The burden of depression

Depressive disorders are ubiquitous. Among the general population the prevalence of depression is up to 3%. With the exception of hypertension depression is likely to be the commonest condition seen in primary care. Among medical inpatients up to 25% suffer from depression.

The mean age of onset for a major depressive episode is 40 years and 50% of depressive episodes will have their onset between the ages of 20 and 50 years. However, depressive disorders can affect other age groups and can begin in childhood or in older age groups. The estimated prevalence rate for those over 65 years is 11–16%.

Depression is more common in those with chronic medical illnesses, of lower socioeconomic status, unemployed and in those with no close relationships. There do not appear to be any cultural differences in the prevalence of depression, however, the presentation of less severe forms of depression may be influenced by cultural factors.

In primary care, up to 25% of high health-care utilizers will suffer from depression, and another 75% will have a history of depression. Adequate treatment of depression in this group has been shown to not only improve symptoms but also reduce service use.

Depression is important from an individual and socioeconomic point of view. Depression causes individual suffering, significant disability and can lead to suicide. Apart from ischaemic heart disease it causes greater levels of disability than other common chronic physical illnesses (Shah, 1992). Up to 55% of people suffering depression will be at least moderately disabled and suicide accounts for 0.9% of all deaths in the general population. Depression not only affects the individual but also impacts significantly on their family, leading to marital discontent that can result in a breakdown of the family unit.

The socioeconomic burden of depression is huge, largely because of lost workdays and disability. The estimated cost of depression in 1992 was £5.6 billion per year. In the USA, Murray and Lopez (1996) estimated the annual cost of depression in 1990 to be $43.7 billion. They calculated the number of disability-adjusted life years lost as a result of depression to be 1 428 000 per year.

ISSUES IN DIAGNOSIS

Diagnosing depression can be difficult. Patients rarely present with symptoms that fit neatly into diagnostic taxonomies. Patients in medical settings usually present with a combination of physical, psychological and social problems, somatic symptoms often being presented first. The clinician faces the difficult problem of not only having to tease out a depressive illness from comorbid physical illness but also having to identify underlying depression in patients who present with somatic problems that lack an organic cause.

Patient and doctor factors are important in determining whether or not a depressive illness is recognized (Tylee, 1995).

Patient factors

The mode of presentation is a predictor of recognition of depression. Patients who present with somatic complaints are less likely to be correctly diagnosed as depressed. Patients with less severe depression are more likely to be missed. Patients with psychiatric histories or high consultation rates, however, are more likely to be correctly identified. Other patient factors that affect recognition include stigma and an ignorance of depression on the part of the patient.

Doctor factors

Doctors who have a positive attitude towards and interest in mental health problems are more likely to accurately diagnose depression. Consultation styles influence whether depression is recognized. In primary care it has been found that doctors who ask open questions initially, give more time, are more empathic, make more eye contact and interrupt less are more likely to detect depression (Tylee, 1995). These skills have been successfully taught in interview skills training using video feedback.

COMORBIDITY

Psychiatric comorbidity aside, depression is frequently associated with medical illness. Between 20 and 30% of the chronically medically ill suffer with depression but it is only recognized in a minority. The medically ill are at more risk of becoming depressed and depression adversely affects the prognosis of medical illness. Depression is especially associated with cancer (20–45%), cardiovascular disease (25%), Parkinson's disease (40%), cerebrovascular accidents (26–34%) and chronic pain (35%). Lesperance and Frasure-Smith (2000) found that the 18-month mortality rate for people post-myocardial infarction was significantly higher for those who subsequently developed depression. Other studies found depression is the best predictor of myocardial infarction, angioplasty or death in the 12 months following cardiac catheterization.

Diabetes is also closely associated with depression. Up 33% of people with diabetes suffer with depression. In the elderly the strongest predictors of mortality from diabetes were depression and retinopathy. It not only makes diabetic control difficult to achieve but uncontrolled diabetes can adversely affect the depressive illness.

In general comorbid depression and medical illness results in a poorer prognosis for both the depressive and medical illness. Unfortunately, in the face of medical illness, patient and doctor alike frequently overlook depression. However, it is important that depression in this population is identified as it is treatable and treatment improves the prognosis of the comorbid illness. Patients with chronic physical illness are also at a higher risk

of completing suicide and treatment of depression in this group may help to decrease suicide rates.

SOMATIZATION

Somatization is a universal phenomenon and probably an integral part of depression as it presents to primary care and secondary medical services. Unfortunately, psychiatric definitions of depression do not take into account somatic presentations. In primary care and other medical services, somatic presentations of depression account for a substantial proportion of undiagnosed psychiatric morbidity. The ability to diagnose depression when presented with somatic complaints relies on the interview style of the clinician, an awareness of and a high index of suspicion of depression as a possible cause.

ANTIDEPRESSANT TREATMENT IN DEPRESSION

Given the degree of personal suffering, disability and socioeconomic burden it is vital that people with depression are adequately treated. Pharmacotherapy with antidepressants is usually the first line of treatment for people suffering from major depression. However, only 50% of depressed people contacting health services for treatment are recognized as suffering from depression and in those who are recognized only 50% are treated with medication. The other 50% are often put on a 'watch and wait' regimen.

Current antidepressants are far from perfect. In those treated with antidepressants (about a half of those put on medication) only 70% will respond, despite receiving adequate doses. There is also a delayed onset of action of 2–6 weeks. This delayed response and ineffectiveness in 30% of depressed people has fuelled a search for better antidepressants that have a quicker onset of action and are more efficacious.

The delay in onset of antidepressant efficacy is important for a number of reasons. A quicker onset of action would benefit patient, clinician and ultimately the economy (Culpepper, 2001). Clinicians using antidepressants would be able to monitor doses more effectively. It would facilitate an assessment of whether a therapeutic dose had been attained and obviate the need for prolonged antidepressant trials in the face of non-response. This may encourage clinicians to prescribe antidepressants. A quick response may improve patient compliance, no longer necessitating the need to suffer side effects with no apparent benefit. It would provide a faster relief to suffering, quicker improvements in disability, less family disruption and consequently less cost to society and the economy.

CONCLUSION

Depression is a common and debilitating illness that is under-recognized and under-treated. It has been declared a major public health problem by the World Health Organization, meeting the criteria for frequency, severity, temporal trends and existence of effective interventions. In order to alleviate the suffering and socioeconomic burden it poses, we need to improve its treatment. This means increasing recognition and instituting appropriate management. Current pharmacological treatments do have shortcomings in terms of efficacy, side effects and delay in onset of action. However, the search for newer antidepressants has important implications not only for those diagnosed as depressed, but also in changing patients' and doctors' perceptions about depression and its management. HM

Andre Tylee/Paul Walters
Professor of Primary Care Mental Health/
Waller Fellow
Section of Primary Care Mental Health
Department of Health Services Research
Institute of Psychiatry
London SE5 8AF

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KEY POINTS

- Depression is common and has a high burden for society.
- Depression is often undetected in people with physical illness and undertreated when it is detected because of 'understandability'.
- Treating depression vigorously can often improve prognosis and control of the physical illness.