

USING EXTENDED CONSULTATION TO HELP THE PATIENT ACCEPT ANTI-DEPRESSANTS

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ABSTRACT

Depression is a complex disabling condition that is common in primary care. Mr. X was previously diagnosed with depression but had defaulted treatment. It was through an extended consultation that we could unmask the diagnosis and initiate the therapeutic process.

Objectives

To use the model of an extended consultation to both diagnose depression and to formulate the psycho-social factors that predispose, precipitate and perpetuate the depression as well as the positive factors that ameliorate it (4 Ps).

Methods

An example of an extended consultation with Mr. X. was videotaped with his permission. Excerpts from the video transcript are reproduced to demonstrate the 4 Ps formulation and how the pattern approach of narrative therapy was employed to help Mr. X.

Results

Mr. X. gained insight into his condition. He was hence agreeable to initiate anti-depressant medication and continued to follow up for his depression.

Conclusion

The extended consultation can be used to uncover therapeutic opportunities when engaging patients with depression, and to formulate the 4 Ps in order to complement pharmacotherapy for holistic management.

Keywords: Depression; Extended consultation; Narrative therapy; Psychotherapy

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"We are healed by our stories" - Terre Tempest Williams

INTRODUCTION

In the management of patients who do not seem to get better with medications, it is useful to revisit the diagnosis, the prescription and adherence to medication. It is also important to extend the consultation to ferret out any psycho-social

issues. Extending the consultation does not only allude to just lengthening the duration of the consultation. It entails using open questions, reflective communication and conversation skills to explore the psycho-social issues in the patient. Just as in the usual consultation we take a history, examine the patient, and do investigations as are necessary, in the extended consultation, the parallels of an extended history, reflective communication, and investigation of the patient's thinking using CAR ACE are also done. CAR ACE is an acronym for the investigative steps of clarification, assumption, rationale, alternative assumption, consequences of the alternative assumption, and experience arising out of the alternative assumption Cheong et al.¹

The objective of this case study is to describe the application of the extended consultation processes in the diagnosis of major depressive disorder in our patient Mr. X, and the psychotherapy techniques used to convince him to accept anti-depressants.

PATIENT'S REVELATION

"Doctor, I do not know what is wrong with me. I am not depressed. Can you help me?"

Mr. X was a 62-year-old gentleman who was first seen in our public-sector health center in March 2015. He presented with complaints of giddiness, tinnitus, weakness and insomnia since 2013. He had decided to seek medical attention from us because he was not getting better despite seeing several doctors. Past history: He had no previous history of psychiatric problems. At the time of the first consultation in our clinic, he had consulted several specialists including a cardiologist, an ENT specialist, a neurologist and a psychiatrist. He was prescribed anti-depressants by the psychiatrist but had defaulted treatment as he did not accept the diagnosis.

Figure 1. A timeline representing the significant stages in Mr. X's healing journey.

Emotional Phase	Negative themes
1953	Born to 13-year-old mother, eldest of 9 children
Emotional deprivation	Unloved and unfairness
2009	Mother's death from oral cancer
Anger and agitation	Mother is a "Pontianak". In Malay mythology, a Pontianak is a female vampiric ghost.
2013	MBA Freak-out – Anger turned inwards
Depression and Somatization	
2015 ~ present	Extended consultation – Insight gained
Reflection and Healing	

Social history: He had a Bachelor of Laws (Honors) and was a managing director in his own company. 18 months earlier, he

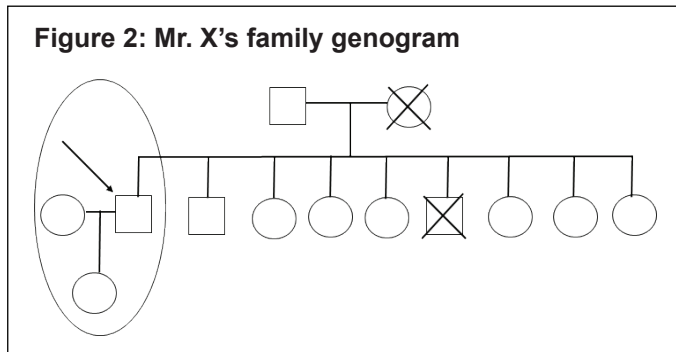
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had enrolled in a course leading to the Master of Business Administration (MBA). However, during a presentation that was part of the MBA assessment, he was overcome with stage fright and had to drop out of the course.

