this area, particularly in primary care, where these concepts (eg, depression, stress) are explained and applied with patients. Although treated by some as relatively stable,[31] ideas about where non-disordered affective experience stop and depressive disorder begins, remain dynamic and are applied in different ways by GPs. This is despite guidelines promoting the use of validated measures for identifying depression, and omitting discussion of whether life context should play a role in identification or diagnosis.[12]

Importantly, many of the GPs in this study saw helping patients determine the nature of their symptoms as a key part of their role. Developing frameworks that acknowledge complexity and include definitions of depressive disorder where distinction from stress-related negative affective experience can be made clear, may help improve consistency in explanation/diagnosis. Such frameworks may have a direct impact on management of distress and depression in clinical practice. The utility of new frameworks should be compared with the standard approach recommended in current guidelines.

Research is needed to explore the benefits and costs of language used and narratives provided by GPs to patients regarding symptoms. For instance, chronic stressors were seen by some as a complex case. Previous work by Chew-Graham *et al*[32] has suggested that GPs may take a palliative approach to such patients, offering treatments for depressive disorder to palliate distress when stressful life circumstances are unlikely to resolve. It is important to consider impact of such approaches on patients. Conceptualising symptoms as the result of chronic stress may have a different effect on patients compared with initiating treatments that imply diagnosis of depressive disorder. Additionally, some GPs considered the relation between distress and disorder as a process, with emotional distress leading on to depressive disorder. This is consistent with research on the relationship between stressful life events and depressive disorder.[33] When exploring alternatives to thinking of severity as key in disorder, GPs might be able to help patients see where they are in this process: if symptoms are still primarily being driven by external stressors, explanations involving distress may be helpful. If symptoms appear to be being driven internally (eg, by belief, affect, behaviours) and are less affected by changes in context, explanations and treatments for depressive disorder may be more appropriate. Importantly, this may help validate the full range of symptoms as worthy of support from GPs; countering the proposed view from some in our sample that GPs may be too busy to deal with 'upset'.

Ideas around coconstruction of labels and understandings of symptoms with patients were rarely raised by GPs in our study. We expect this was due to the context of the interview; GPs were asked about their understanding of stress/disorder processes as medical professionals. Future observational work could be undertaken to observe if/how conceptualisations are coconstructed[34] within the consultation. Mapping this in detail may provide the grounds to begin to determine whether some constructions are more beneficial than others for patients in the long-term.

With regard to limitations, our sample of GPs were from a relatively small geographical area in the South of England. Although we purposively sampled for practices and GPs within this area, the patients these GPs see may be relatively homogenous. GPs who work with more diverse patients may have different perspectives on depression/distress. The interview topic guide was developed with

GPs, nonetheless, we acknowledge that direct patient and public involvement may have further contributed to the topics covered in the interviews.

To conclude, our analysis has highlighted the complexity and variability of views GPs hold regarding emotional distress and depressive disorder. These views often diverge from assumptions underlying national guidelines on the detection of depression. Importantly, further research is needed to develop more consistent frameworks for understanding emotional symptoms in primary care, and to determine their utility compared with current recommendations.

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