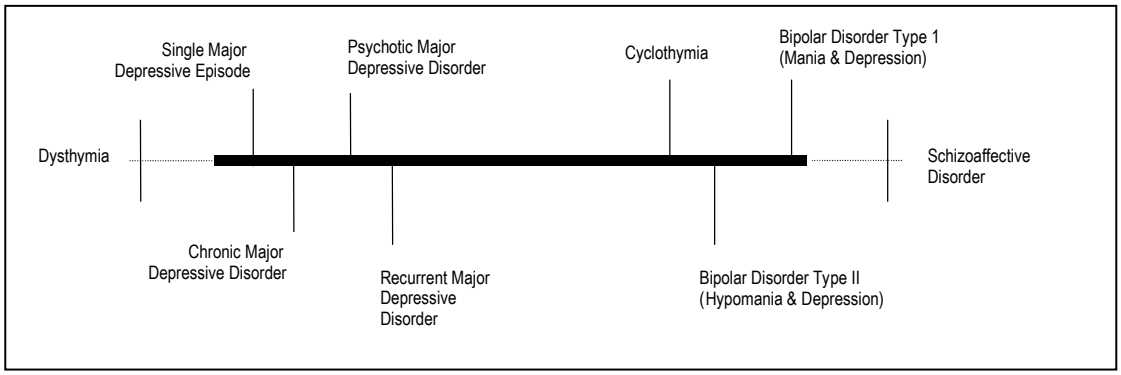
Medical Services

DEPRESSION

1. Introduction

Mood disorders can be thought of as occurring along a spectrum with a single major depressive illness and bipolar type 1 disorder at the extremes.[1]



This protocol deals with **unipolar mood disorders.** These are characterised by recurrent episodes of depression without intervening episodes of mania or hypomania. Bipolar disorders, persistent mood disorders (including cyclothymia and dysthymia), schizoaffective disorders and anxiety disorders are described in separate protocols.

Unipolar mood disorders may be primary, or secondary (to medical conditions or misuse of alcohol and other substances).

Primary unipolar mood disorders can be divided into:

- Depressive episode - single episode
- Recurrent depressive disorder - recurrent episodes
- Mixed anxiety and depressive disorder.

Each depressive episode may be:

- Moderate or severe
- If severe, with or without psychotic symptoms.

This protocol also includes:

- Other mood disorders not covered in other protocols, (**Seasonal Affective Disorder, Post-natal Depression and Depression in the Elderly**) and
- Conditions which may be associated with mood disorders as well as other psychiatric disorders. **Suicide and Deliberate Self-Harm** are described in appendices A and B respectively. **Bereavement** is discussed in Appendix C.

Historically mood disorders were often referred to as affective disorders. The term 'affective' has been replaced with 'mood' in both international classification systems of mental disorders (ICD-10[2] and DSM IV)[3] in order to emphasise the duration of the episodes of depression.

The distinction between mood and affect is sometimes blurred. **Definitions** based on DSM IV[3] are:

- *Affect*. A pattern of observable behaviours that is the expression of a subjectively experienced feeling state (emotion). Common examples of affect are euphoria, anger and sadness. Affect varies over time, in response to changing emotional states.
- *Mood*. A pervasive and sustained emotion that colours the person's thinking and perception of the world. Common examples of mood include inappropriate depression, elation and anxiety.

Depression has a range of meaning from a lay description of normal unhappiness, to a medical description of a psychotic illness. Research studies using symptom-rating scales have shown that about 10 symptoms are sufficient to characterise depressive states. These can be divided into core symptoms and other symptoms.

Core Symptoms	1.	Depressed mood	Most of the day, nearly every day
	2.	Loss of interest and enjoyment	Most of the day, nearly every day
	3.	Loss of energy, fatigue	Nearly every day
Other Symptoms	4.	Poor self confidence and self esteem	Nearly every day
	5.	Ideas of guilt and unworthiness	
	6.	Ideas or acts of self-harm or suicide	
	7.	Poor concentration, attention and indecisiveness	
	8.	Psychomotor agitation or retardation	
	9.	Disturbed sleep	
	10.	Disturbed appetite	

Diagnosis of a mild depressive episode requires at least two of the three core symptoms, plus two of the seven other symptoms. Over a period of more than 2 weeks, the symptoms should be present nearly every day, for most of the day, and cause disruption of the person's normal activities.

Diagnosis of a major depressive episode requires six of the ten symptoms listed above. Negative beliefs such as loss of self-esteem and inappropriate guilt are the core symptoms of major depression. In severe cases, hallucinations and/or delusions may occur, the content being consistent with the depressive mood (e.g. auditory hallucinations expressing derogatory comments or delusions of guilt). These cases are described as **major depression with psychotic features**.

In both ICD 10 and DSM IV, major depressive states can be further categorised by the presence of physical symptoms indicating a somatic syndrome.

Somatic (or endogenous) depression is characterised by:

- Anhedonia
- Loss of emotional reactivity to pleasurable surroundings and events
- Early waking (>2 hours early)
- Psychomotor retardation or agitation
- Marked loss of appetite
- Weight loss of >5% of body mass in one month
- Loss of libido.

This is in contrast to **Reactive Depression,** which is not depression that is a reaction to circumstances, but depression in which emotional reactivity to events is preserved.

Depression is commonly associated with anxiety disorders. Many patients do not fall neatly into categories of either anxiety or depression, so the concept of mixed anxiety and depression is now recognised. The differential diagnosis between generalised anxiety disorders and depressive disorders is listed in appendix E.

2. Description

2.1 Epidemiology

The **prevalence of unipolar mood disorder** in the community is 5%.

The prevalence is higher in women (2.0 to 9.3%) than men (1.8 to 3.2%).

The prevalence of depressive symptoms is much higher, 13 - 20%.

Community surveys suggest that as many as 16% of older people may be suffering from depression, though only a fraction of these may be known to the GP and/or psychiatric services.[4]

The **incidence** of mood episodes in women is 250 – 7,800 new cases / 100,000 population / year and in men is 80 - 200 new cases / 100,000 population / year.

In developed countries, the **lifetime risk** of a depressive episode is 9-26% in women and 5-12% in men.

2.2 Sociodemographic Factors

Depressive disorders can start at any age from childhood onwards. In women the highest prevalence rate occurs between 35 and 45 years and in men the prevalence rate increases with age. Recent trends suggest that depression is becoming more common, (or at least being diagnosed more commonly), in younger age groups.

Overall, depressive disorders are twice as common in women; however due to the increasing prevalence with age in men, in the elderly the female:male ratio is 3:2. Various explanations for the sex difference have focussed on social hypotheses relating to women's role and status in society and biological differences in hormonal effects. However as these differences are evident in community studies, consistent across cultures and persistent over time, the results are unlikely to represent biases in help-seeking behaviour.[5]

2.3 Risk Factors for the Development of Mood Disorders

Genetics

- Vulnerability to the development of major depression has strong genetic determinants.
- The heritability of major depression has been estimated at about 40%, however estimates of up to 70% have been quoted.[6]

Childhood Experience

Lack of parental care (as opposed to loss of a parent) is a consistent risk factor for the development of a depressive disorder as an adult.[6 7]

- Childhood sexual abuse is a risk factor for adult major depression.
- Cumulative childhood disadvantage poses a greater risk of depressive disorder than any single childhood variable in isolation.

