Risk Factors, Clinical Features, Health Seeking Behaviour and Treatment for Depression

Article · January 2016

1 author:

Godfrey Zari Rukundo
Mbarara University of Science & Technology (MUST)
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Risk Factors, Clinical Features, Health Seeking Behaviour and Treatment for Depression

Author: Godfrey Zari Rukundo (Department of Psychiatry, MUST)

Depression is a major health problem worldwide [1-3] but commonly unrecognised and untreated. It is one of the most debilitating illnesses in the world and is projected to be the second most common disease by 2020. Depression impairs normal functioning, causes distress and has an adverse effect on an individual's quality of life. It can cause severe morbidity and has a high incidence of mortality. Depression affects people of different ages and backgrounds. It presents in several ways. The presentation, treatment and complications of depression depend on the severity of the disease. The point prevalence of major depression ranges from 5% to 15% among adults in primary care settings

How does one know whether he/she is depressed?

Depression is different from sadness, which is a normal response to loss. Feeling sad is a normal response to experiences that are stressful or difficult to bear with. However, when these feelings go on for a long time and interfere with the person's usual life routines, it becomes an illness called depression. Depression can present as a symptom of some other illness such as dementia, parkinsonism, schizophrenia, HIV/AIDS or substance use, or it can be considered as a syndrome called depressive disorder [4]. In depressive disorder there is a prolonged lowering of mood accompanied by cognitive and behavioural changes.

According to diagnostic guidelines (ICD 10 and DSM V), depressed mood, loss of interest and pleasure/enjoyment, and loss of energy are the most typical symptoms of depression. At least two of them together with at least two other symptoms should be present for at least 2 weeks for diagnosis. The other symptoms of depression include:

- Being irritable or easily upset or tearful
- Becoming withdrawn, avoiding friends and regular activities
- Feeling guilty or bad, being self-critical, self-blaming, hating self
- Feeling hopeless and wanting to die
- Finding it difficult to concentrate
- Feeling tired most of the time
- Loss of interest in eating, eating so little
- Changes in sleep patterns: sleeping less-early awakening an failing to sleep again
- Someone feeling that he/she is not good looking
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Unusual presentation of depression

Frequently patients with depression present with non-specific musculoskeletal symptoms and medically unexplained symptoms. Up to 70% of depressed patients report only somatic symptoms. Despite the high prevalence in primary care settings up to 50% of depressed patients go undiagnosed probably due to the unusual presentation or lack of knowledge by the health workers in the primary care settings. Some of the unusual presentation includes:

- Loss of interest in eating, eating too much
- Suffering aches and pains, such as headaches and stomachaches

- Changes in sleep patterns: sleeping too much
- Not looking after personal appearance

How common is depression?

Depression is one of the four major diseases in the world and is the most common cause of disability from diseases [5]. The lifetime risk for major depressive disorder is 10-25% in women and 5-12% in men. It is significant that women are twice as likely as men to develop depression although the reasons for this difference are unclear. Most depressed patients come to primary care settings and the point prevalence of major depression ranges from 5% to 15% among adults. However, it one of the most under diagnosed mental illnesses due to the various ways of presentation [6].

Who is at increased risk of becoming depressed?

Depression is not selective. It affects people from all walks of life and backgrounds. There is no specific cause of depression but rather a mixture of factors and circumstances. These include:

- Too many changes in life that occur too quickly
- Being under too much stress with no one to confide in
- Experiences or events like family breakdown, loss of a a loved one
- Neglect or abuse
- Being bullied
- Sedentary behavior
- Physical illness associated with pain, shame or guilt
- Depression can run in families
- It can be linked to chemical changes in the part of the brain controlling mood

Depression is more common among the female gender. Higher prevalence of depression has been reported among women who are widowed, divorced or separated. Absence of someone to confide in is a vulnerability factor to depression while marriage has been reported to have a protective effect on depression. Some occupations like long truck drivers, health workers and personalised care givers have increased risk for depression [7].

How is depression treated?

Depression can be prevented though developing individual resilience, screening high-risk individuals and reducing that risk, improving organizational literacy, and integrating health care systems to allow access to proactive quality interventions. Otherwise, both pharmacological and psychological treatments are effective in treating depression. A combination of psychological therapy and antidepressant medication produces better outcomes than antidepressant medication alone in moderate and severely depressed patients. Non-pharmacological treatments should be considered as first-line treatments for patients with mild-moderate depression.

