Book

Psychiatry without context: turning sadness into disease

There are many things in life to make one feel sad. Losses abound. Relationships go to pieces. People get sacked from a decent job. Careers fail. Aesthetic or moral projects are checked. Families fall down the class and status ladder. A myriad of disappointments can demoralise and defeat any of us. And, as we age, we sense death coming.

Researchers and clinicians (even the general public) have come to use the euphemism "stress" to stand for the routine and extraordinary dangers that each of us experience. These run from financial crisis to health catastrophes; from serious accidents to disabling chronic disorders; and, especially among the truly poor, from incidental to structural violence. In most societies the popular culture's wisdom makes the point that life is difficult, uncertain, and only poorly predicted or controlled. That folk wisdom increasingly flies in the face of hyped claims by experts that we know enough about life to manage "risk". The actual experiences of people (including the experts) in the real world belie this utopian distortion of our existential condition: what the great American philosopher-psychologist-physician William James called "genuine reality".

Allan Horwitz and Jerome Wakefield's important book, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*, is part of a gathering blowback against the pathologisation and medicalisation of the ordinary human condition of sadness after loss. More specifically, these senior social scientists, whose research careers have been devoted to studying mental illness and psychiatry, respond to the inflated claims (and findings) of psychiatric epidemiologists that we are living through an epidemic of depressive disorder. Although they do not underestimate the social forces driving the political economy of pharmaceuticals and the global cultural changes that underpin the overconsumption of these substances, Horwitz and Wakefield choose to focus on professional diagnosis as the main culprit.

Their argument runs like this. For thousands of years of recorded medical history, it is well documented that physicians understood that symptoms

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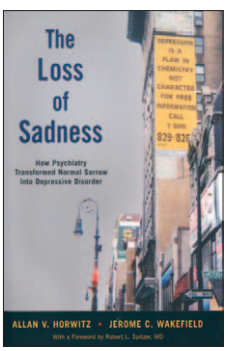
cannot be interpreted outside of the actual context of the patient's life. No master clinician, in the past, would confuse depressive disorder with normal grief, unless the symptoms of grief lasted such a disproportionately long time and were dangerously dysfunctional to the patient and his or her world as to indicate pathology. Horwitz and Wakefield suggest that the same professional common sense informed the diagnostic systems from Hippocrates and Galen to pre-1980 medicine in the West for other losses from jobs and status to lovers.

Then came the cultural revolution of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III*, 1980). To improve clinical reliability, *DSM-III* simply added up symptoms. With the exception of bereavement—which the latest version (*DSM-IV*) grudgingly regards as normally lasting 2 months—*DSM-III* recognised no contextual events, besides other diseases, that might qualify the depressive syndrome as a normal response to serious life events. A modern Romeo might experience sadness after the break-up of a consuming love affair and would have several weeks or a month of sadness, sleeplessness, exhaustion, difficulty concentrating on his work, agitation, and lack of interest in eating and other previously valued things. In the *DSM-III*, the symptom count would easily make the cut off for depressive disorder, never mind the obvious social source of the problem or even the fact that, left to his own devices, our young man might no longer experience symptoms as he got over his loss and found a new love.

So far so good. Most of us doubtless do not want to see sadness transformed into clinical depression. And for good reason. Treating normal sadness has not been shown to be effective, may expose the non-disordered person to serious side-effects, may interfere with cultural and personal meaning-making that is a natural part of being human, and almost certainly will divert resources away from the care of those who are seriously disordered.

Had the authors stopped at this point, they would have been on firm ground and the book would have been much shorter. But Horwitz and Wakefield are not satisfied with writing a powerful critique of the mainstream psychiatric diagnostic programme; they have an alternative programme of their own to advance. They assert that what amounts to most of human travail in the face of loss can be understood as a specific instance of a putative human evolutionary biology of loss. Sadness, they repeat, has an adaptive function—albeit neither they nor anyone else knows for sure what that might be. Thus, all sadness that is the result of troubling life events is normal, if that syndrome of sadness is proportionate in quality, does not last too long, and does not produce dysfunction. How they (or we) are to recognise what is proportionate, not too long, or a dysfunction seems to be based on even thinner evidence than the claims of the ever-expansive



The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder
Allan V Horwitz, Jerome C Wakefield. Oxford University Press, 2007. Pp 287. US$29·95, £17·99. ISBN 0-19-531304-8.

