A STUDY OF CASES OF DEPRESSION IN MALTA

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The clinical picture of depression

Depressive illness is one of the commonest and most challenging problems facing the medical practitioner to-day. Its frequency, though largely unknown, is probably very high. About 3 per cent. of the general population have a chance of developing Manic Depressive Psychosis in their lifetime. If we are to add the depressive swings of the neurotic and the unstable person or the severe reactive depression that goes with many of the physical or mental illness, we would have to multiply this figure many times. Ayd (1961) maintains that one out of every ten persons will have an emotional disorder of sufficient severity to warrant psychiatric aid. In England alone, 14 per 100,000 people attempt suicide every year and 5,000 of these are successful. The underlying cause is presumably a depressive illness. (Brit. Med. J. 1960). In Malta 27.8 per cent. of all mental hospital admissions are due to affective illness, while depression accounts for 25 per cent. of the mental health outpatient population (M. & H. Report 1962).

Depression is besides one of the most painful conditions afflicting mankind. It makes life so miserable that death is often preferred. Suicide as an alternative to suffering readily suggests itself to the depressed mind. Homicide is less frequent, the patient killing his beloved in the hope of sparing them the agony he himself is experiencing. Family life is disrupted by the patient's rumination, indecisiveness and loss of interest.

Fortunately depression can be very well treated by the physical methods of treatment we now have at our disposal. Its frequency, the misery it causes and its response to treatment put a grave responsibility on the physician of diagnosing early and treating properly any depression he meets in his practice.

Classification of depression

Depression can be a disease entity in its own right or just a symptom of other diseases. For practical purposes it can be divided into an "endogenous group" and an "exogenous group". In the endogenous group the depression is unprovoked, hitting the patient like a bolt fro mthe blue and changing his personality to a caricature of his former self. He becomes gloomy chiefly in the morning and this sense of gloom envelops his whole being so that he becomes insensitive to environmental changes. He becomes retarded in thought and action and morbidly preoccupied with ideas of unworthiness and guilt. In another form previously known as "involution melancholia" the patient becomes very agitated, endangering his life through exhaustion and very emaciated as he stubbornly refuses food and is tired from sleepless nights. The danger of suicide is very real in either case.

In the "exogenous group", one mentions the neurotic depression where the patient shows marked anxiety and phobias, depressed mood especially towards the evening, early insomnia and a readiness to complain about the symptoms in an effort to draw sympathy and manipulate the environment. It is said that the endogenous type affects females more than males especially if they have a family history of a similar complaint and more typically hit if they happen to be pyknic in stature and cyclothymic in temperament. Such characteristics are very irregular in the neurotic type.

The reactive type of depression is an exaggeration in depth and time of the normal grief reaction one associates with loss of loved objects, failure in life and threats to health and wealth.

Depression can occur as a symptom of various mental illnesses (schizophrenia,

epilepsy, psychopathy, alcoholism) and physical disorders (toxic infective states, arteriosclerotic and senile brain changes). It is debatable whether in fact there is any real difference between these types of depression but recently much evidence has been adduced that real difference does exist and it serves the physician well to note for prognostic and therapeutic purposes. Differential diagnosis may in practice be very difficult and at times impossible.

Material and aim of this study

The aim of this study is to examine the mode of presentation of depression in patients admitted to the Hospital for Mental Diseases in Malta during the year 1962. This paper forms part of a study carried out earlier. In 1962, 304 patients were admitted to hospital, 213 being hospitalised for the first time. Affective illness accounted for 86 patients or 28 per cent., Schizophrenia claimed 118 admissions and arteriopathic disorders 28. Of the 86 patients with affective illness 38 were males and 48 were females. 18 patients were in a manic phase and were excluded from this study. 6 other patients were not considered, as the picture favoured a diagnosis of schizophrenia. This leaves 60 patients (2 females were admitted twice during the same year); 19 males and 17 females were first admissions, the rest had previous admissions. The ages varied but showed two peaks at 30-40 and at 50-60 years.

Hospital cases offer advantages in that the diagnosis is made by the practitioner and confirmed by the psychiatrist, the depression has marked features involving the relatives as well as the patient and the practitioner, the patient is observed and treated under uniform conditions and the social aspect of the illness can be sorted out and studied. It offers disadvantages in that it does not represent a cross section of depression in the general population since the milder forms are rarely included, hospitalisation carrying a stigma scaring many people who go out of their way and try every means to treat the patient at home.

