Depression

The scientific interest on depressions and questions about this disorder noticeably increased. This has different reasons: Nearly each person who occasionally feels unwell (and who doesn't?) ask him-/herself if he/she might probably suffer from a depression. Additionally the enormous economic significance of this disorder is recognized more clearly. Experts assume that it might soon take top priority of all diseases leading to disability. Furthermore the interest in understanding the function and consequently the dysfunctions of our brain has dramatically increased. Some among us living in a rather rationally pronounced civilization still find it hard to accept that we often are only performers of our cerebral functions and not, as preferred, their controllers. Depressive people get irritated through this view of the world and people, as there does not seem to be a perceptible reason for their feeling depressive, unmotivated, shiftless and cheerless. Therefore it is important to understand that mood changes in the daily life can usually not be equated to depressions. The symptoms mentioned above have at least to occur for two weeks continuously in order to consider a possible depression. This happens to 10-18% of patients once in a lifetime and to approx. 5% several times.

In these cases it is important to know that there are many other symptoms which can add individually in a varying intensity. Typical symptoms are: sleeping, appetite and sexual disorders and depressive triads (negative thoughts about oneself, the environment and the future). Pain develops and the sensation of pain increases since the brain is unable to suppress them as in healthy persons. Agitation, retreat, increased sensibility to infections, suicidal thoughts (8 – 15% commit suicide), intensified feelings of guilt and worthlessness, emptiness and feelings of indifference. Additionally concentration and memory disorders add due to a decline of cells in the responsible brain regions (hippocampus region). Fortunately these cells regenerate through the influence of medications. 70% of depressive patients only come to see their general practitioner because of pain problems, who will diagnose a depression in only 10% of the patients (still German general practitioners do much better than their European colleagues!). Only 3 - 4% are immediately diagnosed and treated by a psychiatrist/psychotherapist, although this would be the right address at least after an unsuccessful medical treatment attempt.
Initially the therapy is adjusted to the severity of the depression. In cases of severe forms medications (anti-depressants) are an integral part of the treatment. These medications usually show an effect 1 – 2 weeks after intake in 60 – 70% of the cases and among other effects are responsible for the sufficient supply of certain proteins (brain growth factor) in the brain cells. These substances are not addictive although this is embarrassingly stated differently on the website of the ministry of health!

The closer relatives are often very exhausted and have to be included in the treatment. The medical treatment should always be accompanied by psychotherapy, preferably at a psychiatrist. The best results could be achieved by applying individually adapted forms of cognitive behavioural therapies and in some case interpersonal psychotherapy, which is not covered by the health insurances. Additionally in certain cases electroconvulsive shock therapies, sleep deprivation, and/or depth psychological therapies are applied. The application of the transcraniel magnetic stimulation (rTMS) is still a subject of research and its outpatient application is presently only performed by "charlatans". Each kind of therapy should be designed in a way that it does not additionally stress the already strained patient but teaches him/her to carefully deal with the temporarily decreased energy. This raises new hope in patients.