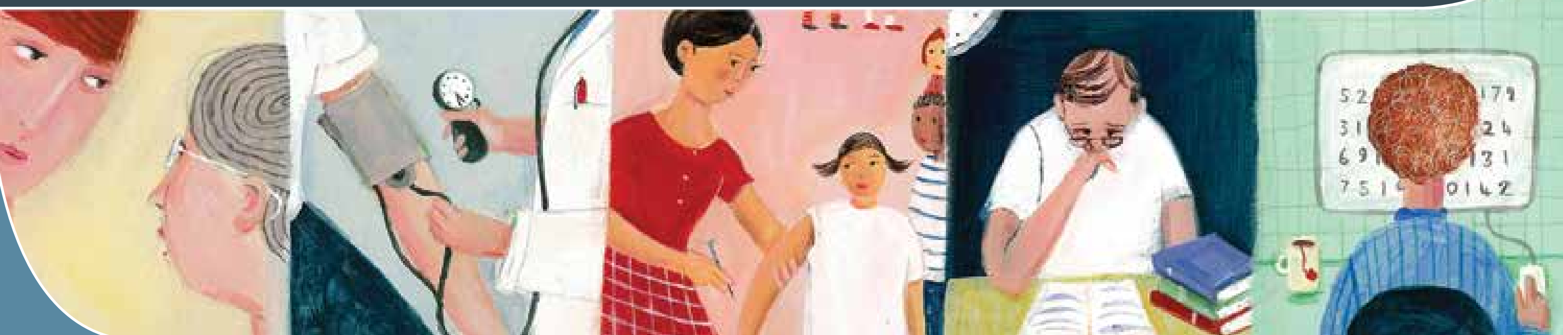

Units 490/491 January/February 2013

Depression

The Royal Australian
College of General
Practitioners

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Depression

Units 490/491 January/February 2013

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The five domains of general practice Communication skills and the patient-doctor relationship
Applied professional knowledge and skills Population health and the context of general practice
Professional and ethical role Organisational and legal dimensions

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Depression is a common condition and the GP is ideally placed to screen for depression as well as diagnose, support and treat patients who present with it. This develops from their relationship of mutual trust, and the GP's knowledge of their patients as individuals and as people in their broader sociocultural context. However, it is important, where appropriate, to involve other health professionals such as psychologists and psychiatrists, who can provide valuable input in a range of situations.

Many of us could reflect back and identify patients who have not responded as intended to treatments we have recommended or support we feel we have given. These patients, in particular, highlight the importance of active listening to patient concerns, understanding their unique context, reconsidering the diagnosis, identifying and managing comorbidities, attending to perpetuating factors and responding to reasons for non-adherence.

This issue of *check* looks at clinical scenarios in relation to diagnosis and management of depression at various stages of the life cycle and aims to explore making a diagnosis of depression, as well as some of the issues involved where a patient does not improve with treatment.

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The learning objectives of this unit are to:

- understand the differential diagnosis in patients who present with symptoms suggestive of depression
- display increased confidence in assessment of risk in patients who present with depression
- display an awareness of the importance of considering a diagnosis of bipolar disorder in patients who present with depression
- obtain a comprehensive history in patients who present with symptoms suggestive of depression and identify comorbidities such as anxiety, substance misuse or features of a possible personality disorder
- understand the role of psycho-education, psychological therapies, antidepressant medication and some common complementary therapies in the management of depression and individualise treatment to the patient involved
- identify reasons for persistence of depressive symptoms despite treatment
- assess when it is appropriate to cease antidepressant medication in patients treated for depression, and manage the process of ceasing antidepressants with confidence.

We hope you enjoy reading the interesting hypothetical scenarios of people who present with depression and that you gain some practical tips to help manage your patients.

Kind regards,

Catherine Dodgshun MBBS, DRANZCOG, FRACGP

Medical Editor, *check* Program

GUIDE TO ABBREVIATIONS AND ACRONYMS IN THIS UNIT OF *CHECK*

AMI	acute myocardial infarction	IPT	interpersonal therapy	PTSD	post-traumatic stress disorder
CBT	cognitive behavioural therapy	MDD	major depressive disorder	SNRI	serotonin and noradrenalin reuptake inhibitor
DSM IV-TR™	Diagnostic and Statistical Manual of Mental Disorders (fourth edition – text revision)	MDE	major depressive episode	SSRI	selective serotonin reuptake inhibitor
		NSAID	non-steroidal anti-inflammatory drug		
GAD	generalised anxiety disorder	OCD	obsessive compulsive disorder		
GPMHTP	GP mental health treatment plan	PND	postnatal depression		

CASE 1

FRANK HAS SUICIDAL THOUGHTS

Frank, aged 48 years, owns an accounting business. You have known Frank for many years. Over that time, you have found some of his behaviour challenging. He has frequently been irritable if you were running a few minutes late, reminding you of how important he is and that he has little time. He has often told long-winded stories of business successes and appeared to enjoy exploiting competitors. You have gathered from his wife that he has always been a workaholic and has few friends or interests outside work. She also indicated that Frank has always been very sensitive to perceived criticism or insufficient admiration.

Frank consults you for 'something to help me sleep.' You ascertain that his mood has been morose since he lost a large client a month ago and his wife subsequently left him. Initially, he was humiliated and angry because he felt he had worked hard to give her everything she could want and she was ungrateful and 'cold-hearted.' Now he wonders if he was ever good enough for his wife and he thinks she had wanted to leave him for a long time.

For the past few weeks Frank has had difficulty concentrating at work and his business has suffered. He no longer enjoys his work or watching television, has no appetite or energy and has difficulty getting to sleep. Four days ago, Frank received threatening letters from his wife's lawyers. He was indignant and, after half a bottle of whisky, left messages on his wife's telephone complaining that she never appreciated him. He hasn't gone to work since. He feels there is no way out for him and has been thinking about ending his life.

Frank has no past medical illnesses and takes no regular medications. He has no family history of psychiatric illness.

QUESTION 1

What is your working diagnosis? What other diagnoses would you consider in Frank?

QUESTION 2

How would you assess Frank's risk of completing suicide?

FURTHER INFORMATION

With Frank's consent, you obtain further history from his wife, who confirms that Frank's irritable mood and grandiosity is longstanding and stable. You ask Frank about his alcohol use, and he says he drinks two bottles of wine every night to help him get to sleep, and has been doing so for the past month. Frank does not have any symptoms that suggest an underlying physical illness. You perform a physical examination and request investigations.

Frank acknowledges that he doesn't really want to end his life, but feels overwhelmed by hopelessness at times, especially when he is drinking. You are confident that he has no specific suicide plan, but you are concerned that there are limited protective factors. You are also concerned that Frank feels worse when drinking, but has no intention of stopping because it's the only way he can get to sleep.

After discussion, Frank agrees with your diagnosis of depression and wants help, but worries that he will never feel better and his future is doomed. He identifies his brother as someone who he feels close to and could call when overwhelmed.

QUESTION 3

What is your initial management plan?

FURTHER INFORMATION

You review Frank 3 weeks after commencing a selective serotonin reuptake inhibitor (SSRI) and referring him to the local mental health crisis team, who saw him for a week. He found them helpful. Frank says the crisis team recommended he continue treatment with you, but you have received no direct correspondence from them. Frank's mood and sleep have both improved and he is no longer suicidal. However, he remains upset and angry about his financial troubles.

QUESTION 4

What additional management issues should you consider?

CASE 1 ANSWERS

ANSWER 1

Frank describes over 2 weeks of a pervasively low mood, anhedonia, reduced concentration, energy and appetite, insomnia and, more recently, suicidal ideation. These symptoms are consistent with a major depressive episode (MDE).[1] The Diagnostic and Statistical Manual of Mental Disorders fourth edition – text revision (DSM IV-TR™) criteria for a major depressive episode (MDE) are listed on page 5. MDD requires the presence of at least one MDE and is the most likely diagnosis in Frank.

It is important to confirm the diagnosis of MDD and exclude other diagnoses. If Frank consents, collateral history from his wife could assist in confirming the diagnosis of MDD and excluding other diagnoses.

Other diagnoses to consider in Frank include:

- a bipolar disorder (type 1 or 2). Always consider this diagnosis and ascertain if there is any history of manic, mixed affective or hypomanic episodes, which would indicate a bipolar disorder. Distinguishing between unipolar and bipolar depression has important treatment implications (see *Case 4*). While Frank displays some features that can be part of a hypomanic or mixed affective episode such as an irritable mood, grandiosity, a sense of entitlement and a need for admiration, these features appear to be longstanding and stable. Therefore, they are more likely to be part of his personality.
- adjustment disorder with depressed mood. An adjustment disorder is characterised by the development of clinically significant emotional or behavioural symptoms in response to an identifiable stressor. Frank's cluster of symptoms is more consistent with an MDE.
- narcissistic personality disorder. Frank has characteristics such as grandiosity, a sense of entitlement and a need for admiration, which may be considered narcissistic personality traits or part of a hyperthymic temperament. Further longitudinal assessment and careful history are required to determine if these symptoms are of sufficient clinical concern to merit an additional personality disorder diagnosis (see *Page 5*).[1]
- an anxiety disorder. An anxiety disorder such as generalised anxiety disorder (GAD) may present with symptoms that can be confused with irritability, and may co-exist with MDD. Further history regarding excessive worry about a variety of situations should be sought from Frank.
- substance-induced depression, or substance misuse comorbid with depression. Alcohol abuse, dependence and withdrawal are all associated with dysphoria and depressive symptoms. Further history regarding the amount and pattern of alcohol intake and symptoms of dependence or withdrawal is required.
- major depression due to a general medical condition or the effects of medication. Further history, physical examination and investigations can exclude physical illness or medications (*Table 1*)[2] that may cause or exacerbate depressive symptoms. *Table 2* lists screening investigations to consider in order to help exclude physical illness.

