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Depressive Illness

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The word depression is being used to describe both a symptom and an illness. The symptom is the experience of gloom, despondency, sadness, grief; the feeling of being run down, dispirited, miserable, melancholic, in the dumps, or of being low. The richness of our language in synonyms for depression may be taken as an indication of its frequency. It is an emotional experience, though sometimes it is described as an emptiness or flatness, seemingly a loss rather than a lowering of affect.

Depression, like anxiety, is a universal experience, and we regard it as abnormal only if it appears without reason or if it seems excessive in its degree or duration in relation to the provocation. Not surprisingly such a common feeling may be associated with any psychiatric syndrome; the depressive disorders are those in which the depressed affect appears to be the primary phenomenon or at any rate one of the more prominent of the clinical features.

Broadly there are two depressive entities—endogenous depression, which is a variant of manic-depressive illness, and neurotic depression. In practice the differentiation of these two conditions is often difficult, but this is not surprising when we recall that any primary psychiatric disturbance may be associated with secondary or reactive features, and of these depression is one of the more common. A convenient though over-simplified view that attempts to quantify this relationship suggests that in any individual case we can regard the patient as showing say—to give an example—40% endogenous and 60% reactive or neurotic depression. If so, one should not forget that irrespective of the magnitude of the figures it is the endogenous component that is important, for the remainder is a reaction to it. Successful treatment of the endogenous component is likely to lead to total recovery, whereas treatment directed only at the reactive component can hardly be more than partly successful. The term "atypical depression" has been applied to some of these cases.

It is only in the last 10 or 15 years we have come to appreciate how common is depressive illness. Watts[1] estimated that in general practice one could expect that of every 1,000 patients 12 would present as new cases each year. Older figures, largely hospital derived and therefore making little allowance for milder cases, suggest that the incidence of endogenous depression alone is 1% in males and 2% in females. It would be unwise to suggest that depressive illness has become more common in the last 10 years; the much larger number of cases seen reflects the fact that we have learned to recognize its milder forms.

Endogenous Depression

Let us take endogenous depression first. Though less common and less likely to be overlooked, the more severe cases will be described first. The onset is usually gradual, the patient often looks ill, his skin may be sallow and dry, the hair lustreless, and the eyes dull. The facial expression and indeed the whole posture may express misery. There are two broad ways in which the patient may present, depending on the relative preponderance of psychomotor retardation and agitation. When retardation is extreme the patient is stuporous, mute, and in need of constant nursing care; when less severe, the patient performs slowly, and the increased sense of effort is obvious. The agitated patient is restless, unable to sit or settle, and indulges in continuous purposeless activity. The retarded patient speaks slowly with obvious effort and has difficulty in self-expression; the agitated patient, on the other hand, may be voluble perhaps to the point of incoherence.

The content of the patient's talk displays his restriction of interests and his preoccupation with his illness. Depressive ideas of guilt, self reproach, and unworthiness are common, and overconcern with personal idiosyncrasies, spiritual matters, or with physical or psychological problems may form the basis of delusionary beliefs. These sometimes take on a markedly paranoid colouring. Sleep is almost always disturbed, the patient typically waking early; initial insomnia and broken sleep are also quite common. An occasional patient will experience hypersomnia.

Even though the word depression may not be used by the patient and he may complain of apathy and loss of feeling, observation alone in these severe cases confirms his despondency, sadness, or despair. In many patients the depression shows a clear diurnal variation, being at its worst in the mornings and improving later in the day, so that the evenings may be more or less tolerable. The depression may show some reaction to the surroundings, but commonly it is relatively unaffected by environmental events. In the agitated patient anxiety symptoms may dominate the clinical picture; unremitting feelings of tension with their usual physical concomitants such as palpitations, headaches, and loss of appetite are common, but the anxiety may be expressed in episodic form, including panic attacks and phobias. Weariness and fatigue are almost invariable. Amenorrhoea is frequent, and sexual desire is commonly diminished. Fears of disease are common, particularly when somatic anxiety manifestations are prominent, and hypochondriacal preoccupation with aches and pains and bowel or menstrual function may lead to the conviction that the patient is suffering from cancer, heart disease, or hypertension. Other patients express fears of insanity or intellectual deterioration. Secondary hysterical features may occur in association with hypochondriasis leading to an invalid reaction.

