A qualitative study on general practitioners' perspectives on late-life depression in Singapore—part I: patient presentations and behaviours

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Summary

Background Detection and management of late-life depression largely relies on primary care. Yet in Singapore, older adults are unlikely to seek help for their mental health from their primary care providers. This qualitative descriptive study explores how late-life depression manifests to general practitioners (GPs) in the Singaporean primary care setting.

Methods Twenty-eight private GPs practicing in Singapore were asked about their clinical experience with late-life depression during semi-structured group and individual discussions conducted online. Participants were purposively sampled across age, gender, and ethnicity (Chinese, Malay, Indian). Transcripts were analysed with reflexive thematic analysis.

Findings To GPs, depression in older patients often manifests through somatic symptoms or subtle behavioural changes, only detectable through follow-ups or collateral history. GPs reported that older patients attribute depressive symptoms to normal ageing or do not mention them, particularly within an Asian culture encouraging stoic endurance. GPs perceived late-life depression as reactions to ageing-related stressors, with male, low-income, or institutionalised patients being at particular risk of insidious, severe depression. GPs noted ethnic differences regarding families' involvement in care, which they described as helpful, but sometimes stress-provoking for patients. Fear of burdensomeness or loss of autonomy/social role could prompt rejection of diagnosis and treatment in patients. GPs considered good patient-doctor rapport as a facilitator at every step of the care process, noting more favourable prognosis in care-concordant patients.

Interpretation Depression in older adults in Singapore can be covert, with favourable outcomes relying on GPs' ability to pick up on subtle changes, assess patients holistically, and build rapport with patients and families.

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Keywords: Late-life depression; Old age; Primary care; Singapore; Community mental health; Geriatric psychiatry; Cross-cultural psychiatry

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Research in context

Evidence before this study

Late-life depression (major depressive disorder in adults aged ≥65 years) is a leading cause of disability among older adults worldwide and remains comparably prevalent in Singapore as in other high-income countries. Primary care is generally considered the main entry point for late-life depression's diagnosis and treatment, yet local evidence suggests that Singaporean older adults remain reluctant to seek help when facing depressive symptoms.

Added value of this study

Employing a qualitative descriptive approach, this study explores how private general practitioners (GPs) encounter late-life depression in Singapore. It focuses on GPs' own impressions of the disorder's clinical manifestations and evolution, and on GPs' perceptions of older depressed patients' perspectives. The study finds similarities with reported experiences of GPs elsewhere in the world, but also notable differences, namely ethnic specificities related to Singapore's Chinese, Malay, and Indian communities (Singapore's three main ethnic groups). The study highlights the importance of the patient-GP rapport, given the frequently covert and heterogeneous manifestations of late-life depression.

Implications of all the available evidence

Singapore is currently deploying Healthier SG, a national initiative which aims to shift the healthcare utilisation towards preventive care coordinated by each patient's main primary care provider. The present study's nuanced overview suggests that GPs are indeed well-positioned to build trust and rapport with older patients and their families, detect minor changes suggestive of depression, and build a holistic understanding of each case.

Introduction

Late-life depression, defined here as major depressive disorder occurring in adults aged ≥65 years,[1] is a leading cause of disability in this age group globally.[2] Late-life depression has been found to differ from depression occurring earlier in life by less emotional manifestations, more somatic symptoms and anhedonia (a loss of pleasure in usual activities), and more frequent associations with cognitive decline or physical illnesses.[1,3] Primary care has been identified as the main entry point for older adults to get diagnosed and treated for depression.[4,5] Even so, late-life depression is likely missed by general practitioners (GPs) in about half of the cases.[6]

According to the 2021 Global Burden of Disease Study,[7] Singapore has a diagnostic point prevalence of late-life depression of 2.5% (95%CI = [1.7,3.5]) in adults aged 70 years and older, which is comparable to the disorder's average prevalence in high-income countries, estimated at 3.2% (95%CI = [2.6–4.0]).[2] Yet, Singapore has less than half as many mental health professionals per 100,000 inhabitants than other high-income nations (4.6 psychiatrists and 9.7 psychologists in Singapore vs 10.5 psychiatrists and 29.9 psychologists in the United States for example),[8,9] making the gatekeeper role of primary care all the more important for late-life depression.

Nevertheless, Singaporean adults aged ≥65 years are the least inclined of all adult age groups to use crisis services for mental distress[10] and less likely to seek mental health treatment from any service provider compared to adults aged 18–34 years.[11] These findings suggest that older patients seldom seek treatment for depression in primary care in Singapore.