Criteria for major depressive episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1. depressed mood or 2. loss of interest or pleasure

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations

1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or a decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. fatigue or loss of energy nearly every day
7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet the criteria for a Mixed Episode*

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, or a medication) or a general medical condition (e.g. hypothyroidism)

E. The symptoms are not better accounted for by bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation

*See page 365 of the publication below

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Most **Axis 1 disorders** are syndromes of commonly co-occurring symptoms and include psychiatric conditions such as MDD, bipolar disorders and adjustment disorders as well as mental conditions due to a general medical condition and substance-related disorders.[1] Most of these disorders have symptoms that are associated with significant distress or impairment in functioning. Although these conditions may be chronic, they are thought to have a natural history that does not encompass most of adult life. Treatments to which they may respond include medication and/or short-term psychological interventions, depending on the disorder involved.

A **personality disorder** is diagnosed on the basis of symptoms in at least two of the following: thought, emotion, interpersonal functioning or impulse control, where the symptoms are not due to another psychiatric illness, a general medical condition or a substance. Examples include borderline personality disorder, narcissistic personality disorder and avoidant personality disorder.[1] Symptoms of a personality disorder consistently cause significant distress or impaired functioning in multiple aspects of an individual's life. Symptoms of a personality disorder are present for most of adult life and are pervasive and stable over time. Unlike Axis 1 disorders, in general, personality disorders do not respond to medication and longer-term psychological therapy is the treatment of choice.

While **personality traits** are characteristic patterns of thought, emotion, interpersonal functioning and/or impulse control and they are also usually stable over time, there are some key differences that separate them from personality disorders. Personality traits are more flexible than patterns in a personality disorder and do not consistently cause significant distress or impairment in functioning.[1]

ANSWER 2

A recent long-term cohort study suggests approximately 7% of people with MDD commit suicide, but some groups are at higher long-term risk, particularly males with severe depression.[3] Demographic, social, mental and physical health factors may influence both acute and chronic suicide risks (*Table 3*).[4, 5]

Enquire about suicidal thoughts. Be tactful but direct. Frank gives a history of suicidal thoughts. Enquire about the frequency and persistence of these suicidal thoughts, any specific suicide plan, the means to carry out the plan and any final acts undertaken (such as settling affairs, making a will or writing letters). Take particularly seriously any plans involving pain or lethal means (such as firearms or hanging). Ask about past suicidal attempts and the seriousness of these attempts. Also enquire about protective factors including intellectual functioning, internal coping resources, value systems and available social supports. Ascertain if there is a family history of suicide.

Various clinical features can help differentiate between clinical disorders referred to as 'Axis 1 disorders', personality disorders and personality traits in DSM IV-TR™.

ANSWER 3

Immediate management consists of determining the most appropriate setting for treatment depending on the severity of the MDE, risk of suicide and social supports available.

Frank has a moderately increased risk of suicide, but is willing to accept treatment. Community management is likely to be appropriate, but short-term support, such as that provided by an outreach or crisis team from a local mental health service, is advisable.

Crisis team support allows close monitoring of Frank's mental state and suicide risk as treatment is being implemented, the effectiveness of that treatment and any adverse effects that might emerge. The process of referral to these teams varies according to the Australian state or territory.

Short-term management consists of:

- psycho-education
- treating the presenting symptoms
- determining the plan for future reviews
- making appropriate referrals.

Table 1. Physical conditions and medications or substances that can cause depressive symptoms

Physical condition	Medication or substance
• Malignancy • Hypothyroidism • Congestive cardiac failure • Cerebrovascular disease and stroke • Other intracerebral lesion • Delirium • Diabetes • Anaemia • Post-infective states	• Beta-blockers • Corticosteroids • Benzodiazepines • Alcohol

Adapted with permission from Murtagh JE. General practice. 5th edn. Sydney: McGraw Hill, 2011.

Table 2. Screening investigations to consider to exclude 'organic' causes of depression

- Full blood examination
- Urea, electrolytes and creatinine
- Liver function tests
- Thyroid function tests
- Vitamin D level
- Fasting blood glucose level
- Inflammatory markers
- Urine toxicology
- Cerebral imaging

Adapted from: Curan EM, Loi S. Depression and dementia. MJA Open 1 October, 2012:1Suppl4:40-43.

Table 3. Risk factors for suicide

Social/demographic

- Male
- Increasing age[4]
- Widowed or divorced[4] (especially if recent or if near to anniversary)
- Other recent losses[4]
- Social isolation[5]
- Unemployment[4,5]
- Immigrant
- University student
- Doctor

Psychiatric (most important single cause)

- Depression[4,5]
- Anxiety disorders (especially if comorbid depression)
- Personality disorders
- Schizophrenia
- Alcohol dependence[5]
- Substance abuse[5]
- Prior suicide attempts or deliberate self-harm
- Family history of suicide

Medical

- Chronic medical conditions[4]
- Chronic pain
- Incapacity
- Post-injury

Mental state

- Current acute suicidal thoughts
- Plan, especially if involving pain or lethal means (such as firearms or hanging)
- Acquired means
- Completed final acts (such as making a will)
- Prominent hopelessness
- Agitation
- Tormenting psychotic symptoms (such as command hallucinations)

Goldney R. Suicide prevention. New York: Oxford University Press, 2008.[4] Knox KL, Conwell Y, Caine ED. If suicide is a public health problem, what are we doing to prevent it? American Journal of Public Health, 2004;94(1):37–45.[5]

Antidepressant medication is indicated as Frank's symptoms are of moderate severity. Discuss the different treatments available and the likely side effects of each with Frank and reach a decision together. An SSRI would be appropriate for Frank. Possible side effects, including an increase in anxiety and agitation over the first few days of treatment and sexual side effects, should be discussed. Despite the absence of past manic or hypomanic symptoms, the possibility of an occult bipolar illness remains. The crisis team and Frank himself should be warned about the risk of antidepressant medication provoking a manic 'switch' in his mood (see *Case 4*). Check baseline sodium level because SSRIs may cause or worsen hyponatraemia.

Psycho-education regarding depression, antidepressant medication treatment and the roles of stress and alcohol is imperative to optimise treatment outcome in Frank. Issues to be addressed include the possible effect of depression on his work performance, the importance of adequate sleep and behaviours that form part of sleep hygiene as well as the importance of a balanced diet and regular exercise and the perpetuating effect of alcohol on depressive symptoms and its possible interaction with antidepressant medication. It is also important to discuss the mechanism of action of antidepressant medication and the consequent need to take the tablets every day rather than on an as-required basis and reassure Frank regarding possible 'mild' side effects. Encourage Frank to identify and respond appropriately to mild and more serious side effects. Literature consistently confirms that these interventions, supporting the taking of antidepressant medication, do improve adherence.[6]

In general, the specific techniques used to address alcohol use depend on the patient's motivation to change, the severity of their alcohol use and the associated risks. Inform Frank of the links between alcohol use, depressive symptoms and suicidality. The ongoing use of alcohol may reduce the effect seen from the antidepressant medication, and may also substantially increase the risk of completed suicide.[7] Be aware that depressive symptoms may last for many months following cessation of alcohol consumption.

ANSWER 4

As psychosocial stressors, and Frank's reactions to them, have a central role in his problems, multimodal treatment is optimal. Consider referral for formal psychological therapies. Refer to *Table 4* for a list of some of the Medicare item numbers available for mental health services provided by GPs, clinical psychologists and psychiatrists.[8] See *Table 5* for the steps involved in the preparation of a GP mental health treatment plan (GPMHTP).[8]

It is important to note that suicidality is not a contraindication to psychological therapy and referral should not be delayed until partial recovery. Cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and psychodynamic psychotherapy all have evidence for effectiveness. It is important to note that the benefit of psychological therapy and medication combined may be greater than that from either on their own.[9]

Antidepressant medication may be used long term depending upon the severity of the symptoms experienced, the duration of the episode and the number of previous episodes of depression.

Other factors to consider, and assist Frank with (where possible), include:

- personality and interpersonal relationship problems
- social isolation and accessing available informal supports
- stigma
- the absence of meaningful roles or purposes in life
- employment problems and risks to reputation (medical certificates and return to work plans may help)
- financial problems such as unpaid bills
- accommodation problems
- legal problems.

