THE AGE OF MELANCHOLY

"MAJOR DEPRESSION"

AND ITS

SOCIAL ORIGINS

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Contents

Preface

Depression causes more disability than any other psychiatric disorder and challenges the public's health worldwide. Many now view the burden of depression as being of epidemic proportions. Perhaps the frequency of depression is increasing dramatically in Western societies. Perhaps we are just more aware of depression. Regardless, epidemics demand a name, such as an epidemic of tuberculosis or arteriosclerotic heart disease. The name psychiatry and society have chosen for this epidemic is *major depression*. Society-wide epidemics, however, are almost always caused by some change in the environment, not the body or mind. What is the cause of the current epidemic of depression? We don't know. Why don't we know? We haven't looked. We explore body and mind to understand our age of melancholy, not the environment, especially the social environment.

Even as depression has come to the public's attention more than ever before, the search for its social origins has all but ceased. The epidemic of depression has been "medicalized" as major depression. Medical scientists search for the locus of the problem solely within the individual, whether that locus is hypothesized to be biological vulnerability or inaccurate "depressogenic" perceptions of the environment. We are autonomous souls, alone in the crowd. If we are depressed, the problem must reside within us, uncoupled from wider social and economic forces. The diagnosis major depression, when viewed as a medical disease, affirms this uncoupling. If major depression is more frequent among young women, among the economically disadvantaged, and among people exposed to violence, we dare not explore the causal linkage between depression and discrimination, poverty, or fear. Or so it seems.

The rise of major depression (as the prototypic diagnosis of modern psychiatry) and the retreat of social psychiatry reflect the sea change in psychiatry over the past 40 years. In this book, I make an argument for connecting these two trends and suggest reasons for their rapid evolution and devolution, respectively. In addition, I propose that social psychiatry should be revived, albeit in a different form. We must explore the social

causes of depression. Social psychiatry must not replace but rather complement current psychobiological and clinical research. *Complement* is too weak a term. Basic social psychiatric investigations will compel mental health investigators and practitioners to embed depression within the society from which it emerges.

The reader will notice a piece of the causal puzzle dramatically underrepresented in this book—the mind. Understanding cognitive processes, the nature of consciousness, and the influence of the unconscious, memory, and reasoning, to name but a few aspects of the mind, is, of course, critical to understanding the nature and origins of depression and its treatment. I have chosen to juxtapose the current focus on the biology of the brain and the disappearance of interest in social origins. Many propose that the mind is the mediator between body and society. Others view the mind as an epiphenomenon of the activity of the brain influenced by environmental stimuli. For the purpose of my argument, I see no reason to enter this debate. I do not propose a grand model of depression.

The reader will also note that I do not focus on the contributions of the disciplines of sociology and social psychology, though I refer frequently to studies that have been published by these disciplines. I purposefully have focused my comments on psychiatry. Psychiatry in many ways drives other disciplines, especially in the move to a biomedical model of emotional distress. In addition, only the medical profession at present widely prescribes medications, the most obvious manifestation of our changing views toward depression as a society. Fully 10% of the adult U.S. population takes antidepressant medications. I also have focused on the experience with depression and psychiatry primarily in the United States. Though similarities abound across Western countries, the United States has tracked a unique history in my view.

Each chapter contains a section titled "A Case in Point" that segues to the real world of psychiatrist, patient, and society. Some cases reflect real people. Even though names are changed or omitted, the events are described accurately while at the same time limited in description so that anonymity and confidentiality can be maintained. The essence of the cases accurately reflects the patients' experiences, though the patients would have great difficulty identifying themselves.

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1

Introduction

The biological and the social are neither separable, nor antithetical, nor alternatives, but complementary. … All human phenomena are simultaneously social and biological.

—Richard Lewontin, Stephen Rose, and Leon Kanin, *Not in Our Genes* (p. 1)[1]

We live in an age of melancholy.[2] Depression, the most frequent of the serious chronic mental illnesses, causes disability equal to if not greater than medical illnesses such as diabetes and hypertension. Epidemiologic studies have demonstrated that depression exerts the greatest societal burden of all the psychiatric disorders.[3–5] According to the World Health Organization, depression ranks 4th among the 10 leading causes of the global burden of disease and is expected to rise to 2nd within the next 20 years.[6] Psychiatry and society have chosen a name for this melancholic burden: *major depression*. The diagnosis and treatment of major depression dominates the practice of therapists from psychiatrists to pastoral counselors.

