Depression

Depression - F32# (Clinical term: Depressive episode Eu32)

Presenting complaints

The patient may present initially with one or more physical symptoms, such as pain or 'tiredness all the time'. Further enquiry may reveal low mood, loss of interest or irritability.

A wide range of presenting complaints may accompany or conceal depression. These include:

- anxiety or insomnia
- worries about social problems, eg financial or marital difficulties
- increased drug or alcohol use
- (in a new mother) constant worries about her baby or fear of harming the baby.

Diagnostic features

- Low or sad mood.
- Loss of interest or pleasure.

At least four of the following associated symptoms are present:

- disturbed sleep
- disturbed appetite
- guilt or low self-worth
- pessimism or hopelessness about the future
- fatigue or loss of energy
- agitation or slowing of movement or speech
- diurnal mood variation
- poor concentration
- suicidal thoughts or acts
- loss of self-confidence
- sexual dysfunction.

Symptoms of anxiety or nervousness and physical aches and pains are also frequently present.

Some groups are at higher risk, for example:

- those with adverse life events and social difficulties (eg the unemployed, single parents, the homeless, those living in care, those experiencing social isolation)
- those with a past history of depression and other psychiatric disorders
- those with chronic physical disorders
- women who have experienced recent childbirth (see Postnatal depression -F53).

It may be helpful to ask the following questions:

- During the past month, have you been bothered by little interest and pleasure in daily activities?

- During the past month, have you been bothered by feeling down, depressed and hopeless?
  A negative answer to either of these questions makes depression unlikely.

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Differential diagnosis

- Acute psychotic disorder - F23 (if hallucinations [eg hearing voices] or delusions [eg strange or unusual beliefs] are present).
- Bipolar disorder - F31 (if patient has a history of manic episodes [eg excitement, rapid speech and elevated mood]).
- Alcohol misuse - F10 or Drug use disorder - F11 (if heavy alcohol or drug use is present).
- Chronic mixed anxiety and depression - F41.2
- Postnatal depression - F53
- Bereavement - Z63
- Adjustment disorder - F43.2
- Unexplained somatic complaints - F45
- Generalized anxiety - F41.1

Some medications might produce symptoms of depression (eg beta-blockers, other antihypertensives, H2 blockers, oral contraceptives and corticosteroids).

Essential information for patient and family

- Depression is a common illness and effective treatments are available.
- Depression is not weakness or laziness.
- Depression can affect a person's ability to cope.
- Emotional and practical support from family and friends are very valuable.
- Recommend information leaflets or audiotapes to reinforce the information (see Depression).

General management and advice to family

(ref 72)

- Assess suicidal intent – see Self-harm. The belief that enquiring about suicidal ideation may prompt some people to consider self-harm is not supported by research findings or clinical experience. Placed in the context of asking people about symptoms of depression, such questions feel less awkward for the interviewer, for example 'It sounds as if you have been feeling very down recently; has there ever been a time when you have felt as though you couldn't be bothered carrying on? Have you ever felt that life was not worth living/that you would be better off if you were dead? Have you ever thought of harming yourself in any way?' Close supervision by family or friends or hospitalization may be needed.
- Consider high-risk groups, for example older people, men, those with physical illness, substance abuse, a family history of suicide and those who have previously demonstrated self-harm.
- Identify current life problems or social stresses, including precipitating factors. Focus on small, specific steps patients might take towards reducing or improving management of these problems. Avoid major decisions or life changes (see Solving problems and achieving goals).

