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The Role of the Family Physician in Managing Depression

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Abstract:
Depression is a common serious but treatable psychiatric disorder that is mostly dealt with in general practice. It is easily missed if the consulted physician is not alert to the tendency of somatisation in this disorder. The family physician plays an important role in the management of depressed patients. Therefore, the physician should be clear about the diagnostic criteria, different modalities of treatment, importance of regular follow up and indications for referral. Evaluating the severity of the illness and the suicidal risk is essential and can save lives. Treatment resistance is common and there are some strategies to overcome this problem. Relapses and recurrence of depression is frequent.

Key words: Depression, Family physician, Somatisation, Suicide, Antidepressants.

Introduction
In their daily work the family physician faces a lot of psychiatric challenges. Depression is one of the commonest serious but treatable psychiatric diseases seen by the family

physician. It has a prevalence of 5 percent for adults in general[1]. Women are affected twice as often as men. The commonest ages are for women 35-55, and for men 45-65. Depression can affect the basic human activities: Energy, Sex, Appetite, Sleep and ability to cope with life[2]. Early detection and management may reduce severity, alleviate distress, and possibly reduce the risk of recurrence or chronicity. General practitioners play a key role in this process since 90 percent of depression is managed in primary care[3]. If depression is not noticed early and treated it may result in catastrophic complications. The family physician is in an excellent position to intervene in depression because of his established rapport with patients[4]. Once the physician detects and treats depression the outlook is very good and this can save lives.

Is it difficult?

It is not easy for any physician to detect every case of depression. Fifty percent of cases are missed at the first consultation. This may deepen depression and patients may develop a negative way of thinking. They may feel hopeless and helpless and may harm themselves or even resort to suicide. There are several factors making depression underdiagnosed and not recognized early in the consultation. These factors may be related to the patient, the family physician or to the clinic. The tendency for somatisation is a very important factor where half of all patients with depression present with common somatic symptoms such as general body pains, headache, backache, dizziness, chest oppression, feeling breathless, tiredness, sweating, palpitation or nausea. To overcome this problem the family physician should always ask about the cause for attendance, patient worries, fears and expectations. This is required more in frequent attenders with simple complaints, multi-complainers and mothers, with a well healthy child using the child as a ticket for admission.

The family physician's previous clinical experiences, his attitude to psychological complaints, his factual knowledge about depression and behaviour during consultation also contribute to the problem. Busy clinics and limited consulting time are also factors. However, the standard consultation in general practice is usually adequate for the recognition and management of depression. Having more time is less important than making the best of it. [5]

DIAGNOSTIC CRITERIA AND CLASSIFICATION OF DEPRESSION

The family physician should be alert and clear about the diagnostic criteria of depression to avoid under or overdiagnosis. This is best done by applying the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria. It includes nine symptoms in the diagnosis of major depression. These symptoms are:

1-Depressed mood,

2-Loss of interest in all activities,

3-Poor appetite or loss of weight,

4-Insomnia or hypersomnia,

5-Psychomotor agitation or retardation,

6-Loss of sexual drive,

7-Fatigue or loss of energy,

8-Lack of concentration,

9-Recurrent thoughts of death/suicide ideation/wishes to be dead or suicidal attempt.

Depression is diagnosed if either depressed mood or loss of interest and pleasure are present, plus four or more of the other seven symptoms. These symptoms should be present for a minimum of two weeks and there should not be evidence of other primary disorders.[1,5]

Depression can be classified into mild, moderate or severe cases based on the presenting symptoms. This is very helpful in the management plan. If the patient fulfills the diagnostic criteria but has no psychomotor agitation or retardation or suicidal risk this is classified as mild depression. If the patient has psychomotor agitation or retardation, but no suicidal risk, this is classified as moderate depression, but if the patient has suicidal risk this is classified as severe depression which is a psychiatric emergency.

How to manage depressive patients

The key in managing patients with depression is to build a solid therapeutic partnership by communicating interest, respect, support and empathy for the patient's emotional situation before turning to the prescription pad[4].

