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Creating an Age of Depression: The Social Construction and Consequences of the Major Depression Diagnosis

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Abstract

One type of study in the sociology of mental health examines how social and cultural factors influence the creation and consequences of psychiatric diagnoses. Most studies of this kind focus on how diagnoses emerge from struggles among advocacy organizations, economic and political interest groups, and professionals. In contrast, intraprofessional dynamics rather than external pressures generated perhaps the major transformation resulting from the *Diagnostic and Statistical Manual of Mental Disorders*, third edition, diagnostic revolution in 1980—the rise of Major Depressive Disorder as the central diagnosis of the psychiatric profession. Other interests, including the drug industry and advocacy groups, capitalized on the features of this diagnosis only after its promulgation. The social construction of depression illustrates how social and cultural processes can have fundamental influences over diagnostic processes even in the absence of struggles among forces external to the mental health professions. It also indicates how diagnoses themselves can have major professional, economic, political, and social consequences.

Keywords

major depression, *DSM*, diagnoses, social construction

Most studies in the sociology of mental health examine the psychological consequences of stressful social arrangements (e.g., Aneshensel 1992; Pearlin 1989; Schwartz 2002). These studies treat mental health outcomes as aspects of individuals and explore how properties of social systems relate to psychological well-being. A less common type of study in this field treats outcomes as components of cultural systems rather than as individual states of mind. Psychiatric diagnoses are particularly important objects of explanation for culturally based studies because they organize the fundamental subject matter of the medical and mental health professions, provide legitimacy to professional practice, create boundaries between normality and pathology, organize illness experiences, and shape what interests can profit from treating diagnosable conditions. Despite the fundamental importance of these processes, the study of how various diagnoses arise, become institutionalized, change over time, and have consequences for social practices remains an underdeveloped field of study (Brown 1995; Jutel 2009).

In general, the sociology of psychiatric classification has viewed diagnoses as resulting from

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political struggles, powerful economic interests, and compelling moral narratives that pit medical professionals against lay advocacy groups. Most studies in the area examine how political and economic forces shape the development of conditions including posttraumatic stress disorder (PTSD; Scott 1990), fibromyalgia (Hadler 1996), and adult attention deficit/hyperactivity disorder (Conrad 2007). A related body of research emphasizes the influential role of the pharmaceutical industry in creating new diagnostic categories (Conrad 2005; Moynihan and Cassels 2005; Payer 1992). Other studies focus on social movements that try to demedicalize conditions such as female sexual dysfunction (Tiefer 2006), homosexuality (Bayer 1987), or premenstrual syndrome (Figert 1996).

Depression is a particularly important object for studies that examine how social and cultural forces affect the emergence and consequences of diagnoses. One reason is that Major Depressive Disorder (MDD) has become the most dominant diagnostic category of the psychiatric profession and the major vehicle of psychiatry's medical and social success. Shortly after the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (*DSM-III*), in 1980 by the American Psychiatric Association (APA), MDD became the most common mental health condition in medical and psychiatric practice, constituting about 40 percent of all diagnoses (Olfson et al. 2002). Another indicator of the prominence of depression is that, while psychiatric research was evenly distributed across the major categories of depression, anxiety, and schizophrenia in 1980, since that year research about depression has grown far more rapidly than studies of other conditions, to become the single largest object of investigation (Horwitz and Wakefield 2007). In addition, depression is claimed to be the most important threat to public health of any mental health condition; the oft-encited World Health Organization (WHO) report indicates that depression is the leading cause of disability for 15- to 44-year-olds and by 2020 will trail only heart disease as the most disabling condition among all age groups worldwide (Murray and Lopez 1996). Finally, depression has become the most emblematic mental illness in the broader culture, with a number of scholars suggesting that an Age of Depression has replaced the Age of Anxiety (Blazer 2005; Ehrenberg 2010; Hirshbein 2009; Horwitz 2010; Horwitz and Wakefield 2007).

This article examines several aspects surrounding the construction and employment of the major depression diagnosis in the *DSM-III* of the APA (1980). First, it indicates that the *DSM-III* definition of MDD was not the result of the development of a well-established body of research but instead was grounded in attempts by one wing of the psychiatric profession to gain professional dominance and scientific legitimacy and to distinguish itself from professional competitors. Second, although psychiatrists were sensitive to economic and political pressures for explicit and reliable diagnostic criteria, intraprofessional rather than external political and economic dynamics drove the creation of the MDD category. Third, it shows how the *DSM-III* diagnostic criteria transformed a condition that was thought to be very serious and rare into one that was extremely common. A number of interest groups capitalized on this aspect of the MDD diagnosis and shaped it to their own ends. The unintended consequence of the diagnostic criteria was the emergence of an age of depressive disorder.

DEPRESSION BEFORE THE *DSM-III*

The *DSM-I* (APA 1952) and *DSM-II* (APA 1968), the two manuals that preceded the *DSM-III*, primarily viewed depression as a psychotic disorder. They characterized it as a chronic and very severe condition often marked by gross misinterpretations of reality, delusions, hallucinations, and vegetative states (APA 1952:25). These manuals associated depression with conditions that typified the conditions of hospitalized patients more than the symptoms of the clients of general physicians or outpatient psychiatrists.