There is a need to better understand how depression manifests in the Singaporean older adult population and how GPs can pick up on its symptoms. Singaporean adults aged 60 years and above had a 34.8% increase in suicide rates between 2021 and 2022.[12] Understanding how to improve detection and management of depression in primary care can be at the root of more effective suicide prevention, considering the 40% overlap between depression and suicidal ideation and behaviour in Singaporeans adults regardless of age.[13]

Given Singapore's diverse Asian population, a variety of ethnic, religious, and cultural factors may play a role in the way depression manifests in the primary care setting. To date, knowledge about these factors that might be applicable to Singapore's three dominant ethnic groups (Chinese, Malay, Indian) comes from research in other countries. For instance, regarding spiritual attitudes, research in Hong Kong found that Chinese adults ignored or stoically endured depression based on traditional fatalistic life views,[14] a Malaysian study described spirituality as an important coping mechanism for Malay adults experiencing depression,[15] whereas findings from Gujarat, India indicated that attributing depression to a religious cause was related to more pessimistic views about its outcome in Indian adults.[16]

However, as Asian cultural representations of depression have been increasingly intertwined with Western views[17] and also depend on each nation's shared geo-cultural characteristics, it remains unclear to what extent the above ethnic differences still apply to Singapore. The country is undergoing a large-scale restructuring of its healthcare system in the form of Healthier SG, a Singaporean national healthcare initiative launched in 2023 whereby each Singaporean is encouraged to voluntarily register with a family doctor for their basic care.[18] As a result, community mental healthcare is to be progressively integrated with primary

care, making it timely to develop a nuanced understanding of how depression manifests in older primary care patients. The present study employs a qualitative approach to explore this question from the perspective of GPs.

Methods

Design

This qualitative descriptive study explored private GPs' perspectives on how they encounter late-life depression in their practice, including patients' representations of the disorder, presentation of symptoms, reactions to diagnosis, and clinical progression.

Participants

To be eligible, participants needed to be GPs working in Singapore who had at least five years of practice experience in primary care and were currently practicing in a private primary care setting. Private GP clinics meet about 80% of the total primary care demand in Singapore.[19] Whereas certain GP clinics are independently managed solo or group practices, others have integrated a Primary Care Network (PCN), which grants them access to shared resources, such as nurses, care coordinators, and allied health professionals. In an effort to keep the sample more homogeneous and closer to a traditional, smaller-scale family medicine practice, this study excluded family physicians working in the public outpatient primary care clinics in Singapore, which are equipped with dedicated mental health clinics with more direct access to psychiatric resources.

Participant recruitment channels included mailing lists and WhatsApp groups of primary care physician networks and academic primary care networks of major Singaporean medical schools (National University of Singapore and Nanyang Technical University), as well as snowballing. Our sample was constructed with the aim of achieving maximum variation by age, gender, and ethnicity (Chinese, Malay, and Indian). At the start of data collection, we included all eligible GPs who were interested in the study, followed by targeted searches for participants belonging to underrepresented variation (e.g., non-Chinese GPs). Targeted searches used the same recruitment channels as initial recruitment but specified in the call for participation which GP profiles were sought in priority at that stage of the study. Data collection continued until both key information saturation and maximum variation purposive sampling by age, gender, and ethnicity were achieved.

Procedure

All procedures were approved by the NUS Institutional Review Board (protocol number NUS-IRB-2022-306) and reporting of the study in the present manuscript followed the COREQ checklist (Supplementary Table S1). Data collection took place between September 2022 and May 2023. The study team comprised members with qualitative research experience as well as medical expertise in family medicine, geriatric medicine, and mental health. Team members' characteristics and roles can be found in Supplementary Table S2.

After giving written informed consent and receiving a study ID to ensure anonymity, GPs filled out a short survey asking about their age, gender (male, female, or other), ethnicity (Chinese, Malay, Indian, or other), medical training and experience, and exposure to depression in their private life. Afterwards, participants underwent a 1-h long semi-structured interview in groups or individually. All discussions were conducted in English, via Zoom (the first one by VWKL and all others by AS), with the additional presence of a second moderator for group discussions to manage any technical issues and take notes (AS in the first group, and later VMEL, AHO, or FLL). Reflexive notes were recorded by the moderators at the end of each discussion. Each interview started with the moderators introducing themselves by their name, title, role, the study purpose, and the study's definition of late life as 65 years of age or older.

Our data collection strategy prioritized group discussions of two to five participants at the start to get a more diverse global overview of the topic, and individual discussions towards the end to explore the unique perspective of under-represented profiles in the sample, such as younger GPs, female GPs, Malay and Indian GPs. Each participant was only interviewed once. One participant was unable to participate in the study due to technical problems (could not unmute their microphone on Zoom).

