How Did Everyone get Diagnosed with Major Depressive Disorder?

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How Did Everyone Get Diagnosed with Major Depressive Disorder?

Allan V. Horwitz

ABSTRACT Psychiatric diagnoses often reflect a matrix of sociological factors associated with professional prestige, economic forces, and cultural fashions. Diagnostic systems conceptualize the same underlying psychosocial problems in very different ways during various time periods. Since the publication of the third edition of the Diagnostic and Statistical Manual (DSM-III) in 1980, psychological distress resulting from social circumstances that previously was viewed as a general problem of nerves, neuroses, and anxiety was transformed into the specific diagnosis of major depressive disorder. Several factors, including the contrasting ways in which DSM-III defined anxiety and depression, the necessity of using explicit diagnoses to obtain professional legitimacy and reimbursement for services, and the marketing practices of the pharmaceutical industry, account for why depression replaced anxiety as the diagnosis most suitable for treated mental health conditions. Beneath the changing veneer of psychiatric labels, however, lies the same mélange of psychic ills that resist the precise labels current diagnostic fashions strive to impose upon them.

AN ICONIC ROLLING STONES SONG FROM the mid-1960s, “Mother’s Little Helper,” portrays the typical predicament of a housewife at the time. Her life is boring, and she doesn’t find pleasure in her everyday activities. She cannot satisfy her...
husband, who fails to appreciate her prodigious efforts to take care of the children, housework, and cooking. Meanwhile, she steadily grows older. She obtains refuge from her unfulfilled and unrewarding life in the tranquilizing drugs that she takes:

Mother needs something today to calm her down
And though she’s not really ill
There’s a little yellow pill
She goes running for the shelter of a mother’s little helper
And it helps her on her way, gets her through her busy day

This woman was hardly alone: during the 1960s, fully 10% of all American women received prescriptions for some psychoactive drug (Smith 1985).

These lyrics illustrate the nonspecific and generalized distress that result from difficult life circumstances. Indeed, this mother is “not really ill.” During the 1960s, her mixture of nerves, fatigue, inability to experience pleasure, mild depression, and anxiousness would likely have been called “anxiety,” “tension,” or “stress” and treated with a tranquilizing drug. Feminist author Betty Friedan (1963) captured the capacious aspect of this condition when she labeled the characteristic psychic dilemma of middle-class women as “the problem that has no name,” one that featured “mild, undiagnosable symptoms . . . malaise, nervousness, and fatigue” (407). Today, however, mental health professionals in the United States would be likely to diagnose the same blend of symptoms as “major depression” and treat them with a regimen of anti-depressant medication. What accounts for this shift in labeling, from a collection of global symptoms associated with anxiety to a more specific diagnosis connected with depression?

This paper postulates that psychiatric diagnoses often reflect a matrix of sociological factors associated with professional prestige, economic forces, and cultural fashions (see Brown 1995; Jutel 2014). Because these influences are subject to historical changes, diagnostic systems conceptualize the same underlying psychosocial problems in very different ways during various time periods. Since the publication of the third edition of the Diagnostic and Statistical Manual (DSM-III) in 1980, psychological distress resulting from social circumstances that previously had been viewed as general problems of nerves, neuroses, and anxiety has been transformed into depressive disorders (APA 1980). Beneath the changing veneer of psychiatric labels, however, seem to lie the same mélange of psychic ills that resist the specific labels current diagnostic fashions strive to impose upon them (Shorter 2013).

The Movement to Diagnostic Specificity

Before the 19th century, physicians generally viewed health as a state of equilibrium within the body, while disease was a disturbance of this balance (Porter 1999; Sigerist 1943). For most of history, doctors emphasized how a variety of factors including diet, lifestyle, living conditions, and atmospheric elements could impact health and
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To the extent that they considered particular diagnostic categories, physicians focused on external, visible signs and symptoms, such as fever. This process was perhaps inevitable, if only because neither the prevailing technology nor theory could establish a causal relationship between biological mechanisms and resulting signs and symptoms.

