Medicalising and medicating unhappiness

This article is part of a series on overdiagnosis looking at the risks and harms to patients of expanding definitions of disease and increasing use of new diagnostic technologies.

Many patients report sadness or distress during consultations with primary care doctors. Such emotions may be related to grief and other life stresses, including the stress of physical illness. Sometimes sadness appears out of the blue, without obvious relation to external causes. Over recent decades there has been an increasing tendency, especially in primary care, to diagnose depression (commonly major depressive disorder) in patients presenting with sadness or distress and offer them antidepressant medication.

In this paper we offer a critical review of the diagnosis of major depressive disorder, showing how and why this broad diagnostic label has resulted in overdiagnosis and overtreatment, and suggest how the approach to diagnosis and management of depression should change to reduce stigmatising the sad and provide better help for those who most need vigilant care and medical treatment.

Evolving views of what constitutes depression

Descriptions of depression can be found in the Bible and Shakespeare, but no formal definition existed until the third version of the American Psychiatric Association’s classification systems for mental disorders was published in 1980 (DSM-III). The manual set out clear operational criteria to aid clinicians in diagnosing mental disorders (see box 1) and introduced the term major depressive disorder.

Since then major depressive disorder has received more research attention than any other diagnosis in psychiatry but has created many problems. The criteria, which have not changed since 1980, capture too heterogeneous a population for research studies and are so loose that, in everyday clinical practice, ordinary sadness can be easily confused with clinical depression.

Unhelpful classifications of mental disorders

Under DSM-III the term major depressive disorder combined what had formerly been described as “melancholia”—characterised by severe, disabling, and sometimes life-threatening depression, often coming out of the blue and characterised by marked diurnal variation, suicidal thoughts, and somatic symptoms—with “reactive depression.” Reactive depression contrasted in almost every way with melancholia, with onset closely linked to a definable life event and with symptoms that were milder and typically including sadness, loss of interest, and feelings of guilt and unworthiness. Somatic changes, including difficulty sleeping and loss of appetite, were less profound and enduring in reactive depression than in melancholia. Those affected retained the capacity to feel pleasure. Symptoms were usually least troubling in the morning and patients tended to get better over time and respond well to placebo and psychotherapy. Those with melancholia, by contrast, were more likely to have disturbed sleep and abnormal dexamethasone suppression test results and to respond to drug treatment or electroconvulsive therapy.

Although the DSM-III definition of major depressive disorder was meant to provide simplicity and increase reliability of diagnosis, from the beginning it was recognised that it would capture a heterogeneous population of patients. The definition therefore provided severity ratings and different subtypes (box 1). Unfortunately, however, the valuable distinctions offered by severity and subtype ratings were generally ignored in both clinical practice and research. Major depressive disorder became homogenised to include “mild” major depression—arguably a contradiction in terms for it is not major, nor really depressive or a disorder.

DSM-III-R and DSM-IV carried forward the DSM-III definition, and the recently published...
DSM-5 broadens the diagnosis of major depressive disorder still further. It allows major depressive disorder to be diagnosed just two weeks after a bereavement. The change in the diagnostic status of grief from bereavement (not a mental illness) to depressive episode (a mental illness) introduced by DSM-5 was designed to provide more patients with access to effective treatments.10 This is particularly relevant in insurance based health systems such as the US, where a specific diagnosis is needed before funders will agree to pay the costs of treatment. It has, however, provoked both controversy and concern focused on the medicalisation of the normal human experiences of loss.5 11 12

Homogenisation of depression has been a mistake
People with uncomplicated episodes of major depressive disorder (lasting no longer than two months and not including suicidal ideation, psychotic ideation, psychomotor retardation, or feelings of worthlessness) are hardly more likely to have a further episode within 12 months than people with no history of major depressive disorder (3.7% v 3.0%).13 These episodes, along with mild and non-melancholic episodes, may be better understood as normal intense sadness.13 An Australian primary care study of 789 patients with depressive disorders found four different trajectories: most patients (n=532) had a mild and static symptom trajectory, very different from the experience of the small minority of people (n=69) with severe persistent depression, who had high levels of disadvantage, abuse, morbiditity, and disability.14

Including people, as the DSM-5 classification does, who are experiencing grief only two weeks after the loss of a loved one is a mistake. Bereaved people follow a course very different from those with recurrent major depressive disorder. A study of over 30000 US citizens found that single bereavement related brief depressive episodes have distinct demographic and symptom profiles that differ from those of other types of depressive episodes and are not associated with increased risk of future depression.15 Uncomplicated bereavement is not associated with an increase in suicidality.16

