
FORUM

Part 1: It is Time to Bring Depression Out of the Closet — Dr R Kirkby



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Curriculum vitae

Russel Kirkby obtained his MBChB from the University of Pretoria in 1974. He succeeded in getting the Diploma in Anaesthetics in 1978 and a BSc Hons in Pharmacology from the University of Potchefstroom. He continued to study and was awarded the MFGP and the MPrax Med (Medunsa) in 1985. He and his wife Robyn, lived in Umkomaas where he practiced as a GP for several years, but has now joined a group practice in Pietermaritzburg. He is an active leader in the Academy of Family Practice and has given some well-received talks to CME groups. They have three children.

Summary

GPs often avoid (and neglect!) patients with depressive disease. This may be the result of their medical training. As students they only see depressed patients in "Mental Institutions" – and these are not the same category of patients who come to them in their practices. Students are being trained to diagnose depression by exclusion, thus creating the impression it is a less significant disease. There is a great need to train students "hands-on" in this field to change their bias against mental diseases, show them that depression is a legitimate organic disease with significant biochemical abnormalities – a disease that needs not only insight into a life style, but sometimes aggressive treatment with a follow-up programme to prevent relapses.

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Two contributions by Russell Kirkby are placed in our Forum section for discussion. He firstly gives his opinion on South African general practitioners' views on depression. Secondly he relates a patient story that sparked his interest in the subject. He and I await your responses.

Editor

"Doctor, do you have a bias against mental disease; considering it of lesser significance than organic or bodily disease?"

I can sense your irritation that anyone should suggest this. This is 1993 and all enlightened physicians treat patients holistically, considering their body, mind and spirit equally.

Is this so? I believe the experience of patients and my own experience in dealing with this entity suggest that this is but lip service and the majority of doctors are still biased towards mental disease and in particular against the condition of Depression.

"That doesn't apply to me," I imagine you thinking.

It certainly doesn't if you are seeing and treating depression frequently and you need read no further as this article has nothing for you.

Recently I received a telephone call from a lady in Johannesburg. She asked me if I did not know of a doctor in Johannesburg who took an interest in treating stress and depression. Her boss had referred her to me as I had treated him for depression and he was so much better. She said she did not have the R1 500,00 it had cost him to visit me.

"Have you spoken to your own GP?" I asked.

"I don't have one, but most doctors are not interested if you tell them you are not handling things and

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struggling with headaches, tension and the like," was her reply.

Her boss had travelled by air to Durban, hired a car, travelled to Pietermaritzburg and repeated the process on return. All of this for one

... and these patients are desperate

consultation to make the diagnosis of depression in a stressed executive. He had been started on an antidepressant. The rest of the follow-up had taken place per telephone. He reports now that he has not felt this well in five years.

The point to be made here is that a perception exists that we, general practitioners, won't or can't treat depression. Furthermore, these patients are desperate in that they will go to great lengths and expense to obtain help.

This is not an uncommon occurrence or complaint.

So what?

Does depression occur often enough to warrant us worrying about this?

Is Depression Common in South Africa?

Whenever one attends a lecture on Depression the lecturer invariably states that:

i) Depression is a common and serious disease

ii) It is underdiagnosed and undertreated.

Literature searches tell us the same: Boyd¹ reports a lifetime risk of developing depression as between 8-12% for men and between 20 and 25% for women. Burke² reports an overall lifetime prevalence for major depressive episodes with or without a manic episode to be 5,6% (higher rate in females than males). In Britain depression appears to be the most common formal psychiatric disorder representing between 8% and 10% of consecutive consultations in general practice.³

What about South Africa?

Preliminary data from a SASPREN morbidity surveillance project⁴ reported that in general practice there are 9 new people with depression per 1000 consultations in South African general practice.

Whilst taking part in this study, I have recorded my own experience.

Risk of developing depression is 8%+ for men and 20%+ for women

In a 5 month period (March to August 1993) out of 2 599 patient encounters, 290 (11%) were concerned primarily with treating depression; 246 (9,5%) were concerned with the presentation of other complaints in patients currently being treated for depression; 132 (5%) of patients seen had previously

been treated for depression but were currently not on medication at time of consultation.

For the purposes of my survey I did not differentiate the different

In General Practice in RSA there are 9 new patients with depression per 1 000 consultations

diagnostic categories of depression, but defined the condition as being present when the patient was on anti-depressant medication.

Hence in 20% of my consultations the fact that the patient was currently on anti-depressant medication was a factor in the equation. In 25% of my consultations current or previous depression was a significant factor.

Why is Depression Still in the Closet?

This is not surprising given the exposure most South African doctors have to depressive illness in their training.

Psychiatric Training

The public have negative perceptions about mental disease. These are the perceptions that one brings into one's student years. These perceptions are only strengthened during one's training. In medical schools when psychiatric lectures are presented, the subjects of anxiety and depression are handled as if they have

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nothing in common with one another. This is unlike the usual presentation in practice.⁵ Students are then whisked off to some or other "Mental Institution" or Psychiatric Hospital. If they are exposed to any depressed patients they almost certainly are not representative of the depressives they will see in general practice.

Depression is mainly treated in an outpatient setting. Medical students hardly ever work in an outpatient setting.

