Clinical Diagnosis and Treatment of Mild Depression

JMAJ 54(2): 76–80, 2011

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Abstract

The chief complaint of those suffering from mild depression is insomnia, followed by physical symptoms such as fatigability, heaviness of the head, headache, abdominal pain, stiffness in the shoulder, lower back pain, and loss of appetite, rather than depressive symptoms. Since physical symptoms are the chief complaint of mild depression, there is a global tendency for the patients to visit a clinical department rather than a clinical psychiatric department. In *Mild Depression* (1996), the author Yomishi Kasahara uses the term "outpatient depression" for this mild depression and described it as an endogenous non-psychotic depression.

The essential points in diagnosis are the presentation of sleep disorders, loss of appetite or weight loss, headache, diminished libido, fatigability, and autonomic symptoms such as constipation, palpitation, stiffness in the shoulder, and dizziness. In these cases, a physical examination and tests will not confirm any organic disease comparable to the symptoms, but will confirm daily mood fluctuations, mildly depressed state, and a loss of interest and pleasure.

Mental rest, drug therapy, and support from family and specialists are important in treatment. Also, a physician should bear in mind that his/her role in the treatment differs somewhat between the early stage and chronic stage (i.e., reinstatement period).

Key words Mild depression, Outpatient depression, Dysthymia, SSRI, SNRI

Introduction

Classic endogenous depression tends to develop in people in their 30s to 50s,[1] and can indeed be called "workers' depression." The word "endogenous" is a conventional term that assumes that the central nervous system and hormonal system are involved, although at this point we do not fully understand all of the mechanisms in play. This type of mild depression is thought to be the most common. Among patients with depression, bipolar depression and severe depression account for about 15%, with the proportion of mild to moderate depression accounting for the great majority of cases.

A study of the chief complaint of patients suffering from mild depression reveals that the most common one is insomnia, followed by physical symptoms such as fatigability, heaviness of the head, headache, abdominal pain, stiffness in the shoulder, lower back pain, loss of appetite, abdominal discomfort, constipation, dizziness, and palpitation—rather than depressive symptoms. Accordingly, physicians must examine patients with the suspicion of mild depression as the underlying cause when faced with clinical conditions and diagnoses such as headache, dizziness, insomnia, autonomic dystonia, menopausal syndrome, low blood pressure, cardiac neurosis, gastrointestinal neurosis, gastric ptosis, chronic gastritis, gastric atonia, irritable bowel syndrome, hyperventilation syndrome,

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This article is a revised English version of a paper originally published in the Journal of the Japan Medical Association (Vol.138, No.11, 2010, pages 2247–2250).

Table 1 Clinical symptoms of mild depression

Physical complaints	Mental complaints
1. Sleep disorders	5. Feeling of depression
2. Loss of appetite	6. Sense of reluctance (diminished motivation)
3. Diminished libido	7. Anxiety and irritation
4. Other mild autonomic symptoms (headache, palpitation, dizziness, dry mouth, bowel movement disturbances or constipation, etc.)	8. Inability to make decisions 9. Feeling of self-condemnation, suicidal thoughts 10. Daily mood fluctuations (Not well in the mornings, but feel better in the evenings)

(Extracted and modified from Kasahara 1996.[2])

Table 2 Characteristics of mild depression (key points in diagnosis)

1. Age at onset is frequently 35 years of age or older
2. Work-oriented person up until now, serious and overachiever
3. Physical symptoms typically dominate more than depression
4. Obsessive personality (mild compulsive personality)
5. Daily mood fluctuations (80%)
6. Hard on oneself
7. Many are reluctant to rest

(Extracted and modified from Kasahara 1996.[2])

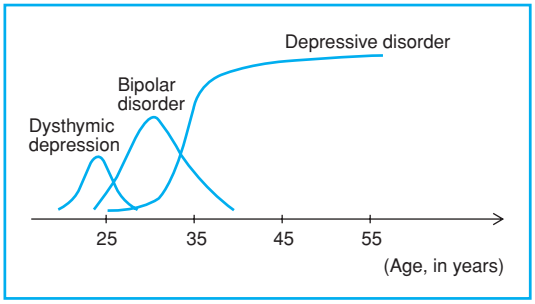

Fig. 1 Age at onset

diabetes, and dementia, or when they have had such complaints over a long duration.

