Diagnosing and managing depression in adults

The profound effect that even mild depression can have on the quality of life of an individual and his or her family should not be underestimated. The condition is often not recognised when patients present with it, and patients in whom it is diagnosed are often undertreated.

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Depression is a common and treatable disorder with a 12-month prevalence of 7.4% for women and 4.2% for men.[1] While the highest prevalence rates are among young adults, it is important to remember that the young, especially teenagers, and the elderly are also liable to develop depression. Depression carries with it a high disease burden; it has been estimated that by the year 2020 depression will be the second most burdensome disease worldwide.

Although depression is common and treatable it often goes unrecognised and untreated. In a recent national mental health survey, over half of those people with depression had not sought treatment for their depression.[2] Up to half of those that presented for treatment did not have their depression recognised, and undertreatment was common among those whose depression was diagnosed. Most of those who did seek treatment went to GPs; hence, depression accounts for a large number of presentations in primary care.

Management principles

The successful management of depression requires:

- recognition of clinical depression when it presents
- clarification of the type and severity of depression
- suicide risk assessment
- identification of antecedent, precipitating and maintaining psychosocial factors
- psychoeducation
- implementation of specific treatment strategies based on patient preference and the evidence base.

Diagnosis

A diagnosis of depression is straightforward when the patient complains of depressive symptoms. The key issue here is to determine whether such symptoms are an extreme of 'normal' depression or pathological. Depression is a normal human emotion; all of us can experience a depressed

IN SUMMARY

- **Management of depression includes the correct identification of clinical depression, distinguishing pathological from 'normal' depression, assessment of risk to self and to others, psychoeducation of the patient and patient's family, and application of evidence-based treatments.**
- **All treatments should involve basic counselling.**
- **Psychological therapies are recommended as first line treatment for mild to moderate depression. Antidepressants are required in addition to psychological treatments for moderate to severe depression.**
- **It is important to ensure that medication is continued for a year to prevent relapses.**

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mood in response to stress and/or loss. Pathologising 'normal' depression may lead to unnecessary treatments being used and the patient may come to consider normal unhappiness as an illness. For example, a depressive illness may be incorrectly diagnosed when the depressed mood is part of normal grief. This misdiagnosis may then inhibit normal grieving. Pathological or clinical depression is generally determined by its persistence (throughout the day), its duration (generally longer than two weeks) and the presence of additional symptoms. Guidelines for diagnosing depressive episodes are listed in the box on page 10.[3]

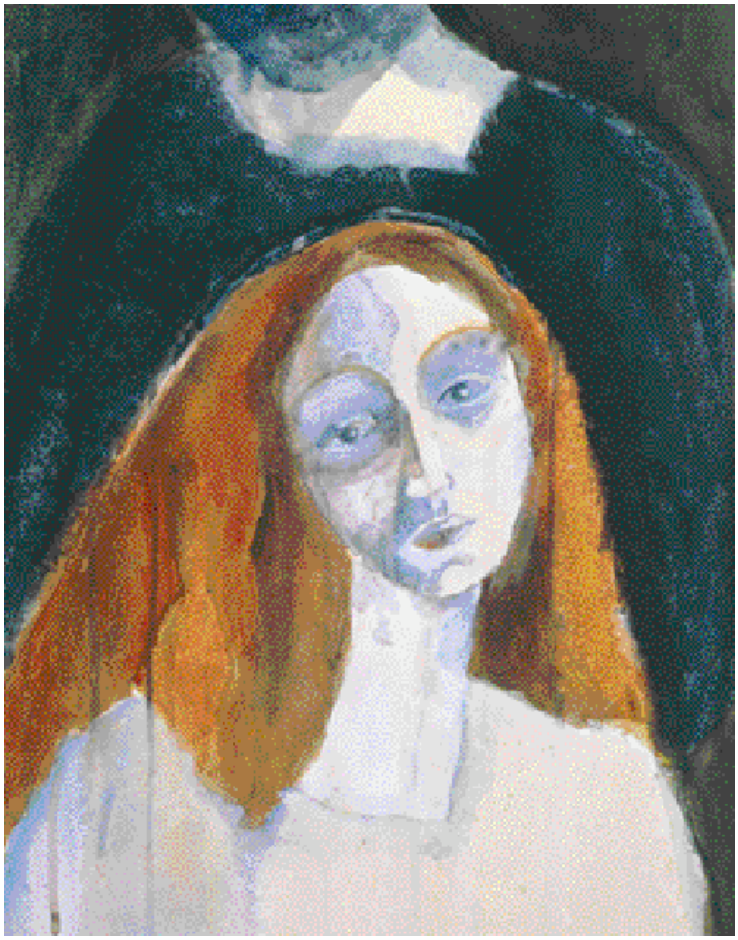
The reality, however, is that many patients with depression do not recognise that they are suffering from the condition and thus do not seek help. Their depression may be recognised only if they seek help for nonspecific physical symptoms or during a consultation for some other illness for which they are being treated. Depression can accompany a range of physical illnesses, and may be the presenting symptom of an underlying disorder such as anaemia, hypothyroidism and, in rare cases, cancer (Table 1). When it is an accompanying condition, it may have a profound effect on the outcome of illness, such as in myocardial infarction.[4] All depressed patients, therefore, should have a physical review and undergo limited investigation to exclude any underlying disorder.