Discussions were based on a topic guide developed by the study team, with minor adaptations during data collection to improve flow (see Supplementary Table S3 for the initial version). The topic guide included four main sections: exposure to late-life depression, presentation of symptoms by the patient, recognition and management of symptoms by the physician, and how to improve care at the three levels commonly described in patient-centred models of quality of care (patient – physician – system).[20]

Participants were not compensated directly, but were informed that for each participating GP, a charity organisation working with older adults in Singapore received SGD 20.

Data analysis

All interview recordings were transcribed and proofread. The analysis employed Excel and followed an inductive, reflexive thematic approach as outlined by Braun and Clarke.[21] The analysis did not employ an a priori conceptual framework when deriving the initial set of codes. Five study team members (AS, VMEL, AHO, ML, and FLL) coded the first two transcripts and reviewed

them together, to create an initial set of codes. Each remaining transcript was coded by one member of the coding team, with the coding tree updated and revised through a shared online document and discussed during regular meetings. Given the diversity and abundance of the initial codes (>500), the study team divided them into the three main domains used in the topic guide: patient-related factors, physician-related factors (e.g., communication and treatment strategies used by GPs), and system-related factors (e.g., resources in the community). The analysis of physician- and system-related factors will be reported elsewhere.

The first and second authors (AS and VVL) derived the first set of subthemes and themes from the codes classified as patient-related factors. The analysis was finalised through a discussion with most other co-authors during a meeting. The three senior authors (DY, JMV, and ABM) reviewed the final analysis for face validity. In the results presented below, all quotes are verbatim and some contain Singaporean English (Singlish) expressions, such as "lah", which indicates emphasis. We provided context about participant characteristics where relevant, such as a GP talking about their own ethnic community.

Role of the funding source

The funder played no role in the study design, data collection, data analysis, interpretation of findings, writing of the manuscript, nor in the decision to submit the paper for publication.

Results

A total of 28 GPs completed the study (Table 1). Participants were mainly male and Chinese and varied in age from 29 to 59 years. No participant indicated their gender or ethnicity as "other". Four had a graduate diploma in mental health. Participants were interviewed through six group discussions (n = 21) and seven individual discussions, with a diverse representation of age, gender, and ethnicity in both discussion types (Table 2). Discussions ranged from 51 to 76 min (median = 61 min).

The first four themes derived from the data follow the chronological order of the clinical process from initial presentation to late-life depression's evolution during follow-up and are complemented by an overarching fifth theme: "Patient-GP rapport" (Fig. 1). Themes alternate between GPs' direct perspectives on late-life depression (first and fourth themes) and GPs' understanding of patient perspectives (second and third theme). The fifth theme has elements of both perspectives.

Total number of participants	28
Demographics	
Age in years	min–max = 29–59, mean = 46
Age > 45 years (cut-off used for sampling)[a]	16
Age groups	
20–29 years	1
30–39 years	10
40–49 years	4
50–59 years	13
Gender	
Female	10
Male	18
Other	0
Ethnicity	
Chinese	18
Malay	5
Indian	5
Other	0
Clinical practice & experience	
Type of private practice	
Solo	14
Group	14
Private practice included in a PCN	24
Years of experience in primary care	min–max = 5–26, mean = 16
Primary care practice experience abroad	1 (Australia, 1 year)
Experience related to mental health & depression	
Mental health qualifications	
Graduate Diploma of Mental Health	5
Attendance of any mental health course	
Never	12
More than two years ago	3
In the past two years	13
Depression in private life experienced by self, a close friend, or a family member	20
Exposure to older patients and depression in older patients	
Estimated number of patients aged ≥ 65 years seen per week	range = 1–150, mean = 51
Estimated number of patients aged ≥ 65 years seen per week with depressive symptoms	range = 0–40, mean = 4
Estimated number of patients aged ≥ 65 years seen per week with clinical depression	range = 0–20, mean = 2

Note. Numbers represent counts unless otherwise specified. PCN, Primary Care Network. [a]The age cut-off for sampling (≤ vs >45 years) was determined based on a large study on members of the College of Family Physicians Singapore (N = 631), which found that 45 years was close to the sample's median age.[22]

Table 1: **Sample characteristics.**

Encountering depression

Initial clinical picture as seen by the GP

Possibly frequent but frequently hidden. The GPs' impressions differed on the commonness of depression, with some of them finding that depression was increasing in all age groups and others seeing it more often in younger patients. Other GPs found that most of their older patients would have depressive symptoms, if they were to investigate, especially those living in lower-income neighbourhoods.