While these initial manuals connected depression with severe mental illness, following the dominant psychodynamic theory that influenced their classifications, they considered anxiety to be the central psychoneurotic condition. In contrast to the prominence these manuals accorded psychotic forms of depression, they viewed psychoneurotic depression as one type of defense mechanism against anxiety. The very first sentence of the *DSM-I* classification of psychoneurotic disorders stated, "The chief characteristic of these disorders is 'anxiety' which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense

mechanisms (depression, conversion, displacement, etc.)" (APA 1952:31). During the 1950s and much of the 1960s, nonpsychotic forms of depression were largely submerged into the broader conception of psychoneuroses.

Diagnostic practices in the 1950s and early 1960s reflected the relative prominence the manuals accorded to anxiety compared to depression (Horwitz 2010). In 1962, for example, anxiety was the most prevalent psychoneurotic condition: About 12 million patients received diagnoses of anxiety reactions, compared with just 4 million with diagnoses of neurotic depression (Herzberg 2009:260). One large study at the time found an even larger disparity: Three quarters of neurotic patients received anxiety diagnoses, whereas most of the rest were simply considered "neurotic." In contrast, depression was "absent from the diagnostic summaries" (Murphy and Leighton 2008:1057). Beginning in the 1960s, clinicians and researchers started to pay more attention to depression, and by the end of the decade the disparity between anxiety and depressive diagnoses had narrowed. Nevertheless, anxiety was still far more commonly diagnosed: By 1968 depressive diagnoses in outpatient treatment grew to 8 million, whereas those of anxiety remained at around 12 million (Herzberg 2009:260).

While psychotic forms of depression were central to psychiatric theory, research, and practice before 1980, diagnostic chaos reigned in the study of neurotic depression (Grob and Horwitz 2010:chap. 6). Most researchers argued that melancholic (or psychotic) depression—a particularly serious state marked by vegetative symptoms, delusions, and hallucinations—was a distinct type of disorder (e.g., Kiloh and Garside 1963; Klein 1974; Mendels and Cochrane 1968; Paykel 1971). While researchers concurred that a separable, psychotic form of depression existed, they could not agree about the nature of nonpsychotic types of depression. One unresolved controversy was over whether depressive illnesses fell on a continuum or were categorical (Kendell and Gourlay 1970). Another was that diagnosticians who argued for discrete types could not agree on how many types existed. Some concluded that depression had a single neurotic type, as well as a melancholic, psychotic type (Kiloh and Garside 1963). Others suggested that three or more distinct, neurotic states of depression existed (Hamilton and White 1959; Paykel 1971; Raskin and Crook 1976). Various classifications of depression embraced from a single to as many as nine or more separate categories (Kendell 1976). Still others conceived of neurotic depression as more closely resembling a personality or temperament type than a disease condition (Eysenck 1970). Disputes abounded over whether depression should be classified according to its symptoms, etiology, or response to treatments (Ehrenberg 2010).

In 1976 the prominent psychiatric diagnostician R. E. Kendell published an article whose title accurately conveyed the situation at the time: "The Classification of Depressions: A Review of Contemporary Confusion." He outlined 12 major systems of classification, most of which had little to do with the others. Kendell (1976:25) concluded that "there is no consensus of opinion about how depressions should be classified, or any body of agreed findings capable of providing the framework of a consensus." In 1979, just a year before the publication of the *DSM-III*, psychiatrists Nancy Andreasen and George Winokur (1979) likewise noted the presence of "a hodgepodge of competing and overlapping systems" in research about depression. Like the other major diagnoses in psychiatry at the time, opinions regarding the classification of depression at the end of the 1970s featured an extraordinarily broad range of unresolved conflicts on how to best measure this condition.

The Feighner Criteria

One of the 12 classifications of depression that Kendell reviewed in his 1976 article was "The St. Louis Classification," developed by a group of psychiatrists at Washington University. During the era when psychodynamic perspectives dominated the psychiatric profession, the Washington University Department of Psychiatry was an outpost of traditional medically minded thinking. Led by Samuel Guze and Eli Robins, this group's primary concern was to develop a reliable system of diagnosis that could differentiate the etiology, prognosis, and drug responses of various conditions. They developed operational criteria for 14 disorders, known as the "Feighner criteria" after the psychiatric resident who was the first author of the article that described them (Feighner et al. 1972).

The Feighner criteria for depression required fulfillment of three conditions. First, patients must have a dysphoric mood marked by

symptoms such as being depressed, sad, or hopeless. Second, the criteria required five additional symptoms from a list, including loss of appetite, sleep difficulty, loss of energy, agitation, loss of interest in usual activities, guilt feelings, slow thinking, and recurrent suicidal thoughts. Finally, the condition must have lasted at least one month and not be due to another psychiatric or medical illness. Patients whose symptoms arose from preexisting mental or physical illnesses would receive a diagnosis of a secondary affective disorder.

