An epidemic of depression or the medicalisation of unhappiness

Roger Mulder MBChB FRANZCP

Sadness, anhedonia, insomnia, poor appetite, exhaustion, irritability and reduced ability to concentrate are experiences most people are familiar with and have suffered from time to time.

In psychiatry these phenomena have been aggregated into a discrete disease entity called depression. The most widely accepted definition of this illness is in DSM-IV.[1] This definition requires the presence of at least one of two necessary symptoms (sadness and anhedonia) plus an additional four or more, all of which are present for at least two weeks. Despite the fact that all illness definitions in DSM-IV are acknowledged as human constructions without adequately specified boundaries, depression has been increasingly viewed by most health workers as a specific mental illness.

***Roger Mulder**'s research is focused on mood disorders including their relationship to personality and temperament, their biology and genetics and their long-term outcome, and personality disorders. He has also been involved in research on psychiatric aspects of medical disorders and the history, philosophy and ethics of psychiatry.*

Prevalence of depression

Perhaps the most interesting aspect of major depression is that it has either increased markedly or it has been increasingly recognised over the latter half of the 20th century. Epidemiological studies performed in general population samples report that depression is becoming more frequent, that it begins at an earlier age and that it may be more severe and recurrent.[2] While estimates in the late 19th century suggest that around 50–100 persons per 100 000 were depressed, a prevalence of less than 0.1%, current World Health Organization estimates are that depression will be second in the International Burden of Disease ranking and affects around 15% of men and 24% of women in their lifetime.[3]

Despite the fact that all illness definitions in DSM-IV are acknowledged as human constructions without adequately specified boundaries, depression has been increasingly viewed by most health workers as a specific mental illness

While this high prevalence has been accepted by many health workers, others have been more critical. They point out that since all persons who report enough symptoms are counted as having a mental illness called depression, and since depressive symptoms are common, this will result in depression being a widespread medical illness. In addition, there is little evidence that having five or more DSM-IV symptoms of major depression for two weeks does create a distinct category. On the contrary, the evidence suggests that major depression is a diagnostic convention imposed on a continuum of depressive symptoms of varying severity and duration.[4] Despite these criticisms claims of a high prevalence persist.

Advantages of a high prevalence disease

There are a number of advantages to having an illness that is said to have a high prevalence. Clinicians can claim that only a small proportion of people with the illness are receiving the professional treatment they need. In the case of depression this leads to pressure for increased spending on mental health services. Researchers benefit from depression being viewed as a public health problem of vast proportions. Such an illness deserves priority from funders and policy makers. Mental health advocacy groups also promote the pervasiveness of depression. Because it is common, claiming it is a mental illness leads to sympathy and decreased stigmatisation. Last but certainly not least, drug companies also greatly benefit from high prevalence estimates of an illness as the explosive growth of sales of antidepressants attest. There are also disadvantages.

Problems with a high prevalence of depression

If depression is truly a widespread illness then it requires a medical solution. Untreated cases of depression like other untreated illnesses require professional treatment. What would such a response actually entail? The lower estimates for the 12 month prevalence rates of depression as currently stated imply that one in 15 people in the general population require professional treatment for depression.[3] Some argue that it is more practical to initiate treatment at the primary care level. However, published rates of depression among patients attending general practice in New Zealand are around 20%.[5]

Taken at face value these figures imply that one in 15 in a general population or one in five patients visiting the general practitioner should be undergoing a clinical intervention for depression. This would presumably involve at least 10–12 sessions of psychotherapy or prescriptions and monitoring of an antidepressant drug for at least six months. The effort required would overwhelm primary care and mental health services. No country could afford, even if it had sufficient trained staff, to offer treatment to such a large group of its citizens.[6]

It appears most of the vast growth in depression has been at the milder end of the illness. There is no consistent data suggesting psychotic depression, for example, has increased significantly. For those suffering milder depression there is no evidence that professional mental health treatment produces better outcomes than non-specific treatments. Talking to friends or intimates, exercise, problem solving strategies and St John's Wort have all been shown to be equivalent to antidepressants and psychotherapy in mildly depressed patients. Social and political efforts to change stressful situations may be more effective than individual treatments. It is even possible that conceptualising distress as a mental illness can do harm. Pathologising distress in an individual may lead to increasing self-identification as a helpless victim relying on the services of mental health professionals. The belief that mildly depressed individuals are missing out on necessary treatments has no empirical support.[7] There is evidence that they are consuming resources that more severely depressed individuals might benefit from.[8]

Potential solutions

The obvious solution would be to generate a valid mental disorder called depression. This should involve the reliable identification of a dysfunctional psychological syndrome and be clearly distinct from individuals who do not have depression. This solution is some way off but to begin to address it requires acknowledgement that the current concept of DSM-IV major depression is invalid. This would at least allow ongoing investigation into alternative potentially more useful and valid conceptions of the illness.

