

The Review

An end to depression in primary care?

It is time to consider alternatives to diagnosing and treating depression in primary care. GPs' prescribing of antidepressants continues to increase, but most patients stop taking the medications soon after starting them. Depression is mostly dealt with in primary care, but GPs' assumptions about mental health and its medical management have been inherited from the powerfully vested interests of psychiatry and pharmaceutical companies, while being influenced by financial incentives. Meanwhile, social issues continue to be overlooked in depression management guidelines, in practice, and in society at large; enabling serious engagement with psychosocial determinants of distress to be avoided. A clear-sighted revision of how best to help with patients' emotional needs is due.

UNHELPFUL DIAGNOSES AND TREATMENTS

The most compelling challenge to current practices of depression diagnosing and antidepressant prescribing in primary care comes from studies that show massive rates of treatment drop-out. The most recent UK research, published in the *BJGP* earlier this year, found that one-quarter of patients commenced on antidepressants took them for less than 30 days;¹ confirming similar findings from the Netherlands.² Other researchers have found over 50% of patients quit antidepressants before a pharmacological effect could be achieved and mostly this occurs in the absence of discussion with a GP.^{3,4} Some of this may be due to unwanted side-effects of the drugs, but not all, for it has been shown that a sizable proportion of patients receiving a first time prescription never even initiate drug taking.² Nor is it due to diagnosing and prescribing that could be considered inappropriate according to existing criteria, since evidence suggests that GPs are more liable to under-diagnose⁵ and under-treat.⁶ But something in the nature of those diagnoses and treatments is evidently not right: when people present with emotional distress and we respond with symptom scores and SSRIs, most will evidently not find this helpful.

PSYCHIATRY, PHARMACY, AND FINANCIAL INFLUENCES

Although depression is diagnosed and

treated almost entirely in primary care, it has been defined exclusively by psychiatrists. The assertion of actual brain pathology amenable to physical or pharmacological therapy has historically been crucial to psychiatry's claims to credible scientific status. While psychiatrists appear to remain occupied with discriminating types of mental pathologies (evident in the innumerable DSM diagnostic codes), often among a minority of individuals in a hospital setting, this is clearly a wholly different endeavour to that of the GP seeking to understand people's problems in the community.

The limits of psychiatric methodology have been admitted by the eminent American psychiatrist Robert Spitzer. It was Spitzer who designed the PHQ-9 depression questionnaire with sponsorship from Pfizer (soon after that company had entered the antidepressant marketplace with its new drug sertraline).⁷ However, Spitzer has recently acknowledged that using the PHQ-9 to diagnose depression permits 'normal responses to stressors to be mischaracterised as symptoms of disorder', thereby easing the patient's path to clinical diagnosis and drug treatment.⁸ Despite this, and despite the explicit objections of some GPs, the PHQ-9 is nonetheless endorsed by NICE and its use in primary care has been financially incentivised by the Quality and Outcomes Framework.⁹ Meanwhile, the revelations of selective publication of antidepressant trial data¹⁰ and Kirsch *et al's* well-conducted meta-analysis,¹¹ (the 'gold standard' of evidence based medicine according to doyens of the discipline)¹² showing that antidepressant medications offer little benefit beyond those of placebo, have brought surprisingly little change in primary care prescribing patterns. Antidepressant prescribing continues to increase: by an average 10% per year in England.¹³ This trend is not based on mounting evidence of antidepressant efficacy or of growing certainty regarding

the nature of depression. The increase in antidepressant prescribing in primary care is upheld by the inherited influences of psychiatry, the pharmaceutical industry, and the effect of financial incentives on our practice.

SOCIAL REALITIES

'Assumptions embedded in the culture of late modernity' have also been implicated as influencing both patients and practitioners; specifically, the assumption of depression as a problem of the individual ('rather than a relational phenomena originating in social interactions') whose underlying pathology is amenable to 'technical management of the self'.¹⁴ Likewise, depression guidelines have been shown to 'fail to acknowledge individual patient circumstances', including adverse life events, support networks, and other social contexts.¹⁵

Clearly though, it cannot be imagined that mental health exists as an entity distinct from its social setting and amenable to treatment in isolation from that setting. Indeed, the evidence proving poverty, unemployment, and inequity as causes of depression^{16,17} — as currently defined — is so much more convincing than the serotonin theory that we may reasonably propose depression would be treated far more effectively by social justice and appropriate distribution of wealth than by medications.¹⁸ Yet our collective societal reluctance to countenance this reality is apparent in the fact that depression is more likely to be considered as a cause of economic loss than as a consequence of economic policy: the 'cost' of depression to society is frequently cited in the medical literature and lay media (*The Guardian* has declared that depression is 'costing the economy nearly £11 billion a year in lost earnings, NHS care and drug prescriptions', which, incidentally, may prompt reconsideration of the motives behind David Cameron's Happiness Agenda).¹⁹

"... each of us should question our own role and consider whether our diagnoses of depression and prescriptions of antidepressants are the most helpful response to our patients' emotional needs."