Table 4. Medicare eligible mental health services by item number and provider

Medicare items available	Purpose
Items 2700, 2701, 2715, 2717 Provided by GP	To establish a GPMHTP (specific item number linked to the amount of time spent with the patient and to the presence or absence of mental health training by the GP). Usually maximum frequency of annual
Item 2712. Provided by GP	To review a GPMHTP or psychiatrist assessment and management plan. Recommended frequency is an initial review between 4 weeks and 6 months after the plan was created, and further review at least 3 months after the first review
Item 2713. Provided by GP	GP extended consultation with the patient where the primary treating problem is related to a mental disorder
Items 2721, 2723, 2725, 2727 Provided by GP	GP provision of focussed psychological strategies derived from evidence-based psychological therapies (where the GP has satisfied associated training requirements)
Items 80000, 80020; provided by clinical psychologist Items 80100 to 80170; provided by occupational therapist or social worker	Psychological therapy services and focused psychological services provided by an allied mental health worker where specific referral requirements are met. Individual therapy sessions (up to ten per calendar year with an additional six sessions in exceptional circumstances) and up to ten group therapy services per calendar year
Items 291, 293 Provided by private psychiatrist	Private psychiatry referral for assessment and establishment of mental health management plan to be implemented and monitored by GP (with annual review)

Adapted from: Australian Government, Department of Health and Ageing. Medicare Benefits Schedule. 2012. Available at www.mbsonline.gov.au [accessed 5 December 2012]

Used with permission of the Australian Government.

Table 5. Steps to access Medicare-eligible psychological services
Assessment
• Obtain and record the patient's consent to produce a GPMHTP • Obtain a history, including presenting complaint, relevant past and present biological, psychological and social factors and comorbidities • Conduct a mental state examination • Conduct a risk assessment • Make a diagnosis and/or formulation • Administer an outcome measurement tool, if clinically appropriate
Plan
• Discuss the assessment and findings with the patient • Discuss alternative treatment and referral options with the patient • Establish collaborative treatment goals • Establish actions or strategies that the patient will take responsibility for undertaking • Provide psycho-education • Develop a plan for crisis intervention and/or relapse prevention • Make arrangements for required referral, treatment, appropriate support services, review and follow-up • Ensure documentation of the above and establish a date for formal review
Adapted from Australian Government Department of Health and Ageing. Medicare Benefits Schedule. 2007. Available at www.mbsonline.gov.au [accessed 5 December 2012]. Used with permission of the Australian Government.

CASE 2

MATTHEW ISN'T HIS 'USUAL HAPPY SELF'

Matthew, aged 14 years, attends your practice with his mother Jan. You have not seen Matthew for several years. He is in year 9 at the local high school, and lives at home with his parents and sister, aged 9 years. You remember that Jan's pregnancy with Matthew and his delivery were uncomplicated, and that Jan and Matthew had bonded well. Your records show that Matthew reached all developmental milestones at the expected age. As a child, Matthew experienced mild exercise-induced asthma, but this has now largely resolved. He has attended hospital on several occasions with minor injuries, but has not required surgery or a prolonged hospital stay.

You see Jan and Matthew together, at Matthew's insistence. He tells you that 'Mum's the one that's worried, not me'. Jan agrees that she and her husband are concerned that Matthew has 'changed over the last few months' and that he 'isn't his usual happy self'. She is concerned that Matthew's teachers have also noticed a significant deterioration in his attitude and school performance over the previous 3 months. Jan is concerned that Matthew does not have much energy, despite 'sleeping all the time'. Jan is not aware of any recent conflict or losses.

During your consultation, Matthew appears sullen and makes little eye contact. After some time, Matthew agrees to see you alone. He reluctantly tells you that he often feels like crying and feels angry. He is embarrassed and concerned about his school marks, as he is struggling to concentrate. Matthew has a small group of close friends, but increasingly prefers playing online games alone as he 'can't really be bothered'. He has tried alcohol on one occasion earlier this year, but did not enjoy the taste or 'the way it made everyone act'. He has not tried cigarettes or other drugs and says that he is not interested in doing so. On specific questioning, Matthew says he has no thoughts about harming himself or wanting to die.

QUESTION 1

What is your working diagnosis? What is your differential diagnosis?

FURTHER INFORMATION

You explain the likely diagnosis to Matthew. He is happy for his mother to be involved. You invite Jan back into the room and explain the diagnosis. Jan asks you about treatment options.

QUESTION 2

What advice can you give Matthew and Jan about treatment options?

QUESTION 3

When would you consider referral to a specialist child and adolescent health service?

QUESTION 4

What clinical features might be present if Matthew were being bullied?

CASE 2 ANSWERS

ANSWER 1

Matthew has a history lasting several months of low mood; reduced concentration, motivation and energy; social withdrawal; and hypersomnia. These symptoms are consistent with an MDE. The most likely diagnosis is MDD.

The differential diagnoses that should be considered when adolescents present with depressive symptoms include:

- MDD
- dysthymic disorder. This diagnosis should be considered if the young person has experienced low or irritable mood for most days over at least 1 year. Depression can sometimes complicate dysthymic disorder, but the latter is usually well established first[1]
- an anxiety disorder. GAD and social phobia may present with similar symptoms, causing significant withdrawal and functional impairment. They often co-exist with depression and anxiety can be confused with irritability. However, both GAD and social phobia are usually more chronic than depression. GAD is characterised by excessive anxiety or worry occurring in a variety of settings.[1] Social phobia is a marked fear of scrutiny in social situations[1]
- a bipolar disorder. This diagnosis should always be considered. Seek any history of sustained periods of elated or irritable mood as there are important treatment implications. Depression may be the first presentation of bipolar disorder and there is no way to reliably differentiate these diagnoses at cross-sectional interview. Review and monitoring are essential
- prodromal symptoms of a psychosis. While psychotic illnesses are less common than mood or anxiety disorders, it is imperative to exclude them where depression is suspected. This is because mood and anxiety symptoms, in association with functional decline, may indicate the early ‘prodromal’ phases of a psychotic illness. Again, ongoing review is paramount.

Other diagnoses to consider include:

- substance misuse. Ask about alcohol and drug use. Substance misuse is commonly comorbid with depression in young people
- a physical condition (*Table 1*). This may contribute to depressive symptoms or impact upon mood
- physical and/or sexual abuse, especially if there is a history of presenting to hospital on multiple occasions with minor injuries. Mandatory reporting requirements of some description apply to doctors in all states and territories of Australia.

ANSWER 2

Treatment for depression in adolescents differs from that in adults. Antidepressants are only recommended in severe depression or where other interventions have been unsuccessful.[10]

A comprehensive management plan includes:

- employing an empathic approach
- psycho-education, including utilising written and internet resources (see *Resources*)
- utilising problem-solving techniques
- advising about lifestyle factors such as diet, exercise and sleep hygiene
- regular monitoring of mental state and risks
- obtaining collateral history
- assessing for and managing parental depression or anxiety, inconsistent parenting, marital discord
- liaising with Matthew’s school with his consent
- monitoring Matthew’s 9-year-old sister for emotional and behavioural disturbances
- referring to a psychologist or psychiatrist for a structured psychological intervention (see *Tables 4* and *5*). The current best evidence is for CBT and IPT.[10]

ANSWER 3

Referral should be considered where:

- depression is moderate to severe in intensity
- depression is complicated (for example, there is a suicide risk or concurrent substance abuse), or there is diagnostic uncertainty
- prior to commencing antidepressant medication
- a coordinated approach is required involving multiple clinicians and components of the management plan.

ANSWER 4

Bullying is increasingly common in young people of school age and may significantly affect emotional, social and academic functioning.[11] Forms of bullying are diverse, including physical and verbal abuse, and newer forms through the internet and social media. As many young people will not seek help directly, routinely consider bullying for any young person presenting with distress. Refer to *Table 6* for a list of clinical indicators of bullying.[11]

Table 6. Clinical indicators of bullying

- School refusal or refusal to discuss school day
- Being tense, tearful or unhappy before or after school
- Changes to routines around school or wanting to be driven to school
- New talk about hating school or other children
- Physical injuries, including minor ones
- Unexpected/unexplained damage to, or loss of, belongings
- Insomnia, nightmares, secondary enuresis
- Social withdrawal
- Somatic symptoms, especially if used as excuse to avoid school

Adapted from: Carr-Gregg M, Manocha R. Bullying – effects, prevalence and strategies for detection. Aust Fam Physician, 2011;40(3):98–102.

CASE 3

ANGELA HAS CHRONIC BACK PAIN AND DEPRESSION

Angela, aged 44 years, is a divorced childcare assistant with three children who recently commenced attending your practice. She presents requesting treatment for depression and chronic back pain for the first time. She says she has a past history of chronic depression, and has taken several different antidepressants without full symptom resolution.

Angela has been using over-the-counter medications to manage her back pain and describes using 20 ibuprofen 200 mg/codeine phosphate 12.8 mg tablets almost every day for the previous 6 months; she believes these tablets also help her mood.

Angela describes a prolonged history of low mood on most days, longstanding thoughts of deliberate self-harm or suicide, mood swings and periods of intense anxiety. She says she has never attempted suicide and her children have prevented her from acting on her suicidal thoughts in the past. She is not suicidal at present. She is able to work and values her job. She identifies her mother as a support.

Angela is agreeable to ceasing use of ibuprofen/codeine phosphate, but wants you to prescribe something else for the pain, in addition to something to help her mood.

QUESTION 1

What is your differential diagnosis?

QUESTION 2

What further information do you need in order to assess Angela's chronic back pain and depression?

FURTHER INFORMATION

Angela described an incident of injury to her back occurring while lifting 8 years ago with chronic pain ever since. Her pain is the focus of her current thoughts. You determine that Angela has symptoms consistent with a chronic pain disorder, MDD and substance misuse. She says that her mood worsens in association with her back pain.