The current public health approach to depression, with its greater emphasis on community education and reducing stigma, encourages people suffering from depression to recognise for themselves that they are depressed and to seek help early from their GP.[5]

The key to recognising when depression is present involves a high index of suspicion (always expect patients to be depressed), putting into practice good communication skills and explicitly asking patients whether they have been feeling depressed, feeling low or not able to get pleasure and enjoyment from activities (Table 2).[6]

Finally, an assessment of the risk of harm to self and others (especially children) is an essential part of the examination of the depressed patient and is crucial to treatment planning. Suicide or self-harm is an all too often accompaniment of depression, and the doctor needs to be constantly vigilant about the emergence of suicidal thoughts, ideas or plans. It may be anxiety provoking for both doctor and patient, and the doctor has to deal with his or her own anxiety as well as that of the patient. It is essential to see the patient alone at some point during the interview and to sensitively enquire about, and listen long enough to elicit, suicidal thoughts, plans or intent (Table 3). This is especially true if the patient is feeling slowed down, ashamed or fearful of the consequences of admitting thoughts of harm. Ask directly about

Depression in adults



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Depression is both common and treatable but often goes unrecognised and undertreated. Psychological treatments are recommended as the first line treatment for mild to moderate depression; moderate to severe depression requires the addition of antidepressant drugs.

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thoughts of self-harm – it does not 'put the idea' in the patient's mind – and do not apologise for asking.

Table 1. Physical conditions associated with depression

- Thyroid disease
- Autoimmune diseases
- Malignancy
- Anaemia
- Nutritional deficiencies
- Alcohol misuse

Differential diagnosis

The boundary between anxiety disorders and depression is not clear, and in the primary care setting a mixed presentation is common. Anxiety is a common symptom of depression, and it is possible that the depressive component of the illness may be missed when assessing a patient. It is, important therefore, to ask anxious patients about anhedonia, loss of self-esteem, feelings of guilt and preoccupation with past misdeeds, as these are characteristic of depression and are not part of a pure anxiety disorder.

Chronically ill patients may show a low mood with reduced ability to experience pleasant events. Vegetative symptoms (for example, early morning awakening, mood worse in the mornings, poor appetite and weight loss) are difficult to interpret in these patients, particularly in the terminally ill in whom somatic complaints are complex, anxiety is common and agitation may be due to many causes. While hopelessness for his or her own predicament may be understandable, pervasive global hopelessness, preoccupation with guilt or punishment and suicidal thoughts in a patient all suggest depression.

