



coordinated by Professor Gordon Parker

mind over matter

Parting the fog of 'major depression'

The current thinking that there is only one type of depression should be replaced by a 'horses for courses' approach, says Professor Gordon Parker, in the first of a series of monthly columns looking at the diagnosis and management of mood disorders.

THIS monthly column – via illustrative case studies – will tour the clinical world of diagnosing and managing mood disorders. The travel guide messages are that a comprehensive history is fundamental; that current 'painting by numbers' guidelines are to be abhorred; and that – until more commonsense guidelines are developed – adopting an informed 'horses for courses' management approach is wise.

Provocative and declamatory? Surely. So, what drives my concerns? In essence, the current model for conceptualising depressive disorders – and its consequences.

For the past 20 years, the dominant classificatory model of depressive disorders has assumed that there is only one type of depression, merely varying by severity.

In reality, and underpinning our approach at the Black Dog Institute, there are differing conditions that benefit from identification and differential management. Regrettably, their variegation is homogenised into a pseudo-entity called 'major depression'. Magnificent in its simplicity, it has also been majestic in its unhelpful impact.

'Major depression' is an abstract concept that has become thought of as real. It is viewed as a disease entity in itself, reflecting 'a chemical imbalance'.

However, major depression does not show any clearcut clinical picture, and no consistent aetiology or biological perturbations have been identified.

Worse, randomised control trials of differing antidepres-

sants, differing psychotherapies, and many other interventions including St John's wort, all show similar efficacy for major depression.

All roads lead to remission.

This is hardly surprising when treatments are tested non-specifically (as if they have universal application) across a non-specific diagnostic category.

Such a diagnosis is no more useful than a diagnosis of 'major dyspnoea'.

No GP would regard something so generic as sufficiently definitive to dictate treatment alone. Could it be pneumonia or asthma or pulmonary embolus? Only when the underlying cause is identified does treatment become rational.

Similarly, we need to sub-type,

'Major depression' is an abstract concept

identify causes and apply specific (as against universal) management strategies for the *major depressive disorders*.

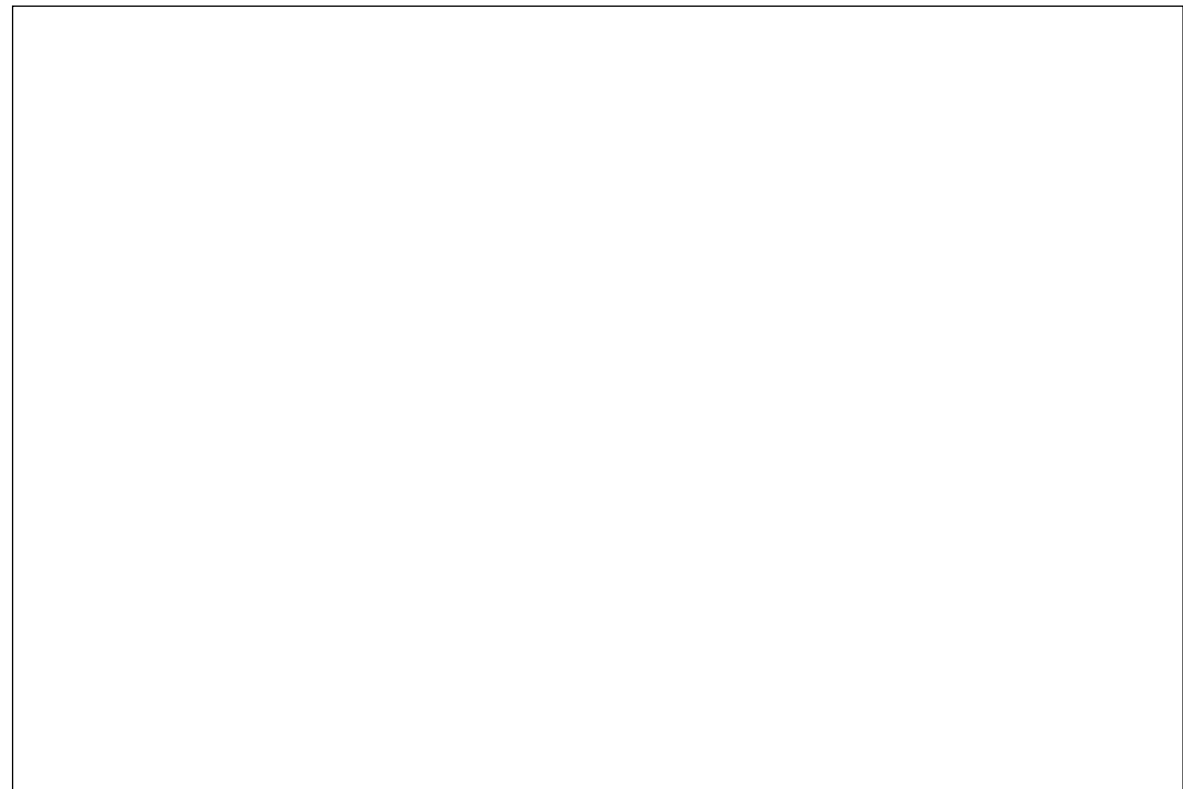
Commonsense then prompts a 'horses for courses' paradigm for management.

There are many expressions of depression. In this column we'll try to part the black fog of major depression and capture the heterogeneity.

A soupçon of a case study now, until next month's column.

CASE HISTORY

A young man, aged 28, presents with a diagnosis of chronic mild anxiety and depression that had



not only been non-responsive to a series of differing antidepressants, but which appeared to worsen his depression.

The history in relation to taking antidepressants

Initially, he would perceive some benefit on commencing each different antidepressant but, after a short period of time (usually days), he would develop nausea, fatigue, light-headedness and a worsening of his mood. This reaction occurred even at low dosages. At times, myalgia and a range of gastrointestinal symptoms also developed as side-effects.

Medical history

Gilbert's syndrome, ADHD and motor tics – with salt and tomatoes worsening the tics. He also had a history of a range of somatic symptoms including nausea, intermittent constipation and diarrhoea, flatulence, dyspnoea, fatigue, myalgia and

light-headedness. He had tried self-treatment and had found some improvement in symptoms when he eliminated wheat, milk, and milk products from his diet.

Family history

His grandfather had been on a modified diet (for unknown reasons) for 50 years, while three other relatives had significant bowel symptoms that responded to dietary changes.

INVESTIGATIONS

To investigate the somatic symptoms, he was referred for double-blind placebo capsule testing of suspect chemicals. This allergy testing identified acetylsalicylic acid challenge as inducing the symptom profile detailed on referral.

DIAGNOSIS

A food intolerance syndrome contributing to depression and other somatic symptoms, and with susceptibility to food intoler-

erance effects from psychotropic drugs (both from their constituents and from any colourings or preservatives). Thus, principally a secondary depression and not a primary psychiatric condition.

TREATMENT

An elimination diet was associated with distinct improvement, and a rechallenge confirmed the diagnosis.

PREVALENCE OF SCENARIO

Rare, but sufficient to justify consideration when a history of antidepressant drug intolerance (as against resistance) is obtained.

The vagueness of the history can test the tolerance of the doctor.

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Information reference:
www.blackdoginstitute.org.au