Depression | Te pōuritanga

Symptoms based on DSM-III

Five of the following nine symptoms must be present for most of the day and for longer than two weeks to indicate a major depressive disorder. One of the symptoms must be depressed mood or diminished interest. Fewer than 5 symptoms of less intensity or duration of symptoms could still indicate a milder form of depression or adjustment disorder:

1. Depressed mood, feels sad, empty, hopeless, or appears sad and tearful to others
2. Diminished interest or pleasure (family/whānau, friends, usual hobbies or activities, sex)
3. Significant weight loss or gain (> 5 percent of body weight in 1/12)
4. Sleep disturbance (usually insomnia but can be hypersomnia)
5. Fatigue or loss of energy
6. Psychomotor agitation or retardation (observable by others)
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Uncharacteristic indecisiveness or problems with concentration
9. Recurrent thoughts of death or suicidal ideas (with or without plan or intent).

Note:
In older people, the symptoms are often noticed by others (family/whānau, friends) rather than reported by the individual. Somatic (physical) symptoms also commonly occur in the older person with depression.

Risk factors

- Psychosis, eg, delusional/paranoid thoughts, hallucinations
- History of depression either personal or family history
- History of depression, current substance abuse (especially alcohol), previous coping style
- Recent losses or crises, eg, death of spouse, friend, pet, retirement, anniversary dates, move to another residence or nursing home, changes in physical health status, relationships or roles
- In elderly people, frequent somatic complaints may actually represent an underlying depression
- Chronic pain
- Diseases, eg, respiratory, cardiac, stroke, cancer.

Assessment

- Describe presenting symptoms, including: onset, duration, character, aggravating and alleviating factors, severity. Symptoms may vary throughout the day (diurnal variation)
- Are there any triggers? Note any contextual psycho-social stressors
- Any previous history of depression or any family history?
- Take a brief social history, eg, living arrangements/conditions, family supports, income, activities, note any significant history including history of trauma
- Alcohol and/or drug use – current and past
- Relevant medical information, present and past, eg, anaemia, thyroid dysfunction, hypocalcaemia or hypercalcaemia, hypoglycaemia, B12 or folate deficiency, infections, lung or heart disease
- Review recent medical investigations
- Current medication, particularly and potentially depressive agents, eg, benzodiazepines, antihypertensives, narcotics, sedatives, opiates
- Review physical health systems and arrange for, or complete, neurological and any other relevant physical examination
- Mental state assessment (BATOMI) and complete depression screening tool, such as GDS or CSSD
- Assess cognitive function – consider MoCA
- Refer to mental health services, if assessment indicates that a major depressive disorder is likely and/or if suicide ideation is present.

Anxiety, while a separate diagnostic entity, is strongly linked to depression

Anxiety is an arousal state. People experience anxiety in different ways, but the following three elements are considered to be common symptoms:

- A conscious feeling of fear and danger without the ability to identify immediate objective threats that could account for these feelings
- A disruption or disorganisation of effective problem-solving and mental control, including difficulty in thinking clearly and coping effectively with environmental demands
- A pattern of physiological arousal and bodily distress that may include miscellaneous physical changes and complaints, such as heart palpitations, faintness, feeling of suffocation, breathlessness, diarrhoea, nausea or vomiting.

Geriatric depression scale (short form)

		Answer		Score
1	Are you basically satisfied with your life?	YES = 0	**NO = 1**	
2	Have you dropped many of your activities and interests?	**YES = 1**	NO = 0	
3	Do you feel that your life is empty?	**YES = 1**	NO = 0	
4	Do you often get bored?	**YES = 1**	NO = 0	
5	Are you in good spirits most of the time?	YES = 0	**NO = 1**	
6	Are you afraid that something bad is going to happen to you?	**YES = 1**	NO = 0	
7	Do you feel happy most of the time?	YES = 0	**NO = 1**	
8	Do you often feel helpless?	**YES = 1**	NO = 0	
9	Do you prefer to stay at home rather than going out and doing new things?	**YES = 1**	NO = 0	
10	Do you feel you have more problems with memory than most?	**YES = 1**	NO = 0	
11	Do you think it is wonderful to be alive now?	YES = 0	**NO = 1**	
12	Do you feel pretty worthless the way you are now?	**YES = 1**	NO = 0	
13	Do you feel full of energy?	YES = 0	**NO = 1**	
14	Do you feel that your situation is hopeless?	**YES = 1**	NO = 0	
15	Do you think that most people are better off than you?	**YES = 1**	NO = 0	
Answers in **BOLD** indicate depression. A score > 5 points is suggestive of depression and warrants follow-up comprehensive assessment. A score > 10 points is almost always indicative of depression.				Total score

