Family Practice Forum

The Dilemma of Depression

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Family physicians are told that their ability to diagnose depression is poor. It is alleged that when the "experts" compare the diagnostic accuracy of a list of 20 questions in the form of a self-rating scale with the diagnostic and clinical sensitivity of the family physician, the standardized instrument is likely to be acclaimed the winner. Even if the diagnosis is rendered correctly the family physicians are told that their use of modern psychopharmacological agents is not adequate. The results of such criticism allow specialists to retain handsome fees for continuing education programs and add to their curriculum vitaes multiple publications concerning the complex art of diagnosing and treating depression. No longer are anxiety and pain the most common accompaniments of vague complaints or the manifestations of chronic disease; rather it is depression—or masked depression, or depressive equivalent, or finally an atypical depression. Insomnia, job dissatisfaction, gastrointestinal disturbance, obesity, alcoholism, low back pain, sexual dysfunction, headache, and marital disharmony all may be viewed as suggestive markers for depression.

Indeed we are amidst a societal era of depression. The mood of the times dictates that prescriptions for sedatives and tranquilizers by family physicians are inappropriate and lead to habituation, sometimes addiction, and a serious self-destructive risk for the unknowing patient. The physician is led to experience an element of guilt when prescribing such agents. The benzodiazepines are said to likely become a crutch and are alleged to numb the intellect. However, the tricyclic antidepressants are promoted as chemotherapeutic agents which correct and thereby alleviate a neurochemical disorder or diseased state. So dramatic and pharmacologically profound are the claims for these antidepressant agents that high-milligram potency single tablets or capsules are now made available for once daily dosage. Fervor is such that we have created a milieu in which drugs for the treatment of depression—tricyclic antidepressants (TCA), monamine-oxidase inhibitors (MAOI), lithium—represent the most lethal psychotrophic agents on the household kitchen counter. As one might predict, we are seeing progressively more and more depressed people killing themselves with antidepressants.

The social values concerning depression are in fact promotional. Whereas anxieties or phobias have represented an unwanted human frailty, weakness, or an inadequate neurotic imagery, depression is viewed as an acceptable reaction to life events. Anyone may become depressed, especially in this era of affluence, welfare, and the fragmentation of family and religious spirit. Males are seen as more honest or sensitive if they admit they are depressed, women and minorities are expected to become depressed as a predictable

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sequela to psychosocial problems. The burdens and the pressures are therefore soundly upon the family physician to become responsive to the alleged depression era and to administer antidepression drugs. Concomitantly, the cardiologist has developed expertise in the treatments of newly found iatrogenic drug-induced arrhythmias, and physostigmine has joined adrenalin and naloxone as a life-saving antidote to be found in any sophisticated emergency kit.

As a family physician fortifies him or herself for the epidemic, he is afforded assistance from the time-honored media of journal advertising and pharmaceutical representatives. They remind the physician that the depressed patient who is also anxious really has a unique disease called anxious depression and should be treated differently. Physicians are advised that the anxious depression can be countered by patient ingestion of specific antidepressant drugs which uniquely are highly sedating or highly anticholinergic. Others oblige the anxious-depression dilemma by mixing potentially tardive dyskinesia-inducing phenothiazines with antidepressants. Physicians are told that the Europeans have long had the luxury of a single tablet which contains both an antidepressant and a minor tranquilizer. There are other examples of this same diagnostic confusion. Once the assumed intellectually insolated practicing physician becomes aware of his new therapeutic and diagnostic responsibility, he must then move on to develop the vital and finer skills of differentiating types of depression: reactive from characterological, exogenous from endogenous, primary from secondary, bipolar from unipolar, high MHPG from low MHPG (3-methoxy-4-hydroxyphenylgycol—a metabolite of norepinephrine), retarded from agitated, neurotic from psychotic, organic from functional, dementia from pseudodementia, and all from each other to say nothing of the alleged therapeutic implications of each.

In my view, the issue may be summarized as one of premature enthusiasm leading to a predictable confusion. The family physician is best advised to react with cautious clinical inquiry until the science of depression catches up with the alarm. Fortunately, his/her patients are seeing a physician whose specialty is patient care, and whose most reliable diagnostic tool remains himself and his physician-patient relationship. If indeed he feels that the basic criteria for a diagnosis of depression are in evidence, ie, a sad or dysphoric mood state which persists and is accompanied by pervasive feelings of hopelessness, helplessness, and other signs and symptoms supportive of this diagnosis, he is well advised to inquire as to the patient's significant life events and initiate a therapeutic trial on a single TCA in conjunction with appropriate psychological and family supportive therapy. Antidepressants, like all pharmacological agents are most effective and safe when the dosage and duration of administration are titrated against patient symptomatology. The ability to monitor tricyclic antidepressant plasma levels is forthcoming and should add a desirable safety factor.

Especially, I trust that the family physician will not become overly concerned by all the alarm and confusion about depression because the future does, in fact, appear optimistic. The study of affective disorders has managed to attract the minds and interests of many outstanding medical scholars and researchers. The evidence for psychopharmacological relief is impressive and carries the promise of future clarification and advancement. An unrecognized or untreated depression truly has a morbid and painful effect upon patients. It also impairs their ability to function as marriage partners, as parents, or as productive workers. An untreated depressed member of a family will invariably yield a dysfunctional family. The cognitive manifestations of depression are such that the patient will not only perceive his own dysfunctional effects upon the family, but will distort and exaggerate them so that suicide may evolve as a self-perceived logical and humanistic solution.

In summary, we are witnessing a time when the experts and society have essentially proclaimed depression as a major health problem. The family physician may at first fall victim to the alarm, especially when he feels he is alone in the primary care setting and that unknown numbers of patients will be appearing before him for treatment. However, time and tradition give the family physician an advantage. His sensitivity to emotional changes in families and his specialized skills in patient care are likely to be coupled with wise clinical inquiry to effect a desirable approach to the recognition and care of depressed patients.