

Depression as a General Medical Problem

BY VALERY KRASNOV

Modern psychiatry in the NIS is currently undergoing reforms aimed at democratizing psychiatric care and making it more affordable and accessible to the public. Yet at the same time, such reforms are impossible within the narrow framework of the available mental health services. There is an obvious need for interaction between the mental health and general healthcare systems, specifically in terms of integrating the diagnosis and treatment of certain types of psychiatric care into primary healthcare settings—first of all, into territorial outpatient clinics (polyclinics). One promising area for such an integration is depression.

Depression can well be considered a general medical, rather than purely psychiatric, problem. This is due to the specific nature of the clinical manifestations of depression, which heavily affect various somatic functions—sleep, general activity, and physical fitness—while mental activities themselves may remain relatively intact for a long time. It is therefore reasonable for various specialists to participate in the diagnosis and treatment of depression, as well as in the prevention of its severe, chronic, and disabling forms.

Depression in its various clinical versions is now considered a key cause of decreased working ability. In terms of years lost from a full-fledged life, depressive disorders outstrip all

other mental diseases—including Alzheimer's, alcoholism, and schizophrenia.¹ Depression currently ranks fourth among all diseases, and is expected to rank second after ischemic heart disease by 2020.²

Rates of depression vary widely depending on the criteria used. For the population of the former Soviet Union, the rate of 0.5 percent³ was found for severe depression, although it reflects a rather narrow diagnostic range. And while our understanding of depression has begun to change and its diagnostic range has been expanded, the disease is still on the rise worldwide.

Research carried out in the United States with the use of the Diagnostic and Statistical Manual of Mental Disorders—known as DSM-III-R—criteria^{4, 5} has revealed a very high percentage (9.5-11.3 percent) of people suffering from various affective disorders—including depression—with a frequency of at least one depressive episode during a given year. That rate may be much higher with the addition of the so-called disorders of the depressive spectrum, namely some forms of pathologic compulsion, some cases of alcohol/psychoactive substance abuse, some somatoform or initial phases of psychosomatic disorders, and numerous conditions generally classified as neuroses. The rate of depression is especially high among patients of primary care facilities. According to a multi-center study conducted in 12 countries, about 10 percent of patient visits to general practitioners are associated with depression.⁶ However, general practitioners (internists) recognize depressive disorders only in 10-30 percent of these cases. In turn, untimely and inadequate therapy exaggerates the relevant somatic disease (where it accompanies the depression) and renders the depressive state chronic.

The key diagnostic category for depressive disorders is termed a “depressive episode” (F 32 according to ICD-10 or 296.2, “major depressive disorder, single episode,” according to DSM-IV). Diagnosis of a depressive episode is based on a low mood and decreased interests and energy, in combination with a number of cognitive and vegetative symptoms that persist for at least two weeks (see Table 1). Similar signs are identified with “recurrent” depression and with depressive episodes related to bipolar affective disorder. The latter shows itself as alternating



Photo courtesy of Valery Krasnov

Dr. Valery Krasnov addresses a recent conference held at the Moscow Scientific Research Institute of Psychiatry, while Dr. Darrel Regier, executive director for the American Psychiatric Institute for Research and Education, Olga Borisova, representative of the US Embassy in Russia, and Dr. David Lozovsky, senior scientific advisor, US National Institute of Mental Health look on.

Symptoms of Depressive Episodes According to ICD-10

Main Symptoms

Depressed mood (irrespective of the situation).
Loss of interest and ability to feel pleasure.
Decreased energy and increased fatigability.

Additional Symptoms

Reduced concentration of attention, inability to focus.
Decreased self-esteem and lack of self-confidence.
Ideas of guilt and self-abasement.
Bleak and pessimistic views of the future.
Recurrent thoughts of death, suicide, or self-injury.
Sleep disturbances.
Disordered appetite (accompanied by changes in body weight).

2 or 3 symptoms must be present.

2 to 4 additional symptoms must accompany the main ones.

Minimum duration is 2 weeks.

Table 1. Criteria used to diagnose a depressive disorder.



depression with manic or hypomanic periods (increase in mood and general activity). Less severely manifested depressive symptoms are usually identified with “dysthymia” (relatively light chronic depression), mixed depressive and anxiety episodes, as well as symptomatic forms of depression that evolve from serious somatic diseases and organic brain lesions (see Table 2).

