A clinical approach to diagnosing depression in adults

Depression and its separate clinical expressions can be diagnosed in general practice settings by screening measures, observation and refined symptom assessment, as well as by interview of corroborative witnesses, especially relatives.

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Depression is currently generally viewed as an 'it' – a disease – and therefore as a single condition. In practice, however, depression can manifest as a normal mood state or a disorder with a number of symptoms and impairment, and can also be a categorical disease. Thus, we need to diagnose both 'depression' and its separate expressions. Furthermore, most depressed people will have some level of anxiety, and most anxious individuals commonly experience depressive symptoms; this co-occurrence risks the regarding of anxiety and depression as synonymous. Similarly, grief is often described or viewed as synonymous with depression. We therefore need to be able to differentiate depression from several other states in coming to a correct diagnosis.

This overview will first distinguish between depression, anxiety and grief, and then suggest how GPs might best screen for and identify depressive states in adults.

Differentiating depression, anxiety and grief

Depression

Phenomenologically, depression is cognitively experienced as a depressed mood and a lowering in self-esteem. All individuals have an intrinsic level of self-esteem (whether high or low) and from the extent to which their baseline self-esteem drops, we can infer whether they are depressed or not and, if they are, the severity of the depression.

To determine whether an individual has a depressed mood, the following three questions can be asked:

- Are you feeling depressed (or pessimistic, hopeless and helpless, feeling like giving up or that others have given up around you)?
- In comparison to how you generally value yourself, has there been any drop in your self-esteem or sense of self-worth?
- Are you being any more self-critical or tough on yourself than usual?

A depressed individual will generally affirm two or all three of these probe questions; denial of all three largely rules out depression.

These central probes are highly efficient in establishing whether an individual has a depressed mood or not, although in severe biological depressive states (such as melancholic and psychotic depressions) a small percentage of individuals are more likely to describe a profound lack of drive or

IN SUMMARY

- **Depression, anxiety and grief are often regarded as synonymous, but need to be differentiated.**
- **A set of probe questions enquiring about depression, lowered self-esteem and increased self-criticism will generally identify most depressed people.**
- **Normal depression is common and lasts only minutes, hours or days.**
- **Clinical depression is depression with a mood state of some severity that has lasted more than two weeks and has an impairment component in functioning.**
- **Patients with the melancholic subtype of clinical depression have psychomotor disturbance; patients with the psychotic subtype additionally have psychotic features; and patients with the nonmelancholic subtype have neither psychomotor nor psychotic features.**

Table 1. Signs and symptoms of normal and clinical depression

Normal depression

Feelings of depression
Lowered self-esteem
Increased self-criticism
Feelings of hopelessness and helplessness
Feeling like 'giving up' and sense that others have given up on the individual
Being pessimistic about the future

Clinical depression

The above with duration of longer than two weeks and greater severity
Significant social and/or work impairment
Presence of associated features, such as:
- anhedonia
- nonreactive mood
- sleep changes
- appetite changes
- fatigue
- lack of motivation
- libido changes
- avoidance of social contact

even a feeling of being profoundly unwell ('As if I have the flu, doctor'). Of course, a denial of depression by an individual risks impacting on the accurate assessment of the individual's depressive symptoms, but denial is decreasing rapidly with destigmatisation of the disorder. Even in ethnic groups in whom denial of depressed and related moods is common (the Chinese, for example), evidence suggests that once an empathic interview has been initiated, truly depressed people will admit to such states, and that recourse to questioning about nonspecific proxies (such as insomnia and somatic symptoms) is unnecessary.

Anxiety

Anxiety is experienced as a sense of uncertainty, apprehension, insecurity or even fear. There is often associated hyperarousal, so that individuals lose their appetite and cannot sleep and, in severe instances, may describe a sense of 'going mad' during acute attacks.

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Grief

Grief is more a separation anxiety than a depressed state, so that the individual will experience a sense of loss but not any primary loss in self-esteem. Only in one-third of grieving individuals does grief proceed to a depressed state.

Normal depression

Studies undertaken in Sydney in nonclinical populations in which individuals were asked if they had experienced feeling depressed, having a lowered self-esteem, feeling hopeless and helpless, feeling like giving up, and being pessimistic about the future showed that more than 90% had experienced such states.[1] The average frequency was six episodes per year, and in more than 80% the duration was minutes, hours or days, rather than weeks. Thus, 'normal depression' is common.

Clinical depression

Clinical depression is distinguished from a normal depression mood state by its persistence and greater severity, together with an increased chance of associated features and the emergence of gravid features, such as suicidal thinking and psychotic states (Table 1). Thus, in comparison to normal mood states of depression, a clinical state of depression requires that the individual has been depressed for at least two weeks, that there is an impairment component in their functioning at home and/or work, and that the mood state is of some severity.

