REVIEW ARTICLE

Depression in general practice

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The object of this study is to increase the general practitioner's awareness of the prevalence of depression, its multifaceted presentation in all age groups and the concomitant danger of suicide. It highlights the vital role the general practitioner can play in the early diagnosis and adequate treatment of this disorder.

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Approximately 80% of people who successfully commit suicide have consulted a medical practitioner in the month prior to their death.[1] In some studies the risk of suicide is reported to be high in the first week following assessment of a patient's depression. In one study 42% of suicides were found to have consulted their general practitioner or psychiatrist within a week of their death, with half of these having made a clear-cut threat.[2] What does this statistic show? Are doctors failing to recognise and treat depression and the possible consequences?

Frequency

Most persons with emotional disorders are evaluated and treated by primary health care physicians rather than mental health professionals: one study found that only 17% of patients were referred to a psychiatrist.[3] In another study conducted in Italy the 1-day prevalence figure for general practitioner referral to specialist psychiatric services was 7,3%.[4] Furthermore, an estimated 25 - 75% of patients in primary care settings have psychosocial rather than biomedical reasons for their visits.[5] Major depression is one of the most common of psychiatric disorders, with a lifetime prevalence of approximately 6% in the USA.[6]

Presentation

General practitioners tend to view depression from a different perspective to that of a psychiatrist because they usually see patients in the early stages of the illness, before the full clinical picture has emerged, and in most of their patients the depression is a relatively transient disorder. Moreover, the relationship of general practitioners with their patients is continuous, and often involves the patients' families. Thus, general practitioners are able to relate other aspects of patients' lives to their condition more easily than psychiatrists. This dimension provides important advantages for the general practitioner where treatment is concerned.[7]

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Patients do present to their general practitioners with classic signs and symptoms of depression, but more frequently the depression is hidden and they present with a variety of somatic complaints. Risk factors for depression are listed in Table I.

Table I. Risk factors for depression

Poor physical health	Drug and/or alcohol abuse
Females	Schizophrenia
Chronic disease	Major loss
Malignant disease	Positive family history
Old age	Trauma in childhood
AIDS	Lower socio-economic groups[8]

Depressed patients in medical settings may focus on the somatic complaints accompanying the mood disorder, which may lead to unnecessary tests and medications, occasional iatrogenic morbidity, and a high rate of dissatisfaction in both patient and physician as a result of poor response.[5] About one half of all patients with depression seen by primary care physicians initially present predominantly or exclusively with somatic symptoms. Many of these depressions are not recognised or are misdiagnosed and mistreated. The proportion of depressions that are masked is positively correlated to the patient's tendency to somatise and negatively correlated to the doctor's ability to recognise depressions that present with somatic complaints.[9]

Presentation of depression varies in different cultures and it is not easily recognised in a person with a different cultural background. For instance, depressive illness in black patients presents somewhat differently from the usual pattern. In particular physical symptoms, anxiety symptoms and florid behavioural disturbances are important presenting features.[10]

General practitioners need to be alert to the presentation of ill-defined symptoms without a demonstrable physical basis. For example, dyspepsia, dizziness, bowel dysfunction, hyperventilation, and persistent unexplained pain such as headache or abdominal pain, may be manifestations of depression.

If a child is repeatedly brought to the surgery for minor complaints this may in fact be due to a depressive illness of the parent. The apparently demented elderly man found wandering and confused in the road, the 35-year-old man with recurrent chest pain and no underlying physical cause, and the child who refuses to go to school, may in fact all be depressed. Skill is required to recognise the underlying depression in such cases.[11] Table II lists some other presentations.

Grief can occur as a result of a variety of losses: loss of a spouse, a friend, a job or loss of status. The loss may have been recent, but can often be a long-standing problem such as a difficult marriage or previous child abuse. Because grief reactions may develop into depressive reactions or pathological mourning, specific counselling sessions for those who have suffered a loss are essential.[8]

Anniversaries are classic times for heightened feelings of depression; birthdays, memorial days and Christmas need to be considered. The family physician is ideally suited to handle this as he has knowledge of the entire family, and the community in which the family lives.

