

Chapter 2

The Stigma of Depression: History and Context

'I'd love to lie about it – invent an acceptable cancer that recurs and vanishes, that people could understand – that wouldn't make them frightened and uncomfortable'.²²

For many people with depression, feelings of personal stigma are so pervasive that they are an inherent part of the experience and to tell another person that you are suffering from depression carries the fear of evoking feelings in others that range from confusion to distrust and disgust. For many, depression is quite simply not an illness and many fail to understand why others cannot just 'pull themselves together' or 'snap out of it'. For my own part, this makes about as much sense as telling a diabetic to snap out of a diabetic coma or telling an epileptic to snap out of his fit. Hardly appropriate behaviour but many people close to depressives tell them exactly this. Because of centuries of failing to understand the illness and a social and political perspective that has ran counter to the development of empathy for people with mood disorders, feelings of embarrassment, shame and self-disgust are rife within sufferers.

The link between mental illness and stigma is well established and this chapter discusses how these perceptions of stigma are borne and why they are so prevalent for sufferers today. To understand this, we have to better understand the history of depression over the centuries and the way that this history of depression has interacted with a history of individualism and personal responsibility. The difficulty in separating the self from the illness is a recurring confusion in depression and this lies at the root of much of the stigma associated with the illness. Unlike physical illness, you are the disease. When depression takes hold, it infuses every aspect of the sufferer's being and many have reported feeling disconnected, unable to recognize the person that they have become. Depression inhabits the sufferer and talks through them. It can live within and take control of sufferers' thoughts and feelings, often making them feel like strangers in their own bodies. As such, the judgment of others is not on some temporary, disembodied concept afflicting the body but of the sufferer themselves. They are unlikely to see physical symptoms like cuts or scars, bandages or a limp; they simply see the person, physically speaking, much as they did before. For this reason the sufferer is judged and not the disease.

The culturally entrenched Western beliefs regarding personal freedom and personal responsibility operate so that the depressed patients can be seen to be somehow ‘allowing’ this illness to engulf them. For many people depression and mental ill-health fall into the arena of the moral rather than the medical and losing control over the body as one might experience in a number of more physical illnesses is very different from losing control over one’s thoughts and feelings. For a number of reasons, society chooses to sanction sympathy for the former but not for the latter.

A Brief History of Despair: The Journey from Melancholy to Depression

Ancient Greece

Reading some recent texts, one could be forgiven for thinking that depression and concepts of depression did not exist before the 1950s, the dawn of the antidepressant era, but a careful look at the literature suggests that concepts of depression existed in ancient Greece. Hippocrates, who played such an important role in the development of modern medicine, suggested that an imbalance in the four humours and an excess of black bile predisposed people to melancholy and he believed that such an imbalance could be induced by trauma. Black bile was also felt to be responsible for the ‘demonic diseases’ like epilepsy, dysentery and eruptions on the skin. Although the theory of the four humours and their effects on health failed to survive the transition to modern times, the generic concepts are still popular in some contexts, especially in the food industry where concepts of internal balance are claimed to be regulated by a number of modern wonder foods.

Plato was responsible for the revolution in thinking that posited a man’s childhood as an influence on his character as an adult and he felt that the family environment was crucially important in matters of illness. Although these concepts were advanced for the world they lived in, the solutions for people who suffered from depression in ancient Greece appear to be anything but. In the post-Hippocratic world, some believed that placing lead helmets over the heads of depressed patients would allow them to be fully aware of their heads as they often complained of feeling ‘light-headed’. As has been the case throughout much of history, explanations of a sexual nature were posited, with Philagrius suggesting that depressive symptoms emanated from a loss of excess sperm in dreams and believed that ginger and honey were the solution to the dilemma. Exactly how this might have explained female depression is less clear. During these times, sexual concepts were rife and some physicians blamed depression on an absence of sex, with many depressed patients being sent to their bedrooms. Since a lack of interest in sex is one of the features of depression, this solution probably felt particularly ungratifying for many sufferers.

A discussion of ancient Greece would not be adequate without a mention of the perceived role of the gods in generating mental illness. It was believed by many that mental illness was a direct punishment from the gods for previous misdeeds and in early Christian times was said to be a test of the faithful (which many, presumably, failed), sent by the devil. Aristotle believed that melancholy was less an illness than the natural temperament of the creative artist, a view that became popular again in early modern times.

The Dark and Middle Ages

During the early dark ages, physicians had begun to develop a different set of procedures to address melancholy in their patients. Rufus of Ephesus believed that the key was to reach the illness before it became established and that such activities as bloodletting, regular walking and travel would do just this. Other physicians used a range of 'treatments' to address the problem of melancholy. These ranged from the more benign, such as consuming moist foods and breast milk or placing the sufferer in a hammock, to punishing the sufferer, perhaps by placing them in chains.

Galen, the personal physician to Marcus Aurelius, became one of the most influential physicians of his age. He noted that his patients tended to experience interrupted sleep, palpitations, vertigo, anxiety, sadness, diffidence (symptoms that exist in the classification of depression today) and beliefs of being hated by God and/or being possessed by demons. Not for the last time medicine took recourse in a sexual genesis of symptoms, with deficient sexual release being the precursor for these brutal consequences. One patient has been reported as having being cured by manual stimulation of the vagina and clitoris after 'much liquid came out'.⁵³ Galen was also prone to developing his own recipes and potions to address the needs of this patient group and this reflected his predisposition towards psychobiological explanations for melancholy.

During the dark ages, St. Augustine declared that it was reason that defined men from the beasts and so a loss of reason was, by definition, a mark of God's dis favour. It was seen as a punishment for a soul that had sinned. Melancholy was a noxious complaint and represented a turn from all that was holy and sacred. Those who showed melancholy were not suffused with the glory of God's love. Worse than this, a deep depression was viewed as a sure sign of possession and melancholics were considered to be Judas-like in their treachery towards all that was holy. As a result, it was not uncommon for melancholics to be sent out to work under the presumption that this would cure them of their sloth and rejection of God's love. In the fifth century, Cassian, a monk and ascetic writer from Gaul, recommended that the brethren of the melancholic abandon him or her lest they too be guilty of a rejection of God's glory.

Alas this was not the worst treatment that was to befall the depressives. By the time of the inquisition in the thirteenth century, many were actually fined and imprisoned for their sin. St. Thomas Aquinas, a hugely influential theologian, doctor

and philosopher, placed the soul hierarchically above the body and believed that the soul could not be subject to bodily illness. An illness had to either be of the body or of the soul and melancholy was assigned to the soul. During these times, the gift of reason was thought necessary for man to choose virtue, without it he could but sin against God. The soul was a divine gift and to feel melancholy was to sin against God directly. The medieval church henceforth defined the deadly sin of 'acedia' or sloth as particularly important. This word was common at the time and essentially described the symptoms of the melancholic/depressive. Unfortunately for melancholics, the most passionate clerics equated acedia with original sin and nominated acedia and idleness as the root of all evil. Hildegard of Bingen, a prominent writer and theologian, even went so far as to claim that Adam had melancholy coagulate in his blood the moment he disobeyed God's will.⁵³ As such, there was a drawing together of physical and mystico-religious symbolism, which acted to stigmatize melancholics with one of the great historical acts of defying God. If this was God's punishment to Adam, who had so sinned against him, then surely it was a punishment for the sins of the modern melancholics.

Disorders of the mind were particularly threatening during these times and explanations that postulated personal responsibility and deserving punishment placated a populous who lived in fear that they themselves might suffer such a curse. It also helped to ensure that the people thought twice about committing even minor religious transgressions lest they themselves develop this feared melancholy.