The very early stages of grief due to the loss of a loved person, pet, job or relationship show considerable overlap with depression. Caution in diagnosing any but the most obvious case is wise. However, grief rarely encompasses thoughts of death (except in relation to the deceased), preoccupation with guilt and hopelessness, prolonged functional impairment or hallucinations (except, again, in relation to the deceased).

Diagnostic guidelines for depression in adults[3]

Presenting complaints

- The patient may present initially with one or more physical symptoms (e.g. fatigue, pain). Further inquiry will reveal depression or loss of interest.
- Irritability is sometimes the presenting problem.
- Some groups are at higher risk (e.g. those who have recently given birth or had a stroke, those with Parkinson's disease or multiple sclerosis).

Diagnostic features

- Low or sad mood.
- Loss of interest or pleasure.
- The following associated symptoms are often present:
  - disturbed sleep, especially waking early with feelings of anxiety or despair
  - guilt or low self-worth or loss of self-confidence
  - fatigue or loss of energy or decreased libido
  - motor restlessness or slowing of movement
  - poor concentration
  - disturbed appetite
  - suicidal thoughts or acts.
- Symptoms of anxiety or nervousness are often present.

Differential diagnosis

- If hallucinations (hearing voices, seeing visions) or delusions (strange or unusual beliefs) are present, consider an acute psychotic disorder. If possible, consider consultation about management.
- If history of manic episode (excitement, elevated mood, rapid speech) is present, consider bipolar disorder.
- If heavy alcohol or drug use is present, consider alcohol use disorders or drug use disorders.
- Some medications may produce symptoms of depression (e.g. β-blockers and other antihypertensives, H_2-blockers, oral contraceptives, corticosteroids).

Subtypes of depression

It is important to recognise the different subtypes of depression, especially the melancholic type – which has a biological basis. Melancholia can vary in severity from mild to severe and is characterised by the presence of vegetative symptoms, psychomotor changes and pervasive anhedonia. Patients suffering from melancholia will require antidepressant medication (or electroconvulsive therapy [ECT] in severe cases) in addition to psychosocial treatments.

Patients suffering from bipolar disorder generally will have more depressive than (hypo)manic episodes.[7] Bipolar depression is characterised by a melancholic type of depression with significant psychomotor change or atypical depressive symptoms, especially hypersomnia and anergia.[8] The treatment response to bipolar depression tends to be poor, and may be a contributing factor to treatment resistance. It is worth considering that

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patients may be suffering from bipolar depression if they are not responding to standard treatment. A past history of treatment for mania or hypomania would confirm this. Episodes of feeling elated, full of zest or energy could suggest unrecognised hypomania (bipolar II disorder). There is also a risk that antidepressants may induce a 'switch' to mania and so adjunctive mood stabilisers are required. Lamotrigine is now being suggested as the preferred mood stabiliser for patients with bipolar depression, but it is not yet indicated on the PBS for this so there is a high cost for the patient.

A comprehensive approach

In order to understand a patient's depression it is essential to take a biopsychosocial approach. Such an approach means that it is necessary to determine the biological, social and psychological factors contributing to the depression in terms of:

- the background factors predisposing the individual to become depressed
- the precipitants to the onset of the depression (the resolution of these life stressors may be an important focus for counselling)
- the factors that act to maintain the depression (for example, being in a dysfunctional relationship).

With regard to the background factors:

- biological factors include genetic predisposition, other medical illnesses and concomitant medications
- social factors include particularly social adversity, poor social support and being in dysfunctional (and/or abusive) relationships
- psychological factors include early developmental experiences (e.g. child sexual, physical or emotional abuse), personality and coping style.

Management planning

The evidence based treatments for depression have now been summarised in several clinical practice guidelines, such as those developed by the Royal Australian and New Zealand College of Psychiatrists and beyondblue.[9,10] These guidelines suggest there is evidence for the efficacy of a number of nonpharmacological therapies for mild to moderate depression and for the efficacy of the SSRIs for mild to moderate depression. For moderate to severe depression, the evidence suggests the importance of using antidepressant medication. Working in partnership with a psychiatrist is recommended for the more severe and treatment resistant depressions.

