many adherents also use social and psychological causes and treatments. A second model conceives of depression as the result of external stressors, loss events, and other problems of living that naturally subsides when these conditions improve. In this view, optimal responses lie in addressing the social conditions that underlie depressed states. In this essay, we examine how each edition of the Diagnostic and Statistical Manual of Mental Disorders *(DSM) since DSM-III in 1980 has blurred the medical and social approaches and conceived of all sorts of depressive symptoms as needing medicinal responses. Although the distinction between the social and medical types is often difficult to make, it is an essential first step in developing accurate conceptions of the two sides of depression.*

The question of whether it is most useful to treat depression as a medical or as a social problem has generated considerable discussion. On one side,

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social forms of depression have been seen as medical disorders, resulting in mistaken views of its prevalence, etiology, and treatment.

The medical view of depression dominates public discourse. According to this approach, we are in the midst of a tidal wave of depressive disorder that should be addressed with an equally forceful medical response. In contrast, just a few decades ago, prior to the use of current diagnostic criteria, depressive disorder was considered a serious but relatively uncommon disorder, affecting perhaps 2–3 percent of the population over a lifetime.[3] This situation drastically changed after 1980 when DSM-III inaugurated symptom-based criteria for MDD in order to improve the reliability of psychiatric diagnosis. This meant abandoning traditional standards for validity that required more subjective judgments, such as "with or without cause" or "unexpected duration" that had previously separated medical from social forms of depression.[4] The unintended result was to combine situational responses to external losses with long-standing individual dysfunctions without distinguishing these two very different conditions.

Population surveys using DSM measures soon found that huge proportions of people met MDD criteria. The major survey of mental disorder in the United States conducted after 1980 indicated that over 20 percent of community members had suffered from MDD.[5] MDD's Janus-faced nature allowed researchers to downplay its severity when explaining how it could afflict such a substantial portion of the population. For this purpose, it was the common cold of psychiatry. Yet when it was advantageous to emphasize its devastation, depression was labeled a

Whether depressive emotions are normal depends on the situation. Four specific qualities indicate that depressive reactions, like other emotions, are evolutionarily designed responses to particular circumstances.[11] First, these reactions are highly context-specific, emerging in response to losses and other stressors, including loss of relationships, status, resources, and meaning. This fits the evolutionary understanding that each emotion is biologically designed as an adaptive response to a particular kind of challenge and is thus triggered by specific types of events. Like many other clearly biologically designed features – for example, sleep – the adaptive purpose of sadness, grief, and depressive feelings remains disputed. Various explanations include disengagement from valued goals that have become hopeless, withdrawal when a loss of status or resources places us in danger if we continue in the fray, as well as warnings that things are not going well and need our attention and signs that we need to devote our mental processing toward rumination on complex problems in our social relationships.[12] Whatever the precise answer, for better or worse, sadness and grief are part of our natural humanity.[13]

The second indication that depressive reactions are evolutionarily designed is that the symptomatic intensity of the emotional response is roughly proportional to the magnitude of the loss that triggers it, subject to individual and cultural variability. From an evolutionary point of view, the greater the adaptive challenge,

Of course, emotions are often unwanted or distressing without being disordered. Given that our environment is so different from the environment in which the human species evolved, there will be mismatches between the way we have evolved to react and the transformed social environment in which we find ourselves. Such mismatched reactions can be normal but no longer useful, and we may want to treat them while recognizing that no medical disorder is present.[16]

We reject the common idea that when depressive feelings are reactive to some situation rather than unprovoked, they are normal. Social triggers can cause both normal and disordered depressions. The majority of cases of both kinds start with a stressor, so very few depressions are completely out of the blue. Most cases described since antiquity arise after hearing news of the death of a loved one or some other major loss. So, the medical or social distinction must lie elsewhere.

