

General practitioners' views about diagnosing and treating depression in Maori and non-Maori patients

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ABSTRACT

INTRODUCTION: The study investigated general practitioners' (GPs') views about recognising and treating depression among patients to establish possible reasons for reported lower levels of diagnosis and treatment of depression among Maori compared to non-Maori patients.

METHODS: Semi-structured interviews with 23 GPs in the Auckland region, including both Maori and non-Maori GPs, elicited GPs' views about risk factors for depression, recognising depression and circumstances in which GPs would prescribe medication or recommend other treatments for depression.

FINDINGS: A framework was developed which incorporated the strategies GPs reported using to diagnose and treat depression. This consisted of three categories: (a) how depression is identified, (b) factors influencing treatment decisions, and (c) treatment outcomes. Reasons reported by GPs as most likely to lead to ethnic differences in diagnosing depression were greater stigma relating to admitting depression among Maori patients, Maori patients being less likely to talk about being depressed, and the need for patients to have effective communication with their GP. Effective communication, where Maori patients felt free to talk about personal feelings, was more likely when there was an established relationship between the GP and patient.

CONCLUSION: The findings are consistent with previous reports that depression is less likely to be diagnosed by GPs among Maori patients, compared to non-Maori patients. GPs who are able to establish effective communication with patients, gain their trust and take account of the reluctance of some Maori patients to talk about personal feelings, are more likely to diagnose and treat depression effectively.

KEYWORDS: Depression; diagnosis; treatment; primary care; Maori; ethnicity; New Zealand

Introduction

A study of depression in one general practice in Auckland noted that Maori patients were prescribed antidepressants at a much lower rate than non-Maori patients.¹ A similar finding was reported from the 2002 National Primary Medical Care Survey (NatMedCa) on general practice in New Zealand (NZ), which noted that antidepressants were less commonly prescribed for Maori patients.² In NatMedCa, antidepressant prescriptions accounted for 1.6% of all Maori prescription items compared to 3.3% of prescription items

among non-Maori patients. The prescribing rate was 2.1/100 visits by Maori patients compared to 4.2/100 for non-Maori patients. In total, antidepressants accounted for 12.9% of the nervous system drug prescriptions for Maori compared to 22.0% of non-Maori.

Research on the prevalence of mental health disorders in NZ has indicated that Maori people tend to have similar or somewhat higher prevalence of depression than non-Maori.^{3,4} Given the apparent undertreatment of depression in Maori,

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what factors might be influential? A 2005 national survey noted that Maori respondents were somewhat less likely to encourage someone with depression to seek professional help than non-Maori (48% vs 58%).⁵ In relation to people who do seek primary health care, are general practitioners (GPs) less likely to diagnose depression in Maori? Are they less likely to prescribe antidepressant medication to Maori even when diagnosed, or both? The study reported here addressed the question of why Maori patients seem to be prescribed antidepressants by primary health care providers at a lower rate than non-Maori.

To identify other demographic factors that might be related to the differences in prescribing antidepressant medication to patients, we approached the authors of the NatMedCa study in June 2006 to further analyse their data.² In the NatMedCa study data, the diagnosis rate for depression as a percentage of all visits and all ages was 0.7% for Maori men and 2.8% for non-Maori men, and 3.1% for Maori women and 4.5% for non-Maori women. The differences between Maori and non-Maori in both diagnosis and prescribing were most evident among males 25–44 years of age. A key issue is whether these ethnic differences in diagnosing depression and prescribing antidepressants are due to doctor or patient effects, or both.

A qualitative study of mental health consultations in general practice in New Zealand reported four key features that had an impact on consultations with GPs.⁶ These included:

- **practice pressures** (lack of time, a primary focus on physical conditions);
- **sociocultural factors** (stigma attached to patients disclosing mental health problems, patient qualities of stoicism and self-reliance);
- **the medicolegal framework** (e.g. patient access to medical notes, resistance to mental health labels that might disadvantage patients); and
- **the consultation process** (dealing with physical problems first).

