
Disease Entity or Culture-Bound Syndrome?

The Troubled History of DSM-IV’s Major Depressive Disorder

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The United States is currently gripped by a very controversial political campaign. I am not speaking of the forthcoming election of a new president. Instead, I am speaking of the political battles now being waged to change the content and the character of the forthcoming 5th edition of the Diagnostic and Statistical Manual of Mental Disorders, which is scheduled to appear in print in 2012. The 4th edition of 1994, commonly referred to as DSM-IV, has remained relatively unchanged since the appearance of the third edition in 1980. Most historians of psychiatry regard the appearance of DSM-III some 28 years ago as a fundamental turning point in not only the history and practice of medicine, but also as the engine of a profound cultural change. The new diagnostic classification system and new nomenclature introduced in 1980 has not only framed scientific research on mental disorders since that time; it has also significantly influenced the therapeutic
practice of psychiatrists, psychologists, counselors and other mental health professionals. In the medical model, treatment rationally follows from diagnosis. The way in which individual diagnoses are defined, therefore, also defines the type of distress a person is suffering from and categorizes the person seeking help. Since 1980, the diagnosis of a mental disorder has relied upon whether or not a person in distress meets a set number of criteria in a list of signs and symptoms, many of which are often vague in nature. However, since DSM-III, the diagnosis of a mental disorder does not depend on the personal history of the patient nor the social, emotional, or economic context in which the person’s distress arose. This dehistoricizing of the human life of an individual has led to a cultural transformation in many Western countries with regard to the treatment of mental disorders. Psychotherapy and counseling have been devalued as treatment modalities in part, I believe, because the emphasis is on the personal narrative of the individual in distress. Instead, since 1988, when Prozac was first widely prescribed in the United States, there has been a general acceptance of treatments that rationally follow the contextless and ahistorical DSM diagnostic entities. The social, emotional and economic context of an individual’s life is largely irrelevant to most physicians who prescribe a pill – only the disease entity itself matters. This is especially true for the large categories of mental disorders that DSM classifies as Mood Disorders or Anxiety Disorders. Unlike the Western treatment of traditional medical diseases, where a thorough history and objective analyses of blood or urine samples, or imaging, can lead to a reliable diagnosis and rational treatment, the current Western treatment of the most common mental disorder – depression – relies on no objective physical tests and almost entirely disregards the history of an individual. When a depressed person in the United States goes to his or her
general practitioner or family doctor – as most depressed persons do in America -- the personal history of the patient is irrelevant. It does not matter if the person is depressed because this is something that happens to them every winter whether their lives are good or not, nor if the person has lost a job or ended a romantic relationship, nor if the person is grieving the death of their father or their pet dog, the treatment is invariably the same: pharmacological treatment with an antidepressant or anti-anxiety drug.

The political campaign to influence the ways in which the American Psychiatric Association defines depression, bipolar disorder, and anxiety disorders in the next edition of the DSM is not trivial. The stakes are high. In the United States a third to a half of all patients coming in to see their general practitioner or family doctor are doing so because of problems with depression and anxiety. Psychiatrists, psychologists, counselors, social workers and other mental health professionals who work in clinics or in private practice all report that a majority of their patients are seeking help because of problems related to mood or anxiety. Pharmaceutical companies have received the highest profits in the history of that industry through the introduction of a continual stream of newer (but not necessarily better) antidepressants, mood stabilizers and anti-anxiety drugs since the age of Prozac began in 1988. Millions in the Unites States receive disability payments from the government for mental disorders, many of them for Major Depressive Disorder and Bipolar I Disorder, and any alteration in the diagnostic criteria for specific syndromes in the next DSM could affect their financial survival as well as their mental health. As I say, the stakes are high. How the American Psychiatric Association defines mental disorders such as depression will not only have a profound economic effect but will also directly affect the individual lives of persons seeking treatment.
How the Western medical community defines depression is also of direct relevance to the diagnosis and treatment of persons in non-Western societies. Since 1999 there has been an initiative to unify the diagnostic criteria of the American Psychiatric association with the mental disorders listed in the *International Classification of Diseases* of the World Health Organization. Since the *ICD* is more widely used in non-Western societies, the importation of Western – indeed, essentially American – concepts of mental health and mental disorder, and the fundamentally biological, molecular, and ahistorical view of human nature itself which underlies it, will be a form of cognitive colonization that must be assessed clearly and rationally. In India, for example, where seeking treatment from psychiatrists, psychologists, counselors and other mental health specialists is still not a widely accepted practice, will an unquestioned adoption of Western diagnostic definitions of depression lead to a culture that demands – and expects – pills instead of psychotherapy, counseling, or treatment by traditional Ayurvedic healers? Will a more holistic and traditional view of human nature one day be replaced by Western biological psychiatry’s view of human nature as exclusively biological and molecular?

