ABC of mental health

Depression

Anthony S Hale

Depression has a range of meaning—from a description of normal unhappiness, through persistent and pervasive ways of feeling and thinking, to psychosis. Textbook descriptions of depression seen in hospitals are often very different from presentations in primary care.

In recent community surveys, 2% of the population suffered from pure depression (evenly distributed between mild, moderate, and severe), but another 8% suffered from a mixture of anxiety and depression. Even patients with symptoms not severe enough to qualify for a diagnosis of either anxiety or depression alone have impaired working and social lives and many unexplained physical symptoms, leading to greater use of medical services.

Key practical questions relate to treatment. Is any required at all and, if so, what sort and for how long?

Forms of depression

Most depressions have triggering life events, especially in a first episode. Many patients present initially with physical symptoms (somatisation), and some may show multiple symptoms of depression in the apparent absence of low mood ("masked" depression).

Less severe depression has been awarded many labels, including neurotic depression, minor depression, and reactive depression (not depression as a reaction to circumstances but when reactivity to events in the surroundings is preserved). It is now termed dysthymia, a persistent low grade condition. This may be complicated by episodes of more severe depression, resulting in "double" depression in which resolution of the more severe syndrome is difficult to judge.

Many patients do not fit neatly into categories of either anxiety or depression, and the concept of mixed anxiety and depression is now recognised. The presence of physical symptoms indicates a somatic syndrome (melancholic or endogenous depression). The value of these features in predicting response to treatment is not clear. The presence of psychotic features has major implications for treatment. Brief episodes of more severe depression are also recognised (brief recurrent depression). More prolonged recurrence is now termed recurrent depressive disorder (formerly depressive illness).

Diagnosis

There are three main distinctions to be made. Is the depression an illness or "normal" unhappiness? If it is an illness, is it a primary psychiatric condition or is it secondary to a physical illness or to alcohol or other drugs? If it is a primary psychiatric illness, is it unipolar or bipolar?

Severity of depression is largely a question of number and intensity of characteristic symptoms. A few mild but persistent symptoms suggests dysthymia. More numerous or more severe symptoms suggest a depressive disorder. Psychotic symptoms (delusions, hallucinations) or depressive stupor are present only in severe depression.

Features of depression

Core features

- Pervasive low mood
- Loss of interest and enjoyment (anhedonia)
- Reduced energy, diminished activity

Other features

- Poor concentration and attention
- Poor self esteem and self confidence
- Ideas of guilt and unworthiness
- Bleak, pessimistic views of the future
- Ideas or acts of self harm or suicide
- Disturbed sleep
- Diminished appetite

Somatic syndrome

Present if more than four of the following features are present

- Anhedonia
- Loss of reactivity (loss of emotional reactivity to normally pleasurable surroundings and events)
- Early waking (> 2 hours early)
- Psychomotor retardation or agitation
- Marked loss of appetite
- Weight loss > 5% of body mass in one month
- Loss of libido

Depression in primary care

- One in 20 visits to doctor due to depression
- >100 depressed patients per doctor's list, but half unrecognised
- 20% develop chronic depression
- Why patients may not mention their depression:

Embarrassed	Avoid annoying doctor
Avoid stigma	Avoid lack of sympathy
Somatisation	

Treatment

Much depressive illness of all types is successfully treated in primary care. The main reasons for referring depressed patients to a mental health team are that the condition is severe, failing to respond to treatment, complicated by other factors (such as personality disorder), or presents particular risks. The presence of agitation has been shown to mask psychotic features. Patients with marked psychomotor retardation are also often difficult to treat in primary care.

Medication versus psychotherapy

Basic treatment for mild, moderate, and severe depression and the depressed phase of bipolar illness is generally similar. The principal decision is whether to treat with drugs or a talking therapy. Surveys have shown that most patients in primary care settings would prefer a talking therapy, but evidence of effectiveness is limited to particular forms of psychotherapy.

For mild to moderate depression, cognitive-behaviour therapy and antidepressants are equally effective. For more severe depression, antidepressant drugs are more effective. Cognitive-behaviour therapy is a "brief" focused psychotherapy requiring from six to 20 sessions, and its availability may be limited in some areas. In mild depression patients' response to tricyclic antidepressants may be no better than to placebo, but this may be related to high levels of non-compliance.

