

## DEPRESSIVE SYMPTOMS — DIAGNOSIS AND MANAGEMENT

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As practically all my listeners are non-psychiatric men, my object of this article will be to introduce a psychiatric subject and not a report on special psychiatric cases or research work in psychiatry.

Brain and Strauss (1955) have quoted that the emotional expression depends on the integrative action of the hypothalamus. The participation of the cerebral cortex is essential for the conscious emotion experience. Papex (1937 as cited by Brain and Strauss 1955) has demonstrated the connections between the subcortical centres and the cerebral cortex so that the depressive emotion may be initiated at two points namely, the cerebral cortex and the hypothalamus.

The causes of depression may be outlined as follows:—

- (1) Psychological (external environmental stress)
- (2) Endogenous.
- (3) Biochemical/Metabolic Disturbance.
- (4) Structural alteration or irritation of the brain.
- (5) Organic release.

**Psychological:** The feelings of joy and sadness are experiences of every day life. We react to good news with contentment and frustration with sadness. The depth of emotion depends not only on the intensity of the stimulus but also on the personality make-up and the psychological state prevailing. The same frustration causes different degrees of reactions in different individuals. An intelligent person as a rule has better resources to overcome his setbacks and any reactive depression is likely to be brief. The other extreme — the dementia, mental defective and deteriorated schizophrenia will be unable to respond to environmental stress appropriately. The emotionally unstable tends to react readily with longer reactive depression. Some neurotics (the hysterical type) react with conversion symptom and showing no anxiety or depression. I have referred earlier certain psychological states such as dementia, mental defective and schizophrenia. When a person is

in a hypomanic mood he is full of life and gay and he becomes unconscious of any worries. A person suffering from endogenous depression will not cheer up by any pleasant news. It is a common knowledge that we would ask for a favour from someone only when he is in a good mood and not when he is grumpy.

Depression attributed to environmental stresses are classified as neurotic (reactive) depressions. Pathological grief reaction, psychopathic depression and abreactive reaction may be listed under the neurotic group.

**Endogenous:** Depression can also occur spontaneously, especially in a cyclothymic person. Such depression is often referred as endogenous depression as opposed to reactive (neurotic or exogenous) depression. It appears in the manic depressive, schizophrenic depression and involuntional melancholia. Endogenous depressions are not uncommonly precipitated by environmental stresses and sometimes by physical causes.

**Biochemical/Metabolic Disturbance:** Metabolic causes include avitaminosis, pernicious anaemia, Addison's disease, chronic anoxaemia (chr. cardiac disease, chr. CO poisoning), basophil adenoma and myxoedema.

An opium addict or an alcoholic may have depressive symptoms on withdrawal. This is a release phenomenon. The nervous system previously attuned to euphoric effect of the drug is temporarily "thrown out of balance".

Febrile illness tends to cause a mild depression in most people. Severe depression could occur following an influenza. Pneumonia and hepatitis are not uncommon causes.

Pre-menstrual tension is not uncommonly accompanied by depression. The disturbed oestrogen/progesterone ratio is the cause of the pre-menstrual tension and the majority of the patients can be relieved by hormonal therapy.

Drugs like reserpine and sulphonamide have the tendency to produce depression.

Puerperal depression is usually regarded as being precipitated by hormonal disturbance.

Vitamin B deficiency causes neurological and psychological symptoms including depression.

**Structural alteration or irritation of the brain:** Lesions affecting cerebral cortex of frontal and temporal lobes could lead to depressive features. Lesions in the posterior hypothalamus are likely to produce lethargy, indifference and depression (Foulton 1949). Diseases of basal ganglia such as paralysis agitans are prone to depressions.

Besides paralysis agitans, common organic diseases of the C.N.S. that give rise to depression are head injury, epilepsy, arteriosclerosis, senile dementia, neoplasm, and G.P.I. Less common diseases are disseminated sclerosis and epidemic encephalitis.

**Organic release:** A physical illness, cerebral or systemic could precipitate an endogenous depression. Previous history of depressive illness is present.

The aetiology of depressive symptoms is a complex one. Similar environmental stresses or physical causes including structural alteration of the brain giving rise to depressive symptoms to some and not to others imply the presence of other factors like heredity and constitution.

The psychological causes act on the central cortex which in turn acts on the hypothalamus.

The endogenous and the biochemical/metabolic groups are probably due to enzymatic disturbance acting on the hypothalamus.

Depressive symptoms are therefore very common but only a relatively small proportion of the affected individuals suffer from social disorganization, requiring psychiatric attention.

The principal features of a depressive state are the sad, tired appearance and the diminished motor activity. There is a general loss of interest for everything including food. In patients with frank depression tears may be discerned and suicidal thoughts leading to suicides are not uncommon. They feel life so miserable or entertain such severe self reproach or delusion of guilt that they prefer death. Homicides — killing of family members do happen but are relatively rare as compared with suicides. The homicides are as a rule followed by suicidal acts. The idea is to put an end to the imaginary intolerable sufferings befallen to the family and himself.

