

Depression

Author: Dr Pamina Mitter (MBBS, INTERCAL BSC, MRCPSYCH)

Topic Reviewers: Dr Marcus Tabart; Kaz Knudsen (RAN, WA); Vivien (RAN, Amata); Jane Kollner (RAN, Ampilatwatja); Teresa Bowmen (RAN, Papunya)

What is depression?

Depression is a mood state characterised by significantly lowered mood and a loss of interest or pleasure in activities that are normally enjoyable. Such depressed mood is a common experience in the general population. However, a major depressive episode can be distinguished from this 'normal' depression by its severity, persistence, duration, and the presence of characteristic symptoms (see later).

Common presentation

- Markedly depressed mood
- Loss of interest or enjoyment
- Reduced self-esteem and self-confidence
- Feelings of guilt and worthlessness
- Bleak and pessimistic views of the future
- Ideas or acts of self-harm or suicide
- Disturbed sleep
- Decreased libido
- Reduced energy leading to fatigue and diminished activity
- Reduced concentration and attention.

The depressed mood is relatively constant from one day to the next, although mood may vary somewhat during the course of the day. Often the mood gets better as the day progresses. Depression can also be accompanied by biological features (see somatic syndrome).

Atypical presentation

Mood is reactive and brightens during positive events.

Two or more of the following are present:

- i. Increased weight gain
- ii. Excessive sleepiness
- iii. Heavy, leaden feelings in the arms or legs, often lasting for many hours
- iv. The individual has a lifelong trait of being particularly sensitive to perceived interpersonal rejection.

Atypical presentation tends to be associated with younger age of onset of depressive disorder and are more common in women.

Diagnosis

According to the World Health Organisation's International Classification of Diseases tenth edition (ICD-10), a diagnosis of major depressive episode requires the following criteria to be met:

- The presence of a minimum number of symptoms
- Symptoms must be present for at least two weeks, unless the symptoms are particularly severe or of rapid onset
- The individual has not experienced a manic or hypomanic episode

- The episode is not due to psychoactive substance abuse or any organic mental disorder.

For a diagnosis of depression according to ICD-10 at least two of these three must be present:¹

1. Depressed mood
2. Loss of interest or pleasure in normally pleasurable activities
3. Decreased energy or increasingly more easily fatigued.

Additional symptom(s) from the following list should be present to give a total of at least four:

1. Loss of confidence or self-esteem
2. Unreasonable feelings of self-reproach or excessive and inappropriate guilt
3. Recurrent thoughts of death or suicide, or any suicidal behaviour
4. Complaints or evidence of decreased ability to think or concentrate (for example indecisiveness)
5. Change in psychomotor activity, with agitation or retardation (noticed by self or others)
6. Sleep disturbance
7. Change in appetite and weight gain or loss.

Somatic syndrome

To meet criteria for depression with a biological (somatic) syndrome four of the following must be present:

- Marked loss in interest or pleasure in activities that are normally pleasurable
- Lack of emotional responsiveness
- Waking in the morning two hours or more before the usual time
- Depression worse in the morning
- Marked psychomotor retardation or agitation as observed by other people
- Marked loss of appetite
- Weight loss (at least 5% in the last month)
- Marked loss of libido.

The severity of the disorder can be classified as mild, moderate or severe depending on the number and severity of the symptoms.

In severe depression there is marked impairment of occupational and social functioning, and most of the features of depression. Somatic features are likely to be present and there may be some psychotic features. Psychotic features can be hallucinations or delusions. Hallucinations are things that a person can hear, see, taste, smell or touch that are not really present. Delusions are firmly held false beliefs, e.g. that the person is being persecuted by aliens.