- Plan short-term activities which give the patient enjoyment or build confidence. Exercise may be helpful (ref 73)
- If appropriate, advise reduction in caffeine intake (ref 74) and drug and alcohol use (ref 75)
- Support the development of good sleep patterns and encourage a balanced diet (ref 76)
- Encourage patient to resist pessimism and self-criticism, not to act on pessimistic ideas (eg ending a marriage or leaving a job), and not to concentrate on negative or guilty thoughts.
- If physical symptoms are present, discuss the link between these and mood (see Unexplained somatic symptoms - F45).
- Involve the patient in discussing the advantages and disadvantages of available treatments. Inform them that medication usually works more quickly than psychotherapies (ref 77,78). Arrange another appointment to monitor progress one to two later, whether or not on medication.
- After improvement, plan with the patient the action to be taken if signs of relapse occur.
- Patients might find it helpful to keep a mood diary, rating mood changes between 1 and 10 and noting down any external influencing factors. This can be practically useful in identifying patterns.

References

72 NICE will publish a guideline on the management of depression in February 2004.

73 Lawlor DA, Hopker SW. The effectiveness of exercise as an intervention in the management of depression: systematic review and meta-regression analysis of randomised controlled trials. Br Med J 2001, 322: 763-767. (BI) Fourteen studies were analysed. The effectiveness of exercise in reducing symptoms of depression cannot be determined because of a lack of good-quality research on clinical populations with adequate follow-up.

74 Greden JF. Anxiety or caffeinism: a diagnosis dilemma. Am J Psychiatry 1974, 131: 1089-1092. (AV)

75 Schuckit M. Alcohol and major depressive disorder: a clinical perspective. Acta Psychiatrica Scand 1994, 377: 28-32. (AIV)

76 Wallin M, Rissanen A. Food and mood: relationship between food, serotonin and affective disorders. Acta Psychiatr Scand 1994, 377(Suppl): 36-40. (CV) Quoted in Guidelines for the Treatment and Management of Depression by Primary Health Care Professionals. National Health Committee of New Zealand, 1996.

77 Schulberg H, Katon W, Simon G, Rush AJ. Best clinical practice: guidelines for managing major depression in primary care. J Clin Psychiatry 1999, 60(Suppl 7): 19-24. (BII) The authors conclude that recovery rates for an acute episode of major depression in primary care are similar for guideline-driven pharmacotherapy and depression-specific psychotherapies, such as interpersonal therapy and problem-solving treatments. Medication takes four to six weeks to show effect and psychotherapies six to eight weeks. Another conclusion from this paper is that recent randomized controlled trials conducted in primary care show a 50-60% response rate to all classes of antidepressants in primary-care patients.

78 Lave J, Frank R, Schulberg H, Kamlet M. Cost-effectiveness of treatments for major depression in primary-care practice. Arch Gen Psychiatry 1998, 55(7): 645-51. (BII) The authors describe a high-quality randomized control trial comparing standardized treatment by nortriptyline, interpersonal psychotherapy and primary physician's usual care (n >90 for each group) for major

depression in primary care. Both standardized therapies were better than usual care, and more expensive. Those taking drugs did slightly better with respect to both quality of life and economic outcomes.

Medication

(ref 72)

Consider antidepressant drugs if sad mood or loss of interest are prominent for at least two weeks, preferably four weeks, and if four weeks or more of the following symptoms are present (every day for most of the day), accompanied by significant impairment of functioning:

- fatigue or loss of energy
- disturbed sleep
- guilt or self-reproach
- poor concentration
- thoughts of death or suicide
- disturbed appetite
- agitation or slowing of movement and speech.

There is no evidence that people with recent onset of only few or very mild depressive symptoms respond to antidepressants (ref 79). There is evidence that persistent mild depression, lasting two years or more, responds to antidepressants (ref 55).

Consider delaying medication until the second or subsequent visit because there is a high rate of spontaneous recovery (see again within a week to reassess).

There is no evidence to suggest that any antidepressant is more effective than others; (ref 77, 80) however, their side-effect profiles differ, and therefore some drugs will be more acceptable to particular patients than others (BNF section 4.3).