Common associated features include anhedonia (anticipatory anhedonia is the failure to look forward to anything; consummatory anhedonia is the failure to gain any pleasure in any activity),

a nonreactive mood, sleep and appetite changes (increased or decreased), fatigue, lack of motivation, libido changes and hiding away socially.

The three principal categories of clinical depression – melancholic, psychotic and nonmelancholic – each have their own diagnostic nuances (Table 2). Psychotic and melancholic depressions are rare in general practice (about three and 15 patients, respectively, each year for the average practitioner, compared with several hundred nonmelancholic patients per year). However, as for other low prevalence disorders (e.g. breast cancer), this is no argument for not seeking to detect such conditions.

Melancholic depression

Melancholic depression (a categorical state with strong biological determinants) can be distinguished from a heterogeneous residue of nonmelancholic conditions by the presence of psychomotor disturbance.

Psychomotor disturbance is expressed by a central or truncal component of distinct difficulty in concentrating or attending to issues, so that individuals may say that they cannot study or read or, in severe states, even focus on a conversation. In addition to a cognitive processing problem, they frequently show motor retardation or agitation. In very severe instances, the cognitive impairment can lead to a spurious diagnosis of dementia, and such a state has been described as a 'pseudo-dementia'. Those with pure retardation speak more slowly, have a latency in responding to questions or instructions, have poverty of thought, walk slowly and often show postural slumping. Those with agitation tend to show slow writhing movements of the hands or legs, or experience epigastric churning, or both, with the agitation being experienced continually or as epochs superimposed on a base of retardation. Both expressions are associated with a loss of normal 'light in the eyes'.

Melancholic depression, therefore, is often more readily diagnosable by observation of such signs rather than by symptoms. Psychiatry's previous diagnostic emphasis on the so-called endogenous symptoms (e.g. early morning wakening, appetite and weight loss) was remarkably inefficient in subtyping, in that while a percentage of patients with melancholic depression have such features, so do a high percentage with nonmelancholic depression, grief and other conditions.

Table 2. Specific features differentiating clinical depressive subtypes

Melancholic depression
Moderate psychomotor disturbance – cognitive and possibly also motor retardation or agitation
Moderate mood disturbance
Psychotic depression
Severe psychomotor disturbance
Severe mood disturbance
Psychotic features – generally delusions but hallucinations may also occur
Feelings of guilt and 'deserving to be punished'
Nonmelancholic depression
No psychomotor disturbance
No psychotic features
No specific clinical features

Psychotic depression

In psychotic depression, the individual usually has a severely depressed mood state, severe psychomotor disturbance and the additional presence of psychotic features (generally delusions but possibly also hallucinations). The psychotic features may be 'congruent' or ' incongruent' with the mood state. Mood-congruent psychotic symptoms are consistent with the patient's depressive mood, such as delusions of guilt, delusions of poverty and nihilistic delusions. Mood-incongruent psychotic features are psychotic symptoms that do not involve typical depressive themes, such as persecutory delusions, delusions of reference and thought insertion.

In severe psychotic depression, a person may not volunteer or even admit to psychotic features, and thus the diagnosis has to be suspected when there is a history of an individual developing depressive symptoms and then progressing to a seemingly catatonic state in association with their psychotic state. The other useful indicator of a possible psychotic depression is the presence of feelings of guilt or deserving to be punished, and individuals should be asked about this. In recent years this has resulted in patients telling me about how they have inappropriately referred themselves to professional boards for minor indiscretions. While the common vignette in the old days was of a woman becoming preoccupied with guilt about having had an abortion at a young age, people are now more likely to talk about minor indiscretions in handling their tax concerns in the past.

Nonmelancholic depression

Nonmelancholic depression is distinguished from melancholic and psychotic depressions by the absence of psychotic and psychomotor disturbance features. Thus, it has no specific clinical features, and is a heterogeneous residue of personality driven and stress-related disorders.

Assessment of clinical depression

The three-class model of clinical depression described above (with two classes having class-specific features) allows a more rational and logical approach to assessment and treatment than viewing depression as a single condition varying in severity. For instance, after establishing that clinical depression exists by asking probe questions and enquiring about severity, duration and impairment, subtyping decisions require pursuit of any

evidence indicating psychomotor disturbance, psychotic features and pathological guilt.

In certain circumstances, interview of a relative may provide key information. When in doubt, such corroborative witness information is usually helpful in shaping a diagnosis and management plan. Depressed patients are increasingly presenting with an accompanying relative – this allows a richer picture of the condition to be obtained and for a management plan to be more firmly locked in.

For those with a residual nonmelancholic disorder, assessing antecedent and current stressors and the individual's personality style will assist diagnosis and formulation of a management plan.

Screening for depression

A screening measure recently developed at the Black Dog Institute in Sydney, the 10-item 'Depression in the Medically Ill' measure (DMI-10), represents a progressive refinement of items shown to discriminate depressed and non-depressed subjects (see the box on this page). The first two questions on the list (aimed at assessing 'stewing' and 'a greater sense of vulnerability') are not specific to depression – being likely to occur in anxious and depressed subjects also – but were shown to improve the discrimination of depressed and non-depressed individuals in hospital and general practice samples.