QUESTION 3

How would you approach assessment of her misuse of ibuprofen/codeine phosphate?

QUESTION 4

What would management of Angela's issues in the longer term involve?

CASE 3 ANSWERS

ANSWER 1

The differential diagnosis includes:

- a mood disorder such as MDD, a bipolar disorder or dysthymic disorder. Angela has features of MDD including low mood and suicidal thoughts. She also describes 'mood swings'. Further history is required to determine their significance
- an anxiety disorder. Angela describes periods of intense anxiety. Anxiety may co-exist with depression
- borderline personality disorder. Caution and longitudinal assessment are urged before any diagnosis of personality disorder is made as symptoms of an Axis I disorder such as MDD may influence reporting of pre-morbid functioning and interpretation of personality features
- a pain disorder associated with psychological factors and/or a general medical condition. Angela describes chronic pain. If her pain is the predominant focus of her clinical presentation, if it is associated with significant distress or impairment in functioning, and if psychological factors play a major role then she may have a chronic pain disorder associated with psychological factors
- somatisation disorder. If Angela had pain in multiple sites or systems and it was associated with gastrointestinal, sexual or pseudo-neurological symptoms, she could have somatisation disorder
- substance-induced depression or substance misuse comorbid with depression.

ANSWER 2

The following information should be obtained:

- current symptoms such as sleep, appetite and concentration disturbance that suggest an MDE
- information in order to assess risk, which should form part of any mental health assessment. Ask about thoughts of deliberate self-harm or suicide (differentiate chronic suicidality from acute increases in intensity), previous suicide attempts and their lethality, previous episodes of deliberate self-harm, family history of suicide and risks to others, especially Angela's children
- details of her past psychiatric history such as previous episodes of depression, including whether there were any psychotic or manic symptoms, precipitants of these episodes and previous antidepressant treatment, including duration, response and side effects
- personality vulnerabilities, including feelings of abandonment, emptiness, isolation, affective instability and poor frustration tolerance that suggest borderline personality disorder. It is associated with increased tendency to depressive symptoms and MDEs
- details of Angela's back condition and pain, given the close relationship between chronic pain and depression. Ask about her past history of injury, results of investigations and the current pattern of pain, its precipitants and previous treatments including both medications and non-pharmacological treatment, previous referrals to health practitioners and perpetuating factors such as psychosocial stressors
- current substance use including current use of ibuprofen/codeine phosphate and over-the-counter medications, alcohol, illicit drugs, reasons for use and motivation to cease ibuprofen/codeine phosphate, physical complications of non-steroidal anti-inflammatory drug (NSAID) use, such as gastritis and renal dysfunction, and side effects of opiates, such as constipation and fatigue
- past history of substance abuse or dependence
- past medical and surgical history
- family history of psychiatric illness.

Collateral history, with Angela's consent, would be helpful.

Include assessment of her current mental state: in particular, assessment of mood and thinking. Thoughts often change with disturbances of mood. Depressed mood may be associated with thoughts that one is worthless, guilty and remorseful thoughts about relatively minor past indiscretions and pessimistic or hopeless thoughts about the future. Anxious thoughts and particular worries about health may be present. These thoughts can be unrealistic or even delusional in intensity (psychotic depression). The organisation, flow and production of thought, termed 'form' of thought, is also frequently disturbed in depression: there may be fewer thoughts overall and they may be slow.

ANSWER 3

Adopt an empathic and collaborative approach to a comprehensive drug and alcohol assessment. Use principles of motivational interviewing.[12] Provide education regarding dependence (including tolerance and withdrawal) and other long-term issues associated with NSAID use and codeine use.

Principles of motivational interviewing include: expressing empathy, exploring discrepancy, avoiding argument, rolling with resistance and supporting self-efficacy.[12]

A warm and genuine approach facilitates engagement. As discomfort generates change, tactfully highlight inconsistency between how the patient sees their current situation and how they would like it to be. In the process it is important to avoid argument, as confrontation increases resistance and does not help change. When confronted with resistance such as arguing, interrupting, negating and ignoring, explore the reasons for such resistance. Alongside all these techniques in promoting change, it is crucial to build the patient's confidence in their capacity to change.[12]

ANSWER 4

Longer-term management of Angela's issues could involve:

- explaining the relationship between a chronic pain disorder and depression. Emphasise the need to adequately manage her mood in order to improve her pain
- managing her depression and anxiety. Antidepressant medication may be appropriate. If so, consider a serotonin and noradrenalin reuptake inhibitor (SNRI) such as venlafaxine or duloxetine, as these also have pain modulating properties.[11] Side effects should be discussed and monitored for. Benzodiazepines for treatment of anxiety should be avoided as Angela may be at high risk of developing dependence
- reassessing Angela's pain once she has ceased use of ibuprofen/ codeine phospate and consider:
  - referral for physical therapy
  - referral to a pain management service
  - referral to drug and alcohol services for discussion of longer-term management options. These services may also be of assistance in providing initial advice regarding cessation of codeine-containing medications
- exploring personality vulnerabilities, as they may affect prognosis and treatment. Comorbid borderline personality disorder may limit the effectiveness of antidepressant treatment. Consider non-pharmacological measures to manage anxiety and mood swings. Examples include breathing exercises and scheduling pleasurable activities. Similarly, practical measures to address current stressors, such as childcare concerns or financial issues, are helpful and important. A GPMHTP and referral to a psychologist to utilise psychological therapies may be helpful in this regard (*Tables 4* and *5*)
- exploring Angela's social supports and encouraging opportunities for social interaction.

CASE 4

BERNADITA IS TEARFUL AND WITHDRAWN

Bernadita, aged 24 years, lives alone and works as an article clerk in a large corporate law firm. You have been her GP since she was a young child, but have seen her infrequently over the years. She has no known psychiatric history.

Bernadita says she has been struggling with low mood recently. She feels heavy and tired, and she has been frequently tearful. She has been sleeping excessively, resulting in frequent lateness to work, and comfort eating, with 4–5 kgs of weight gain. She feels unable to cope with work, lamenting that she has wasted the opportunities her parents worked so hard to give her.

Bernadita was socially active throughout her university years, but has become increasingly withdrawn and stayed at home over the previous 2 months. She has started drinking at least a bottle of wine each night 'just to forget about how I've stuffed everything up and about how pathetic I am'.

QUESTION 1

What further information do you need in order to make a diagnosis?

FURTHER INFORMATION

Bernadita reports that she was 'pretty down' during her final year of high school and a couple of times in university, but says that she had not suffered from any significant depression in the past. She is physically well. Her childhood was relatively uneventful. The only family psychiatric history is a maternal aunt who had 'manic depression.'

QUESTION 2

What is your working diagnosis?

FURTHER INFORMATION

You diagnose an MDE and assess risk. Your management includes commencing venlafaxine 75 mg daily. You arrange to review Bernadita again in 2 weeks.

However, in the meantime, you are called by a psychiatry registrar at the hospital nearby, where Bernadita has been admitted with a manic episode. She had not been sleeping and was giving friends expensive gifts, dressing in flamboyant and provocative clothes at work and acting strangely. Her parents called the crisis team when she contacted them late one night to excitedly say 'goodbye' as she believed she had been asked to report to duty by the secret service to 'save the world.' They reported that Bernadita experienced a similar episode when she was in her first year at university. However, Bernadita's behaviour at that time had not been quite as erratic and had settled after 4 or 5 days.

In hospital, venlafaxine was ceased. Lithium and olanzapine were commenced, effectively treating the manic and psychotic symptoms. You receive a discharge summary cautioning against further use of antidepressant medication and requesting you check Bernadita's serum lithium levels, but little other follow-up advice. Bernadita sees you 2 weeks after discharge and appears to be doing well.

QUESTION 3

What is your revised diagnosis?

FURTHER INFORMATION

You arrange to see Bernadita monthly. One month later she has returned to work, but still experiences a low mood at times. She is worried about what a diagnosis of bipolar disorder means for her future and often thinks about her behaviour when she was an inpatient, feeling very embarrassed. She is also having trouble sleeping. She ceased olanzapine as she believed it hampered her ability to think properly at work. You are concerned that Bernadita has some residual depressive symptoms and has not returned to the mental state and level of functioning she had prior to her most recent episode of illness.

QUESTION 4

How would you manage Bernadita?

CASE 4 ANSWERS

ANSWER 1

Bernadita's presenting symptoms require clarification. Enquire about:

- the duration, severity and pervasiveness of her current symptoms
- the presence of melancholic symptoms, such as worsening of mood in the morning, and psychotic symptoms, such as thought insertion or auditory hallucinations
- concurrent symptoms of an elevated mood suggesting that her current presentation is part of a 'mixed affective episode'
- suicidal ideation – and perform a risk assessment.

Subsequently, clarify Bernadita's past psychiatric history, and:

- exclude unrecognised manic or hypomanic symptoms
- consider whether functional decline has been in conjunction with acute symptoms or has been more insidious.

Also ask about:

- past medical history
- medications
- substance use
- family history of psychiatric illness.

ANSWER 2

The most likely diagnosis is a mood disorder, such as:

- MDD (see *Page 5*) or
- dysthymic disorder.

Other diagnoses to consider would be:

- major depression due to a general medical condition
- substance-induced depression or substance misuse comorbid with depression
- bipolar disorder–depressive episode or mixed affective episode
- prodromal symptoms of a psychosis
- alcohol abuse or dependence comorbid with depression.

