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BRIEF REPORT

Primary care physicians' knowledge, attitudes, and clinical practices regarding the management of anxiety and depressive disorders in Georgia

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ABSTRACT

Objective: This study assessed primary care physicians' (PCPs') knowledge, attitudes, self-efficacy, and clinical practices regarding anxiety and depressive disorders in Georgia and identified key barriers to effective care delivery.

Method: A cross-sectional survey was conducted among 78 PCPs in two regions of Georgia using a structured questionnaire that included the Depression Attitude Questionnaire (DAQ). Data were analyzed using chi-square tests and binary logistic regression.

Results: PCPs relied heavily on pharmacotherapy, which was used by 78.2%, whereas fewer than 13% reported using structured psychological interventions. Physicians expressed significantly greater confidence in diagnosing and managing anxiety than depression ($p<0.001$). Although 65.4% recognized psychotherapy as an effective treatment, 67.9% regarded it as an intervention that should be delivered only by specialists. Female physicians were more than twice as likely to use nonpharmacological interventions than male physicians (odds ratio=2.15, $p=0.019$), despite reporting lower self-confidence.

Conclusion: Primary mental health care in Georgia is constrained by the predominance of pharmacological treatment and low physician self-efficacy. Improving service delivery requires targeted training in psychological interventions, supportive financing mechanisms, and greater multidisciplinary integration.

Keywords: Primary care, anxiety disorders, depressive disorders, psychotherapy

INTRODUCTION

Anxiety and depressive disorders are leading causes of disability worldwide, substantially reducing quality of life and increasing healthcare costs. Despite the availability of effective treatments, these conditions remain underdiagnosed and undertreated, particularly in low- and middle-income countries where access to specialist mental health services is limited (1).

Primary care (PC) is a critical setting for addressing these disorders because of its accessibility and role as the first point within the healthcare system (2, 3). Global strategies, including those promoted by the World Health Organization, emphasize the integration of mental health services into primary care as a scalable and cost-effective approach (4). Evidence from high-income countries indicates that collaborative and stepped-care models can significantly improve patient outcomes (5).

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Successful integration, however, is often hindered by provider-level barriers, including insufficient training, low self-efficacy, and stigma, as well as system-level constraints such as limited consultation time, inadequate financing, and weak referral pathways (6). Consequently, primary care frequently remains dominated by a biomedical model characterized by a strong reliance on pharmacotherapy and limited use of psychological interventions.

These challenges are particularly pronounced in post-Soviet healthcare systems such as Georgia's. Structural reforms have historically prioritized hospital efficiency, while the integration of mental health services into primary care has remained fragmented and specialist-centered (7). Empirical evidence regarding Georgian primary care physicians' (PCPs') knowledge, attitudes, and clinical practices related to mental health care remains limited (8).

This study aimed to assess the knowledge, attitudes, and self-reported clinical practices of PCPs in Georgia regarding anxiety and depressive disorders and to identify key educational and systemic barriers to effective care. By situating the findings within the broader context of health system transformation, the study seeks to inform context-specific reforms and contribute to the international literature on mental health integration in primary care.

METHODS

Study Design and Setting

A cross-sectional survey was conducted between September and December 2025 to assess primary care physicians' knowledge, attitudes, self-efficacy, and clinical practices regarding anxiety and depressive disorders in urban and semi-urban areas of Georgia.

Sampling

Using nonprobability convenience sampling, 103 PCPs were invited to participate, of whom 78 completed the questionnaire, yielding a response rate of 75.7%. Eligible participants were family physicians actively practicing in primary healthcare facilities. Although the sampling method may have introduced selection bias, the sample size was considered sufficient to detect medium effect sizes in an exploratory study.

Data Collection

A structured, self-administered questionnaire assessed four domains: sociodemographic and professional characteristics, knowledge, attitudes, self-efficacy, and clinical practices. Attitudes were measured using the Depression Attitude Questionnaire (DAQ).

The DAQ was translated into Georgian using a forward-backward translation procedure and was reviewed by experts to ensure cultural appropriateness. A pilot test involving five physicians was conducted to assess clarity. Internal consistency was acceptable, with Cronbach's alpha values ranging from 0.72 to 0.81.