What was the basis for the Feighner criteria of depression? In contrast to the widespread belief that a strong empirical research base underlay the diagnostic criteria leading to the *DSM-III* (e.g., Kendler 1990; Sabshin 1990), in fact, the evidence supporting its classification of depression was very limited. Only one of the five publications cited in the footnotes to the article provided empirical substantiation for the depression criteria (another citation refers to unpublished research by Robins and Guze). This was a study by psychiatrist Walter Cassidy and several colleagues that reported findings from a quantitative study of 100 patients called "manic-depressive" and 50 medically sick controls (Cassidy et al. 1957).

The Cassidy et al. (1957:1535) criteria for depression required that patients

> (a) had made at least one statement of mood change, including any of the following: blue, worried, discouraged, and 16 equivalent expressions and (b) had any 6 of the 10 of following special symptoms: slow thinking, poor appetite, constipation, insomnia, feels tired, loss of concentration, suicidal ideas, weight loss, decreased sex interest, and wringing hands, pacing, overtalkativeness, or press of complaints.

Feighner himself noted that he "relied a lot on an article by Cassidy," and his eponymous criteria made only four relatively small changes to these conditions, dropping constipation, adding feelings of self-reproach or guilt, expanding insomnia to encompass sleep difficulties, and combining weight loss with anorexia into one item (Kendler, Munoz, and Murphy 2010). In addition, the Cassidy diagnostic criteria did not mention any necessary duration of symptoms, perhaps because all patients in their study were hospitalized and most had symptoms that endured for more than six months. The Feighner criteria added the stipulation that the symptoms must last for at least one month, a far shorter duration than that typifying the Cassidy hospitalized sample.

Several aspects of the Cassidy criteria are noteworthy. First, all of the patients in the sample were "considered sick enough to require hospital observations, and in most cases the patients were admitted for electroconvulsive treatment" (Cassidy et al. 1957:1535). The diagnosis was thus grounded in symptoms that characterized state hospital patients, which could differ substantially from those found in outpatient settings or acute psychiatric wards, not to mention untreated community populations. In addition, Cassidy et al. (1957:1542) recognized the inexact nature of their criteria, stating, "The question immediately arises as to whether all these patients did, in fact, have manic-depressive disease. At present, one cannot go beyond saying that the patients had a psychiatric illness. . . ." In particular, the Cassidy group noted the unresolved relationship of manic-depressive disease to patients with melancholia, manic-depressive psychoses, anxiety, alcoholism, and manic-depressive personality types. They clearly believed that their diagnostic criteria were highly exploratory and far from the last word on depressive diagnoses and their relationship to criteria for other diagnoses.

Likewise, the Feighner group presented their criteria as a tentative first step that awaited future validation and noted that they were "not intended as final for any illness" (Feighner 1972:57). Similarly, Kendell (1976:25) did not place any special priority on the Feighner measurement of depression, noting that "no evidence has been offered to suggest that it is anything more than a convenient strategy." Yet, just four years after Kendell made this assessment, the Feighner classification of depression became virtually the sole basis for the *DSM-III* diagnosis; indeed, by 1989, the article in which the Feighner criteria first appeared was the single most cited article in the history of psychiatry (Feighner 1989). In a remarkably short period of time, the process of diagnosing depressive disorder was transformed from a contentious battle among many competing systems to the unchallenged dominance of a single classification, the *DSM-III* diagnosis of MDD. How did this hegemony come about?

The DSM-III

During the 1970s, the classification system of psychodynamic psychiatry embodied in the *DSM-I* and *DSM-II* came to pose serious problems of legitimacy for the profession. Precise diagnoses provide the foundation of medical authority (Friedson 1972; Rosenberg 2008). These manuals, however, focused on understanding underlying unconscious mechanisms; they did not develop clear definitions of specific mental illnesses. Researchers and clinicians had trouble identifying and specifying disease conditions. Other medical specialists viewed psychodynamic psychiatry as more of an art than a science and as a field lacking the kinds of discrete disease entities that were foundational for any respectable medical discipline. Research indicated that psychiatry could not diagnose its most basic entities (Cooper et al. 1972). Moreover, the profession was mocked in the broader culture for its inability to even recognize what mental illness was (e.g., Rosenhan 1973; Szasz 1974). The spread of third-party reimbursement led to growing concerns about the ability of psychiatrists to be paid for treating the murky psychodynamic entities of the extant diagnostic manual. The growing importance of psychopharmacology also increased the importance of knowing what specific disease conditions were the objects of treatment.

The perception of the unscientific character of psychiatry was especially troublesome because the profession faced intense competition from nonmedical professionals including clinical psychologists, counselors, and psychiatric social workers (Abbott 1988). These professionals seemed as qualified as psychiatrists to treat the sorts of psychosocial problems that the dynamic paradigm emphasized. Psychiatry could only secure a unique medical identity through establishing a diagnostic system based on discrete disease entities analogous to the conditions that other medical specialties treated. Such a diagnostic system would both establish psychiatry's primary jurisdiction over the care and treatment of a well-defined and reliably measured group of medical conditions and protect it from challenges from other professions.