Modernity

As we will see in more modern times, concepts of mental illness and melancholy, particularly, have shifted through the ages. In direct contradiction to the dark ages and the middle ages, the renaissance glamorized melancholy as it came to be understood as a prerequisite to artistic inspiration and creation. The irrational pain and original sin of the middle ages was now beginning to be viewed as an illness. For Marsilio Ficino, one of the fathers of the renaissance and a profound influence on some of its most important writers and artists, this melancholy mind was now closer to God than that of others since it represented the inadequacy of its knowledge of God and was tortured as a direct result. It should be noted that not all concepts of melancholy changed equally in different countries and cultures but illness was gradually overtaking possession as the framework through which melancholy was explained. For instance in England, the illness grew to be associated with the aristocracy since those with the resources to travel to Italy and become inspired by the ideas of Ficino came back with this melancholic sophistication.⁵³ Everything had changed and melancholy represented sophistication, intellect and creativity and mock melancholy became the latest fashion accessory of the rich. This new enlightenment had not captured the church in the same way as it had captured the aristocracy and the sixteenth century saw the church forbid suicide to the extent that the family of the deceased would be punished by being stripped of all economic assets and possessions.

The end of the feudal system ushered in the era of modernity and the age of reason with a steady growth in market capitalism. Empiricist philosophers like Descartes and Locke questioned the role of church in society and the material world came to be understood only by scientific exercise rather than through reverence to the church. For the depressives who lived through these times, such a change in perspective may have been easier to accept than for the non-depressed since it could have been understandable to question what kind of benevolent God would strike them with such an agonising disease and then let society torture and humiliate them as a means of addressing it. Indeed in 1773, the poet William Cowper, due to his feeling of 'living in a fleshy tomb, buried above ground', was 'plunged into a melancholy and considered himself deserted by God'.⁸

Now that the tenets of science could explain and quantify that which had previously not been understood in the exterior material world, there was a movement towards locating the unknowable within the interior of the self-contained individual and this shift in perspective opened up a new front for this burgeoning science to attempt to quantify and comprehend. For some, this breakdown in the acceptance of a supreme and benevolent God led to a sense of existential alienation and confusion as the previous regime that had dictated and inspired their existence was rapidly changing. This revolution in thought was the new path to enlightenment and power was moving from the church to secular institutions. Depressed patients might have had little reason to fear such a change since religious hegemony had conspicuously failed to provide little more than hardship and brutality.

Although great scientific advances were made, this was not always reflected in societies' attitudes to the mentally ill. With the movement of the unknowable to the interior of the self-contained individual, mental health came to represent an aspect of self-discipline and so the melancholic would often be viewed as a somewhat self-indulgent figure rather than someone possessed of demons. Squalor and torture tended to be the experience of the mentally ill at this point with Boerhaave taking the time to suggest that patients be caused great physical pain as a way of distracting them from their mental anguish. As such, taking depressives to the point of drowning and regular torture was commonplace. As a result, many depressives understandably became reclusive and certainly circumspect on the topic of their suffering.

Following the initiation of the age of reason, the romantic period was once again a more understanding era for the depressive to live in. Kierkegaard and Hegel provided a philosophical platform for the acceptance of depression where people were exhorted to understand that 'any man with real intelligence will recognize the wretchedness of this condition'.⁵⁴ This era in the nineteenth century represented an element of rehumanization of depression and the mentally ill and a change in perspective that began to vitiate the torturous treatment of these people, so often forced into hiding.

With regard to aetiology, this new scientific approach was providing discoveries that lent themselves to reinterpretations of what caused and constituted the illness. By the seventeenth century, Harvey's discovery of the circulation of the blood led to theories⁸ based on faulty circulation which then in turn gave way to theories implicating the electrical properties of the brain.

The Nineteenth Century

With the nineteenth century came great industrial, social, political and medical innovations in both Europe and North America. In North America, the 'great awakening' involved population expansion and growing opportunities for commercial ventures for the colonists, originally hailing from Europe.⁵⁴ However, to maximize many of these potential opportunities provided by the unique and fertile land, a change in social and political outlook was required by the colonists and only the rapacious could maximally benefit from the new found opportunities. A movement from a communal ethic, which had existed in Europe for hundreds of years, to a more individualistic, separate and entrepreneurial ethos provided just such a way of making the most of these territories. Many communities were already infused with the work ethic of Protestantism. A reinterpretation of the word of God, already nebulous in these times of secular growth, contended that he wanted his flock to fend for themselves, to take the initiative and acquire material possessions and maximally exploit their environment.⁵⁴ Indeed, to not do so was to fail to embrace this new concept of God's glory and urbanization and industrialization combined with secularism to promote a growing sense of disorientation in many of the communities in North America. This confusion and isolation was not helped by the ravages of the civil war and concepts of shared understandings became severely strained in the new territories.

On both sides of the Atlantic, the era of the Victorians represented the peak of enlightenment thinking, this unstoppable faith in progress through science and profit and individual entrepreneurial application. Like North America, Europe was in the thrall of rampant capitalism, although a great history of community and communal living meant that adapting to the whims of individualism and capitalism has been a less straightforward process over the years. However, the enormous disruptions brought about by the industrial revolution led to a destruction of community life, immigration to the cities and unreliable employment for many. Many of the poor came to experience anxiety, confusion and hopelessness during these times and the only solution for many of these displaced wretches was the savagery of the Victorian poorhouses.

During the Victorian era, the devil had been well and truly discredited as the source of mental illness and, in keeping with the spirit of the times, mental illness became a failure of rationality and a failure of will. Early asylums focused less on treatment than on coercing inmates into complying with the rules of modern society. Practices such as restraint, imprisonment, vomiting, beatings, public humiliation, bloodletting and torture were the tools of choice.

By the mid-nineteenth century, the medical profession had wrested complete control of these asylums, although this did not automatically bring about improvements in 'treatment'. A new series of conditions like the vapors, neurasthenia and hysteria were popularized and tended to be used for middle and upper class patients who experienced a period of mental distress. Labels for mental illness continued to evolve; the patient who had convulsive cries and fainting spells in the eighteenth

century and hysterical paralysis in the nineteenth century could today be diagnosed with depression or chronic fatigue.

The ability to express symptoms of depression had always been a difficulty for people in the years leading up to the Victorian era because of the religious outcry and inevitable social or physical punishment that would result. During the Victorian era, women particularly suffered with regard to the consequences of expressing their mental distress. As a result of their powerlessness, women suffered most from the whims of medical nomenclature as physical aetiologies were used to describe their 'mental weaknesses'. Today one might reflect on their lack of legal and political standing, their total economic reliance on men, or the multitude of patriarchal mores that governed their dress, speech and behaviour as possible causal factors in their mental travails. Victorian women were not allowed to express a number of unbecoming behaviours and anger, and depressive symptoms were included in this. As such, many of their symptoms showed up as somatic complaints that were considered to be acceptable during these times. This would then reinforce a culture that viewed them as naturally and inherently physically weak and vulnerable, imprisoned by the caprice of their reproductive organs; supposedly irrational and unpredictable in nature at a time when these were cardinal sins.

As the medical revolution continued apace, old school physicians failed to see why a medical man would have need of a microscope since diseases so obviously involved the whole person. To focus on tiny cells would have appeared senseless and counter-intuitive to many. However, this changed towards the end of the nineteenth century as Lister, Pasteur and Koch generated succeeding revelations regarding the role of microorganisms in disease. At this point, mental illness was undergoing a fundamental evolution itself and the arrival of Emile Kraepelin profoundly affected the way we would come to understand it in the following century. He suggested that mental disorders be split into two categories; those of manic depressive insanity and dementia praecox. These divisions essentially corresponded to the mood disorders and the schizoaffective spectrum of disorders.⁵³ Sigmund Freud was also rising to prominence at this time following his assertion that hysteria was caused by childhood sexual abuse, a claim he later retracted and restated.

