EDITORIAL

Depressive Illness - The Need for a Paradigm Shift in its Understanding and Management

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Introduction

Depression as a symptom and a disease has been recognized from antiquity. While numerous references to melancholia, illnesses of the heart broken, and delusions of guilt are found in Shakespearean literature, world literature, stories, and dramas the world over, yet the development of modern western medicine has by and large tended to ignore all things psychological in the process of disease recognition and understanding. Even the face of a depressed patient, so obvious to the initiated, is a rarely taught and recognized sign of ill health by non- psychiatrists. The long association of psychiatry with severe psychoses in the minds of medical teachers has dulled the sense of astuteness in the picking up of anxiety and depression. It has also dulled the medical profession into the delusion that mental illnesses do not occur in general hospitals. Thus the fairly large number of mental problems in every day clinical practice remains an area of darkness. In practice, the pick up rate of all mental illnesses in primary care remains very low at less than 5% of all mental illnesses while studies show that about 25% of all primary care patients have significant mental problems that necessitate their attendance in the primary care clinics.

Among the non-psychotic mental illnesses that are commonly seen in practice, depression is by far the most important and the most treatable condition that remains under detected and treated. It occurs in 2-55% of the population but 5-10% of primary care patients and 6-14% of inpatients in medical and surgical settings[1]. The World Health Organization has quoted many studies that reiterate that worldwide 121 million people suffer from depression, and every year, one million people die from suicide, and a further 10-20 million people attempt suicide. And yet studies also show that up to 60% of patients recover from depression with available medicines[2]. This issue of the MJM carries two papers, one relating to depression in the elderly [3] and another on postnatal depression[4]. Clearly depression as a disease is a public health problem - but one that is most treatable as well. There is also growing evidence that depression in patients with myocardial infarcts and cancer worsens the outcome and increases risk of morbidity and mortality

Why then is this group of diseases not detected or treated as often as they should be? This is the question that begs answers in the training of medical students, and family doctors who will care for large numbers of depressed persons in the community in their future years. The answers lie in the following areas.

Teaching in Medical Schools

The teaching of medical students in Malaysia has been particularly fortunate from the opening of the first medical school in 1964 to include a fairly good amount of time in the understanding of psychiatry or psychological medicine. This has proved to be a good guideline for the 20 or more schools in the country now to follow, that have for the most part included the teaching of psychiatry for more hours (8-10 hours of clerkship) and in more comprehensive ways than the majority of medical schools in Asia, where psychiatry may rate 2-4 weeks of lectures and some demonstrations.

However, unfortunately, in many countries of the world as in Malaysia, psychiatry is taught for logistic rather than academic or logical reasons in psychiatric units of

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general hospitals or rarely in the mental hospital which are for the most part filled with the psychotic or severely depressed patients. Unfortunately, few medical students will ever see and treat these successfully in their future practices. The result is that the severe mental illnesses that the students see during their clerkships will seldom be seen again by them. The estimated 24% per cent of patients with mental problems in primary care settings[5] are unfortunately seldom used for teaching medical students - because they are not part of the psychiatric department to which medical students are attached.

Even in the postgraduate training of family physicians, these 24% of mental problems in primary care seldom figure in their training and most are sent to the psychiatric wards to understudy psychiatrists in their work with the more severe mentally ill persons - whom once again few will deal extensively within their future in family practices. In studies done in Malaysia and Mongolia the pick up rate of mental problems in primary care clinics run by family doctors and specialists was below 3%[6,7].

Currently, depression has been reported to have been identified in about 10.4% among primary care patients in studies done in 15 countries of the world (range from 2.6 to 29.5%). As long as the focus of teaching is on the severe one percent of all mental illnesses that are in the community, and ignores the 10.4% or more in primary care, the pick up rate will remain poor. In most busy government primary care clinics in Malaysia that see over 300 patients a day, there are less than ten patients recognized to have any form of emotional problem - missing out the many presentations of depression or anxiety that may come with physical complaints. A paradigm shift in the teaching settings for the teaching of psychiatry is needed. For this to happen that change has to occur both from the point of view of the psychiatrist as well as the primary care provider, or specialist.

Recognition of psychosomatic symptoms in depression

One of the complex reasons for the failure in recognition of depression in primary care relates to the presentation of symptoms of anxiety and depression with non specific physical symptoms or specific symptoms that mimic real physical illnesses. Thus many anxious persons complain of chest pain similar to angina or a coronary artery disease. Similarly gastric symptoms may be thought to be due to physical rather than mental stress. The excess emphasis on all physical symptoms being related to clear physical illnesses by many teachers leads students to conclude that patients with these symptoms but without demonstrable physical pathology "must be pretending". Indeed that is what many are taught. The reality is that a negative physical examination or investigation for a physical pain does not mean that the person is "pretending" or is not having an "illness". Many persons with depression and anxiety present with physical pain, intractable pain, and indeed many with depression do also succumb to a myocardial infarct. This approach and a lack of awareness to consider a holistic approach to suffering, distress and diagnosis has been at the root of not only missed diagnoses but also under treatment of depression.

The role of Depression as an illness in the many physical illnesses from hypertension, diabetes to coronary artery disease and cancers is only now becoming recognized. Depression often precedes many serious illnesses; but it also follows in the wake of serious illnesses, the consequences the person cannot accept. The management of these conditions is best done by the primary physician himself rather than by referral to a psychiatrist. But then again the basic skills in managing depression in the context of a physical illness have not been emphasised in the training of doctors and specialists. The resultant referral of the depression that has been recognized by the physician to a psychiatrist may be self defeating, for the patient, like his physician, has deep prejudices about referral to a psychiatrist.

Basic treatment of depression by non-psychiatrists

While the treatment of Major Affective Disorders, or intractable depression, or a highly suicidal person with depressive illness is certainly the task of a psychiatrist, the treatment of a post-infarct depression, or a depression that puts the heart patient at risk should best be done by the patient's own doctor. With basic training in the use of anti-depressants and basic counseling skills taught to nurses, any clinician should be able to manage his depressed patient. What has not allowed this so far has probably been born out of poor training in undergraduate days.

Most depressed persons present with reduced sleep, appetite, and concentration or interest in work or social

life which result shortly after a loss in their lives - from position, at home or work, like marital discord, work related problems, family problems, financial stress or unemployment or substance abuse. Such patients are still able to function in the activities of daily living.

The principle is to provide relief first for sleep and anxiety related symptoms in depression and counseling later when he is less distressed by sleep, appetite, anxiety problems. For this, what is first required is a low dose of a mild anxiolytic such as lorazepam 0.5 to 1 mg at night to 2 mg in divided doses. If this helps, as it usually should. it may be sufficient to start the process of allowing the person to discuss his or her problems - and be a supportive listener to the patient. Giving advice is not a part of counseling. Merely being non-judgmental and a supportive listener is helpful to most depressed patients. Where the treatment approach is not very effective an anti-depressant such as fluoxetine 20mg may be prescribed. All antidepressants take 10-20 days to start working effectively. If there are anxieties on the part of the doctor at any stage, a second opinion from a psychiatrist is most certainly in order.

In conclusion, depression in this day and age should not be a mysterious disease only to be treated by the rare specialists in mental health while patients by the thousands suffer unattended because of a lack of awareness in the medical profession. It is time to make the recognition and treatment of depression in clinical practice through a bold and effective paradigm shift that will transform the management of depression into a part of the available skills of any medical doctor.

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