The social and cultural context surrounding psychiatry in the 1970s led the times to be ripe for a scientific revolution in the classification of mental disorders. In 1974, the APA appointed a prominent research psychiatrist, Robert Spitzer, to head the task force charged with revising the *DSM-II*. Spitzer was a close collaborator of the Washington University group, working with Eli Robins and his wife Lee Robins to develop the research diagnostic criteria (RDC), which operationalized the Feighner criteria for use in standardized interviews and research. The two major goals of Spitzer and his allies, whom he appointed to the various committees charged with developing particular diagnostic categories, were, first, to create a classificatory system based on the manifest symptoms that each condition displayed and, second, to purge the new manual of psychodynamic etiological inferences (Bayer and Spitzer 1985). For example, the *DSM-II* definition of depression had stated, in its entirety, "This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession" (APA 1968:40). This definition not only was useless for research purposes but also embodied assumptions about psychosocial causation that were unacceptable to the newly emerging group of biologically oriented psychiatrists surrounding Spitzer who were beginning to become a dominant force in the profession.

The *DSM-III* revolutionized psychiatric classification by developing explicit definitions of several hundred diagnostic entities, including depressive disorders, which remain the standard of what counts as a mental disorder (Horwitz 2002; Kirk and Kutchins 1992; Klerman 1983; Wilson 1993). At the heart of the construction of the new diagnostic system was the struggle between Spitzer and his allies who were committed to developing reliable, operationalized definitions for each disorder and psychiatrists who embraced psychodynamic assumptions about the causes of mental disorders. The triumphant research-oriented psychiatrists insisted that the only solution to the diagnostic confusion regarding depressive disorders was to give up the attempt to use any underlying pathology, unconscious dynamics, life history, or personality as the basis for diagnostic criteria (Wilson 1993).

The definition of MDD in the *DSM-III* required either a dysphoric mood or a loss of interest or pleasure in usual activities. In addition, at least four of the following symptoms must be present nearly every day for a period of at least two weeks: (1) poor appetite or significant change in weight; (2) insomnia or hypersomnia; (3)

psychomotor agitation or retardation; (4) decreased sexual drive; (5) fatigue or loss of energy; (7) feelings of worthlessness, self-reproach, or excessive or inappropriate guilt; (8) diminished ability to think or concentrate or indecisiveness; (9) recurrent thoughts of death or suicidal ideation or suicide attempt (APA 1980:213).

These criteria almost completely mirrored the Feighner criteria, which themselves closely resembled the original Cassidy diagnosis. The only major changes the *DSM-III* made to the Feighner criteria were to, first, exempt from diagnosis anyone who meets these symptom criteria if his or her symptoms are due to bereavement after the death of a loved one that lasts no more than two months and are not of extreme severity (APA 1980:214).[1] The earlier criteria, in contrast, contained no exceptions except for symptoms that arose from a preexisting mental or physical condition. Second, the *DSM-III* lowered the necessary duration of symptoms from one month to two weeks. Finally, the *DSM-III* abandoned the differentiation that Kendell (1976:23) had considered at the core of the Feighner criteria: "The most important feature of this classification is the distinction it draws between primary and secondary affective disorders."

The choice of the Feighner criteria from among the many possible diagnostic schemas as the basis of the *DSM-III* MDD diagnosis stemmed from the close collaborative relationships between Spitzer and the Washington University psychiatrists. Samuel Guze (2000) notes that Spitzer worked "hand in glove" with his group. Fully half of the psychiatrists Spitzer named to the *DSM-III* task force had a current or past affiliation with the St. Louis group (Wilson 1993). The five members of the particular Advisory Committee on Schizophrenia, Paranoid, and Affective Disorders whose work primarily concerned depression were Spitzer himself; his two close collaborators from Columbia, Jean Endicott and Janet Williams (Spitzer's wife); and two Washington University psychiatrists, Paula Clayton and Robert Woodruff. Every member of the depression subgroup was therefore part of the research network centered on the Washington University group members and their allies at Columbia (Grob and Horwitz 2010). All shared a commitment to using symptom-based diagnoses that could be precisely measured; none represented the analytic, or any other, wing of the profession. While the broader professional need for scientific credibility and legitimacy mandated that psychiatry create a reliable and scientific diagnostic system, the close professional affiliations among the group members, as well as their shared commitment to establishing a medically based classification system, led to the particular adoption of the Feighner criteria and the RDC instrument that Spitzer had derived from them as the foundation of the *DSM-III* depression diagnosis.

The pharmaceutical industry, insurance companies, lay advocacy groups, or other third parties were not involved in the deliberations of the task force that constructed the depression diagnoses. Indeed, with the notable exception of the PTSD diagnosis (Scott 1990), the development of the *DSM-III* was remarkably free from participation of groups or interests external to the psychiatric profession. Certainly, the group constructing the *DSM-III* was intensely concerned with external pressures on the profession to create a specific, categorical diagnostic system (Mayes and Horwitz 2005; Wilson 1993). For example, Samuel Guze (2000:20) quotes one member of the *DSM-III* working group who opposed Guze's suggestion for a more tentative and incomplete diagnostic system as saying, "If we do what you're proposing, which makes sense to us scientifically, we think that not only will we weaken what we are trying to do but we will give the insurance companies an excuse not to pay us." Nevertheless, no outside advocacy groups participated in the development of the MDD diagnostic criteria.

