UNIT 2 DEPRESSIVE AND PSYCHIATRIC DISORDERS

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2.0 OBJECTIVES

After reading this unit, you should be able to:

- elicit information about clinical history and symptoms;
- diagnose and manage common problems; and
- refer to tertiary care in case it is difficult to treat a case.

2.1 INTRODUCTION

You will realize after reading this unit that depression is a major public health problem. It constitutes 10-30% of the OPD attendance in general hospital. It is an under diagnosed and under treated disorder. There is a large heterogenecity in both, aetiology, symptomaology and response to treatment compared to younger people. You thus will realize after reading the unit that diagnosis in time lead to avoidance of unnecessary laboratory investigations and unrelated drug administration and more side effects. Elderly not responding to adequate antidepressed therapy, a history of several episodes of depression and excitement, psychomotor retardation, high suicidal risk needs a psychiatrist opinion. You must learn to identify elderly who would require this referral.

2.2 EPIDEMIOLOGY AND CLASSIFICATION

Community based studies find symptoms of depression is as high as 15% in people over 65 years of age. Symptoms are more common in women. There is presumptive evidence that ecological, cultural and social factors have considerable influence on the incidence and clinical manifestations. Depression is characterized by a sad mood, slow thinking and activity, with loss of interest and pleasure. It has been classified as mild, moderate or severe. Depression is also seen in bipolar effective disorders, persistent mood status and recurrent depressive state. Causes of depression are enumerated in Table 2.1. Increased physical ill health, psychological factors and an aging brain, all contribute to the high prevalence.

Table 2.1: Causes of Depression

Biological	Psychological	Socialfactors
• Genetic factors	• Poor self esteem	• Reduced social network
• Neurotransmitter loss	• Lack of capacity for Intimacy	• Loneliness
• Physical ill health (e.g. Neuroendocrine function)	• Physical ill health (e.g. Cancer)	• Bereavement
		• Poverty
		• Physical ill health like disability and increased dependence on others.

There are certain physical diseases like, anaemia, diabetes mellitus, some nutritional disorders, hypothyroidism, patients on antihypertensive drugs, steroids and malignancy which may present with depressive symptoms.

According to I.C.D. 10, the criteria to diagnose depression include the following:

- Common symptoms of depression
- Depressed mood
- Loss of interest
- Loss of energy or feeling of fatigue

While other symptoms include the following:

1) Reduced concentration
2) Reduced self esteem
3) Guilt feelings
4) Pessimism regarding the future
5) Self harm or suicidal ideas
6) Altered sleep
7) Decreased appetite.

2.3 ASSESSMENT OF DEPRESSED PATIENT

Detection of depression in the elderly has improved in the recent past. A reliable clinical diagnosis is the first step towards successful management of depression. Besides a good clinical examination and history the use of some screening instruments seem promising.

2.3.1 Screening History

Some screening for depressed patient procedures are also seem promising. The four item scale (Table 2.2) is a good starting point for assessing depression and usefully supported by a check-list of vulnerability factors (Table 2.3).

Table 2.2: Four Item Scale

	Items	Score	Points
1.	Are you basically satisfied with your life?	No	Yes
2.	Do you feel your life is empty?	Yes	No
3.	Are you afraid that something bad is going to happen to you?	Yes	No
4.	Do you feel happy most of the time?	No	Yes

Table 2.3: Vulnerability Factor

	Factors		
•	Does the patient have a history of depression?	Yes	No
•	Is the patient socially isolated?	Yes	No
•	Does the patient suffer from chronic illhealth problem?	Yes	No
•	Has there been a recent bereavement?	Yes	No

Elderly people scoring more than GDS-4 or more than **one** on the vulnerability checklist should be subjected to more detailed assessment. You must refer such cases to psychiatrist for further evaluation and management.

2.3.2 Physical Examination

The physical examination will exclude medical illness like Parkinson's disease or occult carcinoma of the lung, large bowel or pancreas, which is a common comorbidity. Patient with disability and discomfort as seen in pagets disease react secondary in the form of depression. Nutrition and hydration, that should also be evaluated in elderly.

You should not confused with the normal blues. Everyone has brief down periods and sometimes depression strikes for perfectly understandable reason, the death of the house, the retirement from service. However, majority of the people gradually adjust to their loses. The symptoms and signs of depression usually divided into core groups seen in all types of depression and others may be seen to a variable degree in the subtypes.

