



Case Histories for Understanding Depression in Primary Care

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The chief complaint of depressed patients in a primary care setting is often *not* their dysphoric mood. Physical complaints are frequently the presenting symptom. Primary care physicians should include a depressive disorder in the differential diagnosis of patients complaining of multiple somatic symptoms, increase in alcohol or drug use, sleep and sexual dysfunction, or reports of anxiety. In the case of acute onset of depression, the physician should first rule out underlying medical illness or medication side effects as the etiology of the symptoms.

Two case presentations described here illustrate the key points primary care physicians should observe when evaluating a patient whose somatic or other complaints may suggest depression, stress, or anxiety.

Case Presentation 1

A 52-year-old man is seen by his family physician with complaints of headache, fatigue, and generalized lower back pain that have been occurring intermittently during the past 4 weeks. He also reports that he has had repeated episodes of nausea and he is sleeping "a lot." He

notes that he falls asleep quickly but wakes up repeatedly through the night and fails to feel refreshed on awakening in the morning.

The patient discounts a prior episode of depression 14 years ago, noting that it "was just stress" related to a corporatewide merger at the insurance company where he works. He does not feel sad but lately finds it increasingly difficult to cope with "the way people around me are acting." He denies abusing alcohol and reports that his drinking patterns and amounts of alcohol consumed have not changed. Current medications include hydrochlorothiazide and captopril for treatment of mild hypertension.

On further questioning, the patient's wife reports that for the past several months, her husband has been extremely irritable and difficult to rouse in the morning. She notices a definite increase in his alcohol consumption, estimating that he now has a few shots of whiskey every night. The patient disagrees and rebukes her sharply for "making a big deal about everything I do lately."

Look Twice at Nonspecific Somatic Complaints

Because somatic symptoms are so prominent in the presentation of depression to primary care physicians, depression should always be included in the differential diagnosis of multiple nonspecific musculoskeletal or gastrointestinal complaints. Of course, all somatic complaints must be considered individually and evaluated in the context of a careful history and physical examination, which includes a comprehensive structural review. For example, a backache that started after an acute sports injury or a fall has different diagnostic meaning than one that came on slowly or began after the onset of mood changes. History and physical findings dictate the course and extent of any further workup.

Insomnia is a key finding in depression, particularly with multiple awakenings rather than difficulty falling asleep. In fact, it is this complaint, rather than mood changes, that drives many patients to their physicians. However, insomnia must be analyzed cautiously in a patient who appears to be drinking nightly, because alcohol may disturb normal sleep architecture by intensifying delta-wave sleep.¹

Clues From the Family

Family members are an important source of corroboration or additional insights into the patient's mood or behavior, particularly when the patient denies any change. In this case, the wife confirmed her husband's increasing irritability. She also provided a different and concrete picture of how much and how often the patient drinks. This information could be clinically significant in considering the possibility of alcohol abuse.

The family may also be helpful in providing critical information about the patient's history of depression. In this case, there appears to be a previous depressive episode of some sort, but the patient readily discounts it. His wife could provide more objective details that may challenge a negative history and therefore heighten the index of suspicion toward depression. She may also recall whether the patient received any specific antidepressant treatment and how

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he responded to it—information that is not only useful from a diagnostic perspective but that may also influence a therapeutic strategy.

“I’m Not Sad!”

The patient’s denial of sadness or loss of interest in formerly pleasurable activities does not preclude a diagnosis of depression. Older men in particular may find it difficult to express themselves and instead may find themselves feeling markedly irritable or frustrated with their family or their colleagues. Once again, family members may provide important information about the patient’s mood and they should be interviewed in the initial consultation.

The Specter of Alcohol Abuse

This case illustrates two important clinical points. First, patients may not be accurate self-reporters about alcohol or substance abuse. Once again, as in this case, the spouse or another family member may be an excellent source of information about any change in the volume or frequency of drinking. Second, it is important to explore the meaning of increased drinking in a patient with depression. Does it represent attempts at self-medication, eg, the patient intentionally drinks alcohol at bedtime to help himself fall asleep, or does it meet the criteria for classic substance abuse? In addition, the *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR: Fourth Edition Text Revision* distinguishes between a substance-induced mood disorder and a major depressive episode based on which factor is etiologically related to the symptoms observed.²

When Medication Changes Mood

The patient’s medication history should be reviewed thoroughly for classes of agents known to cause depression, such as interferon, isotretinoin, benzodiazepines, β -blockers, and sleep aids containing diphenhydramine. However, even if a patient is taking an agent in these categories, it is not necessarily the cause of depressive symptoms. A carefully taken history will dictate the next step: If symptoms preceded the start of medication, it should probably not be the focus of subsequent management

Key Points

- Always consider depression when the patient has nonspecific somatic complaints.
- Corroborate history and complaint with family members.
- Remember that many patients will present with marked irritability in place of sadness.
- Explore the possibility of substance abuse.
- Rule out depression induced by medication through a careful history.
- Determine what depression means to the patient in presenting the diagnosis and treatment plan.

Figure 1. Key points to remember when examining patients with somatic complaints.

strategies. However, if mood changes appeared after the patient began taking the medication, it might be appropriate to consider changing the dose or switching to another agent.