Marital Status

- For men, married men have the lowest rate of depression, whilst separated or divorced men have the highest rates of major depression. In women the association is less clear.[6 8]
- The nature of the association between marital status and depression is less clear. Depression may contribute to marital breakdown, or the stress of separation or divorce could precipitate a depressive episode.

Social Environment

- Studies by George Brown of working-class women from inner London boroughs from1975 onwards[9 10 11 12] identified having three or more children, a lack of paid employment and the lack of a confidant as vulnerability factors for depressive episodes. Subsequent studies have shown only lack of a confidant to be a consistent risk factor.[6]
- Adverse life events, especially those characterised by loss, increase the risk of a major depressive episode.[13] The increased vulnerability to a depressive episode lasts for a period of 2-3 months following such an event.[14]

3. Diagnosis

The clinical features of a depressive episode can be subdivided into the biological symptoms of depression and findings on examination of the mental state.

3.1 Biological Symptoms

Synonyms: - somatic or vegetative symptoms.

Sleep disturbance

a) Characteristically *early morning wakening (middle or terminal insomnia)* – occurs 2 – 3 hours before the patient's usual time.

b) Also *initial (or onset) insomnia* – difficulty and delay in falling asleep.

c) Some depressed patients sleep excessively – but still feel *unrefreshed* on waking.

d) *Intractable sleep disturbance* is common in the elderly.

Change in appetite

Characteristically loss of appetite, less commonly increased appetite.

Change in weight

Characteristically loss of body weight (at least 5% in a month), less commonly increased weight.

Change in psychomotor activity

a) Common in the elderly.

b) Characteristically psychomotor retardation (slowed up).

c) Sometimes agitation.

Diurnal variation in mood

a) Characteristically worse in the morning – patients wake up feeling very depressed and possibly suicidal.

b) Their mood gradually lifts during the day, but is sometimes worse again in the evening.

Anhedonia

Total lack of interest in and enjoyment of hobbies / pleasure activities.

Loss of interest in work

Reduced energy and drive

Causing fatigue / tiredness and reduced activity.

Loss of (or markedly reduced) libido

Change in bowel habit

Constipation.

Change in menstrual cycle

Amenorrhoea.

3.2 Mental State Examination

3.2.1 Appearance

- Unkempt
  a) Neglected dress and grooming
  b) Poor self-care and personal hygiene – often dirty clothing.
- Facial features / depressive facies
  a) *Sagging* / turning down of the corners of the mouth
  b) *Tearfulness*
  c) *"Knitted brow"* – vertical furrowing of the centre of the forehead, between the eyebrows
  d) *Downward gaze* - poor eye contact and reduced rate of blinking

  But - some patients maintain a smiling exterior while depressed.
- Weight loss.
- Reduced gestures.
- Shoulders bent and head inclined forwards.

3.2.2 Speech

- Poverty of speech and/or speaking in a monotone.
- Slow and hesitant – long delay before questions are answered.

3.2.3 Mood

- Low and sad – often one of misery.
- Qualitatively different from one of unhappiness.
- "Autonomous" – i.e. loss of reactivity to circumstances.
- Anxiety, irritability and agitation may occur.

3.2.4 Thought

Morbid/pessimistic thoughts

- *Concerned with the past*: – often taking the form of unreasonable guilt and self-blame about minor matters, e.g. feeling guilty about past trivial acts of dishonesty (such as taking home an office pencil many years ago). Such minor misdemeanours may be exaggerated out of all proportion and used as "proof" that the patient is "evil" and does not deserve his current status in life.
- *Concerned with the present*: -

  a) Pessimism - the patient sees the unhappy side of every event.

  b) He thinks he is failing in everything he does and that other people see him as a failure.

  c) Low self-esteem - he no longer feels confident, and discounts any success as a chance happening for which he can take no credit.

- *Concerned with the future* (which seems bleak)*:*

  a) Ideas of hopelessness and helplessness - the patient expects the worst.

  b) Often accompanied by the thought that life is no longer worth living and that death would come as a welcome release.

  c) May progress to thoughts of, and plans for, suicide.

  d) Homicidal thoughts may occasionally occur: - e.g. a depressed mother may decide the future is equally bleak for her children and plan to kill them before committing suicide; or a depressed elderly man may persuade his wife to enter into a suicide pact.

Poverty of thought

Few thoughts – these lack variety and richness, and seem to move slowly through the mind.

3.2.5 Cognition

- Impaired attention and concentration.
- Poor memory – not permanent, as is often feared by the patient.
- In the elderly, depressive pseudodementia may occur.

3.2.6 Physical Symptoms

- Aching discomfort anywhere in the body.
- Increased complaints about any pre-existing physical disorder.

3.2.7 Psychotic Features of Depression

These occur in more severe episodes of depression: -

1. Delusions

a) Concerning themes of worthlessness, guilt, ill health (especially cancer) or poverty.

b) Concerning persecution (e.g. that others are going to take revenge on him); the supposed persecution is often accepted as having been brought on himself.

2. Hallucinations

a) Usually mood-congruent, derogatory, second-person auditory hallucinations – voices addressing repetitive words and phrases to the patient, confirming his ideas of worthlessness (e.g. “You are an evil sinful man; you should die”), making derisive comments or urging suicide.

b) A few patients experience visual hallucinations, such as scenes of death and destruction.

3.2.8 Depressive Stupor

- Episodes of being unresponsive, akinetic, mute and fully conscious. Rare with modern treatment.
- After an episode of stupor, the patient can recall events that took place and their mood at the time.
- Periods of excitement may intervene between episodes of stupor.

3.2.9 Other Psychiatric Symptoms

- Features of anxiety, e.g. tension, apprehension and phobic, obsessional or hysterical symptoms.
- Hypochondriacal preoccupations – these (and other somatic complaints) are common in old age.
- Depersonalisation.

3.3 Investigations

Major depressive episodes and episodes of psychotic depression may have some or all of the following investigations performed, in order to exclude the differential diagnoses listed below.

1. Urea and electrolytes, full blood count, thyroid and liver function tests.
2. A drug screen – if psychoactive substance use was suspected as a cause.
3. Vitamin B_{12} and folate levels; syphilitic serology.

4. EEG and/or CT scan if clinically justified.
5. In the elderly, hearing and vision tests - to exclude sensory deprivation (paraphrenia).

