A critical overview of the current treatment approaches offered to individuals experiencing depression

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Health, as defined by the World Health Organization, encompasses complete mental, physical, and social well-being. Despite this, mental health issues are prevalent in the UK, with depression being notably pervasive. This paper reviews the historical and current approaches to treating depression, highlighting a significant reliance on pharmacological interventions. Historical data shows that treatments have evolved from confining patients in asylums to using antidepressants, which became prominent in the 1950s. These medications, while beneficial for symptom management, have led to dependency issues due to their side effects and the body's tolerance development. Current statistics indicate a substantial increase in antidepressant prescriptions, which some attribute to over-diagnosis rather than advancements in understanding depression. The treatment spectrum for depression includes various antidepressants like Selective serotonin reuptake inhibitors (SSRIs) and Serotonin-norepinephrine reuptake inhibitors (SNRIs), with prescriptions often extended without thorough evaluation of long-term effectiveness or patient well-being. This practice has raised concerns about the over-medicalisation of depression, overshadowing alternative therapies such as cognitive behavioural therapy (CBT), which may offer sustainable benefits without the drawbacks of medication. Given the complex interplay of biological, psychological, and social factors in depression, this paper argues for a more integrated treatment approach. It suggests prioritising personalised care and broadening treatment modalities to better address the multifaceted nature of mental health issues.

Keywords: antidepressants; depression; mental health; pharmacology; treatment

The World Health Organisation (2015) implies health is the state of complete mental, physical and social well-being, with an absence of disease or illness and is the reflection of the prevention of mental disorders and rehabilitation of the individual. However, nearly a quarter of the population in the UK will suffer from a form of mental health problem (Mental Health Foundation, 2014a), with depression being the most common. While existing studies show, one in ten men and one in four women are affected and require treatment for depression. Characteristically, depression is an affective disorder defined by affecting personality moods and manifesting in an uninterested feeling in doing activities. More specifically, depression is the "persistent exaggeration of the everyday feeling that accompanies sadness" (Wilkinson et al., 1999). The terminology is commonly overused in everyday life to explain people's mood alteration affecting the individual for a short period rather than the person just feeling miserable or having an unproductive day (Hammen, 1997). Depression sufferers have been commonly prescribed antidepressants, such as citalopram (Cipramil) and paroxetine (Seroxat). Significantly, between 1998 and 2010, there was a 10% increase in long-term antidepressant prescriptions; according to Olfson and Klermen (1993), there was an increase in prescribed antidepressants between 1980 and 1989, from 2.5 million to 4.7 million prescriptions. However, NHS Choices (2014) suggests this was due to over-diagnosis rather than a better understanding of the condition.

Professor Michael Baigent, an advisor of the National Depression Initiative, suggests the proven treatment for severe depression is antidepressant and psychotherapy treatment (Hickie, 2008). Furthermore, Rogers and Pilgrim (2003) suggest that predominantly mentally ill people are encouraged to use medicines rather than alternative methods. Across the twentieth century, a radical development of understanding and treatments provided for the mentally ill has emerged. Previously, people suffering from mental illnesses such as depression were placed in institutions or asylums, similar to jails, with no opportunity to leave and locked up without external communication. Additionally, until the 19th century, there was no structured care for the mentally ill. Asylums use many treatments, including sedation, such as laudanum orally and baths in calming oils (Bewley, 2008). Asylums in the 1800s were overcrowded, with hundreds of patients having a range of different mental health problems. By the 1930s, sedatives were still commonly used, including Somniphine, which was given to patients to allow them to sleep for one or two weeks. For instance, one nurse remembered the process; the 'patients slept for a fortnight, and we would wash them, change them, and inject them again' (Gittins, 1998). The overuse of medicines was common practice in both the 1800s and 1900s to relax patients to contain their mental illnesses like depression. Within today's society, medicine is still used to suppress depression in the form of antidepressants.

In the 1950s, the introduction of antidepressants was released and was widely accepted as a solution for depression. They produced a mood-lifting response in patients and were a valuable tool for other mental health illnesses (Wilkinson et al., 1999). However, it was not until 1990 that further research into previously used medicine suggested they could be extremely harmful to patients. All antidepressants have side effects, such as drowsiness, migraines, and headaches. With a broader range of medicines, doctors can trial patients on different versions of antidepressants to establish the ideal medicine for the patient.