GPs employed a number of strategies during consultations and do recognise mental health problems in patients. However practice pressures and the other features noted above result in

WHAT GAP THIS FILLS

What we already know: Maori are prescribed antidepressant medication in primary health care less frequently than non-Maori patients, even though prevalence surveys show high rates of depression among Maori. A likely reason for the difference is that general practitioners are less likely to diagnose Maori patients as having depression.

What this study adds: GPs reported that Maori patients tended to show greater stigma relating to admitting depression and were less likely to talk about being depressed compared to non-Maori patients. Effective communication that allows Maori patients to talk about personal feelings related to depression is more likely when there is an established relationship between the GP and patient.

consultations not being given the label ‘mental health’.⁶ Previous studies have reported a general trend for depression to be underdiagnosed, or difficult to diagnose in primary health care services^{7–9} and that stigma associated with mental health problems and depression is a major factor in lack of disclosure of relevant information by patients.^{10,11}

The aim of the current study was to explore processes related to diagnosis and treatment of depression among Maori and non-Maori patients. The focus was on the views and experiences of GPs in relation to patients who may have depression. The specific research objectives were to:

1. Explore the views of GPs about causes, diagnosis and treatment of depression among patients.
2. Develop a framework to describe the processes and procedures GPs typically use to diagnose and treat depression.
3. Document GPs’ views about possible differences between Maori and non-Maori patients in the diagnosis and treatment of depression.

The study reported here was part of a larger qualitative study examining the treatment of depression by GPs. Given that the New Zealand Health Strategy includes a section on reducing the rate of suicide in New Zealanders¹² a better understanding of depression should help in this endeavour.

Methods

The research design was a qualitative interview study using face-to-face interviews with GPs working in the Auckland region in NZ.

Interview sample

A total of 23 interviews were completed. Both Maori and non-Maori GPs were included to ensure that Maori perspectives were represented in relation to diagnosis and treatment of Maori patients and that the findings were based on a diverse sample. The study began by recruiting Maori practitioners identified through the networks of the research team. For each Maori GP who agreed to participate, a non-Maori GP matched by gender, approximate age and area of practice was recruited for interviewing. The final sample consisted of 11 Maori GPs (seven male, four female) and 12 non-Maori GPs (seven male, five female). All were from practices in the greater Auckland area. Most worked in small group or private practices. Seven worked for iwi-based (Maori service provider) health clinics. The interviews were carried out by the second author (BA), a Maori public health researcher (a non-clinician). Ethics approval was obtained from the Northern X Ethics Committee.

Interview questions

The interview schedule included semi-structured and open-ended questions (Table 1). Interviews were conducted in a flexible manner that allowed GPs to share their experiences in relation to the topics covered by the questions.

Procedures

Face-to-face interviews were conducted with 22 GPs at their health practices. One was interviewed by phone. Most of the interviews took approximately half an hour and all were audio-recorded and transcribed verbatim, with the transcripts used for qualitative analysis.

Data analysis

The analysis used an inductive approach¹³ suitable for the research objectives and the interview data collected. An initial analysis was conducted by the interviewer to identify specific themes and categories. Subsequently text from the interview transcripts was imported into the qualitative analysis software NVivo (v7) and analysed by a second team member (DRT). This confirmed the initial categories and constructed an overall framework that incorporated the specific categories and provided an overview of GPs' strategies for identifying and treating depression. The final set of categories was reviewed by the research team. A key focus of the analysis was on GPs' experiences in relation to potential differences in identifying and treating depression between Maori and non-Maori patients, not to systematically compare Maori and non-Maori GPs.

Findings

Findings from the reports of GPs were organised into two sections: (a) the framework incorporating the processes and procedures GPs reported using to diagnose and treat depression and challenges they faced, and (b) differences between Maori and non-Maori patients.