Anxiety, phobic symptoms and hypochondriasis are common and are often mistaken for neurotic symptoms. An endogenous depression presenting with neurotic features has sustained

depressive mood, which is unaffected by the environment. There is often no obvious environmental stress and his past history is free from neurotic symptoms. When a person develops neurotic symptoms for the first time after the age of 40 he is most likely to be a case of endogenous depression. Presence of stress does not necessarily mean he is neurotic.

A typical neurotic has been unstable all through his life. He is easily upset and shows tendency to brood over trivial matters. When depression is present it is ill sustained and it can be lifted when in cheerful company. A young City Council employee of about 22 years of age had been incapacitated for many months because of neurotic pain in one of his shoulders. He was first thought to have the usual neurotic illness. On careful elucidation, patient had all the time a mild but persistent depressive mood which was more intense in the morning (typical). He responded to E.C.T. promptly. This case was one of endogenous depression with hypochondriacal symptom as the subjective complaint. Recently there was a teacher of 30 years of age complaining of loss of confidence for some weeks. He had spells of this feeling over a period of some years. He could not attribute this feeling to any cause — family or place of work. A number of occasions he was at the door steps of a doctor but indecision prevented him seeing the doctor. Questionings on the patient revealed definite persistent depressive mood whenever he had feelings of loss of confidence. He was originally believed to be a case of neurotic. Periodic attacks of loss of confidence, indecision and mildly depressed mood suggest recurrent mild depressive illness. The two illustrations listed above are misleading in that patients are unable to tell that they feel depressed. We have to look for them objectively. Certain direct questions are permissible, for instance, never forget to ask a depressive patient if he had any desire to end his life or feeling at times that life was not worth living.

Depression in an epileptic is sudden in onset and lasts not more than a few days.

Depression in a dementia is typically fleeting or ill sustained. A senile dementia weeping profusely or even attempted suicide a moment ago was seen laughing happily.

Persistent depression does occur in organic cerebral diseases. A man of 50 had a stroke and developed a persistent depression. History revealed that he had previous attacks of endogenous depression. The organic disease (an internal stress) had triggered off a depression in a predisposed individual.

Diagnosis of post influenza and reserpine depressions can only be made from the history. They can be so severe as to demand the application of E.C.T. as a life saving measure.

Schizophrenics present depressive symptoms in two forms, endogenous and reactive. The endogenous types appear depressed and retarded. Rapport cannot be established. They are vague and are unable to give reasons for being depressed, a contrast to other endogenous depressions. The reactive ones feel perplexed, distressed and depressed over their fantastic hallucination and delusion which are bizarre and without consistent depressive colouring. If they hear anything depressive they also hear things pleasant.

Depression due to hormonal disturbance such as hypothyroidism and menstruation (40% of women are affected) respond to hormone therapy. The clinical features of the former and the relation of the depression with the menstrual cycle clinch the respective diagnosis.

The psychopaths have life long history of antisocial behaviour. Emotional reactions of any sort including depression may occur.

The tension and weeping during an abreactive reaction are obvious and require no amplification.

Pathological grief is occasionally seen. The affected individual continues to grieve over the loss of some one who is dear to him. He feels guilty for the death which he now believes could have been prevented by him. He might even continue to see and hear the deceased as if the deceased was still alive. The prevailing mood is one of depression and anxiety.

Depressive stupor is the most severe degree of depression. Here the psychological and

motor retardations are complete. He is mute and does not take anything by mouth. The facial expression is one of depression. Tears sometimes could be seen. The catatonic and the hysterical stupors do not bear the typical depressive appearance. *Flexibilitas cerea* may be elicited in the catatonic. Past history of hysterical illness is the rule for the neurotic.

When depression occurs in the older age group such as the involuntional melancholia and the aged, distortion of thought content in the form of hallucination and paranoid delusions are more frequently seen. Differential diagnosis from schizophrenia may arise. Unlike those of schizophrenia, the distortion of thought content in the pure depressive psychosis has a depressive theme. That of schizophrenia is silly and bizarre.

In the aged simple retarded depression is quite common. Features like those occurring in the involuntional period — anxiety, agitation, ideas of guilt, nihilistic delusions and hypochondriacal preoccupation are also frequent. Some patients are apathetic and even with clouded consciousness and exclusion from dementia arises. True affective illness is acute in onset and there is no history of impairment of memory, poor grasp, disorientation, emotional blunting and deterioration of habits.

It is clear from the above discussion that pains taking history is important. Past, present and family history are all relevant. Mental examination and neurological investigations are routine. Biochemical investigations are indicated in some.

The word depression commonly refers to endogenous of manic depressive and involuntional melancholia types, and reactive depression of neurotic type. Depressions due to organic or schizophrenic should be qualified accordingly.

