Depression: epidemic or pseudo-epidemic?

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There are a number of under-examined fault lines running through the medical literature on depression, and current clinical practice in the UK. This chiefly stems from a too exclusively biomedical focus, neglecting the social construction of the human mind. For a start, the term 'depression' tends to be used without qualification, as if it was settled that we were always referring to a free-standing biologically-based disorder. Yet in everyday usage, as much by doctors as by the general public, 'depression' can mean something figurative or literal, can denote a normal or abnormal state, and if abnormal either an individual symptom or a full-blown disorder. And though depression-as-disease may have acquired the status of a natural science category, this was an achievement rather than a discovery: the history of the concept demonstrates the gradual incorporation of a Western cultural vocabulary of guilt, energy, fatigue and stress.[1]

Orthodox teaching has been that a 'functional shift', the presence of so-called biological features, points to medically significant depression (and responsiveness to anti-depressants). But, bar a small subset of severe cases, there is no reliable demarcation of depression from ordinary unhappiness or misery on this basis. Poor sleep and concentration, weight loss, reduced motivation and drive, anhedonia, etc. (as well as suicidal ideas), not uncommonly accompany ordinary misery as well.

In 1996, just before the Royal Colleges of Psychiatrists and General Practitioners began a Defeat Depression campaign, they surveyed lay people's attitudes to depression and its treatment.[2] The views they elicited tended to portray depression in terms of emotional problems, like unhappiness, caused primarily by social and situational factors, and not something to take to general practitioners (GPs). Of the 2003 people polled, 78% saw anti-depressants as addictive, and liable to dull symptoms rather than solve the problem. The Royal Colleges seem to have been undeterred by these findings, which were rather at odds with their view of 'depression' as straightforwardly connoting a psychiatric disorder. Indeed the Royal Colleges initiated the Defeat Depression campaign because they believed that 50% of people with depression did not consult their GPs. They wanted to increase this figure. But was the lay view wrong? We can see here how professional pronouncements can contribute to a blurring between unpleasant but commonplace mental states, part of life, and those associated with objective dysfunction and breakdown, meriting medical attention.

The other explicitly stated reason for the campaign was the belief that GPs often missed depression anyway. Since then the notion that there were large numbers of undiagnosed cases has been remarkably tenacious. Why? There is, in fact, no sound evidence for an epidemic of depression (as psychiatric disorder) in the UK. On the other hand, the case for an epidemic of antidepressant prescribing is now cast iron. In Britain prescriptions rose from 9 million to 21 million during the 1990s, and in the USA have doubled in only 5 years—mirroring the production and marketing of SSRI (selective serotonin reuptake inhibitors) antidepressants.

What remains striking is how unrobust the evidence base for antidepressants still is, particularly for the mild/moderate cases that account for the majority of all prescriptions.[3] Part of the reason is surely that antidepressants will not cure human misery, whether presenting in primary care or in psychiatric clinics. Indeed many of those difficult cases described in psychiatric journals as having 'treatment resistant depression' may be 'resistant' precisely for this reason.

It is possible that this repeatedly aired assumption about under-recognition at primary care level has itself led GPs to prescribe more readily. Further, some GPs prescribe for low mood *per se*, even if other features of the syndrome are absent, and the simpler dose regimens of SSRIs by comparison with tricyclics have helped. Patient feedback is influenced by placebo effects, and by factors like nonspecific sedation that have nothing to do with 'anti-depression'. People whose record indicates prior prescription of anti-depressants are more likely to be prescribed them again at a later time by other doctors. It remains to be seen if NICE guidelines—which do not recommend antidepressants as the primary intervention in 'mild/moderate' cases, make a difference to these trends.[4]

Pharmaceutical promotion of SSRIs made much of the claim to have fewer side-effects than the tricyclics, and this contributed to the confidence with which GPs recommended them to patients. In view of the public concern

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about addictive effects evident in the survey described above, it is ironic that discontinuation reactions are now emerging as a distinct clinical problem (extending to litigation against doctors in the USA), both in SSRIs and in other new anti-depressants like venlafaxine.

The weak construct validity of psychiatric categories, and the dominance of empiricism over theoretical development, are overarching issues for the psychiatric profession.[5] Both are apparent in the discourse about depression. So, too, is a lack of explicit reflection on the ideological and societally-framed nature of medical practice, which would need to take account of cultural shifts in attitudes to adversity and the emergence of an expressive, less stoical individualism.[6] The surge in anti-depressant prescribing is as much a cultural trend as a medical one, reflecting the rise of a medicalization and professionalization of everyday life and its problems across Western societies.[7]

There is also an important international dimension. 'Depression' is said to contribute 12% of the total burden of nonfatal global disease.[8] The World Health Organization describes it as an epidemic that within two decades will be second only to cardiovascular disease in terms of global disease burden. But 'depression' has no exact equivalent in non-Western cultures, not least because these do not share a Western ethnopsychology that defines 'emotion' as internal, often biological, unintentioned, distinct from cognition, and a feature of individuals rather than situations.[9] Non-Western peoples would tend to see the problem in situational and moral terms (as some Western citizens still do, as evidenced by the survey described above), though when they migrate to the West they become more likely to ascribe to a depression-as-disease model.[10] This is to highlight the work of culture and its opinion formers—including the medical profession—in shaping a particular interpretation of the world.

Thus the use of Western-derived quantitative instruments to estimate population prevalences worldwide is likely to commit a category fallacy, which is the assumption that mental and bodily state phenomena mean the same thing in whatever setting they are detected. There is no such thing as depression, if by this we mean (as the WHO appear to mean) a unitary, universally valid, pathological entity requiring medical intervention. Such claims seem a serious distortion, one serving to deflect attention away from what millions of people might cite as the basis of their misery, like poverty and lack of rights. The one clear-cut beneficiary would be the pharmaceutical industry, with its vested interest in the biologization of the human predicament.

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