Discussion	1	2	3	4	5	6	7	8	9	10	11	12	13
Number of participants	5	2	4	3	4	1	3	1	1	1	1	1	1
Participant characteristics represented in each discussion													
Age													
Age ≤ 45 years	+	–	–	+	+	+	+	+	–	–	+	–	–
Age > 45 years	+	+	+	+	+	–	–	–	+	+	–	+	+
Gender													
Female	–	–	+	+	–	–	+	–	+	+	+	+	–
Male	+	+	+	+	+	+	–	+	–	–	–	–	+
Ethnicity													
Chinese	+	+	+	+	+	+	+	+	–	–	–	–	–
Malay	+	–	–	–	+	–	–	–	–	+	+	+	–
Indian	+	–	+	–	–	–	+	–	+	–	–	–	+

Note. The "+" symbol indicates that a given participant characteristic was represented by at least one of the participants.

Table 2: **Discussion characteristics.**

"The patients do not mention depression to me. But, if I am forced to dig out, I would say at least 50% of them are depressed. Especially those you mentioned, above 65 years of age. … This is the poor part of town …."

While some GPs did not note any difference between male and female older adults, others found that females would have more depressive symptoms or disclosed them more easily than males. This could add diagnostic complexity in cases where depressive symptoms were reported together with numerous other concerns, as explained by a female GP:

"Females tend to … mix up the emotions a bit more so I find … that I need more time to tease out … whether it's anxiety or low mood or … pure primary insomnia, or … just them overthinking, or it's their personality."

GPs found clinical presentation in males more insidious and severe, with higher suicide risk.

"Men tend to present a bit more obliquely, and when they do present, they tend to be worse. So that does sort of match what we see in terms of … attempted suicides and in things like that."

Presence of precipitators. GPs found depression in older adults to be more common after a stroke, a hospital discharge, or in older patients seen in nursing homes or in homecare settings. They highlighted that there was almost always a precipitator underlying depression when it occurred in older adults. Ageing-related losses were often identified as triggers: e.g., loss of function, loss of autonomy, or loss of control over life.

"Feeling … everything under your control, [and] now you lost the control. It's about the identity."

Loss of one's social role following bereavement or functional decline was in turn linked to depression through social isolation, and more often encountered in older Chinese Singaporeans, who were more likely to live alone than older Malay and Indian Singaporeans. GPs often mentioned empty nest syndrome (parents experiencing sorrow after their children move out of the family home) as an example of social isolation.

"Some of [the older patients with depression], they're really the empty nesters. … A lot more of the women [who] seem to be living alone. … Their children maybe visit them once or twice a week and quite a few of them have not much friends already. Some of their friends passed on."

Paradoxically, social isolation could arise in older adults who moved closer to their children and lost their social network as a result, as described by an Indian GP in her community:

"The children are living and working here, and then the elderly [Indian] parents end up coming and living here, but they're displaced from their original social networks. So, they're very lonely …. So that's automatically the recipe for depression."

Depression could also follow difficult interpersonal roles within the family, such as being a caregiver of a declining spouse or ongoing arguments with one's children.

"Some conflicts with her children, actually just one child, … sort of brought [the patient] into a downward spiral, and since then, she does not even want to go back for any of her daycare activities."

Nevertheless, GPs viewed children in Singapore's Asian culture as generally caring towards their elders. GPs found social support most prominent in Malay