Until the importance of societal factors in relation to mental health (and not only as the source of problems, but as potential solutions) are more widely acknowledged and addressed, accepting a merely medical approach toward the individual will remain ineffectual and only sustain injustice.

REVISION OF MEDICAL INTERVENTIONS

'It may be more productive to view the presentation of emotional distress in a medical setting as a situation to be understood and addressed, rather than as an illness awaiting treatment', suggested Middleton and Moncrieff in the BJGP last year.²⁰

Their perspective shows much in common with the response of the British Psychological Society to the latest draft of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-V)*:

'Sadness and unhappiness which are deserving of help and intervention — are not best considered illnesses ... by regarding them as such, there is a danger of misunderstanding their nature and cause and applying inappropriate medical remedies ... The Society recommends a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience, and that psychosocial factors such as poverty, unemployment and trauma are the most strongly-evidenced causal factors.'²¹

Many GPs may agree intuitively with the idea of social causation and the continuity between life events and 'emotional distress' presenting in primary care. However, the failure of current UK depression guidelines to acknowledge the importance of psychosocial context²² alongside GPs' increasing efforts to intervene with biochemical 'cures' seem to confirm Richard Bentall's perception of 'a kind of intellectual myopia, which has blinded professionals to the fact that distress in human beings is usually caused by unsatisfactory relationships with other human beings' (rather than depleted serotonin). Bentall's book *Doctoring the Mind* provides a readable and notably well-endorsed account of how 'by any reasonable standard, the dominant paradigm in psychiatry, which assumes that mental illnesses are genetically influenced brain diseases, has been a spectacular failure'.²³ Nonetheless, it is with this paradigm that those of us working in primary care have tended to align.

UNCERTAINTIES AND UNANSWERED QUESTIONS IN PRIMARY CARE

In practice, GPs are at equipoise: we have been shown to be guided by our patients in discussions and treatment decisions relating to depression.²⁴

In a counter-point to the article by Middleton and Moncrieff cited above, 'patient-centred treatment' was put forward as one of the reasons to consider antidepressant treatments.²⁵

Similarly, a recent editorial on the subject of antidepressant prescribing advised 'shared decision making'.¹⁵

But being patient-centred does not mean working from a diagnosis, it means working from the reason for encounter.²⁶ A truly patient-centred response would involve Middleton and Moncrieff's advocated efforts to understand a patient's problems, before any consideration of symptom-scoring, diagnosing, or discussions about medications. And shared decision making does not mean leaving decisions up to patients, it may involve challenging beliefs (including those 'assumptions embedded in the culture of late modernity', referred to above) and exchanging knowledge. In the light of Kirsch's meta-analysis of antidepressant efficacy¹¹ it was suggested that it would be unethical not to inform patients that the effect of antidepressants is no greater than placebo.²⁷ At the very least, if not additionally, Kirsch's findings surely demand that we endeavour to better understand the placebo effect and how elements of it may be utilised in primary care treatment of depression.

Diagnosis and treatment of depression raises profound philosophical questions: about what we mean by disease, about the relationship between mind and body, and about the relationship between individuals and society. These questions have not been adequately considered in the context of primary care. The answers that we have inherited only sustain an untenable myth that antidepressants can act as definitively on something as easily definable as other entities in our pharmacopeia, like, say, antibiotics for pneumonia, or antacids for heartburn. Our equipoise looks less like patient-centeredness, more like uncertainty and incoherence.

AN END TO DEPRESSION IN PRIMARY CARE?

Perhaps, as more evidence becomes available, and that which is available becomes better understood and acknowledged, drugs for depression in primary care will become recognised as

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akin to antibiotics for earache: little more than placebo in most cases, with potential side effects, to be resorted to on only the most uncommon occasions. Before that happens, we need to confront the fact that we do not yet have an adequately considered theory of depression and its treatment in primary care. Nor, more pertinently, do we have a coherent response to the presentation of emotional distress.

The 'revision of the way mental distress is thought about' called for by the British Psychological Society is surely due. A clear-sighted revision of emotional distress in primary care may demand that we resist financial incentivisation as a rationale for action. Also that we reconsider the assumptions inherited from psychiatry and the pharmaceutical industry that have enabled us to respond to mental distress with measures of physical symptoms, categorical diagnoses, and treatments that target only the individual's most proximal biochemistry, while ignoring psychosocial circumstances.

Even if we can achieve this, and certainly if we cannot, we should ultimately not avoid asking whether the changing nature of primary care and the challenges of dealing appropriately with socially-determined emotional distress will make general practice best suited to that task in future. Meanwhile, each of us should question our own role and consider whether our diagnoses of depression and prescriptions of antidepressants are the most helpful response to our patients' emotional needs.

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Provenance

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