During the 19th century, however, specific diagnoses replaced holistic conceptions of mind and body within general medicine. Diseases became associated with mechanisms related to anatomy, cell pathology, and microbiology that were unrelated to the particularities of the individuals who harbored them. Each distinct condition was presumed to have a characteristic underlying pathology, cause, prognosis, and treatment. “[The] modern history of diagnosis,” historian Charles Rosenberg (2007) observes, “is inextricably related to disease specificity, to the notion that diseases can and should be thought of as entities existing outside the unique manifestations of illness in particular men and women: during the past century especially, diagnosis, prognosis, and treatment have been linked ever more tightly to specific, agreed-upon disease categories” (13).

Some psychiatrists, most notably the German diagnostician Emil Kraepelin, applied the specificity model to mental illnesses. Kraepelin (1921) sharply differentiated cases of dementia praecox (schizophrenia) from ones of manic depression through careful observation of the nature of symptoms and their development over time. Kraepelin’s diagnostic system, however, was limited to a very small number of conditions that were usually found among hospitalized patients. In any event, it had little impact on American psychiatry during the first seven decades of the 20th century (Grob 1991a).

Non-Specificity in American Psychiatry

Despite Kraepelin’s efforts to apply the model of specificity that prevailed in general medicine to psychiatric conditions, the amorphous terms “stress,” “neuroses,” and “nervous disease” prevailed as characterizations of the heterogeneous range of psychosocial conditions in the United States during much of the 20th century. The stress tradition encompassed a diffuse and multifaceted array of psychic, somatic, and interpersonal problems that often arose as responses to the strains of everyday life. For example, physiologist Hans Selye (1956) termed the many consequences of stress the “general adaptation syndrome,” indicating the wide array of conditions that fell into this domain. The common psychological features of these problems included a combination of symptoms involving nervousness, sadness, and malaise. Typical physical symptoms consisted of headaches, fatigue, back pain, gastrointestinal complaints, and sleep and appetite difficulties, often accompanying struggles with interpersonal, financial, occupational, and health concerns. These complaints accounted for a large proportion of psychological disturbances found in outpatient psychiatric and in general medical treatment (Smith 1985).

The first diagnostic manual of the American Psychiatric Association (APA), the Diagnostic and Statistical Manual (DSM), was published in 1952. This nosology built
on the experiences of military psychiatrists during World War II, who found that the overwhelming majority of psychiatric casualties during this war experienced brief, but intense, reactions to extremely stressful conditions that couldn’t be understood within the framework of extant classifications (Grob 1991b). It combined the psychoanalytic approach of Sigmund Freud, which emphasized the unconscious forces that presumably underlay mental illness, with the life course approach of American psychiatrist Adolf Meyer, which focused on how mental illnesses were reactions to challenges individuals faced in adjusting to their environments. The DSM-I (as the manual came to be called) also embodied the belief that mental disorders were continuous with normality: it made no sharp distinctions between mental illness and mental health.

The definitions in the DSM-I reflected the lack of attention psychodynamic clinicians at the time paid to overt symptoms of the various disorders. Therapists focused on the unconscious conflicts they believed led to nonorganic conditions and tended to give short shrift to the symptoms that expressed each underlying condition. Therefore, all of the DSM-I’s approximately 100 diagnostic definitions were short, cursory, and infused with psychodynamic assumptions. Most were no more than two or three sentences long.

