

DEPRESSION IN GENERAL PRACTICE

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Attempts to classify depressive illness have become increasingly more complex and controversial. Perhaps from the General Practitioner's point of view it is wise to adopt this simple but clear classification.

1. A naturally motivated mood or normal non-pathological reaction
2. Reactive or neurotic depression and
3. The depressive Psychosis.

Experience in our field shows that only about 5% of all depressions that we encounter daily belong to group (3). In my opinion any case belonging to this group should be immediately referred to the psychiatrist or to a mental hospital — preferably the former as admission as an in-patient is costly, regressive, diminishes the patient's self esteem and leaves him with a stigma which causes both embarrassment and difficulties later on in life. General Practitioners should never treat such cases at home without the consultant's help and under no circumstances should they prescribe any of the monoamino-oxidase inhibitors. It is rather a pity and also a tragedy that General Practitioners are not always aware that their patients have been prescribed these preparations. General Practitioners must be aware that they must not prescribe any of the tricyclic antidepressive drugs, reserpine, pethidine, sympathomimetic amines, methyl dopa, tyramine containing food such as cheese, yoghurt and bread beans and alcohol in view of the serious and sometimes false effects.

It is no exaggeration to state that at least 15% of all adult cases that come to surgery are suffering from "depression" — the bulk being reactive which is an exaggerated response to adverse external circumstances — viz — family conflict including marital discord, excessive use of alcohol, unemployment, financial worries, bereavement or grief reaction, problems of adolescence, and of old age, school problems, medical illness, the unmarried mother, postpartum depression and postoperative reactions. A small proportion of this percentage belongs to the endogenous type of depression which, as we all know, belongs to the realm of psychosis. Very often as is the custom in Malta the patient is frequently brought in by a relative who gives the initial presenting features. Without being impolite I usually ask the relative to leave the room as I believe that this is the first step to break down the barrier of the patient's initial reaction of "You cannot possibly help me". Furthermore this helps in gaining the confidence of the patient and to establish the most important and fundamental criteria of family practice — the patient-doctor relationship. A word of warning regarding female patients — stress in front of the relative that there will be no "initial" physical examination — this I feel puts the patient's mind at rest and diminishes some the worries that she may be harboring some serious physical illness. During the first session I usually listen to the patient's complaints hardly giv-

ing any advice but encouraging him in dish- ing out his problems, fears and worries. After having gained the patient's confidence I then proceed to a thorough physical examination. I never do this just to please the patient, but to avoid falling into one of the most dangerous diagnostic pitfalls, I always ask myself this question "Does this depression result from or does it mask a physical ailment — the cure of which will return the mental state to normal." Look out for tuberculosis and chronic sepsis particularly when associated with influenza, watch out for the young woman whose depression results from too rapid weight reduction by dieting. Vascular disorders especially atherosclerosis and Parkinsonian degeneration can also give rise to an intense depression; do not forget that hypothyroidism may present as a depressive illness. Watch out for personality changes as these are often associated with brain tumours. After the complete examination I ask the patient to come again in a few days time and this has proved of immense value as it is during these calls that his real problems come out. It is disastrous in my opinion as a General Practitioner to bring out pad and pen and to prescribe the first tranquillizer or antidepressant that comes to mind and to ask the patient to see you in one month's time. Many patients may not need any medicines. These patients need help, understanding, sympathy, and advice — drugs will tidy over some of the symptoms but will never solve their problems. Let us limit ourselves to a few drugs so that we can acquaint ourselves with their mode of action, their benefits and side effects. I have spent many an hour including Sunday evenings discussing their problems with our local priests, their employers and teachers, the social and insurance officers and relatives — at times I have also gone to their neighbours to get down to the bottom of their problem — in some cases I have met with success but in others unfortunately I have failed — maybe because I could not find enough time and the necessary qualified help to devote to such cases. I believe the time has come, if such cases are to be treated properly and urgently, to have

in each district trained non-professional helpers. The kind and understanding priest, teacher or policeman are not good enough — they must know what they are dealing with. Perhaps in the not too distant future with community care pushing us along we will have "District Psychiatric care" with the psychiatrist/General Practitioner, mental health officers and other helpers discussing four or five cases per session every month or so.