Drug treatment

The use of tricyclic antidepressants at doses well below those that are therapeutically effective (< 125 mg daily imipramine equivalent) has often been reported, especially in primary care. Chopping and changing treatments before giving any one a chance to work (six to eight week trial) is also common.

Effective antidepressant drugs have been available since the 1950s. In the past eight years eight new drugs have been added to those already available—12 tricyclic antidepressants, three monoamine oxidase inhibitors, seven other monotherapy antidepressant compounds, and six fixed combination preparations.

The newer drugs were developed "rationally" to be more selective in their actions than the older antidepressants and hence have far fewer serious side effects than the tricyclics or the monoamine oxidase inhibitors. However, some older drugs—such as desipramine, maprotiline, and nortriptyline—are also selective for noradrenaline reuptake blockade. The differences between drugs lie primarily in their side effects and their potential interactions with other drugs.

Side effects, in particular anticholinergic effects and weight gain, are thought to have a major effect on the frequency with which patients do not take antidepressants as prescribed. Careful clinical studies show large differences between older and newer antidepressants, with much higher non-compliance rates in patients taking the older drugs with more side effects. This merely demonstrates what is clinically obvious—that patients prefer taking drugs with fewer side effects.

Guidelines on the rational prescribing of antidepressants balance their side effect profile, and hence tolerability and compliance, against cost. Economic studies have tended to show little overall difference in costs between drugs, but costs are distributed between many different budgets and it is often difficult for those paying the immediate purchase cost of a drug to take a global view about savings accruing to others' budgets. Clinically, the choice between antidepressants lies in their safety and tolerability to the patient.

Reasons for referral to specialist psychiatric services

- High risk of suicide
- Failure to respond to usual treatment
- Diagnosis is difficult
- Comorbid conditions in which the other illness or its treatment makes treatment of depression problematic (for example, serious physical illness or personality disorder)
- Patients with psychotic depression who may require either combinations of different antidepressants or electroconvulsive therapy
- Patients with bipolar disorder who represent a higher suicide risk during depressed phases and may need careful monitoring of lithium concentrations

Virtually all available antidepressants are equally effective if given at an adequate dose for a sufficient period

Choice of antidepressant

Tricyclic antidepressants

Available since the 1950s, effective and cheap, but all have dose related anticholinergic side effects that limit compliance. They produce variable degrees of sedation, and postural hypotension may cause falls. Often fatal in overdose. Lofepramine is relatively safe in overdose and almost free of anticholinergic side effects

Selective serotonin reuptake inhibitors

Five now available (fluvoxamine, fluoxetine, paroxetine, sertraline, and citalopram). All lack sedation and are free of anticholinergic effects. This improves compliance but gives less immediate benefit for disturbed sleep (hence, may be combined initially with low doses of sedative antidepressants or hypnotics). All seem safe in overdose. A major benefit with several is that a single or narrow range of doses can be advocated for most patients, usually taken once daily, overcoming the tendency in general practice to prescribe doses of a third to a half of effective therapeutic dose

Monoamine oxidase inhibitors

Rare fatalities from hypertension when taken with foods containing tyramine require a restrictive diet that is unpopular with patients. Traditionally used for "neurotic" or "atypical" depression

Other types

Moclobemide

A reversible selective inhibitor of monoamine oxidase A. Its efficacy is similar to most other antidepressants except, perhaps, in severe depression. An alternative for patients not responding to other agents. Side effect profile is relatively benign, and it is generally not necessary to impose a low tyramine diet. Drug interactions may occur. It seems safe in overdoses of up to 20 g

Nefazodone

A mixed selective serotonin reuptake inhibitor and 5HT₂ receptor antagonist. Fairly free of gastrointestinal side effects and the sexual dysfunction seen with selective serotonin reuptake inhibitors. More sedative so helps sleep, but some postural hypotension