Early Twentieth Century

The early twentieth century ushered in the widespread acceptance of psychoanalysis and psychodynamic theory. Freud had traveled to the US to lecture and the mental hygiene movement was founded, although the Emmanuel movement, containing many important advocates from the ranks of professional medical men, was still prominent with regard to maintaining the age-old link between religion and medicine. The psychological trauma experienced by soldiers in the aftermath of World War I helped to alter this.

The nineteenth century had seen the development of unfettered capitalism and laissez faire market fundamentalism. New societies were created in the UK and the US, and the ethos of communal living had receded into the distant past. This was driven principally by a wealthy political and industrial elite keen to maximize profits but with little regard to the quality of life of their workers/electorate. The brutality of World War I destroyed many of these concepts of laissez faire logic in Europe and a fundamental change in values was driven by the devastation of the war. Social democracy, political and industrial legislature, union representation and social service grew in Europe, a movement not reflected in the US where the devastation of the war had not affected them with quite the same force. In Europe, the moral and political compass was changing but in the US there was a general apathy towards such democratic staples as the antitrust laws. Child labor and violent union-busting tactics were dominant, although Roosevelt was prompted towards a degree of social democracy following the depression with the development of the New Deal.

At the beginning of the twentieth century, mental disorders were still well within the medical domain and restricted to a very small number. Such pioneers as Freud were keen to expand their professional domain by encouraging the relocation of psychiatric practice from the asylum to the office so that mental health professionals could address serious mental issues and also lifestyle issues, personal problems, unhappiness and deviant behaviour.⁵⁵

The psychoanalytic movement and dynamic therapy, its treatment of choice, helped to draw together and cement the relationship between neurotic behaviour and normal behaviour so that both were considered different expressions of common developmental processes. This allowed professionals to potentially address anybody, regardless of their problem. Ordinary behaviour was argued to stem from the same origins as pathological behaviour, a focus removed from the more biologically based psychiatry that is currently in vogue. Dynamic psychiatry promoted the belief that by turning inwards and reflecting on their own histories, people could find the answers to their everyday ailments and serious psychological disorders. Social and political perspectives were sidelined in the haste to trace the origin of people's problems in events in their distant past and a growing group of psychodynamic analysts were prepared to support this.

The movement was initially popular with intellectuals and bohemians whose individual experiences prompted them to embrace individualistic solutions to their lifestyle dilemmas. This therapeutic movement was bound to flourish in the US, an individualistic culture that encouraged personal responsibility and personal freedom of choice. By focusing on individual historical biographies in such a narrow and intense manner, the movement synchronized perfectly with the prevailing cultural ethos of the US. It was a fundamentally conservative movement at heart, overcoming the repressive nature of social and community ties by providing personal solutions.

As with the experience of shell shock in World War I, the psychiatric experiences of World War II further emphasized the understanding that noxious environments can play a role in the development of mental disorders.⁵⁶ This new psychosocial framework acknowledged that the boundaries between those who are well and

those with mental disorders is fluid and that these illnesses are continuous rather than discrete. The belief developed that anyone placed in a sufficiently difficult environment, whatever that may be, would be at risk of developing mental disorders.

American psychiatry continued to apply the psychodynamic and psychosocial model of mental illness to a wide variety of social practices like child rearing, junior education, business and poverty. It became a social panacea for those who were dissatisfied with their lifestyles, with their careers, their partners or their lives in general and a framework for a broad approach to modern psychotherapy had been established.

Psychiatric Classification

In the early 1950s, the development of the tricyclic antidepressants led to the evolution of measurement scales such as the Hamilton rating scale for depression, which became the gold standard measurement of current depression. At this point, endogenous depression was considered to develop from constitutional or genetic factors as it appeared to arise without any psychological or social precursors. It was this specific type of depression that such antidepressants and treatments like ECT were developed to address. Neurotic or reactive depression, which stemmed from life adversity, was considered to be more appropriately managed by psychoanalysis. The path to the development of a rating system based on a standardized instrument was not straightforward since many clinicians were unable to appreciate the utility of standardized scores for depression; that is, an aggregate of symptoms that could provide a measure of degree of disability. For instance, could the symptom of early morning waking or low appetite be considered equal to that of suicidal ideation or anhedonia?

Many clinicians remained skeptical about this instrument and other instruments like Beck's depression inventory, which they felt were overly individualistic with large areas of personal and social functioning not sufficiently addressed. It was in this early post-war period, with its growing focus on constitutional dispositions to depression, that a number of researchers searching for cures for depression focused on some curious biological domains.

Centuries of mistreatment towards depressives was recalled as patients were subjected to some barbaric potential 'cures' such as the removal of gonads, tonsils, uteri (Galen might have approved of this effort), teeth and intestines among other body parts.⁵³ Some unfortunates were rendered comatose with insulin, put to sleep for days, made hypothermic or were injected with a concoction of different substances. Ewen Cameron, a psychiatrist from Montreal, developed a technique to brainwash patients with the optimistic hope that faulty memory traces could be reprogrammed. Some of his patients underwent repeated ECT to the point of forgetting their names or becoming incontinent but alas with no success, although suspicions about his medical integrity should be considered when we take into

account his work being sponsored by those well-known medical philanthropists, the CIA.⁵³ As many as 50,000 operations were mobilized for the treatment of depression, many of which could barely be justified.

So How Did We Arrive at the Psychiatric Classifications That We Have Today?

Between the years 1917 and 1970, the USA embraced psychotherapy with gusto and the number of psychiatrists in practice grew enormously. A therapeutic culture grew out of the blurring of the boundaries between ‘normality’ and non-normality and it was not until the 1960s that the practice began to fall out of favour. There were a number of reasons for this reassessment.⁵⁵ In the 1950s, the process of scientific falsification was in vogue and the nebulous nature of dynamic psychiatry did not lend itself to the development of objective verification. The movement was simply out of step with these new scientific priorities. During the 1950s, mental patients began to be deinstitutionalized and this meant that a group of patients with more severe disorders were released, often requiring more robust treatment than analysis. In the US alone, the number of institutionalized mental patients dropped by 470,000 between 1955 and 1980. Moreover, the growing protest movement developed a psychiatric arm with much of the previous theory being criticized by prominent psychiatrists like Szasz and Laing, and changing sexual mores meant that the importance of the repression of sexual instinct lost a degree of relevance.

Public embarrassment on social issues such as the disease status of homosexuality emphasized that psychiatric diagnosis was wrapped up in social constructions of deviance. A new model was needed that would medicalize the discipline and legitimize mental health practice and research. As such, specific, discrete and quantifiable diagnostic criteria were formulated. This allowed professionals to aggregate cases, employ the use of statistics and pull their discipline onto an equal footing with other branches of medicine. This new diagnostic culture meant that problems in ordinary life as well as more severe illnesses had to be reconceptualized in diagnostic form so that there was a key for clinicians to refer to. This was supported by a growth in third party insurance payments for psychological trauma where greater accountability and diagnostic certainty were required. You quite simply cannot reimburse continua. Moreover, government programmes that funded an increasing amount of psychotherapy also required categorical accountability. President Carter’s 1978 commission on mental health stated that psychiatry was in serious jeopardy, since there was simply inadequate case finding methodology. It was difficult to know who was and who was not depressed or schizophrenic or bipolar?

With regard to the actual process of categorization, there was much rancor and disagreement in the discipline.⁵⁶ The problem was that many psychodynamic practitioners felt that careful descriptive diagnosis was at best irrelevant and at worst anathema to good clinical work. There was a concern that such diagnostic criteria

might be a greater help to people wishing to commodify mental illness rather than address the needs of the patients themselves.