At the heart of the DSM-I (and DSM-II) was the concept of “neurosis.” It was the synthesizing rationale behind the psychoneurotic category of the manual, which itself was the category that was at the center of clinical practice. The term referred to the psychological conflicts that were present in virtually all individuals, so that almost everyone fell on the continuum that ranged from minimal to severe neurosis. Inspired by psychoanalytic theory, these conflicts emerged as a way to deal with underlying conscious or unconscious anxiety. The first sentences of the summary description for the overall psychoneurotic disorders category 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.). . . . “Anxiety” in psychoneurotic disorders is a danger signal felt and perceived by the conscious portion of the personality. It is produced by a threat from within the personality (e.g., by supercharged repressed emotions, including such aggressive impulses as hostility and resentment), with or without stimulation from such external situations as loss of love, loss of prestige, or threat of injury. (APA 1952, 31)

This definition indicates the extent to which psychodynamic assumptions infused the DSM-I classifications. Anxiety, by definition, expressed defense mechanisms that were largely unconscious and that emerged from some inner threat. Moreover, the ways patients expressed anxiety, through such mechanisms as “depression, conversion, or displacement,” were secondary to the fundamental process of anxiety that was behind each overt manifestation. The specific categories (phobic reaction, obsessive
compulsive reaction, depressive reaction) were divergent expressions of common 
neurotic conflicts rooted in anxiety.

For example, the DSM-I’s full definition of neurotic depression (which it called “depressive reaction”) read as follows:

The anxiety in this reaction is allayed, and hence partially relieved, by depres-
sion and self-depreciation. The reaction is precipitated by a current situation, 
frequently by some loss sustained by the patient, and is often associated with a 
feeling of guilt for past failures of deeds. The reaction in such cases is dependent 
upon the intensity of the patient’s ambivalent feeling toward his loss (love, pos-
session) as well as upon the realistic circumstances of the loss. (33–34)

This definition, like the others in the DSM-I, focused solely on the psychodynamics 
(loss, guilt, ambivalence) that presumably led to depressive conditions but contained 
no definitional criteria that would indicate the presence of a disorder. Depressive 
reactions themselves were one manifestation of underlying anxiety. The next edition 
of the manual, the DSM-II (1968) made few changes in the definitions of the 
various diagnoses and continued to describe each condition in perfunctory and 
theory-infused ways.

Before the 1970s, this nonspecific diagnostic system was not a problem for 
American psychiatry, as precise diagnoses had little role to play in psychodynamic 
explanations or in clinical practice. Dynamic theory downplayed the importance 
of overt indicators of symptoms and instead focused on the unconscious anxiety 
that presumably underlay external signs of psychic disturbances. Psychodynamic 
therapies were generalized across different conditions so that particular diagnoses 
did not guide treatment plans. In addition, most outpatients at the time paid for their 
own therapy, so clinicians did not have to provide specific diagnoses to private or 
public third parties in order to obtain reimbursement for their services. Moreover, 
during the 1950s and 1960s, drug companies generally touted their products as relief 
for broad conditions such as stress, nerves, or anxiety, not as responses to particular 
types of mental disorders. The lack of specific definitions of the variety of conditions 
found in the DSM-I and DSM-II were not liabilities for mental health practitioners 
or the pharmaceutical industry during this period.

Shortly after the DSM-II was issued in 1968, however, psychiatry began to 
undergo dramatic changes. While the brief and theory-infused definitions of the first 
two editions of the manual were suitable for psychodynamically oriented clinicians, 
this group was losing legitimacy in both the wider society and the psychiatric 
profession. Beginning in the late 1960s, psychiatry was being mocked in the larger 
culture for its inability to define even the most basic entities that it studied and 
treated (see, for example, Rosenhan 1973; Szasz 1974). Other medical specialists also 
ridiculed psychiatry as more of an art than a science. Research demonstrated that 
psychiatrists were unable to measure even the field’s most fundamental conditions, 
such as schizophrenia or manic depression: a condition that one clinician called
“schizophrenia” was often called “manic-depression” by others (Cooper et al. 1972). This poor reliability resulted from a classification system that was unconcerned with how to measure particular diagnoses. The combination of the lack of formal criteria with unproven etiological assumptions inevitably led clinicians to rely on their subjective intuitions about what condition they were treating. Researchers were unable to conduct multi-site projects because of the lack of reliable diagnostic categories that applied to different populations.