We are thankful that we do not live in an age of hopelessness, at least from the perspective of psychiatry. Major depression is a treatable disease. Indeed, 70% of those who take antidepressant drugs respond,[6, 7] and relapse following initial treatment can be significantly reduced with a combination of antidepressants and psychotherapy.[8]

Despite the good news—a better understanding of the brain, improved diagnostic capabilities, and the improvements in therapy—something in therapists' understanding and treatment of the disease is missing. W.H. Auden believed that society was adrift after World War I, leading to widespread anxiety, and he designated the era between the world wars of the 20th century the "age of anxiety."[9] He coupled the epidemic of anxiety with the unstable, "anxiogenic" social environment of Western Europe and America. The world was a threatening place in which to live. Uncertainty abounded. Given the world situation, anxiety was to be expected. Somehow, however, we seem to have lost sight of the connection

between the way we feel and the world around us. How does the world around us currently contribute to our feelings of depression?

The Medicalization of Depression

Today, biological explanations of the burden predominate. Biological treatment is focused on the brain in the form of medications, and psychotherapy for depression emphasizes the need of the individual to adjust to the social environment. Psychiatrists rarely acknowledge that something is wrong with the social environment, and they encourage change in that environment even more rarely. In other words, despite the commonly accepted facts that major depression is prevalent in our society and that our social environment is rife with stressors that make us vulnerable, psychiatry does not link our melancholy with the society in which we live. Social psychiatry—the study of the social origins of psychiatric illness—has all but disappeared as a paradigm for investigating the origins of depression and, instead, has been replaced by biological explanations.

A Case in Point

A few years ago, I worked with a group of valued colleagues to sketch a geriatric psychiatry research agenda for the future. We agreed that a focus on major depression made sense as a starting point. The umbrella term *major depression* encompasses quite a few types of inquiry. We added many research projects to the agenda, including brain imaging of severely depressed older adults and clinical trials of new, promising medications. I am a social epidemiologist and a geriatric psychiatrist. I also am a little older than these colleagues and well remember the heyday of social psychiatry in the United States. It seemed obvious for me to add items to the agenda from my research and clinical experience.

I suggested that we add the study of primary prevention for late-life depression to the agenda. The social stressors of late life, such as the lack of economic resources or the fear of crime, seemed obvious topics to study. In other words, I proposed that we research ways in which depression can be prevented in the first place. My colleagues turned to me in disbelief. One responded, "There is no primary prevention of major depression." I stared back in equal disbelief. Of course, no one had yet proved that changing the

living conditions or the social context of an older adult would prevent late-life depression. But we were setting a research agenda for the future, not summarizing findings from the past. Could my colleagues believe that such an intervention was not even feasible? Could they totally discount the context of late-life depression and refuse to add explorations of the social origins of depression to the agenda? Yes, they could! I realized, to my dismay, that social psychiatry had all but disappeared from the view of most psychiatrists.

The Advance of Major Depression and the Retreat of Social Psychiatry

Social psychiatry, which thrived during the 1960s, is virtually moribund in the United States, whereas major depression, born during the late 1970s, has become an everyday label accepted by psychiatrists, their patients, and the public. The term *major depression* could scarcely be found in the psychiatric literature prior to the publication of the research diagnostic criteria in 1978 and their expansion in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders–Third Edition* (*DSM–III*) in 1980.[10, 11] (John Feighner and other psychiatrists at Washington University developed the core operational construct of major depression as early as 1972 and applied the term *primary depression*.)[12] I believe the advance of major depression as a diagnosis and the retreat of social psychiatry are linked.

During the 1960s, clinically significant depression was divided into two categories: reactive and endogenous (or internal). The most common form of depression was diagnosed as depressive neurosis (a reaction). In contrast to the more severe endogenous depressions, such as manic-depressive illness, the much more frequent depressive neurosis was caused by an excessive reaction to internal (psychodynamic) and external stressors.[13] An external stressor was essential to the onset of reactive depression, whether that stressor was the loss of a loved one or a response to a dysfunctional social environment. Depression was a complex malady that required a comprehensive explanation.

