BJPsych The British Journal of Psychiatry (2011) 199, 512–519

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Edited by Kiriakos Xenitidis and Colin Campbell

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Depression: a cultural panic attack

Mario Maj overlooks the wider importance of an evolutionary perspective in discussing when depression becomes a mental disorder.[1] He rejects the contextual approach, which considers whether depression is a normal response to circumstances, because of the difficulty of being certain that it is a proportionate response to specific adverse circumstances and the consequent low reliability of the clinician's judgement. However, the contextual approach does at least have a significant degree of validity, which is lacking in the current DSM-IV criteria. These are the equivalent of classifying any tachycardia, in excess of a particular rate or duration, as abnormal without considering whether it is occurring in the context of exercise or stress.

We recognise sadness or depression as the normal response to a range of major losses (including bereavement). There is evidence that it occurs as a consequence of evolutionary design, in view of the presence of equivalent responses in non-human primates, the response of human infants to the loss of a caregiver before socially acceptable responses are learnt, and cross-cultural universality (with a degree of cultural shaping). Specific mood states may give evolutionary advantages in particular situations that have been faced recurrently over evolutionary time. The possible benefits that depressive symptoms conferred, leading to their natural selection over the course of human evolution, include protection from aggression after losses of status, attraction of social support, and promotion of disengagement from non-productive activities.[2]

Depressive responses probably developed within small, egalitarian, cohesive, hunter–gatherer societies on the African plains. Modern humans have moved away from the support of close relatives to function within many larger, less supportive groups. In these, they are subject to the mass media, which encourages comparison to others of higher status, motivating the pursuit of unreachable goals.[3] The depressive response mechanisms may be functioning normally in environments to which our brains have not yet had sufficient time to adapt. The intensity of response to loss exists on a continuum within the population, related to the meaning of the loss for the individual and their underlying personality, and it is accepted that the precise boundary between normal and abnormal responses is unclear. Yet, it is when depression is not proportionately related to real losses that it is truly disordered, and we risk excessively pathologising depression if we fail to consider context.

A tachycardia is the normal cardiac response to exercise and stress, and a cognitive misinterpretation of the tachycardia can lead to a panic attack. Sadness or depressed mood are the normal response to loss, and our current cultural misinterpretation of the significance of these symptoms could be considered a cultural panic attack or health anxiety. This has consequences. Patients may be encouraged to consider themselves disordered and receive unnecessary treatment. Even if response to antidepressant medication is unrelated to preceding life events, this would not mean that a disorder is being treated. Psychiatric research into depression may be flawed because of the failure to distinguish normal from abnormal responses of the brain. There may also be a failure to adequately relate sadness to adverse social conditions, and a simultaneous promotion of a lack of resilience in society.

Allen Frances, the chair of DSM-IV, now believes that these flaws in research contributed to a false-positive epidemic of diagnoses of psychiatric disorder exacerbated by drug company marketing. He argues that the current DSM-5 draft will exacerbate this epidemic because of lowering of the threshold for diagnosis.[4] Disconcertingly, in this draft (www.dsm5.org) the Workgroup on Mood Disorders, of which Mario Maj is a member, proposes not the encouragement of an understanding of depressive symptoms in terms of the meaning to an individual of particular adverse circumstances, but instead the removal of even the bereavement exclusion from the diagnosis of major depressive disorder, thereby removing context completely from diagnosis, exacerbating our current cultural misunderstanding and promoting the over-medicalisation of everyday life.[5] Worrying times, exacerbated by the lack of an evolutionary perspective.

1 Maj M. When does depression become a mental disorder? *Br J Psychiatry* 2011; **199**: 85–6.

2 Horwitz AV, Wakefield JC. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. Oxford University Press, 2007.

3 James O. *Affluenza*. Vermillion, 2007.

4 Frances A. The first draft of DSM-V. *BMJ* 2010; **340**: c1168.

5 Wakefield JC. Misdiagnosing normality: psychiatry's failure to address the problem of false-positive diagnoses of mental disorder in a changing professional environment. *J Ment Health* 2010; **19**: 337–51.

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doi: 10.1192/bjp.199.6.512

The discussion by Maj[1] can be related to a recent article by Huber *et al*[2] in the *BMJ* reviewing the definition of health. The authors propose a definition of health on the basis of an individual's ability to react to perturbations in their physiological or psychological state – thus, a healthy individual can respond appropriately to the challenge of a viral infection or life event. Failure of the appropriate coping strategy, whether physiological (e.g. an inflammatory response) or psychological (e.g. a defence mechanism) leads to illness. Social health is proposed to be the ability to respond to opportunities despite limitations imposed by ill health. Huber *et al* suggest that health be measured through assessment of biological, psychological and social domains using instruments such as COOP/Wonca Functional Health Assessment Charts[3] or World Health Organization measures.[4]

A similar idea is contained in DSM-IV-TR, in the Global Assessment of Functioning Scale.[5] Perhaps an adaptation of this could be used to provide a unifying measure of severity and definition of mental disorder. Diagnosis could be based on the presence of symptoms and their duration, and the use of a uniform health rating scale for all disorders would allow for severity grading. Treatment would remain symptom directed, but the increased information provided by structured assessment

https://doi.org/10.1192/bjp.199.6.512a Published online by Cambridge University Press

would allow it to be focused on specific psychological and social domains. Overall distinction between mental health and disorder would be determined by the impact of symptoms on global assessment of health.