Increase in diagnosis of depression and antidepressant drug prescriptions
The prevalence of depressive disorders in the community is stable. In the United States two national comorbidity surveys a decade apart found prevalences of major depressive disorder of 6.1% and 6.6%.17 18 In England the one week prevalence of depressive episodes among adults decreased from 2.6% in 2000 to 2.3% in 2007.19 20

Meanwhile, rates of diagnosis have increased considerably. Although community surveys that use lay interviewers have shown little change in prevalence over time, diagnoses of depression among Medicare beneficiaries doubled between 1992-95 and 2002-05.21 This is not because primary care doctors are getting better at identifying major depressive disorder; overdiagnosis is now more common than underdiagnosis. A meta-analysis of 41 studies, including 50371 patients, estimated that for every 100 unselected cases seen in primary care, there were more false positive cases (n=15) than either missed (n=10) or identified cases (n=10) of depressive disorder as judged by standard diagnostic criteria.2 In a study of 5639 participants from the 2009-2010 US National Survey of Drug Use and Health, clinician identified depression was compared with assessments for major depressive episodes using a structured interview. Only 38% of adults (including only 9% of those aged 65 and over) with clinician identified depression met diagnostic criteria for depression during the previous year; nevertheless, most participants were taking psychiatric drugs.21 The trend to overdiagnosis may increase as DSM-5 diagnostic criteria loosen. Rates of prescribing of antidepressants to patients having no evidence of major depressive disorder, or fewer symptoms than DSM would advise, are also increasing in primary care. The
Turning grief and other responses to loss into a mental disorder substitutes a superficial medical ritual for deep and time honoured cultural ones and stigmatises the experience.

Drivers of overdiagnosis
The homogenisation of major depressive disorder has been in part a consequence of heavy drug company marketing and an overstrong focus among many psychiatrists on the biological correlates of psychiatric symptoms rather than the psychological, social, and cultural. The rate of diagnosis of depression has increased substantially since the development and marketing of selective serotonin reuptake inhibitors, a trend assisted by drug companies’ financial support for prominent academic psychiatric units and direct to consumer advertising in the US.

General practitioners and the public are complicit in this. For GPs a diagnosis of depression may be an attractive instrument for managing uncertainty in the consulting room, especially as its commonest treatment comes in the form of a once daily pill and is encouraged by clinical guidelines and indicators. Patients often request treatment for symptoms of sadness, and doctors and patients can feel obliged to offer and accept a diagnosis of major depressive disorder.

In addition, there is a trend in Western societies to expect the right to happiness and a need to restrict the range of negative emotions that are considered “acceptable and normal.” Pharmaceutical companies and psychiatric nosologists derive their positions on depression diagnoses from a set of common but implicit value judgments.

What the evidence shows
The weight of evidence from meta-analyses of placebo controlled trials shows that antidepressant drugs have little or no effect in mild depression. Although there is some evidence that the benefits of treatment compared with placebo are not related to baseline severity, there are continued concerns about publication bias in data provided by drug companies. The placebo effect of antidepressant drugs is substantial and increasing, partly because less severely depressed people now take part in drug trials. The role of regression to the mean in assessing the effects of antidepressants is also important since many people with reactive depression get better with time, regardless of treatment. Watchful waiting can have a stronger effect than antidepressants.

There is no substantive evidence that people with uncomplicated bereavement benefit from antidepressants, and a dearth of clinical trial evidence of response to medication in those with complicated grief reactions. Many conditions currently diagnosed as major depressive disorder, especially those related to other forms of loss, are better understood within a model of grief that does not assume drug treatment.

Harms from overdiagnosis
Turning grief and other responses to loss into a mental disorder is a medical intrusion into private emotions. It substitutes a superficial medical ritual for deep and time honoured cultural ones and stigmatises the experience. It leads people to act under the description of a psychiatric diagnosis, believing themselves to be and behaving as if they are someone with a mental illness and compromising their sense of agency. By putting a simplistic time frame on recovery from grief, DSM-5 is stepping further away from the personal interaction that should be the basis of healthcare.

