PRACTITIONERS SECTION

DIAGNOSIS OF DEPRESSION IN GENERAL PRACTICE

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ABSTRACT

Depression is well recognized as a public health problem that usually runs the risk of becoming chronic, disabling and life threatening if left untreated. Unfortunately depression remains largely under diagnosed in primary care although more than one in ten cases seen in primary care suffers from this condition. Primary care physicians are strategically placed to detect and treat depression early and thus contribute in secondary prevention of this disorder. This article highlights the problems in diagnosis, the ways depressed patients present to the clinicians, the diagnostic criteria, the detailed interview techniques to arrive at a diagnosis of depression. The article also offers an outline of management of depression in primary care.

***KEY WORDS:** Depression, general practice, primary care, treatment guidelines*

INTRODUCTION

Depression represents a significant proportion of contact by patients with primary health care providers. This happens either as a direct result of psychiatric disorder itself or because of an indirect association with physical problems. Depression is a treatable condition. Its timely recognition by the physicians can minimize the subsequent disability and bring down the risk of suicide commonly associated with depression. However, depression remains unrecognized in the society not only because of social factors like stigma but also due to the fact that doctors often fail to diagnose depression especially in the medical settings.

Depression could mean a normal feeling state, symptoms of medical or mental disorders or a syndrome (a cluster of symptoms with a defined course) by itself. Not all human distress is mental disorder and not all states of low feeling are depression. Certain essential criteria must be satisfied to make the diagnosis of the depressive syndrome.

Clinical features and diagnostic criteria

A wide range of symptoms may be present in depressive conditions. Symptoms that are commonly present across all types of depression and serve to characterize a depressive syndrome are called criterion symptoms (symptoms used in making the diagnosis). The diagnostic criteria of a depressive episode are shown in Table 1.[1]

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Table 1: Diagnostic criteria of a depressive episode

In a typical depressive episode an individual usually suffers from
1. depressed mood.
2. loss of interest and enjoyment.
3. reduced energy leading to increased fatigability and diminished activity
Other common symptoms are:
(a) reduced concentration and attention
(b) lowered self esteem and self confidence
(c) ideas of guilt and unworthiness
(d) bleak and pessimistic views of the future
(e) ideas or acts of self harm or suicide
(f) disturbed sleep
(g) diminished appetite.

A. Criterion Symptoms

1. **Low mood:** In depression mood is described as sad or low. The mood varies little from day to day and is often unresponsive to circumstances, although may show a characteristic diurnal variation (worse in the morning and gradually lifting during the day).
2. **Loss of interest and enjoyment:** There is often loss of interest in daily activities, work, hobbies and events that are normally enjoyable. There might be loss of interest in sex leading to decreased frequency of sexual intercourse.
3. **Reduced energy:** Increased fatigability and diminished activity after slight effort are common. Patients may wake up just as tired as when they went to bed.
4. **Reduced attention and concentration:** Diminished concentration interferes with academic and other intellectually demanding work. Trouble in concentrating also leads to difficulty in decision making and subjective forgetfulness (especially in elderly patients).
5. **Reduced self-esteem and self-confidence:** Depressives become more aware of their shortcomings than their strengths. They hesitate to face simple challenges of daily life with the previous level of confidence.
6. **Ideas of guilt and unworthiness:** Depressives characteristically blame themselves for trivial things or for problems that they have not caused. They tend to undermine their potentials and see their actions in a very gloomy light.
7. **Bleak and pessimistic views of the future:** Loss of hope for the future (hopelessness), frequently accompany other negative thoughts and leads to a belief that life is not worth living.
8. **Ideas or acts of self-harm and suicide:** Accompanying the symptoms just described, there are often worries and fears about fatal illness or death, wishes for death and actual suicidal plan and attempts. Depressed persons account for the largest single group of successful suicides. It has been estimated that 15-20% of all types of mood disorders ultimately kill themselves by committing suicide.[2] However the rate of completed suicide among the treated depressives in the community is much lower.[3]
9. **Disturbed Sleep:** Depression is characteristically accompanied by disturbed sleep, initial insomnia (trouble getting to sleep within an hour of retiring), middle insomnia (waking frequently during the night) and terminal insomnia (waking in

the morning at least 2 hours before the usual time).