Venlafaxine

The first mixed serotonin and noradrenaline reuptake inhibitor. It should offer the benefits of tricyclic antidepressants with fewer drawbacks. Side effects are nausea, headache, and sweating. Anticholinergic and cardiovascular adverse events uncommon, and it causes less weight gain than tricyclics. It seems safe in overdoses up to 6.75 g. May cause swings into hypomania in patients with bipolar disorders. Rapid onset of action has been observed

Non-compliance with antidepressants may reach 50%

Maintenance treatment

Half of all depressed patients only ever have one episode. The risk of a subsequent episode increases with the number already experienced and with increasing age of onset. As risk of recurrence increases, so prophylactic maintenance treatment should be considered, although most patients hate this. There is good evidence of the efficacy of tricyclic antidepressants for up to five years, but few studies of newer drugs extend beyond one to two years. For long term treatment, the burden of side effects with the older drugs is a major consideration in choice of treatment.

Dysthymia

Recently, research has led to a change in the concept of persistent low grade depression from personality disorder to chronic affective disorder.

Past treatment with anxiolytics has now changed to that used in other forms of depression, and there is evidence that most types of antidepressant are effective. However, dysthymic patients may be more sensitive to the side effects of tricyclic antidepressants than those with more severe depression, and hence newer antidepressants may be the treatment of choice. The chronic nature of dysthymia may require long term treatment, particularly when it is associated with episodes of more severe depression (double depression) as recurrence of severe episodes is more likely if the dysthymia is not controlled.

Focused psychotherapies such as cognitive-behaviour therapy and marital and family therapies benefit social functioning but have less effect on symptoms. The marked social and interpersonal debility associated with dysthymia and patients' need to acquire coping skills in managing symptoms and problems suggest that an approach combining antidepressants and focused psychotherapy is most likely to produce lasting benefit.

Psychotic depression

Patients with psychotic depression are the most severely depressed, and they respond poorly to antidepressants alone. Two treatments are effective: combined use of antidepressant and antipsychotic drugs, and electroconvulsive therapy.

Combining some of the newer antidepressants, particularly the selective serotonin reuptake inhibitors, with antipsychotics should be done with caution as inhibition of the liver cytochrome enzymes can raise the plasma concentrations of both drugs, so monitoring may be needed.

Electroconvulsive therapy is an older treatment than antidepressant drugs. It is exclusively a hospital based treatment, and most patients remain as inpatients during the course of treatment. It is effective only for depressed patients who are either deluded or have marked psychomotor retardation. The treatment entails administering an electric charge to the head of a patient under a general anaesthetic in order to produce a generalised fit. From the patients' point of view, they will have a general anaesthetic twice weekly for three to four weeks and experience a mild transient confusional state for an hour or so after each treatment.

Bipolar affective disorder

The clinical features and treatment of the depressive phase of this illness are identical to those of other depressions, but watch for drug induced swings into mania. Effective long term prophylaxis may be achieved with lithium (this requires

Duration of antidepressant treatment for major depression

	Age at first episode (years)		
	<39	40-49	>50
First episode	6-9 months	6-9 months	Indefinitely
Second episode	6-9 months	4-5 years	Indefinitely
Second episode with complications	4-5 years	Indefinitely	Indefinitely
Third or subsequent episode	Indefinitely	Indefinitely	Indefinitely

Classification of depression*

Primary

Unipolar

- Mixed anxiety and depressive disorder—With prominent anxiety
- Depressive episode—Single episode
- Recurrent depressive disorder—Recurrent episodes
- Dysthymia—Persistent and mild ("depressive personality")

Bipolar

- Bipolar affective disorder—With manic episodes ("manic depression")
- Cyclothymia—Persistent instability of mood

Other primary

- Seasonal affective disorder
- Brief recurrent depression

Secondary

May be secondary to medical condition or alcohol or other drugs

Depressive episode

Each episode may be

- Moderate or severe
- With or without somatic syndrome
- If severe, with or without psychotic symptoms

*ICD-10 (international classification of diseases, 10th edition)

Electroconvulsive therapy in treating depression*

- The greater the number of typical features of depression, the greater likelihood of a good response to electroconvulsive therapy
- Electroconvulsive therapy is particularly effective in treating depression with psychotic features
- Patients who do not respond to antidepressant drugs may respond to electroconvulsive therapy
- It is essential to continue drug treatment with antidepressants after a successful course of electroconvulsive therapy