There are several types of depression; mild, moderate, and severe. Bipolar and unipolar affective disorders are also classed as forms of depression, depending on the severity of the illness. Antidepressants are commonly prescribed as treatments for moderate to severe depression. There are several categories for antidepressants: Selective serotonin reuptake inhibitors (SSRIs), Tricyclic, and Serotonin-norepinephrine reuptake inhibitors (SNRIs). SSRIs medicines are used for short-term use due to the withdrawal effects and are generally for moderate depression. Whilst, Tricyclics have addictive tendencies and take several weeks to begin effect. Both SNRIs and Tricyclic antidepressants are used for moderate and severe depression; courses for the medicine are usually a minimum of six months. These are both long-term medicines that work by lifting the patient's mood by affecting the levels of serotonin and noradrenaline within the brain. However, there is no 'magic pill' to cure depression as antidepressants only compress depression. Antidepressants relieve the symptoms, shorten the episode of depression, and reduce the risk of relapse (Wilkinson et al., 1999). Furthermore, according to Wilkinson et al. (1999), medication is the typical approach of psychiatry to

improve the symptoms of depression, compared to alternative therapies such as cognitive-behavioural therapy (CBT).

Fundamentally, the GP's role is to provide an early diagnosis. Regular check-ups are required as some patients may relapse within the first twelve months (Wilkinson et al., 1999). This is due to other contributory factors preventing the necessary change, whilst also, the medication takes a while to create the desired effect. Significantly, UNISON (2014) suggests that GPs feel understaffed and are unable to support patients effectively, as they may feel overstretched due to several patients per surgery. Consequently, this can result in regular check-ups being postponed or repeated medicines.

Furthermore, prescriptions are commonly repeated for up to 180 days before the patient's next review (Moore et al., 2009), impacting the patient's health. More particularly, Moore et al. (2009) suggest that long-term repeat prescribing of antidepressants reduces the risk of relapsing, even though the patient may be unlikely to relapse. This offers insight into why many patients remain on antidepressants for up to several years. However, those patients with unstable depression are more likely to relapse, which is why it is advised for them to use their antidepressants for a more extended period or indefinitely (Hallstrom & McClure, 2005).

Interestingly, studies have suggested that those doctors who prescribe high levels of antibiotics are more likely to prescribe antidepressants, thus correlation is significant. Demonstrating the use of the medicines as being highly favoured by GPs in treating their patients, in 2012, a further 2.7 million antidepressants were issued, Spence et al. (2014). Additionally, the Prescription Pricing Authority (2007) confirms there has been an increase in antidepressant prescribing, increasing 36% between the years 2000 and 2005. Furthermore, there is a yearly increase in the number of antidepressant medications, and the length of the medications used before reviewing is also longer. Annually there has been an 8.5% increase in antidepressant prescriptions, and some of these have been linked to economic factors such as unemployment rates (Spence et al. , 2014). Consequently, there is a need to acknowledge that the overuse of antidepressants can harm the patient and cause dependency, which can create long-term health problems.

Even though antidepressants are the standard treatment for depression, it has been suggested that they are not ideal for all patients. 'More than half the patients on antidepressants do not take their medicines as prescribed' Wilkinson, Moore and Moore (1999 p.57). This emphasises how the incorrect treatment has been issued for the patient. This may be attributed to being unable to feel the medication's full effect, suffering side effects, or having concerns regarding taking antidepressants. Therefore, this indicates that a range of treatments should be offered to the individual, enabling them to access the most suitable treatment course.

Regarding legislation, government policies aim to provide ongoing care for mental health, ensuring consistent advice and assistance is provided for those with mental health illnesses (Rogers and Pilgrim, 2003). Furthermore, the Mental Health Act 2007 was developed to assist with the policies, ensuring mentally ill patients were treated fairly and with dignity. It offers a more suitable approach to cater to patients' well-being. More particularly, the Act was developed to aid mental health sufferers in protecting themselves and others from harm by detaining them and administering medicine if required (The British Psychological Society 2009, p.22). However, the Act focuses more on severe mental health issues such as patients with schizophrenia.

