DIAGNOSIS OF DEPRESSION IN GENERAL PRACTICE

SOMNATH SENGUPTA

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 undiagnosed 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 depressive conditions include:

- **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).
- **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.
- **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.
- **Reduced appetite 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).
- **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.
- **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.
- **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.
- **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. However the rate of completed suicide among the treated depressives in the community is much lower.

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Table 1: Diagnostic criteria of a depressive episode

<table>
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<th>In a typical depressive episode an individual usually suffers from</th>
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<td>1. depressed mood.</td>
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<tr>
<td>2. loss of interest and enjoyment.</td>
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<tr>
<td>3. reduced energy leading to increased fatigability and diminished activity</td>
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<td>Other common symptoms are:</td>
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<td>(a) reduced concentration and attention</td>
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<tr>
<td>(b) lowered self esteem and self confidence</td>
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<tr>
<td>(c) ideas of guilt and unworthiness</td>
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<tr>
<td>(d) bleak and pessimistic views of the future</td>
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<tr>
<td>(e) ideas or acts of self harm or suicide</td>
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<tr>
<td>(f) disturbed sleep</td>
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<tr>
<td>(g) diminished appetite.</td>
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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 somatiform (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 wide 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.[8] 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.\[22\]

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 you were away from work? Did you use to enjoy doing those things? Have you been able to enjoy them as before?

**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 see yourself as 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 it? Does everything seem quite hopeless?

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

**Prognosis of treatment**

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.

**Management of depression**

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**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.\[22\]

Moreover, a sedative drug like dothiepin or mirtazepine may be preferred for those with agitation or sleep problems.

**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.\[51\]

### Table 2: Commonly used antidepressant drugs

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

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: any two of the first three symptoms and two or more from other symptoms should be present for some difficulty in continuing with ordinary work and social activities.
- Moderate: any two from the first three and three or more from other symptoms along with considerable difficulty in continuing with daily activities.
- Severe: 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.

REFERENCES

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The World Health Assembly, the supreme decision-making body of the World Health Organization (WHO), wrapped-up its fifty-eighth session today. More than 2200 people from WHO’s 192 Member States, nongovernmental organizations and other observers attended the meeting which took place between 16-25 May.

This news release summarizes decisions taken at the 58th World Health Assembly. Please note that full texts of all documents including resolutions are available on the WHA documentation web site.

The Assembly reviewed progress made so far in polio eradication and identified what needs to be done to interrupt the final chains of wild-type poliovirus transmission worldwide by the end of this year. The Assembly also noted the progress made in scaling-up treatment and care within a coordinated and comprehensive response to HIV/AIDS and discussed smallpox vaccine reserves and research on the smallpox virus.

Recognizing that too many people suffer and die in crises and disasters as a result of untreated and often preventable health problems, the World Health Assembly adopted a resolution on health action in crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004. The resolution calls on WHO to improve access to clean water and sanitation, and increase the availability of health care for people’s physical and mental health. It also urges Member States to formulate disaster preparedness plans and pay more attention to gender-based violence as an increasing concern during crises.

WORLD HEALTH ASSEMBLY CONCLUDES: ADOPTS KEY RESOLUTIONS AFFECTING GLOBAL PUBLIC HEALTH

Ms Elena Salgado, the Minister of Health and Consumer Affairs of Spain was elected as the President of this Assembly. WHO Director-General Dr LEE Jong-wook encouraged delegates to determine the best ways to bring available health solutions to everyone who needs them. Invited speakers included the President of the Republic of Maldives His Excellency Maumoon Abdul Gayoom, who spoke of the recent devastation caused by the tsunami and the continuing efforts to reconstruct homes, communities and lives. Bill Gates, the Co-Founder of the Bill & Melinda Gates Foundation also addressed the Assembly on its first day, underlining his hope for the future, which he said rests on the “astonishing miracles” of science and technology. Ms Ann Veneman, the Executive Director of UNICEF stressed the importance of child survival in a world where almost 11 million children die before their fifth birthday. A quartet from the Vienna Philharmonic Orchestra spoke with music, and played in the opening ceremony before being appointed as WHO Goodwill Ambassador.

Highlights of the Assembly included the adoption of the revised International Health Regulations, which govern national and international response to disease outbreaks, the approval of the Proposed Programme Budget for 2006-2007, which includes a 4% increase in the Regular Budget and the establishment of World Blood Donor Day as an official annual event to be celebrated every 14 June.