Mental health nowadays is not just the work of psychiatrists or psychologists. Many people with depression are reluctant to see mental health professionals. Sometimes they attend their general practitioners but hide their depressive symptoms behind the commonly presented somatic complaints.

Depression is common and has many severity levels. The severe one is called Major Depression. There are more than 50% of the core features shown in the 9 key criteria for major depression. These nine features include:

1. Depressed mood
2. Lack of interest or pleasure in all, or almost, all activities
3. Insomnia or hypersomnia
4. Feelings of worthlessness or excessive guilt
5. Psychomotor agitation or retardation
6. Poor appetite or weight loss
7. Poor concentration
8. Fatigue or loss of energy
9. Suicidal idea or attempt

The features have regular strong appearance for at least 2 weeks and disturb the social and occupational life of the patient.

Minor depression has slightly less than 50% of the core features.

Long term lower level of depression is also very common. Dysthymic disorder is characterised by chronic depression, but with less severity than a major depression. The essential symptom for dysthymic disorder is an almost daily depressed mood for at least two years, but without the necessary criteria for a major depression. Low energy, sleep or appetite disturbances and low self-esteem are usually part of the clinical picture as well. The diagnostic criteria are as follows: On the majority of days for 2 years or more, the patient reports depressed mood or appears depressed to others for most of the day.

When depressed, the patient has 2 or more of:

1. Appetite decreased or increased
2. Sleep decreased or increased
3. Fatigue or low energy
4. Poor self-image
5. Reduced concentration or indecisiveness
6. Feels hopeless

During this 2 year period, the above symptoms are never absent longer than 2 consecutive months.

ICD 10 diagnosis for dysthymia is even looser. It requires 4 out of 12 symptoms:

1. Energy decrease
2. Insomnia
3. Self confidence decrease
4. Difficulty in concentrating
5. Frequent Tearfulness
6. Loss of interest
7. Feeling of hopelessness
8. Inability to cope with the routine responsibilities of everyday life
9. Pessimism about the future or brooding over the past
10. Social withdrawal
11. Reduced talkativeness
12. Depressed mood

The Elderly are prone to dysthymia. In addition, elderly patients often show the below features.:

1. Persistently depressed mood
2. Anhedonia: loss of ability to enjoy usual pleasures
3. Loss of interest in usual activities
4. Decreased concentration, leading to short term memory impairment: "Depressive Pseudodementia"
5. Feelings of worthlessness and suicidal thoughts or actions
6. Psychomotor changes, agitation and irritability commoner than retardation
7. Psychotic symptoms, which are mood-congruent, including delusions and hallucinations
8. Somatic complaints: “masked depression”
9. Burden to family and society
10. Increased morbidity and mortality
11. Risk of suicide or physical harm to others

Depression can be presented with pure depressive symptoms but mixed emotional problems are common too. With stressful living common in Hong Kong as in many cosmopolitan cities, anxiety mixed with depression is common. Depression mixed with anxiety can be well controlled by treatment from general practitioners.

Depression can alternate with mania and can be more tricky in dealing with, requiring care in not shifting the depression pharmacologically into mania. The following is a comparison of the unipolar and bipolar depression.

<table>
<thead>
<tr>
<th>Features</th>
<th>Unipolar Depression</th>
<th>Bipolar Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of onset</td>
<td>30-40</td>
<td>20</td>
</tr>
<tr>
<td>Gender</td>
<td>Mostly women</td>
<td>Equal</td>
</tr>
<tr>
<td>Genetics</td>
<td>High risk if parents and siblings are diagnosed</td>
<td>High risk for both types of depression</td>
</tr>
<tr>
<td>Motor activity when depressed</td>
<td>Agitated</td>
<td>Lethargic</td>
</tr>
<tr>
<td>Sleep</td>
<td>Less</td>
<td>More</td>
</tr>
</tbody>
</table>
Depression can affect children to the elderly. It is of grave concern as it can be closely linked with killing of one self, a type of premature death that is preventable and treatable.

Depression is a major burden in Hong Kong and over 1000 suicidal deaths are recorded every year for over a decade. The Elderly with depression have a higher suicidal rate than younger people.

How common is depression?

Depression prevalence can be one in ten persons. It is of social concern because of the high frequency in the community. It is more common in females than males. It is a social problem aspect as well as a personal problem aspect. The sick person might not have done anything wrong to cause the illness.

While psychiatrists frequently dealt with major depression and in-patient treatment, it is just the tip of the depression iceberg. Depressive reaction to lost events are very common. Depression can also worsen the presentation and prognosis of physical illnesses.

Aetiology of depression:

The aetiology of depression is linked with stress and losses. Genetic contribution is also important and depression can run in the family. In depression, the brain serotonin and noradrenalin metabolism are frequently disturbed. The neuroendocrine changes are dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis.

