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WHEN DOES DEPRESSION BECOME A MENTAL DISORDER?

M. Maj

Department of Psychiatry, University of Naples, Naples, Italy

Major depressive disorder is reported to be the most common mental disorder, with a lifetime prevalence in the community ranging from 10 to 25% in women and from 5 to 12% in men. These figures are frequently quoted in the psychiatric literature, but are viewed by many, both outside and within the psychiatric field, with a substantial degree of skepticism. From outside the psychiatric field, it has been pointed out that “determining when relatively common experiences such as sadness should be considered evidence of some disorder requires the setting of boundaries that are largely arbitrary, not scientific, unlike setting the boundaries for what constitutes cancer or pneumonia” (1). From within the psychiatric field, it has been stated that “based on the high prevalence rates identified in both the ECA and the NCS, it is reasonable to hypothesize that some syndromes in the community represent transient homeostatic responses to internal or external stimuli that do not represent true psychopathologic disorders” (2). It is likely that these arguments will be increasingly endorsed by the public opinion in the years to come, and it is therefore crucial for our profession to articulate a convincing response to the question “When does depression become a mental disorder?”. In this presentation, I will summarize three approaches to this issue, pointing out their weaknesses and the lessons we may take from each of them. The first approach is the one proposed by Wakefield (3), emphasizing the context in which depressive symptoms occur. The second approach is the one endorsed by several European psychopathologists, according to whom there is a qualitative difference between true depression and normal sadness, a difference which has been lost in the recent process of oversimplification of psychopathology. The third approach is the one according to which, since there is a continuity between “normal” sadness and clinical depression, the boundary has to be decided arbitrarily on pragmatic grounds. This is what the DSM-IV actually tries to achieve, regarding depression as a “disorder” when it reaches a given threshold in terms of severity, duration and degree of suffering or functional impairment, thus deserving clinical attention. The problem is, however, that the threshold fixed by the DSM-IV for the diagnosis of major depression is not only arbitrary, but also not based on reasonably solid pragmatic grounds (4).

References:

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3. Wakefield JC. Psychol Rev 1992;99:232-247.
4. Maj M. Am J Psychiatry 2008;165:1373-1375.