The process began officially in 1974. Robert Spitzer was appointed by APA President-elect Judd Marmor to be chairman of a task-force on nomenclature and statistics. The previous diagnostic guide required revision and the new guide (DSMIII) was conceptualized as a defense of the medical model. To eliminate the possibility of false positives (diagnosis of an illness to people who did not actually have that illness) and false negatives (no diagnosis of an illness to those who did actually have that illness), it was decided that mental disorders should be narrowly defined. What was publicly visible was given more prominence than what was privately inferred, and hence a direct challenge to the precepts of psychoanalysis. As such, this draft document was attacked on a number of grounds, particularly its lack of clinical relevance and explanatory power, since this new manual did not actually address the factors that caused mental distress. It simply described these different mental disorders. The need to achieve consensus, was for reasons discussed earlier, considered more important than the causes of these various mental illnesses and so the resulting manual came to be symptom-based. Spitzer contested that a diagnostic manual based on 'unproven' causes would splinter the discipline at a time when unity was necessary.

Every time a criticism was launched (and there were many, usually by a district branch of the APA), a task force would make a show of taking account of the criticism without effectively changing their approach. As such, there was widespread umbrage within the discipline against the essentially wholesale removal of psychoanalysis from the psychiatric statute. This new system was refuted by a great number of practitioners from within the discipline, probably a majority, but was pushed through due to the actions of a powerful minority of the APA elite.⁵⁵ This new system of criteria may have had dire consequences for psychoanalysis but it allowed new branches of mind sciences like cognitive behavioural therapy, with a focus on discrete symptoms, to flourish. The careful description of symptoms grew to be taken as an adequate psychiatric assessment and formed a narrower perspective that reduced the importance of family dynamics and social factors.

DSM-III has since been translated into more than 20 languages and has grown to become the centerpiece of the knowledge base of American Psychiatry. The DSM description of depression provided in Chapter 1, together with that of dysthymia, bipolar disorder and many others, is the result of these machinations. Through teaching and psychiatric practice over recent years, this system has come to be seen more and more as a natural code; almost as if it was not constructed on non-clinical terms. As Bourdieu⁵⁷ noted, every established order tends to produce the naturalization of its own arbitrariness and there are few clearer cases of this than with psychiatric diagnosis. As with other diseases, the symptoms of depression have come to be viewed with greater importance than that which actually causes those symptoms, hence the gradual disintegration of the reactive/endogenous dichotomy that emphasized the causal nature of the illness. The involvement of the pharmaceutical industry has also played a part in the focus on the symptomatology of the depressive diseases. The growth of the antidepressant industry and the

growth of the practice of providing antidepressants, regardless of the perceived cause of the illness, have reinforced this practice.

In the US in the 1980s, a very strong lay advocacy group, the National Alliance for the Mentally Ill gained influence in the US congress and the central theme of this organization was that mental illnesses are biological-based brain disorders. The importance of such institutions should not be removed from modern concepts of mental diseases and have helped to shift the psychodynamic influence on faulty parenting practices towards biological factors beyond the control of the sufferer. This has had a major impact regarding issues of responsibility and who we actually 'blame' for depression. It could be construed as beneficial for sufferers, since the way that they are viewed may change; people may be less likely to ascribe depression as a lack of moral strength or laziness or some such designation. However, as will be discussed in later chapters, this is not necessarily beneficial when attempting to understand the political, social and economic factors that can influence the course of depression. A singular focus on the biological can minimize these issues and, in doing so, play a direct role in the continued growth in prevalence over recent years.

What we can see from the concepts of depression through the ages, and especially in recent years, is that there have been a number of different medical definitions and lay beliefs regarding depression. What we can be sure of is that no single one of these representations of depression is 'natural' or objectively defined as we understand the term. Some parties will benefit from defining mental illness in certain terms and it is not always the patients.

Stigma and Depression: A History of Individualism

As touched upon earlier, the strong sociopolitical history of individualism in the US, particularly, has had important implications for the stigma associated with depressive illness. A large Christian evangelical movement swept the country in the first half of the nineteenth century infusing religion with new elements of individualism. Preachers like Henry Ward Beecher spread the message that individuals had to begin to find God within themselves.⁵⁸ Protestantism came to be boosted by a new individualist ethos.

With the onset of modernism and with enlightenment thinking placing such an emphasis on scientific rigor and quantifiable measurement, it was a short step to locating that which sciences did not or could not know within the individual. Since we would eventually understand the exterior world, this shifted the responsibility for the unknowable to people rather than the contexts in which people lived.⁵⁴ Towards the end of the Victorian era, the idea of personal character, a judgment defined by the adherence to moral or religious guidance, was superseded by the more self-contained concept of the personality. Social and political problems really began to be understood in personal and psychological terms and such movements like mesmerism and positive thinking came to represent popular

'cures' to the ills of the personality. Such a focus on individuality was no doubt influenced by experiences in the new cities that were growing around the country. Where hysteria had established a prominence in European psychiatric thinking, Neurasthenia, through men like George Beard, came to be popular in the US. This represented a form of exhaustion or a paralysis of the will and could be seen to share many of the symptoms in common with what we know now as depression. A therapeutic ethos grew to address these individuals and their individual problems and return them to the workforce, cured.

There were enormous material gains and wealth to be made in the US in the nineteenth century. The idea that great prosperity was open to anyone so long as they had the right work ethic became fundamental to US culture. This is the great self-sustaining myth in the US and is brutally effective since it will always, by definition, have supporters among the powerful elite. However as a result of the political, social and economic restrictions based on class, race, gender and other demographics, the probability of sustained success are very much slanted towards a very particular demographic within this culture. However, this culture of the self has been promulgated by the cultural elite for many years. Phineas Quimby, an important figure in the late Victorian mental health movement, lectured that 'all good things are found within'. Mary Baker Eddy of the New Thought practitioners argued that people could harness the power they had within and use it to take control of the material world. In the world of the mesmerists and the New Thought practitioners, there were no social and political barriers to material success and mental health. Any alienation felt by the monumental move to capitalism and consumerism could be compensated by the knowledge that such riches are open to all.

Particularly in the US, mental ill-health came to be defined as an absence of personal initiative and an inability to work. This was a sickness and this was what mental health practitioners should address. In the early part of the twentieth century, the concepts like 'psyche' and 'mind' were reified by the mental health movement and moved into the colloquial vernacular. By factoring out social and historical influences and medicalizing and individualizing personal problems, the early mental health movement moved concepts of mental health in line with capitalism and the growing importance of consumerism in the West.

Corporatism and psychology grew in parallel in these early years of the twentieth century. It was in the particular interests of corporate and political elites that the importance of the self was promulgated through society. In the US, the disenfranchisement of organized labor was seen as a major necessity in order to achieve sustained corporate success and so individualizing citizens and removing the importance of the social was important not only for the creation of a culture of consumption but also national and international corporate competition. If citizens could be persuaded through advertising, media and legislation that communalism and community were outmoded and indeed dangerous concepts, and that their problems and difficulties were related not to the social or political but to their personal circumstances and their personalities, then they could establish an ethos where consumer rather than political solutions would be the answer.

Consumer choice came to be elevated to the highest of patriotic values, a proxy measure for personal, individual freedom and choice. It became one of the defining aspects of what it meant to be an American. Advertising thrives on individualist and liberationist dogma and during the rise of communism, the action of expressing personal choice through consumption was almost seen as a blow against the enemy.⁵⁴ Viewed from this context, depression is an illness that interferes with personal and moral freedom. Unlike many physical illnesses, it is very much an anti-American disease. Individualist ideology states that we are all responsible for the good and bad fortune that we encounter and that dispositional characteristics control this fortune. Simply put, depressives must be at fault somehow for not embracing the American dream, for failing to make the most of their situation and letting themselves fall into this cycle of negativity. As individualism has grown over the last 150 years, so too has the likelihood that depressives would be stigmatized as being responsible for their illness. After all if they decide to mope around rather than be positive then that had to be viewed as their prerogative.