In depressive illness there are, of course, no cognitive or intellectual changes, though these may be suspected because a patient emphasizes difficulty in concentration and consequent failure of recent memory.

In many of these patients there will be a history of similar previous episodes coming on without reason and terminating either spontaneously or in response to anti-depressant treatment. In perhaps 5% there will be a history of one or more attacks of mania.

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Mild Cases

Many mild cases of endogenous depression never seek medical help—many indeed never appreciate that they are ill. For the period of the illness its sufferer continues his normal existence with a decreased sense of enjoyment, an increased sense of effort, and perhaps some reduction in efficiency. Occasionally the sufferer attracts attention by committing suicide, to the surprise even of his close associates.

Many such patients, however, do attend their general practitioners, though they frequently fail to mention the word depression. Capstick[2] investigated coroners' records of 881 patients who committed suicide and found that 78.2% had consulted their general practitioners within a month of their deaths, though in few was it suspected that they were depressed. Outwardly such a patient may appear and behave normally, though those who know him well may appreciate that he is avoiding his friends, minimizing his social contacts, and seems disinterested in sport, his family, and television. When questioned he may emphasize somatic disturbances and complain of headache, a pain in the chest or back, of giddiness, or of dyspepsia. In the majority of cases tiredness, loss of energy, or fatigue is prominent, and it is worth remembering that malaise—the feeling of being run down—is seldom an early symptom of a physical disease in the absence of other features of the condition. It is such patients who stress somatic features without emphasizing their psychological turmoil that constitute the group regarded as suffering from "masked depression." In most cases it is not the illness that is masked but the doctor who is blind. The doctor who is sensitive to the existence and frequency of depressive illness seldom has difficulty after phrasing the appropriate questions in establishing the depressed mood of such patients. Nevertheless, it is well worth remembering that the patient's spouse may prove a vital informant and should always be interviewed if there is any doubt. Any of the symptoms shown by the severely depressed patient may be evident in milder form.

Neurotic Depression

Whereas there is a note of surprise about an attack of endogenous depression, neurotic depression seems less foreign to the individual—a development that seems appropriate to him and his circumstances. Here, perhaps, is the great advantage possessed by the general practitioner over his hospital colleagues. He knows the patient and his family and is in a much better position to appreciate such subtleties. The onset is more likely to be abrupt, with an evident relationship to some situation which is stressful for that particular patient.

The earlier history of the patient provides evidence of the vulnerability of his personality. In childhood, shyness, timidity, and phobias may have been prominent, and the stresses of everyday life may have proved impossible to absorb and to have provoked undue anxiety or depression. The illness is generally much more variable and responsive to environmental factors than endogenous depression. The patient can brighten up if things seem hopeful, but is readily tilted into gloom if circumstances become adverse. Good days and bad days are a feature of the history.

The quality of the depression experienced by the neurotic patient is often more akin to normal sadness or grief than is the emotional experience of the endogenously depressed patient. It tends to be aggravated by the vicissitudes of the day and to be at its worst in the evenings. Though generally mild to moderate in degree, the depression may in occasional patients be severe. The mood of the patient tends to reflect self-pity rather than self-blame or guilt. Initial insomnia is the common form of sleep disturbance. Anxiety is often prominent and is associated with poor concentration and fatigue. Suicidal ideas and both attempted and successful suicide are common, and certainly the belief that the depression is "only" neurotic should not engender any false optimism.

Suicide

In England and Wales and in Australia the suicide rate is around 12 per 100,000. The real figure may well be twice as high, since it is not always easy for coroners to differentiate suicide from accident, and not surprisingly when there is doubt a verdict of suicide is avoided. The frequency of attempted suicide is at least eight to ten times as high. A relationship between a large number of social factors and suicide has been made evident as the result of epidemiological studies. Social class, the nature of employment, geography, race, and the degree of social disorganization exert subtle influences on the individual decision to kill oneself ; but though the determinants of suicide are always multiple and complex, in the majority of patients mental illness is of the utmost importance. Though depression is not the only psychiatric disorder associated with suicide it is unquestionably the most important.