Instead, a crucial difference between medical and social depressions is whether symptoms respond to changing external conditions, as they are biologically designed to do. For example, cases that develop after people have lost jobs or romantic relationships should remit when they enter new jobs or new involvements. In other cases, such as grief reactions, symptoms should gradually dissipate with the passage of time and the construction of new meaning-systems. In contrast, depressive disorders are unresponsive to positive changes in the initiating circumstances and persist over long time periods regardless of the social environment.

> here is a long history of medical recognition and treatment of depressive disorder, known in antiquity as “melancholia” or “black bile disease” af -

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phasized the distinction between melancholia and normal-range but symptom

to stressful situations, such as unrequited love, were diagnostically distinguished

The modern concept of depressive disorder emerged most directly from the

cent thinking that the present diagnostic system is commonly referred to as

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sadness and medically disordered depression as described above. Like his med

ing context into account when diagnosing depressive disorder and differentiating

tions chiefly through the lack of a sufficient cause, as well as by their intensity and

certain external occasions, but they do not vanish with the cause like normal

[19]

ry psychopharmacologist Donald Klein echoed Kraepelin’s last point, that a key

distinction between medical and social depressions is whether the condition responds to changing conditions: "Once the episode is underway, it is autonomous,

Yet another problem with the DSM criteria lies in the lifetime trajectories of people who qualify as disordered. When Kraepelin developed the notion of depressive disorder, the single feature that most convinced him that he was justified in attributing medical disorder was the actuality or expectation of an eventual recurrence. The research literature regularly describes depression as recurrent as a rationale for its being pathological. Eminent psychiatric researcher Kenneth Kendler explains: "For Kraepelin, the 'construct' of . . . manic-depressive insanity assumed a relapsing disorder without deterioration" and thus "course and outcome would be the most important validators."[32] Recurrence is interpreted as evidence of an ongoing internal dysfunction that disposes the individual to new episodes so recovery from depression is interpreted as "recovery from the episode, not from the illness per se."[33] Consequently, treatment should focus on preventing recurrence, often by extending services beyond recovery.

However, recent analyses of the literature reveal that over half – likely approaching 60 percent – of all depressive episodes are the only ones that the individual experiences during lengthy follow-up periods.[34] That means that most cases of what is diagnosed as depressive disorder do not satisfy the crucial criterion, recurrence, that persuaded Kraepelin to consider this condition a mental disorder, and that current researchers cite as justifying its pathological status.

As a result, many MDD diagnoses are questionable as medical pathologies. For example, a recent national epidemiological survey found that about 13 percent of individuals diagnosed with MDD had their depressive episodes only after the deaths of loved ones and these episodes lasted less than two months.[35] The 11 0 081 (ths o 0)-2

ly disordered ones is to preclude research from establishing the etiology, course, treatment effectiveness, and possible biomarkers of depression. Far more research is needed that explores questions such as when natural responses to social losses become medical disorders, the reasons for the high variability of depression rates across cultures, and the relative effectiveness of medical and social responses to depression. Although the distinction between social and medical forms of depression is often difficult to make, it is an essential first step in developing accurate conceptions of the two sides of depression.

ABOUT THE AUTHORS

Allan V. Horwitz is Board of Governors and Distinguished Professor Emeritus of Sociology at Rutgers University. He is the author of twelve books, including *The Social Control of Mental Illness* (rev. 2002), *The Logic of Social Control* (1990), *Creating Mental Illness* (2002), *The Loss of Sadness: How Psychiatry Transformed Normal Misery into Depressive Disorder* (2007), and *Conundrums of Modern American Medicine* (2010).

Jerome C. Wakefield is Professor of Social Work and formerly Professor of the Conceptual Foundations of Psychiatry in the School of Medicine, with additional appointments in Bioethics and Philosophy, at New York University. He is author or coauthor of several books, including *The Loss of Sadness* (2007), *Freud and Philosophy of the Mind* (2018), *Freud's Argument for the Oedipus Complex* (2022), and *Attachment, Sexuality, Power* (2022), and the subject of an edited volume of critiques and replies, *Defining Mental Disorder: Jerome Wakefield and His Critics* (2021).

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