In the past, psychiatrists expended many words describing the emotional suffering of their patients, for no one word conveyed from one psychiatrist to another the nature, context, and severity of the suffering. The advent of the new diagnostic system allowed psychiatrists to use one label, such as *major depression*, and another psychiatrist knew what the first had observed. The new nomenclature

says, essentially, that "a person has major depression if the following criteria are met, such as a depressed mood and five additional symptoms lasting at least two weeks." Therefore, psychiatrists have become more reliable—that is, consistent—in their use of terms.

Unfortunately, though, much of the richness and context of the more lengthy discussions of the past have been lost. Psychiatrists, it seems, have come to believe that if they label the person with a diagnosis such as major depression, they have said it all. In other words, there is a "real disease" called major depression and, by attaching the label, the psychiatrist pronounces that the patient has this disease. (This process of making an idea real has been labeled "reification." To treat an abstraction as substantially existing is to reify the abstraction.) Reification numbs us to the possibility that depression can be more a signal of the emotionally toxic society in which we live than a thing in and of itself. And if the effects of this toxicity are initially expressed through depression, then depression should signal a need to better understand and improve society.

During the first 60 years of the 20th century, medicine in general and psychiatry in particular became increasingly concerned about social and cultural contributions to illness onset. There was widespread interest in the potential of community-wide interventions that might decrease the onset and persistence of those illnesses. Social medicine arose from general medicine as a separate entity, even a specialty (though never a large one). The research arm of social medicine was epidemiology, with a specific emphasis on social epidemiology.[14] In addition, the social sciences, especially anthropology[15] and sociology,[16] focused many of their efforts on health and illness. Of all the medical specialties, however, only psychiatry formalized a special relation to the social sciences by developing a subspecialty of social psychiatry—there was never a "social obstetrics" or a "social pediatrics."[17] Departments of social medicine were almost always separate from departments of internal medicine and were more aligned to schools of public health.

Following World War II, social psychiatry gained momentum in Europe and the United States. This momentum was fueled by the belief that social factors contributed more to emotional suffering than biological and individual psychological factors did. The 1960s saw an overarching optimism about the ability of social interventions to counter destructive social conditions. As a result of that optimism, the Community Mental Health Center (CMHC) movement was launched, with the goal of intervening in society's institutions, from families and schools to the federal government. Gerald Caplan, a prominent social psychiatrist in the 1960s, described the goal of the CMHC movement:

> *Primary prevention is a community concept. … It does not seek to prevent a specific person from becoming sick. Instead, it seeks to reduce the risk for the whole population, so that, although some may become ill, their number will be reduced. … A program of primary prevention will focus on identifying current harmful [environmental] influences … [seeing] that harmful pressures will be reduced in intensity, [and] that people will be helped to find healthy ways of dealing with them.*[18]

Society, not just the individual, was the patient. To treat depression, one must treat a depressogenic society. This focus on society was considered the most effective means of reducing the burden of depression.

Psychiatry and government, however, were inept at treating society and quickly retreated from the broad objectives of the CMHC movement. The retreat was almost universal, and psychiatrists turned their backs on the implications of a potentially noxious society. Social psychiatry, as it was known during the 1960s, had all but disappeared by the mid-1990s. The rapidly emerging medical model of depression within psychiatry facilitated the retreat of social psychiatry. Sam Guze summarized the medical model for psychiatry:

> *Scientific progress in psychiatry … comprises two broad streams of investigation … one epidemiological and the other neurobiological. … Each requires, reinforces, and ultimately validates a classification of psychopathology. Classification is indispensable for thinking, studying, teaching, and communicating.*[19]

In the move to sharpen classification, *depression* became *major depression*. Specifically defined cases of illness caused by identifiable neuropathology characterized the medical model in psychiatry. If you can define it, you can count it, and if you can count it, then you can search for neurobiological causes. Epidemiology counts—counts cases, that is.

