

# Psychiatry's main method to prevent mistaken diagnoses of depression doesn't work: study

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A study in the March edition of the *American Journal of Psychiatry* senior-authored by Jerome C. Wakefield, a professor at the Silver School of Social Work at New York University with Mark Schmitz of Temple University and Judith Baer of Rutgers University, empirically challenges the effectiveness of psychiatrists' official diagnostic manual in preventing mistaken, false-positive diagnoses of depression.

The findings concerning the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders' (DSM) criteria for diagnosing depression rebuts recent criticism of earlier research by Wakefield. That earlier research suggested that misdiagnoses of depression are widespread, and touched off considerable controversy.

According to the DSM, the diagnosis of [major depression](#) requires the presence - for two weeks - of at least five possible symptoms out of a list of nine, which include, for example, sadness, loss of interest in usual activities, lowered appetite, fatigue, and insomnia. However, these symptoms can also occur in normal responses to loss and stress. False positive diagnoses occur when someone reacting with intense normal sadness to life's stresses is misdiagnosed as having [major depressive disorder](#). Recent studies suggest that a very large percentage of people have such symptoms for two weeks or longer at some point in their lives; therefore, how many of these individuals really are afflicted by a mental disorder or are responding within normal limits to loss or stress has been

a matter of debate.

The journal article, entitled "Does the DSM-IV Clinical Significance Criterion for Major Depression Reduce False Positives? Evidence From the National Comorbidity Survey Replication," examines the primary method by which the official diagnostic criteria for depression -the Clinical Significance Criterion (CSC) - are supposed to distinguish normal from disordered cases and thereby prevent false positive diagnoses. The CSC was added to the symptom and duration criteria in the DSM's fourth edition in 1994 (DSM-IV) in the wake of criticism that too many of the listed symptoms - loss of appetite, say, or sadness, insomnia, or fatigue - were being identified as evidence of major depressive disorder even when they were mild and possibly normal responses to distress arising from such events as the loss of a job, the dissolution of a marriage, or other triggers for sadness, and that such errors might be contributing to the very high reported rates of untreated depression in the American population drawn from epidemiological surveys. Under the 1994 DSM revision, in addition to the two weeks of sadness and other depressive symptoms, a specified minimal "clinically significant" threshold in the form of harm due to distress or role impairment (in occupational, family, or interpersonal contexts) must have resulted from the symptoms in evidence before they could be considered signs of depression. Researchers have subsequently assumed - without definitive evidence - that the CSC eliminates substantial numbers of false positives.

In a 1999 article in *American Journal of Psychiatry*, Wakefield and co-author Robert Spitzer, the originator of the modern DSM symptom-based approach to diagnosis, argued that the CSC would not eliminate false-positive diagnoses of major depression because anyone having the specified symptoms - even an individual experiencing a normal intense reaction to loss - would be likely to experience distress or role impairment. Thus, they asserted, the CSC was redundant with the

symptom criteria and could not distinguish normal from disordered symptoms—a claim that has come to be known as the "redundancy hypothesis." The researchers' argument was purely conceptual, and largely ignored.

The issue of whether the redundancy hypothesis is correct became suddenly more important after Wakefield senior-authored a much-discussed 2007 article in *Archives of General Psychiatry*. The article argued that there were indeed large numbers of false-positive diagnoses of major depression in community surveys of mental disorder—possibly as high as 25% to 33%. However, that study used data from a national survey that was conducted before the DSM-IV's addition of the CSC to the major depression diagnostic criteria. Thus, there was no CSC in the criteria that Wakefield and his team used to identify cases of major depression at the time. Critics of that study argued that the lack of a CSC was fatal to the argument because if the CSC had been used, then the supposed false-positive diagnoses that Wakefield and his group identified would likely have been eliminated as cases too mild for diagnosis. For example, one noted psychiatrist argued that Wakefield's results were due to a "glitch" in the diagnostic criteria Wakefield used, and that the diagnosed individuals identified by Wakefield as having normal reactions would have been eliminated from the depression category if current diagnostic criteria including the CSC were used. A paper later submitted by Wakefield that built on the 2007 article was rejected for publication partly based on a reviewer's assertion that if the CSC had been included in the earlier study, the supposed false positives likely would have been eliminated. So, the issue of whether the CSC is in fact redundant or actually eliminated many false-positive [major depression](#) diagnoses became key to the debate, which is still ongoing, about the prevalence of depressive disorder.

The latest study, coming in the *American Journal of Psychiatry*, offers an empirical demonstration, based on nationally representative data, that the

Critical Significance Criterion fails to distinguish normal from disordered conditions. In this analysis, Wakefield undertook to evaluate independently the impact of the CSC on epidemiological survey estimates of major depressive disorder by using data from a later survey that included a carefully worked out CSC criterion for depression whose inclusion, according to the claims of its authors, was an effective way of eliminating former false positives. Wakefield then compared estimates of depressive disorder with and without the use of the CSC. Confirming the redundancy hypothesis put forward a decade earlier, he found that the CSC eliminated virtually no one from diagnosis—in fact, even among those who experienced prolonged sadness without meeting other diagnostic criteria for depression, about 94% of them satisfied the CSC just on the basis of the "distress" component alone. Thus the Clinical Significance Criterion, according to Wakefield and his co-authors, is not doing what it is supposed to do - reducing the over-diagnosis of normal mood fluctuations as depression - and the issue of preventing false positives needs to be revisited. And contrary to critics' speculations, the earlier findings suggesting many false positives in community surveys cannot be dismissed on the basis of the CSC.

The results take on further importance, Wakefield says, in light of proposals for changes to the DSM in a revision currently taking place that will lead to DSM-V. Concern about increasing false positives is at the heart of criticisms of the proposals that have been put forward by leading psychiatrists, including Allen Frances, the Editor of DSM-IV. Moreover, some of the proposals seem to rely heavily on the CSC to justify diagnosis of disorder even when symptoms are minimal—when in fact the current research underscores that normal distress can easily satisfy the CSC.

**More information:** To see the research abstract, please visit [ajp.psychiatryonline.org/cgi/c ... .ajp.2009.09040553v1](http://ajp.psychiatryonline.org/cgi/c...ajp.2009.09040553v1)

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