Editorial

Depression: Let's Talk

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On April 7 each year, the World Health Organization commemorates its founding with World Health Day and the theme for this year is depression. As described at its website: "Depression affects people of all ages, from all walks of life, in all countries. It causes mental anguish and impacts on people's ability to carry out even the simplest everyday tasks, with sometimes devastating consequences for relationships with family and friends and the ability to earn a living. At worst, depression can lead to suicide, now the second leading cause of death among 15 to 29 year olds".

According to the 2010 Singapore Mental Health Study (SMHS), a nationally representative survey of adult Singapore residents aged 18 years and above, depression is indeed common in our local population. Using the World Mental Health Composite International Diagnostic Interview (a structured diagnostic instrument), the prevalence of major depressive disorder (MDD) in the general population was 5.8%. It was significantly higher among females, Indians, those who were divorced/separated, or widowed. Chronic physical conditions were present in approximately half of those with MDD.[1]

Other than the individual personal costs, the societal impact of depression stems from its relative pervasiveness among the population; from its early onset (typically starting in adolescence or early adult life), recurrent nature and its multifarious impairments—often leading to substantial loss in quality of life and premature death.[2]

In the SMHS, we found that MDD was also associated with considerable disability in terms of days of role impairment and considerable economic losses that come from the loss of productivity. Depression represents one of the major causes of loss of productivity in the workplace from both absenteeism (loss of production caused by days missed from work) and presenteeism (loss of production caused by reduced work performance while at work as a result of decreased concentration, reduced motivation, fatigue, or errors in decision-making)—all of which constitutes a substantial cost to employers.[3]

One of the startling findings of the SMHS was that about 60% of those with MDD had never sought any form of professional help. There are various reasons for this treatment gap.

One of the important determinants of help-seeking is how a person perceives the nature and cause of symptoms which in turn may be influenced by the prevailing culture. It has been suggested that Asians tend to focus on physical (somatic) features of depression (like fatigue, loss of appetite and weight) than on the emotional or psychological symptoms—which understandably would not lead them to seek help from professional mental health providers.[4] In a subsequent study that assessed the level of mental health literacy among the general population of Singapore, we found that the common perception about a person suffering from depression as expressed by the majority of the members of the public was that the person is "weak" rather than sick.[5] The corollary is that someone with depression could get better on their own will, and if not, the person is lacking in fortitude and resilience.

So, people with depression would feel ashamed and to circumvent the stigma associated with depression, there is 'label avoidance' (i.e. people are reluctant to be diagnosed with or be seen as seeking treatment for depression). Stigma has been linked to adverse outcomes for people with mental illness as it acts as a barrier to help-seeking.[6]

Addressing and overcoming these barriers to appropriate help-seeking is obviously important, particularly when there are effective treatments including proven antidepressant medications and psychotherapies.

On the issue of treatment, there is perhaps, in our opinion (and in absence of any good studies), a predilection among local psychiatrists for the use of medications over psychotherapy. Antidepressant drugs are generally effective only as long as the treatment is continued. On the other hand, psychotherapy, especially cognitive behavioural therapy (CBT) provides long-term benefits probably because patients learn and internalise skills that they continue using after the treatment stops. Consequently, discontinued CBT might be as effective as continued treatment with antidepressant medication and more effective than antidepressant medication that is discontinued.[7] However,

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the question which is yet to be answered pertains to the extent that high quality CBT is used for depressed patients in Singapore—something that needs to be addressed with research that would assess not just the availability of CBT but its effectiveness (including cost-effectiveness) for our local patients. Another possible limitation is the acceptability of CBT by some patients who want and expect a "quick fix" for their depression, and/or are unable to commit the amount of time for CBT.

Still, there are limitations to the current treatment: it has been estimated that, even under optimal conditions, contemporary treatments can reduce only about one-third of the disease burden associated with MDD.[8,9] A way to further reduce the disease burden of depression would be to reduce the incidence through prevention. There are different types of prevention: universal prevention which focuses on the general population and selective prevention that targets individuals or subgroups that are at higher risk of developing mental disorders than average individuals or subgroups. A meta-analysis of 32 randomised controlled trials examining the effects of preventive, psychological interventions in participants with no diagnosed depression at baseline (but deemed to be "at risk" of becoming depressed, as assessed with a diagnostic instrument) on the incidence of diagnosed depressive disorders at follow-up found that these preventive interventions lowered the incidence of depression by 21% in the intervention group compared with controls.[10]

Moving forward, what would be important from the perspective of population health, is to narrow the treatment gap for depression which calls for a raft of initiatives that specifically target those groups in the populations where depression is over represented. It also calls for an effort to combat stigma with a concerted and collaborative political, social, medical and media will and efforts. Early detection/screening systems should be established in schools, polyclinics, general hospitals and workplaces. It is important for businesses to understand the economic case for the detection and treatment of depression among their employees and be cognisant of the existing literature supporting the economic case for employers to invest in interventions to address depression in the workplace.[11] However, most employers would not know how to do this and would need expert help such as that rendered by The Partnership for Workplace Mental Health, an initiative by the American Psychiatric Association that helps employers in raising awareness and reducing stigma.

Other innovative ways to improve the rates for treatment contact ought to be considered. This includes the use of Internet and telephone-delivered therapy which have the advantage of alleviating the fear of loss of privacy and lack of confidentiality (although, of course, more research is needed to evaluate the efficacy and effectiveness of such non face-to-face therapy in the local population).

More research is also needed (especially qualitative research) to elucidate the social, cultural, and religious factors that might influence help-seeking behaviour and the stigma of depression; as well as studies to test out preventive strategies that are contextualised to the local setting.

Depression is a condition that has long been recognised to be a public health problem worldwide which is expected to worsen in the future. Between 1990 and 2010, major depression moved up from 15th to 11th in terms of global disease burden measured in disability-adjusted life years (DALYs).[12] By 2030, it is projected to become the single leading cause of disease burden.[13]

However, with our existing knowledge and with a concerted and determined effort to understand more and to do more (through enlightened mental health policies, funded programme development and evaluation and research), we might be able to bend the curve for our own population.

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