The MDD diagnosis that emerged in the *DSM-III* was in many ways a major achievement. It succeeded in establishing a single standard of measurement that has been almost universally adopted in psychiatric research on depression (McPherson and Armstrong 2006). It has thus facilitated communication and understanding among the research community and provided diagnostic criteria that clinicians and researchers from a variety of theoretical persuasions can use. In addition, it realized the major aim of Spitzer and his colleagues to create a reliable way of measuring depression.

While the MDD diagnosis was a major accomplishment for research-oriented psychiatrists, it also entailed serious deficiencies. The emphasis on creating measurable and reliable diagnoses, which were necessary to legitimize the psychiatric profession, came at the expense of establishing validity. The *DSM* itself defines a valid mental

disorder as a dysfunction in the individual that "must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one" (APA 1994:xxi). In line with this definition, the MDD criteria exclude bereaved people from diagnoses unless they have particularly severe or long-standing systems. The criteria do not, however, exclude people whose symptoms arose from other life events such as the dissolution of a romantic relationship, loss of a valued job, or failure to achieve a long-desired goal. Such people do not have individual dysfunctions but are responding naturally to undesirable losses in their lives (Horwitz and Wakefield 2007).

The failure to include exclusions other than bereavement enhances the reliability of the MDD diagnosis because clinicians and researchers might disagree on whether or not depressive symptoms represent appropriate contextual responses. Yet, the use of symptoms themselves without regard to the context in which they develop and are maintained (aside from bereavement) conflates nondisordered people whose symptoms result from some loss with those whose symptoms either are inexplicable or are disproportionate to their social contexts. Likewise, the criteria encompass conditions that are as brief as two weeks as well as those that persist for long periods of time. They also treat such severe symptoms as suicide attempts or feelings of worthlessness as comparable to such common symptoms as insomnia and fatigue. The result is that the MDD diagnosis encompasses an extraordinarily heterogeneous range of conditions under a single label.

The many issues that the varied classifications of depression could not resolve before the publication of the *DSM-III*—for example, how many distinct types of depression existed? What was the relationship between psychotic and neurotic forms of depression? Is depression best measured by dimensions or categories?—were settled by fiat. Although the Feighner group framed its criteria as a tentative first step toward the eventual establishment of a reliable and valid classification scheme, the *DSM-III* adopted these criteria with few changes. Moreover, the MDD criteria have remained virtually intact in subsequent manuals, the *DSM-III-R*, *DSM-IV*, and *DSM-IV-TR* (APA 1987, 1994, 2000). The wholesale, and largely arbitrary, adoption of one among a number of competing ways of defining depression perhaps accounts for why—30 years after its promulgation—research on depression has yet to yield any major breakthroughs in the understanding of the etiology, prognosis, or treatment of this condition (Blazer 2005; Horwitz and Wakefield 2007; Shorter 2009).

THE CONSEQUENCES OF THE MAJOR DEPRESSION DIAGNOSIS

MDD has had a dramatic effect on changing mental health practice, research, epidemiology, and treatment. It became—aside from bipolar conditions—the single dominant category of mood disorder. In contrast to the sharp split of depression into psychotic and psychoneurotic forms in the *DSM-I* and *DSM-II*, MDD embraced both unipolar psychotic and psychoneurotic forms of depression. Melancholic depression—the central depressive condition before the *DSM-III*—became a subcategory of MDD (APA 1980:215). People could only qualify for a diagnosis of melancholy, which required symptoms of greater severity in the morning, early-morning awakening, marked psychomotor retardation, weight loss, and excessive guilt, if they already had met the criteria for MDD. The submersion of melancholia into the broader MDD category ensured its fall into obscurity (McPherson and Armstrong 2006; Zimmerman and Spitzer 1989). Likewise, the category of Dysthymic Disorder (or Neurotic Depression), which was inserted into the manual to mollify the psychodynamic group, never gained traction as a well-established disorder (Bayer and Spitzer 1985; McPherson and Armstrong 2006). Indeed, because this diagnosis required *two-year* duration it was inherently applicable to only persons with the most long-standing types of mood disorder. Major depression was the sole depressive diagnosis of any importance.

The MDD category thus encompassed all of the heterogeneous categories of endogenous, exogenous, and neurotic forms of depression that existed before 1980. MDD captured both amorphous and short-lived psychosocial problems as well as serious and chronic conditions that in the past had been associated with melancholic depression. Brief reactions to life stressors could be equated with the serious and long-standing conditions associated with the most impaired depressive conditions. This heterogeneous quality of the MDD diagnosis was especially consequential

when the diagnosis was used outside of hospital settings.