Prevalence in the Aboriginal population

The National Survey of Mental Health and Wellbeing (1995) found that in the 12 months prior to the survey 5.8% of the adult population had one or more depressive disorders either major depression or dysthymia.²

The prevalence figures for children (4-12 years) and adolescents (13-17 years) who may suffer from anxiety and/or depression are 3.5% and 6.8% respectively.³ Unfortunately, there is no comprehensive data describing the extent or nature of psychological problems or mental disorders in Aboriginal or Torres Strait people. The lack of data collection is problematic due to inappropriate measuring tools and diagnostic instruments, and what Reser describes as 'conflicting cultural perspective of mental illness'.⁴ The National Survey of Mental Health and Wellbeing also did not include this population group in the survey.² However, work

done by McKendrick, Hunter and Kyaw suggests that rates of mental disorder are high amongst Aboriginal people, but no higher than in the non-Aboriginal community.^{5,6,7} According to Windsor the effects of spiritual disruption, environmental insult, ideological conflict, political and sociological disadvantage, physical ill health and an array of transient fixers and medical staff have all contributed to the damage of mental health.⁸

The most recent figures available for the Northern Territory (except for the Katherine region) are from an informal survey done for the CARPA STM to find out what sorts of mental health issues health professional were dealing with at the clinic level.⁹

Common concerns among health staff were family violence, psychotic illness, suicide and self-harm, substance misuse problems, aggressive persons and depression.

The CARPA survey figures for depression were higher: 20%, compared to 5.8% noted in the National Survey of Mental Health and Wellbeing for the non-Aboriginal community.^{2,9} The CARPA survey took a broad definition of depression and asked if depression was due to chronic illness, cultural reasons, post-natal disorders, women's issues (such as miscarriages, domestic violence, sexual assault), bereavement and other.⁹ The survey also did not differentiate between major or mild depression. To conclude, there is no accurate data on the prevalence of mental illness in the Northern Territory, but it is clear from existing literature (in particular 'Ways Forward') that it does exist and can be debilitating if appropriate care is not provided.¹⁰

Depression is under-treated because of:

- Low rates of diagnosis
- Patients' attitudes
- Inadequate antidepressant prescribing.

The goals of treatment are to:

- Remove symptoms
- Restore patient functioning
- Prevent relapse.

Use of antidepressant medication

Worldwide depressive illness is a growing burden economically and on quality of life. Current projections indicate that depression will rank only second to ischaemic heart disease by 2020.¹¹ Depression is a chronic and recurrent disease with morbidity analogous to diabetes or hypertension.¹²

The use of antidepressants in treatment of depression has benefits and pitfalls in all populations, however, in remote areas there are additional difficulties that need to be considered. Medication is more easily available than psychological therapies in the remote areas and so will have a central role in any management strategy. Nonetheless, taking the time to listen to someone's problems can be very useful, even if practitioners have no formal psychiatric training.

Types of antidepressants

SSRI (selective serotonin reuptake inhibitors): These are the newer antidepressants. They tend to have fewer side effects (except for some gastrointestinal disturbances) than the older drugs and they are relatively safer if taken in overdose. The SSRIs have almost rendered the TCAs obsolete.

TCA (tricyclic antidepressants): These tend to have more side effects (like dry mouth and constipation) and are toxic in overdose.

SNRIs (selective noradrenaline reuptake inhibitors) like Venlafaxine are also available, and there are a range of other antidepressants with different side effects and properties.

The choice is based on efficacy, safety, tolerability, real world efficacy and economic value.

There is very little evidence to show that any antidepressant is generally more effective than another, but for an individual patient one drug may suit or work better than another. It is reasonable to base choice on the medications that have fewest side effects and are safest in overdose. These tend to be the newer and more expensive drugs but, as patients are more likely to take these and improve, it is worth using them as first-line. In the UK patients are seven times as likely to take an adequate course of SSRIs than TCAs.¹³ Usually an SSRI would be suitable as a safe first choice.

Reasonable treatment strategy for first-line treatment of depression

First choice: Sertraline 50 mg (an SSRI). This has less interactions with other drugs and is less agitating, but reduce the dose in severe liver disease.

(First-line treatment is with SSRIs, though if need further treatment because of poor response or too many side effects then consult with Mental Health Team, and they may recommend other drugs such as TCAs or SNRIs.)

Clinical trials of antidepressants suggest an efficacy rate approaching 80%, but in standard primary care only about 25% of patients have an adequate dose and duration of treatment.¹² This figure is likely to be lower in remote communities where communication and follow-up is often less than perfect.

There is general agreement between guidelines from the British Association for Psychopharmacology, WHO and Royal College of Psychiatrists guidelines.¹⁴

Given that a frequent problem is that too low a dose is used, the treatment needs to start at a low dose and build to a high dose over a few weeks, titrated against side effects, and to continue the dose for sufficient time to be effective.