3.4 Differential Diagnosis

Secondary mood disorders can occur in various psychiatric conditions described in separate protocols. In such cases, the primary illness should be treated, with symptomatic treatment being given for the secondary mood disorder:

Organic Disorders	Cushing's disease, dementia, hypothyroidism or carcinoma.
Substance Use Disorders	Alcohol or drug misuse.
Schizophrenia	"Negative symptoms" and the pre-morbid phase of schizophrenia may be difficult to distinguish from depression. In such cases, a careful search should be made for other features of depression, such as the biological symptoms. . Depression is commonly co-morbid with schizophrenia, both in the acute phase and after an episode of schizophrenic illness – post-schizophrenic depression.
Neuroses	Appendix F describes the differential diagnosis between generalised anxiety and depressive disorders.

3.5 Co-Morbidity

Mood disorders are commonly co-morbid with other psychiatric disorders. In one study of American psychiatric outpatients with unipolar major depressive disorder, 65.4% had at least one other psychiatric disorder.[15]

Co-morbidity is important as it is associated with a longer duration of the depressive episode, more psychiatric morbidity and more social and occupational impairment. The greater the number of co-morbid conditions, the greater the psychiatric and psychosocial impairment.[15]

4. Other Types of Depression

4.1 Postnatal Depression

Non-psychotic postpartum psychiatric disorders are usually taken to include those with an onset up to about 12 weeks after delivery.

Epidemiology

- Post-natal depression (PND) affects about 10% of women in the early weeks postpartum, with episodes typically lasting 2-6 months. Residual symptoms are common up to a year after delivery.[16]
- PND is more common with increasing maternal age and lower social class.
- Most receive no treatment at all, or treatment from their GP. Fewer than 1% see a psychiatrist.

Aetiology

- There is little evidence to support a biological basis to PND.[16]
- The presence of 'baby blues' in the immediate postpartum period appears to be related to the subsequent development of PND but no hormonal basis has been identified.
- Obstetric factors are important in a sub group of vulnerable women. Women with a previous history of depressive disorder who experience complications during delivery have higher rates of postnatal depression.
- The major aetiological factors are of a psychosocial nature. Stressful life events, unemployment, marital conflict, and the absence of social and personal support have all been shown to raise the risk of PND. The absence of social support and a history of depression approximately double the baseline risk of developing PND.[16]
- Women who experience PND as their first experience of a mood disorder are at greater risk of developing PND in subsequent pregnancies (but not of non-postpartum depression).[17]

Clinical features

- Despondency, tearfulness and irritability are typically seen.
- Fatigue, anxiety and phobias often occur (e.g. fears about inability to cope with her baby and her own health).
- Feelings of inadequacy and confusion, as well as difficulty in sleeping and concentrating are common.
- A poor appetite is also common, as is decreased libido (which may be the main symptom).

- The depression itself may be mild and somatic symptoms may be more prominent.
- Symptoms are often worse at night, creating a vicious cycle of worry and insomnia.

Management

- Improved detection of PND can been facilitated by the use of the Edinburgh post-natal depression scale. The scale is used as a screening device by health visitors in the post-natal period.[16]
- In 90% of sufferers, PND is a self-limiting condition, often lasting less than a month, even without treatment.
- Non-directive counselling provided by trained health visitors has been shown to be effective.[16]
- There is no systematic evidence to support the use of progesterone.
- Fluoxetine has been shown to be effective in the treatment of PND.[16]

Prognosis

- In about 6%, the depression lasts at least 6 weeks, but in less than 5% does it persist for longer than a year. Hence, less than 5% may be certified unfit for work (after their Maternity Leave) and thus claim Incapacity Benefit.

4.2 Seasonal Affective Disorder

- In some people, there is a regular relationship between the onset of depressive episodes and a particular time or season of the year. Depression usually starts in the autumn or winter and ends as daylight hours increase in the spring or summer. This pattern is widely known as seasonal affective disorder (SAD), but is more correctly termed seasonal mood disorder.
- Variations in day length are thought to modulate the rhythmic secretion of melatonin by the pineal gland. The rate-limiting serotonin *N*-acetyltransferase step is probably stimulated at night by the suprachiasmatic nucleus of the hypothalamus acting as an endogenous pacemaker and thus as a biological clock. Patients with SAD (and bipolar depressive disorder) have been found to have an increased sensitivity of melatonin biosynthesis to inhibition by phototherapy.[18]
- During depressive episodes patients with SAD frequently exhibit an increase in appetite and weight, often with carbohydrate craving, hypersomnia and a reversed diurnal variation in mood (at its lowest later in the day), which are opposite to the somatic symptoms of other forms of depression.[18]
- SAD does not include cases in which distinctive seasonal psychosocial stressors, such as regular winter unemployment, cause depressive episodes each winter.

4.3 Mixed Anxiety and Depressive Disorder (Anxiety Depression)

- Anxiety-depression (AD) is frequently seen in primary care but rarely seen by a psychiatrist.
- Symptoms of anxiety and depression are both present but do not reach diagnostic criteria for either a depressive episode or anxiety disorder. Appendix E demonstrates the theoretical differential diagnosis between pure anxiety and pure depressive disorders.
- Mixed anxiety and depressive disorder is frequently misdiagnosed as a generalised anxiety disorder.
- If the symptoms are associated with a stressful life event, then a diagnosis of adjustment disorder should be considered (see protocol on adjustment disorder and PTSD).
- Treatment is best undertaken by counselling, cognitive therapy or psychotherapy, especially interpersonal therapy
- Antidepressant medication, especially the selective serotonin re-uptake inhibitor antidepressants (SSRIs), may be used.

4.4 Depression in the Elderly

In the elderly, depression **may present atypically** in ways that include: -

1. *Agitated depression* – with purposeless activity due to anxiety (e.g. pacing the floor or fidgeting); this contrasts with the retardation more commonly seen in younger patients.
2. *Symptoms masked* – by concurrent physical illness or minimisation / denial of low mood.
3. *Hypochondriasis* – complaints disproportionate to organic pathology / pain of unknown aetiology.
4. *Complaints of loneliness*.
5. *Onset of neurotic symptoms*.
6. *Behavioural disturbance* – e.g. food refusal, aggressive behaviour, shoplifting or alcohol abuse.

Management.

Antidepressants are usually tried first, but there are several problems with their use in the elderly. Lower doses of tricyclic antidepressants (TCADs) are needed owing to a longer half-life (reduced distribution-volume and clearance); their anticholinergic side effects reduce compliance and worsen pre-existing somatic problems, such as: postural hypotension (falls, myocardial or cerebral infarction); dry mouth (dentures difficult); urinary retention (anuria); impaired concentration and memory (delirium). The SSRIs and RIMAs (see 5.1) are generally better tolerated than TCADs.

In resistant cases, *ECT* (to which elderly depressed patients respond particularly well) is used. Socially isolated elderly depressed patients are at a very high risk of committing suicide, so they need close observation and energetic treatment.

5. Management

The majority of depressive episodes can be treated in the community by GPs. Referral to Mental Health Teams or Psychiatric outpatients is indicated if the depression is severe, failing to respond to treatment or complicated by other factors such as personality disorders. Patients suffering from psychotic and severe mood disorders may be admitted to hospital. Compulsory admission may be necessary in cases of high suicidal risk or where poor intake of food and fluids is life threatening.

