Introduction

Depression is one of the most prevalent medical disorders. It is also under-recognized and under-treated. Only about half the depressive disorders in primary care are recognized and of these less then half receive adequate treatment even though effective treatments are available. Depression has serious consequences for the well being of a patient and his family. It results in marked psychological, social and physical disability besides causing considerable, emotional suffering and economic loss to the community.

Epidemiology

About 9.0 % (3% of men and 6% of women) of the general population suffer from major depression. About 3% suffer from dysthymia. Overall there is a lifetime risk of about 20% for developing a major depression, women being affected about twice as often as men. Most people develop depression between age 20 to 40. Ill effects resulting from depression are serious and about 15%-20% go on to develop chronic depression. About 7%-10% depressives may commit suicide in the next 10-15 years. This figure is higher (about 15%) for severely depressed patients receiving in – patient care.
In Malaysia a rural survey on psychiatric illness showed that depressive disorders were the commonest, psychiatric illness identified with a point prevalence rate of 3.6%. Local studies of specific population groups such as general outpatient, medical outpatient, post partum women and drug dependants has shown that prevalence of depression is much higher.

Diagnostic Criteria

A Major Depressive Disorder - Diagnostic Criteria (based on DSM IV)

A-1 Major Depression – This is a severe type of depression which may occur as single or recurrent episodes. At least 5 of the following symptoms should be present (one of which is either depressed mood or loss of interest/pleasure) for a minimum period of two weeks.

a. Depressed Mood (feeling sad, empty, tearful) nearly everyday
b. Markedly diminished interest or pleasure in most activity
c. Significant change of appetite or weight
d. Insomnia or hypersomnia nearly everyday
e. Psychomotor agitation or retardation
f. Fatigue or loss of energy nearly everyday
g. Feeling of uselessness or inappropriate guilt
h. Decreased ability to think, to concentrate or to make decision everyday
i. Recurrent thoughts of death or suicidal ideas or suicidal plans or attempts

A-2 Bipolar Mood Disorder – Depressed phase
Some patients with Bipolar Disorders may develop both Manic and Depressive episodes. Patient experiencing mania may be elated and/or irritable, hyperactive, have pressure of speech and grandiose ideas. They may also be disinhibited, full of energy with decreased need for sleep. Manic patients almost invariably develop depressive episode at some time in the course of their illness.

A-3 Major depression may also coexist with other psychiatric conditions such as Schizophrenia or delusional disorder. It may also have a Post Partum onset.

A-4 Major Depression has been recognized to occur in physical illnesses such as hypothyroidism, Cushing’s Disease, diabetes, cardiovascular disorders, chronic ability conditions & cancer. All depressed patients should receive full physical examinations and appropriate investigations. Such investigations are particularly important in patients who develop a depression for the first time after the age of 40 years.

A-5 A minority of patients with Major Depression have psychotic symptoms such as delusions and hallucinations. These are usually depressive in content eg., "My intestines have rotted" or "I’m the greatest sinner in the world and hell is too good a place for me." These patients may hear voices saying for eg that they and their family are doomed. Sometimes they may only hear sounds like birds or insect noises. Such patients needed anti-psychotic medications in addition to anti-depressants.

B Minor Depressive Disorders

B-1 Adjustment Disorder with Depressed Mood:

- Development of emotional and/or behavioral symptoms in response to a stressor;
- Symptoms occurring within 3 months of the stressor;
- Marked distress that is in excess of what would be expected from exposure to stressor;
- Significant impairment in social or occupational functioning;
- Symptoms do not persist for more than 6 months after the stressor has ceased;
- Predominant symptoms are depressed mood, tearfulness and feelings of hopelessness.

B-2 Dysthymic Disorder

- Depressed mood for most of the day, for more days than not, for at least two years (for children & adolescent 1 year)
- Patient may also experience the following symptoms – poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration and feelings of hopelessness.
C Other Conditions Involving Depressed Mood:

C-1 Acute Stress Reaction

- The person has been exposed to a traumatic event in which both of the following were present:
  
  i. the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury;

- the person’s response involved intense fear, helplessness, or horror;
- symptoms may include subjective sense of numbing, detachment, absent of emotional responsiveness, reduction in awareness of surrounding (eg. "being in a daze"), derealization, depersonalization, dissociative amnesia, reexperiencing the trauma, avoidance of stimuli impairment of social and occupational functioning;
- lasts from 2 days to 4 weeks;
- onset within 4 weeks of the traumatic event.

