INVITED ARTICLE

A PRACTICAL APPROACH TO THE MANAGEMENT OF DEPRESSION

H L Lim

ABSTRACT

Depression is a common and treatable condition. Failure to diagnose it may lead to unnecessary investigations, delay in treatment and an increased risk of suicide. Anti-depressant drugs are the first line of treatment. Tricyclics are generally the drugs of choice as their efficacy is very well established. Second generation antidepressant drugs are preferred for the elderly and those with heart disease as they tend to have milder side effects and are less toxic in overdose. Electroconvulsive therapy is indicated in those with severe depression, high suicide risk or failed drug treatment. Psychotherapy is usually used as an adjunct to pharmacotherapy whilst lithium is used to prevent recurrence of depression.

Keywords : *depression, diagnosis, drug treatment, electroconvulsive therapy, psychotherapy*

SINGAPORE MED J 1993; Vol 34: 449-451

INTRODUCTION

Depression is a very common experience, characterised by a feeling of sadness, misery or being low in spirits. It is often a reaction to stress or disappointment (reactive sadness) or due to loss of something or someone important (grief). These types of depression usually lessen and disappear with time and may not require any special treatment. However, in some people depression can appear without reason or be so severe and prolonged that it dominates their lives. They are unable to function at home or at work and may complain that life is not worth living. Depression of this severity is an illness and requires treatment. After adjustment disorder, depressive disorder is the commonest formal psychiatric disorder in primary care constituting some 8 - 10% of consecutive-patient consultations[1].

Classification

The classification of depression[2] is based on

1. *Aetiology*
   (a) Reactive depression and endogenous depression, depending on whether symptoms are or are not caused by external stressors,
   (b) Primary depression and depression secondary to other physical or psychiatric illness.
2. *Symptoms*
   Neurotic depression and psychotic depression, depending on the presence of neurotic or psychotic symptoms.
3. *Course*
   Unipolar depression and bipolar depression, depending on whether there are episodes of depression only or episodes of both depression and mania.

Symptoms of Depression

Certain symptoms are characteristic of depression

(a) Persistent low mood, feeling worse in the morning
(b) Loss of interest or pleasure in usual activities
(c) Slowness in thinking or doing things
(d) Loss of appetite and weight, loss of libido and energy
(e) Sleeplessness or excessive sleeping, early morning waking
(f) Recurrent thoughts of death, suicidal thoughts and attempts
(g) Feeling hopeless or worthless, self-blame and guilt

3 Mt Elizabeth #15-07
Mt Elizabeth Medical Centre
Singapore 0922

H L Lim, MBBS, DPM, FRC Psych, FRANZCP, FAMS
Consultant Psychiatrist

Diagnosis

The first thing is to recognise the existence of depression, based on the presence of a number of the symptoms listed above. Next, one should decide whether the depression is a reaction to stressful circumstances, secondary to a physical or psychiatric illness, or whether there is evidence of neurotic or psychotic depression.

Since depression can present in a variety of ways, often mimicking the symptoms of a physical illness, failure to diagnose it may lead to unnecessary investigations, delay in treatment, and an increased risk of suicide.

The depth of depression is assessed by noting the severity of the symptoms. Enquiry should also be made about the patient's desire for death and his thoughts of suicide. The more severe the depression, the greater is the suicidal risk. Some factors which increase the risk of suicide[3] are:

(a) severe agitated depression
(b) being an elderly male
(c) living alone
(d) presence of alcoholism and/or drug addiction
(e) serious physical illness
(f) previous suicidal attempt
(g) talking of suicide
(h) recent worsening of social situation, and
(i) guilt and feelings of unworthiness.

Treatment

Depression is a treatable condition. Lack of treatment or ineffective treatment may lead to a continuation of the distressing disorder or suicide.

After having decided to treat the patient for depression, the first question to ask is whether he requires inpatient or outpatient treatment. The answer depends on the severity of the disorder and the quality of the patient's social resources. Special attention should be paid to the risk of suicide, the risk of harm to others and the failure to eat. If the patient is to be treated as an outpatient, the next question is whether he should continue to work. If the depression is mild, work can provide a valuable distraction and a source of companionship. When the disorder is more severe, work performance is likely to be

impaired and such failure may add to the patient's feelings of hopelessness.