Depression is a disease that can grow within, insidiously, to the point where a sufferer's entire outlook is coloured by the illness. Should one's body be overtaken by a physical illness then this could be excused, since the physical freedom of the sufferer would be compromised but not necessarily the personal and moral sense that they had freedom to live their life as they wish. This is not the case with depression. Personal and moral freedom is usually removed by an illness that often leaves no physical symptoms. Freedom is the last word that most depressives would use to describe their sense of being when they are depressed. This makes the suffering experience a particularly un-American suffering.

Depression also violates the foundational work ethic deeply ingrained in US culture. It violates the belief that hard work and 'pulling your socks up' is simply not enough sometimes. Free market ideology is rife again in the US and the UK and to have faith in the free market and the possibilities afforded everyone under these conditions requires a degree of incomprehension towards those that life has not treated with such beneficence. It is the essence of competition that there will be winners and losers and many of those who arrive on the positive side of that equation are encouraged to rationalize those who have suffered by ascribing attributions of personal responsibility. This belief system contributes to the stigma felt by depressed patients, the archetypes of those rejecting and rejected by the American dream.

What Is Stigma and Why Does It Occur?

So far I have provided a description of some of the principal themes in modern history that have influenced both lay and medical concepts of depression. I have discussed the relationship between growing cultures of individualism and how it relates to the way that depression is represented. In this section, I will outline in more detail how this history might have carried through to substantially affect the

current attitudes of people with and without depression. Why is there such heavy stigma associated with depression and what does it mean for our approach to treating the illness?

The issue of stigma is complex and it leads to unjust behaviours and discrimination. It can affect personal identity and social interactions and contributes to social isolation, delays in help seeking and personal distress. It can lead to feelings of guilt, anger and anxiety and is a pervasive phenomenon. Stigma can come from family members, from work colleagues, from health care professionals, educators and members of the general community.⁵⁹ It is not unusual for people with mental health disorders to refuse to seek help or to disclose an edited version of their illness and suffering should they feel stigmatized by their disease. Elderly patients with major depression are particularly prone to this discontinuation of treatment via stigma.⁶⁰ Stigma can be both felt and enacted, with those feeling stigmatized not necessarily party to actual discrimination from others. The stigma associated with mental health has changed very little in the last 50 years and has contributed negatively and significantly to social exclusion.⁶¹ Indeed it is not uncommon for enacted stigma to lead to the loss of opportunities at work.⁶²

Stigma, the Entertainment Media and Mental Illness

Modern media and film has a role to play in our concepts of mental illness generally and a cursory analysis of representations of mental illness does not provide particularly positive findings. Research has shown that when current psychotic symptoms are controlled, there is no difference in recent violent behaviour between patients and never-treated community residents and that only 3% of mentally ill patients are considered dangerous to others. Nevertheless, nearly half of all press coverage of the mentally ill is disproportionately focused on how dangerous such people are. There is an obvious disparity between the actual danger and the danger that one might perceive if exposed to the media.

Many of the misconceptions about mental illness and the treatment of those with mental health problems result from images of mental illness and therapists routinely depicted on film and television.⁶³ No other art form is so pervasive and we often have little conscious awareness of the huge influence of the entertainment media. This is particularly important when we consider that many people can be uninformed about mental illness. Most of us have probably watched films where a serendipitous bang on the head magically improves a character's personality. Or perhaps the sentimental liberal humanist portrayal of the mentally ill might see them as happy clowns or buffoons where a little bit of freedom from the shackles of the mental health system magically cures them from the evil constraints that were causing their illness.

The general portrayal of mental illness tends to be misleading although that can perhaps be expected, since the function of film is not to educate but to scare, titillate and act as a vehicle for dramatic effect. Wedding and Niemiec⁶³ isolated core myths

regarding mental illness and film. For instance, harmless eccentricity is frequently labelled as mental illness but labelling mental illness as nothing more than harmless eccentricity might well contribute to the idea that this might be the case with many mental disorders. If they are simple eccentricities then surely they cannot be serious disorders that require treatment and sympathy? Such portrayals minimize the suffering of the patient and justifies disparaging attitudes to the serious and prolonged difficulties that many mental health patients experience.

Hollywood films can perpetuate curious beliefs regarding the mental illness spectrum. One such key misunderstanding is the message that 'love can conquer all', a message that is often exhibited in films about mental illness; this idea that with enough loving care and support, people with mental illness can overcome their difficulties and return to society as functioning healthy members. Now while I would agree that having a supportive social network is crucial for many patients with mental illness, 'love' itself is not a panacea for these disorders. To suggest that it is might placate the sentimentalists among us but it manifestly reduces the complexity of the issue and again can contribute to feelings of insufficiency on the part of carers and families. It further influences concepts of mental illness as mild mood fluctuations that can be cured with a bit of tender loving care.

The victims of mental illness are often portrayed as aggressive, unpredictable and dangerous with psychiatrists commonly essayed as inept or manipulative. Horror films are particularly prescient when portraying the psychiatric patient as homicidal and/or fundamentally dangerous and I have lost count of the number of horror films that have used mental illness as a convenient vehicle to explain the most gruesome atrocities. In fact the more able film directors know how to use these concepts of mental illness to pander to the anxieties of their viewers, anxieties that are often driven by disproportionate media representations in the first instance. This is perfectly understandable from the view of generating thrilling entertainment but less so if we are seeking to minimize the misconceptions associated with mental illness.

On occasion, a representation of a mental illness like depression may be reasonably accurate but the need to leave the audience with a smile on their face as they exit the cinema means that pat resolutions and happy endings fail to realize either the true seriousness of the illness or a realistic outcome. Films like *Scent of a Woman* spring to mind in this case. Some films can portray treatment as punishment as was the case with the use of ECT in *One Flew Over the Cuckoos Nest*. This has contributed to the fear and trepidation over what is now one of the safest and most effective treatments for very severe depression.

When we talk about the mental illness myths that are portrayed on film, it is important to reflect on all mental illnesses, be they depression, bipolar disorder, schizophrenia, personality disorders, obsessive compulsive disorder or any other illness. When the public go to the cinema or rent a video, and are exposed to damaging or unhelpful myths regarding a given mental illness, the effect of these myths may be long lasting and influence their beliefs about mental illness in general. Unless they have experience of specific disorders, many people may not know the spectra of specific mental illnesses and nor should they. As such, many of the

myths they are exposed to may be applied to the generic category of 'mental disorders' and so concepts relating to a mental health care facility or therapeutic relationship for schizophrenia may be applied to depression.

Many people are not exposed to mental disorders through the everyday course of their lives and films and television may well be their primary source of information. As such, there is an immense responsibility on those who create and screen these images to make them as accurate as possible. Unfortunately this responsibility does not square very well with the financial imperatives of film studios whose sense of responsibility generally stretches to expanding their box office. The real extent of the stigma generated from these representations is difficult to quantify but we would not need Einstein to discern the very real threat of salacious, violent and despicable acts being repeatedly explained by inaccurate representations of mental disorders. When we understand the increasing amount of time that people (particularly children) watch television and films, it is perhaps not difficult to understand why there has been little decrease in the stigma associated with mental illnesses in the last 50 years.

Stigma and Depression

As the brief history of depression showed at the beginning of the chapter, the medical and religious firmament should not be patting itself on the back with regards to how it has represented and treated depressives through the years. Two thousand years of humiliation, mistrust, outcasting, punishment and general antipathy will leave its effect on how we currently feel about people with depression. Concepts are passed on from generation to generation and the ideas of depressives having 'sinned against God' or having a sexual aetiology to their illness does not necessarily encourage people with the disorder to proudly put their hands up and identify themselves with a history of supposed malingerers, sinners, sexual miscreants, and lazy and self-obsessed serial complainers, who drain the personal and financial resources of others.