The SSRIs are recommended as first line medical treatment due to their effectiveness, less troublesome side-effects and lower toxicity in overdose. Drugs should be started at the minimum effective dose. These drugs have a long half-life and many can be administered once a day. It is

important to note that although side-effects may appear early a therapeutic response should not be expected until 2-4 weeks. If the response is poor after 6 weeks the dose can be increased. Interpersonal therapy (IPT) is aimed at improving the usually impaired interpersonal relationships of depressed patients. It can be practised by primary care works after a period of training. It has been demonstrated that Cognitive Behavioural Therapy (CBT) and IPT may be as effective as antidepressants in moderate depression.

Electroconvulsive therapy (ECT) is indicated when a rapid response is required, such as in severe depression where food intake is poor, or in those with high suicidal risk. Patients with psychotic depression respond well to ECT. Elderly patients often develop side-effects to antidepressant medication and may find it difficult to tolerate a therapeutic dose. Such patients benefit by ECT as do patients with resistant depression.

Does depressed really get better?

The average length of an episode of depression is 6-8 months and, with mild depression, spontaneous recovery is likely. For major depression, approximately 80% of people who have received psychiatric care for an episode will have at least one more episode in their lifetime, with a median of four episodes. The outcome for those seen in primary care also seems to be poor, with only about a third remaining well over 11 years and about 20% having a chronic course [8]. In light of this, some argue for a model of chronic disease management for depression, similar to that for diabetes or asthma. There is inadequate evidence to determine the clinical effectiveness or cost-effectiveness of low-intensity interventions for the prevention of relapse or recurrence of depression. The risk factors for increased risk of depression recurrence include:

- Having three or more episodes of major depression.
- High prior frequency of recurrence.
- An episode in the previous 12 months.
- Residual symptoms during continuation treatment.
- Severe episodes – e.g. with suicidality or psychotic features.
- Longer previous episodes
- Relapse after drug discontinuation

Why people with an episode of Major Depression do or do not seek treatment

Significant predictors of treatment seeking include a history of prior treatment, higher education, and greater episode length. People who do not seek treatment often feel they can handle the episode themselves, do not consider it serious or do not recognize it as an illness. Seekers on the other hand often feel the episode is too painful and lasts too long and causes significant disruption in their interpersonal relationships and role functioning. In addition, stigma of mental illness stands in the way of care seeking. In patients with medically unexplained symptoms, clinicians generally miss depression because they tend to look only for physical causes of symptoms. For instance, in patients with poor sleep, poor appetite and lack of energy, vague joint or limb pain, are usually not assessed for depression although these are common features of depression. As a result these patients are not referred for depression treatment.

Recommendation

Assessment and treatment of depression should be an integral part of routine patient care. Continuing professional development should include courses on stigma, depression and health seeking behavior.

References

1. Modabernia, M.J., et al., *Prevalence of depressive disorders in Rasht, Iran: A community based study.* Clin Pract Epidemiol Ment Health, 2008. **4**: p. 20.
2. Aichberger, M.C., et al., *[Transcultural aspects of depression].* Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz, 2008. **51**(4): p. 436-42.
3. Barrera, A.Z., L.D. Torres, and R.F. Munoz, *Prevention of depression: the state of the science at the beginning of the 21st Century.* Int Rev Psychiatry, 2007. **19**(6): p. 655-70.
4. Benton, T.D., *Depression and HIV/AIDS.* Curr Psychiatry Rep, 2008. **10**(3): p. 280-5.
5. Culpepper, L., *Understanding the burden of depression.* J Clin Psychiatry, 2011. **72**(6): p. e19.
6. Kastrup, M.C. and A.B. Ramos, *Global mental health.* Dan Med Bull, 2007. **54**(1): p. 42-3.
7. da Silva-Junior, F.P., et al., *Risk factors for depression in truck drivers.* Soc Psychiatry Psychiatr Epidemiol, 2009. **44**(2): p. 125-9.
8. Gayetot, D., M. Ansseau, and J.M. Triffaux, *[When depression does not end. Resistant depression: recent clinical and therapeutic aspects].* Rev Med Liege, 2007. **62**(2): p. 103-11.