Finally, one has to decide what type of treatment is to be given. The various forms of treatment are:

1. *Antidepressant drugs*

Antidepressant drugs are the first line of treatment.Tricyclics are the drugs of choice[4] as their efficacy in the treatment of acute depression and the prevention of relapses has been well demonstrated. The two longest established and best known are amitriptyline and imipramine. Agitated and anxious patients benefit more from amitriptyline which is sedative whilst withdrawn and retarded patients benefit more from imipramine which is less sedative. The tricyclics are ineffective in 25% of depressive patients and have a lag period of 2-4 weeks before the onset of the therapeutic effect. They also have many adverse effects (anticholinergic, cardiovascular, weight gain, sedation) and are very toxic in overdose. They need to be used with great care in patients with heart problems, urinary retention or glaucoma. The patient must be warned of likely side effects like drowsiness, constipation and blurring of vision.

Amitriptyline or imipramine should be started at 75mg a day in divided doses and increased by 25mg every second or third day, up to 150mg - 225mg. Doses must be halved for elderly patients. If the patient does not improve after 3 weeks, the doctor should find out why there has been no response. He should consider whether the patient has been taking the drug in the correct dose, whether the diagnosis is correct and what social factors are playing in maintaining the disorder. Poor compliance with anti-depressant drug treatment is common.

When the therapeutic effect has been achieved, the drug should be continued in full dose for at least six weeks. After this, a reduced dosage (usually half to two-thirds of the therapeutic dose) should be continued for a further six months. If a relapse occurs when the dose is reduced, the former dosage should be reinstated for at least a further three months before lowering it cautiously for a second time.

Monoamine oxidase inhibitor drugs (MAOI) are less effective than tricyclic antidepressants for moderate to severe depressive disorders. They should be used only for the atypical, mild depressive disorders with neurotic symptoms. Their therapeutic effects have to be balanced against the many interactions of the MAOI drugs with foodstuffs and other drugs. The dose for phenelzine (nardil), the most widely used MAOI drug, is 30-90mg daily.

Amineptine (survector) is a dopaminergic antidepressant which is devoid of any sedative, anticholinergic or cardiotoxic effects. It is well tolerated and the dose is one tablet (100mg) in the morning and one at noon.

Maprotiline (ludiomil) and mianserin (bolvidon) are tetracyclic antidepressant drugs which have sedative activity without the anticholinergic effects of the tricyclics. Mianserin is also devoid of cardiotoxic effects. The dose is 75mg-150mg daily for maprotiline and 30-90mg daily for mianserin.

The second generation drugs like the reversible monoamine oxidase inhibitors (eg moclobemide) and serotonin reuptake inhibitors (eg fluvoxamine, fluoxetine) have a mild side effect profile and are less toxic in overdose. Their therapeutic efficacy is comparable with that of the tricyclics. They are particularly useful for those patients who are often unable to tolerate the adverse effects of the tricyclics, especially the elderly and those with heart disease.

Moclobemide (aurorix) is particularly suitable for outpatient treatment as it has no anticholinergic effects, is not sedative and does not impair vigilance. The initial dose of 300mg in divided doses may be increased to 600mg daily, depending on the severity of the depression. Common side effects are nausea, headache and sleep disturbance.

Both fluvoxamine (faverin) and fluoxetine (prozac) cause fewer anticholinergic and cardiovascular side effects than the tricyclics. They share common side effects, including nausea, headache and insomnia. The initial starting dose for fluvoxamine is 50mg twice a day for the first week and increased to 300mg daily if necessary. Fluoxetine is given as a single dose of 20mg per day but may be increased to 60mg in divided doses if necessary.

2. *Electroconvulsive Therapy (ECT)*

ECT should be considered if[2,5]

(a) rapid improvement is needed because of high suicide risk or depressive stupor,
(b) patient has delusions,
(c) patient fails to respond to antidepressant drugs.

3. *Lithium treatment*

Although lithium does exert some therapeutic effect in depression, its principal use is to prevent the recurrence of mania and depressive disorders[6].

It is contraindicated in children, early pregnancy, renal and cardiac disease. Before starting therapy, do a full blood count, electrocardiogram, thyroid and renal function tests. For patients under the age of 60 years, the starting dose of lithium carbonate is 250mg twice daily. After a week, the serum lithium concentration is determined 12 hours after the last dose. The dosage is increased if necessary to achieve a therapeutic serum lithium level of 0.5 to 0.8 mmol/l. Doubling of dosage leads to doubling of serum lithium level. The patient should be seen weekly for a month, and monthly thereafter. Regular serum lithium estimation, thyroid and renal function tests should be carried out because of the toxic effects of excessive dosage and the possible development of hypothyroidism and nephropathy. Prodromal symptoms and signs of lithium intoxication include nausea, vomiting, diarrhoea, coarse tremor, sluggishness and dysarthria.