According to the World Health Organization’s Global Burden of Disease study, which was first published in 1996, by the year 2020 depression will be the number one cause of disability across the world. This would of course include countries such as India. Epidemiological studies in North America and Europe have found that the numbers of people suffering from depression have risen markedly since the 1940s, and particularly since the publication of *DSM-III* in 1980. Of course, the first question that must be asked is: How exactly are we defining depression? And the second question is: Are we defining
depression correctly? As I say, the stakes are high – even for countries such as India. Perhaps I should say, especially for countries such as India.

I would like to approach these issues from the perspective of history. I believe that a perspective on how Western psychiatry has evolved its concepts of depression will help us understand not only what is wrong with the current situation, but also what is right with it.

Depression is a creation of the 20th century. In the Western medical tradition, what we now term depression has been part of the various clinical pictures of a mental disorder the ancient Greeks called melancholia. The term melancholia was in wide use until the early 20th century, disappeared from official psychiatry for most of the latter two-thirds of the century, and now in the 21st century is being resurrected by some prominent psychiatrists with the hope that it will reappear in DSM-V when it is published in 2012.

Although signs and symptoms of depression were always at the core of melancholia since ancient times, melancholia was a broad category of insanity that also included many clinical phenomena that would today be defining characteristics of other DSM mental disorders. Melancholia also included anxiety, obsessions, fixed ideas, phobias, delusions, agitation, gastrointestinal problems, headaches, and other signs and symptoms that are not part of the set of criteria for diagnosing a Major Depressive episode or Major Depressive Disorder in DSM-IV. Also, for more than 2000 years physicians recognized that melancholia could be categorized into two basic types. The first consisted of forms of melancholia that seemed to be “uncaused” and afflicted the person even during times in their lives when there were no traumas, stressors, or any
other negative life situations that might lead to such negative states of mind. The second kind of melancholia consisted of forms of insanity that seemed to be directly “caused” as a reaction to events in the life of the person. Although the numerous authors of medical treatises differed widely on the subtypes and definitions of melancholia, they all tended to agree on this basic division between types of melancholia that were endogenous and seemingly uncaused and those that were seemingly reactive and caused by stresses or traumas in the individual’s life.

It was only after the year 1886 that a few Western psychiatrists, primarily from Germany, began advocating for the term depression or depressive states as a replacement for the ancient term melancholia. In that year the Danish neurologist Carl Lange of Copenhagen introduced the use of the term depression to describe a syndrome recognizable to us today in the modern sense of the word. From later authors there was also an increasing focus on the core symptoms of depression – low spirits, lack of vitality, poor self esteem, fatigue, anhedonia, social withdrawal, excessive guilt, sleeping and eating irregularities, preoccupation with death and negative thoughts, suicidal ideation and even suicide attempts. The close connection of depression with anxiety was also noted by the 1880s, as it is today.

A major turning point came in 1899 with the publication of the 6th edition of the German psychiatrist Emil Kraepelin’s textbook, *Psychiatrie*. Although Kraepelin had referred to “depressive states” in earlier edition of his book, the term depression was enshrined in Western psychiatry with the introduction of the new term, manic-depressive insanity, which Kraepelin coined as a general, all-encompassing term for what we would call all the Mood Disorders today. Kraepelin believed that all mood disorders (except one
– involutional melancholia) were expressions of one underlying disease entity. Because Kraepelin’s major division of the insanities into manic-depressive illness and dementia praecox (which constituted all of the psychotic disorders) was widely accepted into American, British and German psychiatry, until 1980 anyone who suffered from depression in its various forms would be labeled manic-depressive even if they did not have a history of a manic episode in their past. With the publication of DSM-III in 1980, manic-depressive illness disappeared as an official psychiatric diagnosis in the United States and was split into two separate entities: Major Depression (in which a person experiences one or more major depressive episodes) and Bipolar Disorder (in which a person suffers from recurrent manic episodes as well as major depressive episodes, with a manic episode being the trigger for the diagnosis). In the 21st century there is a political movement among some prominent psychiatrists to revive the term manic-depressive illness and return to Kraepelin’s idea that all mood disorders are really aspects of a single underlying disease entity. There is also a movement underfoot to widen the definition of what constitutes a mood disorder by identifying a whole host of new disorders that are presumed to be part of a “bipolar spectrum.” I will return to this issue.