Choice of medication:

- If the patient has responded well to a particular drug in the past, use that drug again.
- If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side-effects.
- If the patient is suicidal, avoid tricyclics and consider dispensing a few days' supply at a time.
- If the patient is anxious or unable to sleep, use a drug with more sedative effects, but warn of drowsiness and problems driving.
- If the patient is unwilling to give up alcohol, choose one of the SSRI antidepressants that do not interact with alcohol (eg fluoxetine, paroxetine and citalopram; BNF section 4.3.3).

Explain to the patient that:

- the medication must be taken every day (poor adherence is very common, particularly in pregnancy and breastfeeding);
- the drug is not addictive in that higher and higher doses are not required, but withdrawal symptoms may occur if drugs are stopped suddenly;
- improvement in mood will start two to three weeks after starting the medication;

- side-effects occur from the beginning but usually fade in seven to ten days with SSRIs; they may be more persistent with tricyclic antidepressants;
- individuals vary in their reaction to different drugs, including absorption time, which will influence the appropriateness and timing of taking drugs with a sedative profile.
- Stress that the patient should consult the doctor before stopping the medication. The drug should never be stopped abruptly (withdrawal symptoms may then occur). All antidepressants should be withdrawn slowly, preferably over 4 weeks in weekly decrements.

Continue full-dose antidepressant medication for at least four to six months after the condition improves to prevent relapse (ref 81,82). Review regularly - at least monthly - during this time to monitor response, side-effects and adherence. Consider, jointly with the patient, the need for further continuation beyond four to six months. If the patient has had several episodes of major depression, consider carefully long-term, prophylactic treatment (ref 83). Obtain a second opinion at this point.

If sleep problems are very severe, consider a sedative antidepressant, for example a tricyclic.

If using tricyclic medication, build up over seven to ten days to the effective dose (eg dothiepin: start at 50-75 mg and build to 150 mg nocte; or imipramine: start at 25-50 mg each night and build to 100-150 mg) (ref 84). It is reasonable to treat with doses of between 75 and 100 mg a day if the patient is responding (ref 85).

Withdraw antidepressant medication slowly, and monitor for withdrawal reactions and to ensure remission is stable. Gradual reduction of SSRIs can be achieved by using syrup in reducing doses or taking a tablet on alternate days.

Hypericum perforata (known as St John's Wort and available from health food stores) is efficacious for mild to moderate symptoms of depression, both acute and chronic, but not significant major depression (ref 86). GPs should enquire whether patient is taking St John's Wort because it is widely available and might interact with prescribed medication and diet (eg oral contraceptives, warfarin). (ref 87-89) Over-the-counter formulations are very variable in dosage.

References

55 Lima M, Moncrieff J. Drugs versus placebo for the treatment of dysthymia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI). Fifteen studies were looked at. There is some evidence of efficacy of most antidepressants in dysthymia (chronic, mild depressive syndrome) that has been present for at least 2 years.

72 NICE will publish a guideline on the management of depression in February 2004.

81a Prien R, Kupfer D. Continuation drug therapy for major depressive episodes: how long should it be maintained? Am J Psychiatry 1986, 143: 18-23. (BII) The authors conclude that patients treated for a first episode of uncomplicated depression, who respond well to an antidepressant, should receive a full therapeutic dose for at least 16-20 weeks after achieving full remission.

81b A Cochrane Review will soon be available. Carney S, Geddes JR, Furukawa T et al. Duration of treatment with antidepressants in depressive disorder (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Issue 4, 2003.

82a Reimherr F, Amsterdam J, Quitkin F et al. Optimal length of continuation therapy in depression: a prospective assessment during long-term fluoxetine treatment. Am J Psychiatry 1998, 155: 1247-1253. (BIII)

82b A Cochrane Review will soon be available. Cipriani A, Brambilla P, Barbui C, Hotopf M. Fluoxetine versus other types of pharmacotherapy for depression (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Issue 4, 2003.

