Reviews

The Presentation of Depression: Current Approaches. Edited by P. Freeling, L. J. Downey and J. C. Malkin (Occasional paper No. 36). London: The Royal College of General Practitioners. 1987. Pp 21. £4.00, inc. postage (Cheques should be made payable to RCGP Enterprises Ltd.)

This slim volume is a valuable digest of information on the present state of play with regard to the important problem of depressive illness in general practice. A small number of eminent workers present their most recent findings in easily digestible form and attractively spiced by their personal opinions.

Copeland summarises recent findings which enabled him and his co-workers to estimate the prevalence of depressive illness in the elderly community in disparate groups in New York, London and Liverpool. They examined the relationship between identification by GPs and by psychiatrists and diagnosis standardised by the AGECAT computer method. The elderly patient samples studied numbered several hundreds in the various locations. The overall figure of about 10% in the elderly community for severe and moderate depression combined reported over 20 years ago in Newcastle by Kay was confirmed. In both London and New York, physical illness and depression correlated strongly and the prognosis for many cases was poor. There was much evidence of under-diagnosis and bad treatment. A year later only about 50% of cases identified in London and in New York were under treatment by a doctor for any illness: 14% of identified depressives had received antidepressant treatment in London and only 4% in Liverpool. The usual male: female predominance was confirmed and it was noted that there was a decline of depression with age in females but not in males. The Liverpool studies involved 1070 people aged 65 and over selected by random sampling of general practitioners' lists. At follow-up a depressing outcome was observed, 40% being still ill with depressive symptoms some years later. Despite professional awareness of this problem for some years, little progress seems to have been made in the matter of primary diagnosis and treatment of the depressed elderly.

Copeland asks: "How much longer is this suffering going to continue, which destroys so many potentially useful lives and is clearly associated with increased mortality? It is for epidemiologists to reveal the problem, but it is up to general practitioners, particularly in academic departments of general practice, to investigate the causes and decide how the problem can be resolved in terms of the individual patient. Why has nothing been done? Could not the neglect in otherwise developed countries be described as a twentieth century scandal?" Strong words.

Of equal interest, significance and clarity is the short presentation by Bridges and Goldberg summarising recent work on the somatic presentation of depressive illness in primary care. With typical attention to rigorous method and clever use of the General Health Questionnaire, data are presented with reference to 590 consecutive attenders in general practice. Major depressive disorder was confirmed in no less than 13%. Of these, only 26% presented with psychological symptoms such as depressed mood—the majority had presented physical symptoms only, divided equally between those consulting their doctor for a physical disorder with co-existing depressive illness and a second most important group who 'somatised' their psychiatric illness. Of patients with major depressive disorder, 57% fulfilled strict criteria for somatisation and accounted for over 7% of all new illnesses. Overall 53% of patients with diagnosable depressive illness escaped detection by their doctors. Not only did their doctors fail to question closely to confirm the diagnosis of depression but the majority of missed cases had a physical illness with co-existing psychiatric disorder, the latter being missed.

This paper completes the picture so depressingly initiated by Copeland by showing that under-diagnosis and under-detection of depression also occurs in young and middle aged adults. The following wisdom is offered in conclusion: "There are, however, several ways in which recognition of a patient can be improved. These include guarding against the habit of diagnostic parsimony which sees a psychiatric illness as an alternative to a physical illness; being alert to cues of underlying psychological disturbance such as overt distress, presentation of atypical complaints and autonomic symptoms, and exacerbations of chronic physical illnesses; using screening questionnaires in a busy clinic such as the General Health Questionnaire and using screening questions during the consultation".

In response to these thunderous psychiatric broadsides, Burton and Freeling, both family doctors engaged in psychiatric research, summarise their well-known recent papers on the problem of unrecognised depression and give notice of data (yet to be published) on what promises to be the first really satisfactory double blind placebo controlled study of an antidepressant in the field of general practice.

This impressive collection of papers is completed by Paul Williams who took an original line in carrying out a detailed examination of depressive thinking in general practice patients. No less than a third of patients from one London practice admitted to ideas of worthlessness, hopelessness and a notion that life was not worth living. Suicidal thoughts affected 9 % of older men and a quarter reported two or more of the four categories of depressive thoughts studied intensively. The statistical analysis of the relationship between depressive thinking on the one hand and GP and psychiatrist diagnosis on the other is presented in some detail. A finding of particular interest was that the association between depressive thinking and correct diagnosis of depression was stronger in men than in women, and only slightly stronger for psychiatric than for general practitioner assessment. The concise style of this paper asks

more of the reader than do the more forthright presentations mentioned earlier but the conclusions are much the same.