C-2 Post-traumatic Stress Disorder

Similar to Acute Traumatic Stress Disorder but duration of the disturbance is more than one month and onset may be delayed.

Recognition Of Depression

Clinical depression should be differentiated from normal sadness (eg following a loss) based on the following:

i. clinical depression is severe
ii. lasts longer than expected
iii. affects patients daily functioning

Depressed patient may present with various other complaints such as:

- pain (headache, backache)
- lethargy
- excessive worry/anxiety
- gastrointestinal complaint
- feeling of irritability
- sexual complaints (eg loss or libido)
- frequent medical consultation and request for medical leave
- depressed children may present with conduct problems, school refusal or deterioration in academic performance or substance abuse.
Assessment Of Depressed Patient

In the assessment of a depressed patient, the following are essential:

i. History – take a full history including alcohol /drug use and past psychiatric history.

ii. Mental State Examination – Depressed patient is usually depressed but in some cases psychotic symptoms may be present.

iii. Risk of suicide – it is essential to assess the severity of depression along with risk of suicide and self-harm.

iv. Physical examination – a full and complete physical examination must be conducted.

v. Laboratory investigations - where appropriate eg. Thyroid function test, renal function, fasting blood sugar may need to be done.

Management primary

Management of Major Depressive Disorder in Primary Care

Flow Chart for Management of Depression in the Acute Phase
NOTE:

**Antidepressants** - choice based on:

- Tolerability
- Safety
- Compliance
- Cost

**Choice of antidepressants**

- SSRI
- RIMA
- Tetracyclics
- TCAs
- SNRIs
- NaSSA

**Counselling include:**

- Crisis intervention
- Problem solving
- Social / emotional support
- Cognitive approach

**Treatment of associated symptoms:**

- Hypnotics for insomnia
- Anxiolytics for anxiety
  - Benzodiazepine
  - Non-Benzodiazepine

eg.

- MIDAZOLAM
- ZOLPIDEM
- ZOPICLONE
- LORAZEPAM
- ZALEPLON
Management Specialist

Management of Major Depressive Disorder in Specialist Care

Flow Chart for Management of Depression in Specialist Care

Psychotherapy
  • CBT
  • Supportive
  • Individual
  • Family

Etc.

Management

1. Bipolar Mood Disorder - Depressive Phase

This condition should be managed by specialized unit during the acute phase.

  • With antidepressants (TCA should be used with caution in view of danger of inducing rapid cycling)
  • With mood stabilisers (according to efficacy and tolerability) – check serum levels
  • Others

- psychotherapy
- adjunct therapy
- social intervention
- ECT

2. Dysthymia

May be managed in both primary care and specialized settings

  • with counseling
  • with SSRI

3. Adjust Disorder

  • With supportive psychotherapy
  • With psychosocial intervention
  • Symptomatic treatment – Hypnotics + anxiolytics (short term) – 2-6 weeks
4. Depression in Children and Adolescents

4-1 Antidepressants

- Is limited value in children
- More useful in older adolescents

4-2 Psychosocial intervention and family therapy and CBT are the main modes of management.

Follow Up & Prophylaxis

Follow-up Management and Prophylaxis of Depressive Disorders

Indication for Prophylaxis

- 3 or more episodes irrespective of age
- If patients aged 40-50 years has had 2 episodes, patients aged above 50 years, 1st episode
- Double depression
- Long index episode more than 1 year
- Chronic depressive disorder

General Guidelines for follow-up

a. All cases need to be followed up. Frequency of follow-up will depend on the;

- Severity of depression and response to treatment
- Availability of social support

b. The duration of follow-u also depends on:

- Type of depression:
- Frequency of past episodes,
- Severity of past episodes,\n- Presence of psychosocial stressors
- Age of patient
- All patients should be followed up for at least 6 months
- Therapeutic dose should be maintained
- Prophylaxis – termination of treatment should be gradual over a period of at least 4 weeks
c. Other factors need to be addressed:

i. Compliance to medication and follow-up,
ii. Side effects of medication,
iii. Assessment of symptoms at follow-up,
iv. Psychological aspects, eg. suicidal ideas, insight, confusion

v. Functioning level

- Psychological functioning,
- Social functioning
- Occupational functioning

vi. Rehabilitation that will be needed, depending on area of deficit,
vii. Assessment of underlying physical factors

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