For the diagnosis of depression, GPs are usually the first port of call, and due to their educational background, the medical approach is the primary source of care provided. The use of medicines for depression is the primary use of treatment. Rogers and Pilgrim (2003) agree that GP's first suggestion for treatment is medical work. As an extension, Rogers and Pilgrim (2003) state that doctors historically knew patients personally, understanding the definitive aspects affecting their lives. However, instead of establishing a level of familiarity and personability, there is a distance between the patient and the GP. Therefore, doctors rarely focus on the individual's experiences, providing a lack of confidence in the treatment, as many doctors use checklists to compare. This provides a lack of understanding of whether social effects cause depression. Fundamentally, Spence

et al. (2014) claim that antidepressants were under-prescribed in 1998; however, they have become overprescribed now. They believe this is due to the better level of understanding regarding the antidepressant's side effects, as more studies have taken place.

Depression is typically diagnosed using simple questions such as 'How are you?' These enable an understanding of the stability of the person in question. In 1950, the Hamilton Depression Rating Scale was created. The development of the rating is used within general practice today to assist in diagnosing patients with depression. The rates are a measure of the severity of the depression. The higher the rating, the more severe type of depression the patient has (Hallstrom & McClure, 2005). Even though the Mental Health Act enforces an understanding of the individual's well-being, this system strips the individual factors away and focuses on whether the patient fits into a criteria list. Consequently, understanding the person's needs, which are stated in the Mental Health Act, would allow a better strategy to be formulated to assist the person back to a healthier level of well-being.

Sociologists who have observed the overuse of medicines within the general practice have discovered that there has been an increase in medicines within the UK (Williams, 2000), which is indicative of a growth in the use of medicines concerning everyday life problems. Drivers behind such growth are outlined by Williams and Calnan (1996), who suggest that media use is related to medicalisation, as people can research their diagnosis. This can develop a false diagnosis, as the information retrieved may not be factual, and consequently, when the patient attends the doctor, they can expect medications to be prescribed. Furthermore, Williams and Calnan (1996) suggest the doctor would be more inclined to prescribe medicines, as the patient would exaggerate their symptoms due to the information read.

Medication for mental health illness has become problematic due to the overuse of services, as Rogers and Pilgrim (2003) stated. Other alternatives could be suggested instead of medication, as medication has become dependent upon within the last fifty years. To reduce withdrawal symptoms, doctors may allow patients to slowly withdraw their medicine, resulting in further prescriptions for antidepressants. Intrinsically, Kato and Kanba (2015) suggest that depression is a multifactorial syndrome associated with multiple risk factors: genes, environment, individual personality, and psychosocial stressors. Health psychologies support this theory, believing that illnesses are caused by biological, psychological, and social factors (Naidoo & Wills, 2008). This is reflected in the Biopsychosocial Model of Health and Illness (year?), highlighting the different factors affecting mental illnesses like depression. Consequently, the medication can impact the biological factors of the individual.

Depression is experienced due to many factors, and it has been suggested by NHS Choices (2014) that the individual's well-being is affected by social factors, including unemployment and housing. Andy Bell, Chief Executive of the Centre for Mental Health, believes unemployment, uncertain prospects, and financial problems are two of the leading causes of depression (The British Psychological Society 2011). Payne et al. (1993) agree that several studies have shown that there is a secure link between depression and unemployment. Economic problems can result in poverty and unemployment, explicitly affecting the lower social class. Poverty factors such as unemployment and poor education can lead to depression, which can cause economic impacts, including expense and an inability to work. Ultimately, these can then lead back to poverty. This vicious cycle will only change if poverty and economic impacts cease. As an extension, Wilkinson et al. (1999) suggests that lower social classes are associated with higher depression due to their social class vulnerability factors. Ambient hazards of chaotic social factors have been associated with increased rates of depression (Aneshensel & Succoff, 1996). Consequently, tackling economic problems would reduce depression illnesses and improve mental health across the country.

