The depths of depression

The medicalisation of depression is now becoming the norm in the UK. But is the client's experience of depression being unwittingly reduced to a number? **Alan Pope** argues that therapists in private practice have an opportunity to provide something different

My title refers not to the patient's experience of depression but rather the therapist's response to it. I intend not to answer questions but rather to raise them. Depression, in a positive sense, has now become a colloquialism. It is no longer something that is mentioned in hushed tones but is part of the everyday, the mundane. Before going any further I will set out the one statement around depression that I hold true for all patients: you can tell a patient that they are depressed when they don't know it but you can never tell anyone who is depressed that they are not. I distil this from RD Laing's *The Politics of Experience* where he states in the opening chapter: 'I see you and you see me. I experience you and you experience me. I see your behaviour. You see my behaviour. But I do not and never have and never will see your experience of me. Just as you cannot "see" my experience of you.'[1]

In 2001 the World Health Organization (WHO) named depression as the fourth leading contributor to the global burden of disease and expects this to rise to second by 2020.[2] Just over one in three Europeans suffer from some form of mental health problem in any year.[2] I am presuming that the majority of these will be what the NHS via the National Institute for Health and Care Excellence (NICE) calls 'common mental health problems', such as depression, anxiety with depression, and generalised anxiety disorder. Nevertheless, these are staggering numbers. But what does all this mean for the practitioner at the coalface, and how should we respond?

The medicalisation of depression

The fourth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and the recently published DSM-V claims that it has broadened its scope and now offers a wider range of possible diagnoses for depression. Nevertheless, it still remains reductive. It has created a category called mood disorders, which includes both neurotic and psychotic forms of depression. It then subdivides this into about 15 categories and you can pick and mix from these to create a diagnosis that can be bandied about among professionals. This represents the total medicalisation of depression that is now becoming the norm in the UK. This has grown rapidly since the introduction of IAPT (Improving Access to Psychological Therapies) in 2008 but was already well advanced by the introduction of the group of psychotropic drugs known as selective serotonin reuptake inhibitors (SSRIs), of which Prozac is probably the most famous. In 2011 over 43 million prescriptions for antidepressants were handed out in the UK, and about 14 per cent (or nearly 6 million prescriptions) of these were for Prozac.[3] I am not against antidepressants and on occasion have said to patients, 'Would you not put a plaster cast on your leg if it was broken?' Indeed, medication can sometimes make it possible for people to engage in the therapeutic endeavour.

In the UK, IAPT and NICE grew out of the last government's desire for monitoring, evaluation, measurable outcomes and results. What is alarming about IAPT is how it privileges getting people back to work as a non-contextualised aim. IAPT was originally totally dominated by cognitive behavioural therapy (CBT) but as time has passed the limits of CBT have become more apparent. Having worked in a multi-theoretical service in the NHS I was somewhat amused by trainee CBT therapists circulating emails looking for 'motivated depressed' patients.

Of course, the medicalisation of therapy is not a new thing. Freud's medical background made him desperate for psychoanalysis to be part of the medical canon. He was unhappy that his Nobel Prize was for literature rather than medicine. As the 20th century progressed, psychoanalytic thought became more and more accepted by the arts, philosophy and more recently business as a way of understanding the world and our place in it. Ironically, as this was being taken up, so psychoanalytic thought in medicine began to diminish. At first, psychoanalytic treatment was seen as a luxury within the NHS and only accessible to those who had the motivation to seek it out. And, let's face it, there was and still is a class issue here: therapy for the middle classes and medication for the supposedly inarticulate masses. When I first began to work in the NHS in 2000 in Kensington and Chelsea there was a marked divide in counselling provision between the affluent south of the borough and the impoverished north. I don't think I need to say where the majority of the provision lay. To give NICE and IAPT their due they have forced Health Authorities to at least address the issue of inequity.