The retreat of social psychiatry and the profession's wholehearted embrace of the medical model, however, can only partially be explained by the failure of the CMHC movement to influence society as a whole. Financial constraints (which, in large measure, scuttled Lyndon Johnson's Great Society) or the influence of the pharmaceutical industry, a popular target,[20] cannot be held responsible for the changes. Other social forces must be explored to explain changes in the view of depression and the virtual disappearance of social psychiatry during the past 30 years. In chapter 6, for example, I examine war syndromes, such as the Gulf War

syndrome, which many people are inclined to attribute to specific physical toxins, such as oil well fires, excluding the stress of war. Although it should be noted that multiple factors can contribute to war syndromes, perhaps the most significant factors are ignored because they are not specific—that is, they are societal rather than physical.

Methodological Individualism and Its Limitations

A broad-based psychiatry must consider biological, psychological, and social origins of disease and dysfunction.[21] Psychiatry, however, has retreated into a narrow, "medicalized" view of depression, ignoring, for the most part, the connection between depression and society. Medicalized depression has focused etiological and interventional research on biological origins and person-specific treatments. The classic medical model insists that disease represents specific biological vulnerabilities interacting with specific environmental insults. For example, a family history of coronary heart disease coupled with a diet high in cholesterol and fat leads to a heart attack. Treatment consists of specific interventions to correct the individual genetic-environmental aberration, such as a change in diet. This medical model has been called methodological individualism.[22]

Recently, however, the limitations of methodological individualism for many of the most frequent chronic physical illnesses have been revealed. For example, the serving sizes and fat content of fast foods have increasingly come under attack. Indeed, there is a substantial literature suggesting that the influence of advertising fast foods has contributed significantly to the increase in our sedentary lifestyle and increased obesity.[23, 24] The intuitive answer to the problem of obesity—either that we, as individuals, are responsible for our weight or that there is something genetically wrong with us that leads to obesity regardless of our behavior—has been expanded to include social forces. In other words, the treatment and prevention of obesity must include intervention beyond the individual to the types and quantities of foods served by the restaurant industry.

Consider, also, exposure to another person's cigarette smoke—passive smoking. Because passive smoking is now thought to increase the risk of lung cancer, many hospitals and other public places have begun to prohibit smoking on the premises. The prevention of lung cancer extends beyond the individual's genetics and behavior. For example, people have known of the connection between smoking and lung cancer for years. Yet only when the government banned advertisement of cigarettes on TV and put bold warnings on tobacco products has there been a reduction in smoking.[24]

Depressive illness, likewise, should not be constrained by methodological individualism. As with cardiovascular disease, depression must be viewed as more than an interaction between a biologically vulnerable person and his or her behaviors toward a unique environment. Regardless of biological vulnerability, most first episodes of major depression are closely associated with a stressful life event, events often out of the control of the individual. During times of economic turndown, for example, the rate of depression goes up. When the economy is in recession or depression, people lose jobs or face other financial challenges. These social stressors clearly increase the frequency of depression.[25] Yet the individualistic approach maintains a strong hold on the way we think about depression.

All cultures place individual experiences into agreed-on social categories. Americans increasingly project the mood of depression onto biological processes, such as a chemical imbalance, and then turn to biology to validate that mood as natural and unique to the individual. Those in the United States are not alone in turning to biological processes and pharmaceutical answers. In Japan, where severe depression has long been recognized as a medical illness, less severe downturns in mood have been attributed to *ki*—a downturn in mood because one's vital energy was leaking—because that energy was sluggish.[26] *Ki* was a state of the soul. These downturns were not considered abnormal, for happiness was believed to be not the continued natural state but rather a fleeting experience. Therefore, seeking medical help for mild to moderately severe depression (what we might consider a less severe case of major depression or minor depression) was not an option.

In recent years, however, things have changed in Japan, in large part because of an advertising blitz by the pharmaceutical industry. *Kokoru no kaze* became a byword across the airwaves: Your *kokoru* was coming down with a cold and you could do something about it. What can be done? Take antidepressant medications. Though few would deny that romanticizing suffering is something to be avoided, nevertheless the loss of sadness as a signal to reflect and to assess the world around cannot bode well for any society.