Mode of presentation

1) ATTEMPTED SUICIDE

About 75 per cent. of all admitted patients attempted or threatened suicide. Attempted suicide (by throwing oneself from a height, hanging, or poisoning) is the main gesture which convinces the relatives to seek medical help and the practitioner to resort to hospitalisation. The remitting doctor emphasised the danger of suicide to justify his referral of the patient to hospital. About three quarters of patients who attempted suicide spoke openly of suicide but their relatives never took them seriously. This gives the lie to the common idea that those who speak of suicide never commit it. Though these cases did not succeed in committing suicide the failure of the endeavour was often due to some unknown factor quite out of the patient's control. A quarter of the relatives, however, said that they never expected such a gesture from the patient and it came as a complete surprise, underlining the other important notion that a depressed patient, whether he talks of suicide or not, is always potentially suicidal and care must be taken to forestall it. Surprisingly four fifths of the patients who attempted suicide, even the most desperate ones, said on admission that they never intended to take away their lives and that admission to hospital was unwarranted. This makes sense in the light of the findings of Stengel and Cook on the psychopathology of attempted suicide. The attempt has "an appeal function" by which the patient tries to draw the attention of his relatives to his desperate plight. Once this is done the air is cleared, the aim is reached and the patient feels better. The "air of conciliation" is reflected in the relatives' attempt to demand the patient's untimely release from hospital.

Of those who attempt suicide the chances are that 16 per cent. will make a second attempt within two years and 2 per cent. would eventually be successful in terminating their lives. These findings agree with statistics from other places.

2) PHYSICAL SYMPTOMS

a) Sleep disturbance

Most patients volunteered to say that they slept very little, dreaded the approach of night or were tormented by recurring unpleasant thoughts during the night. The characteristic sleep pattern (i.e. late insomnia in the endogenous and early insomnia for the neurotic) was not found in this series. To the relatives, sleeplessness is a most annoying symptom which forces them to seek medical advice. Unfortunately the doctor often tries to relieve the symptom by ordering hypnotics (thus increasing the risk of suicide) instead of trying to cure the underlying depression.

b) Appetite disturbance

Four fifths of our patients admitted to having lost their appetite. Relatives were very worried about refusal of food and half of the relatives attributed the illness itself to the fact that the patient was not eating well enough. Two thirds of the relatives reacted by cooking more expensive and appetising dishes and some doctors obliged by prescribing vitamins and appetite stimulants.

c) Somatic complaints

About a third went to their doctor with a somatic complaint. The order of frequency was: headaches, gastric complaints, dizzy spells, flushes, tremors, fatigue, palpitations and breathlessness. No mention was given of changes in sexual function though probably they occurred. Mayer-Gross, Slater and Roth give a useful hint which applies very well here: "If functional complaints occur periodically and have an effect on the patient's well-being exceeding by far the objective findings, affective disorder should be suspected."

3) EMOTIONAL DISTURBANCES

i) Depressed mood

Not more than one fifth admitted spontaneously that they felt depressed but on skilful questioning two thirds admitted that they felt gloomy. The diurnal variation (i.e. the endogenous depression makes the patient feel worse in the morning and vice versa for the neurotic type) stands out very clearly in this study. A sixth of the patients attempted to hide their feelings and categorically denied ever feeling depressed. "They feared insanity" and liked being given a diagnosis of "dirty liver" and "low blood pressure". "For the patient, admitting to feeling depressed is tantamount to giving up his struggle with himself to maintain a cheerful exterior" (Campbell 1945).

ii) Anxiety

Our clinical tools to assess "anxiety" are very inadequate but in depression "angst" assumes an acutely displeasing feeling tone. It gives rise to irrational fears and phobias of which a third of our patients complained bitterly. Anxiety is usually accompanied by somatic changes which in extremes are responsible for agitation and restlessness.

