Knowledge And Attitudes Of General Practitioners About Depression

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ABSTRACT
Objectives: The purpose of this study is to learn more about general practititoners' knowledge, attitudes and social distance towards depression which is the most prevalent mental disorder seen in general practice.
Method: The survey was conducted in 2002 using face-to-face interviews in offices of 300 general practitioners in Turkey. Data were derived from the questionnaire developed for the survey called "Attitudes Towards Mental Disorders".
Results: Almost all of the practitioners believed that depression was treatable, and it could be completely cured according to 90% of the respondents. 80% of the practitioners considered "extreme sadness", near half of them "weak personality" and more than 90% "social handicaps" to be as the causes of depression. 66% believed that these patients would not improve unless social problems were solved. Attitudes of the subjects with relatives diagnosed depression, married, and older were more positive than the others with respect to social distance characteristics.
Discussion: Although general practitoners with closer social distance held more positive attitudes towards depression than community people, the results suggest that incorrect knowledge and beliefs about etiology, nonmedical treatment methods and risk of dependency have a tendency to persist in this group.
The results of this study underline the need for development of new education programmes aimed to decrease effects of stigmatization based upon information obtained more studies about attitudes and beliefs of physicians.
Keywords: depression, general practitioner, attitude

ÖZET
Pratisyen Hekimlerin Depresyon İle İlgili Bilgi ve Tutumları.
Amaç: Hekimlerin bilgi, tutum ve davranışlarının ruhsal hastalığı olanların uygun biçimde yardım alabilmelerini belirleyecek önemli bir etken olması nedeniyle, bu çalışmada pratisyen hekimlerin temel sağlık hizmetlerinde görülen ruhsal bozuklukların başında gelen depresyona ilişkin bilgi, tutum ve sosyal mesafe özelliklerinin araştırılması amaçlanmıştır.
Yöntem: Bu araştırma, 2002 yılında, İstanbul, Bolu, Trabzon, Adana ve Diyarbakır illerinde, il merkezi ve ilçe sağlık ocaklarında çalışan 300 pratisyen hekim üzerinde yapılmış olup, araştırmada "Ruhsal Hastalıklarda Tutum Projesi" için geliştirilmiş anket formu kullanılmıştır.
Bulgular: Pratisyen hekimlerin tamamına yakını depresyonu tedavi edilebilen, %90'ı da tam olarak düzelen bir hastalık olarak görmektedir. %90'nın üzerinde öncelikle bir hekime gidilmesi gerektiği, dörtte üç oranında da gidilen hekimin sağlık ocağı doktoru olması gerektiği düşünülmek-

tedir. Buna karşın, hekimlerin %80'i depresyonun aşırı üzüntü hâli olduğunu, yarıya yakını ruhsal zayıflık hâli olduğunu, %90'ından fazlası sosyal sorunlar nedeniyle ortaya çıktığını, üçte ikisi sosyal sorunlar çözülmeden iyileşmeyeceğini belirtmiştir. Depresyonu olan bir yakının olması, evli olma ve yaşın artması hastayla olan sosyal mesafeyi kısaltan değişkenlerdir.
Tartışma: Pratisyen hekimler depresyon için sosyal mesafeyi azaltarak, toplumun diğer kesimlerine göre daha olumlu tutumlar gösterebilmekle birlikte, hastalığın etiyolojisi, tıp dışı tedavi metotları ve ilâç bağımlılık riskleri bakımından doğru olmayan bilgi ve inançların yüksek sayılabilecek oranlarda devam edebildiği dikkati çekmektedir.
Bu araştırmanın sonuçları, hekimlerin depresyona ilişkin önyargılı ve hatalı tutumlarının azaltılmasına yönelik eğitim programlarına gereksinim olduğunun ve geliştirilecek bu eğitim programlarına temel teşkil etmesi için daha fazla sayıda araştırma yapılmasının önemine işaret etmiştir.
Anahtar Kelimeler: depresyon, pratisyen hekim, tutum