Mild, moderate and severe depression are treated in similar ways and the principal decision is whether to treat with antidepressant drugs or a talking therapy. Surveys in primary care have shown that most patients would prefer a talking therapy.

Antidepressants and cognitive behaviour therapy are equally effective in treating mild to moderate depression. In severe depression, antidepressant drugs are more effective.[19]

5.1 Antidepressant Medication

Drug treatment is effective in moderate and severe episodes of depressive disorder. There is a wide and increasing range of antidepressant drugs available, varying in their side effects, toxicity and cost.

Most available antidepressants are equally effective if given at an adequate dose for a sufficient period of time.[19]

Non compliance with antidepressants may reach 50%.[19]

The recommended duration of antidepressant treatment for an initial depressive episode has increased over recent years. Guidelines produced by the British Association for Psychopharmacology suggest antidepressant treatment should be continued for 6 months following remission,[20] however emerging evidence suggests continuing treatment for 9-12 months following remission.[21] [22] Following this, antidepressants should be withdrawn gradually over 3 months.

Antidepressants are effective prophylaxis for recurrent depression and are indicated where there is clear risk of further episodes. The risk of further depressive episodes increases with the number of depressive episodes experienced and increasing age of onset of depression. In those with onset of a major depressive episode after 50 years of age, or with three previous episodes of depression, it is recommended that antidepressant medication is continued indefinitely.[19]

There are two main classes of antidepressant in common use, the selective serotonin re-uptake inhibitors (SSRIs) and the tricyclic antidepressants (TCADs). A third group, the monoamine oxidase inhibitors (MAOIs) have become less popular recently as safer alternatives are now available. They all achieve an antidepressant effect by increasing monoamine activity in the central nervous system.

All have a slow onset of action, so patients should be warned that it might be 2-3 weeks before they start to notice any benefit. The dose should be titrated to the maximum dose tolerated before considering a different drug.

5.1.1 Selective Serotonin Re-uptake Inhibitors

- For example Fluoxetine, Paroxetine, Sertraline, Citalopram and Fluvoxamine.
- Act by inhibiting the re-uptake of serotonin into the pre-synaptic nerve cell.
- Have little or no effect upon noradrenergic processes: no daytime sedation in most cases, far less anticholinergic and clinically significant cardiovascular side effects than TCADs. Hence they are better tolerated and safer in overdose; also, their onset of action is more rapid.
- Side effects include nausea, diarrhoea, headache, insomnia, agitation and sexual dysfunction.

5.1.2 Tricyclic Antidepressants

- Widely used since the 1950s, and still commonly prescribed. They act by inhibiting the re-uptake of the monoamine neurotransmitters noradrenaline *and* serotonin into the pre-synaptic nerve cell.
- *Sedative* (e.g. amitriptyline, clomipramine and dothiepin): useful for agitation and initial insomnia.
- *Less sedative (*e.g. imipramine & lofepramine): useful when lethargy and apathy are problems.
- *Side effects* - Arrhythmias, heart block, postural hypotension, drowsiness, convulsions, paralytic ileus and blood dyscrasias – hence dangerous in overdose and can cause death. Their anticholinergic actions cause blurred vision, dry mouth, constipation and urinary retention, so they are contra-indicated in glaucoma, pyloric stenosis and prostatic hypertrophy. All of these impair compliance, and some can be dangerous for patients being treated in the community, such as drowsiness and blurred vision for those who drive, operate machinery or work at heights.

5.1.3 Comparison of TCADs and SSRIs

As TCADs and SSRIs are equally effective, the choice of drug for each patient depends on other factors such as side effects, safety in overdose and cost, as well as the range of presenting symptoms.

	TCADs	SSRIs
Onset of action	Take 2-3 weeks for benefit to start.	Effect begins within 1-2 weeks.
Side effects	Sedation (may provide relief for patients with marked insomnia or anxiety). Autonomic effects (dry mouth, postural hypotension, urinary hesitancy, constipation, sexual dysfunction)	Generally better tolerated – no cognitive impairment, weight gain or anticholinergic effects. Nausea, GI disturbance, headaches and sexual dysfunction may occur
Safety in overdose	Cardiotoxic, may cause death if taken in overdose. (Lofepramine is an exception.)	Safe in overdose and the treatment of choice for patients at risk of suicide.
Compliance	Worse - more side effects.	Better – fewer side effects.
Cost	Cheap.	Expensive. Benefits due to improved compliance and reduced cardiotoxicity may offset some of the additional cost.

5.1.4 Other re-uptake inhibitors

Selective Serotonin and Noradrenaline Re-uptake Inhibitors (SNRIs) - e.g. venlafaxine. Compared with TCADs, SNRIs have far fewer side effects. Their more rapid onset of action (within 2–4 weeks) makes them especially effective for depressives with melancholia, anxiety, retardation or agitation.

Selective Noradrenaline Re-uptake Inhibitors (NARIs) - e.g. reboxetine, are useful for alleviating the negative symptoms of depression.

Noradrenaline and Selective Serotonin Antidepressants (NASSAs) - e.g. mirtazapine. Side effects of nausea, insomnia, anxiety, agitation or sexual dysfunction reported less commonly.

5.1.5 Monoamine Oxidase Inhibitors (MAOIs)

E.g. phenelzine. *Irreversibly* inhibit MAO-A and MAO-B, preventing the breakdown of monoamine neurotransmitters and prolonging their action. To prevent a potentially life-threatening hypertensive crisis, they require adherence to an α-tyramine free diet (excluding, for example, hard cheeses, yeast extracts, broad bean pods, and red wine) which is unpopular with patients; as well as avoidance of certain drugs, e.g. SSRIs, pethidine, l-dopa and amphetamine. Their use has been superseded by:

Reversible Inhibitors of Monoamine-Oxidase type A (RIMAs)

E.g. moclobemide, brofaromine, cimoxatone, & toloxatone. Fewer systemic effects: less risk of drug or dietary interactions than MAOIs; shorter washout period needed for transfer to other antidepressants.

5.1.6 Other Antidepressant Drugs

$5HT_2$ antagonists (e.g. nefazadone) have beneficial effects on sleep architecture and sexual function compared with SSRIs.

Tetracyclic antidepressants (e.g. mianserin, maprotiline) have a sedative profile, but cardiovascular and anticholinergic side effects much less than with TCADs; also rarely cause convulsions, so they are safer in overdose.

Trazodone has anti-serotonin and α_2-receptor antagonist properties, but does not block noradrenaline re-uptake. It has fewer anticholinergic side effects than TCADs and a sedative effect useful against concomitant anxiety.

Flupenthixol in low dosage can relieve symptoms of apathy, lowered mood, asthenia, despondency, and lack of initiative or inertia.

5.2 Mood Stabilisers - Lithium

The evidence for using lithium in unipolar / recurrent depression is less clear than in bipolar disorders. It can be effective in the acute stage of depression when other measures have failed, e.g. in patients who have not responded to a cyclic antidepressant drug. It enhances the effect of TCADs and MAOIs.

