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Depression: a cultural panic attack

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

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

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

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

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

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

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

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

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

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

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

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