DEPRESSION IN PRIMARY CARE – LESSONS FROM A CASE STUDY

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ABSTRACT

Depression is under-diagnosed in primary care as it may present with atypical symptoms such as those of somatization. The psychological distress may also be modified by cultural, social factors and incidents. Family doctors are well placed to diagnose and manage many patients with depression. Referral to clinical counselors and psychiatrists for co-management should be done when appropriate. These issues are exemplified by the case study presented.

Keywords: Depression, primary care, somatization. Cultural and social factors

INTRODUCTION

The prevalence of depression in Singapore was estimated from a National Mental Health Survey in 1997/8 to be 8.6 % in adults and 5.7% in the elderly. These figures are higher than those reported in surveys in Asian societies for example Japan (3%) but lower than those reported in the West (usually more than 10%).

Prof Tajima, Professor of Psychiatry in Kyorin University Japan[1] believes that in traditional Asian culture, people who have depression-related symptoms may not view or report their problem as needing psychiatric or psychological intervention. He cited the observation that in the Japanese society, 'melancholic mood is socially acceptable, so mild or moderate depression is not considered abnormal'. This perception may account for the low reported prevalence of depression in Japan even though the suicide rate is high (Japan 37/100,000 1996; Singapore 24/100,000 population 1994).

Many patients may be either unaware that they are suffering from depression, or may not seek help as they accept some degree of suffering as part and parcel of living. Patients may also deem other avenues of help, for example from traditional medical healers and clergy, as being more appropriate than doctors. Many cases of depression may thus remain undetected and untreated. This phenomenon is not peculiar to Asian societies, as even in the developed societies of Western Europe, there is evidence that "45.4% of people suffering from depression get no treatment"[2].

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The known incidence of patients being treated for depression in primary care in Singapore is low. The 2001 survey of primary health care in Singapore revealed that depression was not in the 10 most common diagnoses made in primary care consultations[3]. This contrasts with the family practice patterns in Australia, where depression is reported to be the 4th most common illness encountered. It is estimated that between 15% to 29% of patients consulting GPs have depressive symptoms[4].

The under-diagnosis in Singapore may be due to both patients' and doctors' perception of depression. As an indication of the former, the Singapore Health Promotion Board 2002 Survey of "Singaporeans' knowledge and attitude towards mental disorders" revealed that while most respondents had heard about depression and could identify some of the symptoms, 1 in 4 thought that people with depression had "only themselves to blame" for their condition and two thirds viewed depression as a condition in which "depressed people could use their personal will-power to pull themselves together if they wanted to".

These social expectation and stigmatization may therefore make it difficult for patients to present to their doctors with affective symptoms. Instead, the somatic symptoms of depression become the more acceptable complaints to seek help by. As a result, patients often present with symptoms that masquerade as culturally and socially presentable illnesses. If the attending doctor approaches symptoms biomedically only, the diagnosis of depression may be missed.

In addition to the social and cultural factors, social incidents may also affect the presentation of depression, as will be illustrated by the case study below. It can be said then that to be receptive to the depressed patient, the family doctor has to be aware of the social, cultural and incidental backdrop in which the patient presents.

The authors reported a case of depression occurring in a middle-age woman in the Singapore Medical Journal[5]. This case illustrates issues relevant to family doctors viz. atypical presentation of "fever" incident to the SARS outbreak with social and marital discords as precipitating factors. It also provides lessons for the management of depressive illness in the primary care setting. We believe that this is the first report in the literature of fever attribution in a depressed patient. An abstract is available at www.ncbi.nlm.nih.gov and the full paper from www.sma.org.sg.

CASE REPORT

Recurrent Fever during the SARS outbreak in Singapore

A 48-year-old female teacher consulted her family doctor repeatedly for recurrent 'fever' during the SARS outbreak.

Mandatory temperature monitoring was instituted in schools nation-wide to detect and contain the novel virulent virus that presented like influenza. She was sent home from work several times when she was thought to have a high body temperature, which in the early part of the outbreak was defined as oral temperature greater than 37.5 degree centigrade. The family doctor did blood tests and treated the 'febrile' episodes with extended home leave, antibiotics and other medications but the fever recurred.

She was referred to the author who did not find any biomedical cause to explain the fever. Basic blood tests like thyroid function tests and blood counts were normal. Fever attribution was diagnosed when a one-week self-charting of temperature showed that temperature readings reported to be high by patient were in fact consistent with normal diurnal variation. She was reassured and prescribed medicine for anxiety disorder.

Marital Discord and depressive symptoms Revealed

On review two weeks later, the 'fever' did not recurred but other complaints such as 'lump in the throat' surfaced. *Active listening* revealed that her husband who was teaching in a university in China had sought a divorce from her at the time her fever attribution started. The patient then revealed also having symptoms suggestive of depression such as mood swings with uncontrollable crying when at home in the evening, early awakening, feeling of worthlessness, fatigue, poor concentration and appetite and psychomotor retardation (Fig 1). She was fearful of dying from SARS but did not contemplate suicide.

The outpouring of emotions came when the author enquired about the family and its relation when sketching the *family genogram* (Fig 2). Her two adults sons who were with her in Singapore did not offer her any counsel. Despite her lack of sleep, she felt better at work by keeping busy. But once back home alone in the evening, she would sob uncontrollably sometimes during the long-distance phone conversations with her husband in China.