## SUMMARY OF DIAGNOSIS

DISORDERS  
Manic Depressive  
(depressive)

### SALIENT POINTS

- (a) Family history 10% of parents.
- (b) Cyclothymic personality 70%.
- (c) Symptoms — simple and psychotic.
  - Persistently depressed, more so in the morning.
  - Early waking.
  - Indecision.
  - Anxiety.
  - Delusion of self reproach and guilt.
  - Anorexia.
  - Stupor (extreme).

DISORDERS	SALIENT POINTS
Involuntional Melancholia.	(a) F.H. Schiz. + (b) Obsessional personality. (c) Age 40 - 60. (d) No previous depression. (e) Symptoms — Agitation. Nihilistic delusion. Delusion                    } Hallucination            } bizarre with depressive theme. Hypochondriasis.
Depression in the aged.	Similar to involuntional. Also simple or apathetic and confused symptom. Recent history of illness.
Neurotic (Reactive)	F. H. nervous illness + Personality --- Mood liability. Difficulty of falling off to sleep. Mood can be lifted by environmental changes.
Psychopathy	Antisocial behaviour. Unpredictable impulses.
Schizophrenia	F. H. + Personality --- Schizoid 50%. Vague. No depressive theme. Other schiz. symptoms.
Hypertension	High B. P. Recent personality changes.
Cerebral lesion	Neurological signs. Lab. and other special investigations.
Epilepsy	History of Epileptic fits. Brief depression not more than a few days.
Dementia	Fleeting depression. Labile emotion. Poor memory and grasp.
Metabolic/Biochemical:—	
(a) Premenstrual tension	Related to menstrual cycle.
(b) Avitaminosis	Clinical signs.
(c) Drug	e.g. reserpine, sulphonamide.
(d) Thyroid dysfunction	30% of myxoedema patients.

DISORDERS	SALIENT POINTS
(e) Addison's disease	} Clinical findings.
(f) Chr. Anoxaemia	
Chr. Heart disease	”
Chr. CO poisoning	History of Exposure.
(g) Withdrawal symptoms	History of addiction.
(h) Infection	e.g. Influenza, pneumonia, hepatitis.
(i) Basophil adenoma	Clinical features.
Abreactive Reaction (neurotic)	Self-explanatory.
Pathological grief reaction (neurotic)	Immediately following death of some one very attached. Rarely delayed reaction.

### MANAGEMENT

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| <p>1. Depending on the diagnostic label.</p> <p>2. Hospitalization</p> <p>    (a) Observation</p> <p>    (b) Special investigation and treatment</p> <p>    (c) Because of suicidal risk</p> <p>    (d) The aged may be confused — bed rest and care of nutritional state</p> <p>    (e) Treatment of addictions.</p> <p>3. Treat or remove causative factor —</p> <p>    (a) External environmental stress in endogenous and reactive depressions</p> <p>    (b) Infection e.g. G.P.I.</p> <p>    (c) Removable tumour</p> <p>    (d) Drugs (e.g. reserpine)</p> <p>    (e) Avitaminosis</p> <p>    (f) Hormonal dysfunction</p> <p>    (g) Chr. Anoxaemia.</p> <p>4. E.C.T. for in-patients and out-patients.</p> <p>    (a) Endogenous depression</p> <p>    (b) Reserpine depression</p> <p>    (c) Epileptic depression</p> <p>    (d) Schizophrenic depression</p> <p>    (e) Post influenza depression</p> <p>5. Anti-depressant drugs:</p> <p>    e.g. Catron, Marplan and Niamid — the monoamine oxidase inhibitors</p> <p>    Response is less predictable than E.C.T.</p> <p>    More for ambulant or milder patients (Rees, 1960)</p> | <p>Contraindication — history of liver damage</p> <p>Taractan — neuroleptic and anti-depressive; claimed to be very effective for a variety of psychiatric conditions including depressions. Advantage over other anti-depressant is that i/m injection is available for acute cases.</p> <p>6. Hypnotics.</p> <p>For sleep disturbance e.g. sodium amytal for neurotic type and soneryl for endogenous type.</p> <p>7. Psychotherapy.</p> <p>Reasonable intelligence and stable previous personality decide suitability for psychotherapy.</p> <p>Sympathetic ear and patience are key note to success.</p> <p>It is used in practically all psychiatric conditions — for the neurotics from the onset of treatment and the psychotics during the period of rehabilitation (i.e. after acute symptoms have subsided).</p> <p>Reassurance, suggestions, counselling and mobilization of patients' resources if stress cannot be removed.</p> <p>8. Group Therapy.</p> <p>Occupational therapy, other social therapies — dancing, games etc., specific group therapy for psychopaths. It is relieving to know that others have similar illness. The psychopaths will be able to see for themselves the impact of their behaviour on others through group therapy.</p> |
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### 9. Leucotomy.

Prefrontal leucotomy for those with years of persistent, incapacitating depression not responding to all other measures of treatment.

Good previous personality is essential.

Caution must be exercised for those who had manic psychosis in the past — fear of releasing manic symptoms.

Schizophrenics distressed by their symptoms may be relieved.

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