Can We Fight Depression?

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If one enters the term "mood disorder" in the largest online medical database - Medline - you get close to 62,000 hits. If you restrict your search to randomized controlled trials, generally considered the most reliable design for investigating the efficacy of treatments, still more than 3,200 hits appear.

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Of course, there are still roughly 1,500 studies of a multitude of treatments: psychopharmaceutical drugs, ECT, bright light, exercise, psychotherapies, and even acupuncture. True, many of these studies document the short-term, and in some cases the long-term, effects of various treatments, and generally with an acceptable trade-off between efficacy and safety.

To be sure, if many millions of people are prescribed a group of drugs, not only for depression, but also for many other mental health problems, it is quite reasonable that some of them will suffer an adverse effect or reaction. But blanket claims that antidepressant drugs are dangerous, addictive, or bad in other ways are not based on strong evidence. Reports of severe adverse effects in adults are rare, while children and adolescents with depression seem much more vulnerable.

Possibly the biggest obstacle to more effective treatment is that the diagnostic category "major depression" is so heterogeneous as to be outright unhelpful when trying to decide on a therapeutic plan for an individual patient. Of course, the level of severity of depression is obviously relevant, but few treatment studies use this criterion. Melancholia, a depressive subtype with more biological abnormalities, should be another candidate for treatment studies, yet few have been undertaken.

Pharmaceutical companies sponsor most drug treatment studies, with the primary purpose being to secure the licenses required to market their products. To increase the speed of the process, patients are recruited by advertising and many trials are subcontracted to specialist trial companies with little or no interest in the long-term welfare of patients. In many trials, companies are paid per patient recruited, regardless if a patient remains in the trial or not. Unsurprisingly, dropout rates are high, often more than 50% after six weeks.

Failed studies - meaning studies that do not demonstrate significant differences between an active drug and a placebo - are common. This obviously is contrary to the interest of the funding company, but so far it has not resulted in substantial changes in the way trials are done.

Because pharmaceutical companies want their drug to work, they are rarely interested in studying what to do if it is ineffective. That is true even when we know that only two-thirds of patients respond to a drug, and that significantly fewer get completely well.

So clinicians are faced daily with questions about which drug to administer, but the base of empirical evidence for this decision is appallingly thin. Several large government-funded trials are ongoing, and it is hoped that these will improve the scientific basis for decision-making within the next few years.

Another major area of ignorance concerns the extent to which results generated in specialized mental health settings can be transferred to primary care, where the majority of patients with depression are treated. The uncertainties are not so much about treatments, because patients with similar levels of severity should respond in rather similar ways regardless of the treatment setting. A much more important uncertainty is whether the chronic course of major depression treated in psychiatry is similar in primary care. If so, many more patients should probably be recommended to receive long-term treatment with antidepressants. Moreover, the huge problem with compliance, similar for all prophylactic treatments in medicine, must be addressed.

Finally, has the enormous increase in prescriptions of anti-depressive drugs, and the greater availability of short-term psychotherapies, self-help manuals, and Internet support, had any positive impact on health? Here, too, the data are contradictory or preliminary, with some indicating a decrease in suicide accompanying the increase in use of

antidepressants. But this does not hold true in all countries or all age groups, so other factors must be influential, too.

A more revealing-and distressing - indicator is that sick leave and disability pensions due to depression are on the rise in many Western countries. Moreover, the first depressive episode occurs in ever-younger children or adolescents, implying that research on primary or secondary prevention should receive higher priority.

On the level of the wider population, the battle against depression has not been won.

But there is good news: for individual patients with depression, the possibility of getting completely well is high, assuming that effective treatments are used in a skillful and persistent way.STEN THELANDER
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