Family history: He was the eldest in a family of nine children. His mother married when she was thirteen years old. See Figure 2.



Physical examination: Well-kempt and soft-spoken, he was cooperative and able to give a good account of his past experiences. Notably he had psychomotor retardation, otherwise systemic examination was unremarkable.

GAINING INSIGHT

The salient issues in Mr. X's revelations created several insights. We used the techniques of reflective communication, open inquiry and formulation of issues in the extended consultation as described by Cheong et al¹.

1. What was he looking for in seeking consultation in our clinic?
2. What in the patient's history confirmed that he was depressed?
3. Why was he depressed?
4. How could we help him accept the diagnosis of depression, and to agree to take the medications?

MANAGEMENT

1. What was he looking for in seeking consultation in our clinic?

Although he presented with disparate medically unexplained symptoms, and had expected organic medical diagnoses from his doctors, it turned out that what he was really searching for was an understanding of his predicament. As we sensed that his presenting complaints did not reflect his true concerns, we took the opportunity to extend the consultation by adopting a more challenging role, as opposed to the usual detached listener role. We questioned the contrast between his successful persona and the person we saw (‘double reflection’: defined as contrasting two perspectives of the same object to demonstrate ambivalent nature), using a non-confrontational technique known as ‘relational irony’ (asking the interviewee to adopt the perspective of a close associate, to emphasize the emotion that needs to be expressed).

“Tell us, how do you feel ... when you observe your family, your employees who respect you ... if they were to see you now in this state.”

This immediately evoked a barrage of his inner emotions – a moment of catharsis which drew out his hidden memories – amongst which his answers lay. Was the previous diagnosis of depression still valid then?

Figure 3: DSM-5 criteria for major depressive disorder	
Criteria for depression: Either (1) or (2) and 5 or more from (3) – (9), with each being displayed most of the day, nearly every day for at least 2 weeks	Did Mr. X exhibit them?
(1) Depressed mood	✓
(2) Anhedonia	✓
(3) Significant weight or appetite changes	✓
(4) Insomnia or hypersomnia	✓
(5) Psychomotor agitation or retardation	✓
(6) Fatigue or loss of energy	✓
(7) Feelings of worthlessness or excessive or inappropriate guilt	✓
(8) Diminished ability to think or concentrate, or indecisiveness	✓
(9) Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide	

2. What in the patient's history confirmed that he was depressed?

The symptoms had begun to impair his work and his day-to-day interactions with the others around him significantly. There was no doubt that Mr. X was indeed clinically depressed.

3. Why was he depressed?

A proper history was necessary to elicit all relevant details, including those pertaining to family and upbringing. On probing further, we recognized a recurrent pattern in his personal life events dating back to his childhood.

As the eldest of nine siblings, Mr. X grew up with negative thoughts of unfair treatment by his mother and frustration at being considered ‘never-good-enough’ despite his best efforts.

“Any other examples of how your mother treated you unfairly?”

He brought up many examples of day-to-day incidents which seemed trivial at the outset, but had apparently etched themselves in his mind, examples of his mother giving his younger brother more money “50 cents more... (to eat) chocolate milk, nasi lemak” (Malay dish of rice cooked in coconut gravy with side dishes), visiting his younger brother in the army and not him, or attending her grandchildren's graduation ceremony but not his own.

We asked him to clarify the differential treatment of his mother towards him and his brother: *“Why do you think so?”*

Believing that he was not as good as his brother – *“I am not up*

to his mark” – this sense of inadequacy and inferiority permeated his view of his self and drove a wedge deep into the mother-son relationship.

The perceived differential treatment of his mother towards him proved to be the *predisposing* factor, which in turn generated the feelings of unfairness, self-doubt and frustration that perpetuated his entire life.

