MIND FIXERS

PSYCHIATRY'S TROUBLED SEARCH FOR THE BIOLOGY OF MENTAL ILLNESS

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CHAPTER 6

Depression

IN THE 1980s, AS SCHIZOPHRENIA WAS FINDING ITS BIOLOGICAL REGister, depression too came to be presumed to be caused by faulty biochemistry—a "chemical imbalance." By common consensus, it also became the "common cold" of psychiatry. Finally, it became gendered, a disorder that experts felt was more likely to be suffered by women than by men. All these understandings were part and parcel of depression's peculiar biological revolution—a revolution that involved a radical expansion in ideas about what "counts" as depression, and a radical narrowing in ideas about how it should be treated.

WHEN DEPRESSION WAS RARE

After World War II and up through the early 1960s, depression was rare, in two ways. First, it was rarely used as a diagnostic category by psychodynamically oriented psychiatrists. The historian David Herzberg, reviewing the *National Disease and Therapeutic Index* (a medical industries' market survey), found that in 1962 so-called neurotic depression accounted for fewer than one in ten diagnoses.[1] The epidemiologists J. M. Murphy and A. H. Leighton also examined epidemiological work on the prevalence

of mental disorders during and after the Second World War. They found that three-quarters of the so-called neurotic patients received an anxiety diagnosis, whereas most of the rest were simply considered "neurotic." Depression as a diagnostic category was *not even included in the summaries.*[2]

To be sure, patients in these years frequently complained to their clinicians about feeling despondent, low-energy, or chronically sad. However, psychoanalytically oriented clinicians (and even many primary care physicians) assumed that these feelings were not primary symptoms but rather a defense against more taboo and fundamental feelings of anxiety, which was supposed to lie at the heart of *all* "psychoneurotic disorders." Depression was just one of its many forms of expression—or more precisely, one of the ways neurotic patients coped with their underlying anxiety. As the Freudian-leaning first *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-I*), published in 1952, explained: "The anxiety is allayed, and hence partially relieved, by depression and self-depreciation."[3]

That said, all psychiatrists agreed that alongside the derivative "neurotic depressive reaction," a different kind of primary depression also existed, one that was a serious kind of psychosis. It was also—thankfully—quite rare.[4] The same 1952 *DSM* that had dismissed "depressive reactions" as a defense against anxiety described "psychotic depressive reaction" as follows: "These patients are severely depressed and manifest evidence of gross misinterpretation of reality, including, at times, delusions and hallucinations."[5]

For centuries, a disorder akin to psychotic depression was called "melancholy" and was believed to be caused by excess levels of a cold, wet substance in the body (a "humor") known as black bile. It was assumed to be basically a biological disorder that could be triggered by misfortune, guilt, or grief or arise for no apparent reason at all.[6] All through the nineteenth century, the so-called melancholic was a fixture of asylum life: immobile, despairing, wracked with mental pain.

Even after medicine abandoned the term *melancholy* for *depression* in the early twentieth century, American hospital psychiatrists, like their European counterparts, still widely assumed that the disorder had a biological cause. Some called it "endogenous" depression (to highlight its putative

of doctors in general practice. The book sold 150,000 copies. "It was a best seller," Ayd happily recalled later.[42] He was right, although one reason was that Merck purchased fifty thousand copies of the book itself, to distribute to general practitioners at no cost.

In 1966 Merck took its marketing strategy a step further by paying RCA to develop a promotional record album called *Symposium in Blues*, which it also distributed to physicians. The album included blues numbers with titles such as "Rocks in My Bed," "I've Been Treated Wrong," "Lonesome Road," and "Blues in My Heart." The company spared no effort in producing an album any jazz aficionado would be pleased to own, one that featured performances by jazz greats Duke Ellington, Louis Armstrong, and Artie Shaw, and liner notes written by the American jazz critic Leonard Feather. When a doctor opened the album, he encountered an insert with the Elavil logo, a strap line that read "therapy often helpful in depression," and notes on the improvements clinicians could expect to see by prescribing the drug for their patients.[43]

A CHEMICAL IMBALANCE

There is no question that many patients given a tricyclic antidepressant experienced profound relief. One patient, interviewed in 1977 by the *New York Times*, felt he had experienced close to a miracle: it was "as if I'd been living in a perpetual fog, a drizzle, or wearing misted glasses for a long time and something had suddenly wiped them clean. . . . Everything shifted back into focus."[44]