A remarkable consensus emerges from this collection of studies conducted by a variety of methods and in different places. The most pressing need is for better training of family doctors in the examination skills necessary for diagnosis of depressive illness. The challenge to academic departments of both psychiatry and general practice is clear. Teachers of undergraduate psychiatry in particular should be moved to review urgently the content of their teaching on both sides of the Atlantic. For general practitioners and psychiatrists—and especially for trainee psychiatrists—this is a valuable booklet which provides an easy entrance to what has now become quite a complicated and important area of psychiatric research. The lists of references are comprehensive and this modest volume is likely to become a landmark of easy reference. No psychiatric library should be without a copy and the problem of case definition continues to vex.

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Psychological Problems: Who Can Help? By Hilary Edwards. Leicester: The British Psychological Society in association with Methuen (London). 1987. Pp 86. £3.95

> "This book is for you if you are an adult and you feel you have a psychological problem or have been told you have one. It may also be useful for other family members and friends".
>
> "It is not a self-help manual: It won't do the treatment for you, but it will give you some idea of what to expect from your therapist".

The aim is to present a factual and detailed picture of the world of mental health professionals. Accounts are given of the 12 different professionals involved, including a general practitioner, a psychiatrist, a clinical psychologist, a nurse therapist, a social worker and a counsellor. In addition, using case studies, the reader can 'glimpse' the workings of an anxiety management group, a desensitisation programme for a specific phobia, and a behavioural treatment for bulimia nervosa. The final 10% of the text is devoted to a 'spotlight on professional psychologists'.

From a medical and psychiatric perspective, the contents present a highly selective view of clinically important psychological problems. The section dealing with 'some common problems and their treatment' concerns the anxiety management of cat phobia, a severely overweight man, bulimia nervosa, sexual problems, learning to live with diabetes, chronic pain and rehabilitation after a stroke. Moreover, the 'different approaches to therapy' detailed are: counselling; a behavioural approach; cognitive therapy; a psychodynamic approach; and family therapy.

The author explicitly excludes consideration of drug and medical treatments. Nevertheless, there is repeated attention to the desirability of the patient reducing or stopping minor tranquillisers. Doctors might be interested in the ethical and professional assumptions underlying the following description: "After discussion with the psychologist (the patients) each wrote out a plan for gradually cutting down their tablets. For some this involved seeing their doctor to obtain lower dosage tablets or tablets which it would be easier to cut down... Some continued reducing their tablets after the group had finished meeting weekly".

The scope of the clinical psychologists' enterprise is apparently wide-ranging, and everywhere seeks to supplement, or substitute for, medical practice. Gemma Paris is learning to live with diabetes. Gemma's diabetes was diagnosed when she was 24. Four years later she met a clinical psychologist when she attended an information group for people with diabetes. The group helped her to develop the skills of looking after herself so that she could achieve good metabolic control. She got her diabetes under very good control, but she felt terrible about having diabetes at all. "So she went to see the psychologist... Using cognitive methods she learned to be much more realistic and positive about herself and her diabetes." With the psychologist she set goals for things she would do, like going out socially, and began to enjoy a more fulfilling life. Her more positive attitude was rewarded at work when she got promoted.

Perhaps the most interesting section of the booklet answers some of the questions one might have about clinical psychology. Here the reader learns what a professional is, and about the thorny problems, for psychologists, of registration and chartering. It may come as a surprise to some to find that at the moment anyone can call him or herself a psychologist. The British Psychological Society has applied to the Privy Council for a Charter to set up a *Register of Chartered Psychologists* to provide the public with a professional guarantee of qualifications. I understand that the Privy Council approved the Charter at the end of 1987 and interesting details will no doubt emerge shortly.

The author's postscript emphasises the difficulties faced by people with mental disorders in finding appropriate professional information, advice and treatment. She concludes with the hope that the reader will find the most suitable help and the, arguably appropriate, injunction, "Good Luck".

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Creating Community Mental Health Services in Scotland. Volume I: The Issues. Pp 132. £5.00. **Volume II: Community Services in Practice.** Pp 134. £5.00. Edited by Nancy Drucker. 1987. Obtainable from Scottish Association for Mental Health, 40 Shandwick Place, Edinburgh EH2 4RT

The publication of these two volumes is timely. The Scottish Home and Health Department and at least two of the major health boards in Scotland have admitted that, despite the various documents in recent years purporting to show a