At the time, psychiatrists also faced challenges from other mental health professionals such as clinical psychologists and social workers, who argued that they possessed as much training and skill to study and treat psychosocial problems (Mayes and Horwitz 2005). The boundaries of the conditions found in the DSM-I and DSM-II were so broad that they considerably overlapped with the processes emphasized in these other disciplines. Medical training seemed irrelevant for understanding the kinds of dynamic processes the diagnostic manuals assumed produced mental illnesses, and nonmedical and medical professionals alike could diagnose and manage most of the psychosocial entities that they defined.

Within psychiatry itself, during the 1960s and 1970s an energized group of biologically oriented researchers emerged, who emphasized the need for careful definitions of each mental disorder and who objected to the theoretical assumptions that framed the DSM-I and DSM-II definitions. These new biological psychiatrists, who grew in both numbers and prestige, challenged the psychodynamically oriented practitioners by emphasizing the grounding of mental illness in brain structures and functions. They rejected the theory-driven basis of the diagnostic manuals that had no place for somatic underpinnings of nonorganic mental disorders, and they also employed psychoactive drugs as opposed to talk therapies as the first line response to psychiatric conditions. Because they believed that different drugs targeted distinct forms of mental illness, they advocated for the development of a far more precise diagnostic system than the first two DSMs provided (Klein and Fink 1962).

As they entered the 1970s, psychiatrists also confronted a new economic context. Government and private insurance programs were beginning to pay for most outpatient treatment. The amorphous conditions in the DSM-I and DSM-II did not fit an insurance logic that required clinicians to treat some distinct disease. Insurers were not content with diagnoses that emphasized such vague mechanisms as “displacement” or “conversion,” and they also started to demand greater accountability for the outcomes of therapy. This accountability, in turn, required some system that could more precisely measure the conditions that clinicians were treating. The livelihoods of psychiatrists and other mental health professionals began to depend on their ability to treat specific, reimbursable diseases.

The Food and Drug Administration’s (FDA) mandate that the pharmaceutical industry must target psychoactive drugs to specific biomedical conditions was another spur toward specificity of psychiatric diagnosis (Healy 1997). During the 1950s and 1960s, the popularity of tranquilizers stemmed from their marketing as
remedies for general life stresses and protean conditions of stress and anxiety, with little consideration of whether or not they treated explicit disease states. Pharmaceutical companies presented these drugs to physicians and psychiatrists as treatments for a variety of nonspecific complaints including anxiety, tension, depression, and mental stress. Advertisements (which at the time were directed at physicians, not consumers) emphasized how tranquilizing drugs provided relief for such common problems as dealing with unruly children, traffic jams, demanding bosses, and housekeeping (Herzberg 2009; Tone 2009). Studies of this period found that only about a third of the minor tranquilizers were prescribed for specific mental disorders, while the rest were given as a response to more diffuse complaints and psychosocial problems (Cooperstock and Lennard 1979). In the 1970s, however, government regulators began to enforce more stringently the legislative requirement dating from 1962 that drug companies target the marketing of their products to particular biomedical conditions. Like psychiatrists, the increasingly influential pharmaceutical industry required a more highly defined system of classification than was found in the extant DSM.

The DSM-III

The death knell of the brief psychodynamic era of classification was sounded in the mid-1970s as research-oriented psychiatrists, led by Robert Spitzer, gained control of the next revision of the DSM that was to culminate with the 1980 DSM-III. This manual was almost the diametrical opposite of the DSM-I and DSM-II. It featured precise, symptom-based classifications, not perfunctory definitions. The number of diagnoses grew from 182 to 265, and the manual itself burgeoned from 134 to 494 pages (Mayes and Horwitz 2005). The many entities of the DSM-III were carefully split apart from each other on the basis of their overt symptoms, rather than being viewed as diverse manifestations of some broader underlying condition. Although they came to be associated with biomedical conceptions of the causes of mental illnesses, the DSM-III diagnostic criteria themselves were atheoretical. In contrast to the theory-infused conditions of its predecessors, they did not specify particular causes of the entities they specified (PTSD being the major exception).