From a theoretical standpoint, Maslow's Hierarchy of Needs, which was developed in 1943, still provides valuable assistance in identifying what quantifies to be requirements for the basic needs of life and what motivates people, offering further insight into central drivers and determinants of poor mental state. As identified, different factors can affect the mental state of someone, which can lead to

depression. Therefore, sustaining the basics of life will benefit the individual. The lower levels denoted by Maslow are needed to sustain life, and the higher levels will benefit personal satisfaction, leading to a healthier and happier existence. This can be identified as the development of tracking the growth of the individual. Specifically, there are five needs in Maslow's Hierarchy of Needs: physiological, safety, community and belonging, esteem, and self-actualisation. Physiological needs include maintaining life with the basics, including food and oxygen. At the same time, safety needs include meeting and maintaining personal well-being. Addressing community and belonging ensures the individual has stable surroundings, whether within the community or at home with family. Whilst esteem is needed to ensure a sense of belonging, which allows self-actualisation to occur for the desired outcome of fulfilment. Thus, Maslow's Hierarchy of Needs can be related to depression sufferers, as each stage can assist the person in maintaining and encouraging them to reach and sustain a healthier mental state. The hierarchy can emphasise how people who feel unable to fulfil these stages can experience the onset of depression.

Furthermore, mental health problems such as depression can manifest themselves in people from different backgrounds, such as people experiencing homelessness or those with no sense of community belonging. Subsequently, Maslow's Hierarchy of Needs' refers to each person fulfilling their human potential' Pilgrims (2014). The hierarchy can be used to encourage sufferers, as improving these factors can result in a better mental health state, especially by improving their safety and self-esteem.

The Mental Health Strategy, 'No Health without Mental Health', involves working together to improve the outcomes of mental health problems. This includes encouraging people back into work and remission (Department of Health, 2014). Fundamentally, the central component of the Department of Health’s policies is to treat the individual. This reduces the individual's worry of receiving inadequate help and the risk of being prescribed antidepressant programs like others. Importantly, it allows a tailored program for the person to achieve their recovery goals. Doing so ensures that the treatment works at the patient's pace, encouraging the patient to reform into a healthier mental state.

Notably, antidepressants assist in depression recovery, whereby recovery is defined as the regaining of a meaningful life with or without symptoms (2014). The recovery process can be complicated for depression sufferers, as many need to become used to their medicine. Additionally, many undergo trials of different medicines to find their ideal treatment due to the side effects caused. Along with antidepressants, mental health services provide the guiding vision of recovery (Pilgrims, 2014; Pinto-Coelho & Relojo, 2017). There are many treatments for depression, such as Cognitive Behavioural Therapy (CBT), counselling, and self-help groups. The focus on the medicalisation of depression emphasises the use of medicine to tackle mental illnesses. It also shows that doctors are overprescribing, resulting in patients missing out on alternative treatments, which may be more beneficial in the long term.

From anecdotal experience, as gained from working within a pharmacy, an understanding of prescribed medications has been discovered, noticing patients taking antidepressants commonly use repeat prescription services. This allows the individual to repeat their dosages without seeing their GP, and many prescription repeats continue until the patient's annual GP review. Worryingly, this clearly shows that GPs can repeat antidepressants without assessing the patient's well-being or establishing whether they are required. This is a growing concern, as antidepressants are dispensed regularly, and situations for the patient may have altered. Also, NHS Choices (2014) concerns are also growing, as they believe 'medicalising' average human experiences such as life stresses or grief is becoming too familiar, and importance of support is needed for these individuals. Additionally, there is a clear suggestion that a better program for supporting severe depression sufferers is required.

The Mental Health Act has allowed people's well-being to come first; however, with depression, there seems to be a lack of consideration. Overall, there seems to be a powerful suggestion that the patient can overuse antidepressants. This suggests a lack of understanding concerning treating people based on their experiences rather than checking which criteria they fit into. However, GPs and the NHS are

overworked, which has resulted in the absence of focus on patients suffering from depression. This is imperative, as over a quarter of all GP attendances are related to mental health problems, and a third of these are related to depression (Department of Health, 2000). GPs struggle to attend adequately to their patient's needs due to the high number of patients assigned to their surgery, primarily mental illnesses. The absence has allowed patients to repeat their medication without review, resulting in a high level of prescriptions for depression medication. To reduce the medicalisation of depression, a focus on different treatments may be required to find the root cause of the need for antidepressant medications.

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