Recall that the foundation of the MDD diagnosis, the Feighner criteria, transferred measures developed in hospitalized populations of severely impaired patients to deal with all depressive conditions. Within hospitalized populations, the symptoms comprised in the diagnostic criteria can be assumed to be severe and, usually, long lasting. Yet, MDD is used not just in inpatient institutions but in all settings that require diagnoses, including general medical practice, private mental health practice, and clinics. It is also the diagnosis used in epidemiologic investigations among untreated community populations, in research studies, and in treatment outcome assessment. The *DSM-III* diagnosis of major depression in effect became the arbiter of what depression was in clinical settings, community studies, and the culture at large.

The significance of the MDD criteria changes when they are applied to outpatient populations and, especially, to community populations where their application can result in many false-positive diagnoses (Wakefield et al. 2007). In these settings, low mood, poor appetite, insomnia, fatigue, lack of concentration, and the like can be common responses to ubiquitous stressful experiences such as the loss of valued relationships, jobs, or goals that, as noted, even the *DSM* definition of mental disorder itself does not consider to be valid disorders. When diagnoses require just two-week duration, they can include many short-lived responses to stressors. Moreover, the lack of exclusion criteria other than bereavement virtually ensures that the criteria cannot separate natural symptoms of sadness from dysfunctional depressive disorders. Thus, MDD in the *DSM-III* encompasses both symptoms that typify very severe and enduring symptoms as well as those that are short-lived signs of distress.

One major spur to the growing popularity of the diagnosis stemmed from the findings of epidemiological studies. Before the *DSM-III*, depression was thought to be largely confined to patients with very serious conditions. Studies that translated the *DSM-III* criteria for use in untreated community populations found unexpectedly high rates of MDD. The initial epidemiological studies found that from 3 percent to 6 percent of the population suffered from this condition (Robins et al. 1984). Subsequent studies, using similar criteria but differing methodological techniques, found that depression affected close to 20 percent of the population (Kessler et al. 2005). Prospective studies indicate even higher amounts, encompassing over 40 percent of community members (Moffitt et al. 2009). The depressive diagnosis, when applied to community populations, generated extremely high prevalence rates and at the same time associated these rates with the presence of a serious and specific disease entity.

Its apparent ubiquity led MDD to become perhaps the brightest light in the firmament of the new diagnostically oriented psychiatry. Pharmaceutical advertisements, public health campaigns, internet Web sites, and stories in the mass media widely trumpeted the huge amount of putative depressive disorder in the population. Lay mental health advocacy groups took advantage of the huge estimates of the number of people who suffered from depression to show how people who suffered from mental illnesses were not unusual misfits but people with a genuine biological disease who comprised a substantial portion of the population. Institutions such as the National Institute of Mental Health and the WHO made depression the centerpiece of their efforts to convince the public that mental illness was a serious, widespread, and treatable form of disease.

For example, the widely trumpeted WHO studies indicated that depression would soon be the world's most serious health problem, behind only heart disease, and was already the single leading cause of disability for people in midlife and for women of all ages (Murray and Lopez 1996). The seeming enormity of the problem of depression stemmed from taking the large number of people who met the depressive criteria in community studies and considering the severity of all their conditions as comparable to paraplegia and blindness. While this might be justified for cases of serious and chronic cases of depression, the same can hardly be said for someone who was sad, fatigued, unable to concentrate, and had sleep and appetite problems for two weeks. The questionable equation of disability from such conditions with blindness and paraplegia was trumped by the rhetorical value of viewing depression as "the major scourge of mankind" (Kramer 2005:215). In fact, the enormous amount of depression and its presumed impairment reflected the characteristics of a diagnosis that did not separate short-lived responses to ubiquitous stressors

from chronic and severe conditions and so could equate mild and self-correcting states with extremely serious and impairing ones.

The MDD diagnosis also had a dramatic impact on mental health practice. The capaciousness of the diagnosis, which included such common symptoms as sadness, sleep and appetite difficulties, and fatigue, put it in the best position of any major diagnosis to capture the most frequent symptoms of stress found in outpatient medical and mental health treatment. Between 1987 and 1997, the proportion of the U.S. population receiving outpatient therapy for conditions called "depression" increased by more than 300 percent (Olfson et al. 2002). In 1987, 0.73 persons per 100 adults in the United States were treated for depression; by 1997, these rates leaped to 2.33 per 100. While 20 percent of patients in outpatient treatment in 1987 had a diagnosis of some kind of mood disorder, most of which were major depression, these diagnoses nearly doubled by 1997, to account for 39 percent of all outpatients.

More recent figures indicate that there were 51.7 million outpatient visits for mental health care in 2002. Depression accounted for fully 21 million of these (Centers for Disease Control and Prevention 2009). Depression is also the single most common topic of online searches for pharmaceutical and medical products, attracting nearly 3 million unique visitors over a three-month period in 2006 (Barber 2008:14). Likewise, in a mirror image of figures from the early 1960s, by the early part of the 21st century general physicians were more than twice as likely to make diagnoses of depression than of anxiety (Schappert and Rechtsteiner 2008). For whatever actual problems people sought mental health care, the treatment system and, in all likelihood, the patients themselves were calling them "depression." The expansive qualities of the MDD diagnosis allowed it to become the avatar of psychiatry's medical and social success.

