British Journal of Psychiatry (1994), **164**, 285–287

Editorial

Improving the Management and Knowledge of Depression

Marking "Defeat Depression Action Week" for the Defeat Depression Campaign

R. G. PRIEST

This month's issue of the *BJP* has been given over to reports of research into depression, to mark "Defeat Depression Action Week", 3–11 March, organised by the Defeat Depression Campaign to bring to public attention the nature and treatment of this common mental illness.

The Defeat Depression Campaign

The Defeat Depression Campaign is being organised in the UK by the Royal College of Psychiatrists in association with the Royal College of General Practitioners (Priest, 1991).

It is well known that most patients with depressive illness are treated by their general practitioners rather than by psychiatrists (Priest, 1982*a*,*b*). We are concerned that many patients in the community with serious depression do not even consult their general practitioners. We wish to improve this situation, since the proportion not going for medical help may be as much as half the total. Clearly, if we do persuade more depressed people to accept treatment, we face the prospect of an increase in the workload in primary care, and as a prior step we are seeking to increase the expertise of general practitioners (and other primary care staff) in the recognition and treatment of depression (Paykel & Priest, 1992).

Improved recognition is important, because it has been shown that as many as half of depressive illnesses are not recognised as such by the primary care doctor, at least at the first interview. The diagnosis is particularly likely to be missed when the presenting symptoms are more physical than psychological complaints, or when there is a dual diagnosis, with the depression accompanying a physical disease. The proportion of patients who present with psychological symptoms may be only a quarter of all patients with a major depressive disorder in primary care (Bridges & Goldberg, 1987; Herbst & Paykel, 1989; Baldwin & Priest, 1992).

To provide a firm base for educational initiatives in this area, we have held two consensus meetings, attended by experts in depression both from general practice and from psychiatry. One meeting was on recognition and the other on management (Paykel & Priest, 1992). The problems in recognition and diagnosis were clarified, and the interviewing skills necessary to overcome these were identified.

As far as management is concerned, we pointed out the value of non-pharmacological methods of management (including psychosocial management and psychological treatments). The efficacy of cognitive therapy was emphasised and, even in the absence of a full programme of cognitive therapy, primary care doctors have used its principles to good effect. (A useful review of depression in primary care is provided by Wright (1994) in a book resulting from further collaboration between the Royal Colleges of Psychiatrists and General Practitioners.)

Antidepressant drugs were considered to be particularly useful for more severe illness. We recommend that antidepressants be prescribed in full doses for four to six months *after* full remission of depressive illness in primary care, even with first episodes (Paykel & Priest, 1992; Priest & Baldwin, 1992*a*). This is because relapse rates in controlled trials are as high as 50% in the six months after remission with inadequate treatment (compared with 20% when treatment was continued). Surveys show that at present patients take the antidepressants prescribed by their general practitioner for an average of only three or four weeks *in total*. Clearly, compliance is likely to be a major problem when trying to follow our advice. Our own surveys of the public for the Defeat Depression Campaign show that lay people consider antidepressant drugs to be addictive, and this may be one reason why they are reluctant to take them for long (Vize & Priest, 1993; Priest & Baldwin, 1992*b*). Doctors who initiate antidepressant medication would be well advised to emphasise the lack of addiction potential of these compounds.

We have prepared a video training package, *Depression: From Recognition to Management*[1], for use in primary care postgraduate centres, comprising videotapes, booklets and other educational material. This has been well accepted and enthusiastically reviewed. In addition, the College has published three

booklets on depression[1] in its "Help is at Hand" series: *Depression*, and *Depression in the Elderly*,, for patients and their relatives; and *Depression in the Workplace*. These explain the features of depression, what the patient can do about it, and what treatment is available, and has a section on support groups and caring organisations. Also, a book,[1] *Down with Gloom!*, has been published that aims to inform lay people about depression. A vigorous media campaign directed at the general public culminates this month in "Defeat Depression Week".

The Swedish experience

There is a precedent for our campaign. On the Swedish island of Gotland, an intensive postgraduate educational programme was mounted for general practitioners on the subject of effective treatment of depression (Rutz *et al*, 1992). Following the campaign, a number of indices signalled the success of the venture. Prescriptions for antidepressants rose, and those for sedatives and tranquillisers fell. Admissions to hospital for depressive illness fell by over half. There was a similar reduction in the number of suicides. Unfortunately, in subsequent years the effects of the campaign were not sustained. The challenge for our campaign is to do as well as the Swedes in the short term, and to ensure an enduring effect.