Managing Depression in Primary Care

The patient was diagnosed to have major depression. She was counseled using techniques of *cognitive based therapy* and prescribed paroxetine (Seroxat) 20 mgm a day. Her symptoms abated only to relapse when her husband instituted legal proceedings for the divorce.

The patient was then referred to a clinical counsellor for co-management. She was able to come to terms with the loss and steadily improved. Nine months after the diagnosis was made, she was taken off medication and has remained well.

DISCUSSION

Depression is under-diagnosed in primary care for many reasons. Psychological distress is often somatised by patients and tends to be presented as physical complaints like headache, chest, abdominal pain and even fever. Family doctors unfortunately sometimes fixate on such physical symptoms, investigating and treating these symptoms without exploring the psychosocial issues that could lead to a better understanding of the patient's suffering.

In describing the cultural dimension to depression during WONCA Kyoto 2005 Conference's Seminar on Depression, Prof Tajima, professor of psychiatry in Japan Kyorin University believes that in many Asian societies, social harmony is considered so paramount that interpersonal and internal conflict are avoided whenever possible. This is in contrast to the open expression of interpersonal conflict and confrontation, which are more acceptable and even considered healthy for individuals in Western societies.

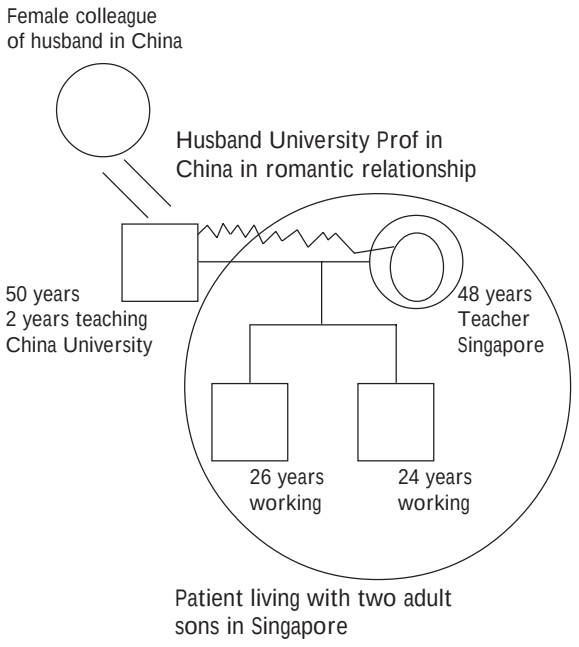
Fig 1. Diagnostic Criteria of Major Depression According to the Diagnostic Statistical Manual IV Of the American Psychiatric Association

DSM IV - M SIG E CAPS

(5 of 9 of the symptoms for > 2 wks including M or I)
(Significant impairment & not due to substance abuse alone or bipolar disorder)

- Mood down
- Sleep disturbance
- Interest/pleasure loss
- Guilt inappropriate/worthless
- Energy down
- Concentration poor
- Appetite change
- Psychomotor down/Agitation
- Suicide/death focus

Fig 2. Family Genogram of index patient



Parallel to these observations, Dr Christopher Moody who also spoke at the same seminar, attributed the decline in suicide rate in Australia the over past 6 years from 14.7 (1997) to 11.1 (2003) per 100,000 population to the destigmatisation of depression in his country. The destigmatisation is reflected in the open discussion in the media by those so afflicted and depression being a common reason for encounter in GP practices[4].

There is abundant opportunity to detect and treat depression in primary care. The family doctor has a long and on-going relationship with many patients and their families. The knowledge and understanding of the patient and his/her family and the trust built up form a firm foundation for counseling. Brief counseling techniques such the 'BATHE' technique[6] pioneered by Stuart and Liebermann and Cognitive Based Therapy have been shown to be effective in primary care practices. These psychological interventions can be used with the many effective anti-depression drugs now available.

Some depressed patients need to be referred to professional counselors for more formal therapy and to consultant psychiatrists for specialized treatment. Some indications for referrals to social work agencies and professional counseling centres include complex social dysfunctions, the need to establish social support and safety network, and for long-term follow-up and rehabilitation for the patients and their family. The specialized skills of psychiatrists are needed in a number of clinical situations[7] viz. when the diagnosis is uncertain, when risks of suicide are high, when drug treatment did not work or produce unacceptable side effects or when special intervention such as electro-convulsive treatment is deemed appropriate. Even then, the family doctor should remain a part of the greater team caring for the whole patient and his family, particularly during the phase of social re-integration in the community.

WHO forecast that the disease burden of depression would rise from being forth in year 2000 to second in 2020. It therefore is imperative that family doctors detect depression early and to manage it well. Prompt detection and appropriate treatment of depression reduces both mortality and morbidity. Moreover, managing depression in patients with chronic illnesses should also be an integral part of total patient care for the same reasons. There is therefore a real need for family doctors to upgrade themselves in psychological interventions and pharmacological treatments to meet these present and future challenges.

CONCLUSION

- Depression is under-diagnosed in primary care.
- Family doctors must be aware of atypical presentation of depression in primary care such as somatization.
- The presentation of psychological distress may be modified by cultural, social factors and social incidents.
- Family doctors are well placed to diagnose and manage many patients with depression with anti-depressant drugs and brief counseling.
- Referral to clinical counselors and psychiatrists for co-management should be done when appropriate.

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