Psychiatrists and Clinical Depression – Part 3

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Continued from ***Psychiatrists and Clinical Depression – Part 2***

In Part 1, we pointed out the worldwide pervasiveness of depression and quoted the following: “Depression has been declared by the World Health Organization in March of 2017 to be the illness with the greatest burden of disease in the world.”[1]

Many Forms of Depression

The signs, symptoms, and treatments vary for clinical forms of depression: Major Depressive Disorder (MDD), Persistent Depressive Disorder (Dysthymia), Seasonal Affective Disorder (SAD), Postpartum (Perinatal) Depression, Premenstrual Dysphoric Disorder (PMDD), Disruptive Mood Dysregulation Disorder, and Bipolar Disorder.[2]

DSM and Depression.

The manual of mental disorders used by psychiatrists is called the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*).[3] The latest edition, DSM-5,TR (Text Revision) contains over 200 distinct mental health disorders. While all of the above individually named “depressions” are in the DSM-5-TR, **the generic word “depression” as a mental disorder has never been listed in the manual, so it is difficult to know what is meant by the generic term “depression**.”

Idiopathic Depression

Idiopathic depression would be a mental condition that appears to arise without any known cause. Freud spent his lifetime searching for his patients’ memories to find a cause for their depression. Today, even after research that refutes it, individuals believe that the cause is embedded in forgotten memories, which in the final analysis become false memories created in certain forms of psychotherapy.

Overlapping Symptoms

Another problem occurs because of the **fact** that **many** mental disorders have **overlapping symptoms** with other mental disorders. For instance, major depressive disorder (MDD) and schizophrenia have overlapping symptoms. The same is also true of MDD and bipolar disorder.

Physical Illnesses

In addition, many illnesses that are obviously bodily are preceded by depression or other mental symptoms, which suggests biological involvement even when not clearly identified. Psychiatrist Barbara Schildkrout has written two books to encourage her fellow practitioners to look beyond psychological symptoms. They are titled *Unmasking Psychological Symptoms: How Therapists Can Learn to Recognize the Psychological Presentation of Medical* Disorders[4] and *Masquerading Symptoms: Uncovering Physical Illnesses That Present as Psychological Problems*.[5] There is the possibility of emotional symptoms preceding physical illnesses, which would be valuable information for readers to know. More valuable are the topics of misdiagnosis and medical conditions with mental symptoms.

Misdiagnosis

At the beginning of *Masquerading Symptoms,* Schildkrout quotes E. K. Koranyi, who says:

> Non-specific behavioral and mood alterations often represent the very first and, occasionally for prolonged periods of time, the one single and exclusive sign of an undetected physical illness. Flagrantly and convincingly “psychological” in nature on presentation, such masked physical conditions frequently mislead the examiner and obliterate any further medical consideration, resulting in misdiagnosis and thus, inevitably, in treatment gone astray.[6]

Medical Illnesses with Mental Symptoms

Schildkrout says:

> Many medical conditions can produce mental symptoms as their dominant clinical feature. This creates a diagnostic problem. How is one to know whether an underlying medical disease might be the cause of a patient’s presenting psychological symptoms? This question is a serious one for all mental healthcare practitioners, indeed for all clinicians.[7]

In her book, Schildkrout describes seventy illnesses that may have psychological symptoms and may therefore elicit a misdiagnosis rather than a diagnosis associated with the actual illness. In addition to known diseases, there may be excruciating mental-emotional symptoms for diseases not yet discovered. With many of the disease descriptions, she lists “Possible Presenting Mental Signs and Symptoms,” and in another section, she lists diseases “that may present with anxiety,” a “depressed mood,” “episodes of fear,” and so on.[8]

Normal Sadness or a Diagnostic Category

Because of the various forms of depression and the problem of overlapping symptoms, a medical doctor or a psychiatrist is required to determine whether or not a person is experiencing normal, but deep and possibly debilitating sadness or if the person fits into one of the diagnostic categories. Making an accurate diagnosis requires thorough testing and a medical history. This also requires time to parse out **circumstances** surrounding the symptoms, such as stress at work or elsewhere, lack of sleep, side effects from current medications, illness or death of family members, or other depressing challenges.

Dr. Allan Horwitz and Dr. Jerome Wakefield verbalize their concerns in their book *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder.* In the Foreword, Dr. Robert Spitzer, a professor of psychiatry, says that the authors:

> … persuasively argue, as the book's central thesis, that contemporary psychiatry confuses normal sadness with depressive mental disorder because it ignores the relationship of symptoms to the context in which they emerge. The psychiatric diagnosis of Major Depression is based on the assumption that symptoms alone can indicate that there is a disorder; this assumption allows normal responses to stressors to be mischaracterized as symptoms of disorder.[9]

In their Preface, the authors say: "We hope that the result of our collaboration is a book that does indeed manage to wend a balanced path between the biological and the social and between normal suffering and mental disorder."[10]

Caution

We want to make it clear that we do not recommend that individuals get on or off psychotropic medications. We generally have not written about psychotropic medications, but we do say that such medications are grossly overprescribed and greatly overused. Through the collaboration of psychiatrists and pharmaceutical companies, psychotropic drugs have been unnecessarily foisted upon millions of naïve individuals. Mental disorder labels are often recklessly and fecklessly applied by doctors to people who are undeserving of them. Moreover, based upon recommendations from friends and pharmaceutical advertising, consumers request such psychotropic medications from their doctors, and doctors who are on tight timelines too readily prescribe them. There are many skeletons in the psychiatric closet of the past and too many questionable practices of today, including sometimes clandestine relationships between psychiatry and the pharmaceutical industry. And the research on depression being a systemic illness may point away from antidepressants and other psychotropic medications to medications that may apply to one or more of the areas systemically involved in an individual's depression. **Nevertheless, all decisions regarding whether to take or stop psychotropic medications should be made only under the supervision of a medical doctor.**

[1] James J. Strain (ed) and Michael Blumenfield (ed), Abstract of *Depression as a Systemic Illness*, Oxford University Press, 2018, https://academic.oup.com/book/24777.

[2] “Depression: Learn More—Types of Depression, NIH National Library of Medicine, https://www.ncbi.nlm.nih.gov/books/NBK279288/.

[3] “DSM-5,” Wikipedia, https://en.wikipedia.org/wiki/DSM-5, 02-14-2026.

[4] Barbara Schildkrout. *Unmasking Psychological Symptoms: How Therapists Can Learn to Recognize the Psychological Presentation of Medical Disorders*. Hoboken, NJ: John Wiley & Sons, Inc., 2011.

[5] Barbara Schildkrout. *Masquerading Symptoms: Uncovering Physical Illnesses That Present as Psychological Problems*. Hoboken, NJ: John Wiley & Sons, Inc., 2014 (Kindle Edition).

[6] E. K. Koranyi (1979), “Morbidity and rate of undiagnosed physical illnesses in a psychiatric clinic population.” *Archives of General Psychiatry*, 36 (4), 414.

[7] Schildkrout. *Masquerading Symptoms*, *op. cit.*, p. xi.

[8]*Ibid.*, pp. 15ff.

[9] “Forword,” Robert L. Spitzer in Allan V. Horwitz and Jerome C. Wakefield. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder.* New York: Oxford Unversity Press, 2007, p vii.

[10] Horwitz and Wakefield, *op. cit.*, p. xii.

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