INTRODUCTION

According to the results of a study on more than 3000 US citizens in 1950 by Shirley Star (1955) who is one of the pioneers of social psychiatry and epidemiological research, people consider psychiatric disorders as dangerous situations which destroy logical thought. Later, it has been shown by studies in various cultures that the bias of "such patients are dangerous" is still going on and such stigmatizing affects the patients' lives and the society tends to decrease the interaction and stay away from such patients in places where social closeness exists (Arkar 1991, Crisp et al. 2000, Eskin 1989, Gureje et al. 2005, Link et al. 1997, Markowitz 1998, Özbek 1970, Pescosolido et al. 1999). Furthermore, findings are obtained which led us think that bias and false attitudes about psychiatric disorders are still effective in patients' relatives, medical stuff and even in psychiatrists. For instance, psychological health staff may have more negative attitudes towards patients who have alcohol addiction (Farrel and Lewis 1990) or an expression of "I do not prefer to take patients who have learning difficulty and psychiatric disorder into therapy program" can be used by consultant psychiatrists (Lennox and Chaplin 1996). In a study performed on 187 nurses and nursery students (Özyiğit et al. 2004), around 2/3 of the subjects declared not to work with a schizophrenic person and it was detected that the personality weakness was believed to be the reason for the disorder by almost half of them. The results of another study on 98 schizophrenic patient relatives in Istanbul, Izmir and Adana (Sağduyu et al. 2003), is interesting in that 72% of the subjects declared that the schizophrenic patients are hostile.

Schizophrenia and alcohol-substance abuse get the most biasing and labeling attitudes in psychiatric disorders (Crisp et al. 2000, Shulze and Angermayer 2003). For instance, according to a study performed on 707 adults in 24 towns of Istanbul (Sağduyu et al. 2001), 26% of the population believe that the schizophrenics are hostile and should not be allowed to live freely in the community. This ratio was found around 50% in another study performed in the rural area of Manisa on 208 adults (Taşkın et al. 2002). It was detected in a study performed on 1737 adults in England (Crisp et al. 2000) that schizophrenics and alcohol-substance abusers are believed to be dangerous and "unpredictable" with the ratios of around 70% and 80%, respectively. Although the study results point out the effects of common bias and false beliefs about schizophrenia, there are studies informing that depression gets such biasing and labeling attitudes as well. For instance it was detected in a study on 1737 subjects in England (Crisp et al. 2000) that 23% of the community believes that the depressed patients are dangerous for others, 56% believes that they have unpredictable attitudes, 62% thinks that it is impossible to get contact with them and 19% believes that the patients cannot control themselves. In the Istanbul group of 707 subjects (Özmen et al. 2003), 43% of them believes that the depressed patients are hostile, 23% thinks that they should not be allowed to live free in the community, 40% declared that they cannot work with a depressed person while 65% declared that they do not marry a depressed person, 28% stated that they do not prefer a depressed neighbor, 43% declared that they do not hire their apartment to a depressed person and 77% thinks that depressed people cannot give proper decisions about their own lives. Considering the sociodemographic variables about attitudes towards the depressed patients, many studies revealed that older age, decrease in the education and cultural levels negatively affect the attitudes (Brandli 1999, Özmen et al. 2003, Rahav et al. 1984); however, conflicting results can be encountered (Sellick and Goodear 1985).

Overall, although it is a common but successfully treated disorder, the findings point out that bias and inappropriate attitudes are still effective on depression, and the education and awareness-raising attempts are inade-

quate On the other hand, depression is the most common psychiatric disorder seen in primary health services and it is known that nearly _ of the patients consult general practitioners (Andrews and Carter 2001, Rezaki 1995, Üstün et al. 1997). There are many factors effective on proper diagnosis and appropriate treatment of depression at primary health care level; among those, attitude towards patient, knowledge and experience are the leading ones related to the physician. Results of a study performed on 420 general practitioners in Australia (Richards et al. 2004) revealed that physicians, who were intensively informed and educated about psychiatric disorders, believe more that they can help depression patients and can be professionally satisfied. In a study that compares the attitudes of psychiatrists, general practitioners and other specialists on 375 physicians working in two different health centers in the USA (Shao et al. 1997), it was found that the attitudes of psychiatrists were more positive, attitudes improved as the experience increased, as well as the level of psychosocial education increased. It was also revealed in this study that the general practitioners prescribed the antidepressant drugs without hesitation and more courageously than the other specialist group, the physicians were professionally more satisfied when working with such patients and sent less patients to psychiatry clinics. In another study that was performed on 520 physicians and medical school students in England (Mukherjee et al. 2002), it was found that the most negative attitudes were towards schizophrenic and alcohol-substance abuser groups, such patients were considered as dangerous and unpredictable (more than 50%). It was also detected in this study that more than 50% thinks that being in contact with a schizophrenic, demented depressed person is difficult, the level of labeling in preclinical students was similar to that of the community but decreased in the students of clinical period and observed least in physicians.

