BROADER HORIZONS

Broader Horizons is a series of short papers on topics that are outside the field of bereavement, but linked to it. The aim is to give some information about subjects allied to bereavement that readers may find relevant in their work, eg cognitive behavioural therapy, nutrition and mental health, therapies for children, how to use a library/the web, the Cochrane reports, family therapy, EMDR, or psychological trauma.

Depression

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The term 'depression' may be used in a number of ways. Many people may say that they are depressed when it would be more accurate to describe them as being unhappy. Depressive symptoms (sad mood, misery, tearfulness, feeling down) may be a proportionate and potentially reversible response to adverse circumstances, such as bereavement, and such a person may be colloquially termed depressed.

However, the medical syndrome of depression (often referred to by doctors as clinical depression) is, typically, characterised by more severe and pervasive feelings of low mood, despair, self-deprecation, guilt and self-blame, with feeings of hopelessness and helplessness. These feelings may be most marked in the morning. People with clinical depression typically suffer from loss of appetite and weight, and difficulties in sleeping, usually waking in the early hours of the day. However, in atypical cases, appetite and weight may increase and the individual may sleep more than usual. Sleep is not refreshing, and the person may feel constantly tired, and more tearful. They may lose interest and pleasure in activities (anhedonia), and sexual drive may also decrease. There may be irritability, hypochondria, impaired concentration, social withdrawal, anxiety, or agitation, though of course not all symptoms may be present in any one case.

People who are clinically depressed may have thoughts and even plans of self-harm and suicide, and they may act on these. In the most severe cases, the individual may lose touch with reality (become psychotic) and experience delusions (false beliefs that are persisently held, despite all evidence to the contrary), such as they have no money, or that their body is rotting, or that they are responsible for all the evils in the world and so on. Hallucinations may also occur in such cases.

Clinical depression may be caused by an interaction of both inherited (genetic) vulnerability and life stresses. Acute life events or chronic difficulties often precede the onset of depressive disorder. Thus, bereavement may precipitate the onset of a depressive illness, especially if the individual is vulnerable to such an illness, or if there are additional stresses present. It seems likely that serotonin, a chemical that plays a part in the functioning of the brain, is involved in mood regulation.

In children, clinical depression is uncommon before puberty, but can occur. The prevalence in adolescents is 5%. Some manifestations of depression in young people and adolescents may differ from those seen in adults, eg running away from home, separation anxiety (may present as school refusal), pain in head, abdomen or chest and/or hypochondriacal ideas, decline in school work, and antisocial behaviour (in boys). There may be reversal of sleep pattern, with sleeping during the day and staying awake at night. As with adults, appetite may increase or decrease, though weight loss may be masked by continuing growth. Auditory hallucinations consonant with guilt or low mood are not uncommon. Complaints of boredom and poor memory (actually poor concentration) are common. Anhedonia and, especially, social withdrawal are powerful indicators of the presence of depression and there may be fluctuations in mood. Adolescents may initially present with substance abuse in an attempt to self-medicate.

Some apparent indicators of depression in childhood are misleading. Tearfulness is more likely to be caused by pain, fear, or anxiety. Mild doubts about the purpose of life are not un-common among intelligent adolescents. Downward mood swings are quite common, particularly among girls, although are not usually severe. Over-doses are taken for various reasons.

At any age, clinical depression may overlap with other psychiatric diagnoses, such as anxiety, substance abuse and, in children, such conditions as school refusal and behavioural difficulties. Depression is an illness that tends to develop gradually and so may not picked up until it has become marked and severe. Sufferers may not seek help, blaming themselves for feeling tired or low in mood. They may mention feeling despair and hopelessness or suicidal thoughts or plans to others, but these may be ignored or minimised with the risk that preventative interventions do not take place.

The management of clinical depression depends upon its severity. Mild cases may usually be treated by out-patient cognitive behaviour therapy (CBT), guided self-help, or supportive therapies. Moderate or severe cases may benefit from CBT, interpersonal therapy or family therapy, combined with antidepressant medication if there is no response. The response to antidepressants is not immediate and may take some weeks to begin.

Electroconvulsant therapy (ECT) may be required in the severest of cases although this treatment is almost never used in children and adolescents. Suicidal intent is an indication for admission to an in-patient unit. Since depression may co-exist with other psychiatric conditions and with other problems (such as educational failure, impaired psychosocial functioning, family psychopathology and adverse life events), management will also need to consider such difficulties identified during the assessment period.

The UK National Institute of Clinical Excellence (NICE) has published guidelines (http://guidance.nice.org.uk/CG23) on the treatment of depression, and these should be consulted for full details. Assessment and treatment of clinical depression needs to be by appropriately trained professionals and it is likely that referral to the patient's general medical practitioner will be the usual route to access the appropriate services.

The possibility of clinical depression should always be considered, whatever the age of the individual. ●