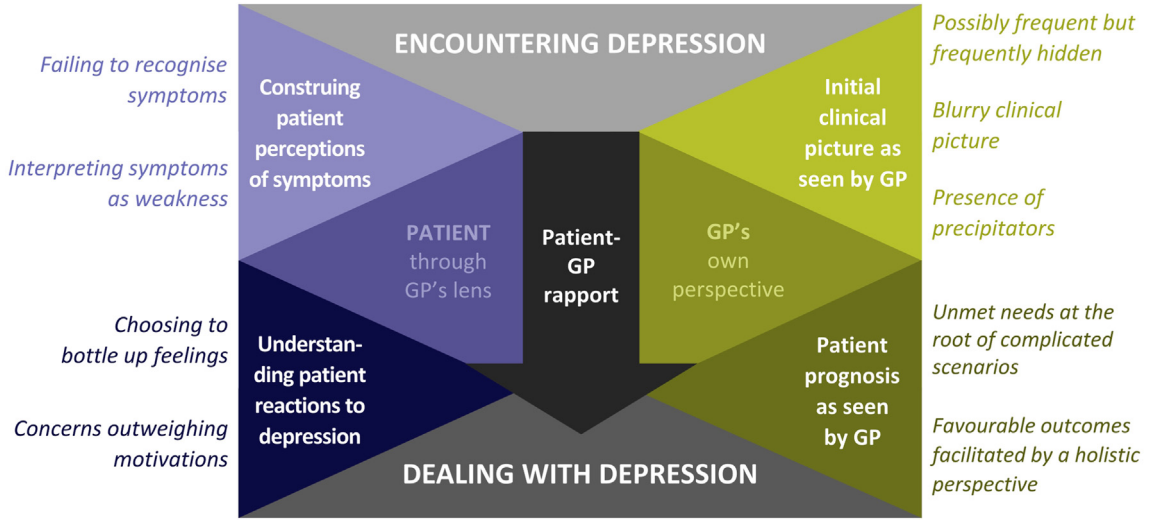

Fig. 1: **Schematic representation of main themes, subthemes, and meta-themes.** Note. The themes progress from the top meta-theme "Encountering depression" to the bottom meta-theme "Dealing with depression". Under each meta-theme, the theme on the right (in shades of green) explores GPs' own impressions of late-life depression whereas the themes on the left (in shades of purple) describe patient perspectives as perceived by the GP. Themes are presented in bolded, white font and are further divided into two to three subthemes each, represented in italic font. The theme "Initial clinical picture as seen by the GP" (top right corner) details how depressive symptoms in older patients present to the GP initially. The theme "Construing patient perceptions of symptoms" (top left corner) describes GPs' understanding of how patients perceive their symptoms. The theme "Understanding patient reactions to depression" (bottom left corner) details GPs' comprehension of how older patients process the notion of having depression. The theme "Patient progression followed by the GP" explores GPs' experience with late-life depression's evolution. Finally, the theme "Patient-GP rapport" (central arrow) links the two meta-themes together by describing the relational factors between the patient and the GP that play a role at each stage.

patients, who were usually tightly connected to both their religious community and large family structures. However, Malay GPs highlighted that social expectations and over-protective attitudes could also be sources of stress in large, close-knit families:

"I find that down here in Singapore [the children] are very very overprotective, especially among the Malays, lah. You … have them going out with wheelchairs for their parents even though they (the parents) are able to walk."

Blurry clinical picture. The GPs sometimes encountered cardinal symptoms of depression in older patients, namely low mood and anhedonia,[23] but vaguer complaints were more frequent in this age group.

"The elderly … would … tell me … 'Aiyah (exclamation among Chinese speakers expressing dismay), old and useless already.' … When I explore a little bit more, it seems that they do have depression."

It was often the presence of unsystematised somatic symptoms and their persistence over time that would prompt GPs to suspect depression, as explained by a GP with more than 20 years of experience in primary care:

"They don't really tell you depression. So, they will always say that 'I'm not like myself. I'm slower, I'm weaker, I don't have appetite, I can't sleep well.' So they come, they will tell you this myriad of symptoms and [that] they are having [them] for some time."

Behavioural changes, such as forgetfulness, aggressive or excessively controlling behaviour were also noticed. Whereas a "poor eye contact [and] a dishevelled" or "thin and frail" appearance would raise clear red flags for GPs, changes could sometimes be more subtle, such as ordinary behaviours that were simply unusual for a given patient.

"[There] was this particular lady. … She's always greeting you and then she wants to … shake your hand, hold your hand for a while before we start the conversation. But that particular visit was none of that. Just came in, 'Hello doctor', that's it. So it was a big change. So I wondered what happened."

Family members were generally helpful at bringing subtle behavioural changes to the GPs' attention. Yet, on some occasions, they could mislead GPs by attributing these changes to physical illness, without the patient correcting their views. According to an Indian GP, such

dynamics could be more frequent in Indian and Malay families.

"Some of [the older Indian and Malay patients] just keep quiet and they just allow the family member to talk. … Because they feel that it's part of [their children's] filial piety. … They don't want to contradict the son or the daughter … who is worrying for them. … Although they may actually feel the other way around."

Construing patient perceptions of symptoms

Failing to recognise symptoms. GPs explained that many older patients did not bring up their depressive symptoms because they failed to recognise them as such due to low mental health literacy.

"Because of the fact that many [older patients] do not have the opportunity to study, … a lot of them are blunted, they don't even know what … depression [is]."

Interpreting symptoms as weakness. The GPs viewed older Singaporeans as a generation that was taught to stoically endure hardships and keep a strong spirit, which also shaped their understanding of depression as something they needed to live with.