Since physical symptoms are the chief complaint of those suffering from mild depression, there is a global tendency for the patients to visit a clinical department rather than a clinical psychiatric department. Yomishi Kasahara[2] uses the term "outpatient depression" for this mild depression in his work because it can be treated on an outpatient basis, and described such case as an endogenous non-psychotic depression.

Clinical Diagnosis of Mild Depression

Table 1 presents the clinical symptoms of mild depression. The patient commonly presents sleep disorders, loss of appetite or weight loss, headache and/or muscle pain, fatigability, diminished libido, and autonomic symptoms such as constipation, palpitation, stiff shoulder, and dizziness. In these cases, a physical examination and tests will not be able to confirm any organic disease comparable to the symptoms. However, a physician will be able to confirm daily mood fluctuations, mildly depressed state, and a loss of interest and pleasure.

Kasahara[2] has already identified the characteristics of mild depression that I describe in this paper, which are listed in **Table 2** with some alterations.

Next, I would like to briefly discuss dysthymia and dysthymic depression, which are disease groups with a superficial resemblance to mild depression.

Dysthymia is a group that used to be known as neurotic depression, and is currently defined as chronic mild depression lasting for 2 years or more and accompanied by 2 or more of the following symptoms: 1) diminished appetite or overeating, 2) insomnia or excessive somnolence, 3) decline in energy or fatigue, 4) decline in self-respect, 5) decline in ability to concentrate or difficulty in making decisions, and 6) a feeling of despair.

The dysthymic depression is a clinical condition recently proposed by researchers such as Shigenobu Kanba and Shin Tarumi. It is different in several respects from depression in its

Table 3 Brief psychotherapy during chronic stage

1. As the condition becomes chronic, the focus gradually shifts from the "rest" that is emphasized during the acute phase to "social reintegration."
2. Take every opportunity to repeatedly convey that people can recover from mood disorders.
3. With discretion, discuss the patient's life history and family relationship.
4. Study the fluctuations in the patient's conditions over a 2- or 3-week period without getting hung up on daily progress.
5. Occasionally discuss which symptoms have improved and which remain compared to the initial consultation.
6. Provide opportunities to reconfirm the significance of drug therapy.
7. Consider the psychological and physical exhaustion of the patient's family and friends and provide them with as much psychological support as possible.
8. Be wary of the antipathy that those of us providing treatment are susceptible to—for example, blaming the patient or the family for any difficulties in curing the patient.

(Extracted and modified from Kasahara 1996.[2])

classic sense. According to Tarumi's paper,[3] the pre-morbid character is the polar opposite of the obsessive personality, and is characterized by the absence of self-absorption, irresponsibility, and a lack of tenacity. In addition, it commonly develops in people in their early 20s (**Fig. 1**), and although they self-diagnose themselves with depression when they visit a physician, in many cases anti-depressives have no effect on them.

Treatment of Mild Depression

Treatment in the initial stage

First, a physician should tell the patient that he experiencing a "depressed state" but not conclude as "depression." The patient should be informed that in either case medical treatment may be successful, as well as the fact that depressed conditions are not very unusual.[4] The physician should mention that he/she has experience in treating depression, and that the patient's feelings and emotions are accepted as they are. When proposing a course of treatment, the patient should understand that rest and drug therapy are the most important aspects.[5] The patient is often very resistant to taking rest and drugs, and in this case the physician should not persist in pushing his argument but instead take the time to explain. In some cases, the physician must let the patient do as he chooses and monitor developments for 1 to 2 weeks. The patient should be brought to the understanding that emotional rest is more important than physical rest. If the patient is extremely resistant to taking time off of work, the physician should recommend easing up the work load or less stressful work.