Important epidemiological differences between those who commit and those who attempt suicide have been demonstrated.[3] Successful suicide is most common in elderly males, whereas attempted suicide is most frequent in females, particularly in the middle age group. Nevertheless, in the present context, in which we are concerned with the individual patient, the similarities are more important than the differences. Both in those attempting and those succeeding in suicide the same social factors and the same psychiatric disorders play their interacting parts.

It is often apparent from the patient's history—his sense of unworthiness and guilt, his loss of interest, and his general air of despondency—that suicidal ideas are entertained ; some patients state bluntly that they wish they were dead. Should doubt remain there is no difficulty in establishing the fact ; one just has to ask. There need be no fear that one will put ideas into the patient's head—the ideas are there already. Naturally there is no need to be too blunt about it. The question should be put gently and sympathetically. Some such query as, "Do you sometimes feel life is not worth living ?" is a useful beginning, and it is seldom necessary to be more pointed. Mapother once said, "There is a maxim to be discredited: those who talk of suicide never commit it." This is evident from the study reported by Capstick[2] in which 10% of those who committed suicide had made direct threats while 70% gave covert hints either to their doctors or their families. Any warning from the patient—a direct threat, a half-expressed suggestion, or even a suggestive form of behaviour—should always be taken seriously. The precise diagnosis is relatively unimportant, for the incidence of suicide and attempted suicide does not seem very different in endogenous or in neurotic depression.

The recognition of the protean presentations of depression is the most important way we can help to prevent suicide ; and it is well to recognize that certain groups of individuals such as the elderly, those living on their own, and those recently bereaved are especially at risk.

Differential Diagnosis

The distinction between endogenous and neurotic depression may have had sufficient emphasis ; a list of the features favouring the diagnosis of endogenous depression includes: good previous personality, age over 40 years, gradual onset, lack of precipitants, unresponsive depression, quality of depression different from normal grief or sadness, ideas or delusions of guilt or self-depreciation, lack of self-pity, morning aggravation of symptoms, early morning waking, and weight loss greater than 7 lb. (3.2 kg.).

As a group the depressive states show problems in differential diagnosis. Severe depression may create the illusion of advanced malignancy or Parkinsonism, while the patient who emphasizes somatic symptoms may be regarded as having primary disease of his cardiovascular, musculo-skeletal, alimen-

tary, or genito-urinary systems, according to the precise nature of his complaints.

Dementia may be simulated when poor concentration, forgetfulness, and general neglect are prominent. Before a diagnosis of dementia is made the possibility of depression is always worth considering. The reverse situation, in which structural disease of the nervous system presents with depression, also occurs, but with the exception of arteriosclerotic dementia it is rare. Certainly there is no justification for extensive neurological investigation unless there is some clear indication in the history or physical examination of the possibility of a neurological lesion.

Metabolic disturbances of the central nervous system are more common. Depression may be an early symptom of vitamin B_{12} deficiency or myxoedema, but far more frequently results from drugs, not infrequently self-prescribed. Barbiturates and bromides are particular offenders which the patient may take unknown to his doctor. The antihypertensive agents —particularly reserpine and methyldopa—are common culprits, and the possibility of depression as a side-effect should be borne in mind whenever they are prescribed.

Early schizophrenia may present with depression, and the distinction may be hard to make, especially in the middle-aged or elderly patient. Sooner or later a bizarre quality, with some incongruity or lability of affect and other florid schizophrenic features, may become apparent, but many such patients are regarded as depressives during the early episodes of their illness.

Treatment

When the diagnosis of a depressive state is made three interrelated decisions have to be made.

(1) Can the patient be reasonably treated by a general practitioner or should the case be referred for specialist care ?

(2) Is hospital admission required ?

(3) Is the patient suicidal ?

