A different way of looking at depression

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THE INTERNATIONAL JOURNAL OF CLINICAL PRACTICE

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Journal:	*International Journal of Clinical Practice*
Manuscript ID:	IJCP-01-10-0042.R1
Manuscript Type:	Perspective
Date Submitted by the Author:	29-Jan-2010
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Specialty area:	

A different way of looking at depression

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The value of the diagnosis of depression in primary care has been under debate for many years now, even though the focus of this discussion has changed from time to time, shifting from under to over-diagnosis. In this contribution we suggest a different way of looking at depression in primary care, and we will substantiate this opinion with arguments why it might be more appropriate using a stepped model for diagnosis as well as for treatment.

Why do we need a different way of looking at depression?

In a recent systematic review Mitchell et al. concluded that general practitioners over-diagnose depression more than they miss cases: for every 100 unselected cases seen in primary care, there are more false positives (n=15) than either missed (n=10) or identified cases (n=10); general practitioners (GP's) diagnose depression too frequently and not too in-frequently(1). This is a relatively new sound in scientific literature. For a long time the importance of a diagnosis and therefore the need to screen has been stressed. The focus was on under-diagnosis of depression in primary care, supposing that detection will lead to a better outcome. But evidence showed that, unfortunately, this is not always the case in primary care(2). Both conclusions, that of over-diagnosis as well as under-diagnosis, suggest that there is something seriously wrong with the diagnosis of depression in primary care settings. This is important because only a correct diagnosis can be followed by adequate and effective treatment as set out in various guidelines(3;4). A further problem is that results of treatment for depression in primary care are disappointing. Antidepressants have a strong placebo effect and in general practice only one in about every 5 or 6 patients benefit specifically from medication(5). This result is often attributed to inadequate treatment by general practitioners or to a low compliance by patients for instance because of side effects of medication. But over-diagnosis and over-treatment might also explain the disappointing effectiveness of antidepressants in primary care, using these medications in patients who do not need them. Furthermore the effectiveness of psychotherapy is also is not very large as it is roughly equal to the effectiveness of medication.

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Different views on depression

We would like to discuss the diagnosis of depression in primary care from another perspective, believing that the main problem is not compliance with diagnostic criteria, but having a different view on the reality of patients consulting their GP with depressed feelings. General practitioners' guidelines advocate using strict criteria for the diagnosis of depression. These criteria are provided by the DSM-IV classification system. Since the overall acceptance of this classification, all depression is looked upon as one and the same. According to the DSM, the diagnosis is symptom-based without reference to a cause. The classification is said to be value-neutral. However, it denies the fact that the concept of

depression is relative; it is a diagnosis by agreement and not by essence. It has been argued 'that depression has reached a status which goes far beyond its true status and that the concept has been widened gradually to a concept containing many heterogeneous categories'(6). This might also be one of the reasons why general practitioners currently prescribe antidepressants too often. Due to this model many patients receive antidepressants even when consulting with depressive symptoms for the first time(7). Even though antidepressants are sometimes combined with psychotherapy, the question remains how many of these patients really need these depression specific medications and treatments. Perhaps prescribing of antidepressants to too many patients is also causing a dilution of their effectiveness, which is much lower in primary care where the whole spectrum of depressive symptoms is seen, than in secondary care; with on average more severe and more chronic cases in which antidepressants are really needed(8;9).

The value-neutral, symptom-based DSM-IV approach leaves out the existence of situations where patients experience intense sadness (and other symptoms of the list of items for depression) as a completely adequate response to what has happened in their life. Many of these patients fulfil the criteria for major depression. However, the intense sadness has a function and as such distinguishes between normality and disorder(10). We think that treating these patients with antidepressants or psychological treatments might be one of the causes of the low effectiveness of treatments for depression in primary care as a whole, medicalising too many cases of human suffering. Many of these people might be more in need of talking through what has happened, thus experiencing support and stimulating the restoration of hope. We think that such approaches and generic interventions are often already used in primary care.

A new approach

Underpinning the last statement and the relativity of the classification system, we return to the systematic review by Mitchell et al. They mention many possible reasons for their findings of more false positive depression diagnoses than true positives. They point out the strikingly high specificity and sensitivity of the diagnosis in a study that we performed in the practices of the Continuous Morbidity Registration (CMR)(11). This is the registry of the department of Primary and Community Care of the Radboud University Nijmegen Medical Centre. It is a network of four practices in the Nijmegen region that records all morbidity on an ongoing basis since 1971 with a total practice list of about 12.000 patients. The authors contributed this high specificity and sensitivity of the diagnosis to the training these GPs received in using diagnostic criteria of the ICPC(12). Of course training in diagnostic criteria does contribute to a correct diagnosis, but in this case there was no specific training for the diagnosis of depression, no training in DSM diagnosis, nor had the training been given recently. The real reason for the adequate diagnoses might be that in these practices most patients have been registered in the same practice for many years. They receive a person-centred longitudinal

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approach in which the GP knows most patients well (as is often the case in The Netherlands), and takes into account symptoms as well as context.

Having mentioned all these arguments we propose a stepped care model, not just for treatment but also for diagnosis(13). We believe this will decrease the number of over-diagnoses of depression, make it easier to distinguish between 'normal' human suffering and the illness of depression, and act accordingly. The main arguments for our proposal are the insufficient distinction between depression and 'normal' sadness and the disappointing effectiveness of treatments for depression in primary care.

With reference to the diagnosis it means that symptoms, when first presented, should be seen in the light of what is going on in that person's life, taking into account context matters as well as symptoms. We should try to avoid labelling symptoms to illness immediately, giving the patient's own explanation and story an important role. Checking symptoms may be helpful, and many patients even like discussing their symptoms in a structured, detailed way using checklists. It is probably good to discuss symptoms in detail as long as patients have the opportunity to tell 'the story' as well as the symptoms(14;15). Using checklists also helps to choose between watchful waiting and active treatment as it sheds light on the symptoms and their severity, as much as the story tells about circumstances and possible causes. Watchful waiting is safe as in primary care many cases of depression are mild and patients might recover without medical interventions, looking at the 'natural' history of depression in primary care(16). Watchful waiting is not the same as doing nothing. We think that it is often justified to follow-up and see if the symptoms improve with a few supportive consultations aiming at restoration of hope, or with a generic intervention or a specific treatment for relevant co-morbidity which is likely to contribute to depressive feelings. Patients for whom the depressive symptoms do not improve as a consequence of our activities will eventually be subject to a formal diagnostic procedure, and if necessary receive depression specific treatment. In this person centred stepped approach it is appropriate to wait a little longer before making a diagnosis. It serves to see if the symptoms are a 'normal' response to circumstances the patient experiences, and if this develops in a positive direction or whether an intervention is needed.

Conclusion

We do not deny the value of using classification systems for patients, but we think that in primary care it might be suitable to use it as a second step believing that most patients with 'normal sadness' are better off without an immediate diagnosis.

Having made this case, we believe that this new approach deserves a try-out. We would then like to study what GP's discuss with their patients, how they diagnose and treat depressive symptoms over several consultations, and the influence of this approach on prognosis and well-being, rather than trying to mould stories from patients into the categories of the DSM classification immediately in first consultations. It will also be interesting to see if a new classification system for mental health in

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primary care, as suggested by Gask et al, will help in distinguishing between distress and disorder, and lead to more appropriate subsequent interventions(17).

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