"I feel like it's … very pantang (Malay word for 'taboo'). They don't like to talk about … feeling sad …. I guess a lot of the culture in which they grow up in is, you know, you suck it up, right? If you have hardship, you go through it, right? Because of all [of] them have gone through hardship, poverty, some of them have gone through World War II. … Having to be stoic through difficulties is quite ingrained in the Asian culture regardless of gender and ethnicity."

According to GPs, this representation often resulted in older patients being ashamed and in denial of their depressive symptoms.

"Depression is a stigma. … They always think they are strong and, … of course, most of them [do have a] strong will. … So when you say … 'Are you depressed?' They get very upset: 'No, of course I'm not.'"

In turn, denial and low mental health literacy led older patients to normalise their depressive symptoms or write them off as part of regular ageing.

"A lot of them thinks it's because it's part and parcel of being old …, so it's okay."

Dealing with depression

Understanding patient reactions to depression

Choosing to bottle up feelings. According to GPs, the above negative perceptions of depression led many older patients to decide to keep their mood symptoms to themselves. Chinese GPs found the tendency of bottling up feelings to be most pronounced in older Chinese patients:

"With Chinese, with age, [there is] the feeling of pride also; the feeling of wanting face, wanting to look good in front of others. So they tend to underreport their symptoms and their situation. To put up a brave front."

GPs found that older Indian and Malay patients also tended not to disclose their depressive symptoms but attributed this reluctance to other factors in their case. According to an Indian GP, older Indian patients were concerned to shatter their role within the family by acknowledging they felt depressed, whereas Malay GPs highlighted that older Malay patients tended to understand depression in a religious way (e.g., drifting away from God) and primarily sought spiritual solutions:

"There are also cases whereby [older Malay patients] seek treatment from certain religious figures …, and they feel better. And I think, if it helps the patient, then why not?"

However, other GPs reflected that the clinical picture in different ethnicities tended to converge with age, and that having a more private personality could be a more important factor.

"I do think that personality plays a part as well because there are those who are adamant about not having anyone in their network know about their problems. And that cuts gender and ethnicity."

Concerns outweighing motivations. The GPs explained that some older patients were reluctant to address their depressive symptoms because they were lacking the motivation to get better altogether and did not expect anything more out of life.

"In a negative way, they don't see what they want out of life anymore. They say 'No, I lived my life, I'm fine', that kind of thing."

Often however, it was the concern of being a burden to others that drove older patients to hide their depressive symptoms, even when this could feel isolating, as explained by a GP with a graduate diploma in mental health:

"I have a patient who … has a fear of dying alone, … and yet she does not want to be a burden to the family. So she does not voice it to her family, the children, the sons."

Fearing to burden loved ones would also extend to financial and logistic aspects.

"A lot of [the] times, [patients'] decisions are … affected … by the financial aspect. … Not wanting to burden their children because they have to see a specialist: … 'My [daughter] can't take leave. She's the only one who's working, she's a single mother'. That kind of thing."

Mirroring this fear of burdensomeness, GPs also identified the fear of losing autonomy by having to rely on others in many of their older depressed patients.

"Some [patients] are living on their own and they may not feel that they have a problem. And they want to … retain their independence and not be on any medication or seek any help from the mental health specialist or allied health."

Patient prognosis as seen by the GP

GPs commented on depression's prognosis in their older patients by considering both negative and positive determinants.

Unmet needs at the root of complicated scenarios

Certain cases of late-life depression would evolve negatively, leading to death by suicide.

"[The patient] used to just come in and take Stilnox (zolpidem) for sleeping. And I did ask about depression and everything. … I was quite afraid to prescribe [that treatment] actually. She committed suicide."

Death could also ensue from extreme self-neglect, as witnessed in nursing homes during the COVID-19 Pandemic by a GP:

"It was just depression, [the nursing home residents were] just not eating because the family members weren't coming to see them. … Some of them were literally dying because they were so depressed that they were just not eating."

GPs also gave examples of unfavourable outcomes in older patients with incompatible expectations, who refused antidepressants and demanded a fast-acting treatment for the physical manifestations of depression. GPs tended to lose such patients to follow-up. They pointed out that the Singaporean Asian culture favoured this attitude.

"I think it's a cultural thing. Maybe you see a doctor, you expect to get a pill or some medications, and you think that's the wonder drug? Yeah, I guess it's the way that it's portrayed on media and … the Asian culture [encourages] being brought up in that manner."

Care could also be delayed by the patient's attempts to manage depression with traditional methods. A Malay GP highlighted that many older Malay patients sought treatment from traditional healers or religious leaders before turning to their GP:

"[Malay patients] do seek treatment outside of evidence-based medicine and sometimes that delays treatment, and then they come back, and they're not in such good shape."