It is important to evaluate the severity of the illness. Is the patient at suicidal risk? Does he/she require inpatient assessment? Is referral to a specialist psychiatrist indicated?[2]. Usually mild cases need supportive psychotherapy and regular follow up only. Moderate cases in addition to the supportive psychotherapy, may require starting patients on a pharmacological agent. Severe cases are an indication for referral. Other causes of similar symptoms should be considered before starting the management plan. In some elderly patients, depression can be mistaken for dementia when changes in cognition result directly from changes in mood. This reversible condition is referred to as "pseudodementia"[6].

Supportive Psychotherapy

A variety of mental health workers provide psychological therapies which may include: non-directive counselling, cognitive behavioural therapy, problem solving skills training, interpersonal therapy and psychodynamic therapy. All of these approaches are popular, but there are issues about individual preference, effectiveness and availability in general

practice.

Non directive counselling is widely available. It is usually given as a course of six to ten sessions. The best recent evidence shows that it is effective in at least the short term, but probably has no long-term effect on outcome. Women with postnatal depression have been found to be the group which responds best to this type of treatment.

Cognitive Behavioural Therapy is well established in secondary care but is not widely available in primary care. Its basis is the idea that emotional problems are due to maladaptive thoughts and beliefs and self-defeating behaviours. Therapy usually lasts between six and sixteen sessions, and aims to change the way the patient thinks about themselves or their situation, and the way they behave. Some trials show it is effective in primary care, but in the short term only. There is evidence that adding this therapy or interpersonal therapy to drug treatment is more effective than either alone, but only in severe depression, with no such effect in mild to moderate depression.

Problem Solving Therapy is a structured treatment, which aims to help people to identify and solve their inter-personal and social problems. It has been shown to be effective when administered in primary care when given by general practitioners with special training. Interpersonal therapy is a brief supportive therapy linking recent problems in interpersonal relations to the mood. It is not widely available. It has been shown to be as effective as Cognitive Behavioural Therapy. Psychodynamic therapies look at the origins of present difficulties in the person's early experiences and relationships. Sessions are usually weekly, and can last from several weeks to years. They have been shown to be effective in specialist centres. Exercise has been reported as being beneficial in the treatment of depression, but probably only as an adjunct to other therapies, and not alone.[7]

Pharmacological Treatment

Research has shown drug treatment to be effective in the acute treatment of all grades of depression, however the greatest benefit is seen in moderate to severe illnesses. There are a number of different drugs available and the choice can be tailored to the individual patient depending on the way their illness manifests itself and how he or she responds.

Patients must be fully involved in understanding the treatment possibilities and know what to expect. Antidepressants are unlikely to have a noticeable effect in under two weeks. One of the biggest reasons for treatment to fail is because the drugs are not taken in sufficiently high dosage and for the correct length of time. This is often either because the patient was expecting to feel better more quickly and stops taking the tablets or because he or she starts to feel a little better and feels that treatment is no longer required. In fact treatment usually needs to continue for four to six months, a lot longer than most other treatments an individual might have experienced before. Working closely with the patient and carers with regular reviews will help to achieve the maximum benefit.[7]

The basis of the pharmacological treatment is to replace the missing chemicals (e.g. 5-

hydroxytryptamine (5HT) and Noradrenaline (NA)) with antidepressant medications. Noradrenaline (NA) is the neurotransmitter most closely associated with motivation, where as 5-hydroxytryptamine (5HT) is most closely associated with anxiety and repetitive behaviour such as ruminations and compulsions. Antidepressants are classified into several groups; the tricyclic antidepressants (TCA), monoamine oxidase inhibitors (MAOI), reversible inhibitors of monoamine oxidase type A enzyme (RIMA), selective serotonin reuptake inhibitors (SSRI), selective serotonin and noradrenaline reuptake inhibitors (SNRI) and noradrenaline serotonin selective antidepressants (NASSA).

