

## mindovermatter

by Professor Gordon Parker

# The blues is the new black

The defining and re-defining of depression.

IN last month's column, a model was considered for choosing among the differing antidepressant drugs. As an extension, this month's column synthesises issues recently debated in the *British Medical Journal*<sup>1</sup> addressing definitions of 'depression' and which have implications for treatment.

## SOME HISTORY

Until the 1950s, 'typical depression' was essentially the endogenous or melancholic expression, affecting some 2% to 5% of the population over their lifetime, while the residual depressions (variably called neurotic, reactive or atypical) were viewed as conditions reflecting interactions between stress and personality.

The introduction of antidepressants in this era revolutionised the management of 'depression' – with some qualifications. In essence, placebo-controlled trials of the tricyclic antidepressants showed a marked response gradient (some 60% versus 10%) for those with melancholia, but minimal differential for those with the atypical depressions. Thus, specificity of antidepressant response to the type of depression was demonstrated.

While clinical depression was previously too strictly defined, we now observe an over-correction

In 1980, the North American Diagnostic and Statistical Manual (DSM)-III classificatory system published a new model for classifying the depressive disorders – principally dimensional in that it distinguished major and minor expressions of depression.

The criteria for major depression could be met in quite contrasting ways, whether by demonstrating substantive features of melancholia (e.g. psychomotor disturbance,

anhedonia, delusional guilt) or by having fairly trivial and non-substantive symptoms (e.g. feeling blue, appetite change, sleep disturbance, drop in libido and fatigue).

In essence, the new entity 'major depression' homogenised differing expressions of depression into a severity-based diagnosis. The 'minor' depressive disorders required even fewer clinical symptoms.

And over the last 15 years many academic psychiatrists have argued for an even less severe 'condition' – sub-clinical depression – and contend that major, minor and sub-clinical depressive disorders are all of clinical and public health importance.

But consider just one current investigation: in our non-clinical longitudinal study of 242 Sydney teachers, we established that by the time that they had reached their late 30s, 42% had met DSM lifetime criteria for major depression while 89% had met criteria for either minor or sub-clinical depression. Only a small percentage had, however, received a formal treatment. The question "over-diagnosed or under-treated?" is clearly posed by such data.

## NORMAL DEPRESSION

While clinical depression was previously too strictly defined, we now observe an over-

correction, with definitions extending into normal mood states, a model that risks pathologising ordinary human emotions.

Of greater concern is the suggestion that treatment should be mandated for many of these sub-clinical depressions, in fact normal transient low moods.

## THE ISSUE OF 'OVER-TREATMENT'

In the subsequent media

pick-up of the debate, several commentators argued that we should not worry about the over-treatment that is implicit in over-diagnosis, as the increased treatment of depression overall has resulted in benefits – including a reduction in the suicide rate.

As an increased rate of antidepressant prescriptions does appear associated with a lower suicide rate,<sup>2</sup> such a population-based argument appears attractive at first, but the key question is whether that impact is a general one or only linked to certain expressions of depression.

Let's imagine 200 people with respiratory symptoms: 100 are given antibiotics and 100 a placebo. Even if the group receiving the antibiotic showed a superior result, that difference might reflect benefits being confined to a diagnostic subset (e.g. pneumonia) but with no impact on residual conditions (asthma, emphysema) where there was no logic for an antibiotic.

Similarly, while certain

antidepressant drugs are highly effective for the management of melancholia, there have been multiple meta-analyses showing that their superiority to placebo is less marked for major depression, while their specific benefit for the minor and sub-clinical depressive disorders is quite problematic.

In essence, extrapolating both need for treatment and the benefits of treatment along a dimension of depressive disorders that encapsulates categorical conditions such as melancholia through to non-substantive conditions has predictable limitations and risks.

Prescribing antidepressant drugs to those who are unlikely to gain any benefit and who may, indeed, experience significant side-effects, shifts the cost-benefit ratio.

Unnecessary treatment can medicalise a commonplace problem, impair self-efficacy and court a range of iatrogenic complications (viz. the over-prescription of benzo-

diazepines and barbiturates of earlier times). Providing formal and extended evidence-based psychotherapies to those with minor disorders is less of a concern in terms of side-effects but can waste resources.

## CONCLUSIONS

Once depression is dimensionalised, determining 'caseness' by imposing a cut-off will always risk under-diagnosis or over-diagnosis. Current diagnostic systems run the latter risk. Mandating treatment across all expressions of such dimensionalised depression risks application of a model that views all treatments (drug or non-drug) as having universal application and inappropriate treatment as a consequence of such a non-specific and largely atheoretical model. ☺  
Professor Parker is Scientia Professor at the University of New South Wales and Executive Director of the Black Dog Institute.

References available at [www.medicalobserver.com.au](http://www.medicalobserver.com.au)