The management of depression requires a collaborative approach between the doctor and the patient. The patient needs to be informed about the diagnosis and the treatment options, and his or her treatment preferences need to be taken into consideration as these will influence treatment adherence. Information sharing is crucial and can be facilitated by providing the patient and the carers with good quality information such as the RANZCP consumer and carer clinical practice guidelines (available online at www.ranzcp.org/publicarea/cpg.asp#consumer) or directing them to websites such as those of beyondblue (www.beyondblue.org.au/), the Black Dog Institute (www.blackdoginstitute. org.au/) or depressioNet (www.depressionet.com.au).

The development of a specific treatment plan will depend on the clinical presentation (including the type and severity) of the depressive episode, an understanding of the main contributing factors to the episode of depression, and the patient's particular predicament, risk assessment and treatment preferences.

Determining treatment

The type of depression plays an important part in determining the specific treatment to be offered:

- for patients with a predominantly biological depression (melancholia and bipolar depression), antidepressant medication and psychological treatment will be required
- for patients with nonmelancholic depression, psychological therapies should be the first choice of treatment, although there is evidence for the efficacy of the SSRIs and other antidepressants.

It is important to discuss with patients the options and the pros and cons of drugs

Table 2. Keys to recognising depression

- Allow the patient to speak freely without interruption
- Listen actively and empathically
- Encourage the patient to speak about personal issues
- Explicitly ask the patient about depressive symptoms such as:
  - the inability to derive pleasure and enjoyment from activities
  - low self-esteem
  - feelings of worthlessness or guilt
  - sleep disturbances
  - appetite disturbances
  - anxiety symptoms
- Ask the patient if he or she would like help[1]

Table 3. Harm assessment in depressed patients

- See the patient alone
- Ask the patient specific questions, such as:
  - have you thought life was not worth living?
  - have you thought about killing yourself?
  - do you have any plans to end your life?
- Assess the risk of the patient harming him or herself or others (especially children)

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versus nonpharmacological treatment. As mentioned before, considering a patient's preferences for treatment aids adherence.

The process of assessment – active listening and permitting the patient to speak freely (ventilation) to an empathic'healer' – has nonspecific but very important therapeutic effects. It may be that an invitation to reflect on their circumstances after the initial interview provides some patients with enough support to induce change.

Psychological treatments are indicated for all patients with depression and should constitute the initial treatment for many patients. However, antidepressants are likely to be also needed for those with melancholia and bipolar depression. Psychological treatments have been well researched, are evidence based and may offer the patient considerable advantages in relapse prevention. The choices are described below.

- Cognitive behaviour therapy (CBT), while considered to be the treatment for everything, is the preferred therapy for patients who have clinical features that reflect disturbance in their cognitive style or who are exhibiting depressogenic behaviours (avoiding participating in activities for fear of failure). For example, patients who have low self-esteem, are oversensitive or who construe everything in a negative way will benefit from CBT.
- Interpersonal therapy (IPT) is an appropriate treatment for patients who are experiencing interpersonal conflict such as marital difficulties or work related conflicts.
- Structured problem solving is an appropriate treatment for patients who have become overwhelmed by their predicament and feel they are unable to find a solution.
- Supportive counselling is the most appropriate treatment for patients who are finding themselves without significant support and who need someone to be a sounding board to help them cope with their depression.

Elements of each type of focused psychological treatment can be applied at different times during the course of treatment in an individual patient, depending on what is happening with the patient.

If an antidepressant is to be used, the choice depends on the efficacy, safety (including potential drug interactions) and tolerability of the available drugs and the patient's preference. The newer classes of antidepressants, the selective serotonin reuptake inhibitors (SSRIs), the serotonin and noradrenaline reuptake inhibitors (SNRIs), the noradrenergic and specific serotonergic agents (NaSSAs) and the selective noradrenergic reuptake inhibitors (NARIs), are safer in overdose than the tricyclic antidepressants (TCAs) and the monoamine oxidase inhibitors (MAOIs). However, this should not preclude the use of the older antidepressants if they are clinically indicated.

