COMMENT

Antidepressants and the treatment of clinical depression

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Antidepressants recently hit the headlines in most newspapers when the results of a large-scale meta-analysis of all well-conducted trials of several popular antidepressants, including fluoxetine (Prozac), paroxetine (Seroxat) and sertraline (Lustral and Zoloft), was published (Kirsch *et al* 2008). A meta-analysis is a statistical method for combining results of several studies. In this case it included 35 clinical trials involving over 5,000 patients. Children and adolescents were not included in this meta-analysis as antidepressants are not the first line of treatment for depression in this age group (National Institute of Clinical Excellence 2005).

Although press reports made it appear that these antidepressants were ineffective, what the trials actually showed was that as a group they were slightly more effective than placebo, but the difference may not have been enough to justify their use. The analysis showed that they were more likely to be helpful if the depression was severe, and the authors concluded that antidepressants were only likely to be worth trying for severe cases. For mild to moderate levels of clinical depression, prescribing either a placebo or an antidepressant was usually followed by improvement, implying either that the non-specific components of prescribing a tablet were more important than the ingredient of the tablet, or that the individuals would have got better no matter what help was offered.

It has always been unclear just how severe depression has to be before antidepressants have a specific benefit, and it is likely that antidepressants have been over-prescribed for mild, transient forms of distress. Even after the publication of these findings it is still unclear at what level of depression antidepressants are worth using – the authors suggest it has to be very severe, but it is not possible from the rather imprecise data, which was pooled between many studies, to be as categorical as the authors were.

No doubt public confidence in these drugs will be undermined, which begs the question of what should be done for people presenting with mild to moderate symptoms of clinical depression. Fortunately, there are other treatments for depression that are safe and effective. Best supported by research is Cognitive Behaviour Therapy (CBT), which is provided by a range of mental health professionals who have received special training (Dobson *et al* 1989). In Britain the provision of this treatment under the National Health Service is patchy but government plans include the provision of 3,600 new therapists by 2010-11 (http://www.iop.kcl.ac.uk/news/?id=188). In other countries it is often unavailable or expensive.

Excellent results have also been reported for the use of a form of CBT (www.moodgym.anu.edu.au/) which is available, free of charge, on the internet (MacKinnon *et al* 2008). The increased use of such services makes it likely that this will become the first choice for many sufferers.

Readers of *Bereavement Care* will recall Tirril Harris's paper (Harris 2005) in which she described a form of 'fresh start' or befriending for people with mild to moderate depression that can be provided by trained volunteers. Well-conducted studies have shown this to be an effective treatment, which it is well within the power of bereavement volunteers to provide (Harris *et al* 1999).

Although grief and depression commonly coexist in bereaved people they should not be confused with each other (Parkes 1985; Prigerson *et al* 1996). The lesson from research seems to be that there is no reason why organisations, such as the UK charity Cruse Bereavement Care, that make use of carefully selected, trained and supervised volunteers, should not train their volunteers to provide the kind of focused support that has been shown to help the many people who become depressed after bereavement. More expensive professional services could then be reserved for the minority who do not respond. ●

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