According to GPs, some patients harboured negative beliefs about Western medicine or antidepressants, or expressed the desire "to take as little medicine as possible", whereas others feared of getting hospitalised in Singapore's Mental Health Institute (IMH; Singapore's mental health hospital).

"I think a lot of [patients] are not aware, especially the older patients, they might think that 'Oh no, I … have to go to IMH. That's the only place.' … There is unfortunate stigma amongst a lot of the older patients that IMH … is where crazy people go."

Favourable outcomes facilitated by a holistic perspective

GPs described that families contributed to a favourable prognosis by providing social, financial, and emotional support.

"So by and large, [the mild and moderate cases] do get better and largely because … the families give them a bit [of] extra support and you know TLC (tender loving care), … that's all they need, right? They need a lot of love, and care, and sometimes a bit of medication to help them out."

Families also facilitated care by helping GPs tailor solutions to the older patients' situation and by assisting older patients in following through.

"This group of patients, … they are on many medications, and the family members … tend to be a bit more agreeable for a referral. Like they'll tell me, 'Oh, this patient is seeing [a doctor at] Changi [General Hospital] for [her] stroke, maybe you can refer us there for her possible depression issue?'"

GPs described a bidirectional effect between physical and mental health in many patients, with improvement of their physical health and autonomy contributing to the improvement of their depressive symptoms.

"[The patient] was referred from [name of a general hospital] for his chronic medical conditions. … But he's quite well now. He's quite ambulant. He's running around actually, he's driving around. Just that about six months back, he was rather negative about everything."

Similarly, remission of depressive symptoms sometimes increased older patients' willingness to accept treatment for their physical illnesses.

"So after … persuading [the patient] to take the antidepressants, he really got better. He started to see the light …, so to speak. And now he's got a colostomy done and his cancer's been treated. He went through radiotherapy and he's totally in remission right now."

GPs noted that outcomes were generally positive in cases where patients were in concordance with the GP and followed through with treatment.

"The types that come back and follow up and maintain [and have] the connection over the years, they will definitely get better."

Patient-GP rapport

GPs emphasised the importance of their older patient's relationship with them at all stages of late-life depression. If the older patient could build rapport with the GP over time, they would be able to discuss depressive symptoms together more openly and stand a better chance of finding effective solutions.

"I mean that [it] is expected that you are not going to pour out your troubles to someone you met first time. … We are very privileged that in the GP setting, we usually know the patient [through] several consults for other conditions, so they feel comfortable. Then one day they decided that ' … maybe this is the person I can talk a bit more [to], since I'm gonna need some help'. So, we already have that rapport."

GPs extended the importance of rapport to the older patients' families:

"Certain families that we have good rapport with as well … would want to share that these are the observations they have. That … helps with management."

Being of the same ethnicity or religion and speaking the same language were mentioned as facilitators to rapport building, as explained by a Malay GP:

"So, I find that my Malay patients, they open up more if you speak the language and are able to dive deeper in their cultural context also."

A GP with a graduate diploma in mental health pointed out that this privileged relationship with older patients sometimes failed to develop with mental health specialists, to the point that some older patients insisted on being treated by their GP:

"[Older patients] find that the psychiatrists are very impersonal and don't … have the time to listen to them …. That's frequently the feedback we get when the patient goes to the government hospital, or even [to] private psychiatrists and [patients] would rather pay me for extended consultation than to see the counsellor."

Discussion

Depression in older patients often manifested obliquely to GPs practicing in Singapore, who could nonetheless identify a concrete precipitator at its root in the form of individual difficulties, social isolation, ageing-related losses, or stressful family dynamics. GPs considered symptoms and precipitators to vary by ethnicity. While the GPs found that some older patients were unable to recognise depression, many others chose to ignore or deny depressive symptoms because they viewed them as part of normal ageing or were concerned that addressing them would make them lose autonomy or become a burden to others. Treatment concordance was seen as key for good prognosis and relied on GPs' ability to build rapport with the patient and their family.

Taken individually, many aspects of late-life depression as described by the GPs overlapped with Western findings, such as older patients' fear of being a burden to others,[24] or perceiving depression as a weakness or a normal consequence of ageing,[25,26] and GPs' view of families as both a source of help and distress for older patients with depression.[25] Similar to some of their Western counterparts,[25] GPs in our sample reported that depression in older adults was due to external precipitators. These precipitators also aligned with risk factors identified by quantitative studies in Singapore.[27–30] For example, GPs named male gender[27] and low socio-economic status[28,30] as challenging cases to diagnose, and bereavement or functional decline[27,28,30] as more straightforward risk factors enabling early detection.