Some of Bernadita's symptoms, including hypersomnolence and increased appetite, are termed 'atypical' features of depression. There is some evidence that depression with atypical features is more common in people who have a bipolar mood disorder than a unipolar mood disorder. This is not conclusive and should not be used as a basis for diagnosis.[14] Comorbid anxiety disorders, substance use disorders and personality disorders may also be more common in bipolar disorder and should be screened for.[14]

ANSWER 3

Bipolar disorder type 2 is now apparent, as Bernadita's earlier symptoms occuring while she was at university are consistent with an episode of hypomania.[1] Although her current symptoms meet the criteria for a full-blown manic episode, they do appear to have been due to the effects of antidepressant medication so should not 'count' towards a diagnosis of bipolar disorder type 1.

Bipolar disorder commonly presents with depressive symptoms prior to the onset of any manic or hypomanic symptoms.[15] Although there may be some indicators, bipolar and unipolar depression cannot be reliably distinguished cross-sectionally.

Treatment of bipolar depression with antidepressant monotherapy can induce a manic or mixed affective episode (termed 'switching'). Antidepressant monotherapy may also be ineffective for depressive symptoms or may worsen the cycling nature of the patient's mood, without inducing frank mania.[15]

ANSWER 4

Management of bipolar depression can be difficult and medications often result in incomplete symptom resolution. Bipolar disorder is thought to have a 'polyvalent' aetiology, involving biological, psychological and social factors. Thus, multi-modal treatment is most likely to optimise outcomes.[15]

In general, regarding medications for treatment of bipolar depression:

- first line monotherapy for bipolar depression could involve lithium, lamotrigine, quetiapine or olanzapine[15]
- avoid using an antidepressant medication first line, and certainly not without mood stabiliser 'cover'

- ensure a therapeutic dose, adequate patient adherence and sufficient duration of treatment. Where lithium is prescribed, check serum lithium level; generally, a serum level between 0.4–0.8 mmol/L is considered therapeutic, but check with your local pathology provider
- all medications used to treat bipolar depression have some limitations regarding effectiveness and/or tolerability.[16] See *Table 7* for an outline of medications used in bipolar disorder
- if considering adding or changing medications, specialist psychiatric support is often helpful.

For Bernadita, it would be advisable to:

- check adherence to lithium treatment and check her serum lithium level
- explore further her reasons for ceasing olanzapine
- discuss the treatment options available to her (including adding quetiapine, lamotrigine or sodium valproate to her lithium) and involve her in the decision
- assess her for comorbidities such as alcohol abuse or dependence.

Bernadita would be eligible for a GPMHTP and referral for assessment by a psychiatrist (*Tables 4* and *5*).

Psychological therapy may aid recovery from depressive symptoms, improve social functioning and reduce relapse:[17]

- psycho-education, including mood mapping (charting mood on a daily basis) and discussion about recognition of early warning signs of relapse
- CBT: addressing negative thinking
- IPT and social rhythm therapy: to help Bernadita come to terms with the losses associated with her illness and learn to regulate her activity and sleep.

Lifestyle factors to address include:

- substance abuse or dependence
- exercise
- social connectedness.

Table 7. Medications used for bipolar depression

Medication	Effectiveness	Problems
Quetiapine (300–600 mg/day)	Effective as treatment for bipolar depression Effective as prophylaxis for mania and depression	Significant side effects, especially sedation and weight gain/metabolic effects
Lithium (serum level 0.4–0.8 mmol/L)	Likely to be effective as treatment for bipolar depression, but concerns exist with methods in research to date Effective in reducing suicidality May be effective as prophylaxis for bipolar depression	Slow onset of action Monitoring requirements Significant side effects
Lamotrigine (50–200 mg/day)	Possibly effective as treatment and prophylaxis for bipolar depression Uncertain effectiveness as prophylaxis for mania May be best when used in combination with lithium	Slow titration required Optimal dose unclear Small risk of rash (reduced with slow titration)
Sodium valproate	Little evidence for use in treatment of bipolar depression as a monotherapy May be effective as prophylaxis for bipolar depression Probably effective as treatment and prophylaxis for mania May be best as an adjunct to lithium	Side effects, especially weight gain and sedation Caution in women of childbearing age required (teratogenic)
Antidepressants	Not likely to be effective, either as monotherapy or in combination with a mood stabiliser May have a role in a very select group of patients	Should not be used first line or without concurrent mood stabiliser Risk of manic switch or rapid cycling

CASE 5

MARY WANTS TO STOP HER ANTIDEPRESSANT MEDICATION

Mary, aged 32 years, is a married accountant and mother of two children who recently moved to your practice. She has been treated for moderate post-natal depression (PND) with 150 mg of sertraline for the past 12 months. She now feels that she has fully recovered, and has gone back to work part time. Her youngest child is aged 16 months and attending childcare. She wishes to discuss cessation of her antidepressant treatment and management of her depression with complementary therapies and dietary and lifestyle factors.

Mary also recently started seeing a naturopath to treat her mild eczema. She has been otherwise well in the past with no past history of medical illnesses.

QUESTION 1

What factors would you consider in the decision to stop Mary's antidepressant?

QUESTION 2

If Mary had a past history of recurrent MDD, how long should she consider staying on antidepressant medication for?

FURTHER INFORMATION

Following further discussion, you ascertain that Mary has no current symptoms of depression. She has experienced no other episodes of depression other than the PND described, which responded well to treatment. She says that her husband, mother and two close friends are supportive and she has regular contact with other mothers with small children. You decide that it is appropriate to cease Mary's antidepressant.

QUESTION 3

In general, what is your approach to the cessation of SSRIs?

QUESTION 4

What would you say to Mary about the role of complementary therapies and dietary and lifestyle factors in the management of depression?

CASE 5 ANSWERS

ANSWER 1

PND is a common condition, affecting one in seven women.[18] Risk factors include antenatal depression, a traumatic delivery, a past history of MDD, a family history of depression, and limited social support.[19] Although Mary states that her depression has resolved completely, deciding to cease effective treatment also depends on the risk of relapse and the risks associated with relapse. Risks to children from PND are manifold, including disturbed attachment (with significant implications for subsequent interpersonal functioning and mental health in adulthood), neglect, abuse and infanticide. These risks should be carefully explored, including with collateral sources of history.

You should consider the following factors in deciding whether it is appropriate to stop Mary's antidepressant medication:

- Mary's current mental state:
  - assess Mary's current mental state, particularly focusing on her mood, anxiety, energy and the presence of suicidality
- features relating to the episode of PND:
  - its precipitating factors
  - whether it commenced as antenatal or perinatal depression
  - the severity of symptoms experienced during the episode
  - whether suicidality was present or not
  - its response to antidepressant medication including number of trials of different medications necessary before response to treatment
  - the presence of psychotic or manic symptoms during the episode
  - the risks to Mary or others (especially her children) during the episode
  - Mary's insight in relation to the episode
- features relating to Mary's past psychiatric history:
  - previous depressive or manic episodes
  - functioning in between episodes of depression
  - previous treatment with antidepressant medications
- whether Mary has a family history of depression or not
- features relating to her current social circumstances:
  - social supports
  - social stressors. In the presence of current psychosocial stressors, for example, financial strain or relationship problems, it would be advisable to consider deferring withdrawal from her antidepressant until this stress resolves, given the potential for deterioration of her mood in this context.
- Mary's family planning preferences:
  - ascertain whether Mary is planning to have more children. In general, if a woman has experienced PND with one pregnancy, it is more common to experience PND with subsequent pregnancies. If Mary was planning a pregnancy in the future then a discussion involving a risk–benefit analysis about whether to remain on antidepressant medication during pregnancy is warranted (*Table 8*).

ANSWER 2

If Mary had a past history of recurrent MDD, this would indicate a significant potential for relapse. Current evidence suggests a minimum treatment period of 2–5 years of pharmacological treatment to prevent further recurrence.[16]

ANSWER 3

The general principles for antidepressant withdrawal are:

- explaining to the patient the possible effects including anorexia, nausea and anxiety, and the emergence of symptoms suggestive of any underlying depression
- slow weaning over at least 4 weeks (for example, for sertraline 150 mg – a dose reduction of 50 mg every 1–2 weeks is suggested)
- more frequent review during tapering – for example every 2–4 weeks
- monitoring for depressive symptoms and particularly enquiring about worsening sleep, energy levels, reduced concentration, low mood, increasing anxiety and the presence of suicidal features.

ANSWER 4

Complementary therapy use is increasingly widespread.[20] Modifying lifestyle factors potentially contributing to depression is part of an integrative approach to its management. Exercise has been shown to have a small effect size in the treatment of mild to moderate depression.[21] Where possible, use evidence-based complementary therapies alongside 'mainstream' approaches (e.g. medication and psychological therapy).

The role of dietary factors in depression is a focus of investigation: a 'junk food'– style diet may correlate with depression in women.[22] A diet including lean red meat and a high intake of fruit and vegetables may be protective. There is also preliminary evidence for protective effects from a Mediterranean diet,[23] and possible antidepressant effects from seafood and omega-3 fatty acids.[24] Eating regular meals to maintain blood sugar will prevent hypoglycaemia-associated anxiety. Ceasing or reducing caffeine intake may reduce anxiety and improve sleep.

