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Research paper

Analysing UK clinicians' understanding of cognitive symptoms in major depression: A survey of primary care physicians and psychiatrists

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ABSTRACT

Background: Cognitive dysfunction occurs in depression and can persist into remission. It impacts on patient functioning but remains largely unrecognised, unmonitored and untreated. We explored understanding of cognitive dysfunction in depression among UK clinicians.

Methods: A multi-step consultation process. Step 1: a multi-stakeholder steering committee identified key themes of burden, detection and management of cognitive dysfunction in depression, and developed statements on each to explore understanding and degree of agreement among clinicians. Step 2: 100 general practitioners (GPs) and 100 psychiatrists indicated their level of agreement with these statements. Step 3: the steering committee reviewed responses and highlighted priority areas for future education and research.

Results: There was agreement that clinicians are not fully aware of cognitive dysfunction in depression. Views of the relationship between cognitive dysfunction and other depressive symptom severities was not consistent with the literature. In particular, there was a lack of recognition that some cognitive dysfunction can persist into remission. There was understandable uncertainty around treatment options, given the current limited evidence base. However, it was recognised that cognitive dysfunction is an area of unmet need and that there is a lack of objective tests of cognition appropriate for depressed patients that can be easily implemented in the clinic.

Limitations: Respondents are likely to be 'led' by the direction of the statements they reviewed. The study did not involve patients and carers.

Conclusions: UK clinicians should undergo training regarding cognitive dysfunction in depression, and further research is needed into its assessment, treatment and monitoring.

1. Introduction

Cognitive dysfunction is an important aspect of depression that includes problems with thinking, concentration and memory (American Psychiatric Association, 2013; Hammar and Årdal, 2009). Cognitive dysfunction is highly prevalent in people with depression and has a significant impact on functioning (Jaeger et al., 2006; McIntyre et al., 2013; Shilyansky et al., 2016). In a recent, cross-sectional, observational study in South Korea, greater functional disability and impairment in daily activities, including worse work-related productivity outcomes, were associated with more severe perceived cognitive dysfunction (Kim et al., 2016). The domains of executive function, working memory, episodic memory, attention and psychomotor processing speed are commonly affected in people with depression (McIntyre et al., 2013; Shilyansky et al., 2016), with poorer performance in neuropsychological tests being in the order of small (0.2) to medium (0.5) effect sizes compared to healthy individuals (Lee et al., 2012). Cognitive problems may also remain as residual symptoms

Abbreviations: GP, general practitioner; HCP, health-care professional

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during periods of remission from major depressive episodes (Conradi et al., 2011; McClintock et al., 2011), with residual symptoms increasing the risk of relapse (Judd et al., 1998). In a systematic review and meta-analysis of cognitive function, significant moderate deficits in executive function and attention (effect sizes ranging from −0.52 to −0.61) were found to persist in patients in whom depressive symptoms had remitted (Rock et al., 2014). This has been confirmed in a recent, large (n = > 700 completers), randomised trial of three antidepressants (escitalopram, sertraline and venlafaxine), which showed that even in patients whose depression remitted with treatment, there was no significant improvement in cognition, which remained impaired compared to matched healthy control individuals (Shilyansky et al., 2016). It has been suggested that cognitive dysfunction in depression is largely unrecognised and unmonitored by clinicians (Greer et al., 2010).

We aimed to explore the understanding of aspects of cognitive dysfunction in clinical depression (major depressive disorder) in the UK, using a multi-step consultation process involving primary and secondary care clinicians with an interest in depression. It was intended that through this process, priority areas to be addressed through education would be highlighted.

2. Methods

Using a multi-step process, we obtained and evaluated the views of primary and secondary care experts in depression. In Step 1, a multi-stakeholder steering committee (including eight psychiatrists, psychologists, primary care physicians, and representatives from occupational therapy and a depression charity) provided the three key themes, which were burden, detection and management of cognitive dysfunction in depression. Through round-table discussion, the steering committee developed ~10–15 statements for each of these areas to explore the understanding of clinicians and the level of agreement among them.