That same year the nephrologist Rafael Osheroff voluntarily admitted himself to Chestnut Lodge, a private mental hospital in Maryland, with acute symptoms of anxiety and depression. Chestnut Lodge had a strong psychoanalytic orientation, and Osheroff's clinicians there interpreted his symptoms as evidence of an underlying narcissistic personality disorder. They consequently put him on a course of intensive psychoanalysis. It was ineffective. Osheroff and his family requested tricyclic antidepressants (from which he had previously benefited). The hospital refused, Osheroff's condition deteriorated, and eventually his mother arranged for him to be transferred to a different hospital. There he was given both a new diagno-

was convicted of manslaughter instead of murder and received a seven-year prison sentence, of which he served only five. Less than two years after his release, at the age of thirty-nine, he committed suicide.

THE COMMON COLD OF PSYCHIATRY

As depression was being redefined as a chemical imbalance, it was also becoming known as a common disorder, as common, people said, as the common cold.

There are a number of reasons why this happened. Perhaps the most important is that "anxiety"—psychiatry's previous go-to diagnostic category—was running into trouble. By the 1970s, the minor tranquilizers that had once been routinely prescribed for myriad "anxious" patients were increasingly recognized as highly addictive. Newspapers blared the warnings: "A New Kind of Drug Abuse Epidemic," "Abusers Imperil Valium," "Pill-Popping can be Risky."[58] In 1975 government hearings prompted the FDA and the Drug Enforcement Agency to reclassify Valium as a Schedule IV narcotic, meaning that physicians were required to report all the prescriptions they wrote for it, and patients could obtain only limited refills. In 1978 the former first lady Betty Ford publicly

NOT JUST ABOUT CHEMICALS AFTER ALL?

Some felt that there was another reason depression had become so much more common. It had to do less with changes in diagnostic practices and more with changes in the world. We were under greater *stress* than ever before, some began to say, and our stress levels put us at a heightened risk of depression.

In the 1970s, the concept of stress was still relatively new. It had emerged after World War II out of a marriage between interwar laboratory science and attempts to make sense of the mental breakdown of soldiers. Postwar anxieties about the cost of prosperity on American's emotional and physical well-being had then encouraged interest in the idea that some people—especially overworked (white, middle-class, male) Americans—might be at particular risk of suffering from excess stress. The classic stressed worker was believed to be, above all, at risk of heart attack, but there was also concern about the effects of stress on mental health.[65]

An important technology in focusing the conversations about stress and ill health in general was the Social Readjustment Rating Scale. Designed in the mid-1960s by the psychiatrists Thomas H. Holmes and Richard H. Rahe, the scale aimed to measure the cumulative effects of stress on health. It presented individuals with forty-three more or less common life events and asked them to check the ones they had experienced in the previous twelve months. Each event on the list had been given a "stress" score, calculated in "life change units" or LCUs, ranging from 0 to 100. "Death of a spouse" was considered the most stressful thing a typical person might experience, so it was scored a full 100 LCUs. "Taking out a big mortgage" was scored at 31 LCUs, and going through the Christmas holidays was scored at 12 LCUs. Some events on the list were not intrinsically negative (e.g., getting married) but were still judged to be stressful because they required adaptation.[66] A person who racked up more than 200 LCUs over the course of a year was considered to be at significant risk of depression. More than 300 LCUs, and the risk became grave.[67]

It all made so much sense: a person could obviously only cope with so much. A 1974 article from *Better Homes and Gardens* explained the argument to readers this way:

CHAPTER 7

Manic-Depression

IN THE ERA BEFORE THE ARRIVAL OF DRUGS, MANIC-DEPRESSION AS A diagnosis was a kind of clinical no-man's-land, bounded by schizophrenia on the one side and depression on the other. It was given to patients who had bouts of agitation such that they did not seem to suffer just from depression yet who also, for whatever reason, did not seem quite ill enough to receive a diagnosis of schizophrenia.[1] Such patients were then generally subjected to any and all the treatments used for schizophrenia or depression—psychotherapy, electroshock treatment, lobotomy—and the outcomes were generally less than ideal.[2]

THE INVENTION OF MANIC-DEPRESSION

It was not supposed to be like this. Manic-depression was the "other" psychosis in Emil Kraepelin's bipartite division of the psychoses. The diagnostic category had been his attempt to synthesize and bring order to the whole vexed subject of mood disorders, including (but not limited to) disorders that fluctuated between pathological agitation (with or without elation) and despondent listlessness.

The roots of the confusion he was sorting out, in his view, were old