The use of the term depression in American psychiatry as a replacement for the ancient term melancholia can be traced to a lecture given by the Swiss émigré Adolf Meyer in New York in 1904. In that lecture Meyer strongly advocated dropping melancholia and using the word depression instead. From that point on fewer and fewer American psychiatrists referred to melancholia, although a few British psychiatrists, such as Aubrey Lewis, continued using the term until well into the 1930s.
Meyer was the most influential psychiatrist in the United States from approximately 1904 until his death in 1950. For most of his career he strongly resisted the classification of mental disorders, claiming that too little was known about their nature to even begin the process of classification. This was a perspective shared by the psychoanalysts who began to influence American psychiatry in a perceptible way by World War I, and who dominated the American Psychiatric Association from the late 1930s until the early 1980s. Another perspective shared by both Meyer and the Freudians was the notion that most mental disorders were caused by the reaction to life experiences and not by heredity or any primary underlying biological process. In Meyer’s “dynamic psychiatry,” mental disorders were “reactions” or “reaction-types” that were caused by an abnormal response to psychobiosocial stressors. Most cases of depression were largely a reaction to the stresses of life, Meyer argued. The Freudians spoke of “depressive neuroses” or other “psychoneuroses,” and they too placed the cause of depression in the life experience and personal history of the individual. However, Adolf Meyer differed with the Freudians on one essential point: Meyer believed that there were also cases of depression which seemed to be autonomous or uncaused by any reaction to the stresses of life. Some people seemed to sink into major depressive episodes without any apparent cause, and did so sometimes even when they were most successful in life. Meyer believed that this type of depression was probably biologically-based.

This distinction between two very different types of depression – one that was a reaction to the stresses of life and the other that seemed to be biologically-caused – was identified by every major Western psychiatrist in the 20th century except two: the British psychiatrist Aubrey Lewis and the German psychiatrist Karl Leonhard, who both
believed there was only one type of depression. Despite this long history in psychiatry, this distinction completely vanished with the publication of *DSM-III* in 1980. Instead, the lines were blurred. The personal history of the individual no longer mattered. A person could be suffering from a single episode of depression due to a recent loss, they could have a history of multiple episodes of depression following major losses, chronic stress or traumas in their lives, or they could have a history of major depressive episodes that seemed to be unrelated to the events of their lives, and in some instances might be related to the changing of the seasons. Since 1980, all of them would be given the same diagnosis: Major Depression or, in *DSM-IV* terms, Major Depressive Disorder. The context of the origin of the distress was regarded as irrelevant.

How did this happen? How did the American psychiatrists who created *DSM-III* ignore 2000 years of observations that there were two fundamental types of depression, caused and uncaused? To answer this question, I’ll review the political climate of American psychiatry in the 1970s when *DSM-III* was being written.

From the 1940s until the early 1980s the psychiatrists on the faculties of medical schools were mostly psychoanalysts or influenced by psychoanalysis. To most Americans, psychoanalysis and psychiatry were synonymous during those decades. As I have already mentioned, psychoanalysts in America were resistant and indeed largely dismissive of attempts to classify mental disorders. As a group, they were generally opposed to scientific research that investigated genetic or other biological hypotheses regarding the causes and nature of mental disorders. Although two previous editions of *DSM* had appeared – the first in 1952, heavily influenced by Meyer’s notion of “reaction-types” and the second in 1968 which used mostly Freudian terminology – before 1980
very few psychiatrists actually used the diagnostic terms in the *DSM*. Incredibly, many psychiatrists did not even own a copy of the diagnostic manual. They regarded diagnosis as a mere formality that could be ignored.

There was only one psychiatric department in an American medical school that did not have a single psychoanalyst on its staff – the medical school of Washington University of St. Louis. In the early 1970s a group of psychiatrists on that faculty who were interested in exploring experimental psychiatric research devised Research Diagnostic Criteria for each major mental disorder. The idea was to develop a set of operational definitions of the major mental disorders that could be used by researchers interested in exploring their biological and psychological basis. According to their logic, if scientific studies were conducted using the same diagnostic criteria to identify subjects for experiments, then findings across studies could be generalized. Psychiatric research until that time was a mess – different criteria were used to identify subjects by different researchers, and results across studies were difficult to interpret. The Washington University group was joined by Robert Spitzer of New York, a psychoanalytically-trained psychiatrist who had lost his Freudian faith. Since most of the members of the American Psychiatric Association were psychoanalysts and had little interest in revising the *DSM*, Robert Spitzer was approved to head the project for developing *DSM-III* and paid little attention to what he and his colleagues were doing. Spitzer and his colleagues used the Research Diagnostic Criteria developed in St. Louis as the basis for *DSM-III*. The idea was to produce a manual with definitions of mental disorders that would be useful to scientific researchers as well as clinicians. Spitzer single-handedly created many of the mental disorders in that edition himself in order to appease various special interest groups
within the psychiatric community. By the time the membership of the American Psychiatric Association learned of the fundamental change in the philosophy of the *DSM* -- especially the elimination of almost all Freudian terms and any claim about the “cause” of a mental disorder, whether as a reactive neurosis or something biological – it was too late. *DSM-III* was published in 1980 and within a few years became the basis for reimbursement for treatment by American insurance companies. By the mid 1980s, when using an official *DSM-III* diagnosis determined whether a physician would be paid for services or not, even the oldest psychoanalysts had to buy a copy of the book and actually start reading it.