psychiatric epidemiologists whom they so effectively critique. The data on this allegedly universal biology of loss are simply not there. We do not have the cross-cultural evidence to define the characteristics of normal bereavement, let alone sadness in response to other kinds of loss. Recent research on bereavement among Americans finds strong evidence that yearning is as powerful an affective response as sadness. Does yearning carry with it its own, distinctive biology? How does the biology of anxiety or anger interact with that of sadness? Does anyone really know what the range of duration of normal sadness is among the 90% of the world's population that lives outside EuroAmerica? Is replacing the medicalisation of depression with the biologisation of sadness a useful trade-off? After all, if the various loss responses are due to a universal process of human evolutionary biology, why wouldn't that process, once known of course, become a new target for pharmacological modification? And what a target that would be! None of us would escape treatment and prevention efforts. Sadly, Horwitz and Wakefield close one door in a powerful critique of medicalising depression, only to open a new door that turns all of sadness and much of life into a potentially modifiable target for the brave new world of human evolutionary biology.

Georges Canguilhem, the influential 20th-century French historian and philosopher of medicine, showed that the relation between pathology and normality was an abiding theme crucial to medicine. This was so not only because history altered categories, including the line between the normal and the abnormal, but also experiences: context and reaction. Norms, for Canguilhem, and for many of his followers in medical anthropology and history, infold into the body creating normality; the body itself is both universal biological processes and culturally particular local biology.

Horwitz and Wakefield do not have much to say about these issues, which if seriously considered would demand qualification and criticism of their evolutionary project. But what they do accomplish in critiquing psychiatric diagnosis of depression is important enough to make much of this book required reading for depression researchers and clinicians.

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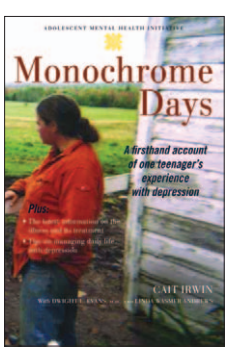

Monochrome Days: A First-Hand Account of One Teenager's Experience With Depression
Cait Irwin, Dwight L Evans, Linda Wasmer Andrews.
Oxford University Press, 2007.
Pp 184. US$9·95.
ISBN 0-195-31005-5.

For *The Lancet*'s adolescent health series see *Lancet* 2007; **369:** 1057–58.

In brief

Book Teen depression

What's the major health issue affecting young people today? The answer's simple. Indeed, the story was broken in *The Lancet*'s recent series on adolescent health: depression and a raft of related mental and substance use disorders. In developed countries, the greatly improved physical health of adolescents and young adults has allowed the spotlight to fall squarely on mental health issues. *Monochrome Days* tackles this issue weaving together a blend of personal experience, key facts about depression and its management, and self-help tips and guidelines.

Despite the fact that up to a quarter of young people will have clinically significant depressive symptoms at some point during the transition to adulthood, and many others will develop other mental or substance use disorders, there is much ignorance and misinformation about how these problems develop and how they can be helped. Mental health literacy, a concept developed by Australian researcher, Anthony Jorm, is central. We now know that levels of knowledge and competence among young people and their families about depression are quite poor, but can be improved through various strategies. Books like *Monochrome Days* are part of the process, but recent evidence suggests that electronic media and internet-based strategies are likely to be more potent with young people themselves—for example, the Australian *Reachout!* website (http://www.reachout.com.au). Penetrating youth culture, educational settings, and workplaces directly and via various media is the way to go.

Importantly, this book is part of a broader US initiative to target adolescent mental health, and is based on the real life experience of depression of Cait Irwin, a young woman who successfully overcame the illness. The book is clear and accessible, and woven around Cait's story are facts about depression and its treatment. Although most of this information is useful and contains much wisdom, the tone has a culture-bound feel to it, embedded as it is in middle America.

A key issue that *Monochrome Days* fails to highlight is the degree of difficulty in seeking help and gaining access to skilled mental health professionals. Little mention of the ubiquitous blind alleys, wrong turns, false starts, and lame therapists. It is quite extraordinary, given the public-health importance of unrecognised and untreated mental and substance use disorders among young people, how low on the health-priority list these feature and how embryonic are mental health literacy strategies for adolescents. A move to polychrome is overdue.

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