Common reactions to depression (or variants on these themes) are considered below and hearing these from people with little experience of the illness is not unusual. Indeed, sometimes these are said with sanctimonious and pious glee. Many of the prompts are used by family/friends/employers to try to shake the sufferer out of their depressive stupor but are usually about as effective as telling a heart attack or stroke victim to 'run it off'. The real reason many of these comments are so incredibly unhelpful is that they presuppose that depression is a choice of the sufferer and that they can choose not to be depressed should they so wish.

"What have you got to feel so miserable about, you have a roof over your head and a good job?"

This comment supposes that depression itself must automatically be related in some way to the worldly possessions of the sufferer, and that there could be no reason that the sufferer would be depressed other than what they possess financially.

Many episodes of depression are related to life events or are exacerbated by life events in some way but some are not. For both kinds of depression, having a given set of possessions or lifestyle is usually not enough to protect the sufferer from slipping towards the illness. We can be sure that once the sufferer has tipped over into the clinical syndrome of major depression, it is utterly irrelevant to link their suffering and pain to a roof and a safe job. In the abstract sense, it makes about as much sense as saying to someone ‘what have you got to have a heart attack about, you have a nice job and house’. Heart disease and depression are illnesses, not life choices.

“Look at all the starving children in the world, don’t you know how lucky you are?”

As anyone who has suffered major depression will know, it is usually a horrendous and debilitating illness that infuses every aspect of the sufferer’s life. The last thing you feel is lucky, regardless of how many objective reasons there are for people to consider you lucky. Comments like those above lead to further guilt and self recrimination, two unpleasant properties that depressives are usually not short of in the first instance. Depressed people usually know that being a starving child is unpleasant but there is no linear relationship to the number of bad things happening to you and how bad you feel. Depression is an illness and it is very different for different people in different places. There is no rule of thumb that stipulates that x amount of bad things will lead to y amount of feeling bad. Exhorting a diabetic patient with such a prompt would probably just lead to confusion on the part of the patient but such a reaction will not be experienced by the depressive patient because they often share the same beliefs systems as those doing the exhorting. As such, it can simply lead to further guilt and worthlessness.

“I know many people worse off than you.”

Ditto. See above. ‘Worse off’ is a subjective term and the comparison is futile. At the root of this is the basic belief that the person saying it does not understand depression itself to be a worthy item to add to a prospective list of good and bad things that are happening to you. This exhortation relies on good old fashioned logic. Being ‘worse off’ is an irrelevance, since many depressives no longer have the capacity to ‘objectively’ judge whether things are that bad or not. Appeals to this kind of logic are futile and will more likely intensify the distress experienced by the depressive. Logic needs to be removed from any appeal because depression is not a logical state, it is an illness that removes the capacity to balance the normal pros and cons of life.

The above perception boils down to the fact that this person, and many others, simply have no idea of the agony, pain, hopelessness and despair that often characterizes depression. If they did then they would probably be prompted to think ‘actually there are very few people worse off than you at this present time’. I think that a great many people suffering a severe depressive episode would give away all of their worldly possessions for the guarantee of feeling human again, to leave the ‘black hole’ behind.

"Don't worry, it will all come out in the wash."

This is a worthwhile statement for someone who is feeling a little down because their pet is ill or because they have been admonished by their boss. Illnesses tend not to come out in the wash. Most often people with serious major depression will require some kind of treatment in order for them to go into remission and, at the very least, this will hasten the process. While it is perfectly reasonable to assume that some people may eventually recover without medical help, this is not a serious option and should not be recommended. People with depression should seek medical help from their general practitioner because otherwise they could endure a prolonged period of despair. There is a feeling among some members of the public that depression somehow fails to warrant treatment. This is because it is a 'mental' illness rather than a physical illness and so is simply a reflection of dispositional weakness of character. Depression is actually a physical and a mental illness and it needs to be addressed as soon as possible to minimize the possibility of more recurrent and severe episodes in the future. The message is, seek help.

Pull your socks up.

Ah yes, now we are getting to the bare bones of the problem. I suspect that some depressives would be quite wealthy were they to be given a pound for every time they heard this. Regarding treatment for depression, the views of the public are interesting. 36% of people interviewed believed that you 'have to pull yourself together' if you are depressed.⁶⁴ This fundamentally betrays the belief that the sufferer has a choice to be depressed or not. Depression is characterized here as some form of extended self pity, wallowing in a misery that they could easily choose to leave behind. This is one of the most frustrating things that the sufferer can hear because (a) it shows a fundamental misunderstanding of the severity of their suffering, (b) it suggests that they could stop this suffering should they choose to and (c) that they do not want to recover and are happy with their life as it currently is.

Anyone who knows the pain of depression knows that this is an insult. However, many depressed people can become so dependent on the people around them that they are in a position where they have to absorb and accept such comments. Very many are unlikely to have the energy or the inclination to argue the point.

People obviously want their loved ones to be well and it is often easier to blame the sufferer for their behaviour than to accept and process the knowledge that they, as the loved one, are completely powerless to address the despair of this person who is probably changing beyond recognition. Comments like this are more likely to prompt people to suffer in silence than to make them consult a GP. After all, if my husband or daughter or best friend does not believe me, why should a general practitioner?

There is a theme behind the above comments and that is the simple failure to acknowledge that depression is an illness. Until this is appreciated then patients and their loved ones are going to continue to struggle. Exhortations and appeals are quite simply not enough to bring people out of major depressions because they are based on fundamental inaccuracies.

There are a number of fundamental myths that pervade the experience of depression in the west and they are directly responsible for the reactions above as well as the stigma, shame and anxiety that haunt the experience of depression.

We All Get Down Sometimes

This is true but we do not all get depressed sometimes. Depression is not a transitory state of mild dissatisfaction in relation to minor difficulties. The creation of some imaginary scale with clinical depression at one end and slightly perturbed at the other is unhelpful and inaccurate, despite the contentions of recent professionals.⁶⁵ Depression does not exist on a spectrum that incorporates natural reactions to everyday difficulties because, for one, the symptoms are often different. In the vast majority of cases, transient sadness and feeling ‘down in the dumps’ is exactly that. People will feel sad or they will be upset or they will feel slightly low in mood. They will not, however, usually feel apathy, anhedonia, fatigue and emptiness. They will not experience a feeling of lingering despair or dread and it is unlikely that they will experience serious fluctuations in their weight and sleeping patterns. People can suffer clinical depression without feeling apathy and emptiness but they are very common symptoms of the depressive illness and they are simply not experienced during transitory sadness. Indeed, by definition, transitory sadness shows an ability to feel affect, to care and to hurt. These functions are often not available to the depressive and it is a qualitatively different experience. About 67% of people believe that the support system of family and friends should be the source of help for people with depression.⁶⁶ Only a few people recommended seeing a psychiatrist for major depression. This support system can be extremely helpful and in many cases utterly essential in the recovery from depression. However again this result betrays an understanding of depression as a mood rather than an illness. I doubt such surveys for cancer or heart disease would recommend the family as the source of help for patients and while this parallel may appear extreme, I believe it is fundamentally fair. A refusal to accept depression as an illness will continue to contribute to the often monumental distress and poor recovery of depressives.

It is true that the clinical definition of major depression is an arbitrary abstraction. However, that does not preclude the existence of a distinct illness entity. The bottom line is that there is debate within the mental health sciences regarding the nature and form of depression or depressions and we are nowhere near the point of fully comprehending the biological, psychosocial or nosological issues involved. It may well be that a dimensional model of the illness is more appropriate than a categorical model but starting the scale at transiently feeling down in the dumps for a few hours or an evening could be a dangerous avenue to travel down. Such conceptualizations play a role in the generation of ignorance and stigma that surrounds the illness and could contribute to reduced

help-seeking. No matter how you choose to cut the categorical cake, it still exists and the arbitrary definition does not denude this.