Diagnosing and treating depression

Three primary categories were constructed from the inductive analyses of the interviews. These were:

Table 1. Questions used in interviews with GPs

- How would you recognise depression in a patient?
- What kinds of people do you think might be more likely to get depression?
- In your experience, what are the main causes of depression?
- Are there differences between your Maori and non-Maori patients?
- When would you prescribe medication to treat depressed patients?
- When would you prescribe other therapies to depressed patients?
- How effective do you think medication is to treat depression?
- How effective do you think other therapies are to treat depression?
- What do you think would be 'best practice' treatment for depression?
- Are there differences in the way you would prescribe either medication or another therapy to your Maori and non-Maori patients?
- What, if any, do you think some of the barriers might be to adherence of treatment for patients?
- Do you think there are any differences in patient adherence?

Table 2. Categories constructed from GP interviews

Primary categories	Specific categories	Descriptions
Identifying depression	Communication effectiveness	Good communication and a sense of trust between the GP and patient are important for identifying depression
	Recognising depression	Signs or indicators used by GPs to recognise depression
	Causes and risks for depression	GP views about causes of depression and risk factors for depression
Treatment decisions	Treatment options and strategies	GP options relating to pharmaceutical (medication) and non-pharmaceutical treatments
	Patient expectations re treatment	Patients' views about medication and other treatments
	Factors influencing treatment decisions	Patient factors affecting GP decisions about treatment, including age, treatment preferences and availability of treatments
	Barriers to effective treatment	Barriers relating to medication and counselling treatments, and stereotyping of mental illness
Treatment outcomes	Patient compliance with treatment	Patient characteristics related to compliance and reasons for non-compliance
	Effectiveness of treatments	GP views about the effectiveness of treatments for depression
	Patient responses to treatment	GP reports about how patients responded to treatments

- **identifying depression**—how GPs reported identifying depression;
- **treatment decisions**—factors which influenced GPs' treatment decisions; and
- **treatment outcomes**—the outcomes of treatment for depression.

Table 2 shows these categories, the associated subcategories and their descriptions. These provide a framework for understanding the strategies GPs use to identify and treat depression, and a context for the differences some GPs reported between Maori and non-Maori patients.

Identifying depression

Three specific categories relating to identifying depression were evident in GPs' accounts.

1. Communication effectiveness

Having good communication and a sense of trust between the GP and patient were important in detecting signs of depression. Effective communication requires GPs knowing their patients well

enough to be able to recognise any significant changes in their behaviour that might indicate risk factors for depression. Some GPs emphasised that an adequate level of trust by their patients was needed before patients would be comfortable enough to disclose personal issues.

Unless your patient feels that they have confidence in you then they're not going to tell you anything. They're often divulging very personal, private information and they're just not going to tell you unless they have confidence in you. [Maori GP11, female]

2. Recognising depression

Most GPs reported that patients with depression could present in several ways, with different symptoms. The most common ways of identifying depression were disclosure of depression directly by the patient, the patient reporting symptoms that were commonly associated with depression and, less commonly, the use of screening questions or a checklist to assess depression. Some GPs noted that women appeared more

likely to say they were depressed. When patients did not directly disclose depression, GPs reported other indications such as lack of motivation, not sleeping well or major negative events occurring in the patients' lives and changes in behaviour patterns. Patients might use phrases like feeling low, down, wanting to give up, complaining of tiredness, or not being able to sleep.

Quite often it's their behaviour rather than necessarily what they say. For instance I find if they start being difficult and a little bit aggressive and demanding, or just different from how they have been. And then there's the obvious ways when they actually tell you, which is easy. I guess I'm probably always looking for underlying reasons for why they're presenting, rather than just the symptoms that they come with. [Non-Maori GP3, female]

3. Causes and risks for depression

The most frequently mentioned cause of depression for their patients was related to life events and the patient's social environment. GPs referred to *reactive depression* developing as a result of a major traumatic life event. Some examples given were breakdown of a relationship, loss of a loved one, or becoming chronically ill.

Many GPs related depression to specific risk factors. A personal or family history of depression was seen as a risk factor, as was having experienced abuse, including physical, sexual, and verbal abuse, as well as drug and alcohol abuse. Isolation was also seen as a major contributing risk factor for depression. Isolation included being separated from families, from social groups, from work, geographical isolation, or emotional isolation.