Depression screening

Cornell scale for depression in dementia

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

	Symptom/sign	Answer	Score
A	Mood-related signs		
1	Anxiety; anxious expression, rumination, worrying	A 0 1 2	
2	Sadness; sad expression, sad voice, tearfulness	A 0 1 2	
3	Lack of reaction to pleasant events	A 0 1 2	
4	Irritability; annoyed, short-tempered	A 0 1 2	
B	Behavioural disturbance		
5	Agitation; restlessness, hand-wringing, hair-pulling	A 0 1 2	
6	Retardation; slow movements, slow speech, slow reactions	A 0 1 2	
7	Multiple physical complaints (score 0 if GI symptoms only)	A 0 1 2	
8	Loss of interest; less involved in usual activities (score 0 only if change occurred acutely, ie, in less than 1 month)	A 0 1 2	
C	Physical signs		
9	Appetite loss; eating less than usual	A 0 1 2	
10	Weight loss (score 2 if greater than 2.3 kg/5 pounds in 1 month)	A 0 1 2	
11	Lack of energy; fatigues easily, unable to sustain activities	A 0 1 2	
D	Cyclic functions		
12	Diurnal variation of mood; symptoms worse in the morning	A 0 1 2	
13	Difficulty falling asleep; later than usual for this individual	A 0 1 2	
14	Multiple awakenings during sleep	A 0 1 2	
15	Early-morning awakening; earlier than usual for this individual	A 0 1 2	
E	Ideational disturbance		
16	Suicide; feels life is not worth living	A 0 1 2	
17	Poor self-esteem; self-blame, self-depreciation, feelings of failure	A 0 1 2	
18	Pessimism; anticipation of the worst	A 0 1 2	
19	Mood-congruent delusions; delusions of poverty, illness or loss	A 0 1 2	
	Scoring system A = unable to evaluate 0 = absent 1 = mild to intermittent 2 = severe Score > 12 = probably depression		Total score

! *Refer to secondary services if there are suicidal ideas or moderate-to-severe symptoms are present.*

Intervention

- Institute safety precautions for suicide risk, as per institutional policy – ensure continuous. surveillance of resident while obtaining an emergency psychiatric evaluation and disposition.
- Remove or control risk factors: consult with GP/NP to avoid/remove/change medicines that can worsen depression; work with GP/NP to correct/treat physical/metabolic/systemic medical issues.
- Monitor and promote nutrition, elimination, sleep/rest patterns, physical comfort especially pain control.
- Enhanced physical function, eg, structure regular exercise/activity, refer to physical occupation, recreational therapies, develop a daily activity schedule.
- Enhance social support, eg, identify/mobilise a support person, eg, family, confidante, friends, facility resources, support groups, resident visitors; ascertain need for spiritual support and contact appropriate clergy.
- Maximise autonomy/personal control/self-efficacy, eg, include patient in active participation in making daily schedules and setting short-term goals.
- Identify and reinforce strengths and capabilities.
- Structure and encourage daily participation in relaxation therapies, pleasant activities (conduct a pleasant activity inventory) and music therapy.
- Monitor and document responses to medication and other therapies; re-administer depression screening tool.
- Provide practical assistance, help with problem-solving.
- Provide e-therapy (beating the blues) and other self-help resources.
- Discuss pharmacological treatments with GP/NP. SSRIs are first line of treatment.
- Ensure mental health community link-up; consider psychiatric, nursing-home care intervention.
- Provide information about physical illness and treatment(s) and about depression, eg, that depression is common, treatable and not the person's fault.
- Provide emotional support, eg, empathic, supportive listening, encourage expression of feelings and hope instillation, support adaptive coping and encourage pleasant reminiscence.

Depression medication

First line treatment	Useful for patients with depression
• Sertraline • Citalopram • Escitalopram • Fluoxetine • Paroxetine	Useful for those with anxiety, can cause hyponatraemia
• Mirtazapine	Useful for insomnia, weight loss, reduced appetite, give at night, causes weight gain
Second line treatment	**Useful for patients with depression**
• Amitriptyline • Clomipramine • Dosulepin (Dothiepin) • Imipramine • Nortriptyline	Used for insomnia, severe depression or comorbid pain, has anticholinergic side effects
• Venlafaxine	Used in severe depression or treatment-resistant depression

Bibliography | Te rārangi pukapuka

Depression

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