5.3 Electroconvulsive Therapy (ECT)

ECT entails administrating an electric charge to the head of a patient under a general anaesthetic in order to produce a generalised convulsion. The therapeutic agent is the convulsion; a normal course is 6–12 treatments at a rate of 2-3 per week.

The risk of death is similar to that of general anaesthesia for minor procedures, about 2 deaths per 100,000 procedures. There is no evidence that it causes brain damage or permanent intellectual impairment. Unilateral ECT is less likely to cause memory loss.

ECT is reserved for cases of resistant depression unresponsive to pharmacotherapy, especially those with psychotic or marked biological symptoms. The presence of biological and psychotic features of depression predicts a good response to ECT.

ECT produces a more rapid resolution of depression compared to antidepressant medication and may be lifesaving in severe depression. However antidepressant medication should be continued following a successful course of ECT.

5.4 Psychosurgery

In extremely rare cases of chronic disabling depression, when all other treatments have failed, the extreme option of psychosurgery may be considered. About 50 operations are performed each year in the UK, (involving the implantation of yttrium seeds into the forebrain, just in front of the 3rd ventricle).

5.5 Phototherapy

For those patients with SAD, where the onset of depression is in the autumn or winter months, treatment with high-intensity light is possible.

5.6 Psychosocial Treatments

5.6.1 Counselling

Much of the depression treated in primary care is amenable to simple counselling using problem-solving techniques, which can be performed either by the GP, a psychologist, CPN, or counsellor. Problem solving treatment is most likely to benefit patients who have a depressive disorder of moderate severity and who wish to participate in an active psychological treatment. The combination of problem solving treatment and antidepressant medication is no more effective than either treatment alone.[23]

Employing practice-based counsellors may enable patients with moderately severe depression to recover faster, and non-directive counselling appears to be as effective as cognitive behaviour therapy (CBT) within this setting. [24]

5.6.2 Cognitive-Behaviour Therapy

Cognitive-behaviour therapy (CBT) refers to a group of therapies that include behaviour therapy, behaviour modification and cognitive therapy in various combinations.

Cognitive therapy explores how thoughts can alter feelings and behaviour. Therapy consists of identifying automatic negative thought patterns (such as hopelessness or guilt) and teaching the patient to recognise and challenge them. The aim is to enable the patient to counter the negative thoughts with alternative rational thoughts.

Behaviour therapy analyses behavioural aspects of the patient's problem, followed by the use of techniques to change behaviour, which are tailored to the individual patient.

CBT helps prevent further attacks of depression by teaching patients how to counteract a relapse in the early stages.

A full course of cognitive therapy consists of 10-20 one-hour sessions with an appropriately trained behaviour therapist and so is an expensive alternative to antidepressants.[25]

A short course of CBT or non-directive counselling has been shown to enable patients with moderately severe depression to recover more quickly and is more cost effective than usual GP care (discussion and medication) in the short term (<12 months). However there were no significant differences between treatments in either outcomes or costs at 12 months.[24 26]

5.6.3 Other Psychotherapies

These include group therapy; brief focal psychotherapy (after bereavement or other specific trauma); psychodynamic or psychoanalytic psychotherapy; and, when appropriate, family or marital therapy. All can be used in combination with pharmacotherapy.

5.6.4 Increased Activity and Social Contact

Depressed patients should be encouraged not to withdraw totally from work and social activities, and should be encouraged to increase such activities (and exercise) as soon as their condition allows. Meeting other people and developing confiding relationships has a protective function in preventing relapse. Voluntary agencies can provide support and practical help with a variety of problems (e.g. by befriending), which promotes remission,[27] and there are several self-help groups available for those with depressive disorder (e.g. Depressive Alliance) which provide information, support and an opportunity to make social contacts.

Some patients will benefit from the involvement of a *Social Worker*, who can help with housing and financial problems:

1. **Accommodation:** There is a wide range of accommodation available to people with mental health disorders. Most patients live in independent accommodation. Supported accommodation (e.g. warden-controlled flat, hostel, group home or nursing home) is usually necessary only for those with severe illness, especially those who have required frequent or lengthy admission to hospital. The Social Worker may help find suitable accommodation and arrange funding if necessary.
2. **Financial assistance:** Many depressed patients live in poverty and many more have financial problems of some sort. Financial worries can be precipitating or maintaining factors in depressive disorders. Depression can also be the cause of financial problems, as it reduces patients' ability to earn money and manage their financial affairs. They may need to improve their budgeting skills. The Citizen's Advice Bureau or a Social Worker can provide advice regarding managing debts.

5.6.5 Occupational Therapy

Patients with severe or chronic depression may have little to fill their time and if left with nothing to do, their depression is likely to deteriorate. Providing the patient with a structured programme of activity will help maintain their motivation and may distract them from their symptoms. Additional goals are to enable depressed patients to learn to cope with activities of daily living (such as personal and household care), and to improve their social and occupational skills. Such programmes are usually devised by Occupational Therapists, making use of community leisure and educational facilities as well as day centres and community outreach programmes provided specifically for patients with mental illness. Sheltered employment programmes provide a useful stepping-stone back to mainstream work.

5.7 Rehabilitation

Psychiatric rehabilitation services were introduced in the 1960s, as the large psychiatric asylums began to be closed down, to help institutionalised long-term patients adjust to life in the community. Even though patients now spend much shorter periods in hospital, institutionalisation still occurs, causing secondary disability that exacerbates the disability due to severe depression: so rehabilitation is often still needed before discharge. The aims are to teach patients the skills they need to cope outside hospital; then gradually to reintroduce them to life in the community, usually with psychosocial support as above. Some outpatients may also benefit from further rehabilitation, such as patients who are coping poorly in the community but do not yet need readmission, and those who are functioning well in a group home but want to move on to less supported accommodation.

6. Prognosis

The prognosis for individual episodes of mood disorder is generally good.

- Mild cases tend to improve with minimal intervention.
- About 70% with moderate to severe illness begin to respond to treatment within 6 weeks; without treatment, the majority can expect to recover eventually, although the natural course tends to be about 1-2 years.
- Non recovery at 1 year from a major episode of depression, is associated with the following baseline variables: higher state anxiety and depression scores, a lifetime anxiety disorder, higher scores on measures of personality functioning in clusters A and C and the reporting at baseline of life event stressors.[28]
- The presence of social support, increased security, and increased hope (arising from a lessening of a difficulty or deprivation) are associated with recovery or improvement in depression.[29]
- "Fresh-start" experiences, absence of new severe stressors (life-events and other difficulties) and a standard attachment style (to husband or partner) are important predictors of remission.[30]

However, in the long term, the outcome is less favourable:

- 12-20% of patients with unipolar depression develop chronic depression, that is they remain fully symptomatic 2 years after the onset of the initial depressive episode.
- A cohort of patients followed for 15 years showed that of those who recovered from an initial depressive episode, 85% had a further depressive episode. Of those who remained well for 5 years following the index episode, 58% experienced a recurrence.[31]
- The median number of depressive episodes experienced is four.[22]
- Predictors of a recurrence of a mood disorder which have been described are: female sex;[31 32] a previous depressive episode,[31 32] negative attitude to one's own occupation;[32] increasing age at initial onset;[33] and duration of depression prior to initiation of treatment.[33]
- Co-morbidity is an important prognostic factor. A co-existing anxiety disorder (especially social phobia) indicates risk for persistent depression in primary care patients with major depression.[34] Another study suggests that it is the burden of co-morbidity (i.e. the number of co-morbid conditions) rather than any particular disorder that is strongly predictive of functional impairment.[15]

In later life, depression doubles mortality, reflecting partly the association between depression and physical illness, and partly the increased incidence of suicide.

