

ASSESSMENT AND DIAGNOSIS OF DEPRESSION

Establishing Rapport

One reason for the under treatment of depression is reluctance to seek help. GP behaviour will influence the likelihood of depressive symptoms being presented. Specific strategies include:

- Routine questioning about mental health or general wellbeing
- Initiating discussion on apparent mood disturbance
- Willingness to make follow-up appointment
- Active listening and motivational interviewing
- Actively negotiating confidentiality about sensitive areas
- Knowledge of treatment options

Recognition

Depressive symptoms must be recognized as the first step in assessment. Depression may present in a wide variety of ways. Symptoms or behaviours (other than depressed mood) which may indicate an underlying depression include:

- Anxiety, especially in an older person without prior anxiety symptoms. Significant anxiety or panic attacks occurring for the first time in anyone older than 50 should be considered depression until proven otherwise.
- Non-specific psychological symptoms: fatigue, loss of concentration, boredom, depersonalisation
- Sleep disturbance: insomnia of any pattern, or less frequently hypersomnia
- Appetite disturbance: Anorexia or increased appetite, carbohydrate craving
- Somatic symptoms: Weight loss, pain, constipation

Establishing diagnosis

The most widely used psychiatric diagnostic system is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association. Patients in primary care settings may often present with mixed, atypical or transient syndromes which do not neatly fit into DSM-IV. Patients who do not exactly fit the following syndromes but who suffer significant distress and dysfunction should still be considered for a trial of the Sutherland Depression Management Program or referral for assessment.

The presence or absence of an obvious precipitant to depression (such as a recent loss or crisis) does not directly affect diagnosis.

Serious depressions can occur with or without a trigger.

Previous classifications of depression as either reactive or endogenous are no longer used.

DSM-IV classifies depressions according to the type and severity of symptoms and signs, rather than cause. It is clinically important to make a distinction between these subtypes of depression as prognosis, suicide risk, urgency of treatment and type of treatment will all be affected.

The commonest diagnosis for a depressive episode reaching clinical significance is **Major Depression**.

Major Depression (DSM-IV criteria)

- ❖ Depressed mood or loss of interest or pleasure
- ❖ At least one of
 - Significant weight loss or reduced or increased appetite
 - Insomnia or hypersomnia
 - Observable agitation or psychomotor retardation
 - Fatigue or loss of energy
 - Feelings of worthlessness or excessive guilt
 - Reduced concentration
 - Recurrent thoughts of death or suicide
- ❖ Symptoms are present most of the day, nearly every day, for at least two weeks
- ❖ Symptoms cause significant distress or impairment

Episodes with more numerous or severe symptoms and signs are referred to as **Major Depression with Melancholia**.

Major Depression with Melancholia (DSM-IV Criteria)

- ❖ Depression or loss of pleasure is severe and sustained. Loss of reactivity (cannot be even temporarily cheered up).
- ❖ Three or more of
 - Depressive mood has distinct quality of deadness or emptiness unlike normal sadness
 - Depression worse in mornings
 - Early morning wakening (at least 2 hours prior to usual time)
 - Marked psychomotor retardation or agitation
 - Significant anorexia or weight loss
 - Excessive guilt

Subtypes of depression

All depressions are not alike. There are a number of subtypes of depression and typical situations in which depression occurs. These subtypes or situations have significant implications for risk assessment, treatment choice and prognosis.

❖ **Psychotic depression:**

Features of Major Depression (with or without Melancholia) plus presence of hallucinations, delusions or thought disorder. These features may be *mood congruent*, that is of a hopeless, guilty or negative nature in keeping with a depressed mood. These include delusions of poverty, loss of family or possessions, sickness (classically of the body rotting or dying) or guilt (eg unshakeable guilt re a minor past infraction). Less often symptoms may not appear mood congruent, such as persecutory delusions where the patient feels angry rather than guilty.

❖ **Adjustment Disorder with Depressed Mood:**

Mild and transient depressive symptoms after a distinct stressor or loss. This is a residual category, and the diagnosis should only be made when criteria for Major Depression are not met.