In our country (Turkey), data about the attitudes and knowledge of general practitioners towards depression is inadequate. Knowledge and attitude are the important factors that determine the proper help to psychiatric patients. Thus, the goal of this study was to reveal the knowledge and attitudes of general practitioners.

METHODS

Subjects

This study was performed in 2002 on 300 general practitioners who work in primary care units in Istanbul, Bolu, Trabzon, Adana, and Diyarbakir city centers or towns. The city selection was done regarding the level of development of State Institute of Statistics, number of psychiatrists and different geographical regions. The sociodemographic features of the sample group were given in the Results section.

Instruments

A questionnaire which was developed by Psychiatric Studies and Education Center Association (PSECA) for the "Attitudes Towards Mental Disorders" project (Sağduyu et al. 2001) was used. It has 3 sections in which the demographic and health characteristics, medical practice and depression sections have 7, 12 and 30 questions, respectively. The depression section has two subcategories. In the first part, a case of major depression which is similar to the definition in DSM-IV (American Psychiatric Association 1994) is given and the subjects were asked to reply 6 questions about the case. In the second part, the subjects were informed that the diagnosis of the case was depression and were asked to reply 24 questions and their attitudes about depression were examined. In each section, questions were read to the subject by an interviewer and proper choices were marked. Choices were arranged as "I agree1, I partially agree: 2, I partially disagree: 3, I disagree: 4, no opinion: 5".

Application

Five interviewers in total, one in each city, visited the practitioners in selected regions and applied the questionnaire by an interview. Inspectors and researchers were also attended to 10% of the interviews and gave necessary feedbacks. Interviewers were trained by the researchers before the study and their plot applications were observed by the inspectors. Plot applications were not included in the study. The number of interviewers was limited to 5 in order to provide consensus and the study was told in brief to them in order not to allow any bias.

Statistical Analysis

Results were transferred to the data base in SPSS-PC 11.0. In order to determine the opinions, beliefs and attitudes of physicians about depression, the questions were classified into 4 subgroups as "about diagnosis", "about etiology", "about treatment" and "about social distance". Then, the first three subgroups were divided into 2 as "responses to the questions in which the term depression was used" and "responses to the questions about the defined depression case". During frequency outputs, the choices of "I agree" and "I partially agree" were united and evaluated as "I agree"; while the choices of "I partially disagree" and "I disagree" were united and evaluated as "I disagree", and the ratio of "no opinion" choices were mentioned separately. Chi-squ-

Table 1: Sociodemographic Features of the Sample Group

	Istanbul Number %		Bolu Number %		Trabzon Number %		Adana Number %		Diyarbakır Number %		Total Number %	
Place of interview[a]												
City	80	100	9	22.5	25	41.7	30	50.0	31	51.7	175	58,3
Town	0	0	31	77.5	35	8.3	30	50.0	29	48.3	125	41,7
Gender[b]												
Male	28	35.0	26	65.0	38	63,3	36	60.0	48	80.0	176	58,7
Female	52	65.0	14	35.0	22	36.7	24	40.0	12	20.0	124	41,3
Age												
18-25	1	1.3	6	15.0	7	11.7	0	0	6	10.0	20	6,7
26-35	52	65.0	29	72.5	49	81.7	50	83.3	53	88.3	233	77,7
36-45	26	32.5	4	10.0	4	6.7	8	13.3	1	1.7	43	14,3
46-55	1	1.3	1	2.5	0	0	2	3.3	0	0	4	1,3
Marital status[c]												
Married	66	82.5	21	52.5	47	78.3	38	63.3	40	66.7	212	70,7
Widow/widower, separated, divorced	1	1.3	0	0	0	0	6	10.0	1	1.7	8	2,7
Never married	13	16.3	19	47.5	13	21.7	16	26.7	19	31.7	80	26,7
The year worked as a physician[d]												
1-5	20	25.0	27	67.5	30	50.0	23	38.3	46	76.7	146	48,7
6-15	50	62.5	11	27.5	29	48.3	31	51.7	14	23.3	135	45,0
16-25	10	12.5	2	5.0	1	1.7	6	10.0	0	0	19	6,3
Psychiatric disorder in relatives[e]												
Yes	9	11.3	5	12.5	11	18.3	16	26.7	20	33.3	61	20.3
No	71	88.8	75	87.5	49	81.7	44	73.3	40	66.7	239	79.7
If yes, degree of relationship												
Mother- father, brother/sister	6	66.7	4	80.0	5	41.7	13	76.5	2	12.5	30	50.8
Partner, child, other	3	33.3	1	20.0	7	53.8	4	23.5	14	87.5	29	49.2
If yes, previous diseases												
Depression	6	66.7	4	80.0	9	75.0	14	82.4	8	50.0	41	69.5
Schizophrenia and Others	3	33.3	1	20.0	3	25.0	3	17.6	8	50.0	18	30.5