83 Kupfer D, Frank E, Perel J et al. Five-year outcomes for maintenance therapy: possible mechanisms and treatments. J Clin Psychiatry 1998, 59: 279-288. 260 References 05-WHO-(Refs)-resize-cpp 19/1/2004 2:33 pm Page 260 This is a study carried out by psychiatric patients. There are no comparable clinical trials of the efficacy of maintenance treatment in reducing recurrence of depression in primary care.

84 Donoghue J. Sub-optimal use of tricyclic antidepressants in primary care: Editorial. Acta Psychiatrica Scand 1998, 98(6): 429-431. (CV)

85 Furukawa TA, McGuire H, Barbui C. Meta-analysis of effects and side-effects of low dosage tricyclic antidepressants in depression: systematic review. Br Med J 2002, 325: 991-995. (AI) Treatment of depression in adults with low dose tricyclics is justified.

85b A Cochrane Review will soon be available. Furukawa T, McGuire H, Barbui C. Low dosage tricyclic antidepressants for depression (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

86 Linde K, Mulrow CD. St John's wort for depression (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Twenty-seven studies were analysed. St John's Wort demonstrated beneficial effects in mild and moderate depressive disorders. St John's Wort extracts have fewer short-term side-effects than older antidepressants; however, the preparations available on the market could vary considerably in their pharmaceutical quality.

87 Thiede HM, Walper A. Inhibition of MAO and CoMT by Hypericum extracts and hypericin. J Geriat Psychiatr Neurol 1994, 7(Suppl 1): S54-S56.

88 Interactions with tyramine-containing foods (eg beans, some cheeses, yeast, bovril, bananas, pickled herrings), are theoretically possible. However, there is, to date, an absence of spontaneous reports of these problems occurring.

89 Izzo AA, Ernst E. Interactions between herbal medicines and prescribed drugs: a systematic review. Drugs 2001, 15: 2163-75. (BIII) Interactions between herbal medicines and synthetic drugs exist and can have serious clinical consequences. Healthcare professionals should ask their patients about the use of herbal products and consider the possibility of herb-drug interactions.

Referral

The following structured therapies, delivered by appropriately trained practitioners, are effective for some people with depression: (ref 90)

- Cognitive behavioural therapy (CBT)
- Behaviour therapy
- Interpersonal therapy
- Structured problem-solving.

Patients with chronic, relapsing depression might benefit more from CBT or a combination of CBT and antidepressants than from medication alone (ref 91, 92). Counselling might be helpful, especially in milder cases and if focused on specific psychosocial problems related to the depression (eg relationships, bereavement) (ref 14). In the short term, it may have some advantages over normal GP care and patients like it, but after 12 weeks there are no benefits (ref 14).

Referral to secondary mental health services is advised:

- as an emergency if there is a significant risk of suicide or danger to others, psychotic symptoms or severe agitation
- as a non-emergency, if significant depression persists despite treatment in primary care. (Antidepressant therapy has failed if the patient remains symptomatic after a full course of treatment at an adequate dosage. If there is no clear improvement after four weeks with the first drug, it should be changed to another class of drug.)

If drug or alcohol misuse is also a problem, see guidelines for these disorders.

Recommend voluntary/non-statutory services in all other cases where symptoms persist, where the patient has a poor or non-existent support network, or where social or relationship problems are contributing to the depression (ref 93).

References

14a Roth AD, Fonagy P. What Works For Whom? A Critical Review of Psychotherapy Research. New York: Guilford Press, 1996. (CII) The efficacy of counselling in primary-care settings is difficult to assess because of the methodological problems of available research. It seems more appropriate for milder presentations of disorders, however, than for more severe presentations, and evidence is better for counselling focused on a particular client group (eg relationship or bereavement counselling).

