# Depression: mistreatment or maltreatment?

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A grim 34-year-old man slumps back in the chair as you enter.

"I'm sorry for the wait."

He waves it off, sits forward, and glares. "Doc, we've known each other a long time … I thought I'd give you a shot. I've been in a rough patch for months, and it's getting worse. I really don't see a way out."

You take a breath. "You're thinking of ending it."

He sits back, looks down at his hands, clenching. "Doc, you need to do something. Now."

He declines hospital admission but you know he is not alone. It is a small town with one grocery store. You wave on the street.

Your patient makes a contract with you. He will get the bloodwork done. And he leaves with a prescription.

## How are we coping with depression?

The World Health Organization has declared depression to be one of the world's leading causes of human ill health and disability worldwide.[1] The rate of depression continues to rise, posing a challenge to the health care system to better manage this mental health crisis.

Long-practising physicians bear a chain made of those who have died during their service, perhaps the heaviest links being those who have died by suicide.

Family physicians pride themselves on practising in an evidence-based manner. In February 2020, Iltis et al[2] showed quite clearly that there was no evidence for the use of antidepressants in suicidal patients, as none of the 28 publications examined from 2000 through 2013 included persons with suicidality.

A commentary published in November 2019 captured the entire controversy around antidepressant use in its title: "Does the emperor have any clothes? Depends on who you ask."[3] The author, Dr Alexander Tsai, insightfully reviewed the conflicting studies about the merits and liabilities of antidepressants. Key findings were that antidepressants, compared with placebo, improve mood in the short term by 2 to 3 points on the Hamilton Depression Rating Scale, which is too small a difference to appear as an improvement to either patients or clinicians. Studies disconfirmed even what Dr Tsai termed the *treatment-by-severity interaction,* wherein antidepressants are thought to act more powerfully in those more severely afflicted with depression. Dr Tsai also emphasized that there are simply no good data on the long-term use of antidepressants.[3]

Another recent review of antidepressant use revealed no valid evidence of beneficial effects in major depression, no clear evidence for their use in severe depressive states, and no evidence at all for long-term use.[4]

Physicians are taught a biological paradigm. Our very daily routine is to assess, measure, diagnose, and treat—often with a drug. We are taught to not hesitate to prescribe for severe presentations of depression. Further, we are taught to increase the dose of medication or add a booster drug if there is no movement on severity scores on reassessment visits. There is a clear pathway for drug treatment. Physicians know the medications well, and know the steps of drug therapy and their sequence.

Despite having some basic training in nondrug therapies for depression, we simply do not know their steps as well. Although referrals are available, 36% of Canadians see only their family doctor for support.[5] Call it negative expectancy, low frustration tolerance, the scarcity of nondrug therapies, or the simple lack of government funding: many patients start and stay with family doctors. Unfortunately, busy family doctors rarely have time to provide complex, long-term nonpharmacologic support and therapy. An uncertain treatment path and time restrictions lead to visits that tend to focus on airing issues, symptom severity scores, and medication management. This approach disempowers patients by fostering dependence on physicians.

Family physicians correctly identify and diagnose depression less than half the time.[6] Depression diagnosis by family doctors is thus often inaccurate and treatment is woefully inadequate if it is primarily drug based.

## Pause before prescribing

How do you tackle a multifaceted presentation that is so often *not* depression, but something else? The first step might be to pause before prescribing.

Biology must certainly be one facet of the syndrome; we know, for example, that exercise can be helpful. Physicians have all witnessed some patients improve while taking antidepressants, but is the improvement due to the drug itself? Something else might be happening, perhaps even despite the focus on medications. Depression can be seen to have at its very root a societal, psychological problem.

We need to more clearly understand the fruit, if any, borne by a medication-based treatment.

Core patterns of depression exist, with clear risk factors and components. A futile search for that nebulous thing called happiness[7] marks this disorder of perspective. There is passivity. One feels the clinical inertia. People with depression have negative expectancy, which must be addressed immediately. Patients can be taught through appropriate psychotherapy to stop making the bad decisions that exacerbate depression.