It is necessary to continue the effective dose for at least 4-6 months beyond initial symptom resolution (or longer for subsequent episodes). Depression is usually characterised by repeated relapses or recurrences, and continuation studies show that up to half of patients will relapse if treatment is stopped before this time.

Standard Effective Daily Doses: Sertraline 50 mg, citalopram 20 mg, venlafaxine 150 mg.

Maintenance therapy

In the 1980s there were several studies including, in the USA, The National Institute of Mental Health Collaborative Program of the Psychobiology of Depression. In this study, 400 patients were followed up for 15 years. One in eight remained well. 80% had at least one recurrence, and 6% remained chronically depressed throughout.¹⁵

Patients who are at high risk of relapse (that is, a return of symptoms that meet the criteria for a major depression prior to the end of the index episode) are those who: have a more chronic course; more than three past episodes; severe index episode; family history; co-morbid anxiety or substance abuse; co-morbid medical illness; poor social support; and ongoing psychosocial stressors.^{12,16}

There is good evidence that for these patients long-term maintenance on treatment would be beneficial. Though there are some unresolved issues about how long this maintenance treatment should be, the best available evidence suggests 4-5 years.^{16,17}

Withdrawal of medication

Antidepressant medications do not have an addictive potential, but a withdrawal syndrome has been described in some patients who suddenly stop their medication. This is particularly described for the SSRI and SNRI groups. Therefore, it is recommended that medication is gradually decreased over a two to four week period.

Some drugs, which stay in the body for a short time, have a higher risk than others that are slow to be removed. Thus, paroxetine causes withdrawal symptoms much more commonly than fluoxetine. Please check current drug information about withdrawal syndrome for patients before starting.

Local considerations

Diagnosis

Many aspects of diagnosing mental illness are more complex when one is unfamiliar with the local culture. Often a useful marker is other people's perception of a change in appearance or behaviour, for example acting in a culturally inappropriate manner. After a bereavement it is culturally acceptable for some Aboriginal people to make 'sorry cuts', but cutting at other times may be a sign of mental health problems.

Shyness towards strangers can be extreme, especially in those less exposed to Western culture. This can make interactions extremely frustrating and the temptation for health workers to jump to the wrong conclusion must be anticipated. The client may also wish not to appear rude and so try to please the health worker with their answers. Thus, information from a third person is very important.

People may not be able to verbalise their mood as depression. Often 'worries' or 'cranky mood' can be useful ways to understand low mood and irritability. Also, some people who persistently attend the clinic with non-specific physical problems may actually be depressed.

Beware that seemingly odd beliefs and hallucinations (especially visual) may not be pathological. However, persistent auditory hallucinations are likely to need treatment.

As a result of multiple social stressors (like multiple bereavements, unemployment, separation from family, substance misuse) people in remote Aboriginal communities have many risk factors for developing depression. It is important to keep a high index of suspicion when considering this as a diagnosis.¹⁸ 'Compliance' with treatment and management plans

Involving other community members and family as much as possible is often the most important method of ensuring compliance. Good communication, understanding manner and explaining things also helps. However, never assume compliance. Patients all over the world often don't want to be embarrassed by admitting they are not taking their medication. Often clients do not communicate much or trust you until they have met you on several occasions and understood your background and 'story'. A useful strategy is to talk in the third person about someone who had depression and how they got better with medication.

Overall, in my experience, when people were ill they were keen to get help and felt that Western medicine may have some special beneficial properties.¹⁹

Lack of monitoring

Because of the erratic nature of follow up and treatment out bush it is preferable to have a simple treatment plan. Start low and rapidly build to a good dose, and make sure they understand that it takes 2-4 weeks to have effect and they may be bothered by side effects initially.

No response to treatment

If the client does not respond it may be useful to consider the possible reasons:

- Are they taking the drug?
- At the right dose?
- If not, why not? Is it because of side effects or forgetfulness: could someone help administer the drug daily?
- Are they taking drugs or alcohol that may counteract any antidepressant?

- Do they need a trial of an alternative medication (i.e. true therapeutic failure)? If you think the latter is the case, seek psychiatric consultation.