These problems are greater in cross-cultural consultations with patients for whom depression may be an alien concept. Recent asylum seekers, for example, have often experienced severe and traumatic losses. Subsuming the consequent distress within a diagnosis of depressive disorder replaces loss with illness and individualises previously social problems.

Bringing grief within the category of major depressive disorder adds unnecessary medication, with its inevitable side effects, and carries added risks including increased suicidal thinking in children and young people, and risks of interaction with drugs prescribed for other health problems. Unjustified use of antidepressants increases the costs of healthcare. The excess cost of care associated with prescribing antidepressants to older Canadians without depression was estimated as €1200 (€1000; €1250; $1700) per person. An expanded focus on grief will also affect existing psychiatric diagnosis, distracting attention and resources from those who have severe mental health problems.

How to do better
Diagnostic criteria should be tightened. Milder symptoms must be persistent throughout the day, be present for at least a month or two and cause significant distress or impairment before a diagnosis of mild major depression is made. For moderate and severe major depression, existing diagnostic criteria should be accurately applied, so that diagnoses are made only in the presence of substantive symptoms and clear associated impairment. Patients presenting with milder or loss related symptoms should not be dismissed, but more attention should be given to benefits of time, support, advice, social networks, and psychological interventions. There are opportunities to avoid the mistakes of DSM-5 in ICD-11, which is now in preparation.

GPs should focus on identifying patients with severe depression and provide them with better access to adequate evidence based care. These include two main groups of patients:
Patient perspective: mild depression must not be ignored

The minimum that a GP should do is to hand over easily accessible information that patients can use to understand their feelings better

Dowrick and Frances express concern that two weeks is too soon to diagnose depression after a major bereavement. Most patients would probably agree with this. They are also troubled by recent increases in antidepressant prescriptions and relate this to changes in the criteria for diagnosis. Most of this increase is actually the result of patients being advised to continue with antidepressants after symptoms have disappeared to reduce the chance of relapse, rather than a large increase in new diagnoses.

However, the biggest worry, from a patient’s perspective, is the authors’ apparent dismissal of the benefits of the placebo effect. Antidepressants do provide benefits to mildly depressed patients; the issue is that those benefits are much the same as those produced by a placebo pill. But patients don’t actually care whether the lifting of their dark mood has a physiological, psychological, or pharmacological cause—even mildly depressed patients will take any benefit they can get. To deliberately kill placebo benefits by explaining away the placebo effect and refusing to prescribe seems counterproductive. General practitioners should bear in mind placebo and psychological effects when making decisions, while balancing these against the potential for harmful side effects. GPs should also be open to other options, such as herbal medicines.

Indeed, a GP has previously suggested that I try St John’s wort in lieu of a prescription antidepressant. Nearly all patients would agree with the authors’ recommendation that their GP spend more time with them finding out about their situation over a series of visits. However, the typical 10 minute consultation constrains such discussions radically. Patients also need to see the same GP at each visit, something that some appointment systems make difficult. Given this recommendation it is surprising that the article makes only a brief mention of the role of talking therapies in the treatment of depression. It is now widely accepted that a combination of drugs and a talking therapy offers the best chance of long term recovery from depression without relapse.

My fear is that mildly depressed patients will be sent away empty handed. I have often heard people in this situation making comments such as, “My GP was a waste of time,” or “My GP made me feel small; he thinks there is nothing wrong with me.” Having such emotive thoughts buzzing around your head as you leave the consultation room is guaranteed to lower mood even further. Even mild depression is characterised by cycles of negative thinking that are hard to break out of unaided. The aim of GPs should be that patients leave the consulting room with a positive feeling, knowing that there are more options open to them than when they walked in, even if they have not been given the drugs they perhaps expected. It would also be ideal if there were more consistency in the response of GPs to such patients. At the moment the treatment offered can vary widely depending on the GP’s personal view of depression and its treatment, so that one GP might prescribe antidepressants, another cognitive behavioural therapy, while another does nothing.

As the authors suggest, the minimum that a GP should do is to hand over easily accessible information that patients can use to understand their feelings better. Websites with reliable information on depression such as [www.healthtalkonline.org](http://www.healthtalkonline.org) are very useful, as is information on local counselling and support organisations. The GP can thus help patients to help themselves, which is much better than handing over an antidepressant prescription and showing the patient the door.

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Competing interests: None declared.
Provenance and peer review: Commissioned; not externally peer reviewed.

References are in the version on bmj.com.

Cite this as: BMJ 2013;347:f7225