10. **Diminished appetite:** Severely depressed people often have poor appetite and lose weight. Others may eat excessively and gain weight instead of losing it.

B. Non criterion symptoms

In some cases anxiety symptoms (nervousness, apprehension, panic attack and phobic symptoms) may be prominent and mood changes may be marked by added features such as irritability, excessive consumption of alcohol, (attention seeking, theatrical, emotionally over reactive) histrionic behaviour and somatoform (bodily symptoms without any physical basis) symptoms. The term psychotic depression is used when there are delusions and hallucination (the content is usually understood in the context of depressed mood) or the individual is unresponsive, immobile or mute (depressive stupor).

Depression is most often recurrent and sometimes may become chronic.[4-5] It is more common in women than in men. The point prevalence is 1.9% for men and 3.2% for women. About 5.8% of men and 9.5% of women will experience a depressive episode in a 12-month period.[6] Depressive disorders place an enormous burden on society and are ranked as the fourth leading cause of burden among all diseases and thus account for 4.4% of the total DALYs (disability adjusted life years i.e. the years lost due to premature death and disability).[6]

Why General Practitioners need skills of diagnosing depression?

There are several reasons why general practitioners need to be familiar with diagnosis and management of depression.

1. Depression is a common mental disorder in the community and is the largest psychiatric morbidity in general practice. About one in ten patients seen in the primary care settings suffer from depression.[7-8] In a recent cross-cultural study of WHO conducted at 14 sites, the most common diagnosis in primary care settings was depression (9.1% in Bangalore - Indian center).[9] A number of Indian studies,[10-13] has, however, reported a vide range of point prevalence (21-83%) of depression in primary care.
2. Depression is a psychological disorder but patients with depression usually communicate their distress in nonpsychological language. Thus the patients usually present with physical symptoms like pain, fatigue, loss of appetite and weight loss. In fact, the number of physical symptoms has been shown to highly correlate with presence of depression.[14]
3. In general practice doctors are likely to see patients with comorbid mental and medical disorders. Milder forms of depression are particularly common in patients with chronic medical conditions. Medical patients with depression often present with behaviour problems like poor compliance with medical treatment[15] as a gesture of self-neglect. Moreover, an increased risk of suicide is reported in such patients.[16]
4. General practitioners frequently miss the diagnosis of depression presenting with physical symptoms with or without co morbid medical problems.[17] in about one third to half of the cases.[9] The detection could be especially poor among the elderly.[18] There could be several reasons to explain this problem in primary care. The doctor may not ask the right question to elicit depressive symptoms, as the attention is preferentially given to the medical aspects of the patient's complaints and the associated emotional problems get overlooked. The physicians often think that psychiatric conditions occur secondary to the medical conditions and so hardly require any specific treatment. Furthermore, doctors commonly believe that psychiatric treatment is by and large ineffective and is therefore unnecessary.[19].
5. Finally, general practitioners must be reminded that a reliable diagnosis is a prerequisite to appropriate intervention at the individual level as well as for accurate epidemiology and monitoring at the community level. Precisely diagnosis has an immense bearing on the application of clinical and public health principles to the field of mental health.

DIAGNOSIS

Depressive disorders are identified and diagnosed using clinical methods that are similar to those for physical disorders. These methods include a careful and detailed collection of historical information from the individual and the key family members, a systematic clinical examination and specialized investigations, as needed.

The doctor must have a high "index of suspicion" based on an awareness of the prevalence and risk factors for depression. Recent studies have identified certain risk factors for the presence of depression among the patients in primary care. Men presenting with physical symptoms, feeling tired/reduced energy level, expressing low job satisfaction or with a past diagnosis of depression, are likely to suffer from depression.[20] Similarly female sex, dysthymia, panic attacks, patient with more than 7 primary care visits pose high risk for depression among the primary care patients.[21]

The practical task of detection is aided by careful interviewing of the patient.