1 Maj M. When does depression become a mental disorder? *Br J Psychiatry* 2011; **199**: 85–6.

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3 Nelson E, Wasson J, Kirk J, Keller A, Clark D, Dittrich A, et al. Assessment of function in routine clinical practice: description of the COOP Chart method and preliminary findings. *J Chron Dis* 1987; **40** (suppl 1): 55S–63S.

4 World Health Organization. *WHO Family of International Classifications*. WHO, 2011 (http://www.who.int/classifications/en).

5 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (4th Edn, Text Rev) (DSM-IV-TR)*. APA, 2000.

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doi: 10.1192/bjp.199.6.512a

Author's reply: Dr Geaney echoes arguments put forward for many years by Jerome Wakefield and already extensively addressed in the literature (e.g. Kendler,[1] Murphy & Woolfolk[2]). Indeed, the evolutionary approach may help us to understand how and why depression has developed in the human species as a response to major losses. However, the relevance of that approach to ordinary clinical practice (i.e. in helping the clinician to discern whether the depressive state of a given individual is a mental health problem deserving clinical attention) is, at the present state of knowledge, very doubtful, and the risk of 'over-romanticizing the suffering associated with major depression'[1] is very high.

Wakefield himself has documented that as many as 95% of depressive episodes seen in the community are triggered by an adverse life event, according to the affected person's report.[3] This is not surprising, because many people with depression try to find a meaning in their current state, ascribing it to a recent event. Whether there is really a causal relationship between the event and the depressive state, what is the direction of that relationship, and whether the depressive state is 'proportionate' or not to the event is very difficult or even impossible to establish reliably in the vast majority of cases. This was already acknowledged by Sir Aubrey Lewis many decades ago, when he tried to apply a set of criteria aimed to distinguish 'contextual' from 'non-contextual' depression and had to conclude that almost all cases he had encountered were 'examples of the interaction of organism and environment, i.e. personality and situation; it was impossible to say which of the factors was decidedly preponderant'.[4]

Actually, whether there is something like a 'normal' or 'proportionate' response to a given life event is highly debatable. Even when exposed to the most extreme life event, the majority of people will not develop a depressive state. Which 'standard' are we going to apply when deciding whether a given depressive response is proportionate or not to a given life event? Are we aware that there are mental health professionals who do believe that every psychopathological manifestation can be 'explained' by the individual's environmental circumstances? Would we feel comfortable in basing the diagnosis of depression on that subjective judgement?

In addition to having poor reliability, the proposed 'contextual' exclusion criterion does not seem, at the current state of knowledge, to have a significant clinical utility (the main element which is being taken into account in the revision of ICD-10 and DSM-IV). Currently available evidence suggests that the response of a depressive state to pharmacological treatment does not depend on whether that state was or was not preceded by an adverse life event.[5] Furthermore, interpersonal psychotherapy is based on the assumption that depression is often understandably related to a disturbing life event, such as a loss, a role dispute or a role transition, and that 'if the patient can solve the life problem, depressive symptoms should resolve as well'.[6] Should we conclude that all cases in which interpersonal psychotherapy is effective are not 'true' cases of depression?

Finally, that the 'proportionality' criterion enables us to 'distinguish normal from abnormal responses of the brain', or to identify those depressive states in which there is 'a failure of some internal mechanism to perform a function for which it was biologically designed (i.e. naturally selected)',[7] is at the moment an interesting theoretical assumption with no empirical basis. In Arthur Kleinman's words, 'the data on this allegedly universal biology of loss are simply not there'.[8]

Dr Shepherd's comment clarifies that the mere diagnosis of depression is not sufficient to guide decisions concerning management. The assessment of the severity of the clinical picture and the characterisation of the individual case on biological, psychological and social domains are essential for that purpose. Both DSM-IV and ICD-10 identify different degrees of severity of depression based on the number of symptoms and the entity of functional impairment. However, the conceptualisation of functional impairment in both systems is too vague and depends too much on the subjective judgement of both the patient and the clinician. In the new edition of the two diagnostic systems, it will be necessary to anchor the assessment of functional impairment to clear and objective variables.

Furthermore, as Dr Shepherd implies, the functional status of a person with depression depends not only on the depressive state *per se*, but also on the multiple physical and mental conditions which commonly co-occur, so that a global assessment of functioning may be more relevant for management purposes. Ideally, that assessment should be as comprehensive as Dr Shepherd suggests, but the search for comprehensiveness will have to be balanced with the need to ensure feasibility (as well as reliability) in ordinary clinical practice.

Declaration of interest

M.M. is President of the World Psychiatric Association, member of the Workgroup on Mood Disorders for DSM-5, and Chairperson of the Working Group on Mood and Anxiety Disorders for ICD-11. He has no financial conflict of interests.

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doi: 10.1192/bjp.199.6.513

https://doi.org/10.1192/bjp.199.6.512a Published online by Cambridge University Press