Anxiety, the core condition in the DSM-I and DSM-II, was a particular target of Spitzer and the DSM-III Task Forces that he appointed (Horwitz 2010). Spitzer had concluded that the concept of “neurosis” was a major obstacle to the building a scientifically based psychiatry (Bayer and Spitzer 1985). It was theory-infused, rather than empirical, overly general, and directed clinicians away from dealing with the overt symptoms that their patients displayed. The underlying philosophy of the new manual was that psychiatry needed to become a data-driven specialty, as opposed to the “dogma and theory” that guided psychoanalysis (Spitzer 1978). In particular, its core mission was to develop presumably more reliable criteria that allowed different psychiatrists to distinguished one condition from another (Kirk and Kutchins 1992).
Because underlying anxiety was foundational for conceptions of neuroses, the developers of the *DSM-III* particularly targeted anxiety conditions. This manual revolutionized conceptions of anxiety, creating multiple, distinct conditions that were based on the manifest symptoms each displayed, without reference to any underlying etiological process. Its classifications also removed the depressive, neurasthenic, and hysterical neuroses from the anxiety neuroses and made them separate categories of mood, dissociative, and somatization disorders—in effect eliminating the notion of “psychoneurosis” altogether. The anxiety category itself was carved into nine different conditions. These included three types of phobic disorders: simple phobia, social phobia, and agoraphobia, which itself was split into conditions with or without panic attacks. Other categories were panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, and conditions not otherwise specified.

The rejection of any unifying etiology behind the various anxiety diagnoses thoroughly distinguished the *DSM-III* from the first two *DSM* manuals. The result was that anxiety was no longer suitable as the representative diagnosis in the stress tradition. The symptoms of each category were too specific to capture the more diffuse indicators of “nerves,” “tension,” or “distress,” and the category of generalized anxiety disorder (GAD), which might have been suitable for this purpose, was classified as a residual diagnosis that was not to be used when any other condition was present. Because GAD usually occurred alongside of other types of anxiety, it became a rarely used diagnosis in the *DSM-III*.

The highly specific nature of the *DSM-III*’s diagnoses created a vacuum: what label could clinicians apply to the diffuse psychosocial problems that so many of their patients presented? Fortunately for them, the manual provided a solution to the problem of what diagnosis could fit an unspecific condition: major depressive disorder (MDD).

**Major Depressive Disorder**

For most of Western history, depression was equated with “melancholia,” a very serious disorder marked by thoroughgoing lethargy, despondency, and suicidal thoughts, among other severe indicators (Horwitz and Wakefield 2007; Shorter 2013). Unlike anxiety, melancholy was not central to psychodynamic theory or practice. Melancholic disorders were also outside of the stress tradition and were more closely associated with hospitalized patients than with outpatients. Depressive neurosis in the *DSM-I* and *DSM-II*, while within the stress tradition, was not a free-standing condition but an epiphenomenon of anxiety.

The *DSM-III*’s treatment of depression sharply contrasted with its division of the anxiety disorders into many distinct conditions (Horwitz 2010). First, neurotic depression was no longer treated as a derivative of anxiety, as in the first two *DSMs*, but was subsumed into a free-standing category of affective disorders. In contrast
to the nine separate categories of anxiety, MDD was the only significant type of nonpsychotic depression among the affective disorders and so had unquestioned prominence within the category of affective disorders.

