Depression: Its Detection And Management In General Practice

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Introduction

It is one of the foremost mental health problem prevailing today. Despite of it being very common, widespread and ubiquitous, it is one of the many human maladies which is frequently missed or even if detected, largely remains unhandled. Poor sufferer keeps on suffering and his quest for remedy continues unabated from one doctor to another, one hospital to another or even one country to another; also through uncharted odyssey in search of a detectable disease in the form of an abnormal laboratory report or cultivation of a pathogen in the petridish. But the disease eludes the patient and his doctor most of the time. Thus, continues the human suffering and also the nation, specially those with meagre health resources who keep on battling the fight.

What is it-Which is know as 'Depression' ?

Frequently, it is argued that all of us do have 'low mood' or 'sad mind' or 'frustrated feeling' or 'boring period' at least once in a day or two day and we get better after sometime- so how can that be called 'a disease'. Yes, the disease 'depression' is different than normal sadness of mood or depression.

Depression, with its different shades and severity is a normal human mood. So

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does occur in human but as other normal phenomena, it is not long lasting, not very painful or disabling and also usually related with bad event or something similar.

In contrast to this, it becomes abnormal once it lasts for a long time, becomes very severe and disabling; and if it appears out of the blue for no obvious reason. Therefore, normal depression becomes depressive illness or disorder, once it crosses those boundaries and remains for a long time. Depressive illness is characterized by slowness in thinking and activities, diminished interest in enjoyment, social activities and work and sadness of mood with episodes of weeping.

There are two main forms of this disorder which are- i) Neurotic depression, or depressive Neurosis or Dysthymic Disorder & ii) Manic Depressive Psychosis- depressed type or Major Depressive episode etc.

Prevalence

Depression is widely seen in the community. Many of these patients seek help from the general health setup like outpatient department of a general hospital; health centres or general medical practitioners etc.

It is estimated that roughly 5% of all patients who visit the general outpatient department (OPD), do so for the reason of depressive illness only, with no accompanying physical illness.

Data from general clinics and community surveys have provided ample proof that depression is a commonly seen disorder. This is contrary to the popular belief of the past that depression was not common in the non-western world as people there were not psychologically matured enough to suffer from it. World Health Organization (WHO) has estimated that more than 100 million people of the world have been suffering from significant depression and around 20 million of them need urgent care. Problems of living which have been of varied nature in different societies too have depressogenic effect which maintain the disease for a longer period.

Besides, it has been found that 20-30% of people will develop significant depression once in their life-time. All humans, poor or rich, literate or illiterate, male or female; from developed or developing country can suffer from this universal malady. No misconception should be harboured that doctors working in different specialities will not encounter this disease- on the contrary, it is seen in different guises and clinical forms.

Historical documents have shown it to be present since ancient times. Many mythological heroes have been portrayed in forms which today would be identified as cases of depression. Even, many legendary figures who have shaped our world have suffered with episodes of depression.

Types of depression

Classification of depressive illness, based on the etiology is not possible at present time, as the exact cause and pathogenesis of it have yet to be discovered. However, there are many ways one can look at the problem of classification. Following are the main ways:

- I) Neurotic and psychotic
- II) Reactive and endogenous
- III) Primary and secondary,
- IV) Unipolar and bipolar,
- V) Major and minor,
- VI) Depression as such.

I) Neurotic & psychotic

As the name implies, the depressive illness may be either one of neurotic type or of psychotic type; thereby meaning either it may have neurotic features without psychotic features or it may have predominantly psychotic features. Important psychotic features are loss of touch with reality, impaired insight and grossly disturbed daily activities. It means the patient will have gross thought and perceptual disturbances which may manifest as delusions or hallucinations. So, if any of these features are also present in a case of depression, then the diagnosis of psychotic depression is given. In the absence of which and with the presence of other neurotic features, the disease is called neurotic depression.

II) Reactive and endogenous

This dichotomy puts a case of depressive illness into either as caused in reaction to some environmental factor such as stressful events, death, loss of employment, failure in 'love' etc. or as caused with no obvious external cause. The former cases will have a clear cut precipitant, a temporal relation with it etc. and these can be easily discovered in a brief interview.

The endogenous type of depression is said to be caused by some internal biochemical disturbances of neurotransmitters and not related to the occurrence of a life event. Besides, disturbances in the bodily functions like sleep, appetite, sex also are present along with the core depressive symptoms.

III) Primary and secondary

This means depression as arising out of the blue or secondarily as many other illness as depression accompanying other psychiatric and physical illnesses.

A large number of diseases can secondarily produce depression which may be significant enough not to be neglected. Some of them are schizophrenia, epilepsy, alcoholism, drug dependence, influenza, viral hepatitis, rheumatoid arthritis, pancreatic cancer, hypothyroidism etc.