The lifetime risk of suicide is as high as 15% in those with severe illness.[4]

7. Main Disabling Effects

In the developed world, the burden to society of unipolar major depression quantified by disability adjusted life years (DALY)[1] is second only to ischaemic heart disease, and is predicted to become the leading individual illness by 2020.[35]

In terms of disability[2] alone, unipolar major depression ranked first in 1990, affecting 51 million people and accounting for 10.7% of the total years lived with disability from all causes.[36] Within the community, major depression is associated with a diminished level of physical and mental functioning, higher use of health services and more days lost from work and normal duties.[37] Recovery from depression is associated with significant reductions in work disability.[38]

In general, the degree of disability (and thus the level of interference with daily activities, including work) correlates with the severity of the depressive episode. Many claimants presenting for disability assessment have a lesser degree of depressive disorder – towards the mild end of the spectrum. It is important to separate the diagnosis from functional impairment, since many depressed patients on treatment may function well with regard to daily activities.

For all benefits, all available information should be used to obtain a picture of how the claimant's function is currently impaired on an average day. Information from the spouse, son, daughter, carer or other person accompanying the claimant is useful.

In severe depressive disorder, continuous supervision is necessary in cases where there is substantial risk of suicide or self-harm. This can usually only be reliably provided on a 24-hour basis in a hospital setting.

In those people with severe depressive disorder displaying self-neglect, there may be an inability to maintain adequate levels of nutrition and cleanliness. Performing essential domestic tasks, or coping with day to day transactions and communicating with others generally are all likely to be significantly affected.

First depressive episodes of this severity are likely to last a few months at most. Any recurrent severe episode is likely to show response to treatment in 6 to 12 months.

Apart from the rare occurrence of depressive stupor, depression does not affect the physical ability to walk.

Mild purely depressive episodes are unlikely to result in significant disability. However, mild depression may be associated with anxiety, phobias, or obsessive-compulsive features, in which case, any functional impairment is likely to be determined by the severity of the associated disorder rather than the mild depression.

[1] which expresses years of life lost to premature death and years lived with disability of a specified severity and duration.

[2] defined as the restriction or lack of ability to perform an activity in the manner or range considered normal for a human being (WHO).

7.1 Assessing the Claimant

The examining doctor should consider the information on file, informal observations, medical and psychiatric history, medication and other treatments, typical day, mental state examination and, in some cases, physical examination.

7.2 IB-PCA Considerations

As in every case where the mental health assessment is applied, the doctor should consider whether the criteria for exemption on the grounds of severe mental illness are met. The legislation defines a severe mental illness as: "involving the presence of a mental disease which severely and adversely affects a person's mood or behaviour, and which severely restricts his social functioning, or his awareness of his immediate environment". The Continuing Medical Education Module 10, "Exemption Advice at the Examination Stage," gives the following "positive features with which to consider exemption in depressive disorders":

1. History of recent self-harm, especially attempted suicide, may provide a strong pointer. This self-harm is likely to have been in the last 6 months for it to be particularly relevant at the examination stage.
2. A more distant history of attempted suicide needs to be considered in the light of evidence concerning the claimant's current mental health.
3. Evidence of self-neglect.
4. Requirement for recent hospital admission [within 6-12 months] and/or current day hospital treatment.
5. Supervision by community mental health team as well as GP.
6. Mental state examination indicating abnormal appearance or behaviour, little speech, severe mood disturbance, or a thought disorder.
7. Lack of insight and/or poor compliance with treatment or supervision.
8. Additional conditions, including personality disorder or alcohol abuse.
9. These factors will also have been considered beforehand at the IB-PCA exemption (IB113) and IBSK Scrutiny stages, but the paper-based evidence may have been insufficient to justify exemption then.

7.2.1 Moderately Severe Depressive Episode

In cases of moderate depression not warranting exemption, several mental health descriptors are likely to indicate impaired function: -

1. Coping with tasks

Sufferers likely to have difficulty with answering the 'phone / taking a message; their concentration is often poor (3 descriptors); lack of enjoyment of leisure activities is usual.

2. Daily living

Such claimants are likely to need encouragement to get up / dress and be distressed by fluctuating or low mood; they are prone to self-neglect and sleep commonly interferes with their daytime activities.

3. Coping with pressure

It is likely that mental stress contributed to their stopping work; avoidance of routine activities and poor coping skills are common; sufferers often give up activities because of fatigue / apathy / disinterest.

4. Social interaction

Claimants are likely to need help for self-care; their communication is often impaired; they are frequently irritable and prefer to be alone.

7.2.2 Mild-Moderate Depressive Episode

Claimants with mild-moderate depression, (including those recovering from a more severe depressive episode), are likely to score on a smaller number of the mental health descriptors given in 7.1.2.

7.2.3 Mild Depressive Episode

Claimants with mild depression (including those who have largely recovered from a more severe depressive episode), as well as those using the word “depression” to describe unhappiness or normal reactions to stressful events, are likely to score on only a few mental health descriptors, if any.

7.2.4 Review Advice

The longer the history of depression, the longer is likely to be the period before review is advised.

Cases in which exemption is advised for a short-medium term illness are unlikely to merit review in less than 12 months. For more established cases, review advice of “not less than 2 years” or “in the longer term” may be appropriate.

Non-exempt claimants with depression who have been off work for more than 12-18 months are unlikely to improve significantly in less than 12-18 months. In more longstanding cases, review advice of “not less than 2 years” or “in the longer term” may be appropriate.

Appendix A - Suicide

Suicide accounts for about 1% of all deaths every year. The current suicide rate for the general population is 10 per 100,000 per year.

All mental disorders apart from learning disability and dementia have a significantly raised standardised mortality rate (SMR) for suicide.[40] Considering psychiatric illness as a whole, in all treatment settings, the mortality risk for suicide was 10 times that expected. Considering major depression (as defined by DSM III) the mortality risk was 21 times that expected.[41]

Psychological autopsy studies collect all available relevant information on the suicide victim's life preceding his or her death, which is then used to construct an overview of suicide. A recent study in the UK in young suicides, showed a psychiatric disorder to have been diagnosed in 70.4% of subjects, commonly depressive disorders (55.5%), followed by personality disorders (29.6%). Co morbidity of psychiatric disorders was found in a third of subjects.[42]

Epidemiological Trends

Worldwide (excluding China), the male suicide rate is 2-4 times higher than the female.

