

Depression: Beyond the Disease Era

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Depression has now become established as one of the major illnesses affecting the mind. It is heading for even greater heights, moving rapidly up the charts of the world's top ten disabling diseases, and tipped to achieve an impressive second place by the year 2020¹. What is going on? Is there an epidemic of misery and sadness sweeping the world, a time bomb of depression waiting to explode²? Or are we radically altering our interpretation of our perceptions, our physical and emotional experiences, even our understanding of the human condition?

While the diagnosis of depression may have a definable utility, I think it is often insufficient, sometimes unnecessary, and occasionally harmful. It encapsulates certain aspects of human experience, and in so doing sets artificial boundaries around them, conferring on them both the rights and responsibilities of an illness, and leading us towards treatment paradigms which tend to reduce – rather than enhance – our ability to live our lives. We use it too readily as a tool to create an artificial sense of order, an 'irritable reaching after fact and reason', when we may do better to follow Keats' advice and remain in 'uncertainties, mysteries, doubts'³, particularly when the boundaries between emotional and physical problems are unclear, and our attempts to create a distinction are misleading and potentially damaging. As a concept it is severely constrained by language and culture, and may easily be turned to the advantage of vested interests.

The time has come to abandon the concept of disease as the focal point of depression care. Instead of making diagnoses and management plans on the basis of structured histories, examination and special investigations, clinical decision making should be predicated on the attainment of patient goals and the identification and treatment of modifiable factors⁴. We should talk to our patients about their concerns and priorities, the factors which impede their goals, and the types and outcomes for treatment which they consider to be important.

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EXTENDING THE BOUNDARIES

There are some types of mental problems, for example bipolar affective disorders and obsessive compulsive disorders, where conventional management strategies may well continue to be helpful. Current diagnostic concepts of depression may also, sometimes, be helpful: but they are used in primary care in much too cavalier a fashion. They would be better reserved for fewer, more specific cases.

Changing diagnostic behaviours

To begin with, we need to adopt some important changes to current diagnostic behaviours. It is not sufficient to focus on diagnostic thresholds or duration and severity of symptoms⁵. It is also necessary to take account of impairment and disability, of social and cultural factors, and of our patients' value systems and beliefs.

Impairment is different from diagnosis or severity: many people with sub-threshold disorders in the current classifications have significant levels of

disability, while people with high depressive symptoms may continue to function with a remarkable degree of normality⁶. A tailored assessment of disability, such as the Social Functioning Questionnaire⁷ or the Disability Assessment Schedule⁸, should be linked directly with routine primary care diagnostic systems.

To address the gaps in our social and cultural understanding of patients' problems we can turn to the International Classification of Primary Care, which provides methods for recording details of social context⁹; or to the Cultural Awareness Tool developed for general practitioners in Australia¹⁰. We should be interested in our patients' values, and may seek assistance from the self-acceptance and purpose of life questions within Ryff's psychological well-being inventory¹¹; or from the seven item spiritual symptom scale in the (awkwardly-named but potentially useful) BIOPsychoSocioSpiritual Inventory¹².

We should pay careful attention to our patients' perspectives on what may be causing their problems, not least because these may be radically different from our own. Although patients may sometimes have clear and consistent explanatory models, they are more likely – particularly when seeking help for the first time – to hold beliefs about the cause of their mental health problems which are tentative and fluid, sometimes internally contradictory, and characterised by uncertainty. As Williams and Healy put it, they are likely to be working from an exploratory 'map of possibilities, which provides a framework for the ongoing process of making sense and seeking meaning'¹³.

CHANGING THE DELIVERY OF CARE

We should also look more carefully at the ways in which general practice delivers mental health care, and how this impacts on patients' illness experience. Collaborative models of care appear to reduce symptoms for people diagnosed with depression in primary care, but their mechanisms of action are unclear¹⁴. Complexity theory encourages us to understand general practice as a complex adaptive system, involving 'a collection of individual agents with freedom to act in ways that are not totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents'¹⁵. I am working with Jane Gunn, Frances Griffiths and colleagues in Melbourne Australia on a study which is using these ideas to help us define and then implement the essential ingredients or minimum specifications for effective primary mental health care, with a particular focus on the management of depression¹⁶.

What is more, we need to find ways to increase equity of access to those high quality mental health services that do – or could - exist within primary care. Many people with high levels of mental distress are currently disadvantaged: either because they are unable to access care, or because when they do have access to care it does not address their needs. With Linda Gask and colleagues, I am undertaking a programme of research to clarify the mental health needs of people in these under-served groups. We

propose a new multi-faceted model of care with three principal components: increasing community awareness that primary care can provide help for common mental health problems; increasing the competence of primary care teams in understanding and responding to the differing ways in people present suffering; and tailoring psychosocial interventions to meet the needs of people from under-served groups. We are now testing interventions designed to address these components. Once we know how these work best, we will establish dissemination strategies in order to integrate them effectively into primary care¹⁷.