Anonymous paper-based questionnaires were distributed to physicians who voluntarily agreed to participate. To reduce social desirability bias, no personally identifiable information was collected, and participants were assured of confidentiality. No incentives were provided.

Statistical Analysis

Data were analyzed using IBM SPSS Statistics, version 26.0. Descriptive statistics were used to summarize participant characteristics and survey responses. Chi-square (χ^2) tests and Cramer's V were used to examine associations between categorical variables and estimate effect sizes, with values of at least 0.10, 0.30, and 0.50 interpreted as small, medium, and large effects, respectively. Binary logistic regression was used to identify predictors of the use of nonpharmacological interventions. Results are reported as odds ratios (ORs) with 95% confidence intervals (CIs). Statistical significance was set at $p<0.05$.

Ethical Considerations

The study was approved by the Caucasus University Ethics Committee (Protocol No. CU 53-12.01.25) and was conducted in accordance with the Declaration of Helsinki. All participants provided informed consent.

RESULTS

The study included 78 PCPs of whom 46 were women and 32 were men. The overall response rate was 75.7%.

Pharmacological approaches predominated. Antidepressants were identified as effective by 79.5% of participants, whereas 62.8% recognized psychotherapy as effective. Perceptions of treatment effectiveness were less consistent for anxiety disorders than for depressive disorders.

A substantial confidence gap was observed between the management of anxiety and depression (Table 1). PCPs reported greater confidence in recognizing and diagnosing anxiety than depression (66.7% vs. 33.3%, $p<0.001$). They were also more

Table 1: Confidence in clinical practice and gender differences in clinical interventions

Domain/intervention	Total/subgroup	n (%)	p
High level of confidence	Anxiety	Depression	
Recognition and diagnosis	52 (66.7%)	26 (33.3%)	**<0.001**
Overall management	38 (48.7%)	11 (14.1%)	**<0.001**
Gender differences in clinical practice	Female (n=46)	Male (n=32)	
Psychoeducation	31 (67.4%)	13 (40.6%)	**0.022**
Supportive therapy	28 (60.9%)	12 (37.5%)	**0.041**
Family-oriented care	22 (47.8%)	8 (25.0%)	**0.040**
Pharmacotherapy	39 (84.8%)	26 (81.3%)	0.681

Female physicians were more likely than male physicians to use non-pharmacological interventions (OR=2.15, 95% CI: [1.12–4.11], p=0.019). Bold values indicate statistical significance (p<0.05).

Table 2: Attitudes of primary care physicians toward the management of depression

Attitudinal statement	Respondents agreeing n (%)
Working with patients with depression is emotionally demanding.	71 (91.0)
Depression is a natural consequence of life stress.	64 (82.1)
Helping patients with depression is more difficult than treating patients with other conditions.	61 (78.2)
Most patients with depression require care from a mental health specialist.	55 (70.5)
Psychotherapy should be provided only by mental health specialists.	53 (67.9)
Psychotherapy is the most effective treatment for depression.	51 (65.4)
Nurses play an important role in the management of depression.	46 (59.0)
Treating depression is an important responsibility of family physicians.	41 (52.6)
Antidepressant medications only mask the symptoms of depression.	32 (41.0)

confident in managing anxiety than depression (48.7% vs. 14.1%, p<0.001). Overall, PCPs reported independently managing only 34.6% of patients with anxiety or depressive disorders, while 65.4% were referred to specialists. Pharmacotherapy was the most frequently used intervention, reported by 78.2% of participants. In contrast, structured psychological approaches, including counseling and problem-solving interventions, were used by fewer than 13%.

PCPs expressed ambivalent attitudes toward their role in depression care (Table 2). Although 52.6% regarded the treatment of depression as part of the family physician's role, 70.5% believed that most patients with depression required specialist care. High levels of perceived burden were also reported. A total of 91% described working with depressed patients as demanding.

DISCUSSION

This study identified a consistent pattern of pharmacological dominance, low physician self-efficacy, particularly in depression care, and limited use of psychological interventions within Georgian primary care. These findings institutional and professional barriers commonly observed in transitional healthcare systems (9).