Treatment decisions

1. Treatment options and strategies

The GPs reported two main types of treatment options, pharmaceutical (medication) and non-pharmaceutical treatments such as counselling. Within each treatment type, treatment decisions were related to patient age, severity of depression, past history, duration of symptoms as well as patient preference.

All GPs spoke about offering medication to treat patients with depression, most commonly for patients who had moderate to severe levels of depression. They reported choosing medication they felt would work best for the level of severity or that would suit the patient. The main non-pharmaceutical treatment GPs mentioned was counselling or psychotherapy. This included psychological and psychiatric therapies such as cognitive behavioural therapy, as well as basic counselling and group counselling.

Some GPs mentioned they preferred to offer their patients counselling therapies first before they would prescribe antidepressant medication, particularly for mild depression. For the more severely depressed cases they were more likely to consider medication.

I don't like using medication for depression unless I'm at a point of saying these other things haven't done enough to help a person. They're still really down to despite our own efforts. So I don't go to medication first. [Maori GP1, male]

Many GPs noted that a combination of both medication and a counselling therapy was their recommended 'best-practice' treatment for moderate to severely depressed patients. Some non-pharmaceutical treatments that were mentioned by the GPs included recommending a 'Green Prescription' for physical exercise to help lift the mood of patients. As well as these treatments, alternative therapies were mentioned by a few GPs. These included rongoa Maori (Maori traditional medicine), homeopathic remedies and acupuncture.

2. Patient expectations regarding treatment

Several GPs talked about patients' views about, and expectations of, treatment for depression. These often related to patients' attitudes regarding antidepressant medication, which were reported to be diverse. Some mentioned patients who did not want to be given antidepressant medication, because they were seen as being addictive or having negative side effects. In contrast, some patients had no problems with taking antidepressants—they just wanted a 'quick fix'.

3. Factors influencing treatment decisions

GPs referred to multiple influences on their choice of treatments for depression. Treatment choices could be influenced by the patient's age, personal preferences and the availability of specific treatments. Discussion with the patients about depression as an illness and the possible treatment options was a priority for many GPs.

I really talk to the person and it's a discussion with them and where they're at, you know... a lot of other people are like yeah I'm not into pills and you know, you've just sort of got to leave it there as an option. [Maori GP9, female]

During discussion with their patients, GPs would talk through the treatment options that they felt were most appropriate for their patient. They were more likely to go ahead with a suggested treatment once the patient had agreed.

I treat them with medication when I feel that they're using all their energy to just control their symptoms and so they've got no extra energy to make changes in their lives. I give the similarity of, it's like a Panadol for a headache. That you take the Panadol to get rid of the headache, but you've still got to work out why you're getting the headaches. And I often say that as an idea to patients. [Non-Maori GP3, female]

GPs' decisions regarding treatment options for their patients were usually made after assessing the severity and duration of the depression. If the GP thought the patient's level of depression was moderate or severe, they might be more likely to try antidepressants, or antidepressants in conjunction with counselling therapy.

Well I think if someone, if someone is suicidal you want to have them on treatment and if they're suicidal, see a specialist, or a psychiatrist. I mean if someone has had a chronic ongoing depression for, you know some months and they're just not getting out of it, it's worthwhile trying an antidepressant. Yeah it's people generally with more serious symptoms, or with ongoing symptoms, consider trying an antidepressant. [Non-Maori GP11, male]

Access to counselling services was considered by GPs when considering this option. Some access

difficulties mentioned were cost, lack of good quality therapists, or no therapists being available in some regions.

4. Barriers to effective treatment

Barriers to effective treatment mentioned by GPs included patient concerns about taking medication for depression, views about counselling treatments, and negative stereotyping around mental illness. Many GPs felt that the stigma surrounding antidepressant medication was a significant barrier to patient acceptance and compliance with treatment for depression.

Other barriers to treatment mentioned included beliefs about negative side effects from the drugs, having to take the medication regularly and the lengthy duration of the treatment. Access to counselling treatments was very difficult for many patients due to cost, lengthy waiting lists to therapists, and therapists not being available locally.