If we adopt these richer perspectives on the assessment and management of mental health problems, it will enable primary care teams to target their scarce resources more effectively on those patients in greatest need. It will provide opportunities for patients to play a much more substantial role in assessment, and will also offer them greater choice in what to do: in deciding what sorts of problems they see as important; in thinking about whether - and if so when - they might wish for help with them; and in considering whether the focus of help should be on reducing their mental symptoms, increasing their functional ability or resolving their social or cultural difficulties.

If medical treatments are to be considered, my preference would be to concentrate on psychosocial rather than pharmacological interventions. Antidepressant drug treatments are attractive to doctors because they are quick and simple to apply. They are also now relatively cheap treatment options, as most of the major antidepressants are available without product licence. On the other hand, the strength of the evidence for psychosocial interventions is generally equivalent to that for drug treatments, and most patients prefer them. They are also becoming more readily accessible in many countries, for example through the Improving Access to Psychological Therapies initiative in England, and Australia's Better Access to Mental Health Care. And, importantly, psychosocial approaches which help people increase mindfulness, or improve confidence in their ability to solve problems, contain within them valuable messages about agency, coherence and the active self.

However these initiatives on their own will not enough to address the 'epidemic' of depression that is apparently engulfing the world.

BEYOND THE BOUNDARIES

These steps represent a considerable and necessary shift from current practices. But they are not sufficient. We should have the courage to be even more radical. In many, probably the majority of presentations which are currently labelled as depression in primary care, there is a sufficient degree of uncertainty with regard to both diagnosis and management to allow alternative approaches to be legitimately - and safely - considered.

PERSONS LEADING THEIR LIVES

We should focus our attention not on particular

symptoms and thresholds for diagnosing depression, but on the many and various ways in which our patients are suffering¹⁸. General practitioners' knowledge and skills are not the primary concern here: the focus needs to be on our attitudes and values. What I am advocating is a reorientation of our assumptions about the nature and purpose of the consultation, a re-vision of our understanding of our patients: not as passive victims of disease or circumstance but as active agents, experts in leading their lives, who occasionally need some help, some new ways of looking at old ideas, and perhaps an instillation of hope.

There is huge potential for health benefit from modifying GP communication in routine consultation. In the United Kingdom, for example, general practitioner consultation is the most common of all healthcare interventions: in 2006 there were 154 million in England, with an increase from a mean of 3.9 per patient-year in 1995 to 5.3 in 2006 (19). This means that even small changes at the individual level can have substantial population effects.

What we need to do in our encounters with patients whom we think may be depressed is to help them find meaning and purpose out of suffering and distress. This is the essence of healing, a word which had fallen into disuse in modern medicine, but may now be making a comeback²⁰. At the heart of the process lie two assumptions. The first is that the emergence of meaning, order or form is therapeutic in itself, particularly for people who are feeling lost, alone, frightened or misunderstood²¹. The assumption is that such emergence is most effective if it is mutual, if we find ways of engaging with our patient's conceptual worlds, if understanding of problems and their solutions are negotiated and agreed by both sides, not just imposed arbitrarily by the doctor.

Instead of focusing on symptoms and signs, we should talk with our patients about their desires, their understanding of their position in time and (social) space, their sources of engagement and their conversations with others. All these combine to give us a coherence of self, an awareness of purpose and value, and a sense of meaning. And they invite us to move beyond depression as a concept. They offer a framework based not on medicine or notions of disease, but on fundamental ideas about how to live our lives with a sense of enjoyment and fulfilment, how to flourish as human beings.

MINDFUL PRACTICE

The process of generating understanding and hope is not always straightforward. Doctors can experience severe personal difficulties when faced with seemingly overwhelming distress. Ian McWhinney invites us to be open in the face of suffering, and to follow the wisdom traditions with their emphasis on listening²². Ron Epstein encourages us to expand our attentiveness, curiosity and presence. We should cultivate habits of mind such as experiencing information as novel, thinking of "facts" as conditional, seeing situations from multiple perspectives, suspending categorization and judgment and engaging in self-questioning. Mindful practice requires mentorship

and guidance. But its goal of 'compassionate informed action in the world'²³ is of high intrinsic and instrumental value.

So, to provide world class care for people in distress, those of us who are privileged to work in primary care need to make two major changes to our practice. First, we can usefully extend the current boundaries of depression, both in terms of our diagnostic approaches and also in the ways in which we deliver care. Second – and to me more important – we should stop sheltering behind diagnostic labels and formal treatment packages of uncertain benefit, and allow ourselves to be exposed to the raw experience of human suffering – while retaining the belief that our patients are persons fundamentally capable of living fulfilling lives. Only then, I believe, will we genuinely enable our patients to generate new meaning and hope.

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