The context and aetiology of depression needs to be reintegrated into diagnosis rather than simply ticking off symptoms

From a pragmatic point of view, it appears that if depression is so common that resources have to be rationed it is sensible to preferentially give medical treatment to those for whom it is most likely to be effective. One obvious group of patients is those whose chance of spontaneous recovery is least. Two patient groups are emerging; the first are those whose depression is more severe, particularly if they are psychotic (where the placebo response is close to zero) but also those with severe vegetative symptoms. The second are those with chronic depressive symptoms. There is some evidence that the placebo response is significantly lower in patients with more than six months of symptoms. Kahn et al.,[9] for example, report that placebo response is 23% for those whose length of illness is greater than 12 months versus 45% in those with less than 12 months. In patients with mild and fluctuating symptoms the evidence for specific treatment effects are unconvincing. There is no clear evidence that specific treatment is superior to supportive practical help or alternative treatments.

Conclusion

The historical continuity of depression and the consistent description of its severe and psychotic forms suggests that there is an underlying mental illness. However, DSM-IV does not identify it. To begin to address this requires alternative diagnostic systems which can be systematically tested. The context and aetiology of depression needs to be reintegrated into diagnosis rather than simply ticking off symptoms. The purported high prevalence of DSM-IV depression makes it impossible to treat everyone with these symptoms. Based on limited clinical data it seems rational to focus on patients with severe and psychotic depression and those with more chronic depressive symptoms. Those with milder symptoms may be better served by monitoring and encouraging simple strategies such as exercise, normalising sleep patterns and problem solving presented through books or via the Internet. Some type of treatment stratification will be necessary. Claiming all depressed individuals are mentally ill and require professional help does the patients and us a disservice.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders DSM-IV (4th ed.). Washington DC: American Psychiatric Association; 1990.
2. Weissman, MM, Bland, RC, Canino, GJ, Faravelli, C, Greenwald, S, Hwu, HG, Joyce, PR, Karam, EG, Lee, CK, Lellouch, J, Lepine, JP, Newman, SC, Rubio-Stipec, M, Wells, JE, Wickramaratne, PJ, Wittchen, H & Yeh, E. Cross-national epidemiology of major depression and bipolar disorder. JAMA 1996; 276(4):293–299.
3. Hirschfeld, RM, Keller, MB, Panico, S, Arons, BS, Barlow, D, Davidoff, F, Endicott, J, Froom, J, Goldstein, M, Gorman, JM, Marek, RG, Maurer, TA, Meyer, R, Phillips, K, Ross, J, Schwenk, TL, Sharfstein, SS, Thase, ME & Wyatt, RJ. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. JAMA 1997; 277(4):333–340.
4. Kendler, KS & Gardner, CO, Jr. Boundaries of major depression: an evaluation of DSM-IV criteria. American Journal of Psychiatry 1998; 155(2):172–177.
5. The MaGPIe Research Group. The nature and prevalence of psychological problems in New Zealand primary health care: A report on Mental Health and General Practice Investigation (MaGPIe). New Zealand Medical Journal 2003; 116(1171): 379.
6. Mulder, RT. Long-term outcome of depression. In PR Joyce & PB Mitchell (Eds.), Mood Disorders Recognition and Treatment (pp. 423-432). Sydney: The University of New South Wales Press Ltd; 2004.
7. Goldberg, D, Privett, M, Ustun, B, Simon, G & Linden, M. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. British Journal of General Practice 1998; 48(437):1840–1844.
8. The WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization world mental health surveys. JAMA 2004; 291(21):2581–2590.
9. Khan, A, Leventhal, RM, Khan, S & Brown, WA. Severity of depression and response to antidepressants and placebo: An analysis of the Food and Drug Administration database. Journal of Clinical Psychopharmacology 2002; 22:40–45.

'The therapeutic role of general practitioners (GPs) is one that, over the years, has slowly diminished with the growing fashion for evidence-based medicine. However, it is clear that the art of healing and the strength of the doctor-patient relationship play a vital role in improving the well-being of patients. This is exemplified by the placebo effect, where the attitude of the doctor can make an appreciable difference to the psychological response of the patient who feels the need to be understood and listened to empathically. By maximizing the role of the physician healer, there is considerable scope for bridging the gap left by the impersonality of medical science, while at the same time increasing the GP's effectiveness.'

Dixon DM, Sweeney KG, Gray DJP. The physician healer: ancient magic or modern science? Br J Gen Pract, 1 April 1999, vol. 49, no. 441, pp. 309-312(4)