This failure to separate the illness from the vernacular appropriation of depression can be traced back to the birth of the mental health sciences. As mentioned, the psychoanalytic movement helped to cement the relationship between neurotic and normal behaviour so that both were variants of common developmental processes. This had the benefit of making people appreciate that anyone could become mentally ill if they were exposed to the right stimuli and that people with mental disorders were not necessarily a breed apart from normal people. On the whole this was a positive. However in the case of common mental disorders like depression, it is also likely to have played a role in cementing the idea that general dissatisfaction with lifestyles is a milder form of depression as they both now received the same treatment. This dissatisfaction with the vicissitudes of life was given clinical credibility and with it, the barriers between everyday up and downs and major depression, were eroded. A simple failure to separate these two distinct experiences has contributed to a lack of sympathy towards sufferers of depression over the years.

There is a need to educate the public about this particular aspect of depression in order to address this stigma associated with the 'we all get sad, what is special about you' doctrine. Yes, negative events can lead to crises and act as precipitating factors in the development of depression. Difficult circumstances like financial strain, abuse, gender issues and occupational stresses, among others, all relate to depression and can play a fundamental role. However, they are not necessary and depression can, for some people, develop in what seems like a vacuum. Depression can just happen. Sometimes, from nowhere, and with no warning or rational justification, the most savage and brutal despair will descend upon a sufferer and this aspect of the illness needs to be more fully appreciated in order to generate greater public empathy. Sometimes, it simply does not matter what you have done and how you have done it, many people will become terribly depressed despite living in a virtual paradise.

This seeming randomness can be very difficult to understand. It can also be a little frightening and this fear can make it easier to blame the sufferer rather than understand that a harrowing illness can strike from nowhere. Enacted stigma can emanate from the characteristics of those who stigmatize as much as representations of the stigmatized. John Updike, in reference to people who were stigmatized as a result of a disfiguring skin disease, believed that people turning away from those with such skin diseases stemmed from a fleeting identification with the person who is afflicted. The afflicted individual represents our own vulnerability and imperfection and our real lack of autonomy and control over many of the forces that shape our lives. This desire to link depression with life events in a logical, systematic way may be influenced by just such attitudes, making those of us lucky enough not to be affected by the illness keen to link the illness to dispositional characteristics. When you experience mental illness, a new vulnerability opens up that stays with you. It sometimes destroys previous concepts of cause and effect, of illness and aetiology.

Strength and Depression

There is a popular sense that if you are a strong person then depression simply cannot happen to you. For many, strong people do not get depressed because they can bear the vicissitudes of life, they cope with whatever life throws at them and they do it because they have an implicit strength. However, depression is not related to how strong you are and some of the most powerful people in history, people like Winston Churchill, have suffered from crippling bouts of depression.

Many people with depression are not fond of the concept that they have capitulated under conditions that another may endure and sufferers will often keep quiet for as long as possible. Having talked to depressed patients, much of the stigma is acutely felt by those who perceive themselves to be weak. Again we can reduce this attitude down to the basic belief or lack of belief in the status of depression as an illness. If you fail to accept it as an illness then it is usually contextualized as a character trait. However recent figures have suggested that as many as 50%²² of people will suffer from depression at some point in their life. Whether all of these people develop severe depression is debatable but if we follow the logic that depression only affects the weak then that is a lot of weak people.

Biology, Stigma and Depression

As mentioned, many people with depression are not fond of the idea that they have failed to withstand challenges that another person may cope with and so there is a self-preservative interest in implicating chemical processes beyond our control. This is especially the case in Western societies where the ethos of personal responsibility and the 'just world hypothesis' are subscribed to by so many. During the 1980s, a strong US lay advocacy group, the National Alliance for the Mentally Ill (NAMI), gained influence in the US congress and the central theme of the organization was that mental illnesses were brain-based disorders that resulted from biological factors. This biological focus meant that responsibility for their suffering could be removed from the patient. Factors beyond the role of the sufferer were implicated and this has proved to be a useful way of reducing the stigma associated with the illness, especially in Western culture. Of course there are very important biological findings that relate to the illness, not least with respect to genetics, cerebral blood flow and antidepressant action, and the NAMI are right to emphasise these.

While the NAMI use strictly medical and biological terminology in their information pamphlets, research has suggested that the public still prefer social explanations for the causes of depression and fail to reflect the legitimizing practice of biological explanations.⁶⁷ Recent research with college students suggests that people recognized biological, psychological and environmental explanations of depression. Endorsement of the biological model tended to be

empowering and predicted greater help-seeking behaviour and had a positive impact on stigma.⁶⁷ Adopting the psychological model increased the blame towards participants who had depression and this suggests support for anti-stigma organizations like the NAMI.

Implicating the biological basis of depression is effective with regard to reducing the stigma of personal weakness. However, despite there being strong evidence implicating biological processes in depressions, an excessive emphasis on this will denigrate the role of social, psychological and political organizational factors and this can be a profoundly deleterious consequence. The ways in which this can work to disable sufferers are discussed further in Chapter 5.

Different people hold different beliefs based on their personal experiences with the illness. Some sufferers may prefer to attribute their depression to psychological causes for the very reason that this means they do have some aspect of responsibility or control over it. The attributions that are formed depends on a number of factors including the need for control, the need not to be blamed for the condition and the desire to avoid stigmatization and the latter need is one that can be partly ameliorated by moving responsibility to biological factors.

What Does the Public Think About Depression Today?

Work has been carried out to try to ascertain exactly what people generally know about depression. It is interesting that only 39% of the public recognized vignettes of depressed people as actually being depressed and that 11% thought that the cases had a physical disorder.²⁴ Other work suggests that a US sample of the general public were reasonably knowledgeable about mood symptoms but less so regarding the somatic changes that often represent the symptoms of depression.

On the topic of stigma, 35% of the general population would not rent a room to someone with depression and 42% would refuse to recommend them for a job, probably in fear that the participant would not be able to keep the job or manage the tasks that the role would entail.⁶⁸ One of the more interesting aspects of this research with a German sample was that there appeared to be no changes over the last decade with regard to people's attitudes to those with depression. It was suggested that a tendency to act with irritation and anger towards depressives had actually increased slightly and so this suggests that public initiatives to address the stigma surrounding the illness are a long way from being effective, certainly in Germany at least. The participants reported that the desire to distance themselves from someone with depression was as strong in 2001 as it was in 1991 and this inertia showed no particular variance with regard to such socioeconomic factors as gender, age or education. This kind of research that looks at public attitudes to depression over time is useful as it allows us to understand and address the effectiveness of initiatives designed to make the public more understanding and sympathetic to those suffering with illnesses like depression.

Regarding the causes of depression, recent work has shown that 48% of people believe that depression is a reaction to an external problem⁶⁴ and that it is due more

to psychosocial circumstances than biological causes.⁶⁹ While this can often be the case, such strong beliefs in causality may not leave room for the high number of depressed people whose depression has not come as a response to external events, the so-called endogenous depressives. Such a belief may be unlikely to predispose many of this 48% to a sympathetic attitude when faced with someone with whom they could see no reason as to why they should be depressed. Many depressed people cannot find such a reason and feel doubly stigmatized, first of all for having the illness, and second, for their failure to isolate 'valid' reasons for their depression. Work has also confirmed that depression is perceived by many to be a normal extension of the feelings that most people experience. This confirms the earlier discussion of the link between minor ailments and clinical depression.⁶⁶

Regarding treatment, other work has shown that for people suffering with depression, psychiatrists and psychologists are rated less highly than general practitioners,²⁴ although in the UK the majority of the public would feel embarrassed about visiting their GP for depression. The public have had a tendency to perceive psychiatric medicine as more harmful than helpful⁷⁰ and a skeptical attitude towards mental health practitioners is age-old. As far back as Greek antiquity, sophists, party to behavioural and lingual knowledge not immediately available to the lay person, were often seen as manipulating essential public health institutions such as the practices of law and health. A part of the stigma associated with being a service user of a mental health system, whether it is a general practice, psychiatrist or psychologist, is that you are now part of this context that uses rhetorical services and specialized, secret and manipulative knowledge. People under this care can be seen as being agents of mental health practitioners and can become objects of skepticism and mistrust by association. They have crossed over to the metaphorical 'other side' and have removed themselves from the unwritten contract of living their lives within the straightforward terms of the everyman. For some, this can also play a role in concepts of stigma and a desire not to receive treatment and medical recognition for a mental health problem.