Existing prejudices and concerns about stigmatization often prevent people with depressive disorders from going to mental health institutions where they could gain access to the most experienced practitioners who have all the necessary methods to diagnose and treat depression at their disposal. Fortunately, with changes in the system of care for patients suffering from depression in their common non-psychotic forms, the condition can be treated by general healthcare institutions, in particular, by territorial polyclinics. This has become possible with the appearance of new antidepressants that have few serious side effects, or “behavioral toxicity.” It is the frequent negative effects of traditional tricyclic antidepressants—primarily sedation, dry mouth, urinary retention, cardiac arrhythmias, disordered fine coordination of movements, and hampered intellectual activity, which limit the opportunities for social functioning—that prevent them from being used outside of psychiatric institution outpatient services. Modern antidepressants, such as selective serotonin re-uptake inhibitors (SSRIs),

have far fewer side effects and can, therefore, be widely used in outpatient practice. Outpatient treatment also allows a more flexible combination of pharmacotherapy and psychotherapeutic methods, which themselves are not necessarily sufficient to overcome depression. Yet treatment of depression at a polyclinic should not be the prerogative of a single specialist such as a general practitioner or psychiatrist. This goal can be most successfully achieved with professional interaction among various specialists, as well as health education programs for physicians, nurses, patients, and the public in general.

The experience in some countries shows that health education programs among general practitioners and an increase of their awareness of depressive disorders and therapies can substantially reduce the number of unnecessary procedures and laboratory examinations—as well as inadequate therapeutic prescriptions—while expanding specific therapy with antidepressants. As a result, the frequency of referrals to hospitals, both general somatic and psychiatric, is also decreased.

A New Model for Treating Individuals with Depression

In 1997 the Moscow Research Institute of Psychiatry of the Russian Ministry of Health, and in cooperation with the US National Institute of Mental Health in Bethesda, Maryland, began developing a research and practical program called “Recognition and Treatment of Depression in Primary Health Care Settings.” This program is providing Russia with a new approach to the organization of consultancy and treatment services for patients with depression outside of traditional psychiatric institutions such as hospitals and dispensaries—namely, at regional polyclinics. Currently being implemented at several territorial polyclinics in Moscow, Dubna, Yaroslavl, Tomsk, and Tula, the main goal of the program is to reduce the risk of disability, or limited working ability, due to depression.

The following objectives have been set for the program under the above goal:

1. Screen the population of people who apply to polyclinics, to identify patients with affective disorders (including subdepressive and anxiety disorders) and diagnostically evaluate the disorders revealed.
2. Develop and test a model of interaction among various specialists (such as therapists, other internists, psychiatrists, clinical psychologists, and nurses) in the process of caring for patients with depressive disorders at a polyclinic.
3. Develop methodological approaches to the diagnosis of depressions and other affective disorders in patients of polyclinics, and choose safe methods of treatment suitable for use in this category of patients.

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Diagnostic Categories of Depression According to ICD-10

Depressive episode	F 32
Recurrent depression	F 33
Bipolar affective disorder, ongoing depressive episode	F 31.3-5
Cyclothymia (depressive phase)	F 34.0
Dysthymia	F 34.1
Mixed anxiety/depressive disorder	F 41.2
Prolonged depressive reaction due to adjustment disorder	F 43.21
Organic depressive disorder (psychotic)	F 06.32
Organic depressive disorder (non-psychotic)	F 06.36
Postnatal depression	F 53.0
Post-schizophrenic depression	F 20.4
Schizo-affective disorder (depressive type)	F 25.1

Table 2. Less severely manifested depressive symptoms are usually identified with dysthymia and symptomatic forms of depression that evolve from serious somatic diseases and organic brain lesions.

A Patient's Point of View

Yelena P. is a patient at the Ukrainian Psycho-Diagnostic Center in Kiev who has suffered for about 20 years from periodic depressive episodes and has been treated many times at inpatient or outpatient psychiatric institutions in Kiev. Psychologist Irina Tikholaz, a member of the AIHA's Mental Health Task Force, spoke with Yelena about her experience with this disorder.

Question: Please describe your condition when you are depressed, and how you overcome it through treatment.

Answer: I have suffered from depression since I was young—about 20 years now. I'm 38. My depressive phases recur annually, generally in the fall, and last about a month. The intensity varies. Sometimes my melancholy and depression passes without hospitalization, treatment, or time off from work, but more often I have to resort to pills and injections.