The strong reliance on pharmacotherapy, despite widespread recognition of the effectiveness of psychotherapy, indicates a substantial implementation gap (10). This pattern suggests the persistence of a biomedical model in which mental disorders are conceptualized primarily as conditions requiring medication. Such an approach is common in post-Soviet healthcare contexts, where mental health services have traditionally been specialist-driven and pathology-oriented.

The marked deficit in self-efficacy related to depression, compared with anxiety, suggests that PCPs perceive depression as more complex and less manageable. This finding is consistent international evidence showing that PCPs often experience difficulty managing the chronic and psychosocial dimensions of depression (11). Low self-efficacy remains an important barrier to integrating mental health care into primary care. Greater confidence in anxiety management may be related to the frequent somatic presentation of anxiety symptoms. In contrast,

effective depression care often requires nuanced communication and longitudinal monitoring, all of which may be difficult to provide during time-limited consultations.

The finding that many PCPs acknowledged a role in depression care while still preferring specialist referral reflects a referral-oriented clinical culture (12). In healthcare systems with weak integration mechanisms, responsibility for mental health care may formally remain within primary care but be functionally transferred to specialists.

Female physicians were significantly more likely to use nonpharmacological approaches, including psychoeducation and supportive therapy, despite reporting lower self-confidence. This finding is consistent with international evidence indicating that female physicians may use more patient-centered communication and psychosocial approaches than male physicians. Its relevance in Georgia, however, is context-specific (13). Within a healthcare system historically dominated by a specialist-centered biomedical model, female PCPs may demonstrate greater behavioral readiness to adopt integrated mental health practices. Their proactive use of psychosocial strategies despite lower perceived confidence suggests that they may serve as early adopters of reform. Consequently, mental health policies in Georgia should build on these gender-specific clinical strengths to support the transition toward a more holistic model of primary care.

System-level barriers, including high patient workloads and the absence of adequate reimbursement mechanisms for mental health services, create structural disincentives for comprehensive care (14). Under these conditions, pharmacotherapy may become the most feasible and readily available intervention. Transitioning to integrated care will require strengthening training in primary care–appropriate psychological interventions and integrating mental health professionals into multidisciplinary primary care teams (15).

The findings demonstrate how global models of mental health integration are shaped by local institutional conditions. Improving mental health service delivery in Georgia requires a dual approach that strengthens physicians' competencies while addressing structural barriers that reinforce pharmacological dominance.

Specifically, introducing performance-based financial incentives for mental health screening and embedding mental health nurses within primary care teams could help shift the current referral-oriented culture toward integrated care while reducing the workload of individual primary care physicians.

Study Limitations

The cross-sectional study design and convenience sample of 78 participants recruited from only two regions limit the generalizability of the findings and preclude causal inferences. Additionally, the use of self-reported data may have introduced social desirability bias. Despite these limitations, the findings highlight the urgent need for targeted educational initiatives and health system reforms to strengthen mental health care in primary care settings.

CONCLUSION

This study identified important gaps in Georgia's primary mental health services, particularly the persistent reliance on pharmacotherapy and low physician self-efficacy in managing depression. These challenges reflect both individual competency gaps and structural constraints within a transitional healthcare system.

The findings reveal a mismatch between the recognized importance of primary mental health care and PCPs' practical capacity to deliver it. This mismatch is reinforced by a referral-oriented culture and insufficient training in psychosocial interventions. Addressing these challenges requires a coordinated system-level response that prioritizes practical training in primary care–adapted psychological interventions and creates supportive institutional conditions through improved financing, reduced workloads, and the integration of multidisciplinary primary care teams. Ultimately, the successful integration of mental health services into primary care in Georgia will depend on aligning evidence-based models of care with local institutional realities to ensure that policy ambitions translate into effective service delivery.

Ethical Approval: This study was approved by the Research and Ethics Committee of Caucasus University (Approval No. CU 39-21.01.24 – 01.21.2024).

Informed Consent: Written informed consent was obtained from all participants.

Conflict of Interest: The author declared that there is no conflict of interest.

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