a: The relation between the place of interview and city variables being significant, depending on Istanbul and Bolu group (x2= 87,943, df= 4, p= 0.001)
b: The relation between gender and city variables being significant, depending on Istanbul group (x2= 30,984, df= 4, p= 0.001)
c: The relation between marital status and city variables being significant, depending on Istanbul and Adana group (x2= 31,029, df= 8, p= 0.001)
d: The relation between the year worked as a physician and city variables being significant, depending on Istanbul, Bolu, and Diyarbakir group (x2= 50,346, df= 8, p= 0.001)
e: The relation between psychiatric disorder in relatives and city variables being significant, depending on Diyarbakir group (x2= 12,483, df= 4, p= 0.009)

are test was used for the evaluation of the relation between the sociodemographic categorical variables, while t-test was used for the evaluation of the difference between the averages of the two groups. Scores obtained from the responses of the questions on the beliefs about the diagnosis, etiology and treatment of depression and the social distance were added and the general total scores were obtained for the questions in which the term depression was used. During this procedure; if the choices "I agree" and "I disagree" pointed out positive attitudes or beliefs, it was given 1 point; if they pointed out negative or false attitudes or beliefs, it was given 0 point. In order to evaluate the demographic, health, diagnosis, etiology, treatment and total variables that affect the social distance points, multiple regression analysis was done by "retrograde elimination" method. The dependent variable of the analysis was the average of the total point that was obtained from the items which evaluated the social distance. The independent variables were the point averages that were obtained from the diagnosis, etiology, treatment and the sum of these three variables and the demographic-he-

Table 2: Social Distance Features towards Depressed Patient

	I agree number	%	I disagree number	%	No opinion number	%
I can work with someone with depression	266	88.7	31	10.3	3	1.0
I can marry someone with depression	168	56.0	126	42.0	6	2.0
Having a neighbor with depression does not disturb me	252	84.0	45	15.0	3	1.0
I do not rent my house to someone with depression	82	27.3	213	71.0	4	1.7
Depressed people are aggressive (hostile)	34	11.3	264	88.0	2	0.7
Depression patients should not be allowed to live freely in the community	17	5.7	282	94.0	1	0.3

alth variable. During these statistical evaluations, because of the fact that the number of the subjects who replied the questions as "no opinion" was 6 (2%) and under, these replies were excluded.

FINDINGS

Sociodemographic features of the sample group

Among the 300 physicians, 176 (58.7%) were male while 124 (41.3%) were female. Eighty physicians from Istanbul, 40 from Bolu, and 60 from each of the three cities Trabzon, Adana and Diyarbakir, were included in the study (Table.1). The average age was 31.40 (SD=5.01); the difference between the average ages of the female and male physicians was statistically significant (average age in men: 31.94, SD=5.24; average age in women: 30.63, SD=4.56; t=2.244, p=0.026). More than 2/3 of the physicians were married (n=212, 70.7%), the average duration of professional experience was 6.58 (SD=4.59). The difference between the working years of male and female physicians was not significant. 20.3% of the sample group (n=61) declared that they had a relative with psychiatric disorder. In this group, 50.8% declared that their parents-siblings had such disorders, among which 69.5% was depression.

When the distribution of the sociodemographic variables according to cities was investigated, differently from the other cities, the Istanbul group had more female physicians; married physicians in Istanbul group and widow/widower or separated physicians in Adana group were more than those of other groups. The professional life of the physicians in Bolu and Diyarbakir groups were shorter than that of the Istanbul group. The highest ratio (33.3%) for psychiatric disorders in physician relatives was found in the Diyarbakir group (Table 1).