Research suggests there is a link between low vitamin D levels and mild to moderate depression.[25] Evaluating vitamin D levels is particularly important in women with PND who are breastfeeding as their infants may also be at risk of vitamin D deficiency.[25]

Hypericum perforatum (also known as St John's Wort) is the most researched herbal medication for treatment of depression. This agent acts via a similar mechanism to SSRI antidepressant medications and St John's Wort has evidence of effectiveness in treating mild to moderate depression.[26] Issues with purity of the compound and difficulties in estimating the delivered dose of the drug can make its use problematic. St John's Wort also has multiple drug interactions and must not be prescribed with antidepressant medication, given the risk of serotonin syndrome. As it is freely available without a prescription, its use should be routinely enquired about.

Table 8: Risks to consider in prescribing antidepressant medication during pregnancy

	Infant	Mother
Risks of prescribing	• Possible teratogenic effects • Short-term toxicity • Possible long-term neuro-developmental effects	• Overdose • Adverse effects • Possible negative impact on therapeutic alliance
Risks of not prescribing	• Infant abuse/neglect • Adverse impact of maternal mental state on the mother–infant relationship	• Relapse of psychiatric illness • Suicide/self-harm/infanticide • Family/relationship deterioration • Use of harmful substitutes

CASE 6

REKIK IS FEELING 'RUN DOWN' AND HAS BEEN LYING AWAKE AT NIGHT WORRYING

Rekik, aged 45 years, is a single teacher who is originally from Bosnia. He has been your patient for 10 years. He presents with 2 months of difficulty sleeping and feeling 'run down'. He has been lying awake at night worrying about his job, his relationships and other aspects of his life. Rekik has missed a few days at work recently because he says 'I just can't get out of bed'.

Rekik has previously sought treatment for asthma and various minor illnesses, but has not sought your help for this problem before. He does not take any medications. He usually does not drink alcohol and has not taken any illicit drugs.

QUESTION 1

What is your differential diagnosis?

QUESTION 2

What further information do you need in order to make a diagnosis?

FURTHER INFORMATION

Rekik describes 3 weeks of low mood, which is worse in the evening. He finds initiating sleep difficult and wakes frequently throughout the night. He has been having a glass or two of wine 'to get to sleep', but no more. Rekik also describes poor appetite and a few kilograms of weight loss. Over the last few weeks, Rekik has lost interest in his usual hobbies of reading and bird-watching, and feels that his concentration is diminished to the point where he has lost track of the lesson while teaching. He feels guilty about this and worries that he is a poor teacher. He has not had any suicidal thoughts.

Rekik has always appeared to be a shy, nervous man and describes himself as being a 'worrier' all his adult life. There is no particular focus to his worry. It includes his work, finances and relationships. His family left Bosnia when he was a young child for his father's work and he did not experience any trauma as a result of the conflict there. You exclude post-traumatic stress disorder (PTSD). Rekik agrees that his fears are excessive and can be reassured. Worsening anxiety pre-dated his low mood. Symptom review reveals no other symptoms. Physical examination is normal. You request some investigations to help exclude physical illness. You diagnose Rekik with GAD and a MDE.

QUESTION 3

What is your initial management plan?

FURTHER INFORMATION

Rekik is initially not keen on CBT as he feels his energy and motivation are too poor to commit to this. You commence him on escitalopram 10 mg. You increase this to 20 mg at 4 weeks after he does not experience any symptomatic relief. Rekik describes only minor improvement after a further 4 weeks at 20 mg, but he agrees to commence CBT. He does find the sleep hygiene techniques you outlined helpful and is able to return to work.

Rekik misses the next appointment with you. After a phone call, he tells you he is going well and will make an appointment following a holiday. He also tells you that he has completed his CBT course and found it helpful.

Three months later, Rekik returns saying that his antidepressant is not working any more. He is experiencing persistent low mood and has lost interest in things he previously enjoyed. He is worried that he will never get back to 'normal'.

QUESTION 4

What are your next steps in managing Rekik and his condition?

CASE 6 ANSWERS

ANSWER 1

The differential diagnosis includes:

- a mood disorder such as MDD
- an anxiety disorder such as GAD, social phobia or PTSD. Rekik may have experienced significant trauma in the past, relating to conflict and war in his country of origin and/or may face ongoing stress or trauma. Depending on the nature and extent of his symptoms, he could have PTSD.

Consider issues particular to Rekik's cultural background as some of his symptoms may be normal within his culture.

ANSWER 2

Obtaining further information should aim to:

- explore Rekik's own sense of his cultural identity and identify culturally bound expressions of distress that can be normal within his culture
- identify or exclude organic factors (*Tables 1* and *2*)
- exclude differential diagnoses,
- assess risk.

To distinguish between anxiety and depression:

- ask about low mood and other symptoms of depression (see *Page 5*)
- ask about anxiety. You need to determine if this is the primary issue.

Table 9 outlines symptoms that can help differentiate between primary anxiety and primary depression, but it important to note that these two disorders often co-exist.

Table 9. Distinguishing between depression and anxiety

Symptoms indicating primary depression	Distinct depressed quality to mood Diurnal variation of mood Psychomotor retardation Negative cognitions (guilt, worthlessness) Suicidal thoughts Change in appetite or weight
Symptoms indicating primary anxiety	Irrational, excessive worry Feeling tense/wound up
Symptoms shared between both diagnoses	Anxiety Irritability Restlessness Poor concentration Insomnia Fatigue

If anxiety is the primary issue, you need to determine what type of anxiety Rekik experiences (*Table 10*). Note that different anxiety disorders commonly co-exist. PTSD should be screened for by tactfully asking about specific traumatic experiences, his response to them at the time, re-experiencing the trauma, emotional numbing and hypervigilance.

ANSWER 3

Given that you have diagnosed comorbid depression and anxiety and Rekik's depression is of moderate severity, his illness warrants both biological and psychological management. Medication, most likely an SSRI, should be commenced. Rekik should also be referred for a course of CBT. Both of these treatments are effective for GAD and depression.[9]

Psychological management includes psycho-education. This includes discussion about depression; collaborative exploration of factors such as vulnerability, triggering and perpetuating factors; and information regarding treatment, including medication, psychological and social strategies, relapse prevention and early warning signs. Rekik's insomnia should be specifically addressed. Education about sleep hygiene techniques should be first line (see *Page 22*).[27] Close follow-up in the initial stages to monitor response to the medication, side effects, and possible risk to self is imperative.

Basic **sleep hygiene** recommendations include maintaining a sleep routine and comfortable pre-bedtime routine; avoiding naps; reserving bed for sleep and sex and avoiding watching television, using a computer or reading in bed; avoiding inappropriate ingestion of caffeine or other substances; exercising regularly; and ensuring the bedroom is quiet and comfortable.[27] If confronted with waking during the night, it is advisable to avoid staying in bed for more than 5 to 10 minutes and instead get out of bed and rest in a chair in the dark (and avoid watching television or using a computer) until feeling sleepy.

More specifically, in order to improve sleep quality, Rekik should be advised to go to bed at the same time and wake up at the same time. His bedroom should be quiet and dark with a slightly cool temperature and clocks should be obscured from view.[27] As coffee, tea and some sodas contain caffeine, which can significantly disrupt sleep,[27] these substances should only be consumed before noon. Cigarettes and alcohol can also interfere with sleep and should be avoided before bedtime.[27] A warm bath, shower, meditation or quiet time may help prepare the mind and body for sleep. Inform Rekik that exercise can help sleep be more continuous. Rekik should aim to exercise before 2 pm as exercise close to bedtime can stimulate the production of endorphins, which interfere with sleep initiation.

ANSWER 4

Management could include:

- reviewing the history to confirm the diagnosis
- checking for and addressing any comorbid substance use disorder
- revisiting and addressing psychosocial stressors. If Rekik has significant problems in interpersonal relationships, managing at work or with grief, he may benefit from a course of IPT. This views depression as intimately linked with interpersonal circumstances and aims to ameliorate depressive symptoms by identifying and working through the particular interpersonal difficulties at play
- ensuring medication is prescribed at an adequate dose, for an adequate duration; is not interacting with other medications; and is being correctly taken
- maximising other lifestyle interventions such as diet, exercise and social opportunities.

Once these issues have been addressed, consider changing medication or adding augmenting medication. In a situation such as Rekik's, switching to an antidepressant from a different class, such as an SNRI, which also has proven efficacy in anxiety disorders, is usually indicated. Alternatively, when considering augmentation of antidepressant medication, lithium has the most evidence, but care must be taken regarding toxicity and side effects.[16] Keep in mind that specific discussions regarding risks and benefits must be undertaken for women where pregnancy may be a possibility or may be considered in the future.