The limitations of diagnostic tools

Returning to diagnosis: it is now standard practice within the NHS and I believe the independent and voluntary sector to use the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder 7-item scale (GAD-7) to ascertain levels or depths of depression. For those of you unfamiliar with these questionnaires, the numbers 7 and 9 refer to the number of questions asked and scored at every session. These form the basis of diagnosis and are used by GPs as well. A high score will encourage a hard-pressed GP to write a prescription for an SSRI. It might be worth pointing out here that Pfizer own the copyright to the PHQ-9 and also manufacture the SSRI Venlafaxine.

Here follow two anecdotes: a working-class client said to me, 'I came here to talk not to fill in forms.' A colleague had a very depressed client in front of her, and when questioned about how low her scores were, she said, 'You didn't ask me the right questions.' You may be wondering what all this has to do with private practice. Well, for a start I suspect quite a lot of you work in both areas. The NHS, because of pressures on funding, is increasingly concerned about 'recovery', whatever that means. Well I do know what that means in IAPT terms. It means a final session score on a PHQ-9 of 10 and under out of a maximum score of 27. This is not a blood test; it is subjective and affected by many external influences. Depression is not reducible like flu or measles to a definitive virus. Many patients will come to private practice after having been introduced to the therapeutic process in the NHS and feel it is not enough. However, they may articulate their anxiety in terms of asking how they are doing. The medicalisation they have experienced takes away the collaborative nature of therapy. It places the therapist as 'well' and 'expert' and infantilises the patient.

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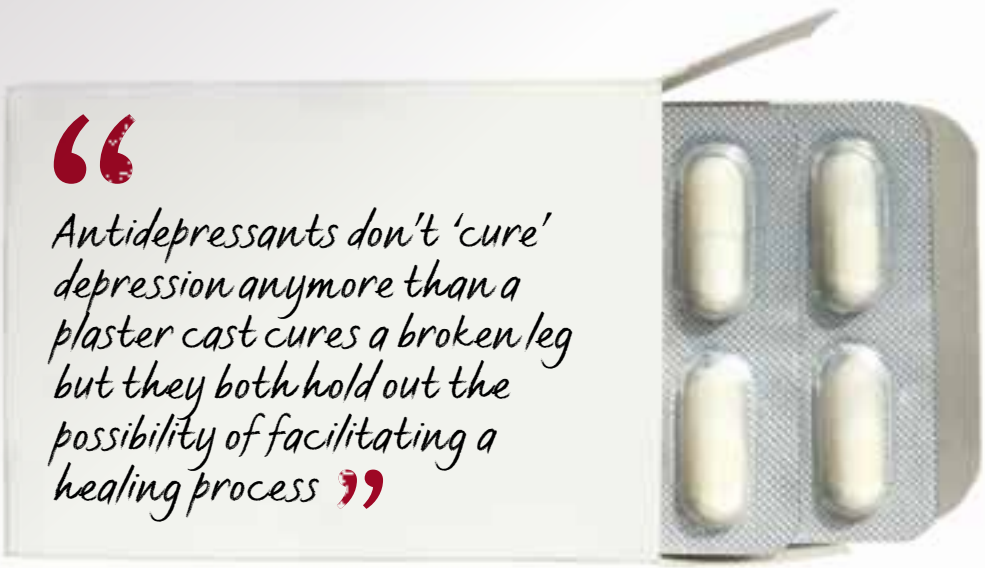
Psychodynamic counselling and psychoanalytic psychotherapy have been rather sidelined by IAPT and NICE and person-centred counselling almost entirely wiped out. NICE even suggests that patients who request or opt for counselling rather than CBT should be warned that there is no evidence that it works. A rearguard offensive has been mounted by the introduction of dynamic interpersonal therapy (DIT) and a person-centred model. They were both specifically designed as treatments for depression. They use a manualised model that satisfies the data requirements of NICE and IAPT. They are now being rolled out widely in the NHS. I did the DIT training myself and have practised it with some success. Patients tend to like it. Its strength lies in the acceptance of its own limitations and this is encapsulated by its use of a focus for treatment. However, there is a certain amount of frustration in this. It is based on what is economically possible for the NHS and works on a 16-week model.