Treatment outcomes

Three themes were evident in GPs' views about the factors affecting treatment outcomes.

1. Patient compliance with treatment

Patient compliance or non-compliance with treatment was usually raised in relation to patients not taking their prescribed medication. Some felt lack of compliance in taking antidepressant medication was related to the long course of treatment, or to side effects that some patients reported after taking medication.

2. Effectiveness of treatments

There was a range of views among GPs about the effectiveness of treatments for depression. Some used observed improvements in their patients as a basis for assessing treatment effectiveness and some referred to research evidence they had read. Most GPs felt that antidepressant medication was in many cases an effective treatment for depression, especially in conjunction with other treatments. While noting benefits from using medication with their patients, some

GPs also emphasised the limitations and other factors that needed to be considered. Medication could be ineffective or inappropriate for some people. Some medication suited younger patients but were not suitable for elderly people. The uncertain nature of outcomes from taking medication was pointed out.

3. Patient responses to treatment

The GPs interviewed commented that there was a wide range of patient responses to treatments. One response noted was patients stopping their medication. While patients had various reasons for ceasing their drug treatments, it was common not to notify or discuss the issue with their GP.

... you see them six months later and you ask, how is your depression? And they say, they're a lot better. And you say, did you take the medication? And they say, yeah I took it for a week or I took it for a month, or I didn't take it. So yeah there certainly are some people who don't take it even though they accept it. [Non-Maori GP6, male]

Differences between Maori and non-Maori patients

During the interviews GPs were asked about differences among Maori and non-Maori patients relating to diagnosing and treating depression. The most common theme evident in the analysis related to ethnic differences was the difficulty in identifying or diagnosing depression in Maori due to differences in communication styles.

1. Identifying depression

Several GPs referred to the difficulties they had with diagnosing depression in some Maori patients. Three specific features evident in the interviews were:

- i. A greater sense of stigma relating to mental illness generally and depression among Maori patients;
- ii. Maori patients being less likely to talk about being depressed;
- i. Effective communication and an established relationship in which the

patient trusted the GP being especially important for Maori patients before they are likely to talk about personal feelings such as depression.

The stigma attached to depression was mentioned by several GPs. This was consistent with the themes that Maori patients were less likely to talk about depression and needed to develop a greater sense of trust with GPs before they were willing to talk about personal feelings.

My impression is that the Maori patients are perhaps less likely to be forthcoming... like certain groups, you know they're always thinking about psychological things. So your average middle-aged European woman is going to come in and tell you I think I'm depressed, because... they'd been reading it in a magazine. Your average Maori patient is not going to come in and say that as a general rule. Some do, some of the younger ones [but not] some of the older women, and hardly ever any of the men. [Maori GP4, female]

Some GPs noted that it is more difficult to diagnose depression among Maori, particularly Maori men. They are less likely to say they are depressed and more reluctant to accept a diagnosis of depression. Maori men tend to become less communicative when depressed.

Quite a few of them [Maori males] might come in with sort of funny other symptoms, physical symptoms and gradually they might disclose that they're depressed as well. But often it can be quite hard to get that group of people to admit to depression in any sort of consultation type really. [Non-Maori GP7, male]

Several GPs reported that some Maori patients have a different communication style from non-Maori. They take longer to get to know their GP and trust them, particularly among older Maori. GPs may need to use culturally-specific communication styles with Maori patients and allow more time for trust to develop.

I think that sort of trust is more likely to be an established GP. They don't want to bring it up with an A&E GP. That's a problem with Maori people.

They're worried about the trust... You can imagine what depression does to an uncommunicative Maori male. It just makes them less communicative. And sometimes you need Maori doctors to be able to link into that uncommunicative person. Like we're used to it and don't get frightened by it and can handle it. [Maori GP3, female]

A few GPs noted that Maori patients can present differently from non-Maori. This meant depression may be diagnosed late.