Carbamazepine (usual dose 400-600mg daily in divided doses) may provide an alternative to lithium in patients who do not respond adequately to lithium or are unable to tolerate lithium's adverse reactions.

4. *Psychotherapy*

The psychological management of depression consists of supportive psychotherapy, dynamic psychotherapy, cognitive therapy, and interpersonal psychotherapy.

Supportive treatment is part of the management of every depressed patient. He requires support and encouragement. If the depression is mainly a reaction to stressful life events and is not severe, discussion and counselling should be started. The patient should be encouraged to talk about his feelings and to discuss his problems.

If provoking factors can be altered, he should be encouraged to think of suitable means for changing them; if they cannot be altered, he should be helped to come to terms with the new situation.

The use of dynamic psychotherapy is restricted to the less severe cases of depression. Both cognitive therapy developed by Beck[7,8] and the interpersonal psychotherapy of Klerman and Weissman[9] are reported to be as effective as pharmacotherapy in mild to moderate depression[10]. The main aim of cognitive therapy is to modify the patient's negative way of thinking about life situations and about the depressive symptoms.

In interpersonal psychotherapy, depression is viewed as a disorder of interpersonal relationship, regardless of aetiology. Therapy aims at symptom relief and a more effective approach to relationship.

DISCUSSION

Effective treatment of depression is impossible without attending to social, family and personal factors. Counselling and family therapy may reduce social and psychological distress. The patient may benefit from advice or help with changing adverse social situations such as financial, housing and unemployment difficulties.

Three major errors in assessment that lead to ineffective or lack of treatment are :

(a) failure to recognise that the patient is in fact depressed,
(b) failure to appreciate the severity of the depression, and
(c) failure to establish the cause of the depression.

When antidepressant drugs are used, errors that are commonly made include:

(a) prescribing an inadequate dosage,
(b) stopping the drug too soon,
(c) failing to take account of any possible drug interactions that may occur with other drugs being administered concurrently.

CONCLUSION

The overall treatment strategy for depression[11] should be:

(a) the early recognition of the disorder by the doctor, the patient and his family, coupled with early initiation of treatment of the acute episode,
(b) continuation of treatment, aimed at reducing the likelihood of relapse, and the return of symptoms before the episode has run its course; and
(c) prophylaxis, aimed at preventing new episodes of illness.

References

1. Blacker CVR, Clare AW. Depressive disorder in primary care. Br J Psychiatry 1987; 150:737-51
2. Gelder M, Gath D, Mayou R. eds. Affective disorders. In: Oxford Textbook of Psychiatry. Great Britain: Oxford University Press, 1989:217-67.
3. Hawton K. Assessment of suicide risk. Br J Psychiatry 1987; 150:145-53.
4. Kragh-Sorensen P, Gjerris A. The present state of pharmacotherapy in depression. In: Kragh-Sorensen P, Gjerris A, Bolwig TG.eds. Depression: New trends in research and treatment.Copenhagen: Munksgaard, 1991: 77-103.
5. Kendell RE. The present status of electroconvulsive therapy. Br J Psychiatry 1981; 139: 265-83.
6. Schou M. Lithium treatment: a refresher course.Br J Psychiatry 1986; 149: 541-7.
7. Beck AT, Rush AJ, Shaw BF, Emery G. eds. Outcome studies of cognitive therapy. In: Cognitive therapy of depression New York: The Guilford Press, 1979:386-96.
8. Fennell M. Depression. In: Hawton K, Salkovskis PM, Kirk J, Clark DM . eds. Cognitive behaviour therapy for psychiatric problems. A practical guide. Great Britain: Oxford University Press, 1992: 169-209.
9. Klerman GL, Weissman MM. Interpersonal psychotherapy. In: Paykel ES. ed . Handbook of affective disorders. London: Churchill Livingstone, 1992: 501-9.
10. Stravynski A, Greenberg D. The psychological management of depression. Acta Psychiatr Scand 1992; 85: 407-14.
11. Kupfer DJ. Maintenance treatment in recurrent depression: Current and future directions. Br J Psychiatry 1992; 161:309-16.