❖ **Dysthymia:**

Chronic depression, with symptoms persisting for at least two years.

❖ **Mixed anxiety and depression**

❖ **Post-natal depression**

❖ **Depression as part of a Bipolar Affective Disorder**

❖ **Depression and substance use**

❖ **Adolescents and young people**

❖ **Depression in the elderly**

❖ **Depression and Personality Disorder**

Clinical and treatment aspects of these subtypes are discussed in Medication section below.

Differential diagnosis

Depressive symptoms may be caused by a number of psychiatric and medical conditions. Part of the assessment of depression is the exclusion of such conditions. The major differential diagnoses for depressive symptoms are:

❖ **Drug and alcohol problems.**

These may produce significant depressive symptoms. Alcohol in particular is a powerful depressant and may produce not only depressed mood but also disturbances of sleep, appetite and concentration which may resemble melancholia.

❖ **Emerging psychosis.**

Depression may be prominent in the early stages of development of a psychotic illness. There is considerable evidence that psychosis may emerge in nonspecific ways in young people, only differentiating into a typical schizophrenia or bipolar disorder after several episodes.

In any young person with a first onset of psychiatric symptoms, ask about possible psychotic symptoms, check carefully for family history of psychosis and reassess frequently if the situation is not settling. If in doubt refer for assessment.

❖ **Organic conditions**

(see Specific Medical Assessment below)

Specific medical assessment

Hidden medical illness may produce depressive symptoms, or even a full depressive syndrome clinically indistinguishable from other depressions. Depressive features may occur before any other signs or symptoms of the underlying illness. Suspicion of an organic cause should be highest when:

- ❖ *First onset of depression occurs after the age of 50*
- ❖ *The patient has multiple medical illnesses or medications*
- ❖ *There are risk factors for malignancy or vascular disease*

The list of possible **organic causes** of depression is extremely extensive. Common causes include:

- ❖ Malignancy: Any, but particularly lung, breast, bowel, brain, pancreas.
- ❖ Infection: Hepatitis, HIV, Mononucleosis.
- ❖ Neurological: Stroke, depression.
- ❖ Cardiac: Acute myocardial infarction, cardiac failure.
- ❖ Endocrine disease: Hypothyroidism, hypercalcaemia, Addison's disease, Cushing's disease.
- ❖ Haematological disease: Anaemia, lymphoma, leukaemia.
- ❖ Medications and substances: Alcohol, corticosteroids, beta-blockers.

Suicide risk assessment

Untreated depression is associated with a significant risk of suicide, and “psychiatric post mortem” studies have consistently found that the majority of people committing suicide were suffering from a depressive illness at the time. Assessment of suicide risk needs to consider several dimensions:

Presence and type of suicidal ideas

- Suicidal ideas
- Hopelessness
- Behaviour suggesting preparation for suicide (eg making wills, saying goodbyes, settling bills)
- Presence of a specific plan
- Accessibility of means of suicide (eg gun, medications, means in workplace)

Nature of psychiatric illness

- Severe or psychotic depression
- Past history of suicide attempts
- Drug or alcohol use

Factors in the person

- Adolescent or older aged
- Impulsiveness
- Serious medical illness

Factors in the social situation

- Poor social supports
- Recent loss

These risks are additive – the more present, the greater the risk. Several of these factors are particularly powerful predictors of risk (see checklist). No patient expressing suicidal ideas should leave the GP surgery without a plan for management of suicide risk. If you feel that suicide risk is high, or are in doubt about the level of risk, you should arrange urgent assessment with either a private psychiatrist or Sutherland Hospital Mental Health Service (9540 7474).

Suicide Risk Checklist

- Hopelessness
- Past suicide attempts
- Psychotic symptoms (Hallucinations, delusions)
- Substance abuse
- Social isolation, loss of supports
- Current suicide plans
- Ready access to means of suicide

*If two or more risk factors, or you are concerned,
seek urgent advice or assistance.*