He began to resent his mother but dared not vent his anger and hatred towards her until after her demise when he was imagining her *“like the Pontianak (a female vampiric ghost in Malay mythology whose spirit dwells in banana trees during the day), jumping from tree to tree... when (he was) driving”*.

“How did you feel when you think of that?”

He admitted to feeling torn – on the one hand, he was relieved to be free from his mother’s *“torture”*, on the other hand, he felt guilty about his persistent hatred towards his late mother.

The recurrent pattern of having to prove his worth and of being often deprecated by his late mother despite his best efforts had been ingrained in him, to the extent that it drove him to embark on his master’s course just because his employee attained it, and he felt that he needed to prove that he was equally capable as his employee.

However, “going blank” during a course presentation and dropping out only served to further reinforce his feelings of inferiority and hence *precipitated* the downward spiral of depression as he turned his anger upon himself instead, having no maternal figure to blame.

4. How could we help him accept the diagnosis of depression, and to agree to take the medications?

Despite seeking medical attention, he was unable to accept the diagnosis of depression and anti-depressant medications as he lacked insight. It was essential to extend the consultation in Mr. X’s case as he had unresolved issues which were interfering with the management of his condition.

After the emotional outpouring experienced in the first consultation with us, he was able to acknowledge his own condition and thereby accept both psychological and pharmacological therapy.

In this patient, the breakthrough was to get him to have another way of looking at his depression. He had rejected depression as the psychiatrist’s diagnosis despite the fulfillment of the major criteria of depression using DSM-5.

Essentially in going through the steps of CAR ACE, we invited Mr. X to divulge information, and took the opportunity to clarify observations, and question assumptions that he had made and rationale for his beliefs. We also invited him to speculate on other alternative explanations or scenarios, as well as the consequences and experiences derived

from them subsequently in these alternative assumptions.

Through the extended consultation, we formulated his predisposing, perpetuating, precipitating factors in this illness. In this context, we found his daughter to be a protective factor.

PSYCHOTHERAPY TECHNIQUES USED TO HELP THIS PATIENT

As one of the authors is a trained psychotherapist, we were able to help the patient through the use of psychotherapy techniques. We describe two techniques that were useful in the management of this case.

1. Pattern approach –Re-framing, Re-remembering

To help him overcome his negative memories, we addressed the predisposing and perpetuating factors as identified earlier and his ‘never good enough’ narrative. We also helped him reconstruct his personal story into a more positive one – which would allow him to fixate less on the negatives in the past and instead to view his present and future selves more positively. For example, with regards to the differential treatment he had experienced as a child, the conversation led him to unearth hidden memories of his mother, such as that of her preparing a meal and *“always keep(ing) chicken drumsticks for (him)”*. We prompted him to explore the experiences that arose from this new revelation.

“What does that mean to you?”

The purpose of the question was to instill insight, by allowing him to elaborate on his thoughts, feelings and beliefs, a method known as relational experiencing Cheong et al².

Indeed, he found reason to rejoice as he felt *“that was very important to (him) because out of the whole family, she only looked after (him)... (which meant he) must be important to her also”*.

2. The “empty chair”

This was another psychotherapy technique we used. In order to resolve his past grievances and suppressed emotions, we adopted a technique known as ‘empty chair’ via the re-creation of a vivid memory of his mother’s deathbed scene. “Empty chair” is defined as a therapeutic intervention utilizing role-play to resolve one’s inner conflict and to develop new insight – an empty chair is placed opposite the participant, who has to imagine the other party ‘sitting’ in the chair and thereby communicates with the other party. Mr. X was asked to imagine his mother in the same room as the doctor and himself, literally, upon an empty chair. As Mr. X was transported back in his own mind to a time and space of his mother’s last moments, he was given an opportunity to roleplay his final farewell and to give release to his emotions. The following is an excerpt of the conversation that occurred:

Doctor (D): “If she could talk to you in the special way, what

would you have heard?"

Mr. X (Translated from Tamil): "X have u forgiven me? I meant well."

