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## Is depression overdiagnosed? No

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Rates of diagnosis of depression have risen steeply in recent years. **Gordon Parker** believes this is because current criteria are medicalising sadness, but **Ian Hickie** argues that many people are still missing out on lifesaving treatment

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**NO** It is appropriate for the wider community to ask if the benefit of increased treatment of depression over the past 15 years has outweighed any harm. If increased treatment has led to demonstrable benefits, and is cost effective, then depression is not being overdiagnosed. From a health and economic perspective, we can give a clear answer—more adults are alive and well, and we can easily afford to treat more. Increased treatment of depression reduces suicides<sup>1 2</sup> and increases productivity.<sup>3</sup> The provision of appropriate medical and psychological care is also cost effective.<sup>4</sup>

The increased rate of diagnosis has had other benefits, including reduced stigma, removal of structural impediments to employment and health benefits, increased access to life insurance, improved physical health outcomes, reduced alcohol and drug misuse, and wider public understanding of the risks and benefits of coming forward for care.<sup>5</sup> We have at last abandoned the demeaning labels of stress, nervous breakdown, and adolescent angst. Most doctors can now differentiate normal sadness and distress from more severe clinical conditions. A new wave of neurobiological, genetic, and psychosocial risk factor studies has followed,<sup>6</sup> and informational and psychological interventions delivered in person or through the internet now have wide appeal.<sup>7</sup> In turn, this has stimulated social psychiatrists to call for a renewed focus on societal determinants<sup>8</sup> and testing of preventive strategies in the postnatal, childhood, and adolescent periods.<sup>5</sup>

Health system reform, particularly in the US and Australia, has emphasised the use of collaborative teams that deliver high quality interventions and achieve desirable health, social, educational, and vocational outcomes.<sup>9 10</sup>

A new generation of health practitioners now recognise that clinical forms of anxiety and depression commonly exist outside

of mental hospital environments. Without diagnosis of these conditions, we would still distance ourselves, our families, and our communities from the benefits of receiving mental health care.

The promotion of safer antidepressants in the 1990s was the catalyst for change. It challenged the categorical and specialist diagnostic systems. It also reawakened broader community interest in the experiences of people with depression and in how their lives are changed by drug or psychological treatments.<sup>11</sup> Population health studies that assess the effect of disability, increase emphasis on prevention and early intervention, and promote the benefits of treatment have resulted from these new perspectives.<sup>12</sup>

#### Caveats and concerns

Although those under 18 years old seem to benefit from psychological and drug treatments, the evidence is not as strong as for adults.<sup>13</sup> The resulting community concern should focus on whether drugs or psychological approaches are given as first line treatments. As with adults, among young people with more severe disorders the overall response to treatment is encouraging.<sup>14</sup>

Closer examination of prescribing<sup>15</sup> reveals other health promoting patterns. Although the number of prescriptions for antidepressants rose sharply during the 1990s, it now seems to have slowed. The use of new antidepressant drugs often results in reduced prescribing of less desirable sedatives such as benzodiazepines, as well as the more dangerous tricyclic antidepressants and monoamine oxidase inhibitors.<sup>15</sup> Although there has been much regulatory concern about increased prescribing of the new drugs,<sup>13</sup> there is little hard evidence of harm to a significant number of people. The real harm, as evidenced by the suicide statistics, comes from not receiving a diagnosis or treatment when you have a life threatening condition like depression.

Large general practice based audits in the UK, Australia, and New Zealand do not support the notion that depression is now overdiagnosed or treated exclusively with

antidepressants. In fact, substantive personal, demographic, geographical, professional, training, and health system barriers remain in place. The net result is that diagnosis of major depression is largely restricted to people with severe or persistent disorders, those who present many times, those who request treatment, or those who attempt self harm.<sup>16</sup>

Although critics may be reassured by such findings, these low recognition rates should be quite concerning. Most major mental disorders start before the age of

25 years and result in lifetime reductions in productivity and quality of life.<sup>17</sup> Often the best opportunities for changing this course arise early and before secondary medical, health, educational, and social comorbidity develop. Persistent depression also seems to have specific and enduring effects on brain structure and resultant cognitive function.<sup>18</sup>

To respond to these trends, modern psychiatry needs a new clinical model<sup>19</sup> combining early intervention and clinical staging perspectives (like those that have been so successful in cancer care). If this happens, increased rates of diagnosis will be balanced by a move to more overtly dimensional models and less reliance on medical therapies—that is, those with less severe forms or in the early phases of illness will receive the least harmful informational and psychological strategies.

Evidence about the lack of care provided when young people present with psychological disorders to primary care<sup>16 20</sup> supports the public promotion of the benefits of these more dimensional diagnostic models. We will also need to push for greater access to informational and psychological treatments and concurrent monitoring for possible harms.

**Competing interests:** IH was chief executive officer and clinical adviser of beyondblue, the Australian national depression initiative. He has led projects for health professionals and the community supported by government, community agencies and drug industry partners on identifying and managing depression and anxiety. He has served on professional advisory boards convened by the drug industry in relation to specific antidepressants, including nefazodone and duloxetine.

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