Table II. Some presentations in general practice

Children	Adolescents
Problems of insecurity	Substance abuse
School phobia	Antisocial behaviour
Encopresis/enuresis	Truancy
Disinterest in play	Sexual promiscuity
Recurrent abdominal pains	Poor academic performance
Anorexia	Running away from home
Withdrawal from friends	Withdrawal from the family
Adults	**Elderly**
Headache	Social withdrawal
Menstrual problems	Unexplained weight loss
Loss of libido	Confusion
Insomnia	Pseudodementia
Co-morbid anxiety	Lack of adaption/
Pain of unknown origin	maladjustment
Fatigue	Difficult patient

Other support systems may be needed to alleviate the severity of the depression. These include family, friends, co-workers, members of the church or other support groups.[11] A healthy family system can be as good a support system as any hospital.[12]

Suicide and depression

In any assessment of depression it is essential to consider the risk of suicide. Women are more likely to attempt suicide, although men, particularly the elderly, are more likely to succeed. Suicide in children is rare but is now the second leading cause of death in adolescents.[8]

Patients with suicidal ideation or behaviour do not often volunteer such thoughts. The general practitioner must actively seek out information, with the necessary finesse, from each patient to assess the individual risk.

The following supportive measures reduce suicide risk in major depression: (*i*) ensure that the patient is not left alone; (*ii*) medication should be in the hands of a reliable relative or friend; (*iii*) the role of the doctor should be supportive, firm and optimistic; (*iv*) express confidence that treatment will succeed; (*v*) explain that treatment takes some time; (*vi*) explain that the patient may initially feel worse before the medication takes effect.[13]

Treatment of depression

Pérez-Stable and colleagues[5] report the following important and disturbing finding: a significant percentage of primary care physicians fail to detect and diagnose major depression in their patients (up to 50%); in addition, the fact that benzodiazepines or analgesics have been prescribed implies that the diagnosis has been missed. Even more disturbing is the fact that many psychiatrists — who, it may be assumed, treat the most seriously ill patients — also underdiagnose and undertreat major depression. Finally, and rather sadly, even when they suspect a psychiatric disorder many clinicians are not confident of their ability to make psychiatric assessments.[14,15]

In the final instance, the ability of primary care physicians to recognise and institute adequate and appropriate treatment is important since only 20% of persons suffering from depression are treated by mental health professionals.[5]

Before planning a treatment programme it is essential to make a diagnosis. The classification system of the *DSM-IV*[16]

is a practical choice because it has clear-cut diagnostic criteria and supports the multifactorial pathogenesis of psychiatric disorders. To improve compliance, both the patients and their families should clearly understand the pathogenesis and pathophysiology of the depression.[12]

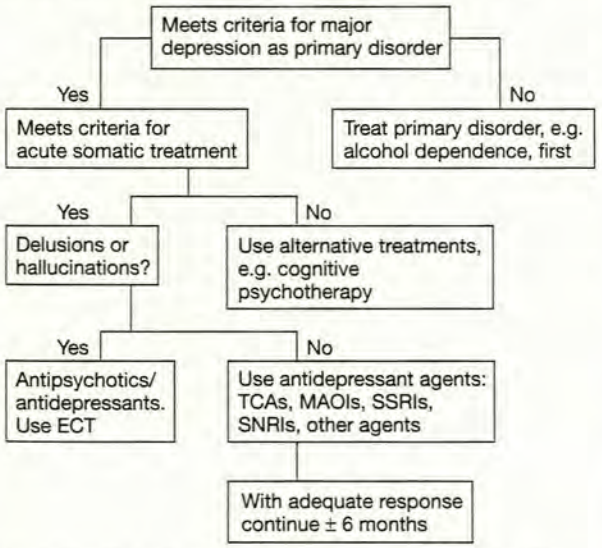
Initial management of depression includes assessment of the severity of the illness, the risk of suicide, and whether specialist referral or even inpatient treatment is required.

It is very important to offer a listening ear. Most depressed patients will have interpersonal, social or occupational problems. It is imperative that they have an opportunity to discuss these with someone who is uninvolved but empathetic. The most neglected aspect of treatment is that of spending sufficient time with the patient.[7]

There are a variety of approaches, including counselling, which involves listening, talking and explaining, and short- and long-term psychotherapy. Others include relaxation therapy, assertiveness training, rational emotive therapy, cognitive behavioural therapy and medication.

