Major Depressive Disorder: Psychiatric nosology's 'black dog'

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Winston Churchill, known for his recurrent states of gloominess and melancholy, is famously quoted for saying "I have a black dog on my back". Whether he was allegedly citing his childhood nanny or celebrated English writers and essayists such as Samuel Johnson and Hester Thrale, his personal contribute certainly disseminated that expression from the English folklore – 'black dog' – as a metaphor for one's feelings of sadness and depression (1). Such an emphatic designation endured in the mainstream culture, and has been adopted by the World Health Organization in education materials about mental health.

Remarkably, fifty years after W. Churchill's death, one could argue that the current classification of depression is not substantially more accurate or consistent, negatively influencing both scientific research and clinical practice.

Major Depressive Disorder (MDD) aroused from DSM-III classification, itself a scientific and theoretical mutant designed to prevail over political disputes between the psychoanalytical hegemonic power and the forthcoming biological partisans. Robert Spitzer was appointed as the head of the task force for the new DSM edition – a minor character in American psychiatry at the time, in charge of redesigning psychiatric nosology, also a footnote in those psychoanaly-

lytical times (2). Spitzer holds credit for rescuing American Psychiatry to scientific method, and thus positively influencing psychiatric practice worldwide, but he also created several "black dogs" that keep on thriving nowadays.

One of the capital sins of DSM-III was the end of the traditional view of depression regarded as two different subtypes: melancholic and non-melancholic type. In fact, despite the myriad of classifications and terms created to categorize depression throughout time, until DSM-III roughly all of them assumed a split between a disease-like, melancholic form, known since ancient times, and a non-melancholic form, much more prone to various subcategories and designations, according to the language and theoretical framework dominant at each historical moment. In our own contemporary language, one could divide such two dimensions as disorders of "hardware" and disorders of "software". The first referring to melancholic depression eminently as a dysfunction of the body, and the latter, primarily referring to existential geometries arising from the interaction of individual aspects of vulnerability/resilience and psychosocial aspects of protection or stress.

The psychiatric landscape prior to DSM-III, greatly dominated by psychoanalysis, also had such a perspective. Melancholic unipolar and bipolar depression were bundled together and considered part of manic-depressive illness, as stated by Kraepelin, whereas neurotic depression was a separate entity, along with other so-called neurotic disorders, derived from consecutive layers of psychoanalytic theory (3). Most of them, we posit – with the clear exception of obsessive-compulsive neurosis – could well remain within the group of the "software" disorders. DSM-III not only lumped together those two dimensions, against an empirical classification which for centuries had resisted to cultural and social bumps in the conceptualization of mental problems, but it also medicalized what until then had been regarded as a matter of character, developmental history and as a result of a general discomfort of living.

Most strikingly, the decision of unifying depression was not made based on any reliable data or concrete theoretical approach to the subject. In fact, it was the opposite. After the edition of DSM-III, Spitzer recognized that the new classification was essentially politically driven, and assured that the next edition would be "more scientific" (4).

Another capital sin committed in the DSM-III was to separate anxiety from depression, as well as of

course considering all its forms as different diseases. Again, the task was done regardless of any existing clinical background and without solid evidence supporting such proposition. In the case of anxiety, the decision was even against what had been agreed earlier with the development of the Research Diagnostic Criteria (RDC), which included the concept of "mixed anxiety-depression", now erased. And so, in a single blow, the two most common diagnoses at the time – mixed anxiety-depression and neurotic depression – were wiped out from the psychiatric lexicon (2, 5).

Paradoxically, Spitzer had also been involved in the development of RDC, with the firm purpose of defining and articulating the elements of construct validity in Psychiatry. MDD, however, represents its antithesis. Producing a valid model for depression will always be an indisputably difficult task – one just has to think about the conceptual and theoretical conundrum of non-melancholic depression to acknowledge the complexity. In fact, it has been one of the most important alibis for not changing the diagnosis at all, but beyond the necessary – indispensable – validity criteria, other questions should be posed regarding MDD: is it helpful in identifying specific treatments, in improving communication between health professionals or in distinguishing itself from adaptive reactions such as grief?

As it stands we consider MDD a bottom-of-barrel diagnostic entity. It says nothing clear about etiology, prognosis or treatment approaches (6). Even clinical description is not clear, filled as it is with criteria referring to vegetative manifestations that may be present pointing at either way, as seen regarding sleep, weight, appetite or activity. On the other hand, it medicalizes the experience of depressed mood, favoring iatrogenesis of subjective experience. In spite of all rhetoric saying otherwise that surrounds it, Psychiatry has become a translator of emotional suffering with only one entry: disease.

Interestingly, although assumedly based on a scientific and evidence-based approach, current psychiatric nosology created a flawed construct such as MDD at the same time that it virtually discarded the only entities that really stood up to the definition of disease. In fact, melancholia, along with catatonia, are the only ones in which it is possible to describe relatively clear clinical features, biological changes and specific treatments. Both of them, however, lie in classifications virtually as outcasts (7).