Core Group of signs and symptoms are:

1) Specific alteration in mood (characterized by the feeling of sadness, hopelessness and pessimism).
2) Marked changes in sleep pattern (Insomnia)
3) Decreased energy (Fatigue)
4) Negative self-concept associated with feeling of guilt
5) Loss of interest in social environment due to sad, anxious or empty mood
6) Self neglect
7) Loss of appetite and weight loss, sometimes weight gain and overeating
8) Thoughts of death or suicidal threats.

However, try to elicit other warning signs of depression which are not obvious such as Diurnal variation, agitation or psychomotor retardation, symptoms like constipation or dryness of mouth, somatic symptoms and loss of libido.

As you examine your patients clinically, you may realize that recognizing depression in elderly require special clinical skills and experience. In cases of suspicion of depression, you must refer the case to a psychiatrist.

Check Your Progress 1

1) Define depression in elderly people

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2) Classify the types of depression.

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3) Describe common symptoms of depression.

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2.3.3 Investigations

Investigations are usually none, but may be needed to exclude differential diagnosis. Besides, the elderly patients are extremely vulnerable to metabolic disturbances secondary to the effects of a severe depressive illness, such as failure to maintain an adequate fluid intake. Urea and electrolyte may be altered by dehydration in the elderly depressed. Metabolic upset causes restlessness, agitation and confusion. Full Blood count and ESR are carried out to rule out chronic infections. Presence of anemia causes lassitude, B_{12} and Folate deficiency resulting from a poor diet can lead to altered cognitive function and confusion. Thyroid function test is required to rule out hypothyroidism. X-ray chest will rule out of carcinoma, heart failure and chronic chest illness. Additional investigations include ECG, EEG and computed tomography of brain (CT Scan).

Check Your Progress 2

1) What is the importance of four-item scale?

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2) What are the tests done to rule out medical illness?

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2.3.4 Treatment

The elderly respond well to drug therapy, which include monoamine oxidase inhibitor like phenelzine, Tranylcypromine and Tricyclic antidepressants like imipramine. These drugs are relatively safe, cheap and highly effective. Dosage and side effects of these drugs is given in Table 2.4. Antidepressant drugs do not effect the normal person (in a base line state) but corrects an abnormal condition.

Table 2.4: Tricyclic Antidepressants

Drugs	Average Dose	Common Side Effects
1) Imipramine	75-250 mg.	Constipation, urinary hesitancy
2) Doxipine	75-250 mg.	Tachycardia, sedation, weight gain
3) Clomipramine	75-250 mg.	
4) Nortriptyline	75-250 mg.	
5) Amitriptyline	75-250 mg.	
6) Trimipramine	75-250 mg.	

The development of SSRI (Selective serotinin reuptase inhibitors) are safe, effective and well tolerated by the elderly. Drugs in this category are Fluoxetine and Sertraline (Table 2.5). The average duration of depressive episode is 6-12 mouth and medications are to be continued for this period. When patient fails to respond therapy, then you should refer the case to specialist.

Table 2.5: Selective Serotinin Reuptase Inhibitors

Drugs	Average Dose	Common Side Effects
Fluoxetine	20 - 40 mg.	Nausea, diarrhea insomnia anorexia
Sertraline	50 - 150 mg.	Nausea, tremors, dry mouth diarrea
Fluvoxamine	100 to 200 mg.	Nausea, drowsiness, sweating, anorexia
Other Drugs		
Venlaxaxine	112.5 to 225 mg.	Nausea, drowsiness, dizziness, dry mouth
Bupripion	150 to 300 mg.	Agitation, insomnia, anorexia

Lithium

Lithium acts as a mood stabilizer in the prophylaxis of bipolar depression but has also antidepressant effect. It can be used alone as an antidepressant or as an adjunct to treatment with other antidepressants. Most patients tolerate lithium well and as long as serum levels are monitored and kept within the range.

Dose 900-1200 mg. of lithium carbonate ($LiCO_3$)/day. Therapeutic lithium level (0.6-1.2 m/l) level of more than 2.0 meq/l results in toxicity.

Common toxic effect are neurological and nephrological and endocrinological especially Hypothyroidism.

Electro Convulsive Therapy

ECT is a useful form of treatment in elderly depressive patients, if patient is highly suicidal and there are no serious physical illness. The only real absolute contradiction to ECT is the clinical evidence of raised intracranial pressure.

About 10-30% of depressive patients fail to respond to adequate drug therapy. In these cases ECT is worth consideration. ECT is specially beneficial when the patient comes with acute suicidal preoccupation and severe guilt feelings with modern techniques ensuring safe anesthesia, muscle relevant and adequate oxygenation and by using unilateral electrodes, most of drawbacks of ECT can be eliminated.