IV) Unipolar and bipolar

When the depressive episodes in an affective disorder occurs separately with no accompanying manic episodes, then it is known as the unipolar depression, otherwise it is bipolar depression. This helps, more in classifying the depressive phases of affective disorder, rather than an average episode.

V) Major and minor

A depressive episode becomes a major illness when it is severe and accompanied with gross disturbances of appetite, sleep and other bodily functions and seriously disabling. Remaining are the minor episodes.

VI) Depression as such

As the classification seems to be a problematic, at times impossible task, many research workers seem to be contented, not trying to classify it further, because it besets difficulties. Attempts also have been made to classify it on the basis of biochemical disturbances.

Etiology of depression

Less the writing about the cause, lesser will be the confusion. As in many other illnesses, etiology, here can be talked about in terms of many factors; not knowing exactly how strong is any one of them. The common ones which are accounted mostly are:-

1. Heredity/Genetic.
2. Other constitutional factors.
3. Biochemical factors.
4. Psychological factors.
5. Familial and sociological factors.

Exploiting this state of confusion fully, proponents of various theories have tried their best to pull it on their sides of fence vainly. One consensus opinion regarding etiology has yet to emerge. It appears, at the moment, that it may consist of many illnesses with similar clinical patterns and courses.

Features of depression

The features of depression follow certain trends that are universal. But one of the most important thing is that the vast majority of patients do not come with the complaint of depression or sadness to the doctor. This is especially so in people who find it difficult to talk about their emotional problems to the health workers. They often present with somatic complaints that appear vague and non specific.

Common modes of presentation

a) Multiple somatic complaints:

They are the most frequent complaints of depression, in fact, especially so in such patients from developing countries some of them are headache, heaviness of head, pulling sensation on the neck and shoulders, burning or 'hot' sensation all over the body, gastric trouble, burning epigastrium, distension abdomen, flatulence, 'gas' in abdomen, indigestion, anorexia, loss of weight, dizziness, pins and needle sensation, weakness, aches and pains, tiredness, lethargy etc

Such complaints are usually vague often transitory, changeable and on examination, do not appear to fit into any specific pattern of physical illness. And on further questioning, other features of depression can be found.

b) Anxiety and other neurotic symptoms:

Many depressed patients complain of symptoms of anxiety like palpitation, tremors, giddiness, restlessness, sweating, cold and clammy extremities, darkness in front of the eyes etc.

Besides them, patient also feels sad and mental state examination (MSE) reveals the core features of depression.

Similarly such patients may present with hysterical fits or obsessional features but accompanying depressive features will help in clinching the diagnosis.

c) Sadness of mood:

At times, the patient, himself complains of a general lowering of mood that is severe enough to hamper his daily activities.

The complaining of weeping spells, pessimistic ideas, excessive worry or brooding over trivial matters are frequently found in depressed patients; other features are lack of self confidence, guilt, self blame etc. Impaired concentration and forgetfulness are constant problems. Indecisiveness and lack of initiative and confidence make the person feel worthless and inadequate.

Psychomotor retardation results in slow, low tone speech and reduced motor activity. In severe cases, the ominous triad of hopelessness, helplessness and worthlessness is seen and this stage warrants urgent attention and management, as suicidal thoughts

and preoccupations are the frequent accompaniments. At times depressed patients may express the futility of life and want to die off by committing suicide-but they may not express this, in which case the danger is quite high.

Many times, depressed patients may complain of an inability to enjoy activities those were previously pleasurable e. g. lack of enjoyment in T. V. or games. Increasing lack of interest in household and other activities, recreations and talk may withdraw the patient away from society. This associated with diminished psychomotor activity may bring in a stupor like state.

d) Other complaints:

Certain changes are known to occur in normal bodily functions. Disturbance of sleep is amongst the commonest of these, others are constipation, decrease in appetite, loss of body weight, diminished sexual desire etc. sometimes these symptoms may be prominent and only complaint of depression.

These, patients with depressive illness may present in different ways in the general health setting. Relative absence of the core depressive features as the presenting complaint makes it liable to be missed by clinicians. A high index of suspicion is the key for detection. In different age groups, depression appears and presents in different ways. In cases of children and adolescent depressives, presentation may be with hyperkinesis or hypokinesis, underachievement in academics etc.

Similarly, depression of old age may present as involutional melancholia. Transcultural variation in the symptom pattern has also been known.

Diagnosis of depression

The diagnosis depends upon:

- i) the presence of a constellation of specific symptoms of depression,
- ii) characteristic features in history,
- iii) and absence of a clear-cut physical basis to explain the symptom.