How Medicalization Affects the Research of Depression

No one can reasonably deny that those suffering from depression deserve as much attention as those suffering from diabetes or lung cancer, and one cannot reasonably deny that relieving the burden of depressive symptoms is a central challenge for health care providers. Yet the boundaries of major depression are far more fuzzy than those of most established medical diagnoses.[27] Although we have tests to

identify malignancy in tissue, we cannot diagnose depression by looking at it under a microscope. We have no way to know where the boundary lies between a depression that deserves clinical attention and the usual adaptations to the slings and arrows of everyday life, adaptations that lead people to moan and groan but from which they emerge as strong as before and perhaps a little wiser.[28]

This fuzziness renders the diagnosis major depression especially deceptive. Specifically, major depression as a medical diagnosis effectively shapes and limits the explorations of its causes. In other words, when clinicians make a diagnosis of major depression, they make a sharp distinction in a span of otherwise indistinct emotional suffering. Grouping so many sufferers under the medical diagnosis of major depression leads to two troublesome outcomes: First, the social forces that contribute to the person's symptoms are not considered, and, second, by ignoring social factors, the diagnosis limits the search for treatment and prevention to the individual.[29]

Do clinicians have evidence that the medicalization of major depression limits inquiry into its causes? According to the Depression and Bipolar Support Alliance,

> *Depression is a treatable illness involving an imbalance of brain chemicals called neurotransmitters. It is not a character flaw or a sign of personal weakness. You can't make yourself well by trying to "snap out of it." Although it can run in families, you can't catch it from someone else. The direct causes of the illness are unclear, however it is known that body chemistry can bring on a depressive disorder.*[30]

Personal weakness in our society is usually attributed to not being able to adapt to the social situation, to not being able to pick oneself up by one's bootstraps regardless of the circumstances. In other words, the stress (external) versus diathesis (constitutional predisposition) model that traditionally was the basis for investigations into the causes of depression has tipped sharply in favor of diathesis—in this case, biological vulnerability. Medicalization also leads to unambiguous assumptions regarding prevention and treatment. Because the assumption is that biological vulnerability is innate, the conclusion is that primary prevention (preventing the onset) of depression is virtually impossible to achieve (except through use of medications in high-risk populations). According to this model, treatment should focus on individuals, and the core treatment is biological (pharmacological).

These assumptions, in turn, shape the research agenda. Within this model, an appropriate research question is, "Does this antidepressant medication lead to greater symptom improvement than placebo does?" In contrast, an inappropriate

question is, "Does reducing stress in the workplace reduce the frequency of depressive symptoms?" Of course, it is much easier, logistically, to conduct pharmaceutical trials than it is to carry out workplace interventions, but it is not the difficulty of intervention that should drive the research agenda. Rather, focus on the individual and, specifically, on the biology of the individual reflects a belief that the manifestation of depression signals pathogenic brains, not pathogenic social environments.

Beyond the Medical

The current views of depression can be attributed largely to the progressive uncovering of the biological etiology of depression and the development of new and improved medications, as well as to the influence of the pharmaceutical industry.[7, 31] Nevertheless, other factors beyond the influence of biological science and industry focus attention on the body rather than on society. For example, the advertising industry hammers home the message that, if we want to *feel* better, then we must lose weight, improve our complexion, or change our hair's style or color. In addition, we, as a society, face a paradox. Even though we seem to be gaining much more knowledge of and control over our bodies—the promise of gene therapy, for example—our increasingly complex society makes us, in reality, even less in control of our lives than we used to be. We are working far more hours in, probably, more stressful jobs than we were 40 years ago, but we see no way out of the increasing demands at work and home.[32] Therefore, when looking for answers to our disease, we tend to look in areas that appear to offer the simplest hope of success—improving our bodies and ourselves. But despite the specific success stories we so often hear about in the media (such as the discovery of a new therapy for cancer), the ability of the new biology to appreciably improve our quality of life in the face of today's societal ills is questionable. Nevertheless, the emphasis on the individual body and brain means that the social origins of depression (especially causes beyond personal control) are, today, of little interest to psychiatrists and, perhaps, the public.