GPs' accounts helped to understand late-life depression in the Singaporean context by fleshing out older adults' past experiences (e.g., tradition to endure hardships), current financial considerations (e.g., inability to afford mental healthcare), and familial and cultural expectations of social roles (e.g., preserving their own autonomy and authority vs complying with their children's wish to help). These observations partly arise from a shared Singaporean Asian culture but are further coloured by ethnic and religious differences in family dynamics and attitudes towards spiritual leaders as sources of help.

Also consistent with findings from Western countries,[31,32] GPs in Singapore considered the patient-doctor rapport as a cornerstone of all diagnosis and management processes, suggesting the need of a long-term care relationship with the same provider for effective mental health treatment. This aligns with the national initiative of Healthier SG,[18] which aims to shift the Singaporean population's healthcare utilisation from opportunistic consultations to preventive longitudinal care coordinated by a single primary healthcare provider. Our

findings support that such changes have the potential to improve mental health care in primary care.

Our results align with prior research on the benefits of a holistic, patient-centred approach[33,34] by highlighting the multilayered nature of older depressed patients' characteristics and needs. Family physicians have been encouraged to pursue this approach by patients, community stakeholders, and international organisations.[35,36] The diverse observations reported by Singaporean GPs in the present study suggest that many of them already use a holistic lens in their understanding of late-life depression. This can serve as foundation for the envisioned shift towards better integrated mental and primary health care. However, as highlighted by the heterogeneity of GPs' point of views on questions such as the frequency of late-life depression, a shared understanding about what counts as late-life depression may be lacking and may represent one of the immediate challenges to tackle to improve late-life depression care.[37]

Strengths of the present study include its nuanced description of GPs' perspectives on late-life depression in a sample with variation across age, gender, Singapore's three major ethnic groups, practices characteristics, as well as both primary care and mental health training and experience.

The present study is nonetheless limited by its inability to characterize the patient population of each GP participant, for example in terms of demographic characteristics, relationship with the GP, or existing help-seeking habits. As the aim of this study was to understand how private GPs' encounter late-life depression in Singapore, study design, data analysis, and findings were geared towards building knowledge on GPs. Including individual discussions with GPs likely helped address social conformity bias, yet several other forms of potential biases could not be accounted for. These include hindsight bias (the fact that GPs' retrospective accounts of clinical cases may have been influenced by the outcome of those cases), and self-selection bias (the possibility that only GPs who had affinity with mental health care signed up for the study). As data collection overlapped with the COVID-19 Pandemic, the unusual circumstances of clinical practice during that time may have also influenced GPs' general views on late-life depression. Finally, even though private GPs in Singapore see a large and diverse portion of the population,[19] they could not report on patients who only utilise public healthcare services and who may have distinct characteristics.

To get a more complete clinical picture of late-life depression in Singapore, future works should compare and contrast the present findings with the perspectives of other stakeholders, most importantly older patients with depression and their families and family physicians in the public sector. Future research should additionally explore how GPs in Singapore experience their own role within the healthcare system with respect to the management of late-life depression in their older patients. The cultural and ethnic specificities in the Singaporean population highlighted in the present work should be considered in both mental health research and primary care practice.

Contributors

Anna Szücs: conceptualisation, data curation, formal analysis, investigation, methodology, project administration, visualisation, writing - original draft; **V Vien Lee**: data curation, formal analysis, methodology, writing - review & editing; **Victor W.K. Loh**: conceptualisation, investigation, methodology; **Monica Lazarus**: conceptualisation, methodology, formal analysis, writing - review & editing; **Choon Kit Leong**: conceptualisation, methodology, resources; **Vivien M.E. Lee**: investigation, formal analysis, writing - review & editing; **Alicia H. Ong**: investigation, formal analysis, writing - review & editing; **Foon Leng Leong**: investigation, formal analysis, validation; **Laurie J. Goldsmith**: methodology, formal analysis, writing - review & editing; **Doris Young**: conceptualisation, funding acquisition, writing - review & editing; **Jose M Valderas**: conceptualisation, funding acquisition, supervision, writing - review & editing; **Andrea B Maier**: conceptualisation, methodology, supervision, writing - review & editing.

All authors had full access to all the data in the study. Authors Anna Szücs, V Vien Lee, Monica Lazarus, Vivien M.E. Lee, Alicia H. Ong, and Foon Leng Leong verified the data. All authors accept responsibility to submit the manuscript for publication.

Data sharing statement

The data that support the findings of this study are available on request from the corresponding author, AS. The data are not publicly available as they contain information that could compromise the anonymity of research participants.

Declaration of interests

The authors have no conflicting interests to declare.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lanwpc.2024.101170.

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