Table 10. Distinguishing between different anxiety (and related) disorders

Anxiety disorder	The patient is anxious about:	Helpful questions
GAD	numerous everyday life events or conflicts	Do you find that you're worried more often than not?
Panic disorder	having a panic attack	A panic attack is a sudden rush of intense fear or discomfort that comes from out of the blue. Have you experienced something like this?
Specific phobia	a specific object/situation	Do you have any particular fears or phobias?
Social phobia	social or performance situations	Do you have fear in social situations or when you have to perform in some way?
PTSD	re-experiencing a traumatic event	Have you ever had a terrible experience where your life was in danger that still bothers you now?
Obsessive compulsive disorder (OCD)	obsessions and compulsions	Do you have any annoying, repetitive thoughts that you can't stop? Is there anything you need to do repeatedly, such as washing or checking?
Hypochondriasis	having a serious illness	Do you spend a lot of time worrying that you have a serious illness and find it hard to be reassured by others?
Somatisation disorder	various physical symptoms	Do you have lots of physical worries that getting in the way of you enjoying life?
Body dysmorphic disorder	a perceived physical flaw	Do you think that you spend more time than others worrying about a particular aspect of your appearance?
Anorexia nervosa	perceived fatness	Do you think that you spend more time than others worrying about your body shape or size?

CASE 7

THOMAS IS TIRED FOLLOWING HIS HEART ATTACK

Thomas, aged 78 years, is a widower who has been your patient for several decades. He lives alone and has always been socially active. His three children live interstate. He has no known psychiatric history. His medical history includes hypertension and hypercholesterolaemia. He has been mildly overweight for many years and does little physical exercise. He gave up smoking 18 years ago.

Thomas consults you for his first appointment following an acute myocardial infarction (AMI) 1 month previously. His recovery was complicated by pneumonia and delirium, with significant physical deconditioning. He had a brief period of inpatient rehabilitation and was discharged 2 weeks prior to you seeing him. His discharge medications included aspirin, atenolol, perindopril, atorvastatin and esomeprazole.

After discharge, Thomas was very anxious. He feared that he would have another heart attack, but would be unable to obtain the help he required in time. He increasingly thought about how close he had come to death and that he might never get his 'life' back. He has struggled with his medication regime and feels irritable. He has little energy and is too tired to bother leaving the house. He mainly eats canned soups and toast. He has lost 8 kg since you last saw him. His children want him to go and stay with them, which he says makes him feel like a child.

QUESTION 1

What is your working diagnosis? What is your differential diagnosis?

QUESTION 2

What investigations would you request to exclude differential diagnoses?

QUESTION 3

What is your initial management plan?

FURTHER INFORMATION

You diagnose an MDE and commence escitalopram. You request relevant investigations to exclude medical causes of his symptoms. You also refer Thomas to an inpatient cardiac rehabilitation program. When you review him 1 month later his mental and physical health are both much improved.

QUESTION 4

What medication side effects should you monitor Thomas for?

CASE 7 ANSWERS

ANSWER 1

Thomas is most likely experiencing an MDE (see *Page 4*). Symptoms consistent with MDE include: low and irritable mood, reduced energy and motivation, hopelessness and loss of weight.

Thomas' anxiety after discharge from hospital may have been a normal response to his experiences. However, it may also be part of depression and can occur in delirium or dementia as a result of diminished capacity to comprehend experiences and environmental stimuli.

MDD is more common in patients with cardiovascular disease and there is a particular connection between acute cardiac events and MDD.[28] Depressive symptoms increase an individual's risk for a first cardiac event and patients with sub-syndromal depressive symptoms prior to a cardiac event are at particular risk of subsequently developing a full MDE.[29]

Identifying depression in patients post-AMI or cardiac intervention is vital as depression significantly influences physical outcomes, including mortality and recurrence of cardiac events, slower recovery, more functional impairment and greater healthcare utilisation.[28, 30]

Commonly, depressive symptoms in patients who are elderly or who have significant medical issues are considered 'normal' or 'expected'. These symptoms are frequently attributed to the effects of the physical illness, especially in the case of symptoms such as fatigue or insomnia. However, unless there is a clearly established and direct physical reason for the symptoms they should 'count' towards a diagnosis of depression.

'Sub-syndromal depression' or milder symptoms may also be particularly common in elderly patients, including in up to 20% of all elderly people.[31] While they may not meet the specific DSM IV-TR™ criteria, there is evidence that at least some of these people may benefit from treatment.

Important diagnoses to exclude in the elderly include:

- depression due to a general medical condition or medication (*Table 1*). Prescribed medications that may be responsible for depressive symptoms should always be considered and enquired about
- delirium. This is common in elderly people who have physical illnesses and the hypoactive form may present like depression. The main differentiating factor is the presence, in delirium, of fluctuating impairment in consciousness and impairment in attention and (usually) orientation[1]
- dementia. The relationship between early dementia and depression is complex and many symptoms are common to both. Cognitive impairment may be the primary presentation of depression and vice versa. Bedside cognitive testing, such as the mini-mental-status examination, may be useful but formal neuropsychological testing is sometimes required to assist in differentiating between these diagnoses.

ANSWER 2

Investigate for medical conditions that may be causing or exacerbating the depressive symptoms (*Table 1*).

Mid-stream urine for microscopy and culture, chest X-ray, blood tests and electrocardiograph (ECG) may help determine a physiological 'cause' of delirium such as a urinary tract infection, pneumonia, electrolyte disturbance or arrhythmia. A diagnosis of dementia is made on the basis of the history, cognitive testing and, usually, cerebral imaging. Less common causes of dementia such as vitamin B12 deficiency may require specific investigations.

ANSWER 3

An initial management plan could include:

- assessment of risk

  Risks of MDD in the elderly may include suicide, physical neglect and falls. Risk assessment helps determine the most appropriate setting for management, and may help to establish the need for use of legal measures to compel treatment. The specific legislation regarding this issue differs across states and territories in Australia

  The history suggests that Thomas' depressive symptoms are impairing his capacity to appropriately care for himself. An inpatient admission may be appropriate. Alternatively, additional services and support may be provided to allow Thomas to receive treatment in his own home. Aged psychiatry teams usually form part of community mental health services and provide outreach for further assessment as well as implementation and modification of treatment
- psycho-education

  Regular, sensitive educational discussions regarding depression, its causes and consequences, including physical health and management strategies the patient may be able to institute, are important.
- medication

  SSRIs are usually better tolerated than other antidepressants in older people and are recommended first line.[9, 32] The SNRIs, such as venlafaxine or duloxetine, are possibly more effective than SSRIs but may also be less tolerated.[29]

  Tricyclic antidepressants have numerous, well-studied adverse cardiovascular effects and are relatively contraindicated in the elderly. Problematic pharmacodynamic and pharmacokinetic interactions with other prescribed medications may also occur. Overall, sertraline is recommended first line in post-AMI patients,[33] but other SSRIs and mirtazapine may be suitable alternatives.[16]

- Increase of psychosocial support
  The relationship between depression and cardiac mortality diminishes as perceived psychosocial support increases.[33] Cardiac rehabilitation programs often deliver psychosocial management and physical rehabilitation, possibly improving physical and psychological parameters, including depression.[35,36] Both inpatient and outpatient programs are described, but availability varies according to geographical location.

  Other psychological and social interventions that should be considered include:

  – psychological therapy. CBT has been specifically studied following AMI and found effective for achieving remission from depression (12–16 sessions).[28] Combining psychological therapy with medication is recommended for moderate or severe depression and may be more effective than either treatment alone.[28]
  – respite care. Where there are significant concerns about elderly patients' safety at home due to physical or psychiatric symptoms or significant carer 'burnout', a short-term period of residential respite may be appropriate to provide a safe environment for implementation of effective treatment and to increase perceived psychosocial support. These services may be accessed through government aged-care assessment services/teams.
  – other community supports. These are available on a temporary or permanent basis, usually through local governments or non-governmental organisations. They include Meals on Wheels, Home Help, shopping assistance, volunteer community visitors, and transport assistance.

ANSWER 4

Differences in the side-effect profiles between the individual antidepressants should be considered. Elderly patients and those with physical comorbidities are more susceptible to medication side effects and/or interactions. Initial side effects on commencement of SSRIs include anorexia, nausea, diarrhoea and dizziness. Other possible side effects include hyponatraemia, postural hypotension and falls, reduced bone density and fractures, bleeding (especially gastrointestinal), and, with some SSRIs (e.g. paroxetine), ECG changes can occur and should be monitored for.[32]

Risk factors for hyponatraemia include: old age, female gender, low body weight, low baseline sodium, concurrent use of medications that may affect sodium levels/renal function (such as diuretics, NSAIDs and carbamazepine), impared renal function, other medical comorbitities (such as hypothyroidism, diabetes, chronic obstructive pulmonary disease, hypertension, cerebrovascular disease or cerebral injury) and numerous cancers.