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each other, none appears clearly superior to the others. More variance in outcomes may be due to the strength of the therapeutic relationship, rather than to the treatment method used. Problem-solving is the easiest therapy to learn and can be provided by GPs and primary-care nurses. Brief cognitive behaviour therapy is difficult to deliver, even using trained therapists (Scott J. Editorial: Psychological treatments for depression - an update. Br J Psychiatry 1995, 167: 289-292). Evidence for the effectiveness of therapies in depression in primary care tends to be weaker than in major depressive disorder in secondary care.

91a Thase M, Greenhouse J, Frank E et al. Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. Arch Gen Psychiatry 1997, 54: 1009-1015. (CIV) Combined therapy was not significantly more effective than psychotherapy alone in patients with milder depression; a highly significant advantage was observed in more severe recurrent depressions. Poorer outcomes were also observed in women and older patients.

91b A Cochrane Review will soon be available. Churchill R, Wessely S, Lewis G. Combinations of pharmacotherapy and psychotherapy for depression (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

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93 Ostler KJ, Thompson C, Kinmonth ALK et al. Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care: the Hampshire Depression Project. Br J Psychiatry 2001, 178(1): 12-17. The authors show a strong link between high indices of deprivation and poor prognosis for depression in primary care.

Resources for patients and families

Solving problems and achieving goals

Depression

Dealing with depressive thinking

Depression Alliance http://www.depressionalliance.org
England: 020 8768 0123
Wales: 029 2069 2891 (10am-4pm, Monday-Friday)
Scotland: 0131 467 3050
Provides information and self-help groups.

Aware Defeat Depression Ltd 02871 260602
Email: info@aware-ni.org; website: http://www/aware-ni.org
Provides information leaflets, lectures and runs support groups for sufferers and relatives.

Samaritans 08457 909090 (24-hr helpline)
Email: jo@samaritans.org; website: http://www.samaritans.org.uk
Offers confidential emotional support to any person who is despairing or suicidal.

Calm 0800 585858 (helpline 5pm-3am)
Helpline for young men who are depressed or suicidal.

SAD (Seasonal Affective Disorder) Association 01903 814942
Website: http://www.sada.org.uk
Information about seasonal affective disorder (SAD). Offers advice and support to members.

UK Register of Counsellors 01788 568739
Provides a list of BAC-accredited counsellors.

Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk): Antidepressants, Depression

The Mental Health Foundation produces the information booklet All About Depression. Publications, The Mental Health Foundation, 7th Floor, 83 Victoria Street, London SW1H 0HW UK. Tel: 7802 0304. website: http://www.mentalhealth.org.uk.

Overcoming Depression by Paul Gilbert. Constable & Robinson, 2000
Self-help book.

Overcoming Depression by Chris Williams. Arnold Publishing, 2001
Self-help book (also available as a CD-ROM; see below).

Mind over Mood by Dennis Greenberger and Christine Padesky. New York, Guilford Press, 1995
Self-help manual designed to be used as an adjunct to therapy (a clinician's guide is also available).

The Feeling Good Handbook by David D Burns. Avon Books, 1989
A self-help manual.

Depression – the Way Out of your Prison, 2nd edn by Dorothy Rowe. London: Routledge, 1996
An explanatory book.

Coping with Depression. Talking Life, 1A Grosvenor Rd, Hoylake, Wirral CH47 3BS, UK. Tel: 0151 632 0662 http://www.talkinglife.co.uk
Tape programme, produced with The Royal College of Psychiatrists' Defeat Depression initiative, describes strategies for coping with all types of depression using cognitive techniques.

Overcoming Depression. University of Leeds Media Innovations Ltd, 3 Gemini Business Park, Sheepscar Way, Leeds LS7 3JB, UK. Tel: 0113 262 1600; website: http://www.calipso.co.uk
A CD-ROM self-help package.

Beating the Blues. Ultrasis UK Ltd, 4th Floor, 13/17 Long Lane, London EC1A 9PN. Tel: 020 7600 6777; website: http://www.ultrasis.com

Interactive multi-media programme designed for use in primary care setting, with practitioner assessment and progress review each week.