The state of research as reported in the current issue

The review article in this issue concludes that there is a paucity of conclusive investigations into the outcome of depression. Nonetheless, it appears that a quarter of patients recovering from a first episode suffer a relapse within a year, and only a quarter remain well for ten years or more.

The notion that most patients with depression in primary care do not put forward the psychological features as their presenting symptoms receives further support in this issue. In this study the patients were elderly (Blanchard *et al*, this issue). The authors reasonably suggest health education to deal with this problem.

Another aspect of education in depression (directed at ensuring that depression is treated) is 'understandability'. Many doctors are reluctant to treat a state of depression if they can understand it as a reaction to clear-cut disappointments and losses. As part of the campaign, based on the consensus statements, we are emphasising that depression that is severe or disabling merits treatment no matter how readily the precipitating factors can be identified. Nevertheless, this begs the question of why sometimes the "slings and arrows of outrageous fortune" produce a reaction that is so extreme or debilitating as to be best described as an illness. What influences the vulnerablity of a person towards such a response? Cowen *et al* (this issue) report data suggesting that major depression may be associated with the impaired sensitivity of 5-HT_{1A} autoreceptors. A major autosomal dominant susceptibility locus (close to the gene for Darier's disease) is postulated by Craddock *et al* (this issue). A further possibility is a single major susceptibility locus of recessive effect in bipolar disorder (Craddock, Brockington, Mant *et al*, this issue).

Given a predisposition to the illness, how may it be precipitated, other than by understandable losses and disappointments? One intriguing possibility is the effect of geomagnetic storms, at least in men (Kay, this issue). Organic brain disease is another, perhaps more familiar, precipitant, including large lesions as a result of strokes (Sharpe *et al*, this issue).

The importance of brief recurrent depression is increasingly being recognised, and Jules Angst has been one of the key people outside the UK to identify its characteristics. He and his team report on this subject (Merikangas *et al*, this issue) and emphasise the association of suicide attempts with recurrent depression.

For a long time psychiatrists have pondered the validity of self-reports of personality traits when instruments are administered during the course of mental illness. Peselow *et al* (this issue) have been able to distinguish clusters of traits whose scores do in fact change as the illness recovers, and describe other traits which do not change significantly.

The variety of topics covered in this issue should present something of interest to everyone.

1. All available from the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. A charge of £30 is made for the video training package. The *Depression* and *Depression in the Elderly* booklets are free (requests must be accompanied by a stamped addressed envelope); the *Depression in the Workplace* booklet costs 40p. *Down with Gloom* is £3.50 (post free), and is also available in bookshops.

References

BALDWIN, D. & PRIEST, R. G. (1992) Diagnosis of depression. *Practitioner*, **236**, 497–500.

BRIDGES, K. W. & GOLDBERG, D. P. (1987) Somatic presentations of depressive illness in primary care. In *The Presentation of Depression: Current Approaches* (eds L. J. Freeling & J. C. Malkin), pp. 9–11. London: Royal College of General Practitioners.

HERBST, K. R. & PAYKEL, E. S. (eds) (1989) *Depression: an Integrative Approach*. Oxford: Heinemann Medical.

PAYKEL, E. S. & PRIEST, R. G. (1992) Recognition and management of depression in general practice: concensus statement. *British Medical Journal*, **305**, 1198–1202.

PRIEST, R. G. (1982*a*) The treatment of anxiety and depression in general practice. *Practitioner*, **226**, 549–556.

—— (1982*b*) *Psychiatry in Medical Practice*. Plymouth: Macdonald & Evans.

—— (1991) A new initiative on depression. *British Journal of General Practice*, **41**, 487.

—— & BALDWIN, D. (1992*a*) Effective treatment of depression. *Practitioner*, **236**, 664–671.

—— & —— (1992*b*) *Depression and Anxiety*. London: Martin Dunitz.

RUTZ, W., VON KNORRING, L. & WÅLINDER, J. (1992) Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. *Acta Psychiatrica Scandinavica*, **85**, 83–88.

VIZE, C. M. & PRIEST, R. G. (1993) Defeat Depression Campaign: attitudes towards depression. *Psychiatric Bulletin*, **17**, 573–574.

WRIGHT, A. (1994) Depression. In *Psychiatry and General Practice Today* (eds I. Pullen, D. G. Wilkinson, A. Wright & D. P. Gray), pp. 93–111. London: Gaskell.

R. G. Priest, MD, FRCP(E), FRCPsych, *Professor of Psychiatry, Paterson Wing, St Mary's Hospital, Praed Street, London W2 1NY*

(Received December 1993, accepted December 1993)