Second, and more importantly, the DSM-III allocated the most general symptoms of distress to MDD rather than to any of the anxiety diagnoses. The diagnostic criteria for the various anxiety disorders were quite specific and centered on expressions such as intense fears of specific objects or situations, obsessions and compulsions, and posttraumatic stress. In contrast, the MDD diagnosis required that five symptoms out of the following nine be present during a two-week period (the five must include either depressed mood or diminished interest or pleasure): (1) depressed mood; (2) diminished interest or pleasure in activities; (3) weight gain or loss or change in appetite; (4) insomnia or hypersomnia (excessive sleep); (5) psychomotor agitation or retardation (slowing down); (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive or inappropriate guilt; (8) diminished ability to think or concentrate or indecisiveness; and (9) recurrent thoughts of death or suicidal ideation or suicide attempts. (APA 1980, 213–14). Yet, an MDD diagnosis did not require that any of the final three more serious symptoms needed to be present. The capacious MDD criteria could cover a heterogeneous group of people, ranging from irritable adolescents who constantly sleep, eat little, are uninterested in school, and do not concentrate on their schoolwork, as well as morose elderly people, who cannot sleep, overeat, are fatigued, and feel worthless (Murphy 2006).

Third, the duration criteria for the anxiety conditions were considerably longer than those for MDD. Most anxiety diagnoses required “persistent” symptoms, usually of at least six months’ duration (APA 1980, 227), which ruled out diagnoses of short-lived responses to stressful conditions. In contrast, symptoms that endured for a mere two weeks met the MDD qualifications (213). Transient responses to stress, therefore, could meet diagnostic criteria for depression but not anxiety.

Finally, the disparate treatment of the contextual basis of anxiety and depression favored diagnoses of depression over those of anxiety. A very high proportion of patients enter mental health and primary medical care settings with psychosocial problems of stress that are often the proximate reasons for their symptoms. Yet the diagnostic criteria for the anxiety diagnoses were hedged with qualifiers that distinguished them from contextually appropriate symptoms. For example, only “irrational” or “unreasonable” fears met the criteria for phobias, thus ruling out proportionate and reasonable fears (227–30). Or panic disorders had to occur “unpredictably” and could not be responses to life-threatening situations (230). The treatment of anxiety according to the DSM-III, therefore, ruled out proportionate responses to dangerous situations as possible diagnoses.

In contrast, many patients reacting to stressful psychosocial contexts could meet the MDD criteria. Bereavement was the sole relevant exclusionary criterion for depression: people grieving the death of an intimate who otherwise met the MDD criteria would not be so diagnosed so long as their symptoms were not
especially severe or long lasting (213). But no comparable exclusions were made for those who met the criteria after they were laid off from jobs, rejected by romantic partners, or informed of a serious medical diagnosis for themselves or an intimate. Unlike the diagnostic criteria for the anxiety disorders, the MDD criteria did not preclude diagnoses even when the symptoms were proportionate responses to the losses that provoked them. The range of conditions in the stress tradition that featured mixed depressive and anxious symptoms thus became more amenable to depressive than anxious diagnoses. The removal of the bereavement exclusion from the diagnostic criteria in the DSM-5 (APA 2013) makes MDD even more amenable to encompassing the normal distress that stems from distressing life events.

Whether the problems that people bring to therapy have changed much over the past half century is questionable (Swindle et al. 2000). Their labels, however, have dramatically altered. The DSM-III unintentionally created the conditions for depression, rather than anxiety, to incorporate the disparate manifestations of stress and thus become the central diagnosis in the mental health system.

The Triumph of Depression

During the 1950s and 1960s, anxiety had been a far more prominent diagnosis than depression. In 1962, for example, anxiety was the most prevalent psychoneurotic condition: according to the National Disease and Therapeutic Index, about 12 million patients received diagnoses of anxiety reactions, compared with just 4 million with diagnoses of neurotic depression (Herzberg 2009). One large study at the time indicated that three-quarters of neurotic patients received an anxiety diagnosis, whereas most of the rest were simply considered “neurotic.” In contrast, depression was “absent from the diagnostic summaries” (Murphy and Leighton 2008, 1057).

While depressive diagnoses were already growing during the 1970s, their major surge emerged after the DSM-III was published in 1980. From that time to the present, the upward trajectory of depressive diagnoses has been marked. Between 1987 and 1997, the proportion of the U.S. population receiving outpatient treatment for conditions called “depression” increased by more than 300% (Olfson et al. 2002a). In 1987, 0.73 persons per 100 adults in the United States were treated for depression; by 1997, these rates had leaped to 2.33 per 100. While 20% of patients in outpatient treatment in 1987 had a diagnosis of some kind of mood disorder, most of which were MDD, depressive diagnoses nearly doubled by 1997 to account for 39% of all outpatients.