In general, it is probably better to use the SSRIs for mild to moderate depression where they have proven safety and effectiveness, although they do have significant side effects. The dual action (serotoninergic and noradrenergic) antidepressants, such as the SNRI venlafaxine (Efexor) and the NaSSA mirtazapine (Avanza, Axit 30, Mirtazon, Remeron) and some of the TCAs, have greater efficacy for melancholia and severe depression than other antidepressants. The selective NARI reboxetine (Edronax) is of benefit when patients experience psychomotor retardation and require activation. If a patient has responded to a particular antidepressant previously then it should be used again.

It is important to discuss with patients the options and the pros and cons of drugs versus nonpharmacological treatment. As mentioned before, consideration of the patient's preference for treatment aids treatment adherence.

'Better outcomes in mental health'

The Commonwealth initiative 'Better outcomes in mental health' provides rewards to GPs (in the form of a service incentive payment) for using a '3-step mental health process' for the management of the common mental health problems. The process includes an assessment, a mental health plan and a review. Details about this initiative are available from the Australian Division of General Practice (www.adgp.com.au).

When to refer to a psychiatrist

Patients may be referred to a psychiatrist for an opinion or ongoing management. A new MBS item number allows GPs to refer patients to a psychiatrist for an opinion, with the psychiatrist providing a management plan back to the GP. Reasons for referral include:

- severe symptoms
- depression complicated with physical illness
- depression complicated by personality problems
- depression nonresponsive to treatment
- concerns about suicide
- psychotic (delusional) depression
- bipolar disorder (bipolar depression)
- discomfort in managing the patient.

Patients who have a psychotic depression or are at risk of suicidal behaviour need urgent assessment and treatment, and may require referral to a hospital under the Mental Health Act.

Psychological treatments

Structured problem solving

Structured problem solving allows a structured approach to patients 'stuck' or overwhelmed by life difficulties. A number of carefully defined problems are identified, all possible solutions are 'brainstormed', and each possible solution is discussed. The patient and therapist choose a solution to attempt, a detailed plan is developed and the patient is encouraged to carry out the plan. How the plan was carried out is reviewed, the solution is re-evaluated as necessary and further efforts are encouraged.

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Interpersonal therapy

IPT aims to remove symptoms and prevent relapse and recurrence. It does not attempt to define the cause of a depressive episode but uses the connection between current life events and mood disorder to help the patient understand and deal with his or her episode of illness. IPT is based on research findings on the psychosocial and life events aspects of depression that have demonstrated the relationship between depression and the four domains of IPT: loss, role disputes, role transitions and interpersonal deficits. The overall strategy is that by solving an interpersonal problem the patient will improve his or her life situation and relieve the symptoms of the depressive episode.

IPT treatment lasts 12 to 16 sessions and there is good evidence for its efficacy in major depression.

Cognitive behaviour therapy

CBT is based on the premise that depressive thoughts are induced by, but also induce, a depressed mood. Studies show the thinking of depressed people to be dominated by self-derogation, negative expectations, overwhelming problems and responsibilities, deprivation and loss, and escapist and suicidal wishes. Beck suggested that recovery from depression could be achieved by teaching patients to re-evaluate everyday thoughts and to understand the longstanding belief systems underlying them.[11]

CBT is a goal orientated therapy, an active treatment that encourages optimism about change. Treatment proceeds through the stages:

- problem identification
- specific cognitive interventions designed to reduce the frequency of negative thoughts, behavioural and motivational deficits
- monitoring and questioning of negative automatic thoughts
- relapse prevention.

There are many self-help manuals available on CBT, and also an effective evidence based self-help program online (MoodGym, formulated by the Centre for Mental Health Research at the Australian National University; http://moodgym.anu.edu.au).