The social distance features related to the depressed patient

According to the responses obtained from the social distance questions in which depression was given as the term (Table 2), 15% or less of the physicians declared that they will be disturbed by a depressed neighbor, will not want to work with such persons and they think that such persons are dangerous and should not be allowed to live freely in the community. Furthermore, 27.3% does not prefer to rent his/her apartment to a depressed person while 42% does not prefer to marry a depressed person.

Features of beliefs about recognizing depression, its etiology and its treatment

When depression was given as a term, 95.3% of the physicians consider it as a disease, while 4.3% consider it as a mental disease, 99% as a treatable disease (97.3% with drug therapy, 93.6% with psychotherapy) and 90.7% as a totally curable disease. According to the responses given to the questions in which the depression was given as a case, 98.7% of the physicians thought that the case has a psychiatric disorder while 6.3% thought a physical disease, 92.3% advised to consult a physician, 74.3% to a primary care unit physician and 24.7% to a psychiatrist (Table 3).

However, when depression was given as a term, it was found that 80% of the physicians think that depression is the state of being deeply sad, 47.3% as psychologically weak state while 39.7% consider it not as a disease but as a state that everybody may have from time to time. Similarly, again when it was given as a term, 94.7% believed that it is because of the social problems, 8.7% thought that it is contagious and 7.4% considered it congenital. Some 25.3% thought that there are severe side effects of the drugs, 20.5% believed that it is an addiction, 12.7%

Table 3: Beliefs about the Recognizing, Etiology and the Treatment of Depression

	I agree number	%	I disagree number	%	No opinion number	%
Recognizing depression						
• Depressed people are mentally disordered	13	4.3	285	95.0	2	0.7
• Depression is a disease	286	95.3	14	4.7	0	0
• Depression is being deeply sad	240	80.0	60	20.0	0	0
• Depression is the state of mental weakness	142	47.3	15	52.7	0	0
• Depression is not a disease but a mental state people frequently experience	119	39.7	181	60.3	0	0
• There is mental disease in A	296	98.7	4	1.3	0	0
• There is physical disease in A	19	6.3	277	92.3	4	1.3
The etiology of depression						
• Depression occurs because of social problems	284	94.7	16	5.3	0	0
• Depression is contagious	26	8.7	274	91.3	0	0
• Depression is congenital	22	7.4	273	91.9	1	0.7
• Social problems caused A to be in this situation	274	91.3	23	7.7	2	1.1
• Personality weakness is the cause of A's situation	97	32.3	198	66.0	5	1.7
Treatment of depression						
• It is a curable disease	294	99.0	0	1.0	0	0
• It is a disease that can be cured with drug	289	97.3	7	2.7	0	0
• It is a disease that can be cured with psychotherapy	278	93.6	19	6.4	0	0
• Not totally curable	28	9.3	272	90.7	0	0
• The drugs used in the treatment create addiction	61	20.5	235	79.1	1	0.3
• The drugs used in the treatment have serious side effects	75	25.3	220	74.1	2	0.7
• Mystic or religious people may be of help	38	12.7	258	86.0	3	1.3
• It will not be cured before social problems are solved	199	66.3	100	33.3	1	0.3
• Change of environment contribute greatly to the recovery	268	89.3	32	10.7	0	0

A: Defined depression case

thought that mystic or religious people may be of help, 66.3% thought that it can not be treated without solving the social problems, 89.3% declared that change of environment may contribute to treatment. 91.3% believed that the social problems are the reason for depression while personality weakness was considered by 32.3% (Table 3).

Belief features about sociodemographic, health and diagnosis-treatment-etiology that predict the social distance score about the depressed patient

To investigate the demographic features that affect the social distance point in depressed patient such as psychiatric disorder in the family, recognition of the disease (term or case sample) and beliefs about etiology and treatment, regression analysis was performed. In order to do that, the "I agree" responses which were given to the first 3 item in Table 2; 2nd and 6th items from the diagnosis part of Table 3; 1st, 2nd, 3rd and 10th items from the treatment part of Table 3 represented positive belief and attitudes and were coded as 1, "I agree" responses to other items represented negative belief or attitudes and were coded as 0. According to the responses that were obtained from the questions in which the depression was given as a term; the points for the beliefs towards social distance, diagnosis and treatment and the total point (except for the social distance feature); according to the responses that were obtained from the questions in which the depression was given as a case; the points for the beliefs towards diagnosis, etiology and treatment and the total points were calculated. The average points of the questions in which the depression term and case sample were used, other descriptive sta-