Depression is generally diagnosed by exclusion in our organic disease-orientated medical schools – the impression is left that it is a less significant disease. "You must exclude all important pathology first." Hence, in training, this disease entity is a theoretical one – if you

Very little exposure to depressive illness in our medical training

never see it how can you diagnose it or believe in it? If you don't believe in it how can you recognise it? If you are in a busy clinic/MOPD type situation it is easier to get involved with organic "easy to identify and measure" disease.

Then develops the following mind set:

"This disease is merely a rare theoretical one of minor importance as it does not even merit hospital

admission. I have Not seen many patients suffering from it so I accord it the importance it merits." Students' exposure to General

Medical students only see a category of depressed patients who are definitely not representative of the depressed patients they will see in their practices

Practice at present is still limited – then when they do see depression they are probably shown this by doctors who have had the same training as they have.

Reluctance to Accept Depression as a Condition with Biochemical Changes

No-one doubts the biochemical mechanism in Diabetes or Parkinsons Disease. Treatment is directed towards changing the biochemical imbalances and when this is done symptomatology and the course of the disease are improved.

The limbic system controls not only the emotions but also memory and much of behaviour.⁶ The hypothalamus and limbic system are intimately concerned not only with emotional expression but with the genesis of emotions as well.⁷

From the first moment a foetus strikes the cold air of his new environment ex utero, he is subjected to his first stress.

Stress has biochemical influences on our mood centres – Gold et al^{8,9} cite 137 references in exploring the biologic basis of major depressive disorder. They propose a model that accommodates the clinical observation that chronic stress early in life in vulnerable persons, predisposes them to major depression with contemporary observations of the potential consequences of repeated central nervous system exposure to effectors of the stress response.

If you feel uncomfortable that the biochemistry of depression has not been worked out fully, consider the following:

We accept Parkinsons Disease as having a biochemical imbalance in the basal nuclei. However, when we consider the limbic system and other areas where our mood centres are found, there seems to be a tendency

Depression is diagnosed by exclusion ... suggesting it is a less significant disease

to ignore the possibilities that biochemical change can also occur here. Patients are often labelled as neurotic. They have a so-called "psychological" disease with the connotations that this is "not organic" in origin and therefore of lesser significance.

Why can the rest of your body legitimately pack up and give you illness and disease but when these

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areas malfunction you are nuts, or weak in the head?

Failure of Family Medicine Departments to Adequately Address this Field.

Even in some Departments of Family Medicine, depression seems to take a back seat. This seems paradoxical as Family Medicine Principles are big into "all encompassing care" and considering not only the patient's body, but also his mind and spirit. How often is depression diagnosed *de novo* in clinics or outpatient departments?

In post graduate student sessions it is striking to note that students in private practice are always keen to have lectures on anxiety/depression and say it comprises a major proportion of their work, whereas

We fear the side effects and dependency upon anti-depressant drugs – but strangely don't think this way about anti-hypertensives

hospital doctors are far less interested because "they never see it."

Is this discrepancy true or is it a result of the lack of emphasis placed on this condition in our training?

The idealistic family medicine principles of a deeper diagnosis or a three stage diagnosis, emphasise the importance of understanding the patient's perception of disease and

how the disease affects all facets of his life.

Once the clinician has evaluated the problem in its entirety, ie made the deeper diagnosis, in the ideal world the patient will have understanding of his problem and gain insight into it. In a flash the mists will rise and the problem will disappear.

This sometimes does happen in practice and when so, this is satisfactory all around. This is akin to a diabetic adhering to diet and reversing his hypoglycaemia and, as long as he adheres to his adjusted lifestyle, stays out of trouble.

Like the diabetic analogy however, in the real world, things are much different. Even if one adheres to the guidelines, often the disease doesn't go away and the next steps have to be taken. Likewise in depression a lot of circumstances are just not changeable.

Very often the end result is that, despite insight, lifestyle modification and attention to changeable factors, one is still left with a patient with a severe disabling disease that cries out for aggressive treatment.

Pharmacological ineptitude

Pharmacology is taught theoretically in third or fourth years and then more appropriately with practical application to diseases one treats in clinical years. Thus the pharmacology of anxiolytics and antidepressants is theoretically covered, but in hospital clinical years or internship, never put into practice, as very few depressives are hospitalised.

There are also often misunderstandings concerning the differences between anxiolytics and antidepressants and fears concerning all the massive lists of side effects and concerns regarding dependence upon drugs. Strangely enough we do not harbour these same concerns when

Quite a number of clergy with depressive illness

prescribing antihypertensives, cardiac drugs or hypoglycaemic agents.

We argue that if patients do not take them, they will suffer significant morbidity and mortality. How does this differ with respect to depressives? Are you any less dead if you blow your brains out, than someone who has a fatal cerebrovascular accident?

Bias against Depression by those with Strong Religious Beliefs

I was initially surprised by the number of clergy who have depressive illness. When one considers their lifestyle however, then it is no longer surprising. Convincing them of the diagnosis and the need for treatment is always a great problem as they generally believe that accepting they are depressed means that their faith is deficient. If their faith was stronger and they were not so weak, they would not be in this mess.

Doctors with similar beliefs also seem