Another major consequence of the *DSM-III* categorization was to make depression a more promising target for the new class of medications—the selective serotonin reuptake inhibitors (SSRIs)—that came on the market in the late 1980s. Although they are called "antidepressants," prescriptions for SSRIs have little relationship to MDD or any other particular diagnostic category in the *DSM*. They are used nonspecifically to treat not only major depression but also various anxiety disorders, eating disorders, and alcohol and drug problems as well as many other conditions. These drugs act very generally to increase levels of serotonin in the brain that raise low mood states, lower levels of inhibition, and decrease anxiety.

Depression entered the cultural limelight largely through its identification with the trade name of Prozac, one of the most popular SSRIs. In particular, Peter Kramer's (1993) wildly popular *Listening to Prozac: A Psychiatrist Explores Antidepressant Drugs and the Remaking of the Self* cemented the association of the SSRIs with the treatment of depression. Kramer associated antidepressant treatment with miraculous transformations of selves, focusing on how the new class of drugs empowered and enhanced its users. Yet, while Kramer emphasized the general impact of the SSRIs on changing personalities, he connected the condition that the drugs transformed with "depression."

Advertisements for Prozac focused on its use in treating major depression, using the imagery depicted in Kramer's book such as women becoming "better than well" while cheerfully fulfilling both work and family roles. The FDA's loosening of restrictions on direct-to-consumer drug advertisements in the late 1990s both enhanced the popularity of the SSRIs and reinforced their link to depressive illness. Many of these ads were aimed at selling the disease of depression itself, rather than a particular type of antidepressant (Healy 1997; Hirshbein 2009). They relentlessly pushed the view that "depression is a disease" linked to deficiencies of serotonin in the brain. Advertisements typically connected the most general symptoms of depression from the *DSM*'s diagnosis—sadness, fatigue, sleeplessness, and the like—with common situations involving interpersonal problems, workplace difficulties, or overwhelming demands.

Network television shows, national newsmagazines, and best-selling books widely featured the SSRIs as antidepressant medications. Much as "anxiety" had during the 1950s and 1960s, "depression" came to refer to disparate experiences of suffering during the 1990s and early 2000s that could be overcome through taking an "antidepressant" medication. From 1996 to 2001, the number of users of SSRIs increased rapidly, from 7.9 million to 15.4 million. By 2000, the antidepressants were the best-selling category of drugs of any sort in the United States; fully 10

percent of the U.S. population was using an antidepressant (Mojtabai 2008). By 2006, Americans had received more than 227 million antidepressant prescriptions, an increase of more than 30 million since 2002 (IMS Health 2006). General medical providers are particularly likely to prescribe the SSRIs, using them for a cornucopia of complaints including nerves, fatigue, back pain, and sleep difficulties (Mojtabai and Olfson 2008). Yet, when antidepressants are used to treat such an array of symptoms, these symptoms all come to be seen as signs of "depression." As French sociologist Alain Ehrenberg (2010:189) notes, "Everything becomes depression because antidepressants act on everything."

In large part, the MDD diagnosis was responsible for the antidepressant craze. Its nature readily lent itself to encompass the vast array of conditions that the SSRIs treated. The diagnosis unified a broad and heterogeneous range of conditions into a single set of criteria. In addition, many of the symptoms—sadness, fatigue, sleep and appetite problems, and restlessness—captured the vast array of symptoms that are associated with a huge number of ordinary life and physical problems. The two-week duration requirement allowed the diagnosis to encompass short-lived reactions to stress as well as long-standing depressive conditions. Finally, the absence of exclusionary criteria other than bereavement allowed MDD to define many natural responses to stressors as a genuine type of disease. The developers of the *DSM-III* could hardly have imagined the vast consequences that the MDD diagnosis would entail.

CONCLUSION

The study of the major depression classification sheds light on a number of issues in the social construction of psychiatric diagnoses. MDD, the most influential diagnosis of the past 30 years, emerged from intraprofessional pressures and the ability of research-oriented psychiatrists to gain dominance within the profession. Most importantly, psychiatry needed a credible classificatory scheme to maintain its legitimacy in both the broader medical profession and the culture at large. As prominent depression specialist Gerald Klerman (1984:539) succinctly summarized: "The decision of the APA first to develop *DSM-III* and then to promulgate its use represents a significant reaffirmation on the part of American psychiatry to its medical identity and to its commitment to scientific medicine." Medical legitimacy required easily measurable and reliable diagnoses. The diagnostic criteria grounded in the Feighner measure that emerged in the *DSM-III* to resolve the many unsettled diagnostic controversies—and that have remained mostly unchanged until the present—did produce a far more reliable system of measurement than the amorphous criteria they replaced. Yet, this particular diagnostic system was not tested against the many alternative classifications that were available during the 1970s that might have been as good or even superior to the Feighner criteria. Instead, their adoption resulted from the shared commitment to a view of psychiatric diagnoses and the path that the psychiatric profession should follow among the research-oriented psychiatrists who controlled the development of the *DSM-III* classifications.