This lack of interest in the social origins of depression reflects the tendency to attribute depression (and virtually all illnesses) to causes that can, in theory, be controlled by the individual or by interventions directed toward the individual. This person-specific, concrete approach undoubtedly reflects our highly individualistic society, coupled with a loss of confidence that we can effect society-wide social changes. Such social nihilism contrasts sharply with the vision during the 1960s,

the zenith of social psychiatry, that society could be changed through aggressive policy in service of the common good.

Organization of the Argument

In chapter 2 I trace the origins of the diagnosis *major depression* and its rapid ascendance as the prototypical psychiatric diagnosis. If a mental health professional addresses a general audience, the chances are high that most of the audience will be familiar with the term *major depression*. From their exposure to the media, listeners will, most likely, already have formed ideas of what is meant by the term. *Major depression* conjures images of a severe but common emotional disturbance caused by a chemical imbalance. We do not bring major depression on ourselves; it "happens to us," just as a stroke happens. Such an image is in stark contrast to our views of depression earlier in the 20th century. Depression was a sign of psychological weakness or overwhelming life events, especially losses. Our minds and experiences, not our bodies and brains, caused depression.

In chapter 3 I describe the history of the belief that depression is a reaction to a toxic social environment. Prior to the 20th century, the depression of interest to psychiatrists was of the most grave variety: severe melancholia or manic-depressive insanity. Sigmund Freud's psychoanalysis centered psychiatry in the office, not the hospital. The depression of interest to Freud was widespread, the neurotic response to the loss of something valuable to a person. During and following World War II, psychiatry moved out of the office and into the community. Depression was mostly reactive depression, and depressives reacted to a toxic social environment.

Critics challenged psychiatrists' attraction during the 1960s to psychoanalysis and social psychiatry, encouraging the discipline to return to the fold of medicine. This return to the medical model provided the background for the birth of the diagnosis major depression, and, as a result, reactive depression disappeared. In this chapter I trace the rise and fall of depression as a reaction to problems in the world around us. In addition, I examine the criticisms of psychiatry during the latter half of the century. An antipsychiatry movement arose during the 1970s, largely in response to social psychiatry. In the early 21st century, psychiatry is facing another dilemma: psychiatry has found the brain but lost the person within his or her family and community. And critics are once again emerging.

In chapter 4 I trace the birth and growth of social psychiatry. Emotional suffering is a social and personal experience. We feel a range of emotions in large part because of our interactions with people around us. Our feelings of comfort or fear

are frequently based on our perceptions of the safety of our neighborhoods or on the extent to which we feel that the world around us makes sense. The way in which we communicate our emotions depends on the standards society sets for expressing how we feel.

Social psychiatry—the study of our feelings and behaviors within the context of society—was virtually unknown prior to the 20th century. Psychiatrists grew more interested in society as they became more interested in psychoanalysis, and social psychiatry blossomed during the 1950s and 1960s in the United States, especially given the boost from President Kennedy's Mental Health Act. Social research soon gave way to social activism as the movement advanced in parallel with the establishment of community mental health centers. Community psychiatry has been labeled "social psychiatry in action."

I trace the roots of social psychiatry, roots that run much deeper than the social activism of the 1960s. Interest in the social causation of psychiatric disorders, such as depression, was expressed earlier in the 20th century by sociologists such as Emil Durkheim, psychiatrists such as Adolf Meyer and Harry Stack Sullivan, and organizations such as the U.S. Army during World War II. The flowering of the movement during the latter 1960s, in conjunction with President Johnson's Great Society, led many psychiatrists to proclaim that real psychiatry was *social* psychiatry.

In chapter 5 I propose that social psychiatry has been in fast retreat for many years. The field, which flowered during the 1960s, wilted quickly during the 1970s. Though the social origins of emotional suffering continue to be of marginal interest to psychiatrists, they have been dramatically eclipsed by the biological origins. Yet the retreat of social psychiatry cannot be attributed purely to psychiatrists' increased knowledge of neurobiology. Rather, the social psychiatry of the 1960s has all but disappeared primarily because interest in society in and of itself, as well as in how society affects its members, has vanished. Attention to social factors has been restricted to assessing individual social risk factors, such as stressful life events, or individual social outcomes of psychiatric disorders, such as loss of employment or disruption of the family.