The suicide rate is higher in the elderly, however in the developed world, rates are declining in this age group due to improved social and health services. Traditionally, suicide rates were low in younger age groups, however suicide rates in young males increased by over 80% between 1980 and 1992, and although rates have declined in recent years, they remain higher than previously. In contrast, the rate in young females has remained static.[42]

Suicide has no single cause but is an individual process in which several risk factors can be identified:

Social status	Low
Educational status	Low
Marital Status	Unmarried, separated, divorced, widowed
Residential status	Living alone, homeless[43]
Employment status	Unemployed, retired, insecure employment
Profession	Vets (3x rate of general population); farmers, doctors, dentists, pharmacists (2x)
Season and time	Spring and autumn, weekend, evening, anniversary.
Life events	Adverse life events such as losses, separations and criminal charges

40 – 50% of those who kill themselves have made previous attempts.

Two thirds of those who commit suicide have seen their GP in the last month.

A quarter of those who commit suicide are psychiatric outpatients at the time of death – half of these have seen a psychiatrist within the previous week.

Methods Used

Men use more “successful” or violent methods of suicide, such as firearms, jumping, hanging or asphyxiation with car fumes, whereas the most common method used by women is self-poisoning with drugs, the effects of which can be unpredictable.

Assessment

Patients should be asked about suicidal thoughts since there is no evidence that doing so might put the idea into their mind. The reasons for such thoughts and the methods being considered should be explored. Feelings that life is pointless or that there is no future should be taken very seriously. Evidence should be sought of loneliness, reduced or absent social contact and the psychiatric or physical illnesses associated with increased suicide risk. Relatives and/or friends should also be interviewed, and information obtained about any losses.

Management

1. Hospital admission in cases of serious risk – compulsorily if necessary.
2. Removal of anything that could be used in a suicide attempt, e.g. sharp objects or a belt / pyjama cord (which may be used as a noose).
3. Regular or continuous observation, depending on the degree of risk.
4. Consider nursing the patient in nightclothes by day, to make it more difficult for them to abscond without being noticed.
5. Appropriate treatment of any psychiatric disorder, particularly ECT for a severe depressive episode.
6. Awareness that patients with psychomotor retardation are at greater risk of suicide once their symptoms begin to improve – when they develop the energy to carry out the act of suicide.

Appendix B - Deliberate Self-Harm - Parasuicide

The term deliberate self-harm (DSH) is generally used to cover all acts of self-harm, self-injury or attempted suicide. Acts of DSH do not always involve the intention to die.

Definition of Parasuicide

"Any act deliberately undertaken by a patient who mimics the act of suicide, but which does not result in a fatal outcome. It is a self-initiated and deliberate act in which the patient injures himself or herself or takes a therapeutic substance in a quantity which exceeds the therapeutic dose (if any) or his or her own habitual level of consumption, and which he or she believes to be pharmacologically active." Thus if a patient takes only a small dose, believing it to be lethal, then this is classed as parasuicide, even though such a dose is not usually lethal.

Methods Used

In the UK, 90% of cases of parasuicide involve deliberate self-poisoning with drugs. Substances used in self-poisoning have changed over the years. There has been a steady increase in the use of paracetamol, and a decrease in minor tranquillisers and sedatives. There has been an increase in overdoses of antidepressants over the period 1985 -1995, which is thought to reflect their wider prescription in the treatment of depression.[44] Hence SSRIs are preferred to TCADs for patients at-risk of DSH due to their lower toxicity in overdose.

Paracetamol, which is freely available without prescription, is particularly dangerous since an overdose of as little as 10g, (i.e. 20 x 500mg tablets), can lead to severe hepatocellular necrosis. Patients who had not really wished to die may develop encephalopathy, haemorrhage and cerebral oedema, and then die.

The most common form of self-injury is cutting, but it can also include bruising, scraping, scratching, burning and other self-inflicted wounds.

Epidemiology

An estimated 142,000 people per year are referred to hospitals in England and Wales after DSH.[44]

DSH is more common in women than men, however a marked increase in DSH in young males has decreased the female:male gender ratio from 1.4 in 1985, to 1.33 in 1990 and 1.23 in 1995.

The highest rates of DSH are seen in the age group 25-34 in women and 15-24 in men.

Different problems precede DCH in men and women. Problems concerning a partner, employment or studies, alcohol, drugs or finances were all more common in men presenting with DSH. Problems with family members other than a partner were more common in women.

There is a high incidence of DSH among offenders supervised by the Probation Service.[45]

Psychosocial Assessment

The medical seriousness of self-harming behaviour is unrelated to the psychiatric seriousness. The patient's account of the medication ingested may not be reliable. The presence of any predisposing factors and/or associated psychiatric disorders, as above, should be established. All patients attending hospital A & E Departments following DSH should be fully assessed.

A high degree of suicidal intent before the act of parasuicide is indicated by:

a) *Planning and preparation*, e.g. buying equipment or collecting medication.

b) *Precautions taken to avoid discovery*, e.g. doors locked; the act timed to avoid disturbance or carried out in isolation.

c) *No help sought* after the act.

d) *A violent method attempted*, e.g. hanging, electrocution, shooting, jumping or drowning.

e) *A final act* was performed, e.g. making a will or leaving a suicide note.

f) *Regret* for not having died and *still wanting to die*.

Other factors to assess are:

a) A previous history of suicide attempts.

b) The patient's current problems and the social / financial support available to him.

Management

Following an act of parasuicide, the patient should be treated medically as necessary and any psychiatric disorder should be treated appropriately.

Prognosis

Repetition is a core feature of suicidal behaviour. Of those who commit suicide, up to 40% have had previous suicide attempts. Of those who deliberately self-harm, 10-15% eventually die because of suicide. The risk of suicide after DSH for males is nearly twice the female risk, the risk being greatest in the first year.

Risk Factors for Suicide following DSH

- High suicidal intent as elicited by the above assessment
- Psychiatric disorder, particularly depressive episodes, alcohol dependence, substance use disorders, schizophrenia and dissocial or anti-social personality disorder
- A history of previous suicide attempt(s)
- Social isolation
- Age > 45 years
- Male
- Unemployed or retired
- Chronic painful illness

Risk Factors for Repetition of DSH

- Previous act of DSH
- Previous psychiatric treatment
- Dissocial or anti-social personality disorder
- Alcohol dependence
- Other psychoactive substance use disorder
- Criminal record
- Low social class
- Unemployment

Appendix C - Bereavement

Bereavement can occur after any loss event, e.g. the loss of a relative by death, unemployment, divorce, or even the loss of a family pet.

The effects of bereavement can be modified by:

a) The significance of the loss – death of a spouse, child or (if the bereaved is under 18 years of age) parent.

b) The suddenness - unexpected, untimely and/or multiple deaths.

c) The degree of anticipation.

d) The degree of dependence or interdependence with the deceased.

e) The support available before, during and after the loss.

f) The degree to which appropriate mourning occurs.

g) The material and social consequences of the loss.