A. Interviewing techniques

For first few minutes it is necessary to actively listen to the complaints and then to try to explore the nature of the complaints by facilitating the patient to give details about the complaints.

B. Screening for depression

Since primary care physicians do not have time to conduct lengthy interviews several brief screening questionnaires have been tested for rapid recognition of depression in the medical settings. For example, Hopkins Symptom Checklist Depression scale (HSCL-D) has been tested for minor depression and dysthymia in European American population.[22] A 2-question screening[23] has been found to be modestly useful for recognition of depression in general practice. The questions are as follows: (i) During the past month have you often been bothered by feeling down, depressed, or hopeless? (ii) During the past month have you often been bothered by little interest or pleasure in doing things? The two item version of Patient Health Questionnaire Depression module (PHQ-2),[24] with similar

questions enquired over a shorter time frame (past two weeks) was also found to be useful in primary care settings. It has been reported that the yield of true positive case of improves when the screening targeted to those at a higher risk for depression for more effective use of health care resources.[25]

C. Sample questions to elicit the nature and extent of depressive symptoms and the associated dysfunctions

Loss of energy - Do you feel you have lost energy or vigor?

Loss of concentration - Do you find you can't read an article in the paper or watch a TV programmed right through even though previously you have done so?

Self confidence - How confident you feel in yourself – e.g. in taking to other or in managing the day to day activities?

Loss of self esteem - What is your opinion of yourself compared to other people? Do you seen to feel less competent than they are? Do you feel inferior or worthless?

Hopelessness - How do you see the future? Does everything seem quite hopeless?

Preoccupation with death - Do you often feel that life is not worth living? Or you wouldn't care if you did not wake in the morning?

Suicide or self harm - Have you thought of harming yourself or even made an attempt at suicide?

Probable cause of depression - What do you think about the cause of your distress?What has made you so unhappy these days?Did anything go wrong with you or your family in the days preceding your illness?

Every positive response should be followed by a question how severe or continuous was it? Or how often have you felt like this? How much interference has there been with your every day activities because of depression? What sort of problems is it? Which spheres of life have got affected-social, personal, family, occupational, etc?

D. Interviewing a patient who denies having depression but clinically judged depressed

How would you describe your mood over past several weeks?

Tell me a little about how have you been feeling recently?

What kind of things would you like to do when you were away from work? Did you use to enjoy doing those things? Have you been able to enjoy them as before?

What were your interests before? Have you lost interest in those things recently?

MANAGEMENT OF DEPRESSION

Once depression has been diagnosed, it must be treated appropriately. Antidepressants remain the mainstay of the treatment in depressive disorders. Apart from medications, reassurance, education and offering realistic guidance to the patient and the family are the other essential components of an effective management of depression.

(a) Drug treatment

The drugs that are commonly used for the treatment of depression in this country are shown in Table 2.[26] The prescribing guidelines for the primary care are briefly given below.[27]

Table 2: Commonly used antidepressant drugs

Name of Antidepressants	*Usual Dose range (mg/day)*	*Side effects*
Tricyclic antidepressants		
Imipramine	150-200	Sedation, postural, hypotension, dry mouth,
Amitriptyline	150-200	constipation, urinary retention
Dothiepin	150-200	
Specific serotonin reuptake inhibitors (SSRI)		
Fluoxetine	20-40	Insomnia, headache, agitation, sexual dysfunction,
Escitalopram	10-20	nausea and vomiting, anxiety
Serotonin and noradrenergic reuptake inhibitors (SNRI)		
Venlafaxine	75-225	Nausea, insomnia, dry mouth dizziness, sweating, elevation of BP
Others		
Mirtazepine	15-45	Drowsiness, headache, weight gain, dizziness

Choice of medication: The antidepressants do not differ in their efficacy but differ in the profile of side effects. The choice of medication should be guided by certain factors related to the patient (age, associated medical problems, past response) and to the drug (cost, side effect profile and availability). The tricyclic antidepressants are well known for their efficacy. However, their anticholinergic effects tend to limit their use for the elderly depressives as well as those having depression with medical problems. Drugs like SSRIs, on the other hand, have been found to be safe for such patients.[28] Moreover, a sedative drug like dotheipen or mirtazepine may be preferred for those with agitation or sleep problems.