As you are aware, modern research has tended to make the difference between the anxiety states and depression fairly clear but the clinical manifestations overlap considerably and it is obvious that most patients diagnosed as suffering from anxiety state show some depressive symptoms and that a large proportion of depressives show a greater or lesser amount of anxiety. In order to help me in reaching a diagnosis of depression I have been using for a number of years charts based upon and adapted from the Hamilton Rating Scale for depression — from these I have concluded that depression can be diagnosed if these five symptoms are present viz disturbed sleep pattern, loss of interest, loss of appetite, loss of libido and diurnal variation of symptoms. Remember that the initial attack of depression often comes later on in life whereas neurosis comes earlier on.

Having established the cause of the patient's depression and having excluded any physical cause including the taking of reserpine and contraceptive pills I usually plan what line of action is best for the patient. I usually "but not" invariably prescribe an anxiolytic or a tranquillizer or an anti-depressant.

During the various psychotherapeutic measures the dialogue with the family doctor probably plays the most important role as this enables the patient, to purge himself of his problems. I always give these patients "weekly appointments" on days during which I know that the work load is not too heavy so that I can devote at least 20 — 30 mins. per sitting until the case is under control. These weekly appointments help me in seeing that patients are taking tablets regularly and that their moods are better. Furthermore such sessions often

help me to spot the early signs of the greatest hazard of any depressive illness viz "suicide". This must never be taken lightly even if the patient makes only a passing remark about it. In such cases I always call one of the members of the family and advise preventive measures — if the patient lives alone I ask him to stay with his relatives until he improves: If I notice that the depressed patient, is not responding well to treatment within the expected time of 4 weeks I have always sought psychiatric help and where suicide is a real threat have sought hospitalization.

I have noticed in my practice that a high proportion of depression is encountered in female patients and yet the five cases of successful suicide that I have been were all males, — three of them aged between 30 — 36 years, one aged 45 years, the other 80 years. Incidentally three took an overdose of barbiturates, one died by hanging and the other threw himself under a bus the next day after I advised him that he needed a Prostatectomy for his obstruction.

In my view, in certain respects the family doctor has an advantage over the psychiatrist because he has probably known the patient, his family and his environment for a long time. He knows what type of personality he is dealing with — emotional or mentally strong, stable or misleading attitudes. He knows whether the patient tends to exaggerate his symptoms or makes light of them.

He may know that the patient is very sensitive in his reactions to the words and actions of others. He may know the patient's personal events such as lack of success in his employment, quarrels with friends or family members. The General Practitioner being part and parcel of the family is fully acquainted with its problems: moral, social or financial. This acquaintance will contribute sometimes decisively in constructing the real picture of the disturbance. In case it is necessary he will find it much easier than the consultant to con-

tact the family without the patient's awareness.

We are all aware that in psychiatry the evidence provided by the family, in comparison with that offered by the patient is more commonly useful than in other branches of medicine (excluding Paediatrics). However in some cases conditions and reciprocal relations with the family may have helped or indeed determined the development of the patient's depression. From the family's evidence one can assess the majority of the patient's illness, how much it is effecting his human relations. Through it also the General Practitioner can more accurately find out the time and mode of onset and the eventual course and later the effect of treatment.

The General Practitioner has the advantage that he is in constant contact with other helpers — the priest, the teacher, the policeman. These he can readily and easily talk to, obtain information and advice as to management of a case. A recent example is a young girl who gets severe hysterical attacks at Zabbar Secondary School. The headteacher referred this girl to me asking for advice. The girl told me that everytime she goes out into the yard she gets vivid recollections of last year's air-disaster. I wrote back to the teacher advising her to move the girl to another school which she promptly did. The girl is now much better and happier — incidentally no drugs were prescribed to this young girl. Of course not all cases can be scived as easily and quickly as this. We are all aware that treatment of the mentally sick patients especially those suffering from depression is one of the most time consuming and exacting demands on the General Practitioner but with all the sources available at his disposal the General Practitioner can and will succeed in most cases.

There is no quick way round this help — some will take months to recover but the hours of exhausting listening and advice and the minimal use of the prescribing pad usually repay dividends in the end.