In contrast, the rates of any anxiety diagnosis for treated patients rose much more slowly, from 10.5% in 1987 to 12.5% in 1997 (Olfson et al. 2002b). By 1996–97, diagnoses of mood disorders were more than three times as common as anxiety diagnoses in office-based psychiatry (Mojtabai and Olfson 2008a). A large study of psychiatric practice that the APA conducted in 1997 is illustrative, finding that about a third of treated patients had a principal diagnosis of MDD, whereas just 10% had received a diagnosis of an anxiety disorder (Pincus et al. 1999).
More recent figures present a mirror image of the overwhelming dominance of anxiety in general medicine and psychiatry during the 1950s and 1960s. In 2002, 51.7 million outpatient visits were for mental health care. Depression accounted for 21 million of these, compared with only 6.2 million for anxiety (CDC 2015). Likewise, by the early part of the 21st century, general physicians were more than twice as likely to make diagnoses of depression as anxiety (Schappert and Rechtsteiner 2008). Depression accounted for 42% of mental health diagnoses among office-based physicians between 2007 and 2010 (Olfson et al. 2014). Whatever the actual problems were for which people sought mental health care, the treatment system—and in all likelihood the patients themselves—were calling them “depression.”

For example, depression is 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).

The substitution of depression for anxiety during this period was a feature of clinical practice, not of changing rates of depression and anxiety in the community. Indeed, epidemiological studies that do not rely on treatment statistics show that depression was not more common than anxiety among undiagnosed subjects in the community during the 1980s and 1990s (Kessler and Wang 2008). The disproportionate growth of depressive compared to anxiety diagnoses after 1980 reflected the greater suitability of MDD diagnoses for clinicians, not the fact that depression was actually becoming a more prevalent condition.

Another result of the divergent classifications of depression and anxiety in the DSM-III was to change the nomenclature of pharmaceutical treatments from anti-anxiety to anti-depressant treatments. The takeover of the stress marketplace by the “antidepressant” class of selective serotonin reuptake inhibitors (SSRI) medications strengthened the association between common mental health problems and depression. When the SSRIs came on the market in the late 1980s, anti-anxiety drugs were about twice as likely to be prescribed in outpatient visits as were antidepressants (Olfson and Klerman 1993). But at that point, the trends changed abruptly. Between 1985 and 1993–94, prescriptions for antianxiety drugs plunged from 52 to 33% of all psychopharmacological visits, and the number of users of antianxiety drugs grew very slowly after that, rising from 5.5 million to 6.4 million in 2001 (Zuvekas 2005).

Conversely, from 1996 to 2001, the number of SSRI users 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% of the U.S. population was using an antidepressant (Mojtabai 2008). In fact, these drugs were used so widely in general medical practice that in 2003–4, 310 of every 1,000 female patients received a prescription for an antidepressant (Raofi and Schappert 2006). Prescriptions for SSRIs continued to grow, and by 2006, Americans had received more than 227 million antidepressant prescriptions, an increase of more than 30 million since 2002. Antidepressants were prescribed for mood and anxiety disorders alike, gaining unchallenged control of the market once held by the anxiolytic drugs (Mojtabai and Olfson 2008a).
The conditions associated with the stress tradition thus underwent a widespread transformation between 1955 and the present (Shorter 2013). Before the 1970s, a broad conception of mental health problems, with stress and anxiety at its core, dominated mental health treatment, research, and policy. The heyday of anxiety during the 1950s and 1960s was followed by its steep decline beginning in the 1970s, accelerating during the 1980s and 1990s, and stabilizing in the early 2000s. Conversely, depression, once a rarely found but very serious disorder, became the common moniker for stress-related diagnoses, particularly after the publication of the DSM-III.