I trace the retreat of social psychiatry over the past 30 years. I explore seeds of social psychiatry's demise that were evident long before its decline. How could the obvious role of society in the origin and development of emotional suffering recede so dramatically? What were the signs of the demise of social psychiatry during its halcyon years of the 1960s? Why are psychiatrists today so averse to exploring the social origins of major depression and other psychiatric disorders?

A front-page headline in the *San Francisco Chronicle*, June 18, 2003, proclaimed, "Help for Depression Lacking, Studies Find: 14 Million Americans Suffer Major Episode Annually." The reporter summarized findings from a recent national survey of more than 9,000 people to determine the frequency of major depression (and other psychiatric disorders) and the frequency of treatment (differentiating adequate and inadequate treatment).[33] The message from the authors of this study is clear: Major depression is a critical public health problem, and people are not being treated nearly as often as they should. In chapter 6 I explore how to assess the studies of the frequency of depression in our society.

Community studies of the burden of psychiatric disorders provide the key evidence for the declaration that depression will be the number two public health problem worldwide during the second decade of the 21st century. How should we interpret such news reports of these studies? Would these headlines have been different 50 years ago? Given the wide attention these studies of emotional suffering command, we first must understand the assumptions on which they are based.

I review the studies that support such startling headlines. The study of the burden of emotional suffering in the community has progressed through two waves during the past 50 years. I examine these two waves and the distinctly different assumptions of the investigators who led the studies. Remarkably, the estimation of the overall burden of emotional suffering—and the specific burden of depression—has, if anything, increased despite the movement from a view of depression as a natural reaction to social stressors to the acceptance of major depression as a disease.

Because our views of depression have changed dramatically during the past century, our views of other types of emotional suffering should also change. War syndromes provide an excellent example of changing views of emotional suffering through time, and in chapter 7 I survey war syndromes as responses to the stress of war. Although every war in our history has been stressful and has taken an emotional toll on the soldiers who fight, our interpretation of the emotional response to the trauma of war has changed dramatically since the Civil War. The symptoms associated with Gulf War syndrome and our interpretation of those symptoms provide a critical lesson in the study of the social origins of depression.

Each of the major military conflicts in which the United States has participated during the past 150 years has caused the participants physical and emotional problems that have not been easily categorized or explained by physical causes. During each conflict, however, a particular characterization of these problems has emerged. The names given them include "shellshock" during World War I, "combat exhaustion or fatigue" during World War II, "post-traumatic stress

disorder" following the Vietnam War, and "Gulf War syndrome" following the Persian Gulf War.

When perceived as one specific disease with clear yet undiscovered causes in the physical environment, Gulf War syndrome, is, in part, an example of societal "framing" of nonspecific symptoms into an understandable entity. The names changed according to the conflict. I discuss Gulf War syndrome and how the history of the syndrome in part illustrates such framing. As with major depression, society has been loath to attribute Gulf War syndrome, even in part, to the stress of war.

Although the study of the social origins of depression might be an interesting intellectual pursuit, how might it change the relationship between doctor and patient? In what ways can the perspective of social psychiatry be brought into the therapeutic encounter? Should the psychiatrist be interested in the world in which his or her patients live beyond the accounts provided by that patient? Does therapeutic encouragement to discover ways to better adapt to the social environment always meet the needs of the patient? In chapter 8 I address these questions.

Western culture is in the middle of a fundamental transformation that has shaken the foundations of the way we think, feel, and behave. The old "sacred canopy" of modern progress has blown away and the biting chill of anomie now settles on city and state. In other words, the society that we believed we understood and in which we felt secure during the 1950s has become incomprehensible and threatening in the 21st century. Our level of trust of authority, from religion through medicine to politics, has declined dramatically (despite the passionate and dogmatic religious and political proclamation we hear). Though much of our trust in the past was misplaced, our more accurate view of society has lead to what some call "the gravest sort of anxiety." Such anxiety results from a sense that we have lost our foundations and that chaos reigns. Chaos and its resultant anxiety cannot be tolerated for long, and depression, a signal to withdraw, is perhaps a natural adaptation to these feelings. People living in such a society will naturally react to that society.

I suggest that depression is one expected response to current Western society. Much of the natural emotional response to Western society is a negative experience. Depression captures the essence of this experience of the negative, especially the sense of not being one's self and the loss of meaning and hope. If the therapist ignores the society that contributes to the experiences of the patient, the therapist cannot treat the patient effectively.