The DMI-10 is highly acceptable to patients as there are no intrusive items such as asking about suicidal thinking. (Such items were excluded because of their intrusiveness, after establishing that those individuals with suicidal ideation invariably scored above the cut-off score without such questions.) The DMI-10 identifies those who are acutely depressed as well as those with chronic depression.[2]

One-third of general practice patients will score above a cut-off score of 9 on the DMI-10, which is clearly above the likely prevalence of clinical depression in general practice (about 5 to 20%). However, screening measures are generally designed to ensure that all true cases are detected, so the cut-off score tends to result in a number of false positive cases. If an individual scores above the cut-off level, a diagnosis of clinical depression would also require impairment and a duration of two weeks, issues that can be readily clarified by the GP.

The DMI-10 has been shown to be an efficient, acceptable and useful screening measure in general practice settings, and we commend it to GPs.

Stress and clinical patterning

It is normal for individuals to develop a depressed mood. For most, it is transient (lasting minutes to days) but for some it persists and because of its severity and duration achieves 'disorder' status (i.e. 'reactive depression', 'adjustment disorder with depressed mood').

The disorder may reflect the impact of severe stress on the individual or, more commonly, the impact of a salient stressor. An example of this would be a normally resilient individual who becomes depressed after being bullied by a boss and whose vulnerability was laid down by an authoritarian critical father. In these stress states, the individual usually experiences hyperarousal symptoms (such as patchy sleep, appetite and weight loss, hypervigilance) in addition to depression symptoms.

Alternatively, the stressors may be more low grade but continuing, sapping continually at the individual's self-esteem, and with the person feeling unable to overcome the depressogenic stressors. A woman who is married to a demeaning and unsupportive husband and who has a number of young children but insufficient money to 'escape' might suffer this way. Here the clinical pattern is dominated by a sense of demoralisation and lack of motivation, akin to Seligman's concept of 'learned helplessness' whereby individuals who feel that there is nothing that they can do to shape outcome become depressed and 'give up'.

Personality, temperament and depression detection

GPs have been criticised in the past for a seemingly low capacity to detect depression. The usual research paradigm has been to have patients complete a screening measure and then to compare those scores above a cut-off level with the respective GP's 'case' assignment. The problem is that each patient's personality

DMI-10 screening measure for depression*

1. Are you stewing over things?
2. Do you feel more vulnerable than usual?
3. Are you being self-critical and hard on yourself?
4. Are you feeling guilty about things in your life?
5. Do you find that nothing seems to be able to cheer you up?
6. Do you feel as if you have lost your core and essence?
7. Are you feeling depressed?
8. Do you feel less worthwhile?
9. Do you feel hopeless or helpless?
10. Do you feel more distant from other people?

For each item a 'very true' response scores 3; 'moderately true', 2; 'slightly true', I; and 'not true at all', 0. A cut-off total score of 9 indicates a depressed mood.

In Australian general practice studies, one in three patients will score above cut-off. Two subsequent questions assessing duration of mood state and any associated impairment will clarify the likelihood of clinical depression.

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and attributional style will influence his or her responses to screening measures and enquiries from a GP. If the GP asks a question addressing (say) fatigue, then patients who are psychologically minded (or anxious worriers) will tend to attribute this to a psychological problem, so increasing the chance of being rated as depressed. Those, however, who 'normalise' the symptom ('I've been working hard in recent times') or who somatise it ('I know I am a bit anaemic at the moment') will be more likely to deny depression to their GP. When the influence of attributional style is accounted for, it appears that GPs are, in fact, much more successful in detecting true depression than previously realised.

Personality is important as a 'shaper' of the clinical pattern as well as a modifier of the risk of nonmelancholic disorders.[3] The most common pattern emerges from high trait anxiety, which can be subdivided into an internalising anxious worrying 'anxious depression' picture and a more externalising 'irritable depression', with the overall feature reflecting 'emotional dysregulation' patterns. Also common is 'hostile depression', usually observed in those with volatile and nonempathic personality styles and who have poor frustration–aggression control. Other over-represented personality styles are shyness, obsessiveness and sensitivity to rejection. In the last group, there is again an impact on the clinical pattern, with such individuals being more likely to report atypical symptoms of hyperphagia and hypersomnia. Such clinical patterns have implications for management.

Conclusion

Detection of depression is generally relatively straightforward. A set of probe questions enquiring about depression, lowered self-esteem and increased self-criticism will generally identify most depressed people. Observation (and sometimes close questioning) will identify any psychomotor disturbance. Questioning of the patient (and a relative, if available) should identify any psychotic features or expressions of pathological guilt. In the nonmelancholic disorders, determining personality style and the contribution of salient stressors will aid management. The DMI-10 is a suitable depression screening measure for use in general practice settings. MT

References

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