How Do Depressed People Experience Stigma?

Stigma dominates the experience of depression and upward of 70% of people with depression do not seek care. There are effective treatments available but most people will avoid visiting a health professional regarding their depression and this strong sense of perceived stigma is a powerful barrier to help-seeking behaviour. Taking antidepressant medication can confirm the subjective feeling that they are failures who are unable to cope with the problems that everyone else seems to be able to manage. Taking antidepressants for a prolonged period often makes sufferers feel pathetic; reinforcing negative views that they may have of themselves. Many people forget that it is not only non-depressed people that hold negative attitudes to the depressed but people who become depressed themselves. Indeed, compared to those

who seek treatment, those who fail to seek treatment for their illness are more likely to be embarrassed if friends or relatives find out about their depression and treatment.⁷¹ Moreover, feelings of stigma have been shown to be significantly associated with the severity of depression.

A number of focus groups and interviews showed that those who suffered with depression and anxiety had a strong sense that people were not sensitive to their problems.²⁶ When we consider the earlier figures on public beliefs regarding the causes and remedies for depression and the strong history of stigmatization associated with the disease, then this is perhaps understandable. People with depression are stigmatized and in many instances people are not sympathetic to their problems. It should be emphasized that these feelings are not necessarily a further symptom of the illness or a cognitive distortion or error on the part of the sufferer. Because of a history of stigmatization, ignorance and misunderstanding concerning the disease and its causes, sympathy for depressives is often in short supply. Many of these patients feel a pervasive sense of being different, of being misunderstood and of feeling isolated, and feel that their general practitioners are too busy to address such a trivial illness as depression. This may or may not be the case but there can be little doubt that many people feel that their time in health consultation at their local practice is severely limited.

Common feelings of low self-worth often mean that depressed people do not feel worthy of their doctor's time and this, combined, with perceptions of doctor's attitudes and the limited time available in consultation contributes to a real lack of recognition and treatment of depression. Opening up to a general practitioner, especially a GP that you may not know, is not easy for many people and so the next best option is not to provide any information or limited information in the hope that a doctor can diagnose them without trudging through the difficult and shameful feelings. Other concerns might be about having the stigma of an emotional problem 'on record' and how this might impact upon such future lifestyle issues like parental fitness, custody and occupational suitability. Indeed the example of a severely depressed woman who was told by a social worker that, as a result of her 'resorting' to prescription drugs, she was vulnerable to having her child taken from her if the child experienced problems, highlights a not uncommon source of concern.⁷² Many patients simply want someone to acknowledge that they are struggling and this should be the least a patient can expect from a visit to a health professional.

Of course stigma is not the only reason that people keep their depression to themselves and fail to tell their general practitioner or family members. Some people are simply unaware that they are suffering from depression and it has been suggested that up to 50% of the untreated depressed did not perceive themselves to have a mental health problem.⁷¹ Then again, many people do not consider depression or the subjective symptoms of depression to constitute a mental health problem with such symptoms as poor sleep patterns, lack of energy and low mood being perceived outside of the domain of mental health.

Concluding Remarks

The Royal College of Psychiatrists in the UK has launched a five-year campaign to reduce stigmatization for people with mental health problems and it has centered around such concepts as open communication, community awareness, education and protection against discrimination. This Defeat Depression Campaign has registered a small but positive change in certain attitudes such as the effectiveness of antidepressants. However, the need for such initiatives continues, especially within a primary care context.

The stigma felt by many with depression is understandable because the consequences of their illness are often minimized or personal blame attached to their actions and behaviour. The public should continue to be informed, perhaps through adverts and programmes in the media and in health care environments, that depression is an illness and that the support system of family and friends, whilst absolutely crucial, is often not enough. Medical treatment is appropriate and necessary in many cases. If a person has little knowledge of depression then they may feel that natural remedies or lifestyle change are the only cures. Taking medication for a prolonged period can make people feel pathetic and weak but such perceptions need to be challenged. A focus on depression as an illness will help us to achieve this. A reformulation of drug use in the context of other chronic conditions like epilepsy and diabetes could help many people to appreciate that it is in the best interests of some patients to undertake lengthy and perhaps even permanent medication for their illness.

Not all antidepressant medications work for everyone and psychological therapies have been shown to benefit many sufferers. Finding the right treatment for the individual is important but breaking down the stigma associated with these treatments is fundamental to any approach to instituting and prolonging recovery. Following agreement to take antidepressant medication, there are a number of factors that can act as barriers to adherence to this treatment and these include the nature of the disease itself; the associated problems with memory, hopelessness and concentration. The stigma related to concepts of the depressed individual as morally weak or flawed, or a general unawareness of the importance of consistently taking the medication could also contribute and should be addressed in any future initiatives to destigmatize the condition.

In recent years, a group of self-help books on depression have emerged. Some of these texts are more helpful than others but the great majority fall foul of the major financial conflict involved in successfully marketing any book on a medical illness. That is, the promise that the book in question will somehow bring about improvement in the sufferers' condition or effect a cure based on a given set of principles contained within the book. The certitude of the language contained in many of these self-help books can support feelings of failure in participants who are unable to achieve the promised or implied successes that should automatically result from following the tenets. Such promises as 'restoration is available to anyone who embarks upon tackling depression through the suggestions in this book'⁷² do not leave much sympathy for those who do not find restitution after following

the miracle suggestions. Does this mean the illness is their fault? Do they not want to get better? Do they actually have depression in the first place? When the text in question contains a foreword by the head of SANE, the prominent UK mental health charity, there seems to be little room to disagree with the validity of its conclusions and recommendations. This is one example but there are many others on the market and their promises of immediate restitution should be taken with a king-sized spoonful of salt. Depression can be a particularly idiosyncratic illness experience with different people experiencing different symptoms at different times and with varying magnitude. Since the waiting list for counseling can be long and since there can be such mistrust of antidepressant medications, many resort to these texts that may end up exacerbating the distress associated with the illness.

One other problem that afflicts the community of people suffering from depression, and the way that they are represented, is the disenfranchisement that comes from being afflicted by a disease that can make sufferers so hopeless and helpless. The depressed have little political say due to the restrictions of their disease. You cannot vote if you are not able to leave your house and you will not vote if you do not care whether you wake up or not. This basic principle means that generating a political lobbying effort for depression is more difficult than it is for other illnesses, since many who are suffering the most severe ravages of the condition are unable to contribute to a source of political momentum.

Generally speaking, a focus on depression has always tended to be a focus on the well-being of individual people suffering from depression from a psychological and/or biological perspective. This approach towards depression has the individual as the level of analysis for research and treatment. However, people with depression and their families and friends exist in a society and I have already discussed how important this society can be with regard to the stigma surrounding the illness. The relationships between the political, economic and structural events in society that play a role in the epidemiology of the illness are rarely discussed. However, the well-being and mental and physical health of those who live in society are intimately related to the political, social and economic events that influence what it means to exist within that society. Such a macroscopic perspective tends to be less prominent than the microscopic perspective that focuses on the biology and psychology of the problems that people struggle to cope with in their everyday lives.

Exactly how does modern living in the west relate to the psychological problems and biological predispositions that people exhibit? Before addressing this question in Chapter 5, the next two chapters focus on some of the prominent political, economic and social changes in the post-war era. In the recent era of globalization, such structural changes have had profound consequences for people who struggle with depression on a day to day basis.