Something needs to change. Social psychiatry must be reborn. How? What are the next steps? In chapter 9 I review the rebirth of social psychiatry, evidence of

which is already seen. Now is the time for psychiatry to take full advantage of the maturity of the social sciences and to create and develop a new wave of basic social psychiatric research. Social psychiatry needs young investigators grounded in the basic social sciences who can conduct interdisciplinary research, exploring the impact of social forces on the frequency and distribution of emotional suffering, especially depression. These psychiatric investigators must move upstream from the phenomenology of psychiatric disorders that has dominated diagnostic psychiatry and the neurobiologic aberrations that have dominated biological psychiatry; that is, investigators must seek the root origins of the depression epidemic.

To accomplish this task, psychiatry must take full advantage of the advances in the social sciences during the past 25 years, advances of which most psychiatrists are unaware. Young psychiatrists considering a career in research should be encouraged to consider the basic social sciences, such as anthropology, sociology, and social epidemiology, and the basic physical sciences, such as molecular biology and neuropsychopharmacology. I review two areas—depression in the workplace and the social ecology of depression—to illustrate how the basic social sciences can be applied to understanding the causes of depression. In other words, risk factors for depression should be considered that are not strictly tied to the individual.

A rebirth of interest in the social origins of depression cannot ignore the dramatic advances in the understanding of the biology of depression during the past 30 years. Social investigations cannot proceed isolated from biological investigations. How can the two be linked? I explore in chapter 10 the linkage between body and society through emotion.

The future study of body and brain within the context of society must be linked through concepts familiar to social psychiatry and biological psychiatry, such as emotion. Depression is, if nothing else, an emotion. An informed study of emotion is a key link between body and society, given its rich history in biology, psychology, sociology, and anthropology. The empirical study of emotion should buffer the tendency of the biological sciences toward reductionism and the social sciences toward social construction.

I review two examples where the link has become more clear—social zeitgebers and allostatic load. Social zeitgebers refer to those personal relationships, social demands, or tasks that serve to entrain biological rhythms, rhythms that are core to the psychobiology of depression. For example, our work schedule shapes the time we go to sleep and the time we awaken. Sleep disturbance is a key symptom of major depression. The interaction of the body's natural rhythms and society's demands, therefore, shapes a key component of depression—sleep.

The allostatic load theory links the psychosocial environment to depression by means of neuroendocrine pathways. Allostatic systems (*allo* meaning variable) are those systems that help keep the body stable—that is, adapt to changes in the environment—by being able to change (such as the change in hormone levels when the environment changes). The price paid by the body and brain to make these changes over time is wear and tear on the organism, such as an increased vulnerability to depression.

One consequence of the rise of major depression as a medical disease and the retreat of social psychiatry is the increasingly widespread use of antidepressant medications. Is this a problem? If the drugs work, why should we be concerned? Yet many today have expressed grave concerns about the use of the medications. In his 1932 novel *Brave New World*, Aldous Huxley anticipated the conflict over the use of such powerful drugs, describing the use of the fictional drug *soma* (used by the leaders of Huxley's dystopia to placate the people).[34] In chapter 11 I explore the problem with soma. Huxley specifically recognized the likelihood that antidepressant drugs would emerge and be very effective in his retrospective *Brave New World Revisited*.[35] His caution regarding their use is perhaps an even more critical message today than it was 70 years ago.

Psychiatrists today focus their own complaints about the profession almost totally onto managed care, cuts in federal and state support of mental health services, federal cutbacks in research and training dollars, and a lack of respect from medical colleagues and patients. Each of these external challenges to the specialty is very real. Even so, psychiatry is numbed to an intrinsic problem, similar to the problem Huxley described with soma in *Brave New World*. The problem with soma, put simply, was that it numbed Huxley's fictional society to its social problems.

Although we are far from the tyranny of Huxley's brave new world, we have become numbed to the social context from which mental illness (especially depression) emerges, and we have become numbed to those social forces that shape the specialty. We have lost our sociological imagination. The loss of this sociological imagination is my greatest concern for psychiatry in the 21st century.