4) PSYCHIC DISTURBANCES

i) Psychomotor retardation

This term refers to "reduction in purposeful activity or withdrawal of interest from the outside world" (Campbell 1953). As such it is the most universal symptom of depression. Our female patients complained that they had become careless of their home and children and lost all interest in personal appearance, while the male patients admitted to having become neglectful of their familiies and incapable of ordinary routine work. All patients admitted to having lost all zest for living, were unable to enjoy anything anywhere and found it particularly difficult to engage in "social intercourse requiring facility of thought and action".

ii) Delusions and Hallucinations

Hypochondriac ideas are common but delusions and hallucinations rare. Not more than three complained of bizarre delusions of guilt and sin..

Discussion and conclusion

Two related facts emerge from this study (a) the mode of presentation of the depressive illness itself and (b) the reasons necessitating admission to a mental hospital. It would be anticipated that only the "severe" form of depression would be represented in hospital. By severe we mean to include mental manifestations which could not be tolerated by relatives or considered as normal by the public e.g. suicidal attempts, delusions and hallucinations, marked restlessness and stubborn refusal of food. These occur more commonly in the psychotic group and hence one meets the endogenous depressions more often in hospital than, say, the neurotic group, where the failure in social intercourse is better understood and tolerated by the general public. We are in fact seeing that hospitalisation is a function not only of the kind of mental illness but of social factors or contingencies. "The 'threshold' for admission results from the delicate balance between the severity of the patient's illness, measured in terms of his social adaptation, the current view of both the doctor and the public at large on the degree of domestic and/or personal upset which is tolerable, and the prospect of effective care in the local hospital" (Reid 1960). Social factors (and at times iatrogenic) can easily be adduced from the relatives' utterances. "The patient has no one to look after him", "he cannot afford treatment at home", "he was given all sorts of pills with no effect", "his behaviour is harassing all at home", "his children all have to go to work". It is also to be noted that the relatives' tolerance diminishes with each successive hospitalisation. There is much truth in the saying that one hospitalisation facilitates the next.

One of the commonest occurrences necessitating admission to a mental hospital is a suicidal threat or attempt. This aggressive act on life is a potent factor calling for urgency in treatment. It must be emphasised that the threat to kill oneself is not confined to the psychotic but occurs with significant frequency and seriousness in the panicky attacks of the neurotic, in the despair of reactively depressed and in the confused state of the "symptomatic". All depressed patients irrespective of diagnostic grouping are potentially suicidal and care should be taken to warn relatives and institute early treatment. Treatment does not stop at curing the underlying depression, but a serious effort should be made to understand the "appeal for help" of the act itself. Careful scrutiny should be directed to the patient's underlying problems whether personal, social or material. Admission to a hospital for mental diseases though often indispensable, seems a harsh procedure often resented by the patient and regretted by his relatives. A ward in a general hospital adequately staffed seems to be a better answer.

Though we are dealing with depressed patients, they rarely volunteer to say that they are depressed. The diagnosis has to be made on collateral evidence and by bearing the possibility of affective disorder in mind. The shrewd physician will perceive that his patient is sicker than the objective physical findings and the results of reasonable investigations warrant. Loss of appetite and sleep disturbance, together with withdrawal of interest from the outside world, should give him a firm clue. Our doctors are taught not to miss an organic lesion lest this omission should kill the patient; it is time an equal insistence was laid on not missing a psychiatric illness lest it should make the patient kill himself. Unfortunately depressed patients are diagnosed late. A third of our patients had been ill for 3 months or more before the diagnosis of effective illness was made. The relatives are mainly to blame for insisting that there is nothing wrong with the patient and he should try to pull himself together. Another reason could be found in the prejudice against anything "mental" which deters the patient from seeking early advice. But we cannot exonerate the doctor who insists on reassuring the patient there is nothing the matter with him and often embarking on prolonged and useless investigations and, often, on sham vitamin therapy.

The question of differential type of depression should not detain the practitioner unduly. It is true that the majority of hospital cases are "psychotic" while the patients who occupy our outpatient appointments are merely neurotic, but even intensive comparison fails to reveal anything which modifies greatly the conclusions drawn from the hospital study. After all there is no depression which is exclusively endogenous without reactive elements, just as there is no purely neurotic depression without an endogenous component. This is to be expected because any patient is a product of his genetic endowment and of the effect of his environment. All the physician has to do is to remember that "depression" as an illness does exist, that the core of depression is the patient's "helplessness" and "hopelessness" and then use the modern means to help his helplessness and thus improvement gives hope which dispels his hopelessness.

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