Because the creators of *DSM-III* strove to eliminate diagnosis based on presumed cause – in part, as a reaction to the psychoanalysts and their emphasis on personal experience as the cause of all mental disorders -- the boundary was blurred between the two forms of depression. The context in which a person became depressed was lost, and remains so today. This has had two profound effects in the past 28 years. First, the number of persons diagnosed with a *medical* disorder known as Major Depression or Dysthymia – the two major forms of depression in *DSM* – dramatically increased. Whereas experiencing depression as a natural, normal reaction to a loss or a trauma was seen as a part of life, now even those aspects of human existence became medicalized. Even today, according to *DSM-IV* the depression that naturally follows the death of a loved one that is part of normal grieving is only considered “normal” for two months following the loss. After that, the grieving person is considered to be suffering from Major Depressive Disorder – a medical condition akin to a disease process.
A second effect of the blurring of the boundaries of caused and uncaused depression has been the confounds created in biological research on depression. The purpose of biological research in psychiatry is to identify the biological substrates of persons suffering from a specific mental disorder in order to understand the etiology and pathophysiology of that disorder as well as to lead to the development of more effective medications to treat it. However, as American sociologists Allan Horwitz and Jerome Wakefield have recently argued in a book published last year, much of the hundreds of millions of dollars used to fund research on the biology of depression since 1980 may have been wasted due to the fact that these studies used the faulty *DSM-III* operational definition of depression, which does not distinguish between caused and uncaused depression. Horwitz and Wakefield compare the situation to an upside-down pyramid: the tip of the pyramid rests on a single unstable point – the diagnostic criteria for major depression in *DSM-III*. If the definition is faulty and does not distinguish well between reactive and endogenous depressions, then the scientific research will be contradictory, inconclusive, and filled with confounds. And indeed this has largely been the case for studies of the biology of depression.

In their influential 2007 book, *The Loss of Sadness*, Horwitz and Wakefield outline the argument I have made above: that historically there have been two forms of depression, caused and uncaused, and *DSM* has blurred the boundaries. However, they further make the case for the return of the recognition on the part of Western psychiatrists that sadness is a normal reaction to loss, and that the experience of loss is a part of the human condition. Most sadness, in their view, is reversible with a change of life
conditions, or psychotherapy, and does not require a medical diagnosis or pharmacological treatment.

Horwitz and Wakefield’s book has generated considerable attention in the psychiatric community because it includes a foreword by Robert Spitzer – the prime editor and author of *DSM-III*. Spitzer, as it turns out, has changed his mind. He now understands the mess caused by *DSM’s* rejection of the context in which depression arises. He admits that this mistake has poisoned the large scale epidemiological research studies of depression, leading to the conclusion that it is more common than may really be the case. Without doing so explicitly, Spitzer is implicitly criticizing the World Health Organization’s claim that depression will be the number one cause of disability in the world by the year 2020. He is also casting doubt on the vast amount of research into the biology of depression. However, although he acknowledges that ignoring the context of a person’s life that may give rise to depression was a mistake, he remains skeptical that a way could be found to incorporate this new perspective into *DSM-V*.

So what does the future hold? Melancholia may return to official American psychiatry as the term for the “uncaused” and presumable biologically-based form of depression. The Mood Disorders may very well return to Emil Kraepelin’s notion that they are almost all aspects of a single underlying disorder that will be called manic-depressive illness once again or bipolar spectrum disorders. The definition of the Mood Disorders will probably widen to include many forms of bipolar disorder that shade into the normal fluctuations of mood, with almost no room left for identifying what “normal” mood fluctuations may be. Indeed, the pharmaceutical industry has long been funding researchers who promote this bipolar spectrum idea, in part to widen the number of
persons who can receive a diagnosis so that they can be prescribed medications for them. The medicalization of human existence has reached deep into the lives of everyday people in North America, and whereas 30 years ago most Americans and Canadians would have been reluctant to seek out medication for sadness or anxiety, today they flock to their general practitioners in massive numbers to gain access to the continuous stream of new medications introduced every year for depression and anxiety.

I have approached the problem of depression from an historical perspective in the hope that these shifting political views in American psychiatry might provide a context for the critical evaluation of American concepts by those of you here in India who may be unaware of these debates. I believe an awareness of the Western debates about what constitutes depression will be of direct relevance to the students of Montfort College who are now be trained to counsel persons in distress. I am also hoping to stimulate a discussion that will enlighten me as the perspective of Indian psychiatry regarding the treatment of depression in India.

Thank you.

References