Psychotherapy

Psychotherapy has been found to be useful in mild to moderate depression. Cognitive therapy seems to be particularly appropriate method for older depressed patients. It requires special skills and training to give cognitive psychotherapy.

Family Therapy

Family problems may contribute to the developments of a depressive illness and the support of a patient family is most important in ensuring a successful outcome of treatment.

Psychosocial Intervention

A full understanding of the patients social is as important as the understanding of his psychological make up. In many situations, a tactful intervention by the therapist may be therapeutically as effective as psychotherapy. Both psychodynamic and cognitive behavioural approaches are equally successful with elderly. However in the recent past cognitive therapy has been found to be particularly appropriate method for treating depressive patients.

2.3.5 Prognosis

The early and increasing recognition of depression in the elderly by adequate treatment using a combination of pharmacotherapy and psychosocial intervention leads to good prognosis while complete recovery without relapse is the goal of the treatment, a brief but treatable relapse should not herald therapeutic nihilism in the elderly anymore than it does in the young or middle aged population, with depression physical illhealth is possibly the single biggest factor, with those suffering from chronic disability or progressive illness being most vulnerable to relapse.

Check Your Progress 3

1) Name three important Tricyclic antidepressants, which are cheap and safe.

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2) Fluoxetine and sertaline belong to which group of drugs.

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3) What is absolute contraindication for ECT in depressed elderly.

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2.4 IDENTIFYING OTHER PSYCHIATRIC DISORDERS

You have already read about depression and how to assess a depressed patient. Now let us read about other psychiatric disorders. These include:

- Anxiety Disorder
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder
- Hypochondriasis
- Somatisation Disorder
- Paranoid Disorder

Supportive psychotherapy is the main line of treatment. If significant anxiety and depression are present, antianxiety or antidepressant drugs may be used.

Anxiety Disorders

Anxiety is a universal phenomenon observed in everyday life in all age groups and is one of the commonest clinical manifestation in a general functions clinic.

Definition

Basically anxiety is an emotion of usually unpleasant nature which can be both distressing and unbearable. Secondly anxiety is a prospective emotion directed towards the future in contrast to emotions such as regret and guilt which refer to past events. Thirdly it is related to a feeling of threat which has little or no objective external basis. Fourthly, anxiety leads to multiple and mixed somatic, endocinological, physiological, biochemical, autonomic and other associated behaviour changes.

In medicine, anxiety is a technical term with a precise meaning and is different from fear but has in common with that emotion, it's unpleasant anticipation of future and its basis is in past memory and experience. In everyday geriatric practice anxiety disorder is seen commonly either as generalized anxiety disorder mixed anxiety, phobic anxiety, disorder, obsessive conpulsive disorders, adjustment disorders and other neurotic disorders.

In generalized anxiety disorder there are symptoms which include restlessness, shakeness and excessive sweating, palpitation and gastro intestinal symptoms, and palpitation.

Post Traumatic Stress Disorders

In this condition, there is always a history of recent traumatic experiences like accidents or intressing traumatic death. The disorder is characterized by experiencing of the trauma through dreams and working thoughts with marked emotional disturbances.

Obsessive Compulsive Disorder

It is a very distressing condition where obsession are recurrent intrusive thoughts, impulses, images or feelings which the person tries to resist while compulsion are conscious repetitive behaviors like hand washing or mental acts e.g., counting numbers that the person feels and are driven to perform in response to an obsession.

Treatment

Treatment includes use of benzodiazepines like lorazepam, buspirone, psychotherapy relaxation excersises, in anxiety disorders and behaviour therapy like thought stopping and response prevention are used with use of antidepressant drug like clomipramine(75-250 mg/day) or fluoxetine(20-80 mg/dl) in obsessive compulsive disorders. In case of panic attacks, Alprazolam is effective. For social phobias, propanol has been found to be useful.

Hypochondriasis

In hypochondriasis, there is persistent preoccupation with possibility of having one or more serious and progressive physical disorders. Normal sensations or symptoms are often interpreted by the patient as abnormal or distressing. Hypochondriasis is usually occurs as a symptom in the course of other psychiatric disorders, such as depression or anxiety disorder. A diagnosis of hypochondrical disorder is made only if hypochondrical symptoms are occurring in the absence of other psychiatric disorders.

The most common symptoms are pain and symptoms gastrointestinal and cardiovascular systems. Symptoms usually run a waxing and wanning course.