The effects of bereavement can be aggravated:

a) If the death involved pain or severe mutilation.

b) If the survivor feels responsible / guilty for the death.

c) By loneliness and social isolation, especially in the immobile elderly.

The loss of a loved person is one of the most severe psychological stresses an individual can undergo. It inevitably causes great distress, and can give rise or contribute to the onset of psychosomatic disorders. Such a loss has profound effects on the autonomic and endocrine systems, and probably on the immune response. Several studies have shown an increase in the mortality rate, (and particularly in deaths from ischaemic heart disease), during the first year of bereavement – especially in widowers over the age of 55 years.

Grief

Grief can be defined as those psychological and emotional processes, expressed both internally and externally, that accompany bereavement.

Three characteristic components of grief, manifested at different phases of bereavement, are:

1. An urge to cry aloud and preoccupation with the deceased, such as: -
    a) Vivid imagery or being drawn towards mementoes and places connected with the lost person.

b) Perceptual disturbances, e.g. transient hallucinations.

c) Mummification, e.g. preservation of possessions and/or the deceased's room.

2. The conflicting urge to inhibit, avoid and minimise these painful antisocial urges – distraction (keeping busy) or avoidance behaviour may achieve this.

3. An urge to discover and confront the implications of the loss, and to revise the thoughts and behaviour that relied on the lost person.

Phases of uncomplicated grief

1. Shock and disbelief - often described as a feeling of numbness.

2. a) Increasing awareness of loss with painful pangs of grief (yearning) accompanying emotions of sadness and anger – the anger felt may be denied, especially if there is conflict or ambivalence concerning the deceased.

   b) Increased irritability may be intensified by the denial.

3. a) Disorganisation and despair as the full reality of the bereavement is accepted.

   b) Other symptoms, indistinguishable from those seen in depression, may include:

   - Sleep disturbance, with early morning wakening.
   - Loss of appetite, weight and libido.
   - Reduced performance, energy, drive and interest in everyday activities.
   - Social avoidance, emotional numbness, depressive ideation and tearfulness.
   - Constipation.
   - Somatic symptoms of pain or discomfort.

4. Reorganisation as the appetites for food, sex and other human needs return, and a new identity is discovered.

Mourning

Mourning refers to the necessarily lengthy period of culture-bound social and cognitive processes through which one must pass in order to return to more normal functioning. Feelings may be hidden because of social pressures not to share grief. Regressions are likely at times of anniversaries and other reminders of loss, which cause pain that occurs less frequently but remains just as intense.

Pathological grief

Pathological (or morbid) grief occurs when there is disruption of the normal mourning process. The expression of grief may be delayed or prolonged. Such disruption may occur in the following situations:

1. Children are particularly vulnerable, because grieving parents or carers may miss the grief of the children and thus fail to provide an appropriate environment for the children to grieve. Children may be sensitive to the adults' distress and so hide their own grief. Uncharacteristic behaviour may be the expression of a child's grief and be misinterpreted by observers.
2. Conversely, caring for children or other dependants, or dealing with the practical consequences of the loss, may take precedence over individual concerns, providing a barrier to proper mourning and disrupting the grieving process.
3. Social or family disapproval of the expression or sharing of emotion may inhibit mourning. Such disapproval may be associated with inadequate mourning of previous losses and the consequent avoidance of the reawakening of painful memories and emotions.
4. Separation from the reality of loss may interfere with adequate mourning. Involvement of Western-style hospitals may separate a large proportion of the population from contact with the reality of death. Over-reliance on psychoactive medication by the bereaved may similarly separate them from the bereavement experience.
5. Mental or physical illness and alcohol or substance abuse may delay grief.
6. If the loss is due to traumatic circumstances, then post-traumatic stress disorder is likely to interfere with normal mourning – characterised by recurrent memories or images, which are so painful that people go to considerable lengths to avoid any trigger situation. Social withdrawal may persist, together with a continued fantasy relationship with the dead person.

Facilitation of normal grieving

The bereaved need reassurance that the normal physical and mental features of grief will pass. They need permission and time to grieve and, later, permission and encouragement to stop grieving and face the new challenges and opportunities that confront them. Normal grieving may be facilitated by the extended family, the primary health care team, religious organisations and specialist voluntary sector organisations such as CRUSE and the Stillbirths and Neonatal Deaths Society (SANDS). True depression may occur in the context of normal grieving and needs appropriate treatment.

Treatment of pathological grief

Only when grief becomes pathological in its intensity or length do mental health services need to be involved. Specialist treatments include bereavement counselling and guided mourning. Medication may be used if mental illness supervenes, but care must be taken that this does not interfere with the grieving process. SSRIs are preferable to TCADs because of the increased risk of suicide during bereavement. β-blockers may reduce the otherwise increased risk of death from IHD in bereaved people with known coronary impairment; they also reduce the palpitations, which are a common accompaniment of anxiety during the early phases of grief.

Disabling effects

"Bereavement" is not an acceptable diagnosis for the certification of incapacity for work. However, if a true mental illness supervenes, then this can properly be recorded as the reason for incapacity, and the expected length of disability will be related to the nature of this condition.

Appendix D - Simplified Version of the Criteria for a Depressive Episode

Based on the criteria given in the International Classification of Diseases version 10, World Health Organisation.[2]

Major Depressive Episode

A to **D** must all apply:

A. At least 5 of the following have been present for at least 2 weeks, representing a change from previous functioning; one of the five symptoms must be symptom 1 or 2:

1. Depressed mood nearly every day for most of the day.
2. Markedly diminished interest or pleasure in all, or nearly all, activities nearly every day for most of the day.
3. Significant weight loss or weight gain when not dieting, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death or suicide.

B. **1.** No organic cause.

2. Not caused by bereavement.

C. No delusions or hallucinations in the absence of mood symptoms for as long as 2 weeks during the course of the illness.

D. Not superimposed on schizophrenia or other psychosis.

Minor Depressive Episode

Minor depression is defined as depressed mood **or** anhedonia, **and** one other of the 9 depression symptoms – **B**, **C** and **D** must also apply.

Appendix E - Differential Diagnosis between Generalised Anxiety and Depressive Disorders

Generalised Anxiety Disorder	Depressive Disorder
Common in early adult life	Commoner in later adult life
Onset age 20–40 years	Onset age 20-60+ years
More frequent in those of premorbid anxious personality	More frequent in those of previous stable personality
Previous episodes of anxiety	Previous episodes of depression or even mania
Panic attacks frequent	Panic attacks uncommon
Lack of concentration	Loss of interest (anhedonia)
Minor loss of appetite	Major loss of appetite (or increased appetite)
Sexual performance reduced	Reduced libido
No diurnal variation of mood	Marked diurnal variation of mood
Initial insomnia	Early morning wakening
Somatic symptoms common	Ideas of reference, guilt and hopelessness common
More related to external precipitants	Less often related to external precipitants
Chronic course	Episodic course

N.B. (1) Diagnostic category of neurosis often changes over time and in different medical records.

(2) 90% of individuals with neurosis are labelled as having neurotic depression.

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