The core depressive symptomatology has to be present for the purpose of diagnosis. As said earlier, these features may be apparent without any extra effort or they may need to be searched for when suspected. Features in the history like recent changes, onset, duration, progression etc. all help in chalking out the onset and progression of the disease. Similarly, physical illness or prolonged drug intake have to be ruled out for making the diagnosis.

Management of depression

It is one of the most satisfying and rewarding condition to treat. With specific treatment a depressive episode can be fully treated and suffering of patient considerably reduced, changing patient's outlook.

There are many treatment methods available which are used singly or in combination of two or more methods. These are:

- i) Pharmacotherapy
- ii) Interview/psychotherapy
- iii) Electroconvulsive therapy
- iv) Cognitive therapy
- v) Others.

Treatment depends largely upon the severity of illness, namely mild, moderate and severe. In severe depressives, particularly those with suicidal risk, that is with history of attempt or strong preoccupation with suicidal ideas, immediate measures must be instituted and hospitalization is required.

For the majority of cases, where disease is in a milder form, outpatient treatment with counselling and antidepressant drugs are helpful.

Pharmacotherapy: Antidepressant drugs are the mainstay of treatment of depression. The advent of these drugs has revolutionized psychiatric treatment methods and has even contributed to the understanding of the biochemical nature of the disease. Main antidepressants are the following:

I) Tricyclic antidepressants

- Amitriptyline
- Imipramine
- Doxepin
- Desipramine etc.

II) Monoamine oxidase inhibitors

- Tranylcypromine.
- Isocarboxazide etc.

III) Other newer antidepressants

- Mianserin
- Zimeldine
- Maprotiline etc.

Following are the tips to remember to be able to use antidepressants effectively:

- 1) Treatment should be started with lower dosage like 25 to 75 mgm. per day and then gradually raised to an adequate dose which for Imipramine and Amitriptyline is 150-200 mgms per day.
- 2) During the initial period of 10 to 15 days, clinical benefit is not usually noticed. This delay in onset of benefit does not mean ineffectiveness of the drugs.

- 3) After building up the doses to an adequate level, it should be maintained for adequate period, that is, 6 to 8 weeks, before discarding the drug. So, the key words in the treatment **adequate dose adequate time period**.

Most of the treatment failures are the results of not following this simple rule.

Total duration of drug treatment depends on various factors, besides clinical judgement

- 4) Patient must be warned of the side effect, particularly dryness of mouth, increased thirst, giddiness, postural hypotension, constipation, drowsiness etc. which usually make the patient feel worse in the beginning. Not forewarning the patient about this, usually results in therapeutic failure. Initially, along with antidepressant, antianxiety drugs may be required.

Electroconvulsive therapy (ECT): is an effective and cheap treatment method. It is usually indicated in endogenous depression, psychotic depression, severe depression with suicidal risk or depression not responding to drugs etc.

Interview therapy / psychotherapy / counselling: It encompasses a large number of psychotherapeutic treatment methods, varying from simple counselling to highly structured psychotherapies namely psychoanalysis etc.

Psychotherapeutic maneuvering at the basic level, that is, plain counselling, any doctor or health worker can do. In this, patient has to be helped in understanding his conflicts, and the way to resolve it. A little extra time spent beyond the usual prescription writing, can be enough to do so.

Probing in to patient's family life, marital relationship, sexual conflicts, problems in vocation or financial stresses can bring in lot of emotional relief. Doctors definitely cannot change the life situation of the patient but they definitely can help in his efforts to cope with his situation. Even explanations about the nature of the illness, course, prognosis and treatment can make him feel much less hopeless. Inquiries about suicidal ideas, and attempts must be made in each case of depression, without hesitation, or fear of reminding him. It has been shown that this will lessen the risk rather than increasing it. In a mild case of depression, this alone is sufficient to treat it, whereas in moderate and severe cases, the patient has to be given drugs along with it.

Among other methods of treatment, cognitive behavior therapy (CBT) has emerged as an effective treatment method in the recent years. It should be kept in mind that depression is a treatable condition and patient must not be kept suffering for lack of proper treatment.

Referral or help from a specialist therapist always should be sought in case of any problem in diagnosis or management, otherwise patient will remain as such.

Conclusion

Thus, it should be evident from above that

- i) depression is a quite common disease in any setting.
- ii) it is frequently missed by doctors and health workers.

- iii) It can be managed reasonably well with proper use of antidepressant drugs and counselling at the outpatient level.
- iv) In many of the physical illnesses significant amount of secondary depression is associated with and in most of the cases these are missed too. Therefore with this in background depression should be attempted to detect.

Sources

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