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RESOURCES FOR DOCTORS

GP Psych Support provides GPs throughout Australia with access to patient management advice from a psychiatrist within 24 hours. It is available by calling telephone number (03) 8699 0414 or at www.psychsupport.com.au

Twenty-four hour mobile on-call psychiatric services are available in most but not all parts of Australia. Contact details vary depending on the state or territory of Australia or location within that state or territory

beyondblue aims to improve community awareness of depression in order to prevent and respond effectively to depression. It is available at www.beyondblue.org.au and provides information for health professionals on depression as well as links to relevant journal articles and resources

Mental Health Professionals Network is available at www.mhpn.org.au. It provides clinical information and allows networking between health professionals who provide mental healthcare to their patients

The Australian Society of Psychological Medicine aims to provide a peer support network for GPs to increase their competency and confidence in managing mental health problems. It is available at www.aspm.org.au

MBS online provides information on Medicare item numbers in relation to the provision of mental healthcare. It is available at www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

Information on psychological strategies and motivational interviewing techniques is available in the September 2012 issue of *Australian Family Physician*, which can be found at www.racgp.org.au/afp/2012/september

RESOURCES FOR PATIENTS

beyondblue is available at www.beyondblue.org.au. It provides a symptom checklist for depression, information on predisposing factors and treatment of depression, managing stress and information for carers of people with depression

Sane Australia is available at www.sane.org.au and provides factsheets and podcasts on a variety of mental health issues

Lifeline is available at www.lifeline.org.au. It provides information on depression, a 'coping kit', a search facility to access services according to location and a 24-hour crisis telephone counselling crisis service by calling telephone number 13 11 14

The Post and Antenatal Depression Association is available at www.panda.org.au and provides information about postnatal depression and fact sheets on various issues in relation to parenthood

Mens Line Australia is available at www.menslineaus.org.au. It provides information on common issues affecting mental health as well as 24-hour access to counselling. Counselling is available online, via Skype or telephone 1300 78 99 78

Kids Help Line is available to children aged 5–25 years and is available at www.kidshelp.com.au or telephone 1800 55 1800. It provides 24-hour access to counselling

Headspace is available at www.headspace.org.au and is the National Youth Health Foundation. It provides information on general health, mental health, education, employment and other services, and alcohol and other drug services for young people aged 12–25 years

Australian Indigenous HealthinfoNet is available at www.healthinfonet.ecu.edu.au. It provides culturally appropriate information on a range of medical conditions, including depression, for Indigenous Australians

Mental Health in Multicultural Australia is available at www.mhima.org.au. It has links to articles and reports on mental health as well as links to transcultural services available in some states or territories of Australia

The Australian Psychological Society provides a search facility to help patients find a psychologist based on location and area of specialisation. It is available at www.psychology.org.au

The Royal Australian and New Zealand College of Psychiatry provides a search facility to help patients find a psychiatrist based on location, area of specialisation and primary clinical problem. It is available at www.ranzcp.org

The Better Health Channel is available at www.betterhealth.vic.gov.au and provides general information for patients on a range of medical conditions including depression

The following online programs are available to consumers, but are not a substitute for seeking advice from a health professional where appropriate

- MoodGYM is an interactive web program designed to prevent depression, which utilises CBT skills. It is available at www.moodgym.anu.edu.au
- E-couch is a self-help interactive program with modules for depression, generalised anxiety, social anxiety, relationship breakdown as well as grief and loss. It is available at ecouch.anu.edu.au
- Anxiety online is available at www.anxietyonline.org.au/ and provides information, assessment and treatment for a range of anxiety disorders

Depression

In order to qualify for 6 Category 2 points for the QI&CPD activity associated with this unit:

- read and complete the unit of *check* in hard copy or online at the *gplearning* website at www.gplearning.com.au, and
- log onto the *gplearning* website at www.gplearning.com.au and answer the following 10 multiple choice questions (MCQs) online, and
- complete the online evaluation.

If you are not an RACGP member, please contact the *gplearning* helpdesk on 1800 284 789 to register in the first instance. You will be provided with a username and password that will enable you access to the test.

The expected time to complete this activity is 3 hours.

Do not send answers to the MCQs into the *check* office. This activity can only be completed online at www.gplearning.com.au

If you have any queries or technical issues accessing the test online, please contact the *gplearning* helpdesk on 1800 284 789.

FOR A FULL LIST OF ABBREVIATIONS AND ACRONYMS USED IN THESE QUESTIONS PLEASE GO TO PAGE 3.

FOR EACH QUESTION BELOW SELECT ONE OPTION ONLY.

QUESTION 1

Murali, aged 33 years, presents with symptoms suggestive of both depression and anxiety. In distinguishing depression from anxiety, which of the following features is MOST likely to indicate depression as the primary, underlying problem?

A. Poor concentration
B. Insomnia
C. Irrational, excessive worry
D. Feeling tense and 'wound up'
E. Diurnal variation in mood.

QUESTION 2

Nick, aged 35 years, presents with low mood, insomnia, appetite loss, fatigue and diminished concentration. You diagnose an MDE and consider the most appropriate treatment to recommend. Regarding treatment of an MDE, which of the following is true?

A. Psychological therapy should not be used where suicidality is present.
B. There is evidence for the effectiveness of CBT in the treatment of depression.
C. IPT is commonly used, but evidence for its effectiveness is lacking.
D. Psychodynamic psychotherapy is commonly used, but evidence for its effectiveness is lacking.
E. Psychological therapy, when used in combination with antidepressant medication, rarely confers benefit over the use of antidepressant medication alone.

QUESTION 3

Paolo, aged 49 years, has a history of recurrent MDD with two major depressive episodes, both treated with antidepressants. He presents with a further episode; you prescribe antidepressants and he achieves remission. In a patient such as Paolo with recurrent MDD, current evidence suggests treatment with antidepressants for which of the following minimum periods to prevent further recurrence?

A. 6–9 months
B. 1 year
C. 2–5 years
D. 10 years
E. Lifelong.

QUESTION 4

Caitlin, aged 17 years, says she has not been enjoying school or her extracurricular activities. She has insomnia, is fatigued and has fallen behind in her homework – about which she has felt very guilty. She has lost 5 kg in weight, but is otherwise physically well. She has been withdrawn, tearful after school and says she hates school. Her mother says Caitlin has been asking to be driven to school. These symptoms have been present for the past month. Based on these initial historical features, what is Caitlin most likely to be experiencing?

A. Bipolar depression, anxiety
B. Personality disorder, MDE
C. MDE, psychosis
D. MDE, bullying
E. Dysthymic disorder, bullying.

QUESTION 5

Stephanie, aged 18 years, presents with mood swings, poor frustration tolerance and feelings of emptiness and isolation. You consider whether she has a personality disorder, but are reluctant to label her with a diagnosis of a personality disorder at this stage. In general, which of the following is true with respect to personality disorder?

A. Symptoms usually arise for the first time in middle age.
B. The criteria for diagnosis of a personality disorder can be met without necessarily causing significant distress or impaired functioning in multiple aspects of a person's life.

C. In the presence of a personality disorder, an MDE cannot be diagnosed.

D. The presence of an MDD may influence interpretation of personality features and contribute to difficulty in coming to a definitive diagnosis of a personality disorder.

E. Medication is the most effective treatment for a personality disorder.

QUESTION 6

Jairo, aged 26 years, is new to your practice and presents with depression. Given that his father suffers from bipolar disorder, you consider if Jairo's depression might be due to bipolar disorder. When considering bipolar disorder and comparing bipolar depression with unipolar depression, which of the following is true?

A. When presenting for the first time, bipolar depression and unipolar depression can be reliably distinguished from one another at the one interview.

B. Atypical features such as hypersomnia appear to be more common in bipolar depression.

C. Bipolar depression appears less likely to be associated with comorbid anxiety disorders.

D. Bipolar depression appears less likely to be associated with substance use disorders.

E. Bipolar disorder usually presents with hypomanic or manic symptoms prior to the onset of depression.

QUESTION 7

Samuel, aged 25 years, has a past history of bipolar disorder. He was on prophylactic medication, but ceased it because he felt he didn't need it any more. He now presents with depression and wants to know about his medication options for treatment of depression. Which of the following should NOT be considered a first line medication option when used alone without other medication in the treatment of Samuel's depression?

A. Sertraline

B. Lithium

C. Quetiapine

D. Olanzapine

E. Lamotrigine.

QUESTION 8

Shakra, aged 28 years, presents with an MDE. He has read about the use of St John's Wort in depression and would like to know more. Which of the following is true regarding the use of St John's Wort in depression?

A. There is very little research regarding the use of St John's Wort in depression.

B. St John's Wort has been shown to be more effective than placebo in treating mild to moderate depression.

C. St John's Wort has more side effects than SSRIs.

D. St John's Wort can be used in conjunction with SSRIs.

E. St John's Wort acts in a similar way to TCAs.

QUESTION 9

Tara, aged 34 years, consulted your colleague 3 months ago, who diagnosed GAD and an MDE. Your colleague excluded medical conditions and a comorbid substance abuse disorder, recommended lifestyle interventions, discussed psychosocial factors, referred Tara to a psychologist for a course of CBT and IPT and commenced escitalopram 20 mg. He subsequently increased it to 40 mg. Tara presents with persistent anxiety and depression. You seek further history to confirm the diagnosis, explore psychosocial factors once again, ask about her engagement with the psychologist, check adherence to medication and decide that further pharmacological intervention is warranted. Which of the following would be the next most appropriate step in relation to management of her medication?

A. Increase the dose of escitalopram to 60 mg.

B. Cease escitalopram and start an SNRI.

C. Cease escitalopram and start a TCA.

D. Continue escitalopram and add quetiapine.

E. Continue escitalopram and add lithium.

QUESTION 10

Maude, aged 78 years, presents to you after being discharged from hospital following an AMI. She takes atorvastatin, metoprolol, ramipril and aspirin. You diagnose an MDE, exclude depression due to a medical condition or medication, assess risk, discuss the diagnosis and explore her social supports. You decide that medication is appropriate and consider your options for treatment of her depression. Which of the following groups of medications or groups of medications would be the LEAST suitable option in Maude?

A. SSRIs

B. SNRIs

C. TCAs

D. Noradrenalin reuptake inhibitors

E. Tetracyclic antidepressants.