Anticipate What Depression Means to the Patient

For many patients, a psychiatric diagnosis is darkened by considerable stigma. Patients who must divulge such a diagnosis in their workplaces for purposes of insurance reimbursement are particularly uncomfortable with a diagnosis of depression. Other patients recoil from it because they associate it—and the possibility of antidepressant medication—with personal weakness, not medical illness.

Therefore, it is necessary to listen closely to patients during the consultation and workup in order to determine what specific meaning depression holds for them. It may then be necessary to present the diagnosis and treatment plan in the context of a disease that is causing the physical symptoms that brought the patient into the physician’s office. For example, this particular patient may be more open to antidepressant therapy if

Key Points

- Patients who are experiencing extreme stress are not immune to psychiatric disorders: there is no “good reason” for depression.
- Patients may not volunteer critical information about stress, and physicians need to listen closely and follow up fully regarding any clues that emerge.
- Somatic symptoms of depression should not be treated as if they were manifestations of organic disease.
- The level of clinical impairment dictates the level of intervention.
- Depression can be managed effectively in the primary care setting.

Figure 2. Key points to remember when examining patients with anxiety and depression related to life stress events.

depression is discussed as a medical condition that is known to disrupt sleep and cause musculoskeletal pain, rather than a mood disorder. *Figure 1* outlines key points to remember when examining a patient with somatic complaints.

Case Presentation 2

A 63-year-old woman seeks medical care because of headache, soreness in her neck, and increased urinary frequency. She notes that she has a difficult time falling asleep and generally feels as if she is “all wound up” and weepy at the same time. Although she has previously been normotensive, her blood pressure at this visit is 144/94 mm Hg and her pulse rate is 92 beats per minute.

The patient is not currently taking any medication. She was hospitalized for severe depression at age 23 years. Recently, osteoarthritis developed in several joints. When questioned about whether her insomnia makes it difficult for her to go to work in the morning, the

patient reveals that she is able to sleep in since being recently laid off from her bookkeeping job of 28 years. She also wonders if her neck soreness could be related to the additional driving she has undertaken since her husband's recent diagnosis with lung cancer.

Listen for Hints About Stress

Patients who seek medical attention often find it more comfortable to focus on their somatic aches and pains rather than on their emotional discomfort. To have an accurate picture of the patient's life, the clinician needs to listen closely for any hints about problems in the patient's world and then probe for further information instead of making assumptions. In this case, for example, the patient was not actively forthcoming about becoming unemployed or about her husband's cancer, though either event in and of itself could be considered a major stressor. The patient's hypertension (or any other positive physical finding) would also provide a segue into active questioning, ie, "I notice that your blood pressure is unusually high for you. Are you under any kind of stress right now?"

No "Good Reason" for Depression

Even patients who are having major life stresses are not immune from psychiatric disorders. In fact, because stress often precipitates depression, it is not surprising that loss of a lifelong job and the potentially terminal illness of a spouse could trigger major depression. When confronted with a patient in crisis, it is easy to assume that the patient has good reason to feel depressed. However, this perception does the patient a disservice if it stands in the way of the patient's receiving the same kind of treatment administered to a depressed patient with no overt stresses. A patient in pain deserves to receive treatment, no matter how severe his or her life circumstances are at a given moment.

Screening Tools That Work

Many physicians view depression-screening instruments with trepidation, believing they are simply more forms to stack on top of the mountain that already fills the primary care office. However, depression-screening instruments are

actually the psychiatric equivalent of the complete blood cell count or blood pressure measurement, that is, a tool for obtaining objective data that make diagnosis easier. Among the many instruments validated for clinical use, the Beck Depression Inventory is available in a primary care version and can be completed by the patient in less than 1 minute. It has been effective in the primary care setting.³

Treat Symptoms in Context

Patients are more vulnerable to physical problems when they are depressed. Although it is often tempting to address these complaints directly with medication targeted at an organic disorder, it is more appropriate to first treat the underlying psychiatric problem. As the mood disorder lifts, so too may musculoskeletal pain or gastrointestinal distress.

What about the patient's hypertension? Certainly, it must be followed up closely. However, it does not necessarily require treatment with an antihypertensive agent at this point. Her diet, exercise patterns, and body weight should be carefully evaluated and lifestyle modifications instituted as necessary. Given her exogenous stress and her general feelings of anxiety, it is also appropriate to repeat the blood pressure measurement in a second office visit in about 2 weeks.

Supportive Counseling or Pharmacotherapy?

Depression is a recurrent disease, and given the patient's history, prompt intervention with an antidepressant agent is advisable. An agent that has demonstrated efficacy in both depression and anxiety would be a good choice, given that this patient appears to be anxious

in the face of her life's stresses.

It is important to point out that if this patient's history were not positive for depression, it might be appropriate to recommend only supportive psychotherapy, rather than antidepressant therapy, to help her manage her life. Treatment with medication could certainly be additionally recommended in this patient. Similarly, her anxiety may be addressed with stress reduction techniques. The variable in making these therapeutic decisions is the level of the patient's emotional pain and how it affects his or her function. The level of clinical impairment determines the level of intervention.

Figure 2 outlines key points to remember when examining a patient with anxiety and depression related to life stress events, ie, loss of job, death of family member, serious illness, break up of relationship, etc.

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