There are several factors to be considered when selecting an antidepressant agent. Some factors are related to the patient such as; age, sex, previous patient or first degree relative response to antidepressants, cardiovascular and medical status and target symptoms of depression. Other factors are related to the antidepressant agent, like side effects, overdose safety, simplicity of use, cost, drug interactions and familiarity and comfort of the family physician with the drug[1].

How To Overcome Treatment Resistance

Partial response or non-response to antidepressant medications are common problems in patients with depression. Between 10-30 percent of patients are partially or totally resistant to treatment[8]. In those patients the family physician should review the diagnosis and check that the patients are taking the medication prescribed in the dosage prescribed[1]. Some factors are involved in treatment-resistance such as undiagnosed medical conditions (e.g. hypothyroidism and anaemia), non-psychiatric drugs like methyldopa, beta blockers and reserpine which may cause or exacerbate depression, comorbid psychiatric disorders (e.g. eating disorders, substance abuse or dependence and depression subtypes), side effects of the antidepressant and poor compliance.

There are five strategies for treating partial response or nonresponse to antidepressant medications. These are Optimization, Drug Substitution, Combination Therapy, Electroconvulsive Therapy (ECT) and Augmentation Therapy. Optimization is prescribing the antidepressant in the best possible way by maximizing the dose and duration of therapy, encouraging compliance and keeping attention on the patient's psychosocial situation. Drug Substitution is replacing an ineffective drug with a new drug. Switching to a new drug keeps things simple and avoids potential drug-drug interactions. Monotherapy might also be associated with greater compliance. Some controlled studies have shown that when patients are switched from one TCA to another TCA the response rate is only 10 - 30 percent. When double-blind studies examined patients switching to different classes of antidepressants (e.g. SSRI to TCA), however, response rates were higher at 40 -70 percent. Combination Therapy is concurrent administration of two or more antidepressant agents which may result in a different therapeutic response than monotherapy. However, there is no strong evidence suggesting the usefulness of this practice. Electroconvulsive Therapy (ECT) is still the most effective treatment for psychotic depression and severe refractory depression. The physician should not hesitate to recommend it and should reassure patients as to its appropriate and safe use under medically monitored conditions. Augmentation Therapy is

adding a second agent, but one that is not routinely regarded as an antidepressant like lithium, thyroid hormone, the beta blocker pindolol and buspirone. This is to boost or magnify the effects of the original antidepressant.[8,9]

When To Refer Depressive Patients

Psychiatric consultation may be sought to enhance the safety and effectiveness of the treatment if the patient has severe depression, substantial suicidal risk (Table1), associated psychiatric or physical disorders, or poor or partial response. Also the patient should be referred if the diagnosis is still unclear or if the patient needs an alternative treatment such as ECT.

Follow-up:

Depressed patients should be followed up regularly. The aim is to review the management plan, evaluate the symptoms and response and to assess the social support. The severity of the depression and the response to the treatment decide how frequent follow-up is required. As a start it is advisable to fix a weekly follow-up visit to support and encourage the patients and to assess compliance and the drug's side effects.

Depressed patients cannot play the same part in managing their own care as patients with asthma or diabetes. Doctors may fear that because depressed people often have reduced self esteem they may lose insight into their own needs for treatment and fail to play their part in the management plan[10]. This should not be the case - the patients must be involved and incouraged to share in their management plan.

Depression is a chronic illness, so relapses and recurrences are frequent. Therefore, long-term use of antidepressants is sometimes necessary. It is recommended for six to nine months after the first episode, one year after the second and indefinitely after the third. Patients are at risk of recurrence if the age is less than 20 years or if they have frequent relapses with severe episodes, poor recovery between the episodes or dysthymia preceding the depressive episodes. Tapering over at least four weeks is recommended when antidepressant therapy is to be stopped[11].

Conclusion

Depression is a common serious but treatable psychiatric disorder that mostly dealt with in general practice. It is easily missed mainly because of the tendency of somatisation in this disorder. Family physician, who plays an important role in the management of depressive patients, should have a clear diagnostic criteria and a good plan of management. Suicidal risk evaluation is essential and can save lives in this disorder.

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