Family and community input

The family are usually the main carers in remote communities and often act as nurses, occupational therapists, rehabilitation officers and give emotional and practical support. They are an invaluable resource in treating mental illness. It is important that the correct family member becomes involved, as there is a system within the family to determine who takes responsibility for that individual. Work with the family to identify who best to do this. And who can be responsible for the care when the primary carer has to go away.

Use of traditional healers

In remote communities traditional healers are often consulted before medical advice is sought. Aboriginal people sometimes hold beliefs that they are ill or hear voices as a result of a curse. In this context it can be very useful to seek help from traditional healers and also to use medication. The two approaches are not mutually exclusive and you may be regarded as more acceptable if you are flexible with working with the local cultural beliefs.¹⁸

Complex patient groups

Women: pregnant or breastfeeding

If possible withdraw all drugs in the first trimester. If pregnancy is planned try to withdraw drugs slowly beforehand. If an antidepressant is required SSRIs have been found to have low teratogenicity and so are relatively safe to use in pregnancy.²⁰ As with all medications with pregnancy and breastfeeding, the risks of medication needs to be weighed against the benefits and discussed with the woman.

Very few studies have been carried out about breast-feeding and antidepressants. All antidepressants pass into the breast milk but usually in small amounts. There have been some cases of neonatal discontinuation syndromes with SSRIs, though SSRIs are safe and there is growing clinical support to continue SSRIs if indicated post partum.²⁰

Postnatal depression

This occurs in 10-15% of all women.²¹ Depression in the mother can effect the long-term development of the infant if untreated. One quarter of these will need medication. If women have had previous episodes of depression they may be at higher risk, and it may be worth considering prophylactic antidepressants after delivery.

Men: impotence

There is a higher risk with paroxetine and sertraline, but can be problem with all SSRIs.

Children (<15 years old)

There is no clear evidence that antidepressants are effective in this age group. However, it is extremely important to try to sort out the cause of stress for the child. If a child seems to be suffering from depression, talk to the mental health team about treatment options.

Elderly

The elderly have an increased sensitivity to medication and as one ages drugs get removed from the body more slowly. Thus, it is best to try to minimise medications.

'Golden rule': start low, go slow and monitor effects frequently.

Avoid drugs that put elderly at risk of falls, e.g. by lowering blood pressure or making them sedated, e.g. benzodiazepines.

Medical co-morbidity

Medical ill-health increases the risk of depressive illness. Seek medical advice about medication use and take care with interactions with other drugs. Sertraline and Citalopram have relatively few drug interactions.

Diabetes: Do not use fluoxetine as there is a risk of hypoglycaemia.

Hepatic impairment: All antidepressants are cleared by the liver. SSRIs may be used with caution at a half dose for severe hepatic impairment.²⁰

Drug interactions in people on medications for chronic diseases are possible, but prescribing information needs to be checked.

Psychiatric co-morbidity: anxiety

Often depression can be associated with anxiety, and starting treatment with an SSRI can initially make this worse. Although the use of benzodiazepines can be given for acute agitation and distress it is extremely important to use benzodiazepines for less than two weeks and avoid their use completely if possible.²²

Substance abuse

Alcohol and substance misuse (e.g. petrol sniffing and marijuana use) can affect diagnosis and treatment of mental illness. Substances can directly cause low mood and hallucinations, but also some clients use substances to try to cure themselves of mental health problems. In those with alcohol dependence 80% of people with depression recover within a few weeks of abstinence without the need for antidepressant medication.²³

In the real world abstinence may be difficult but, if someone continues to drink alcohol, it is unlikely that the antidepressant can work effectively. Pointing out the impact that alcohol is having in their lives may be the only step possible.

High suicide risk

Starting antidepressants can be a high-risk time as a patient may have more energy but still feel suicidal, and thus act on this. The family may need to be more vigilant, and potentially toxic drugs should be avoided. Liaison with the specialist team would be advisable when making management decisions (even if over the telephone only).

Self-care/colleague care

It is important to be aware of one's own and one's colleague's mental health. Working in remote health care is challenging and one can feel professionally isolated. As a result the risk of mental stress and developing depression is increased. As well as personal distress depression may affect one's ability to cope with the job or lead to leaving the post. Being aware of the risks is important and it is a sign of strength to be able to accept help and advice, e.g. from the Bush Crisis Line. Remember that when you are treating colleagues, relate to them as patients rather than other professionals.

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