D: "How would you have responded?"

Mr. X: "I would have kissed my mother... (Translated from Tamil) Not to worry, whatever happens I will look after you.'

This powerful exchange gave Mr. X the opportunity to resolve his past properly, thereby allowing him to move forward and to begin his journey of healing.

Mr X began to improve. The steps in his healing journey are shown in Figure 4.

Figure 4. A timeline representing the significant stages in Mr. X's healing journey.		
Emotional Phase	Negative themes (techniques applied)	Re-framing into positive themes (techniques applied)
1953 Emotional deprivation	Born to 13-year-old mother, eldest of 9 children Unloved and unfairness (clarification, assumption)	Mother illiterate but still loves him, evidenced by giving chicken drumsticks (rationale, relational experiencing)
2009 Anger and agitation	Mother's death Mother is a "Pontianak" (assumption)	Mother is only human (alternative explanation)
2013 Depression and Somatization	MBA Freak-out- Anger turned inwards (Relational irony, double reflection)	
2015 ~ present Reflection and Healing	Extended consultation – Insight gained (Empty chair)	

Experience and prior knowledge in psychotherapy is a bonus when extending the consultation – however the prerequisites are mainly time and commitment, as the consultations often have to take place over a series of multiple sessions. The team of family physicians looking after him tried to limit his appointments to the few who were familiar with his background to ensure continuity of care and establishment of the doctor-patient relationship.

EPILOGUE

As Mr. X often spoke of his daughter and the good memories they shared, it was evident that their close father-daughter bond served as a protective factor and a reminder that he was a parent with a role to fulfil and not as "worthless" as he made himself out to be. Hence, we invited him to bring his daughter for subsequent consultations in order to seek her collaborative efforts. The rapport thus garnered in the ensuing consultations contributed to his improved adherence to the medications.

Mr. X had shown some progress in that he was now adherent to his anti-depressants and concurrent psychotherapy sessions. He also claimed that thoughts of his mother no longer plagued him.

He continued follow-ups with both the psychiatrist and family physician for co-management of depression.

DISCUSSION

What is new is we used the extended consultation principles to understand this patient's non-acceptance of the diagnosis that he had depression and consequent rejection of the use of anti-depressants. We showed how the parallels of the extended history, reflective communication, and the CAR ACE investigative steps may be applied.

In the appraisal of this patient's depression, the useful framework of the formulation of the 4 Ps of predisposing, perpetuating, trigger, and protective factors helped us to identify his support system and negative factors. The management would then be targeted towards addressing these 4 Ps. For example, the perpetuating factor of his pattern of negative thoughts was successfully addressed. The empty chair technique allowed him to resolve his guilt in the negative feelings towards his late mother.

It is pertinent to point out here that the use of psychotherapy techniques such as those described here needs training. As one of the authors is trained in psychotherapy, psychotherapeutic techniques could be used. Family physicians are advised not to embark on psychotherapy techniques if they have not undergone any training and had no supervision. The authors recommend careful patient selection and for family physicians to update their skills and undergo training, when available.

Learning begins with understanding and incorporating the concepts of the extended consultation into complex cases. A paper by Cheong & Goh ³ described how the extended consultation was used in six cases they encountered in their family practice. Further study in this area requires the accumulation of similar patient-based experiences, in order to identify and develop specific skills set that may be adopted in family practice for the management of such complex cases.

CONCLUSIONS

Evaluation of the psycho-social background of this patient was essential in understanding wherein lies this patient's problems of rejection of the diagnosis of depression and the non-acceptance of anti-depressants. The use of the extended consultation through taking an extended history, examining this thinking through reflective communication, and getting the patient to clarify his assumptions allowed him to have less negative attitudes of being "not good enough" and to accept the fact that his negative perception of his childhood days contributed to his feeling depressed – even he did not recognize that these experiences created problems in his adult life. He was consequently able to accept anti-depressants as necessary for him to overcome his illness.

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The patient Mr. X has given permission for his consultations to be videotaped and for sections of the transcript to be reproduced in this article.

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