## Tracing a better path

In 2007, the authors of the *Family Physician Guide for Depression, Anxiety Disorders, Early Psychosis and Substance Use Disorders,* a project of Simon Fraser University's Centre for Applied Research in Mental Health and Addiction,[8] stated that medication was no better than psychotherapy for less than severe or intransigent mood disorders. They found no reason to add an antidepressant to therapy in these less severe situations. They recommended that physicians use a brief psychological intervention that reflected cognitive-behavioural therapy guidelines, explaining the biopsychosocial model and emphasizing the physical, emotional, and psychological factors involved. Movement in any of these areas was reported to bring about tangible improvement. This intervention was advised instead of medication.

In the subsequent decade we have veered off course. The increasingly pervasive prescription of antidepressant medications suggests their use is an early, common maneuver. It is one that grossly oversimplifies treatment and fosters patient passivity.[9]

Family physicians can find the help their patients need. No neighbourhood therapist? Mental health care provided at a distance is here and now, with sites like BounceBack Ontario and Togetherall becoming commonly part of a treatment plan. Online platforms make therapy sessions possible from virtually anywhere. Encouraging active self-help is another good option. There are well-proven self-help books, such as *Mind Over Mood,*[10] *Feeling Good,*[11] and *Breaking the Patterns of Depression,*[12] among others. Patients can thus play an active role in their own treatment and recovery. Online self-help programs can provide patients with structured education and help, and there are also cell phone apps available that can offer meaningful support, education, and even helpful therapeutic focusing experiences (eg, the mental health chat bot, Woebot, which teaches basic cognitive-behavioural therapy concepts on a cell phone, and self-hypnosis training through the Stanford University website [**imaginaction.stanford.edu**]).

The mere biological treatment of depression, even if it is not resting entirely on the placebo response, thus appears neglectful. It is clearly undertreatment.

Is it maltreatment?

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**Competing interests**
None declared



**References**

1. World Health Organization [website]. *Depression: key facts.* Geneva, Switz: World Health Organization; 2020. Available from: **www.who.int/news-room/fact-sheets/detail/depression**. Accessed 2020 Oct 12.
2. Iltis AS, McCall WV, Deria R. Suicidality, depression, and the FDA: health inequities and the ethical conduct of research. *J Clin Psychiatry* 2020;81(2):19m13050.
3. Tsai AC. Does the emperor have any clothes? Depends on who you ask: PLOS Medicine 15th anniversary. *Speaking of Medicine* [PLOS blog] 2019 Nov 1. Available from: **https://speakingofmedicine.plos.org/2019/11/01/does-the-emperor-have-any-clothes-depends-on-who-you-ask/**. Accessed 2020 Oct 12.
4. Jakobsen JC, Gluud C, Kirsch I. Should antidepressants be used for major depressive disorder? *BMJ Evid Based Med* 2020;25(4):130. Epub 2019 Sep 25.
5. Vasiliadis HM, Tempier R, Lesage A, Kates N. General practice and mental health care: determinants of outpatient service use. *Can J Psychiatry* 2009;54(7):468-76.
6. Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. *Lancet* 2009;374(9690):609-19. Epub 2009 Jul 27.
7. Ladouceur R. Prescribing happiness. *Can Fam Physician* 2019;65:599 (Eng), 601 (Fr).
8. Anderson E, Dive L, Kang S, Newth S, Vidal C, Bilsker D, et al. *Family physician guide for depression, anxiety disorders, early psychosis and substance use disorders.* Burnaby, BC: Centre for Applied Research in Mental Health and Addiction, Simon Fraser University; 2007.
9. Yapko MD. Treating depression with antidepressants: drug-placebo efficacy debates limit broader considerations. *Am J Clin Hypn* 2013;55(3):272-90.
10. Greenberger D, Padesky CA. *Mind over mood: change how you feel by changing the way you think.* 2nd ed. New York, NY: Guilford Press; 2016.
11. Burns DD. *Feeling good: the new mood therapy.* New York, NY: William Morrow and Company; 1980.
12. Yapko MD. *Breaking the patterns of depression.* New York, NY: Broadway Books; 1997.

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