**Table 1.**

**Moderne post-1980 incidentie studies van depressie in engere zin (major depressive disorder (MDD)**

**die de voldoen aan de inclusie criteria.#**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Country | N (age range), case-finding  | Data-collection;Duration follow-up  | Person- yearsat risk (pyar) | Annual incidence per 1000 pyar (95% CI or s.e.) |
| ECA, USA53  | 10,035 (18+), DIS, DSM-III | 1981 - 1982; 12 months | ~10,861 | 15.9 (1.7) |
| Edmonton,Canada54 | 1964 (18-65), DIS, DSM-III | 1986 - 1989; 33 months | 4683 |  27.9 (3.7) |
| Netherlands, NEMESIS-155  | 4664 (18-64), CIDI, DSM-IIIR& | 1997 - 1999; 12 months  | 4757 | 27.2 (22.6-31.9) |
| ODIN, Finland56 | 1412 (18-64), SCAN, ICD-10 | 1998 - 1999; 12 months |  ~1412  | 20.5 (NN) |
| USA, Nesarc*57* | 28859 (18+), AUDADIS-IV | 2004 - 2006; 12 months | 28,614 | 15.2 (0.9) |
| Netherlands,NEMESIS-258  | 4172 (18-64), CIDI, DSM-IV& | 2008 - 2011; 36 months  | 12,311 |  15.8 (13.6-18.0) |

#, Inclusion criteria: post-1980 prospective follow-up study of community-based sample, sample size 1000+, operationally defined diagnostic classifications (e.g. DSM-III or IV), standardized psychiatric interview administered by experts or trained lay interviewers, follow-up up to 3 years. pyar, person-years-at-risk.

&, Difference in incidence between NEMESIS-1 (DSM-III-R) and NEMESIS-2 (DSM-IV) might be due to differences between DSM-editions.

**Table 2.**

**Vertekeningen (bias) in RCTs en meta-analyses.**

|  |  |
| --- | --- |
| **Type of bias** | **Description** |
| *Selection bias*  | Biased allocation to interventions due to inadequate generation of a randomisedsequence or inadequate concealment of allocations before assignment. |
| *Selective reporting* or *Outcome reporting bias* | Failure to describe negative findings within a published report or switching the status of (nonsignificant) primary and (significant) secondary outcomes.  |
| *Outcome misclassification bias* | Measures and assessors are imperfect. In studies that discontinue medication, withdrawal symptoms may masquerade as depressive symptoms, thereby conflating the two. |
| *Imperfect blinding*  | Patients, treatment providers or assessors know the true status of the randomized subjects. In ADM trials, this may occur because of side effects. |
| *Spin bias*  | Reporting strategies in a manner that often misleads readers  |
| *Citation bias*  | Trials with positive results receive more citations than negative studies, leading to a heightened visibility of positive findings and reduced discoverability of negative trials. |
| *Completer analysis*  | Only individuals who completed the treatment and post-treatment assessment are included in the analysis Because treatment completion is not random results can be biased, typically in favor of the experimental treatment.  |
| *Inappropriate controls*  | Controls do not fully meet the objectives of the study. For instance, if no-treatment is the best control condition given the study objectives then wait-list (nocebo effect) and the heterogeneous treatment as usual are imperfect controls.  |