Supportive counselling

Supportive counselling is helpful for many patients who may be unable to deal with the stresses they confront. It is helpful to be able to discuss and talk through these stresses with a nonjudgemental and empathic person. The purpose of such counselling is to allow patients to come up with their own solutions (with encouragement to consider

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other options) and not be just given advice.

Pharmacological treatments

Real differences in the efficacy of the antidepressants remain uncertain, although those with dual action (serotonergic and noradrenergic) are considered preferable for melancholic or the more severe types of depression. As mentioned earlier, the choice of medication depends on the tolerability, safety, potential drug interactions, patient preferences and type of depression.

Critical issues in the pharmacological management of depression are ensuring that the dose of medication and the duration of treatment are adequate. All antidepressants require use for at least two weeks to achieve a good clinical response, and it is essential to ensure that the patient understands this. It is worth scheduling regular visits during the early stages of treatment as patients can become demoralised when they are not getting an instant 'cure'. All too often patients will stop their medication once they are in remission, and they are then at risk of having a relapse. It is generally recommended that patients continue taking their antidepressant for a year before ceasing treatment.

SSRIs

The SSRIs are the most widely used of the antidepressants and are now considered to be the first line antidepressant for mild to moderate depression. They have the distinct advantages of having a simple dosing regimen and being generally safe. When they were first introduced, their advantage was their side effect profile compared with the TCAs. With 15 years of experience of using SSRIs, it is now apparent that some of their side effects can be troubling for the patients, particularly the sexual side effects (such as decereased libido and delayed or absent orgasm). Of note, it is recognised that SSRIs can cause agitation during the first weeks or so of treatment, which could precipitate suicidal thoughts. Any patients being started on an SSRI should be warned about this; use of a benzodiazepine can help in reducing the agitation. A marked withdrawal syndrome occurs with some of the SSRIs, particularly paroxetine, and doses need to be tapered with these drugs.

Dual action antidepressants

The SNRI venlafaxine and the NaSSA mirtazapine can be highly effective, especially for melancholia. Venlafaxine carries a risk of hypertension as well as side effects of nausea, vomiting and dizziness on both initiation and withdrawal (the withdrawal syndrome can be particularly severe), and it can be lethal in overdose. Mirtazapine is

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often sedating and causes significant weight gain.

Duloxetine is a new SNRI that, in addition to its antidepressant effectiveness and favourable side effect profile, has a beneficial effect on pain syndromes. It is not yet approved for use in Australia, although TGA approval is expected this year.

NARIs

Reboxetine, a selective NARI, is an activating antidepressant that is useful in severe depressions with prominent retardation. It needs to be introduced slowly as many patients have difficulty with anxiety and agitation.

TCAs

TCAs are highly effective antidepressants, now generally regarded as second or third line choices since the introduction of the SSRIs.[12] Their anticholinergic side effects can be burdensome and they can be lethal in overdose, but they are still useful antidepressants, especially for those with a melancholic depression. A problem with the tricyclics has been that underdosing is common; it is generally considered that 150 mg per day is required to achieve a full therapeutic response, although there are patients who benefit from lower doses.

Other agents

Other medications used to treat depression include the MAOIs and augmentation strategies such as lithium (Lithicarb, Quilonum SR) and anticonvulsants. MAOIs should be used with caution in general practice because, although they are effective and safe antidepressants, they require the patient to be on a low tyramine diet to avoid a hypertensive crisis.

St John's Wort is increasingly being used as an over-the-counter antidepressant and is supported by some evidence of its efficacy in mild depression, although this is not as clearcut as was previously thought. It is considered attractive by patients as it is regarded as a 'natural' therapy; however, it does have side effects and some drug interactions. It is important to enquire about its use to avoid any interactions.

ECT is still the most effective (and safe) antidepressant therapy for severe, intractable depression; however, it should be used only in specialist units where appropriate monitoring can take place.

Conclusion

Depression is a common treatable disorder. Therapist optimism is appropriate and treatment of depression can be highly rewarding. It is crucial not to underestimate the profound effect even mild depression can have on the quality of life of an individual and his or her family. MT

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