In Step 2, these statements formed an online survey (hosted by medeConnect, part of Doctors.net.uk) completed by 200 health-care professionals (HCPs) (100 general practitioners [GPs] and 100 psychiatrists) with an involvement in the management of depression in the UK. In order to be included on the HCP panel, participants had to have seen or treated a minimum number of patients with major depressive disorder in the previous 3 months: GPs ≥10 patients; psychiatrists ≥20 patients. Participants were asked to rate their level of agreement with the statements as “strongly disagree”, “disagree”, “agree”, “strongly agree” or “don’t know/uncertain”. Participants also had the ability to add free-text comments to expand on their responses. The level of agreement among respondents was defined by the steering committee as follows: High agreement, > 66% of respondents; Very high agreement, > 90% of respondents.

In Step 3, the steering committee reviewed feedback from Step 2 and highlighted priority areas for future education and research.

3. Results

A total of 200 respondents from across the UK completed the questionnaire (Table 1). In addition to rating the proposed statements, some respondents provided specific comments (Supplementary Table S1). Overall, there was High/Very high agreement among GPs and psychiatrists for 10 of 13 statements related to burden of cognitive dysfunction in depression, seven of nine statements on detection and seven of 12 statements on management.

3.1. Burden

There was High/Very high agreement from both GPs and psychiatrists for all except three of the statements related to burden of cognitive dysfunction in depression (Fig. 1). This suggested that both GPs and psychiatrists recognise that cognitive dysfunction occurs in depression and can have a significant impact on a patient's life, impairing a person's occupational, social, marital and parental functioning, and reducing their confidence. Additionally, clinicians agreed that cognitive dysfunction contributes to an overall increased economic and social burden of depression on the individual, their family and society as a whole. These views are illustrated by one psychiatrist who commented, “In clinical practice, I have seen the impact of cognitive dysfunction on patients’ lives and rightly so, it is disabling”. There was also agreement that more research into the burden of cognitive dysfunction in depression is required..

However, there was less agreement among clinicians regarding the persistence of cognitive dysfunction and the relationship with depressive symptoms, with views being inconsistent with the evidence that cognitive dysfunction persists into remission, at least in some patients (Rock et al., 2014; Shilyansky et al., 2016). Low agreement (≤50% agreement) was reached on Statement 2 *(Cognitive dysfunction in depression is independent of depressive symptoms)*; 50% of GPs and 57% of psychiatrists disagreed with this statement, with GP comments including, “How can you have cognitive dysfunction in depression without depression?” and “I’ve found some patients with “chronic depression” often have associated impaired or reduced cognitive function. I don’t know which causes which”. Similarly, only 40% of GPs and 54% of psychiatrists agreed with Statement 11 *(More than 30% of patients experience persistent cognitive symptoms despite remission of depressive symptoms)*. Individual comments included, “I associated cognitive dysfunction with the depressive illness but generally expect this to be restored once the patient has recovered from depression”, “Usually cognitive function improves in my patients, though not necessarily right at the outset of the improvement in mood” and “I don’t routinely see cognitive dysfunction persisting after symptomatic remission. If I did, I’d be investigating them for an independent cognitive problem”.

Despite High agreement from psychiatrists, only 52% of GPs agreed

Table 1
Role and geographical location of HCP panel.

Role	GPs	Psychiatrists
Seniority GP, %		
GP partner/Principal	78	
Salaried GP	22	
GP with special interest in mental health, %	26	
Seniority psychiatrist, %		
Consultant		79
Associate specialist		7
Staff grade		7
Specialist registrar 4		7
Psychiatry sub-speciality, %		
General adult psychiatrist		73
Old age psychiatrist		27
Mean major depressive disorder caseload in previous 3 months, n	43	64
Region, n		
North West	11	9
North East	4	4
Yorks and Humber	8	4
East Midlands	7	6
West Midlands	8	7
Eastern England	9	7
London	13	19
South East Coastal	7	11
South Central	6	7
South West	9	6
Scotland	10	8
Wales	5	5
Northern Ireland	3	7

Abbreviations: HCP, health-care practitioner; GP, general practitioner.