Hypochondriasis can be differentiated from somatisation disorder by the emphasis, which the patient lay on presence of serious physical illness rather on symptoms as happens in somatisation disorder.

Somatisation Disorder

It is characterized by multiple, recurrent and frequently changing physical symptoms of several years' duration. There is a long and complicated medical history of contact with both primary

and specialist medical services during which many negative investigations or fruitless operations may have been carried out.

The history is usually vague, imprecise, inconsistent and disorganized. The patients often describe their complaints in a dramatic, emotional and exaggerated fashion using vivid and colorful language. Marked anxiety and depressive symptoms may be present.

Paranoid Disorders

Nearly 10 per cent of the elderly patient seeking psychiatric treatment suffer from paranoid disorders. Stressful life circumstances, deafness, impaired vision and loneliness are important contributing factors. There occur persistent persecutory delusions. Response to treatment is not so good. Antipsychotic drugs like Risperidone are Olanzapine are drugs of choice.

Check Your Progress 4

1) Which of the following symptoms has been reported less commonly in Indian elderly patients with depression as compared to those in the West?

   a) Marked changes in sleep pattern

   b) Somatic symptoms

   c) Guilt feelings

   d) Reduced family interest

   e) Retardation

2) Which of the following is not related with etiology of depression?

   a) Genetic factors

   b) Physical ill health

   c) Poverty

   d) Neurotransmitter excess

   e) Aging brain

3) Which of the following psychotherapies has been found specifically effective in depression?

   a) Psychodynamic therapy

   b) Cognitive therapy

   c) Behaviour therapy

   d) Family therapy

   e) Supportive therapy

4) Percentage of patients of depression who fail to respond to adequate drug therapy is :

   a) 5-10%

   b) 10-30%

   c) 20-40%

   d) 30-40%

   e) 40-50%

5) Doses of Antidepressant required for elderly depressed as compared to those for adults are:

   a) Same

   b) Higher

   c) Slightly lower

   d) Lower to the level of about half

2.5 LET US SUM UP

Depressive and psychiatric illness are fairly common in 15 % over 65 years of age. Ecological, cultural and social factors influence the incidence and clinical manifestations. Diagnosis of depression is based on I.C.D.10 criteria laid down by WHO. Screening test help in differentiating the normal depression with Psychiatric illness. Investigations are usually none but help in ruling out underlying medical illnesses. Treatment includes monoamine oxidase and Tricyclic antidepressant, which are safe and effective. Lithium and ECT are used in 10-30% cases where drug therapy failed. Early recognition and adequate treatment leads to good prognosis but relapse may occur, physical ill health is the major risk factor in causing relapses.

Other psychiatric disorders include Anxiety disorders, post traumatic stress disorders, obscession, compulsive disorders, and paranoid (occurs in 10% seeking Psychiatric treatment). Anti anxiety or anti depressant drugs along with supportive Psychotherapy is the main line of treatment.

2.6 KEYWORDS

Depression : is characterised by sad mood, slow thinking, with a loss of interest and pleasure.

Hypochondriosis : is a condition relates to persistent preoccupation with one or more serious and physical disorders.

Obsessive Compulsive disorder : is a recurrent intrusive thoughts, impulse or feeling inspite of trying to resist and compulsive disorder relates to repetitive behaviour such as hard working etc.

Somatisation disorder : relates to multiple, recurrent and frequently changing physical symptoms of several year duration.

2.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) There is no standard definition of depression .It is characterized by a sad mood, slow thinking and activity, loss of interest and pleasure.

2) There are three types of depression. They are classified as mild, moderate and severe depression.

3) Common symptoms include reduced concentration, reduced self-esteem, guilt feeling, pessimism regarding the future, self harm or suicidal ideas, decreased appetite and altered sleep.

Check Your Progress 2

1) Four items scale is a good screening test for assessing depression. If the score is more than one on GDS-4 or more than one in the vulnerability check list the patient should be to Psychiatrist.

2) Tests done to rule out medical illness are complete blood count, X- Ray Chest, thyroid function test. Additional test includes ECG, EEG and CT Scan.

Check your Progress 3

1) Imipramine, Amitriptyline and Trimepramine are cheap and safe and well tolerated by elderly.

2) They belong to SSRI group. (Selective Serotinine reuptase Inhibitors).

3) Increased Intracranial pressure is an absolute contraindication for FCT in depressed elderly.

Check your Progress 4

1) c

2) d

3) b

4) b

5) d

Depression

Diagnostic Flow Chart

Patient may present with single or multiple complaints