Table 4: Average Points of the Items where the Beliefs and Attitudes towards the Social Distance, Diagnosis, Etiology and the Treatment are Questioned, Other Descriptive Statistics and Reliability Values

	Average	Standard deviation	Minimum-maximum	Cronbach alfa
According to replies taken from the questions in which the term depression is used:				
Social distance	4.82	1.28	1-6	0.76
Diagnosis	3.23	0.99	1-5	0.58
Etiology	1.88	0.48	0-3	0.56
Treatment	6.59	1.34	1-9	0.62
Total (except social distance)	11.70	2.12	3-16	0.60
According to the replies taken from the defined depression case:				
Diagnosis	1.91	0.29	1-2	0.55
Etiology	0.74	0.54	0-2	0.59
Treatment	1.91	0.29	0-2	0.64
Total	4.56	0.73	2-6	0.61

*High averages show positive beliefs and attitudes.

Table 5: Demographic Features and Beliefs towards the Disease Which Predict the Scores of Social Distance to the Depressed Patient

	P value	Regression coefficient	P. correlation coefficient	%95 reliability interval
The type of mental disorder in his relatives	0.027	-0.836	-0.293	-1.571/-0.100
Age	0.029	0.056	0.290	0.010/0.171
Marital status	0.046	-0.789	-0.266	-1.562/-0.015

Sociodemographic-health variables, variables of beliefs and attitudes towards the depression term and case were included in the analysis.

tistics and reliability values were given in Table 4; variables that affect the social distance features were given in Table 5. Age, marital status and having a relative with psychiatric disorder were observed as statistically significant predictors for the social distance scores. In other words, older age, being married, and having a relative with psychiatric disorder tend to make social distance closer.

DISCUSSION

In the sample group which consists of 26-35 year-old physicians with a ratio of around 3/4, around 1/5 of the physicians' relatives have a psychiatric disorder, with a majority of depression. When the social distance features were examined, except the items about rent and marriage, the negative attitudes were detected as 15% and below. This result is consistent with the literature data which points out that the bias and negative attitudes towards depression are less than those towards schizophrenia.

On the other hand, it was observed that the general practitioners within the sample group had reduced social distance and positive attitudes towards depression than the community, patient relatives and other medical staff, including these two items. This finding is consistent with the studies which conclude that negative attitudes and bias increase as the age increases and the psychosocial information and level of education decrease. Because 1/5 of the sample had a relative with psychological disorder, and were composed of younger and educated people relatively. According to the results of the regression analysis, having a psychologically disordered relative, being married and getting older positively affect the social distance; having such relatives may have led to obtain accurate information and attitude about the disorder. On the other hand, the effects of age and marital status on the social distance were interesting and worth studying on. Moreover, different from the results of another study which used the same questionna-

ire (Sağduyu et al. 2003), the internal reliability was found moderate-low except for the social distance items. This underlines the necessity for new studies to have more accurate comments on the measurement techniques and evaluation items.

The results of the study revealed that depression was well recognized and the physicians were optimistic for the treatment when depression was given either as a term or in case sample. Nevertheless, it was found that inappropriate knowledge about its etiology, extra medical treatment methods and drug addiction risks were present with relatively high percentages. For instance, the findings of considering it as deep sadness (80%), as psychological weakness (around 50%), not as a disorder but a state that everyone may experience from time to time (%40), as a contagious disease (9%), as a congenital disease (7%) and believing that the drug used for its treatment cause addiction (1/5) are striking. Moreover, more than 90% of the physicians believe that social problems are responsible for depression and 2/3 think that it cannot be treated without solving the social problems. These findings revealed that the community as well as the physicians underline the social problems in the etiology of depression and when evaluated with the results of other studies (Özmen et al. 2003, Özyiğit et al. 2004, Sağduyu et al. 2001, Sağduyu et al. 2003), it is believed that the social factors are more responsible for depression than for schizophrenia.

CONCLUSION

Overall, general practitioners play an important role in the diagnosis and effective treatment of depression which is one of the leading psychiatric disorders in primary health services. Studies that evaluate the factors which are effective on the attitudes of the practitioners towards depression will improve the data about the subject and will lead to develop new education programs to decrease the negative effects of bias and labeling.

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