Initiation of treatment: Once the patient has been informed about the need of drug treatment the minimum effective dose of the particular drug (as shown in Table 2, e.g. fluoxetine 20 mg/day, venlafaxine 75 mg/day) may be started. It is not advisable to start the patient on multiple drugs or any drug with suboptimal dosage.

Monitoring: The clinical effect of the antidepressants starts within 2-4 weeks. Patient should be followed up once in 2-3 weeks initially to monitor the response (decrease in the level of symptoms of depression), and emergence of any side effects. The decision to increase the dosage may be considered only after two to four weeks and a minimum 6-8 week trial is required before it may be deemed necessary to change the drug. Once the patient becomes clinically stable follow up may be spaced to once a month visits. It is essential to check from the family members if the drug is being taken regularly as non compliance is common and is one of the reasons for apparent non response.

Duration of Drug Treatment: Once the patient improves it is necessary to maintain the drug for a period of 9 months to 1 year in order to prevent relapse. A recent study has reported that antidepressants are frequently prescribed in general practice but usually in short courses. This kind of prescribing behavior often leads to chronicity of depression in general practice.[5]

(b) Education of patient and family

The patient and the family members often have stigmatizing beliefs about depression and its treatment. A minimum amount of information should always be imparted at the time drug treatment, for example; i) depression is a common illness and effective treatments are available ii) depression is not weakness or laziness iii) depression can affect a person's ability to cope iv) emotional and practical support from family and friend is valuable v) antidepressants are not addictive.

(c) When to refer to a psychiatrist?

The common indications for referral include; i) patient expressing active suicidal intent ("I want to kill myself") ii) failure of respond to the drugs in spite of adequate dosage, duration and compliance iii) those with associated psychiatric problems like obsessive compulsive disorder or substance use disorder iv) severely ill patients, presence of psychotic symptoms or severe agitation v) patients preferring psychological therapies like cognitive behaviour therapy.

It should be explained to patient and the family members why he/she is being referred to a psychiatrist.

Key points for clinical practice

- Depression is a common mental disorder
- Depression is the commonest psychiatric morbidity (1 out of 10 patients) in general practice.
- In medical settings depressives usually present physical symptoms and coexistent mental and medical disorders are common
- Doctors in the medical settings frequently fail to diagnose depression
- Based on an index of suspicion it is crucial to ask certain screening questions of psychological symptoms of depression.
- It is also necessary to ask about anxiety symptoms, alcohol and drug use, medical problems and past history of depression or mania.
- SSRIs are safe drugs in general practice
- Education and support are also important ingredients of the management of depression

The symptoms should be present for a minimum period of *two weeks* for making the diagnosis of a depressive episode. The severity is then determined in the following way:

- Mild (with or without somatic symptoms): any two of the first three symptoms and two or more from other symptoms should be present with some difficulty in continuing with ordinary work and social activities.
- Moderate (with or without somatic symptoms) any two from the first three and three or more from other symptoms along with considerable difficulty in continuing with daily activities.
- Severe (with or without psychotic symptoms) All three symptoms along with four from other symptoms with inability to continue with ordinary activities.

When a patient presents with symptoms that do not satisfy the criteria of a depressive episode, following conditions may be considered:-

1. Dysthymia - a chronic (two years or more) low grade depression without any difficulty in continuing with daily activities.
2. Mixed anxiety and depression - a mixed state with both anxiety and depressive symptoms but not fulfilling the criteria of either of the conditions.
3. Adjustment disorders with depressive symptoms - a stress related condition, usually short lasting for few weeks.

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