Letter to the Editor

From non-adaptive depression to general distress

Adam W A Geraghty\*a, Berend Terluinb, Tony Kendricka, Michael Moorea.

*a Primary Care and Population Sciences, University of Southampton, United Kingdom.*

*b Department of General Practice and Elderly Care Medicine, EMGO Institute for Health and Care Research, VU University Medical Centre, Amsterdam, The Netherlands.*

Correspondence concerning this article should be addressed to Adam WA Geraghty, Primary Care and Population Sciences, Aldermoor Health Centre, Aldermoor Close, Southampton, Hampshire, SO16 5ST. Email: A.W.Geraghty@soton.ac.uk. Tel +44 02380 241051

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Response to Rantala et al. (2017). Depression subtyping based on evolutionary psychiatry: Proximate mechanisms and ultimate functions. *Brain Behav Immun.*

We read Rantala et al.’s (2017) paper entitled ‘Depression subtyping based on evolutionary psychiatry: Proximate mechanisms and ultimate functions’ with great interest. The authors present a wide-ranging argument suggesting the need to focus on the triggers of particular depressive episodes in order to determine depression subtypes. Whilst we found much to agree with in the paper, we believe the clarity of their thesis may be improved with a tighter focus on definitions.

First, we were surprised not to see a broader discussion of what constitutes a ‘mental disorder’. Their propositions are close to Wakefield’s (2007) notion of disorder as a harmful dysfunction, and in the case of major depressive disorder, a harmful dysfunction of the loss-response. Wakefield defines *dysfunction* as a failure of an internal mechanism, mental or biological, to perform its natural, evolutionarily defined function.  To use Rantala et al.’s terms, symptoms become pathological when they are non-adaptive.

Second, throughout, Rantala et al. use terms ‘depression’ ‘depressive symptoms’ and ‘depressive episode’ somewhat interchangeably. These terms were contrasted with ‘pathological depression’, seemingly referring to non-adaptive depression symptoms and low mood. The problem with essentially the same root term ‘depression’ being used to refer to adaptive negative affect-related processes and psychopathology/psychiatric disorder, is that it increases difficulty in applied settings and can lead to misunderstandings in the general public. In primary medical care where the full range of symptoms are seen by General Practitioners (GPs) patients may present with symptoms driven by an adaptive process (grief, loneliness, romantic rejection), label this depression, and receive potentially inappropriate treatment targeting psychopathology. Additionally, the misbelief that one has a psychiatric disorder when symptoms are adaptive may well be iatrogenic in itself.

In our work within primary care (Geraghty et al., 2015) we are exploring the utility of conceptualising adaptive negative affective-related process as general distress, and reserving the term depression to refer to depressive disorder; a pathological process.  We conceptualise general distress as symptoms (which can be severe) that manifest as results of attempting to maintain homeostasis in the presence of life stressors. Depressive disorder, however, reflects a non-adaptive dysfunction of emotional regulation (Terluin et al., 2006). Setting up a clearer distinction is consistent with theory regarding mental disorder vs. adaptive stress responses, may facilitate targeting of care approaches in practice, and accords with patient experience (Geraghty et al., 2016).

Finally, on a clinical note, we urge caution around propositions that only pathological responses should be treated. Although adaptive, distress can be severe and cause a great deal of suffering. It is the form of care that may need to differ based on the nature of symptoms, rather than whether interventions should be received or not.

In sum, we agree that there may be much to be gained by moving beyond symptom counts and durations to more nuanced characterisations of symptoms. With careful consideration of definitions, we must now begin to test these ideas empirically.

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