The major opposition to the establishment of the *DSM-III* diagnoses and, in particular, to major depression stemmed from psychodynamic psychiatrists (Bayer and Spitzer 1985). This group emphasized processes such as unconscious dynamics, internal conflicts, and life histories that were difficult to operationalize and to study in a scientific manner. They were excluded from the committees that established the criteria for MDD and the other diagnoses that emerged in the *DSM-III*. These diagnoses, which were foundational for establishing the legitimacy and prestige of psychiatry as a medical discipline, were compatible with the values of researchers but far from the psychosocial model embraced by the analysts. Neither lay advocacy groups, pharmaceutical companies, nor any other interests from outside of the psychiatric profession became engaged in the construction of the MDD diagnosis. Nevertheless, the research psychiatrists who established the diagnoses were acutely aware of factors such as the need to have diagnoses suitable for obtaining third-party reimbursement, credibility in the broader culture, and dominance over competing mental health professions (Mayes and Horwitz 2005). The fact that external groups did not become directly involved in shaping the MDD criteria does not mean that this diagnosis developed in a cultural vacuum.

The demonstration that MDD emerged because of social and contextual factors does not necessarily indicate that it is not a useful diagnosis. Nevertheless, certain aspects of MDD have rendered it unable to resolve central issues in the

study of depressive conditions. The most important deficiency from the standpoint of the sociology of mental health stems from its conflation of normal distress that stems from various life stressors and positions in social systems with genuine depressive disorders. It also leaves unresolved whether melancholic depression—the central depressive condition before the *DSM-III*—is a distinct condition or simply the most severe type of depression (Fink et al. 2007). Pre-*DSM-III* controversies over whether depression is best viewed as a categorical or dimensional condition likewise remain unresolved.[2] In addition, the question of how to distinguish depressive disorders from depressive personality types is unsettled. While the *DSM-III* generated consensus about the operational definition of depression, questions about whether depression is continuous or categorical, how many categories it has, what its relationship to melancholic conditions is, and how it can be distinguished from normal sadness seem no closer to resolution now than they were when the *DSM-III* arose.

An alternative explanation to the one presented here is that the rise in depressive diagnoses reflects a genuine increase in depression since 1980. Yet, it is difficult to imagine factors that would account for the immense and continuous growth in rates of depression during this period. Genetic and psychological explanations rely on factors that are either invariant or that change very slowly over time and so are inconsistent with the expansion of depression in recent decades. Sociological theories do predict changing rates of depression over time and so potentially provide the best explanations for this increase. Indeed, some social predictors of depression such as rates of social isolation and parental divorce are more widespread now than in the past. Others, however, such as rates of poverty, education, and physical health, have improved. Some important trends that could be connected to depression, including rates of unemployment and crime victimization, have changed erratically, rather than consistently upward, over this period. Changing levels of other factors connected to depression such as child sexual abuse are impossible to know, but no evidence indicates that they are more common now than in the past. No social theory about the cause of depression predicts why there has been such a consistent increase in the prevalence of depression in recent decades.[3] Instead, changes in the criteria that measure this condition provide a more plausible explanation than changes in actual rates of depression.

The developers of the MDD diagnosis did not foresee the profound consequences it would have. They inadvertently developed criteria that encompassed what had previously been viewed as a number of distinct types of depressive conditions. Endogenous, exogenous, and neurotic forms of depression could all meet the expansive criteria of the MDD diagnosis. Moreover, because it could incorporate short-lived responses to stressful conditions, MDD was the most suitable label for many of the heterogeneous and diffuse complaints that many primary medical care patients present. Likewise, depression became the most prevalent form of mental illness measured in epidemiological studies because so many community members suffer from common symptoms such as sadness, sleep and appetite difficulties, and fatigue that need only last for a two-week period to be considered disordered (Kessler et al. 2005). The sweeping qualities of the diagnosis also made it the most attractive target for the vastly popular SSRI medications that came on the market a few years after the publication of the *DSM-III*. Primarily through pharmaceutical advertisements, ubiquitous messages associated the most common forms of distress with major depression. This condition became psychiatry's most marketable diagnosis, driving mental health treatment, research, and policy. Ultimately, the Age of Depression that has engulfed the United States and much of the Western world since 1980 resulted from relatively esoteric changes in diagnostic criteria.

NOTES

1. Current proposals for changing the Major Depressive Disorder diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*), which is scheduled to appear in 2013, would move it closer to the original Feighner criteria by eliminating the bereavement exclusion entirely. According to the argument presented here, such a change would *decrease* the validity of the diagnosis.
2. The *DSM-5* task force has proposed adding a continuous measure of depression to its current categorical form, but at present it is unclear how these two forms of measurement would coexist.
3. Likewise, no theory of the causes of the actual amounts of anxiety and depression—whether biological, psychological, or sociological—can explain why treated rates of the former condition have

declined, while those of the latter have increased between the 1950s and 1960s and the period since 1980. Instead, the divergent ways that the *DSM-III* defined anxiety and mood disorders seems to account for the varying levels of these diagnoses in recent decades (Horwitz 2010).

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