One of the things that you're always meant to be aware of, that they [Maori patients] may present quite differently. And because of that, I guess if we're not aware of it, we may not pick it up at the same point in time. We may be a bit late in diagnosing it. And so there could be a consequence to that... They may have progressed to a more serious stage. [Maori GP5, male]

2. Factors influencing treatment

Most of the GPs (14 out of 23) stated explicitly that their antidepressant treatment was not related to the patient's ethnicity and that treatment was tailored to the specific needs of patients.

...if I felt medication was indicated on the case I would offer it to anyone, who was even, regardless of their ethnicity, I wouldn't differentiate on that basis. [Non-Maori GP1, male]

Whichever treatment option was recommended, consultation with the patient and the patient's agreement were required. The likely cost of treatment and whether the GP thought the patient could afford a specific treatment were issues that were taken into consideration when recommending counselling or similar therapies. The availability of suitable counsellors and counsellors of the same ethnic background as the patient were important factors for some GPs when considering counselling for their patients.

The other thing is cognitive behavioural therapy... Is it readily available? Not as much as I'd hoped. I mean counsellors are certainly around, you know, you can get hold of counsellors. They've been

through some difficulties like if you're trying to find a Maori one, they're quite few and far between. So there are difficulties trying to tailor your patient's needs to what's available. [Maori GP12, male]

A number of the GPs viewed Maori as generally having better whanau support systems. Some recognised whanau support as being an integral part along the pathway of care to better health for patients.

I think my Maori patients are more likely to have support structures in place that we can tap into, that I can say to them, hey how about talking to so and so. [Maori GP1, male]

Some GPs reported that Maori patients tend to be less accepting of the idea of taking medication. Reasons for reluctance in taking medication included being suspicious of pharmacological products, cost and cultural reasons.

I think probably the Maori perhaps are a little bit [less] keen on taking anti-depressants than the Europeans... part of it may be cost, part of it just, you know, perhaps a little bit fearful of perhaps a lot of medicine, or antidepressants. You know it may be partly cultural, where some of the elders might say, you know, you don't have to take those, or what are you taking those for, that sort of thing. [Non-Maori GP11, male]

Discussion

The present study investigated reasons why Maori patients might appear to be less likely to be diagnosed with depression and less likely to be prescribed antidepressant medication. The most likely contributing factor to the disparity was the process of diagnosing depression. If depression was diagnosed, GPs reported that Maori patients were offered or recommended a similar range of treatment options to non-Maori patients. Processes most likely to lead to ethnic differences in diagnosing depression were a greater stigma relating to admitting depression among Maori patients, Maori patients being less likely to talk about being depressed, and the need to have effective communication with their GP. Effective communication that allowed Maori patients to talk about personal feelings, such as

those related to depression, was more likely when there was an established relationship between the GP and patient.

The findings of the present study were intended to contribute to an understanding of the reasons why Maori patients are less likely to be prescribed antidepressants even though prevalence studies show Maori to have similar rates of depression to non-Maori. The findings are consistent with previous reports that depression among Maori patients is less likely to be diagnosed by GPs than among non-Maori. The implications of these findings point to the need for GPs to take special care in establishing effective communication with Maori patients, the need to gain the trust of Maori patients and note the reluctance of some Maori patients to talk about personal feelings which may provide clues about mental well-being and depression.

A previous study has suggested that Maori health care providers are better able to establish effective communication with Maori who have experienced cancer.¹⁴ The pattern of findings we have reported is consistent with the view that both patient characteristics and health care provider characteristics are influential in whether Maori patients get effective treatment when they are depressed.¹⁵ Compared to non-Maori, some Maori patients may be reluctant seek professional help for depression and to disclose information that provides GPs with clues about depression. Health care providers who are able to establish effective communication with Maori patients are more likely to diagnose depression among Maori and then be able to treat it.

A limitation of the present study is the relatively small number of GPs interviewed and the reliance on GPs' accounts only. However, the findings do provide a lead for further research on possible reasons for the underdiagnosis of depression among Maori patients. A strength of the study was the inclusion of both Maori and non-Maori GPs. While the GPs interviewed worked in a range of different practices, we did not have sufficient numbers to make comparisons between those working for Maori health care providers and GPs working in other health care settings.

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COMPETING INTERESTS

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