Psychiatric nosology of depression also bears important questions regarding treatment. Bundling melancholic and non-melancholic depression together smashed the psychoanalytical perspective of depression in which psychotherapists heal by the power of word and introspection, and turned it into a neurochemical imbalance, susceptible of correction by psychopharmacology. This was nothing but good news to the pharma industry and it led to the opening of the psychopharmacological gates to a large majority of patients who would not hitherto be offered any drug treatment.

However, such growing number of engaged patients also brought snowballing heterogeneity. Decades of dissemination of the construct of MDD progressively contaminated mainstream culture and everyday life. Generations of psychiatrists trained as per DSM, along with the pressure from insurance companies and pharma industry to label patients with a medical diagnosis made MDD an even sketchier concept and with a progressively lower threshold. Cultural and social context also wielded their power, and with an increasing demand for cosmetic intervention in psychological performance, along with a general aversion to sadness and frustration, the use of medication was taken even further (6).

Ironically, pharma industry is paying the price for this flawed nosology and practice, and it is losing its favorite game. After the boom of the SSRI, it is increasingly difficult to produce new antidepressants, and placebo is an antagonist each time harder to beat. In addition, the cumulative experience of using antidepressants allowed extensive naturalistic studies such as STAR*D, showing a much darker picture than the pink universe of controlled trials (8). On top of this there is a growing lay view of biological treatments for depression and anxiety as unnatural, potentially harmful and useless, as more people seek to make sense of their suffering beyond neurobiological reasoning, and new narratives for psychological wellbeing are emerging. In fact, this cycle is nothing less than what neurotic patients did for at least the past 200 years, electing and discarding waves of selected treatments and models of conceptualizing their existential burden.

Current nosography of depression also represents an obstacle to sound research on mood disorders. It is difficult to grasp how we will ever build consistent knowledge on heterogeneous samples, made of patients with strikingly different clinical profiles and basic psychopathological characteristics if we do not acknowledge those differences. It is important to highlight that an undisputed system of classification will hardly ever be achieved – natural sciences and the Linnaean taxonomy are prime examples of this unsurmountable task – nor should one fight a never-ending battle of splitters versus lumpers. Yet we argue that fundamental differences have been artificially erased.

Having described such a grim picture of current status of MDD and clinical practice, it would be reasonable to question how and why there has been no change in *status quo,* more than thirty years after DSM-III and several other DSM editions down the road. We believe that the answer to that question lies in the biopsychosocial model, the psychiatric mantra on approaching and treating mental patients.

The biopsychosocial model is essentially a way of assuring that all perspectives regarding each patient are taken into account by psychiatrists or any other mental health professionals. It is meant to promote the integration of different mental health providers, from doctors to nurses and all sorts of therapists, al-

lowing everyone to play a role, and enabling the combination of psychotherapeutic interventions with biological treatments.

At a glance, it appears to buy peace between the psychosocial and the biological trenches, and thus avoiding biological dogmatism and assuring that everyone gets their share. However, it is a rather one-size-fits-all model that while appearing wise and flexible is, in fact, a source of bias and confusion. The biopsychosocial model allows any theory or method to be potentially correct, but does not state if any is definitely incorrect; it is superficial and does not propose a methodology; it gives professionals permission to do everything but no specific orientation to do anything in particular. At the end of the day, any prioritization among the many available interventions happens according to each one's idiosyncratic skills or perspective (9).

This model of approach, a virtually undisputed benchmark of Psychiatry, suits just fine on MDD. As stated before, MDD is an ill-defined, over-inclusive construct, which relates to very heterogeneous clinical profiles. As such, all approaches are deemed to help, but in many cases none is definitive. The current trend turned the biopsychosocial model into monobio: patients are by default submitted to psychopharmacological interventions, and then maybe – just maybe – they are given access to any other therapeutic approaches, anything ranging from behavioral therapy to a new meditation strategy followed by a movie star in Hollywood. The result is frustration for patients and professionals, mental suffering and the risk of discrediting the art of Psychiatry.

At this point, the description of such a gloomy scenario may raise the question of whether the Authors themselves are having a black dog on their back. By no means we intended neither to be nihilistic, nor to succumb to such a weight. In fact, there is solid ground for being optimistic. A growing number of researchers and clinicians are pointing out different paths and designing new frameworks. The recent work of Gordon Parker et al. is fundamental not only in detailing limitations to the construct of 'major depression', but mainly repositioning it as a proxy for 'clinical depression' and arguing for its re-operationalization in constituent depressive subtypes: non-melancholic, melancholic and psychotic (10). Others have proposed MDD as a complex dynamic system in which symptoms are directly connected to one another in a network structure, and individual patients could have their own network with its unique architecture and resulting dynamics (11). Symptoms, not syndromes, may be the way forward (12).

The bottom line is that there are enough data and clinical evidence available to question the disease model and the ways we currently conceptualize depression and anxiety. It is of crucial importance that clinicians and researchers can communicate better and that new generations of psychiatrists feel encouraged to question the discrepancies between clinical practice, classifications and outcomes for their patients. Like Alessandro Manzoni, the Italian poet and novelist, once said, "Il buon senso c'era, ma se ne stava nascosto per paura del senso comune" (There was good sense, but it was hidden, fearful of common sense).

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