The family doctor is ideally situated to use a psychotherapeutic approach, and those who do so bring to the therapy a knowledge of the patient's family and environment. Thus, if family doctors provide the necessary support they give a very positive and hopeful message to their patients. Cognitive therapy has been shown to be effective in the management of depression. It would be unreasonable to expect the general practitioner to have either the time or the skill to offer comprehensive cognitive therapy. However, it is possible to incorporate the broad principles of this approach into the treatment programme. Depressed individuals tend to be negative rather than positive, pessimistic rather than optimistic, and tend to underestimate their abilities and achievements. Every effort should be made during the interview to change these false or irrational perceptions.

Unquestionably, the cornerstone of the treatment of depression is a specific antidepressant administered in an adequate dose for a sufficient period of time.[17] The golden rule is to stick to monopharmacy as far as possible.[12]



ECT = electroconvulsive therapy, MAOIs = monoamine oxidase inhibitors, TCAs = tricyclic antidepressants, SSRIs = selective serotonin re-uptake inhibitors; SNRIs = serotonin noradrenaline re-uptake inhibitors.

Fig. 1. Decision tree for acute somatic treatment of major depression.[18]

Depression in children

Mood disorders in preschool children are rare. In schoolchildren the prevalence of depressive disorder is approximately 2%, and in adolescents 5%.[8] Depression is common in attention deficit disorder where hyperactivity masks low self-esteem, and in anorexia nervosa where 30% of patients have a co-existing depression.

Depression is also common in both the short-term and the long-term in children who have been physically, emotionally or sexually abused.

It is important to consider the possibility of depression in a young child and to distinguish this from sadness in response to problems. The characteristic features of depression in children are a depressed or irritable mood, anxiety, sleep disturbance, changes in appetite and weight, suicidal thoughts, abdominal complaints, obsessions and hypochondriasis.[7] An important symptom is disinterest in playing.

Treatment in childhood requires multiple interventions, including family therapy and parental guidance, together with a combination of individual and group therapy, and educational and behaviour modification programmes. The best results have been observed when there is a positive change in the family and the psychosocial environment.[11] Increasingly it is being noted that evaluation of the family system sometimes explains why a short therapeutic input at a critical junction may result in far-reaching changes.[8] Although antidepressants may be necessary, they should not be the first or only line of treatment.

Depression in adolescence

Inner turmoil, misery and low self-esteem occur frequently in adolescence. General practitioners may be reluctant to diagnose depression because of the view that depressive feelings are so common in teenagers. In fact, psychiatric disturbances occur about as often in this age group as in any other age group.

Depression in the elderly

A study of 24 clinical problems was done in order to establish which generated the most difficulties. Depression, confusion in the elderly, chronic back pain and loss of autonomy were found to be the most common.[19]

Previous studies have shown that general practitioners underdiagnose both dementia and depression in their elderly patients.[20,21] A recent study (1992) in Canberra, Australia, investigated the knowledge general practitioners have of these disorders. Thirty-six general practitioners were assessed and it was found that they had limited knowledge of the symptoms and signs of dementia and depression. Furthermore, 60% of the general practitioners did not know that Alzheimer's disease is the most common cause of dementia.[22]

The incidence of depression increases with age in men but not in women, and is highest in the divorced, the widowed and the separated. Severe depression affects 1 - 2% of the elderly population and about 10% have significant depression interfering with everyday life. Milder and isolated symptoms affect a further 20%.

Many of the clinical features are the same as those of depression in the rest of the adult population, but there

could be other features. These include agitation, pseudodementia, psychomotor retardation, hypochondriacal preoccupation and delusional thoughts. Symptoms of depression (for example poor appetite, constipation and sleep difficulties) are commonly found in the elderly, which makes diagnosis difficult.[23] Management is the same as for depression in younger adults, but includes management of the additional problems associated with ageing, such as housing and problems of daily living. Lower doses of antidepressants may be required and occasionally electroconvulsive therapy is recommended. A major feature is the psychosocial management; this involves a team approach using all available community resources.[11]

Conclusion

It is certainly within the scope of any general practitioner to treat nearly all the depressive disorders, except for the most severe, and this fact has not been emphasised sufficiently in the past.

General practitioners could achieve much by simply heightening their awareness of depression and its somatic presentations. Early recognition and adequate treatment could lead to great improvement in the quality of life of many patients who might otherwise suffer needlessly.

The treatment of mood disorders is rewarding for the general practitioner. Because the prognosis is good, optimism is always warranted and welcomed by both the patient and his family.

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