With antidepressant drug treatment aiming at the correction of neurotransmitter disturbance, we hope to improve the emotional and behavioural functioning of our clients. The depressed elderly are more prone to develop dementia later in the course. There are structural changes with enlarged ventricles for some depressed patients.

Assess depression in relation to physical illnesses and suicidal risk?

Watch out for some physical illnesses closely linked with depression. These include:

- Endocrine/metabolic
  - Hypo/hyperthyroidism
  - Pernicious anaemia
  - Cushing’s syndrome
- Organic brain diseases
  - Cerebrovascular disease
  - Parkinson’s disease
  - Tumours
  - Alzheimer’s disease
- Chronic infections
  - Brucellosis
  - Neurosyphilis
  - AIDS
- Occult carcinoma
  - Pancreas
  - Lung

Some drug treatment can cause secondary depression:
- Centrally acting antihypertensive drugs, e.g. methyldopa
- Steroids
- Analgesics
- Anti-parkinsonism drugs
- Psychotropic drugs
- Miscellaneous, e.g. sulphonamides

It is important to assess the risk of suicide of a patient. We can use the "S A D P E R S O N S" to help us:

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Patients with the following factors having higher risk of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>S (Sex)</td>
<td>Male</td>
</tr>
<tr>
<td>A (Age)</td>
<td>Younger than 19 or the elderly</td>
</tr>
<tr>
<td>D (Depression)</td>
<td>Depressive disorder</td>
</tr>
<tr>
<td>P (Previous suicidal attempt)</td>
<td>History of suicidal attempt</td>
</tr>
<tr>
<td>E (Ethanol or drug abuse)</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>R (Rational thinking impaired)</td>
<td>Irrational thinking or psychotic</td>
</tr>
<tr>
<td>S (Social support)</td>
<td>Lack of social support</td>
</tr>
<tr>
<td>O (Organised plan)</td>
<td>Well-organised suicidal plan</td>
</tr>
<tr>
<td>N (No spouse)</td>
<td>Widowed</td>
</tr>
<tr>
<td>S (Sickness)</td>
<td>Physical illness, esp., chronic, severe or debilitating</td>
</tr>
</tbody>
</table>

To effectively prevent suicide, we should avoid leaving the depressed patient into a helpless and hopeless position. Seriously suicidal patients need to be watched over until the risk subsides.

The steps in the treatment of depression involve taking a history and doing a mental state examination. A basic physical examination should be performed such as blood pressure, pulse and ECG. Modern antidepressants have better side effects and cardiac safety profiles than the first generation tricyclic agents which are now rarely prescribed.

How to treat depressed patients?

Different people might require different drugs. The aim of pharmacotherapy for depression is to start low, go slow, reach there and stay there especially for elderly patients. Many modern medications are simple and often without need for titration. Patience is required as therapeutic effects might take 2 to 4 weeks to appear. Suitable nocturnal sedation is required for some patients especially those on Selective Serotonin Reuptake Inhibitors (SSRI).

Psychosocial counselling and support are helpful additions to drug treatment which puts the patient in a better performing platform for interaction with others.

Irrational beliefs like the ones listed below can be challenged if the patient is ready for that and in the communication mode:

1. It is of the utmost importance that an individual is loved or approved of by almost every other important person in his or her social world.
2. I must be competent and successful in just about everything I do if I am to consider myself worthwhile.
3. Some people are evil and wicked and should be severely punished for their behaviour.
4. It is dire devastating and catastrophic when things are not how I want them to be.
Electroconvulsive therapy (ECT) is effective but decreasingly performed with success of modern drug treatment for depression. An anaesthetist is involved for general anaesthesia although the procedure is safe with no long term side effects. ECT can help up to 80% of depressed patients returning to health.

Apart from drug treatment and psychotherapy, patients should be helped to feel at ease and have undertaking which help to promote self esteem and community living and adaptation.

Active problem solving would relieve the patients some difficulties and maintain the task solving ability of the patient.

Effective monitoring of the mood through the visual analogue scale or Geriatric Depression Scale (GDS) is helpful. GDS is a 15-question assessment scale with 7 as the cut off point for depression.

Last but not least, learn what is important for mental health and prevention of depression.

Protective factors for depression include:

- **Medical/Physical**
  - Optimising physical health
  - Correcting physical deficits e.g. hearing loss
  - Good nutrition

- **Coping behaviour**
  - Adaptive, integrated personality
  - Capacity for confiding relationships
  - Active coping style

- **Social supports**
  - Adequate social network
  - Tangible social support
  - Positive perceptions of support
  - Confiding relationships
  - Religious/spiritual beliefs