Safety of electroconvulsive therapy

- There are no absolute contraindications to its use
- It may be a lifesaving treatment in cases of severe depression
- There is no evidence that it causes brain damage or permanent intellectual impairment
- The risk of death is similar to that of general anaesthesia for minor surgical procedures—about two deaths per 100 000 treatments
- Several drugs, including selective serotonin reuptake inhibitors, may prolong the duration of the induced seizure

*Based on *The ECT handbook*. London: Royal College of Psychiatrists, 1995 (Council report CR39)

pretreatment screening of renal and thyroid function) or carbamazepine; these treatments are usually initiated by psychiatrists.

Suicide and deliberate self harm

There are about 5000 suicides each year in England and Wales, of which 400-500 involve overdoses of antidepressants. Deliberate self harm is 20-30 times commoner. Not all people who commit suicide have psychiatric illness, but, among those who do, depression is the commonest illness and 15% of depressed patients eventually kill themselves.

Assessment of risk is thus important and guides treatment. Many older antidepressants are often fatal in overdose, while the newer effective drugs—such as selective serotonin reuptake inhibitors, lofepramine, and others—are safer and should be used with high risk patients.

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Information leaflets for patients

Bereavement. From: Help the Aged, St James's Walk, London EC1R 0BE (tel 0171 253 0253)

Depression and your sex life. From: The Depression Alliance, 35 Westminster Bridge Road, London SE1 7JB

Down on the farm? Coping with depression in rural areas; a farmer's guide. Available by calling Health Literature Helpline (0800 555 777)

The experience of grief. From: National Association of Bereavement Services, 20 Norton Folgate, London E1 6DB (tel 0171 247 1080)

Suicide or deliberate self harm

Features to be assessed

- Motive
- Circumstances of attempt
- Psychiatric disorder
- Precipitating and maintaining problems
- Coping skills and support
- Risk

High risk indicators for suicide

- Male
- Age > 40 years
- Family history of suicide
- Unemployed
- Socially isolated
- Suicide note
- Continued desire to die
- Hopelessness, sees no future
- Misuse of drugs or alcohol
- Psychiatric illness (especially depression, but also schizophrenia, personality disorder)

Further reading

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Kendrick T. Prescribing antidepressants in general practice. *BMJ* 1996; 313:829-30

Paykel ES, Priest RG. Recognition and management of depression in general practice. Consensus statement. *BMJ* 1992;305:1198-202

Williams R, Morgan G. *Suicide prevention: the challenge confronted.* London: HMSO, 1994

A memorable patient

It's the community that counts

Soon after qualifying in 1988 I was assigned to a remote health centre in Ethiopia. People would travel for days to reach the centre and then queue for hours to see a doctor. During this time I encountered an old man with his son who were to change my outlook on public health.

The old man had brought his son to be treated. They were both diagnosed as having scabies and were given appropriate instructions and prescriptions. But the old man refused his prescription and emphasised that he was concerned only for the welfare of his child. I asked him why? He didn't answer the question, so then I tried to explain the complications that might follow if he was not treated, such as the superimposed bacterial infection leading, for example, to infection of the kidneys. He was not impressed by the explanation and he said that he wished he could develop serious complications and die. I was shocked, and asked again: "Why?" He replied that his life was a misery; he had no education, job, money, or future to look forward to and said that he came to the centre only because he could not bear the distress his son was suffering from the continuous itch caused by the infection.

He walked out of the office leaving his prescription behind. I followed him to the door not knowing what to say, but suddenly

something came to my mind and I said that treating his son would be meaningless unless he was also treated because of the contagiousness of scabies. He said that if that was the case there was no point in treating him because his wife, his eldest son, his neighbours, and most of the people in his village all had scabies. I could not agree more.

This encounter taught me a valuable lesson: that to make a difference in the health of the population there needs to be a change in emphasis from that on the individual to that on the community. It was apparent that the greatest potential for improving the health of the population lay in changing peoples' social, economic, and physical environments.

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We welcome filler articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk.