

# **A NEW ERA IN THE MANAGEMENT OF ANXIETY AND DEPRESSION: CHALLENGES AND OPPORTUNITIES FOR PRIMARY CARE PRACTITIONERS**

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## **Dr. Sing Lee**

*Director, Hong Kong Mood Disorders Centre,  
The Chinese University of Hong Kong*

Global recognition of the magnitude of mental health problems is partly reflected by the selection of mental health as the technical subject of the World Health Report for the year 2001. "One in four people will experience mental illness at some point in their lives, but neglect, stigma, and a dismal lack of resources prevent most of them from getting any help", said the report. "The magnitude of the burden is not matched by the size and effectiveness of the response." By the year 2020, the World Health Organization (WHO) estimates that, world wide, depression will be the number two cause of "lost years of healthy life" (DALYS).

Anxiety and depression are often referred to as "mood disorders", which, if not treated, can result in significant impairment in patients' daily functioning. Studies have demonstrated that mood disorders are not just a psychological state of nervousness, but have a neurobiological basis. In other words, they are disorders affecting the brain. For instance, clear evidence has shown that the levels of critical neurotransmitters including serotonin and norepinephrine are deficient in subjects with mood disorders.

Untreated mood disorders are a major risk factor for successful suicide. Data shows that, among victims of successful suicides, 70% had experienced symptoms suggestive of mood disorders 4 to 6 weeks before the suicide event. It has also been estimated that approximately 40% of mood disorder sufferers seek help from their private general practitioner (GP). Hence, family physicians have an important role to play in the proper management of patients with mood disorders. Early diagnosis and treatment, as well as accurate evaluation of suicidal thinking, are highly valuable in decreasing the likelihood of suicide and socioeconomic burden associated with mood disorders.

Traditionally, the achievement of a clinical response has been regarded as the main goal in treating mood disorders. However, response-oriented treatment cannot guarantee the complete resolution of symptoms. Therefore, it is now widely recognized that the goal of therapy should be remission, which is a virtual elimination of symptoms. Patients in remission are more likely to be free of relapse and to do well in their daily lives. In this respect, despite their rapid onset of action and high initial rate of acceptance by patients, the benzodiazepines are not considered desirable medications for treating mood disorders because they cannot achieve true remission. In addition, they have little effect on the symptoms of depression, which is a common co-morbidity of anxiety disorders. Consequently, benzodiazepines are generally restricted to short-term or intermittent use. In clinical practice, benzodiazepines can be used temporarily during the initial 2 or 3 weeks of SSRI (specific serotonin reuptake inhibitor) type of drug treatment. SSRIs are mostly similar in pharmacological profile. Although all of them have been approved for the treatment of depression, only a few have been approved for the treatment of particular anxiety disorders such as generalized anxiety disorder, panic disorder, post-traumatic stress disorder, and social anxiety disorder. There has also been concern that fluoxetine may worsen the symptoms of patients with anxiety disorders.

Mood disorders often go undiagnosed partly because of the diversity in their clinical presentation. In fact, family physicians should take into consideration the possibility of mood disorders in patients reporting unexplained somatic symptoms, anxiety or substance abuse. Correct diagnosis of a mood disorder is based on the recognition of a cluster of signs and symptoms suggestive of the disorder. Although the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th ed.) certainly helps physicians to evaluate the possibility of mood disorders in affected patients, its applicability to primary care settings is limited as it is designed primarily for psychiatric researchers and mental health specialists.

Apart from the careful selection and use of pharmacological agents, family physicians also have a significant role to play in terms of patient education, support and follow-up. Studies have shown that patient education improves treatment compliance in patients with depression. Adequate information should be provided to both the patient and his or her family about the condition and its treatment. Patients should be informed of the possible side effects of medications and reassured that many of them are self-limited. Particularly, all patients with mood disorders should be reminded not to expect immediate effects from treatment — it may take 1 to 3 weeks before there are any observable changes. A different medication may be tried if there is little or no improvement after 5 to 6 weeks.

Although psychotherapy is generally provided by mental health specialists, a competent family physician can carry out brief yet effective counselling. Mood disorders are too often intermingled with psychosocial issues, which need to be addressed for true recovery to occur. For instance, the physician may play the role of a sympathetic listener who assists the patient in working through the conflicts he or she is facing. If needed, other family members of the patient can also be involved in the counselling process.

Given the chronic nature of mood disorders, a plan for long-term care involving both continuation and maintenance treatment is clearly required. The goal of continuation treatment is to prevent the return of a current episode of illness (relapse). The physician should avoid premature discontinuation of therapy once the patient responds well to acute treatment. Instead, the treatment should be continued on the same therapeutic dosage for an extended time period (about 4–9 months) to reduce the likelihood of relapse.

The goal of maintenance treatment is to reduce the likelihood of the recurrence of a subsequent episode of illness once the current episode has resolved. Not all patients with mood disorders require long-term maintenance treatment. Patients who show a tendency of recurrence shortly after discontinuation of adequate initial medical treatment may require maintenance therapy.

While most patients with mood disorders can be adequately treated as outpatients in primary care settings, some may require referral to a psychiatrist. Consultation with a psychiatrist should be considered if a mood disorder patient has had a suicide attempt or a specific suicide plan, or presents with psychotic or bipolar features. Inadequate response to optimized treatment also may necessitate psychiatric consultation. In such cases, the psychiatrist can help to clarify the diagnosis and/or make appropriate recommendations for treatment including hospitalization.

The Hong Kong Mood Disorders Centre is devoted to the well-being of patients with mood disorders. Apart from the provision of patient education, psychological intervention service, and referral service, it also conducts research, and physician training and education in an effort to enhance the quality of care for patients with mood disorders. For further information, please call 2833-0838 or visit us on the Internet at [www.hmdc.med.cuhk.edu.hk](http://www.hmdc.med.cuhk.edu.hk).