The great majority of cases can readily be treated by general practitioners, and indeed their numbers are such that there is no alternative. Immediate referral to a consultant psychiatrist or even to a psychiatric hospital is generally advisable if the patient has strong suicidal ideas or has made a suicidal attempt. Severe agitation, obvious retardation, delusionary ideas of guilt or unworthiness, and severe loss of weight are other indications. Failure to respond to adequate doses of one of the antidepressant drugs over a period of say three weeks also makes referral advisable.

It is worth bearing in mind that occupation plays an important role in the hospital treatment of the depressed patient and is just as necessary if the patient remains at home. Much will depend on the nature of his normal employment, but in many cases it is advisable for the patient to continue at work, and there is certainly no virtue and indeed may be considerable danger in insisting that the patient remains at home, particularly if he will be alone for long periods. On the other hand, it is equally important to avoid overburdening the patient with an endless succession of social activities in the mistaken belief that this will take his mind off his problems. Nor is the advice to take a holiday or go on a cruise—advice so often given—particularly helpful, except perhaps in some of the milder cases where reactive factors are of major importance.

Neurotic Depression

In the treatment of neurotic depression, where social difficulties and environmental influences are so prominent, psychotherapy has a valuable place. It is seldom necessary to resort to more than superficial methods. Symptomatic treatment may be indicated for such features as anxiety and insomnia, but if there is any likelihood that these will not resolve quickly the danger of drug dependence should be weighed carefully against the short-term benefit that these drugs confer. If it is likely that the symptoms will be long continuing and that there will be difficulty in withdrawing the drugs it is better not to prescribe them at all. Drug treatment of the depressive symptom is equally unsatisfactory. The stimulants such as the amphetamines may have remarkable short-term effects, but the danger of drug dependence is so great that their administration is seldom justified. The antidepressant drugs, both of the monoamine oxidase and the tricyclic series, are relatively ineffective in this variety of depression, and should a patient respond it is more likely to indicate that a mistake has been made in the diagnosis or that natural history has played a beneficial role. Electric convulsion therapy is contraindicated in neurotic depression.

Endogenous Depression

It should be borne in mind and impressed on the patient that an attack of endogenous depression is generally a self-limiting condition. Superficial forms of psychotherapy, as in all illnesses, are helpful, but more formal and time-consuming techniques are contraindicated. The use of sedatives may be justifiable on a short-term basis, but the amphetamines are almost always contraindicated because by decreasing lethargy and psychomotor retardation they may increase the risk of suicide.

It is worth making an effort to avoid giving E.C.T., as this commonly necessitates admission to hospital for a period of at least three weeks followed by a further three weeks off work while the memory disturbance improves. The indications for immediate E.C.T. are similar to those given for admission to hospital. If it is decided that ambulant treatment is justified one must choose between two series of drugs—the monoamine oxidase inhibitors and the tricyclic compounds. The latter are the more effective and safer drugs, but unfortunately they are less pleasant to take. The details of treatment with these substances were given in an article "Treatment of Depression" in the series *Today's Drugs* published on 20 April, 1968, p. 164. In the case of the tricyclic compounds the traditional one tablet three times a day is seldom an adequate dose for the treatment of endogenous depression. A response may be obtained with a dosage of 50 mg. t.d.s., but it is often necessary to prescribe 200–250 mg. a day.

Many studies have been published drawing attention to the fact that patients do not always take their tablets. In a study of outpatients treated with imipramine nearly half were shown not to be taking their tablets ; a high proportion of these continued to insist that they were when faced with the results of urinary tests.[4] In most cases improvement occurs about 10 to 14 days after starting treatment. The same dose should be continued for several weeks and then gradually diminished over a period of three or four months. If at any time symptoms return a higher dose should be given. Unfortunately there is no way of telling when the drug may be safely stopped except to reduce the dosage and see what happens. It is probable that the drugs merely control the illness until a natural remission is due.

Failure of the episode of depression to respond to drug treatment is not necessarily an indication for E.C.T. In many of the milder cases and those that have made a partial response to drug treatment the disturbance created by E.C.T. is simply not worth while. In each case the advantages and disadvantages must be weighed against the individual needs and suffering of the particular patient being treated.

References

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