The medicine should be either an SSRI or SNRI, starting with a very small dose that is then gradually increased while watching for any side effects and their degree.[6] After 8 weeks of the medication, the effect is to be assessed. In advance, the physician should explain to the patient that gradually increasing dosages from the initial small dose alleviates side effects and will maximize the effect. In addition, the physician should recommend that the patient take advantage of the support offered by the family, work colleagues, and specialists as much as possible. If the initial stage of treatment proceeds smoothly and most effective dosage of the drug can be administered, there will be modest signs of improvement in the second or third week of treatment. The patient him/herself will seem relieved, making statements like "I'm starting to eat more" or "I can sleep a little," and he may smile a bit. When the physician notices these signs of improvement, casually tell the patient that it is good news. The physician should explain that, although it may take some time, this illness is one that the patient can completely recover from without any residual problems while repeating the explanations given at the initial consultation.

As regards advice for daily life, the physician should tell the patient that it is fine to do nothing at all and that the patient should not make forceful effort. The patient must not assume that he/she has a "weak personality." During the initial treatment stage, recommending that the patient

try new things, such as a trip to lift the spirits or a new hobby, would merely be a burden for the patient.

The patient's family, friends, colleagues, and supervisor should be explained that mild depression is a reaction in some of the brain's functions caused by emotional exhaustion, and that a complete recovery from this illness is possible through rest and drug therapy. It is important to ask their understanding and support for the patient.

Next, I will briefly discuss sleep inducers and anti-anxiety drugs. As a general rule, I recommend that patients take these medications for about 2 weeks when they complain of insomnia or suffer from strong anxiety and irritability. I choose sleep inducers that are short-acting, such as zopiclone (Amoban®), zolpidem (Myslee®), brotizolam (Lendormin®), and triazolam (Halcion®). I use rilmazafone (Rhythmy®) for elderly people and lormetazepam (Evamyl®, Loramet®) for those with compromised hepatic or renal functions. The frequently used etizolam (Depas®) and ethyl loflazapate (Meilax®) are also effective.

The long-acting ethyl loflazapate (Meilax®) is also used as an anti-anxiety drug. Shorter-acting drugs can form dependencies even at the recommended dose.

Suicidal thoughts

Even among the patients suffering from mild depression, 10–15% of them are said to have suicidal thoughts. There are also cases that become increasingly severe, difficult to treat, or lengthy in duration. In an interview to confirm whether a patient has suicidal thoughts, the physician often asks questions such as, "Have you ever thought it would be easier if you were dead?" or "Have you ever thought that you just want to just disappear?" When confident in the diagnosis of mild depression, I believe that the physician can ask the patient directly if he/she thinks about suicide. Direct intervention is actually more effective when the diagnosis is certain.

One measure to prevent suicide is to tell the patient that "Suicide is the worst thing you could do, so I want you to promise me you won't" or "If you commit suicide, you will really be troubling your family and everyone that cares about you" or "Why don't we consider hospitalization." Another method is to give the physician's mobile phone number, saying "Please call me directly if you are completely lost and don't know where to turn." In any event, the approach is case-by-case, and the physician is required to respond with all the resources at the disposal. However, a single doctor cannot fully address the problem of suicide on his/her own, and in this sense it is essential to establish collaboration with trustworthy specialists, counselors, and inpatient facilities.

Points to note during chronic stage

Table 3 provides a summary of Kasahara's brief psychotherapy, which the physician should bear in mind when dealing with chronic patients.

Conclusion

In this paper, I have noted that an overwhelming majority of patients suffering from depression are experiencing mild depression, and that the chief complaint of mild depression is physical symptoms and therefore patients often visit clinical physicians rather than psychiatrists.

The essential points in diagnosis are the presentation of sleep disorders, loss of appetite or weight loss, headache, diminished libido, fatigability, and autonomic symptoms such as constipation, palpitation, stiffness in the shoulder, and dizziness. In these cases, a physical examination and tests will not confirm any organic disease comparable to the symptoms. Instead, daily mood fluctuations, mildly depressed state, and a loss of interest and pleasure will be found.

Treatment of mild depression requires rest, drug therapy, and support from family members and specialists. It should be noted that the physician's role in the treatment change slightly between the early stage and the chronic stage (i.e., reinstatement period).

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