Returning to Freud

Let us return to depression itself. From now on I will use depression phenomenologically. In other words as something that can be described and observed rather than as a diagnosis. You may feel this is semantics but I assure you it is not, because it alters our relationship to what is being presented



to us. Freud's *Mourning and Melancholia*[4] was first published in 1917 and is still pertinent in today's world. Freud posits that at the heart of all melancholia, as with mourning, there is loss. He differentiates them by pointing out that what is lost is known in mourning but this often is not the case in melancholia. The German psychiatrist Kraepelin may have introduced the term depression as a way of describing all forms of melancholia in the 19th century and it was gradually adopted as a definition through the early years of the 20th century.

What Freud does is place depression squarely in the psychosocial. He sees it as a result of what has happened to people in their world. Obvious examples are loss of a relationship, loss of employment, loss of country. As loss is a universal experience, perhaps the WHO statistics that I quoted at the outset are not as surprising as they first appear. However, why some losses are more difficult for some people to process than others is a much more complex matter. I believe this throws a challenge to the reductive nature of the DSM and the medical model. Antidepressants don't 'cure' depression any more than a plaster cast cures a broken leg but they both hold out the possibility of facilitating a healing process. In diagnosis there is the idea that certain 'behaviours' have to be present to achieve a diagnosis and be taken seriously. This to me doesn't seem very far from, 'Pull yourself together, there's plenty worse off than you.'

However, there is also a dichotomy here. By diagnosing mild to moderate depression are we pathologising something that is simply a reaction to life's difficulties, which could very likely go away by itself? My managers in the NHS would often purport that people on waiting lists can often spontaneously recover and some of my own experience would support this. However, this could suggest that we are in danger of medicalising the trials of life and ordinary unhappiness both of which are not automatically persistent and enduring. An equally effective intervention could come from non-professional sources.

On the other hand, by using narrow criteria and focusing on behaviour, might we be resisting the possibility of something more profound? Additionally, if we look at Melanie Klein's case studies there is often a point in the analysis where she declares something on the lines of 'and as is to be expected the patient becomes depressed'. In this scenario becoming depressed is also about recovery. It is perhaps the start of processing what has been recovered in the therapy.

Payment by results

A more concerning development for the therapist is the growth of payment by results. It is being introduced fully in the NHS from April this year and services are being set targets of recovery, which will grow tighter every year. As I mentioned earlier, a score of 10 and under on the PHQ-9 is considered a recovery. Services are being set targets of around 40 per cent for the first year. This doesn't mean that individuals' salaries are at risk, but funding to services could be, and managers will be looking at individual practitioners to see what results they are achieving. However, results also mean data, so if there is incomplete data, services will be penalised. In brief work the full effect of what has taken place may not have happened by the last session and the patient, consciously or unconsciously, may be resisting the ending or expressing negative transference.

How might this impact on private practice? For those of you who do sessional work for employee assistance programmes (EAPs), you could find that this system is picked up by them, which would operate on an individual basis. I have nothing against evaluation of a therapist's work but isn't it for the patient to do that in a more expressive way? Here is another anecdote: A patient at the end of a course of brief treatment, after her scores had gone up rather than down, told her therapist that despite this she actually felt better because now she had some understanding of what was troubling her. This reveals that the scores did not reflect the patient's personal sense of recovery.

In private practice we have an opportunity to provide something different. We can leave the shallows and tackle the depths of depression. This isn't always easy because patients can be caught up in the quick-fix culture. However, I am beginning to feel a sea change in referrals I am receiving now and people are specifically seeking longer-term work. Longer-term work in private practice gives us the opportunity to be playful, take risks, make mistakes and allow patients to recover at their own pace.

The late psychiatrist Anthony Storr wrote a book for doctors who were wanting to train as psychiatrists, called *The Art of Psychotherapy*. I think this title is very telling, and the perspective he takes is not a medicalised view of psychotherapy. Indeed, he states in the introduction: 'Many of those who become psychiatrists are temperamentally unsuited to the practice of psychotherapy as a whole-time occupation.'[5] To me, counselling and psychotherapy have much more in common with art than medicine. ■

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Your thoughts please

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