Modelling and Managing the Depressive Disorders

A Clinical Guide

This book will interest clinicians, researchers and inquiring readers. The authors argue that the current modelling of depressive disorders compromises research and clinical management and present an alternative approach to sub-typing and managing the mood disorders.

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Cover by **Matthew Johnstone**, Sydney-based artist and writer.

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Much of our research was undertaken at the Mood Disorders Unit, a tertiary referral facility established in 1985, and which was incorporated into the Black Dog Institute in 2002. The Institute is based at Prince of Wales Hospital, housing a research team together with clinical services, education and training facilities, as well as a consumer and community resource centre, and allowing iteration between these components. This structure advances our long-standing model of seeking to have clinical observation inform research hypotheses and, in turn, research findings inform modifications to clinical practice as well as to education and training. Our web site (www.blackdoginstitute.org.au) provides additional information about the organisational structure and how research studies have historically evolved.

Our research would not have been able to be undertaken without long-standing support from Australia's NHMRC for funding our research over the last 15 years. We are also indebted to the Centre for Mental Health, NSW Department of Health, for providing Infrastructure Grant funding to

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Introduction

There are major problems in modelling the depressive disorders and in evaluating available treatments. In the last few decades, the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994) model has dominated the classification of depression. It shares its largely dimensional model with the World Health Organisation's International Classification of Diseases (ICD-10) (World Health Organization, 1992) recent classificatory system. Thus, the current dominant model for conceptualising the depressive disorders is a dimensional or continuum view – with depression essentially seen as a single condition varying by severity.

We have long argued for a differing paradigm: one that allows (on the basis of specific clinical features) categorical status to certain expressions of depression such as melancholia and psychotic depression. However, once these more categorical conditions are excluded from the broad landscape of 'depressive disorders', there are difficulties in modelling the heterogeneous residue of non-melancholic conditions, as they are not categorical, vary in their status (as disorders, conditions, and stress responses) and are often multi-axial. For these, we favour a 'spectrum' model: viewing them as reflecting an interaction between salient life stresses and personality style.

In addition to challenging current diagnostic models we also challenge the 'evidence base' for evaluating antidepressant therapies. We question the reliability or 'gold standard' value offered by evidence-based approaches, at least as currently undertaken. We do not dispute the ideal – whereby judgements about the effectiveness of available antidepressant treatments benefit from randomised control trials (or RCTs) – when such data provide objective, impartial, systematic, and valid information. However, we note a number of intrinsic limitations to both the design and to the actual conduct of such trials and the 'meaninglessness' of the derived information. Many of the consequences include clinicians relying more on their own 'pattern analyses' rather than being able to trust results from the RCTs – a clearly unsatisfactory scenario.

Our alternative classificatory model allows that 'depression' can exist as a disease, a disorder, a syndrome and even as a 'normal reaction', and therefore requires a mix-and-match model for capturing both categorical and dimensional depressive disorders. Our model components are strongly weighted to clinical pattern analysis or what has been described by anthropologists as 'thick description', a base camp approach pursued by our team of clinical researchers before moving up the testing slopes of formal studies.

After establishing the Mood Disorders Unit in 1985, we spent nearly a decade seeking to distinguish psychotic and melancholic depression from the non-melancholic disorders. In the following decade, we have focused on developing the most appropriate model for conceptualising and differentiating the non-melancholic disorders from each other, with study results re-shaping our clinical approach to patients. Integral components of the model are tested in 'clinical effectiveness' studies, where we seek to define the most appropriate treatments for managing differing depressive disorders with increasing precision. We have cut our cloth on the iteration between clinical observation and research testing, and now we seek to persuade others to 'feel' its quality.

This book then reports a series of models and makes a number of treatment recommendations for managing the principal depressive conditions. As we considered melancholia and psychotic depression in considerable detail in a previous monograph (Parker & Hadzi-Pavlovic, 1996) this present volume gives greater attention to modelling and managing the non-melancholic disorders. We argue against an eclectic, and for a pluralistic approach to managing depressive conditions. This is best illustrated in regard to the non-melancholic disorders, where we seek to detail the impact of salient life events on predisposing personality styles, specifying the vulnerability points and arguing for pluralistic intervention strategies that we identify within our 'psychotransmitter model'. Thus, the book ranges from polemical to practical, and from provocative to precise. The identified models should not be seen as immutable, and we would welcome readers' responses, particularly if they could advance any of our current treatment strategies – and even coin a superior term to describe the 'non-melancholic' disorders.

The book is presented in four sections. Part I details the limitations to the current dimensional model for depressive disorders and the impact on clinical management. Part II considers the phenomenological definition and distinction of both *psychotic depression* and *melancholic depression*, and provides treatment recommendations based on published clinical effectiveness studies.

Introduction

Part III & Part IV present our principal focus and aspirations for this book – how best to model and manage the non-melancholic depressive disorders. The 'diagnostic model' is rooted in clinical observation but, as noted, also respects a rich tradition of viewing these conditions as reflecting interactions between life events and vulnerable personality styles. The 'aetiological' model (termed a 'psychotransmission model') is partly metaphorical but, like all metaphors, seeks to advance communication – here, by identifying vulnerability processes for more rational pluralistic treatment approaches. At this stage, the 'evidence base' for the clinical effectiveness of the psychotransmitter model is not available beyond systematic clinical observation. We are currently testing its utility in 'real world' effectiveness studies, and we have some confidence in offering it as a logical model in managing these common conditions. Its logic emerges from combining the literature base with clinical observation, in avoiding therapeutic eclecticism (where a favoured therapy is applied non-specifically), and in promoting therapeutic pluralism in a commonsense and rational manner. We hope that readers judge it of value.

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