Usually depression comes on gradually. At first, I feel an inner disturbance and tension. Anxiety keeps me from falling asleep and wakes me earlier than usual. My mood is inexplicably depressed. In this state, I can still work, but I do everything more slowly than usual and I talk less, I don't want to talk. It's as if I lack mental energy. Then the melancholy fills me completely, my movements are minimized, I slow down, colors become pale, the world loses its color—it becomes gray—and I lose my will. My friends' and family's lives, my mother and my brother, no longer concern me. The melancholy and tension become unbearable. Useless and helpless thoughts take over, and the only escape I can see is death. The first time—when I didn't yet know what I had—I almost ended my life.

Now, as soon as my first symptoms appear, I start taking my pills (amitriptyline). I don't think the drug cures me, but it does help me survive the depression. The medicine is like a bandage, it envelops me, immersing me in a cottony drowsiness, and the melancholy eases. In about three weeks, the darkness gradually lifts, I become interested in my surroundings, and I start wanting to care for myself. I gradually start smiling, and my appetite returns. I become interested in my mom's and my brother's lives, and then I want to see my friends. The depression passes, and I recover.

Q: How do your relatives and friends feel about your disease?

A: At first, before we knew that I had depression, my mom didn't understand what was wrong with me. She would get angry at me, telling me I was making it up, I was lazy, or else I was hiding something from her, something unpleasant that had happened to me. Of

course she felt sorry for me, but she thought I could take hold of myself and overcome my own problems. Then, after talking to a doctor, she began to understand that it was depression, a disease. She understood that I couldn't just affect my condition myself, and that I had to be treated. Now my mom understands my depressive episodes, and she tries—as best she can—to ease my melancholy and anxiety, and when I start to feel better, she supports me. Of course she worries that I might somehow harm myself when I am sick, and I understand how hard this is for her. It's very painful for her to live through my difficult periods, when she can't help me at all.

Q: What do you think of the mental health system in Ukraine and what would you change about it?

A: I'm very grateful to my doctor, who will always hear me out and help me gradually come out of my depression. Of course, the conditions in the hospitals are not the best, but when I'm depressed, I don't care where I am or what's going on around me. After the sickness eases, the hospital surroundings start to bother me and I want to get out quickly.

Now I know that there are many patients like me. After an attack passes, when I'm still in the hospital, it's gotten a little easier for me. I can talk about my problems and feelings, not just with the doctor, but with other women just like me. We understand each other and can face our condition together. But it's also important for me to interact outside the mental hospital with people who have the same problems. I would like to see support groups organized for depression sufferers that would help support us in our acute phases and in between, too. I think such groups would also ease the load on doctors and help the relatives of depression patients.

Of course, psychiatry has undergone many positive changes lately. Hospitals have become more open, and radio, television, and newspapers have started informing the public of emotional illnesses and

how to help people suffering from mental problems, and how patients can protect their rights. These are definitely very important beginnings, and I really hope they continue.



Interview procedures at an outpatient clinic at the Moscow Scientific Research Institute of Psychiatry.

Photo courtesy of Valery Krasnov.



A Son's Point of View

Leonid K. has suffered from depression for approximately 10 years, during which time his wife was his primary caretaker until her death two years ago. Now his son Vasily has assumed the responsibility of taking care of his father. Vasily and his family live in a two-bedroom apartment near the center of Almaty; his father lives in a small home nearby. CommonHealth asked Vasily to answer some questions about how his father's illness affects his family.

Question: Can you describe your father's illness from your perspective?

Answer: My father has been suffering from depression for several years, and his condition is torturous both for himself and for the rest of our family. To me, his disease resembles a suppressed power that cannot find a way out and devours him from within. He is constantly brooding about his life, about his pains, and, most important, about his grievances—and that heart-searching has a destructive effect on him. At times, I think that if he would only stop pitying himself for a moment, if he would “forget” about his disease and think how HE might help other people, he would live a much happier life and his disease would then retreat.

But the doctors have explained to me that my father's depression has an endogenous etiology and that the disease greatly exaggerates his normal character, which is already given to complaining. Knowing that, I can hardly hope my father's behavior will change some day.

Q: When your father is depressed, how does that affect you emotionally? How does it affect your family socially, emotionally, financially, and physically?

A: My father's disease has definitely changed a lot of things. First of all, it has changed the relations within our family. Regrettably, these relations have become burdensome. My father's continued attempts to blame his illness on those people who surround him rather than himself have resulted in relatives beginning to avoid him. The relatives, who initially took his problems to heart, now have concluded that he simply tries to manipulate them and make them serve him. People who are not knowledgeable about psychiatry cannot understand “paralysis of will,” a condition in which a person understands the need—and is physically able—to take an action, but does not want to do that, preferring voluntary suffering instead. To outsiders, this looks like he is just being selfish. They cannot believe that it's the disease that creates the situation and thus do not regard such a person as ill.