**Conclusion**

The transition from anxiety to depression did not result from any new scientific knowledge. Instead, it was a product of the social, economic, and political pressures that the psychiatric profession faced at the time. The discrediting of the analytically oriented DSM-I and DSM-II forced psychiatry to adapt a diagnostic system based on the model of specificity that prevailed in other branches of medicine. The lack of specific diagnoses also threatened the livelihoods of psychiatrists who were becoming increasingly dependent on revenue from insurance companies, which required that treatment be restricted to patients with well-defined mental disorders. Governmental funders of research were also demanding that psychiatry adopt a reliable diagnostic model that was conducive to precise measurement of the conditions under study. As well, the pharmaceutical industry, which was becoming increasingly intertwined with the psychiatric profession, had come to need distinct diagnoses in order to market its products.

The specificity model that Spitzer and the DSM-III Task Force adopted for psychiatric classification addressed the lack of reliability and resulting crises of legitimacy that arose in the 1960s and 1970s. The DSM-III brought a measure of coherence to a reeling profession by providing a common language for psychiatry. It almost instantly became the basis for psychiatric training, clinical practice, and drug trials. Perhaps most importantly, it provided clinicians a well-grounded justification for reimbursement from third-party payers. Political and economic circumstances made depression a more attractive vehicle than anxiety for realizing psychiatry’s ambitions to become a scientifically respectable branch of medicine. At the same time, depression replaced anxiety at the core of drug industry’s marketing efforts.

While the specificity model embodied in psychiatry’s diagnostic manuals since 1980 has proven to be a tremendous professional success, it has not led to comparable scientific achievements. The well-defined entities of the recent DSMs, however necessary they are to bolster the profession’s legitimacy, are unsuited to the nature of the often ill-defined and overlapping conditions with which psychiatry deals. Despite the anticipation that the DSM-III’s diagnostic system would bring about great progress, psychiatry has not yet produced any scientific breakthroughs.
in understanding the nature, causes, or treatments for its most common conditions. Attempts to bring dimensional forms of measurement, which echoed some aspects of the earlier, analytic style of thinking, back into the DSM-5 in 2013 floundered because clinicians feared the economic and cultural consequences of such a radical transformation of the categorical diagnostic system (Whooley and Horwitz 2013).

Another profound threat to the DSM edifice stems from its repudiation by one of the major original sponsors of the specificity model, the National Institute of Mental Health (NIMH). Shortly before the release of the new manual, Thomas Insel (2013), the Director of the NIMH, very publicly announced that his agency was going to establish an independent diagnostic system unrelated to the DSM's specific entities. “As long as the research community takes the DSM to be a bible,” Insel cautioned, “we'll never make progress” (qtd. in Belluck and Carey 2013). Even more fundamentally, Insel warned that “we might have to stop using terms like depression . . . because they are getting in our way, confusing things” (qtd. in Greenberg 2013, 340). The NIMH’s recent rejection of the DSM nosology illustrates the contradiction of trying to place the psychosocial difficulties of millions of women and (to a lesser extent) men into the specific categories that legitimate medical classifications demand. The generalized and overlapping nature of psychosocial problems linked to the stress tradition resist such precise labels.

Psychiatric classifications inevitably reflect the social forces prevailing in any particular historical era. The replacement of anxiety by depressive conditions among treated psychiatric patients illustrates how which conditions are diagnosed depends not only on the symptoms that patients display but also on factors that include professional fashions in diagnoses, the financial rewards from various treatments, the concerns of funding agencies, and the activities of various interest groups. The amorphous psychic, somatic, and interpersonal problems that bedeviled humans long before the emergence of standardized diagnostic categories will continue to underlie whatever specific labels are used to classify them. Today’s mothers might be diagnosed with “depression” and be treated with “anti-depressant” drugs, but the underlying difficulties that they face seem little different than those that persisted for many decades before depression became the most useful label for their plights.

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