At times, I begin to think that all his suffering is just an attempt to keep me to himself. And his most reliable way of doing that is to make me feel guilty about his illness. Sometimes, my father goes so far as to try to influence my feelings by saying he will commit suicide to put an end to his suffering. Other times he says that the only reason he does NOT commit suicide is, as he puts it, “out of pity for me”—thus making me responsible for his suffering, over and over. Anyone would find it very difficult to sustain such treatment from someone you love—his words tend to unsettle me for a long time.

Worst of all, I'm going to run out of my internal reserve of moral mercy. As I increasingly understand that my father's condition is a disease—all of his complaints are just a figment of his imagination, but that doesn't mean his suffering isn't real—I try to provide him with professional care and available conveniences, but tend to increasingly estrange myself from him spiritually. That's one of the paradoxes of this disease that depresses me most of all.

Of course, providing professional care eats into our monthly budget and puts an additional strain on my family.

Q: What do you think about the mental health system in your country and what would you change about it?

A: Obviously, psychiatry in this country—and in other countries as well—is far from perfect. It took my family several years before we managed to form the correct diagnosis and find a doctor who was able to find a way to my father's heart. Medicine and society in general restrict their care to pharmaceuticals only and leave the family face-to-face with the mentally ill person. Having said that, there is no society where a stranger can or should take on the moral obligations of relatives and friends! I believe any ill person should be cared for primarily by those who love him or her.

Of course, psychiatry is faced with an additional problem in this respect—the disease of a mentally ill person also has a destructive effect on the mental health of those people surrounding that person. Sometimes, the individual who takes care of an ill person needs somebody to share his or her problems and distress with. That's where a doctor can help. They can help family members understand the exact nature of the illness and help them survive in situations when they still deal with, still have relationships with, and still care about the mentally ill person. I think those people surrounding a depressed person—people who love that person and hold that person dear—need some care from a psychiatrist or psychotherapist as well.

Disease/region	Number of cases, identifying in 1999	per 100,000 population	Total number of cases since 1961	per 100,000 population
Affective disorders, Total (F30-F-39)*	4,631	9.29	45,330	90.93
Donetsk Oblast	523	10.49	3,182	63.80
Zakarattia Oblast	297	23.19	1,380	107.75
L'viv Oblast	76	5.81	1,102	84.28
Odessa Oblast	116	6.87	1,261	74.67
Kharkiv Oblast	301	10.11	3,839	128.93
Kiev City	225	8.67	3,998	154.01
Mental Disorders Total (F00-F09, F20-F-99)*	132,506	265.89	1,199,344	2,405.90

*F numbers correspond to ICD-10 diagnostic numbers. See Table 2.

Number of affective mental disorders among children, teenagers, and adults in Ukraine. Numbers for adults where AIHA partnerships are located are also given.

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4. Implement health education programs and develop information materials for physicians, nurses, patients, and their relatives.

The working procedure developed under the program includes the following six stages.

1. Screening of depressive disorders among patients of a polyclinic (based on a special questionnaire).
2. Clinical diagnosis of depressive disorders in accordance with the ICD-10 criteria.
3. Selection of patients for referral to depression therapy based on the minimum expression of 15 scores according to Hamilton's depression scale and absence of any contraindications against polyclinic therapy.
4. Pharmacotherapy of depression: monotherapy with a selected antidepressant (during at least one month); if there is no effect, change of antidepressant, followed by psychotherapy or combined therapy.
5. Clinical evaluation of the therapeutic effect.
6. Continued observation for two months upon completion of the main course of therapy to evaluate functional and symptomatic change.

Based on the data collected to date, one can claim a high identification rate of both affective disorders (some half of those who apply to polyclinics) and clinical forms of depression themselves (about 25 percent, with some 15-20 percent of the applicants having a clinical evaluation of depression that warranted the prescription of antidepressants).

It is important to note a substantially higher positive

treatment response rate for depression with polyclinic therapy—perhaps due to the moderate expression and lack of complications—as compared with those forms of depression that psychiatrists usually deal with at mental health institutions. While positive treatment response does not exceed 80 percent for regular patients of a psychiatric hospital, significant reduction of depression symptoms or full remission is observed in more than 90 percent of outpatients of primary care settings.

In addition to the direct effect of therapy on depression, there are certainly humanitarian reasons for providing patients suffering with depression timely and adequate services in the most accessible, familiar, and non-stigmatic environment possible.

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